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**A MODEL FOR TRAINING HOME HEALTH EDUCATORS
WITHIN THE SEVENTH-DAY ADVENTIST CHURCH**

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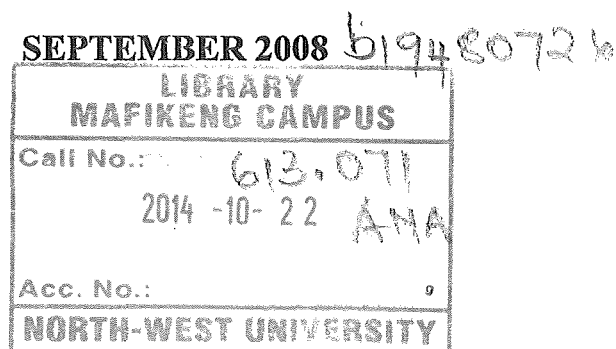
MUFUNGULWA MAURICE ANAKOKA

BSc.Ed., PGDip., B.Ed(Hons)., M.Ed.

**THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY (ADULT
EDUCATION) IN THE SCHOOL OF POST GRADUATE STUDIES**

**FACULTY OF EDUCATION
NORTH WEST UNIVERSITY
MAFIKENG CAMPUS**

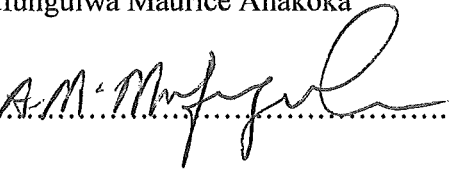
**SUPERVISORS: DR. K.N. MAGWENZI
DR. K.P. QUAN-BAFOUR**



DECLARATION

I, Mufungulwa M. Anakoka, hereby declare that this dissertation for the Degree of Doctor of Philosophy (PhD) in Adult Education, submitted to the North-West University (Mafikeng Campus), has not been previously submitted by me or any one for a degree at either this University or any other University. I further declare that this is my work in design and execution, and that all materials contained herein have been duly acknowledged.

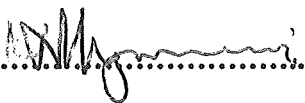
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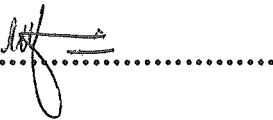
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CERTIFICATE OF ACCEPTANCE

This Thesis entitled “A MODEL FOR TRAINING HOME HEALTH EDUCATORS WITHIN THE SEVENTH-DAY ADVENTIST CHURCH,” written by Mufungulwa Maurice Anakoka (Student number: 16159209) of the School of Postgraduate Studies, North West University, is hereby recommended for examination.

Supervisors: DR. K.N. MAGWENZI

DR. K.P. QUAN-BAFOUR

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DEDICATION

I whole-heartedly dedicate this work to the following:

Anakoka, Sibupiwa I, my wife.

Anakoka, Mufungulwa, my son.

Anakoka, Sepo, my daughter.

Mufungulwa, C.A.L.M, my father.

Silukena, Nawa, my mother.

Family members and friends.

Co-workers in Home Health Education Service.

North West University Adult Education Specialization.

ABSTRACT

The main objective of the research was to design a training model that would assist directors of Home Health Education Service to develop and formalize the Home Health Education Service training programmes in the Southern Africa Union Conference. The model will assist Home Health Education Service directors to design pre-service and in-service training programmes that are in harmony with the demands of the South African Qualifications Authority (SAQA). At the moment, the training offered is not in harmony with SAQA demands.

The literature review was tangentially approached because there was not enough literature directly related to the training of Home Health Educators within the Seventh-day Adventist Church's educational institutions. A careful examination of the literature review revealed that pre-service training was a desirable goal pursued by the Seventh-day Adventist Church's educational institutions. Although no formalized structure was put in place, in-service training was considered to be of great value to the institution.

Although the researcher interacted with the population for the verification of data up to 2007, the population of the study however was made up of all the Home Health Educators in the Southern Africa Union Conference of the Seventh-day Adventist Church in 2003. The research assumed a combination of both the qualitative and quantitative approaches in order to ensure that findings from the data are more valid and authentic. To collect data, the researcher used questionnaire, interview, and examination of historical records. The data was analyzed, leading to specific interpretations and conclusions.

Data collected indicated that Home Health Education Service has no pre-service training model from which to obtain pre-service training programmes and that the in-service training is in need of a comprehensive formal structure. A training

model to address the training needs of the organization was designed in this research.

Informed by the study findings, an Evaluation Training Model (ETM) was designed to meet the needs of training issues in Home Health Education Service organization. The new designed training model is designated: Evaluation Training Model (ETM) because evaluation is central to all the steps of the model.

The researcher has recommended that for transformation to take place in Home Health Education Service, the organization has to use the new designed training model (ETM) and establish organizational training institutions in Southern Africa Union Conference for the training of Home Health Educators and their trainers.

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CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Organizations all over the world are working towards reaching their goals for success. For this reason employees of various organizations need to undergo some training related to their organization's intended goals. The Seventh-day Adventist Church has many departments responsible for different organizational functions. The Church's departments include the following: Education for Universities, Colleges, Schools, and Early Learning Centres; Health for Hospitals, Sanitariums, Hospices, and other health related centres; Family Ministries for family education and development; Publishing Ministries for Publishing Houses, Home Health Education Service, and other learning activities that are run by means of print media. For these departments to function properly, training of members of staff is of great importance (Seccritariat, 2005: 51, 101-170). Workers in Home Health Education Service have many titles through which they are known, one of which is Home Health Educators. They educate people through awareness and promotional seminars on life skills supported by the literature they distribute (Appenzeller 1989:19-32). Training of Home Health Educators is a key issue in this study that invites further exploration.

Home Health Educators (HHEs) in the Southern Africa Union Conference (SAUC) of the Seventh-day Adventist World Church (SDA-WC) are part of those that may need training in this ever changing world. In the southern part of Africa, the SAUC of the SDA-WC is operating in the four countries of Lesotho, Swaziland, Namibia, and the Republic of South Africa. The head office of SAUC is in the city of Bloemfontein of the Republic of South Africa (RSA). This means the influence

of RSA on administration of this organization cannot be overlooked. Since the inception of the democratic dispensation in 1994, the term "training" has found a place in almost every institution that has the development of human resource at heart. The term "training" has taken many forms such as work - shopping, course, coaching, learnership, and many more. Training is a very important part of Human Resource Development (HRD) Strategic Plan for the organizations that have goal achievement as an objective. The study is herein set to design a training model for HHEs in SAUC, which will introduce the pre-service phase of training, and formalizing the in-service phase of training in the Home Health Education Service (HHES) organization.

Talking about training of people, Ettore (1979:48) gives the idea that "both knowledge and practical skills are necessary in every innovation". In agreement with the above idea, Appenzeller (1989: 5) points out that Home Health Educators need training so as to reach higher levels of professionalism. Jerling (1996:3) asserts that training is a vital component of organizational development.

Training of Home Health Educators will therefore help reduce the current problems faced by Home Health Education Service.

1.2 STATEMENT OF THE PROBLEM

Home Health Educators educate the people through awareness programmes and the use of print media. These printed pages may be obtained at a cost in most cases. At times the Home Health Educators have played the role of enrolling community members in a Distance Learning School for worthy living through Bible lessons. Such a task requires them to have some competencies in the fields of salesmanship, project management, communication, accounting and office practice with book - keeping, and a bit of theology. Observation of the Home

Health Education Service revealed to the researcher that there was no pre-service training for Home Health Educators and the quality of the in-service training offered was not up to the standard required by the Republic of South Africa.

Since there's no pre-service training and Home Health Educators are subjected to traditionally informal in-service training which has no recognition with the South African Qualifications Authority (SAQA), the researcher saw a need for the development of a training model that would reduce the following problems: lack of pre-service training, availability of fragmented training programmes for in-service phase, critical shortage of workers (about 300 workers in the SAUC which is made up of four countries of Namibia, Swaziland, Lesotho, and RSA) and poor recruitment procedures (no formal interviews and short listing). Thus the crux of the matter is to design a training model that will help Home Health Educators to have knowledge, skills, and attitudes to achieve the organizational objectives, and be able to conduct training sessions that are coherent in nature. Since SAUC has its Headquarters in RSA, it is very appropriate to have every functional aspect of its organization to adhere to SAQA standards that have international implications in design. In this way Home Health Education Service may be encouraged to have a training model that will help solve the problem of not having a pre-service training and that of not having formal in-service training.

This study was guided by the following research questions.

1.3 RESEARCH QUESTIONS

In finding solution to the problem stated in 1.2 above, the study was guided by the following questions:

1.3.1 What current practices, in relation to both pre-service and in-service

training, in Home Health Education Service in Southern Africa Union Conference, are taking place?

1.3.2 Does the Home Health Education Service management assess the needs of Home Health Educators with a view to adjusting training models for successful service delivery?

1.3.3 Do Home Health Educators acknowledge having been trained adequately to perform the tasks they are assigned?

1.3.4 Does Home Health Education Service management carry out an evaluation of the types of in-service training so as to warrant an adjustment in training programmes for workers of the organization?

1.3.5 What kind of training model would suit Southern Africa Union Conference Home Health Educators to ensure successful service delivery?

1.4 PURPOSE OF THE STUDY

The purpose of the study was to design a training model that would help Home Health Education Service directors to develop pre-service training programmes and adjust, accordingly, the in-service training programmes for the Home Health Educators in the Southern Africa Union Conference. Developing a training model that would address the pre-service and in-service training needs of the HHES was the key issue of this study.

1.5 SPECIFIC OBJECTIVES OF THE STUDY

The following specific objectives guided the study:

- To investigate the current practices in Home Health Education Service, as related to both pre-service and in-service training activities.
- To assess the involvement of Home Health Education Service management in the evaluation of the training needs of Home Health Educators with a view to adjusting in-service training programmes for successful service delivery.
- To investigate the Home Health Educators' level of acknowledgement as related to their being trained adequately enough to perform the tasks of their assignments.
- To investigate the involvement of the Home Health Education Service Management in the evaluation of the types of in-service training programmes available with a view to warrant an adjustment in the training programmes for Home Health Educators.
- To suggest the best possible training model that will ensure successful service delivery for Home Health Educators in the Southern Africa Union Conference.

1.6 RATIONALE AND SIGNIFICANCE OF THE STUDY

Training of Home Health Educators is an urgent and rationale issue. White (1953:57) indicates that those occupying top offices in the Seventh-day Adventist Church should pay particular attention to the training aspect of Home Health Educators. Speaking about the training of Home Health Educators, McAdams (1954:120) connotes that the value of training Home Health Educators should be approached from the corporate point of view, in which leaders combine their efforts to build up worthy curriculum for training purposes.

According to Hunt (1981:83), training covers a series of experiences of those who served as Home Health Educators. Henning (1989:6) implies that there is a need to improve the training skills, knowledge and attitudes of Home Health Educators for quality service delivery. With the above stated statements, it becomes imperative to suggest a training model from which training programmes for Home Health Educators can be drawn.

The study has been motivated by problems (such as that of some of Home Health Educators not reporting their performance to the higher authorities) reflected in the monthly news bulletins and comments made by some prominent Home Health Education Service management officials or junior workers (News bulletin from 1994 to 2004). Due to the above stated nature of training in Home Health Education Service, Jose (2002:2) acknowledges the fact that Home Health Educators, on global scale, are encountering difficulties in the procedures of getting education to the people due to the changes in this modern world. In support of this, Faigao (2002:7) recommends that Home Health Education Service related subjects/courses be incorporated in the Seventh-day Adventist schools, colleges, academies, and universities, which will serve as some form of pre-service training for Home Health Educators on global scale. Moreover, he went on to recommend that for those doing theological studies to graduate they will need to practically get engaged in the fieldwork for home health education operation for at least 350 hours. For this reason the study that seeks solution to the current training problem is desirable.

The significance of developing a training model for Home Health Educators is motivated by the following reasons:

- There is great need to carry out research in the training aspect as there is evidence that such a study has not been done before, according to two researches done by Anakoka in both 1993 and 2001, respectively.

- According to the discussion held at Annerly Youth Camp (in Port Shepstone – RSA) in 2003 by Jose, a world church leader for Home Health Educators, current training programmes are limited to in-service diploma qualifications that are informal in nature.
- Southern Publishing Association News Bulletin for February 2003 indicates that the total population of Home Health Educators in the four countries of Namibia, Swaziland, Lesotho, and South Africa was 214 for the regional population of over 45,000,000 people. So, there is a need to increase this number of Home Health Educators in SAUC.
- According to Brown and Tomori (1979:269), Hurter (2003 lecture), and Anakoka (1993:4), Home Health Education Service programmes are considered part of adult education. In this study, the researcher assumes that the training of Home Health Educators will help the community to acquire adult education necessary for community development.

The findings of this study will help contribute to the existing knowledge by affecting the following groups of people as explained below:

- **Home Health Education Service directors responsible for designing training programmes** will be using the training model, suggested by this study, to design training programmes that are nationally recognized for the advancement of Home Health Educators in SAUC for the benefit of consumer community members and those researching on behalf of Home Health Education Service.
- **Home Health Educators** will receive training that puts them in a position of belonging to an organization that derives its training programmes from a training model that is in harmony with the SAQA requirements. This will help them to perform to the expected

organizational standard for the sake of both of their personal development and that of the organization they belong to. This will motivate them both internally and externally.

- **Service consumers** will quickly see relevancy in the presentations by Home Health Educators thus leading them to make favourable decisions for their personal benefit.
- **Researchers in Adult Education** will be able to extend their research influence to the designing of training programmes in Home Health Education Service. This is made possible by an awareness made by this study that highlights the link between Home Health Education Service and Adult Education Institutions.
- **The research community** will find a very unusual new area for exploration.

1.7 DELIMITATION AND LIMITATIONS OF THE STUDY

While the study looks into the designing of a training model for Home Health Educators in Southern Africa Union Conference, the results may find universal applications on international scale, outside of Lesotho, Namibia, Swaziland, and Republic of South Africa, in the Home Health Education Service, because of the universality of training principles. The findings of the study may also be useful in other departments outside the church parameters, such as those of Health and Education, where adult education and training is of relevance.

However, the study may not cover 100% of its intended populations due to differences in the intervening variables in different locations where this study is expected to exert some influence. Such variables may include different attitudes of Home Health Educators in SAUC, and latent reasons for becoming Home Health Educators in the location where duty is to be done.

The study was limited to Home Health Education Service as related to the method (or approach) of service delivery that involves health education promotions attached to the community members' acquiring of learning support materials which have cost implications. This kind of approach, of direct linking learning support materials to costs, is not usually used by the Departments of Health and Education, as the relaying educational methods are different, e.g. complementing the spoken word by the written word, with sales not avoidable in Home Health Education Service.

1.8 DEFINITION OF TERMS

In this section, the researcher has operationalized some major concepts used in this study as follows:

1.8.1 Home Health Educators

In this study, Home Health Educators are those people working with Home Health Education Service, and they do not only distribute books for life skills education but also display product knowledge by conducting studies for health restoration in the homes of community members. The terms: literature evangelist, colporteur evangelist, canvasser evangelist, book minister, and canvasser agent are deemed synonymous to Home Health Educator. Home Health Educator has been used (White 1997) to imply service providers educating the people on both home (family) and health matters. In most cases she uses the titles in the immediate sentence above. The term or title for Home Health Educator is not documented except by impression made by the work (Home Health Education Service) title in the purchase agreement form filled by clients and HHES Workers. In the Southern Africa Union Conference, literature evangelists use this term to functionally identify themselves with their work, though informally.

1.8.2 Southern Publishing Association (SPA)

In this study, SPA does not only refer to the publishing house of the Seventh-day Adventist Church Head Quarters in Bloemfontein, but an organization that is responsible for the recruiting, remuneration and training of Home Health Educators in the whole region made up of Namibia, Swaziland, Lesotho, and the Republic of South Africa. This is made evident in the letters written to the co-service providers and has its reflection on the letterhead from Southern Publishing Association (SPA). SPA is a complete subset or function of the Seventh-day Adventist Church organization, based on a principle of improving the lives of people through print media and the team of agents that educate people on lifestyle issues. According to SPA and Southern Africa Union Conference statements in news bulletins (2000 to 2003), SPA is the principal supplier of learning support materials for life skills education in the Southern Africa Union Conference, and for Home Health Educators' distribution. Peters (2005:2) makes the name (Southern Publishing Association) known in a magazine called "Maranatha".

1.8.3 Southern Africa Union Conference (SAUC)

In this study, SAUC refers to the territory covering the four countries of Lesotho, Swaziland, Namibia, and the Republic of South Africa, in which the Seventh - day Adventist church has established centres for community development such as hospitals, learning institutions, farms, conference offices, and church buildings. Constitutionally, it is called the Union of the Seventh-day Adventist World Church in the four mentioned countries in Southern Africa. The Head Office is in Bloemfontein with all chief administrators (Peters 2005:2). It should be understood that Mwansa (2005:10) refers to the same SAUC by using a name Southern Africa Union (SAU). Mwansa (2005:5) refers to SAU as SAUC. The two abbreviated names, SAU and SAUC, are used synonymously in the references

reflected in this paragraph.

1.8.4 Seventh-day Adventist World Church (SDAWC)

In this study, the SDAWC is the same as the generally well-known Seventh-day Adventist Church, generally abbreviated as SDA. The distribution of this church on global scale has qualified it to earn the term "World". Thus, SDAWC is synonymous to SDA. According to the Secretariat (2000:2) for the Seventh-day Adventist Church, the concept of the term 'World', refers to the globe to mean the whole earth; hence it (SDA) has been usually referred to as the Seventh-day Adventist World Church during the General Conference Session. The Church Manual (2000:51) endorses this idea, in terms of the mission of SDAWC. Ziegler (2005: 12), in Maranatha magazine, uses the term "world church" to mean the Seventh - day Adventist World Church. Wilson (2005:2) uses the term "world church" to imply the Seventh-day Adventist World Church.

1.8.5 Training

In this study, training means imparting relevant knowledge, skill, and attitude to someone for the performing of specified tasks related to particular job situations. The following authors have substantiated the definition of training: Kallaus (1987: 179) says that training is the process of providing individuals with an organized series of experiences that comprise opportunities to learn. Collins (1995:883) supports this idea by stating that training is the process of bringing a person to an agreed standard of proficiency by practice and instruction. Erasmus and van Dyk (1999) regard training as a systematic and planned process to change the knowledge, skills, and behaviour of employees in such a way that organizational objectives are achieved. In harmony with the above quotations is a statement made by VanDyk, Nel, VanZloedolff, and Haasbroek (2001:147) who define training as "a systematic and planned process to change the knowledge

and behavior of employees in such a way that organizational objectives are achieved”.

1.8.6 Pre-service Training

In this study, pre-service training refers to that type of training offered to prospective employees with the hope of preparing them for effective and efficient service delivery. The term also refers to sharing experiences about the Home Health Education Service work with people who are intending to become workers of the organization, thus promoting proficiency when employed. Kallaus (1987: 179) classifies this type of training as that which qualifies people to enter jobs. Thus before people are employed to work as book distributors, they must receive pre-service training to help them perform better when employed.

1.8.7 In-service Training

In this study, in-service kind of training refers to the task oriented education given to people regarded as employees of the HHES organization, with the hope of making them proficient through induction, re-training, up-grading, and supervisory stages of the workers concerned. Commenting on the importance of in-service training, Furjarnic and Trotman (2000) indicated how training can turn into learning but in the work related situation. As long as training is given to people who are already in the working environment, this is in-service training. It is training for the people who have already been employed.

1.8.8 Training Model

In this study, a training model means a map or skeleton of ideas of how training should flow, and from this map a training programme may be extracted, as related by Nadler (1990:4). Training model, in this case, means a set of routes on a map of training programmes that includes elements of a programme and how they relate to one another.

1.8.9 Population

According to Collins (1995: 626) population means "all the particular class in a place" Hittleman and Simon (2002:91) say that a population is a group of individuals or objects that has at least one characteristic that distinguishes them from other groups. In this study it refers to the number of Home Health Educators working for Home Health Education Service in Southern Africa Union Conference (a geographical location made of Namibia, Swaziland, Lesotho, and the Republic of South Africa).

1.9 CHAPTER DIVISIONS OF THE STUDY

Chapter one provides background to the study including a discussion of the problem of the study, research questions, determination of its purpose and objectives, rationale, definition of relevant terms and the general limitations.

Chapter two provides related literature including theoretical framework to the study, examples of training models and how they are designed.

Chapter three focuses on the research design and methodology for data collection, presentation and interpretation including the population and sampling processes used.

Chapter four focuses mainly on the presentation of data collected as well as its presentation using descriptive statistics as instruments for interpretation.

Chapter five provides information on the justification of the need for the new training model and its design.

Chapter six concludes the study by providing summary, recommendations and suggestions for further study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In chapter one, Background to the study, the following aspects were discussed: Introduction to the study, statement of the problem under investigation, research questions, purpose, rationale, and significance of the study, study objectives, study limits, study methodology, definitions of terms, and chapter divisions. This chapter presents a review of literature that is related to this study.

Thornhill (2000: 161) firmly believes that the training and development of employees as a vital component in the realization of business plans for the survival of any organization. This implies that if training is not afforded a priority in an organization, then such an organization may find it hard to survive in a world of change. This is in harmony with the opinion of Davies (2001: Back cover page) who gave the comment that "training is a vital part of professional development." However, it may be realized that training of members of staff is a dynamic concept due to the fact that relative knowledge is not static. Hackett (2003:5) indicates that training improves the capability of the organization, and that it helps employees to achieve the organizational objectives which are described in terms of processes, people, and performance.

All over the world organizations are occupied with thoughts of how to be effective and efficient in service delivery. At times, training models are amended, developed, or designed with the aim of meeting progressing challenges. In the process some models are crashed and replaced by new ones, which also get adjusted until objectives are achieved by organizations. Some organizations may take time evaluating their systems, while others learn through some difficulties

affecting performance outcomes. The competencies of staff members may stimulate the kind of training models to be used, which may promote endemism of knowledge, skills, and attitudes (KSA), or transfer of the KSA obtained in another organization (Buckley and Caple 2000:1)).

2.2 TRAINING THEORETICAL FRAMEWORK

2.2.1 Training

Before one starts working on a particular job related to a profession, one has to undergo a series of experiences of how to relate to that work. Home Health Education Service Workers in Southern Africa Union Conference are not an exception. It was in this light that De Beer, Rossouw, Moolman, Roux, and Labuschagne (1998:181) say, "Training focuses on the technical and other skills that an employee requires to perform a specific task. The main aim of training is therefore to enable a person to perform his or her task as effectively as possible". Here is an indication that training is required for a specific task, either in pre – service or in – service phase of a developmental process of any organization.

Buckley and Caple (2000:1) also endorse the idea in the paragraph above by defining training as "a planned and systematic effort to modify or develop knowledge/skill/attitude through learning experience, to achieve effective performance in an activity or range of activities. Its purpose, in the work situation is to enable an individual to acquire abilities in order that he or she can perform adequately a given task or job." Van Dyk, Nel, Loedolff, and Haasbroek (2001: 146) define training as that which should be task and result-oriented, with an aim of achieving measurable organizational goals and internal efficiency by the application of specific skills, knowledge, and behaviour.

Therefore, training is a process of providing individuals with knowledge, skills, and attitudes towards building a conceptual approach as to how the phenomenon may be dealt with for better developmental results. An example of such an issue is that of providing an individual with knowledge, skills, and attitudes on how to teach or educate adults for development. Training therefore covers theoretical and practical experiences transferred to another with a view of helping the recipient to acquire for himself/herself some particular discipline, its principles and functions.

2.2.2 Training Principles

For successful training to take place, the following principles should be observed (Van Dyk *et al*, 2001:150):

- Regardless of learning approach and different capacities to absorb information, all people are capable of learning.
- People must be motivated to learn, though they need more intrinsic motivation than extrinsic.
- Learning is an active process.
- Guidance is important in the learning process.
- Appropriate learning aids are essential.
- Training's learning methods should be varied.
- Satisfaction should be experienced by all learners in a training session.
- Each training participant should be given positive reinforcement for good behaviour in a training session.
- Each training programme should be given measurable goal to be achieved in session.

The above stated principles of training should be able to help this research project address the research questions concerning the following issues:

- Training activities in operation in Home Health Education Service in Southern Africa Union Conference.
- Training needs of Home Health Educators in Southern Africa Union Conference.
- Training adequacy in Home Health Education Service in Southern Africa Union Conference.
- Training programmes evaluation in Home Health Education Service in Southern Africa Union Conference.
- Training Model design for the betterment of Home Health Educators in Southern Africa Union Conference.

Since training has facilitators, all the facilitators should be governed by the principles of facilitating training as outlined by Van Dyk et al (2001:151 – 156).

- **Totality principle:** The facilitator, learner, and training content should reflect wholeness in approach. Each of the three entities should be valid or legitimate aspects of the training session.
- **Individualization principle:** The training session should consider learners and their learning abilities as individuals who need due attention so as to effect meaningful learning in the training situation.
- **Motivation principle:** Training facilitator should do all it takes to motivate training participants to see relevance in the training session. Learners should see the training session as that which empowers them for success at their work situations.
- **Perception principle:** Training should proceed in such a manner that learners are able to logically follow the presentation in a training session.

- **Objectives principle:** Training session should have its objectives clear to both the facilitators and learners, how and when these objectives are to be achieved.
- **Activity principle:** To enhance purposeful learning, due activities should be done in a training situation while taking cognizance that such activities are necessary for better learning and message retention.
- **Psychological principle:** Training facilitators should consider respecting learners and their training curriculum for the sake of training situation acceptance by the learners.
- **Socialization principle:** Training session should have an environment that creates social belonging to the right class, time , teaching method, and such as that is socially accepted as sound social principle relevant for meaningful learning.
- **Development principle:** Training content should be presented in such a logical manner that participants see it as developing from one concept to another in a developmental way, such as from the known to the unknown, for example.
- **Communication principle:** This principle states that to achieve understanding in the learning situation, the trainer needs to apply certain communication principles such as; message clarity, communication originator's objective, trainer's qualification to present the subject matter, timing message presentation, relevant various presentation methods, presentation structure, pre-evaluation of presentation before the actual presentation, and how to obtain the feedback that communicates the success of the communication principle.
- **Science principle:** The trainer should be knowledgeable about the nature and structure of the science s\he is practicing. The trainer should be familiar with the psychology of learning.
- **Control principle:** The trainer should be in control of the environment in which learning is taking place.

- **Planning principle:** Trainer must make sure that s\he plans to create an environment conducive for learning. Things like, the methods applicable at which stage of presentation, media for teaching aids, and other strategies necessary for learning to be meaningful.

The above stated principles are universal in nature and application, it may be necessary to understand that training does not have principles only, it also has functions.

2.2.3 Training Functions

In general, training is usually provided so as to help an individual to perform proficiently, or to be both effective and efficient. It was in relation to this view that Dorray and ArrowSmith (1997:39) say "All members of a society must be motivated and enabled to access and use lifelong learning as a tool for acquiring the knowledge and skills needed for active participation in the processes that shape the future of the society". Viewing the effectiveness and efficiency of training, Van Adelsberg and Trolley (1999:X) define effectiveness as "delivering services that tangibly help businesses to achieve their goals," and efficiency as "making the true costs of training clearly evident and highly acceptable to its customers."

In agreement with Caffarella (2002:10), the purpose of training is:

- To encourage continuous growth and development of individuals.
- To assist people in responding to practical problems and issues of adult life.
- To prepare people for current and future work opportunities.
- To assist organizations in achieving desired results and adapting to change.

- To provide opportunities to examine community and societal issues, and foster change for the common good, and promote a civil society.

Training has a lot of benefits to both an individual and the organization. Individual trainees can benefit in a number of ways. In relation to their current positions, trainees may gain greater intrinsic and extrinsic job satisfaction. Intrinsic job satisfaction may come from performing a task well and from being able to exercise a new repertoire of skills. Extrinsic job satisfaction may be derived from extra earnings accrued through improved job performance and the enhancement of job career and promotion aspects both within and outside the organization to which they belong. Benefits for the organization include improved employee work performance and productivity; shorter learning time which could lead to less costly training and employees being 'on line' more quickly; decrease in wastage; fewer accidents; reduced absenteeism; lower labor turnover and greater customer or client satisfaction (Buckley and Caple 2001:4).

In short, training ends its functions in quality service delivery, meaning, if that training is for producing adult educators, then it must do so, and the community which receives the service should indicate that they are benefiting from the adult educators from that training school in question. Contextually, the training of Home Health Educators, should make them both effective and efficient, in terms of service delivery to the community members who are living or working with them, such educators, should portray that their minds, hearts, and hands have received education good enough to perform acceptable activities for community development, hence making that community a safe and secure one to live in. Using different wording on the three (mind, heart, and hand), McCall and Cousins (1990:238) argue that training and development must address issues of skill development at all three levels of learning to ensure maximum effectiveness, and managers must be given support and encouragement in learning about

communication, both in training events and during their everyday experience of work. The functions can be classified as cognitive, affective, and conative.

- **The Cognitive function**

In his book "Hands On Training," Sisson (2001) points out that on-the-job training is quite informal in the beginning but adding structure and effectiveness to it makes it cheaper but more rewarding. He actually indicates that no training can be considered as such if the three (cognitive, affective, and conative) domains of learning are not addressed properly.

In my view, training helps the learner to exercise his/her mind to conceptualize, analyze and exercise logic in relation to decision alternatives. In the cognitive domain, the trainee may learn to have access to knowledge, comprehension, application, analysis, synthesis, and evaluation process, in a theoretical framework.

- **The Affective function**

At this level of training, the trainee learns by "involvement with his own values, beliefs, feelings, attitudes and self-image..." This function helps the trainee to understand that training will affect his/her own values, beliefs, feelings, attitudes, and self-image. The affective part of training can either encourage those behavioural traits or discourage them in the learner's life. This is the training of the heart (emotions). Lefrancois (1997:533) agrees with this view too.

- **The Conative function**

In this function of training, the trainee may learn through his interaction with

others, may receive feedback by which he/she can, access and restructure his/her perceptions and so learn how to learn. This process is formalized and extended in the concept of experiential learning, which encourages the learner to sort things out for himself by the interaction of thinking and doing processes. This function of training can be referred to as the psychomotor domain, because it helps the trainee to connect between the mind and the practical part of life in any organization. This is the training of the hand (practical) as directed by the mind.

Home Health Education Service in SAUC is part of adult educational systems; therefore, learning or training processes outlined above cover the organization too. Hence, it is worthy to look into their training models.

2.2.4 Training Models

2.2.4.1 Training Models Defined

Models for training are actually systems or routes following training trends via experiences. Collins (1995:512) says that a model is "a design or style of a particular product". In my view training model is a bigger training picture or map in which a phenomenon exists; it is a reflection of reality from which a training programme can be drawn to achieve a specific need related to task performance.

2.2.4.2 Training Models

Since training can be equated to learning by experiences, McCall and Cousins (1990:235) design the following learning cycle that is a modified learning cycle of Kolb's (1881) learning cycle. Noe (2005:118) comments on Kolb's learning cycle as that which moves in a cycle of four areas: meeting a concrete experience, reflective observation, abstract conceptualization, and active experimentation.

Authors in the immediate paragraph above give an indication that training can only be classed as such if and only if learning has taken place, and that learning does not happen sporadically, but in a particular pattern called Kolb's learning cycle as generally agreed by theorists of the psychology of learning.

McCall and Cousins (1990:235) make the following modification as shown in figure 2.1 below:

Fig. 2.1

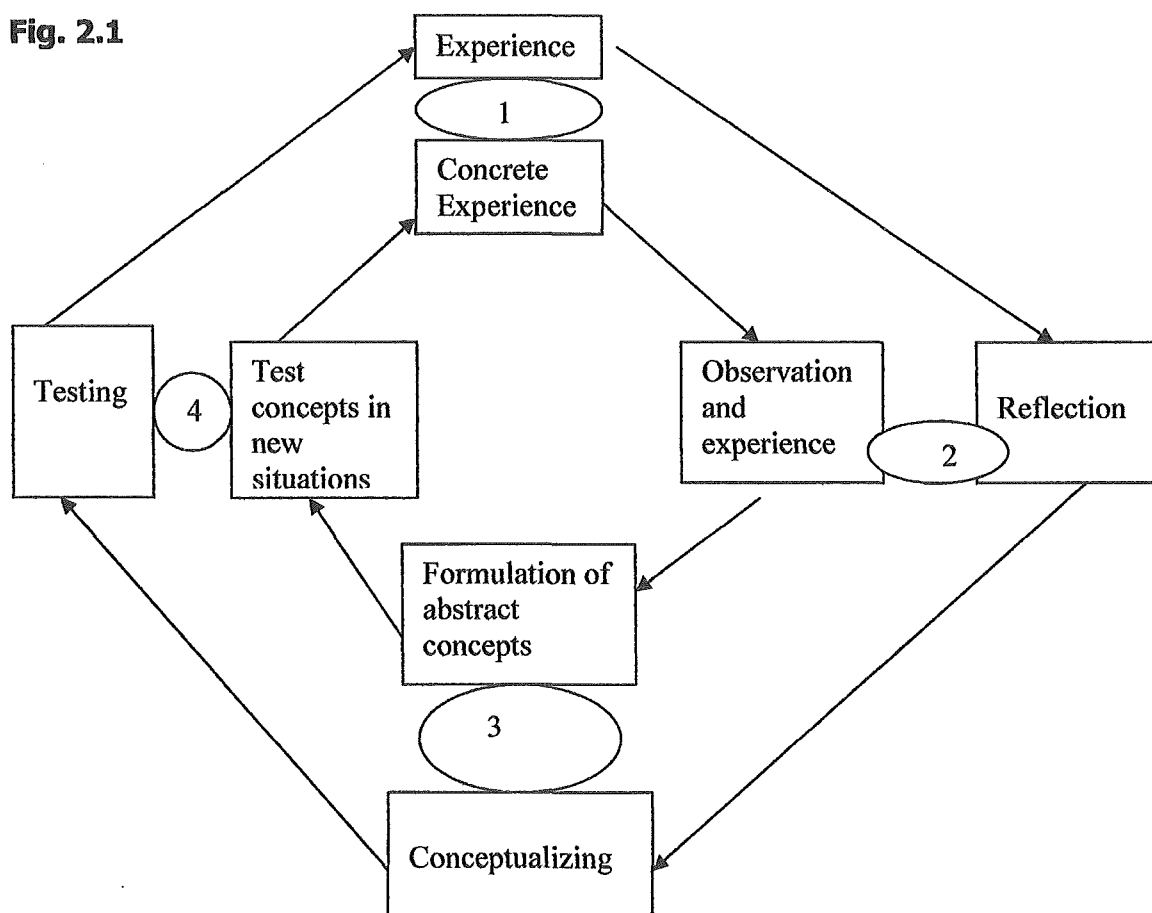


Fig. 2.1 Kolb's Modified Learning Cycle

Source: McCall and Cousins (1990:235)

The figure 2.1 is a learning cycle that can be understood also as a training cycle in this manner:

Experience is either told or personally encountered, one reflects on the experience, forms abstract concepts which can be tested in the new environment, and then it can either be thrown away or concretized that it is an experience worthy to be retold or re-experienced. How can this be a training model for Home Health Educators?

Since training is about transferring the experiences, Home Health Educators can also fit in the above model, though it was not specifically designed for them. An example can be as follows:- Home Health Educator gives a lecture on how to live a healthy life in the family, the client (family) gets interested in the subject, the educator plans to supply literature that covers many parts of healthful living which may include such things as reading books together, the client orders forty six (46) pieces of literature, and the Home Health Educator's economic status goes up. Such an experience will be reflected on, a concept may be developed about that experience, and the experience can be tested whether it can always bring the same results, or a variety of results, then finally the experience can become either a good concrete one or thrown away with an aim of forgetting it. In this fashion, books on Home Health Education can be distributed as single copies, or as sets, depending on the advantages of that experience in question. Such an experience like this one can come up in any phase of training, but the model can be incorporated for successful outcomes. McCall and Cousins (1995:235) give such a notion. Depending on the evaluation done in Home Health Education Service, a training model should cover sharing experiences as part of knowledge, skills, and attitude employed to achieve a particular goal in the organization. It may be a good idea to say that the training model should engulf Kolb's learning cycle for quality training sessions.

From documents, there has been some deduction that Home Health Education does more of the in-service training than pre-service. According to Appenzeller (1989:30), there is the record of George King; apparently the first formal Home Health Educator of the Seventh-day Adventist Church trained his co-workers only after they had yielded to the recruitment calls. This was another model of training, where George King literally took his recruits into the field, and after that field experience the recruits would be allowed to go into the field alone, no certificate offered to such recruits. This model of training was similar to that of Hardinge and Shryock (1999:4) on preceptorships as a model for training medical practitioners of early times of medicine, and this was also identical with the South African's Department of Labor's Learnerships developed in 2002. These are all models of training. Whatever, the quality of training, training should aim at balancing the triangle of training the mind, heart and the hand, as shown in the figure 2.2 below. This is an ideal situation.

Fig. 2.2

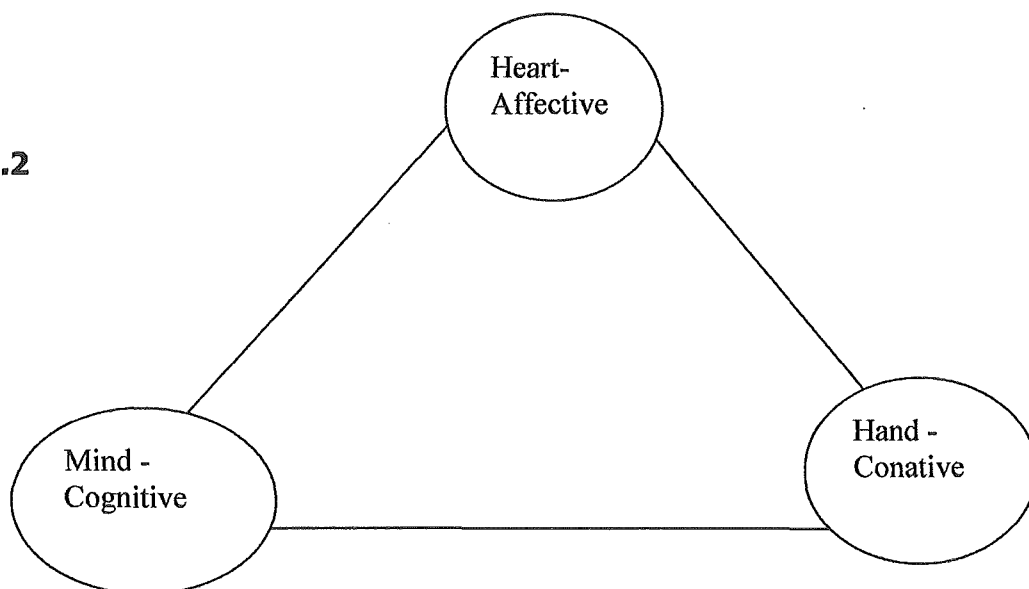


Fig. 2.2 Training Triangle

Source: Anakoka Arrangement

2.2.4.3 Training Model Designs

To design a training model, one needs to have certain guidelines. Tobin and Wise (1979:116) give an indication that in putting such a design, there are certain core elements to consider, for example, introduction to a new job, operational information necessary to function competently, and new information necessary for professional development. However, the researcher of this project finds it suitable to think of designing a training model as setting up a new programme for a particular project. This has found place in the research done by Anakoka (2001:46), where the issue of programming recognizes the following principles: Needs Assessment, objective setting, activity design, activity implementation, and evaluation of each step in the programme.

Bramley (1991:6) indicates that every training model should have the following: Identification of training need, training objective, selection and design of programmes, carrying out training, and evaluative feedback loops as shown in figure 2.3 below:

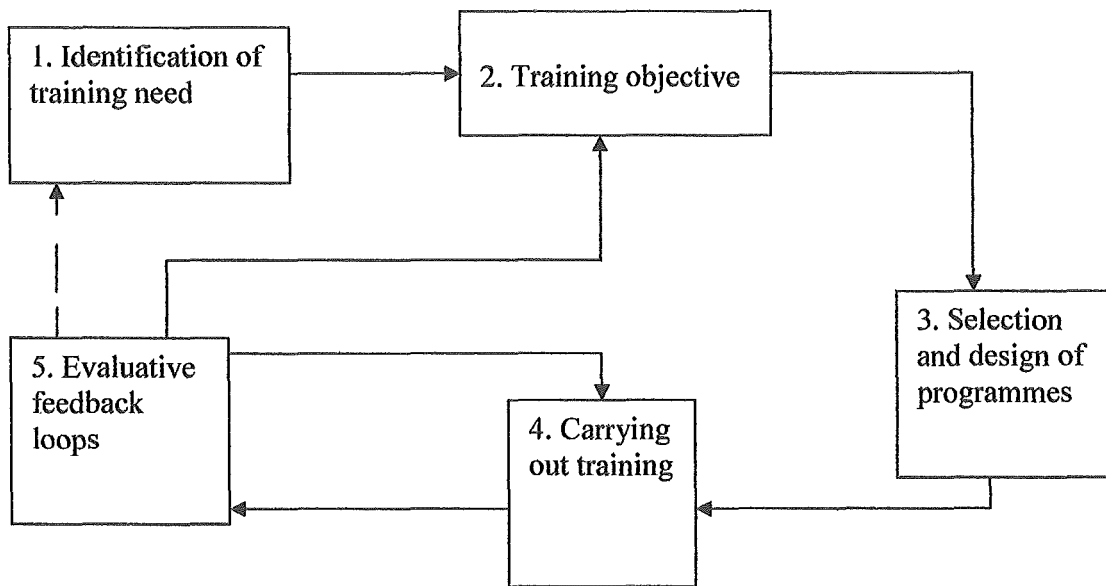


Fig. 2.3 The Main Elements in Training Model Design

Source: van Dyk *et al* (2001:163).

Nadler (1990:4) says that models are not in themselves reality, but they represent the reality of those who have developed them. He likens a model to a road map from which people make sense of which route to follow should they desire to travel to some place from where they may be. From this statement, a deduction can be drawn that a model is a representation of reality from which a programme can be drawn, like a route map for a motorist intending to travel from Mafikeng to Cape Town. According to McQuail and Windahl (1990:2) a model is a consciously simplified description in graphic form of a piece of reality. He goes on to say that a model seeks to show the main elements of any structure or process and the relationships between these elements.

In order to design a model one has to understand the functions of any model. Cautiously looking at the benefits of models, Nadler (1990:5) said that the utility of the specific model depends upon one's understanding of the reality for which s/he is designing. He gives the benefits of models as follows:

1. To explain the various aspects of human behavior and interaction.
2. To integrate what is known through research and observation.
3. To simplify complex human processes.
4. To guide observation.

In another development, McQuail and Windahl (1990:2) give the following functions and benefits of models as:

1. To order and relate systems to each other by giving a general picture of a range of different particular circumstances. In this way a model serves to organize things.
2. To help in explaining, by providing, in a simplified way, information which would otherwise be complicated or ambiguous. This gives the model a heuristic function, since it can guide the student or researcher to key points of a process or system.
3. To help in predicting outcomes or the course of events. Models can be at least a basis for assigning probabilities to various alternative outcomes, and hence for formulating hypotheses in research.
4. To describe phenomenon.

The two sources cited above agree in the four stated points, and they both suggest that training models can be changed (or modified), or discarded, and that there is no single model suitable for all functions. Each model has its limitations in functions and applications. Therefore, designing a training model for Home Health Educators in Southern Africa Union Conference (SAUC) is another unique experience in terms of functions and applications. From the prospective model many programmes may be drawn for Home Health Educators in Seventh-day Adventist World Church in SAUC.

Nadler's critical events model was designed, as a nine events/steps training model, to help training programme designers to consider the process of training a programme as that made of events that are connected to one another. The model requires that each event must be evaluated and feedback is given to those in charge of training programming for progress (Van Dyk2001:167). This training model was basically designed to meet the needs of workers subjected to in-service kind of training.

Nadler's critical events training model is as shown in figure 2.4 below:

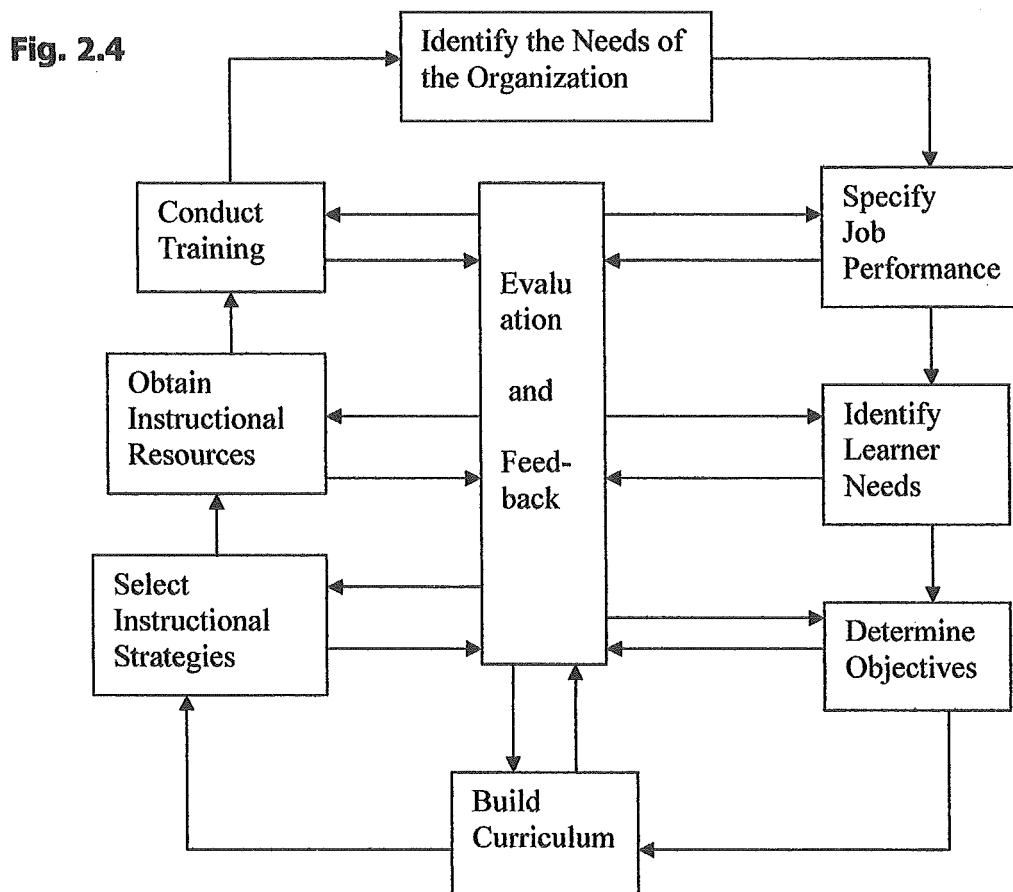


Fig. 2.4 Nadler's Critical Events Training Model (CEM)

Source: Nadler (1990:104)

The other training model that was designed to meet the needs of organizations for instructional purposes was developed by Camp, Blachard, and Huszco. This model could be used for both pre-service and in-service training programme designs, and was also made of nine steps like Nadler's critical events model. The model which was developed by Camp, Blachard, and Huszco, is shown in figure 2.5 below:

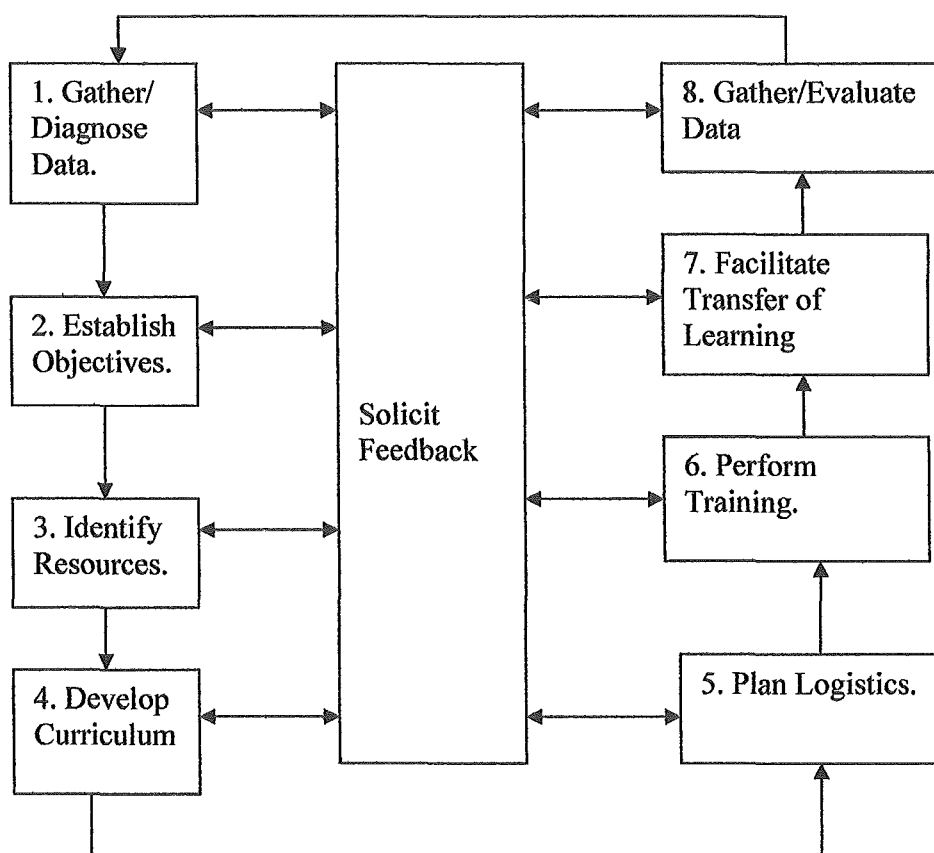


Fig. 2.5 Training Model of Camp, Blachard, and Huszco

Source: Erasmus and van Dyk (1999:44)

In their book, *Training management in South Africa*, Erasmus and van Dyk (1999:45) give the six-phased High-Impact training model, and say, "The high-impact training model is a six phase process that focuses on providing effective, targeted training. Each phase of the model moves the training effort forward. The result of each phase is the input for the next phase." Training model in figure 2.6 below indicates another training design by Sparhawk:

Fig. 2.6

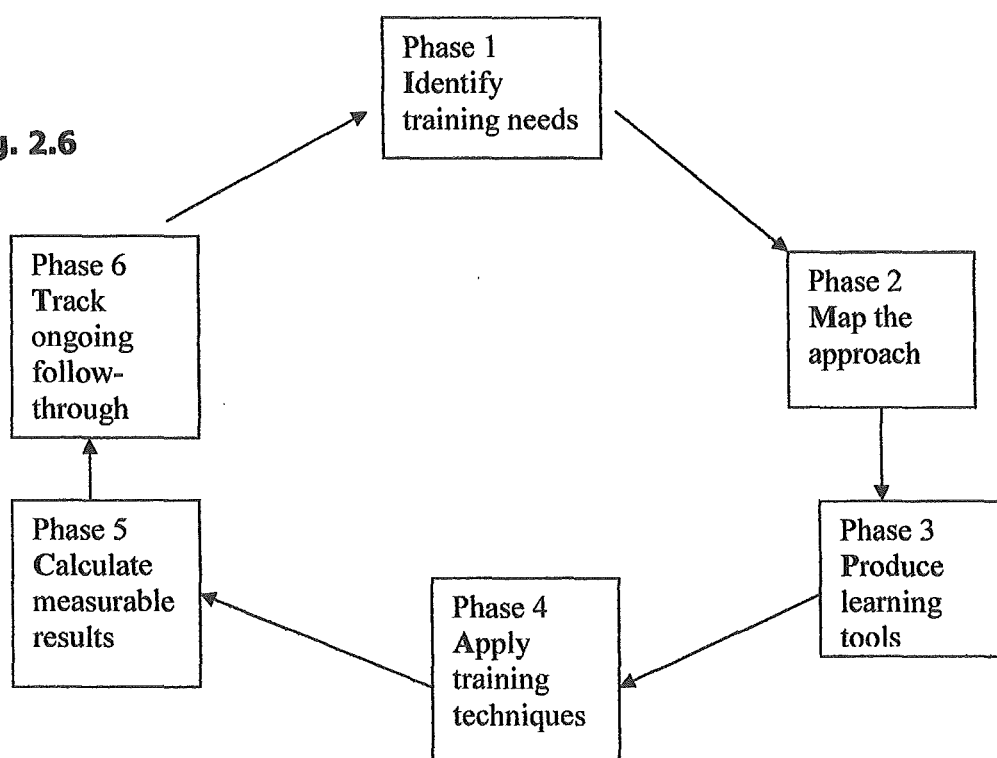


Fig. 2.6 Sparhawk's High-Impact Training Model

Source: Erasmus and van Dyk (1999:45).

According to Erasmus and van Dyk (1999:45), the six (6) phases of the six-phased High-Impact training model were explained as follows:

Phase 1: To identify training needs

This means finding out the specific training needed to address the challenges of work, and with an intention to improve performance of workers for effective and efficient service delivery.

Phase 2: To map the training approach

This means that after the identification of training needs, measurable objectives which define in detail what training is required to improve job performance must be set so that the trainer may be guided on choosing the approach to meet the training objectives.

Phase3: To produce effective learning tools

This means certain learning tools like audio-visuals, job-charts, and others, are introduced as part of what shall be used to promote effective learning during the training session, with an aim of achieving the training objectives.

Phase 4: To apply successful training techniques

This means training learning tools to be used must suit or match the training content or curriculum. It is at this stage that if coaching is the best technique to apply for best learning promotion, the better. If learning process needs the use of question and answer method (Socratic approach) for the sake of successful learning, the group may be the best to handle for effective learning.

Phase 5: To calculate measurable results

This means that training conducted must be able to be measured to confirm the success of training. It is at this stage that the trainer should find out whether the training conducted has contributed to effective efficient job-performance that should be viewed as job improvement.

Phase 6: To track ongoing follow-through

This means after training has been confirmed successful, the trainer must stick to the training for the same problems, but must be ready to change to adapt to the new changes in the environment. In other words, the trainer must remain objective when success has been observed.

The other training model that was designed is by Lapidus (2000:30) for in-service kind of training. This training model is made of seven steps forming the word "HIGH-IMPACT," and the main objective of this training model was to manage the training and development function in organizations (Lapidus 2000: xi). The structure (Figure 2.7) below is showing the diagram of the High-Impact training model.

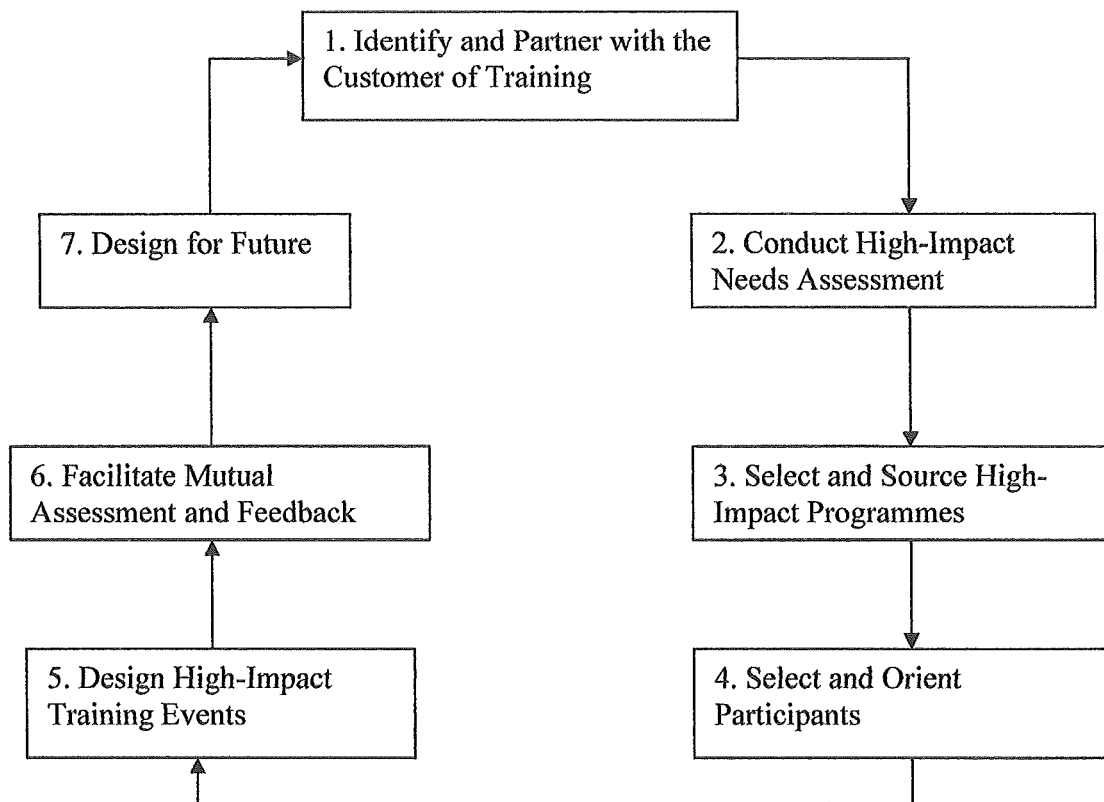


Fig. 2.7 Todd Lapidus' Seven-Step High-Impact Training Model

Source: Lapidus (2000:30), but Anakoka's personal design.

2.2.5 Approaches Governing Training Model Designs

Having considered the sources above, the researcher herein takes a blended route of how to design or develop a training model according to different approaches as follows:-

2.2.5.1 Need Based Approach

Tobin and Wise (1979:116) put needs assessment first before any other section stated above. The authors make a point that it is a handy thing to assess the

needs of the organization before the training programme is designed. Henning (1990:12) indicates that it is a dutiful thing to point out people's needs before Home Health Educators make their presentations to them.

Section 2.7 below favours the idea that the needs of Employees, Employers, and the organization be considered from the holistic point of view. Lekoko (2003) supports the above statement when she says that the Botswana Government looks at the needs of the people before considering the contents of the training programme to take to the masses for consumption.

Therefore, needs assessment of the organization, on holistic point of view, is quite critical before a training model is designed. This is true for Home Health Education Service just as it is true for any other organization.

When looking at the organization, especially with reference to members of staff's levels of competence, the KSA (i.e. knowledge, skills, and attitudes) assessment may be advised.

2.2.5.2 Knowledge Assessment-based Approach

As pointed out by Sutherland and Canwell (1997:47), as conditions at work change, there is a need for training, refreshing individuals' understanding and knowledge. This indicates that before a training model is designed, the would-be trainers should assess what knowledge is required by staff members of the organization (H.H.E.S, in this case) to perform duties effectively and efficiently. This idea covers the knowledge competencies members of staff have as compared to what they were supposed to have.

Knowledge, as a need, should be assessed, so as to keep the organization performing effectively and efficiently. From sources of literature quoted before

this section, Home Health Education Service requires health educational knowledge, and recently, computer related knowledge is required due to C-D Rom being circulated by the Home Health Educators. In his address on how to take advantage of change, Martinelli (2002:7) emphasizes the point that Home Health Educators should develop themselves as work advances for the sake of issues like internet, power-point presentations, family education, and others, that demand such a change. This is a clear-cut statement demanding the assessment of knowledge for the sake of developing a suitable training model.

2.2.5.3 Skills Assessment-based Approach

Home Health Educators should have their skills assessed with the aim of improving their competences for effective and efficient service delivery. In support of this, Martinelli (2002:9) says, Home Health Educators who are used to working with lead cards and flyers should find new way of distributing them. They could, for example, try to put them in the local newspaper and other magazines with local circulation. Such an approach needs some skill of some kind, i.e. what must be done conatively to get what, is of great value here.

If a training model to be designed has to be relevant to the service, skills, in terms of competencies, should be assessed for effective and efficient service delivery.

2.2.5.4 Attitudes Assessment-based Approach

In his address on awakening interest, Villarreal (2002:10) says, "we live in a time when people are busy and overburdened. They find it difficult to pay attention, especially if we are trying to sell them something. For this reason it is important to awaken an interest on their part." For this idea to make sense, the issue of positive attitudes cannot be avoided. For this reason, like in relation to

knowledge as a need, Home Health Educators should have their attitudes towards the world changes be assessed, if a correct model of training has to be developed or designed for effective and efficient service delivery.

2.2.5.5 Objective-based Approach

According to West (1969:252), an objective is a "purpose" or "aim". Collins (1995:656), defines an objective as a "reason for which anything is done, created, or exists." Summing up these two definitions, an objective is therefore some kind of a goal one wants to achieve or realize, and does certain tasks to make sure such a goal is realized. Commenting on the goals of Home Health Educators, Henning (1990:13) says that Home Health Educators have a serious goal of freeing their customers from evil practices. Therefore, the kind of training developed should be able to help the organization to achieve their objectives, so that organization staff members may be able to sell their knowledge elsewhere should they get fired. In other words, objective-based approach of training should be equitable in its rewards to the members of the organization.

2.2.5.6 Task/Activity-based Approach

Since organizational training is part of continuing education, the issue of competencies of employees as related to tasks or activities to be performed cannot be avoided. Talking about nursing personnel, Tobin and Wise (1979:124) say, "Continuing education is that part of staff development designed to assist nursing personnel to gain new knowledge and skills, review and add to knowledge already gained, investigate new approaches in nursing, and strengthen their clinical and leadership competencies".

This indicates that tasks or activities change with time. Hence training should bend towards addressing such evolutionary trends in each progressive

organization. This idea is not foreign to Home Health Education Service (HHES). It found favour in the sight of Martinelli (2002:7) when he says that publishing ministry should take advantage of change for the advancement of the organization's (HHES) objectives.

In short, H.H.E.S should establish training that will enable its workers to develop with work in the organization. Training should also aim at improving the way activities are handled so as to make the organization effective and efficient. This type of training can rightfully be classed as Task/Activity-based.

2.2.5.7 Implementation-based Approach

The argument of Appenzeller (1989) is, if training has to be done, it must be that which makes workers do what they are taught. This is implementation. Without implementation, training becomes theoretical only and can not be considered worthy.

The above stated idea was supported by Van Adelsberg and Trolley (1999:X) when they say, "Being effective means delivering training services that tangibly help businesses to achieve their goals. Being efficient means making the true costs of training clearly evident and highly acceptable to its customers".

The issue at heart here is that training development or designing should take into account the implementation phase of it so that goals can be achieved.

2.2.5.8 Validation-based Approach

This approach considers the value, application and the place of training itself. It considers the validity of training in relation to its ability help the recipient for life

in any task performance. Much of this approach is concerned about helping both the organization and the worker so as to achieve the intended organizational objective which may be internal, external, or both in its application.

Rae (1997:2) seems to have a very close connection to the use and exchange values of training by introducing internal and external validation of training. He defines internal validation as, "A series of tests and assessments designed to ascertain whether a training programme has achieved the behavioural objectives specified," and external validation as, "A series of tests and assessments designed to ascertain whether the behavioral objectives of an internally valid training program were realistically based on an accurate initial identification of training needs in relation to the criteria of effectiveness adopted by the organization." Rae's argument is that training programme should not only address the specific needs of its original design but, it should measure up to the standard of achievement expected by other training programmes it was adopted from. It must be both internally and externally valid.

This idea brought great concern to one of the publishing directors of Home Health Education Service. In his address to Home Health Education Service global workers, Martinelli (2002:9) says, "Be prepared to develop and try new methods". In essence, Martinelli's argument is that training self or otherwise, should be valid in such a way that it produces results it was intended to bring. Such results should be deemed effective (if felt within - internal validity) or efficient (if felt by the clients - external validity).

The approach to training development should also be validity-based, and be understood in terms of its value to training recipient. Training can have its validity in terms of use-value or exchange-value.

- **Use-value**

Winterburn (1991:299) discusses the concept of use-value. This he describes as the kind of training an employee receives so as to get the organization he is working for, going. It has some restrictions not only in content but in certification also. That is to say the training can be informal in nature, that is; no certification at the end of some training, but the trainee will have received enough information as related to knowledge, skills, and tasks to be performed by the organization.

Such training favours employers because it helps them to keep their employees from causing brain drain. On the other hand, it cripples employees because they can't easily market their knowledge, skills, and attitudes to other market related organizations.

The objective of the training of Home Health Educators may emphasize use-value without workers' realizing that is what it really is. In other words, HHES, especially that in Gauteng Province, according to the report of Schoeman (2003) and Mahoa (2003), much of the training is use-value based. It is difficult at this stage whether or not this is an objective of those in leadership.

- **Exchange-value**

According to Winterburn (1991:299), exchange value kind of training is that kind in which the employee undergoes some learning, most often formal, and makes his value exchangeable so that using the training outcomes and evidences, the trainee may market his knowledge, skills, and attitudes about the job he is doing.

The exchange-value kind of training may disadvantage employers in that the conditions of service may have to be competitively set so as to keep its

employees who have undergone training. Exchange-value kind of training may advantage the employees such that organizational care can be extremely good.

In conclusion, Winterburn (1991:299) says, "There may be an important difference in emphasis between employers and employees on this issue - employers stressing use-value while employees insist on exchange-value. We are not, of course, arguing that these categories are mutually exclusive. However, we look at this, if there is to be mass training take-up, a new qualification structure will need to bring together both use and exchange value in order for employees and employers to back it."

Structurally presented, the objective of training in Home Health Education Service should strike a balance between use-value and exchange-value as shown below:

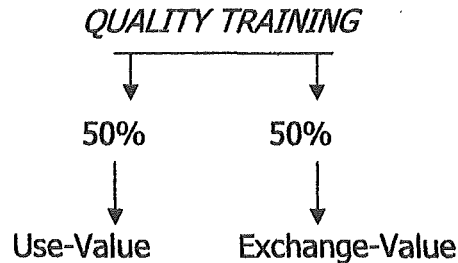


Fig. 2.8 Balance between Use-Value and Exchange-Value of Training

Source: Anakoka Design

The approach to training development should also be validity based, and thus get subjected to evaluation.

2.2.5.9 Evaluation-based Approach

Evaluation is the assessment of the total value of a training system, training course or programme in social as well as in financial terms. Evaluation differs from validation in that it attempts to measure the overall cost benefit of the course or programme and not only the achievement of its laid down objectives. The term is also used in the general judgmental sense of the continuous monitoring of a programme or of the training function as a whole (Rae 1997:2). It is in the interest of the process of evaluation that Home Health Education Service Institutes (annual ones) get evaluated at every meeting time in Southern Africa Union, according to the researcher's observation from 1998 to 2002. Arthur (2002:15) shares this experience too, when he says, "During these meetings over 130 students participated in training workshops and need to elect...Literature Evangelist administration." This was a report from Europe.

In short, training should not be static, but change as times dictate, and the only way this can be achieved is by evaluating the training itself in a holistic approach. When this is done effectively and efficiently, a model for training can be developed or designed.

Choice can be made between pre-service and in-service training, training model and training programmes, and on-the-job training and off-the -job training programmes. Finally, the chapter creates an understanding that there is enough literature to support the evaluation process of a training programme, and the designing of a training model to suit the needs of the organization. Since there is no accredited training programme in Home Health Education Service, it is herein assumed that a training model designed should address training phases in a holistic way, covering both pre-service and in-service aspects.

2.3 HOME HEALTH EDUCATORS' TRAINING

The issue of Home Health Education (HHE) is an old time-concept. Before it was named HHE, the phenomenon was just called "lifestyle education" which was informally and traditionally acquired. Moumouni (1968:29) identifies this type of education as "Traditional African Education" which he views as that which covers "character-building, as well as the development of physical aptitudes, the acquisition of those moral qualities felt to be an integral part of manhood, and the acquisition of the knowledge and techniques needed by all men if they are to take an active part in social life in its various forms." In other words, young adults were taught how to handle issues of life by the old folks in their communities where they lived. With or without literature, HHE is identical with adult education in the sense that young as well as old adults were targeted by the societies they lived in for training on lifestyle education such as family management techniques, expression of attitudes to elderly folks of the community, knowledge about spiritual education and worshipping styles in any traditional community. This type of adult education has also been practised by the Seventh - day Adventist Church's educational institutions under general terms of "Literature Evangelism, Lifestyle Education, Home Health Education Service (HHES), or Colporteur Ministry."

In the ancient times those who practised medicine had their ways of training too. According to Hardinge and Shyrock (1999:4), "the training of physicians was initially accomplished under preceptorships," and this was done in such a way that "a young man-hopefully with high-school education who wanted to become a physician attached or apprenticed himself to a practicing physician, usually for a period of three years." This was another model of training health educators and practitioners, which is identical with today's South African Learnerships developed in the year 2002 by the Labor Market Skills Development Programme, under the Department of Labor, and funded by the European Union. The only

difference between preceptorships of Hardinge and Learnerships of South African Labor Department is that in the former, there wasn't much book work involved, but in Learnerships, there is much theoretical work involved. Otherwise, the practical part is basically the same. Therefore, training of Home Health Educators took different models according to the phase of training education the world adopted from the nearest source.

As may be observed from the statements above, trainees learned through some kind of apprenticeship training models. This was the type of training Home Health Educators received.

2.4 A HISTORICAL BACKGROUND OF HOME HEALTH EDUCATORS AND THEIR TRAINING

Training might be as old as humankind because human beings have always tried to learn how to perform certain activities to improve themselves so that effectiveness and efficiency may be achieved. Quite a good number of authors have written about training for specific purposes. With this idea in place, it may be safe to say that training is not a new phenomenon. Home Health Educators belonging to the Southern Africa Union Conference of the Seventh-day Adventist World Church need on-the-job training too, as they seem not to have pre-service phase of training, and that their in-service phase of training is quite informal in nature. Hurter's telephone conversation with the researcher on the 2nd of June 2003 revealed that Home Health Educators in the Southern Africa Union Conference do not have pre-service training, and do not have formal training that is accredited with the Republic of South African board of learning standards.

It is believed that training would help in increasing the number of Home Health Educators to a great extent. The Southern Africa Union Conference Home Health Educators make up a population that ranges from 250 to 300. This is because of

different changes caused by factors such as resignations and recruitments. This observation is sourced from the monthly bulletins that contain progress report for each month. Meanwhile Appenzeller (1989:30) reports the world statistics of Home Health Educators as amounting to 25000, and Faigao (2005) puts this figure as 40000 as at the end of the year 2005.

Regardless of a few pieces of literature available concerning the training of Home Health Educators, there is evidence enough that designing a training model for the 21st century would be an ideal thing to do. White (1948), McAdams (1954), Hunt (1981), Appenzeller (1989), Henning (1990), and others in Home Health Education Service have written extensively on the need for training Home Health Educators, and have acknowledged that the trend of training programmes might need attention.

Appenzeller (1989:10) records the activities related to training of bible-based educators led by Waldo in the 12th century, whose work is similar to that of the current Home Health Educators, as of great importance then as it is today. Appenzeller (1989: 27-30) reports of George King's historical background of how he started as a fireside life style educator supported by literature (bible-based) distribution in the 1870s, which led to the development of the training trend of the current Home Health Educators that seem to have not drifted from their training design by a wide margin in the 21st century.

Considering the fact that the work of Home Health Educators was not only confined to the distribution of literature, but to the actual teaching of healthful life style, White (1953:57) indicates that the training of Home Health Educators is of great value. The researcher's observation has it that Home Health Educators have been handling issues in the four areas of physiology, sociology, psychology, and spiritual knowledge of human science since 1970s. The researcher has also established a link that Home Health Educators are a go-in-between of

researchers' publications and the public knowledge consumers. Surely, such workers need specialized training related to Home Health Education matters.

Malipilo (1987) states that Home Health Education Service programme originated at Mt. Sinai where Moses and the children of Israel heard God speaking out the ten commandments for life style in the society (Exodus 20:18-21), and finally God decided to write the ten commandments, himself, on the two tablets of stone (Exodus 31:18). The point here is that the spoken word would do better if accompanied by the written word. Such type of communication is valuable adult education in any community where literacy is an answer. Malipilo (1987) continues to argue that Home Health Education was of great value in the Israelite community, and that education for adults was a very unequivocal subject of concern for lifestyle. He added that the Ten Commandments or Decalogue were God's transcript of His character. Through it God wanted His society to be governed, leading them to healthy living, and the knowledge of healthy living occupying some good priority in the lifestyle of all the people of the earth. With this view, Malipilo (1987), gives an insight that the first Home Health Educator to use literature for adult education was Moses of the bible, hence this historical background. However, this does not dwell on the pre-service and in-service training of Moses, but maintains the role he played in the adult education programme during the exodus of the Israelites. This still stands as a question for the Home Health Educators.

Appenzeller (1989) traces the background of Home Health Education from the time of the Egyptian civilizations and Abrahamic age (pp7-13). Appenzeller (1989), states some ways of writing like cuneiform (wedge-shaped letters), hieroglyphics (picture writing), seals (impressed on documents in wax or clay), which were done on stones, wood, clay reeds, or parchments. All these were done with a view of communicating issues of lifestyle at a certain time period. He also states that the Chinese discovered a process for paper making in A.D 105,

and this paper is similar to the one we are using today. He adds on to say that in A.D 1250, the Italians had developed a process for mass-production of paper, and that book making became an art, and rich business people began to have libraries. However, the record goes on to say the book distribution for HHE was not as we know it today. Appenzeller (1989:10), records Peter Waldo, a wealthy Catholic businessman in southern France, who felt that the bible, not the church, should guide men's lives. In the latter half of the 12th century, he used his wealth to translate the bible into the other languages of the common people of southern France and northern Italy. The record goes on to show that the Waldensians (followers of Peter Waldo) were the first people to sell hand-copied portions of scriptures with a motive of changing people's lives through this type of educational system. Thus they traditionally trained Home Health Educators, from generation to generation.

The above model of training Home Health Educators continued until 1870s where George King, a young Canadian came on the map according to the records (Appenzeller 1989:27). The record goes on to say that George King was the first Home Health Educator to professionalize Home Health Education Service, accompanied by the revolving of income between the client system and the publishing department of the Seventh - day Adventist Church. The difference between King's way of training and that of the people of Peter Waldo (Waldensians) was that King actually took his trainees into the field and completed the process of how the learning support material would attract revenue for the revolving of funds and learning support material, which was not mandatory to the Waldensians. Appenzeller (1989:30) gives a record about King who demonstrated his ability to sell literature as a way of educating the people and then began to train others to sell subscription books in a professional way. He recruited and trained until his death in 1906. With such background of training of Home Health Educators, a question may be asked: What is the educational role of Home Health Educators in a community? The answer is that

they help in the transformation systems of knowledge as did George King. However it is clear, according to Appenzeller's record of 1989, that there is an indication that Home Health Educators under George King were not exposed to pre-service training, and that the kind of in-service training they had was very traditional and informal in nature.

If the above stated balance has to be maintained by the Southern Africa Union Conference Home Health Educators, then providing training programmes to help them become effective and efficient is unavoidable. Training that is both effective and efficient is that which makes the workers deliver the services and consumers of that service reciprocate by appreciating the service provided (Van Adelsberg and Trolley, 1999).

2.5 ORGANIZATIONAL ATTACHMENT TO THE SOCIETY (SOCIOLOGICAL CONNECTIONS TO THEORIES OF FUNCTIONAL AND CONFLICT APPROACHES)

Home Health Education Service, like any other functional organization in a society, is identically attached to the society. To support the idea of togetherness of organization in one society, Bray *et al* (1986:28) state that each functional part of the society shares common values, and there is consensus or agreement. In other words, organizations in one society are affecting one another. Therefore, they have to agree in one way or the other to co-exist for survival of all. This is in harmony with the idea of functionalism of organizations in a society, just as body parts do. Giddens (2000:561) gives credit to Durkheim's functionalist approach of any organization in a society, and says, "To study the function of a social practice or institution is to analyze the contributions which that practice or institution makes to the continuation of the society as the whole. The best way to understand this is by analogy to the human body, a comparison that Comte, Durkheim and many subsequent functionalist authors make. To

study a bodily organ like the heart, we need to show how it relates to other parts of the body.... Similarly, analyzing the function of the social item means showing the part it plays in the continued existence of the society." In this way we see the functional attachment of Home Health Education Service to a society, and its contribution to developmental issues cannot be ignored. Therefore, under the functional approach of sociology, Home Health Educators are an appendage of society of adults reaching the community as adult educators who have functional attachment to the society.

In another development, Giddens (2002:415) highlights the conflict theory, which any organization that is educational can impose on the society. He indicates the advocates of such (conflict) theory as Bowles, Gintis, Illich, Parsons, etc. Giddens (2002:415) quotes Bowles and Gintis indicating that "schools help to provide the technical and social skills required by industrial enterprise and they instill respect for authority and discipline into the labor force. Schools help to motivate some individuals towards achievement and success, while discouraging others, who find their way into low-paid jobs.... Schools reproduce the feelings of powerlessness which many individuals experience elsewhere. The ideals of personal development central to education can only be achieved if people can control the conditions of their own lives and develop their own talents and abilities of self-expression. Under current system, schools are destined to legitimate inequality, limit personal development to forms compatible with submission to arbitrary authority...". With this conflict theory in view, Home Health Education rewards those that make use of its educational services and, in most cases, not those that don't access the service. An example of this is if a family gets information on how to avoid contracting HIV/AIDS, and follow educational advice in the Home Health Education Publications, such a family will avoid losses incurred by the HIV/AIDS sickness on that prospective family. This can show a distinction between families, hence conflicting appearances within the same society, just like what education, in general, does. Home Health

Educators can therefore create conflict as adult education service providers too.

The training of Home Health Educators should highlight the relationship between any societal organization and other organizations in that particular society. Home Health Education Service is, irrefutably, a part of the society both functionally and structurally and has potential to create educational harmony or conflict in the society due to the rewards it offers to community members. This may cause conflict in such a way that those who enjoy good health will belong to another class while those of poor health will belong to another class of those losing more money to medical expenses and undergo risks of even losing their jobs due to time losses caused by sick leaves. This, in the final analysis, causes conflict and stratifications in the society. In support of this fact, Willis (2002) alleges that one of the reasons why HIV/AIDS increases with increasing distance from North to South Africa is that informal education through customs, values, ethics, norms and traditions of the society, has correspondingly decreased with the same trend. Thus Home Health Education has benefited the people of Egypt where the total population's reflection of HIV/AIDS infections was 0.02%, and that of South Africa was 19.94%, according to Willis (2002:45-51).

The developing of training model for Home Health Educators in the Southern Africa Union Conference of the Seventh-Day Adventists is of great value due to Home Health Education Service's link to the educational systems of the countries of Namibia, Lesotho, Swaziland, and the Republic of South Africa. This is because Home Health Educators have sometimes served as motivators for educators, and supplied learning support materials as source books for community educational consumption.

2.6 EDUCATIONAL ROLE OF HOME HEALTH EDUCATORS IN A COMMUNITY

The educational role of Home Health Educators is of great significance in the education of adults in a community. With a view of making some distinction between education and training, Buckley and Caple (2000:2) give a notion that training involves learning which alters one's knowledge, skills, and attitudes, with the great aim of addressing specific demands of a particular job or task, while education is seen as that type of learning which "provides more theoretical and conceptual frameworks designed to stimulate an individual's analytical and critical abilities". Thus Home Health Educators have a great role to both train and educate the community, in their lesson presentations and book distribution programmes. For this reason, they need to be trained to perform such an important task.

2.6.1 Educating and Training the Community

Since presentation skills would need time frame-work, Faigao (2002:7) gives an indication of 350 hours of practicals for student theologians. Mbedzi (2004), citing the University of Solusi calendar, indicates 250 hours for Solusi University theology students in Zimbabwe. This confirms the positive role Home Health Educators play in the community and that implies the training of such service providers as indispensably important. However, Mbedzi (2004) agrees with Faigao (2002) that there is no pre – service training for community service providers. The point here is that Home Health Educators need training because they are part of trainers and educators in adult education that is why the Adventist Universities are embarking on field practical schedules for theology students because they are community adult educators too.

2.6.2 Linking the Researchers to Community

Commenting on the book distribution strategic plan as part of the adult education process for Home Health Education, White (1953:90) gives the remark that Home Health Educators should tell the people that they have for distribution books which give much valuable instruction regarding sickness and disease and how to avoid them, and that the study of this instruction saves much suffering and saves much money spent in paying doctor's bills. Home Health Educators act as a medium through which health education can move from the researchers to the general public. They act as teachers/educators that make the public aware of dangers around them, in the field of healthful living, and help them to cut down the costs of medical expenditure by the use of knowledge in Home Health Education. This is part of what Doray and ArrowSmith (1997:39) call lifelong learning. They give an indication that those that received knowledge and traditionally handed it down to the generation after them, thus much suffering was reduced due to the presence of such organized structures like Home Health Education Service. Thus the community will be alert towards the use of knowledge in solving problems in the area of health and how they should be handled at home where only lay people in health profession exist.

2.6.3 Linking Formal to Informal Structures

The educational role of Home Health Educators in a community is very important. The importance has led Faigao (2002:7) to give the advice that the Seventh - Day Adventist learning institutions, at university level, should offer 350 hours of practical training for them to qualify for graduation. This is a clear indication that Home Health Educator's educational role has great value in the transmission of knowledge from those formal knowledge systems to the informal structures, even to the families, which are a minutest entity of any society in existence.

2.6.4 Forming a Link between Formal Governmental Structures through Employee Health and Wellness Programme Learning Support Materials

The principle in operation is that Home Health Educators' training should provide competencies like educating, marketing, and presentation skills for them to perform the expected tasks in the community. In this way Home Health Educators can assist people in knowing that diseases like HIV/AIDS kill, and that community members may know how they can contract it, how they can live with it, and how to avoid it. Though such an educational structure may appear informal, its role forms a connection between the formal structures of the government, health and education departments, and play a part which neither can do, for example: the art of successful parenthood as attached to the general lifestyle.

2.7 TRAINING SELECTION

To select is to choose (someone or something) in preference to another or others (Collins, 1995:740). Selection of who should train, be trained, and a place where training has to be conducted, is of great importance to the organization. Training has some curriculum to follow so that certain objectives can objectively, subjectively, or projectively be achieved. Objectively, if what needs to be achieved is a goal the curriculum must be covered within a given time; subjectively, if the trainees feel directed or subjected to some curriculum; projectively, the results can be inferred. Whatever the case, selection, more especially of the "who" part, cannot be avoided. At times, the employees may be preferred to employers depending on the curriculum set for training and its objectives.

While selection has so many factors, it may be a good idea to consider training to be formal, non-formal, or informal in nature. Looking at the benefits of each of the above, Moreau (1980:176) says, "Formal - training program has been proven to be the most effective way to utilize employees." This is in harmony with what Winterburn (1991) says concerning the use-value and exchange-value of an employee. He says that when the training is formal, the employee gets certificated, and can easily exchange his/her knowledge, skills, and attitudes, because of his accreditation; when training is informal, the employee has only use-value, and cannot easily exchange it, because he has no certification to the knowledge, skills, and attitudes over which s/he has been trained. In trying to make the difference in meaning of three words: formal, non-formal, and informal, Msango (1992) says that the organizational training is classed formal when the learning is having a complete structure of learning e.g. going into a class within a specified time, and be tested at a certain time, and be certificated, as in the University full-time student programme. Concerning non-formal training, he says there is certification, but most learning is done out-side the physical structure e.g. learning through the distance-learning programme of the University, which is normally referred to distance education programme. On informal kind of training, he says that this is usually characterized by non-structured type of approach e.g. learning how to cook at home, and no certification is done.

So, on selecting the training one has to know the advantages and disadvantages of the three kinds stated above. Nonetheless, each has its right place in application.

2.8 TRAINING CURRICULUM

Looking at the designing and implementing the programme for staff development, Tobin and Wise (1979:130) show concern in relation to the

curriculum of any course being run, and they say, "...some agencies offer courses that are divided into two parts, with the expectation that in the intervening period of time the employees will be able to make practical use of the content learned in the first half of the course." In other words, Tobin and Wise (1979) are advocates of training selection that should not only look at the participants of a particular course devoid of that course's content, which in this document has been referred to as the training curriculum. It also indicates that training should aim at balancing the triangle (shown in Figure 2.2 above) for effectiveness and efficiency, and Home Health Education Service has to follow this pattern if success is the desired goal too.

Examining salesmanship and training, Allen (1993:209) says, "before sales personnel can be entrusted with direct responsibility for their territory or department, it is necessary to make sure that they fully understand the company's corporate policy, the sales function's administrative policy." From the above statement, Allen (1993) seems to have been troubled by training curriculum or rather course content of the training session. Questions like: What is the objective of our course? How limited should our course be? Such questions should guide the training curriculum.

This indicates that the selection of training curriculum is of great importance in the process of training selection: for it defines what should be done and for what, hence stating the objectives of that curriculum, then the organization can look into who can participate in such training curriculum.

2.9 TRAINING EMPLOYEES

Employees (workers recruited into an organization) should be trained for productivity. After the curriculum is described, the question of who should benefit from such curriculum and why, becomes quite critical.

In her book, *Colporteur Ministry*, White (1953:57) states that "The presidents... and others in responsible positions have a duty to do in...the different branches of...work. Canvassers are to be educated and trained to do the work they are required in selling the books upon present truth which the people need." Her concern was that employees for Home Health Education were to be educated and trained, hence requiring them to satisfy the training triangle demands of cognitive, affective and conative domains. White (1953:28), emphasized the issue of selecting workers from people of successful background.

McAdams (1954:121) endorses the idea of training the Home Health Education employees by saying that colporteurs must be trained for professionalism. He goes on to say that "it takes careful and wise planning, as well as constant effort to recruit men and women who perhaps know very little or possibly nothing about the science and art of Christian salesmanship, and to train and teach them so they will develop into successful gospel colporteurs" (McAdams 1954:144). It was in the interest of selection of colporteurs that McAdams (1954:94) says that "time has come to raise the standards...in selecting people to enter the book work." The concern was herein, registered by McAdams, that selection in training should not only be in the course content, but in the prospective employees so as to unearth their potentials for competencies required for Home Health Education.

Appenzeller (1989:30) also indicates that the first organized Home Health Educator (George King) selectively recruited and trained his coworkers for success. It was in the same interest that Hyman (1992:6) says, "...employers are in need of skilled adaptable and flexible labor as well as a stable or expanding workforce, and they may train existing employees to meet their requirements and those of their customers." The words "adaptable" and "flexible" indicate the mode of selection of the employees for which training and

for what. Looking into the value of offering training to staff members and the benefits thereof, Allen (1993:10) says, "...although proper sales training is expensive, it costs a lot less in the long run than losing business due to inadequately trained sales staff, whose ignorance may even be dangerous."

Assessing the methodology on how to measure training, Rae (1997:20) indicates that training specifications should match the tasks, knowledge, and skills of the workers/employees as competencies already accumulated so that the training agencies may know where to start and end their training program. This was an accompanying statement to what Rae (1997:18) says, and the record says, "the three major aspects of analysis which can be considered the most useful in identifying training needs are job analysis, task analysis and skills analysis."

These various aspects of the analysis are arranged in descending order of magnitude of extent - job related to the full range of tasks which are required to be performed which in turn require specific skills. In an analysis of training needs there are advantages in following this order." In other words Rae (1997:18) is just looking into the selecting mode of the training of employees by first considering their job, then tasks, and finally their skills required for that job and its tasks.

2.10 TRAINING THE EMPLOYERS

According to Collins (1995:254), an employer is someone or company that hires another for the sake of labour, and in return for payment. This means anyone who is in the capacity to hire another is an employer and such people also need training.

The need for training for employers has been stressed by McAdams (1954:140) when he says, "A successful training program, in the fullest sense of the word,

must also include a study and self-improvement program. If the worker has not received much formal education he should be encouraged to take a few courses by correspondence from the Home Study Institute.... . Naturally, the colporteur should not be overloaded with correspondence work, and the publishing department leader should know about how much time the worker can spare for this kind of study." McAdams (1954:141) also emphasizes that, "the study and self improvement program the colporteur chooses to follow depends on the management of his time. In view of this the train - to - succeed program will include a daily and weekly time budget for the colporteur."

The above training model required principles like, 'you can give what you have,' according to the statements said by many wise people. In short, the supervisor of Home Health Educator can not train unless he/she is also trained for such things like 'time budgeting,' and other lines of management techniques. However, McAdams points out an issue of schooling to be of crucial importance, for he encourages field workers to take up some distance education programme, which he called correspondence course. This was an acknowledgement that employers needed training, and models of training were to be adopted to suit new developments. This idea is supported by Appenzeller (1989:33) when he says that professionalism is of great relevance as long as Home Health Education Service desires to achieve the intended objectives, and he endorses with these words, "Like any worthwhile trade or profession, it calls for patient and continuous effort." This endorses the idea that employers must be trained to train the employees through some training content or rather curriculum so as to be able to evaluate and appraise the work holistically.

In support of the idea of evaluation in training, Rae (1997:2) says, "the assessment of the total value of a training system, training course or program in social as well as financial terms. Evaluation differs from validation in that it attempts to measure the overall cost benefit of the course or program and not

only the achievement of its laid down objectives." For the employers to carry out the work of evaluation, they must undergo some training for such unearthing of sources of difficulties, and points/platforms of success in an organization. Leaders need to undergo phases of training for such knowledge, tasks, and developing worthwhile attitudes for success. It was in the same interest that Caffarella (2002:3) gives a comment that those that train others should have varied backgrounds and experiences, because they have to plan and coordinate training programmes for adult workers over whom they are overseers. In this way, training employers becomes a benefit to an organization.

After the process of evaluation, the process of appraisal is warranted in training, which cannot nullify the question of training phases.

2.11 TRAINING PHASES

According to Collins (1995:603), a phase is a distinct stage in a sequence of events. In an attempt to bring a worker to an agreed level of proficiency in any profession, training is expected to come in stages. Though Kallaus (1987:179) gives broad goals of training as four, they can be grouped into two stages or phases, which are: Pre-service and in-service training. This means Home Health Educators are supposed to undergo two phases of training before they start going into the field or employed fully, then every worker should get subjected to in-service phase of training, as demands arise for tasks.

2.11.1 Pre-Service Training

Kallaus (1987:179) considers pre-service training as initial training. Kallaus (1987:179) outlines the goal of pre-service training as "to provide initial or entry training by which employees qualify for entry job assignments." Commenting on the idea of initial training, Allen (1993:216) says that before employees get into

details of the work they should receive initial training. Allen (1993) indicates that initial training is necessary, and that it is some kind of school where people learn how to produce services and goods in a firm.

White (1953:57) advises that the presidents of the Seventh-day Adventist Church conferences and others in responsible positions had a duty to do in the work of educating and training workers before getting into the field, so that they may gain success in their book distribution mission. The report of 1903 reports White (1953:31) saying, "Our schools have been established by the Lord, and if they are conducted in harmony with His purpose, the youth sent to them will quickly be prepared to engage in various branches of missionary work. Some will be trained to enter the field as missionary nurses, some as canvassers, some as evangelists, some as teachers, and some as gospel ministers." The point White (1903) is making is that, pre-service must be given to Home Health Educators (Canvassers), just as it is done to medical nurses. The Seventh-day Adventist school system was supposed to practise equity.

In an attempt to include initial training in Home Health Education Service, Faigao (2002:7) saw it necessary to encourage the Asian based Seventh-day Adventist academies/universities to enforce the compulsory 350 hour- practicals for gospel ministerial students for them to qualify for graduation and certification. In his communication to Anakoka, Hurter (2003, letter to Anakoka) says, "There are training models available for developing Publishing Directors that are being presented in other divisions." In other words, before one serves as director, in other divisions, training is offered to help such a worker, who is going to be an employer, to perform well. However, Hurter believes this is not available in the Republic of South Africa.

2.11.2 In-Service Training

According to Kallaus (1987:179) this training has such goals as up - grading, retraining, and supervisory in it. Allen (1993:216) calls this type /phase of training as continuous. According to Hurter (2004/03/26 – letter), the Southern Africa Union Conference, through Southern Publishing Association, practises more of in-service kind of training that is basically seen as having four functions of induction, up - grading, retraining and supervisory.

Regardless of the quality of an in-service kind of training, training can either be on-the-job or off-the-job, depending on the motivating factors which can either be intrinsic or extrinsic, (Buckley & Caple (2000:4).

Webber (1981:197) emphasizes the point that regardless of the quality of training (on-the-job or off-the-job), training can either be centralized or decentralized. He says centralization is not like a disease that one can have or do not have. Instead, the range from centralization to decentralization is a continuum.

Looking at the on-the-job and off-the-job kind of training, Rae (1997) makes a difference between the two as follows: on-the-job training is that done while the worker is on duty providing services and goods e.g. working while being coached, mentored, and under learnership; and the off-the-job type of training is that where a worker is taken away from a place of duty to another for proper attention e.g. going for a workshop, seminar, and conferences. However, Rae (1997:87) gives an indication that trainers and designers of training need to have knowledge of the prospective trainees so as to match their needs to the learning methodologies in training sessions. Noe (2005:206) gives the idea that on-the-job training is quite an expensive kind of training because of the investment made on workers while learning how to do the work perfectly well, and that off-

the-job training is much cheaper in this respect. On-the-job or off-the-job training, it still stands that as long as that training trains the employee of the company, it still fall into the in-service phase of training.

2.11.2.1 Induction

Talking about a successful training programme, McAdams (1954:120) says, "One of the great needs of our denominational colporteur training programme is that of having a definite plan and procedure for the instruction of those who engage in this work." This means that one has to receive instruction in relation to protocol of Home Health Education Service. In support of any induction training programme, Allen (1993:209) says, "Before sales personnel can be entrusted with direct responsibility for their territory or department, it is necessary to make sure that they fully understand the company's corporate policy, the sales function's operating policy." This is a very important rule to follow in training phases. One needs to know both his/her limitations and delimitations in relation to operations of the company.

In the above case to induct is to walk through a series of procedures, norms, values, and ethics of the organization. Induction training is therefore, according to Collins (1995:402) is, "a training course to help familiarize someone with a new job."

This implies therefore that HHEs who are still recruits should be inducted into work in Gauteng Province.

2.11.2.2 Up-Grading

According to Kallaus (1987:179), up-grading training involves, "....training for employees who are already in an occupation to improve their knowledge and

skills in that occupation." In relation to HHES, this may mean developing with work, that is to say, if videos, for example, are used to open the ways for some more understanding of the people to accept supportive educational materials (e.g. books), then field HHEs need to be taught how to use such phenomenon. In reality, when a new product surfaces, there is need to have that product knowledge and skills on how to market it, just as it happens in many learning institutions and the development of new courses/modules that address needs of the society.

Commenting on the idea of up - grading due to a shift in product knowledge, Allen (1993:209) says, "Product knowledge is of the greatest importance.... Any training program therefore must begin with an understanding of two essential points:

- (a) How much will the customers need to know about the products?
- (b) How much do we ensure that our sales personnel have sufficient knowledge to inform them?
 - (i) About the product; and
 - (ii) About the company's policies of selling, administration and distribution?"

Contextually, in the event of the new disease, e.g. HIV/AIDS, Home Health Educators should receive up-grading knowledge on HIV/AIDS so as to educate people correctly and enthusiastically. They should receive training on HIV/AIDS awareness and new points on books of reference. In this way they get up-graded.

2.11.2.3 Re-Training

According to Kallaus (1987:179), the re-training goal is achieved if knowledge is given to workers whose job assignments have changed.

In context, when a Home Health Educator gets to a point whereby his learning

support materials have been up-graded, s/he needs to adjust to suit the change of her/his product. An example of this is the book called "Family Medical Guide" which used to get to people without the CD-Rom, but towards the end of 1990s, the CD-Rom was introduced. This meant that a Home Health Educator had to receive training on how to use computer to demonstrate the use of this educational material. According to SPA leadership, this could not be achieved, but the assignment has changed, and customers without CD-Rom knowledge would be disadvantaged. In this case re-training on how to use Family Medical Guide with CD-Rom is justifiable in Southern Africa Union.

2.11.2.4 Supervisory

According to Kallaus (1987:179), the supervisory goal is required "To provide supervisory training and development to qualify workers for the added responsibilities and challenges of higher positions." This implies that as often as workers receive promotions, they need to get subjected to supervisory training because their responsibilities and challenges have experienced a shift from field workers' to higher levels of administration and supervisory. As already seen from the above statement and according to Hurter (2003, 9 June letter) there is no such formal training in Southern Africa Union. Depending on the research findings, this area of supervisory training may need attention. The question is, where?

2.12 TRAINING PROVISION

In his letter to the researcher, Hurter (2003) says that Seventh-day Adventist Church operates a network of schools, colleges, and universities offering diplomas, and degrees up to PhD level. He agrees also that there are training models for developing Publishing Directors in other Divisions to which Southern Africa Union Conference is not a member. However, he acknowledges that

Southern Africa Union Conference used to have Home Health Education Service Diploma course when it belonged to Trans Africa Division (TAD) that was replaced by Eastern Africa Division (EAD) that could not accommodate South African Union due to apartheid protests. The policy document, though undated, seems to state that models for training Home Health Educators were available. These training models favoured the Seventh - Day Adventist learning institutions, except where non- Seventh-day Adventist institutions would offer courses not found in the former (Publishing Departmental Policies-SAI 30). From the policy document stated above, there has been some deduction that training institutions for Home Health Educators were accessible for various reasons, and that there are institutions responsible for the two phases of training.

2.12.1 Pre-Service Training Institutions

Institutions offering pre-service training in HHES may not be as an on-looker may deduce from some distance. According to the section (SAI 85 30) of the policy document sent by Hurter (2003:29) to the researcher, there was reflection that literature evangelist clubs be organized in colleges and secondary schools by Union and local publishing directors in co-operation with the school administration. The policy document quoted above, does not give any indication that HHES is considered as being worthy of academic attention. The view on display is that Home Health Education Service can be studied as a side - line to enhance another programme, hence no specific curriculum designed for HHES in the Southern Africa Union.

From the observations done on calendar books of Helderberg College of Cape Town and Solusi University of Zimbabwe, which are Seventh-day Adventist learning institutions, there is no pre-service training programme for Home Health Educators that would make them graduate and get certificated as such. Thus pre-service training as an academic programme is lacking from the institutions of

learning. It is due to this observation that Faigao (2002:7) sees it fit to encourage the Seventh - day Adventist institutions of learning to include 350 hours of practical training in Home Health Education Service for theologians in the Asian-based learning institutions.

After assessing the available literature, the researcher has concluded that pre-service training is insignificantly available, thus a need to develop a training model that may address training from a holistic angle as this is lacking need.

2.12.2 In-Service Training Institutions

According to the Southern Publishing Director's telephone conversation report (9th June, 2003), almost every course offered in the in-service training sector is informal in nature. However, he (Hurter- publishing director) gave an indication that a few organizations are involved.

2.12.2.1 Southern Publishing Association (SPA)

In the report of 9th June 2003, it is recorded that SPA runs, by means of sponsorship, some in-service training programme where HHES leaders serve as lecturers to newly recruited individuals who are already employed by the organization. Newly recruited employees get to a chosen site by the SPA administration for training, for example: Bloemfontein has served as a training centre, at least twice, in the period between January 2002 and August 2003. In this programme, Home Health Education Service leaders from selected portions of the globe e.g. Washington D.C of America, and others, to come and serve as motivational speakers, so that field workers are motivated, and learn something out of these annual institutes.

2.12.2.2: Others

According to the 2003 annual institute time - table, there was another company that had supplied an Industrial Psychologist to get to that annual institute for in-service training programme and offered a course on skills in time-management. Report on the institute performance indicates that there was no certification done. Though an in-service training programme as it were, it was informal in nature in that it never certificated anyone.

2.13 REASONS FOR TRAINING MODELS' EXISTENCE

Basically, training has two functions to achieve, these are: effectiveness and efficiency of the organization or members thereof in the organization. It was in this light that VanAdelsberg and Trolley (1999:X) say, "being effective means delivering training services that tangibly help businesses to achieve their objectives. Being efficient means making the true costs of training clearly evident and highly acceptable to customers." To expand on this, individuals belonging to an organization have goals to achieve which may not necessarily be the same as an organization they work for. For example, an individual may work for the organization so as to get money for his/her family due to basic needs of that family, but the organization may be there for the sake of popularity because the owner may have accumulated enough money to meet the basic needs of his/her family. But both desire to be effective and efficient in service delivery. For this to work well, models of training may be modified along the intended objectives that are effective skewed.

2.13.1 Training Models for Effectiveness

From VanAdelsberg and Trolley's (1999:X) definition of effectiveness, one can see that effectiveness of the organization depends on service delivery that helps

that organization to achieve its objectives e.g. If the organization (HHES for example), wants to have more titles on a particular subject (e.g. physiological health), the organization may invite many researchers to attend the training sessions where authors can be encouraged to write in a particular way. If this is achieved in such a way that books are written as part of resources for references, then the organization is said to be effective. But effectiveness is not only in such a one thing. In order for an organization to achieve its goals, models of training have to take different shapes due to many factors, such as; fear for losing workers to other competing organizations; fear for internal competition; client system demands on what the organization is doing; evolution of new ideas to address particular needs. In this case, models can be employee-centred, employer-centred, or organization-centred.

2.13.1.1 Employee-Centred Training Models for Effectiveness

According to Winterburn (1991:299), training model for effectiveness, which is employee centred may be regulated by the perceived qualification to be achieved in that training programme. Winterburn (1991) refers to a qualification as "an individual's capacity to display suitable qualities or characteristics. This suitability may be signified by a qualification i.e. a symbol or representation like a certificate, usually associated with the successful completion of an externally accelerated course. It may also refer to accumulated experiential knowledge."

In essence, the above statements mean that if the employer sees that his/her course may reward the employee status, that can make him/her employable in many other organizations, he/she may choose not to give a certificate of the content covered in the course of training. Hence making that training essential for experience in that organization, but other organizations may not access written document testifying what the prospective employee knows about the job.

Models can be modified to suit such interests, when it comes to training.

2.13.1.2 Employer-Centred Training Models for Effectiveness

As stated in 2.13.1.1 above it can be deduced that employers may always want to accredit their training courses by means of certification, hence helping them to moonlight in other organizations, thus making them stronger in terms of economy. Depending on the view of the employers, training can be designed to favour them in terms of inter-organizational mobility.

2.13.1.3 Organization-Centred Training Models for Effectiveness

As stated by Winterburn (1991), training may also be modified to make the organization effective, so that the knowledge, skills, and attitudes of workers of that organization may lead to successful service delivery. This is quite a symmetrical approach to development, because it is not skewed in approach.

Hayman (1992:6) supports this idea when he says, "If, however, employers are in need of skilled adaptable and flexible labor as well as stable or expanding workforce, they may train existing employees to meet their requirements and those of their customers. Even so, employers may prefer to keep their training programmes short in duration, informal in provision and specific to the work place, thereby restricting opportunities for employees to mobilize their skills in search of better rewarded work elsewhere or to make higher demands upon existing employers."

In the organization centred type training models, the organization's effectiveness occupies the most top priorities for service delivery, in an attempt to keep that organization alive.

Thus, models for training will be tuned to suit the environment conducive for success, in terms of service delivery to the client system. HHES is not an exception to this situation.

2.13.2 Training Models for Efficiency

According to VanAdelsberg and Trolley (1999:X), "Being efficient means making the true costs of training clearly evident and highly acceptable to its customers.... To become more effective and efficient, training adopts the values of its customers and eliminates the ambiguities that have traditionally clouded its mission. Training's mission becomes unashamedly economic."

From the above quote, there can be a deduction that an organization can be effective but not efficient. Efficiency can only be said to have taken place if customers' views about that organization's service delivery has been assessed, devoid of this, efficiency cannot be part of the vocabulary of the organization. For example, if people who receive book services from HHES can indicate higher level of service delivery satisfaction, then HHES is said to be efficient. This description may not hold water if the principle of 'work within a given time', does not hold priority in the organizational set of goals.

2.13.2.1 Employee-Centred Training Models for Efficiency

As already discussed in 2.13.2 above, models for training for efficiency can only be so if the customer is satisfied with the type of service the organization offers. In the employee centred training model for efficiency, training organizers see to it that those termed as employees receive appropriate training to meet specific needs of the organization. Henning (1989:6) stresses the fact that employees should receive training for productivity's sake. He goes on to say that these employees will receive skills which they will hand down to their counterpart

which are to come after them in HHES, in this way, "high professional procedures.... become a great asset to the HHES organization." This was just a concern on issues of training an employee, so that those that receive the HHES may positively appreciate the organizational service delivery, and attribute the outcomes to employees.

Depending on the work required, employees may receive training for various reasons which may be in the changing work conditions, evolution of new roles, new machinery, or any other. To support this idea, Sutherland and Canwell (1997:47) say, "With any change in working conditions there may be a need to train, retrain or refresh individuals' knowledge. Factored into the overall implementation plan should be a rolling programme of training. Obviously, depending on the nature of change in working conditions more or less training will be involved. In the field of health and safety, particularly relating to new legislation, significant amounts of training may be required. If, for example, individuals are required to wear protective clothing or maintain equipment, then this may have a significant impact on the productivity for a short period. If new equipment or machinery has been installed, to be used in the manufacturing process, significant training may again have to be undertaken. It is often the case that the suppliers of new equipment include in the cost a basic training program for all operators."

In the above model of training, employees receive priority but they have, in this case, become a centre of concern for operations. In Home Health Education Service, new computer related materials come to the workers who, in turn should, demonstrate how these materials are used. In such a case, some training related to such needs should be organized for employees. Thus the public or consumers will see employees as satisfying the market, putting the factors of supply and demand under subjection.

2.13.2.2 Employer-Centred Training Models for Efficiency

Unlike in 2.13.2.1 above, the employers become central, and training is offered to them with an intention of improving customer service appreciation level due to manager's involvement in the service delivery. For example, Home Health Education Service managers receive new stocks on computer-related matters; it may be expedient to receive training for competence on how to use such materials in the community. This is important because, in order to minimize the operational costs, managers may receive the knowledge, and skills on how to use those computer-related materials, and in turn, teach or rather educate their subordinates on how to use the computer-related materials. This is demonstrated in the news-bulletin for August 2005. (Hurter, 2005:1).

In this case, every model of training will have to be employer-based or centred, and operation and consumers should be able to sense this.

2.13.2.3 Organization-Centred Training Models for Efficiency

Commenting on the flow of circulation of Home Health Educational books, White (1953:85) says, "Men in responsible positions have worked up plans whereby our books should be circulated and not lie on the shelves, falling dead from the press". White's view is quite holistic in nature, for she looks at employees' part, employer's part, things and ideas of the organization, that consumers should see this from the holistic point of view.

It can be better presented diagrammatically as shown in figure 2.9 below:

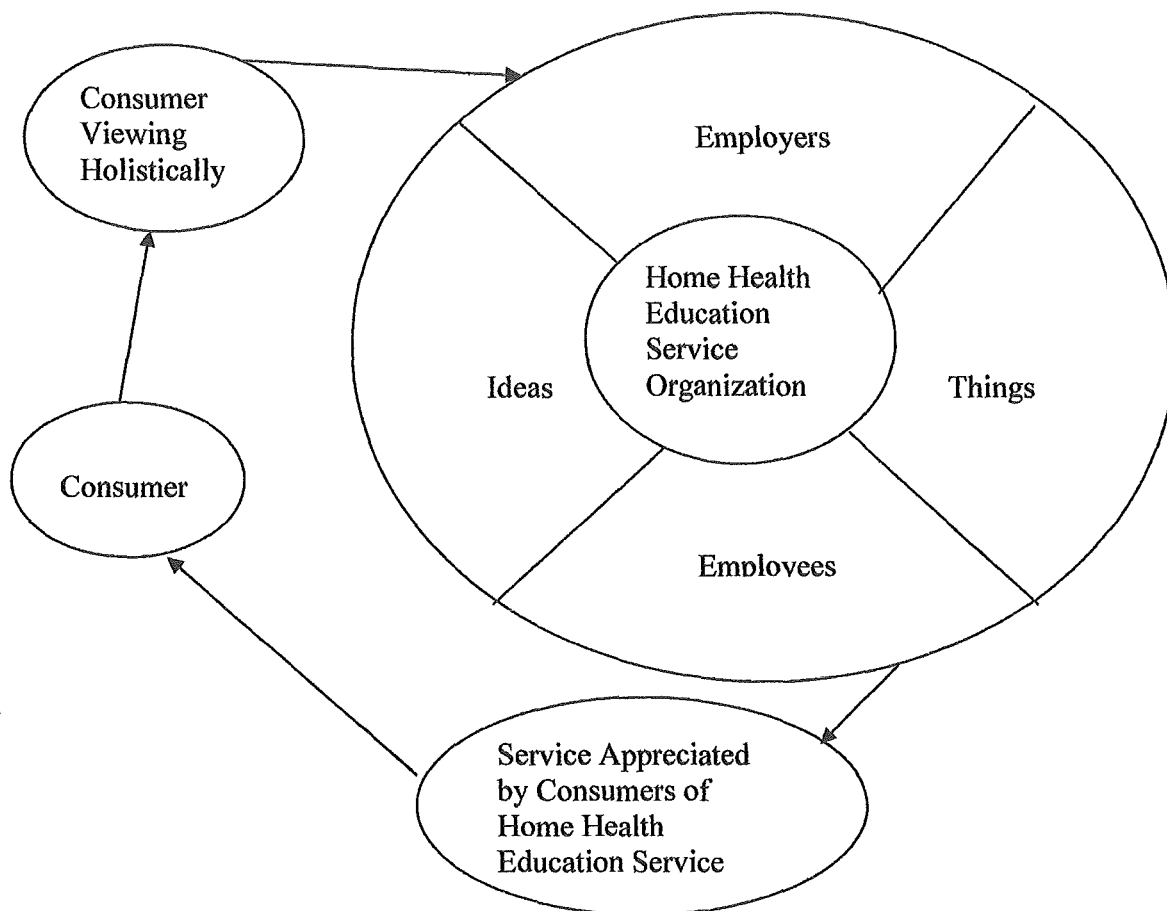


Fig. 2.9 Training Model for Efficiency

Source: Anakoka Design

In this case, the Home Health Education Service can be said to be efficient if, and only if, the consumers appreciate the service rendered to them. This is the organization-centred approach. With this in view, all training models, must aim at improving the whole organization holistically.

2.14 DEVELOPING A TRAINING MODEL

From the discussion above, it is quite evident that a training model should be developed that will address the needs of the employee, employer, and an organization (Home Health Education Service) in Southern Africa Union Conference. A training model to be developed needs to be a valid and evaluative one. Its main objective will be to improve the competencies of the workers, so that Home Health Education Service can be both effective and efficient in service delivery. It is evident, from literature review accessed that there haven't been enough studies done in Home Health Education Service organization. However, studies in training issues have been done by many scholars; hence books from other sources have been consulted more than those of Home Health Education Service origin.

Finally, the model has to be developed from the existing ones or a combination of different designs for training purposes.

2.15 EXPERIENCES

Noe (2005: 145) gives an example of what training can do for a particular company, and how situational analysis helps to make training programme very relevant to the organization. He cites KLA-Tenor, a supplier of process control solutions for the semiconductor industry in San Diego (California) which employs 200 hours per year for training the organizational employees. Observation has it that the KLA-Tenor company has reduced the training fail rate from 20% to 0% and that performance of the organization has improved tremendously to meet the organizational goals because it changed the model of training the employees and managers are remunerated due to training and development invested on their subordinates.

In another situation Lapidus (2000:5) tells of the experience where he was called to go to Hong Kong to conduct training in service delivery. He made a proposal of how he was going to run the programme, and finally he made a training programme without identifying the customer for the training, the end result was resentment by the assumed customers of training, and he experienced chaos. In short the training programme could not achieve its objective, because the trainer did not identify the customer of training so as to prepare the training curriculum suitable for that training.

In the two examples above, it is obvious that before training is conducted it is beneficial to carry out an evaluation of the organizational state of affairs as related to its objectives for its employers, employees, and the organization as the whole.

2.16 SUMMARY

This chapter has given information related to training principles, models, programmes, and institutions, as related to designing a training model suitable for Home Health Educators in the Southern Africa Union Conference. The chapter makes a distinction between pre-service and in-service training model and training programme, and on-the-job training and off-the –job training programmes. Finally, the chapter creates an understanding that there is enough literature to support the evaluation process of a training programme, and the designing of a training model to suit the needs of the organization is quite critical at the time of this research.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, the relevant literature on training models was discussed. The current chapter focuses on research design and methodology for data collection, presentation and interpretation. The chapter describes in detail the population, sample, sampling techniques, research instruments, data collection process, data validity and methods for data analysis.

Research methodology is different from research design in that research methodology is an account of the route followed to make the research achieve its objectives. On the other hand research design is a plan or blue print to be followed for the research to achieve its objective (Mouton, 2003:55 & 123). There is thus the separation between the methodology and design of the research.

3.2 RESEARCH DESIGN

Research design, according to Hittleman and Simon (2002: 8), "is the plan used to study an educational problem or question." Mouton (2003: 55) defines research design as a plan or blue print of how you intend to conduct the research. From these two sources, it can be deduced that research design is a plan or route followed by the researcher to find a solution to a particular problem.

Basically, there are two main research designs followed by researchers. Keeves (1988: 17) identifies these two as quantitative and qualitative paradigms. He

makes the difference between the two by attaching quantitative to the use of empirical quantifications analyzed by mathematical tools, while qualitative is identifiable by being attached to humanities with an emphasis on holistic and qualitative information and to interpretive approaches.

According to Ferreira, Mouton, Puth, and Schurink (1988:1), "the term 'qualitative' is an indication that this approach concentrates on qualities of behavior, i.e. on the qualitative aspects as against the quantitatively measurable aspects of human behavior." Hittleman and Simon (2002:37) say, "Qualitative research is characterized not by the use of numerical values but by the use of text-written words – to document variables and the inductive analysis of the collected information.

In harmony with Branen (1992), in this research study, the researcher made use of both qualitative and quantitative approaches. Under the qualitative approach respondents were asked to indicate what they would like the study to cover as related to curriculum in their training programmes as part of their needs (see fig.4.6 of this research report). On the other hand the study has made use of quantitative approach where numerical values or statistics were involved in data analysis, as supported by Hittleman and Simon (2002: 27/8).

In this research, descriptive statistics have been collected by examining the historical performance documents and data collected has been used to describe data as related to the performance of Home Health Educators for a period of four years in the Southern Africa Union Conference. The researcher employed the use of the questionnaire, examination of historical documents, and interviews as tools for data collection.

3.3 RESEARCH METHODOLOGY

This section of the chapter focuses on the following aspects of the research: the population, sample, sampling technique, research instruments, data collection process, and data validation. The section clarifies how the research was done.

3.3.1 Population

The population for this study was made up of the total number of all the Home Health Educators in Southern Africa Union Conference, that is, 214 people (Southern Publishing Association news bulletin of February 2003).

3.3.2 Sample

Ideally a sample is the representative of the group or population from which it is drawn (Dyer 1979:90). Describing a sample, Collins (1995: 722) says it is a representative of the whole. Hittleman and Simon (2002:97) say that a sample is the representative smaller group of the target larger group whose characteristics should be the same as the target population. In this case, the researcher decided to select three samples as follows:

For the interview schedule, the researcher used stratified random sampling technique to select a sample of 51 out of the 214 Home Health Educators as respondents for the verification of information collected through the questionnaire. The stratum was made up of those Home Health Educators with experience of at least two years of having worked with Home Health Education Service. (For more details, see 3.3.3).

For the questionnaire administration, the researcher used purposive sampling technique to select 100 respondents as a representative group from the 214

Home Health Educators. (For more details, see 3.3.4).

For historical documents, the researcher included all individuals constituting the bulletins for four years (2000 to 2003). Since the aim of using these historical documents was to find out the performance of Home Health Educators in Southern Africa Union Conference for the period of four years, the size of the sample was equal to the population, for each respective month. (For details, see 3.3.5).

3.3.2.1 Sampling Techniques

For the three samples, the researcher used the combination of two techniques: stratified random sampling and purposeful sampling to select respondents or subjects for data collection.

3.3.2.1.1 Stratified Random Sampling

Stratified sampling is a sampling technique that helps the researcher to select his subjects from the population after dividing the population into classes (strata) from which he randomly selects respondents by chance from a stratum of choice (Allison, Rothwell, O'sullivan, Saunders, and Rice 1998: 39). Under this method, the researcher selects his respondents first by a class of choice, as two years experience for example, then randomly selects from that class of two years experience as influenced by the variable in question. In this research, the researcher divided his population of Home Health Educators into two groups, those below two years of work experience separated from those of at least two years experience. Home Health Educators who had worked for at least two years were put in a group (stratum) which was considered to be information rich, and the researcher randomly selected forty three of the fifty-one respondents from the two hundred and fourteen by stratification procedure, but the other eight

were purposefully sampled (as indicated by the last paragraph of the sub-section 3.3.2.1.2 below). The 51 respondents were consulted to answer the interview schedule.

With regard to the historical documents, the stratified random sampling technique was partially applied as follows: Home Health Education Service was divided into two strata; one stratum was made of those who report through the monthly bulletin, while a smaller group of leaders does not. Only those whose names appeared in the monthly news bulletins were selected as part of the required data. For this reason, the data collected for examination of performance historical records resulted into the sample equal to the population (monthly) for 46 months.

For questionnaire administration, the stratified random sampling was used this way: The researcher divided Home Health Educators into two groups – those that qualified to go to the annual institute by merit, and those that could not achieve; hundred questionnaires were handed only to those who qualified to attend the annual institute because they were considered information rich, as related to the questionnaire requirement. The choice of who to receive the questionnaire was determined by random sampling. This was in harmony with the indication made by VanDalen (1979:133) who says that stratified random sampling may be used to select a more representative sample from the population. For the sake of precision stratified sampling may be preferred to other sampling technique, depending on the variable under investigation (Keeves, 1988: 530).

3.3.2.1.2 Purposive Sampling

Purposive sample denotes a sample procedure which cannot easily result in a probability sample (Walizer and Wienir, 1978: 437). A probability sample,

according to Walizer and Wienir (1978: 430), is where each community member has an equal chance of being selected. In the view of McMillan and Schumacher (2001: 401), the power and logic of purposeful sampling is that a few cases studied in depth yield many insights about the topic. In the case of this purposive sampling, there was some deduction made that not every Home Health Educator was able to give the required information, especially as related to giving full attention to every item of the questionnaire (see 3.1.3).

The researcher purposefully selected a sample for each of the following: interview schedule, questionnaire, and the news bulletins (for four years: 2000 to 2003). However, purposive sampling technique depended on the availability of the targeted sample of all Home Health Educators in 46 monthly news bulletins, otherwise change of technique might have been warranted in the process. Selection of eight leaders as respondents to the interview was done purposefully because they were exclusively information rich.

3.3.2.2 Sample for Interview Schedule

Since the leaders were considered to be the trainers, and were in possession of the training curriculum, it was expedient to find out the quality of training that was offered in the Southern Africa Union Conference. To determine the views of these leaders on training issues, eight of the nine leaders (purposefully sampled) and forty-three subordinates from the four countries (Swaziland, Lesotho, Namibia, and the Republic of South Africa) of Southern Africa Union Conference were interviewed. The forty-three subordinates were sampled using a stratified random sampling technique. This sample was of great importance in that it was able to give the true picture of the quality of training and its attachment to NQF and accreditation procedures. The interviews were done in person for the twenty, and thirty-one were interviewed telephonically. To verify certain facts, some interviews were telephonically done with the Union Director. Hurter (2003,

discussion)held an idea that trainers in Home Health Education Service were not trained, and this view was also in harmony with the three other regional directors' views (Schoeman, February 2003; Mahoa, Venda discussion in April 2003, and Oliphant, discussion in Pretoria 2004), directors were trainers though not trained to train. The top three regional directors unavoidably became part of the sample of eight leaders for the interview purposes. The forty-three subordinates were selected by stratified random sampling first and then purposefully sampled on the fact that they were functional Home Health Educators.

3.3.2.3 Sample for the Questionnaire

In administering the questionnaire, a sample of 100 people was selected from a population of 214. The hundred questionnaires were personally handed out to the respondents. Out of the 100 questionnaires handed out, 71 were successfully returned. It was not possible to access the remaining 29 after strenuous efforts exerted on both the distribution and collection processes. It was assumed that 71 out of 214 was quite representative, considering the fact that the sample came from the functional group. This sample was selected on the basis of achievement (those who qualified to go to the annual institute), ability to read and write in English as a language of proficiency, and at least two years experience in the Home Health Education Service profession. These were purposefully selected because they were information rich. They were related to the training activities done in Home Health Education Service, assessment of training needs of Home Health Educators, the evaluation of in-service training taking place, and assessment of the quality of training model needed by Home Health Educators in Southern Africa Union Conference.

3.3.2.4 Sample for Historical Records (Monthly News Bulletins)

Regarding the targeted 48 bulletins, 46 were accessed because the other two could not be found even at the head office. This number was quite representative in terms of supplying the relevant information for analysis and formulation of the training model. The bulletins contain the monthly report of all the Home Health Educators and their activities in the Southern Africa Union Conference. This sample was an equivalent of the population of 214 for a particular month. This sample was selected on the basis of membership of the Home Health Education Service, the aim of which was to check the performance as related to activities required as tasks expected. (See annexure six (6), for an example).

3.3.3 Research Instruments

For the sake of this study, three research instruments were used namely, interview, questionnaire and examination of historical records. These instruments are discussed briefly below (See Annexure 1 – Annexure 2).

3.3.3.1 Interview

Walter (1985: 90) is of the view that an interview relies on the fact that people are able to offer accounts of their behaviour, practice and actions to those who ask them. Collins (1995: 415) also defines interview as "... discussion... conversation in which a person is asked about his or her views," concerning what he/she claims to know. In this research, the researcher conducted some interviews with some sampled members of Home Health Education Service, with a view of collecting information related to training models used in the organization.

According to Mahoa (a discussion held in Venda in April 2003) every Regional Manager is a trainer. Therefore, the researcher had to interview each of the four Regional Managers and four other leaders, in their capacity as trainers, and forty-three subordinates for data collection. This gave a total of fifty-one respondents for the interview schedule.

The interview schedule was structured in nature, and was chosen as a tool for data collection because the respondents would give information concerning activities done in Home Health Education Service, the quality of training as related to what was available in curriculum form, what was missing and needed to be added to the existing curriculum and its implementation so as to make the expected training richer in venues, content, and application (See Annexure 2). The interview outcomes were perceived to be of help in establishing facts related to the quality of Home Health Educator needs assessment and evaluation by the organizational leadership. The instrument was also chosen to help clarify information in the questionnaire tool and statistical display in the news bulletins.

Some interviews were either conducted through telephone system because it was not possible for the interviewee to be met in person for that particular time-period or, person-to-person since the respondents were available at the meeting for the annual gathering (called Institute), and in some instances in small meetings, as well as seeing the respondents in their homes to collect data.

3.3.3.2 Questionnaire

According to Hittleman and Simon (2002:27), "Questionnaires require the respondents either to write answers to questions about a topic or to answer orally. The answer form may be structured; in that there are fixed choices or the form may be open, in that the respondent can use his or her own words. When the respondent answers orally and the researcher records the answers,

researchers consider the instrument an interview.” The questionnaire (for Home Health Educators) in this study forms annexure 1. Basically, the questionnaire has four sections. Section “A” has three choices, “B” has two choices, “C” has three choices, and “D” has open-ended options. All these options were devised to collect information from respondents concerning their aspects of how they view training in the Home Health Education Service in the Southern Africa Union Conference. The questionnaire also asks for information related to how the view the direction of the current training trend as related to the possibility of developing a training model for Home Health Educators in Southern Africa Union Conference.

This instrument has been used to collect much information from Home Health Educators, since respondents needed freedom to self-expression in giving their opinions on specific issues. Though the selection of 100 respondents was targeted, only 71 respondents were reached. Much information in relation to needs assessments and evaluation was gathered here (See Annexure 1).

3.3.3.3 Examining Historical Records

The Southern Publishing Association produces monthly news bulletins where Home Health Educators of Southern Africa Union Conference can be observed in relation to their performance, as well as the performance of the whole group. These bulletins were examined by the researcher to find out some of the important information relevant to the research. This is seen as a study of ‘historical records’.

The historical records (news bulletins) have information related to each individual Home Health Educator’s performance. They display the following column titles: time (in hours) spent in working in a month, number of presentations made in a month, financial value of learning support materials ordered by seminar

attendants, how much of the ordered materials were delivered, the financial value of the delivered learning support materials collected from the warehouse of Home Health Education Service, and the cumulative financial value of delivered leaning support materials. This information would help the researcher to see the activities done in Home Health Education Service, the training needs of Home Health Educators, the adequacy of training offered in Home Health Education Service, the evaluation of the quality of training of Home Health Educators, and the need for a training model that would boost performance in Home Health Education Service.

The examination of historical documents was considered when examining the Southern Publishing Association News bulletins for the time-period starting from 2000 to 2003. This examination of historical records was able to help the researcher to easily examine the performance of Home Health Educators for the past 4 years, and their activities and how they perform in those activities (See Annexure 6).

3.3.4 Data Collection Process

A specific questionnaire was directed to those 100 respondents expected to respond as stated in the purposeful sampling technique. The questionnaire was administered through personal contacts in meetings, and through postal services. Interviews were done face – to – face, and where not possible, interviews were done through the telephone system, and recording was done as conversation proceeded. Assessment of performance and how that is related to activities or tasks was done through the News bulletins collected for the period of four years (2000 to 2003).

In short, data was colleted through, interviews, questionnaires, and examination of historical records (monthly news bulletins). The three instruments for data

collection helped the research to contain valid data easier to evaluate and compare its reliability (See Annexure 1,2 & 6).

3.3.5 Data Validation and Analysis

Data was collected using the interview schedule, questionnaire administration, and examination of historical records. Data collected was compared with what the standard revealed knowledge reflected in the literature review, and considered the fact that it was addressing the research questions. The adherence of data to literature review and research questions validates it by reflecting and confirming facts found in literature review, and at the same time answering the research questions.

For analysis purpose, data was rearranged according to the research questions for presentation, and all the related items in the three tools for data collections were manually grouped and put in tables and figures for interpretation, and then conclusions were made based on the findings.

3.4 SUMMARY

This section has been dealing with the research design and methodology with an aim of collecting valid data by interviewing, questionnaire administration, and examination of historical records, which can be subjected to sound ways of research interpretation procedures leading to the design of training model that will help Home Health Educators to get training suitable for their expected performance.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.1 INTRODUCTION

Chapter three outlined the research design and methodology of this study. This chapter focuses on the presentation of data collected and its interpretation. Basically, the chapter has three sections: introduction, data presentation and interpretation, and summary. Data collected has been interpreted manually, and has been gathered and systematically grouped according to sub-themes in tables, and thereafter interpreted in the space following a table. Descriptive statistical figures (in percentages, except where percentages are not required) have been attached to statements to present and analyze the phenomenological views of respondents as collected through the research tools: questionnaire, interview schedule and historical documents (news bulletins). In most cases, the statistical figures have been presented in percentages.

In order to enhance further understanding on sections A and B of the questionnaire outcomes, both raw and percentage figures are included in the annexure 3 and 5 (extension) respectively.

Items 4,5, and 6 of section B of the questionnaire reveal the academic qualifications of respondents. These are categorized as follows: 12% of the 71 respondents had diploma qualifications (said to have originated from Zambia and Zimbabwe, according to the interview held with the respondents), 88% of the 71 respondents had academic qualifications lower than diplomas, 96% of the 71 respondents expressed an interest to acquire at least a Diploma in Home Health Education Service, and none of the 71 respondents had any university qualification in Home Health Education Service. Respondents came from the four

countries of Lesotho, Namibia, Swaziland, and the Republic of South Africa, and this distribution fully represents the area covered by Southern Africa Union Conference (SAUC).

Data collected provides answers to the following research questions (See the introductory part of section 4.2 for how this has been arranged):

- What type of training (pre-service and in-service) do Home Health Educators in Southern Africa Union Conference (SAUC) need to ensure successful service delivery?
- What current practices, in relation to both pre-service and in-service training in Home Health Education Service in Southern Africa Union Conference are taking place?
- Does Home Health Education Service management assess the needs of Home Health Educators, in the correct format, with a view to adjusting training models for successful service delivery?
- Do Home Health Educators acknowledge having been trained adequately to perform the tasks they are assigned?
- Does Home Health Education Service management carry out an evaluation of the types of in-service training so as to warrant an adjustment in training models for workers of the organization?

4.2 DATA PRESENTATION AND INTERPRETATION

This section outlines the research data and the related interpretation of the results. The section has five (5) sub-headings (Home Health Education Service current practices, training needs assessment of Home Health Educators, adequacy of training, evaluation of training of Home Health Educators, and the appropriate training model for Home Health Educators) related to training issues of Home Health Educators in Southern Africa Union Conference (SAUC).

The general approach to the interpretation process in this section is that, after appropriate consultation with the literature review in chapter two of this research document has been done, a comparative statement that reflects a relationship between what is in the literature review and the research findings is made. Thereafter a general analysis with comment is made, according to each research question.

4.2.1 Home Health Education Service Current Practices in Southern Africa Union Conference (SAUC)

Home Health Education Service (HHES) current practices in SAUC are indicated in Tables 4.1, 4.2, and 4.3 below. The research question addressed here is: "What current practices, in relation to both pre-service and in-service training, in Home Health Education Service in Southern Africa Union Conference, are taking place?" This research question assesses the practices or activities related to training issues in Home Health Education Service (1.3.1). In chapter one of this research document, this question corresponds to question one which had responses in the questionnaire, interview schedule, and examination of historical performance records.

Questionnaire items relating to the practices have been singled out, and arranged as shown below: Table 4.1 outlines responses to the following research

question: What current practices, in relation to both pre-service and in-service training in Home Health Education Service in Southern Africa Union Conference are taking place?

Table 4.1 HHES Current Practices in SAUC: Questionnaire Reflections

Item	HHES current practice	Home Health Educators	
		Number of respondents in percentage (%)	Responses and time frequency (where applicable) attached to options
From Questionnaire section A			
1	Director visits for counselling or progress monitoring on how to work in a month	37	No visits
		36	One visit per month
		17	Two visits per month
		3	Three visits per month
		7	Four visits per month
3	Director assesses Home Health Educators' attitude towards Home Health Education Service	39	No attitude assessment done
		26	One attitude assessment done a month
		11	Two attitude assessment sessions in three months
		17	Uncounted attitude assessment sessions done a month
		7	Uncounted attitude assessment sessions done a quarter

5	Director trains Home Health Educators	44 37 4 3 12	No training in a month One training session in a month Two training sessions in a month Three training sessions in a month Four training sessions in a month
From Questionnaire section B			
8	Interest to develop a higher Quality of Training than the current one for better qualification	94 6	Desire to change the current training for higher qualification No need for changing the current training practice
15	Knowledge of Home Health Educators needs Up-grading	97 3	Workers' knowledge in HHES needs up-grading No need to change the current level of knowledge
16	Training taking place in HHES school buildings (Indicating adequacy of training venues belonging to HHES)	87 13	No training venue present anywhere in SAUC There is training in school buildings
From Questionnaire section C			
3	A change in the	20.5	Training application has

	application of training techniques in a decade time-period	20.5 59	changed Training application has not been changed Training application has not been observed for change
4	The place where your training has value	64 33 3	Training has value only in Home Health Education Service Training has value in other departments, other than HHES Training has value only in other departments
From Questionnaire section D			
1	HHES members of staff need training (From Questionnaire section D)	97 3	Members of staff need training Members of staff don't need training

General comments on the Table 4.1 above

The following practices or activities have been identified:

Director visits

From section 2.2.1 of this research document, training requires both theoretical and practical contact between the trainee and the trainer. Added to this is the idea that the first formal Home Health Education Service leader and trainer, George King recorded in section 2.2.4.2, had visits to his subordinates for

training which covered counselling and general monitoring of how work was done.

Item 1 of the questionnaire section A was included to assess the physical visit and contacts of a director to Home Health Educators. In Home Health Education Service, there is an expectation that the director in charge of the organization should visit each Home Health Educator at least once a month to monitor progress, and provide counselling on the field training.

Analysis of the item 1 above reveals that the director's visits to field Home Health Educators are done on irregular basis. Regardless of the 37% of the 71 respondents who indicated not being visited, there is evidence by the 63% of the same sample report that the director visits at least once a month. Deep analysis of the visit quality indicates irregularity, but that does not disqualify the fact that directors visit their subordinates.

An assessment of the above responses leads one to conclude that a director's visits to field Home Health Educators are very irregular and unsystematic. Considering the fact that one of the responsibilities of the director is to train Home Health Educators as s/he visits, the conclusion may be drawn that the director's schedule of visits requires attention.

Director assessing Home Health Educator: Attitudes, training quality, and training venues

According to Van Dyk (2001: 151 – 156), training programmes should consider trainee attitudes, training quality, and training venues for the training programmes to meet the training principles outlined in section 2.2.2 of the literature review of this research document.

Item 3 of Questionnaire section "A" was included to test the trainer's assessment ability as related to Home Health Educator's attitude towards Home Health Education Service as an organization. This was important because training and sound work output can constructively take place if workers of the organization have positive attitude towards the organization. Results of the analysis of item 3 revealed that 39% of Home Health Educators reported not being assessed hence indicating lack of skill on the director's ability to assess the attitudes of workers. However, 61% of the 71 respondents indicated that there is some kind of assessment taking place, regardless of the irregularity on display.

This leads one to conclude that the director's assessment of Home Health Educator attitudes towards Home Health Education Service is very irregular. It certainly needs attention.

Director trains Home Health Educator

For effectiveness and efficiency of any worker in an organization, training by leadership must be provided for (section 2.2.3 of this research document).

Item 5 was designed to assess the director's involvement in the training activity. Regardless of the 44% who said that there was no training, there is an indication by the 66% that training was taking place, without counting on the regularity. Training, as a matter of practice, was seen as a duty being done in Home Health Education Service in Southern Africa Union Conference.

Careful analysis of responses to the items in table 4.2 has it that the director trains Home Health Educator, as a matter of practice.

Home Health Educator assessing training quality

One of the principles of training in 2.2.2 states that training should proceed in such a manner that learners are able to logically follow the presentation in a training session. This principle indicates that assessment is not confined to the trainer alone but to the trainee as well.

Item 8 of questionnaire section B was included to find out the quality of training as related to qualifications available in Home Health Education Service. Response outcome indicates that 94% of the 71 indicated that they have a desire to see the current training change for the better with a hope that higher certification may be one of the goals of such new training. This also indicates that Home Health Educators are engaged in the assessment of training quality, though on informal level.

Item 15 of the questionnaire section B was included to find out whether Home Health Educators see themselves as workers whose knowledge needs up-grading as related to training quality. The response shows that 97% of the 71 respondents said that Home Health Educators' knowledge needs up-grading. The view of the 97% of the 71 respondents is in harmony with section 2.11.2.2 of the literature review in the sense that knowledge-upgrading, as part of training, is indispensable where organization is looking for progress. This clearly indicates that Home Health Educators are also engaged in assessment of the quality of training they are receiving.

Training taking place in Home Health Education Service venues

The literature review in section 2.12 indicates that training has been mobile, that is, other learning institutions have been hosting and running the training programme, as related to venues for training.

Item 16 was included to find out whether training is taking place in Home Health Education Service venues, as an activity. The adequacy of training venues was tested in item16, and 87% of the 71 respondents said that there are no HHES school buildings where training was taking place. This implies that, 87% believe that Home Health Education Service does not have buildings where training is done. The 13% of the 71 respondents who said that Home Health Education Service has its own training venues might have misunderstood what item 16 was looking for; for they seem to have mistaken it to mean any building other than its (HHES) own, not necessarily belonging to Home Health Education Service.

Regardless of the above finding, training, as an activity, is taking place in venues, not necessarily belonging to Home Health Education Service.

Application of relevant training techniques

Section 2.2.2 of chapter 2 of this research document shed some light on a principle called "Motivation principle". This principle indicates that a trainer should motivate trainees on the relevance of training that it will help them to do their work better than before attending the training session. For the trainer to do this, relevant techniques have to be applied for the training to make sense to the trainees.

Items 3 of section C of the questionnaire was included to assess the change in training techniques application. The findings indicate that 20.5% of the 71 respondents said that training techniques have not been changed for a decade, and an equivalent percentage of 20.5% indicated the opposite, with 59% not in a position to give any observation related to change for the same period of ten years. It may be assumed then that relevant training techniques have not been applied that is why this denial seems to occupy a bigger percentage of the respondents. On overall analysis, item 3 indicates that the application of

relevant training techniques have not been applied in an observable way to the work force in operation and that is why there is 80% not acknowledging the application of relevant training techniques.

Training value skew-ness

Section 2.2.5.8 of the literature review indicates that every training session or programme has its own bias, and that is considered as the validity of training. This makes training of due application to the organization as it is applied as an activity. Terms that are synonymous in this section are: internal validation with use-value, external validation with exchange value, validation with validity. Whatever the terminology, training will always have objectives, and these will serve as the determining factors behind the skew-ness of training application.

Item 4 was included to find out the skew-ness of the Home Health Education Service. This item was actually looking for the direction of the bias of training application in the organization, as an activity. Findings indicate that training seems to have more value inside the organization, and this was indicated by the 64% of the 71 respondents. According to the literature review on section 2.2.5.8, the Home Health Education Service training has more use-value in the sense that training relevance is biased towards internal endemism. This implies that after receiving training in Home Health Education Service organization, the trainee can use that training inside more than outside the organization. External bias of the training value was indicated by 33% of the 71 respondents who said that training in Home Health Education Service has external value only; this has been classified as exchange value, as reflected in section 2.2.5.8. This kind of skew-ness, in terms of value application, comes only when the principles of training have not been properly applied, as outlined in section 2.2.2 of the literature review. The literature also indicates that the quality of training taking place has more of use-value than exchange-value. Sixty-four percent (64%) said there

was greater use-value, 33% indicated a bit of exchange-value, and only 3% indicated that the quality of training has exchange-value. On overall analysis, the training quality of Home Health Educators has more use-value than exchange-value.

Training application

Section 2.2 of the literature review indicates that training is crucial where growth and development are considered as goals for the organization.

Section D, item 1, in the questionnaire required Home Health Education Service members to indicate whether they needed training. The results were such that 97% of Home Health Education Service staff members indicated that while training is done as a practice, there is need to train all members of staff belonging to Home Health Education Service.

From Table 4.1, the following is the summary of current practices done, regardless of the quality thereof:

- Director Visits
- Director assessing Home Health Educator: Attitudes, training quality, and training venues
- Director trains Home Health Educator
- Home Health Educator assessing training quality
- Training taking place in Home Health Education Service venues
- Application of relevant training techniques
- Training value skew-ness
- Training application

Table 4.2 HHES Current Practices in SAUC: A Summary of Interview Responses

Item	HHES current practices	Home Health Educators	
		Number of Respondents	Views
1	Using a pre-service training model for Home Health Education Service in SAU	51 (100%)	No pre-service training in HHES
2	Using an in-service training model that is accredited (NQF compliancy)	51 (100%)	No in-service training model that is registered on NQF. There was no registered programme with SAQA and accredited by HEQC

Section 2.11.1 of chapter two of this research document indicates that, like many other departments of the Seventh-day Adventist Church, Home Health Education Service was supposed to have pre-service kind of training. This is the standard of operation the church is expecting to see as a result of the training given to Home Health Educators before they are actually employed and sent into the field. This approach is applied when the church considers producing teachers, nurses, pastors, accountants, and other professionals in other departments of the church. This standard is in harmony with the expectations of the South African Government. From the interview (annexure 2) outcomes, it is evident that the kind of training offered is not according to the standards of the South African Qualifications Authority, because the training is not registered. The activities performed are therefore quite informal in nature.

The interview tool for data collection has items 1 and 2, and the following practices have been identified: An analysis of items 1 and 2 indicated that, item 1 obtained the result that there is currently no pre-service training in SAUC, according to the 51 interviewed respondents who are Home Health Educators and leaders. Item 2 indicated that the in-service type of training practised is not registered on the NQF, hence has no recognition in the South African Context of programme accreditation.

In summary, the interview schedule gives an indication that there is no pre-service training practice and that the in-service training practice is not accredited. Table 4.2 above is therefore indicating that there is no pre-service training done as an activity and that the kind of training common to Home Health Education Service is that which is called in-service training.

Table 4.3 HHES Current Practices in SAUC: Historical Documents' Reflection

Examination of the historical the documents assembled revealed that there are basically four practices (activities) in Home Health Education Service in SAUC, as shown in the Table 4.3 below. These are prospecting, presentations, reporting, and training provision. The thirteen activities, obtained from annexure 6 and 7, in Table 4.3 below have been classified into four groups which have been explained after the table.

Table 4.3 HHES Current Practices in SAUC: Historical Documents' Reflection

Practices by HHES workers	Practices grouped by researcher
Calls Appointments Voice Of Prophecy Enrollment	Prospecting
Demonstrations Making Orders Service Delivery (Learning Support Materials) Life Skills Education Programmes conducted (Bible Based Studies)	Presentations
Weekly submissions (Report) Monthly Bulletins (Report) L.E Development (Report)	Reporting
Co-Workers with sub-ordinate in the field Course/Training offered	Training Provision

Prospecting

Analysis of annexure 6 has revealed that for Home Health Educators to do their work they need people who are going to both listen to them and benefit from their service. The process of looking for these people is called prospecting. For prospecting to take place, they need to make contacts with people by any means which includes telephone calls, personal knocking on the door, making appointments with people met by chance in a place of convenience, and many more. Some contacts may be made in churches where people indicate that they

would like to undertake life skills studies through the Voice of Prophecy school enrollment. These enrollments are an indication that people would like to study some lessons on how to manage life from a biblical point of view. Based on this Home Health Educators make such indications as points of contact hence they also get classified as calls. Calls are actually the foundation of Home Health Education Service. Without these calls (calls, appointments, and voice of prophecy enrollments), Home Health Educators have no work. So, prospecting is an activity that has to be done if Home Health Education Service has to survive as an organization.

Presentations

In harmony with annexure 6 and 7, presentations manifest themselves in five areas: Addressing people met through prospecting, writing orders for their learning support materials, supplying learning support materials, running a seminar on life skills, and conducting bible studies. In all the five issues reflected above, Home Health Educator has to give orientation of some kind as an address. For this to be done professionally, knowledge, skill and correct attitude have to be combined as stated in the literature review section 2.2.5.

Presentations are a second major step in the work of Home Health Educators.

Reporting

After prospecting and presentations are done, Home Health Educators have to give feedback on work progress to the leadership in form of a form, as indicated in annexure 7. This process of giving feedback to those in charge of the organization is called reporting. Reporting also covers the feedback from management which indicates that they have received an upward report, so they have to give downward report to the subordinates.

According to the Table 4.3 above, reporting has three manifestations: weekly reports, monthly reports, and Home Health Educator development report. If reporting is not done, Home Health Education Service management may not know the progress of their subordinates hence trainers may not be able to know even how to direct their training programmes for the benefit of the organization. So, reporting is a very important activity in Home Health Education Service.

Training provision

In harmony with section 2.2.5.2 of the literature review, there is a notion that training has to happen so as to professionally meet organizational needs. Table 4.3 above indicates two types of training: one offered by more experienced workers to the newly recruited workers, and one managed by the organizational management. From the records, it can be seen that training is one of the activities to be done by Home Health Educators to a large extent for organizational survival.

The analysis of SPA bulletins (2000 to 20003) indicates that training provision, as a matter of practice, was something happening in Home Health Education Service of Southern Africa Union Conference.

As shown in Table 4.3 above, there are thirteen practices performed in HHES in SAUC. Assessment of the document has helped to group the thirteen activities into four practices, which have been summarized as prospecting, presentations, reporting, and training provision. These are current practices according to the historical documents.

4.2.2 Training Needs Assessment of Home Health Educators in Southern Africa Union Conference (SAUC)

This section focuses on the training needs assessment done by management of Home Health Education Service in Southern Africa Union Conference to the Home Health Educators who operate in the field. In any credible curriculum development, a comprehensive needs assessment must be conducted and it provides the basis for the training provided (See 2.2.5.1 of the literature review of this research document).

Table 4.4 below presents training needs assessment questionnaire responses

Table 4.4 Training Needs Assessment: Questionnaire Reflections

Item	Activity (need)	Home Health Educators	
		Number of respondents in percentage (%)	Responses and time frequency (where applicable) to options
From Questionnaire section A			
2	Director assesses Home Health Educator's needs on monthly basis	39	No needs assessment done
		35	Once in a month needs assessment is done
		16	Twice in a month needs assessment is done
		4	Three times in a month needs assessment is done
		6	Four times a month needs assessment is done

3	Director assesses Home Health Educator's attitude towards HHES	39	Director does not conduct attitude assessment
		26	Director conducts attitude assessment once a month
		11	Director conducts attitude assessment once in a month and half
		17	Director conducts attitude assessment in a none specified times a month
		7	Director conducts attitude assessment in a none specified times per three months
From Questionnaire section B			
15	Home Health Educators need knowledge up- grading	97	There is need for knowledge up-grading
		3	There is no need for the knowledge up-grading
19	Self Perception as book distributor	60	Book distributors
		40	Not as book distributors
From Questionnaire section C			
1	Perception of who is favoured by the current training	29	Directors are favored by training
		35.5	Home Health Educators are favored by training
		35.5	The whole organization is favored by training
2	The basis for	42	Training is based on needs

	training model for Home Health Education Service	13 45	of Home Health Educators Training is based on needs of leaders Training is based on needs of the whole organization
From Questionnaire section D			
1	The need to train Home Health Education Service members of staff	97 3	There is need to train HHES members of staff There is no need to train HHES members of staff

General comments on Table 4.4 above

Items 2 and 3 of the questionnaire section A were designed to address issues on training needs assessment procedures in Home Health Education Service.

Training needs assessment

Item 2 in table 4.4 revealed that 61% of Home Health Educators acknowledge that Directors conduct needs assessment, with 39% refuting such an activity. It seems the procedure for assessment is a bit skewed, because the largest percentage is not exposed to the practice, 35% get assessed once a month, 16% get assessed twice a month, 4% get assessed thrice a month, 6% get assessed four times a month. From the percentage distribution, there seems to be no processes or procedures related to training needs assessment in Home Health Education Service. Hence Fig. 4.3, section D, calls for training for all Home Health Education Service members of staff.

Assessment of attitudes

Item 3 indicates that there is no well-defined procedure in terms of assessment of Home Health Educator's attitude towards Home Health Education Service. This is justified by the non-acknowledgement of such an activity by 39% of Home Health Educators, 26% who get assessed once a month, 11% who get assessed three times a month, 17% not knowing the frequency of assessment in a month, and 7% assessed irregularly on quarterly basis. This kind of distribution of assessment is very uneven, and cannot have a well-documented procedure for such a move in terms of standard assessment procedures.

From the research findings, there are no known standard procedures for assessment in the Home Health Education Service.

Programme review

Questionnaire Section B has items 15 and 19 on assessment as related to programme review. Item 15 indicated 97% of Home Health Educators calling for the up-grading of existing knowledge in HHES; if there was assessment of knowledge up-grading in HHES, 97% would not be calling for a change, which they would be experiencing. Hence, there seems to be no procedure for knowledge upgrading in HHES.

Item 19 revealed that 60% of Home Health Educators see themselves as book distributors, and 40% perceive themselves as Home Health Educators, and not merely book distributors. This gap percentage in self-perception was not supposed to be if there were well-known assessment procedures in HHES.

Items 15 and 19 above indicated that there are no well-known assessment procedures in relation to knowledge upgrading and self-perception.

Items 1 and 2 of questionnaire section C were designed to find out the state of affairs concerning the assessment procedures, and the bias of training favor in Home Health Education Service.

Item 1 indicates that there is a tally between Home Health Educators and Organization, and the least favoured (29%) are the directors. From this reflection, it seems that the training done in Home Health Education Service is set to benefit the whole organization. This indicates that there is an assessment of some kind regardless of the quality of assessment procedures used.

Item 2 indicates that 42% of Home Health Educators said that training is based on Home Health Educators, 13% said that it is based on leaders, and 45% said that it is based on the whole organization. In this item, it seems the assessment procedures are also in practice, because the training is perceived to be organization based.

Scrutiny of items 1 & 2 leads one to conclude that the kind of training set seems to get regular assessment, such that it favours the whole organization as the consumer of training. On average (Items 1 and 2), training has been assessed to favour home health educators who are the foundation of the HHES Organization.

Item 1 of Questionnaire Section D was designed to test the need for training the staff members. Data collected on this item indicates that 97% of Home Health Educators said that members of staff of Home Health Education Service organization need training. This reflection shows that while the organization receives training, there is a serious deficiency that has not yet been assessed procedurally.

Table 4.5 Training Needs Assessment: Interview Reflections

Item	Activity (need)	Home Health Educators' views
6	Developing another training model	The interviewed respondents recommended that the following needs must be addressed by the new training model: • Client management • Employing Full-Time Trainers who will be engaged in training workers • Putting up a training institution and venues • Skills Development related to product knowledge and presentations • Employ the full time trained trainers who will specialize in training workers both as workers and trainers • Hire specialized training institutions for training • Training should be systematic • Human resource management • Temperaments of humans • Administration in HHES • Policy education and awareness • Communication skills • Salesmanship • Counseling • Report writing skills • Information and technology skills • Filing skills

		• Financial and accounting skills • Systemic and systematic field practical training • Psychology of HHES • Philosophy of HHES • Sociology of HHES
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General comments on Table 4.5

On assessment procedures related to training needs assessment, responses to item 6 of the interview schedule indicated that there are quite a lot of areas not being addressed by the current Home Health Education training programme in operation. Table 4.5 above reveals that the current training is quite deficient in delivery and design; if this was not the situation, respondents would not have mentioned a lot of needy areas that are seen as not currently available. The needs indicated in Table 4.5 above may turn out to be a solution to the observed deficiency in training of Home Health Educators in Southern Africa Union Conference.

From the analysis of data in Table 4.5, one may conclude that needs assessment procedures seem to be lacking in relation to training needs assessment. There seems to be no well-set standards for assessment of training needs. That is why there is great reflection of deficiency in knowledge design and delivery of the needs for training. The inclusion of the above needy stated areas in Table 4.5 will definitely enrich the in-service training model in operation.

Table 4.6 Training Needs Assessment: Historical Documents

Examination

(See Annexure 4 for clarity).

Period of assessment	Monthly average number of Home Health Educators who reported				
	For 4 years	On hours only	On purchases only	Hours and Purchases together	Nothing
2000 to 2003 (4 years)					
46 months*	248 (100%)	18 (7%)	47 (19%)	63 (25%)	120 (49%)

*The SPA bulletins assessed were only 46 because 2 (February 2002 and October 2002) of the expected 48 months could not be found in the records. So, only 46 SPA bulletins were used instead of 48 to get the monthly average figures.

General comments on Table 4.6 above

In the Table 4.6 above, the researcher worked out the average monthly performance of Home Health Educators as reported by Home Health Educators to Southern Africa Union Conference Head Office for the period of four (4) years. The actual number of months assessed amounted to 46, because the other 2 months' record could not be found from the regional office of Mafikeng (for North West Province) as well as that of the head office in Bloemfontein. For this reason the average was calculated on 46 months in the same period of 4 years (2000 to 2003).

The fact that the number of those Home Health Educators not reporting is higher than any of those in most specified columns in Table 4.6 is a clear indication that

needs assessment for training adjustment is not done according to the expected standards. If training needs assessment had been done, the consistent 49% of none reporting would not be tolerated for a period of four years. Analyzing table 4.6 above, only 25% of Home Health Educators were reporting correctly. Such irregularities would have been addressed by training that is need-based.

4.2.3 Adequacy of Training of Home Health Educators in Southern Africa Union Conference (SAUC)

This section presents Home Health Educators' views on the adequacy of training they receive for task performance in Southern Africa Union Conference.

Table 4.7 Adequate Training: Questionnaire Outcome

Item	Performance task	Home Health Educator views	
		Number of respondents in percentage (%)	Responses and time frequency (where applicable) attached to options
From Questionnaire section A			
5	Director visits to train Home Health Educators	44	No training visits
		37	Training visits once a month
		4	Training visits twice a month
		3	Training visits three times a month
		12	Training visits four times a month

6	Desirable organizational-based training course put up for Home Health Educators	22 30 30 14 4	No such training course A bit of training Occasional training Regular training Excellent regular training
7	Enough training models available to be used for developing training programmes – Assessing courses with relevant curriculum	71 7 7 1 14	Not true Quite true True Very true Could not tell
8	HHES needs a new training model for better work output	1 10 37 51 1	Not true Quite true True Very true Could not tell
9	HHES training models need adjustment/attention for the sake of success	1 4 35 56 4	Not true Quite true True Very true Could not tell
10	Wishing to attend school for training purpose, with Home Health Education Service certification	4 1 31 61 3	Not true Quite true True Very true Could not tell
From Questionnaire section B			
1	Possessing knowledge that training offers	97	Knew that training offers opportunities to learn

	opportunities to learn	3	Did not know what training can offer
2	Acknowledging a variety in the ways Home Health Education Service training is done	63 37	Agreed Disagreed
3	Satisfied with the training offered in Home Health Education Service	35 65	Satisfied Not satisfied
9	Knowing Home Health Education Service training curriculum	12 88	Knowing Not knowing
10	Knowing the formal status of Home Health Education Service training model	23 77	Yes No
12	Home Health Education Service trainers (directors) need extra training	97 3	Yes they do No they don't
18	Experiencing community appreciation of due service delivery by Home Health Education Service	62 38	Yes No
From Questionnaire section C			
1	Most favoured by training models used in HHES	29 35.5 35.5	Leaders Home Health Educators The whole Organization
4	The place of value and recognition of training	64 33	HHES only Both HHES and other departments too

		3	In other departments only
5	In possession of filing as a matter of Office-practice for easy client scanning for record's sake	35 26 39	True Not true Could not tell
From Questionnaire section D			
2	Kind of Training Needed	-	To indicate the inadequacy of the current training, the following issues have been raised as lacking in the current training: Training in general, needs assessment skills, marketing skills, general management skills, business management skills, linguistics and communication, training school, administration skills, financial management skills, sociology of HHES studies, basic theological studies, health education studies, psychology of HHES studies, philosophy of HHES

			studies, curriculum, ethics in HHES, change management skills, computer & technology skills, public relations, motivation studies, clerical skills, teaching skills, counseling skills, retirement annuity
5	Training task related information	-	Training should cover the list found in item 2 above

Adequacy of training

In section 2.2.2 of the literature review of this research document Van Dyk et al (2001:150) indicate a principle that satisfaction of trainees should be experienced by themselves. This indicates that even before a trainee gets into the field s\he should have some confidence due to training received in Home Health Education Service. For this reason the adequacy and relevance of training is paramount. In the Table 4.7 above matters relating to the adequacy of training are considered and the outcome is discussed below.

Questionnaire examination on the issue of training adequacy is found in all sections. Questionnaire section 'A', items 5, 6,7,8,9 and 10 give the following information on training issues.

Item 5 indicates the percentage distribution of how training, through director visits, is offered to Home Health Educators in SAUC. 44% of Home Health Educators are not experiencing training. They don't receive visits from the

director who is also a trainer. 37% indicate one director's visit per month for training purposes, 4% receive such visits twice a month, 3% receive such training visits for three times a month, and 12% experience four times of such a training visit in a month. The kind of training offered is a bit skewed and irregular in approach.

Like item 5 above, item 6 reveals some similar unbalanced percentage-distribution; with a 22% denial that organization-based training is done. 30% reported just a bit of such a training done, another 30% reported occasional training sessions, and only 4% reported regular training sessions provided.

Analysis of the above information revealed that Home Health Education Service organization-based kind of training is not well distributed.

Item 7 indicated that 71% of Home Health Educators did not seem to know any training model from which their training programmes were drawn. Adding 14% to 71% gives an idea about Home Health Educators who did not have a true status of the training models available. On this item, only 15% (made up of the 7% Quite true, 7% - True, and 1% - Very True of the availability of training models) seem to indicate the availability of training models from which HHES training programmes were drawn.

The information here indicates that there may be very informal kinds of training models that are available. This might be the reason why the 85% of Home Health Educators have no idea of their availability.

Item 8 assessed the need for training model for better work output. 1% indicated that there was no need for a new training model, and another 1% was not sure of the need for training purposes. Summary of item 8 indicates that 98% of the 71 respondents saw it necessary for HHES to have a training model

that would help improve the work output. The compound response of 10%, 37%, and 51% indicate that training provided is not adequate, and this is in harmony with items 9 and 10 that were included to test the similar view.

Item 9 indicated whether the training models being used need adjustment or attention. 1% saw no need for adjustment, and 4% were not sure of the need for adjustment. However, 95% saw that the training being offered is not adequate that's why they are calling for an adjustment in the training model from which training programmes are drawn.

In summary, item 9 gave a notion that training provision was not adequate.

Item 10 indicated the expression of establishing a school for HHES training. 4% indicated no need, and the other 3% indicated not being sure of whether establishment of school for training is a need. The remaining 93% indicated that establishing training school would be a good idea. This also revealed that the kind of training offered was not adequate, because if it was adequate, then Home Health Educators would not have considered the establishing of training school a good idea.

Section B of the questionnaire as a tool for data collection has the following items: 1, 2,3,9,10,12, and 18 throwing light on the adequacy of training offered in HHES.

Item 1 assessed the knowledge of whether Home Health Educators understand what actually training is. 97% clearly indicated that they know what training is, and that its benefit is to offer opportunities to learn. Only 3% indicated not knowing. The implication is that Home Health Educators understand what training is, and they also know that it is beneficial for the effectiveness and efficiency of the organization.

Item 2 was designed to test the variety in training programmes in HHES, 63% acknowledged a wide range of how training is done, while 37% denied such a variety.

Linking item 2 to item 3, there is a reflection that the kind of training offered is seen by 65% of Home Health Educators as not satisfactory, while 35% see it to the contrary. Linking items 2 and 3 to 9, it is quite clear that the training offered is not adequate, because 88% of Home Health Educators do not know their curriculum, even if 12% refuted that. Comparative analysis of items 2, 3, 9, and 10, shows that HHES training is not adequate because 77% of Home Health Educators saw the curriculum as informal.

Item 12 evaluated the training status of trainers as related to their having been trained to train. 97% of Home Health Educators clearly stated that trainers have not been trained to train. The 3% of Home Health Educators who affirmatively said that trainers have been trained may be indicating the state of affairs that is not equitable. Item 12 indicated that training is not adequate.

Item 18, reveals that community members are appreciating the work done by Home Health Education Service, regardless of the quality of the training. 62% of Home Health Educators have affirmed that.

In summary, the questionnaire section B indicates that HHES training that is offered is not adequate.

Questionnaire section C has items 1, 4, and 5, on the adequacy of training.

Item 1 indicated that regardless of the adequacy levels of training, training done in HHES favoured the organization as a whole. The distribution of favourable perception is quite normal, with a tally between Home Health Educators and Organization (which cover leaders and all other workers).

Item 4 indicated that the kind of training offered in HHES has more value inside the organization, according to the 64% of Home Health Educators. This means after the training of Home Health Educators by Home Health Education Service, the qualification is not recognized elsewhere, except Home Health Education Service. In short, HHES training has more use value than the exchange value supported by the 3% of Home Health Educators. The fact that 33% of Home Health Educators indicated that HHES training has both exchange and use values, may only be reconciled to the 64% if it is understood in the application of principles of training, but not certificate-wise.

Item 5 tests the clerical aspect of administration of work, by means of formal office practice. 35% say they do filing, but 26% say they don't, and 39% say they cannot tell. Those that say they don't and those who do not know what they are doing can be combined to form a team of 65% of those with no clerical skills. This clearly indicates Home Health Education Service training is not adequate. Therefore it needs attention, as related to knowledge, skills, and attitude (KSA) in office practice.

In summary, the questionnaire section B is revealing that training is not adequate.

Section D of the questionnaire has items 2 and 5. Both items have actually indicated the training needs that should be included in the training programme should there be amendment in training.

On the overall levels, HHES training has been assessed not adequate. It needs adjustment for effective and efficient work output.

Table 4.8 Adequacy of Training: Interview Reflections

Interview reflections indicate that there are things that ought to be added to the current training practices that can help Home Health Education Service training to be adequate with accreditation. These suggestions have been put in Table 4.8 below

Item	Performance task	Home Health Educators' views
5	Additional to current training practices that can help in the process of registration by the South African Qualifications Authority	To address the inadequacy of current training as related to accreditation, the following have been mentioned: • Register with relevant Sector Education and Training Authority (SETA) • Improve, in design and delivery, the Home Health Education Service Curriculum • Engage trained trainers • Set up organizational training venues • Affiliate with a registered and accredited institution for higher learning

General comments on table 4.8 above

As shown in Table 4.8 above there is an indication that Home Health Education Service training programmes need to make adjustment for the sake of

registration and compliancy to NQF. The following proposals have been made to make HHES training accredited:

- ❖ Set up organizational training venues.
- ❖ Register with the relevant Sector Education and Training Authority in RSA.
- ❖ Engage the trained trainers for training purposes
- ❖ Improve, in design and delivery, the current training curriculum
- ❖ Affiliate with the registered and accredited institution for higher learning

Based on the facts in table 4.8 above, Home Health Education Service training is inadequate, it needs attention.

The following table below presents the remuneration of Home Health Educators by means of what they purchase from their depots. It should be understood that Home Health Educators receive their income from the commission obtained from the learning support materials distributed. This helps the study to establish the economic status of Home Health Educators, which in turn reflects on how well trained they were.

**Table 4.9 Adequacy of Training of Home Health Educators
Reflected by Comparative Average Purchases in
SAUC (November 2002 to October 2003)**

All the figures are in South African Rand Value.

Place in SAUC	Average Number of Workers	Total Purchase	Ave. Purchase for each worker per month
Namibia South	8	R66131.00	R688.86
Namibia North	13	R10710.00	R68.00
Swaziland	13	R127195.00	R815.35
Southern Natal	20	R184286.00	R767.86
Northern Natal	12	R45158.00	R313.60
Queens Town	10	R15330.00	R127.75
Port Elizabeth	18	R231688.00	R1072.63
Cape (Monakali)	27	R127039.00	R392.10
Cape (Oliphant)	23	R313759.00	R1136.81
Free State	12	R144837.00	R1005.81
Lesotho	14	R6453.00	R38.41
Gauteng-CCJS	24	R45904.00	R159.38
North-West-AMM	6	R98168.00	R1363.44
Gauteng CCJS (2)	22	R672566.00	R2547.60
W.Rand Soweto	13	R59602.00	R382.06
Jouburg-Adam	5	R35321.00	R588.68
E.Rand (2&4)	12	R103627.00	R719.63
E.Rand (1&3)	4	R53618.00	R1117.04
Low Veld	4	R41713.00	R869.02
High Veld	8	R14258.00	R148.53
C. Gauteng-TK	12	R104175.00	R723.44
Pietersburg	3	R31849.00	R884.69
Venda	5	R26259.00	R437.65

According to Southern Publishing Association protocol, there is an understanding that before Home Health Educators distribute learning support materials to members of the public, there is need to pay a down payment for the learning support materials to be released from the depot. This down payment is almost equivalent to their commission after the distribution is done. This therefore indicates that the greater the purchase amount, the higher the remuneration package of a Home Health Educator. The purchase can also be used to measure how knowledgeable and skilled the worker is, as related to training received. The table 4.9 above is giving average purchase figures per defined area for a period of 12 months (November 2002 to October 2003).

Having examined the News Bulletins, from November 2002 to October 2003, there is an indication that the training Home Health Educators have received is not adequate. Table 4.9 reveals it all. As shown in Table 4.9 above, on average basis no home health educator can have a descent livelihood, according to the economic standards of the places they come from.

The lowest purchase power is reflected in Namibia North where each home health educator could afford only a monthly R68.00 worth of learning support material for distribution, which would give him or her almost the same value of profit. No matter how skilled a person is in budgeting, in Namibia, no one can pay for house rent, water bills, medical expenses, electricity bills, and so forth, if one earns R68.00 per month in the 21st century. This clearly shows that people need adequate training that is better than the current one given during the data collection of this research.

The highest average purchasing power is reflected by Gauteng (CCJS (2)) of R2547.60 per person per month. Considering the economic living standard of Gauteng, such an amount would only allow one to live under strict measures of livelihood, without a choice on where to stay, kind of food to eat, school to take

children to, and so forth. Having considered such a situation, there is definitely a need to change the current programme so as to promote productivity of each individual. This also reflects that the kind of training offered is not adequate.

In summary, the kind of performance revealed by historical documents is in harmony with the interview and questionnaire tools examined. Home Health Educators are definitely not satisfied with the adequacy levels of training offered by HHES. The views of Home Health Educators and their performance seem to agree, and this disqualifies the current training trend from being adequate.

4.2.4 Evaluation of Training of Home Health Educators in Southern Africa Union Conference (SAUC)

This section focuses on management evaluating the in-service training with the view to adjusting the training models for Home Health Education Service for greater output.

Table 4.10 Training Evaluation: Questionnaire Examination

Item	Training evaluation task	Home Health Educators	
		Number of respondents in percentages (%)	Responses and time frequency (where applicable) attached to options
From Questionnaire section A			
1	Director visits Home Health Educator with the aim of counselling on how to work	37	Not at all
		36	Once a month
		17	Twice a month
		3	Three times a month

		7	Four times a month
3	Director assesses attitudes of Home Health Educators towards HHES	39 26 11 17 7	Not at all At least once a month At least once in 1½ months Monthly Quarterly
4	Performance assessed or evaluated as related to Home Health Educator's tasks per month	32 43 11 7 7	Not at all At least once a month At least twice a month Three times a month Four times a month
From Questionnaire section B			
10	Training evaluated as formal	23 77	Yes No
14	Induction period evaluated as one that needs no attention	29 71	Yes No
16	Home Health Education Service has school buildings for training purposes	13 87	Yes No
19	Home Health Educator evaluated self as book distributor	60 40	Yes No
20	Evaluated self as more of a Home Health Educator than	78 22	Yes No

	Book Distributor		
From Questionnaire section C			
2	Whose needs do the training model in existence is based?	42 13 45	Home Health Educators Leaders The whole organization
3	Training techniques evaluated as having been changed in the last decade	20.5 20.5 59	Changed greatly No change Not having observed any change
4	The place of Home Health Education Service training value and recognition	64 33 3	HHES only Both HHES and other departments too Other departments only
From Questionnaire section D			
2	Kind of training needed	-	The following are needs to enhance the adequacy of current training: see Table 4.7 above. It is the same list in a descending order found on item 2 responses of Questionnaire section D
3	Needs evaluated necessary before setting up a training model	-	No one answered as expected.

General comments on Table 4.10 above

According to section 2.2.5.9 of the literature review of this research document, evaluation covers general assessment and monitoring of programme. Table 4.10

concentrated on issues around the evaluation of training of Home Health Educators in Southern Africa Union Conference.

Item 1 of questionnaire section A was included to find out contact visits of a director, who is also a trainer, to Home Health Educators. 37% of the 71 Home Health Educators say that they don't see the director even once in a month. This indicates that the director cannot monitor or evaluate that portion of Home Health Educators that form 37% of the population. From this group of 37%, director visits the remaining 63% in an uneven manner, as can be seen from the percentage-distribution and frequency of director visits. From this item 1, there is an assumption that directors are finding it hard to evaluate the performance of their subordinates.

Item 3 of the questionnaire section A was included to find out whether directors conduct assessment tests related to Home Health Educator's attitude towards the Home Health Education Service organization. 39% of the 71 Home Health Educators deny such an evaluation, 26% record once a month evaluation exercise, 11% report once evaluation that takes place in one and half month. 17% have no knowledge of frequency of such evaluation. 7% say that evaluation is done quarterly. The evaluation process seems to be uneven.

Item 4 of section A of the questionnaire was included to find out the director's assessing the performance of Home Health Educators supposed to be trained by him or her. Thirty-two percent (32%) said that no such evaluation was done, 43% indicated once a month such evaluation was done, 11% indicated that evaluation was done twice in a month, 7% indicated three times evaluation was done in a month, and the other 7% reported four times evaluation was done. This percentage distribution is also uneven, and the zero assessments of the director for evaluation or monitoring the process predisposes the organization to poor performance reflected in the News Bulletin (see Table 4.9).

Items 10,14,16,19 and 20 on training evaluation are on section B of the questionnaire. Item 10 reflects that 23% of Home Health Educators consider training as formal, but this is being nullified by the 77% of the same group that indicate that training in HHES is not formal. If evaluation had normally been done, then, Home Health Educators would have a notion of the formality of the training.

Item 14 reveals that the training induction period of Home Health Educators needs great attention, according to the 71% of the responses. The 71% did not affirmatively agree with the statement that induction period of Home Health Educators does not need attention, while the 29% affirmatively agreed.

Item 16 again deals with the evaluation that Home Health Education Service has school buildings. Findings are such that 87% say there aren't any school buildings for HHES. If evaluation had been done, the school buildings would have been made known to the Home Health Educators.

Item 19 considers the evaluation of self-perception of status of Home Health Educators. 60% see themselves as book distributors, yet there are other tasks they have to perform in the whole process of Home Health Education Service. If evaluation had been done, this perception would have been adjusted.

Linking item 19 to item 20, the term Home Health Educator seems to be more job descriptive than book distributor. 78% indicated that Home Health Educators see themselves more as Home Health Educators than book distributors

Section C of the questionnaire has items 2, 3, and 4 on training evaluation.

Item 2 reflects that training in Home Health Education is organizational need-

based, because the percentage distribution of 42% for Home Health Educators and 45% for organization as a whole. In fact this reflection shows the use-value of training in Home Health Education Service is quite skewed in approach.

Item 3 reflects that there has not been any change in training, according to the 79.5% of Home Health Educators.

Item 4 reflects that the training evaluation reveals that the Home Health Education Service training has more use-value than exchange value, according to the 64% of Home Health Educators. According to section 2.2.5.8 of literature review of this research document training in Home Health Education Service has more of internal application and value than that which can be transferred to other departments or organizations.

Section D has items 2 and 3, on training evaluation.

Item 2 has introduced a list of what training would cover if it had to meet the needs of Home Health Educators. See table 4.7, questionnaire section D.

Item 3 reveals that Home Health Educators are not even aware of what is necessary before setting up a programme, let alone the training model. Evaluation would have helped workers know about programming in Home Health Education Service.

In summary, if training evaluation had been done according to the expected standards, Home Health Educators would have observed the change in training trends.

Table 4.11 Training Evaluation: Interview Outcome

The interview schedule revealed the following views from Home Health Educators:

Item	Training evaluation task	Home Health Educator's view
3	Evaluated aspects of training required by the Home Health Education Service for good performance	Current training is not evaluated, if this was so, the following would have been included in the design and execution of curriculum: • Salesmanship • Communication • Product knowledge • Business Management Studies • Financial Management • Practical Field Training • Theological Studies • Marketing • Philosophy of HHES • Administration in HHES • Public Relations • Sociology of HHES • Computer Related Skills • History of HHES • HHES Ethics • Health Education • Development Studies • Human Temperaments

		• Counseling • Comparative Religion • Leadership Skills • Family Life Education • International Relations
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General comments on Table 4.11 above

The outcome of the interview shows that there is no evaluation done as related to the quality of training offered by Home Health Education Service.

Item 3 seems to reveal that Home Health Education Service does not evaluate the training they offer to Home Health Educators, otherwise those requirements needed would agree with the performance observed in table 4.9. The list of needs of training (stated in Table 4.10) would be so obvious that many of them were needed not to be mentioned as those needed to be included in the training programme for Home Health Educators. This kind of reflection happens only where evaluation has not taken place.

Table 4.12 Training Evaluation: Historical Records

Year	Number of months assessed	Monthly average number of Home Health Educators who reported per year				
		Totals	Hours only	Purchases only	Hours & purchases together	Nothing
2000	12	239 100%	17 (7%)	40 (17%)	71 (30%)	111 (46%)
2001	12	242 (100%)	21 (9%)	56 (23%)	57 (24%)	108 (44%)
2002	10	22 (100%)	20 (7%)	52 (18%)	61 (21%)	159 (54%)
2003	12	229 (100%)	16 (7%)	43 (19%)	62 (27%)	108 (47%)

General comments on Table 4.12 above

From the data distribution, it is clear that most Home Health Educators were not reporting per month, from the 2000 to 2003 calendar years. This is giving another highlight on the possession of knowledge, skills, and attitude of Home Health Educators in their work. This reflects a problem, on a part of trainers (who are also directors), since they could not see such a none-reporting trend for a period of four years. The evidence of this is seen in the largest number of Home Health Educators who were not reporting on monthly basis. If training had been evaluated, this anomaly would have been addressed.

4.2.5: Appropriate Training Model for Home Health

Educators in Southern Africa Union Conference (SAUC)

The main research question in this document revolves around suggesting a training model that will improve the quality of performance of Home Health Educators within the Seventh-day Adventist church in SAUC. Table 4.13 below shows the questionnaire outcome on the issue of justification that there is a need to design or develop a training model for Home Health Educators in SAUC for successful service delivery.

Table 4.13: Need for Training Model: Questionnaire Outcome

Item	Training need	Home Health Educators	
		Number of respondents in percentage (%)	Responses and time frequency (where applicable) attached to options
From Questionnaire section A			
7	HHES has enough training models such that the organization needs none	71	Not true
		7	Quite true
		7	True
		1	Very true
		14	Could not tell
8	HHES needs new training model	1	Not true
		10	Quite true
		37	True
		51	Very true
		1	Could not tell
9	HHES training models	2	Not true

	available need to be attended to	4 35 55 4	Quite true True Very true Could not tell
10	A wish to have a training school where Home Health Educators would graduate as certificate Holders	4 2 31 61 3	Not true Quite true True Very true Could not tell
From Questionnaire section B			
7	A wish to get diploma qualification in HHES	97 3	Yes No
8	Desire to have a training model to address higher HHES qualification need than that which is currently held	94 6	Yes No
11	Wishing to change the HHES Curriculum	94 6	Yes No
12	Training for Trainers (Directors) is necessary	97 3	Yes No
13	Pre- service Training is needed in HHES	83 17	Yes No
16	HHES has training its own school buildings	13 77	Yes No
17	Distance learning	33	Yes

	more beneficial than classroom based for training purposes	67	No
From Questionnaire section D			
4	Need for training model by this study is necessary	97 3	Yes No

General comments on Table 4.13 above

Section A of the questionnaire has items 7, 8, 9 and 10 reflecting the need for training model for successful service delivery.

Item 7, indicates that 71% saw the need for training model development, 15% did not see such a need, and 14% could not make either a head or tail of the need for training which is an indicator for the necessity of a training model, because it may be that the 14% who claimed ignorant of the need for developing a training model may well represent a group of those who do not know even their needs as far as training needs are concerned.

Item 7 clearly indicates that the development of a training model is justified, and it is a need.

Item 8 indicates that 98% of Home Health Educators saw the need to develop a training model. Only 2% here seemed not to know that training model is of vital importance. This item 8 confirms that it is necessary to design a training model for Home Health Educators.

Item 9 indicates that 94% of Home Health Educators saw the need for a design of a training model with a view of adjusting the current training trend in Home

Health Education Service. Though the 4% might not have been able to tell the need for designing a training model, it may be an indication that they don't know their training needs. This is very insignificant compared to those that make the 94%.

Item 10 indicates that 93% saw it necessary to put up a training school where Home Health Educators may graduate as certificate holders. The percentage that rejects the idea is quite insignificant due to percentage difference.

In summary, section A of the questionnaire clearly indicates that a design of a training model with a training school would be vital for sound service delivery in Home Health Education Service.

Section B of the questionnaire has items 7,8,11,12,13,16, and 17 which address the relevance of training model.

Item 7 indicates that 97% of Home Health Educators would like to see themselves getting even diplomas from Home Health Education Service. This indicates the need for training model design, and that the model should help offer diploma levels of in-service kind of training. The three percent that don't see the need are quite an insignificant number.

Item 8 indicates that the training model should address the needs of Home Health Education as an organization. This notion received 94% support, and compared to the opposing 6%.

Item 11 indicates that 94% of Home Health Educators would like to see the curriculum of the current HHES training programme change. 6% that does not support the idea here is quite insignificant.

Item 12 indicates that trainers need to undergo training in Home Health

Education Service. 97% of Home Health Educators hold a contradictory view that they see no need, but their representation of the group is very insignificant.

Item 13 indicates that there is need for pre-service training. 83% supported this idea but 17% of the same group (of Home Health Educators) was not in favor of the pre-service kind of training.

Item 16 reveals that 77% of Home Health Educators would love to have their training sessions in the school buildings of the Home Health Education Service organization. 13% were opposed to this idea, but the 77% who supported the idea are far greater, in number, than their counterparts.

Item 17, addresses the benefit between using distance education programme and compared to classroom based. 67% saw it necessary to have a classroom kind of training, while the 33% see it beneficial to train through distance education programme. The popular side is that of 67% that indicated that school buildings will be vital to classroom learning.

Questionnaire section D has itemed 4 commenting on the need for training model design and what it needs to address.

Item 4 clearly indicates that this research study on training model designs is necessary by 97% of Home Health Educators, with 3% percent opposing the idea.

In summary, section B of the questionnaire has illustrated that it is necessary to have a training model and that the training model should address the needs of Home Health Education Service, and that there is need to have the model address training programmes via both pre-service and in-service phases of training, and much of it should be classroom based, as compared to distance

education learning.

Table 4.14 Needs of Home Health Education Service as Related to Current In-Service Training: Interview Outcome

Needs to be addressed	Percentage score	Priority position
Formalizing the training	21.13	01
Regular training sessions	11.26	02
Product Knowledge	07.04	03
Business Management	07.04	04
Communication	07.04	05
Field Practical	05.64	06
Segmenting Training	04.22	08.5
Change Management	04.22	08.5
Health Education	04.22	08.5
Salesmanship	04.22	08.5
Train Trainer Training	02.82	12.5
Certification	02.82	12.5
Financial Management	02.82	12.5
Accreditation Process	02.82	12.5
Organizational Venues	01.41	16.89
Presentation Skills	01.41	16.89
Reporting Skills	01.41	16.89
HHES History	01.41	16.89
Information Technology Management	01.41	16.89
Family Life Education	01.41	16.89
Counseling Therapy	01.41	16.89
Self Reliance	01.41	16.89
Bloom's Taxonomy	01.41	16.89

General comments on Table 4.14 above

Item 4 was included in the interview schedule to assess the current status of the in-service training and justify the amendment if necessary. The outcome of item 4 resulted in the contents found in Table 4.14 above, and general analysis of the interview schedule indicates that the current training needs great attention, and that a new set of training programmes be introduced, which will address such things as seen in Table 4.14 above, in their order of importance. The list ranges from formalizing training in general to Bloom's taxonomy, and the priority position column indicates that the one rated number 1 is the highest preferred choice with the lowest at the bottom. So, training model should address such things, as indicated in table 4.14 above.

4.3 SUMMARY

Current practices performed in Home Health Education Service in Southern Africa Union Conference can better be summarized as follows: Training is done by directors though it is not NQF compliant, it is not formal, and it is not localized in the HHES organization building; While training is done by the directors themselves, it has been discovered that these trainers are not themselves trained; Director visits Home Health Educator for monitoring progress and advice on work related matters; Director assesses field workers on various aspects of work, though this has been found not done according to standardized methods; Examination of news bulletins have revealed that Home Health Education Service can have its practices summarized into four – prospecting, presentations, reporting, and training provision.

Assessment of training needs by Home Health Education Service is not done according to the expected standards that have universal application. This research has established that directors need assessor training, because there are

many irregularities that could have been avoided if assessment could be practiced in a correct way. According to this research, assessment of training needs in Home Health Education Service is lower than the expected standard. This was confirmed on examining the news bulletins (from 2000 to 2003) which gave an indication that an average of 49% of Home Health Educators was not giving progress report on monthly basis. Such a period is too long to allow non-reporting of 49% to continue existing in a system if there was any good evaluation done.

Adequate training was not given to both Home Health Educators and the management team. According to this research, this has been reflected in the performance of economic viability for sustainability and poor reporting activities by Home Health Educators, and the ability of management to have tolerated the poor performance for a period of four years covered by this research. Moreover, responses from questionnaire items 8 and 15, section B, indicate that training is not adequate by 94% and 97% respectively. This is clearly an evidence of inadequate training that needs attention.

Evaluation of training has also been found not up to standard. This research discovered some irregularities that have been practiced in Home Health Education Service such that the use of proper standardized evaluation methods would have led to some great change in the way things are done in Home Health Education Service. The quality of training has been reflected as not being NQF compliant, and KSA model is quite unknown to the organization. Responses from items 1, 3, and 4 indicated that the 37%, 39%, and 32% of those working with Home Health Education Service deny experiencing the evaluation of training needs, respectively. Moreover, items 10 & 14 of questionnaire tool for the collecting of data indicated that 77% and 71% of Home Health Educators do not experience the evaluation of training needs.

A suggested training model suitable for the Home Health Education Service organization progress has been herein designed and named as Evaluation Training Model (ETM). Megginson, Banfield, and Joy-Matthews (1999:161) define evaluation as a process that essentially determines to what extent organizational objectives have been achieved, which is characterized by assessment. According to this research the model should address both the pre-service and the in-service kind of training. The ETM is expected to consider the training programs that will eliminate some of the irregularities discovered in this research project.

In conclusion, the general assessment of the whole section of 4.2 has an observation that there is need for a training model that can best address the Home Health Education Service, and that training model is the kind which promotes evaluation of the whole organization before a training programme is set. The researcher decided to call this kind of training model as Evaluation Training Model (ETM) due to factors arranged in chapter five of this research document.

CHAPTER FIVE

EVALUATION TRAINING MODEL (ETM): ITS JUSTIFICATION AND DESIGN

5.1 INTRODUCTION

Chapter four contained data presentation and interpretation, this chapter evaluates and discusses the current training of Home Health Educators, and proposes the need for a relevant training model that is designed to meet the training needs of Home Health Educators. The training model found to be suitable in this research outcome has been called Evaluation Training Model (ETM).

The nature of the Evaluation Training Model (ETM), which makes it different from others, is that it emphasizes the evaluation of the system before the trainer embarks on designing a training programme for the sake of relevance to the organization. Bartram and Gibson (1999: 9) say that there is need to evaluate the value of training. In addition to the idea of evaluation, Bartram and Gibson (1999:37) say that needs assessment as related to training needs process is of great value if the trainer has to avoid being irrelevant. Talking about developing an understanding of the organization before one attempts to train anyone in it, Furjanic and Trotman (2000: 16) say, "to lead a learning effort, you need to have an understanding of the organization's beliefs and values and how they are evidenced in the way the organization operates. Where these beliefs and values are present in an organizational life, they affect everything in the organization including the norms that guide the behavior of managers, supervisors, and employees." The authors above are affirming the fact that evaluating the current trend in training issues in an organization is critical before a trainer designs a training programme for such an organization. However, the ETM will help solve

the problems directly linked to the five research questions as discussed in 5.2 below.

Due to the nature of data presented and interpreted in the chapter four of this research document, this chapter has been broken into four vital sections: Introduction, ETM justification, ETM design, and summary of the chapter.

5.2 JUSTIFICATION FOR A TRAINING MODEL

Complete assessment of chapter four of this research document has helped the researcher to put up some justification for ETM due to the following factors discovered in this research. After the evaluation of the activities done in Home Health Education Service in Southern Africa Union Conference, it was seen beneficial to put up a training model. Factors behind the design or development have been arranged according to the research questions as shown below:

- **The unsatisfactory way current practices are done.** This research has discovered that many of the practices are done in a very informal way, and that the kind of training done is not registered with South African Qualifications Authority. There are no well defined standards followed for such activities as directors visit Home Health Educators for monitoring and checking how training is conducted, as reported in chapter four. ETM will therefore help trainers in Home Health Education Service to put correct checks on the current practices as being guided by the model on training issues related to the practices. The model will also help in formalizing activities as required by the Republic of South Africa in which SAUC is headquartered.

- **The unsatisfactory assessment procedures conducted by the Home Health Education Service management.** Performance, in terms of such things as investment of energy into presentations shown by low monthly purchases, and poor reporting reflections, confirm that there was some thing wrong with the organizational procedures, as done by management, in relation to the assessment practice for progress. Evaluation Training Model will help amend the training assessment procedures to a satisfactory level by introducing systems that will assess performance in training and in visits done by directors in Home Health Education Service.
- **Inadequate training.** Poor performance in work output indicates that training has not been given its due attention. This research has confirmed that Home Health Educators are not satisfied with the quality of training they are currently receiving. They have stated in Table 4.13 above that training is not adequate. Since ETM encourages evaluation at every stage of training programme, the training outputs will be quickly checked and corrected, as long as the model remains a guide for training Home Health Educators. This will help elevate the level of adequacy of training of Home Health Educators in SAUC.
- **Poor evaluation procedures followed.** This research has established the fact that there is deficiency in the way Home Health Education Service management is carrying out the processes of evaluation in the organization. There seems to be no culturally acceptable assessment procedures in operation in the organization. ETM will help straighten up the evaluation procedures in training matters seeing that those that will make use the model have to get in the process of evaluation many times and get used to the

process. This exercise will help improve the current low levels of evaluation in Home Health Education Service in SAUC.

- **Lack of well standardized training model.** This research has also established that there is no well-known or rather standardized training model in operation in the Home Health Education Service. So, the model this research is putting across may be the most awaited one to help lift the standard of training in the organization. For this reason, the use of ETM will enhance the adoption of other South African standardized models for training which will play a vital role in the transformation of training in Home Health Education Service.

From the five research question related issues above, it can be seen that designing a training model from which programmes can be drawn is quite indispensable to this research.

5.3 TRAINING MODEL DESIGNING

There are training models found in chapter two of this research document. Steps have been taken to design one which would address specific challenges of Home Health Education Service in Southern Africa Union Conference. This is in agreement with the view put forth by McQuail and Windahl (1990:2), when they say that models could be modified to suit the purpose. The following models have been considered in the designing of a training model for Home Health Education Service in Southern Africa Union Conference of the Seventh-day Adventist World Church: Nadler's Critical Events Training model of Camp, Blachard and Huszco (Erasmus and van Dyk 1999:44); Sparhawk's High Impact Training Model (Erasmus and van Dyk 1999:45) & Todd Lapidus' seven step High Impact Training model (Lapidus 2000:30).

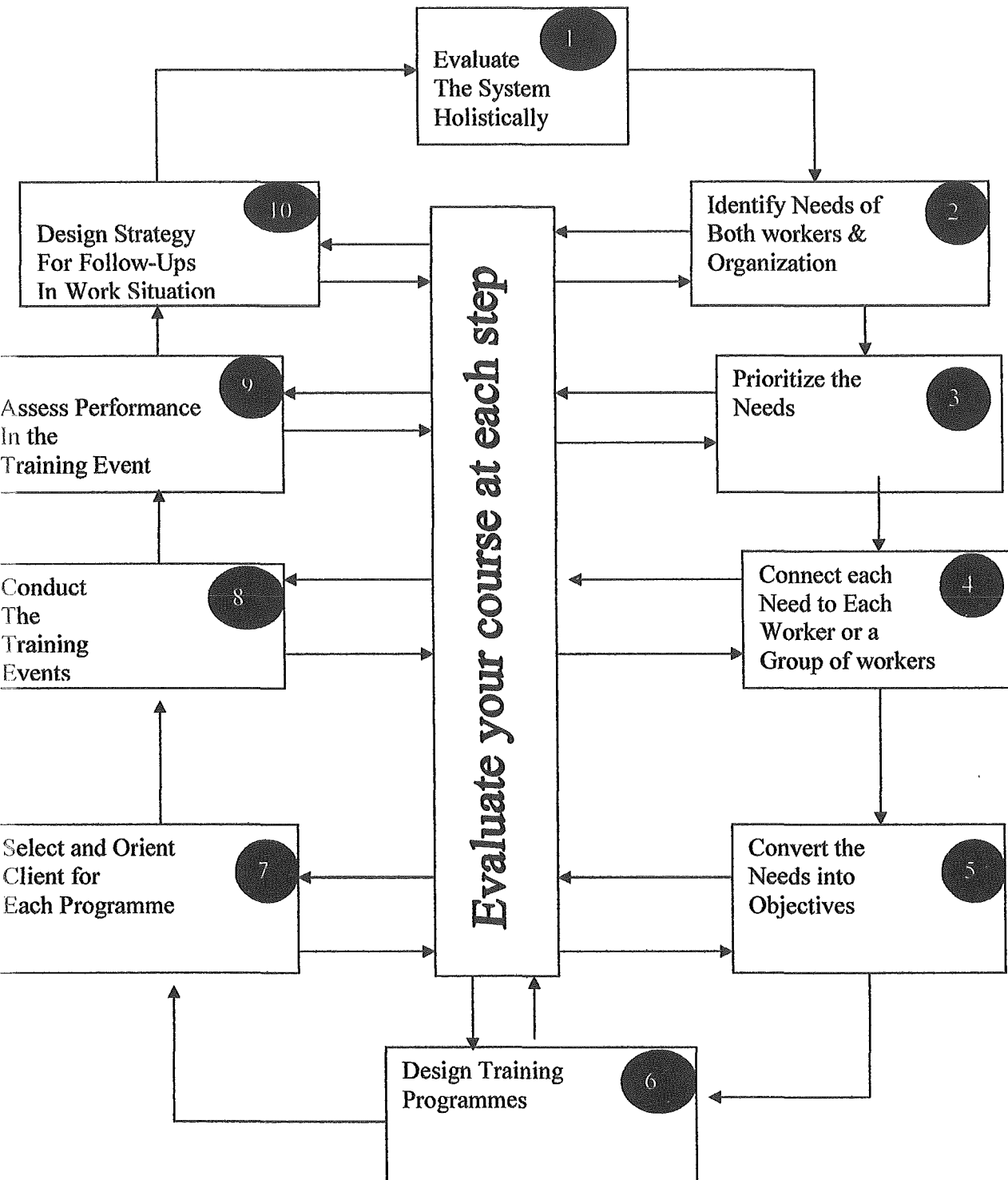
In his book "Designing Training Programs", Nadler (1990:7) indicates that models could either be classified as open or closed. He said that the open one has more room for adjustment in terms of design, than the closed one. In this research, the model that has been designed leaves room for adjustment too. Thus it is an open training model.

After a careful search, the study established the fact that the model that can best address challenges of Home Health Education Service is one that evaluates the organization first, and continues to evaluate each stage of it until the model cycle is complete. The model starts with evaluation as the first step because evaluation will give the trainer a full picture of the main objectives and the mode of operation of the organization, great understanding of the organization before considering the organizational training needs and its workforce. This assessment will help the trainer understand the ins and outs of the organization, conduct situational analysis before s/he engages in needs analysis. The name given to such a model is Evaluation Training Model (ETM), because of the dominance played by evaluation element in the whole model cycle, and this makes the difference between ETM and many training models.

The following aspects have been considered as phases (or steps) of the Evaluation Training Model (ETM): The first step to be undertaken by the trainer is that of evaluating the organization holistically, then the following steps follow in sequence as follows:- needs analysis of both workers and the organization, needs prioritization, linking of needs to specified workers or groups thereof, converting the needs into objectives to be pursued in training, designing training programme for specified groups of organizational workers, the selection and orientation of specified workers to be benefited by an identified suitable training programme, conducting the actual training event, assessing the training event measurable performance, and designing a follow-up programme to observe the impact of the training event in a real work place and situation. The follow-up

strategy step helps the researcher to get to step number one where he will have to evaluate the system again but with special reference to the impact of the conducted training on performance of the trained workers as compared to either the untrained or general work output. These steps have been summarized as shown in Figure 5.1 below:

Fig. 5.1 Evaluation Training Model (ETM)



The ETM satisfies the requirement of model designing as stipulated by Nadler (1990:4-14), Van Dyk et al (2001:163), and other model designers quoted in chapter two (2) of this research document.

The main difference between ETM and others is that most training models (e.g. CEM and IMPACT Training of sparrowhawk) start with needs analysis and end up with evaluation stage. ETM differs from Todd Lapidus' seven-step High Impact Training model in that Todd considers identification and partnering with the customer of training to be first step, while ETM considers holistic evaluation of the system as a first step. ETM calls for evaluation at every stage of the model, but this is not the case with Todd Lapidus' seven-step High Impact Training Model.

ETM differs from the training model developed by Camp, Blanchard, and Huszico in the sense that theirs, as reflected by Erasmus and Van Dyk (1999:45), starts with the gathering or diagnosing of data, and considers establishing objectives as a major step, which ETM considers as the second major step.

The ETM seems to satisfy the functions and benefits of models as stated by Nadler (1990:4-14). The ETM does not start with needs analysis because it seeks to analyze the organization holistically before organizational needs come into picture. The following requirements depict what a model should be like:

- A model should order and relate systems to each other so as to organize things.
- A model should help in explaining key points for guidance to other researchers or students.
- A model should help in predicting outcomes of training events.
- A model should explain phenomena.

5.4 EVALUATION TRAINING MODEL (ETM) STEPS (10)

5.4.1 Evaluate the System Holistically

Before one looks into the needs of the system or organization, one needs to understand what and how the system works. The process that can be employed to decode such information is evaluation of the system or total situation analysis. This seems to receive support from Erasmus and Van Dyk (1999:45). This step is identical to what Van Dyk (2001:175) refers to as a situational analysis which calls for the understanding of the situation before one embarks on designing of a training programme.

In the researcher's view this step should address the following issues: -

- ❖ What is the main objective of the organization?
- ❖ Who are the workers of the organization?
- ❖ What are the standards of the organization?
- ❖ Who is benefited by the organization?
- ❖ How are the members of the organization inter-related?
- ❖ What is happening in the organization in general?

Caffarella (2002:21) identifies this step as "Discerning the context," in her Interactive model of programme planning.

Before any training in Home Health Education Service is conducted, it is a good idea for the trainer to conduct a situational analysis, this will help the trainer to understand what is the main of the existence of HHES, what kind of workers are available for service provision, the organizational standards, levels of HHES beneficiaries, relations among organizational workers, and other related general issues that may need the attention of the trainer. When this is followed, the trainer will find it easier to design and conduct a relevant

training for the Home Health Education Service organization.

5.4.2 Identify Needs of both Workers & Organization

This section looks into organizational needs analysis. Two principal questions may be considered here: -

- i. What does the organization need in order to survive and save the purpose of its design?
- ii. What do workers for the organization need for them to survive and deliver service as required by the organization?

ETM step 2 is identical with what Erasmus and VanDyk (1999:41) have regarded as "identifying the needs of the enterprise".

This step will consider the needs of Home Health Education Service for organizational survival and service delivery, and the needs of Home Health Educators for their survival and successful service delivery.

The needs identified also need to be evaluated in relation to how they relate to the organizational survival and development before proceeding to step 3.

5.4.3 Prioritize the Needs

This step looks into the re-organization of needs of both organization and its workers, and sets them up in order of importance e.g. before looking into the training of all the Home Health Educators in the field, the organization may consider training the trainers first; for the trainers will train the field workers (Home Health Educators). Such prioritizing of needs is of great importance. This step considers the re-arrangement of where among the three (knowledge, skills, and attitude) do the Home Health need training emphasis.

The evaluation process has to take place before proceeding to step 4.

5.4.4 Connect each Need to each Worker or a Group of Workers

One may look into the issue of training the trainer as having its own syllabus as compared to that of the field of Home Health Educator in the same organization. So, each need should be carefully evaluated before linking it to either an individual worker or a group of workers.

5.4.5 Convert the Needs into Objectives

This step looks into considering each need as an objective that has to be achieved. An example, for Home Health Educators to be adequately trained there is need to convert training from a need to an objective, as long as training becomes a goal for higher performance. This applies to all needs such as availability of knowledge, skills, and attitude in the organization.

After the evaluation of each objective that should be achieved, step 6 can be considered.

5.4.6 Design Training Programmes

At this stage, programmes are set according to the general standards as stated in the research document by Anakoka (2001: 46).

- Needs analysis
- Objective setting
- Activity Designing (Curriculum & tools of learning well considered)
- Activity Implementation (well considered) According to de Beer et al

(1998:181)

- Evaluation of Programme achievement, as related to standards of evaluating training mentioned by Bartram and Gibson (1999)

The need for setting training the programmes to standardized levels is important because it will help the Home Health Education Service to adhere to general principles governing training in the Republic of South Africa. This approach will help the HHES organization to suit the international standards that will in turn help the Home Health Educators receive training that has wide application on the international market.

At the end of programme design, evaluation must be made in relation to the selection and orientation of suitable participants.

5.4.7 Select and Orient Clients for each Programme

Talking about orienting training consumers, Moreau (1980:176) emphasizes that each employee must be trained. This is supported by section 2.11 of the literature review of this research document that gives an idea that not every training programme is suitable for all workers in an organization; for others have to be retrained, while others are being oriented into work. It may be necessary for Home Health Education Service administrators to consider training new workers at the same time without worrying about the training content relevance when trainees are made of combinations of new and old workers.

Another example can be herein made considering a training programme on how Home Health Educators can make effective presentations in other established organizations, such as schools. A training programme of this nature will be required more by field workers than those in office-based situations, in the same organization of Home Health Education Service. In such a case there is need to

select and orient the participants for a particular programme. So, such a programme can only attract correct customers for a particular programme. This is an agreement with the view of Lapidus (2000:30). To advance this idea, Caple (2000:163) emphasizes selection, designing and delivery of training to be in harmony with the objectives for learners. The ETM will help on how to conduct the selection by reminding the trainer of a danger of not selecting participants for a particular training programme.

- Careful evaluation should be made to make sure that nobody goes into a wrong programme before getting to step 8 of conducting the training event itself.

5.4.8 Conduct the Training Event

This can be either centralized or decentralized according to Miller (1978:175), advanced by Webber (1981:197), supported by Mersham *et al* (1995:39). At this stage the trainer is expected to have considered the evaluation audit by Bartram and Gibson (1999) where the following have been deduced.

- ❖ Suitable curriculum
- ❖ Suitable Candidate
- ❖ Suitable learning tools
- ❖ Suitable Environment
- ❖ Suitable evaluation sheets and assistants for such a purpose.

This step of the Evaluation Training Model will help a trainer to design a suitable curriculum for a particular group of Home Health Educators, suitable learning tools such as a computer for power point presentation, in a suitable venue (HHES school, for example), and forward relevant Home Health Education Service evaluation sheets and assistants.

During the conducting of training event consider step 9, assessing the performance participants in the training event.

5.4.9 Assess Performance in the Training Event

Step 6 of Todd Lapidus' seven-step High-Impact Training model, step 5 of Sparhawk's High-Impact training model, step 8 of Training model of Camp, Blauhard, and Huszco, and nothing of this sort from Nadler's Critical Events Training, confirm the value of this stage. The major questions here are: Has training been successful? How do we measure its success? Which standards are we using to qualify participants for achievement? This step is identical to the evaluation process advocated by Kirkpatrick (1998). According to Kirkpatrick (1998: 19), the evaluation that comes at the end of training event should be done so as to assess the reaction of participants, whether learning has taken place in relation to the training objectives, the change of behavior due to training, and performance results of participants. This step 9 is very crucial to the whole process of Evaluation Training Model.

Since much of the training done in Home Health Education Service is informal in nature, this step of ETM will help introduce certification that comes due to assessment during training. The Home Health Education Service may benefit by formalizing the training performance assessment which will improve the sense of belonging to the organization, and Home Health Educators will consider their training a valuable exercise. When this is done, Home Health Educators may have higher work output due to job pride motivation.

After the evaluation, get into step 10 of designing strategy for follow-ups for monitoring the work situation.

5.4.10 Design Strategy for Follow-Ups in Work Situations

Step 6 of Sparhawk's High-Impact Training model and step 7 of Todd Lapidus' seven High Impact Training model confirm this step as vital. But beyond this is an issue of follow-up to verify the conversion of theory into practice. Evaluation has to continue until training events get the positive relation to the whole organization, and then the cycle is complete by getting to number 1 step for another need or a series of needs. This idea is also aired by Kiderman (1978:12) when he says, "Training skills can be mastered more effectively if simultaneously related to a real world".

Home Health Educators will benefit from this step if administrators engage trainers to design some strategies on how to know the impact of the training conducted.

In this way, evaluation is part of each step until the model makes a cycle, covering work situations.

Evaluation Training Model (ETM) will be beneficial to pre-service programme designers, and the in-service training programme coordinators.

5.5 SUMMARY

The Evaluation Training Model (ETM) will help in the evaluation and adjustment of the current practices in Home Health Education Service, assessment of training needs of Home Health Educators in Southern Africa Union Conference, introduction of adequate training programmes, evaluation of training programmes, and a kind of training suitable for each class of workers or the prospective ones. ETM is able to help in this process, systemically and systematically.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter concludes the study by providing summary, recommendations, and suggestions for further study.

6.2 STUDY SUMMARY

6.2.1 Practices in Home Health Education Service in Southern Africa Union Conference

A lot of weaknesses, in relation to how training is done in Home Health Education Service, have been uncovered by the research study, as already observed in chapter four of this research document. However, the study has confirmed that there are practices done in Home Health Education Service.

The study has identified the following practices as prominently performed as tasks in Home Health Education Service in Southern Africa Union Conference: Leadership assesses the needs of subordinates, provides training to the subordinates, evaluates performance instead of the training of subordinates, and monitoring the activities of Home Health Educators. While leadership is engaged in the above stated activities, Home Health Education Service subordinates are engaged in the following activities: prospecting, presentations, and progress reporting. On assessing the set of activities, this research has established that the activities are being performed, to a larger extent, on a very informal basis.

6.2.2 Assessment of Training Needs of Home Health Educators in the Southern Africa Union Conference

Assessment of training needs of Home Health Educators is done but not in line with the South African Qualifications Authority requirements. This research has actually found that there are no standardized and consistent procedures followed in the assessment process.

6.2.3 Provision of Adequate Training in Southern Africa Union Conference

From the research findings, the study indicates that the kind of training offered in Home Health Education Service is not adequate, and has no link to the South African Qualifications Authority (SAQA). Moreover, the study has established the fact that training offered has a great bias towards informal settings.

6.2.4 Home Health Education Service Training Evaluation in Southern Africa Union Conference

Careful scrutiny of research findings has indicated that training evaluation has no formal procedures, Home Health Education Service has not registered its training with any governmental or SAQA structure in charge of training, and that training offered is not formal, and not accredited.

6.2.5 Need for Training Model in Home Health Education Service in Southern Africa Union Conference

As observed from items 6.1.1 to 6.1.4 above, there is a great need to design a training model from which Home Health Education Service would draw their training programmes, and solicit formalizing the kind of training offered. Due to

this realization, Evaluation Training Model (ETM) has been designed to meet the perceived need.

6.3 RECOMMENDATIONS

6.3.1 Evaluation Training Model (ETM) Application

In order to improve and transform the current training trends in Home Health Education Service training practices, Home Health Education Service needs to employ sound and formal assessment procedures, formal and registered training provision, well established training evaluation procedures, and acceptable adjustment in training models in use. Due to adjustment and transformation of training models in use, it is suggested strongly that Home Health Education Service makes use of the Evaluation Training Model designed in this research project.

6.3.2 Establishing HHES Training Institution

From the findings of this research, it is clear that Home Health Education Service needs to reconsider the issue of establishing the organization's own learning institution in Southern Africa Union Conference for training purposes. This can help a lot in the establishment of pre-service programmes and formalizing of in-service training programmes, and their adherence to national standards for higher education.

6.3.3 Directors to Attend Train-a-Trainer Programmes

Directors should be trained if they are to be trainers. Otherwise, it may be a good idea for Home Health Education Service organization to look for a well-trained trainer who can run the training programmes.

6.4 SUGGESTIONS FOR FURTHER STUDY

The designing of Evaluation Training Model (ETM) is not an end in itself, but an eye opener to many researchers. Researchers in training issues are encouraged to study ETM for verification and critiquing since it is the first training model in Home Health Education Service designed at this study level. Those who are willing to research and help develop issues in training in Home Health Education Service should consider revisiting programming, pre-service training (as a specialized entity), and in-service training as researchable issues. This will help stabilize training in Home Health Education Service organization.

The following topics have been suggested for future research:

- The impact of using Evaluation Training Model to develop training programmes for Home Health Educators in SAUC.
- The comparative study of the impact of Evaluation Training Model as related to other training models available in this research document, with special reference to the development of the in-service training programmes.
- The validity of Evaluation Training Model in designing a pre-service training programme in Home Health Education Service in SAUC.

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ANNEXURE 1

QUESTIONNAIRE (FOR HOME HEALTH EDUCATORS)

Please give your response as requested below. On each item, there is a piece of advice on how to respond to it. There are four sections in this paper, so read each question/item very carefully and attend to each. Where the item demands your explanation, please be brief and simple. It is not mandatory to have your name written.

This questionnaire is purely for academic purposes, though it may help the Home Health Education Service Department in the development of training models for both pre-service and in-service training programmes. So, do the best you can to answer it and send it directly to:

**ANAKOKA M.M,
827 DR ALBERT LUTHULI DRIVE,
UNIT 3,
MMABATHO.
2735.
RSA.**

QUESTIONNAIRE INSTRUCTIONS

You may want to hand in your questionnaire responses to the administrator, this is highly welcome too.

In sections 'A', 'B', and 'C' of this questionnaire, there are letters (a, b, c, d, and e) for your choice. Each of the letters represents a numerical figure (1,2,3,4, and 5) respectively. If your choice is "a", for example, you cross (X) numerical figure "1", and then you go to the next item. Section "A" has five choices, select only one preferred choice and cross (X) in the appropriate box. Section "B" has two choices; tick only one of the two. Section "C" has three choices; tick only one choice in the box. Below is the key:

SECTION A: (a) = 1, (b) = 2, (c) = 3, (d) = 4, and (e) = 5

SECTION B: () Yes = Y, () No = N

SECTION C: (a) = 1, (b) = 2, and (c) = 3

Your service will highly be appreciated. If possible, send it as soon as you finish attending to the items in this paper.

SECTION A : Cross (X) in the appropriate box of each item of your choice, which is most applicable to you.

(1) My director visits me for counselling on how to work (in a month).

- (a) Not at all (b) Once (c) Twice (d) Thrice
(e) Four times

1	2	3	4	5
---	---	---	---	---

(2) My director assesses my needs in the H.H.E.S on monthly basis.

- (a) Not at all (b) At least once (c) At least twice (d) Thrice
(e) Four times

1	2	3	4	5
---	---	---	---	---

(3) My director assess my attitudes towards the H.H.E.S

- (a) Not at all (b) At least once a month (c) At least twice/a quarter
(d) Monthly (e) Quarterly

1	2	3	4	5
---	---	---	---	---

(4) My director assess my performance as related to my tasks on monthly basis:

- (a) Not at all (b) At least once (c) At least twice (d) Thrice
(e) Four times

1	2	3	4	5
---	---	---	---	---

(5) My director takes his time for training me at least - a month

(a) Nil (b) Once (c) Twice (d) Thrice (e) Four times

1	2	3	4	5
---	---	---	---	---

(6) In my own opinion, my organization (H.H.E.S) has seen it necessary to put up a training course for me.

(a) Not at all (b) Just a bit (c) Occasionally (d) Regularly
(e) Excellently regular

1	2	3	4	5
---	---	---	---	---

(7) We have enough training models in H.H.E.S such that we don't need any more

(a) Not true (b) Quite true (c) True (d) Very true
(e) Cannot tell

1	2	3	4	5
---	---	---	---	---

(8) We certainly need some new training model to help us work better

(a) Not true (b) Quite true (c) True (d) Very true
(e) Cannot tell

1	2	3	4	5
---	---	---	---	---

(9) The H.H.E.S training models need great attention for success' sake

(a) Not true (b) Quite true (c) True (d) Very true
(e) Can not tell

1	2	3	4	5
---	---	---	---	---

- (10) I wish we had a training school where we could graduate as Home Health Education Service certificate holders.

(a) Not true (b) Quite true (c) True (d) Very true
(e) Cannot tell

1	2	3	4	5
---	---	---	---	---

SECTION B: Cross (X) either () Yes or () No, in the column. Choose only one.

- (1) Training is the process of providing individuals with an organized series of experiences and materials that compromise opportunities to learn.

() Yes () No

- (2) There are many ways in which training in H.H.E.S is done

() Yes () No

- (3) Are you satisfied with the way you are trained in H.H.E.S?

() Yes () No

- (4) Do you have a certificate in H.H.E.S Qualification?

() Yes () No

- (5) Do you have at least one (1) Diploma in H.H.E.S Qualification?

() Yes () No

- (6) Do you have at least a first degree (University) in H.H.E.S?

Qualification () Yes () No

- (7) Would you like to get at least a diploma qualification in H.H.E.S?

() Yes () No

- (8) Given a chance to dictate the way of things in H.H.E.S, would you like to develop a training model that would offer you a higher qualification than what you currently hold in H.H.E.S?

() Yes () No

- (9) Do you know your H.H.E.S training model curriculum?

() Yes () No

	Y	N
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

- (10) Is H.H.E.S curriculum in item No. 9 (above) formal?
() Yes () No
- (11) Given the chance to decide the change in curriculum (H.H.E.S),
would you go for the change? () Yes () No
- (12) Do you think that the H.H.E.S Directors need extra training to
train H.H.E.S workers? () Yes () No
- (13) Do you think, H.H.E.S workers need training before recruitment?
() Yes () No
- (14) The time for induction for H.H.E.S does not need attention
() Yes () No
- (15) The knowledge H.H.E.S workers have, in relation to work,
needs up grading; () Yes () No
- (16) H .H.E.S has school building for training purposes
() Yes () No
- (17) Do you prefer distance learning to classroom learning
for training purposes?
() Yes () No
- (18) Do people send you messages concerning the goodness of
your service to them?
() Yes () No
- (19) Do you see yourself as a book distributor?
() Yes () No
- (20) Do you see yourself more as a Home Health Educator
than book distributor?
() Yes () No

10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

SECTION C Cross (X) either 1, 2, or 3. Choose only one.

(1) On examining the existing training models, whom do you think they favor most?

- (a) Leaders (Directors).
- (b) Literature Evangelists (Home Health Educators).
- (c) The whole organization.

1	2	3
---	---	---

2. The training models for H.H.E.S in existence are based on:

- (a) Needs of Home Health Educators.
- (b) Needs of the Leaders.
- (c) Needs of the organization.

1	2	3
---	---	---

3. Training techniques for H.H.E.S have

- (a) Changed greatly in the last decade (10 years).
- (b) Not changed in the last decade.
- (c) Not been observed for change.

1	2	3
---	---	---

4. On examining the way you have been training, where do you think your training has value and recognition?

- (a) H.H.E.S dept only.
- (b) Other society's departments also.
- (c) Other society's departments only.

1	2	3
---	---	---

5. Your personal H.H.E.S office makes your filing easier such that your clients are quickly found should you want to trace their record.

- (a) True.
- (b) Not True.
- (c) I cannot tell.

1	2	3
---	---	---

SECTION D

Give short statement related to the training of members of staff in Home Health Education Service.

- (1) Do you think H.H.E.S members of staff need training?

- (2) What type of training do you think is necessary?

- (3) In relation to the skills improvement of H.H.E.S field workers, what does the organization need to realize before setting up a training model?

- (4) Do you think this study is necessary for the development of training model for H.H.E.S workers? _____

- (5) Any information you would like the study to cover

THANK YOU FOR YOUR EFFORTS. God bless you.

ANNEXURE 2

INTERVIEW GUIDE FOR HOME HEALTH EDUCATORS IN SAU

1. Is there pre-service training model being used in Home Health Education Service in the SAU?
2. Do you have any structured training model for in-service training, which is NQF compliant?
3. Given a chance to design a pre-service training model for Home Health Education Service workers, what issues would you like this to cover and address?
4. Given a chance to modify the current in-service training model for Home Health Educators in the SAU region, what would you introduce in the system to warrant such a modification?
5. What do you think is required to have the current in-service training programme NQF compliant?
6. Since this research project is aiming at designing a pre-service training model, and modify the current in-service training model for Home Health Educators in the SAU region, do you have any other information that can help enrich the said model?

ANNEXURE 3

QUESTIONNAIRE SECTION A (ON TRAINING ISSUES) RESPONSES

Item	Activity	Worker's view of an Activity - Responses in Percentages (%) and Raw Figures in brackets ()					
		(a)	(b)	©	(d)	(e)	TOTAL
1	Visitation (Leader visits subordinate on duty)	37.14 (26)	35.71 (25)	17.14 (12)	2.86 (2)	7.14 (5)	100 (70)
2	Assessment of Needs done	39.44 (28)	35.21 (25)	15.49 (11)	4.23 (3)	5.63 (4)	100 (71)
3	Assessment of attitude done	38.57 (27)	25.71 (18)	11.43 (8)	17.14 (12)	7.14 (5)	100 (70)
4	Performance Assessment done	31.43 (22)	42.86 (30)	11.43 (8)	7.14 (5)	7.14 (5)	100 (70)
5	Leader Training Subordinate done	44.29 (31)	37.14 (26)	4.29 (3)	2.86 (2)	11.43 (8)	100 (70)
6	Organization putting training course for subordinate Acknowledging being done	21.43 (15)	30 (21)	30 (21)	14.29 (10)	4.29 (3)	100 (70)
7	Subordinate viewing Training models- HHES such that they don't need any	70.42 (50)	7.04 (5)	7.04 (5)	1.41 (1)	14.08 (10)	100 (71)
8	See no need of any other training	1.41 (1)	9.86 (7)	36.62 (26)	50.70 (36)	1.41 (1)	100 (71)
9	H.H.E.S Viewed by workers that it needs attention in training models	1.41 (1)	4.23 (3)	35.21 (25)	54.93 (39)	4.23 (3)	100 (71)
10	Workers feel they need training school, because they don't see any in RSA	4.23 (3)	1.41 (1)	30.99 (22)	60.56 (43)	2.82 (2)	100 (71)

ANNEXURE 4

RAW DATA FROM THE 48 BULLETINS (FROM 2000 TO 2003)

MONTH/YEAR	Number of Home Health Educators who reported				
	Totals (Expected)	Hours only	Purchases only	Hours and purchases together	Nothing
JANUARY 2000	231	24	32	34	139
FEBRUARY 2000	230	29	27	68	100
MARCH 2000	233	28	37	77	82
APRIL 2000	234	18	49	80	85
MAY 2000	225	15	47	77	93
JUNE 2000	241	11	45	92	90
JULY 2000	241	9	34	83	114
AUGUST 2000	241	14	35	88	102
SEPTEMBER 2000	246	20	26	79	118
OCTOBER 2000	248	19	47	90	100
NOVEMBER 2000	249	8	60	50	130
DECEMBER 2000	249	6	39	29	174
JANUARY 2001	256	25	35	46	148
FEBRUARY 2001	257	22	24	64	145
MARCH 2001	280	31	61	24	157
APRIL 2001	255	12	70	21	167
MAY 2001	256	13	57	80	128
JUNE 2001	223	19	53	72	105
JULY 2001	223	29	52	66	109
AUGUST 2001	228	27	49	65	104
SEPTEMBER 2001	218	17	70	84	77
OCTOBER 2001	218	20	50	80	103
NOVEMBER 2001	218	7	77	51	129
DECEMBER 2001	272	26	68	25	151
JANUARY 2002	266	9	39	39	174
FEBRUARY 2002	No Record Available143				
MARCH 2002	289	27	56	66	143
APRIL 2002	289	28	66	72	140

MAY 2002	313	15	71	72	156
JUNE 2002	313	23	42	75	179
JULY 2002	313	22	52	59	180
AUGUST 2002	313	25	43	72	176
SEPTEMBER 2002	313	27	42	75	180
OCTOBER 2002	No Record Available				
NOVEMBER 2002	267	15	64	47	156
DECEMBER 2002	247	13	44	35	171
JANUARY 2003	313	48	34	51	141
FEBRUARY 2003	214	15	36	65	126
MARCH 2003	230	21	35	71	114
APRIL 2003	230	16	29	71	131
MAY 2003	230	21	38	59	129
JUNE 2003	230	6	31	55	155
JULY 2003	230	18	52	58	93
AUGUST 2003	210	13	44	70	96
SEPTEMBER 2003	210	6	40	73	107
OCTOBER 2003	210	5	50	67	106
NOVEMBER 2003	218	8	74	52	125
DECEMBER 2003	218	8	53	53	129

ANNEXURE 5

FROM QUESTIONNAIRE SECTION B

ITEM	Workers' Activities	Workers' Response in Percentages (%)		
		Yes	No	Total
1	Understand the definition of training	97.14	02.86	100
2	Viewing Training multivariate presence of training in H.H.E.S	63.38	36.62	100
3	Satisfied with H.H.E.S offered Training	35.21	64.79	100
4	Acknowledging the presence of certificate in H.H.E.S	43.66	56.34	100
5	Obtained at least Diploma in H.H.E.S Qualification	11.77	88.73	100
6	Obtained at least university Degree in H.H.E.S Qualification	00.00	100.00	100
7	Desire to get at least Diploma in H.H.E.S	95.71	04.29	100
8	Desire for the Development of New Training Model in H.H.E.S	94.12	05.88	100
9	Knowing H.H.E.S Training model curriculum	11.59	88.41	100
10	Acknowledging H.H.E.S formal Training model curriculum in RSA	23.21	76.79	100
11	Desire for change in H.H.E.S curriculum	93.75	06.25	100
12	Viewing H.H.E.S Directors' need for Training	97.18	02.82	100
13	Viewing H.H.E.S workers' need for pre-service Training before Recruitment	83.10	16.90	100
14	Time for induction H.H.E.S needs no attention	29.31	70.69	100
15	H.H.E.S workers' knowledge in work needs up grading	97.14	02.86	100
16	Acknowledging H.H.E.S Training School Building's presence	12.68	87.32	100
17	Viewing Distance learning more beneficial than class-room (formal) learning for training	33.33	66.67	100
18	Outside people (Non-H.H.E.S)	61.76	38.24	100

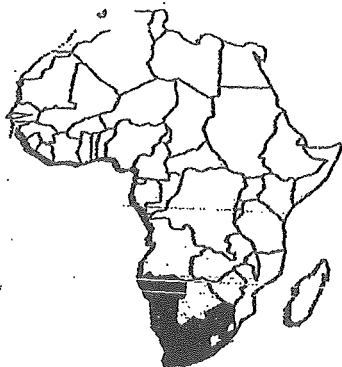
	acknowledging H.H.E.S service as good			
19	View self (H.H.E.S Worker) as Book Distributor	60.00	40.00	100
20	Viewing oneself more as Home Health Educator than Book Distributor	77.94	22.06	100
21				

ANNEXURE 5 EXTENSION

SECTION B OF QUESTIONNAIRE

Item	Response in Raw Figures			Response in Percentages (%)		
	Yes	No	Total	Yes	No	Total
1	68	2	70	97.14	2.86	100
2	45	26	71	63.38	36.62	100
3	25	46	71	35.21	64.79	100
4	31	40	71	43.66	56.34	100
5	8	63	71	11.27	88.73	100
6	0	70	70	0.00	100.00	100
7	67	3	70	95.71	4.29	100
8	64	4	68	94.12	5.88	100
9	8	61	69	11.59	88.41	100
10	13	43	56	23.21	76.79	100
11	60	4	64	93.75	6.25	100
12	69	2	71	97.18	2.82	100
13	59	12	71	83.10	16.90	100
14	17	41	58	29.31	70.69	100
15	68	2	70	97.14	2.86	100
16	9	62	71	12.68	87.32	100
17	23	46	69	33.33	66.67	100
18	42	26	68	61.76	38.24	100
19	42	28	70	60.00	40.00	100
20	53	15	68	77.94	22.06	100

ANNEXURE 6



THE LITERATURE EVANGELIST Southern Africa Union Conference

2 Hildrew Street, Bloemfontein, 9301, PO Box 848, Bloemfontein, 9300, South Africa
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LOOKING ON THE DARK SIDE OF LIFE

JULY 2005

I noticed a bumper sticker on a car: **"LIFE IS HELL AND THEN YOU DIE"**. Are we as Literature Evangelists a little guilty of looking on the dark side too often?

I was told of a story that happened to a truck driver living in Yugoslavia one named Vojin Popovic who sacrificed his life by looking on the darkest possible side of a bad situation. His vehicle had collided with a motorcycle carrying two people. Seeing the two lying under his truck apparently dead, Popovic pulled out a revolver and shot himself.

The pair are still alive – the motorcyclist escaped with a slight head injury and the passenger, his wife, had only a broken leg. But the pessimist is dead! Surely, we have everything to gain and nothing to lose by being optimistic and cheerful even during trying times.

LOOK ON THE BRIGHT SIDE

To those who in God's service are tempted to discouragement, Ellen G White says, "Difficulties will arise that will try your faith and patience. Face them bravely, look on the bright side. If the work is hindered, be sure that it is not your fault, and then go forward, rejoicing in the Lord". If we cannot say something hopeful or encouraging, it would be better to say nothing.

ARE YOU A PESSIMIST OR AN OPTIMIST

"A Pessimist is a person who complains about the noise when opportunity knocks".

"By continually dwelling on the dark side of their experience, they (the Israelites) separated themselves farther from God. Thus they cherished bitter thoughts concerning His dealings with them, and finally they became discontented with everything". Patriarchs and Prophets pp. 428.

A WALK, A TALK, AND A JUMP

A man stood on the edge of a bridge ready to jump and end it all. A passerby persuaded him to first go to a walk with him and talk things over. Surely, things couldn't be that bad. If after the walk and talk he still wanted to jump, the promise was that he would not be prevented. After an hour of walking the two men came back to the bridge and both jumped.

We who profess to have hope above all people, must not be carried along the tide of others discouragements, but must exert a powerful, positive and hopeful influence.

Remember you are on the winning side with God.
Peter C Hurter

SOME IDEAS ON SHARING AN EXPERIENCE

Too often when we approach the platform we are not really prepared to relate an experience to our listening audience. As a result we don't give a positive testimony. As Literature Evangelists we should get the rapt attention of our listeners with what we have to say. And it should be exciting to us as well. Write out your experience, keep it to the point and brief. Preparation and practice pay dividends.

We are actors, spiritual actors for God. I really believe this. By the words we choose we are actors. Now the question may come up and you may be thinking, "just how do I presume to do this?" We are not just entertaining people; we must keep their attention to get the message across.

We want to show the audience God's leading in the life of a Literature Evangelist. We know that God is leading us. We know that God is giving us the sales. We know that God is giving us the words to speak. We know that God is giving us courage to go from house to house, so cite specific examples to illustrate these points.

Don't take the punch right out of an exciting experience by going into unimportant details, for instance a Literature Evangelist may approach the platform and say something like this: "I received a card from Mr. Smith and when I arrived at his home I knocked on the door and waited, but there was not answer. So I decided to get petrol for my car, and when I returned I found Mr. Smith at home". Who cares how you found Mr. Smith - right? Unless the actual finding of Mr. Smith has something significant and unique about it, forget it. Get to the story, keep it moving to the punch line or climax - and then stop.

Avoid expressions that are not familiar, such as "cold-canvassing", "lead cards", "tear-out cards", etc. Don't say "Desire" when referring to "The Desire of Ages".

Be enthusiastic. Let's say I have a box of kitchen matches. If I were to take that box of matches and nicely pile the contents on the floor, save one match from that box and, without striking it, throw it into the pile, what would happen? If you are thinking, Nothing - you are right! But when I take that same match, strike it and throw it into that pile, what happens? That's right - WHAM! We can follow every step, but if we don't strike with enthusiasm, our talk will be in vain and we accomplish nothing. There are people out there who need to be reached, to be awakened to the duty of soul winning.

When we go to rallies we want to be on fire. We want to show that we love the Lord, that we are thrilled about this work, and that we are just bubbling over. I know when I

watch some Literature Evangelists I can't help being happy with them. I am picking up the enthusiasm they are throwing out.

You have something important to say. Say it well; say it with confidence; say it with enthusiasm. Let's share our good stories, and God will give us more.

THE PARADOX OF OUR AGE : *Author Unknown*

- > We have taller building, but shorter tempers; wider freeways, but narrower viewpoints; we spend more, but have less; we buy more, but enjoy it less;
- > We have bigger houses and smaller families; more conveniences but less time; we have more degrees, but less common sense; more knowledge, but less judgement; more experts, but more problems, more medicine, but less wellness.
- > We spend too recklessly, laugh too little, drive too fast, get too angry too quickly, stay up too late, get up too tired, read too seldom, watch TV too much, and pray too seldom.
- > We have multiplied our possessions, but reduced our values. We talk too much, love too seldom and lie too often.
- > We've learned how to make a living, but not a life; we've added years to life, not life to years.
- > We've been all the way to the moon and back, but have trouble crossing the street to meet the new neighbour. We've conquered outer space, but not inner space, we've done larger things, but not better things, we've cleaned up the air, but polluted the soul; we've split the atom, but not our prejudice; we write more, but learn less.
- > We've learned to rush, but not to wait; we have higher incomes, but lower morals; more food, but less appeasement; more acquaintances, but fewer friends; more effort, but less success.
- > We build more computers to hold more information, to produce more copies than ever, but have less communication; we've become long on quantity, but short on quality.
- > These are the times of fast foods and slow digestion; tall men and short character; steep profits, and shallow relationships. These are the times of world peace, but domestic warfare; more leisure and less fun; more kinds of food and less nutrition.
- > These are days of two incomes, but more divorce; of fancier houses, but broken homes. It is a time when there is much in the show window, and nothing in the stock room.

Indeed, it's all true. Think about it ... read it again.

SOUTHERN AFRICA UNION PUBLISHING MINISTRIES

SUMMARY LE PURCHASES JULY 2005				MISSIONS REPORT					NO. OF LE'S		
Publishing Leaders	STAT	PURCHASES	NOV-JULY	FREE LIT	VOP	PRAY	BSTD	BAPT	FT	PT	STU.
Units under A Mahooa	RPD	5973	41533	37	3	45	6	0	6	1	0
T Khumalo	UNIT	5689	112173	67	25	90	13	0	7	0	0
T Masoko	APD	10244	130878	46	11	66	29	0	11	0	0
S Seoketsa	UNIT	6044	69239	53	6	99	17	0	7	2	0
H Mncube	UNIT	9234	93465	19	0	23	4	0	9	4	0
SOWETO	UNIT	1425	82247	38	0	62	7	0	9	1	0
M Anakoka	APD	42066	220303	65	52	221	48	0	9	14	0
A Mahooa Total		80675	749838	325	97	606	124	0	58	22	0
C Schoeman	RPD	1731	84989	22	34	26	0	0	4	4	0
J Schoeman	APD	43813	431216	29	12	22	0	0	7	8	0
C Schoeman Total		45544	516205	51	46	48	0	0	11	12	0
Northern Region Total		126219	1266043	427	189	702	124	0	80	46	0
M Francis	RPD	9843	114011	74	7	83	15	0	7	26	0
J Csejaghy	APD	23042	179682	39	4	56	6	0	3	12	0
S Masoko	APD	48563	240144	114	124	92	36	6	4	6	0
E Moeli	APD	3189	9945	297	234	313	31	0	3	6	0
R Ophant	RPD	33891	230275	153	18	102	49	0	11	13	3
G Calmcross	APD	23999	213007	62	40	118	44	0	6	9	0
S Monakali	APD	17838	181921	48	0	137	4	0	13	16	0
Freddie Nel	UNIT	42547	118177	47	0	56	23	0	6	1	0
M Mus. Jey	UNIT	14202	52817	0	0	0	0	4	10	4	0
SAU TOTALS		343333	2606022	1261	616	1659	332	10	143	139	3

Congratulations to Top 10 LEs JULY 2005

1 Peter Geduld	18421
2 Kwalela Mutemwa	17193
3 Sabelo Masuku	13061
4 Joseph Muziwaya	12671
5 Nicole Gird	11522
6 Pongaponga J	10832
7 Solomon Makhanya	9838
8 Maurice Anakoka	9254
9 P M Loss	9239
10 C J Silwala	9066

NORTHERN REGION

2005 JULY

REGIONAL PUBLISHING DIRECTORS - A MAHOOA AND C SCHOEMAN

LIMPOPO / VENDA - A MAHOOA

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
MISCELLANEOUS		0	0	0	0	0	0
MULANDANA SOPHY M	F	100	0	0	0	189	189
MULAUDZI SALPHY	F	250	45	2	0	171	2,284
NETSHIVALE CHRISTINA	P	64	20	15	0	2,281	2,281
SUBTOTAL		414	65	17	0	2,640	4,753

LIMPOPO/POLOKWANE - A MAHOOA

LUSUKO MORGAN PULE	F	0	0	0	0	0	12,067
NKAUSU RODGERS	F	200	36	12	0	3,333	22,003
PHASWANA CHRISTINA	F	0	0	0	0	0	0
MOABELO PETER	F	0	0	0	0	0	2,710
SUBTOTAL		200	36	12	0	3,333	36,780

CENTRAL GAUTENG - T KHUMALO

CHAUKE J	F	182	57	25	0	0	31,575
KHUMALO THERESA	F	211	68	11	0	3,061	19,597
KUBEKA ROSE	F	0	0	0	0	1,373	26,979
MAGORO NOMSA	F	0	0	0	0	0	9,364
MANYONI ELIZABETH	F	0	0	0	0	0	9,655
MISCELLANEOUS		0	0	0	0	0	842
RANTHLA THEOPHILUS	F	164	23	14	0	904	9,023
SIBANDE GLORIA	F	64	9	6	0	351	5,138
SUBTOTAL		621	157	56	0	5,689	112,173

APD MPUMALANGA - T MASEKO

MANDA CHRISPIN	F	105	0	0	0	0	81,487
MASEKO THOKO	F	18	6	9	0	816	7,715
MOGANO THUSO	F	0	0	0	0	0	0
MPINGA CYNTHIA	F	0	0	0	0	0	0
SIBIYA ABSALOM	F	0	0	0	0	0	0
MOLUJI ALINAH	F	49	29	16	0	0	0
MAELANE JOHANNAH	F	42	7	9	0	1,404	1,404
MASANGO REGINA	F	214	63	23	0	1,645	14,831
SKOBELA PRISCILLA	F	110	86	51	0	1,117	1,117
MASHABA MARTHA	F	236	99	34	0	5,263	24,325
MAWELA MARTHA	F	0	0	0	0	0	0
MISCELLANEOUS		0	0	0	0	0	0
SUBTOTAL		774	290	142	0	10,244	130,878

EAST RAND ZONE 1 & 3 S SEOKETSA

SEOKETSA SOPHY	F	0	0	0	0	1,724	19,537
THOVHAKALE BEAUTY	F	96	31	13	0	2,237	17,007
MALEMELA MARGARET	P	0	0	0	0	0	2,922
MISCELLANEOUS		0	0	0	0	0	1,330
MOCHE DEBORAH	P	0	0	0	0	0	5,667
MTHEMBU JOSEPH	F	50	55	8	0	1,390	10,834
MOKAKE ELIZABETH	F	100	0	6	0	0	4,441
NZIMA SARAH	F	0	0	0	0	0	0
NANO MARGARET	F	0	0	0	0	316	1,921
S/DIA ZODWA	F	0	0	0	0	377	5,580
SUBTOTAL		246	86	27	0	6,044	69,239

EAST RAND ZONE - HEAVY MNCUBE

Name		Stat	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
SHABANGU FLORAH	F	52	14	8	0	189	1,470
MBOKANE ANNAH	F	193	34	24	0	4,862	27,465
NOMVETE JOHANNAH	F	0	0	0	0	0	2,908
MISCELLANEOUS		0	0	0	0	0	1,909
DUBE JEFFREY	F	0	0	0	0	333	4,280
MASHILWANE NONHLANHLA	F	0	0	0	0	0	9,146
MDLALOSE THEODORA	P	0	0	0	0	0	521
NDLOVU SARAH	F	0	0	0	0	0	4,310
NDLOVU SIPHO	F	0	0	0	0	526	4,408
MBUZI (Nyoni) ABIGAIL	F	10	6	6	0	684	6,114
MNCUBE HEAVY A	F	0	0	0	0	2,275	24,044
MAHALUBA CECIL	P	0	0	0	0	0	3,564
MONDE NDAMASE	P	31	6	1	0	364	2,799
WAMULIWE LETIA	P	0	0	0	0	0	526
SUBTOTAL		286	60	39	0	9,234	93,465

WEST RAND (SOWETO)

DLADLA NOMSITHO	F	35	6	6	0	259	1,728
LEBAKENG SANDRA	F	31	35	16	0	0	11,081
LUSHABA STANDO	F	0	0	0	0	0	551
MALATJIE FLORENCE	F	0	0	0	0	0	0
MISCELLANEOUS		0	0	0	0	0	1,322
MDLETYE TAKAZI	P	0	0	0	0	0	377
MKWANAZI ELIZABETH	F	0	0	0	0	0	0
MLOTSHWA BESSIE	F	0	0	0	0	0	3,734
MOFOKENG MARGARET	F	0	0	0	0	1,166	10,160
NTANZI JOYCE	F	0	0	0	0	0	1,229
SAKA BEN	F	0	0	0	0	0	52,065
SUBTOTAL		66	41	22	0	1,425	82,247

APD - ANAKOKA MUFUNGULWA

ANAKOKA MAURICE M	F	100	5	5	20234	9,254	55,482
BOPALAMO M M		0	0	0	0	1,746	2,079
NOTSANE M M		15	22	2	260	31	154
BOGATSU MAELISA J	F	0	0	0	0	53	956
MABATHO M	P	0	0	0	0	0	890
MACHEOANE J	F	0	0	0	260	0	1,692
MOCHOGI K K	P	0	0	0	0	0	500
MOYSHEGWA P	F	188	216	13	4560	6,570	66,671
MOTSWASE JANE ALFRED	P	0	0	0	0	0	2,478
SHBALABALA P	P	0	0	0	0	0	5,045
TSEHOLO P	P	0	0	0	0	1,566	1,623
MOGOERAN	P	0	0	0	0	0	5,162
MUTEMWA A	P	199	25	1	1350	5,654	8,110
MUTEMWA M H	P	138	9	2	260	0	3,463
SEDUPANE L J	P	0	0	0	0	0	7,258
THIBEDI M N	P	0	0	0	0	0	281
CHOUVU G	P	0	0	0	4800	0	519
VENTER H	P	0	0	0	0	0	316
MISCELLANEOUS		0	0	0	0	0	7,351

ANAKOKA MAURICE M

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
MAPOLISA MADODA	F	0	0	0	0	0	2,610
MOKGOETSI M	F	0	0	0	0	0	0
MUTEMWA KWALELA	F	0	0	0	0	17,193	27,013
MUTEMWA PRISCAH S	P	0	0	0	0	0	11,353
ZAHLE B	P	166	56	3	1520	0	9,298
SUBTOTAL		806	333	26	33244	42,066	220,303
TOTAL		3,413	1,068	341	33,244	80,675	749,838

REGIONAL PUBLISHING DIRECTOR - C SCHOEMAN

MAKHUBU DOREEN	F	40	8	4	3570	1,566	8,906
MISCELLANEOUS		0	0	0	0	0	13,544
MOCHIE ITUMENG M	P	20	7	3	376	165	1,112
CARL WILLIE	F	0	0	0	0	0	2,862
STEYN W	P	0	0	0	0	0	1,301
COOKS CLAIRE	P	0	0	0	0	0	19,367
KRUGER CORRIE	F	0	0	0	0	0	27,254
OLIPHANT E J FRANK	P	0	0	0	0	0	2,996
SMIT HENRIETTE	F	0	0	0	0	0	7,647
SUBTOTAL		60	15	7	3946	1,731	84,989

APD - J SCHOEMAN

BOGGENPOEL MARIO	P	0	0	0	0	0	8,851
DEANS CHEREE	F	0	0	0	0	0	12,215
GROVE F	F	103	10	6	6064	4,342	27,629
SCHMIDT ANNE-MARIE	P	4	2	1	800	351	1,064
SCHOEMAN JACO	F	80	18	12	14204	6,230	49,871
SCHOEMAN JANNIE	F	0	0	0	0	0	20,556
SCHOEMAN CHRISTINE	P	80	16	17	14848	6,512	14,903
SCHYFF L V D		20	5	1	160	333	1,333
IONESCU ADRIAN	F	140	12	9	19194	8,418	122,956
GROU NICOLE	F	110	40	19	26270	11,522	54,854
WIGGETT PIETER	F	130	40	13	13050	6,104	37,431
GEY VAN PITTIUS		0	0	0	0	0	0
MATTHYSEN A		0	0	0	0	0	0
BENEKE C	P	0	0	0	0	0	2,644
NEL PETRUS	P	0	0	0	0	0	3,399
COOKS W	P	0	0	0	0	0	73,509
SUBTOTAL		667	143	78	94590	43,813	431,216
TOTAL		727	158	85	97535	45,544	516,205

NORTHERN REGION TOTAL

126,218 1,266,042

KWAZULU NATAL

REGIONAL PUBLISHING DIRECTOR - M FRANCIS

BHENGU ZANDILE	P	11	4	6	1485	0	3,815
BUTHELEZI ELIZABETH	F	121	21	12	5305	3,351	42,813
GASKIN E	P	0	0	0	0	0	0
GOBA E Z	P	56	3	2	1084	605	784
HENDERSON FRANK	P	0	0	0	0	0	0
HENDERSON J J	P	0	0	0	0	0	0
JOSEPH ELAINE	P	0	0	0	0	0	0
KESWA N	P	0	0	0	0	0	259

CONTD - REGIONAL PUBLISHING DIRECTOR - M FRANCIS

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
LUTHULI MDOUDUZI	P	0	0	0	0	333	3,179
LUTHULI NONCEBA	P	0	0	0	0	0	0
MBEJE L C	P	0	0	0	0	0	0
MISCELLANEOUS		0	0	0	0	0	532
MNCHUNU MARIA	P	144	19	7	3820	150	11,255
MOLUTSOANE PATRICK	P	117	63	15	9707	1,998	1,998
MSANI THOKOZANI	P	0	0	0	0	0	11,445
NAIDOO TONY	P	0	0	0	0	0	0
NTOMBELA NYVONNE	P	0	0	0	0	0	0
ROSKRUGE AGNES	P	0	0	0	0	0	0
SING CECILIA SHEILA	P	0	0	0	0	667	667
SMITH HAZEL	P	0	0	0	0	0	377
OLAMINI ANGELINE	P	15	5	5	2000	794	794
OLAMINI MEMORY	P	0	0	0	0	0	518
HLATSHWAYO ALICE	P	0	0	0	0	0	2,371
PANTALONE BARBARA		449	110	42	21401	0	0
KHOZA PETROS	P	0	0	0	0	0	820
KOK ALLISTER		0	0	0	0	79	79
NKABINDE ROSELINE	P	0	0	0	0	0	3,136
MAHAYE DUMISANI	P	0	0	0	0	0	8,386
MBATHA THANDI M	P	0	0	0	0	0	859
MISCELLANEOUS		0	0	0	0	0	0
NTOMBELA ZANDILE	P	0	0	0	0	0	512
NTOMBELA D	P	0	0	0	0	0	354
RADEBE ALEXINA	P	120	20	10	3997	1,531	17,422
RADEBE LUCY M	P	75	30	9	1460	123	1,454
VAN VUUREN M	P	0	0	0	0	182	182
SUBTOTAL		1108	275	108	50259	9,843	114,011

FREE STATE / NORTHERN CAPE

APD - JOHAN CSAJAGHY

CSAJAGHY JOHAN	F	158	48	20	11185	5,053	40,320
JAARS JOHANNES	F	65	169	25	18936	8,908	33,183
LE ROUX VERNE	P	0	0	0	0	0	377
MISCELLANEOUS		0	0	0	0	0	0
MYBURGH SAMANTHA	P	0	0	0	0	0	457
ODENDAAL EUGENE	P	30	50	20	4500	2,368	16,837
RUITERS RANDOLPH	P	0	0	0	0	0	2,358
ROWE-ROWE KEVIN	P	0	0	0	0	0	3,732
SENOGE S.	P	0	0	0	0	0	0
TITUS ANGELO	F	0	0	0	0	6,713	47,982
VAN RENSBURG FRIKKIE	P	0	0	0	0	0	29,336
VISAGIE SULLA	P	0	0	0	0	0	570
PIEDT HELEN	P	0	0	0	0	0	1,918
DIETRICHSEN JURGENS	P	0	0	0	0	0	34
FANELE MANDISA	P	0	0	0	0	0	834
MLOTYA JOSEPH	P	0	0	0	0	0	1,744
SUBTOTAL		253	267	65	34621	23,042	179,682

SWAZILAND

APD - S MASEKO

	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
DLAMINI SICELI PHESHEYA	P	0	0	0	0	158	409
DLAMINI PAULOS	P	0	0	0	0	0	1,445
MALAZA LINDIWE (Gamedze)	F	0	0	0	0	4,842	39,787
MAKHANYA SOLOMON	F	0	0	0	0	9,838	30,310
MASEKO SHAINAH	F	0	0	0	0	0	20,287
MISCELLANEOUS		0	0	0	0	2,846	5,903
MASUKU SABELO	P	0	0	0	0	13,061	39,087
MUDZINGWA JOSEPH	F	0	0	0	0	12,671	84,914
SANGWENI MANDLA	P	0	0	0	0	961	2,939
NXUMALO ZANDILE		0	0	0	0	395	1,342
SITHOLE SIPHO	P	0	0	0	0	662	4,460
GWEBU WINILE	P	0	0	0	0	3,129	9,261
SUBTOTAL		0	0	0	0	48,563	240,144

LESOTHO - EDWIN MOETI

EDWIN MOETI	F	26	8	5	0	596	1,741
NTAOTE SUSAN	F	58	63	5	2302	1,254	5,613
SESINYI LYDIA	F	13	13	4	180	92	92
MOLAPO TANKISO L	P	19	52	3	278	140	140
MABOTE M	P	7	2	0	0	0	0
NTHAMA M		22	11	0	60	31	31
SESIDANA TSEPISO	P	0	0	0	0	0	947
KHOMONNGOE A T M	P	107	0	13	0	0	0
MATETE LILE	P	28	0	4	2043	1,075	1,380
SUBTOTAL		280	149	34	4,863	3,189	9,945

WESTERN CAPE

REGIONAL PUBLISHING DIRECTOR - R OLIPHANT

BARNARD H	P	0	0	0	0	1,800	23,862
DU PREEZ JULIA	P	0	0	0	0	2,860	25,183
DU PLOOY	P	0	0	0	0	702	2,353
HORN JOEY	P	0	0	0	0	0	1,500
JORDAAN H	P	0	0	0	0	0	0
KITSI A N	P	0	0	0	0	0	931
STANDER REINHARDT	P	0	0	0	0	0	7,997
VAN NIEKERK DIRK V	P	0	0	0	0	509	2,821
DAVIDS C	F	0	0	0	0	0	124
DE WET CATHERINE	F	0	0	0	0	442	16,914
GEDULD PETER J	F	0	0	0	0	18,421	69,654
BRANDT MICHAEL A	F	0	0	0	0	5,249	27,832
BOMESTER A	F	0	0	0	0	0	516
JOHNSON VALERIE	P	0	0	0	0	55	2,234
LAING MORRIS D	F	0	0	0	0	0	0
MAGANGA GOBANI	F	0	0	0	0	0	10,638
MISCELLANEOUS		0	0	0	0	0	965
SLINGER FRANS	F	0	0	0	0	0	20,209
SLINGER JOHN	F	0	0	0	0	0	7,785
STEYN L	P	0	0	0	0	0	31
SOLOMON RHODA	P	0	0	0	0	100	1,028
TSHANGA M	P	0	0	0	0	0	0
WILLIAMS D	F	0	0	0	0	0	1,467
OLIPHANT R	F	0	0	0	0	2,289	5,104
VAN STER E	P	0	0	0	0	1,465	9,516
SUB TOTAL		0	0	0	0	33,891	238,663

EASTERN CAPE / PORT ELIZABETH

APD - G CAIRNCROSS

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
BOHME ELIZE	P	0	0	0	0	0	0
DUNBAR DENNIS	P	0	0	0	0	0	128
FIRSTENBURG RONE	P	0	0	0	0	0	0
VAN WYK WALLY	P	48	13	4	2990	1,193	5,529
DU PLESSIS A		33	19	7	5352	1,114	1,857
BAATJES M	P	49	20	9	11850	0	8,459
BOGGENPOEL WAYNE	P	0	0	0	0	0	5,556
CAIRNCROSS GARLAND	P	0	0	0	0	3,453	45,817
FREE VICTOR	P	0	0	0	0	1,921	2,821
HAARDER A	F	83	23	20	14927	2,544	31,413
HENDRICKS GEORGE	F	120	20	10	6500	140	17,661
LENTO ROSE T	P	192	20	8	4200	1,204	4,731
LENTO JANET	P	207	224	7	3716	838	2,560
MISCELLANEOUS		0	0	0	0	0	2,512
NIJENA MALCOLM X	F	0	0	0	0	7,899	78,437
MADIKANE GLADMAN	P	89	40	18	12750	1,232	3,933
NABELA LOVEDELA	P	37	34	19	13400	632	1,593
SUB TOTAL		858	413	102	75685	22,170	213,007

EASTERN CAPE / EAST LONDON

APD - S MONAKALI

DEPAUL B	P	0	0	0	0	0	526
BHEBHE OFFIUS	F	88	16	10	4780	1,254	2,929
BHEBHE SINDISO	F	0	0	0	0	0	5,146
DINGISWAYO SONWABILE	P	68	10	6	2508	158	1,058
YAZE OLAVANA FATH	P	0	0	0	0	0	0
FESI L N	P	0	0	0	0	0	0
JAFTA M	P	0	0	0	0	0	0
JWACU NKOSAZANA	P	46	6	5	1987	395	2,226
KOBE MAVIS T	F	200	118	26	9715	5,579	33,718
MAFUYA L	P	0	0	0	0	0	0
MAKOLA GERTRUDE	F	0	0	0	0	0	0
MANENTSA THEMBSWA JUNE	F	138	292	38	0	4,803	31,120
MASHOLOGU ZOLA	F	120	28	15	5869	1,987	7,835
MAZWI T	P	0	0	0	0	0	636
MENSA NTUTHU	P	0	0	0	0	0	0
MPHLO XOLISWA	F	0	0	0	0	0	3,299
MHLANA THANDI	P	0	0	0	0	0	0
MONAKALI SYLVIA	F	0	0	0	0	0	8,463
MTIMKULU BEAUTY	F	106	89	16	4670	789	61,887
MULENGA KALUMBA	P	0	0	0	0	0	0
MXOLI R N	P	0	0	0	0	0	879
NCUMISA LINDANI	P	0	0	0	0	0	0
NDUNA LUYISILE	L	0	0	0	0	0	0
NGCATSHE NOMONDE	P	0	0	0	0	0	0
SOMYA NOKUZOLA P	P	0	0	0	0	0	0
SOJOLA MIRRIAM	F	67	8	6	1566	0	2,847
SOVITI MALXOLE KNOTTEN	P	80	15	8	3752	1,715	4,623

MONAKALI SYLVIA CONTD.

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
XHONXA ANCY	F	58	12	8	4688	307	10,913
BUWA M	P	0	0	0	0	0	0
MISCELLANEOUS		0	0	0	0	0	2,088
MIKULA T (BOOWANA)	F	99	36	15	0	851	1,395
PETER CECILIA	F	47	8	5	3875	0	333
SUBTOTAL		1,117	638	158	43,410	17,838	181,921

CENTRAL NAMIBIA
FREDDY NEL

Name	Stat	Hrs	Dem	Num Ord	Val Ord	Purchase Cost	Accum Purchase
NEL FREDDY	F	76	12	7	0	622	9,525
GAWASEB J	F	212	43	0	0	6,454	20,034
BRUWER GERT P	P	0	0	0	0	0	0
MISCELLANEOUS		0	0	0	0	0	0
MUTIKANI CLEVAR	F	278	83	42	0	6,333	24,441
PONGAPONGA J	F	143	18	15	0	10,832	21,170
SITWALA C J	F	180	42	27	0	9,066	18,991
LOSS MP	F	165	71	21	0	9,239	24,015
SUBTOTAL		1,054	269	112	0	42,547	118,177

NORTHERN NAMIBIA
MARINAH MUSWEU

KAWALA HAZEL	P	0	0	0	0	395	795
CHOMBO FLORENCE	P	0	0	0	0	737	1,116
KASALE B	F	24	14	13	3950	333	2,320
MALAPO F	P	0	0	0	0	0	0
MASULE ERIS	F	0	0	0	0	697	16,884
MATANGA DANIEL	F	40	18	7	4650	179	2,386
MISCELLANEOUS		0	0	0	0	0	0
MUSWEU MARINAH	F	66	12	10	4220	31	2,762
MWAMPOLE RICHARD	F	40	10	10	4120	1,627	7,862
MBALA W	F	0	0	0	0	447	1,061
MUSONGO DANIEL	F	132	150	32	10050	1,522	2,237
KALALUKA M	F	126	76	15	10290	4,026	4,526
IMAKUMBILI E	F	132	150	32	13650	2,956	5,818
MASASA CH	F	0	0	0	0	1,251	4,602
MASASA CHRISTOPHER	P	0	0	0	0	0	447
SUBTOTAL		560	430	119	50,930	14,202	52,817
Grand Total							327,301

LITERATURE EVANGELIST WEEKLY REPORT

Name										Date (Dd/Mm/Yy) Week ending		PLANS FOR NEXT WEEK										Contract Numbers	
Address										Number of appointments made													
										Area you plan to work in													
LE Number					Code					Sales Target		R					C						
	Hours	Calls	Appointments	Demos	Numbers of orders	Retail Value of Orders		Retail Value of Deliveries		Book Purchases at the Depot (I.E. Cost Incl. VAT)		Free Literature	V.O.P.	Prayers	Bible Studies	Baptisms							
Sunday																							
Monday																							
Tuesday																							
Wednesday																							
Thursday																							
Friday																							
Saturday																							
TOTAL																							