

PD KAA 307

INTFRIM REPORT

RURAL HEALTH AIDES PROJECT

February 17, 1978

EL SALVADOR

**RECORD COPY**

## INTRODUCTION

The proposed Rural Health Services Delivery Project is designed to provide technical assistance and support to the GOES Ministry of Health in the further development and institutionalization of its Rural Health Aide (RHA) activity. The Rural Health aide is the primary component of the GOES's Rural Penetration Program developed in 1976 to improve health care available to the rural populace, the major components of which are training and support of nurse practitioners, indigenous midwives, and outreach health workers. The Aide project is the first part of a three phase USAID strategy to support the GOES Rural Penetration Program. The longer-term objective of the strategy is the integration of all facets of the national health system for the delivery of rural health services.

The initial phase of the RHA activity, which will be further developed under this project, has thus far succeeded in demonstrating the acceptability to the community of a para-professional rural health worker trained to provide primary health, nutrition, and family planning services while promoting sound health practices and hygiene. An extensive evaluation of the activity was carried out by the MOH in January 1977, the results of which have been used to modify various aspects of the activity including training methods and curriculum content. The proposed project is designed to allow the GOES to address additional components which are required if the activity is to serve as the intended catalyst in development of an effective integrated rural health system in El Salvador.

If the work of the rural health aide is to have a significant impact,

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changes will be required in those institutional elements of the national health system which supports the RHA. Recognizing the need for such changes, the Mission and the GOES will develop, within the next several months, an FY 1979 grant-funded Rural Health Improvement Project. This project, which will constitute the second phase of the overall USAID rural health sector program, will be designed to support GOES efforts to upgrade MOH capabilities in management and planning, rural health training, and logistics and communications systems in support of rural health delivery services.

Although the first two phases of the proposed program focus on the principal problems in developing an effective rural health delivery system, a major change in the health status of the rural populace is dependent on provision of safe water, sanitary facilities and vector control. The proposed third phase of the strategy, which has yet to be negotiated with the GOES, is the development of an FY 1980 AID loan-supported program to improve these other services and address continuing administrative and support needs of the rural health delivery system. The grant funded projects, which make-up the first two phases of the overall program, will develop the institutional framework critical for successful implementation of this final phase.

The RHA activity was initially developed as a result of a very strong commitment by the GOES to implement its official population policy (one of the most progressive in Latin America). In 1976 the GOES decided to establish a permanent corps of para-professionals to extend population related services to the most remote rural areas of the country. Although

this corps of para-professionals was initially conceived as a cost-effective vehicle for the promotion of population-related activities and delivery of appropriate family planning services, the concept was soon broadened into that of a rural health aide who would have responsibility for providing primary health care, family planning services and nutrition information. Capitalizing on the commitment of the GOES in the population area, the Mission was able to support initiatives within the Ministry of Health to confront certain pockets of traditional opposition, both within the public and private sectors, to the development of a corps of para-professional health workers.

In order to respond quickly and to take advantage of the special situation existing in El Salvador at the time, initial AID assistance in support of the GOES/RHA activity was provided under the Mission's ongoing Population and Family Planning Project. Once the feasibility of the activity had been demonstrated on a limited scale and the catalytic potential of the activity realized, it became essential, for the further development and institutionalization of the concept, to establish a discrete project, separate and distinct from that of population and family planning. This new project, as described in this Interim Report, is designed to focus greater attention on the activity as an important first step in the development of an effective integrated rural health delivery system.

In response to the questions raised by the DAEC in STATE 301734 the Mission submits the following Interim Report:

1. "Subject project was reviewed by the DAEC on November 8, 1976. The project will require an interim report to be submitted after

the Health Sector Assessment is completed and prior to commencing intensive review for development of the PP. The interim report should provide the rationale of a revised description of the project. The following specific recommendations on conclusions of the DAEC should be addressed in the interim report.

2. Project Purpose. Although the purpose of the project is stated in terms of designing and testing a rural delivery system, the PRP did not specify what was being designed and tested. It was not clear whether the PRP proposed a prototype, a test of coverage and cost of the proposed delivery system in comparison to the existing system, a demonstration, a series of experiments to test various interventions using the rural delivery system, or simply a training program. The DAEC requested that the purpose and rationale for the project be reviewed and clarified to determine exactly what the project is to do.

In discussion subsequent to the DAEC, it became clearer that the Mission may be thinking in terms of an initial effort to establish a Rural Health Delivery System that can subsequently be replicated nationwide. Such an effort would call for developing the appropriate subsystems or components of the delivery system (e.g., selection and training of RHA's improvement of management, supply and information systems, etc. to the point where the MOH will be able to expand them on a national level). One possible project purpose would then be the establishment of a prototype rural health delivery system for national replication. The project would design, install, and evaluate the various subsystems or components of the delivery system. The final project purpose will, of course, depend on GOES and Mission analyses and discussions."

The initial GOES effort in the development of a corps of para-professional rural health workers was a pilot activity conceived to address the problems of long standing opposition to the concept, and to determine its operational and technical feasibility on a limited scale. The initial design and testing phase of the project was carried out with Title X funding under Project 149 as the key out-reach element in the GOES Family Planning Program to date. Initially, 40 RHA's were selected from three regions, trained locally in a six-week "competency-based training" program, and then assigned back to their communities. The group began work in September 1976. In early 1977 an extensive evaluation was designed and conducted by the MOH. The evaluation served as the basis for adjustment

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of the training and administrative elements of the RHA program. A second group of aides began work in mid-November, after completing a revised and lengthened course of ten weeks.

The MOH evaluation indicated that the trial activity, although somewhat limited in magnitude, was rather successful, and that the activity was ready to be expanded in order to develop further those operational and technical capabilities that would be required to support a much larger scale activity. The proposed project is designed to continue assisting the MOH in its effort to expand the RHA activity into a multi-faceted, viable nation-wide service of sufficient magnitude to have a significant impact upon the health status of the rural poor. During this expansion phase, it is planned that the MOH will establish a management information/evaluation system that permits: (1) the measurement of both the quantitative and qualitative effects of the work of the aides; and (2) provision of feed-back necessary for effective program management. The system is expected to provide data that can be used in re-orienting the existing health delivery services, family planning, nutrition and primary health promotion and related services. This data will help to shape the content of the projected FY 1979 grant project and the FY 1980 loan. The Ministry will also continue to experiment with other project components including but not limited to supervisory ratios and training methodologies.

Specifically, proposed AID financing will provide technical assistance and operational support to the MOH for the training and placement of 410 additional RHA's, and for technical assistance in the design and implementation of the management information/evaluation component which is

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essential if the RHA activity is to function as a viable part of an integrated rural health delivery system.

The overall GOES plan is to train groups of increasing size according to the schedule in ANNEX A until the target of 1550 RHA's is reached in 1982. This schedule permits the MOH systematically to develop its financial, administrative and technical capabilities to provide the resources necessary to train, deploy, and support an effective corps of para-professional health workers as one part of a larger scale GOES effort to expand and improve health coverage in the rural areas.

The RHA activity will have a favorable impact upon the health status of the rural poor by providing; (1) preventive care in the form of information and education on health, nutrition and family planning, and (2) basic curative activities, including identification of high risk cases for referral to local health facilities.

The Health Sector Assessment has been completed. The USAID is presently developing program recommendations and strategies prior to submitting the assessment to Washington. Data and conclusions generated by the assessment completely support the priority given to the expansion of rural health personnel as a first step to improving rural health care.

3. "Variation of the Size of Project. The DAEC questioned the level of effort and amount of funding for a "Design and Test" project specifically the necessity of training 500 Rural Health Aides (380 under this project and 120 initial RHA's). However, it was recognized that in order to establish the feasibility of the prototype subsystems, a minimum number of trained personnel may be necessary, to serve, both as a convincing demonstration, and to overcome initial MOH resistance. The Mission should justify fully in the interim report the size of the project, including number of Aides to be trained. It is also suggested that an evaluation be carried out on the 120 RHA's that will be placed

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in the field by mid 1977. The results of this evaluation should be included in the PP."

As described in the introduction, this project is designed to support the GOES in further development and institutionalization of the RHA activity. USAID has supported the RHA activity as the catalyst needed to stimulate changes in operation of the existing national health system so that it can have a major impact on the health status of the rural poor. The activity can serve this function, however, only if sufficient numbers of aides are trained and deployed to form a critical mass which can influence the health system by bringing about changes in the attitudes and practices of both the client population and health personnel. USAID in consultation with the Ministry has determined that approximately two years will be required to develop this critical mass and its basic support elements to the extent that it can have significant effect on the health system. At the end of this period approximately 600 RHA's (200 during the trial phase supported with Population funds and 410 projected under the proposed project) will have been trained and deployed.

As mentioned earlier a very extensive evaluation of the training and initial work experience of the first group of RHA's was conducted in January 1977 by a multidisciplinary committee of the MOH. As requested by the DAEC, the evaluation will be described in detail in the PP. In general terms, however, the evaluation cited the following problems;

- (1) Poor RHA relationships with clinic personnel which affected the level of referrals, and
- (2) lack of clearly defined administrative responsibilities for the program which affected adequacy of supervision, logistic support, and training.

The evaluation included specific recommendations for the resolution of the above problems, and action was taken on them prior to the commencement of the training programs for the second group of RHA's. One of the key actions was the preparation of a revised description of administrative and supervisory responsibilities. In addition, a one-week course in the techniques of supervision was established and made a requirement for supervisors prior to the beginning of the following RHA training program. The same personnel then participated throughout the training exercise serving as supervisors of field training sessions. The evaluation also noted that RHA's had sufficient capability to provide promotional services, but that addition of "minimal curative" functions was required to augment the program's credibility. In partial response to these findings, the MOH decided to increase the curative functions of the RHA's by adding injections to the aides' skills.

4. "Replication. The interim report should address how the MOH proposes to finance the replication of this project particularly if it is a prototype on a national basis. What will be the expected costs and sources of financing (National Budget, other Donors, etc)? Are other donors interested in the program, or is an AID health loan expected to help finance replications costs?"

The total cost for the first three years of this activity is estimated at \$2.9 million, of which AID will contribute \$652,000 (22%). The proposed project financial plan requires the Ministry to absorb project costs on an incremental basis until January 1980 when the MOH will assume full funding responsibility of the activity (See Annex B). It is expected that at the time AID's funding expires under this project, the MOH will have trained and budgeted for 410 Rural Health Aides and will continue to expand with external assistance the project with

additional trained RHA's until the MOH target of 1,550 is reached in 1982.

It is, however, more realistic to assume that the MOH will need to seek additional external financial assistance for achievement of long-term program objectives. Determination of this need and its impact on the proposed FY 1980 loan will be further explored during the development of the PP for this project. Within this context, it should be noted that other donor interest in rural health delivery services, especially in the RHA activity, has been minimal except for UNFPA assistance for the partial funding of salaries for mobile health team medical staffs. The Mission understands, however, that Great Britain is expected to approve a request by the MOH to provide support for the construction and staffing of four regional health training centers. Further details on this proposal will be included in the PP.

5. "Community Involvement. As presented in the PRP, the approach to addressing community health problems once the local RHA is selected, is a MOH imposed, or top-down strategy. The DAEC suggested that the local communities should become more involved in determining local health priorities, and resolving their own health problems. The interim report should explore the possibility of establishing a more community-level approach, through the organization of health committees in the selected communities, which would provide guidance to the RHA on community priorities, and also carry out small health projects (water, latrines, nutrition education, etc.) which address community problems. The PP should consider the possibility of involving the UNION COMUNAL SALVADORENA (UCS) in the organization of health committees, and establishing ad hoc committees in non UCS communities. Other Central American rural health programs have included community health committees with good results."

Although it is true that priorities of rural health aide activities are at present determined by the Ministry of Health, these reflect community concerns and needs ascertained from community consultations that take

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place in both the selection and evaluation stages of the activity. After training, candidates are returned to communities from which they were selected on the basis of a process that includes discussions with community leaders. Community residents were also consulted in the formal evaluation done in January regarding the work of the Aide and their ideas of what the Aide's priorities should be.

As a result of efforts to be made during the period of this project, the liaison role of the Aide from the community to the MOH will be strengthened as the management information system is implemented. Under this system information provided by the Aide from his or her home visits and involvement in other community development activities will be forwarded to the Ministry, and analysis and commentary returned to the Aides to improve the focus of their work.

This information will also assist the Ministry in focusing training of Aide candidates to meet needs of the varying regions of the country. The Aides themselves receive basic training in community development and are expected to serve increasingly as stimuli for development of community consensus regarding needs in health as they gain experience.

In support of increased community involvement, the Ministry has cooperated with the Unión Comunal Salvadoreña in placement of aides in 18 villages in which the UCS is active, and the MOH plans to continue to deploy Aides in response to requests from communal organizations for Aides.

6. "Reorganization. The PRP states that the establishment of a rural health delivery system on a national basis will require a reorganization of the rural fixed service facilities. The DAEC was not sure whether this project would investigate the

nature of this reorganization and the manner in which it would be implemented on a national basis, or whether this reorganization should indeed take place, at least in the project areas, before this project begins. The Interim Report should discuss the nature of the reorganization problem and how this project will address it."

As described earlier, the RHA project is the first part of a proposed three phase approach to improve and expand rural health coverage in El Salvador. The project is designed to continue assistance to the MOH in its effort to further develop and expand a nation-wide corps of para-professional health workers. This project will not address reorganization of rural fixed service facilities. The proposed FY 1979 Rural Health Improvement grant will address some management/administrative problems and will result in some reorganization of delivery of service to rural areas. The project's primary objective is to develop the RHA as the main element in the creation of an effective integrated rural health delivery system, and as such, will only address certain support elements which directly impact on the effectiveness of the RHA. The second part of the proposed program, a Rural Health Improvement Project, will be designed to address those problems relating to upgrading capabilities in management and planning, training, logistics and communications in support of rural health service delivery. The Mission strategy which parallels that of the GOES, is first to create a demand, and then to assist the MOH in developing or improving the mechanism with which to respond. It is also of sufficient importance to note again that the management information/evaluation system to be established under this project is designed to provide specific information to the Ministry so that it can make required changes in the organization and administration

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of fixed facilities and other supporting components of the existing health system.

Although the proposed project is expected to encourage additional reorganization changes by the MOH, the main thrust in this area, will not take place until the second phase of the USAID strategy with implementation of the proposed 1979 Rural Health Improvement Project.

Nonetheless, there have been changes of a organizational nature as a result of initial RHA activities. To strengthen supervisory support of the aides, the supervisor to aide ratio has been increased with the assignment of one supervisor to each ten aides. Supervisors are required to visit aides twice monthly. The Ministry has also reassigned the supervisors, from the Ministry's Central Malaria Division, to the Regional Offices, thereby improving technical and administrative coordination of the program. Another new MOH initiative in support of increased referrals made by RHA's will commence in July 1978. As of that date, mobile health teams which will include a physician and a nurse practitioner, will increase visits to each health post from the present two visits per week to a minimum of three visits per week. It is expected that the mobile teams will strengthen the RHA activities by providing a more frequent technical referral point.

7. "PHA/POP Participation. Less AID funds are presently budgeted (200,000 dollars) for this project in FY 78 than have been requested in the PRP (411,000 dollars). One alternative to increased funding is to utilize Title X money. PHA/POP would consider participating in this activity if the present Salvadorean requirements for pelvic examinations and pill prescriptions were relaxed, or if a demonstration were included which would serve as a basis for a decision to include or eliminate these requirements from a subsequent national program. In developing the PP, the Mission should take into consideration the potential shortfall in AID funding and PHA/POP's

willingness to consider financing a portion of this project provided that one or both of the above conditions are met and funds are available."

To focus attention and produce the necessary level of support from the GOES, the USAID is of the opinion that activities that fall within the health sector of El Salvador must be removed from the protective covering of the population program (an area of great GOES interest) and made to stand on their own merits.

The USAID also believes that there are now more effective ways to utilize Title X money to meet the legislative requirements than projects such as the proposed RHA activity. To assure continuity of the ongoing RHA activity, and in the absence of an approved RHA project, however, the Mission will have to continue providing assistance during FY 1978 as in the past, under its Family Planning and Population Project. Once the proposed project is approved, as part of an overall program to improve rural health delivery services, no additional requirement for Title X funds is contemplated. The USAID has already had discussions with MOH regarding AID funding probabilities, and the final design will not require a contribution in excess of our presently approved budget levels.

The above does not imply, however, that the RHA activity will not address population matters. The Mission's population strategy emphasizes consideration of population related problems in all of its proposed projects and to the extent feasible, in those that are on-going. The RHA activity is one such example. Following an initial pilot program in which indigenous midwives will be trained to dispense oral contraceptives without prescriptions in January 1979, the MOH will begin a similar program with RHA's. The program will be designed specifically to provide

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data on the effectiveness of such screening. On the basis of that experience, it is expected that the present requirement of a prescription/pelvic examination will be removed by the Ministry.

8. "Economic analysis. The DAEC questioned the appropriateness of the cost-benefit analysis used in the PRP. The benefits of Health interventions such as those proposed in this project can be assumed (given MOH and community agreement that these are priority concerns). Therefore, the Economic/Financial Analysis should more appropriately center around determining the cost-effective method of delivering these interventions to the target group. In addition, the rationale for not charging a fee for the medical services provided under this program should be analyzed in light of the limited MOH budget and the ability of clients to presently pay for similar Health services. The Mission should address these concerns in the Interim Report. AID/W assistance can be provided to the Mission if required."

Rural health services are front line services provided at the least complex level of entry into the health care system. The cost of such services are determined by the availability of appropriately trained personnel and the capacity and efficiency of the operating system to produce the service. In El Salvador, prior to the RHA activity, there were three types of health workers who could possibly serve in a front-line rural position due to their knowledge and related expertise both in curative and preventive functions. They are auxiliary nurses, graduate nurses, and doctors. The following chart is a rough cost comparison between the preparation of these personnel and RHA's by numbers per year, length of training, costs per student and entry level salaries per month.

EXISTING PERSONNEL				
Type	Graduates per year	Length of Training	Cost per Student	Entry Level Salary/Month
Aux. Nurse	92	11 months	c 1.025 (11 months)	c325.00
Grad. Nurse	153	3 years 1 year rural field placement	c 6.000 (3 years)	c440.00
Doctor		7 years 1 year rural field placement		2 hrs/day c800./month

NEW PERSONNEL				
Type	Graduates per year	Length of Training	Cost per Student	Entry Level Salary/Month
RHA		10 weeks	¢800	¢152.00

Given the lower costs of preparation of RHA's and the scarcity of primary care personnel, as well as the key problem of concentration of trained personnel in the urban areas, the most appropriate cost-effective course of action is to provide an indigenous worker who is socially, culturally, intellectually and financially part of the client group. The cost of training and placing a multi-purpose worker such as the RHA is substantially lower than that of training a single purpose worker, nurse, doctor, or other curative-technology oriented professional. Moreover, it is generally accepted that the least expensive and most cost beneficial measures are applied at the level closest to the client population (i.e., in the community as opposed to a municipality or twice removed urban hospital). The home visit can be made cost-effective by expanding the number of promotional and curative activities provided by one person (polyvalent). For example, present data show, that RHA's provide on the average of 2.5 combined promotional and curative activities per visit and this average is expected to grow as the program further develops.

The RHA program could be made even more cost-effective by charging a fee for medical services, and information on the utilization of the informal health system does imply an ability of some clients presently to pay for similar health services. Eventually a charge for RHA provided medical services should be introduced. In light of the initial "promotional nature" of the RHA activity to attract the rural population to better health practices and services, and the difficulty it faces in

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changing traditional attitudes and practices, it is the GOES' judgment, and the Mission concurs, that it would be counter-productive at this time to charge a fee for home visits. Standard fees are charged, however, for clinic visits by RHA referred persons.

9. "Competitive Health Systems. The RHA's will be competing with informal Health Personnel (e.g., Curandero, Injeccionista). We assume that one of the elements to be addressed in the prototype is how this informal system will be integrated into the National Rural Delivery System, and how potential resistance of these informal health personnel to the program will effect replication. The Mission and the MOH should also analyze the degree to which doctors will resist this RHA-based system and how the MOH plans to deal with this situation."

An anthropological study completed in El Salvador in May of 1976\* states that the rural population studied demonstrated a greater reliance on modern technological medicine than was heretofore believed, and that a pattern exists of dual utilization of both the formal and informal health systems.

The January 1977 MOH evaluation also shows that although the RHA's serve the same rural population as do curanderos and injeccionistas, there is recognition that the RHA's provide different services. There is no organized resistance to the RHA's by the traditional providers and it is not expected that expansion of the system will be affected by the existence of such groups. The PP will explore the preliminary plan of the Ministry to recruit some RHA's from the traditional providers.

To date, resistance by physicians to the Rural Health Aides has been minimal and has been part of a general resistance to the provision of "medical" services by any personnel other than physicians. This resistance is being overcome as the program expands and physicians are

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\* Polly Fortier Harrison, March-May 1976.

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consulted and involved in the planning of training and utilization of the Aides.

10. "Project Funding. It is recognized that some financing of operating costs may be necessary in the initial stages because of the demonstration nature of this program. However, the Mission should attempt to minimize the amount of operating costs which AID will finance. If such financing is proposed, AID's portion should be phased down with the GOES gradually increasing its portion so that it picks up the full amount by the end of the project."

As indicated in Annexes A and B, the MOH will gradually increase its budgetary resources to absorb on an incremental basis the operating costs of the project until full absorption is achieved as of January 1, 1980. As discussed above the GOES will probably seek loan assistance to support the program through 1982. The absorption plan detailed in Annex B is designed to coincide with the GOES Fiscal Year which begins on January 1. In addition, Annex C further details the projects phasing, cost components and responsibilities.

Funding to be provided under the proposed project includes training costs, salaries, technical assistance and supplies. Specifically \$293,356 is budgeted to cover subsistence costs for 410 Rural Health Aides and their 41 supervisors during their training periods and for Aides and supervisors during a two week period of refresher training. According to the pattern established under the Population and Family Planning Project for this activity, salaries for each group of aides and their supervisors are to be picked up by the GOES at the beginning of the calendar year following their training, and until that time are to be funded by the Project. A total of \$55,000 of the budget is allotted for technical assistance and data processing for design and implementation

of an management information/evaluation system.

11. "Social feasibility of the proposed system. The interim report should address the social and cultural constraints that made the existing health system ineffective, and explain how the proposed RHA system will overcome these constraints. In addition, the Interim Report should establish the feasibility of the assumption that the communities will accept the RHA as a valid source of health service."

In a social anthropological study conducted in El Salvador,<sup>1/</sup> sex differential utilization of clinics showed that while men were more favorably disposed toward the clinics (especially for curative services and consultations), women in general were less satisfied with available services manifesting their displeasure through high drop out rates and non-compliance with control appointment. The reasons for female dissatisfaction are: 1) discomfiture about pregnancy and childbirth; 2) concern for modesty in the gynecological exam, 3) lack of knowledge, about and concern for physical discomfort; and 4) inadequate awareness or commitment about the necessity for such services.

The reluctance of rural Salvadorans to seek modern medical help due to the barriers described above is strengthened by the fact that clinics are often not easily accessible and have inconvenient hours, especially for men, and increasing cash outlays for transportation costs. Waiting periods are extensive. Although most patients have routine ailments which could be addressed by a nurse, they prefer to be treated by a doctor because of his presumed qualifications and status. As a result, clinics are overflowing on days when the doctor is practicing and under-utilized when he is not. The recent decision by the MOH to

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<sup>1/</sup> Polly Fortier Harrison, March-May 1976.

increase the numbers of mobile team visits (teams include both a doctor and a nurse practitioner) is designed to remedy this situation to some degree.

The RHA can relieve both the patient and institutional constraints described above largely by providing information and services regarding basic health requirements and illness related behavior, (the perceived awareness of illness, the decision to seek help and the choice of assistance). As an indigenous worker, the RHA is able to use his training to identify and correct within the same cultural system, misconceptions that occur both about illness and the health system. In addition, through outreach activities and home visits, the RHA can intervene in the earlier stages of illness or health problems making it possible to influence behavioral change. This has been demonstrated in the RHA's have reported observing changes within their villages as a result of their efforts, specially in domestic hygiene and family planning. They attributed these changes simply to the introduction of heretofore unavailable information directed specifically to the target population. Furthermore, the RHA can improve upon many of the services of a pharmacy such as accessibility, assistance in emergencies and continued individual contact. The RHA also serves as an entry point into the health system. To assure that the aide's role in this area is effective, the Ministry is providing in-service orientation courses to clinic personnel describing the work of the aide and the importance of the proper handling of referrals made to health facilities by them.

Finally, through the proposed management information and evaluation system the Ministry will gather information on the impact of the RHA

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on the client population and the health system in general thus creating an informed basis for making improvements in both the physical and social access to health services.

ANNEX A

RHA Training Schedule 1976-1979

GROUP I (40)	Training Sept-Oct 1976 <sup>1/</sup> Assignment October 1976
GROUP II (100)	Training Sept-Oct. 1977 <sup>1/</sup> Assignment November 1978
GROUP III (88)	Training March-April 1978 <sup>1/</sup> Assignment May 1978
GROUP IV (88)	Training July-Aug. 1978 <sup>2/</sup> Assignment September 1978
GROUP V. (22)	Training Oct.-Nov. 1978 <sup>2/</sup> Assignment November 1978
GROUPS VI, VII, (300)	Training 1979 <sup>2/</sup> Assignment 1979

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1/ Funded under POP/FP Project # 149 .

2/ Funded by Rural Health Aide Project.

ANNEX B

RURAL HEALTH AIDE TRAINING/ABSORPTION PLAN

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
Trained	40 (Group I) <sup>1/</sup>	100 (Group II) <sup>1/</sup>	200 (Group III) <sup>1/</sup> IV) <sup>2/</sup> V) <sup>2/</sup>	300	300 <sup>4/</sup>	300 <sup>4/</sup>	300 <sup>4/</sup>
Absorbed on GOES rolls as of Jan. 1		40 (Group I)	3/ <sup>3/</sup>	300 (Groups II, III, IV, V)	300	300	300
Cumulative Total Trained	40	140	340	640	940	1240	1550

1/ Training and initial salary costs funded under POP/FP Project.

2/ (Total of 228) Training and initial costs; to be supported by proposed RHA Project (Total 410).

3/ Due to delays in training program, Group II was not assigned to field until mid Nov. 1978, and therefore by Project Agreement it was determined that GOES would absorb the Group by Jan. 1, 1979 rather than Jan. 1, 1978.

4/ Possible source of funding for RHA support after 1979 would be part of proposed Rural Health Loan.

A N N E X C

RURAL HEALTH SVCS. DELIVERY  
519-0179

	June ~ Dec. 1978		January ~ Dec. 1979		January ~ Dec. 1980		TOTAL		PROJECT TOTAL
	AID	GOES	AID	GOES	AID	GOES	AID	GOES	
<u>Salary Costs</u>	68,040	-	225,316	215,748	-	924,352	293,356	1,140,100	1,433,456
RHA's	62,892	-	225,316	167,076	-	829,192	288,208	996,268	1,284,476
Supervisors	5,148	-	12,000	48,672	-	95,160	5,148	143,832	148,980
<u>Technical Assistance</u>	18,000	-	12,000	-	-	-	30,000	-	30,000
<u>Mgt./Adm. (in-kind)</u>	-	50,000	-	100,000	-	100,000	-	250,000	250,000
<u>Equipment</u>	5,200	-	14,000	5,200	-	33,200	19,200	38,400	57,600
<u>Mat'l &amp; Supplies</u>	35,800	-	98,00	71,600	-	267,600	133,800	339,200	473,000
<u>Training Costs</u>									
Subsistence:	35,262	-	84,672	7,200	-	90,360	119,934	97,560	217,494
RHA's	27,720	-	75,600	-	-	75,600	103,320	75,600	178,920
Refresher courses	5,652	-	-	7,200	-	7,200	5,652	14,400	20,052
Supervisors	1,890	-	9,072	-	-	7,560	10,962	7,560	18,522
Teaching	-	17,820	-	48,600	-	48,600	-	115,020	115,020
<u>Miscellaneous</u>									
Data Processing	-	-	25,000	-	-	-	25,000	-	25,000
Travel	2,000	-	3,000	-	-	-	5,000	-	5,000
<u>Inflation</u>	-	-	25,710	34,114	-	254,750	25,710	288,864	292,204
TOTAL	<u>164,302</u>	<u>67,820</u>	<u>487,698</u>	<u>482,462</u>	<u>-</u>	<u>1,718,862</u>	<u>652,000</u>	<u>2,269,144</u>	<u>2,921,154</u>

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