

PD-ABP-437

**BRIDGING TRAINING ACTIVITIES  
EVALUATION REPORT**

**PRIMARY HEALTH CARE**

**COMPREHENSIVE SKILLS TRAINING  
MANAGEMENT TRAINING**

**U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
REPUBLIC OF SOUTH AFRICA**

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## LIST OF ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival (USAID Project)
BIPH	Border Institute of Primary Health
CDC	Centers for Disease Control and Prevention
DBL	Distance Based Learning
DDM	Data for Decision Making (USAID Project)
DOH	Department of Health
ECDOHW	Eastern Cape Department of Health and Welfare
ECP	Eastern Cape Province
INTRAH	Program for International Training in Health (University of North Carolina)
MEC	Members of Executive Committee
NWP	North West Province
PDOHW	Provincial Department of Health and Welfare
PHC	Primary Health Care
PRIME	Primary Providers Training & Education in Reproductive Health (USAID Project)
RSA	Republic of South Africa
SA	South Africa
TOT	Training of Trainers, Trainers of Trainers
USAID	United States Agency for International Development

## EXECUTIVE SUMMARY

The high priority Bridging Training Activities identified jointly by the RSA and USAID/SA in 1995 in order to lay the foundations for a more rapid implementation of the EQUITY Project have accomplished their objective and set the stage for strengthened and institutionalized Primary Health Care training programs within the provinces.

The planning for the training brought together individuals from diverse parts of the health sector, including teaching institutions, provincial and district government agencies, non-governmental organizations and the private sector to form Working Groups. They forged a partnership to address the development of training curricula in Health Management and Comprehensive PHC Skills and their trial implementation.

The training curricula that were developed and tested have improved facilitation and teaching skills as well as on-site clinical practice and have succeeded in making the PHC approach more practical and feasible. The introduction of distance-based learning concepts in the Comprehensive PHS Skills course has helped alleviate problems with training capacity between regions and districts.

The bridging training effort has already strengthened the primary health care program by training different cadres of health personnel in a range of clinical and management skills for serving as Trainers of Trainers, Regional Trainers, Facilitators, Mentors, Preceptors and frontline Primary Health Care Providers. By-products of the bridging training activities are a province-wide infrastructure of district trainers, local mentors/preceptors and regional co-facilitators essential for the implementation of distance-based learning concepts, and a cadre of inter-disciplinary experts and resource people on training module development.

The failure to complete some activities initially planned by the Working Groups, together with difficulties in the selection of TOTs and Mentors and problems with logistics and communications proved to be barriers to fully effective implementation. The absence of a liaison person and the lack of coordination of the training efforts between the HRD and PHC Directorates in the Eastern Cape were other factors impeding successful implementation and full recognition of the accomplishments under the bridging training activities.

The valuable lessons learned, both at the local and international levels, from the Bridging Training Activities will positively impact the success of the EQUITY Project and related primary health care activities.

# 1. INTRODUCTION

## 1.1 BACKGROUND

USAID's program of assistance to the Government of South Africa/Department of Health has three major components: 1) Long-term bilateral assistance, namely, The Equity in Integrated Primary Health Care Project (The EQUITY Project); 2) short-term assistance provided by Bridging Training Activities in Primary Health Care; and 3) support for educational efforts in HIV/AIDS/STDs prevention and treatment activities conducted by NGOs through the Community Outreach and Leadership Project (The COLD Project). The EQUITY Project was designed to help correct fragmented primary health care (PHC) services in South Africa and to render these services equally to all South Africans. The short-term assistance consists of several high-priority PHC activities conducted before the start of The Equity Project so that the Department can implement the policies it has developed.

In February 1995, the Government of South Africa and USAID entered into a Memorandum of Understanding to address systemic issues related to the provision of integrated primary health care service. The program of assistance provided for short-term assistance to be administered through USAID/Washington, and coordinated by the USAID/South Africa Mission. Three priority areas and USAID centrally funded projects were mutually identified. These areas and project titles are identified as: 1) Health Management and Applied Epidemiology Training [Data for Decision-Making Project /Centers for Disease Control and Prevention]; 2) Comprehensive PHC Skills Training [BASICS and INTRAH/PRIME Projects]; and, 3) Demographic and Health Survey [DHS project]. The training component provided by DDM, BASICS and INTRAH began shortly thereafter and all activities ended in February 1997. The purpose of this report is to present the findings of the evaluation of the Bridging Training Activities in Primary Health Care.

## 1.2 EVALUATION APPROACH

### *1.2.1 Terms of Reference*

The purpose of the Bridging Training activities was to develop an operational plan for a two-year Training of Trainers (TOT) in-service nurse-clinician program in comprehensive PHC skills and health management training programs. The objectives of the activities was to introduce management practices to improve equity and efficiency of Primary Health Care service delivery and to promote accountability of primary health care service providers to users, clients and the public, in the nine provinces of South Africa.

It is important to evaluate the approaches, processes and procedures used by BASICS and INTRAH for the nurse-clinicians comprehensive PHC skills training course and CDC/DDM for the health management training course, before moving into full scale implementation of the EQUITY Project. Important elements to evaluate are the outcomes (products) of these two training courses and their respective strengths, limitations and potential for replication in future programming.

The evaluation team was tasked with the following:

- Assess the training approaches and processes used in planning and implementing both the PHC management and the comprehensive PHC skills training programs;
- Assess the impact of the bridging training activities on USAID's SO3 (Health) and its intermediate results;
- Describe the characteristics and features of the various categories of training centres utilised and their appropriateness as a location for future training;
- Describe the models used to encourage Non-Governmental Organizations (NGOs) to participate in the training design, development and implementation, and identify modules that should either be added or dropped;
- Examine the degree to which the PHC management and the comprehensive PHC skills training reflect the DOH training policy for PHC training;
- Identify the policies that have evolved or are evolving from the PHC training experience - for both programs;
- Identify the strengths and limitations of the PHC management and the comprehensive PHC skills training, and distil lessons learned that may be useful to the EQUITY Project;
- On the basis of these strengths, limitations and lessons learned, propose additional approaches to both training programs, where appropriate.

The evaluation procedures consisted of data collection, review and analysis of organizational reports, workshop reports, and course materials. Interviews of relevant DOH, PDOHW, TOTs and organizational personnel were also conducted.

(See Appendix E for Specification/ Work Statement).

### ***1.2.2 Team Schedule and activities***

On February 24, 1997 the evaluation team began a series of briefings, discussions and interviews of all the relevant players of the Bridging Training Activities in PHC. A review of existing documents on bridging training activities was also done. Most of the interviews took place in the five regions of the Eastern Cape Province. Interviews regarding the PHC management course were also held in the Northern Province and North West Province.

(See Appendix D for Schedule of Bridging Training Evaluation Team)

## **2. THE SETTING**

### **2.1 THE REPUBLIC OF SOUTH AFRICA IN TRANSITION**

During the apartheid era, the Eastern Cape region (now Eastern Cape province) was the most deprived of resources and the most fragmented. The former Eastern Cape and Border area had health services delivered separately for different races and different services by the Cape Provincial Administration, National Department of Health and Population Development, House of Representatives and House of Assembly. The Ciskei and Transkei were "Independent States" with their own ministries of health and could develop more integrated services for their largely rural populations.

Due to the effects of apartheid it was determined that in order to achieve the highest state of health, social well-being and development for South Africa, emphasis should be placed on rendering PHC services at the lowest appropriate, effective level within regional, district, local authority and community contexts based on local needs and available expertise.

The bridging training activities could help towards achieving the priorities for change which were identified as early as December 1994 by the Primary Health Care Commission. These entailed:

- Reorientation of the health policy from being information giving to inclusiveness;
- Discarding fragmentation to ensure equity of resource allocation and to enable effective implementation;
- Emphasis on a comprehensive, collaborative and coordinated approach to health care delivery;
- Curriculum review to effect changes in professional education and training;
- Retraining of existing staff in participatory group methods;

### **2.2 PRIMARY HEALTH CARE IN SOUTH AFRICA**

Primary Health Care in South Africa was in need of change because of the following constraints to equitable delivery of services:

- Health services were facility based with top-down supervision;
- Services were curative rather than promotive and staff were trained in a disease-oriented medical model;
- Preventive and health promotional interventions and coverage were low;
- Staffing patterns were uneven, there were few trained professional staff, teamwork was lacking and tasks were not coordinated;
- Quality of service was inconsistent, especially client-provider interaction, and there was virtually no community participation; and,
- Hours of service were provider-driven despite community factors.

As efforts are being made to change the constraints described above, vertical training programs are still being offered by Universities:

- \* One year diploma course in Clinical Nursing Science, Health Assessment, Treatment and Care;
- \* Two year diplomas of Public Health for multi-disciplinary teams;
- \* Masters of Medicine in Public Health (two years) for doctors;
- \* Community Health Nursing Diploma/Degree (Primary Health care is integrated in all courses).

Courses currently offered by the Department of Health Training Centre are:

- \* Three month courses in Reproductive Health;
- \* Four day courses in Health Promotion for non-professional health workers (nursing aides, community leaders, supervisors of NGOs);
- \* Two week epidemiology courses for all health professionals;
- \* Five day courses on human sexuality and life skills for registered nurses, community leaders, NGOs;
- \* Two week courses in Family Planning;
- \* One week courses for professional nurses in AIDS, transcultural nursing, tuberculosis and prevention;
- \* Six week courses in Primary Health Care;
- \* Two week courses in Genetics;
- \* Two week courses in Geriatrics;
- \* One week course in STDs.

The proliferation of vertical courses highlight the need for change in this area.

### **3. DESCRIPTION OF ACTIVITY**

The bridging training activities address the need to improve PHC services by improving the knowledge and skills of service providers, particularly those in rural and other hard-to-reach areas. To do this the PHC training skills, the management and training tools available to the Provinces must be improved. At the same time, the new roles of the national, provincial and district DOH must be practically defined and mechanisms must be developed to allow the DOH to influence, support and monitor the quality of implementation at all levels.

The health management TOT program provides technical assistance to develop a cadre of PHC TOTs with analytic and management skills for improved PHC program performance in each province. The trainers are to be used to train several different target groups in PHC management including health management teams at provincial, district, and community levels, health clinic supervisors, managers, etc. The proposal was to:

1. Develop and implement a curriculum in PHC management that will provide a small cadre of trainers in each province with the capacity to train different target audiences in health management and data for decision making;
2. Help TOT participants in drafting and developing consensus for provincial training plans;
3. Provide technical assistance and consultation (mentoring) to TOT participants as they carry out locally developed training plans in their provinces;
4. Provide added support to the Eastern Cape Province to ensure the setting up of Provincial PHC management training and evaluation plans.

Three designated trainers from each of the nine provinces were to attend TOT courses during 1996. The focus of the planned courses was on the following three categories:

1. PHC data use and performance-based skills;
2. Management attitudes, behaviours, and styles; and,
3. Training and evaluation skills.

The curriculum uses adult learning, interactive distance learning/open training methods, and emphasizes the practical application of methods and materials to strengthen equitable and quality PHC service delivery. A working group was to develop learning objectives, a curriculum, teaching materials, and mentoring plans. Working group participants would serve as lecturers and facilitators, mentors and evaluators.

Participants completing the course would be able to: carry out training needs assessments, develop curricula, train, and evaluate the quality of management/DDM training for different audiences. They would leave with the following:

1. A plan for implementing modular training activities in their provinces; and,
2. Materials needed to carry out training. Participants would carry out training plans contingent upon available provincial financial and management support.

The proposed comprehensive skills training is a 24-month program carried out in the Eastern Cape Province. The planners envisioned a national program similar to the health management program. However, due to the intensive and costly efforts that an on-site program would have, it was decided that limiting the activity to one province would be sufficient for this "pilot" effort.

The goal of the PHC comprehensive skills training is to increase the availability of integrated and comprehensive Primary Health Care Services and improve the quality of the services through development of training capability and capacity in the provinces.

### 3.1 PLANS FOR DESIGN AND IMPLEMENTATION

Given the existence of vertical PHC programming and training, the Bridging Activities were to pave the way for integrated primary health care. A series of preliminary planning workshops began in 1995 to set the stage for more focused planning for curriculum development and training. The workshops are described below.

\* **WORKSHOP ON PHC ASSESSMENT AND PLANNING FOR EQUITY PROJECT  
IN BRIDGING TRAINING ACTIVITIES.**

- PHC In-service Training
- PHC Management Training

21 May - 9 June 1995

Because of the close relationship in training needs anticipated between the TOT programs for clinicians and managers, it was decided that assessment visits for the two programs would best be carried out jointly by the collaborating agencies: BASICS and INTRAH (nurse-clinician training) and CDC (management training).

Purposes of the workshop:

- Identified training needs as reported in existing documents, interviews and discussions with officials in the Department of Health (DOH) at national and provincial levels, other ministries, non-governmental organisations, and other international agencies.
- Identified other ongoing activities in PHC education and management training conducted by DOH, other ministries, universities, NGOs, and international agencies.
- Identified National and Provincial health management capability and capacity including training facilities and equipment, previously developed curricula, and local expertise and resources in the fields of applied health management, epidemiology training distance learning.
- Collected appropriate data to fill gaps regarding training needs and availability of local expertise and resources at national and provincial levels.
- Identified a training strategy that would achieve desired results.
- Developed an operational plan for the training of trainers training strategy.
- Obtained consensus on findings, conclusions, and recommendations through a forum activity that included all key stakeholders in the project.
- Clarified and confirmed roles and responsibilities of counterparts for implementation of the plans.

- \* WORKSHOP ON IMPLEMENTATION PLANNING FOR PHC MANAGEMENT AND CLINICAL TOT TRAINING  
18 -20 October 1995

Purpose of workshop:

- Planned and prepared an implementation work plan for the Eastern Cape. Included identification of target groups, activities, time lines, responsible parties and identification of resources needed.

Objectives of Workshop:

- Reviewed available data on PHC service delivery and training to use as the framework for the proposed training.
- Explored different PHC service delivery and training models and select a model to be supported by the PHC training activities.
- Reached consensus about where TOT management and clinical trainers and trainees would be drawn and major post-training functions.
- Identified the locus and implementation institutions and persons responsible for the PHC TOT Management and Clinical training in the province including the local contact person to coordinate implementation of the program work plan.
- Discussed specific issues relates to distance learning methodologies for PHC TOT management and clinical training.
- Determined learning objectives and proposed curricula for the PHC Management and Clinical TOT training courses.

- \* WORKING GROUP WORKSHOP  
18 - 22 March 1996

PHC Management program

Mission:

- Brought about needed changes in PHC Management by implementing training programs for capacity building in the health field by March 1997.
- Brought about change in the PHC management by developing and implementing appropriate reorientation programs for capacity building in health science delivery.
- Clarified issues and plan for:
  - o Development of curriculum
  - o Identification of learning objectives
  - o Definition of TOT characteristics
  - o Evaluation plan development
  - o Implementation of plan.

### PHC Comprehensive Skills Program

#### Goal;

- Reorient, reinforce, update and develop new knowledge and skills on key PHC areas for trainers to enable them to upgrade the skills of the PHC workers and reorient them to community involvement and management of PHC services.

#### Workshop objectives:

- Developed a resource inventory (human resources materials).
- Clarified the areas to focus the needs' assessment for potential (or identified) TOT candidates
- Identified the broad curriculum objectives, content, learning experiences, evaluation indicators and distance learning materials.
- Clarified issues and planned for the following:
  - o Preparation of modules/materials.
  - o PHC curriculum consensus - workshop at Provincial level.
  - o Curriculum approval and accreditation.
  - o Criteria for selection of TOT candidates
  - o Orientation of PHC trainers and facilitators, mentors and preceptors.

- \* MEETING OF THE MANAGEMENT WORKING GROUP  
20 - 23 May 1996

#### Objectives

- Assessed progress.
- Agreed on the next steps for completing the curriculum and integrating working group participants.
- Continued curriculum development and set target dates for upcoming tasks.
- Allocated facilitators and identified potential faculty for the courses.
- Identified tasks and issues that needed to be resolved before conducting TOT courses.

## 4. IMPACT: FINDINGS AND ANALYSIS

### 4.1 TRAINING APPROACHES AND PROCESS

Training approaches and processes in the planning, designing and implementing of both the PHC management and the comprehensive PHC skills courses were as follows:

#### 4.1.1 *Planning*

Specific program planning consisted of eighty senior training and management personnel from the Provincial DOH, institutions of higher learning, and NGOs, mainly from the Eastern Cape province. This group represented experts in the fields of clinical skills and management who were to become the curriculum development and teaching body for the training courses. Requirements for this group included training and management skills, a willingness to further strengthen these skills in order to train and manage others, and availability. The participants were invited by the EQUITY and Bridging Activities Coordinators based on predetermined criteria cited by the Bridging Activities' proposal. This group was to form the body for facilitators, co-facilitators, mentors, and preceptors. They also planned to conduct an assessment of training needs for the provinces. Facilitators were selected by regional directors.

The participants of the working group were separated into two equally sized groups based upon interest and expertise. One group focused on the comprehensive PHC skills TOT courses for the Eastern Cape Province, while the other group focused on a PHC Management course that was available for all of the nine provinces.

The roles of facilitators, co-facilitators and preceptors/mentors were identified as follows:

The role of the facilitator during the planning:

- to finalise preparation of self-study material;
- to prepare a posttest for each module;
- to confirm logistic arrangements.

The role of the facilitator during one week intensive course:

- to highlight goal, objectives and expectations of the training program,
- to introduce learners to the training system.

The role of the facilitator during the three-week DBL:

- to help learners understand the DBL materials,
- to discuss the scope and depth of content coverage in each module/submodule,
- to explain new, complex and technical ideas and terminologies in the DBL,
- to introduce the structure and format of the particular module,
- to explain the DBL instructional approach to the trainees,
- to keep record of learners' attendance in the intensive week and submit these records to the co-facilitator at the end of the week.

The role of the co-facilitator:

- to help current modular facilitators,
- to act as coach in break away sessions and assist subgroup facilitation,
- to keep track of sessions and making sure that the facilitators are present for input,
- to prepare an action plan for supporting learners and mentor on-site,
- to identify problems and short comings of self study learning packages and report it to the PHC TOT coordinator.

The role of the mentor:

- to act as technical resource for learners by reinforcing the PHC principles,
- to counsel and encourage the learners to plan their study time to complete and apply knowledge,
- to look out for additional practical learning opportunities,
- to observe learners' skill performance in a specified aspect and provide feedback,
- to participate in the evaluation of learning and the implementation of each module.

Though plans were made for facilitators, preceptors and mentors, the preceptors were never identified. Facilitators assumed this role.

CDC consultants participated in the working groups as facilitators for the management and epidemiology component of the national training program.

INTRAH and BASICS consultants provided information for the PHC Comprehensive Skills' curricula objectives, content and backup support to the Bridging Activities Training Coordinator in the facilitation of the Comprehensive Skills Working Group.

The BASICS Interim Resident Advisor provided general direction by orienting participants to the Bridging Training Activities proposal.

#### **4.1.2 Designing**

##### **The Comprehensive Skills TOT Activity**

The Comprehensive PHC Skills methodology places emphasis on distance-based learning and participatory approach. The course consists of five modules to be covered in six months. Each module covers a block of four weeks consisting of one week intensive residential face-to-face contact followed by three weeks distance-based learning at learners' work site supported by preceptor/mentors. During the intensive week, facilitators introduced the training package to learners and co-facilitators. Because of the expertise in the country, it was anticipated that South African experts would perform as facilitators, supported by consultants from the BASICS and INTRAH Projects.

The major curriculum objectives and content areas for the ultimate beneficiary of the TOT - the PHC rural worker - are outlined as a basis of detecting what the TOT curriculum should address. Curriculum content, as proposed and outlined in the bridging training activities proposal, was reviewed and their appropriateness and inclusiveness verified.

Specifically, they are:

- Community participation
- Child survival interventions
- PHC reproductive health and women's health
- Training facilitation, epidemiological research, monitoring and evaluation
- Management of acute and chronic health problems

The participants divided into five smaller groups and selected an area to work on for module development. Participants selected areas based on interest, experience and expertise.

Selection criteria: The criteria for TOT applicants were:

1. Should have been trained in at least one aspect of nursing experience relevant to the PHC approach, such as community health nursing
2. Commitment
  - willing
  - motivated
3. Willingness to learn .

### **The Management TOT Curriculum**

Unlike the comprehensive skills curriculum, the management curriculum was designed to provide for a continuous six-weeks course taught by South African experts in the field of management, supported by consultants from the CDC.

Course objectives were identified by the working group and a detailed curriculum was laid out. The group also intended to identify specific curricula, criteria for candidate selection to the TOT courses, and a time-frame for when the first course was to be offered.

Working group participants were subdivided into task groups according to the five major themes identified for the management modules:

- Applied epidemiology
- Management
- Economic evaluation
- Communications
- Training

The subgroups developed learning objectives, produced a curriculum framework, and outlined potential resources. Point persons were identified to coordinate the development of specific curricula and identification of tutors.

Selection criteria: The criteria for TOT candidate selection were:

1. Effective communication skills
  - verbal, writing - body language
  - interview, counseling, supervision
2. Commitment
  - willing
  - accountable
  - motivated/dedicated
3. Management/committed/support
4. Willingness to learn

**RECOMMENDATION:** *Regions should conduct an assessment of training needs to set priorities and develop future training programs.*

### **Comprehensive Skills Training**

A brief review of PHC training needs was conducted by Provincial experts and members of the Working Group. This review was used as a needs assessment for curriculum planning. However, the results were too general, lacked depth and could not provide an effective foundation for program planning. In recognition of this, the TOTs were assessed before each module was used to help in appropriate module development and preparation of materials.

The participatory and distance-based learning approach were used as designed. The course consisted of six modules to be covered in six months. The sixth module was added to consolidate learning, include management material, and complete the required assessment and evaluation.

The six modules included lesson plans for the intensives and the DBL for the on-site learning. The DBLs were developed one week before the intensives under much time pressure. There were ample reference materials and consultant inputs. Although the content was sufficient for the current TOTs, it is assumed that additional revisions and refinements will be necessary. Nonetheless, the DBLs form a solid foundation representing the input from a broad spectrum of South African and International experts in health.

Two co-facilitators (10) from each region in the Eastern Cape Province were selected. These individuals, as well as the mentors, were to be provided with training in areas outside of their expertise. However there was not sufficient time to do this before the course began.

Knowledge levels of the participants were determined before and after each module using the pre-test and post-test. A daily evaluation of the day's experience was done and the feedback/recommendations were used to improve the next sessions. At the beginning of the next face-to-face session an appraisal of experiences with the DBL was done.

This innovative method of training, combining face-to-face intensives with the DBL for on-site learning, has been well received and is favoured to models based on face-to-face training only. The DBL was hailed as an excellent way of simplifying learning onsite. The DBL was also in demand in some clinics by staff who were not involved with the TOTs but who acknowledged it's usefulness in enlightening all health service providers. One drawback was cited in the design of the course, in that the users felt that the time allocated to the DBL was too short and that some face-to-face contact was too compact. The preparations of the DBL materials are based on the curriculum and will need revision according to provider needs. The strategies are very complex and the TOTs need support as they apply this new training methodology.

**RECOMMENDATION:** *Time allotted for each module (both face-to-face and DBL) should be reviewed and changed appropriately.*

The training scheme inherently generated new demands at the work site. To be able to apply the knowledge and skills gained from the training, the TOTs expected changes in the work site, the most obvious being the shift from vertical programming to integrated programming of health care service delivery. Applications of some skills require access to the communities and this has implications on TOTs' time and travel arrangements. The issue of time is critical in the use of skills, e.g., Counseling and site visits to the communities requires time. Time for nurses and staff in general is scarce and is deeply entangled with line functions at the clinic that must take preference. There was a general outcry on shortage of staff and therefore, the environment the TOTS operated in was often constrained.

Most respondents agreed with the adoption of the approach used in Bridging training because it was an effective way of reducing the current vertical approach to PHC. The fragmentation and compartmentalization of current courses, eg. two weeks of family planning, two weeks of TB training, posed a major obstacle for standardized training. This is compounded by the fact that the courses are offered by different organizations.

The integration of PHC Management and Comprehensive Skills was viewed in a similar way. The PHC comprehensive skills courses included management principles and concepts applicable to the TOTs as managers in PHC clinical settings; however, there are concepts in the PHC Management training that are applicable to the Comprehensive training and would be valuable learning tools for the TOTs, i.e., leadership and TQM. Additionally, many nursing positions require a great deal of management skills, therefore specific material included in the management course would have been of benefit to many nurses.

The facilitators and co-facilitators who were knowledgeable of the management courses also believed that both curricula would benefit health providers and should be combined. The two curricula could be reviewed for key concepts to be included in future curricula revisions.

**RECOMMENDATIONS:**

1. *Determine appropriate content for further integration of management concepts and skills into the Comprehensive Skills Training course.*
2. *Assess the feasibility of integrating the formal one year course in Clinical Nursing Science with the Comprehensive Skills Training course and the use of distance-based learning and participatory approach.*

Co-facilitators and mentors were very valuable to the TOTs in delivering DBL kits, helping in understanding the course material and general moral support. However, many mentors were not trained as planned, due to time constraints, and therefore could not offer technical assistance and support to the TOTs. The evaluators believe that the mentoring concept is a very valuable one and should be included in future programming.

**RECOMMENDATION:** *Develop a cadre of TOTs who will assume the role as mentors in future programs. The role of the mentor should be clearly defined and communicated.*

The Comprehensive PHC Skills training activities were to include four major activities before the transition to the EQUITY Project: evaluation of the TOTs; revision of the PHC curriculum; reorientation to the provider prospective; and, support to the TOTs as they assume their new roles as trainers.

1. Evaluation of TOTs: The TOTs have not had an evaluation of their competency to provide and manage PHC in the clinical setting. Their ability to apply PHC concepts and skills in their clinical settings can be easily evaluated by a team of co-facilitators who can use prescribed evaluation tools comprised of check lists, observations and interviews. A BASICS consultant who is familiar with the expectations of the TOTs should be a member of the team and with an EQUITY consultant. The evaluation should be completed as soon as possible since the TOTs in some regions have already begun training activities.
2. Revision of the PHC Comprehensive Skills Curriculum: Revisions to the PHC curriculum have been made after each module, as noted earlier.. A master of the revisions has been made and transferred to the ECDOHW. However, further reviews may need to be made based on future assessments.

3. Reorientation to the Provider Perspective: The PHC Comprehensive Skills Curriculum needed to be revised and reoriented to the target audience of providers and their level of competency. To develop a PHC Provider curriculum an assessment of knowledge and skills in PHC needs to be completed. Since the TOTs do not have great capacity to carry out an assessment of the needs, they are going to need support to complete this task. The PHC comprehensive curriculum will provide the foundation for the PHC provider curriculum - it needs an orientation and adaption to the provider role in PHC clinical care.
  
4. Support to the TOTs: The TOTs had many opportunities to teach their colleagues during the intensive face-to-face sessions. Bridging Training Activity plans included a round of support to the TOTs in their roles as trainers as they train providers in their regions - this was to be part of a module only. This support was to be given as observation and feedback to the TOT during an actual training session. The idea was to help the TOT in assuming and feeling confident in her new role. The co-facilitators and EQUITY staff can provide this monitoring and support.

### **The Health Management TOT Training**

The philosophy of the Health Management Training Programme is to improve the managerial culture of health systems by:

- Improving managerial process as it relates to PHC development;
- Strengthening management support systems;
- Causing appropriate reforms in organizational structures including intersectoral support;
- Strengthening weaker elements of health-manpower management;
- Developing work plan and budgets;
- Improving logistics management
- Monitoring and evaluation.

The purpose of the program is to develop in each province a cadre of trainers who will develop and implement local training programmes in their provinces. The trainers will teach different target audiences in applied epidemiology, PHC management, health economics, and communications so that achievements evidenced in the equitable delivery of quality PHC Services. The major thrust is to focus on skill development and management of District Health Services. Participants are expected to be able to carry out training needs assessment, develop curricula for specific target groups within a PHC setting, and train other health professionals using PHC adult education principles around the following competencies: PHC data use/performance-based skills, management attitudes, behaviours, and styles, and training skills.

The target groups for the courses are clinic supervisors, managers from every level of the DOH, persons from existing training positions with DOH, persons free to move from area to area to conduct training, health professionals, NGO Representatives, persons working with parastatals or training institutions.

The training methodology was quite different from the Comprehensive Skills courses. It entailed a modular based courses carried out within one 6-week block. The five modules and common themes were integrated throughout the training. A pre-test and post-test were administered to the participant before and after training for the purpose of evaluating new knowledge.

All participants interviewed were enthusiastic about the course and found it to be very valuable for budgeting, planning, epidemiology, and change management. The most meaningful modules were communication, applied epidemiology and health economics. However, most participants had difficulty with the Applied Epidemiology and Health Economics material - none had been previously trained in these areas. The statistics component of the epidemiology course and the maths component of the health economics course were very difficult and most participants felt more time was needed for them to fully understand these areas.

The interviewees were unaware of the content of the Comprehensive Skills curriculum, however when it was described to them all felt that both management and comprehensive skills courses should be integrated. Management TOTs were interested in more practical assignments covering areas within their own clinic and community situations.

The initial planning for the management courses included DBL as a learning tool. However, due to time and funding constraints experienced by the CDC, the design work was not completed in time for the courses. The CDC is continuing development of management courses using DBL methodology. Considering this, the evaluators believe that the three-week clinic-based field experience and the DBL promoted by the Comprehensive Skills course should be considered for use for the management course as well.

#### **RECOMMENDATIONS:**

1. *Health Economics and Epidemiology modules should be revised to include basic statistical and maths material as preparation for the core course.*
2. *The comprehensive PHC skills methodology of face-to-face instruction and DBL should be analyzed for use in the TOT management training, and incorporated under EQUITY, if found appropriate.*

#### 4.1.4 Program Impact

All participants, including TOTs, facilitators, co-facilitators, mentors, regional directors and deputy directors, and clinic supervisors felt that the program was valuable and were impressed with the program content, design, tutors and consultants. Many believed that the program should be given and redesigned for other health professionals such as: Environmental health officers, pharmacists, social workers, district managers, and educators. Representation from the Department of Welfare, as a whole, was suggested. Many also believed that NGO staff, particularly the community health worker who works very closely with the clinic nurses, would benefit from the course as well.

As nurses began carrying out assigned tasks in the clinics, and carrying out the skills they were trained for after the course was complete, the reactions in the clinics were extraordinary. There were very few instances by which the TOT was discouraged from completing her work. But the TOT was hounded by competing work loads - her regular work assignment and her new program assignments. Many worked hard and dutifully because the course work was meaningful, relevant, and practical. The TOTs embraced the community-based focus of the courses and this was reflected in their daily performances. So much so that clinic attendees witnessed a change in attitude of the TOTs and reported this to clinic personnel. In fact, it was reported to the evaluators that clients favoured attending clinics where TOTs were found.

A prevailing issue for all concerned was the fear that the provider training would not be continued and that the TOTs would not be used after the training is complete. Despite this, efforts are being made to carry-on the training in several regions of the Eastern Cape:

Region A: TOTs are planning to coordinate with region B in planning future training programs. TOTs are also planning to approach District Managers to garner support for future training programs.

Region B: Has developed a training unit within the Region because of all of the training that is being carried out. This has been necessary for the coordination of the current Syndromic Management of STDs Course, Community Health Workers Training, and the TOTs courses.

In addition, a follow-up training course has already been developed in Region B for an integrated Comprehensive Skills and Health Management Training Courses. The courses are scheduled for March 17 - October 19, 1997. It will be conducted at Komani Hospital, Queenstown. There is a nominal fee charged for the course and accommodations are available for a small fee as well. The nurses are willing to pay the fees and take the course. The interest is very high.

Twenty nurses will be trained, 1 selected from each institution. Since many of the local institutions are very supportive of this effort, they are paying the

trainee's fees for the course. The students themselves are interested in updating their skills, especially those from the former Independent States who feel that their exposure to other training opportunities have been limited

- Region C: Is planning a similar course, to be modelled after the Region B course. The TOT in this region has mobilized others to assist in conducting awareness workshops to familiarize others on the content and design of the training so that future TOTS will have no trouble in being released and otherwise supported during future training.
- Region D: TOTs are planning to form a training team. They plan to train clinic nurses in each district. They have already started with in service training and awareness programs at the clinics.
- Region E: TOTs have identified five people for their first training session and will start soon. The program will be introduced and further training programs will be planned from there.

The Bridging Training Activities prepared a cadre of PHC TOTs in Comprehensive Skills and Management Training. The next phase of implementation is to support the TOTs in their new roles as trainers as they train providers in their regions and to address the issues of accreditation and future utilization of the TOTs. Since this was a model pilot training program, time needs to be given to appropriate evaluation of the TOTs and the curriculum before training by TOTs is initiated in the regions and before the training program is disseminated to other Provinces. This is a critical stage and the attention of the National DOH and Provincial DOH are needed in order to develop the standards and policies to proceed with future training activities.

#### ***4.1.5 Health Management Training in Provinces other than the Eastern Cape***

After the initial program, conducted in Sept - Oct 1996 in Cape Town, the TOTs were requested to submit proposals outlining a training program for their province. Proposals have been submitted by six provinces.

#### **NORTHWEST PROVINCE:**

Provincial leadership expressed firm, positive commitment to their TOT utilization with funding and continuing a management training curriculum by the TOTs. The TOTs prepared and submitted their training proposal to the CDC and Bridging Coordinator for review and approval. It was approved, with comments and changes, and a training course as proposed by the TOTs commenced on January 20 for one week for 20 participants representing all 18 regions. The two modules taught by the TOTs were Health Economics (a CDC technical adviser was present) and Epidemiology.

Although these courses proved to be the more difficult of the five initial modules, the TOTs felt that the health professional staff in the regions were in more need of these modules than the others (Communication, training facilitation, PHC management). Subsequent training is scheduled for every 2 months and is expected to last only a couple of days each. Projects completed in the districts as a consequence of the previous training will be presented to political and community leadership and potential donors, and a new module will be designed and given. The province is committed to covering the costs of the training materials and location while the districts are expected to meet the costs of accommodations and per diem. Current management training at the provincial level includes: training of district management teams by the Center for Health Education and Social Studies with Health Systems Trust, and Training of facilitators of Primary Health Care with funding from the Kellogg Foundation.

#### **NORTHERN PROVINCE:**

The HRD has committed financial support to implement the TOT management training of trainers proposal. TOTs have been requested to submit an implementation paper which will address measures to overcome issues of staff attending courses at the expense of their other duties, and the identification of specific target groups. The province is very keen to provide customized training modules as a result of their skills assessment audit. The Management Organization Development training supported by the Overseas Development Administration. The province indicated their desire to utilize the TOT's across all training initiatives.

The provincial leadership is very interested in integrating the Comprehensive Skills course with the Health Management course and plans to make arrangement with the Equity Coordinators for a team from the province to visit Eastern Cape to gain more information on the course.

#### **MPUMALANGA PROVINCE:**

Two district managers are very supportive of the TOTs and have indicated a firm commitment to implement their proposal within their districts and intend to recruit other district managers to show similar support. However, the lack of a provincial HRD Director, inadequate funding and lack of management personnel has hampered the progress of the TOT program.

#### **FREE STATE PROVINCE:**

The TOTs plan to prepare a strategic plan to implement a more specific module, taking into account the management needs of their regions. The province intends to recommend to the Regions from which the TOTs originate that they be moved laterally into HRD training units at the regional level. It is anticipated that the TOTs will be conducting training by June 1997.

#### **WESTERN CAPE PROVINCE:**

The TOTs are eager to move forward but lack of adequate funding is impeding their progress. The TOTs plan to conduct training at their local institutional level where they have more control of their environment and for which needs assessments exist.

#### **GAUTENG PROVINCE:**

The Gauteng Provincial leadership have approved the implementation of the TOTs training proposal for management training of trainers as needed. A Training and Facilitation module was held February 24-28, 1997. The TOTs have already utilized their skills from Cape Town in conducting Values Clarification and training for several hundred personnel in anticipation of the Termination of Pregnancy regulations which came into effect in February.

The province anticipates the audience for the TOT training to come from regional positions and intends to carefully screen for the appropriate senior management and training skills to be held by those candidates selected for the provincial training.

#### **RECOMMENDATIONS:**

1. *The Northern and Northwest provinces may be candidates for early coordination with EQUITY to utilize lessons learned from the Comprehensive Skills Courses. Such dialogue should begin as soon as it is feasible for the EQUITY staff.*
2. *In view of the multiple training programs in PHC Management that are already taking place, the National HRD Directorate should consider the need to coordinate the synthesizing of uniform modules that can be utilised in all the provinces.*

#### **4.2 CHARACTERISTICS AND FEATURES OF TRAINING CENTRES**

The Comprehensive Skills TOT training held in the Eastern Cape was done in several locations - Bisho Hospital and three hotels in East London. Although there were some initial logistical problems for this course, most TOTs felt that future training should be conducted in hospitals, colleges or universities where available accommodations and conference rooms can be used. Region C plans to hold future courses at Bisho Hospital. Region B expressed concerns regarding inadequate and insufficient training facilities since the existing training site, Komani Hospital, was being used by all health programs and was in need of renovation. However, Komani Hospital is being utilized as a future training site.

The North West Province had available training venues which could provide needed accommodations and classrooms.

**RECOMMENDATION:** *Continue to use available training sites as appropriate. The Eastern Cape Province should place the development of training sites as a priority for future planning.*

#### 4.3 MODELS USED TO ENCOURAGE NGO INVOLVEMENT

NGO Representatives figured prominently in the Working Groups and in curriculum development for the early modules for both courses. However, their continued involvement was discouraged by the absence of compensation for their contribution and most left the groups before the completion of the modules.

Most interviewees believed that the NGOs' greatest contribution to the bridging activities was their experience in community-based activities.

**RECOMMENDATION:** *Identify and adopt existing policies and guidelines, where appropriate, which address honoraria for representatives of NGOs and tertiary institutions who are interested in working with the DOH and EQUITY project in continuing PHC training. The National DOH should assist in designing appropriate protocols and policies for this effort, so that this national model can be used equitably in all Provinces.*

#### 4.4 EXAMINE HOW PHC MANAGEMENT AND COMPREHENSIVE PHC SKILLS TRAINING REFLECT DOH TRAINING POLICY FOR PHC TRAINING.

During the planning phase of the TOT program the PDOHW was in transition and in the process of filling positions and restructuring the PHC system at all levels of management and service delivery, especially at the regional level. However, the lack of clear policy development and consensus in some areas of Maternal and Child Health made it difficult to prepare trainers to practice PHC within their clinical context.

Fragmented and vertical health programs have continued to exist under these constraints. Moreover, the lack of clear training policies, at all levels, has contributed to the continuation of fragmented training in the health sector.

**RECOMMENDATION:** *There is a need to develop and adopt training policies at all levels.*

#### 4.5 IDENTIFY POLICIES EVOLVED FROM PHC TRAINING EXPERIENCE

The PHC system remains in transition and the lack of development of PHC policy has been a major constraint to implementation of change at the clinic sites. Suggested policies which may be derived from the bridging training experience include:

##### **RECOMMENDATIONS:**

1. *Integrate existing vertical PHC programs and PHC Comprehensive Skills training.*
2. *Develop specific guidelines on logistical and administrative concerns such as transportation, leave for TOT training, and per diem. Adopt current guidelines where appropriate.*
3. *Develop specific policies and guidelines on honoraria for NGOs and tertiary education institutions.*
4. *Develop specific guidelines on accreditation for TOTs.*

#### 4.6 ASSESSMENT OF IMPACT OF BRIDGING TRAINING ACTIVITIES ON USAID'S STRATEGIC OBJECTIVE 3 AND ITS INTERMEDIATE RESULTS.

USAID's Strategic Objective 3 envisions a *More equitable, unified and sustainable system delivering integrated PHC services to all South Africans*. The PHC Management and Comprehensive Skills training programs under the bridging training activities have contributed directly to the achievement of Intermediate Result 3.4 - *PHC training program strengthened and institutionalized at the provincial level*. More specifically, 21 health care professionals have been trained in Comprehensive Skills and another 34 have been trained in Health Management. In turn, these managers will be responsible for the training of district teams and subsequent service providers on the provincial and district levels. It is through this that the management of integrated PHC will be realized.

The first steps towards an integrated package have already taken place. Plans are currently being made to integrate the Health Management and Comprehensive Skills model in the Eastern Cape Province, specifically Region B. The Northern Province is also making attempts to emulate this effort. Many of the other Regional Representatives whom we spoke with in the Eastern Cape, and Provincial heads in the other provinces voiced their concerns regarding fragmented programs, and articulated their desire to integrate the bridging activities and consider further integration of health programs.

The stage has been set for a strengthened and institutionalized program within the provinces. The bridging training effort has already strengthened the PHC program in that it has trained health professionals in areas whereby no prior training had been offered, such as community based care, applied epidemiology and health economics. As plans emerge to integrate the bridging training and discussions begin on the integration of nurse clinical training, the vision for some provincial officials is to have TOTs begin the training of students in the Tertiary institutions. This is the first step towards institutionalizing the program and follow-up can easily be pursued through the Equity Project.

#### 4.7 SUSTAINABLE OUTPUTS

##### 4.7.1 *Conformity with Proposed Outputs*

PHC Management Training Outputs:

- Thirty-four TOTs trained to provide training to PHC management target groups across nine provinces

Three TOTs from each province and the National DOH were to be selected for training. The National DOH was unable to select individuals who would be available for six weeks, therefore four additional TOTs were selected from the Eastern Cape. A total of 34 TOTs were trained.

- Drafts of provincial management training plans and budgets developed for input, discussion, and consensus building at provincial levels

As noted earlier, proposals were submitted by six provinces besides the Eastern Cape: Northwest, Northern, Mpumalanga, Western Cape, Free State, and Gauteng.

- Implemented provincial training plans (target groups being trained with mentoring) in provinces providing needed complementary support

Training plans have not been implemented due to funding constraints in many of the provinces. Needed dialogue between the National DOH and the provincial governments have not yet taken place to garner the needed support for this effort.

- Selected district health management teams trained by mentored TOTs in PHC management in Eastern Cape Province.

This has not yet taken place.

- PHC management curricula and training materials (lecture notes, overheads, videos, interactive exercises, distance/open learning) were developed and distributed to the TOTs.

- A Lessons Learned Workshop was conducted March 13, 1997 in Bisho to share outcomes, issues and highlights of the training activities.

Proposed Comprehensive Skills Training, End of Program Results:

- Approximately 20 PHC Facilitators, Mentors and Preceptors with improved PHC knowledge and training skills

Training for facilitators and mentors (preceptors were not identified) were not conducted as planned due to time constraints. However, many were able to benefit from the training provided to the TOTs, and therefore were able to indirectly improve their knowledge and skills.

- 15 PHC Regional Trainers trained and providing quality PHC training to frontline health providers.

21 PHC TOTs have been trained, one from each district..

- PHC training Technologies developed in Eastern Cape Province, ready for adaption and replication in other Provinces.

The training technologies prepared and used must be reviewed before adaption and replication. Evaluation of TOTs must be conducted as well.

- 75 frontline PHC Providers trained and providing improved quality of services

Training of frontline providers was in the planning stage, for some regions, at the time of the evaluation.

- PHC Training materials and Distance/Open Learning Modules for Training of PHC

The training materials have been used and disseminated.

#### 4.7.2 Sustainable Outputs

- ***Improved on-site clinical practices:***  
The benefits of the program have been cited by the TOTs, their clinic supervisors, co-facilitators (two of these respondents were also deputy regional directors at the time of the interview).
- ***TOTs are committed to bringing about change and continuing their work as trainers.***
- ***Improved facilitation and teaching skills.***  
Many trainers revised their way of teaching.
- ***Eagerness to plan and implement training for service providers.***  
Program sustainability promoted. TOTs were so pleased with the course that they immediately began plans to organize training in their respective regions. Several TOTs have developed and promoted "awareness workshops" to familiarize other health workers with the content and scope of the program. This has encouraged further TOT participation and opened up the awareness of clinic supervisors, district managers, and others who did not take the courses. Recruitment efforts are being planned to train other TOTs. In some areas village workers (community health workers and traditional healers) will be included in the training. Some district managers are committed to finding funding for training.
- ***Provincial Training Infrastructure.***  
A by-product of the bridging training activities is a province-wide infrastructure of district trainers, local mentors/preceptors and regional co-facilitators. This infrastructure was essential for the effective implementation of the distance-based learning approach especially in light of the differences in capacity between regions and districts. The Bridging Training Activities cultivated a cadre of local interdisciplinary experts and resource people, many of whom contributed to specific module development.
- ***The PHC comprehensive skills curriculum succeeded in making the PHC approach practical and feasible.***  
Although some of the trainees and trainers had taken other PHC courses, the majority expressed the opinion that this course went beyond the simple facility based clinical skills, imparting the importance of practising within homes and in the community. Many of the trainers noted that they did not know how to apply principles of community based outreach or mobilization until this course. The DBL exercises and the field experiences were particularly useful in this regard.

## 5. LESSONS LEARNED

### 5.1 MAJOR STRENGTHS

#### 5.1.1 *Bridging Working Group.*

This group was formed at the beginning of the Bridging Activities to act as an advisory group for the planning and implementation of the training, for both components. It was composed of individuals from diverse parts of the public health sector, including teaching institutions, provincial/district government and private sector agencies. It formed a special body of interdisciplinary expertise from multiple institutions and from all parts of the Eastern Cape Province. Such a forum of policy makers, managers, teacher/trainers and clinicians seldom work together, therefore the Working Group was a strong alliance which successfully forged a partnership to address the development of the curriculum and its trial implementation. The functions of this group should be incorporated into the proposed District Health Training Committees.

#### 5.1.2 *The PHC Comprehensive Skills TOT training methodology.*

For each of the six modules was comprised of a one week of intensive, participatory training in a classroom/seminar setting and three weeks of on-site training in the TOTs clinical work site using distance-based learning materials. The 21 TOTs experienced a variety of teaching/learning approaches utilizing adult learning principles and participatory methods, including presentations, group discussions, case studies, group role play. Clinical field visits assisted in the immediate application. This is a valuable methodology which allowed for classroom instruction as well as hands on learning and problem-solving experiences. The TOTs were able to put to practical use the information gained from the lectures as well as the materials.

#### 5.1.3 *The Distance-Based Learning concept.*

This an excellent model for use throughout the provinces. The DBLs consisted of self-study modules, clinical skill check lists, self evaluations and supportive material that reinforced learning. The three-week on-site application following each of the six modules and expansion of information gained during the intensive weeks proved to be a valuable learning experience.

#### 5.1.4 *Facilitation skills and teaching skills were greatly enhanced.*

This was reported by TOTs and facilitators. Many training officers and tutors who attended the course (or facilitated) took the opportunity to revise their current teaching methods with new skills learned during the course. This was true for participants in the Comprehensive Skills as well as Management course. Many reported that they have used these new skills in their workplace.

- 5.1.5 *Individuals were given the opportunity to excel.***  
With opportunities to also demonstrate previously gained skills.
- 5.1.6 *Team building was galvanized***  
PDOHW, CDC, BASICS, INTRAH, USAID/SA, Regional and District representatives as well as representatives from other provinces all worked together in planning, designing, and implementing the program.
- 5.1.7 *A cohesion of various principalities.***  
This has occurred in the Eastern Cape as well as other provinces.
- 5.1.8 *The courses were practical and community based.***  
This gave the participants the opportunity to recognize and realize the value of community participation and liaison with the community.
- 5.1.9 *Clinical services have become more user friendly.***  
As a result, patients feel more comfortable during clinic visits, based on change of attitude of the TOT (as witnessed by clinic supervisors).
- 5.1.10 *The Bridging Training Activities served as a learning experience for local as well as international parties.***  
Thus, valuable lessons learned will impact on the success of the EQUITY Project and other future health care endeavours.
- 5.1.11 *A valuable network structure is in place for the EQUITY Project to build on what is already available.***
- 5.1.12 *All activities have set the pace for the rest of the country and promises program sustainability.***

## **5.2 MAJOR LIMITATIONS**

- 5.2.1 *In-depth needs assessment was not conducted.***  
There were weaknesses in implementing what had been originally planned by Working Group participants.
- 5.2.2 *Evaluation of Training was not conducted.***  
The TOTs have not been evaluated on individual performance at work site as originally planned. An evaluation of the trainees must be conducted in order to prepare for development of accreditation policies and procedures and for further training efforts.

- 5.2.3 Additional training to meet deficits of the facilitator was not addressed formally.**  
Skills audit of existing facilitators was identified but due to the time pressure of training program implementation The co-facilitators were exposed to all modules to meet the deficit needs. Support to some of the TOTS could not be done as planned.
- 5.2.4 Participation of NGOs and tertiary institutions ceased.**  
Problems arising from the honorarium issue resulted in a narrowing of the composition of Working Groups.
- 5.2.5 Selection of TOTs and mentors were not consistent.**  
There was no time to select appropriate personnel. As a result, participants with line functions were severely disadvantaged in terms of getting their day-to-day assignments prepared.
- 5.2.6 Length of the comprehensive skills module was too short.**  
The intensity and depth of the six modules, DBLs and on-site learning experiences did not allow adequate time for the TOTs to develop and practice their skills as teachers/trainers. They actively participated in adult learning methodologies and were given opportunities to facilitate group discussion but did not give formal technical presentations. The TOTs needed further support and supervision as they assumed their role as trainers of others within their regions.  
During the last three modules, the on-site and DBL time should have been increased from three to four weeks in order to accommodate the breadth and depth of child health material.

### **5.3 BARRIERS TO EFFECTIVE IMPLEMENTATION**

- 5.3.1 Logistics.**  
Issues regarding transportation and per diem haunted the activity from beginning to end. Transportation availability was not sorted out before the start of the program. Facilitators who were responsible for distribution of materials, such as the Distance Based Learning Packages had trouble finding transportation. Many had to use their own transport. Reimbursement for petrol was inconsistent in the Province - there were some nurses who were reimbursed, and others not. Availability of district vehicles was also inconsistent. Disbursements of per diems were often an issue.
- 5.3.2 Structure and policy-development.**  
Some district structures and policies are not in place. This has left the TOTs very frustrated for many see that their new skills may be under-utilized. Training policies and an identified training unit is the primary incentive cited by the TOTs for continuing future training for service providers.

- 5.3.3 **Communication.** Communication was generally poor. Often information and schedules were not communicated in a timely fashion and breakdown in telephone lines and faxes exacerbated the problem.
- 5.3.4 **Fragmentation of courses.**  
Fragmentation of vertical PHC courses will impede on sustainability of PHC Comprehensive skills TOT program.
- 5.3.5 **No liaison person at National level for the greater part of the activities.**  
This person could have helped to sort out many of the logistical and policy issues (accreditation, honorariums) which were prevalent throughout the training.
- 5.3.6 **No coordinated training efforts between HRD and PHC directorates in the Eastern Cape Province.**
- 5.3.7 **Accreditation.**  
An accreditation policy for Bridging Training Activities not yet resolved. The PHC Comprehensive TOT course targeted nurses who worked in PHC settings. The Working Group and key players in the PDOHW decided that application to the Nursing Council for accreditation would limit the course only to nurses. The implementation phased continued while this issue was on the table and has remained unsolved.
- 5.3.8 **Little or no funding available for training, particularly for the health management component.**

## **6. RECOMMENDATIONS FOR SUCCESSFUL IMPLEMENTATION OF PHC TRAINING UNDER THE EQUITY PROJECT**

The recommendations noted below are listed by major implementing body, National DOH , Provincial, Regional or District government. Recommendations cited in the body of the report are incorporated as well.

### **6.1 IMMEDIATE ACTIONS (in order of priority)**

#### **NATIONAL LEVEL**

1. It is imperative that a National DOH counterpart to the EQUITY Training Coordinator be appointed immediately. This is a critical position for the sustainability of the training provided thus far, and for facilitation of plans now being made by the EQUITY team. All recommendations provided by the evaluation team can only be put in place if this position is filled; the recommendations provided below require a close partnership between the National DOH, EQUITY, the provinces, the regions and districts. Only a National DOH counterpart can make this happen. If the position is not filled, then all progress to date and all future programming under EQUITY will be in jeopardy, particularly in the Eastern Cape.

#### **PROVINCIAL LEVEL**

1. Identify and adopt, where appropriate, existing policies and guidelines addressing honoraria for tutors from NGOS and tertiary institutions who are interested in working with the DOH and EQUITY on training.
2. The DOH should convene a body to develop policies and guidelines for Accreditation and other training issues.
3. Provide guidance and follow-up for the integration of the Comprehensive Skills and Health Management Training in the Eastern Cape.
4. Accelerate lessons learned from comprehensive skills training to the other provinces, where appropriate. As noted above, this will be particularly relevant to the Northern Province where provincial officials have already taken steps to learn more about the comprehensive training.
5. Continue health management training for Eastern Cape which was commenced in Port Alfred.

6. Prepare guidance for the utilization of TOTS.
7. Reinforce community participation with relevant NGOs and encourage them to work with the program, particularly as training instructors. This will also enable program to utilize South African instructors more than was done in the Bridging Activities. Clear guidelines on honoraria should be developed so that local talent is identified and utilized.
8. Provide needed medical equipment and supplies, when feasible, to assure quality of care, particularly after training is provided. Examples include: stethoscopes, etc.

#### **REGIONAL/DISTRICT LEVEL**

1. Form District Health Training Committees, an intersectoral group to include all stakeholders within the Districts. A committee will be formed in all 21 Districts in the Eastern Cape. Membership will include: local institutions, regional directors, district managers, clinic supervisors, TOTS, NGOS, community workers. Bridging Working Group infrastructure should be utilized for membership in this committee. Illustrative sample of tasks include:
  - o Review modules and revise as appropriate,
  - o Prepare recommendations for accreditation,
  - o Conduct needs assessment and assure relevant expertise is identified,
  - o Prepare recommendations on integration of programs and training.
2. Conduct an assessment of training needs in order to prioritize and develop future PHC training.
3. Further refinement and revision of modules and curriculum.

##### **For comprehensive skills:**

- o Expand the Childhood Illness Module to include genetic counselling..
- o Expand the Reproductive Health module to include additional material on Adolescent Health, particularly sexuality. Also include HIV/AIDS in the workplace and HIV/AIDS/TB.
- o Expand the Adult Health module to include Tuberculosis.
- o Review time allotted for each module and change appropriately.

##### **For health management::**

- o Revise the Health Economics and Epidemiology modules to include basic statistical and maths material as preparation for the core course. Include practical field assignments, especially in epidemiology.

4. Provide TOTs with further supervision and support.
5. Assure that mentors be trained prior to training of TOTs, for future training. Current TOTs could be used as mentors in future.
6. Provide for early selection and notification of training participants to help ensure adherence to selection criteria.
7. Provide needed incentives for TOTs and trainees in order to sustain motivated participants in training program. Incentives might include: provision of transportation for TOTs, development of training units, recognition, training materials such as overheads and videos, and medical equipment and supplies noted above.

## 6.2 LONG-TERM ACTIONS

1. Establishment of training units in the Eastern Cape. An identifiable structure on the organizational chart can be utilised as an incentive for employees and will certainly provide for better coordination of training efforts. Such a structure will also assure accountability and responsibility. Trainers should be appointed within a training unit without other responsibilities.
2. Integration of selected Primary Health Care Courses and Training. Multi-sectoral training can include registered nurses, environmental health workers, social workers, pharmacists, health inspectors, clinic managers, educators, and agriculturalists. Modified versions of the curriculum will need to be developed for health workers other than nurse-clinicians.
3. Assure accessibility of TOTs to newly proposed Resource Centers, currently planned for East London, Port Elizabeth, and Umtata. Develop a mailing list to provide new and updated materials.
4. Employ a Regional Training Coordinator to work with Regions and Districts in assuring the development and implementation of training policies and guidelines. (Such a position has recently been advertised in the Eastern Cape Province).
5. Include all health staff in a PHC training program, either as an awareness campaign, or training as described in b above.
6. It is important that some TOTs remain at the work site to ensure that best practices are maintained and to be able to implement observable changes in PHC systems and practice.

## APPENDIX A CONTACTS

### EASTERN CAPE PROVINCE

#### BISHO PROVINCIAL OFFICE

Dr S Stamper	-	Deputy Permanent Secretary
Mr A Wild	-	Acting PHC Director
Miss N Tsangana	-	PHC Management Coordinator
Mrs Z Kati	-	PHC Comprehensive Skills coordinator

#### REGION A: PORT ELIZABETH

Dr T Sibeko	-	Regional Director
Mrs V Mayana	-	Deputy Director Health
Ms J Valentyn	-	Co-facilitator - Comprehensive Skills
Ms N Bloko	-	Health Management TOT
Mrs B Macay	-	Comprehensive skills TOT
Ms T Daymani	-	Co-facilitator Comprehensive Skills / Health Management TOT
Ms L Orben	-	Comprehensive Skills TOT
Ms KNC van Heerden	-	Comprehensive Skills TOT
Ms B Uithaler	-	Comprehensive Skills TOT
Mrs B Damons	-	Working Group
Mrs Baatjies	-	Clinic Supervisor

#### REGION B: QUEENSTOWN

Dr V Shaw	-	Deputy Regional Director
Ms T Nkungu	-	Co-facilitator
Ms GN Mpakama	-	Comprehensive TOT
Ms NC Cheba	-	Health Management TOT
Ms EY Gawe	-	Clinic Supervisor
Ms PN Bodla	-	Clinic Supervisor

#### REGION C: EAST LONDON

Nora Shelver	-	Training Coordinator / Health Management TOT
Nosisa Tshangawa	-	Equity Coordinator / Health Management Coordinator
Mrs. Loliwe	-	Nursing Trainer / Co-Facilitator - Comprehensive Skills
Mrs. Laura Makalima	-	Comprehensive Skills TOT
Nomathemba Mazaleni	-	Director, Border Institute of Primary Health /Health Management Working Group / Facilitator - Health Management

**REGION D: UMTATA**

Mr. M.M. Sixaba	-	Regional Director
V.V. Mgudlwa	-	Deputy Regional Director
C.N. Mfingwana	-	District Manager
M.T. Tate	-	District Manager
M.P. Thipanyana	-	District Manager
N. Mtoba	-	District Manager
Mrs N Gqulu	-	Co-facilitator
Mrs. N. Makalima	-	Health Management TOT
Mrs Macingwana	-	Comprehensive Skills TOT
Mrs. Zola	-	Clinic Supervisor

**NORTHERN PROVINCE**

Ms MJ Mojapelo	-	Deputy Director HRD
Ms RM Lamola	-	Deputy Director PHC
TS Malwa	-	Health Management TOT
ME Mashao	-	Health Management TOT
KA Maluleke	-	Health Management TOT
M van Niekerk	-	ODA

**NORTHWEST PROVINCE**

Mr CA Mayela	-	Director HRD
Ms L de Bruyn	-	Assistant Director HRD
Mr R Gotsana	-	Chief Training Officer HRD
Ms S Monamadi	-	Health Management TOT
Mr M Hoque	-	Student - Management Training program NWP
Ms C Phakedi	-	Student - Management Training program NWP

**PRETORIA**

Dr W Kogi- Makau	-	Data Collection Consultant INTRAH/PRIME
Dx S Hendricks	-	Director HRD Dept of Health (National Office)
Ms P Mamogobo	-	BASICS/SA Coordinator
Mr P Abamonte	-	CDC
Mrs C Kruger	-	BASICS/USA
Ms J Washira	-	INTRAH

## APPENDIX B

### NORTHWEST PROVINCE

#### PROPOSED CURRICULUM OUTLINE ON THE PHC MANAGEMENT TRAINING PROGRAM

#### BREAKDOWN OF COURSE CONTENT

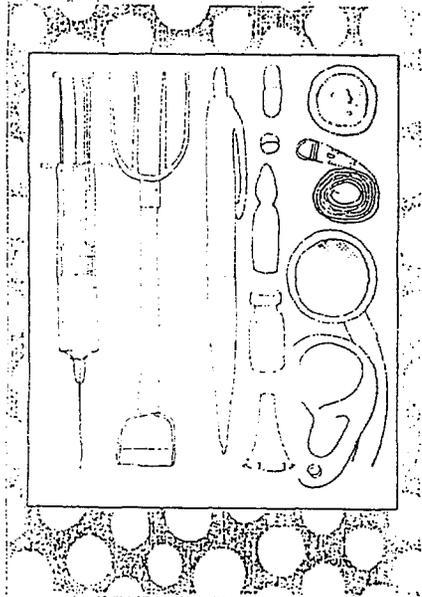
MONTH	MODULE	CONTENT	DURATION	TARGET GROUP
January	1	Applied Epidemiology	1 Week	Nurse Educators and Facilitators
	2	Health Economics	1 Week	Nurse Educators and Facilitators
April	1	Applied Epidemiology	1 Week	Program Managers and Assistant Directors
June	3	Communication	1 Week	Nursing Service Managers and Chief Professional Nurses
August	4	Personnel Management	1 Week	Nursing Service Managers and Chief Professional Nurses
October	2	Health Economics	1 Week	Program Managers and Assistant Directors

## APPENDIX C

### REGION B QUEENSTOWN PRIMARY HEALTH CARE NURSE TRAINING PROGRAM

# Queenstown

Primary Health Care Nurse  
Training Programme



1997

Course Brochure

#### Course Aims

The 1997 Queenstown Primary Health Care Nurse Training Programme is designed to establish and nurture a number of specific qualities within each participating nurse. Our chief aim is for the participant to develop a character of caring which emphasises competence and integrity. Following completion of the course, we hope the nurse will have developed a host of new relationships, and skills, as well as new knowledge.

#### Develop healing/healthy relationships

- with individual patients, their families, and the community.
- with clinic colleagues.
- within the district health system and with their referral network.
- other sisters on the course, and course facilitators.

#### Develop skills in:

- history taking/ interviewing of patients
- physical examination.
- using PHC tools more effectively (e.g. Road to health card, antenatal card).
- statistical assessment of disease patterns.
- problem solving.

#### Develop knowledge about:

- priorities and limitations in Primary Health Care (PHC).
- many common health problems, their diagnosis, differential diagnosis, and management.
- specific preventive interventions that are effective.
- mechanisms of health and disease in the community as a whole.

**BEST AVAILABLE COPY**

**APPENDIX C (continued)**

*Course content*

The Queenstown PHC Nurse course consists of six discrete training weeks spread over a 9 month period, as well as implementation studies between each of the training weeks, a two week clinical skills block, and a final examination.

- The content of the training weeks, as well as their dates, may be noted in the Course schedule. Students are expected to attend all six of the weeks.
- The implementation studies will be done by each sister following every training week. They include application of concepts discussed in the sessions, written work to be handed in, case studies, and some additional research with reading on new topics.
- The clinical skills block introduces the nurse to specific history taking and physical examination skills (e.g. interviewing the whole person, examination of the chest) and refines their application in the management of a number of common conditions. This two week block is often done at the nurse's referral hospital/clinic alongside a chosen facilitator.
- The course examination usually includes two written papers (2 hours each), an OSCE skills station examination, and a clinic-based patient interview followed by an oral exam. Importantly, our focus during the course is promoting learning and nurturing skills, not merely preparing the student to pass the examination.

*Course schedule*

- Week 1 - March 17-21**  
Introduction to Primary Health Care  
Adult learning techniques  
Community entry and participation  
Principles of integrated community based care  
Caring and Teamwork skills
- Week 2 - April 14-18**  
Diabetes - a case management system  
Dental illness  
Respiratory infections  
Nutritional assessment  
19 to weeks
- Week 3 - May 12-16**  
Women's health issues and Sexuality
- Week 4 - June 9-13**  
Adult Health problems
- Week 5 - July 28 - 1 August**  
Paediatric interventions  
Perinatal care  
Neurodevelopmental Assessment  
Breast Feeding  
Immunisation  
Other problems not covered in Case management
- Week 6 - September 1-5**  
Patient and clinic record systems  
Statistics  
Clinical Skill refinements  
Evaluations
- Clinical Skills Blocks - 19-30 May, and 4-15 August**  
Training/practice in Physical Examination techniques, Management of common adult and paediatric conditions, History taking skills.
- Examination Week - October 6-9**  
2 written papers (2 hours each), OSCE skills station examination, Clinic-based patient interview followed by an oral exam

*Course details*

**Venue** The six training weeks will be held within the training block at Komani Hospital, Queenstown.

**Costs** While the region supports most of the costs of running this course, a nominal fee of R125 is charged for each participant. This money is used to purchase books and equipment for the training.

**Accommodation/Meals** Many local participants commute to Komani hospital daily during the course, or make private accommodation arrangements. Additionally, accommodation for 14 participants is available at Komani Hospital Nurses Home during the training course at a cost of R5 per night (no breakfast is provided.) Participants are urged to bring transport if at all possible. Arrangements are made during the training weeks for participants to purchase a lunch from the kitchen at Komani for a cost of R2.60.

**Recommended Texts** Most of the participants discover that the following texts are useful both during the course, and afterwards when working as PHC nurses.

S3 Primary Care Manual, 1992, Jacana publishers.

Primary Health Care Formulary, 2nd edition, Helene Möller, et al. 1995, Medicos Pharmacy Project.

**Enrolment Requirements** Participants are required to be fully qualified professional nurses.

Further, as there is high demand for spots on the course, we request that only nurses likely to actually practice comprehensive PHC attend.

**EQUITY** Many of the course facilitators have taken part in the Equity training program, and the course content and structure represents a blending of our experience in PHC, in running this course for the last few years, feedback from previous participants, and input from the EQUITY primary health care training program.

For further information regarding this course, contact the Regional Co-ordinator for Training:  
Mrs. Thembi Nkunga  
Regional Training Unit  
PO Box 838, Queenstown 5320  
Telephone: 0451-88178, or -4036  
Fax: -88179

**Region B**  
District PHC Training Co-ordinators  
Queenstown District - N. Mpakama & L. Kwatsha - Komani Hospital  
Elliot District - N. Mseti - Cala Hospital  
Aliwal North District - F. Ntantiso - Umlamli Hospital  
Craddock District - A. Bolha - Craddock Municipality

Ms H. Vuba - Resource Co-ordinator  
Ms. P. Ondala - Course Secretary

## APPENDIX D

### SCHEDULE FOR THE BRIDGING EVALUATION TEAM

#### Evaluation Team

Celeste Carr, Team Leader, USAID  
Mary Kingsley, Eastern Cape Province Representative  
Nosinodi Madikizela, Eastern Cape Representative  
Louise Smit, Training Specialist, MACRO

<b>24 February 1997</b>	Pretoria
2.00 pm	Briefing with Dr Wambui Kogi-Makau - Data Collection Consultant
5.00 pm	Depart for airport to East London
<b>25 February 1997</b>	Bisho
9.00 am	Briefing with EQUITY Coordinators
	Briefing with Dr Stamper and Mr Wild - ECPDOHW
	Interviews
<b>26 February 1997</b>	East London
9.00 am	Briefing with Regional Director - region C - East London
	Interviews
<b>27 February 1997</b>	Queenstown
9.00 am	Briefing with Regional Director - region B - Queenstown
	Interviews
	Drive to Umtata
<b>28 February 1997</b>	Umtata
10.00 am	Briefing Regional Director - region D - Umtata
	Interviews
<b>2 March 1997</b>	Drive to Kokstad
<b>3 March 1997</b>	Kokstad
8.00 am	Briefing Regional Director - region E - Kokstad
	Interviews
	Drive to Port Elizabeth
<b>4 March 1997</b>	Port Elizabeth
9.00 am	Briefing Regional Director - region A - Port Elizabeth
	Interviews
	Return to JHB

<b>5 March 1997</b>	Pretoria
9.00 am	Interview Dr Hendricks Director HRD DOH
11.00 am	Interview BASICS/SA
2.00 pm	Interview CDC/DDM
<b>6 March 1997</b>	Pietersburg
7.00 am	Depart for Pietersburg
9.00 am	Briefing Director
	Interviews
5.30 pm	Return to Pretoria
<b>7 March 1997</b>	Mmabatho
7.30 am	Depart for Mmabatho
9.00 am	Briefing Director
	Interviews
6.50 pm	Return to Pretoria
<b>10 - 13 March 1997</b>	Report writing
<b>14 March 1997</b>	Distribute draft report in Pretoria
	Send draft report to ECDOHW via DHL
<b>17 March 1997</b>	Bisho
6.15 am	Depart for East London
8.00 am	Drive to Bisho
10.00 am	Debriefing by Evaluation Team
5.30 pm	Return to Pretoria
<b>18-19 March 1997</b>	Report writing
<b>20 March 1997</b>	<b>Draft Final Report to USAID/SA</b>

## APPENDIX E

### DESCRIPTION /SPECIFICATION/WORK STATEMENT EVALUATION OF THE BRIDGING TRAINING ACTIVITIES

#### Purpose of the Evaluation

Prior to moving into full scale implementation of the EQUITY Project it is important to evaluate the approaches, processes and procedures used by BASICS and INTRAH/PRIME for the comprehensive PHC skills training course and CDC/DDM for the health management training course. In addition, it is important to evaluate outcomes (products) of these two training courses and determine their respective strengths, limitations and replicability in future training programs.

Specifically, the evaluation will:

- Assess the training approaches and processes used in planning and implementing both the PHC management and the comprehensive PHC skills training programs;
- Assess the impact of the bridging training activities on USAID's SO3 (Health) and its intermediate results;
- Describe the characteristics and features of the various categories of training centres utilised and their appropriateness as a location for future training;
- Describe the models used to encourage Non-Governmental Organizations (NGOs) to participate in the training design, development and implementation, and identify modules that should either be added or dropped;
- Examine the degree to which the PHC management and the comprehensive PHC skills training reflect the DOH training policy for PHC training;
- Identify the policies that have evolved or are evolving from the PHC training experience - for both programs;
- Identify the strengths and limitations of the PHC management and the comprehensive PHC skills training, and distil lessons learned that may be useful to the EQUITY Project;
- On the basis of these strengths, limitations and lessons learned, propose additional approaches to both training programs, where appropriate.

#### Evaluation Team Responsibilities:

The Evaluation Team will conduct a thorough evaluation of the PHC management and comprehensive PHC skills training programs as implemented by the CDC/DDM, BASICS and INTRAH/PRIME, respectively. In addition to the tasks described in the preceding section on the evaluation purpose, important questions that the team leader should bear in mind include the following:

#### PLANNING

1. In planning for the training, what processes and procedures were used in selecting working group members to develop the training course? What was successful and should be replicated? What needs to be improved or changed?

## OUTPUTS

2. What were the outputs/products of the PHC training? Which products/outputs can be utilized in future training? Which need improvement?
3. What was the impact of these activities vis-a-vis the long term expected results under SO3?

## SUSTAINABILITY

4. What were the sustainable (replicable) products/outputs or processes of this training program?

## LESSONS LEARNED

5. What were the successes of this training program? What were the pitfalls? What policies need to be put into place to make future training more useful?
6. How effective was the distance-based learning concepts incorporated into the comprehensive PHC skills training program? Should these concepts be an integral part of future EQUITY in-service training programs?

## Specific Tasks of the Evaluation Team

- Task 1            Conduct a thorough review of the PHC Management and Comprehensive PHC Skills training programs in terms of their expected outputs/products/results
- Task 2            Interview representatives from the following groups: Working Group members, Co-Facilitators, Mentors, PHC Management Working Group members outside of the Eastern Cape, Clinic Supervisors, Trainees (Participants), Eastern Cape Department of Health and Welfare (ECDOH&W), CDC Epidemiology Advisor, Department of Health Human Resources Director, USAID/SA SO3 Team Leader, USAID/SA Health Project Development Specialist, BASICS/SA, BASICS/USA, INTRAH/PRIME, CDC/DDM, the INTRAH Data Collection Consultant and the ECDOH&W EQUITY Project Coordinators. This task will involve a series of informational interviews in order to make an independent assessment of the overall performance of the two training programs.

## Evaluation Design Strategy

A tremendous amount of data has already been compiled concerning the PHC management and comprehensive PHS skills training programs. These documents will be made available to the evaluation team for their review and analysis. Specifically, a data collection consultant will have compiled several data sets in preparation for the Evaluation which will include focus group discussions with the community and participants. This document will be available for the use of the Evaluation Team. In completing the evaluation, the team is expected to use evaluation strategies that will provide a comprehensive review of the training process. Evaluation strategies should include review of available documentation, interviews, site visits and analysis of existing data and interviews.