

PD-ABP-231  
94370

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.  
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office <u>USAID/LESOTHO</u> (ES# <u>632-88-3</u> )		B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>  </u> Q <u>  </u>		C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>	
D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
698.0421.32	Lesotho Combatting Childhood Communicable Diseases (CCCD)	84	5.31.91	973,900	973,900

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director		Name of Officer Responsible for Action	Date Action to be Completed
<p style="text-align: center;"><b>Action(s) Required</b></p> <p><u>MANAGEMENT</u></p> <p>1. Consult HSAs in advance of staff transfers and give management teams the opportunity for input into the decisions to minimize the operational disruptions from the transfer of staff.</p> <p>2. Complete the field testing and refinement of the standard supervisory checklist and install it as an operational procedure as soon as possible.</p> <p>3. Encourage the Public service Commission (PSC) to retain the people in question in the HIS unit in the interest of maintaining the flow of current data to the users on a timely basis</p> <p>4. Hire an administrative assistant to become familiar with Family Health Division (FHD) and A.I.D. procedures so that the routine and administrative work flow can continue during the absence of both the CCCD staff members</p>		<p>MOH</p> <p>MOH/FHD</p> <p>MOH</p> <p>CDC/USAID</p>	<p>January '89</p> <p>February '89</p> <p>October '88</p> <p>November '88</p>

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) (Day) (Year)

G. Approvals of Evaluation Summary And Action Decisions:

Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
	David Gittelman	N.T. Borotho	Alde G. G. G. G.	F.L. Snyder
Signature	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Date	23/10/91	27/10/91	1/11/91	1/11/91

A

**ABSTRACT**

H. Evaluation Abstract (Do not exceed the space provided)

The second biannual CCCD/Lesotho external evaluation took place in August 1988, following completion of the Project's first 4-year phase. The purpose of the Combatting Childhood Communicable Diseases Project is to assist the Ministry of Health (MOH) to reduce infant and child morbidity and mortality due to diarrhea and target immunizable diseases. The Project has helped achieve high immunization coverage rates in children, and helped reduce diarrhea admissions and deaths through promotion of oral rehydration therapy (ORT). Measles immunization coverage for children ages 12-23 months is 78% -- one of the world's best. In addition, the MOH now encourages sound diarrhea case management at ORT Units in 90% of the hospitals. The team evaluated the Project through interviews at the central, health service area (HSA), health center and community levels.

Overall, the evaluation team found the CCCD Project well-managed, and admired the dedication of health staff at all levels of service delivery. Their most important recommendations were to:

- give more attention to management skills and training;
- encourage regular internal evaluation efforts;
- establish stronger training links between all MOH units;
- upgrade CCCD topic training modules;
- develop more training materials;
- direct CCCD staff's efforts more toward field activities;
- encourage the MOH to maintain adequate staffing levels in the Health Statistics Unit;
- increase production of mass media materials to reach community leaders.

**COSTS**

**1. Evaluation Costs**

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Noel R. Marsh		21 Days		AID AFR/TR
Dr. S.S. Stolba		14 Days		AID AFR/TR
Dr. S. Foster		14 Days		CCCD
Myra Tucker		21 Days		AID
Mark La Pointe		14 Days		CCCD

2. Mission/Office Professional Staff  
Person-Days (Estimate) \_\_\_\_\_

3. Borrower/Grantee Professional  
Staff Person-Days (Estimate) \_\_\_\_\_

b

## A.I.D. EVALUATION SUMMARY - PART II

### SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)

Address the following items:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Purpose of evaluation and methodology used</li> <li>• Purpose of activity(ies) evaluated</li> <li>• Findings and conclusions (relate to questions)</li> </ul> | <ul style="list-style-type: none"> <li>• Principal recommendations</li> <li>• Lessons learned</li> </ul> |
|--|--|

Mission or Office:

Date This Summary Prepared:

Title And Date Of Full Evaluation Report:

#### PURPOSE OF EVALUATION AND METHODOLOGY USED:

In August 1988, an external evaluation team consisting of a management specialist and a training/health education specialist conducted a three-week evaluation of the Lesotho CCCD project. This exercise was conducted according to the Project Grant Agreement which requires biannual external project evaluations. The objectives were to assess the Project's management, training and health education components in particular, and to make other recommendations to improve the delivery and expansion of CCCD services. The team interviewed officials of the Ministry of Health (MOH), Private Health Association of Lesotho (PHAL), Health Service Areas (HSA's), Health Centers (HC's), and Hospitals, as well as Village Health Workers (VHW'S) and beneficiaries. The team also met with representatives of foreign donor agencies active in the areas of Technical Assistance in Lesotho.

#### PURPOSE OF ACTIVITIES EVALUATED:

The ACSI-CCCD Lesotho project assists the MOH to reduce infant and child morbidity and mortality due to diarrhea and immunizable diseases. It also supports Lesotho's Primary Health Care efforts through assistance in program management; in two technical areas, the expanded program of Immunization (EPI) and Control of Diarrheal Diseases (CDD); and through support strategies in health information systems (HIS), operational research, training and health education.

#### FINDING AND RECOMMENDATIONS:

##### MANAGEMENT

The team found the following: 1) The CCCD project is well managed. 2) Staff shortages remain a major constraint to Project implementation. 3) Supervision requires strengthening. 4) Frequent staff transfers disrupt project implementation. 5) Management skills and training needs require more attention. 6) Internal evaluation efforts should be encouraged. 7) Donor coordination efforts need strengthening. 8) Funds for operational research are not being utilized adequately.

The team's major recommendations were: 1) to give advance notice of staff transfers to minimize operational disruptions; 2) to complete the field testing of the integrated MCH/FP supervisory checklist; 3) to encourage the Public Service Commission (PSC) to retain staff in the Health Statistic Unit (HSU) to ensure updated data input; 4) to hire an Administrative Assistant to allow the CCCD Technical Officer and the Project Assistant to redirect their efforts towards field activities and management skills transfer; 5) to develop an internal evaluation schedule agreeable to both the MOH and A.I.D. for the remaining years of the project; and 6) to develop a stronger donor coordinating mechanism within the MOH.

#### TRAINING:

The evaluators found that the decentralized training program supported by the CCCD Project is a viable program that has succeeded in training an impressive cadre of central HSA and HC trainers. The CCCD program area topics are well-integrated with general training activities. The 1988/89 training plan reflects the MOH's commitment to continue offering CCCD topics and to expand training coordination between the Continuing Education Unit (C.E.U.) and other MOH units.

The team's major recommendations were: 1) to establish stronger linkages between MOH Planning, Continuing Education and Health Education Units, and with the HSA's; 2) to establish a computerized training information system; 3) to upgrade the CCCD topic modules; 4) to develop more training materials for all levels; 5) to establish uniformity in training methods; and 6) to use on-the-job training, drills, discussion groups and demonstration as techniques for teaching technical skills.

HEALTH EDUCATION/COMMUNICATIONS:

The Health Education Unit (HEU) with HEALTHCOM support has made major institutionalization efforts through staff training, equipment procurement and the development of communications strategies.

The team recommended that the HEU increase production of print and media materials to reach more community members in Lesotho, and to improve HSA access to print/audio-visual materials.

OTHER AREAS:

The team found the Health Planning Statistics Unit (HPSU) functioning well, but suggested strengthening its donor coordination mechanisms. The HPSU needs to assume a greater leadership role by calling regular meetings with all Donors involved to try to formalize the various Ad hoc coordinating sessions.

The Health Statistics Unit (HSU) has made dramatic progress attributed to the MOH's staff recruitment and organizational structure. HIS information is current for outpatient data. The evaluators hoped that some means could be found within the system to retain the trained staff of the Unit so that they can continue progress in providing timely and essential data to the MOH and other government Units.

Funds set aside for operational research have not been fully utilized. The team recommended that the MOH stimulate potential researchers by bringing the funding opportunities to their attention and providing them with a clear explanation on how to apply for these grants.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

External Evaluation Report

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The Mission is satisfied with this evaluation and its recommendations. We believe the evaluation team was unbiased, performed in a highly professional manner, and generated a concise, useful report.

Both the program management and training evaluators made significant contributions to help improve CCCD and HEALTHCOM project progress. In management, the hiring of a new administrative assistant and reorientation of CCCD staff to more field activities should substantially assist the MOH to institutionalize its EPI and CDD initiatives. The preliminary analysis of the decentralized training program set the stage for future comprehensive training evaluations planned for late 1988.

We found the training evaluation component more effective than that of program management. In three short weeks, the training evaluator established an excellent rapport with MOH officials, and produced a comprehensive program overview and generally realistic recommendations. The management evaluator, however, could have analyzed closer both the supervisory mechanisms and the integration of CCCD activities with other Primary Health Care efforts. Furthermore, CCCD can address staffing patterns or levels only informally and indirectly with the MOH. The Project cannot allocate staff - that is strictly a MOH decision. CCCD has shared this recommendation with the MOH but has not received a positive response due to severe and growing constraints on the GOL budget which will inhibit MOH's ability to provide additional manpower.

F

ANNEX A

ACTION DECISIONS

RESPONSIBLE FOR  
ACTION; COMPLETION  
DATES.

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Management

5. Reorient the duties of the CCCD technical officer and the Project assistant more towards field activities and management skills transfer tasks.

MOH/FHD, CDC;  
November 1988.

6. Develop an evaluation schedule which is agreeable to both the MOH and A.I.D. for the remaining years of the Project.

AID;  
January 1989.

7. Develop a stronger donor coordinating mechanism within the MOH by having the Health Planning Statistics Unit assume a greater leadership role in coordinating the various health-related donor supported activities.

MOH;  
November 1988.

TRAINING:

1. Establish a computerized training information system which keeps records of numbers and types of trainees, course content, and skills taught.

MOH/CEU/CCCD  
1990

2. Upgrade the CCCD's modules. "The Training Process" and "Support and Supervision" have been identified as the two priority modules in need of immediate revision.

MOH/CEU/  
CCCD  
1990

3. Develop more training materials in Lesotho to be used by HSA trainers. Materials should address adult learners' interests and experiences.

MOH/HEU/CCCD  
1990-1991

G

4. Establish standards to bring about uniformity in training methods and content. In the semi-annual workshops, HSA trainers can develop syllabi for each training course they teach. MOH/CEU/CCCD/  
UNICEF  
1990
5. Promote the use of on-the-job training, drills, discussion groups and demonstrations as techniques for teaching technical skills. MOH/CEU/CCCD  
1990
6. Develop long- and short-term training goals and objectives for the life of the Project and beyond. MOH/CEU/CCCD  
1990
7. Complete generic management training modules Behavioral objectives should be clearly identified for each required task The module should address Project-specific management/supervisory problem areas. MOH/CEU/CCCD  
1990
8. Increase the ability of the Health Education Unit MOH/HEU to reach mothers and caretakers in the community by promoting both face-to-face and media communication techniques creating more community awareness, especially through VHWs, should be viewed as a crucial goal for the next phase of the Project. MOH/HED/  
HEALTHCOM  
1990
9. Seek a closer relationship between formal training behavioral objectives and supervisory functions. MOH/CEU/CCCD/  
UNICEF  
1990
10. Evaluate training materials, teaching methods and abilities to write training plans, supervise others and master new skills on a regular basis. MOH/CEU/CCCD/  
UNICEF  
1990

LESOTHO CCCD PROJECT EVALUATION

August, 1988

External Evaluation Team:

Noel R. Marsh  
Management Specialist/Team Leader

Dr. Soheir Sukkary-Stolba  
Training Specialist

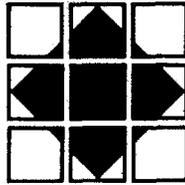
Resource Staff:

Stan Foster  
Director of Field Services, IHPO  
Myra Tucker  
CCCD Assistant Project Manager  
Mark La Pointe  
Supervisory Public Health Advisor

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116 EAST BROAD STREET  
FALLS CHURCH, VA 22046



# THE PRAGMA CORPORATION

116 EAST BROAD STREET  
FALLS CHURCH, VA 22046

Tel. 703-237-9303 • Telex 203507 PRAGMA FSCH UR  
FAX 703-237-9326

President  
**Jacques Defay**

Established 1977

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Telex: RAN HOTEL 5273 BF  
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Southeast Asia Regional Office  
Tel: 50-08-35/58-23-57  
Telex: 40084 [WFFPM]

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J

LESOTHO CCCD PROJECT EVALUATION

August, 1988

External Evaluation Team:

Noel R. Marsh, Management Specialist/Team Leader  
Dr. Soheir Sukkary-Stolba, Training Specialist

Resource Staff:

Stan Foster  
Director of Field Services, IHPO  
Myra Tucker  
CCCD Assistant Project Manager  
Mark La Pointe  
Supervisory Public Health Advisor

## ACKNOWLEDGEMENTS

The evaluation team wishes to thank the Principal Secretary, Mrs. N.T. Borotho, and her staff for their help, frankness and hospitality. The team was impressed by the dedication, motivation and enthusiasm shown by everyone at the Ministry of Health. The team especially enjoyed meeting with the nurses in charge of some of the health centers, all of whom were highly qualified to do their work, and with some of the village health workers. A special thanks goes to Dr. Mpoai Moteetee, Director of the Family Health Division, who was so generous with her time. We would also like to thank her staff for accompanying us both on visits in Maseru and in the field. They provided us with a wealth of information and insight.

We also are grateful to Mr. Jesse L. Snyder, Director of USAID/Lesotho, for his help and that of his staff. Special mention and gratitude should be expressed for the briefings, dialogue and assistance provided by Mr. David Giddleman, CDC Field Technical Officer, Dr. Stan Foster, CDC Director of Field Services, Mr. Mark La Pointe, CDC Supervisory Public Health Advisor, and Ms. Myra Tucker, CCCD Assistant Project Manager.

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LIST OF ACRONYMS

AED	Academy for Educational Development
A.I.D.	Agency for International Development
AIDS	Acquired Immuno-Deficiency Syndrome
ARHEC	African Regional Health Education Center
ARI	Acute Respiratory Infection
BCG	Bacillus Calmet Guerin
CCCD	Combatting Childhood Communicable Diseases
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases
CEU	Continuing Education Unit
DMI	District Management Improvement Project
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program of Immunizations
FHD	Family Health Division
HC	Health Clinic or Health Center
HEU	Health Education Unit
HIS	Health Information System
HPN	Health Planning and Nutrition
HSA	Health Service Area
HSU	Health Statistics Unit
IDM	District Management Improvement Project
KAP	Knowledge, Attitudes and Practices Survey
MCH/FP	Maternal and Child Health/Family Planning
MOH	Lesotho Ministry of Health
NHTC	National Health Training Center

ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHAL	Private Health Association of Lesotho
PSC	Public Service Commission
RSA	Republic of South Africa
SSS	Sugar Salt Solution
TB	Tuberculosis
TBA	Traditional Birth Attendant
USAID	Country Mission of the Agency for International Development
VHW	Village Health Worker
WHO	World Health Organization

## 1.0 EXECUTIVE SUMMARY

The main goal of the Lesotho Combatting Childhood Communicable Diseases (CCCD) Project is to reduce infant/child morbidity and mortality due to diarrhea and immunizable diseases. Through the CCCD Project, the Agency for International Development (A.I.D.) supports Lesotho Primary Health Care with assistance in program management; with two technical strategies, Expanded Program of Immunizations (EPI) and Control of Diarrheal Disease (CDD); and with four support strategies, Health Information System (HIS), operational research, training and health education.

In August 1988, an External Evaluation Team consisting of a management specialist and a training/health education specialist arrived in Maseru to conduct a three-week evaluation of the Lesotho CCCD Project. The objectives of the evaluation were to assess the Project's management and training components and to make recommendations to improve the delivery and expansion of CCCD services. The evaluation team interviewed officials of the Ministry of Health (MOH), Private Health Association of Lesotho (PHAL), Health Service Areas (HSAs), Health Centers (HCs), hospitals, Village Health Workers (VHWs) and beneficiaries. The team also met with representatives of foreign donor agencies active in the areas of technical assistance in Lesotho.

The evaluation's major findings and recommendations for both management and training are as follows:

### 1.1 Major Findings: Management

1. The Project is well-managed.
2. Staff shortages continue to represent a major constraint to the Project implementation process.
3. Supervision is an area which requires more strengthening.
4. At the HSA levels, frequent and sudden staff transfers are disruptive, and lead to loss of highly trained staff.
5. Management skills training is identified by MOH staff as an area needing more attention.
6. Internal evaluation efforts should be encouraged.
7. Donor coordination efforts need strengthening.
8. Funds set aside for operations research are not being used.
9. The HIS Unit has improved its output and needs support to continue efficient operations.

10. The Epidemiological Bulletin is excellent and is widely read among Lesotho's health professionals.

1.2 Recommendations: Management

1. Consult HSAs in advance of staff transfers and give management teams the opportunity for input into the decision to minimize the operational disruptions resulting from the transfer of staff.

Responsibility: MOH                      Date: January, 1989

2. Complete the field testing and refinement of the standard supervisory checklist and install it as an operational procedure as soon as possible.

Responsibility: MOH/FHD              Date: Complete Field Test,  
December, 1988

Install Procedures,  
February, 1989

3. Encourage the Public Service Commission (PSC) to retain the people in question in the HIS unit in the interest of maintaining the flow of current data to the users on a timely basis.

Responsibility: MOH                      Date: October, 1988

4. Hire an administrative assistant to become familiar with Family Health Division (FHD) and A.I.D. procedures so that the routine and administrative work flow can continue during the absence of either or both the other CCCD staff members.

Responsibility: Centers for Disease Control (CDC)/Atlanta  
(increase suballocation)  
USAID (approve PSC hire)  
CCCD/TO (define job)

Date: October, 1988

MOH/FHD (allocate office space)

Date: November, 1988

5. Reorient the duties of the CCCD technical officer and the Project assistant more towards field activities and management skills transfer tasks.

Responsibility: MOH/FHD              Date: November, 1988  
CDC/Atlanta

6. Develop an evaluation schedule which is agreeable to both the MOH and A.I.D. for the remaining years of the Project. Internal evaluations should be encouraged.

Responsibility: A.I.D.                      Date: January, 1989

7. Develop a stronger donor coordinating mechanism within the MOH by having the Health Statistics Unit (HSU) assume a greater leadership role in coordinating the various health-related donor supported activities.

Responsibility: MOH                              Date: November, 1988

### 1.3 Major Findings: Training

1. The decentralized training program supported by the CCCD Project is a viable program that has succeeded in training an impressive cadre of core, HSA and HC trainers.
2. The CCCD program area topics are well-integrated with training activities of other programs of the MOH.
3. Coordination efforts are not clear between the Continuing Education Unit (CEU) and trainers from the HSA, HC and the central level core. Information about who received training, in what skills, and with what frequency is not easily available.
4. HSA trainers differ greatly in their training capabilities and methods.
5. The Health Education Unit (HEU) with HEALTHCOM support has made major institutionalization efforts through staff training and equipment procurement.
6. The training modules, although very effective at the initial stages of the training program, need revision and updating.
7. The 1988/89 Training Plan reflects the MOH's commitment to continue offering CCCD topics and to expand the training base to other health workers and community members such as Traditional Birth Attendants (TBAs), chiefs and traditional healers.
8. Some HSA trainers do not involve the HC staff in needs assessment or teaching VHWS.

#### 1.4 Recommendations: Training

##### Training Program/System

1. Adopt the use of a holistic/systems approach to training. Establish a system with strong linkages between the MOH Planning, Continuing Education and Health Education Units and HSAs. Coordinate all training activities for both health personnel and community members.

Responsibility: MOH/CEU      Date: 1990

2. Establish a computerized training information system which keeps records of numbers and types of trainees, course content, and skills taught.

Responsibility: MOH/CEU      Date: 1990

##### Training Materials

1. Upgrade the CCCD's modules. "The Training Process" and "Support and Supervision" have been identified as the two priority modules in need of immediate revision.

Responsibility: MOH/CEU      Date: 1990  
CDC

2. Develop more training materials in Lesotho to be used by HSA trainers. Materials should address adult learners' interests and experiences.

Responsibility: MOH/HEU      Date: 1990-1991

3. Give careful consideration to developing new Acute Respiratory Infection (ARI) and measles strategy training modules and materials prior to expanding in these program areas.

Responsibility: MOH/CEU/HEU      Date: 1990 or whenever  
a decision is made to  
expand program areas.

##### Training Methods

1. Establish standards to bring about uniformity in training methods and content. In the semi-annual workshops, HSA trainers can develop syllabi for each training course they teach.

Responsibility: MOH/CEU      Date: 1990

2. Use on-the-job training, drills, discussion groups and demonstrations as techniques for teaching technical skills.

Responsibility: MOH/CEU                      Date: 1990

#### Training Goals and Objectives

1. Develop long- and short-term training goals and objectives for the life of the Project and beyond.

Responsibility: MOH/CEU                      Date: 1990

2. Complete generic management training modules. Behavioral objectives should be clearly identified for each required task. The module should address Project-specific management/supervisory problem areas.

Responsibility: MOH/CEU                      Date: 1990  
CDC

3. Increase the ability of the Health Education Unit to reach mothers and caretakers in the community by promoting both face-to-face and media communication techniques. Creating more community awareness, especially through VHWS, should be viewed as a crucial goal for the next phase of the Project.

Responsibility: MOH/HEU                      Date: 1990

#### Training Needs Assessment

1. Give special attention to operational and motivational program area problems in all training settings, including the Continuing Education workshops for HSA trainers.

Responsibility: MOH/CEU                      Date: 1990

#### Coordinating Training Activities

1. Seek a closer relationship between formal training behavioral objectives and supervisory functions.

Responsibility: MOH/CEU                      Date: 1990

2. Develop a closer link between Continuing Education training and the basic training of nurses/midwives, nurse clinicians, health assistants and nurse assistants.

Responsibility: MOH/CEU      Date: 1990

### Evaluations

1. Evaluate training materials, teaching methods and abilities to write training plans, supervise others and master new skills on a regular basis.

Responsibility: MOH/CEU      Date: 1990

## 2.0 INTRODUCTION

The MOH has recently conducted two major evaluations which affect the CCCD Project: The Internal MOH Evaluation in December, 1987 and the biannual International Evaluation of the Family Health Program in May, 1988. The 1988 draft document was circulated in April and the final report is about to be issued. Because all of these in-depth reviews were generally favorable and were conducted so recently, the scope and composition of the team for the regularly scheduled CCCD External Evaluation was reduced. This evaluation therefore focuses on the management and training aspects of the Project, two areas identified as needing more attention.

Two other CCCD Project-related activities are being conducted concurrently with this evaluation: The Project Extension Design and an assessment of the feasibility of adding ARI as a CCCD intervention in Lesotho. In addition, there are plans to conduct a comprehensive evaluation in September, 1988 of the Project's training methodologies and impact. This external evaluation was planned and conducted to contribute to and take account of these other exercises. In addition, the external evaluation was to produce, as an important by-product to its main task, a set of guidelines and suggestions for the September Training Evaluation Team. This document is contained in Annex D.

It should be noted that the format of the management section of this report differs slightly from that of the training section. The variation in format was necessitated by the complex and multi-faceted nature of the training specialists' scope of work. The training advisor's role included two separate yet complementary tasks. The advisor's scope of work called for an evaluation of the training program and the design of a detailed matrix and scope of work for a future training impact evaluation activity to take place in late September, 1988. Hence it was decided that the training advisor's evaluative statements would be included in the body of the report. However, the extensive documentation needed for the September evaluation is included in the annexes of the report.

## 2.1 Scope of Work

### Management

The management specialist's scope of work included the following activities:

1. Assess the institutional integration of EPI and CDD program activities into the established MOH service delivery structure from the central to local level.
2. Assess the MOH's planning efforts involving the CCCD-related technical interventions.
3. Review and assess the quality of annual workplans and evaluate the process of preparation of these plans.
4. Review and assess the supervisory plan at central, regional and local levels and the role of supervision in training and modification of workplans.
5. Review and assess A.I.D. and CDC administration and support of the Project and adequacy of procedures for support.
6. Review and assess the feasibility of CCCD activities and benefits to be sustained.

### Training

The training/health education specialist's scope of work includes the following activities:

1. Review and assess the quality, types and magnitude of training at the central/institutional level.
2. Review and assess training materials.
3. Review and assess the number and categories of personnel trained.
4. Review and assess the training plan for 1988-1989.
5. Assess and make recommendations about the sustainability of the training program.
6. Make suggestions to further refine the scope of work and methodology for the planned training evaluation team (Sept.-Oct., 1988).

## 2.2 Methodology

Interviewing the key staff and donor organizations involved in the program was an important part of the methodology used in this evaluation. The team met frequently with Dr. Moteetee, director of FHD, and also had a number of meetings with the Health Planning, EPI, Oral Rehydration Therapy (ORT), Disease Control, Training, Continuing Education, Health Education and Health Information Units. On the second day of the visit a meeting was held with the principal secretary and the plans for the evaluation were laid out and discussed.

During its stay in Lesotho the team visited six HSAs outside Maseru and met with the management and staff of six hospitals (four government and two PHAL-operated) and nine HCs. The team also observed two VHW training sessions. A map showing the location of facilities is shown in Figure 1.

A debriefing session on the training aspects of the evaluation was held August 23 and an overall debriefing August 24, at which time the team presented and discussed its findings and recommendations with the principal staff and donor groups involved in the evaluations. A complete draft document was left with the MOH prior to the team's departure. Another major part of the evaluation entailed reviewing relevant documents from the MOH and elsewhere. Documents consulted are listed in Annex B.

## 2.3 Project Status

Focusing on the management and training aspects of the Project, the team found it to be well-managed and well-integrated into the MOH structure. The motivation of the staff at all levels was outstanding and the progress impressive.

The overall impression gained from discussions within the MOH and visits to various HSAs and HCs was one of pride in their achievements and a determination to build upon the progress already made in their delivery of primary health care. The recommendations of the evaluation team are made against this generally positive environment and address the areas of management skills (planning, budgeting, time allocation etc.), supervision, training and evaluation.

Like most programs, CCCD/Lesotho is plagued by staff shortages and transportation problems. Nonetheless, it is able to deliver services, the quality and coverage of which are beginning to have a positive effect on child survival, as illustrated by the data presented in Figure 2. It summarizes the goals of the Project and presents data on the overall accomplishments and targets achieved.

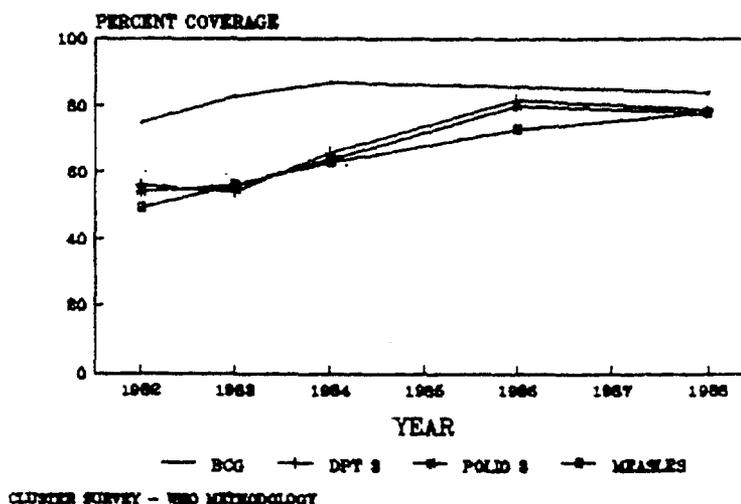


## 2.4 Project Goals and Accomplishments

The goal of the Project is to reduce morbidity and mortality resulting from communicable diseases in children less than five years old. Targets for immunization coverage have been met. The EPI targets included 80 per cent coverage for measles, 75 per cent for DPT 3, and 75 per cent for Polio 3 immunization. Figure 2 graphically shows the increase in vaccine coverage for measles, DPT 3, and Polio 3 as determined by cluster surveys. Coverage documented by the 1988 international survey was 78 per cent coverage for measles, 79 per cent coverage for DPT 3, and 78 per cent for Polio 3.

Figure 2

### LESOTHO MINISTRY OF HEALTH IMMUNIZATION COVERAGE 1982-1988



Targets set for CDD -- to increase the use of ORT by 50 per cent and to decrease diarrheal mortality by 50 per cent -- are less easily measured. As the baseline level for use of ORT was essentially zero, any use of ORT was a 100 per cent increase; therefore, the proposed 50 per cent increase was not a meaningful target. Other indicators show that significant progress has been made in use of ORT. ORT units have been established at 16 of 18 hospitals. ORT use in communities (use reported by mothers) is currently estimated at 74 per cent.

Since this external evaluation is focused on only two elements of the Project, the above data, extracted from the extension design, was included to provide an overview of progress to date. A more complete discussion of the accomplishments of the Lesotho Project in EPI and CDD is contained in the May, 1988 International Evaluation Document.

## 2.5 Administration and Organization

### Delivery Systems Structure

The CCCD project supports MOH initiatives within the primary health care structure under which health delivery systems are decentralized into 19 HSAs. Ten are government operated and nine are run by the PHAL. The PHAL facilities are an important element in the provision of health care in Lesotho since they provide about 60 per cent of health care in the country. This arrangement poses a special set of management problems. While operating under the government's policies and guidelines, the PHAL facilities have a variety of different management structures and hierarchies and there are variations in their daily operating procedures. In addition, some of the PHAL facilities are experiencing difficulty maintaining funding levels from their normal funding sources. This has created additional strains on the system.

The 19 HSAs include 18 hospitals, with the 19th HSA covered by the Lesotho Flying Doctor Service. The 18 HSAs in turn supervise 136 HCs. Within this structure the CCCD Project focuses on two disease interventions: ORT and immunization. The geographic coverage of the system is very good in relation to the distribution of the Lesotho population of 1.5 million. In Figure 3, a map shows the location of the Lesotho HSAs and hospitals. However, it should be noted that the different terrain of the highlands plus the severe winter conditions create access problems for some of the remote areas. There are definite seasonal patterns that need to be taken into account over the planning year.

### MOH Organization

The MOH is now operating under a revised organizational plan; although not yet officially approved, it does in fact represent the way the MOH is actually functioning. A copy of the draft MOH organogram is in Figure 4, followed by a second chart, Figure 5, showing the operational structure of the FHD. Consolidating EPI, CDD and Maternal and Child Health/Family Planning (MCH/FP) under the FHD has accelerated integration of CCCD activities into the overall MOH structure.

At the HSA level a management team approach has been established. The management team, under the leadership of the district medical officer, includes the senior health staff of the HSA. The team meets periodically, usually once a week, to address and deal with management issues affecting operations of the HSA.

Figure 3

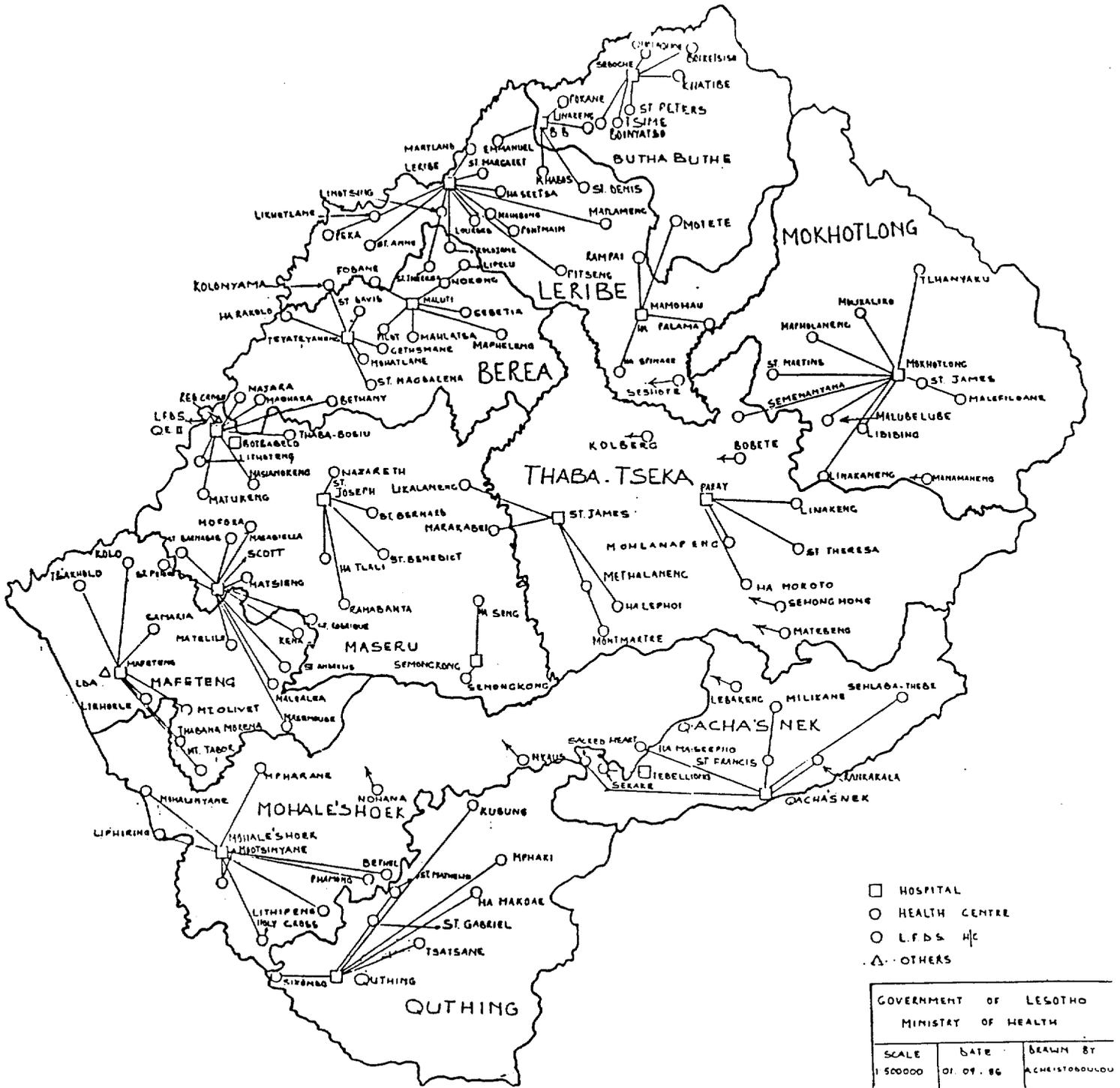
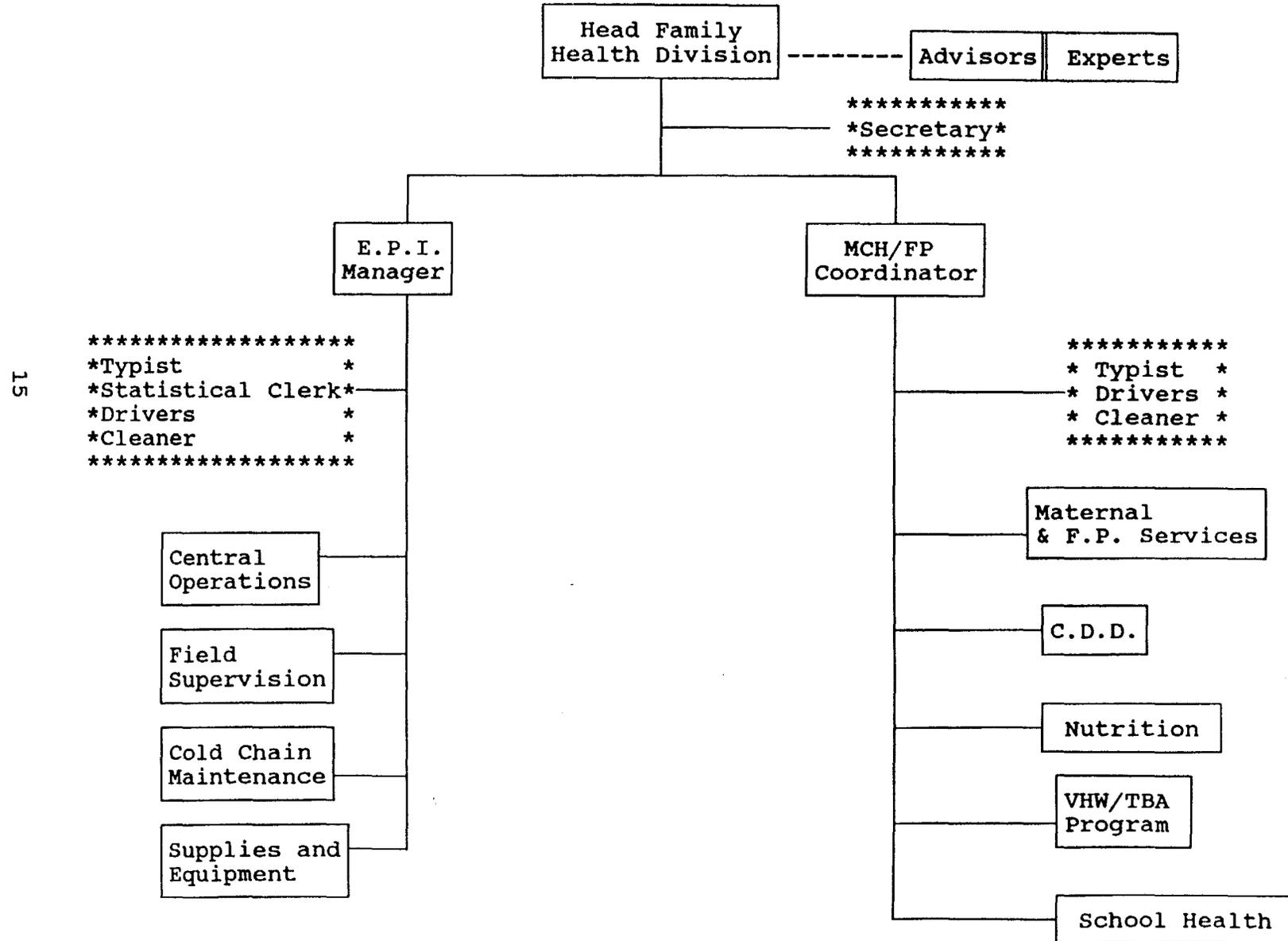




Figure 5

OPERATIONAL STRUCTURE FAMILY HEALTH DIVISION



### 3.0 MANAGEMENT

#### 3.1 Institutional Integration

The structure of the FHD has facilitated the merging of the Ministry's EPI and CDD activities into the primary health care service delivery system. The system is still undergoing change and refinement but the basic task of integration has been successfully executed. During the interviews and visits the evaluation team observed that the CCCD Project, as a separate entity, was beginning to lose its identity. While the people involved in the program are aware of the existence of CCCD and know that it is a USAID-supported activity, operationally it is viewed more as an input to the MOH program and as a means of providing resources and technical guidance to the people who are engaged in day-to-day program management. In this respect the Project is showing signs of achieving its underlying objective of Project anonymity. This observation is equally valid for CCCD support activities such as HIS, health education and training; these activities continue to have a high priority within the MOH and are achieving more recognition and appreciation as a wider range of users find the outputs important tools for planning and implementing their activities.

#### 3.2 Decentralization

While improvement can be and is being made, the task of creating a decentralized service delivery structure has essentially been accomplished. Personnel is the main remaining area that is still controlled and operated from the central level. To a large degree the CCCD Project, and the EPI program in particular, has served as a catalyst in the process by providing the MOH with additional resources and tools to implement its policies.

The decentralized planning and budgeting to the HSA level, now in its third year of operation, and the amount of decentralized decision-making that is occurring, is impressive. This has certainly contributed to the achievement of high coverage rates in the EPI program and the positive impact this and other primary health care interventions are beginning to have on health of children.

Of all the major elements of management, the personnel system lags most in the move towards decentralization. The way in which it most affects the CCCD Project is in precipitous staff changes that occur at the HSA level. This is usually disruptive and often results in the HSA facility losing a training person in a key position with little or no time to train a replacement. While these problems may be more easily dealt with when the personnel function becomes decentralized, some of the HSA management teams have expressed concern and would like to have an opportunity to be involved in these discussions.

Recommendation:

Consult the HSAs in advance of staff transfers and give the Management Team the opportunity to provide input to minimize operational disruptions resulting from such staff transfers.

Responsibility: MOH

Date: January, 1989

3.3 Supervision

The FHD is introducing measures to achieve certain economies (such as efficient vehicle usage) and to maximize their scarce supervisory resources. One of these measures has been the development of an integrated supervisory checklist for EPI, CDD, MCH and other CCCD-related activities. The list is now being field tested and is designed to enable one supervisor to evaluate performance in several related program areas. The MOH proposed an integrated checklist well before it surfaced in the CCCD Internal Review of December, 1987 and it was again mentioned in the 1988 International Evaluation of the Family Health Program. The rationale for the checklist relates directly to one of the problems most frequently identified, namely the inability to provide sufficient supervision to the HSAs and HCs. Once this checklist is installed in the system it is expected that supervisors from any of the major FHD units will be able to gather basic data on all FHD activities and feed this information back to the concerned staffs at the central and local levels. This should also result in obtaining more timely and uniform data on performance and assist in identifying potential performance problems. The system could also provide more of the positive reinforcement that is so strongly desired and needed in the field. This kind of innovation could be an effective management tool to increase supervision within existing staff constraints. The MOH is commended for its initiative and urged to make the system operational as soon as possible. The CCCD Project should support the FHD in its effort to install this by assisting in the computerization of supervisory checklists and by being responsive to requests to help train staff in its use. It should also support the MOH's efforts to refine and to improve it as experience dictates. This could involve workshops, materials preparation, development of specialized skill transfer techniques or other actions to respond to the MOH's needs to make the system function well.

Recommendation:

Complete the field testing and refinement of the standard supervisory checklist and install it as an operational procedure as soon as possible.

Responsibility: FHD

Date: Dec., 1988 (complete field test)  
Feb., 1989 (install procedure)

### 3.4 Health Information

The Health Statistics Unit (HSU) has made dramatic progress over the past six months, attributed both to assignment of a new Health Information Manager and the MOH's ability to recruit and train people to fill the previously vacant statistical clerk positions. The three positions were filled by using a daily-hire mechanism. The persons hired proved to be very productive and were able to significantly reduce the backlog of data coding and processing. As a result the HIS information is current for out-patient department reporting and the unit is producing data that is more timely and responsive to the needs of the MOH.

There is now a possibility that these temporary people may be replaced with permanent people under the government's normal recruitment procedures. Loss of these trained persons could result in a setback and erode some of the recent progress made, especially if the unit is faced with the task of again training new people. It is hoped that some means can be found within the system to retain the trained clerical staff of the HIS unit so that they can continue progress in providing timely and essential data to the MOH and other units within the government.

#### Recommendation:

Encourage the PSC to retain the trained people in question in the HIS unit in the interest of maintaining the timely flow of data to program managers.

Responsibility: MOH

Date: October, 1988

#### Epidemiological Bulletin

The Disease Control Unit has done an excellent job in producing and distributing valuable health information through the quarterly Epidemiological Bulletin. It is a very professional document and the team found during its field visits that it was enthusiastically received at HSAs and HCs. The opportunity provided for feedback was a particularly welcome feature. Some supervisors felt the bulletin would have more widespread appeal and help them more in their tasks if a section were devoted to presenting articles concerning operational issues of particular interest to the workers at the HCs. This section could also be used to provide continuing education information timed to coincide with the onset of seasonal disease cycles.

### 3.5 Operations Research

Funds set aside for this purpose have not been used. So far only two research projects have been supported. It is an important objective to support local researchers and provide assistance to enable them to produce quality work on subjects of concern and

relevance to the Project. There has not been a tradition of operations research in Lesotho and more effort needs to be made to stimulate potential researchers by bringing the funding opportunities to their attention and providing them with a clear explanation on how to apply for these grants. A number of existing communication channels and devices could be used. The Epidemiological Quarterly Bulletin, professional meetings, supervisory visits and the preparation of a pamphlet on how to apply are some examples that might be tried. Bulletin readers could occasionally be informed and given progress reports and reminders that funds are available and awaiting proposals.

### 3.6 Management Skills Development

The 1986 evaluation identified this need and called for the CDC/Atlanta to develop more generic management skills training modules. This has not yet been done, and it was noted in the 1987 internal review that the current management-related CCCD modules concerning supervision and the training process are little used and in need of revision. While updated modules may be useful there is a growing feeling that the time and effort involved might be better channeled towards more "hands-on" in-service and on-the-job training in these basic kinds of management skills. One way the CCCD Project could help address this need would be to redirect its staff towards more on-the-job training and management skills transfer.

The technical officer and the project assistant could be used more as management skills trainers. They could work alongside HSA staff at appropriate times, especially during the preparation of annual workplans and budget requests for submission to the central MOH for approval and in monitoring progress of these plans throughout the year. In order to accomplish this change in CCCD staff task emphasis, a number of administrative and CCCD staff support functions need to be addressed. The first step would be to redefine the jobs of the technical officer and the project assistant to put greater emphasis on field-related activities in general and management skills transfer in particular. This approach contributes to building sustainability. The Project is encouraged to hire an additional administrative person to absorb some of the workload and insure that the office is covered during times when the staff is in the field. Additional funds would need to be allocated to the Project's suballocation to cover the cost of funding a new position under a personal services contract and for any remodeling or refurbishing of additional office space that would need to be made available within the MOH. Additional funds may also be required for site visits or special orientation training for the project assistant to further develop techniques of skill transfer. Such training is mentioned now to alert A.I.D. of a potential funding need. But it is too early to make any specific recommendations on this aspect of the proposal.



self-evaluation and planning; or a combination of these approaches, any of which would serve to enhance the sustainability of the Project.

Recommendation:

Develop an evaluation schedule which is agreeable to both the MOH and A.I.D. for the remaining years of the Project. Internal evaluations should be encouraged.

Responsibility: A.I.D.

Date: January, 1989

3.8 Coordination

The MOH Planning Unit is responsible for tracking donor assistance and for coordinating the numerous activities of the various donors. It is a difficult and complex task not only because of the large number of donors involved, but also because each donor has its own set of guidelines and system of operating. The tracking system appears to be functioning well but the coordinating mechanism needs to be strengthened. The Planning Unit needs to assume a greater leadership role by calling regular meetings and trying to formalize the various ad hoc coordinating sessions that now seem to take place. The donors are concerned about the issue of coordination and would certainly welcome a more structured approach.

In addition to needing a more overall coordinating mechanism it is also necessary for CCCD to continue to use and strengthen its Project Coordinating Committee. Attention should be given to activities in other projects that could influence the implementation of the CCCD Project. In this regard, the following observations are made:

1. Project Coordinating Committee

The CCCD Coordinating Committee appears to be one of the better functioning committees. It only meets quarterly and the size of the group is manageable, largely because many invitees don't attend. This in itself poses another dilemma but does result in the meeting being of reasonable size. It is difficult to develop a formal procedure for achieving coordination between all interested parties in a project that cuts across so many lines; changing behavior and improving health attract about as large an interest group as one can imagine. There are perhaps some guidelines and procedures that could insure that key participants are kept informed.

Following these guidelines and holding regularly scheduled meetings should result in dissemination of information to those who need to be informed.

Some of the guidelines would include getting agendas out early; making sure that the content and discussion does not get so technical that people in related disciplines cannot follow what is going on; and developing a reputation for holding short and well-run meetings. Initiative and follow-up contacts with those invitees whose cooperation and coordination is felt to be particularly important to the program would be another way to try to encourage their participation. By having the Project Coordinating Committee meetings quarterly, sending out invitations to all interested parties and developing a dependable core group of attendees (complemented by occasional visits by other interested parties), CCCD seems to be achieving a reasonably good degree of coordination. The quarterly meetings need to be supplemented by individual meetings with key ministries and such donor groups as UNICEF and WHO, with whom close coordination is essential. DMI/MEDEX may also fall into this special category.

2. District Management Improvement Project (IDM)

The IDM project being supported by the MEDEX group is just now getting under way. It presents an excellent opportunity for CCCD to begin interacting with the IDM project during the design phase to insure that both activities are mutually supportive and complementary. The selection has not yet been made on which areas of management MEDEX will concentrate upon, but it is likely to include supervision, personnel and facilities maintenance. All of these areas have important implications for the CCCD Project. There are several key entry points on the MEDEX calendar that should be noted. Plans need to be made to interact with the MEDEX management at these times: November/October, 1988, when the project analysis will be gathering data; February, 1989, when final decisions will be made on the design; March, 1989, when workshops will begin; and June, 1989, when work will begin on the Distance Learning Element of the Project that will concentrate on bringing supervisory training to the HC staff.

3. Private Health Association of Lesotho (PHAL)  
Information Sharing

Coordination of management decisions made in the field is complex in Lesotho because of the division of responsibility between the government and PHAL-operated facilities. While most of these management issues and questions go beyond the scope of this evaluation, there is one issue that should be addressed. The CCCD project should be able to communicate with the PHAL decision-making field structure so that they are aware and can be kept up to date on the goals, objectives and progress of the Project. At the moment the

process operates informally and the knowledge about what CCCD is doing is uneven at best. As the CCCD staff begin to spend more time in the field they should assume responsibility to inform the PHAL local management structure about the Project and its progress. This could be included with their other duties in the HSA and would not take much additional time.

#### 4. Management Development Committee

This committee has been set up in the MOH to deal with management intensive projects such as the World Bank's Health, Planning and Nutrition (HPN) Project. As CCCD activities become more heavily involved in field on-the-job training there may be a need to interact more closely with this group.

Recommendation:

Develop a stronger donor coordinating mechanism with the MOH by having the HSU assume a greater leadership role in coordinating the various health-related, donor-supported activities.

Responsibility: MOH

Date: November, 1988

#### 3.9 Sustainability

Sustainability was an issue raised when addressing all the management areas examined during this evaluation. Recommendations were made with this central issue in mind. During the team's discussion with MOH officials the MOH raised the question of the need for designating a single counterpart to work with the CCCD Technical Office. Because of the nature of the job itself and perhaps even more importantly for reasons of sustainability, the designation of a counterpart did not seem desirable. Because the technical officer interacts with many people in the MOH, designating a single counterpart would be difficult. The present method of operating -- serving as an advisor and assistant to a number of key staff -- should make it less difficult to phase out the position when the Project is completed. While it may be necessary for several staff members to assume responsibilities currently performed by CCCD there will be no large, uncovered function caused by the withdrawal of the position. Thus the current arrangement appears to be very satisfactory.

#### 4.0 TRAINING AND CONTINUING EDUCATION

Training is an important component of the CCCD Project. Implementation of the program areas' ambitious goals depends on the quality of training offered to all health care service providers and on the community. Lesotho's technical successes of achieving 61 per cent full immunization coverage and 78 per cent measles vaccination coverage, coupled with the decrease in dehydration-related deaths, attest to the massive training efforts undertaken by HSAs and the Continuing Education and Health Education Units.

Lesotho has an expanded training program which is supported by both UNICEF and CCCD. The CCCD component is well-integrated into the MOH decentralized training program. Although the decentralized training program was established in 1984, it has not been fully evaluated. Previous Project evaluations, such as the 1986 Evaluation and the Internal 1987 Review, made some recommendations about the various aspects of the training program. A thorough evaluation is planned for Sept.-Oct., 1988.

The main goals of this present evaluation are to assess the CCCD's assistance to the MOH's training program and to identify broad training issues and strategies to be further examined by the Sept.-Oct. team (see training annexes). Hence, this is not only an evaluation document, but it is also a descriptive report written for the purpose of orienting the Sept.-Oct. team.

In this report, the term training refers to all activities undertaken by MOH, with assistance from the CCCD and HEALTHCOM staff, to teach new skills or produce training materials relevant to the technical and managerial activities of the Project. All Continuing Education programs are coordinated in the Manpower Development unit of MOH. The Continuing Education Unit oversees in-service training programs given to health personnel. At the central level, the CCCD training courses are well-integrated in the division's overall training plan. As for the HEALTHCOM component of the Project, coordination occurs at the Health Education Unit. The MOH has a VHW and TBA training coordinator for these programs. Hence, structurally not all training programs are supervised, planned or implemented by one coordinating office. However, it is important to state that at the HSA level all training activities are coordinated by the HSA trainers. The HSA trainers can be public health nurses, nurses or nurses assistants. Until recently, HSAs had two types of trainers, CCCD and FP. Consolidation efforts are underway. However, issues concerning uniformity in such areas as training techniques and competency in program area skills are to be assessed by the Sept.-Oct. evaluation.

It should be mentioned that the MOH originated and supports the need to assess the CCCD training program. This healthy attitude toward assessing program impact speaks well for the officials involved in implementing the Project. Moreover, the MOH and USAID have agreed to extend the Lesotho CCCD Project to 1991, and the Project looks forward to new challenges, such as efforts to combat acute respiratory infections and expanded activities in measles control strategies. Therefore, there is a need to examine the capability of the training program to undertake new tasks.

#### 4.1 Methodology for Training Evaluation

The evaluation has utilized the following methods to assess program effectiveness:

1. Interviews with MOH central level staff, HSA staff management team members and other health staff members.
2. Interviews with the CCCD Technical Officer, Director of Continuing Education, Acting Chief Health Educator and the HEALTHCOM Resident Advisor.
3. Interviews with PHAL, Red Cross, UNICEF, MEDEX and WHO staff members involved in training activities.
4. Review of evaluation documents pertaining to training. (See list in Annex E.)
5. Observation of a VHW training session at the Village of Matlateng (Butha Buthe HSA).
6. Review of health promotion materials.
7. Interviews by telephone with the former training specialist, Mrs. Sandy Buffington, who worked closely with MOH during the early development of establishing decentralization of the training program.
8. Interviews with CCCD Atlanta-based training staff and representatives of the Academy for Educational Development (AED) staff in Washington, D.C.
9. Examination of the training work plan.

#### 4.2 Training Matrix

For the purposes of assessing the training component of the CCCD Project, the following matrix has been used in this evaluation:

1. The relevancy of the training materials to Project needs  
Examination of training materials and interviews with trainers show that the present training program deals with skills needed to implement the Project.
2. The institutional capability to carry out further training  
Despite staff shortages at the central level, the training program has demonstrated that training sessions can be successfully implemented.
3. The reliability and validity of training materials  
Some of the CCCD modules require updating. A thorough evaluation of the effectiveness of training materials is scheduled for September, 1988.
4. Institutional capability to coordinate training programs  
The coordinating role of the Continuing Education Unit needs to be strengthened to avoid duplication of efforts. Frequent training sessions can overtax valuable time of HSA staff.
5. The degree of sustainability  
Skills and concepts are well-integrated into the overall training courses offered by the Continuing Education Unit.
6. Ability to coordinate supervisory and training functions  
The development of relevant checklists to be effectively used by supervisors is an important task for the next phase of the Project.
7. Clarity of program goals and objectives  
Program goals and objectives need to be identified for the duration of the Project and beyond. Objectives should be skill-oriented.
8. Ability to evaluate training courses and integrate evaluation results in the design of materials for training courses  
At the end of training sessions, training courses are evaluated. Summary statements of the evaluations, if kept at the HSA level, could be effective in identifying future training needs.

9. Ability to carry on follow-up/supervisory activities and in-service training programs

Monitoring and supervision of training activities at all levels is an area which requires strengthening (See Management section).

4.3 The Socio-Cultural Context of the Training

Lesotho is a small country of 30,350 square kilometers. Many among Lesotho's population of 1,577,000 (1986) seek employment opportunities in the Republic of South Africa (RSA). The higher pay attracts educated and well-trained Basothos, constituting a problem in terms of a drain of highly qualified human resources. At the community level, it is common for men working in the RSA to visit their families only once a month. Often, both parents work in the RSA, leaving their children in the care of grandmothers and older relatives. As grandmothers play an important role in the care of children, this has important implications for designing messages to the public.

In rural areas, sick children are usually treated at home first; then the help of traditional healers is sought. Health care delivery services are often utilized when traditional medicine proves ineffective. In Lesotho individuals seek health services at MOH or PHAL health centers, depending on their proximity to HCs, HSAs, central hospitals, private physicians who offer health care services, or other services and facilities. The CCCD training has been primarily directed towards health personnel at the central, HSA, and HC level. Recently, more efforts have been directed towards educating mothers, caretakers, traditional healers, chiefs and TBAs.

In the area of communication, Radio Lesotho and Sesotho radio programs from RSA are listened to by both the urban and rural populations. Conflicting health messages are not unusual; for example, bottle-feeding is promoted in the RSA's programs and breastfeeding is promoted in the Lesotho programs. Also, Basotho men and women working in the RSA come back to Lesotho to visit their families having listened to the RSA's health messages. Although there is not much that can be done to bring about uniformity of messages, it is important for both the training and health education staff to be aware of the impact of the conflicting information.

#### 4.4 The Decentralization Training Program

In August 1984, the decentralized training program was established by the MOH. For Lesotho, the decentralization of training presented a pioneering experience and a true challenge. At the initial stages the program was well-designed and coordinated. The primary goal of the program was to decentralize training to the district level and HSAs. Institutionalizing the program by training skilled HSA trainers and providing them with effective training materials was emphasized. There were two good reasons for decentralizing the training program: First, Lesotho's topography, with its steep valleys and inaccessible mountainous areas; and second, the limited staff positions at the central government level. One of the main motivating forces behind adopting the decentralized training program was to serve training needs without too much disruption to the health service delivery at the district or health center levels.

In Lesotho, the CCCD training component played a pioneering role in preparing a well-qualified cadre of core trainers both at the MOH and HSA levels. At the central level, the training courses of the CCCD project are implemented by the core trainers. The Continuing Education and the Health Education staff of the MOH function as coordinating units for most training programs. The Village Health Worker Training Program is coordinated outside of this structural framework. Also, basic professional training is not linked to the Continuing Education Unit. At the district and village levels, training programs are conducted by the HSA trainers. There are 18 HSAs in the country. Half of the HSAs are operated by the MOH and the other half are operated and funded by the PHAL. One of the unique features of the CCCD Project is that the training needs of both PHAL and MOH facilities are served by the Continuing Education and the Health Education units. Training in program area skills is conducted for all health facilities whether they are operated by the PHAL or MOH.

The CCCD training program was instrumental in laying the foundation for the presently-expanded decentralized training program of the MOH. In the early years of the Project, 1984-1986, training strategies, modules and methods were developed, pre-tested and implemented by the CCCD training advisor and the MOH staff.

Today, the decentralized training program has quadrupled in size. The number of trainees for 1985/86 was 846. The 1988/89 training plan aims at training 5,660 persons. Most of the training courses were offered to health personnel such as physicians, nurses, public health nurses and nurse assistants. Also, "core trainers" at the central level were trained in

teaching methods, evaluations and technical skills to implement program areas. Currently, training programs are directed not only at health personnel but also at the service communities. Traditional healers and birth attendants, teachers, chiefs, and VHWs are often the recipients of training courses. The CCCD training materials and methods are utilized at all training levels. The program topics are well-integrated in all other training courses offered by the MOH. At the central level, the Health Education/HEALTHCOM components of the Project are highly institutionalized.

During the first part of 1985, six seminars were conducted. A total of 240 participants completed a five-day "training of trainers" course. The trainees included nurses, nurse clinicians, public health nurses and other health care providers. These seminars gave impetus for further revision of the training modules. "The Lesotho Clinical Reference Manual for Health Centers," "Village Health Worker Manual," and "District and Health Center Operation" manuals were all utilized in the writing of training modules. Other training modules written included the following:

- Support and Supervision
- The Training Process
- Target Diseases: Expanded Program for Immunization
- Target Disease: Control of Diarrheal Diseases
- Health Information System
- How to Plan for Continuing Education in Your HSA
- Cycle of Health Cards

In May, 1985, a Continuing Education course was conducted for HSA managers. The workshop emphasized the practical side of preparing training plans and budgets. Also, in June, 1985, a Physician's Symposium on Control of Diarrheal Diseases was held in conjunction with the Lesotho Medical Association's annual meetings. One hundred participants attended the symposium, including doctors, nurses, private physicians, and representatives of foreign donor organizations active in training in Lesotho. The participants recommended development of a five-year plan on the subject of CDD. In 1986, the developed plan was adopted by the Government of Lesotho.

In September, 1985, HSAs began implementing their training programs. Fifteen workshops were held providing training for 450 health workers from health centers, hospitals, outpatient departments and public health units. In addition to these workshops, 12 sessions were held for 360 VHWs. Some HSAs opted to hold workshops for private practitioners, women's groups, teachers, traditional health healers and village chiefs. A total of 500 people were trained in the CCCD topics. Core trainers from the central level often acted as resource persons in these sessions.

Between 1986-1988 a total of 79 courses were offered covering EPI topics. An estimated 66 courses covered CDD topics. The decentralized nature of the training program and the inter-relationship of topics make it difficult to provide an exact course count. Moreover, conflicting figures about the number of trainees and training courses are found in many documents.

From its inception the CCCD training program focused on strengthening institutionalization efforts and working within the MOH framework. At the central level, core trainers were trained using the CCCD training materials. Seven workshops were implemented providing orientation to HSA trainers in the technical areas of the Project, CDD and immunization, and in training methods. These workshops were conducted by the core trainers from the central level. During these workshops, the HSAs were encouraged to select candidates for the position of "trainer." Other regional workshops followed at the Berea, Mazonod, Thaba Tska, Mokhotlong, Mohale's Hoek, Qacha's Nek and Leribe HSAs. HSAs became involved in the process of implementing their own workshops to illustrate the importance of the principle of learning by doing.

The regional workshops lasted four to five days and provided complete coverage of the CCCD topics. CCCD Modules were used in the training sessions. The modules used in these initial efforts included the following:

- Encourage Community Participation
- Control Diarrheal Diseases
- Field Workers Guide for Diarrhea Control
- Field Workers Guide for Immunization and Nutrition

The regional workshops provided opportunities for field testing some of the modules. Further revisions were made. Also, the regional workshops were designed to strengthen the skills of HSA trainers in identifying and implementing training courses both at the HSA and HC levels.

From 1986-1988 the volume of training courses and the number of trainees mushroomed, with all 19 HSAs offering their own courses and the central level staff acting as a coordinating body for this ambitious training program. Refresher courses are also offered about twice a year for the HSA trainers.

The CCCD training program is so well integrated within the overall training plans of the MOH and HSAs that it is difficult to obtain an actual count of trainees who have benefited from CCCD training. The CCCD topics (CDD and immunization) are also diffused into the Village Health Worker Training Program. In 1985, approximately 846 health workers and VHWS were trained. CCCD supported 36.5 per cent of the training budget, M20,801-00.

In 1986, 1,479 health workers, extension workers and community members were trained. CCCD paid for 25.7 per cent of the training budget, M21,993. The training program grew considerably in 1987 as 7,711 health workers, VHWS, extension workers and community members were trained. CCCD paid for 32.4 per cent of the training budget, M16,560-00. UNICEF has been the biggest contributor to the training budget because of its sponsorship of training for VHWS, community members, TBAs and traditional health healers.

The training summary statement for 88/89 shows the following figures:

Expected number of participants.....	5,660
Actual number of participants to date.....	121
Number of health workers trained.....	27
Number of VHWS trained.....	66
Number of extension workers.....	0
Community workers trained.....	28
Estimated CCCD costs.....	M20,527
Estimated UNICEF costs.....	M299,084
Estimated UNFPA costs.....	M56,494
Estimated FHS costs.....	M255

Both the EPI and CDD components of the training program were emphasized at the HSA and HC levels. At the central level, refresher courses are offered by the Continuing Education Unit to update HSA trainers and are seen as a way to get feedback from the district trainers. Half-day seminars were offered in May, 1988, to discuss immunization strategies in view of the latest immunization coverage figures.

During the first quarter of 1988, the CCCD decentralized training offered two week-long workshops on ORT. Twenty-four nurse assistants from the Mohales Hoek, Quithing, Butha Buthe and Leribe HSAs received a skills-oriented course in establishing ORT corners in HCs. Guidelines for establishing ORT corners were also presented in the training sessions. In the second quarter of 1988, the MOH, PHAL, CCCD and the World Bank cosponsored a one-week Continuing Education Workshop for 40 HSA trainers. Small groups examined major findings related to program areas, EPI and CDD.

From the above mentioned background of the decentralization training program, one recognizes the fact that the CCCD training provided the vehicle for developing training skills at the district level. The CCCD training materials and methodologies set the groundwork for the extremely ambitious training plan of 1988/1989. Currently 18 HSAs are implementing their own training programs at the HSA, HC, and village levels.

The 1988 International Evaluation lists the following categories of trainees:

- Medical Officers.....	29
- Nurse Clinicians.....	54
- Nurse Tutor.....	4
- Public Health Nurse.....	35
- VHWS.....	3,537
- Extension Workers.....	200
- Cold Chain Technicians.....	33
- Nurses.....	1,120
- Nursing Sisters/Nurse Assistants....	122
- Health Inspectors.....	0
- Health Assistants.....	0
- Pharmacy Technicians.....	6
- Traditional Healers.....	0
- Ward Attendants.....	38
- Soldiers.....	25
- Red Cross Volunteers.....	9
- Pre-school leaders.....	22
- Community leaders.....	100
- Mid-level Managers.....	114
 Total trainees.....	 5,100

The total figure of 5,100 trainees does not match the number of trainees mentioned in other training documents. Neither does it agree with the information reported at Butha Buthe about training courses given to traditional healers reported at the local level. This supports the idea that a training information system is needed, especially with the increase in the number of trainees and training courses. At the central level, this partially can be solved with a training register which receives data on numbers of trainees, names, types of courses, skills taught, and summary of trainees' evaluations, along with the request for reimbursement forms.

Periodic transfers of trainers to other HSAs or HCs often leads to a situation in which too many trainers are found in one HSA or no trainers are found at all. It appears that nurses and public health officers are transferred by the personnel office at the central level without consideration being given to the "trainer" status.

#### 4.5 The Health Education/HEALTHCOM Component of the Project

The Health Education Unit, assisted by HEALTHCOM, answers to the Director of Health Services within the MOH. The MOH is committed to integrate health education materials and messages at all training levels. The Health Education Unit offers semi-annual HSA training courses. Topics such as social marketing and counseling techniques are part of training activities.

The stated objectives of HEALTHCOM are as follows:

1. To provide opportunities to mothers and caretakers to make informed choices and thereby change their behavior.
2. To coordinate a program of in-service training for health education personnel covering all aspects of the Project's educational methodology, as well as overall program planning, management and evaluation functions.
3. To develop a program of formative research, utilizing both qualitative and quantitative techniques, in order to identify existing knowledge, attitudes and practices among health personnel and community members.
4. To conduct behavioral studies, such as Oral Rehydration Solution (ORS) mixing trials and immunization default studies.
5. To develop a comprehensive implementation plan covering the communication intervention objectives, specific messages, channel integration strategies, broadcast schedules, production and distribution of print materials, etc.
6. To produce pilot materials (sample radio programs, draft graphic materials and preliminary training designs) for pilot testing with target populations.
7. To produce, revise and finalize draft materials based on results of pre-testing.
8. To teach an in-service training course for MOH Health Education personnel on topics related to health communication, such as program and media management, message design, basic radio production techniques and formative research methods.

The Health Education Unit has doubled its staff size to achieve some of the above mentioned objectives. A great deal of work has been done to institutionalize the health education and media components of the Project. At the central level, new personnel have been hired, new staff trained and new equipment ordered to promote development of local capabilities.

The HEALTHCOM technique is a labor-intensive methodology. Much time and effort have been spent in hiring new staff and sending current staff abroad for training programs. However, this investment in developing local media capabilities and procuring needed equipment should definitely impact the ability of the MOH

to reach the community at large. Setting up an effective organizational structure is one of the primary goals of the Health Education Unit and impressive achievements have been made.

#### 4.6 Summary of Health Education Achievements

##### Preparatory Work

1. Conducted survey of mothers' Knowledge, Attitudes and Practices (KAP) with respect to diarrhea and immunization.
2. Completed literature search, bibliography of studies and new library construction.
3. Revised MOH policy on ORT. (A response to the 1986 recommendations.)
4. Developed and implemented a work plan for ORT in Lesotho, including commercial production and distribution of ORS packets in order to make possible the widespread use of ORS as the treatment of choice for dehydration.
5. Identified and assigned Health Education Unit staff to learn and carry out HEALTHCOM-style communication strategy for ORT and EPI.
6. Conducted study of radio listenership and newspaper readership.

##### Institutionalization Efforts

1. Added three new staff positions, developed a work plan and created training for the AIDS program.
2. Raised 25 per cent of the funds needed to construct a modest audio-production studio.
3. Received funds to remodel the veranda of the Health Education Unit to make more work space for the staff.
4. Remodelled existing Health Education Unit work space for greater effectiveness.
5. Recommended new organizational structure.
6. Purchased new field recording equipment.
7. Purchased a computer and software for word processing (e.g., radio scripts, reports, correspondence); desk top publishing (MOH Newsletter); and graphics (e.g., font reproduction and type-setting).

8. Hired two temporary staff to fill permanent positions.
9. Reserved a senior position for a staff member completing a health education diploma course at Leeds Polytechnic.
10. Retained former Peace Corps print production volunteer on six-month contract to assist with the production of ORT and EPI print materials.
11. Oriented and trained two new Peace Corps volunteers, one a graphic designer and the other an advertising agency owner.
12. Prepared a job description for social mobilization position to be funded by UNICEF for the EPI program.

#### Products

1. Developed standard messages to be used in all health education on the treatment of diarrhea and the encouragement of immunization.
2. Developed a series of pictures which illustrate the steps to the successful rehydration of children with diarrhea.
3. Produced flip charts using the series of pictures described above to be distributed to every clinic and hospital in the country.
4. Produced 4,000 pamphlets for distribution to mothers.
5. Printed a cover letter sent to all health educators in the country appealing for the use of the standard messages.

#### Training of Health Workers

1. Offered an introductory course about the HEALTHCOM methodology; Nov. 1986.
2. Presented a draft of ORT graphics to HSA trainers for reactions; April 1987.
3. Presented ORT health education materials to HSA managers at ORT Symposium; Sept. 1987.
4. Presented the refined ORT education materials to HSA trainers; Nov. 1987.
5. Conducted an orientation of new medical doctors to HEALTHCOM, explaining their important role in the communication and motivation processes; March 1988.
6. Conducted the ORT and EPI song competition, June 1988.

### Training of Health Education Unit Staff

1. Conducted a one-day seminar on the social marketing of health for the staff and the media.
2. Participated in developing research techniques for carrying out KAP studies using in-depth interview techniques.
3. Designed techniques of literature searches.
4. Helped teach techniques of conducting surveys, questionnaire development and administration to some Health Education Unit staff and to 13 persons hired to do baseline survey.
6. Designed techniques of questionnaire response coding.
7. Taught data entry techniques to two people, one of whom now works for the MOH HIS office.
8. Taught techniques of pre-arranging community surveys.
9. Provided training in development communication for Health Education Unit radio producers.
10. Participated in two four-week training courses for ORT and EPI program managers and communicators at the African Regional Health Education Center (ARHEC) in Nigeria.

With this impressive record, the Health Education Unit/HEALTHCOM component of the Project looks forward to the next phase of Project implementation. The following objectives have been identified by the Health Education Unit and the HEALTHCOM advisor as being important:

1. Coordinate all activities in order to effectively reach more community members.
2. Train staff to improve quality and quantity of work outputs.
3. Improve productivity of existing staff.
4. Invest in procuring more equipment for radio production.
5. Produce audio-visual materials to be used in training.
6. Improve delivery schedules and methods to HSAs, HCs, and VHWS.
7. Continue the efforts of organizational development.
8. Research new program areas and continue the role of being a service unit for the MOH.

#### 4.7 Characteristics of Training and Health Education Programs

##### 1. Integrated Nature of the Training Topics

The CCCD topics of immunization and CDD are well-integrated into all training programs offered by the MOH. The early CCCD training activities set the stage for what is the MOH's present decentralized training program. This highly integrated nature of the program topics -- CDD and immunization -- provide for better program sustainability.

##### 2. Limited but Highly Dedicated Staff

The Continuing Education Unit has been overseen by one staff member. Presently, Mrs. Mantua Seipobi, Director of the Continuing Education Unit, is moving from the MOH offices to the National Health Training Center (NHTC). The potential impact of this move is unknown in terms of whether it might open up such opportunities as increased staff levels or access to more audio-visual equipment.

##### 3. Structurally Segmented Organizational Structure

The administrative separation between the Continuing Education and Health Education Units and some vertical training programs at the central level makes it difficult to view training as an integrated system with common goals and objectives. The biggest challenge is to coordinate training programs to ensure uniformity of messages and methods.

##### 4. High Degree of Institutionalization

An impressive cadre of trainers has been trained at both the central and HSA levels. Currently, each HSA has at least one trainer. Some have two or three trainers. However, transfers of trainers from one HSA to another without considering the impact of the transfer on the required number of trainers which each HSA needs is a problem area which deserves further attention.

##### 5. Diversified Training Outputs at the HSA Level

HSA trainers are often in charge of translating and producing their own training materials so they can deal with different target groups such as VHWs, chiefs and traditional healers and TBAs. At that level, the quality of the training program becomes dependent on the individual's abilities to comprehend, interpret and teach basic concepts. The fact that the HSA trainers differ in educational backgrounds -- some are nursing sisters, others public health nurses or assistant nurses -- leads to even a greater variations in teaching styles.

#### 4.8 Findings: Training

1. The decentralized training program supported by the CCCD Project is a viable program that has succeeded in training an impressive number of HSA, HC and core trainers.
2. The CCCD program area topics are well-integrated with other training programs within the overall training activities of the MOH.
3. Coordination efforts are not clear between the Continuing Education Unit and HSA, HC and central level core trainers. Information about who received training, in what skills and with what frequency is not easily available.
4. HSA trainers differ greatly in their training capabilities and methods.
5. Major institutionalization efforts have been made in the Health Education Unit to train staff and procure equipment. The impact of these efforts on improved accessibility to the community needs to be assessed.
6. The training modules, although very effective in the initial stages of the training program, need further examination and updating.
7. The 1988/89 training plan reflects the MOH's commitment to continue offering CCCD-related courses and to expand the training base to other health workers and community members such as TBAs, tribal chiefs and traditional healers.
8. Although the majority of HSA trainers seem to involve HC trainers in the process of needs' assessment and the teaching of VHWs, some HC trainers are not fully utilized.
9. There is no training plan for the remainder of the Project. The existing plan covers training needs only to 1989. The decentralized nature of the program makes long-term training needs' assessment difficult at the national level. However, broad training goals and objectives could be quantitatively and qualitatively identified. In the absence of goals, it is impossible to measure program performance.
10. Because of the high degree of institutionalization, the CCCD training topics are sustainable because they are taught in all training courses, including the Village Health Workers' Training Program. It seems doubtful though that the MOH can sustain the same level of training activities without the financial support from the CCCD Project and other collaborating donors.

11. The present training program has proven capable of incorporating new technical topics such as family planning and nutrition without de-emphasizing CCCD topics such as immunization and CDD. ARI and new measles control strategies can be easily incorporated into existing training after careful development of suitable training materials and an assessment of trainers' capacity to handle the extra responsibility.
12. The link between supervisory functions and training remains weak. Logistical concerns, staffing levels and time constraints often hinder supervisory visits to HSAs and HCs.
13. Based on visits to three HSAs, it appears that the quality of training methods is very good. Trainers used written, verbal and demonstration exercises to test performance. However, group discussions were limited or non-existent.
14. Participants took training sessions seriously. VHWS made impressive efforts to learn how to mix Sugar Salt Solution (SSS) properly.
15. Interviews with VHWS in Matlateng indicate that the establishment of the ORT Corners has increased the legitimacy of VHWS' efforts to promote ORT to mothers. Now, mothers can see that the instructions received at HSAs and HCs are consistent with those given by the VHWS.
16. VHWS are eager to include ORS packets in their kits. Trainers do not yet know when the packets will be available for distribution.
17. There is a need for CCCD to develop a generic management skills manual which deals with Lesotho system-specific supervisory skills.
18. Delays in reimbursement payments cause major problems for HSA trainers. Shortages of staff and the numerous functions of HSA administrators delay the process of sending receipts to the central level for reimbursement.
19. Training of non-nursing staff is not seen as a priority. Ward assistants -- "helpers" -- receive less attention in the current training program.
20. The present program has emphasized the role of the HSA trainer at the expense of the HC trainer. Often, the public health nurse travels to the villages to implement VHW programs.

#### 4.9 Findings: Health Education

1. Present efforts of the Health Education Unit to reach more mothers and caretakers via increased media use will have a positive effect in creating health awareness at the community level.
2. The HEALTHCOM methodology of pre-testing print and graphic materials has resulted in excellent quality country-specific promotional materials.
3. As per recommendations of the 1986 evaluation, the Health Education Unit has succeeded in staffing several positions to help train a cadre of community education trainers, artists and communication specialists.
4. The Health Education Unit responded well to the 1986 recommendation to develop standard messages for ORT use.

#### 4.10 Summary of Findings: Health Education and Training

It is evident from these findings that a great deal has been accomplished in the following areas:

1. A decentralized training structure has been established at the HSA level.
2. There has been tremendous growth in the number of training courses and trainees.
3. An impressive number of training modules have been completed, forming the basis for substantive training activities.

However, in its next phase the Project will undergo growth in technical program areas and will experience increased competition for training time from other topics (e.g. Family Planning, and MEDEX management courses). The recommendations which follow could streamline training operations and strengthen the responsiveness of training to the technical demands of the Project.

#### 4.11 Recommendations

##### Training Program

1. Adopt the use of a holistic/systems approach to training. Establish a system with strong linkages between the MOH Planning Unit, Continuing Education Unit, Health Education Unit, and the HSAs. Coordinate all training activities for both health personnel and community members.

2. Establish a computerized training information system which keeps records of the number of trainees, their categories, course content and skills taught and so on. This would help develop a system with clear training inputs and outputs. HSAs are encouraged to maintain a Training Register Record.

#### Training Materials

1. Upgrade CCCD's modules. "The Training Process" and "Support and Supervision" have been identified as the two priority modules in need of immediate revision. New training approaches like the "critical thinking" and skill-development approaches might improve the quality of the present training modules.
2. Develop more training materials and teaching aids in Lesotho to be used by HSA trainers. Materials should address the interests and experiences of adult learners. This might be accomplished by involving HSA trainers in a Continuing Education workshop to generate ideas for new training materials like question/answer sheets, graphic materials and so on. It is necessary to ensure closer coordination with the Health Education Unit and other staff members involved in training to facilitate materials development.
3. Careful consideration has to be given to developing new ARI and measles strategy training modules/materials prior to expanding in these program areas.

#### Training Methods

1. Establish standards to bring about uniformity in training methods and content. In the semi-annual workshops, HSA trainers can develop syllabi for each training course they teach. The syllabi could include goals, behavioral objectives, lesson plans, teaching techniques, evaluations and exercises used in training. HSAs can identify needed audio-visual materials and equipment which will be developed and ordered by the Health Education Unit. The produced syllabi could be used to monitor the quality of training.
2. Use on-the-job training, drills, discussion groups and demonstrations as techniques for teaching technical skills. Training sessions often cover many topics at a highly didactic level. Often, the skill development process requires time investments and well-designed drills. Demonstrations, hands-on training, group

discussions and on-the-job training are proven teaching techniques for improving job performance. At the central level, semi-annual workshops could provide HSA trainers with help in the above-mentioned areas.

#### Training Goals and Objectives

1. Develop long- and short-term training goals and objectives for the life of the Project and beyond.
2. Complete generic management training modules. Behavioral objectives should be clearly identified for each required task. The module should address Project-specific management/supervisory problem areas.
3. Increase the Health Education Unit's ability to reach mothers and caretakers in the community by promoting both face-to-face and media communication techniques. Creating more community awareness, especially through VHWS, should be viewed as a crucial goal for the next phase of the Project.

#### Training Needs Assessment

1. Give special attention to operational and motivational program area problems in all training settings, including the Continuing Education Workshops for HSA trainers. Skills in checking intradermal techniques, proper vaccination intervals and drills on correct mixing methods of ORT and SSS need to be allotted enough time in training courses for practice.

#### Coordinating Training Activities

1. Seek a closer relationship between formal training behavioral objectives and supervisory functions. This could be accomplished by clarifying behavioral/performance objectives as well as by viewing supervisory visits as training opportunities. The MOH could revise the existing supervisory checklists according to these clarified objectives.
2. Develop a closer link between Continuing Education training and the basic training of nurses/midwives, nurse clinicians, health assistants and nurse assistants. Orientation sessions for the newly-appointed staff might familiarize new employees with the Project area knowledge and skills.

### Evaluations

1. Evaluate training materials, teaching methods, abilities to write training plans and to supervise others, and degree of skill mastery on a regular basis.

### Health Education

1. Increase production of print and media materials to reach more community members in Lesotho.
2. Improve HSA access to print/audio-visual materials.

#### 4.12 Summary of Recommendations

The above mentioned recommendations require the following:

1. A commitment to viewing training as an important vehicle for developing program skills.
2. An interest in developing a training system with clearly defined goals, objectives and inputs/outputs.
3. An increase of the training staff at the central level.
4. A closer link between supervision and training manifested in increased usage of on-the-job training.
5. A clear and well-defined knowledge of the specific technical skills to be transferred.

ANNEX A

PERSONS CONTACTED

MINISTRY OF HEALTH

Headquarters:

Mrs. N. T. Borotho	Principal Secretary for Health (P.S.)
Dr. Moji	Director General, Health Services
Mrs. A. Ntholi	PHC Coordinator

Family Health Division

Dr. Mpolai Moteetee	Director, Family Health Division
Ms. Ivy Monoang	CDD Coordinator
Mrs. Agnes Lephoto	VHW Coordinator
Mrs. Malika Nkuebe	EPI Manager
Mrs. Lydia November	EPI Field Supervisor
Mrs. Malapo	MCH/FP Unit Coordinator

Health Planning Statistics Unit

Mrs. Matsau	Chief Planning Officer, Health Planning Statistics Unit
Ms. Sarah Bennett	ODI/UK Intern, HPSU
Ms. Madibata Matji	Health Information Manager
Mr. Dan Thakhisi	Health Statistician (Bureau of Statistics)
Mr. Islam	Programmer (U.N. Volunteer)
Ms. Palesa Ts'oene	Health Planner

Health Education Unit

Mrs. Rakhella	Acting Chief Health Educator
Dr. Ed Douglass	HEALTHCOM Resident Advisor
Mr. Martin Masupa	Director, Graphic Arts Dept.
Mr. Brian Aldinger	Technical Advisor, Graphic Arts Dept.

Disease Control Unit

Dr. T. Ramatlapeng	Director, Disease Control Unit
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Training/Continuing Education

Mrs. Manthua Seipoboi	Continuing Education Coordinator
-----------------------	----------------------------------

Other Units

Mr. Nazir Munshi	CCCD Project Assistant
Mr. Rick Pollard	Rural Sanitation Project
Mr. Patrick Dougherty	DMI Project--MEDEX

Ms. M. Ramaeli  
Mrs. Mphonyane Isoelinke  
Mrs. Mildred Nombula  
  
Mrs. Matsili Kheleh  
Ms. Celina 'Maneo Ngatane

DMI Project  
Nurse Clinician, Holy Cross HC.  
Isakholo Private Pre-School Health  
Education  
Nurse Clinician Tsakholo, HC.  
Queen Elizabeth II Hospital  
ORT Unit Coordinator

USAID

Mr. Jesse Snyder  
Ms. Barbara Sandoval  
Dr. Patsy Layne  
Mr. George Kasozi  
Ms. Betsey Robinson  
Mrs. Pearl Drew

USAID Mission Director  
Assistant Mission Director  
Supervisory General Development Officer  
Assistant GDO  
Assistant GDO  
GDO Executive Officer

OTHERS

Dr. Austin Mkandawire  
Mr. Martin Mogwanja  
Mrs. Moleko  
Mr. T. Makara  
Mr. Hector MacGregor  
Mr. David Wadsworth

WHO Representative  
UNICEF Assistant Representative  
UNICEF Assistant Program Officer  
PHAL Executive Director  
Save the Children Fund/UK  
Rural Water and Sanitation Project

A.I.D./WASHINGTON

Ms. Wendy Roseberry  
Ms. Myra Tucker  
Mr. Felix Awangtang  
Mr. Robert Clay

CCCD Project Manager  
Asst. Project Manager  
CCCD Technical Advisor  
HEALTHCOM Project Officer

AED/HEALTHCOM/WASHINGTON

Mr. Mark Rasmuson  
Mrs. Elayne Clift  
Ms. Judy Graeff

HEALTHCOM Director  
Deputy Director  
Technical Specialist

CDC/ATLANTA

Dr. Joe Davis  
Mr. Andy Agle  
Mr. Jean Roy  
Mr. Ross Cox  
Dr. Mike Toole  
Ms. Annie Voigt  
Ms. Laurie Ackerman  
Dr. Sonja Hutchins  
Dr. Ron Waldman  
Dr. Steven Redd  
Ms. Aoko Midiwo

Director of IHPO  
Assistant Director OD  
Deputy Director FSD  
Assistant Director Management  
Medical Epidemiologist/TSD  
Nurse, Educator TSD  
EPI Evaluation Consultant  
EPI Evaluation Consultant  
Technical Support Division  
Medical Epidemiologist, TSD  
Program Analyst/IHPO

ANNEX B

DOCUMENTS CONSULTED

1. CCCD/Lesotho 1987 Annual MIS Report.
2. Quarterly Report, January-March, 1988.
3. Quarterly Report, April-June, 1988.
4. Third Year Internal Project Review Summary, December, 1987.
5. Third Year Internal Project Review, PES fact sheet, December, 1987.
6. List of 1986 CCCD Project External Evaluation Recommendations (divided by topic).
7. Lesotho 1986 EPI/CDD International Evaluation Report.
8. Lesotho 1988 International Family Health Program Evaluation: Main Findings and Recommendations.
9. Laurie Ackerman: "UNICEF Consultancy Report," 1988 International Evaluation.
10. Discussion Notes: "Measles Control Strategies in Lesotho," May 24, 1988.
11. Dale Herman: "Reported Measles Cases 1987 to 15 June, 1988."
12. Outpatient Morbidity Summary Sheets, 1981-1987.
13. Protocol for Reporting Disease Outbreaks for Notifiable Diseases.
14. HSA Training Outline, 1988/89.
15. Training Summary, 1988/89.
16. HSA Trainers Continuing Education Workshop Schedule (and other materials), June, 1988.
17. Suggested Terms of Reference for the Evaluation of Lesotho's Decentralized Training Program (draft of 25 July, 1988).
18. M. Seipobi: "Some Areas of Concern in the Development of Continuing Education."

19. Sara Bennett: "Proposal for a Unit Cost Study of the Immunization and ORT Programs in Lesotho" (Executive Summary).
20. Summary: District Operations Management Improvement Project (DMI Project -- MEDEX).
21. DMI Project Fact Sheet.
22. DMI Management Events Questionnaire, August, 1988.
23. Lipholio Makhetta: "Report on VHW Evaluation," April, 1988.

## ANNEX C

### A CONCEPTUAL FRAMEWORK FOR THE SEPT.-OCT. EVALUATION

A comprehensive impact training assessment usually examines the following issues:

1. The Nature of the Training Program
  - a) What are the components of the training/health education programs?
  - b) What are the training plans? Health Education plans?
  - c) How many people have been trained? In what courses? Identify trainees by category.
  - d) Who are the trainers? Are they from central, HSA and HC levels? Examine variations in capabilities and teaching styles.
  - e) Is training diversified enough to cover program needs?
2. Training Needs Assessments
  - a) How are training needs identified? Examine the process and the methods of these inputs from the different levels (Central, HSA, HC).
  - b) Do training courses reflect the needs of the trainees at the HSA, HC and community levels?
  - c) Are supervisory visits used as opportunities to identify new areas of skill mastery?
3. Training Goals & Objectives
  - a) Do training courses have clear goals and objectives?
  - b) Are behavioral objectives identified for each course?
  - c) Do all trainers at the different levels know the objectives of their training courses?
4. Training Budget
  - a) How is the training budget determined?
  - b) How much is spent for training?
  - c) Is the training budget adequate?

- d) How are spending priorities determined?
- e) Can the training budget be maintained after the Project ends?

5. Training Methods

- a) What are the main methods used in training?
- b) Are the training methods effective? Are case studies, demonstrations and audio-visual presentations used?
- c) Is the duration and frequency of the training adequate?

6. Evaluations

- a) How are training courses used?
- b) Are pre-and post-tests properly designed?
- c) Are evaluation forms skill-oriented, knowledge-oriented or both?
- d) How do evaluation results feed into the system?
- e) Are there follow-up activities?
- f) Have qualitative studies been used to test training impact?

7. Training Materials

- a) How are training materials developed?
- b) Have training modules been tested for validity and reliability?
- c) Are training materials available at all levels?
- d) What are the audio-visual parts of training courses?

8. Coordinating Training Activities

- a) Are training activities coordinated with other programs?
- b) How do training courses serve other Project components?

As this is not a comprehensive evaluation, only a few of the above mentioned issues are examined. However, identifying the issues and questions might be helpful for the Sept.-Oct. evaluation.

## ANNEX D

### SUGGESTED SCOPE OF WORK FOR THE SEPT.-OCT. TRAINING EVALUATION

The evaluators will assist the MOH and PHAL in reviewing and assessing the following activities and topics. Appropriate recommendations about future actions should be identified clearly by the evaluators.

#### I. INSTITUTIONAL/ORGANIZATIONAL ISSUES

1. Assess the present organizational framework of Continuing Education/Health Education Units of the MOH.
2. Examine linkages between the Planning Unit/Continuing Education Unit and other vertical training programs such as MEDEX, etc.
3. Examine the linkages between central level, HSAs, HCs, and community education.
4. Assess the present methods of identifying training needs and of integrating training needs into annual training plans both at the central and HSA levels.
5. Examine training records at central, HSA, and HC levels.
6. Assess the present program's capability to maintain proper training records.
7. Examine the relationship between supervision and training at all three levels: Central, HSA and HC.
8. Suggest specific ways to strengthen linkages and improve the flow of information between different training levels.

#### II. TRAINING IMPACT ISSUES

1. Study the role and number of core trainers and HSA trainers.
2. Assess training impact at all health personnel levels.
3. Examine and assess the quality of training courses offered to central, HSA and HC level personnel.
4. Examine the differences in quality of methods used by the different categories of trainers, e.g., public nurse trainers, nurse trainers and assistant nurse trainers.

5. Analyze the impact of new training topics introduced by other training programs on the CCCD training topics of immunization and CDD.
6. Review and observe the effectiveness of the uses of training materials such as modules. Prioritize the modules in need of upgrading.
7. Assess clarity of training goals and objectives at all different levels of training.
8. Examine the effectiveness of the semi-annual Continuing Education Workshops, including the process of setting up training agendas.
9. Assess the feasibility of holding regional versus central level continuing education in terms of cost and staff time-savings.
10. Assess the impact of non-CCCD training modules and materials of CCCD topics. (WHO, MEDEX., etc.)
11. Assess training programs' impact on the KAP of trainees and communities.
12. Analyze data in the above mentioned areas and suggest specific courses of action.

### III. BUDGET AND FINANCIAL SUPPORT

1. Examine the dynamics of establishing a training budget.
2. Describe the formula used to allocate budget shares per project.
3. Assess the present rules of budget allocations for training.
4. Examine the sustainability issues of the training program from a financial point of view.
5. Suggest specific recommendations for future courses of action.

Suggested number of consultants: Three (One consultant to examine I and III and two to examine II)

### SUGGESTED METHODOLOGY

1. Interview MOH Central staff, HSA Management Team members and HC staff.
2. Interview PHAL, CCCD, HEALTHCOM, UNICEF and other donor organization representatives.
3. Attend several training sessions at all different levels of training to assess impact. Utilize both short interviews and a questionnaire.
4. Examine training modules and training materials.
5. Attend the October 1988 Continuing Education Workshop to present the preliminary findings of the evaluation and to collaborate with the HSA trainers to devise as an implementation plan for the recommendations.
6. Review all relevant literature on primary health care in Lesotho including the CCCD evaluations, HEALTHCOM Baseline Survey, HIS Bulletins, VHWS' evaluations and other documents listed in ANNEX B.
7. Develop a skill performance sheet to be used as an evaluation instrument to assess impact.

## ANNEX E

### SUGGESTED DOCUMENTS TO BE READ BY THE TRAINING EVALUATION TEAM

1. International Evaluation Report, 1988.
2. Interim Evaluation Report- Lesotho Baseline Survey.
3. All Training modules.
4. 1988/89 Training plan.
5. 1987 Annual Report.
6. Report on VHW Evaluation.
7. Consultancy Report (April, 1988), by Lauri Ackerman.
8. ACSI-CCCD Quarterly Project Progress Reports (1987/1988).
9. Educational Messages (Basic Messages for Oral Rehydration Therapy).
10. David Gittelman's presentation on Lesotho's December Training program at the consultative meeting, Yamoussoukro, Cote-D'Ivoire.
11. Outline for CCCD Training Strategy (Draft, 1988).
12. The HEALTHCOM Project of the Health Education Unit, by Edward Douglass.
13. Organization and Staffing of the Health Education Unit.
14. Training schedules, training materials, and all other relevant documents.
15. Some Areas of Concern in the Development of Continuing Education, by Mrs. Seipobi.
16. The MOH Organizational Chart.
17. Lesotho Service Areas Map.
18. Checklists for work performance.
19. Summary Statement of the Training Needs' Assessment Survey.
20. Planning Course Follow-up Activities Document.

21. Pre-testing Health Education Materials, by Dr. Edward Douglass.
22. The Lesotho HEALTHCOM work plan.
23. The Lesotho HEALTHCOM publication.

ANNEX F

HSA TRAINING OUTLINE 1988/89

HSA	DATES	DURATION	COURSE	TARGET	NO	VENUE
BOTHE BOTHE	4-6 JAN	2 DYS	NUTRITION	CHIEFS	20	LINAKENG H/
	3-13 JAN	10	INIT/COURSE	VHW'S	30	MATLAKENG
MOKHOTLONG	5-15 JAN	10	REFRESH	VHW'S	20	LINAKENG
	17-30 JAN	10	REFRESH	VHWS	20	FTC
LERIBE	26-28 JAN	3	REF/CDD/EPI	VHWS	20	FTC
QEII	27-29 JAN	3	REFRSH	VHW'S	20	MAJARAS
MAFETENG	2-22 JAN	21	CDD/EPI/NUT	TBAS	8	MT. OLIVET
QUTHING	28-29 JAN	2	REFRSH	NURS/ASST	8	FTC
LERIBE	7-13 FEB	7	REFRSH FP	VHW'S	20	L/HOTEL
	4-13 FEB	9	FP	VHW'S	20	FTC
MALUTI	15-26 FEB	11	EPI/CDD	VHW'S	20	HLOTSE/RC
	8-9 FEB	2	REFRSH FP	NURSES	10	MALUTI
	9 FEB	1	TBA'S	COMM/LDRS	60	MALUTI
MOKHOTLONG	10-11 FEB	2	TBA'S	NURSES	60	MALUTI
	15-19 FEB	4	FP/EPI	VHW'S	40	FTC
PARAY	FEB(2 WKS)	14	FP	VHW'S	20	MOHLANAPENG
ROMA	8-10 FEB	3	EPI/CDD/AIDS	CHIEFS/TH	20	ST. BERNARD
	9-12 FEB	4	STD/AIDS	NUL STUDTS	30	NUL CLINIC
	22-24 FEB	3	EPI/CDD	CHIEFS/TH	20	RAMABANLA
MAMAHOU	23-26 FEB	5	EPI/CDD/SP	TEACHERS	20	MAMAHOU
QUTHING	15-26 FEB	10	EPI/NUT/CDD	VHW'S/INT	25	FTC
SEBOCHE	8-12 FEB	5	NUT/EPI/	VHW'S	18	MAKHUNOANE
	29-4 FEB	5	EPI/CDD	VHW'S	25	QHOLAQHOE
LFDS	29/2-18/3	21	NUT/CDD/INT	VHW'S	20	ST. JAMES
BOTHE BOTHE	8-19 FEB	10	INITIAL	VHW'S	10	RAMPAI
	8-12 FEB	5	REFRSH/NUT	VHW'S	16	MOTETE
QEII	10-12 FEB	3	CDD/EPI	NURS/ASS	25	CTC
ST. JAMES	29-2/18-3	21	INT/CDD/NUT	VHW'S	20	SEHONGHONG
ROMA	29-4 MAR	5	REFSHR/CDD	CHIEFS/TH	20	KORO-KORO
	7-14 MAR	5	EPI/TG/CDD	VHW'S	25	NAZARETH
MALUTI	14-18 MAR	5	TBA REFRHSR	VHW	20	RAMABANTA
	7-11 MAR	10	TBA'S	VHW	10	MALUTI
BOTH BOTHE	2-14 MAR	3	EPI/CDD	CHIEFS	17	TLOKOENG
	14-18 MAR	5	EPI/CDD	TBA'S	20	MAKHUNOANE
MALUTI	28-1/4	15	FP	TBA'S	7	BB/HOSP
	7-11 MAR	10	ANC	NEW/TBA'S	14	MALUTI
QE II	7-18 MAR	10	INITIAL	VHW'S	20	DOMICILLICE
	30-1/4	3	CDD	TEACHERS	25	CTC
MORIJA	28-30	3	CD/EPI/NUT	VHW'S	13	MATHEBE/PRI
	30-31 MAR	2	HIS/EPI/CDD	VHW'S	46	MATHEBE/PRI
ST. JAMES	13-15 MAR	3	EPI/CDD/NUT	T/HLRS	25	AURAY
LERIBE	1 MARCH	5	EPI/CDD/NURS	NURSES	32	HSA/HOS
MAFETENG	22-26 MAR	5	FP	VHW'S	26	TSOKHOLO
	29-16 APR	21	FP	NURSES	4	TSAKHOLO
LERIBE	17-18 MAR	2	CDD/EPI	CHIEFS	30	LERIBE/HOT
	MARCH	4	CDD	VHW'S/TBA	30	ST. THERESA
PARAY	MARCH	4	EPI/NUT	TBA'S	10	PARAY
	30-31 MAR	2	CDD/EPI	RELG/WOMEN	26	LERIBE/HOT
SCOTT	28-30 MAR	3	CDD/EPI	VHW'S	13	MATHEBE SCH

HSA	DATES	DURATION	COURSE	TARGET	NU	VENUE	
SCOTT	30-1	MAR	2	CDD/EPI	VHW'S	46	MATHEBE SCHO
QUTHING	MARCH		2	REFRSHR	VHW'S	10	DILIDILI
LERIBE	10-16	MAR	7	REFRSHR	TBA'S	20	FTC
MALUTI	11-15	APR	4	FP	TBA'S	10	MALUTI
MORIJA	11-15	APR	10	CDD/EPI/NUT	VHW'S	40	MAFOKA
	11-22	APR	14	CDD/EPI/NUT	VHW'S	80	MASMOUSE
	25-27	APR	3	CDD/EPI/	VHW'S	54	MAFIKA
	18-29	APR	14	TBA'S CURRCM.	TBA'S	6	H/C HSA TRAI
ROMA	11-22	APR	14	ANC	TBA'S	15	ST. BERNARD
LERIBE	25-27	APR	2	CDD/EPI	TBA'S	32	L/HOTEL
BEREA	18-23	APR	5	FP	TBA'S	35	R/CROSS
QUTHING	APRIL		10	R/SANITATION	LLB	50	MAKOA
MAFETENG	14-18	APR	5	EPI/NUT/CDD	VHW	26	THABANE/MRNA
MAMAHOU	11-15	APR	5	SANITATION	VHW'S	25	MOTETE
M/HOEK	11-18	APR	5	CDD/EPI	VHW	30	LIPHIRING
	18-29	APR	10	STD/NUT	VHW	30	MOOTSOMYANE
LFDS	11-29	APR	15	INIT/TOPICS	VHW'S	18	LEBAKENG
QEII	13-15	APR	3	REFRSHR	VHW	23	ST. LEO
	27-29	APR	3	INIT/HEALTH	W/ATT	25	CTC
BOTHE BOTHE	5-27	APR	3	TBA'S	TBA'S	25	LINAKENG
QUTHING	APRIL		20	EPI/CDD	VHW'S	10	MAKOA
QEII	11-13	MAY	3	EPI/CDD	NURSES	25	THABA BOSIU
LFDS	16-27	MAY	10	REFSHR TOPICS	VHW'S	25	NKAU
ST. JAMES	3-6	MAY	5	TBA'S	TBA'S	15	ST. JAMES
	16-20	MAY	5	EPI/CDD	VHW'S	10	MORAKABE
	23-27	MAY	5	EPI/CDD	VHW'S	15	MORAKABE
MOHALES HOEK	16-29	MAY	10	INITIAL	VHW	30	MOOKINYANE
	9-11	MAY	3	CDD	COMM/LDRS	45	LITHIPENG
MAFETENG	17-21	MAY	5	REFRSR/EPI/CDD	VHW'S	41	MT. OLIVETT
PARAY	MAY		4	EPI/CDD	VHW	40	PARAY
	MAY		4	EPI/CDD	TEACHERS	20	MOKOTE
	MAY		10	EPI/CDD	TEACHERS	20	MPHAKE
	MAY		10	REFRSHR	LLB	25	FTC
SEBOCHE	17-19	MAY	3	INITIAL	CHEIFS	25	ST. PETERS
BEREA	16-27	MAY	11	EPI/CDD	VHW'S	35	RED/CROSS
ROMA	16-20	MAY	5	INITIAL	TBA'S	25	NAZARETH
MOKHOTLONG	9-10	MAY	2	INITIAL	TBAS'S	20	HOSPITAL
LERIBE	9-20	MAY	14	CDD/EPI	VHW'S	20	LIBIBING
	25-28	MAY	4	CDD/EPI	VHW'S	42	FTC
	31	MAY	1	CDD/EPI	NURSES	32	HOSPITAL HSA
MALUTI	9-13	MAY	5	NUT	TBA'S	20	MALUTI
MORIJA	10-12	MAY	30	CDD/EPI/PP	VHW'S	30	MATSIENG
	16-18	MAY	3	CDD/EPI/NUT	VHW'S	29	MATELILE
	19-20	MAY	2	CDD/EPI/NUT	VHW'S	70	MATELILE
	16-18	MAY	3	CDD/EPI	VHW'S	41	MATELILE
	19-20	MAY	3	CDD/EPI	VHW'S	80	SEBELEKOANE
	16-27	MAY	14	CDD/EPI/NUT	VHW'S	90	MAFOKA
	16-27	MAY	14	TBA'S CURRCM.	TBA'S	4	TANKA P.S.
MOKHOTLONG	2-6	MAY	4	CDD/ORT/AIDS	VHW'S	20	MAPHOLANENG
	9-10	MAY	2	STD/AIDS	TH	20	MO/HST
	11-12	MAY	2	ANC	TBA	20	LIBIBING
	16-20	MAY	4	CDD/NUT/ORT	VHW'S	20	LIBIBING
ROMA	18-20	MAY	3	EPI/CDD	SOC. MOB	20	NUL CLINIC
	23-26	MAY	4	ANC/PNC	TBA'S	20	ST. BERNARD
	30-1	JUNE	3	EPI/CDD/STD	HOSTEL/SUP	20	NUL CLINIC

HSA	DATES	DURATION	COURSE	TARGET	NO	VENUE
LERIBE	6-9 JUN	3	CDD/EPI	TEACHERS	30	ST. BERNARD
	30 JUN	1	REFRSHR	DHP	50	NUL CLINIC
ROMA	6-8 JUN	3	EPI/CDD	TEACHERS	25	NAZARETH
	27-29 JUN	3	EPI/CDD	TEACHERS	16	RAMABANTA
QUTHING ST. JMS	JUNE	3	RSP	VHW'S	20	FTC
	6-10 JUN	5	EPI/NUT	VHW'S	25	MT. MOTRE
	13-24	10	INITIAL	VHWS	10	MT. MOTRE
QEII	27-1 JULY	5	INITIAL	TBA	10	MT. MOTRE
	8-10 JUN	3	REFRESH	VHW'S	25	MASIANOKENG
MALUTI MORIJA	13-24 JUN	10	INITIAL	VHW'S	20	NTLODUA TSO.
	6-10 JUN	4	EPI	VHW'S	20	MALUTI
MALUTI	13-14 JUN	2	CDD/EPI/NUT	VHW'S	44	MATSIENG
	21-22 JUN	2	CDD/EPI/PP	TCHRS/PRST	44	MASMOUSE
	23-24 JUN	2	CDD/EPI/NUT	TH	24	MATSIENG
	4-8 JULY	12	CDD/EPI/NUT	VHWS	12	AFM CHRCH
MALUTI	11-12 JULY	10	CDD/EPI/NUT	TBAS/RFRSH	10	MALUTI
	13-14 JULY	2	CDD/EPI/NUT	TBA'S/RFRS	20	
BOTHE BOTHE	11-22 JULY	10	NUT/REFRSR	VHW'S	30	MATLAMENG
	25-29 JUL	5	EPI/NUT	VHW'S	22	POKANE
QEII	6-8 JULY	3	REFSHR	VHW'S	14	LOXETHO
	20-22 JUL	3	REFRSR	VHW'S	9	SDA
LFDS	20-8 JUL	10	INITIAL	VHW'S	15	BOBETE
	18-29 JUL	12	EPI/NUT	VHW'S	15	SESHOTE
ST. JAMES	11-15 JUL	5	EPI/CDD/NUT	VHW'S	20	LEPHOI
	18-22 JUL	5	EPI/CDD/NUT	VHW'S	20	LEPHOI
	25-29 JUL	5	EPI/CDD/	TBA	15	LEPHOI
MAMOHOU	25-29 JUL	4	EPI/CDD	NURSES	15	HSA/HOSP
PARAY	JULY	4	EPI/CDD/NUT	VHW'S	20	PARAY/HOSP
QUTHING	JULY	4	CDD	VHW'S	20	ST. GABRIEL
MOHOLES/HOEK	11-22 JUL	14	NUT/EPI	VHW'S	30	RED CROS
SEBOCHE	18-29 JULY	10	EPI/NUT	VHW'S	18	SEBOCHE
BEREA	30-1 JULY	2	B/F	VHW'S	35	BELA/BELA
	10-15 JUL	6	MCH/FP/NUT	VHW'S	30	ST. MAGDELE.
ROMA	20-22 JUL	3	EPI/SSP/	DDC	30	BLUE MT. INI
	11-13 JULY	3	EPI/CDD	DOM/STAFF	20	ROMA HOSP
LERIBE	4-7 JULY	4	EPI/CDD	TCHRS/PRST	30	FTC
	18-29 JULY	10	EPI/CDD	VHW'S	32	MAPUTSOE SD
TEBELLONG	4-8 JULY	5	EPI/CDD	VHW'S	30	PHC CENTRE
	9 JULY	1	EPI/CD	VHW'S	15	PHC CENTRE
	11-15 JULY	5	EPI/CDD	VHW'S	30	PHC CENTRE
	23 JULY	1	NUTRITION	TEACHERS	20	PHC CENTRE
	27-29 JULY	3	EVALUATION	VHW, CHIEFS	50	PHC CENTRE
	1-5 AUG	5	CDD/EPI	VHW'S	20	
	5-6 AUGST	2	STD/AIDS	NURSES	20	HOSPITAL
MOKHOTLONG	1-12 AUGST	10	STD/AIDS	VHW'S	10	MAPHTANENG
	20 AGST	1	STD/AIDS	THCRS	10	LINAKENG
	29/8-20/9	5	FP	N/ASST	16	FTC
	13 AGST	1	ANC/PNC	TBA	20	LINAKANENG
	11-12 AGST	2	ENT/CDD	TH	20	FTC
	15-19 AGST	3	EPI/STD	VHW	20	MALEFILOANE
	11-12 AGST	2	ENT/CDD	TH	20	FTC
	15-19 AGST	4	STD/ANC	VHW	20	MALEFILOANE
	22-23 AGST	2	ANC/PNC/EPI	TBA	20	MALEFILOANE
	25-26 AGST	2	STD/AIDS	TH	20	MALEFILOANE
LERIBE	1-12 AUGST	12	EPI/CDD	VHW'S	30	ST. ANNE
	16-26 AGST	10	EPI/CDD	VHW'S	36	PONTMAIN

HSA	DATES	DURATION	COURSE	TARGET	NO	VENUE
LERIBE	30 AGST	1	EPI/CDD	NURSES	32	HOSPITAL
	15-17 AGST	2	FP	VHW'S	12	SEBED
MORIJA	1-5 AGST	5	CDD/EPI/NUT	VHW'S	22	BOLEKA
	1-12 AGST	12	VHW/MNLS	VHW	13	TSOENENG
	28-30 AGST	3	CDD/EPI/NUT	VHW	38	MOLOMOS HOE
ROMA	1-5 AGST	5	STD/EPI	VHW	35	ST. BENEDIC'
	8-12 AGST	5	CDD	VHW'S	19	ST. BENEDICT
	15-19 AGST	5	MNGMT	VHW'S	35	RAMABAMBA
BEREA	12-13 AGST	2	CDD/EPI/BF	TH'S	25	LITTLE FLOW
SEBOCHE	8-12 AUG	5	EPI/CDD/NUT	VHW'S	20	MAKHUNOANE
	15-19 AGST	5	CDD/NUT/GM	VHW'S	25	BOIKETSISO
	1-3 AUGST	3	CDD/EPI/FP	VHW'S	25	MAKHUNOANE
	22-24 AGST	3	PHC/TYHPOID	TCHRS	15	SEBOCHE
QUTHING	AUGST	10	INITIAL	VHW'S	8	FTC
	AUGST	20	INITIAL	VHW'S	20	TSATSANE
	AUGST	25	INITIAL	TEACHERS	25	NKOBENG
PARAY	AUGST	21	CDD/EPI	VHW'S	10	MOKOKO
MAFETENG	2-13 AUGST	10	CDD/NUT/EPI	VHW'S	8	MT. OLIVET
	23-27 AGST	5	CDD/NUT/EPI	VHW'S	25	LITSOENENG
MOHALESHOEK	1-5 AGST	5	NUT/ENV/FA	VHW'S	40	BETUEL
	15-20 AGST	7	NUT/ENV/FA	VHW'S	35	MPHARANE
ST. JAMES	8-12 AUGST	5	EPI/CDD/NUT	TCHRS/EXT	10	LIKALANENG
	11-19 AGST	9	EPI/CDD	VHW'S	35	MPHARANE
LFDS	3-12 AGST	10	EPI/CDD	SOC/WORK	13	ANG/TC
	12-19 AGST	10	EPI/CDD	SOC/WORK	7	AMG/TC
QEII	3-5 AGST	3	EPI/CDD	VHW	44	MATUKENG
	17-19 AGST	3	CDD/EPI	PRIM/TCHR	25	CTC
BOTHA BOTHE	8-19 AGST	10	REFRSHR	TBAS	50	MATLAKENG
	11-13 AGST	2	REFRSHR	NURSE	9	NOTENG
	15-19 AGST	5	REFRSHR	VHW	17	MOTENG
	22-24 AGST	3	REFRSHR	VHW'S	20	MOTENG
	1-3 SEPT	2	REFRSHR	VHWS	24	EMMANUEL
	12-16 SEPT	5	REFRSHR	TCHRS	16	MOTENG/LDG'
MACHABENG(QN)	24-28 AGST	5	CDD/EPI	HSA TRNR	15	FTC
	17-21 AGST	5	CDD/EPI/TD	HSA TRNR	36	FTC
	31-4 SEPT	5	CDD/EPI	HSA TRNR	15	FTC
	12-15 SEPT	5	ANTENT. CRE	HSA. TRNR	96	H/CENTRE
TEBELLONG	19-23 SEPT	5	RFRSHR	VHW	20	PHC CENTRE
	30 SEPT	1	ORT	NURSES	30	
QEII	7-9 SEPT	3	EPI/CDD/RFRS	VHW'S	18	KHUBELSOA
	21-23 SEP	3	EPI/CDD	NURSE	20	CTC
LFDS	5-23 SEPT	21	INITIAL	VHW'S	20	NOHANA
ST. JMS	5-9 SEPT	5	EPI/CDD TB	NURSE	10	METHABNG
	15-23 SEPT	10	INITIAL	VHW'S	8	METHLNES
	26-30 SEPT	5	EPI/NUT. CDD	VHW'S	20	MARAKABAI
MOHOLESHOEK	5-10 SEPT	5	EPI/CDD	VHW	30	LITHIPENG
MAFETENG	13-30 SEPT	21	EPI/CDD	TBA	10	THABA TSOEU
PARAY	SEPT	4	CDD/SS	NURSES	20	PARAY
QUTHING	SEPT	1	VHW/MNL	VHW	8	MAKOAE
	SEPT	1	VHW/MNL	VHW	10	MPHAKI
SEBOCHE	12-23 SEPT	10	VHW/MNL	VHW	22	ST. PETER
MALUTI	12-23 SEPT	11	CDD/EPI	VHW	15	MALUTI
MOKHOTLONG	5-9 SEPT	2	ANC/PNC	VHW'S	20	SEMENANYANA
MALUTI	1-2 SEPT	2	CDD/NUT/EPI	VHW'S	72	MOLOMO/HOEK
	22/26 AGST	4	CDD/EPI/	VHW'S	12	JOBO/PRIM
	5-9 SEPT	4	CDD/EPI/NUT	VHW'S	15	MASABIELLA

HSA	DATES	DURATION	COURSE	TARGET	NO	VENUE	
MALUTI	5-9 SEPT	10	CDD/EPI/NUT	VHW'S	65	MOTSEKUA	
	5-16 SEP	10	VHW/MNL	VHW'S	19	KOLO H/C	
	5-16 SEPT	10	VHW/MNL	VHW'S	13	MATELILE	
	12-14 SEP	3	CDD/EPI/NUT	VHW'S	53	MASEMOUSE	
	15-16 SEPT	2	FP/CDD/EPI	VHW'S	36	MASEMOUSE	
	19-30 SEPT	10	VHW'S/MNL	VHW'S	24	ST. RODRIQUE	
	12-23 SEPT	10	VHW'S/MNL	VHW'S	24	MANTISEBO	
BEREA	4-9 SEPT	6	FP	VHW	35	RED/CROSS	
	11/23 SEP	11	FP	N/ASST	8	NURSE ASST	
ROMA	5-9 SEP	5	STD/EPI/	VHW'S	20	ROMA/HOS	
	12-14 SEP	3	EPI/STD	CHIEF/TH	20	ROMA/HOS	
LERIBE	12-15 SEP	4	EPI/CDD	TH	20	FTC	
	26-1 OCT	6	REFRSHR	NURSES	10	L/HOTEL	
MAMAHOU	26-29 SEP	5	REFRSHR	VHW'S	20	ST. JAMES	
	14-18 OCT	4	TYPHOID/STD	VHW'S	20	ST. MARTIN	
	21-25 OCT	4	ANC/EPI/CDD	TBA'S	20	ST. MARTIN	
MORIJA	10-21 OCT	10	FP/CDD/EPI	VHW'S	24	MANTISEBO	
	24-26 OCT	3	CDD/EPI/NUT	VHW'S	18	LEHANENG	
	25-27 OCT	2	FP/CDD/EPI	VHW'S	61	LEHANENG	
	10-21 OCT	10	TBA'S CURRCM.	TBA'S	29	ST. ROD. H/	
MALUTI	24-26 OCT	3	CDD/EPI	VHW'S	10	FOBANE	
	9-15 OCT	6	REFRESHR	TBA'S	15	MALUTI	
MOKHOTLONG	5-7 OCT	3	ANC/AIDS	TBA'S	20	LINAKANENG	
LERIBE	10-21 OCT	10	INITIAL	VHW	35	MARYLAND	
ROMA	10-14 OCT	5	EPI/CDD	TBA'S	14	ROMA HOSP.	
	24-26 OCT	3	EPI/CDD/NUT	CHIEFS/TH	20	NAZARETH	
	31-11 NOV	14	REFRSHR	VHW'S	15	ROMA/HOSP	
MACHABENG	17-18 NOV	15	CDD/NUT/BF/NUT	NURSES	140	HEALTH/CTRE	
	13-15 OCT	3	EPI/CDD/BF	WOMENS GRP	30	RED CROSS	
BEREA (TY)	18-20 OCT	3	REF/EPI/CDD	VHW	15	ST. LEONARD	
	SEMOKONG	10-20 OCT	12	INITIAL	VHW	10	SEMOKONG
		OCT	T/A	VHW/MNL	VHW	8	ST. MATHEWS
QUTHING	OCT	T/A	VHW/MNL	VHW	30	ST. MATHEWS	
	OCT	T/A	RSP/LLB	RSP	8	DILLI/DILLI	
	OCT	T/A	REFRSHR	VHW	30	MOHLANAPENG	
PARAY	OCT	4	REFRSHR	VHW	30	MOHLANAPENG	
TEBELLONG	29 OCT	1	ORT	G/MTHRS	25	PHC CENTRE	
MAFETENG	11-29	5	ANC/PNC	TBA	10	TSAKHOLO	
MOHALES/HOEK	17-21 OCT	5	EPI/CDD/NUT	TBA	10	TSAKHOLO	
	12-14 OCT	5	EPI/CDD/NUT	VHW	28	HOLYCROSS	
MAMOHOU	24-28 OCT	5	CDD/STD/AIDS	VHW	35	PALAMA	
	ST. JAMES	10-14 OCT	5	ANC/AIDS	VHW	8	MARAKABEI
		24-28 OCT	5	CDD/STD/AIDS	VHW	15	ST. JAMES
LFDS	10-29 OCT	21	INITIAL	VHW	15	SESHOTE	
QE II	12-14 OCT	3	REFRSH/EPI/CDD	VHW'S	15	BEHTAMY	
	26-28 OCT	3	POLICY PROTC.	NURSES	25	CTC	
	10-21 OCT	10	INITIAL	VHW	15	KHABOS	
BOTH BOTHE	24-4 NOV	10	INITIAL	VHW	15	ST. PAUL	
	24-26 NOV	3	REFRSHR	TBA	20	LINAKENG	
	7-11 NOV	5	REFRSHR	VHW	15	MOTETE	
	15-18 NOV	5	REFRSHR	VHW	16	RAMPAI	
	28-30 NOV	3	REFRSHR	VHW	25	BOIKETSISI	
	QE II	7-11 NOV	3	REFRSH	VHW	20	RLDF
		23-25 NOV	3	REFRSH	NURSE	25	CTC
LFDS	31-18 NOV	21	INITIAL	VHW	20	NKAU	
	14-25 NOV	11	REFRSHR	VHW	15	KOLBERG	
	28-2 DEC	6	REFRSHR	VHW	15	TIHANYAKU	

HSA	DATES	DURATION	COURSE	TARGET	NO	VENUE
MORIJA	14-25 NOV	10	VHW'S/MNL	VHW'S	20	MATSIENG
	NOV. 15	1	ANC	TBA'S	11	MASITE
	NOV 24	1	ANC	TBA'S	8	KOLO H/C
	7-18 NOV	10	FP	NURSES	5	MATELELE
LERIBE	7-11 NOV	4	EPI/FP	NURSES	20	FTC
	7-25 NOV	15	FP	NURSES	10	LERIBE/HOT
	29 NOV	1	CDD/FP	NURSES	32	HSA/HOSP
BEREA (TY)	6-11 NOV	6	FP	TBA'S	35	LITTLE/FLOW
SEMOKONG	1-3 NOV	6	CDD	TH	20	SEMOKONG
	7-25 NOV	18	THEORY/PRCTS.	TBA	10	SEMOKONG
QUTHING	NOV	10	RSP	VHW	20	ZOMO
PARAY	NOV	4	REFRSH	VHW	30	MOHLANEPENG
MAFETENG	15-19 NOV	5	REFRSH	VHW	25	TSAKHOLO
	22-26 NOV	5	REFRSH/NUT	VHW	25	THABA TSOEU
	8-12 NOV	5	REFRSH/CDD/NUT	VHW	25	TSAKHOLO
	31-5 NOV	5	CDD/NUT/RFRS	TBA	20	MONYAKE
	1-3 NOV	3	CDD/EPI	TBA	40	TSEPOS
MOHOLES/SHOEK	14-18 NOV	4	T/A	VHW	30	HA THETSO
	23-25 NOV	3	T/A	VHW	45	RED CROSS
	7-18 NOV	10	INITIAL	VHW	20	CHRST/KING
TEBELLONG	21-25 NOV	5	EPI	VHW	20	PHC/CNTR
	26 NOV	1	ORT	EXT WORK.	25	SEKAKE
	1-3 DEC	2	EPI/CDD	NURSES	8	MOTENG/LODGE
BOTHE BOTHE	1-3 DEC	2	EPI/CDD	NURSES	8	MOTENG/LODGE
QE II	7-9 DEC	3	EPI/CDD	WORD/ATT	25	CTC
LFDS	5-9 DEC	5	REFRSH	HLTH/WORK	12	LESOTHO/COO
MOHOLES/HOEK	6-8 DEC	3	CDD/EPI	EXT. WORK	35	MOOITSINYANI
LERIBE	6 DEC	1	EPI/CDD	D/HLTH	50	HOSPITAL
TEBELLONG	12-16 DEC	5	ORT	VHW	30	PHC CENTRE
BEREA (TY)	JAN'89	11	PHC/NUT	VHW	35	GETHESEMANE
SEMOKONG	JAN'89	5	INITIAL	VHW	11	SEMOKONG
QUTHING	JAN'89	1	INITIAL	VHW	8	TSATSANE
MOHOLES/HOEK	16-20 JAN	5	T/A	VHW	35	EXT. WORK
QUTHING	FEB	T/A	T/A	VHW	8	MORIFI
QUTHING	MARCH'89	T/A	T/A	FP	8	TLATLAMETSI
BEREA	FEB	11	EPI/CDD	VHW	20	ST. DAVID
MOHOLES/HOEK	1-10 FEB	14	FP	VHW	35	ST. CECILIA

**ANNEX G**

**TRAINING SUMMARY FY 1988-89**

	B. BUTHE LERIBE		TOTAL																	
	TOTAL	TOTAL	LFDS	MAFETENG	MALUTI	M. HOEK	MHOTLMS	QCHAS	QE II	QUTHNG	TY	MANTSME	MORRJA	PARAY	RDMA	SEBOCHE	S'KONG	MANOHAI	TEBELLONG	TOTAL
EXPECTED DURATION	92	134	161	144	62	92	52	36	76	212	56	106	226	56	98	49	41	27	49	1,769
ACTUAL DURATION	0	17	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	24
EXPECTED PARTC.	293	737	178	298	238	520	329	302	496	374	298	267	1,070	205	406	183	53	135	300	6,682
ACTUAL PARTC.	0	62	0	0	0	0	0	0	59	0	0	0	0	0	0	0	0	0	0	121
TYPE/NO. PART.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO/SMD	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
N/C	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
PHN	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
MURSE	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MURSE ASST.	0	1	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	9
VHM	0	35	0	0	0	0	0	0	31	0	0	0	0	0	0	0	0	0	0	66
EXTENSION WORKER	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OTHER HEALTH	0	5	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	10
OTHER	0	20	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	28
EST. CCCC COST	0	10,454	0	0	0	0	0	1,669	3,900	0	0	0	0	2,194	0	2,310	0	0	3,088	23,615
ACTUAL CCCC COST	0	1,836	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,836
Est. Trans. Cost	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Est. UNICEF Cost	10,058	11,700	24,134	28,015	6,253	30,390	10,440	196	5,250	18,992	27,805	34,515	7,535	14,925	9,178	11,079	3,551	4,222	22,049	280,486
Act. UNICEF Cost	0	4,851	0	0	0	0	0	0	516	0	0	0	0	0	0	0	0	0	0	5,366
Est. UNFPA Cost	2,080	38,570	0	1,100	1,358	2,640	896	0	0	0	1,672	2,100	200	4,670	0	0	0	0	0	55,286
Act. UNFPA Cost	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Est. Donor 3 Cost	0	0	0	0	0	0	0	0	0	5,700	0	0	0	0	0	0	971	0	0	6,671
Act. Donor 3 Cost	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Est. Donor 4 Cost	0	0	0	0	0	0	0	0	255	0	0	0	0	0	0	0	0	0	0	255
Act. Donor 4 Cost	0	0	0	0	0	0	0	0	255	0	0	0	0	0	0	0	0	0	0	255
Facilitators	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Training Mat. Rec.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EPI:																				
1 - Field Workers Guide	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 - Ensure Public Part.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3 - Target Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4 - Alert!	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CDD:																				
1 - Field Workers Guide	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 - Healthy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3 - Target Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support:																				
1 - Suppl & Spvsn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 - Training	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0