

**A GROUNDED THEORY ANALYSIS OF THE MEANING OF
COMMUNITY-BASED EDUCATION IN
BASIC NURSING EDUCATION IN SOUTH AFRICA**

BY

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DECLARATION

I Ntombifikile Gloria Mtshali declare that this thesis titled “ **A Grounded Theory Analysis of the Meaning of CBE in Basic Nursing Education**” is my original work. It has never been submitted for any other purpose, or at any university. Sources of information utilised in this work have been acknowledged in the reference list.

Signature *Ntombifikile Gloria Mtshali*

Date: *27/03/03*

DEDICATION

THIS WORK IS DEDICATED TO:

MY TWO FAMILIES: SITHOLE AND MTSHALI FAMILIES

**MY PARENTS, AND ALL THOSE WHO LAID A FOUNDATION THAT
SUSTAINED ME THIS FAR.**

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ABSTRACT

An extensive review of literature revealed that although CBE was a familiar concept and a national policy for health professionals' education in South Africa, there was, however, limited understanding of this phenomenon. Most of the existing CBE programmes were a reaction to the inadequacy of traditional nursing education and had emerged without any intellectual discourse on the phenomenon CBE. The aim of this study was to analyse the phenomenon CBE in basic nursing education and the meaning attached to it. Furthermore, the researcher aimed at developing a middle-range theory of CBE.

Strauss and Corbin's (1990) grounded theory approach was used to guide the research process. The South African Nursing Council's (SANC) education committee and seven nursing education institutions with CBE programmes were included for participation in the study. Data were collected by means of observation, interviews and document analysis. Purposive and theoretical sampling was used for selecting interviewees, resulting in a total of 41 interviewees. Data collection and initial analysis took place concurrently. Descriptive analysis followed by conceptual analysis was performed using Strauss and Corbin's paradigm for qualitative data analysis.

The primacy of the community as a learning environment, timing of first exposure, duration, frequency and sequencing of community-based learning experiences, as well as service provision, emerged as discriminatory core characteristics of CBE in basic nursing education. Irrelevance of traditional nursing education and political change emerged as antecedents of CBE. The need to respond to national health policies and community health needs was seen as conditions under which CBE had to operate in South Africa. The nature of the CBE educative

process, which placed emphasis on active learning and curriculum relevance, emerged as essential for the realization of expected outcomes of CBE in basic nursing education.

Based on these results, it was concluded that CBE in basic nursing education in South Africa is (a) relevant education, (b) responsive education, (c) education for social justice, (d) a conscious and deliberate PHC socialisation process and (e) a process and outcomes education. As this was a groundbreaking study on the meaning of CBE in basic nursing education in South Africa, a number of further research studies are recommended.

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CHAPTER 1

INTRODUCTION

Background of the Study

The role of health professionals throughout the world is undergoing significant changes owing to the reorientation of the health care systems towards the World Health Organization's (WHO) goal of "Health for All" through Primary Health Care (PHC). When considering health manpower development, the WHO (1985) stated that health personnel were not appropriately trained for the tasks they were expected to perform in society, and the planning of their education remained isolated from consumer needs and the needs of the health care service (WHO, 1993). The same organization asserted that most health professionals have little training in the wider aspects of health, and they have little opportunity to learn how to address the social, economic and political forces affecting health (WHO, 1993). Cohen (1999) supported the WHO when he maintained that the processes and products of health professionals' education were not in line with the needs of the society because their education was based on the preparation of health professionals in tertiary hospitals. Mc Whinney (1980) highlighted two problems associated with hospital-based training. In his words "(a) A student whose sole experience of illness has been in hospital has seen a small fraction of the illness of the people, and (b) in hospital the patient is isolated from the context of his or her illness, namely the family and social dimensions of the ill health (p. 189). The conventional method of training students in hospitals was thus regarded by the WHO (1987; 1993) as no longer an appropriate method of developing graduates who should be responsive to the needs of the society as a whole.

According to Boaden and Blight (1999), most governments and health professionals

clearly recognize that health professionals' education must be adapted to a Primary Health Care approach in order to be relevant to the health needs of the population and health care system. Tippets and Westpheling (1996) also stated that there is a need for graduates who can practice primary health care in medically under-served communities to increase access to health care, and who will be able to take into consideration the priority needs of the population and the needs of the changing health care system. It is in this context that Boaden and Blight advocate that education of all health professionals should be brought into closer congruence with the changing needs of the society and the health care system.

According to Magzoub and Schmidt (1998) the WHO's (1987) community based education seems one promising approach to make the needs of the community a part of health professionals' education, as CBE is founded on a PHC approach. As a result of the World Health Organization's proposal of community-based education, many community-based initiatives emerged aimed at improving health professionals' education in many countries (WHO, 1993).

Worldwide changes in the health systems and health professionals' education made it imperative for these changes to be introduced in South Africa. The major changes in the health care system and in health professionals' education followed the 1994 democratic elections. Increasing the number of graduates with knowledge of primary health care who would be able to serve the medically under-served areas was, and is still, a national concern in South Africa. The African National Congress's (ANC) 1994 National Health Plan document clearly spelt out that although South Africa has a large number of highly skilled health professionals, much of their training is inappropriate and these professionals are poorly distributed in relation to society's health and health care needs. This document

reflected the need to restructure the health system, with a PHC approach as the underlying philosophy. According to the ANC the restructuring process of the health system would require substantial training and reorientation of the basic education of health personnel to enable such graduates to play an effective role in promoting, maintaining and restoring health. To enable these graduates to meet the needs of the society and those of the health system, their education should be multi-disciplinary, inter-sectoral, gender sensitive, problem based and community-based in character. It should be a shared responsibility of the community, service and training institutions as was proposed by the WHO in 1993, and should be coordinated nationally (ANC, 1994).

The views in the ANC document (1994) were implemented by the Department of Health in 1997, through the White Paper on "Transformation of the Health System in South Africa". This White Paper presented various strategies designed to meet the basic needs of all the people. These strategies included the reorientation of health professionals' education to a comprehensive primary health approach. The Department of Health identified community-oriented education as a vehicle for this comprehensive primary health approach (Mametja & Reid, 1996). While the health system was undergoing change in South Africa, the education system was also in the process of restructuring education to be responsive to the needs of the society. The education system was challenged by the democratic changes in the country to reform because it also had major deficiencies, which were in line with those identified in health professionals' education. The four major deficiencies in the education system included: inequitable access to, and opportunity in, higher education; inadequate response by higher education to developmental needs of the society; inappropriate policies and practices in teaching and research and the failure of higher

education to lay the foundations for critical civil society (Perold, 1998). The National Commission on Higher Education (NCHE, 1996) asserted that higher education had an important role to play in the political, cultural and economic reconstruction and development in South Africa. According to NCHE, health education institutions could fulfil their role by revising their curricula in order to equip health care students and health personnel educators with comprehensive knowledge, competencies and attitudes to respond to the health care needs of the South African population. Furthermore, the higher education institutions should ensure the relevance of courses offered to the health needs of the population served, in order to produce appropriately skilled and community-oriented graduates for the National Health Care System (NCHE, 1996).

In the 1997 White Paper titled “A Programme for Transformation in Higher Education in South Africa”, the Department of Education presented a transformation strategy which was in line with that which was proposed by the Department of Health in 1997. This strategy to transform education had three components: increasing social responsiveness to societal needs through the diversified curricula and improved learning and teaching strategies, achieving equitable participation in higher education; and creating partnerships between government and civil society to meet the challenges of modern society (Department of Education, 1997).

The changes taking place in the country’s health and education system have had an impact on the South African Nursing Council (SANC). The SANC, as one of the bodies influencing education of nurses, also responded to the call for reform in the national health care system and education system in South Africa. As a contribution to the process of change the SANC supports the current thinking that nursing education should become more

community based as opposed to hospital based, to prepare nurses to work independently in primary health care settings and in communities. The SANC in the 1999 discussion document titled “Education and Training of Professional Nurses in South Africa: Transforming Nursing Education”, referred to community-based education as the key to the call for nurses who could provide PHC effectively as required by the transforming health care system. The relevance of education of health professionals is important for the transformation of the health care system. Although it is acknowledged that the complete solution of all society health problems lies outside the scope of health professionals’ education, their education is a vital piece of the solution. This was supported by Fahrenwald, Fischer, Boysen and Maurer (1999) when they stated that community based education programmes help to prepare nurses to lead the health care system into a future focused on the promotion and maintenance of health and prevention of disease. Similarly the World Health Organization (WHO, 1987) stated that community-based education programmes are a powerful means of upgrading health and the health care system. The health professionals’ education must be adapted proactively in the process of change to contribute to the shaping of a more socially accountable health system (Boelen, 1999; Okasha, 1995).

Although CBE is a familiar concept in South Africa, there are obvious gaps in the understanding of what this phenomenon entails. The gaps manifest themselves in the incoherent manner in which this approach to health professionals’ education has been, and is still being implemented in the country. Several factors have been identified as the causes of the apparent lack of the consensus in the understanding and practice of CBE. Firstly, CBE arose as a “reaction” to the realization of the inadequacy of traditional health

education programmes in preparing graduates with relevant knowledge and skills to meet the health needs of the community (Gwele, 1997; Ncayiyana, 2000). Secondly, CBE, in South Africa at least, was popularised by the existence of external donor funds, especially from the Kellogg Foundation (Gwele, 1997). Sudden availability of external donor funds preceded and almost precluded any form of professional and/or intellectual discourse of what CBE entails. The result has been the evolvment of a number of “unconnected” and unrelated CBE programmes in the country. It is appreciated that the diversity provides a rich and vibrant nursing education environment in the country, but a problem arises in the nature of such diversity. For example, in some of the existing programmes the students spend 20% to 35% of their clinical learning time in the community and 75% to 80% in hospital, and that programme is viewed as community-based; in other institutions community-based learning activities are accommodated only in first year and the rest is hospital based; in other programmes the students are given a community project to do and that is called community-based education (Ajibola, 2000; Gwele, 1997; Nazareth & Mfenyane, 1999; Ross & Loening, 1990). It is acknowledged that in a country as heterogeneous as South Africa with regard to cultures, ethnicity, socio-economic factors and so on, diversity both in the nature of health services and in CBE programmes is inevitable. Celebrating diversity, however, should not preclude the appreciation of those aspects of life which are common to all South Africans as a nation, including a shared understanding of what constitutes CBE in the South African context.

Problem Statement

Although CBE is a familiar concept and a policy in South Africa, an extensive

review of literature on the subject has indicated that there is limited understanding of what this phenomenon actually means in the South African context, and within basic nursing education in particular. There is no solid basis of implementing CBE, as most of the CBE initiatives were a reaction to existing problems without any intellectual discourse on the phenomenon CBE. Furthermore, no effort has been made in health professionals' education in South Africa thus far to bring some coherence into the somewhat fragmented descriptions of what is currently practised as CBE. To date no research studies have been reported on the meaning of CBE in South Africa. Hence, there is a need for shared views on this phenomenon in order to facilitate a meaningful practice of CBE.

Purpose of the Study

The purpose of the study was to analyse community-based education in basic nursing education in South Africa with the aim of discovering shared meaning of the phenomenon, by capturing all variations and also examining the conditions under which the phenomenon occurs. This study therefore had two purposes: (a) to conceptualise the phenomenon CBE within the South African context, and (b) to develop a middle-range theory that will guide the practice of CBE in basic nursing education in South Africa.

Objectives of the Study

The objectives of this study were to (a) analyse the phenomenon CBE and the meaning attached to it in various nursing institutions, (b) establish how the phenomenon CBE is utilized in basic nursing education programmes in South Africa, (c) describe the processes involved in a CBE programme, (d) analyse the cause, context, covariance,

consequences, contingencies and conditions under which the phenomenon CBE occurs, and
(e) develop a middle range theory that describes the phenomenon CBE.

Significance of the Study

This study should bring a shared meaning of CBE as an approach to basic nursing education within the South Africa context. Having an understanding of what CBE entails would enhance the meaningful practice of this phenomenon and should also bring some coherence in what is currently practiced as CBE in South African nursing education institutions. Consequently, it is hoped that CBE programmes would be responsive to the needs of the community by producing graduates who can practice PHC in underserved communities, thereby increasing access to health care. Indirectly, CBE programmes would facilitate the implementation of the Department of Health's Policy on PHC. Graduates produced would contribute significantly to the process of transforming the health care system to meet the needs of all people at all levels. The developed grounded theory may also serve as a framework to those nursing institutions planning to initiate CBE basic nursing programmes and those with CBE programmes who are reviewing their programmes. This study also has a potential to contribute to the existing body of knowledge on CBE, as there is a worldwide concern that CBE lacks theoretical basis (Towle, 1992).

Ethical Considerations

In this study permission was sought from the heads of the schools of nursing under study, the University of Free State, University of Natal, University of Transkei, University of Witwatersrand, Frere College of Nursing and Umtata College of Nursing, including its

two campuses (Transkei Campus and St Barnabas Campus). Permission was also obtained from the Department of Health and SANC as policy-makers. Informed consent was obtained from the participants by giving them full information on the purpose of the study, its significance, and data collection procedures. Participation was voluntary. Gathered data was treated with confidentiality and code numbers were assigned to participants to ensure anonymity.

Dissemination of Findings

Executive summaries of the study will be sent to the Department of Health, South African Nursing Council and the nursing education institutions that participated in the study. The University of Natal Library and the Health Systems Trust will be furnished with a report on completion of this study. The KwaZulu-Natal Department of Health requested the researcher to assist in running CBE workshops for the nursing institutions in the province. Moreover, the researcher will present the findings of this study in conferences nationally (Nursing Education Association's annual conference) and internationally (the Network of Community Oriented Institution's Conference) as a follow up to the papers presented in 2001 on the initial phases of this study. The researcher also intends to publish several sections of the completed research projects in a number of academic journals, locally (Curationis, Health Systems Trust Magazine) and internationally (Annals of Community-Oriented Education Journal; Nursing Education Journal).

Definition of terms

The researcher defined the following concepts, which were significant in this study:

Community-based education. The researcher adopted the World Health Organization's (1987) definition of community-based education. "Community-based education is defined as means of achieving educational relevance to community needs and, consequently, as a way of implementing a community-oriented educational programme. It consists of learning activities that utilize the community extensively as a learning environment in which not only students, but also teachers, and members of the community are actively involved throughout the educational experience. Depending on how the population is distributed the learning environment may be an urban, suburban or rural community" (WHO, 1987, p.8).

Basic nursing education. Basic nursing education refers to a comprehensive education of nursing students leading to registration as a nurse (general, community and psychiatric) and midwife. The duration of this basic nursing education is four years.

Meaning. Meaning is the way in which those involved in a CBE programme make sense of their world, their action and interactions in a CBE programme. As a result they might have a 'common' definition of the phenomenon CBE, in their social world.

Middle-range theory. A middle-range theory is made up of limited concepts and propositions, written at more concrete and specific levels. It addresses a relatively concrete and specific phenomenon and encompasses a limited scope with a number of variables, which are testable in a direct manner (jan.ucc.nau.edu/~erw/nur301/theory/ntheory/lesson.html). In a middle-range theory, propositions are clear, and testable hypotheses can be derived (Merton in Wilson, 1989).

Conclusion

This chapter presented the background to the study, which is aimed at establishing the meaning of CBE in basic nursing programmes in South Africa. The rationale for the reorientation of health professionals' education from hospital-based to community-based education has been traced from the WHO's initial proposal to the need for the paradigm shift to community-based education in South Africa. The need for change in South Africa has been highlighted from a number of angles, starting from the ANC's 1994 National Health Plan, the NCHE's 1996 working document, the 1997 White Paper on the Transformation of Health Systems in South Africa, the White Paper titled "A Programme for Education Transformation in South Africa", Perolds' report on Community service in South Africa, to the SANC's 1999 discussion document on "Education and Training of professional Nurses in South Africa". Problems mentioned in this chapter regarding CBE in basic nursing programmes in South Africa and the concern about CBE's lack of scientific basis provided the basis for the need of the study on the meaning of CBE in basic nursing programmes in South Africa.

CHAPTER 2

LITERATURE REVIEW

Introduction

The process of literature search in this particular study was undertaken in two phases: the initial literature search gave background to the study, and the second literature search took place during data analysis as required in grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The literature search conducted during the process of data analysis is referred to as 'selective sampling of the literature' (Burns & Grove, 1997). Explaining selective sampling of literature in grounded theory, Burns and Grove stated "unlike the case in traditional research, the literature is not extensively searched at the beginning of the study in order to avoid development of a sedimented view. At this point in the research, the literature is examined to determine the fit of findings from earlier studies and existing theory with present findings" (p.548).

The University of Natal librarian initially assisted the researcher in the process of identifying databases with the material related to this study. Later the researcher continued on her own to access literature sources. Databases used in searching for literature included: (a) Cumulative Index to Nursing and Allied Health Literature (CINAHL) which contains citations from nursing journals and journals of allied health disciplines, (b) EBSCO Host database which is an electronic data base with a wide range of databases providing full text material, citations and abstracts from journals, newspapers, reports, pamphlets and reference books abstracts. Databases which were accessed via EBSCO HOST included

Medical Literature Analysis and Retrieval System On Line (MEDLINE) and PubMed which covers all aspects of medicine and some life sciences, (d) Educational Resource Information Centre (ERIC); Academic Search Premier which is an academic multi-disciplinary data base with full text journal articles; and Health Source: Nursing/ Academic Edition. Journal articles that were not available in local libraries (Durban and Pietermaritzburg campuses, and Medical school) and from electronic databases were ordered from international libraries.

Key words that guided the search for literature related to CBE included (a) community-based education, (b) community-oriented education, (c) learning in communities (d) community-based learning, (e) service learning, (f) population focused education, (g) PHC in nursing education, (h) nursing education in the community, (i) multi-disciplinary approach education, (j) community involvement in nursing education, and (k) community-based education models. Identifiers of literature related to educational philosophies influencing nursing education were key words such as (a) educational philosophies, (b) conservative philosophies, (c) traditional education, (d) essentialism, (e) modern educational philosophies, (f) progressivism, (g) progressive education, (h) John Dewey, (i) instrumentalism, (j) democracy and education, (k) critical theory and critical theorists, (l) Paulo Freire, (m) oppressive education, (n) liberatory education, (o) postmodernism, (p) postmodern education, (q) postmodern theorists.

This chapter begins with a review of selected philosophical ideologies and their influence on nursing education. It is believed that a study of the meaning of community-based education in nursing education cannot take place outside an in-depth review of various philosophical ideologies influencing the curriculum, precisely because there is no

such thing as value-free education (Bode, in Tanner & Tanner, 1980). In the words of Cooper (1997, p. 1):

In the world that is undergoing unprecedented change, the practice of education is driven by economic, political and societal forces that are constantly redefining educational needs. Ideologies and philosophies, society and individuals provide the base from which decisions are made within educational institutions.

Hence, a review of literature on those philosophical ideologies which the researcher sees as having had the greatest influence on nursing education, is presented. These include essentialism, instrumentalism, critical theory, specifically Paulo Freire's pedagogy, and postmodernism. The rest of the chapter focuses on literature pertinent to CBE, specifically (a) the development of CBE, (b) conceptualisations, rationale, and principles of CBE, (c) models of CBE and (d) a description of current CBE programmes in South Africa.

The Essentialist View of Education and its Influence on Nursing Education

Essentialism, often referred to as 'Back to Basics', is an educational philosophy in which education focuses on academic subjects that will develop students' intellectual abilities and produce good citizens (Cohen, 1999; Ornstein & Levine, 1997; Elias & Merriam, 1995). This education philosophy, according to a number of authors (Kilgour, 1995; Ornstein & Levine, 1997; Tanner & Tanner, 1980), surfaced in the 1930s and was popularised by William Bagley (Cohen, 1999; Kilgour 1995; Shaw, 1995; Tanner & Tanner, 1980). Essentialism was a reaction to progressive education that was prevalent in the 1920s and 30s (Ornstein & Levine, 1997). The essentialists yearned to go back to the

fundamentals of education (Tanner & Tanner, 1980) because they believed that progressive education was lowering academic standards and weakening the intellectual quality of education by focusing on life adjustment and non-essential aspects of life (Ornstein & Levine, 1997), as well as emphasising the interests of the learner and teaching through activity and freedom rather than focusing on academic knowledge and on instilling discipline (Kurtis, 2001; Ornstein & Levine 1997).

Essentialism is rooted in both idealism and realism (Cohen, 1999; Ornstein & Levine, 1997). Idealism has as its central tenet that reality is a world within a person's mind (Kurtis, 2001). The ideas in the person's mind are the only true reality and are the only thing worth knowing (Cohen, 1999). Idealism considers truth to be a fixed set of ideas and postulates that scientific inquiry can reveal the natural laws of the universe (Ornstein & Levine, 1999). In Kurtis' view the idealists' reality is a world within a person's mind, the truth is in the consistency of ideas and goodness is an ideal state to strive to attain. As a result, idealists' schools exist to sharpen the mind and intellectual processes of the students. Realists, on the other hand, believe that reality exists independently of the human mind (Cohen, 1999). They believe in the world as it is (Kurtis, 2001). Kurtis further added that according to the realists the ultimate reality is the world of physical objects, what is observed, and the truth is objective because it is what can be observed (Cohen, 1999). Hence, for the essentialists, schools exist to reveal the order of the world and universe by teaching the students factual information (Kurtis, 2001). Building on idealism and realism, essentialism is based on the three basic components (a) core knowledge and skills, (b) hard work and mental discipline and, (c) teacher-centred instruction (Shaw, 1995). Essentialists accept the idea that the core curriculum may change as a result of the changes taking place

in the society, therefore schooling should be practical and prepare the learners to become valuable members of society (Ornstein & Levine, 1997).

The essentialists on the nature and purpose of education. The essentialists believe that there is an essential body of academic knowledge, skills and character required in a given culture or discipline and that this consists of facts and principles (Cohen, 1999). Therefore the purpose of education is the preservation and transmission of the cultural heritage to the growing generation (Tanner & Tanner, 1980), and the development of character required in a particular culture (Ornstein & Levine, 1997; Shaw, 1995). In view of the essentialists' focus on accumulation or storage of the knowledge from the past for the future, the progressive philosophers, however, question the significance and the relevance of this knowledge in the immediate life of the learner (Tanner & Tanner, 1980). Einstein (cited in Tanner & Tanner, 1980) warns that knowledge transferred by adults to the growing generation is dead, in that the learners are not involved in the construction of that knowledge. According to progressive educators, education should not be isolated from what is lived and experienced by the learners in their present environment. Furthermore, progressives maintain that education is not only the means through which culture is transmitted, but also the means through which a culture is transformed, otherwise learners are taught to conform or accept the status quo in the society rather than influencing change (Elias & Merriam, 1995; Shaw, 1995). Sharing the same view, Fassbinder (2002) pointed out that education of this nature in some countries would mean that the citizens would only get information that the government or the rulers would like them to know, which, according to Freire in Fassbinder, creates subjects, subjects who are all exactly the same,

who could not deviate from the normal pattern and would definitely not rebel against the system.

As one of the shortcomings of essentialism, Ornstein and Levine (1997) postulated that essentialists' education is limiting the learners' abilities by channelling them to what is required as if they cannot think and make decisions or choices on their own. Sharing the same view, Parkay and Stanford (1998) asserted that focusing on basic skills deprives the learners of the opportunity of developing as critical thinkers. Parkay and Stanford feared that if learners are not taught how to think they will not be able to make appropriate decisions on their own. This author advocated a well-rounded education that balances basic skills and critical thinking skills.

The essentialists on the nature of the curriculum. Embracing the fundamentalist-core curriculum (Tanner & Tanner, 1980), the essentialists consider that there is a core body of knowledge that must be mastered in order for the person to be considered 'educated' (Elias & Merriam, 1995; Shaw, 1995). The intention of the essentialists' curriculum is to develop learners, who, upon graduation, will be in possession of basic skills, have knowledge of a variety of subjects and be ready to apply what they have learned in the real world. The essentialists favour a curriculum with well-defined or compartmentalized subjects and skills to be learned, and each subject has to be dealt with in depth (Ornstein & Levine, 1997). Hence, the essentialists' curriculum is characterized by being subject centered, compartmentalized and focused on essential knowledge and skills (Cohen, 1999; Shaw; Tanner & Tanner, 1980). Each subject in the curriculum is organized separately from other subjects.

Progressives and critical theorists however maintain that a subject centred curriculum is oppressive, limiting, and prepares the learners for the present (to pass examinations), not for the future (Bevis & Murray, 1990; Maxwell, 1997; Scarry, 1999). For example, Freire (1972) portrayed subject centred curricula as tools of domination, means of teaching oppressed groups to distrust their own knowledge and to assimilate the ideology of the oppressors. Furthermore, Tanner and Tanner (1980) pointed out that although progressive educators recognize the importance of fundamental skills, they see these skills not merely as preparatory for later learning but as relevant to the learners' present life.

Tanner and Tanner (1980) stressed that the curriculum with compartments of specialized bodies of knowledge that are taught separately encourages fragmentation in the teaching- learning process, thus affecting meaningful learning. It deprives the learner of having a holistic view or comprehensive picture of a phenomenon being studied. More importantly, it is limiting in the development of the learners' thinking skills, as the learners are fed with small separate units of information, which they are not expected to question. Fragmented curricula encourage the creation of walls between subjects, which cannot be broken down to make a connection between these subjects when solving life problems. Knowledge from the past separates knowledge from real life problems (Tanner & Tanner, 1980).

Elias and Merriam (1995) asserted that with knowledge explosion, the essentialists' curriculum is criticized for being congested and overloaded with irrelevant subjects or content. Subjects are included in the curriculum mainly because the teachers understand their intrinsic worthwhileness, not because of their relevance to the current context. In view

of the essentialists' curriculum that is based on knowledge from the past Tanner and Tanner (1980) also pointed out that knowledge is rapidly developing and as new knowledge is assimilated the existing knowledge should be revised and reconstructed as new knowledge, for it to be relevant to the current context.

The essentialists on the teaching learning/process. The essentialists see the teaching/learning process as centred on the transmission and mastering of the academic subject matter. As a result the teacher dominates the teaching/learning process. Freire, cited in Kidd (2000), however, frowned upon the education where the teacher dominates the learning process. He describes the teacher as the oppressor and the learners as the oppressed. According to Freire such education isolates the learner from the content and process. Kidd (2000) pointed out that the transfer of information to the learners is an emblem and an instrument of oppression that inhibits the inquiry, creativity and dialogue expected during the learning process. Freire asserted that there should be a dialogue between the teacher and the learner to encourage the learners to participate actively in their learning. Through the teaching learning/process the teachers should learn with the learners, because teacher cannot know everything.

Essentialists, according to Ornstein and Levine (1997), mix both the traditional methods of instruction and those methods encouraging a certain degree of student participation. The essentialists use regular assignments, work sheets, textbooks, homework, recitations and frequent tests (Bekker, Naicker & Oliver, 1976; Ornstein & Levine, 1997). Lectures are used as the main teaching methods, together with memorization, regular citations or repetitions. They maintain that these teaching strategies facilitate the mastery of the required skills and subjects. Contrary to this, however, in Tanner and Tanner (1980) it is

indicated that these strategies encouraged retention of information as the learners find themselves memorizing and regurgitating information. These strategies limit the intelligence of the learners as they are given ready-made information to retain.

According to Ornstein and Levine (1997) and Shaw (1995,) essentialists believe the teaching strategies they use prepare the learners to function as disciplined members of a civilized society and to acquire the behaviour needed for successful living. The essentialists insist that as much as they accommodate other teaching strategies there are crucial aspects on which the teaching process should focus on the transmission of core knowledge and skills. Hence, the lecture is the dominating teaching method. Influenced by the work of Paulo Freire, Bevis and Murray (1990) described a lecture as an instrument of oppression, as it does not allow for dialogue between the teacher and the learner. According to these authors, the lecture makes learners consumers of information made private by the teacher. It encourages the learners to accept the already digested information; information that has been gathered, sorted, analyzed, put in some desired form and made to support the position favoured by the provider of information. More importantly, lecturing does not teach how to learn, how to critique, nor teach the learner how to establish meaning out of the situation or learning experience. It interferes with the autonomy and independence of learners in the process of construction of knowledge.

The influence of essentialism on nursing education. Nursing as a profession is characterized by having its own body of specialized knowledge to which the students need to be exposed. Oermann (1991) pointed out that from the perspective of nursing, professional socialization represents the process through which students acquire the knowledge and skills needed for practice and the internalisation of norms and values of the

nursing profession into their own behaviour. Conway, in Oermann (1991), elaborated by explaining that professional education is designed to shape the values, attitudes, self-concept, and role behaviours of students, thereby enabling student nurses to assume the new role of a professional practitioner. In other words, nursing education programmes influenced by essentialism have specific core knowledge to be transmitted to the nursing students, as well as skills and attitudes that characterize the nurses.

The preparation of nurses in programmes that stipulate specific or core knowledge to be transmitted to the learners, and skills and character to be developed, has had serious implications for nursing. For instance, according to Scarry (1999), historically, nursing programmes provided nurses with knowledge and skills that prepared them to provide safe technical care, without questioning the policies or the status quo. They were not taught to think or reason about what they were doing. Scarry (1999) further asserted that the norms and values instilled during the training period prepared graduates to be loyal employees to their employers, repress their autonomy and be part of the status quo. It is believed that this influenced them to expect the same from their clients or patients. Maxwell (1997) further added that traditional nursing education deprived learners of the knowledge and skills to analyse the political, social and economic factors that affect the health of society because the models of nursing used focused only on the physical and psychological dimensions of health. According to Maxwell (1997), social and political issues were outside the boundaries of their curriculum. Nursing students were instead made to accept the socio-political situation as it is (Scarry, 1999). In other words, the curriculum core knowledge provided was inadequate and not fully relevant to the needs of the society served, as it catered only for the physical and psychological dimensions of health. Expanding on the

inadequacy of the preparation of nurses in traditional programmes, Jones and Meleis (1993) pointed out that health, which is regarded as a state of physical, social, political and economic well being, is a central concept in the discipline of nursing and is the main goal of nursing. Furthermore, the determinants of health include lifestyle factors, income, social status, education, food, a stable ecosystem, sustainable resources, social justice and equality. Therefore, nursing education cannot afford to ignore these factors in the education of nurses. Traditional nursing programmes are accused of preparing nurses to help people adapt to their oppression, inequality, and poverty, instead of making them question the status quo. If the nurses cannot question the status quo, how can they expect their patients to do so? Because of nurses' socialization in traditional programmes, they are likely to encourage patients to conform, not to question or challenge the status quo or to be involved in their own care.

Nurse educators following essentialists' principles seek to transmit the knowledge and skills characterizing and required in the nursing profession. Shaw (1995) pointed out that the curriculum is well defined, with specific subjects to be covered at each level of education. Separate teachers who are specialists teach those subjects. They determine what is to be learned by the students, when and how. The learners in the classroom depend on the teacher for knowledge and skills required. All these views apply to traditional nursing education, where the curriculum has a number of unconnected subjects which are taught by subject specialists, subjects such as anatomy, physiology, social science, pharmacology and general nursing, which is also divided into smaller units such as paediatrics, orthopaedics, medical, surgical and many other subjects. There is concern however from a number of authors (Fitchardt, & du Randt, 2000; Fitchardt, Viljoen, Botma, & du Rand, 2000; Gwele,

1997; 1999) about traditional nursing education curriculum in that the fragmented subjects overload the curriculum, there is duplication of work, no connection or relevance of what is learned to reality, and subjects are included only because they are believed to be worthwhile to the profession, irrespective of whether they are relevant to the needs of the surrounding community.

Subject specialists are regarded as people who know everything there is to know about that subject. As a result the students are expected to trust the knowledge he or she transmits to them. The lecture method is the main method of teaching. Rather (1994) pointed out that traditional teaching strategies prescribe thoughts, values and behaviour, just as in essentialism. Commenting on nursing education Scarry (1999) asserted that traditional nursing education continues to harbour the remnants of oppressive practices, which according to Bevis and Murray (1990) include the lecture method, the prescribed curriculum content, attitudes and skills as well as authoritative controlling practices. Scarry describes nursing education as a political activity, which prepares learners either to be part of the status quo or to challenge it. Bevis and Murray referred to teaching as a political activity within which there are embedded hidden messages about what is valued, what learning is about, and who is in power, in control and on top. According to Bevis and Murray, in the conservative curriculum authoritarian teaching approaches and roles subtly teach more than nursing. "They teach an attitude towards self and authority that perhaps goes a long way towards sabotaging the very characteristics nurses must have to enhance nursing's ability to serve the public in ways that improve quality, ameliorate injustices, and promote uniform accessibility of health care" (Bevis & Murray, 1990, p. 326).

Learners in traditional nursing programmes pass or move to the next level of their education with limited or no understanding of how different subjects or levels are connected, as is indicated in Ornstein and Levine (1997). Doering (1992) indicated that examinations are used to ensure that characteristics of individual learners match what is considered to be essential knowledge and skills in a particular area or discipline. According to this author it is through the process of examinations that the desired characteristics are rewarded and reinforced. Likewise, Robinow, cited in Doering, pointed out three ways of 'power and knowledge' used to maintain the status quo. These include examinations, normalizing judgment and hierarchical observations, of which examinations and normalizing judgement are more applicable to nursing education and hierarchical observations more applicable to practice or a clinical setting. According to Doering, hierarchical observation allows those at the top of the power structure to supervise activities of those regarded to be in lower positions. For example, historically the doctor (men) in a health team had patriarchal authority over a team that was mainly composed of nurses (females). That hierarchy was used as a way of maintaining a status quo in a health team.

Doering (1992) illustrated by reference to nursing examinations how power is used to maintain the status quo in nursing education. According to Doering, examinations in nursing are "not only used to measure levels of knowledge or skill, but they also impose labels such as competent, sane, knowledgeable, or scientific" (p. 28). Doering asserted that in most cases examinations emphasize the testing of mastery of the rationale for nursing tasks, rather than mastery of the analytical or conceptual abilities required in practice. Therefore the limitation of examinations is that they reinforce "a limited, dependent focus for nursing knowledge"

(p. 28). A normalizing judgment is another form of power used to maintain the status quo in nursing education in the sense that it involves the maintenance of acceptable standards and the reinforcement of conformity. An example given by Doering of normalizing judgment in nursing is that the nurses learning to perform a task have to perform it according to set rules, because the deviation from the routine or rigid or set standard is not tolerated. If nurses deviate from the norm they get a punishment of some form or they fail. Doering, however, pointed out that conforming to the prescribed rules is crippling to the learners in that they do not have an opportunity to be creative. According to Doering normalizing judgment encourages dependency. Doering's view, however, might not always be appropriate in nursing education because of the nature of some of the nursing activities. Some practices demand that nurses conform to set standards for the safety of the patients/clients, for example proper administration of injections.

It is important to note that because nursing is a profession, it is imperative for nursing students to be assessed to establish if they have acquired the competencies required to ensure safe practice. Furthermore, nursing as a profession is accountable to the important public and employers. Hence, it is important to monitor the quality of graduates produced from nursing programmes.

Instrumentalism and Its Influence on Nursing Education

Instrumentalism, according to Peters (1977), is regarded as John Dewey's original philosophy. According to the Concise Encyclopaedia of Western Philosophy and Philosophers, edited by Urmson, Dewey's philosophy of education, instrumentalism (also called pragmatism), focused on learning-by-doing rather than rote learning and dogmatic

instruction. Dewey was influenced by William James, one of the pragmatists (Field, 2002), who, according to Kuklick (1981), believed that consequences were intentions guiding individuals towards satisfying their desires to be either a truth or falsity. Kuklick further stated that James considered pragmatism to be both a method of analysing philosophical problems and a theory of truth. Dewey modified James' pragmatism but, like James, he maintained that the mind is an instrument for realizing purposes (The Radical Academy, 2000). Dewey believed that thoughtful action directed toward resolution of problematic conditions or conflicts is instrumental in producing truths, meaning that the mind is an instrument in producing truths. Furthermore, it forges instruments or tools to cope with problems in a given situation. Dewey's instrumentalism recognized the role education plays in the survival of democracy and the importance of democratic thought and action in the improvement of education (Kuklick, 1981).

Expatiating on instrumentalism, Delahanty (2002) indicated that instrumentalism bears relationship to the utilitarian and pragmatic school of thought, as Dewey (1916) believed that in education there is a need to connect thoughts and bodily activities, develop individual consciousness with associated life, and connect theoretical culture with practical behaviour. Delahanty further pointed out that instrumentalism holds that various modes and forms of human activity are instruments developed by human minds to solve multiple individual social problems. Since the problems are constantly changing, the instruments for dealing with them must also change. Delahanty also highlighted that in rejecting traditional abstract learning, Dewey considered education as a tool that would enable the citizen to integrate culture (education) and vocation effectively and usefully. As Dewey believed in the integration of the mind and bodily activities, he opposed the traditionalists' separation

of education from vocational training. Unlike those who viewed vocational education as the preparation for specific labour Dewey believed that vocational education should be included as part of the comprehensive curriculum to help students develop a greater range of personal capacities that expanded, rather than limited, their future occupational options. Hyslop- Marginson (2001) stated that “rather than preparing learners for specific vocations, Dewey envisioned vocational education as providing all learners with the critical spirit and intellectual capacity to transform an industrial and educational structure designed to reproduce class divisions” (p.8).

Hyslop-Marginson (2001) maintained that Dewey did not reject vocational education, but conceptualised it as an enabling force that would allow all students autonomously to choose their vocational life. Dewey’s stand against the separation of education and vocational training was made clear in ‘Democracy and Education’ (1916). In this book Dewey targeted breaking down the antithesis of vocational and cultural education by suggesting the introduction of practical activities in the curriculum. He referred to those practical activities as ‘occupations’. Hyland (1993) described occupation as a mode of activity, which reproduces, or runs parallel, to some form of work carried on in social life. Dewey (1916) referred to occupation as a concrete term for continuity. It is a continuous activity having a purpose. “It includes the development of artistic capacity of any kind, of specific scientific ability, of effective citizenship, as well as professional and business occupations” (p. 359).

According to Dewey (1916) “the only adequate training for occupations is training through occupations” (p.362) because “education through occupations consequently combines within itself more of the factors conducive to learning than any other method. It

calls instincts and habits in to play; it is a foe to passive receptivity. It has an end in view; results are to be accomplished. Hence it appeals to thought; it demands that an idea of an end be steadily maintained, so that activity cannot be either routine or capricious. Since the movement of activity has to be progressive, leading from one stage to another, observations and ingenuity are required at each stage to overcome obstacles and to discover and readapt means of execution. ” (p. 361).

Dewey (1916) suggested the introduction of more practical activities in the curriculum, for education to be through, occupations not for occupations (Peters, 1977). His argument was, “An occupation is the only thing which balances the distinctive capacity of an individual with his social service” (p. 360) because it assists learners to discover what they can do. According to Dewey learners should not be directed to what they will do after schooling, but should be exposed to a number of experiences in order to discover their potentials. Hyland (1993) maintained that the notion of occupational activity figures prominently in the recommendations for vocational education. Nowadays a National Vocational Qualifications framework in Britain is used as a means of enhancing vocational education and training and as an effort to bridge the vocational/ academic division (Hyland, 1993). Other measures used to bridge the theory-practice gap include service learning (Riley, 1995), community service or community-based learning (Perold, 1998).

Instrumentalism on the nature and purpose of education. According to Tozer and Nelson, in Hyland (1993), the purpose of instrumentalists’ education is not to prepare individuals for a particular occupation or specific range of occupations but to encourage intellectual and moral growth. Some authors (Pendleton & Myles, 1991; Snedden in Hyslop-Margison, 2001) regard instrumentalists’ education as having a utilitarian value in

that it is viewed as a means, or instrument, for achieving economic and social ends. In other words education prepares the learners for the labour market needs. Hyslop-Margison (2001) interprets this purpose of education as skills-focused education essential to meet the labour force needs and to prepare learners with assumed limited intellectual capacities for immediate employment. The industry in this type of education determines the type of skills, values and attitudes it requires. According to Dewey (1916), however, vocational education should be designed to meet the learners' needs and prepare them for the various challenges of social life rather than specific occupations. Dewey believed in principle that "the educative process is its own end, and that the only sufficient preparation for later responsibilities comes from making the most of the immediately present life applies in full force to the vocational phases of education" (p. 362). With an education based on instrumentalism the learners should therefore have an opportunity to experience real life work settings that reinforce workplace expectations and apply information learned in all subjects. Dewey criticised vocational education in that there was more emphasis on skills than meaning.

Instrumentalism on the nature of the curriculum. Dewey (1929) asserted that knowledge is a consequence of an action, therefore individuals know only after acting. Hyland (1993) pointed out that in instrumentalism knowledge is neither given nor absolute, just as reality is not fixed or complete. It is however constructed by humans out of their experience. Hence, the source of the curriculum within this perspective is human experience. Geiger, cited in Hyland (1993), described the concept experience in the context of instrumentalism as the name given to all that passes between the organism and its surroundings.

Often the instrumentalist view of education is equated to vocational education in that it places emphasis on skills acquisition. This, however, contradicts Dewey's views about education. Dewey (1916) favoured the curriculum that exposed the learners to occupations allowing them to be active pursuers and constructors of knowledge, living and working in a world of dynamic social beings (Hyland, 1993). Furthermore, Hyslop-Marginson (2001) asserted that for the instrumentalists' curriculum to be able to prepare the learners to influence change, it should be based on a broad democratic comprehensive curriculum that includes political, social and cultural factors in society. Such a curriculum is believed to prepare learners to change the situations in industries rather than to be passively controlled by market economy forces and existentially limited by inherently prescribed intellectual capacities.

According to Ornstein and Levine (1997) the instrumentalists' curriculum contains tested experiences that are subject to change. The instrumentalists believe that the person, the environment and the experiences are constantly changing. If reality is continually changing, then a fixed curriculum with permanent subjects is not adequate. The interests and needs that learner brings with them to the classroom form an emerging curriculum and the educational institution's curriculum arises from learner's experience and also develops experience in the learner (Ornstein & Levine, 1997).

In Ornstein and Levine (1997) it is stated that Dewey as an **anti-dualist**, (believed in breaking down dichotomy in education) was not completely against accumulated wisdom and cultural heritage, but he believed that people should test and reconstruct the accumulated wisdom and heritage in the light of present needs. He asserted that knowledge

from the past, discoveries and inventions should be used instrumentally in fashioning solutions to problems.

Instrumentalism on the teaching/learning process. In Field's (2002) view, Dewey rejected the term 'epistemology' preferring 'theory of enquiry' or 'experimental logic', because he regarded these as more representative of his own approach. Dewey (1916; 1938) believed in learning through enquiry and through experience. Hysop-Margison (2001) described Dewey as a philosopher, who advocated learning that featured democratic decision-making, experience-based learning, and learning that encouraged self-growth, as well as the use of scientific method of study. From the instrumentalist perspective, learning is accomplished through the process of enquiry or problem solving, and by acting on the environment and observing the consequences of interaction with the social and physical. Furthermore, it involves the manipulation of the environment as stated in Dewey (1916). Dewey believed that consequences of action play a vital role in human experience and learning. Interaction with the environment and the results of that action determine if learning did take place or not. Reflection, according to Dewey (1938), is central to all learning experiences, with the learners taking some time away from their work to reflect consciously on what they have learned and how they have learned it, as stated in Starnes (1999). In other words, learning according to instrumentalism takes place through experiential learning together with reflective learning.

In the instrumentalists' curriculum the problem-solving method is the main teaching. Dewey believed that this scientific process of problem solving enabled the learner to think reflectively and openly (Tanner & Tanner, 1980; Ornstein & Levine, 1997). Furthermore, according to Ornstein and Levine, Dewey argued "human beings experience

the greatest personal and social growth when they interact with the environment in an intelligent manner” (p. 469) and the most intelligent way of solving problems is to use the scientific method of inquiry. This method requires the freedom to think and to question, and it encourages democratic orientation to life in society. More importantly, in Ornstein and Levine’s view it facilitates the development of an educated person who, according to the instrumentalists is a person who knows how to access information from various sources and disciplines and use it in an instrumental manner. Starnes (1999) summarising the teaching/learning process according to Dewey, stated that as education is student centred, all work the teacher and learners do together must flow from student desire, student concern, with the teacher serving as a collaborator, team leader and guide rather than the ‘boss’. A constant feature in Dewey’s education is that teaching/learning is characterised by (a) student’s action, rather than passive receipt of information, with the student viewed as the centre of the learning experience, and a teacher as a co-partner and guide, (b) emphasis on learning by posing and solving problems, making meaning, and producing knowledge, (c) emphasis on teamwork, small group work and peer teaching, (d) teacher constantly striving to increase learners’ participation in decisions that affect them, (e) reflection takes place at key points throughout the work, connections between the classroom and surrounding communities and real world outside the classroom are clear, and (f) continuous spiralling of learning experiences, with learning activities linked cumulatively to make learning more realistic.

The influence of instrumentalism on nursing education. Instrumentalism in nursing education means changing from a traditional curriculum to a curriculum that is based on a model that includes the social domain of health. Teaching strategies would

facilitate the active participation of the learners, experiential learning, reflective learning and cooperative learning for learning to be meaningful. Classrooms are democratic, with power shared between the teachers and the learners. As an example, Kanpol (1992) indicated that democratic classes are characterized by participatory rule-making, use of learning contracts, input on knowledge construction, decision-making reached through dialogue and consideration of different voices during interactions. The needs and interests of the learner and society determine the curriculum content. The curriculum is comprehensive, with integrated subjects encouraging the connection of one to the other in order to have a complete picture of a learning experience. The settings where learning takes place go beyond the classroom, they include community settings.

Critical Theory and Its Influence on Nursing Education – Paulo Freire’s Pedagogy

Hlebowitsh (1992) described critical theory as an approach to the study of a society with the aim of exposing the inequalities and injustices among the institutions in that society. Giroux and McLaren (1994) asserted that the primary preoccupation of the critical theorists is with social injustices and how to transform inequitable, undemocratic, or oppressive institutions and social relations. According to Hlebowitsh (1992) and Ritzer (1988) critical theory represents a wide range of approaches and concerns about inequalities in society.

Jensen (1999) maintained that the task of critical theory in education is to promote a diversified education for all individuals in order to steer them away from over specialization. By so doing it will create individuals with strong mental faculties, who will

be able to think critically about forces that affect their daily lives. Jensen also indicated that another task of critical theory is to promote revolution against all forms of discrimination, including those based on sex, sexual orientation, race and religious beliefs, as well as to preserve the good moral values that promote universal solidarity and help bring about a more just, human, rational and reconciled society. For the purposes of this review the focus is Paulo Freire's pedagogy, specifically because of its influence in community-based education.

As Hlebowitsh (1992) stated, critical theorists cannot be encapsulated into one category. Paulo Freire, as one of the critical theorists, had his own school of thought, which had a major impact on revolutionising education. Elias (1975) asserted that Paulo Freire had a reputation of being an educator who proposed education as a necessary means for achieving revolution. This was evident in his book titled 'Pedagogy of the Oppressed' (1972). This book outlined the type of education necessary for bringing about drastic political and social changes in society. Freire, in writing 'Pedagogy of the oppressed', was challenged by the poverty and developmental shortfall of the oppressed people in Brazil (Bertrand, 1995). Freire was regarded by many authors (Bertrand, (1995; Elias 1975; Roberts, 1996; to mention a few) as the first educator to develop the notion of conscientisation pedagogy and put forward a critical conception of culture. With his insights into what he called "the culture of silence" (Freire, 1998, p. 14) Freire championed changing the world of those submerged in the culture of silence by means of praxis, that is, reflection and action upon the world. In his analysis of Freire's work Bertrand indicated that Freire's pedagogy is positioned between cooperative education, which is very pedagogical in description, and critical pedagogy, which is more social and less

pedagogical. Weffort in Elias (1975) also highlighted that Freire's education policies invested more in political goals and strategies than education.

Freire's pedagogy and the nature and purpose of education. Freire (1972) viewed education as a practice of freedom or liberation where people are encouraged to challenge and change the world, not merely to adapt themselves uncritically to it. The purpose of Freire's education is to bring about social, political and economic changes in society. According to Margonis (1999) Freire's pedagogy advanced by pushing progressive education to reconceive the educational relationship as a social dynamic, shaped by interplay between the student and the teacher, as well as their respective social, cultural and political positions. In other words Freire's education goes beyond the individual to the social. It prepares the learners to participate in the construction of their society. In line with Margonis' (1999) view, Bertrand (1995) referred to Freire's pedagogy as conscientising education as it is aimed at making students aware of their roles as change agents in the society. Education, based on Freire's thinking, should raise questions about inequalities in power, with the purpose of conscientising individuals about the existing social problems (Burbules & Berk, 1999). Wallerstein, Sanchez-Merki and Dow described the purpose of Freire's education as human liberation rather than domination. Liberating education, according to Margonis, is characterized by the bond of true solidarity between student and teacher, and by a political stance of commitment to the causes of oppressed people. Margonis pointed out that what Freire calls 'true solidarity' is more than a political stance, it is also an ethical stance of relating to students, characterizing the appropriate relation of the student and the teacher.

Freire (1972) believed that oppression prevents the oppressed from being fully human because their rights as human beings are violated and their power is taken away as they are dominated by the oppressor. According to Freire, in Kidd (2001), such a situation is dehumanising to both the oppressor and the oppressed. The oppressors in Freire's context are defined as those who deny the personal autonomy of others by imposing a worldview paradigm onto the oppressed that denies them the power to direct their own lives (Kidd, 2001). In Freire's (1972) view the oppressor is dehumanised by the act of oppression while the existential reality of oppression and internalization of the image of the oppressor dehumanise the oppressed. Kidd contended that the oppressors suppress any possibility of action by the oppressed that is in contradiction to the paradigm of the oppressors. Freire asserted that for the oppressed to free themselves from oppression they need to challenge the situations oppressing them. Therefore the purpose of education is to liberate people from themselves and from the oppressors (Kidd, 2001). Freire (1972) provided a description of education that incorporated all the above about education, and more. He referred to education as a democratic practice of empowerment that is based on using an active method built around dialogue, criticism, and formation of judgement, the purpose being to make people aware of themselves as reflective persons who create both history and culture (Freire). Challenging Freire's revolutionary education, Elias (1975) indicated that when one reads about Freire's pedagogy one expects active revolution, but what they meet is another religious middle class reformer. Egerton in Elias (1975) asserted that Freire is no more radical than other philosophers. There is no originality in what he says and there is nothing concrete and specific in his thoughts. "He is a political theoretician" (p. 103)

In conclusion, education that is based on Freire's pedagogy has a social, political and an ethical role. As van Wyk (1999) stated, it is not exclusively for liberating the oppressed who might be learners freed from dominating traditional teachers, or any other socially oppressed people, it is also applicable to all other groups as it emphasizes the importance of dialogue, reflection and critical analysis of situations before acting on them. It facilitates cooperative and collaborative learning, which is important in successful teamwork.

Freire's pedagogy and the nature of knowledge and the curriculum. According to Freire cited in Serpa and Serpa (2002) knowledge is constructed, as learning is a constructivist process owned by the learner and facilitated by the teacher in interaction with the student. The teacher therefore, does not transfer knowledge from his/her dominating position to the learner, but the learners, with the guidance of the teacher, construct it. Bertrand (1995) explained that the teacher commits to constructing knowledge with the student in a permanent dialogue. Regarding Freire's views on knowledge construction, Gadotti (1997) asserted that Freire's constructivism goes beyond research and thematisation. It shows that not everyone can learn, but that everyone knows something and that the learner is responsible for building up knowledge and for resignification of what she or he learns. According to Gadotti, learners only learn when they have a life in which knowledge is meaningful for them. Gadotti emphasizes that subjects learn through their own transforming action on the world. They are the ones who construct their own categories of thought, organise their life and transform the world. In other words, the learners actively participate in constructing knowledge that is meaningful to them.

Freire condemned the transference of pre-existing knowledge, and referred to that as banking education. Dewey, also, did not favour the transference of knowledge to learners. According to Dewey (1916) such knowledge cannot be regarded as knowledge but as just information transferred by the teacher, who claims to know everything, to the learner who is a blank slate. Knowledge, according to Dewey (1916) and Freire in Serpa and Serpa (2002), is constructed; therefore the learners should be actively involved in the process of knowledge construction. Gadotti (1997), however, stated that certain conservative critics claim that Freire does not have a theory of knowledge because he did not study the relationship between the subject of knowledge and the object. He was only interested in the end product. In support of Freire, Gaddoti pointed out that this statement is not true because Freire's thinking is based on an explicit anthropological theory of knowledge, as knowledge is socially constructed through the dialectical tension praxis.

According to Freire (1972) the curriculum should facilitate the challenging of the status quo. Issues such as racism, sexism, exploitation of workers and other forms of oppression should not be ignored but be confronted. There is no predetermined curriculum content but it is derived from the problems associated with oppression of people in society.

Freire's pedagogy and the teaching/learning process. Bertrand (1995) asserted that Freire's education advocates democratic and cooperative instruction. According to Godatti (1997), Freire proposed a new conception of teaching relationship that is based on a dialogue, meaning that the person who is teaching is also learning. Freire advocated dialogue between the teacher and the students (Freire, 1972), as he believed that without dialogue there is no communication and without communication there can be no true education. The dialogue moves the learner from the level of being an object to being a

subject. To promote the learner as a subject, Freire proposed a structured dialogue approach in which every one participates as co-learners to create jointly the understood reality.

Dialogic action has two basic dimensions, reflection and action. Through dialogue, individuals engage in critical reflection or conscientisation, to analyze the social context for personal problems and their own roles in working on the problems (Wallerstein, Sanchez-Merki & Dow, 1999).

According to Margonis (1999) the dialogical unity of the student -teacher relationship provides the basis for the recreation of both students and teachers. To Freire, students often bring a wealth of knowledge to educational interactions, but do not have explanatory models, which are developed in the academy. Margonis asserted that intellectuals are often informed by a variety of explanatory perspectives, but lack the knowledge and multiple sensitivities embodied in students' acts and words. Freire therefore recommends that educators should soak themselves in this knowledge and assimilate the feeling, the sensitivity and the actions of the masses. Teachers are enriched and transformed by understanding the students. Furthermore they learn to respect the knowledge of the students. In view of Freire promoting dialogue in education, Margonis referred to Freire's education as relational education.

Rather than using the banking method, educators subscribing to Freire's pedagogy employ problem-posing methods, which facilitate active learner involvement. Roberts (1996) clarifies that Freire does not use the term 'problem solving' since learners are not always capable of problem solving. According to Freire (1972) problem posing "affirms individuals as being in the process of becoming- as unfinished, uncompleted beings in and

with a likewise unfinished reality” (p. 100). The incompleteness of individuals compels education to be an ongoing activity (Freire, 1972).

Serpa and Serpa (2002) in their review of Freire’s *Pedagogia da Autonomia* indicated that Freire provided a framework of principles that inform the professional practice of teachers and learning anywhere. There are 27 in all, but, they are clustered into three: (a) there is no teaching without learning, (b) to teach is not to transfer knowledge, and (c) the process of education is only a human endeavour. Adding to the principle that there is no teaching without learning, Freire highlighted a number of principles that he believed were crucial in the interaction of teaching and learning. These principles include methodological rigor, research, respect for the personal knowledge of each student, critical thinking, risk taking and acceptance of the new while rejecting any form of discrimination, critical reflection about educational practice, and recognition of the assumption of cultural identity. According to Bertrand (1995), Freire believed in democratic instruction as it allows all learners to express themselves freely and to make their intentions known. More importantly, Bertrand asserted that democratic instruction allows all learners to question the answers, rather than answering the questions as in the traditional system.

In conclusion, according to Serpa and Serpa (2002) Freire viewed teaching as much more than knowing about a subject here and now, but reaching and transforming the beyond. According to Freire teaching demands an educational practice that respects the following principles: (a) to be aware that learning never ends, (b) to respect the freedom of the learner, (c) to use common sense, (d) to have humility, tolerance and advocate the rights of the learners, (e) to be in touch with reality, (f) to have joy and hope, (g) to have the

conviction that change is possible, and (h) to foster curiosity (Freire in Serpa & Serpa, 2002).

The influence of critical theory on nursing education. According to Hall (1999) critical theory employs societal awareness to expose social inequalities that prohibit people from reaching their full potential. According to the advocates of emancipatory nursing (Bevis & Murray, 1990; Kendall, 1992; Maxwell, 1997; Rather, 1994; Scarry, 1999) nursing education should address the socio-political factors influencing the health of society. According to Kendal, poverty, education and other social problems are inextricably linked to health concerns and cannot be addressed in isolation. Nursing education programmes are challenged to produce nurses who will be able to care for clients who are politically, socially and economically disadvantaged. These nurses have to be able to choose actions that seek to help people fight back and challenge the status quo rather than help people adapt to their oppression.

Nursing education has, therefore a responsibility to shape nursing programmes to raise the students' consciousness of the issues of inequality and how these issues impact on health. In Maxwell's (1997) view the medical model used in traditional education programmes obscures the exploration of social and economic factors that have an influence on health and illness, as it only focuses on the physical and mental status of the client, excluding the social, political and other important factors influencing health. Allen (1985) in support of this view asserted that nurses versed in critical theory are equipped to see beyond the perpetuation of the status quo ideas and may be able to generate unique ideas that are unencumbered by previous stereotypes. Furthermore, Allen asserted that education programmes influenced by critical theory can enable health providers to understand

problems of inequality in relation to the historical background and social forces that have an influence on nurses. Through exploration of societal forces, traditions and roles, nursing practice can be enriched by enabling clients to remove the conscious and unconscious constraints in their daily lives, especially those suffered by women and the impoverished.

According to Maxwell (1997), nursing education nowadays is shifting to emancipatory nursing education, in which social change is the core. She explained that emancipatory nursing as nursing that provides direction for nurses to work with the oppressed in such a way that social inequalities influencing health are identified, uncovered and/or confronted. Nursing of this nature challenges nurses to work as social activists to help marginalized and oppressed people overcome social inequalities as a strategy for enhancing health. Hall (1999) asserted that marginalized people are vulnerable to health risks resulting from discrimination, environmental dangers, unmet subsistence needs, and restricted access to health care, therefore nursing education has an important role to play in educating nurses to be able to confront such situations. According to Starzomski and Rodney (1997) nursing knowledge can be used as a socio-political power to enforce a theorized good and affect human health in unforeseeable ways. These authors further asserted that the nursing profession should ensure that its enquiry on socio-political powers has an impact on the development of health policy for the common good.

Postmodernism and Its Influence on Nursing Education

According to Cahoone (1996) and Klages (2000), 'postmodernism' as a widely used term is inherently paradoxical. This word means many things to many people, as its manifestations are different in different fields. Before the analysis of this multifaceted term,

in education it is important to understand its several different conceptions. Cahoon (1996) described postmodernism as a family of intellectuals who have conflicting views, but who all criticize and reject modernity and modernism. It has introduced new and radical ways of thinking about modern society (Leroke, 1994). The term postmodernism is widely used in many artistic, intellectual and academic fields, in which it provides new interpretations and analysis. It can be traced in disciplines such as architecture, zoology, biology, forestry, geography, history, law, literature and arts, medicine, politics, philosophy and so on (Beck, 1993; Cahoon (1996); Leroke, 1994). This shows that seeking a single, essential meaning applicable to all is impossible (Cahoon, 1996). According to Cahoon (1996) although it is difficult or almost impossible to establish the meaning of the term 'postmodernism' due to conflicting ideologies regarding this term, it is important to begin somewhere, by looking for some common ground.

Cahoon (1996) in the attempt to define postmodernism reported on famous themes or ideas that appear in most postmodernists' work. Four of the five prominent themes distinguished were objects of postmodernism criticism and one constituted its positive method. According to Cahoon (1996) "postmodernism typically criticizes the presence or presentation (versus representation and construction), origin (versus phenomena), unity (versus plurality), and transcendence of norms (versus their immanence). It typically offers an analysis of the phenomena through the constitutive otherness" (p.14).

'Presence' refers to the quality of the present experience and to the objects thereby immediately "presented". This usage emanates from Derrida's (1978) work, one of the prominent postmodernists. Derrida (1978) rejected the metaphysics of presence in favour of a system of signs that accentuate difference. Difference refers to the condition of the

existence of dissimilarity in social life, which leads to different meanings (Leroke, 1994).

As a result of Derrida's work, postmodernism denies that anything 'immediately present' is independent of signs, language interpretation, and disagreement. In some cases, postmodernism argues that presentation actually presupposes representation. Thus, Derrida literally denies that there is such a thing as "perception" that is, an immediate, transparent reception of the given.

According to Cahoon (1996), the denial of presence occasionally leads postmodernists to substitute the analysis of a representation of thing for discussion of a thing because they believe that nothing exists outside the text. This does not mean that there is no real world, but that one encounters real referents through text, representations, and mediations. In contrast to this view, Ellis in Slattery (1997), asserted that the crisis of representation provoked by postmodernism challenges some of the vulnerable notions about scientific truth, which in turn results in a loss of faith in the theory of language, on which scientific inquiry has been based. Ellis criticized the postmodernists for challenging the superiority of science over language.

'Origin' is the source of whatever is under consideration, a return to which is often considered the aim of rational inquiry. Inquiry into origins is an attempt to see behind or beyond phenomena to their ultimate foundation. For modern philosophers of the self, for example those exploring existentialism, psychoanalysis, phenomenology, even Marxism, the attempt to discover the origin of the self is the road to authenticity. Postmodernism on the other hand denies any such possibility. It denies the possibility of returning to recapturing, or even representing the origin, source, or deeper reality behind the phenomenon. Postmodernism is viewed as superficial, not through eschewing rigorous

analysis, but by regarding the surface of things, indicating that the phenomena does not require a reference to anything deeper or fundamental. The Greek's saying that 'every author is a dead author' is an example of the denial of the origin because they deny that the meaning of text can be authoritatively revealed through reference to authorial intentions. The author's intentions are no more relevant to understanding of the text than any other set of considerations (Cahoone, 1996).

'The denial of the transcendence of norms' is crucial to postmodernism (Cahoone, 1996; Kanpol, 1992). Norms such as truth, goodness, beauty, rationality are no longer regarded as independent of the process they serve to govern or judge, are rather products of and immanent in those processes. For example, where most philosophers might use the idea of justice to judge the social order, postmodernism regards that idea as itself a product of the social relations that it serves to judge, that is, the idea was created at a certain time and place, to serve certain interests, and is dependent on certain intellectual and social context. Postmodernism rejects norms because they are independent of nature or context because in the postmodernists view norms respond to normative claims by displaying the processes of thought, writing, negotiation, and power, which produced those very normative claims (Cahoone, 1996).

The last theme highlighted by Cahoone (1996) is the idea of **'constitutive otherness'** in analysing any cultural entity. What appear to be cultural units such as human beings, words, meanings, ideas, philosophical systems, and social organizations are maintained in their apparent unity only through the active process of exclusion, opposition, and hierarchisation. Postmodernists, especially in literary studies, turn their attention away from the well known, openly announced themes in a text towards the seldom mentioned,

the virtually absent, the implicitly or explicitly valued. They believe that the presence is constituted by absence; the real is constituted by appearance, the ideal by the mundane. Beyer and Linston (1992) indicated that postmodernists emphasize a concern for the 'other', those who have been oppressed or exploited, for example women, children and economically under-privileged. Hence, according to these authors, within a postmodern perspective, the crucial importance of a multi-vocal 'otherness' makes communality in discourse and action infeasible and/or dangerous. Kanpol (1992) posited similar views in stating that understanding the 'other' forms the basis of a discourse in postmodern educational discourse.

Contrary to the essentialists' view, postmodernism theorists believe that there exist multi-meanings of truth, instead of one all encompassing truth. In that way postmodernists view education as a lifelong process of which schooling is only part. Postmodernists believe that schooling should open doors to the world of learning, which that demands awareness of the environment and openness to the deep ecology of learning.

Postmodernism and the nature of knowledge and the curriculum. Building on Foucault's views on knowledge, postmodernists believe that knowledge is an important form of power. When shared between individuals and groups or between partners, power brings forth 'active subjects' who better understand their own subjectivity (Foucault, 1980). Through that process of power sharing, knowledge is constructed and in the process other forms of knowledge are disqualified when the new ones are discovered thus making knowledge tentative (Beck, 1993). Moreover, knowledge is tentative because reality is in part culture-dependent. It changes over time, as cultures do, and varies from community to

community. Slattery (1995) added that knowledge in the postmodernists' curriculum reflects human interests, values and actions that are socially constructed through inquiry.

Influenced by Derrida's (1978) work, postmodernists assert that to know is to be able to interpret or provide meaning to a text or experience within a system of signs that allow for the substitution of the old meaning by the new. This means that knowledge acquisition in postmodernism is measured by the student's ability to interpret or provide meaning of what is presented before him or her. During that process of meaning-making, new or different meanings may be acquired through the use of the new interpretative languages, languages of those involved in discourse analysis, to clarify and understand the experience according to the immediate context (Beyer & Linston, 1992). Romm and Sarakinsky (1994) also highlighted that during the process of meaning-making, postmodern learners deconstruct the discursive nature of any text, thereby refuting its epistemological claims of truth. Postmodern knowledge is therefore not a reflection of reality but a product of discursive practices, which are social context and processes.

Slattery (1995) stated that the postmodernists' perspective about knowledge makes them challenge the notion of cumulative knowledge, resulting in knowledge that is tentative, multifaceted and constructed by the people. In line with Slattery's (1995) view Delasmutt and Braud (1997) contended that the basic idea in postmodernism is that all knowledge is invented or constructed in the minds of the people through the process of interaction between one's ideas about the world and one's experience of the world. Hence, the main underlying learning theory in postmodern education is constructivism. In other words, knowledge in postmodernism is fluid, contextual, historical and discursive as indicated by Ironside (2001). Furthermore there is "rejection of universal and

transcendental foundations of knowledge and thought, and heightened awareness of the significance of language, discourse and socio-cultural locatedness in the making of any knowledge claim” (Ironsides, 2001, p. 80).

The postmodern curriculum acknowledges the complexity of those involved in the teaching/learning process and embraces tolerance, ambiguity, acceptance of uncertainty, and authentic situated assessment because learning and teaching involves multifaceted people in complex interaction. Consequently, the postmodern curriculum has no autonomous subject to be studied like in modernism; to postmodernists the subject is a myth (Hall, 1999; Reed, 1995). Unlike the modern curriculum, which is based on specific subjects to form the curriculum content, postmodern curriculum is integrated (Slattery, 1995). According to Slattery (1995) an integrated curriculum assists students in their search for deeper meaning. On a similar note, Caine and Caine (cited in Slattery, 1995) maintain that postmodern theorists challenge the modern educators’ strong belief in separating teaching into cognitive, affective and psycho-domains of learning. According to Caine and Caine such categorisation distorts the understanding of learning because the brain does not separate emotion from cognition either anatomically or perceptually. This break-down according to domains promotes fragmented teaching, not meaningful learning.

According to Beck (1993) and DeLashmutt and Braund (1997), knowledge in postmodernists is characterised by its utility, which is contrary to modern society’s view where knowledge is good for its own sake and gained via education in order for the individual to be regarded generally as an educated person. Postmodernists view knowledge as knowledge if it is functional. One should learn not only to know, but also to use that knowledge.

Postmodernism and the teaching/learning process. In the modern world, learning is centred on the content to be covered, with the expert creating knowledge and deciding on learners' needs. In the postmodern world there is no preset knowledge to be learned but the students discover knowledge (Hall, 1999; Reed, 1995). Postmodernists believe that all knowledge is invented or constructed in the minds of people (DeLashmutt & Roger, 1997). Hence it is described as anti-essentialism and deconstruction (Slattery, 1977). Anti-essentialism is a notion that representation is basically flawed, and the essence of things can never be transferred perfectly from one mind to the other. As a result postmodernism is against the transmission of information from the teacher to the learners (Slattery, 1997).

The teaching/learning process in postmodern education is characterized by active involvement of the learners in the process of deconstruction and construction of knowledge (DeLashmutt & Braund 1997), democratic classrooms, participatory rule making and dialogical decision making in class, communities of learning or cooperative learning, collective forms of accountability rather than discipline from the teachers (Kanpol, 1992). Postmodern classrooms are characterized by flexibility, democracy, respect, striving for diversity, creativity and importance of emotions, with learners and teachers engaged in the process of constructing knowledge (DeLashmutt & Braund, 1997). Learning in postmodernist's education is continuous deconstruction of knowledge, of playing with contradictions, and of creatively and productively opening the discourse of a field to an eclectic mosaic of many truths.

The student-centred classrooms, together with opportunities for social action, independent investigations and study, expression of creativity and provision for different learning styles facilitate the creation of knowledge (DeLashmutt & Braund, 1997). Rather

than feeding the students with information, the postmodernists see learning as a participative involvement and control. The learning process and the actions of the learner become the focal points, rather than the teacher who is there to facilitate the learning process. As a facilitator the teacher must ensure that the students go beyond the surface knowledge frequently achieved through rote learning (Slattery, 1995). Therefore collaborative learning occurs in classrooms and in social settings to encourage interaction, as indicated in DeLashmutt and Braud, 1997).

According to DeLashmutt and Braund (1997), in these collaborative groups the students are involved in the process of meaning-making (analysis of text or discourse). Meaning is derived from the relationship between the object of study and the individual studying the object. What is viewed as knowledge during the process of meaning-making depends on the practical significance of that discovered truth. It is important, however, to note that the truth of the discovered knowledge in postmodernism is temporal, it is influenced by time and chance. Ironside (2001) therefore advises that the postmodern teacher should constantly examine knowledge in terms of its uses, limits, conditions and construction.

The limitation of postmodernism is that, as stated in Ironside (2001), it leaves unresolved tension between exposing and deconstructing the hegemony and the needs to function within the existing structure of the society. Furthermore, Ironside (2001) highlighted the problem associated with persistent deconstruction characteristic of postmodernism. According to this author the ongoing process of deconstruction leaves teachers and students with no basis for decision making and no practical conclusions or guidelines for application. In Ironside's view that makes postmodernism more academic

than practical and that accounts for the paucity of literature describing the actual use of postmodern pedagogies in specific situations.

The influence of postmodernism on nursing education. Nursing education curricula influenced by postmodernism are characterised by the ongoing process of deconstruction. The curriculum context changes with context as well as what is viewed as knowledge. There is no specific content to be covered by the students but the content depends on the experiences encountered in the learning environment. According to Reed (1995) postmodernism stimulated greater awareness among nurses of the culture of practice as the source of ultimate meaning about the object of that practice. In other words meaning is based on practice or experience in practical or clinical settings. Popper in Reed (1995) also stated that the ultimate locus of meaning is the culture or the object of inquiry. As a result the students in postmodernism learn in settings that will facilitate meaning-making. The students are placed in a setting that will facilitate better understanding of the theme or concept of interest at a given time. Meaning made by the students in these settings is context based, and that enhances learning and retention of what has been learned.

According to Reed (1995) nursing need not reject completely modernists' views about high theory or universal ideas but should rather use them as the base for examining knowledge as related to the context of a given situation. Metanarratives are therefore used in the process of knowledge construction in that they are used in the analysis of issues of interest.

Ironside (2001) highlighted that postmodernists challenge the grand narrative that teachers, or those involved in teaching of students need one or more degrees than that of their students, which means that the more achievements one has academically, the more

power he or she has. The postmodernists question what academic degrees signify in the teaching/learning process, and the relationship between the ability to teach and what is taking place in practice. As postmodernism encourages diversity and communities of learning, all those involved in the teaching/learning process are regarded as learners who also have an ability to teach by sharing lived experiences with learners. Defining learning communities Wilson and Ryder (1998) stated that the term 'learning communities' has been used by postmodernists as an alternative metaphor to traditional instruction. They are groups of people who support each other in their learning agendas. Learning communities are found where everyone is in learning mode-including the teacher-and where a sense of cohesion and common purpose is present. All members of the community are regarded as both teachers and learners. In the context of learning communities the person with a lived experience is believed to be more knowledgeable in that area irrespective of academic achievements. For example, in nursing education Reed (1995) asserted that patients as part of learning communities are knowledgeable and knowing participants in their healing process. They have deeper understanding of their situation than other members of the team because of the lived experience. Therefore in a curriculum that is based on postmodernism all those involved in the teaching/learning process share the responsibility of teaching and knowledge construction, thus students, patients or community members. The classrooms or clinical learning settings are characterised by diversity to encourage the sharing of different worldviews, thus enriching the knowledge constructed.

The Development of CBE in Health Professionals' Education

An enormous advancement and expansion in the provision of high technology and the focus on curative health care have been blamed for making health care unaffordable and inaccessible to most people, especially in developing countries (Jolly & Rees, 1998). This resulted in the Alma Ata declaration of 1978, declaring the strategy of "Health for All by the year 2000" and promoting primary health care. The adoption of this approach to health care triggered a worldwide educational move to reform manpower development programmes (WHO, 1978). The result of that was the reorientation of the education of health professionals to community-based education. Schmidt, Neufeld, Nooman and Ogunbode (1991) reported that in the 1950s the WHO began to encourage medical schools to establish departments of community medicine in response to the problem of the irrelevance of health professionals' education to the needs of the community. Although a lot was accomplished through these community health departments, the status within the academic environment forced students to use the community as a laboratory. The community was used only for data gathering rather than to learn and gain necessary experience that would help the students after graduation. In addition to this, time constraints had an influence on this failure in reorientation of education to be community-based. A limited time was allocated to the community-based experiences and that limited schools in achieving the set objectives, although not all schools were reported to have failed.

Schmidt et al. (1991) further reported that in 1979 the WHO brought together 19 representatives from medical schools to strategise how community-based education could be incorporated into the preparation of doctors. These representatives agreed that rather than having a single department oriented towards community education, the whole medical

curriculum should be determined by the needs of the community and that in addition the curriculum should be problem-based. Furthermore, the representatives recommended that the successful implementation of CBE requires (a) active involvement of the health care system in the education of students, and (b) establishment of a network as an attempt to strengthen one another's efforts.

Schmidt, Magzoub, Felletti, Nooman and Vluggen (2000) reported that community based education, which was proposed in 1978, developed very slow initially. Similarly, Hamad (2000) asserted that the first few attempts at reform in health professionals' education, in the direction of community based education, did not materialize until the focus changed to reforming the training of health professionals teachers to orientate these teachers to community-based education. The World Health Organization helped in establishing regional teacher training centres to specially prepare teachers for community-based education. The educational objectives in these training centres were defined with reference to the community needs. The outcome of this attempt was rather disappointing in other institutions because of the lack of a living model. It is important to note that Hamad did not specify when exactly this attempt was, therefore one cannot sequence the evolution of CBE well.

Other attempts to change to CBE were reported in a number of countries. In 1969, the reform to a Problem Based and Community Based Education curriculum was noted in the following institutions; McMaster Faculty of Health Sciences, Ontario, Canada, Xochimilco in South America, Maastrich in Europe, Newcastle in Australia, Gezira, Beersheva and Suez Canal region in the Middle East (Richard & Fulop, 1987) as individual institutions initiates. The institutions running community-oriented programmes came

together in 1979 and formed a Network of Community Oriented Educational Institutions or Health Sciences, which is now referred to as 'The Network: Community-Partnerships for Health through Innovative Education, Service, and Research'. This Network was formed before the WHO (1987) organisation's call to reform health professionals' education to be community-based. In 1979 the Network had 25 member institutions and in 1985 the number increased to 50. In 1990 it rose to 167 and the number of member states is reported to be increasing. In South Africa the University of Transkei (UNITRA) is a member of this Network of Community Oriented Educational Institutions for Health Sciences. Other associate members in South Africa are Free State University (Fitchardt, Viljoen, Botma & du Randt, 2000), the University of Natal School of Nursing (Uys, 1998) Pretoria Technikon, and the University of Western Cape.

The Network of Community Oriented Educational Institutions for Health Sciences was formed to present a global association of institutions for education of health professionals who were committed to contribute, through innovative education, service and research, to the improvement and sustainment of health in the communities they serve (Chaytors, 1998; Hamad, 1991). The network aimed at strengthening member institutions in achieving community-orientation and problem-based learning at regional, national and local levels in an attempt to take the education of health professionals along the path of relevance and quality (Boelen, 1999; Hamad, 2000). The network also aimed at assisting institutions that had made a political decision to introduce innovations in the training of health personnel, with the ultimate goal of improving health care and contributing to the achievement of health for all (Richards & Fulop, 1987).

The W. K. Kellogg Foundation, a non-profit making organization, sponsored community partnerships as an initiative to develop further community-based education for health professionals. The W.K. Kellogg Foundation continues to assist those educational institutions interested in transforming their curricula to meet closely the needs of disadvantaged individuals and rural communities. In South Africa, the Kellogg Foundation assisted the University of Transkei (Eastern Cape), Witwatersrand University (Gauteng Province), Free State University (Free State) and the University of Natal (Kwa-Zulu Natal) when they were initiating community based education (Nazareth & Mfenyane, 1999; Ross & Loening 1990). Community-based initiatives are continuing to take place in other parts of the world, including South Africa.

Rationale for the Change to CBE

The rationale or justification for change to CBE is presented under the following headings; quest for relevance, social progress, cost containment, dehumanised care and maldistribution of human resources.

Quest for relevance of health professionals' education. The nature of the education of health professionals has raised a number of concerns, especially because of the training of students within the hospital context (Schmidt, et al., 1991). According to Stewart (1990) hospital contexts socialize and educate the students in the expert care provider role, which is associated with the medical model. The facilities used for the clinical placement of the students include mainly the tertiary care institutions with technology that is not available elsewhere in the country and certainly not available in the places where students are supposed to work after graduation (Schmidt et al., 1991). Such training, according to

Peabody (1999), does not match the everyday demands of clinical environments, especially if the graduates practise in under-resourced and underdeveloped areas.

In addition to the above-mentioned concern Clarke and Cody (1994) pointed out that because traditional programmes offer the vast majority of learning experiences in hospitals, they give the impression that the students have mainly to master the escalating array of technical tasks and hospital driven competencies, which regrettably are not what the majority of the population need and can afford. As a result the graduates have difficulty adapting to an environment alien to those in which they were prepared (Schmidt et al., 2000). Confining the education of health professionals to hospital settings has contributed significantly to the concern about the adequacy of their education in meeting the needs of the population they serve (WHO, 1993). Furthermore, graduates lack interest in, and commitment to, serving rural and under-resourced communities, resulting in skewed or mal-distribution of human resources (Pathman, Steiner, Jones, and Konrad, 1998).

Peabody (1999), criticising hospital focused education, stated that hospital-based education has led to health professionals who are apolitical or politically naive, with little or no understanding of how social and political factors affect the health of the community. In hospital-based programmes there is an inappropriately narrow view of problems of health and disease leading to neglect of the major areas of care, and overemphasis on curative care at the expense of health promotion and illness prevention (Ross, 1989). According to McWhinney (1980) the students from hospital-based programmes do not understand the importance of the client's context when rendering service. The World Health Organisation proposed the reorientation of the education of health professionals to a community-based approach and the preparation of the students in an environment that closely resembled the

one in which they were more likely to practise after graduation (WHO, 1987). This organisation advocated CBE because it exposes the students to social, political and cultural milieu, thus increasing their understanding of the important elements of community life and the relationship of those elements to health (Ezzat, 1995). In other words, CBE gives a more contextual approach to client care, thus making it relevant to the needs of the community served (Boaden & Blight, 1999).

Social progress. Cohen (1999) reported that progress in the society and medical field had influenced the paradigm shift to community-based education. A tremendous improvement in the health of the population has been reported to result from the increase in the number of elderly people with chronic illnesses being managed in community and primary care settings (Chalmers, Bramadat and Andrusyszyn 1998; Cohen, 1999; Curtoni, 1999). The changing lifestyles that accompany political and socio-economic development demand knowledge of and skills in health promotion and illness prevention. The education of health professionals has thus to prepare graduates for these changes and community-oriented education is the best alternative (Gezairy, 1995). The paradigm shift to primary care settings, community and outpatient clinics added a strain in the teaching of health professionals in hospitals. Students no longer had sufficient clinical training because most of the patients were cared for in the community. The education institutions had no choice but to follow the patients or clients to where they were (Towle, 1992).

Cost containment. Jolly and Rees (1998) indicated that in the 20th century health care became unaffordable and inaccessible to most people because of the enormous advance and expansion in the provision of high technology and curative health care in hospitals. Owing to the escalating health care costs in hospitals, patients are discharged

early to be managed in outpatient departments, communities and primary care settings (Blumenthal, Jones & Mc Neal, 2001; Chalmers et al., 1998; Oneha, Sloat, Shoutlz, Tse, 1998; Oneha, Yoshimoto, Bell & Enos, 2001; Towle, 1992). Concerns about the escalating costs of health care have resulted in plans to restructure and re-orientate the health system more strongly towards community-based care and health promotion (Chalmers et al., 1998). In retrospect, the education of health professionals has contributed, inadvertently, to the current crisis in health care costs. Nursing education programmes have been criticized for focussing on curing the disease, which is more expensive than preventing illness, and promoting healthy lifestyles (Curtoni, 1999). Adopting a primary health care approach has been viewed as a solution to the increasing health care costs with the shift to the community, homes and or outpatient departments (Jolly & Rees, 1998).

Dehumanising care. Medical knowledge is progressing rapidly, discoveries in the field are accumulating quickly and technology is advancing rapidly (Curtoni, 1999). These advances are blamed for increasing the gap between education and practice and for distancing health professionals from patients, although this does not mean that these advances should not be an important part of the health care system (Garcio-Barbero, 1995). According to Curtoni new technologies affect the basic aspects of care, which is focusing on the client in total. Health professionals have become disease-oriented, focusing on how technology can help the patient, unaware that technology is dehumanising care.

Maldistribution of health professionals. According to Mattock and Abeykoon, (1999); and Pathman et al. (1998) the maldistribution of health professionals is due to defects in their preparation. They are inadequately prepared to serve rural communities by the nature of their training. Most of them are trained in the hospital context; they have had

little or no training in the wider aspects of health care such as addressing social, economic and political forces affecting health (Peabody, 1999). Their clinical training takes place in tertiary care hospitals that have facilities not available elsewhere in the country. Some developing countries send their students to train in developed countries expecting them to come back and serve their communities with resources which are totally different from what they are used to. Schmidt et al (2000) and the WHO (1993) indicated that graduates from tertiary care institutions and from developed countries have serious trouble adapting to environments different from those in which they trained. They prefer to practice in places with adequate resources and in places closely resembling where they were socialized. Consequently they leave the areas with limited resources, avoid those places under-resourced.

The Concept of Community

Integral to a discussion of CBE is an examination of the underlying concept of community, which has, just like the concept of CBE, multiple interpretations. Jolly and Rees (1999) was certain that conflicting ideologies on the concept of CBE are attached to the different meanings attached to the term 'community', which forms the basis of the concept of CBE.

Historically, the concept of community comes from the Latin term, *Communitas*, meaning fellowship or common relations and feelings (Galbraith, 1995). In exploring the concept community, a variety of definitions and numerous usages were discovered. In 1995 Hillery presented 94 definitions of community found in the social science literature. From these 94 definitions Stanhope and Lancaster (1996) selected three key themes, which are

locality, community feeling or solidarity, and patterns and networks of social interaction. This means that there are definitions which are related to neighbourhood and territory, others associated with social interaction, and others related to the feelings of belonging and solidarity. Galbraith (1995) categorised the definitions of the term geographically, demographically and psychographically. Geographically, the community may be referred to as a total of the geographic area or region in which people share common boundaries. For example, Jolly and Rees (1999) reported that community in the context of CBE refers to the geographic location where students are being placed for community-based learning activities. Demographically, community may be defined as groups bound by common demographic characteristics such as race, gender, sex and age, for example the elderly community. Psychographic communities are those formed by a commonality of value systems, social class and life style, for example a community of 'weight watchers'.

Because of this diversity of meanings attached to the concept of community the World Health Organization (1987) suggested the following definition: "Community refers to a group of individuals and families living together in a defined geographic area, usually comprising a village, town or city. The population of this area requires primary, secondary and tertiary care services" (WHO, p.6). Galbraith (1995) was concerned about defining community in terms of geographic boundaries because such a definition hampers the richness of the meaning and purpose of the community. He/she suggested that community may be defined as a combination of geographic, locational, and non-locational units, systems, and characteristics that provide relevance and growth to individuals, groups and organisations. In view of all the definitions provided in this review it is evident that the definition of the concept community is determined by the context at any particular time.

Community-Oriented Education (COE)

According to Hamad (2000), community-based education and community-oriented education are two terms often confused or used synonymously. The concept community-oriented education (COE) was first defined by the Network of Community-Oriented Educational Institutions of Health Sciences in 1979, basing it on WHO's (1987) definition of the community (geographically). The Network defined COE as education, which focuses on population groups and individual persons in the community. This type of education takes into account in all aspects of its operation, major health problems afflicting the population in which it is concerned. Schmidt et al. (1991) pointed out that the concept of COE implies several things. Firstly, it implies that the curriculum content is no longer defined by the internal structures of disciplines contributing to it. Rather, these disciplines are relevant to the curriculum to the extent to which they contribute to the deeper understanding of the problems that define the curriculum. Secondly, it implies that the COE programmes differ from each other depending on the specific nature of priority problems in particular populations or in the surrounding communities (Schmidt et al., 1991; Matteson, 2000). Thirdly, it implies that the COE curricula are highly adaptive to changes in the environment, because today's problems may not be tomorrow's problems. Curriculum reform is brought about by the empirical and theoretical analysis of the prevalent priority health problems in the community (Schmidt et al., 1991).

The WHO (1987) further stated that the aim of COE is to produce graduates who are able and willing to serve their communities and deal effectively with health problems at primary, secondary and tertiary levels through the delivery of health oriented, rather than disease oriented, education. According to Schmidt et al. (2000) the emphasis in COE is on

health promotion and disease prevention. The commitment to health and social problems distinguishes COE graduates from their colleagues working in acute care or hospital settings (Hamad, 1991). Towle (1992) emphasized that the aim of COE is not to produce a new category of health personnel but to provide health personnel with relevant knowledge, skills and attitudes to respond primarily to needs of the society.

According to Schmidt, Lipkin, de Vries and Greep (1989) the two major characteristics to be stressed in COE are the institutions' commitment to the community-oriented education and the institutional involvement in the actual delivery of health care to a given community. The commitment is determined by the curriculum objectives and curriculum content (Schmidt et al., 2000). Schmidt et al. (1991) pointed out that there is a fundamental difference in an educational approach between an institution that is primarily committed to COE and one in which community-directed learning is but one of several tracks. From these differences stems the need for clearly stated institutional objectives, which describe the desired behaviour of graduates and define institutional commitment to COE. The two characteristics highlighted by these authors are based on the Network of Community Oriented Educational Institutions for Health Sciences criteria which were developed to establish whether a school is community-oriented or not (Richard & Fulop, 1987). These criteria include: (a) the extent to which the guiding principles are community oriented, (b) the emphasis placed in the curriculum on concepts and knowledge of what constitutes a community and a population, how to measure and cope with health needs and how to take proper account of the cultural and social background, (c) the extent to which community based learning forms part of the curriculum, (d) the degree of community

involvement in the training programme, and (e) the organizational linkages between the school or programme and health service system (p.164).

Such criteria, according to Schmidt et al. (2000), are important because an institution which has a slight degree of focus on the population and needs of the community may unjustifiably claim to be community oriented. In an attempt to differentiate between COE and CBE Snadden and Mowat (1995) indicated that the difference is in setting where learning takes place. According to these authors, in CBE teaching is carried out in the community settings, whereas in COE teaching may be carried out in a classroom but the teaching should be oriented towards the health needs of the population. Teaching in COE does not necessarily have to take place in community settings. Magzoub and Schmidt (2000), however, maintained that there is no clear distinction between COE and CBE but stressed that community orientation refers to the objectives of the school and their relevance to community health needs. The objectives are reflected in the curriculum content. In other words, the subject matter learned by the students has direct relevance to the priority health problems of the community for which the students are prepared. From the presented information it is evident that COE has a curriculum that is founded on the needs of the community. The setting where it takes place is not an important issue. The students may or may not be placed in community settings.

Conceptualisations of CBE

CBE is sometimes defined in relation to the setting in which it takes place. For example Margolis (2000) simply refers to CBE as education of health professionals in the community context or primary care setting, outside hospital setting. Magzoub and Schmidt

(1998) defined CBE as a set of instructional activities that uses the community extensively as a learning environment. Magzoub, Ahmed and Salih (1992) defined CBE as an educational process or means by which to achieve COE. Matteson (2000) presented a definition of CBE that captured more than what is incorporated in the above definitions. This author defined CBE as an educational pedagogy that requires a partnership between at least two communities, an academic institution and the community. It is a method of teaching that embraces and values the knowledge and skills of all participants (faculty, students, providers and residents). It enables the participants to work collaboratively to improve the health of individuals, groups, and the neighbourhood as a whole while educating faculty and students in the realities of patient or client lives. There are other definitions that go beyond the process of education to the outcomes of CBE. For example, Galbraith (1995) defined CBE as an educational process by which individuals become more competent in their skills, attitudes and concepts in an effort to live in and gain control of their communities through democratic participation. Individuals, according to this definition, may be all those involved in community-based education. Galbraith's definition focuses on the outcomes of community-based education and there is no reference to what is taking place during the process of learning. In view of the definition that focuses on outcomes Kerensky, in Galbraith (1995), stated that learning in an outcomes-focused programme is a dominant factor because community-based learning activities propel one to desired outcomes. During the process one learns the skills and knowledge. In other words, according to Kerensky in Galbraith, the definition which focuses on outcomes covertly includes the education process.

Notably in some definitions CBE is defined in terms of the setting where learning takes place, without any reference to the purpose and nature of education in such setting. These definitions fail to elucidate that which distinguishes CBE from other forms of education taking place in the community setting, for instance, the traditional placement of nursing students in community settings. Nevertheless, Mattesson (2000) went further than seeing CBE only in terms of “a setting” where learning takes place, to include CBE aims, as well as the knowledge, values and attitudes it embraces. For instance, Mattesson highlights the importance of partnership between the community and the academic institution, and the contribution of all the partners in terms of knowledge, skills and values. This suggests that CBE generates and utilizes available resources and skills within the partners, as well as untapped skills and resources, to meet the diverse needs of the community and others involved in the partnership. In addition, learning in the community setting takes into consideration the realities of patients or clients’ context, thus promoting relevance of education to the needs of the community and the academic institution.

The WHO (1987) posited a similar view to that of Mattesson (2000) in defining CBE as a means of achieving educational relevance to community needs and, consequently, as a way of implementing a community oriented educational programme. According to the WHO, CBE consists of learning activities that utilize the community extensively as a learning environment in which not only the students, but also the teachers, members of the community, and representatives of other sectors are actively involved throughout the educational experience. The WHO further maintains that, depending on how the population is distributed, CBE can be conducted wherever people live, be it in a rural, suburban, or urban area, and wherever it can be organized. For the WHO,

an educational programme can be called community-based if, for the entire duration, it consists of an appropriate number of learning activities in a balanced variety of settings, namely, in both the community and a diversity of health care services at all levels, including the tertiary care hospitals. The distribution of community-based learning activities throughout the duration of the curriculum is an essential characteristic of a community-based education programme (WHO, 1987, p. 9).

What has emerged from the definitions presented is that CBE is education that serves as a means to achieve relevance to the needs of the community. Relevance in this type of education is achieved by using the community extensively as learning environment. In this environment, as Magzoub, Ahmed and Salih (1992) stated, individuals, families and communities are used as units for learning, to enhance relevance of education.

Classification of CBE Programmes

The diversity in existing CBE programmes has led to a number of initiatives in trying to classify them. Some of these attempts have been reported in literature (WHO, 1987; Jinadu, 1992), but currently there is not yet a comprehensive review of community-based education for the purpose of classification (Magzoub & Schmidt, 2000). According to Magzoub and Schmidt, the initial attempts tried to differentiate between conventional education and community-based curriculum. For example, Jinadu (1992) distinguished between the two models, conventional and experiential models of community-based education. The experiential community-based model was differentiated from the traditional model by the learning environment where learning took place, the teaching/learning process,

and by the role of the teacher. The experiential model was described as unique education aimed at educating health professionals towards achieving relevance. It was characterised by the utilization of the entire social environment of the community for learning, the teacher using inductive, non-directive learning processes and deep level approaches to learning. The experiential model encouraged the students to explore the meanings of what they encountered in the environment, and to work in multi-disciplinary teams.

The WHO's (1978) initiative was slightly different from that of Jinadu (1992). The WHO aimed at distinguishing between a community-based curriculum and a community-based learning activity. The WHO described a community-based curriculum as learning activities that utilize the community extensively throughout the educational experience. The distribution of community-based learning activities throughout the duration of the curriculum is an essential characteristic of a community-based programme. On the other hand, community-based learning according to Magzoub and Schmidt (2000), is a short and isolated educational activity that takes place in the community setting.

Another reported initiative was by Magzoub and Schmidt (2000). They hoped that having a taxonomy that described all CBE programmes would encourage the development of a more systematic approach to the study of CBE, thus contributing to the theoretical basis of CBE. In addition, having this approach of classification may help in developing guidelines for the implementation of community-based education. Magzoub and Schmidt (2000), experts in CBE and COE, suggested a classification of CBE programmes which encompassed three categories; service oriented, training oriented and research-oriented programmes. This classification is based on (a) the nature of activities carried out by the students in the community, (b) the level of community involvement and, (c) the level of

involvement of an academic institution in the programme. It is important to note that these categories are not mutually exclusive, but sometimes overlap. They can be divided into six subcategories (see Figure 1). The further breaking down of the three above-mentioned categories is influenced by the activities taking place in the community settings (Magzoub & Schmidt, 2000).

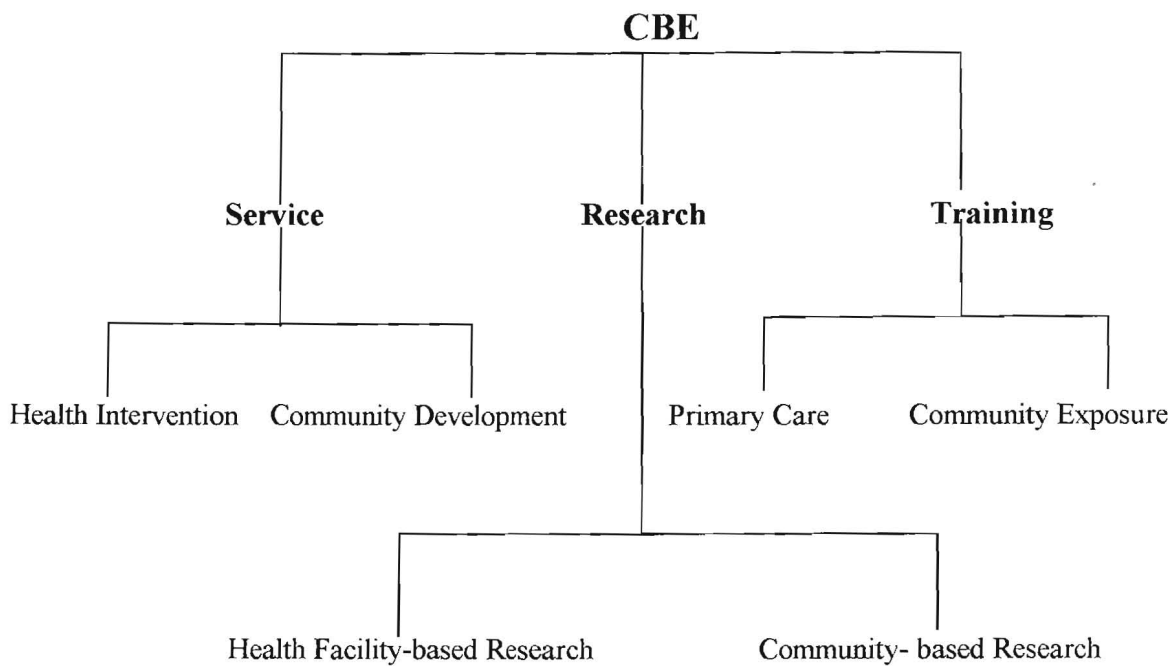


Figure 1: Classification of community-based educational programmes. Source: Magzoub & Schmidt (2000)

Service-oriented programmes. Service-oriented programmes primarily focus on providing services to an under-served community. Such programmes may be further classified as health intervention and community development programmes. Health intervention programmes focus on small-scale problems that can be tackled over a short

period of time, perhaps through health education, or the students' interventions in a problem of sanitation, water supply, just to mention a few.

Community development programmes, on the other hand, focus on developing the community. They run over a long period of time that might extend over three years or more. The students are exposed as early as possible in the programme to the community and they follow the same community development project throughout their education (Magzoub & Schmidt, 2000).

Research-oriented programmes. Research-oriented programmes focus mainly on research that is related to the problems existing in the surrounding community. These can be subdivided into community-based or health-facility based programmes. The site where the research is conducted determines the difference between these programmes. Research may either be conducted in the community setting or in a primary health care facility. The community may not necessarily be actively involved in these programmes. The purpose of conducting research may be to collect data to locate and delineate a major health problem plaguing a particular community; for example, the students may be used as data collectors, gathering information on a disease outbreak in order to inform the respective authorities or department, namely, the department of health, environmental health department, nutrition department and other departments (Magzoub & Schmidt, 2000).

Training-oriented programmes. The primary goal of training-oriented programmes is the clinical training of students. This category can be further divided into primary care based programmes and community exposure. In primary care based programmes, the students are placed in primary care settings for learning experiences. The focus of their learning in these settings is on the health problems affecting the surrounding

community. The health problems are identified through the health facility. The students have less involvement with the community. On the other hand, the training-focused programmes give students exposure to the community only through visits. The students may visit established community projects or health agencies in the community for learning purposes but there is no hands-on involvement (Magzoub & Schmidt, 2000).

Through this exercise of classifying CBE programmes Magzoub and Schmidt (2000) highlighted a number of dimensions that may assist in analysing them. Some of these dimensions are: (a) the timing of the first community-based learning in the programme; (b) the duration of community-based learning activities in the programme in relation to other curricular activities; (c) the level of community involvement, either passive or active; (d) the level of university involvement, which may be technical or financial; (e) the level of student involvement, which may be at the level of an observer, data collector, health provider or community developer/ change agent; (f) the types of training sites used; (g) the time allotted to CBE and (f) the responsibility of the organization towards the programme, whether school or department-based, faculty or university-based.

Principles of CBE

According to the WHO (1987) the success of a community-based education curriculum depends on a number of issues and principles. Some of these important issues include relevance to health needs of the community, the collaboration of the health education system and the health service sector, inter-sectoral linkages, community involvement, a multi-disciplinary approach, valid performance assessment and the development of lifelong learners (WHO, 1987).

Relevance to the priority health needs of the community. According to Ezzat (1995) relevance of health professionals' education to the community and its needs should take priority and be of the utmost importance in a CBE programme, because relevance has been identified as the major shortfall in the current education of health professionals (WHO, 1993). Relevance of the curriculum involves identifying the essential knowledge, skills and attitudes required in the health professionals' education and where these are to be covered in the continuum of the health professionals' education. It is, however, important to note that essential knowledge, skills and attitudes are determined by the health needs of the community. The relevant community-oriented educational programmes are supposed to take into consideration individual and community needs and problems. The curricular design and content should be based on the local demography, socio-cultural characteristics and actual characteristics of the community (Ezzat, 1995). To be able to develop competent graduates with these relevant skills the WHO (1987) proposed collaboration between the health system and the education system in the preparation of graduates.

Collaboration between the health system and the education system. According to Refaat, Nooman and Richards (1989) and Nooman in Schmidt et al (1989), collaboration between the academic institution and health system should begin as early as possible in the process of adopting a CBE curriculum. This early start is crucial and has many implications (WHO, 1987). Garcio-Barbero (1995) stressed an increasing gap between education and service resulting from the contrast between the academic values of educational institutions, on one hand, and the service requirements and consumer expectations on the other. For that reason alone there is a need for collaboration between the health service sector and the academic institution. According to the WHO (1993) any health profession's educational

institution seeking to respond to the demands of the government and needs of the communities must work in consultation with the health care system operating in the same area. The linkages between these two sectors (service and education) ensure that health professionals are better prepared to address the problems facing the health sector, thus increasing the relevance of the training programmes to prevailing health needs. The WHO asserted that the health care system would have a valuable input in defining the profile of graduates and might have an opportunity to play an important role in the development of future health professionals. On the other hand, the academic institution might have input in policy development (WHO, 1993). It was believed that through collaboration the quality of graduates and the standard of the services offered both at primary and secondary level would be improved (Okasha, 1995; WHO, 1993).

An integrated model for medical education and health services is reported to have been successful in other countries such as the United Arab Emirates, where it has resulted in a major transformation in the health care system (Aljouni, 1995). This author reported that it has not been possible in other areas because of the historical differences, objectives and responsibilities of these services; lack of political interest and support; financial implications; traditionalism at centres for health professionals education and health care providers, and because the public does not easily accept changes in the traditional pattern of service.

In conclusion, linkages between education institutions and health service are necessary in addressing the issues of relevance in health professionals' education. The success of this partnership, however, heavily depends on the involvement of the community

in the education of health professionals. All these three partners play an important role in broadening the education of health professionals.

Community involvement. The WHO (1987; 1993) emphasizes the importance of involving the community in a CBE programme, especially in decision-making, because the success of implementing a CBE programme depends on the community's willingness and readiness to participate (Magzoub & Schmidt, 2000). The input of the people is crucial in planning community-oriented educational programmes, as these are based on the health needs of the community and the curricular content is determined by the health needs of the community (Habbick and Leeder, 1996; Okasha, 1995). The WHO warns against the use of the communities as laboratories. Both the students and the community should benefit from CBE programmes. Ezzat (1995) isolated certain principles related to community involvement. Briefly those principles include that:

the community members have the right to share the responsibility of community based learning activities; their contribution is central both to the learning phase and to implementation of action programmes, (b) students cannot use communities as if they were laboratories, (c) partnership rather than paternalism should dominate the interaction process between institutions and communities, (d) the role of the community in students' learning has to be accurately defined and planned according to established goals and objectives, and (e) the students-community links should start early in their educational experience and must continue throughout the whole programme (Ezzat, 1995, p.134).

Ezzat further added that community-based programmes must be of clear benefit to both students and the community in which they are implemented; this implies an active effective community contribution to the educational programme.

The WHO (1993) also indicated that an educational institution, before linking with the community, should take into consideration the following:

(a) the educational institution as a whole should deal with the community as a whole. The separate disciplines should not make separate arrangements, (b) there should be a commitment to a broadened outlook and greater participation of the institution in health services in the community, (c) the institution should require students at all levels (undergraduate, graduate and continuing education) to work in the community (p. 10).

Oneha, Yoshimoto, Bell and Enos (2001) emphasized that the students from various disciplines should approach the community as a team and work together in partnership with the community. That prepares them for the future roles in multi-disciplinary teams.

Multidisciplinary team approach. The WHO (1993) emphasized the importance of using a multi-disciplinary approach in developing students, since community-based education is aimed at developing health professionals who will be able to function in interdisciplinary teams. Interdisciplinary education for health professionals has been advocated by Erkel, Nivens and Kennedy (1995), Oneha, Yoshimoto, Bell and Enos (2001). These authors assert that if health professionals are expected to function in interdisciplinary teams their education should provide socialization in interdisciplinary collaboration and in a

climate that rewards such behaviour. According to the WHO (1987) the multi-disciplinary team approach in training of health professionals has the following benefits:

- (a) it helps each member of the health team to understand the functions of the other,
- (b) it allows the expertise available to be used to the best advantage, (c) it reduces duplication and contradiction in curriculum design, (d) it increases communication among teacher, learners, and health service staff, and (e) it permits the collective assessment, allocation, and utilization of educational resources according to needs and not according to chance or individual bias (WHO, 1987, p. 41).

Oneha et al. (2001) commented that the multi-disciplinary approach enhances professional growth, but it is also challenging because it necessitates respect, trust, common vision, accountability and commitment from other team members.

Inter-sectoral approach. According to the Alma Ata Declaration, PHC involves the health sector all other related sectors, such as agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors. The WHO (1987) highlighted that education and training of health personnel has been mostly intra-sectoral rather than inter-sectoral in action. The success of inter-sectoral linkages depends on the political commitment from the highest national authority. The WHO, describing intersectoral approach, indicated that coordination among sectors means that each one can use its own resources to the best effect or even achieve certain of its own aims which, through lack of coordination with other sectors, it has not been able to achieve in the past.

Valid performance assessment. Assessment closely related to the kind of learning activities that the students are actually engaged in is known to stimulate students to learn.

Fredericks and Knox, cited in Magzoub et al. (1998), asserted that irrelevant assessment may reduce motivation and result in irrelevant activities and negative attitudes. Relevant student assessment and feedback is important in programme evaluation because if assessment is relevant to the programme's primary goals, the results of the assessment will directly impact on the way the programme is operated and further developed (Magzoub et al., 1999, Schmidt, Abdel-Hameed, Dolmans & Mustafa, 1998). The WHO (1978) indicated that assessment instruments should be constructed in relation to the purposes of community-oriented education. Because community-based educational activity involves multidisciplinary learning/teaching with several teachers, construction of the assessment instruments should also involve these teachers (WHO, 1987). Assessment should establish the impact of the programme on the students and on the health of the community (WHO, 1993). Adopting community-based education has led to the problem of how students should be assessed on their performance in community activities. Valid performance assessment in community-based education is important because community-based work is competing with other academic activities that have well-established academic assessment methods. Both the students and staff may consider community-based work as secondary to the core curriculum and then develop less commitment to community-based activities (Magzoub, Schmidt, Abdel-Hameed, Dolmans & Mustafa, 1998).

Problem-centred learning. Problem-centred learning (PCL) was identified as a vehicle for enabling the students to develop a useable body of integrated knowledge and problem solving skills (Harden, Snowden & Dunn, 1984). According to Refaat, Nooman and Richards (1989) graduates of CBE programmes are expected to deal with the problems of individuals as well as community problems: PCL therefore provides an opportunity for

students to work out such problems. In CBE health problems form the basis for learning or teaching and in that way prepare the graduates to handle problems after graduation, especially in under-resourced communities (WHO, 1998)

CBE in Basic Nursing in South Africa

In reviewing the existing community-based basic nursing education in South Africa, the researcher focused on the following; the inception of the programme; rationale for adopting CBE; the teaching-learning process and the nature of community-based learning activities. The analysis of the existing programmes was problematic because of limited reporting on these programmes.

University of the Free State School of Nursing.

Programme inception. In 1997 the school of nursing at the University of the Orange Free State introduced a community-based, problem-based curriculum (Fitchardt & du Rand, 2000). The change process involved the identification and bringing in of foreign experts for faculty preparation (Fitchardt & du Rand, 2000). The old curriculum was reported to have had a component of being community-oriented as the students were spending a substantial amount of time at clinics and community health centres. The old curriculum, however, did not consider community health needs as important variables in programme planning, therefore changes were needed (Fitchardt, Viljoen, Botma & du Rand, 2000). Fitchardt et al. (2000) described the Free State School of Nursing's community-based education programme as a programme that functions in partnership with communities and service providers. According to these authors there is a high level of

community, university, health care service and students' involvement. It is believed that exposing the students to this working partnership affords them an opportunity to understand the capabilities and initiatives of the communities they serve and, on the other hand, the communities realize that they should take care of their health needs. The approach used by this school can be classified as interdependent, consultative, training-focused, and service-oriented (Fitchardt et al., 2000).

Rationale for a change. The process of change began in the early 90s in response to a number of forces nationally and internationally. Firstly, in the early 90s the university entered into a partnership with the Mangaung community and formed a University Community Partnership Programme, the project that was funded by the Kellogg Foundation (Fitchardt et al., 2000). The involvement of the school of nursing in this partnership led to the realization of the importance of a curriculum determined by the needs of the community (Fitchardt, et al., 2000). Secondly, the powerful global movement towards Health-for-All by the year 2000, coupled with the necessity to focus national health care delivery systems on primary care also had an impact. The Agenda for Action by the WHO in 1991 made clear the role of health professionals' education institutions towards meeting the needs of the population served. Universities internationally were challenged to prepare health professionals for the prospective needs and demands of the population they served. As a result the school of nursing, as part of the University of the Free State, had to meet this challenge. Thirdly, political changes in the country as well as the change in the National Health Care Policy with the emphasis on PHC as means to improve and maintain the health of the South African population, more especially communities in under-served areas, demanded a paradigm shift in the education approach used by the school. Health

professionals' programmes had to be structured so that they produced graduates with the relevant knowledge and skills to serve the South African community (Fitchardt & du Rand, 2000; Fitchardt et al., 2000). Lastly, Fitchardt and du Rand (2000) maintained that at the University of the Free State, School of Nursing basic nursing programme had to be changed following the 1996 recommendations by the National Commission of Higher Education (NCHE). The NCHE recommended that health education institutions should revise their curricula to equip the health care students and health personnel educators with comprehensive knowledge, competency and attitudes to respond to the health care needs of the population of South Africa. Explaining this statement further Fitchardt et al (2000) stated that "in reality this meant contextualizing of learning and narrowing the gap between the curricula content and realities of health care practice" (p. 87).

In addition to the above-mentioned reasons for change, Fitchardt et al. (2000) stated that the school of nursing at the University of Free State was using teaching methods which were not adequately synchronized with the principles of adult learning. There was no active learning or active involvement of students, thus promoting passive academic behaviour. As a result the students were deprived of the opportunity to develop problem-solving and critical thinking skills. The school had to adopt problem-based learning (PBL) to facilitate the implementation of adult learning principles. There are a number of interpretations on the concept PBL, but the Free State school of nursing associates with the definition of the McMaster University (Canada), where the analysis of health care problems is seen as the main method of acquiring and applying knowledge, and developing of independent lifelong learning skills in students. They use small tutorial groups, with five or six students and a tutor in each group.

The process of change. Fitchardt et al. (2000) stated that initiating the process of change was not without difficulties. Numerous doubts and questions concerning the new curriculum emerged internally and externally. To overcome these barriers the school implemented Kaufman's four change strategies cited by Fitchardt et al. (2000), (see Table 1).

Table 1: The process of change Source: Fitchardt, Viljoen, Botma & du Rand (2000)

<p>Phase 1: Getting started</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explore external motives for change, <input type="checkbox"/> Explore internal motives for change <input type="checkbox"/> Select appropriate leadership qualities and, <input type="checkbox"/> Obtain educational resources and seek financial support.
<p>Phase 2. Building support, overcoming resistance</p> <ul style="list-style-type: none"> <input type="checkbox"/> Build a broad base support early and avoid isolation, <input type="checkbox"/> Compromise, <input type="checkbox"/> Develop staff through training and, <input type="checkbox"/> Describe the innovative track as an experience.
<p>Phase 3. Evaluation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Evaluate short and long term results and, <input type="checkbox"/> Evaluate the process of change.
<p>Phase 4. Networking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Establish links between the school and other similar institutions that are well- established (nationally and internationally), <input type="checkbox"/> Develop a sister school relationship and, <input type="checkbox"/> Affiliate with a larger, recognized and well organized organization or network.
<p>Phase 5. Options for the future of the programme</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maintain the innovative programme, <input type="checkbox"/> Merge the two tracks into a hybrid and <input type="checkbox"/> Convert the entire programme to the innovative track.

The strategies implemented involved (a) developing a broad ownership for the proposed innovation, (b) winning converts by inviting participation, (c) forming of new alliances to broaden the support base and, (d) sharing success. It was crucial for the planners to build support internally and externally for the successful implementation of the programme. Support was obtained from different departments within the university as well as from the relevant communities and government institutions.

Workshops were held to familiarize partners with the new approach. There were a number of training sessions, which were conducted to develop the staff especially for their new role of being facilitators in PBL rather than being teachers. They also attended several international conferences and workshops on the role of facilitators and the process of facilitation. Networking with institutions running CBE and problem-based learning programmes was important and the exposure of the rest of the staff to field trips in these schools was crucial in creating a sense of understanding and coherence during the implementation of the new programme. In 2000 the school was reported to have obtained membership of the International Network of Community-oriented Educational institutions (Fitchardt and du Randt, 2000; Fitchardt et al., 2000).

Teaching/learning process. According to Fitchardt et al. (2000) the Free State school of nursing is using a community-based and a problem-based approach in their curriculum. The principles underlying the teaching/learning process include (a) a shift of learners towards independent learning, moving away from the narrow world of the teacher and the text, (b) the development of analytical and creative thinking, (c) the development of self-directed learning abilities, (d) the encouragement of cooperative learning, (e) the

integrated application of skills and knowledge in the context of practice and, (f) the encouragement or motivation to engage in learning.

Learning in the Free State school of nursing is based on a conceptual framework, which places emphasis on community partnership, community health care needs and the learning needs of the students. Fitchardt et al. (2000) presented a conceptual framework with the following concepts; health care, partnership, comprehensive health care, critical and specific outcomes, facilitators, student centred approach, nursing student, community, family group, individual and holistic assessment (Fitchardt et al., 2000). This conceptual framework was, however, not explained in the article where it was published. According to Fitchardt and du Rand (2000) the community is used extensively as a learning environment to give students an opportunity to understand the capacities and initiatives of the community they serve. Because both the students and the community should benefit from the CBE programme the community is also given an opportunity, through interaction, to understand the strengths and limitations of the health care system, and in that process of interaction to learn to take care of themselves (Fitchardt et al., 2000).

The community's involvement is more obvious during the placement of the students in the community where community members accompany the students in the community setting to familiarise them with its environmental and cultural activities. The community also accompany those students who are not familiar with the language spoken by the community, and sometimes assist by doing the translation for some of the students who have a problem in understanding the language used by the community (Fitchardt et al., 2000). The community is used as an environment to derive problems for use in the

classrooms, as part of the curriculum content (Fitchardt & du Rand, 2000; Fitchardt et al., 2000).

The students are divided into small groups, with the facilitator facilitating their learning process. During classroom interaction they use patient problems drawn either from the community setting or the health facility as a context in which to learn problem-solving skills (Fitchardt & du Rand, 2000). The students are also encouraged to define their own learning issues, arising from the problem presented at the tutorial session. The students as groups are given learning tasks which they undertake on their own. The students attempt to solve the problem, basing it on the presented scenario. The purpose of this exercise is to assist the students in acquiring knowledge and in developing their self-directed learning skills.

Concluding the presentation of the Free State school of nursing's CBE/ PBL programme, Fitchardt et al. (2000) stated that the unique opportunities offered to students through CBE/PBL assist the students in developing their ability to address the real health care needs of communities and also develop their interpersonal skills, such as leadership characteristics, the ability to work in teams and competence to interact with communities. These authors suggested that in small PBL groups the students should be supported in their efforts to attend to their socio-economic, non-cognitive, psychological, health and lifestyle needs. In addition attention is to be paid in the small groups to learn cultural sensitivity, which is of great importance for political reasons in South Africa.

University of the Witwatersrand (WITS) School of Nursing

Programme inception. McInerney (1998) reported that the curriculum change in WITS from a traditional layered curriculum to an integrated community-based and problem-based curriculum took place in 1995. The process of curriculum review, however, started as early as 1993. The preparation of the staff for the introduction of the new programme included attending workshops and conferences internationally and nationally (on CBE and PBL). The school also invited experts to assist in the process of change (McInerney, 1998).

Rationale for change. The knowledge explosion and inadequate preparation of health practitioners for primary health care were the two main reasons for reconstructing the basic nursing programme. The reconstruction was aimed at having a 40:60% community-based: hospital-based curriculum (McInerney, 1998). Building on the foundation of community-based education, the school decided to use a health to illness continuum, focusing on the individual, the family and the community. The idea behind this model was that each student's experience is built up in stages. The new programme had to expose the students through the stages of normality to problems in individuals, family and the community.

Teaching/learning process. The teaching-learning process is student-centred and problem-based. Small tutorial groups are used, within which adult learning principles are observed and the students are presented with problems emanating from real life situations encountered in the community or in clinical situation. The students are expected to be actively involved in working on these series of health problems. The facilitator is there to assist in the learning process (McInerney, 1998). The whole learning process is supported

by a wide range of educational resources- the library, expert lecturers and tutors, workshops, video and computer-based learning packages, lectures and seminars, site visits and clinical tutorials (<http://www.wits.ac.za/med/nursing>).

Programme structure. The programme is structured so that the focus in first year is on a healthy individual, family and community (McInerney, 1998). The students get their first community exposure at this level in the programme. Muldersdrift Health Centres, Alexandra clinic and a Hillbrow community partnership project are used as the bases when students are placed in those communities. During the first six months in the CBE and PBL programme, the first year students are allocated to different community sites for orientation to community issues, environmental health and community assessment (McInerney, 1998). Exposing the students to these settings as early as the first year not only allows the students to know the community but also to get a deeper understanding of the community and its real problems (<http://www.wits.ac.za/med/nursing>).

The focus in second year is on the individual suffering from illness, the disordered family and community (McInerney, 1998). It is at this level that the nursing students are more involved in Hillbrow Community Partnership Initiatives, which are multi-disciplinary. They participate in the partnership with the students from other faculties, such as environmental health, medical students, social work and other technikon students in conducting a community assessment. They compile a community profile on the health of the community in Hillbrow, and the surrounding community (Hlungwane, 1999). The third year students work at the clinics for their community-based learning experiences as a follow up to the case scenario of a client who has been discharged from hospital. They

follow that client at the clinic and in his or her community for continuity of care

(<http://www.wits.ac.za/med/nursing>).

In the fourth year, the students learn and deliver supervised services in relation to midwifery, which is referred to as women's health. At the primary health care clinics the students' focus is on maternal and child health (Tshabalala, 1999). They are placed at the clinics serving the community to which they have been exposed, and this placement gives them an understanding of the clients in their context. The nature of services and facilities in the health centre offers a conducive, multi-disciplinary environment for community-based teaching and learning of undergraduate students (<http://www.wits.ac.za/med/nursing>).

Community-based activities. Banda and Bruce (1999) reported that the Hillbrow Community-Partnership in which the University of Witwatersrand school of nursing is involved has initiated and sustained a number of community-based activities. These authors reported that the primary health care service operating from Muldersdrift clinic, offered by the University of Witwatersrand school of nursing, in partnership with the Gauteng Department of Health, run projects for the community which are need-driven and which assist in engendering ongoing social responsiveness in graduates. Some of the successful community initiatives reported are income-generating projects such as sewing groups and community vegetable gardens, that are maintained by unemployed community members. Other community projects include a feeding scheme, a road safety project, and a youth project, encompassing a variety of youth activities for youth development. The main aim of this project is HIV/AIDS education through appropriate cultural activities (Banda & Bruce, 1999).

University of Natal School of Nursing

Programme inception. The process of changing from a traditional hospital and content-based curriculum was begun as early as 1993 (Gwele, 1999; Uys, 1998). It is reported that a new group of students was admitted to the new programme in 1994 (Gwele (1997) and this first group graduated in 1997 (Uys, 1998). In their first year in the programme the students registered for the courses in foundational biomedical and social sciences, courses that were offered outside the school of nursing. Their first community-based learning experience was in the second year of the programme in 1995. According to Gwele (1997), CBE in the context of the University of Natal school of nursing does not only refer to exposure of the students to community settings during their training, but also refers to an educational programme whose content and processes are a result of negotiated community partnerships in education and health (Gwele, 1999). In the new programme the students are placed in community settings to increase their understanding and appreciation of the socio-cultural factors influencing health, more especially in under-served or under-resourced communities (Gwele, 1999).

Rationale for change. A number of factors influenced the launch of the new curriculum. Some of those factors were the school's realization of the inadequacy of the old curriculum in meeting the health needs of the community (Gwele, 1997). This author stated that the old curriculum was overloaded with content some of which was not relevant to the needs of the community, but was included because of its intrinsic worthwhileness to nursing. One of the premises of the new curriculum was that it had to be relevant to the needs of the diverse communities served by its graduates, and the curriculum content had to

be determined by community and learner needs (Gwele, 1997; Gwele, 1999). Another concern was the fragmented clinical placements of the students, as they were attending lectures in the mornings and going to clinical settings in the afternoons. Clinical placement was too fragmented to make meaningful learning possible (Gwele, 1997). The initiation of the Reconstruction and Development Programme and its focus on PHC reinforced the need to launch a community-oriented problem-based curriculum (<http://www.nu.ac.za/department>).

As there is a strong emphasis on PHC in the new curriculum, the students spend more time in community settings than in hospital settings. Hospital-based learning is only reported at the third year level and in the midwifery component (one semester course). Dana and Gwele (1998) defined community as a clinical placement in a geographic area, rural, peri-urban or urban where a group of people live and share a similar physical environment and a common way of life.

The new programme is structured so that the first year focuses on the basic needs of individuals of different age groups. The students are placed in community-based organizations (<http://www.nu.ac.za/department>). The second year deals with the family and the community and there is a strong emphasis on health promotion and illness prevention. The students are also introduced to PHC in second year. Third year is hospital-based (Adejumo & Gangalimando, 2000). The fourth year is the year of specialization. One semester is for mental health nursing, which is purely community-based and problem-based and the other semester is for midwifery, which is mainly problem-based. Primary health care as a module is offered at a fourth year level as a winter course, but it is introduced as early as the first year in the programme. The community-based learning activities are

mainly practiced in the second year and half of the fourth year

(<http://www.nu.ac.za/department>).

Teaching/learning process. Adejumo and Gangalimando (2000) pointed out that the teaching process at the University of Natal School of Nursing is characterised by the use of andragogical principles and a problem-based approach with the purpose, according to Gwele (1997) of facilitating the development of self-directed learning skills, meta-cognitive learning skills, problem solving, critical thinking and other skills. During the learning process the students are expected to be actively involved in the process of acquiring knowledge by doing research on the problems existing in the community or in other clinical settings

(<http://www.nu.ac.za/department>).

The students are divided into three small groups of about 10 each and are placed in three different communities, which include urban, suburban and rural communities (Adejumo & Gangalimando, 2000; Gwele, 1997; 1999; Uys, 1998). The placement of the students in the community settings takes place during university vacations to avoid clashes with courses run by other faculties (Gwele, 1997; 1999). According to Gwele (1997; 1999) the second year students where CBE is predominant start their academic year five weeks earlier than the university timetable. The first two weeks are for orientation to community-based learning. The facilitators use that time to approach community leaders to remind them about the placement of the new groups of students. The January period is spent doing a community survey and home visits to identify problems existing in that particular community. The curriculum content emanates from these identified problems. The April vacation is used for validation of community problems identified at the beginning of the year. Feedback is given to the community members on the problems identified by the

students at the beginning of the year. After validation of these problems, community meetings are conducted with the purpose of prioritising the identified problems and deciding on one problem the students can target for their intervention during the winter vacation. The intervention is a joint project with the community. Reported interventions are clean-up campaigns with the group of students, teachers and community members and health education sessions on a number of health issues. Evaluation of the intervention project takes place in September. The September vacation is also used for a nursing education 'expo'; a special function where the students reflect on their community-based experiences. The community members, service personnel or health professionals, parents, university personnel, the students and prospective students attend the expo which is also used as a platform to introduce new groups of students to community-based learning, as the community setting used is a totally different setting to that of the hospital (Gwele, 1999).

University of Transkei School of Nursing

Programme inception. The University of Transkei School of Nursing adopted a CBE curriculum in 1997 (Madalane, 1997). In first year the students are placed in the community once a week throughout the year (Madalane, 1997). Nazareth and Mfenyane (1999) reported that first year nursing students are placed in the community once a week throughout the year, second years spend three weeks, and third years two weeks in the community. This means that the students are exposed to community-based learning as early as in first year and the CBE activities take place throughout the first three years of the programme.

Rationale for change. Nazareth and Mfenyane (1999) indicated that the change to CBE was as a result of the inadequate allocation of resources in Transkei, which is a remote and mainly rural state. This lack of resources was translated to limited health care. In addition, graduates from UNITRA left Transkei for urban areas after completing their courses. Some of the reasons of relocating were poor pay and the fact that their training was not relevant to the needs of the Transkei population. They were frustrated by serving in under-resourced health settings, which were nothing like the institution where they were educated and trained. As a result of the limited numbers of graduates who were remaining to serve in Transkei, a need to train graduates who will be able to serve in the remote, rural and deprived Transkei was identified. The focus changed from hospital-based training to community-based education.

Teaching/learning process. The students are divided into small groups of about 10 with one facilitator (Madalane, 1997). The students are exposed to community-based learning activities throughout the programme. The PBL approach is used in teaching both in the community and in the classroom. Nazareth and Mfenyane (1999) reported that this school is part of the Community Health Partnership, which was formed in 1991. The staff and community representatives from these Community Health Partnership Centres were reported to be working closely with UNITRA, school of nursing, medical school and other health science disciplines as partners all of whom share a teaching responsibility. According to Nazareth and Mfenyane (1999), departments involved in this collaboration are pathology, microbiology, basic sciences, social work, nursing, clinical disciplines and health promotion. Students from different disciplines approach the community as a team and they contribute according to their speciality. Three community health centres, which

were built in partnership with the Kellogg Foundation, are used as the community bases for the students. These centres also serve as the resource centres for the community members. They are sometimes used for research purposes, community service and development.

The information, however, on the UNITRA school of Nursing programme is not adequate, perhaps because the available literature is from the medical doctors' perspective. Nurses have not yet published on this area. There is a need to have information on the UNITRA CBE programme from the nurses' perspective.

CBE in Other Schools of Nursing

According to Gwele, cited in Madalane (1997), the University of Western Cape and Frere College of Nursing are also involved in community-based teaching. The Frere College of nursing did not change the traditional curriculum, but added a component of community-based teaching to it.

In conclusion, several differences and similarities have been noted in the various community-based basic nursing programmes in South Africa. The diversity in the implementation of CBE somehow indicates that there are obvious gaps in the understanding of what CBE entails. According to Towle (1992), the lack of clarity on the concept of CBE leads to inconsistencies of approaches and mixed messages to people. Literature has revealed differences in CBE programmes in the following areas; the percentage of time allotted to community-based teaching, the timing of the first community experience, the kind of community-based learning activities, the level of community involvement in the programme and the level of involvement of other members from other teams and sectors, the approaches (uni-disciplinary; multi-disciplinary; multi-disciplinary and multi-sectoral)

used by different schools of nursing, and the insufficient supervision of community-based learning experiences, as well as uncertainty about the credibility of those involved in teaching students in community settings (Mash & de Villiers, 1999; Nazareth & Mfenyane, 1999; Ross & Loening, 1990; Schmidt et al., 2000; Williams et al., 1999,). According to Schmidt et al. (2000), the gaps identified in CBE programmes in South Africa are the most important dimensions characterizing a CBE programme, which cannot be compromised. The nature of the differences in CBE programmes supported the need for a study that would afford a better understanding of what CBE entails.

Community-Based Education Models

This section presents community-based education models. The reviewer provided a background on each model to provide an understanding of the model's context, the basic assumptions and prepositional statements as well as concepts of each model and their operational definitions. It is important to note that the models presented in this section were developed for community-based medical education. The literature reviewer presented them in this nursing education study because they were the only ones available, but, more importantly they were also applicable to community-based education in nursing education. In view of the lack of CBE models in nursing education, nursing education is challenged to revisit this area of CBE as CBE seems as an current and relevant education approach used throughout the world.

Causal Model of CBE in the Sudan

Magzoub and Schmidt (1998) developed a casual community-based education model. Its development of this model was in two phases; a hypothesized phase and a theory-testing phase. Reasons behind the development of this model were: (a) because of the increasing number of schools that were adopting CBE there was a need to develop a model that might guide efforts to develop a valid student assessment system, and assist in carrying out proper programme evaluation activities, (b) in a number of instances, CBE was criticized as a soft science with no scientific grounds. Magzoub and Schmidt hoped that the development of a CBE model would change that state of affairs, and (c) the number of the schools adopting CBE curricula was rapidly increasing, therefore these authors hoped that a model of CBE might enhance the possibility of sharing of experiences between similar programmes and might open avenues for comparative research.

Assumptions. The assumptions in this model are that (a) the actual involvement of the university is an important input variable in the success of CBE, and (b) the increase in the magnitude of one variable characteristically causes an increase of the magnitudes of other variables (see Figure 2).

Propositional statements. Propositional statements are that (a) the success of a CBE course depends on the readiness of the community to collaborate with the university staff and students in health related projects, (b) the success of CBE is deeply influenced by the leadership skills displayed by the students in dealing with the problems in the community, (c) the amount of activity or effort by the students during the community-based course is influenced by the readiness of the community to collaborate with the university staff and students, d) the students' eagerness to interact with community members is

influenced by the community's readiness, (e) contributions of the students to the subject matter are influenced by the community's readiness, students' leadership skills and effort put forth by the students during the community-based course, (f) the three outcomes of community-based education (effect on the community, student achievement and increased interest in the subject matter) are equally important in a CBE course.

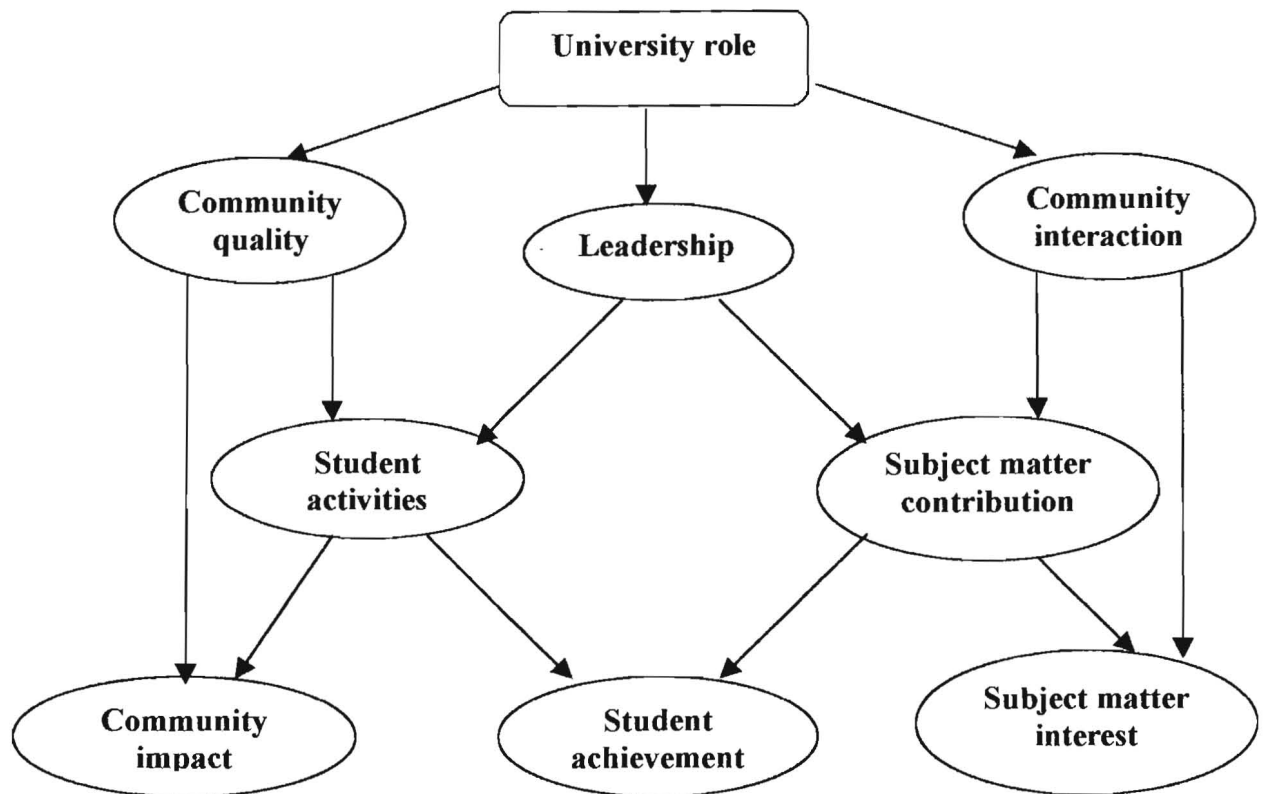


Figure 2: Causal model of community-based education. Source: Magzoub and Schmidt (2000).

Main concepts. The concepts in this model related to the process of learning include (a) the level of community readiness, (b) leadership skills displayed by the students, (c) community interaction, (d) subject matter contributions, and (e) effort. Concepts related

to the output include academic achievement of students, interest in community problems, and the impact (effect) of CBE on the community.

In their 1998 publication Magzoub and Schmidt presented **community readiness** as one of the concepts in their model. In the 2000 refined model these authors replaced community readiness with community quality, but there was no rationale provided for this change in concepts. The definition of these two concepts is, however, the same. Community readiness refers to the community's willingness to work with the students and staff in implementing community projects, the community's level of accepting the students in the community and the magnitude of community participation in community-based learning activities. This concept also refers to the level of the facilities available in the community, the community's social coherence, and the level of education of community members, as well as the quality of the leadership of the community. According to Magzoub and Schmidt (1998) the community must be ready to profit from the presence of the students in the community and at the same time provide an environment where effective learning can take place.

Leadership skills refer to the skills displayed by the students in trying to deal with the problems in the community. These skills, in the studies by Magzoub and Schmidt (1998; 2000), were displayed in leading group discussions, in decision-making, and in the ability to distribute work among group members. The leadership skills displayed by the students in dealing with the assigned problems of a particular community influence the level of success of the community-based course.

Effort is the extent to which students contribute to different activities carried out in the field and on the university campus, such as preparation for field activities, problem identification, report writing and attendance.

Community interaction refers to the students' ability to communicate with the community to facilitate data collection, project implementation and evaluation.

Subject matter contributions are reflected in students' ability to use gained knowledge to help the group progress towards the course objectives.

Achievement refers to the knowledge, skills and attitudes acquired by the students from community-based education. The achievement level is measured by the community members, the teachers and their peers (other students).

Effect on the community refers to the effect of the students' activities on the community.

Subject matter interest refers to the students' interest in community problems, which form the curriculum content.

Evaluation of the causal model of community-based education. Magzoub and Schmidt's (2000) causal model attempted to provide information allowing one to make some predictions about the consequences of relationships between concepts. According to Magzoub and Schmidt's model, relationships between concepts can be predicted as an improvement in one variable, after which all, other things being equal, an improvement in the outcome variables would result.

Secondly, the assumptions in Magzoub and Schmidt's model are not explicitly stated, but one is able to extract them from the report. More importantly, they are related to

the model presented. Magzoub and Schmidt (1998) defined well only the main concepts, community readiness and leadership skills. The sub-concepts were not well defined.

Model of Experiential CBE for Health Care Professionals

Jinadu (1992) developed an experiential model of community-based education at a time when there was an intensive debate worldwide on the relevance of health professionals' education to the needs of the population they serve, as the curricula currently used were adopted from Britain. A tremendous increase in the number of health professionals produced was reported, especially in Africa. Despite this considerable number there was no corresponding improvement in the health status of the people. Infant mortality rate remained unacceptably high, malnutrition and childhood infections remained the major cause of high mortality and morbidity in Africa. As a result of the inadequacy of health professionals' education, several attempts aimed at training health professionals with a strong inclination towards community care and preventive care were reported. In some cases it was noted that the objectives were clear, but the planning, implementation and even evaluation, of the community aspect of the curriculum were haphazard, uncoordinated and ineffective, resulting in poor student motivation to achieve the objectives of community-based care, especially in the area of PHC. In view of all this, Jinadu (1992) was convinced that experiential community-based education might assist in achieving the objectives of PHC in health professionals' education and therefore suggested a model, their purpose which was to educate health professionals towards achieving relevance to the needs of the community, as a theoretical goal.

What needs to be noted in this model is that it provides a systematic approach to CBE with the focus on learning rather than teaching. Jinadu's (1992) model is presented in the form of a table, comparing his model with a conventional method of learning. When explaining this particular model, Jinadu (1992) focuses on the experiential model and only refers to the conventional method when making a comparison. This model does not show how its substantive concepts are related. For that reason, each concept will be explained independently and the relationship will not be highlighted.

Assumptions. The underlying assumptions in this model are (a) health is a total community process, which means that the whole community structure must be considered when dealing with the health problems, (b) experiential community-based learning educates health professionals towards achieving relevance to the health needs of the community.

Main concepts. The main concepts in this model are sources of information, the learning environment, the teacher's role and the approach to learning (see Figure 3).

Sources of information refer to how information required by the students for learning purposes is gathered. In the context of the experiential model Jinadu (1992) described sources of information as observations and enquiry, rather than the teacher in the conventional model. The students actively gather information on the surrounding community or communities through observations and the process of enquiry. Observations and enquiry are in general regarded as a method of collecting data, not sources of information.

Jinadu (1992) explained that as part of their learning experiences, the students in the experiential model carry out fieldwork related to community assessment. During that learning process the students are required to gather information on the community through

observations, observing the socio-cultural environment. The students also carry out problem solving research activities related to the information gathered in the community.

Throughout the learning process the students are encouraged to explore the meaning of what they encounter in their learning environment by researching further on the issues of interest.

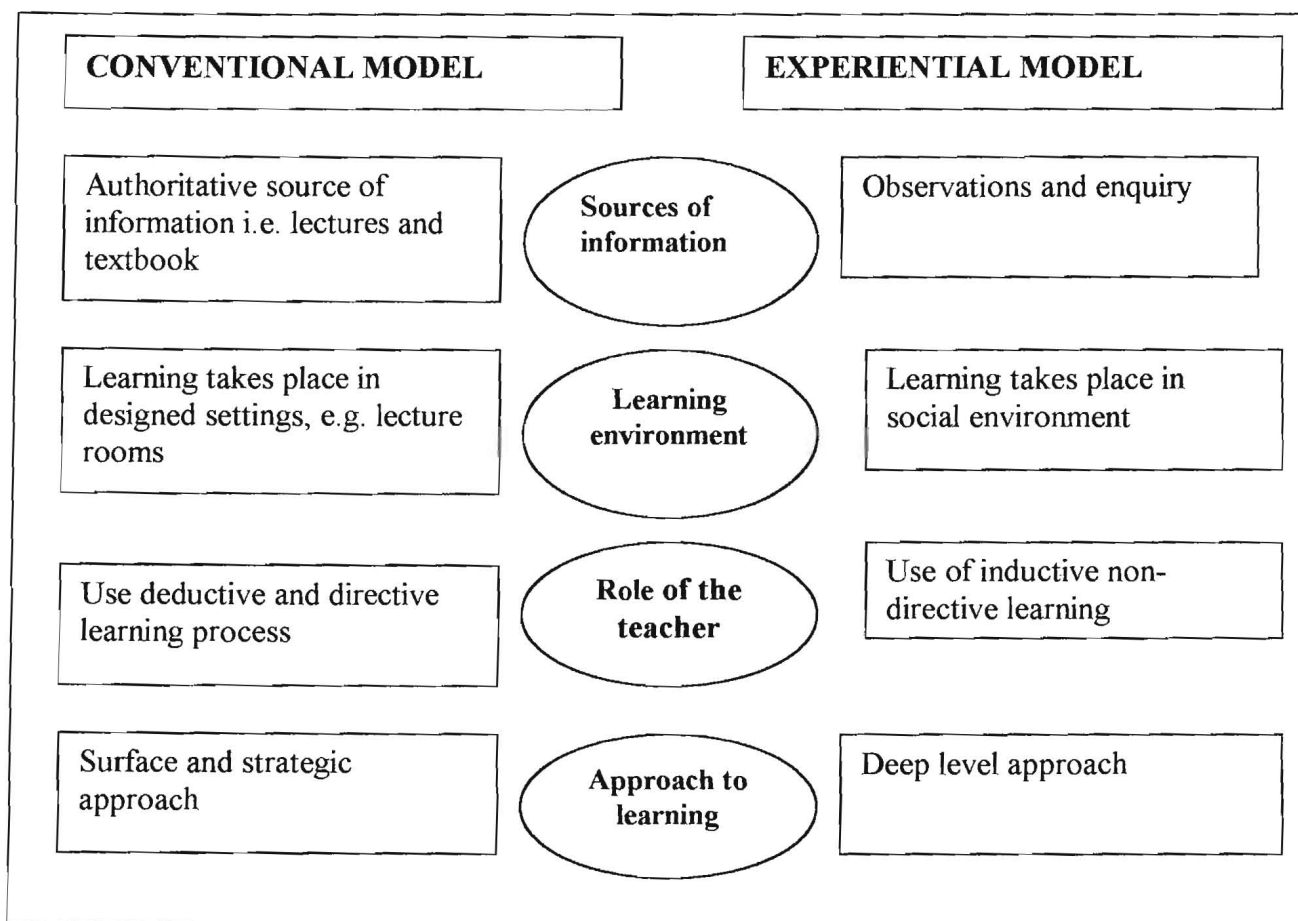


Figure 3: Model of experiential community-based education for health care professionals: Source: Jinadu (1992)

Learning environment in the context of this model refers to the community environment where learning takes place. Learning takes place in an entire social

environment of the community, that is, the family, the community and the health service centres in the community. The use of the community as a learning environment is decided by how Jinadu (1992) understands health, that it is the responsibility of the community, therefore the community must be considered when addressing their health problems.

The **teacher's role** refers to the activities and responsibilities of the teacher, which are directed towards the development of the students. In experiential community-based learning the major role of the teacher is to select appropriate learning experiences for the development of problem-solving skills, attitudes and interest, for the achievement of predetermined objectives. The teacher is also expected to help the students develop thinking skills by helping them to think and work out problems for themselves, using their own initiative. This approach differs from traditional learning, where teachers use a deductive process, but in the experiential learning model the teacher uses an inductive learning process.

Approach to learning refers to problem-based and self-directed learning approaches used in experiential learning.

Model for Community-Based Teaching

Snadden and Mowat (1995) developed a model for a community-based teaching which has six steps (see Figure 4). Snadden and Mowat's model was developed at the time when, throughout the United Kingdom (UK), medical schools were struggling with curriculum changes as a result of the changing patterns in the health care system. CBE was in its infancy in the UK and therefore there was a need for a model that would guide the development and implementation of CBE curricula in institutions for health professionals.

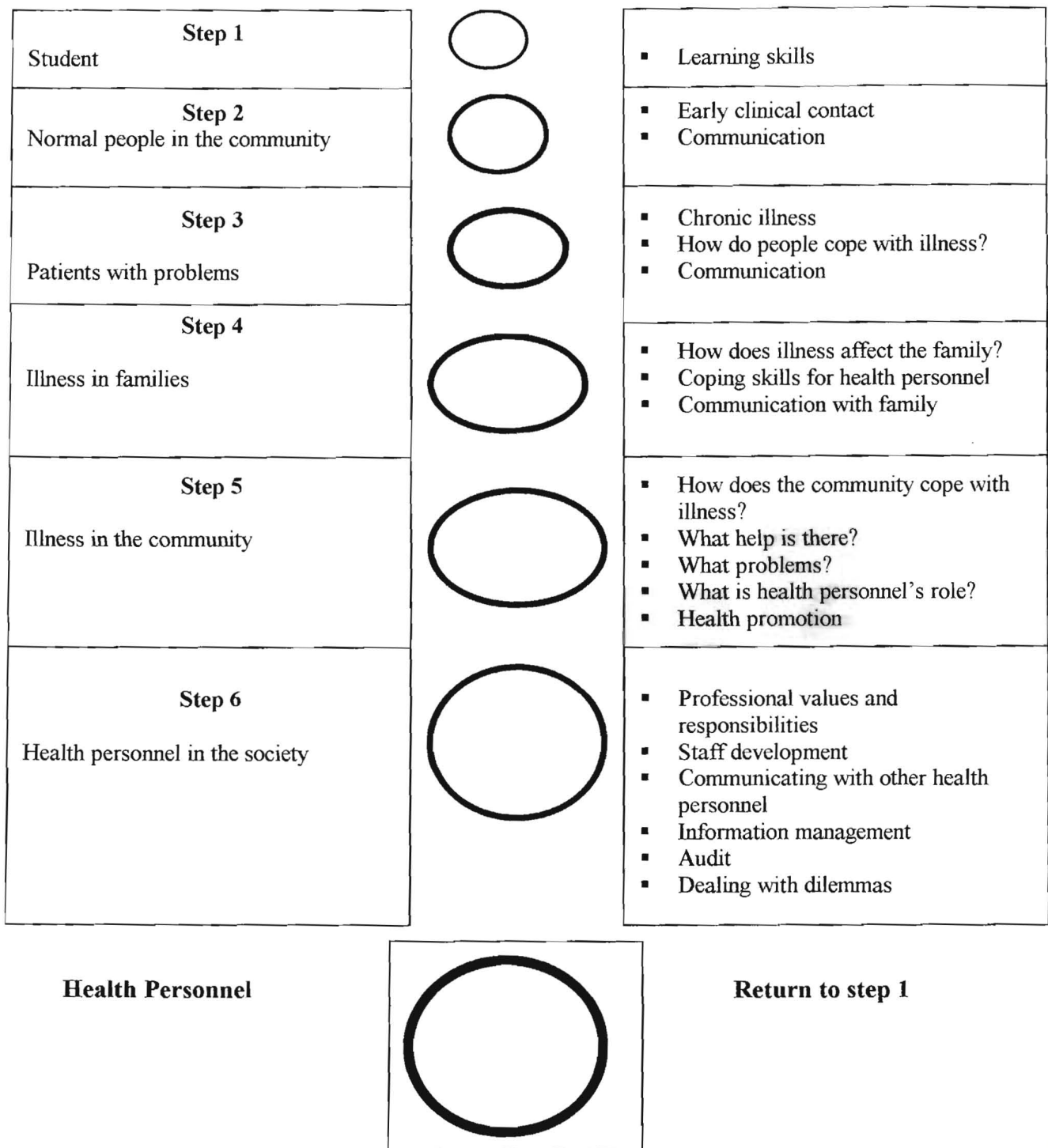


Figure 4: A model of community-based teaching. Source: Snadden and Mowat (1995)

Assumption. The assumption in Snadden and Mowat's (1995) model includes that education is a cyclical process and the large part of education in community-based education takes place in the community.

Propositional statements. The propositional statements are that development in a CBE curriculum begins with the development of the learner and progresses to consider normal people, then people with problems, communities and societies with problems and finally understanding and appreciation of the role and functions of doctors. Community-based teaching is based on a health to illness philosophy.

Evaluation of a community-based teaching model. Snadden and Mowat's model (1995) is a developmental process, as learning or teaching progresses from one level to another. This model, however appears to be too linear for a comprehensive or integrated curriculum. It seems as if steps are not linked, but, according to the modified model in Adejumo (1998), the steps in this teaching model may overlap. More importantly, Adejumo pointed out that step six, which is 'health personnel in the community' may occur at any stage of education.

Snadden and Mowat (1995) acknowledge that their model did not cater for assessment of learning. As community-based learning was new in their country (United Kingdom) they were still grappling with the methods of assessment. Snadden and Mowat highlighted that they were experiencing problems in trying to fit the themes from the community-based model to the traditional assessment framework. In other words this model is incomplete as it lacks detail in the area of assessment relevant to CBE. Snadden and Mowat (1995), however, indicated that there is a special team working on the methods of assessment in a CBE model.

Empirical Literature Review

Obtaining empirical literature on CBE was a challenge, because only limited research has been reported on the phenomenon of CBE, especially in basic nursing programmes. The lack of research-based literature may be ascribed to the fact that CBE is still in its infancy in most countries. The reviewed studies were categorized into (a) community as a learning environment, (b) instruction in community settings, (c) assessment of learning in CBE, and (d) CBE curricula. During the literature search no studies focusing on the meaning of CBE were found.

The Community as a Learning Environment

Oneha et al. (2001) conducted a study that evaluated the effect of learning in community settings through a multi-disciplinary approach. The purpose of their study was to establish what the students viewed as valuable to their subsequent practice in multi-professional community based learning. Participants included 65 former students who had completed five academic years in the programme. Data collection focused on the components of learning experiences that had the most impact on the graduates' practice. The criterion of inclusion as participant in the study was that graduates should have been involved in a multi-disciplinary course during their training.

The findings of the study by Oneha and his/her colleagues revealed that multi-professional interaction among the students enhanced the understanding of other disciplines' points of view in a multi-disciplinary team, which was very important in graduates' practice. The graduates' exposure to students from other disciplines afforded them an opportunity to understand their roles and responsibilities as well as the roles and

responsibilities of other team members within a multidisciplinary team. The participants viewed learning in a team as a valuable experience especially because in their work settings they were applying the skills acquired from their experiences in a multidisciplinary team. The findings suggested that the skills in multi-professional collaboration are fundamental in the preparation of health professionals and should be taught throughout the professional curriculum, not only in an isolated community focused course (Oneha et al., 2001).

According to Oneha et al. (2001) the results also revealed that the graduates appreciated the direct experience of learning in community settings. Through those experiences they had an opportunity to understand their clients' context, and to appreciate the different cultures and problems experienced in the community. The appreciation of exposure to different cultural settings seemed to be consistent across disciplines, especially because it prepared them for the realities in their place of employment. Some of the participants indicated that they did not only grow academically, but also grew personally from learning in the community. Part of this growth was attributed to the accumulation of experience in the employment settings, meeting and working with real patients and clients, and experiencing the satisfaction of helping people even before actual or real employment. The preparation of the students in the settings that closely resembled the ones where they would be employed, and the learning experiences in these settings, contributed to their growth and prepared them for employment. The experiences in the community settings promoted confidence, autonomy and creativity. Oneha et al. (2001) pointed out that the outcomes of the survey surprised them as a large number of respondents stated that they were planning to pursue higher educational degrees. Beyond the fact that the course prepared the graduates for serving in multi-disciplinary teams, it also facilitated the

development of life skills, including lifelong learning. The main recommendation in this study was that schools should ensure that educational experiences available to the students were consistent with the demands of the health care practice environment and should continue preparing graduates confront the dynamic health needs of the community. This relevance can be enhanced through continuous research studies (Oneha et al., 2001).

Simoni and McKinney's (1998) study also focused on learning in the community setting in a multi-disciplinary service-learning programme. Their programme was initiated in response to the emphasis of the health care delivery system on disease or illness prevention and early intervention. This programme included nursing students, human ecology students and physical education students. According to Simoni and McKinney (1998), the objectives of the programme were to better the education of nurses and allied health professionals for changing health needs, increase access for the underserved population in the surrounding rural area to health promotion and disease prevention, and to link those interventions to unmet community health needs documented by community-based health care assessments.

Participants included 45 baccalaureate-nursing students, all second, third, and fourth year students. The researchers were interested in assessing the effect of community-based learning on the students' learning and attitudes, the beliefs regarding competencies needed by practitioners for 2005, and the relation of what was learned by the students in the community to what was identified as necessary service by the community.

The findings of the study conducted by Simoni and McKinney (1998) suggested that the service-learning programme increased consumer access to community-based primary care, as learning activities were based on needs identified by the community, and the

learning process facilitated solving of these real problems. The results also showed that learning in the community enhanced critical thinking, as the curriculum used in the programme was determined by the needs of the community, and learning was related to existing problems. Critical thinking and problem solving skills are regarded as important skills when working with the communities. Through the needs-determined curriculum, the students also received preparation for a health care environment that would rely on their ability to respond to its changing needs. Competencies expected from graduates included the ability to care for the community's health; partnership when working with the communities, especially in identifying needs for services required by the community, ability to plan and implement health promotion and disease prevention interventions, and competence in meeting the changing needs of the community. An instrument on beliefs related to professional nursing competencies was used to quantitatively measure competencies needed by nurse practitioners and interviews were conducted to obtain qualitative data on professional nursing competencies.

The findings in Simoni and Mc Kinney's (1998) study revealed that through the use of a community as a learning environment, learners were involved in increasing consumer access to community-based primary health care services, curricula relating learning to existing problems in the community, and rewarding critical thinking was evident. The students were also receiving preparation for a health care environment that will rely on their ability to respond to its changing needs.

The learners were uncertain about being involved in professional and political activities to improve health care because they were not sure what these activities had to do with their role of caring for sick people. The students, especially the third year students,

were uncertain of the direction of nursing, as it was moving to the community, away from what they envisioned themselves to be; nurses in hospitals looking after the sick. It was noted that though the senior students were also uncertain in the above issues, their uncertainty was less than that of the other groups, especially the second year students. The anxiety of second and third year students might be due to the duration of their involvement in the programme. The difference between the juniors and seniors indicated that the longer the duration of exposure to learning in the communities, the better the understanding of community-based learning was.

Simoni and Mc Kinney's (1998) study also indicated that senior students showed some level of uncertainty with regard to their technical preparation. This was attributed to the fear that they (fourth year students) were about to graduate, but their technical preparation was inadequate owing to the time spent in the communities rather than in hospitals, where they would work after graduation. The findings of Simoni and Mc Kinney's study also revealed that service learning is congruent with the move towards primary health care that emphasizes community health care, which is a valued direction for the accessibility of care to the clients. Concerning the short term and long-term professional goals, hospital employment was high among junior students and there were about 30% of senior students who also preferred hospital employment. According to Simoni and McKinney (1998) the factor that accounted for continued interest in hospital nursing was that although placement in community settings was dominant, there were some experiences that were acquired only in hospitals. It was, however, noted that the long-term goal of most senior students was to participate in primary health care after graduating.

The findings also revealed a lack of awareness among the students of the policies behind the shift to community-care settings. It was therefore suggested that the health care system's policies should be included in baccalaureate programmes as an awareness raising exercise. The results also revealed the problem of the limited employment market for the service-learning or community-based learning graduates. The participants in Simoni and McKinney's (1998) study were cognisant of the limited availability of community employment for the new graduates, because there were very few settings that were ready to employ the graduates from service learning programmes. Most of the graduates were still finding employment in hospital. Simoni and McKinney (1998) recommended the replication of the study, hoping that the results would be of interest to the profession in designing its approach to education in the community settings.

Dana and Gwele (1998) conducted a study with the aim of describing the perceptions of student nurses about the community as a clinical learning environment. Participants in this study were second and third year baccalaureate nursing degree students who were in a community-based programme. Variables of interest were (a) independence in learning, (b) opportunities for learning, (c) quality of supervision, (d) peer support, (e) role clarity, (f) satisfaction with chosen career, and (g) organizational support. The results indicated that the students were positive about the community as a clinical learning environment as they believed that it facilitated personal and academic development. The analysis of variance (ANOVA), however, showed differences between the second years and third years on three variables; personal and academic development, opportunities for learning, and satisfaction with a chosen career. The second year students were more positive than third years about personal and academic development and satisfaction with a

chosen career. The third years perceived the community more negatively with regard to opportunities for learning than the second years. The difference between these groups was explained as due to the fact that the third year students were placed in hospitals at the time of data collection and second year students were in community settings at the time of data collection (Dana & Gwele, 1998).

In general the findings confirmed that the community as a clinical setting is comparable to other traditional settings such as hospital in facilitating personal and academic development, but a need to balance supervision with self-directed learning was highlighted. More importantly, the researchers (Dana & Gwele, 1998) pointed out that careful identification of learning opportunities in the communities might help improve students' perceptions regarding these variables. In view of the difference in the community settings which were used for the placement of students Dana and Gwele (1998) recommended further research to assess the differences in perceptions of students in different community sites, and whether their perceptions would affect the suitability of these sites for learning experiences.

As a follow up to Dana and Gwele's (1998) study, Madalane (1998) conducted a study to analyze the students' views concerning clinical supervision and learning opportunities in community settings. The setting included two nursing institutions with CBE programmes. Madalane's (1998) study confirmed Dana and Gwele (1998)'s findings. Results showed that community settings are ideal for placing students because they facilitate the personal and academic development of the students. The students had learned to identify, analyze, validate and prioritize health problems in the community. They became skilled in partnership building, maintenance and termination of partnerships with the

communities. They gained knowledge of conducting community meetings, negotiating sponsorships, planning community development projects, implementing and evaluating them. Furthermore, they learned to apply nursing values in their community-based learning experiences.

In relation to growth taking place as a result of learning in the community, Gwele (1999) asserted that in the community settings the students learn to appreciate how the social context affects the health of individuals, families and communities. According to Gwele CBE offers the students a platform to reflect on how issues related to inequalities in health care delivery, poverty, and malnutrition affect the health of individuals. That process of learning through experience in the communities and reflecting on the experiences facilitates personal and academic growth.

Madalane (1998)'s study, however, included some factors that hindered the learning of the students in the community settings. Hindrances to learning included lack of proper guidance on community entry skills, inadequate guidance on learning in the community settings, poor orientation and guidance on what to do in community settings, what was relevant information, and what were the things to learn in the community. The students also indicated the need to be provided with a clear understanding of the purpose of community-based learning activities. They had difficulty in conceptualising the relevance of what they were doing in the community in relation to what they were supposed to cover in the curriculum that prepared them as nurses.

The concern about the relevance of community-based learning activities in relation to what the students envisioned as the role of the nurse was also examined in the study by Simoni and Mc Kinney (1998) which revealed that this concern was more common in

junior nurses, owing to their short exposure to a community-oriented programme. The students were confused about the direction which was being taken by nursing education, because they understood as preparing them to look after sick people.

In Dana's (1998) study facilitators were reported to be inexperienced in facilitating learning in community settings, perhaps because of the lack of experience in working in the community, as most of the facilitators were still used to the traditional method of teaching. Concern about how to facilitate learning in community settings was also raised by a number of authors (Seabrook, Lempp & Woodfield, 1999; Shipengrover & James, 1999; Worley, Silagy, Prideaux, Newble & Jones, 2000). These authors also questioned the quality of instruction in community settings and the credibility of those involved in teaching (community members, products of traditional programmes, and staff from organizations that had not before been used for teaching purposes) with no orientation to CBE.

Madalane (1998) recommended that CBE, as a 'new' learning approach should be subjected to a number of research studies to maximize the quality of learning in such programmes. According to Madalane (1998), research studies should be conducted to explore how best the community as a clinical environment could be utilized to enhance the learning of the students. Madalane believed that these studies would help CBE programme planners to modify their educational programmes so as to improve the learning of the students in the community settings.

In conclusion, the studies on learning in communities showed that learning in these communities facilitated the production of graduates with competencies required to meet the changing needs of the community and health care system, and learning through a multi-disciplinary team approach in community settings also facilitated academic, professional

and personal growth. Because of the lack of theoretical basis on CBE, however, researchers recommended more studies in this area, as learning in community-based programmes takes place in unfamiliar settings, and teaching includes other members of the team most of whom are not qualified as educators. From the presented studies it seems as if, although there is positive feedback on using communities as learning sites, most of the schools seem to be having to learn during the process of community-based learning.

Instruction of Students in CBE

Concerned about the quality of instruction in the community settings, Shipengrover and James (1999) conducted a study to measure instructional quality in community-based medical education. Instructional quality, according to these authors, results from an interdependent set of system elements, which in a CBE system, include input variables, process variables, and outcome variables. Input variables incorporate people (clinician teacher, learners and clients) and the environment. Their characteristics of input variables influence the process component of the system, which includes the curriculum and instructional methods. The process component in turn influences the outcome component (a graduate who meets the health needs of the community served). In this particular study the researchers focused on the instructional quality, which is part of the process element.

As a background to their study Shipengrover and James (1999) reported that the shifting of education from the hospital to community settings raised issues of instructional quality, as this paradigm shift redefined who teaches students. More importantly, lack of measures to monitor the quality of instruction in community settings posed a major problem in community-based learning (Shipengrover & James, 1999)

The findings of Shipengrover and James's (1999) study suggested that efforts to evaluate community-oriented education were hampered by the absence of consensus on its process and outcomes. The authors concluded by describing a tool for evaluating community-based instruction that is guided by the context of the experiential learning model. According to Shipengrover and James the measure of the effectiveness of the instructional quality in CBE must go beyond the assessment of the knowledge and skills attained by the students as used to be done in traditional programmes. Aspects such as the clinical environment or community setting (their conduciveness to learning and the effect of learning activities on the environment), learners' responsibilities to acquire new attitudes and information, working within the context of the team, serving community members, sensitivity to diverse opportunities of learning, service that constantly delights its customers and student satisfaction should also be included. Shipengrover and James (1999) asserted that the quality of instruction is based on the outcomes of instruction. These authors also indicated a need for further research in the area of instructional quality, to improve teaching and learning in community settings.

Worley et al. (2000) pointed out that teaching in the community settings raised questions about the credibility of some of those involved in the teaching process, more especially the involvement of community members with patients with chronic illnesses. Concern about the credibility of community-based courses was addressed in Seabrook et al. (1999)'s case study. Seabrook et al. (1999) studied Kings' College Medical school project where special modules were used. These included a health care team module for the students to understand the diversity of roles and functions within the health care team, and to develop team working skills; care of families living with HIV and AIDS; teaching

children about health; health promotion in practice in the community; cultural issues in health and in illness; caring for refugee needs: the community response; mental health and distress; and perspectives and practice. These modules were developed and coordinated by a special academic team, but were facilitated by the community based teachers.

Seabrook et al.'s (1999) case study suggested that the involvement of community-based teachers or health practitioners is important because they have an in-depth knowledge of community services. Blumenthal (1990) asserted that community-based health professionals are ideal for teaching students who are being prepared to serve in underserved communities, because of their lived experiences and expertise in these settings. These practitioners are viewed as very rich resources who are underused because of their distance from the academic institution. Blumenthal (1990) also highlighted the fact that these health professionals also benefit from their involvement in community-based teaching because they therefore have an opportunity of being exposed to updated information and new developments. If they are not involved they are at risk of professional isolation, stagnation and obsolescence in remote communities.

Seabrook et al. (1999) found that community-based teachers and community members had some form of preparation for their roles in the teaching of the students. The findings indicated that giving students exposure to a diversity of teaching personnel establishes the idea that they can learn from other sources and also boosts the confidence of non-medical staff. There is, however, a need for detailed briefings on the aims, methods and expected outcomes and familiarization with the curriculum of health professionals' education. Seabrook et al. (1999) further stated that exposure of students to community-based teachers allows them to have a better understanding of health problems in context and

to develop a sense of the complexity and diversity of health, illness, and health care. More importantly, the students develop skills of working in multidisciplinary teams and thus provide the most appropriate care to the community, family and individuals. Community-based organizations involved in teaching also benefit because they are better understood by current and future health professionals, and they feel valued by the health professionals' schools (Seabrook et al., 1999). These researchers concluded that attempting to change the culture of health professionals' education will be slow, and this calls for a greater preparation for team working, greater mutual understanding, and, more importantly, the preparation of those involved in teaching.

Although the area of community and patient involvement in teaching of students in community based education is not widely researched or reported on, a number of authors (Stacey & Spencer, 1999; Williams, Reid, Myeni, Pitt, & Solarsh, 1999) asserted that community members and patients in community-based teaching see themselves clearly as having specific major contributions to make towards health professionals' education and training. The study by Stacey and Spencer (1999) shared a new perspective on the role of ordinary patients in community based teaching. Stacey and Spencer (1999) researched the patients' perceptions of their role in community-based undergraduate project because patients in traditional programmes had previously had relatively passive roles.

The findings of the study by Stacey and Spencer (1999) revealed that "the patients viewed themselves in active roles as teachers; as experts in medical conditions" (p. 688) because they showed the students how they could manage their own conditions and disability at a primary level and they also shared their experiences of the illness. The patients also viewed themselves as exemplars of their conditions (because the way they

present with the condition gives students a memorable example of the condition) and as facilitators of the development of students' professional skills and attitudes, because the patients gave the students an opportunity to develop the skill of asking questions in order to understand the condition better. Some of the patients reported that they pretended to be well, but the students were able to pick that up and that showed that they were good in practice (Stacey & Spencer, 1999).

As much as the credibility of teaching by community members is questionable Stacey and Spencer's (1999) study suggested that the community has a valuable contribution to make in community-oriented programmes. Stacey and Spencer (1999) recommended further exploration of the involvement of patients in community-based education as they have so much to contribute. As an effort to improve the contribution of patients to the learning of the students, Walker, in Stacey and Spencer (1999), reported on innovative schemes where patients, especially those with chronic illnesses, received training in preparation for their role of facilitating. At the end of the training period these facilitators had to pass an examination related to a specific chronic problem. After such a programme the patients get some form of remuneration for their contribution to teaching.

Following speculative reports on theoretical possibilities and concerns about teaching in community settings, Howe (2000) conducted a study to evaluate the dynamics of different factors, which may facilitate or impair teaching in the community. Data gathered indicated that some of the teachers in the community felt that the level of academic support and guidance was inadequate. To support facilitators, Gwele (1998) also advocated the continuous support of staff involved in these innovative approaches such as CBE and PBL, especially for the new facilitators. The results revealed that in community-

based learning the teaching quality was also influenced by the commitment of students, their attitude and timekeeping. It was reported that some students involved in community-based programme undermined, and failed to respect, community members because of their perception that health professionals knew everything. Howe advised that students with such an attitude would have to adjust to the new culture of teaching in community-based education, because this problem would lead to less effective curriculum delivery unless or until the student became engaged in the new culture of being taught by community members.

According to Howe's (2000) study, instructional quality and the effectiveness of teaching in community-based learning is affected by working or teaching-learning relations between the teachers in the community and the students. The teacher's positive, approachable attitude, the acceptance of the learner's status by the community as well as, the teacher's enthusiasm, contributes to positive learning experience. Factors such as student-tutor ratio, the prolonged relationships, clear structures and expectations, range of clinical opportunities, attitudes of both teachers and learners towards teaching, teaching methods employed, organization of the course, quality of supervision and satisfaction with a chosen career have a potential influence on quality of instruction in community settings (Howe, 2000).

Concluding the section on instruction in community-based learning, one can state that a number of studies have supported the involvement of community members, community-based health professional and patients in teaching of students because of their rich knowledge and experiences. The studies have shown that they are prepared in one way or another for their roles in community-based teaching, therefore the question of credibility

is somehow addressed, and what is evident is that in CBE credibility of teachers is determined by context as all are learners and educators. Therefore having an understanding of CBE that is context-based is significant in community-based learning and the quality of instruction is determined by context.

Assessment of Learning in CBE

A number of authors (Magzoub, 1998; Stone, Schwartz, Quirk, Sarkin & Qualters, 1998) have asserted that assessment in community based curriculum poses a challenge, because traditional methods are not relevant to assessing learning that is community-based. Magzoub (1998) stated that the objective assessment of students in community settings is a problem that has not yet been solved satisfactorily. He elaborated on the problems of assessment by pointing out that there is a discrepancy between the activities undertaken by the students and the subject of assessment in these contexts. Specifically in community-based education, objective assessment is a problem because the students work in groups, and it is therefore difficult to assess them on an individual basis and to quantify the contribution of each group member. Secondly, different community sites are used for the placement of students, for logistical reasons and also for students to share their experiences among these groups. Although the students have the same objectives and uniform activities to perform it is difficult to have a structured objective assessment, based on the set objectives. More importantly, fostering the change of attitude to community-based learning is important but it is a difficult objective to measure or assess.

As an attempt to address this issue of assessment in community-based education Magzoub, Schmidt, Abdel-Hameed, Dolmans, and Mustafa, (1998) reported that the faculty

of Medicine, University of Gezira, adopted a comprehensive approach which incorporated three main approaches to assessment: (a) performance-based approach, (b) knowledge measurement approach, and (c) comprehensive approach, which brings together the other approaches. Describing these Magzoub et al. (1998) stated that knowledge measurement uses pen and paper methods which assess factual recall and in some cases knowledge application. Performance based approaches mainly assess the performance of students during their field activities, through observational methods. Tools applied in performance assessment include logbooks, supervisory visits, peers' assessment, community leaders' feedback, mentoring and monitoring of attendance. Each assessment method focuses on specific aspects of objectives of the community-based programme. Knowledge measurement is characteristically conducted at the end of the community-based activity. Tools applied in measuring knowledge are essays, reports and multiple-choice questions. The comprehensive approach incorporates both performance and knowledge assessment approaches.

Magzoub et al. (1998) conducted a study to measure the validity and reliability of the above discussed comprehensive assessment approach. Each instrument was measured separately and the total score of a comprehensive assessment approach was based on averages of the scores of each test. The results showed that the comprehensive approach was fairly valid and was successful in solving some of the problems of student assessment in community settings. The results suggested that the comprehensive approach assesses a fair spectrum of competencies needed in the context of community-based work. It requires time and the support of those involved in the evaluation process, however, and tutors must be motivated, as continuous assessment is a lot of work. The possibility of teaching rather

than assessing the learning of students was reported in participants from service and community, as they lacked expertise in assessment that was conducted while the students were busy engaged in their learning activities. Further, because assessment is continuous it was reported that the students might have a feeling that they are being watched during every activity undertaken and not take the assessment seriously, or they may try harder to score high marks than to achieve the goals of community health (Magzoub et al., 1998).

According to Magzoub et al. (1998) the comprehensive approach to assessment is sensitive to the objectives of CBE and enhances the production of health professionals who are more likely to be responsive to the health needs of the community. It is appropriate because it measures the various competencies needed in the context of CBE. It takes into consideration not only the impact of community based learning on the students but also considers the community, and it provides some measure of students' attitudes, but it is very time consuming considering the high workload of the staff.

The emphasis in Magzoub et al.'s (1998) work is that assessment is important in learning therefore assessment needs to be relevant to the primary goals of the programme as the results of assessment have direct impact on the way the programme is operated and further developed.

CBE Curricula

Richards, Bannerman, Wunderlich and Fulop (1994) studied 10 innovative schools on behalf of the WHO mainly to ascertain how these schools undertook community-oriented and problem-based education. Data was collected through survey questionnaires, site visiting for observations, interviews and document analysis. The results of this study

revealed that nine of the 10 schools' philosophies were found to be moderately or highly supportive of community-orientation. Emphasis on community concepts in the curriculum was found in all schools. The emphasis was on concepts such as major disease and health problems of the country, epidemiology, maternal and child health and family planning. The community-based learning experiences in all settings included conducting home visits to rural and urban families, epidemiological studies, holding community meetings with community leaders, and working in primary health care clinics in underserved communities. The results showed that about five of the 10 schools provided the students with considerable community-based experiences, two schools provided a fair number, and three had isolated learning experiences in their curriculum.

Furthermore, in most (seven) of the schools, communities were involved in a passive manner. In only three schools community involvement went as far as participation in the selection process of the students, funding process, and students' evaluation in the community. Regarding linkages with the health sector, the results showed two extremes. Some schools went as far as sharing administration with the service sector, but others provided services to the public with little organizational relationship with the health service sector.

Regarding Problem-based Learning (PBL), five schools were found to be using PBL as an organiser of the curriculum to a greater extent, and the rest of the schools strongly promoted active learning both in the classrooms and in the communities. The researchers also ascertained how the schools selected the problems to be used in the curricula. The results revealed that they were using a combination of strategies. They used (a) the frequency with which a problem was seen by a practitioner in the clinical settings, (b) the

extent to which the problem served as vehicle for teaching basic science knowledge, (c) the seriousness of the problem in terms of its life threatening character, and (d) the treatability and the preventability of the problem. The analysis of the data on PBL suggested that the schools tended not to emphasize the health needs of the population in problem selection, except to the extent that problems frequently seen by practitioners were also high priority problems (Richards et al., 1994).

Conclusion

What emanated from the reviewed literature in this chapter is that changes taking place in nursing education are a result of changes in the educational philosophies which served as a basis for nursing education, as indicated earlier on in this document.

From the literature related to CBE, the development of CBE has been traced internationally and nationally, in basic nursing education in South Africa. Empirical literature also covered related research studies that were conducted in other countries and in South Africa. Limited empirical literature on CBE restricted the researcher in the section on reviewed empirical literature to give a stronger background for this particular study. The researchers in the reported studies had a number of recommendations on the practice of CBE. The developers of the CBE models also recommended more studies aimed at developing CBE models as CBE lacks a solid theoretical basis.

CHAPTER 3

METHODOLOGY

Research Design

This study employed a qualitative design and a grounded theory approach.

Qualitative design is a mode of systematic enquiry oriented towards the understanding of human beings and the nature of their interactions in their natural settings (Brink & Wood, 1998). Furthermore, it is directed toward discovering or uncovering new insights, meanings and understandings (Chenitz & Swanson, 1985).

On the other hand, grounded theory, sometimes referred to as the constant comparative method, is a qualitative method attributed to Glaser and Strauss (1967). Grounded theory, according to Fischer (1997), is both inductive and deductive. It is inductive in that it proceeds from empirical incidents to theoretical concepts, and at the same time, deductive in that it applies these concepts in its coding and sampling of data. Underpinned by symbolic interactionism, grounded theory offers systematic, legitimate methods to study the richness and diversity of human experience in natural settings, in order to generate relevant, plausible theory that can be used to understand the contextual reality of the behaviour (Hutchinson, 1993).

Grounded theory makes its greatest contribution in areas where little research has been done and when new viewpoints or gestalts are needed to describe the familiar phenomenon that is not clearly understood (Chenitz & Swanson, 1985). Grounded theory was thus appropriate in a study of this nature because very little has been done in terms of research aimed at understanding the phenomenon of CBE, either in South Africa or

globally. The researcher was interested in developing a theory which explains the meaning of CBE as applied in basic nursing programmes in South Africa.

From the reviewed literature it was evident that there are two main methodological schools in grounded theory, one by Glaser and another by Strauss (Babchuk, 1997; Kendall, 1999; Locke, 1996; Miller & Fredericks, 1999; Stern, 1980). Stern referred to these two versions of grounded theory as Glaserian (after Barney Glaser) and Straussian (after Anselm Strauss) approaches. According to Babchuk (1997) researchers utilizing grounded theory should clearly specify which of the two methodological schools was used to guide the study. Before presenting the version used in this particular study, the differences between the two founders of grounded theory (Glaser and Strauss) will be discussed.

Although Glaser and Strauss share a common research experience in discovering grounded theory and publishing the book 'The Discovery of Grounded Theory', they differ in certain aspects of grounded theory. According to Babchuk (1997) the essential differences between Glaser and Strauss's versions of grounded theory arise from both epistemological and methodological chasms between their approaches. They differ in how they view the procedures and processes of grounded theory. Their approaches vary in the following aspects: (a) sources of research questions, (b) the use of technical literature, and personal and professional experience in grounded theory, (c) data analysis, especially with open coding and axial coding and, (d) verification and validation of the emerging theory and hypotheses.

The debate between Glaser and Strauss began after the publication of Strauss and Corbin's book titled 'Basics Qualitative Research' in 1990. Strauss and Corbin published this book in response to the concerns raised in the book 'The Discovery of Grounded

Theory'. Stern (1994) stated that after the publication of "The Discovery of Grounded Theory" Glaser left teaching and went into business, leaving Strauss to answer the multiple charges laid against grounded theory. According to Stern (1994), grounded theory was criticized for its seeming looseness, without a guiding frame, for its lack of verification, and the tangled description given in the 'The Discovery of Grounded Theory'. Even Strauss and Corbin (1990) admitted that beginners were struggling to construct in depth and dense grounded theories in a consistent manner because of the problems they encountered. Strauss and Corbin therefore perceived a need to fill the gap in the methodology literature on the processes involved in generating meaningful grounded theories from qualitative data (Kendall, 1999). These grounded theorists published a book "Basics of Qualitative Research" in 1990. Glaser realized the difference in their (Glaser and Strauss) approaches after the publication of this book, but according to Stern (1980), their students were aware of these differences long before. The two versions of grounded theory are continuing today, with Glaser's students following Glaser's approach when teaching and Strauss' students continuing with his approach.

Babchuk (1997) identified that Glaser and Strauss differ in the aspect of the research question, about when and how it is formulated and developed. According to Strauss and Corbin (1990) the research question is developed as early as the beginning of the study. The rationale provided is that in grounded theory a research question "is a statement that identifies a phenomenon to be studied" (Strauss & Corbin, 1990, p. 38). It is oriented towards action and process. In other words "the original research question is a directive that leads the researcher immediately to examine a specific performance, the site where events are occurring, documents, people acting, or informants to be interviewed. It gets the

researcher started and helps him or her to stay focused throughout the research project” (Strauss & Corbin, 1990, p. 39). According to Strauss and Corbin, having a research question from the beginning of the study sets the boundaries on what will be studied because it is impossible to cover all aspects of a phenomenon. The research question narrows the study field to a researchable size (Strauss & Corbin 1990).

Glaser (1992), on the other hand, is not in favour of having a research question from the beginning of the study. According to Glaser the research problem is discovered through emergence as a natural by-product of open coding, theoretical sampling and constant comparison. The researcher ideally begins the study with “ the abstract wonderment of what is going on in that issue and how it is handled” (Glaser, 1992, p.22). Glaser felt that having a research question from the initial phase of the study is limiting, in that the developed theory may not naturally develop from the data, but will be shaped by the research question. In defence of using a research question, Strauss and Corbin indicate that one cannot study the whole phenomenon, otherwise the study will be too broad. Having a research question assists the researcher to focus. As a warning Strauss and Corbin pointed out that the initial research question should give the researcher flexibility and freedom to explore a phenomenon in depth. The initial question starts broadly, but not so open that it allows for the entire universe of possibilities, and it becomes progressively narrowed and more focused during the research process as concepts and their relationships are discovered to be relevant or irrelevant. According to Strauss and Corbin (1990), the process of data analysis helps in refining and specifying the research question, whereas in Glaser’s view the process of discovering the research question begins with data analysis.

Glaser and Strauss also have different views on the use of technical literature, personal and professional experiences in grounded theory (Babchuk, 1997; Locke, 1996; Struebing, 1999). Strauss and Corbin (1990) allow for the prior theory, technical and non-technical literature, and personal as well as professional experiences to enter the field of research. Technical literature in this context refers to “reports of research studies, and theoretical or philosophical papers characteristic of the professional and disciplinary writing. They can serve as background materials against which one compares findings from data gathered in grounded theory studies” (Strauss & Corbin, 1990, p. 48). Non-technical literature includes “biographies, diaries, documents, manuscripts, records, reports, catalogues, and other materials that can be used as primary data or to supplement interviews and field observations in grounded theory”(Strauss & Corbin, 1990, p. 48). According to Strauss and Corbin all kinds of literature can be used before the research study is begun and during the study itself. In their view literature can assist in the process of developing a research question and can facilitate theoretical sensitivity during data collection and analysis. Corbin and Strauss warn that this previous knowledge should not be taken as a given, testable framework on how to explain a phenomenon. Instead it should serve as a source of inspiration (Struebing, 1999)

On the contrary, Glaser objects to previous knowledge entering the field of research especially during the analysis (Locke, 1996). Glaser’s argument is that Strauss no longer conforms to the high virtues of grounded theory in that theory emerges from data (Locke, 1996; Struebing, 1999). Struebing argued that allowing previous knowledge to enter the research field restricts the emergence of the theory from the data by forcing the concepts to fit the framework from the previous knowledge. Glaser (1992), however, maintains that

literature should not be reviewed in the substantive area of study so as not to contaminate, constrain or impede the emerging categories, their properties and theoretical codes. Glaser believes in a pure methodology that completely refrains from drawing on any kind of previous knowledge, because he believes that any previous knowledge would guide the intentions of the researcher in specific ways. Struebing also acknowledges Glaser's view that previous knowledge may have an influence on the research study, but the question is how the researcher can clear his/her head of prior knowledge before embarking on a grounded theory research.

The difference between Glaser and Strauss continues on the process of data analysis. According to Kendall (1999), both Glaser and Strauss described coding as an essential aspect of transforming raw data into theoretical constructs of social process, but the types of coding processes differ. Glaser's process is characterized by two coding processes, substantive (open) and theoretical coding. On the other hand, open coding, axial coding and selective coding characterise Strauss and Corbin's process. Open coding is described by Glaser (1978) as a way to "generate an emergent set of categories and their properties which fit, work and are relevant for the integrating theory (p. 56). Corbin and Strauss (1990) refer to open coding as "the process of breaking down, examining, comparing, conceptualising and categorizing data" (p. 61). Concluding on the open coding processes by Strauss and Glaser, Kendall (1999) indicated that their approaches to open coding are similar although Glaser places more emphasis on the importance of allowing codes and theoretical understandings of data to emerge than do Strauss and Corbin. The main controversy in data analysis involves Strauss and Corbin's addition of an intermediary set of coding procedures, called axial coding (Babchuk, 1997; Kendall, 1999). Axial coding

is the process of putting “data together in new ways after coding by making connections between categories and subcategories” (Strauss & Corbin, 1990, p. 97). Rather than looking for all kinds of relations, Strauss and Corbin (1990) emphasize causal relationships and fitting subcategories into a basic frame of generic relationships. This frame consists of the following elements; causal conditions, context, intervening conditions, action/interactional strategies and consequences (Strauss & Corbin). Causal conditions, also known as antecedent conditions, refer to the events or incidents that lead to the occurrence or development of the phenomenon. Context represents the specific set of properties that pertain to a phenomenon, that is, the location of events or incidents pertaining to a phenomenon alongside a dimensional range. Context also refers to a set of conditions influencing action/interaction. Intervening conditions act either to facilitate or to constrain the action/interactional strategies taken within a specific context. Intervening conditions may include time, space, culture, economic status, technological status, career, history, and individual biography. Consequence refers to the certain outcome or consequences of action and interaction taken in response to, or to manage a phenomenon.

According to Strauss and Corbin (1990) subcategories are linked to a category through this frame or model. Arguing for the use of this paradigm model in linking subcategories to categories, Strauss and Corbin claimed that this paradigm model enables the researcher to think systematically about data and to relate data in very complex ways. Glaser’s view on the process of axial coding, however, is that the researchers may easily miss the relevance of the data by forcing it into a preconceived framework. The results may yield full conceptual descriptions at the expense of theory development or generation (Babchuk, 1997). The difference between these two grounded theorists is thus that Glaser

strongly believed in the process of emergence, the methodological requirement for generating a theory and Strauss and Corbin generate codes and categories from a predetermined organizing schema they claim helps grounded theory researchers construct complex and meaningful theory more reliably (Kendall, 1999). Kendall (1999) from her lived experience warns that Glaser's concern about using a paradigm model is true. This author used Strauss' paradigm model and was so consumed in it in that she ended up fitting data to these elements. She highlighted the possibility of ending with conceptual descriptions if one does not move on to selective and theoretical coding. The researchers need to move beyond the conceptual descriptions into conceptualisation and theorizing. Kendall (1999) supports the use of Strauss and Corbin's approach by beginning researchers, as it provides an escape from being lost in the data. On the other hand, Kendall (1999) supports Glaser's approach because, difficult as it is at times, it does lead to a grounded theory.

Glaser (1992) makes theory generation versus theory verification a central theme in his text in his criticism of Strauss and Corbin's approach. Glaser and Strauss differ on verification and validation of the findings. According to Strauss and Corbin (1990), verification and validating are important when developing a theory. Verification is important during axial coding, where the researcher verifies the hypotheses against actual data. If the researcher has questions about certain categories he/she has to return to the data and look for evidence, incidents and events that support or refute the questions. The researcher may also look for evidence in the data to verify statements of relationship and instances where the relationships might not hold up. In other words, verification is important in grounded theory studies to find evidence of differences and variation and

evidence that supports the researcher's original question and statements. "The negative or alternative cases tell us that something about this instance is different, and so one must move in and take a close look at what might be. Following through these differences adds density and variation to our theory" (Strauss & Corbin, 1990, p. 109). Glaser believes in constant comparative analysis so as to develop a theory that is grounded on data. He does not favour verification and validation like Strauss, as in his view verification and validation fall outside the parameters of grounded theory. Glaser argued that rigorous verification methods could be used for testing a few of the central hypotheses only (Glaser, 1992).

Following axial coding is selective coding which according to Strauss and Corbin is "the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement" (Strauss & Corbin, 1990, p.61) Glaser does not support 'validation' because he believes in emergence. Glaser accuses Strauss of validating what is looked for, not what is emerging, and for promoting practices that prematurely anticipate the data and that interfere with the ability of the phenomena studied to inform discovery (Babchuk, 1997). On the other hand, Strauss and Corbin (1990) believe that "validating one's theory against the data completes its grounding" (p. 133). Validation is conducted by laying out the theory in memos either diagrammatically or narratively. Then the statements regarding the category relationships under varying contextual conditions are developed and finally validated against the data. The statements are checked against each case to determine whether they fit or not. The researcher looks at whether they fit in a general sense and in most cases, not necessarily in every case. Modifications and changes can be made in the statements until a general match is made (Strauss & Corbin, 1990). Glaser frowns upon the validation process because it

forces the data to fit into preset categories. Strauss and Corbin warn that occasionally one may come across a case that does not fit the pattern, and the researcher needs to be aware of the factors that might lead to that, such as a different context or intervening variables.

The researcher in this particular study used Strauss and Corbin's grounded theory approach because the researcher had to review the literature in order to establish the need for the study of this nature and to refine the research question. Secondly, the nature of the study, which is analysing education programmes, warranted the use of a broad framework to analyze educational programmes. This framework delineates the value orientations regarding the purpose of education, views about knowledge, sources of the curriculum, the nature of the teacher and the learner. Thirdly, perhaps to reiterate Struebing's (1999) view on the utilization of previous knowledge in grounded theory, the researcher herself is embedded in the practice of CBE, and as a student of education could not successfully wipe clean all her prior knowledge and experience of CBE before embarking on the study.

The researcher used Strauss and Corbin's approach because it also provided a concrete, structured and clear way to analyze grounded theory data, as Glaser's method lacks a definitive process and set of operational steps, making his method extremely difficult. Strauss and Corbin's approach seems accessible and useful in helping to organize, describe, and conceptualise the depth and extent of the processes involved in studying a phenomenon of interest. One of the objectives of the study was to analyze the concept of CBE with the aim of identifying the cause, context, action/interaction strategies, intervening conditions, and consequences under which the phenomenon occurs. To be able to achieve this objective, Strauss and Corbin's approach was identified as appropriate. Nevertheless, the limitations of Strauss and Corbin's' approach as expressed in the reviewed literature

were taken into consideration, especially the need to ensure that data analysis moves beyond conceptual descriptions of the phenomenon under study to conceptualisation and theorizing.

Setting Description

According to Strauss and Corbin (1990) in a grounded theory approach the selection of settings is directed by theoretically relevant concepts. Therefore the researcher should select settings that will provide relevant data. In this study, the criterion for inclusion of the setting was determined by the existence of a well-established community-based basic nursing education programme. In South Africa there are 18 university nursing schools and 36 nursing colleges (Hospital and Nursing Year Book of Southern Africa, 2000). Through the Internet the researcher identified four university nursing schools: University of Transkei in Eastern Cape, the University of the Witwatersrand in Gauteng province, the University of the Free State in Free State and the University of Natal in KwaZulu-Natal, all with well-established CBE programmes. With the help of the South African Nursing Council (SANC), two nursing colleges, Frere College of Nursing and Transkei College of Nursing, both in the Eastern Cape were identified as having CBE programmes. Both these colleges were included. Transkei College of Nursing has six campuses and one sub-campus. Of these the researcher selected one urban campus (Umtata Campus) and one rural campus (St Barnabas).

Sampling Procedure

Building a grounded theory requires participants who are rich in information, as Patton (1990) stated. More importantly, it requires an interactive process of data collection, coding, analysis and planning what to study next, which in this particular study was enhanced through purposive sampling and theoretical sampling. Purposive sampling, according to Merriam (1998) “is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which most can be learned” (p. 61). Patton (1990) refers to purposive sampling as sampling where the phenomenon is known to exist. Morse (1994) describes it as a process of selecting participants who are rich in the information needed by the researcher. Woods and Cantanzaro (1988) portray purposive sampling as a technique used to obtain maximum information as well as a full array of responses from the participants. Theoretical sampling, on the other hand, is a process of data collection for developing a theory whereby the analyst collects, codes and analyses data and decides what data to collect next and where to find them in order to develop a theory as it emerges (Glaser & Strauss, 1967). According to Creswell (1998), the term ‘theoretical sampling’ means participants are selected on the basis of their ability to contribute to the development of a theory.

Sample Description

From the nursing institutions, the selection of participants depended on the role they played in a CBE programme. In South Africa, pre-registration nursing programmes run over four years. Usually each year in the programme has a level coordinator, who is responsible for the administrative work at that particular level. There is also a programme

director who is responsible for overseeing the whole programme. The researcher interviewed the programme director, or heads of schools where there were no programme directors, coordinators and facilitators involved in community-based learning activities. The final sample size differed in various institutions because of the way the programme was structured, and because of the spread of community-based learning activities in the programme. Theoretical sampling continued until the stage where saturation was achieved. Saturation was decided by the completeness of all codes when no new conceptual information was available to indicate new codes or expansion of existing codes. The researcher ultimately achieved a sense of closure as indicated by Hutchinson (1993), by repeatedly checking and asking questions to contrast, compare and verify categories of the data.

To be exact, the sample size for interviews comprised 41 participants. Five of these were heads of schools because the institutions did not have CBE programme directors, two were programme directors, 11 were level coordinators, 17 were facilitators and six were members of the SANC Education Committee. In this particular study members of the SANC's education committee participated in order to establish what CBE means to them as policy-makers. From the SANC education committee members the researcher interviewed the chairperson of the education committee and the deputy chair initially, and then, through theoretical sampling, interviewed four other committee members. Theoretical sampling of education committee members continued until participants had no new information to share.

Data Collection Process

Grounded theory emerges from close involvement and direct contact with the empirical world to enhance the collection of rich data (Patton, 1990). In this study, the researcher intensified the collection of rich data by having two phases of data collection and by using multiple sources of data (observations, documents and interviews). The whole process of data collection focused on the value orientations about CBE and the practice of CBE. The value orientations and the practice of CBE brought an understanding of what CBE means in basic nursing education in South Africa.

Phase 1. This phase was directed towards examining and analysing the practice of CBE in selected nursing schools. During this phase the researcher spent a minimum of five days on each site, mainly doing observations and analysing documents. Observations included looking, listening, and asking questions as they arose out of observations in order to offer insight into what was observed. The researcher observed the phenomenon of CBE as it occurred in community learning settings and in classroom settings, and how learning in the community was transferred into classrooms. During each session, the researcher documented events as they occurred in the form of field notes. Responses from the participants following the asking of questions were audio-taped. Hand-written notes and memos were utilized to provide backup information throughout the process of data collection. Interviews based on the data that emerged during observations were conducted on the last two days on each site. The intention was to do cross checking, filling of gaps, and verification of categories and concepts that emerged from the data.

The researcher also requested copies of the CBE programme documents for analysis. These included CBE programme documents with the philosophy mission

statements and conceptual frameworks, the level or course outlines as well as evaluation instruments. According to Wilson (1989), the agency's perspective and interpretation of the phenomena often emerges from the analysis of the documents. The school documents were analysed in relation to the data that emerged during observations and interviews. Document analysis was conducted in between site visits. Ongoing and concurrent analysis of data at this stage yielded preliminary concepts and constructs describing CBE as it is understood and practised at selected institutions. These concepts and constructs formed the basis for the second phase data collection.

Phase 2. The second phase focused on interviews, which were informed by the data collected during observations. Interviewing participants was in line with Strauss and Corbin's (1998) emphasis on asking questions as a primary tool of collecting data in a grounded theory approach. Furthermore, according to Glaser (1992)

Observational data is not enough. The researcher should provide interviews along with observations so that the analyst can get a meaning of what is observed.

Observations do not in and of themselves have the meaning or perspective in them of the participants (p. 49).

Observations of students in the community and in the classroom setting helped the researcher to gain an understanding of what is practised as CBE. More importantly, interviews brought forth the participants' understanding of, and the meaning behind what was practised as CBE in the community and classroom settings. As the interview guides were informed by data collected through observations, the researcher prepared questions that served as outlines for interviews. The questions were flexible and exploratory in nature

as the researcher was directed by the participants' responses to probe further on issues of interest.

Programme directors, level or course coordinators and facilitators were interviewed during the second phase. Interviews addressed questions related to the CBE context in each institution, CBE curricula, graduate competencies, nature of learning experiences used, community-based learning experiences/activities, the teaching/learning process, roles of the those involved in community based teaching and learning, community involvement (see interview guide – Annexure C). The interviews of the SANC committee members were based on statements in SANC document on “Education and Training of Professional Nurses in South Africa: Transforming Nursing Education” which were repeatedly mentioned by the participants in nursing institutions (see annexure C). The focus of these interviews was on what the policy makers mean by CBE, implementation of CBE curriculum, competencies required from these graduates and their role as policy makers in CBE. The researcher spent two days collecting data from the SANC education committee members.

Data Analysis

Data collection and the initial stages of data analysis (category development, category saturation and concept development) were conducted simultaneously. QRS NVIVO Software was used to assist in the process of analysing data, and the guidelines for analysing grounded theory studies in Strauss and Corbin (1990) will be followed. See Appendix 5 with a sample of how QRS NVIVO was used to organise data during the initial stages of data analysis. Guided by the premise that the study was aimed at uncovering the meaning of CBE in basic nursing education in South Africa, not to compare different

institutions, the researcher, through the constant comparative method of data analysis, looked across all institutions that participated in the study to generate categories representative of all.

The initial step in data analysis was that of **category development**. After the collection of initial data, the researcher began with open coding, taking into consideration that open coding can be done at several levels, that is, line-by-line analysis level, sentence/paragraph analysis level, and/or whole document analysis level, as stated in Strauss and Corbin (1990). The researcher initially used line-by-line analysis coupled with close examination of phrase by phrase to discover and label the phenomenon (CBE) being described. Line-by-line analysis was used in analysing field notes and interviews to avoid missing out important aspects, which were likely to be missed out in paragraph or whole document analysis. An entire document analysis approach was, however, used in the analysis of programme documents. In analysing the documents the researcher initially looked for what made the document similar to the other documents and then specifically analysed the similarities and differences in the documents. Documents analysed included programme documents with the institution's philosophy, mission statement, conceptual framework, and course outlines for the levels where community-based learning was dominant.

The very words used by the participants were utilized in the grouping or coding of data. Initial codes and concepts were written on the margins of transcripts and field notes. All concepts were grouped according to their 'fit' to form categories as indicated in Strauss and Corbin (1990). Some of the categories were named from the words and phrases used by the informants themselves and some were named from a pool of concepts the researcher

knew from her academic subject and professional reading. Strauss and Corbin (1990) refer to the latter source of concepts as literature-derived concepts. **Categories** were developed from data and were used as codes for further data analysis. Out of the coding process evolved additional questions that produced more data, until theoretical saturation was reached as stated in Strauss and Corbin (1990). Categories during open coding were described according to their attributes and properties. According to Strauss and Corbin properties are characteristics or attributes of a category, and dimensions are locations of a property along a continuum.

The following phase was that of linking the developed categories, determining the relationship between the categories that emerged during open coding to form a new category. Categories which came up during open coding changed to become subcategories of the category that was formed through the process of axial coding. Axial coding, according to Strauss and Corbin (1990), is geared towards discovering and relating categories in terms of the paradigm model. It involved procedures for connecting sub-categories found in open coding to a category, and categories to each other. Coding processes concerned matching “ conditions, context, action/interaction strategies and consequences with an intention of uncovering causal conditions of the phenomena observed in the data analysis. Coding process was also aimed at determining the context and dimensions of phenomena and categories found in the open coding and follow-up data gathering. This process of coding data required repeated re-examination of the data and their interpretation and making repeated comparisons of data until the stage of **category saturation was reached**. All instances of the category in the data were examined to

determine whether they fit the emerging pattern of characteristics identified by the researcher.

The phase of category reduction followed immediately after the saturation of categories. Category reduction was aimed at reducing the number of categories, which, at that phase of data analysis, had become numerous. During **category reduction phase** categories were linked according to how they fit the characteristics of a defined category. Categories were then linked together with the intention of understanding relationships among them. Those which were sharing similar characteristics were merged into higher-order categories. The researcher at this stage drew logic diagrams as indicated in Strauss and Corbin (1990) to uncover relationships between categories, using Strauss and Corbin's paradigm model (antecedent conditions, context, action/action strategies, intervening conditions and consequences).

Selective sampling of literature followed the linking of categories to determine the 'fit' of findings from earlier studies and existing theories with present findings. Through the process of reduction and comparison, the **core variable (CBE)** emerged. According to Burns and Groves the concept, or core variable, refers to a category which accounts for most variation in the pattern of behaviour and which helps to integrate other categories that have been discovered in the data. It becomes the central theme or focus of the study. Other categories at this level are named subsidiary categories. Relating of subsidiary categories to the core category was done by means of the paradigm 'conditions, context, action/action strategies, intervening conditions, and consequences' as stated in Strauss and Corbin (1990). Categories were analysed in relation to these paradigms to determine which category fitted these parts of a paradigm. According to Strauss and Corbin A (conditions)

lead to B (phenomenon), which leads to C (context), which leads to D (action/interaction, including strategies), which then leads to E (consequences).

Diverse properties started to become integrated and the resulting theory began to emerge by itself. Eventually the theory solidified. As the researcher continued to compare more incidents there were fewer changes to the theory. Later modifications included taking out irrelevant properties of the categories, integrating details of properties into an outline of interrelated categories. This phase according to Burns (1997) is called **concept modification and integration**. More importantly, the researcher began finding ways to delimit the theory with a set of higher-level concepts. The theory was finalized at this stage and was again compared with the data. According to Strauss and Corbin (1990) “validating one’s theory against the data completes its grounding” (p.133). This was done in this study as stipulated in Strauss and Corbin “by laying out the theory in memos diagrammatically. Then statements regarding the category relationships under varying conditions are developed and finally validated against the data” (p.133)

Academic Rigour

Academic rigour refers to the logical accuracy, scientific adequacy or trustworthiness of the research outcomes with respect to openness, scrupulous adherence to philosophical perspective of the approach and thoroughness in collecting data (Burns & Grove, 1997). The potential strength of a qualitative research theory may be lost if appropriate strategies are not followed, to reduce careless handling of data and the researcher biases (Khalifa, 1993). In grounded theory sampling, data collection techniques and processes used in analysis ensure rigour and comprehensiveness (Strauss, 1987). The

concept of trustworthiness is used to make certain of the quality and value of the final results, and the conclusions reached in a qualitative research (Lincoln & Guba, 1985) and this concept (trustworthiness) is composed of four main aspects, namely credibility, dependability, confirmability and transferability.

Credibility refers to the authentic quality of the data, that is, whether the data portrays what one is looking for (Lincoln & Guba, 1994). To achieve credibility the researcher used several measures. She gave a detailed description of the research process and the process of data analysis, data and categories discovered were discussed with the research supervisor at regular intervals, and other experts in qualitative research were consulted. The researcher also used triangulation, which refers to use of different methods of data collection. The researcher promoted this aspect by using three data collection techniques, in-depth interviews, analysis of documents and observations. Membership check, which refers to the researcher's ability to check back the participants to validate the accuracy of the information given and recorded, was used (Khalifa, 1993). This was achieved through focus groups at the end of phase one in each institution. The researcher went back to those interviewed, using a focus group and verified if the recorded data was accurate or needed correction or elaboration on constructs.

The second aspect of trustworthiness that was considered was *dependability*. Dependability refers to the stability of the data in the study. It is the process of detailing the consistency, reasonable stability over time and convergence of accounts across methods, such as, observations, informants, contexts, connectedness to theory, data quality checks or audits and peer review of coding (Lincoln & Guba, 1985). To ensure dependability, the researcher conducted data quality checks or audits, peer review of coding, and consultation

of qualitative research experts. The qualitative research experts were consulted to monitor the data collection process, analysis and interpretation of data. Triangulation was another form of measuring dependency (Lincon & Guba, 1985) and is viewed as the strongest evidence for dependability. The researcher collected data from various sources, and the various interviewees from different schools of nursing gave multiple perspectives on the phenomena CBE. The researcher also consulted experts in qualitative data analysis and grounded theory to ensure dependability.

The third aspect considered was *confirmability*. Confirmability refers to the objectivity of the research process and outcome, the degree to which data confirms the findings, freedom from the researcher's biases by ensuring that the conclusion depends on the subjects and condition of enquiry rather than on the investigator (Lincoln & Guba, 1985). Confirmability was promoted by taking detailed field notes, by tape recording and transcribing interviews verbatim to identify variations in responses and to make field notes available for audit checks and verification. This was done following data collection, where the field notes were made available to interviewees for cross checking and verification.

Transferability was the fourth aspect of trustworthiness which was considered. Transferability refers to the application of the study to the context in which data were derived or other similar contexts, depending on how it fits between contexts. To ensure that the developed theory is applicable to the context under study, the researcher used purposive sampling, gave a detailed description of the context or setting and provided detailed descriptions of the whole process of the research study, including the research procedures and findings to enhance transferability to other similar contexts.

CHAPTER 4

DATA ANALYSIS

Introduction

The findings presented in this chapter resulted from the “slices of data” (Glaser & Strauss, 1967, p. 65) from multiple sources (observations, interviews and documents) which were used in this particular study. These results address the first purpose of the study, which was to conceptualise the phenomenon CBE in basic nursing programmes within the South African context. These results thus respond to the first four objectives in this study which are to (a) analyze the phenomenon CBE and the meaning attached to it, (b) establish how the phenomenon CBE is utilized in basic nursing education programmes in South Africa, (c) describe the processes involved in a CBE programme, and (d) analyze the phenomenon CBE in terms of antecedent conditions, context, action/interaction strategies, intervening variables, and consequences under which this phenomenon occurs.

Categories presented in this chapter emerged from words and phrases which were used by the participants themselves and some additional categories were extracted from the pool of concepts the researcher learned from her disciplinary and professional reading. Strauss and Corbin (1990) described these concepts as literature-derived concepts. As CBE was the phenomenon of interest in this study, it became the core concept around which other concepts revolved. Through the process of reduction and constant comparison, further concepts emerging were linked to the phenomenon of interest. Other categories such as CBE antecedents, CBE context, CBE intervening conditions, CBE strategies, and CBE expected consequences emanated as subsidiary categories linked to a core variable CBE, as indicated in Strauss and Corbin (1990). Basing the study on Strauss and Corbin’s paradigm

model assisted the researcher in fitting the categories that emerged from the data into the elements presented in Strauss and Corbin's paradigm model (causal conditions, phenomenon, context, intervening conditions, action/ interaction strategies, and consequences).

The results are outlined in a manner which indicates how the first four objectives of this particular study were achieved. The outline is as follows: (a) the conceptualisation of CBE in basic nursing education in South Africa, (b) factors that contributed to the adoption of CBE (antecedent conditions), (c) the context within which CBE is practised, (d) the actualisation and practice of CBE (action/interaction), (e) intervening conditions and (f) expected CBE outcomes. See **Figure 5** for the schematic representation of these results.

Conceptualisation of CBE

Participants indicated that CBE is defined in terms of four important dimensions, which are (a) the primacy of community as a learning environment, (b) timing of first community exposure, (c) duration and frequency of community exposure, and (d) service provision. These four dimensions were regarded as discriminatory factors in the conceptualisation of CBE. They formed the basis of the understanding of CBE. According to the participants all four dimensions have to be considered in the definition of the concept CBE.

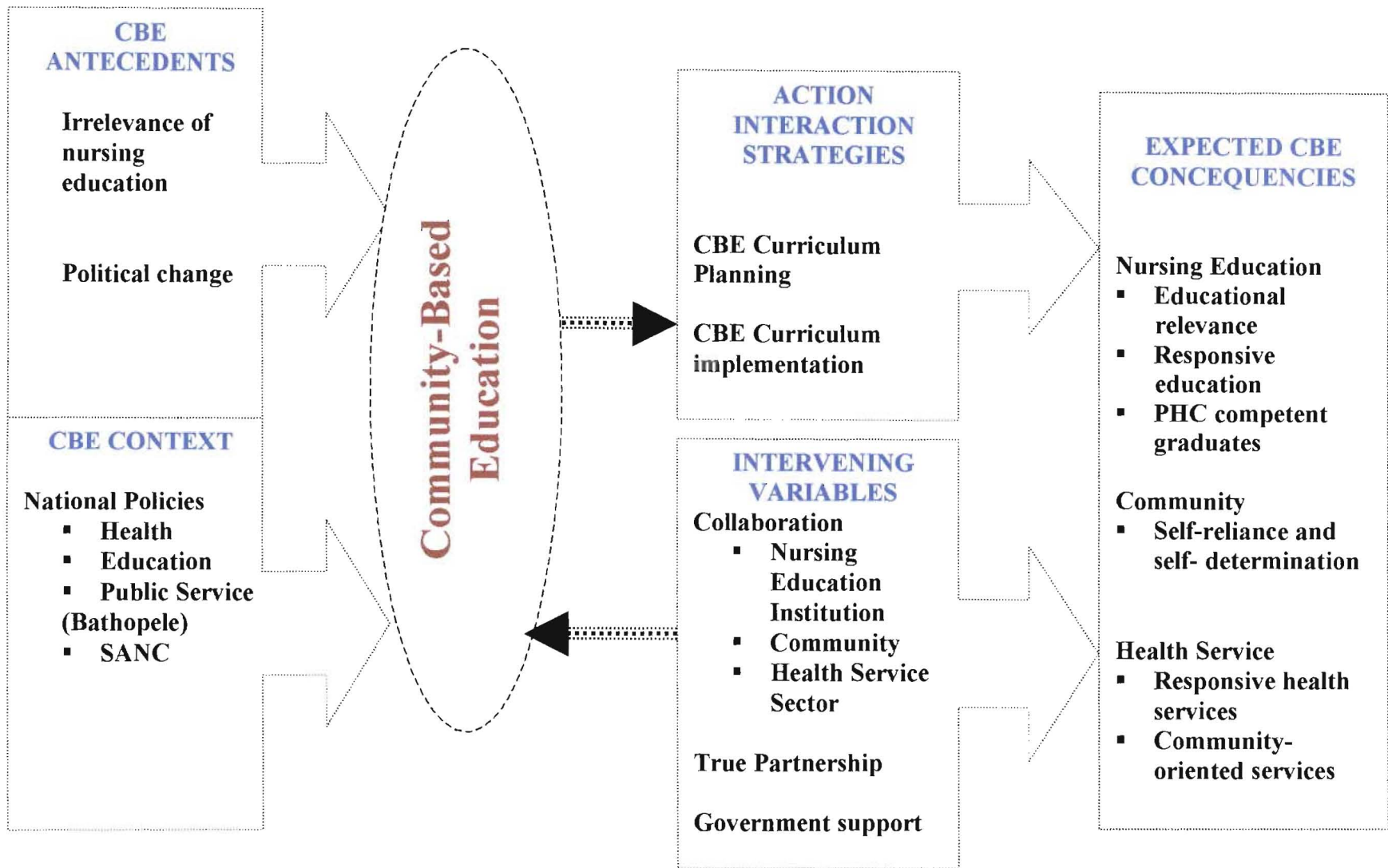


Figure 5: Schematic Representation of CBE, Conditions under which it Occurs and Expected Consequences

The following are some of the extracts from the participants' description of CBE which support the inclusion of all the above-mentioned discriminatory variables in the definition of CBE:

What is important in the definition of CBE is the setting where learning takes place, the timing of the first community exposure and the ratio of community-based learning activities in relation to hospital-based learning activities in a programme.

CBE is defined in terms of the setting where it takes place, that is the community, the time spent by the students engaged in community-based learning activities against the time they spend in hospital settings. As well as the timing of the first community exposure because we are aiming at changing the students' mind set about nursing as a profession mainly for looking after sick people in hospitals.

Primacy of the community as a learning environment. From the data sources it became clear that the setting where learning takes place in CBE is crucial because the environment used in CBE is more than just a place of learning, as was the case in traditional education. According to the participants the environment used, which is the community, connects the students with the wider community, which is a live dynamic context that exposes the students to the realities of life. The use of the community settings in the context of CBE differs from the use of community in traditional nursing education. In all definitions of CBE it emerged that CBE is learning that takes place outside the classroom in community settings where the students develop an understanding of how the social, political and cultural factors contribute to health or ill health. Participants also highlighted that communities used had to expose the students to PHC realities, especially because the programmes were aimed at facilitating the realization of PHC.

CBE is learning that uses the community extensively as a learning environment. Unlike in traditional nursing education, communities used in CBE are carefully selected because they have to help students understand the realities out there and how those realities impact on health of individuals, families and communities.

CBE is education of students in the communities, the communities where clients will be understood in their context. We do not use any community but it has to be under resourced to facilitate the application of the PHC goals and principles. What I am saying is that CBE is learning that takes place in special community settings where students develop an understanding of how these clients' context influences the health of individuals.

CBE is learning that takes place especially in under resourced communities. In our school for example we are surrounded by affluent communities, for our CBE programme to materialise we are placing our student in a community that is more than 30 km away from our school. We were looking for a community where students will develop an understanding of psycho-socio-political and cultural factors in the community that influence health and where PHC goals and principles would be more applicable.

Timing of first community exposure. The timing of first community-based learning experience emerged as another discriminating factor in the understanding of CBE. From the data sources the first community exposure in a CBE curriculum should be as early as possible in a CBE curriculum. CBE was introduced as early as in first year and second year in order to lay the foundation early in PHC and community-focused practice, not hospital focused practice. From the observations, too, the researcher came across first and second year students engaged in community-based learning tasks. The first community

exposure was either in the community per se or in community-based organizations, as stated by the following participant:

Timing of first community exposure is very significant in a programme that is regarded as community based. First exposure should be as early as possible in the programme. For example, in our school their first exposure to community-based learning activities is in first year, as part of the PHC module.

It is true that CBE is also characterised by the timing of first community placement in a programme. In our institution the first year students are placed in community organisations for the self-care needs of individuals and in second year they are placed in a community setting, mainly to orientate them to PHC, which is the basis of our programme.

CBE is defined in terms of the timing of the first community exposure. Early exposure of the students to community-based learning activities is significant in a programme which is regarded as community-based.

Duration, frequency and sequencing of community-based learning experiences.

The duration of community-based learning experiences in relation to hospital-based learning emerged as another important defining factor in the definition of CBE. Repeated exposures to community-based learning experiences were regarded as essential in CBE. The participants emphasized that community-based learning experiences should be spread throughout the curriculum, from the first year in the programme up to the fourth year. Having health promotion and illness prevention activities at all levels in a CBE programme was viewed as essential. Some of the participants were precise about the percentage of the time to be dedicated to community-based learning experiences in a CBE programme. According to the data sources at least 50% of the programme should be dedicated to

community based learning activities. Preferably these activities should not be isolated but should be spread throughout the curriculum, with each learning experience building on the previous experience to facilitate the appreciation of continuity in care, as is indicated in the following extracts:

In a community-based programme learning should take place in a balanced variety of setting with 50% or more of the time spent in activities taking place in community settings and the rest of the time spent in other settings. We believe that the longer the exposure to community-based activities the better are the chances of producing graduates with interest in serving the needs of the community.

Community-based learning activities in a community-based programme are supposed to be spread throughout the programme. In our case, however, third year students are placed in hospitals for hospital-based care. In that year we are unable to send them out to the communities. In classroom activities and in clinical supervision, that after dealing with the sick, we emphasize health promotion and illness prevention. The focus in hospital based learning experiences slightly differs from that in traditional nursing education, which was curative. In CBE we engage the students in activities encouraging the patients to go back to their families, in their normal settings. As a result we emphasise health promotion and illness prevention at all levels of health care.

Participants further indicated that the sequencing of community based learning experiences in a CBE curriculum is characteristic in that it facilitates continuity in learning. From healthy individuals in their natural settings (community) to sick clients in hospitals (health to illness continuum), it facilitated the understanding of different levels of health care (primary, secondary and tertiary), their functioning and the competencies required at each level. It emerged from the data sources that learning experiences in most of the schools nursing education institutions were sequenced so that first year level experiences

were in the community, second year experiences at PHC clinics, which were regarded as entry level to hospital, third year learning experiences were in hospitals, and fourth year was the year of specialisation. What emerged as remarkable in third year hospital-based learning experiences was that the focus was on assisting the clients/patients to return to their natural settings. These views on the distinguishing features of community-based learning experiences were expressed in the following excerpts:

The arrangement of community-based learning experiences is important in that they facilitate the understanding of the clients in their normal environment first so that by the time the students meet them in hospital, they have a better understanding of who the clients are and what is relevant to them with regard to health education. The sequencing facilitates the continuum in care.

In our programme teaching in third year makes reference to returning patients to their communities. We try to emphasize to our students that people do not belong in hospital they belong in the community. They (students) should therefore focus on assisting clients to go back to their communities.

One participant further pointed out how the placement of the students in PHC clinics contributed to the understanding of factors, perspective of the health service that could influence the health of individuals, families and the community:

In second year the students are placed in PHC clinics which are viewed as entry levels to hospitals. Learning experiences in these settings also widen the students' understanding of how availability, accessibility and acceptability of the services, as well as equity and the involvement of the community in the operation of the health clinic impact on health. In first year the students establish the factors influencing health from the community's perspective and in second year they trace them from the clinic's perspective.

Education for service. Data also revealed that CBE is conceptualised by some participants as a way of rendering service to the communities and families. The service was provided through community-based learning activities. The participants specified that service was rendered mainly to underserved communities who had limited access to health care. Examples of services which were provided by the students included home visits for needs assessment, health education based on identified needs and problems, health screening, blood pressure (BP) monitoring, glucose levels monitoring, wound dressings and many other activities. The following extracts were the responses of some of the participants with regard to the understanding of CBE:

CBE is a way of providing health care to community members, especially the underserved communities with limited access to health care. In the communities the students engage in learning activities which are educational as well as a form of service to community members. For example, our students conduct home visits. During those visits they do health education, teach families things like preparing oral rehydration solutions, check blood pressures, do glucose monitoring for those with diabetes, do wound dressings, and many other things.

According to what is practised in our school CBE involves visiting communities and families with the aim of offering some services to them. Our students are placed in needy rural communities, who really have less means of accessing health care. While they (students) are learning in those communities they help the community in a number of ways. Sometimes they teach and demonstrate to the families things like management of a child with a fever at home, dehydration and oral rehydration preparation, nutrition and breast-feeding. Sometimes the students go to the extent of starting vegetable gardens with families who cannot afford to buy food supplements, to ensure that the family gets a nutritious diet.

CBE is a way of rendering service to community members, visiting them in their homes and delivering health care directly to them. Unlike in the old education system, community members were only cared for by the nurses after the illness or disease has set in, in hospitals. Now CBE makes nurses render service that will prevent the occurrence of those diseases which were leading to unnecessary hospitalisation.

In one institution the concept CBE was reported to be used interchangeably with service learning. The rationalization for using these concepts interchangeably was that CBE incorporated both learning and service and these two could not be separated as the students were learning through providing service, as stated in the following extracts:

In our school we use service learning and CBE interchangeably because of the service component attached to CBE. This component is as dominating as learning that is expected to take place in the community. Our students learn by actually providing service to the community. So in that way community-based learning equals service rendering.

We do not really differentiate between service learning and CBE in our department because CBE incorporates both provision of service and learning, and both are important in a CBE curriculum. Another reason for assuming they are similar is that the Service Learning Policy of our university serves as a reference or provides the context within which our CBE curriculum is based.

CBE Antecedents

From the data sources it emerged that the need for CBE in basic nursing programmes in South Africa arose out of (a) the irrelevance of traditional nursing education

to the needs of the South African population, and (b) political changes in the national government in the early 1990s.

Irrelevance of Traditional Nursing Education

The irrelevance of traditional nursing education to the needs of all communities emerged as one condition that led to the adoption of CBE in basic nursing programmes in South Africa. Among the factors that contributed to the irrelevance of nursing education were the type of setting (urban hospitals) used for the clinical placement of students, and the teaching approach that was used. According to the participants, hospitals were supposed to be interwoven into the health care system as one of the settings used for clinical learning of the students, not as the main setting. In traditional nursing education the students had been deprived of learning experiences at other levels of health care, yet these were important in rendering comprehensive and relevant care. Missing out on meeting the clients at other levels meant that the students were not prepared to function in those settings and that frustrated them after graduation, because some were expected to function in those settings, as is indicated in the following excerpts from interviewees' statements:

Offering clinical practice in hospital really limited the students in getting a comprehensive picture of who the patients were. The hospitals should be used as one of the settings in the health care system, not as the main setting in nursing education.

Placing the students mainly in hospitals was problematic in that the students were prepared to serve mainly in that setting. What made matters worse was that the hospitals that were used for training purposes were urban hospitals that had almost all the required facilities. The students after graduation experienced

problems when expected to function in under resourced rural settings, which were nowhere near what the urban institutions had in terms of resources.

The participants also appreciated that traditional nursing education programmes were producing large numbers of highly skilled technical nurses who were able to function well in high technologic institutions. Concern was, however, raised by the inadequacy of their preparation because they were prepared to serve in urban institutions, not to serve the majority of the population which is found in rural communities. These were some of the responses by the participants on the inadequate preparation of nurses in traditional nursing education:

South Africa is regarded as a developing country because of the needs of the majority of the population. Traditional nursing education did not prepare our graduates to serve in these communities. They were prepared in what I can call 'first world' institutions. They were trained in urban institutions to care for people who have access to and who can afford, care in urban hospitals. Functioning in third world communities really frustrated the graduates because they were not trained for that. Their training was not in line with the needs of the majority of the population in South Africa. Nursing education therefore had to change, to be in line with the needs of all communities.

The data revealed that the curriculum which was used in traditional nursing programmes was based on a bio-medical model which focused on the sick, and curative care with little or no mention of health promotion or illness prevention, which is emphasized in a health model. The participants indicated that the materials (books) used were published in developed countries and had problems common in developed countries. Students were taught about those problems, some of which were very rare in South Africa. Current or critical health problems or issues were not addressed in the education of nurses.

Furthermore, these books used a bio-medical approach to care and that further limited the development of graduates for the needs of the South African communities, which are mostly under-resourced and require graduates who are more competent in health promotion and illness prevention than curative techniques. The following excerpts were from the responses to the question on the rationale for the changing the old curriculum to a CBE curriculum:

We did not change to CBE because our old programmes were not producing competent nurses. They were very competent in serving the minority of the population which is found in urban communities. They were not prepared to serve in rural and under resourced communities. This was made worse by the overseas books from developed countries which were prescribed for the students. Some of the problems taught from these books were hardly seen in South Africa but we had to teach them.

The bio-medical model rather than a health model was dominant in overseas books that were used in teaching. This model was also dominant in the settings where learning took place. The need to prepare nurses for health promotion and illness prevention, especially in rural communities and in underserved communities was not a priority. Over and above the fact that the change to CBE was brought about by the irrelevance of nursing education to the needs of under resourced communities, we had to change to CBE because the government is calling for health providers to place more emphasis on health promotion and illness prevention. That is one of the government's priority issues in health.

As a result of their limited preparation the graduates struggled to function in rural and under-resourced settings. That contributed to the problem of poor retention of graduates in under resourced communities and the skewed distribution of nurses in health care

settings. The preparation of nurses was not in line with the needs of the community. The following statements provide the rationale for the change to CBE:

The idea of changing to CBE was in line with educating the students to be able to function relevantly in line with the needs of all communities and to be able to apply the PHC philosophy in caring for all, individuals, families and the community. Nursing education had to be revolutionarized because as much as traditional programmes were producing large numbers of highly skilled nurses, those nurses really struggled in institutions which were not as well resourced as the ones in which they were trained. As a result of the frustration due to inadequate preparation, nurses had go back to urban hospitals leaving rural settings understaffed.

The idea of going to CBE was in line with educating the students to be able to function relevantly in line with the needs of all communities and to be able to apply the PHC philosophy in caring for all, individuals, families and the community. Nursing education had to be revolutionarized because as much as traditional programmes were producing large numbers of highly skilled nurses, those nurses really struggled in institutions which were not as well resourced as the ones in which they were trained.

Our graduates lacked ability to deal with problems unique to South African communities because they were not prepared for that. They lacked important skills such as problem solving skills which were transferable to all situations. As a result retaining these graduates in rural communities with limited resources became a problem because they were really not prepared to function in such settings.

Participants also highlighted the teaching approaches used as another limitation in the preparation of nurses for practice. The nurses were prepared using a lecture method

where a teacher who is regarded as more knowledgeable than the students dominated the whole process. Indirectly the students were socialized to the understanding that there are two groups of people; the more knowledgeable and the less knowledgeable. The more knowledgeable have a right to dominate those who are less knowledgeable. From the participants' view that attitude was unknowingly/unconsciously demonstrated by graduates when dealing with sick people. They did not have an understanding of the concept of partnership and the need for the involvement of the other partner in decision-making. When functioning in teams, it was assumed that the one who was regarded as more knowledgeable would lead the team. The understanding that all members are experts in their areas and can lead the team depending on the situation was missing. There was a need to change to teaching/learning approaches that encouraged a team approach and dialogue during the teaching/learning process. This concern was expressed in the following extracts:

We live in a participatory kind of situation where all can contribute significantly. Gone are the days when the doctors regarded themselves as heads of teams and nurses as their servants. What contributed to nurses assuming that role of working for the doctors was how they were prepared. The teachers who were regarded as 'knowing it all' dominated the students. Even in practice the nurses submitted themselves to the authority of doctors who were viewed as knowing more than nurses. The nurses, in return, unconsciously did the same to the patients. The patients hardly had anything to say. They were treated as objects. I do pardon those nurses because that was the effect of how they were trained. So nursing education had to change its thinking and adopt an approach that would facilitate the development of a team approach.

There was thus a need to change from the lecture method which dominated in traditional education and to adopt strategies that incorporated adult learning principles. The

participants believed that the application of these principles would contribute to developing students academically, professionally and personally, for their roles in practice. Some of the participants were convinced that treating students as adults, irrespective of their level of knowledge, allowing them to build on their past experiences and making them work collaboratively in teams, inculcated in them the attitude that the input of other people is very important, irrespective of who they are. Adult learning principles which were considered to be important in the preparation of nurses were that adults learn best when (a) in teams or groups where the spirit of collaboration is fostered, (b) they use their previous experiences as a resource of learning to make their learning more meaningful, (c) they are actively involved in their learning and in decision making regarding their learning activities, (d) their education is structured so that it cultivates self-directed learning, and (e) they work in an environment that encourages and supports learning. The participants believed that when students are treated as adults in their learning they are more likely to treat their patients or clients with respect, and as adults who could be involved in decisions regarding their needs:

In nursing education there was a need to appreciate that nursing students are adults and they have to be treated as adults for them to treat their clients likewise. Changing to CBE gave us an opportunity to remedy the problem in the teaching approach, which was really limiting our students in practice. They were not assertive enough to engage in problem-solving activities and to consult resources independently where they can access help to be able to deal with the situation confronting them. We indirectly taught them to depend on their seniors without even trying to act on a problematic situation first. South Africa does not need that kind of graduate, considering the diverse problems facing the South African population.

The participants also indicated that in settings where adult learning principles are applied, the students learn to work in teams and to respect views of other team members. They learn to identify and solve problems independently or with some assistance from the facilitators. They learn to take charge of the situation, think through the situation, and make decisions on how to deal with it collaboratively, and important skills are required in practice. The following extracts are from the statements which were made by participants in response to how the application of adult learning principles was significant in relevance of education to practice:

The government of the day is emphasizing a multi-disciplinary approach and client/ community involvement in dealing with needs. As the school we realized that the best time to prepare the nurses for this was when they were still in training but it was not possible through traditional education programmes. We identified a need to accommodate adult learning principles to facilitate the development of the ability to function in teams, to consider people as equals and more importantly to see clients as important in decision-making regarding their health needs. We opted for an andragogical approach because it strives towards developing self-directed and empowered learners who are able to solve problems.

We had to change because in our old programme the teaching methods used were not synchronized with the principles of adult learning which are believed to develop the students academically and personally. In the education programmes our students were not taught to problem-solve and to think critically because of the approach that was used. That shortfall affected our graduates even in practice. Activities that required problem-solving and analytical thinking were regarded as for those more knowledgeable at that time, not to be handled by them. Clients suffered because of that understanding.

From the data it also emerged that another limitation of conventional nursing education was that it had a discipline-focused curriculum that lacked integration of subjects to give students the understanding of a client as a whole. Practice settings required nurses who would be able to nurse patients in total, and not fragmented care. From the participants it emerged that in nursing education there was a need for education that would facilitate a comprehensive analysis of a clients' problems, integrating knowledge across disciplines, for example the knowledge of anatomy, physiology, sociology, anthropology, economics, politics and many other disciplines. The participants believed that such comprehensive analysis enhanced the understanding of the client in total and showed how the different disciplines could work together in solving a problem of one client. The use of information from a number of disciplines gave students a better understanding of the roles of other participants in a multi-disciplinary team approach, as was stated in the following quotes:

Traditional nursing education programmes are still lacking in terms of integration of subjects during the teaching process. As much as the nurses are functioning as part of the teams, the old curriculum which was used was not preparing them, in a way that helped them understand how knowledge from different disciplines can be integrated in dealing with clients' needs. The curriculum was discipline-focused and that promoted fragmentation of care. As a result the nurses in hospitals were unable to consider the client's context when rendering care because they were not taught to link those issues with nursing care.

Traditional nursing education lacked comprehensive analysis of client's problems because of the subject-focused curriculum which was used. Courses such as anatomy, physiology, sociology, anthropology, psychology and many other subjects were offered separately. They were not integrated in teaching. This

approach limited our students in that they struggled when they were expected to integrate their knowledge in practice.

Political Change in the National Government

The participants stated that the changes in the government, especially the 1994 democratic elections, contributed significantly to the change in nursing education. Nursing education was challenged to support the new government's efforts to redress injustices in the provision of health care. Inequalities in health care were mostly reflected in the health status of those in under-resourced communities and those belonging to vulnerable groups, such as children and women. The policies of the old government were blamed for the inequalities in health care, and the new government had the task of changing these policies to make them serve all community members, especially the previously disadvantaged communities. This information emerged from interviews and from document analysis. From the documents this change in attitude appeared as part of the background of CBE programmes. The participants also highlighted that the new policies supported a comprehensive health care system, to facilitate promotion of health for all, especially disadvantaged communities and groups. Nursing education was challenged to adopt a strategy that would prepare the nurses to be competent in providing service to all the population, irrespective of where they were and who they were:

The birth of the new democratic South Africa exposed a number of problems that were not transparent in the old health care system. The government exposed the fragmentation of health and large disparities between racial groups in terms of health care delivery, with disadvantaged rural communities and vulnerable groups being the most affected by these inequalities. The health care system had to address these issues. With nurses forming the backbone of the health care

system, nursing education had to act by changing from traditional education, which had a number of limitations, to adopt an approach that would facilitate the preparing of nurses for these changes in the health care system. We had to change to CBE.

The policies in the old government enhanced segregation and discrimination in health care which was easily accessed by those advantaged minority communities, with limited access to disadvantaged majority groups. There was no emphasis on health and health promotion; the focus was on curative care. The problem was that curative care was not accessible and affordable to all. With the 1994 changes in the government to a democratic government, everybody, irrespective of where they came from, for the first time had to have access to affordable health care. Policies were designed to respond to the needs of those deprived communities and vulnerable groups. Nursing education was challenged to contribute in making health care accessible to all, by changing to CBE.

CBE Context

The national health policies emanated as part of the context within which CBE was introduced. These policies include (a) national health policy, (b) national education policy and (c) professional (SANC) policies. These policies were subcategories under the category CBE context.

National Health Policy

The adoption of CBE in basic nursing programmes was a **response** to the government's call for PHC as the underlying philosophy in the National Health Care System. According to the participants, CBE was regarded as an effort to prepare nurses who would be able to function in a health care system founded on the PHC philosophy. It was

also highlighted that according to the PHC policy accessibility of health care to all, especially under resourced communities was significant and CBE facilitated the realization of that the PHC demand, as stated below:

CBE stems from the government's policy. With our CBE programme we are trying to implement PHC principles as proposed by the government. Therefore our school is trying to put this policy into action. We are not yet there but we are trying.

CBE is really one of the strategies of implementing PHC principles as stipulated in the government's policy. It is a way of making services available and accessible to the people. It is a way of ensuring that no matter how far away health services are, as it is the case in our communities (rural), people have access to health professionals. By sending our students to the communities we are trying to reach out to the needy communities

CBE in our institution is a way of trying to implement government's policies, such as PHC and Batho Pele. PHC emphasizes that services should be taken to the people in the community, and the people and communities should be empowered to be self-reliant. Batho Pele emphasizes that people should come first in whatever we are doing and there should be equity to care.

Because PHC is a national priority, one of the participants stated that they are actually indoctrinating the students with PHC:

PHC is the policy from the government. Our school adopted a CBE curriculum because it was a directive from the government. In order to satisfy the needs of the government and of the community served by our school we have no choice but to indoctrinate the students with PHC as soon as possible in the programme and I think it is working. Our students are very excited about this new approach to nursing education.

National Education Policy

From the participants and from the documents reviewed CBE emerged as a response to education policy regarding service learning. This policy was derived from the 1997 Education White Paper: A Programme for Transformation of Higher Education. According to the participants this White Paper laid the foundation for the inclusion of service learning in higher education institutions, where students learn by actually rendering service to community members. CBE was regarded in other institutions as one of the terms used to describe service learning or community service, but the important thing was that community based education or service learning should benefit equally both the community and the students while they are both learning. CBE programmes were characterised by both learning and service. The following was stated in this regard of as a result of the education policy on service learning:

The 1997 White Paper on Higher Education has been highly influential in the promotion of social responsibility in the students. As a result of this paper a number of institutions engaged their students in activities in the communities that facilitated both learning and rendering of service to community members. CBE policies in a number of higher education institutions are based on this Education White Paper.

In our institution we use the terms service learning and CBE interchangeably because our faculty policy is based on community service policy from the Department of Education. Nursing department uses community-based education as a way of conforming to this community service learning policy. In other words CBE is a response to this policy. CBE in our programme is as a result of the service learning policy following the Community, Higher Education, Service

Learning Partnership (CHESP) projects and Joint Education Trust (JET) Reports.

Professional (SANC) Policy

According to the participants the adoption of CBE was as a result of the new policies from the SANC which also supported PHC because it was a directive from the Department of Health. The SANC also supported rendering of service to community members by the students while on training in preparation for their vocation after graduation. In other words the SANC policy on CBE was informed by the Department of Health policy on PHC and the Department of Education's policy on service learning. Some of the participants highlighted that the changes in the professional policies came as a collaborative consultative effort between the Department of Health and the National Education Department. The SANC required the input of these bodies in the development of the policy that influenced the adoption of CBE in some of the nursing institutions in South Africa.

The new curriculum took into consideration a number of National Health policies such as PHC policy, Higher education policy on service learning as well as the Bathopele principles. These policies also served as reference to the SANC's (1999) policy on nursing education.

We adopted CBE curriculum in year 2000 because it was a directive from the SANC and the Department of Health. SANC policy serves as our point of reference in our CBE programme.

Action/Interaction Strategies

Action/interaction strategies include activities and/or strategies devised to manage, handle, carry out, or respond to, a phenomenon under a specific set of perceived conditions

(Strauss & Corbin, 1990). In the context of CBE, action/interaction strategies are those processes involved in the implementation of a CBE programme as illuminated by the data obtained from participants, document analysis and field observations. Two main categories emerged under action/interaction strategies and those were (a) planning for curriculum change, and (b) CBE curriculum implementation.

Planning for Curriculum Change

Regarding CBE curriculum planning, the participants reported that this phase in a CBE curriculum required (a) collaborative decision-making, (b) ensuring congruence between expected graduate competencies and clinical learning sites, and (c) development of stakeholders for implementation of CBE.

Collaborative decision-making. From the interviews and documents which were analyzed, it was clear that the process of change from an old curriculum to a new curriculum required support and input from all stakeholders. Participants pointed out that collaborative decision on the change to CBE was crucial, because, in principle, CBE required collaboration between the academic institution, the community and the health service sector. More importantly, decisions regarding the priority health problems to be included in the curriculum, as well as competencies required from the graduate on completion of the programme, required input from representatives from these three settings. The input on priority health problems to be addressed in a curriculum was regarded as important, to ensure that graduates were prepared to deal with those problems. Decisions on these aspects were important to ensure that the curriculum fitted its purpose. In view of the

importance of involving all three settings in the process of change, the following participant stated that:

The success as well as the effectiveness of CBE depends on the support from the community and the health settings used for the placement of the students. In our school we invited staff from the neighbouring hospitals and clinics, representatives from the community as well as the non-governmental organizations in the communities which were earmarked for the placement of the students. Involving them was crucial because decisions had to be made concerning the priority problems to be addressed as well as the competencies of the new graduate to be produced from the proposed curriculum.

Participants from four of the seven institutions stated that a special working committee which comprised members from all settings, the hospitals and clinics, the community as well as the academic institution, participated in the reviewing of the old curriculum, and their inputs were welcomed. More importantly, service personnel and communities had to be represented because of decisions regarding graduate competencies that would be put back to use in those settings. This committee served as a core curriculum committee to facilitate the whole process of change. Responding to the question that required an explanation on the importance of having representatives from all these settings one participant stated that:

In the process of changing to a new community-based curriculum our school decided to include representatives from the community, the clinics, and hospitals because crucial decisions were going to be made with regard to the adoption of a new curriculum and, on graduate competencies on completion of the course. The community and, health service people had to be involved in decisions on graduate competencies because the achieved competencies will be put into use in these settings later on.

Participants from the other three institutions reported that nursing education institutions conducted workshops in which all stakeholders were involved. According to the participants all those who attended the workshops participated in the process of reviewing and adopting a new curriculum, as well as in decisions concerning the needed competencies of new graduates. Involving all stakeholders in the process of change enhanced the acceptance of the new curriculum. The following statement was made by one of the respondents concerning the curriculum change:

The initial phase of curriculum planning included holding open workshops on the change to CBE curriculum, with service personnel, community members and surrounding nursing education institutions. This was important because joint decisions had to be made on graduate competencies and the important national and local issues to be considered in this new curriculum. More importantly, our new curriculum had to be acceptable to all.

One of the participants highlighted that deliberation on the change and adoption of a new curriculum required some time:

The process of changing to a CBE curriculum was a lengthy one, as we had to have input from a number of stakeholders. This input from these stakeholders was important after the realization that leaving them out, as was the case in the old curriculum contributed to the production of graduates who were not competent enough to meet the needs of the community and those of the health service.

One of the participants was more specific regarding the time that was spent by their school in the process of change:

Preparing for the change to a CBE curriculum took us about six years because we had to sell our ideas to the health service sectors where we place our students. We also had to sell our ideas to the community members and then engage in the process of developing this new curriculum collaboratively with our new partners.

Taking into consideration that a team approach is crucial in changing from an old curriculum and in developing a new community-based curriculum, one participant also explained how the change process was handled in their institution. According to this participant, decisions on graduate competencies were made, as well as decisions on clinical learning environments where those competencies would be achieved.

All the health centres used for placing the students, including the community members were involved in developing our new (CBE) curriculum. A number of hospitals around the area, the clinics attached to these hospitals, and the community representatives, formed part of the core committee that worked on the curriculum. Together we looked at what should be taught and at which level because our CBE graduates had to be relevant, efficient and effective in addressing the needs of the stakeholders. We also looked at each setting to decide on the competencies that could be attained at each setting. The community representatives as well as service staff had a great input in describing the type of nurse they would like to have, and the learning experiences available in their settings that would contribute to the development of required competencies. They also had a remarkable input on the national as well as local health issues to be catered for in the new curriculum.

Another participant also emphasized the importance of including the community and service sector in the process of change to a new CBE curriculum:

As a school we made it a point that we involved the community and the service people in the process of curriculum review. Getting their input on the

shortcomings of the old curriculum and involving them in the decision to adopt a new (CBE) curriculum was very crucial because the success of implementing this curriculum depended on a good working relationship with them. More importantly, the focus on CBE is to address mainly the needs of the underserved communities.

Congruence between expected graduate competencies and clinical learning sites. The selection of clinical learning environments, especially the community sites to be used for the clinical placement of the students, emerged as important during the process of planning a CBE curriculum. The nature of the graduate to be produced was perceived as one factor to be considered in selecting learning sites because CBE aimed at producing graduates who should be able to serve in all types of communities, be it urban, suburban, rural or an informal settlement. More importantly, they should be able to function in under-resourced communities. The following participant shared these views:

The settings used for the clinical placement of the students had to be in line with the type of graduate to be produced from the programme. In CBE we say we want to produce graduates who will be able to serve communities at all levels, more importantly those who are interested in serving under-resourced communities. This should then be reflected in our selection of community sites.

A number of participants pointed out that community-based learning activities should take place in all settings where people live, urban, suburban, informal settlements and rural communities, because the students were being prepared to function in these settings as is stated in the following excerpt:

In our school, students are placed in three different communities. One is in the heart of the city, another group in a semi-urban area and another group in an

informal settlement. When we started the programme students were placed in a rural community but that community was replaced by an informal settlement for logistical reasons. When selecting learning sites, we try to include all types of communities where people live and where our students are likely to work after graduation.

From the participants and from the documents it appeared that there was a specific criterion that was used in the selection of community sites. During interviews some of the participants kept on referring to the CBE programme documents where this information was documented. These criteria included that (a) in a targeted community there should be a history of a university or other faculty/ies interacting with that community, (b) that the community site should be able to provide relevant learning experiences which are in line with the educational objectives at a particular phase in the curriculum, (c) community-based organizations in that particular community, including the clinics where students will be placed, should believe in PHC and/or should have it as their underlying philosophy, (d) organizing community-based learning experiences in that community should be feasible, taking into consideration issues such as accessibility of the community and facilities in that community, transport availability and cost, as well as working relations between the community and the facilities in that area, (e) the community should be in need of the service to be provided by the students during their community-based learning experiences, and (f) that community should be stable and reasonably safe.

One participant emphasized that the needs and problems in a targeted community should be taken into consideration as well as whether the community meets the set criteria. The following were the words of this participant:

In the selection of communities as learning sites, the decisions on the inclusion of a particular community should be based on whether the community meets the criteria set, and the needs and problems of the community should be another deciding factor because we need a community environment that will serve as a stimulus for learning and at the same time appreciate the service provided by the students during their learning process.

Development of stakeholders for CBE implementation. Because CBE was an unfamiliar concept in basic nursing programmes in South Africa, participants highlighted that the process of curriculum development also included the preparation of those who were going to be involved in the programme, (a) the teaching staff, (b) the service personnel, and (c) the community members. The preparation of students and their families emerged also as important in a CBE curriculum, although their preparation occurs during the curriculum implementation phase:

CBE, as a new approach to teaching required a lot of preparations, the preparation of the teaching staff, administration staff, health service staff, the community, the students and their families, especially because of the paradigm shift, moving away from the traditional setting which was used in the old curriculum to the community setting which is assumed to be an unsafe environment.

According to the participants the preparation of **teaching staff** included workshops, seminars, visiting well established national and international CBE programmes, and inviting experts to assist. The process of preparing faculty was reported in some of the institutions as a very difficult process, because the teachers were used to the old lecture method of teaching in the classroom. Moving them away from their familiar environment

and taking them out to the communities to facilitate learning was reported to be very challenging, as was stated in the following reports:

Our school curriculum was approved by the SANC in 1996 and thereafter the training of staff for the implementation of a new curriculum started. This was the toughest period because changing an old teacher to be a facilitator is a problem, it is even worse to make them facilitate learning in community-based settings. A programme was designed for developing facilitators. An expert from ... (overseas university) had to spend the whole year helping us by running workshops and demonstrating facilitation during the classroom sessions.

This participant further added that:

As part of the preparation of staff two staff members went for a Masters Degree at one of the local universities that specially prepared them for these innovations in education including CBE.

The coordinator from the community-partnership programme organized experts in CBE to prepare us for the facilitation of learning in the community. Two staff members from our school attended workshops in one of the overseas universities as part of preparation for this new adventure in a CBE curriculum.

The preparation of the **service personnel and community members** included meetings and workshops in which the members from these settings actively participated. Because CBE requires more staff, in some institutions more staff members were appointed to assist mainly with the preparations for the adoption of CBE, as stated in the following extract:

On completion of the curriculum, two staff members were added in our school to assist with the preparation of the staff from the clinical settings and communities. They called meetings where the proposed change in the education of nurses was

tabled. Thereafter they conducted workshops with the intention of preparing all the participants for their roles in the new curriculum.

The process of preparing community members started with the key figures in selected communities and the key figures later invited the rest of the community to attend meetings which were directed by the representatives from the nursing education institutions. Community health workers or health promoters who were going to assist in facilitating learning in the community-based learning activities underwent training programmes which were facilitated by the health professionals from Academic-Community Partnership Programmes. The following experience was shared by some of the participants regarding the preparation of staff from the clinical settings and the communities:

As a campus we first decided on the communities that met the criteria of communities to be used in CBE. We then made an appointment with the chief of the area to explain our new proposed curriculum to him. The chief then arranged a meeting with the executive community members, to listen to our request as nurses. Later a general meeting for the whole community was called. After accepting our request, the school representatives (that is, the principal, and heads of specific disciplines) together with the community discussed the roles and responsibilities of the communities, staff and students during community-based learning activities.

It emerged from the data sources that those preparing the community should understand the community's language and culture, and should work towards getting the support of community structures, as they are the key to the successful implementation of CBE. In one institution where they were unfamiliar with the culture and language used in

the surrounding communities they had to appoint lecturers who could assist during this process of preparing the new curriculum. One such participant reported that:

I was specially employed to prepare the community, the reason being that the faculty of the school had a problem in understanding the language and the cultures of the surrounding communities. I worked with those communities for two years preparing them. I also worked with the health centres and NGO's in that community, preparing them for the new curriculum. We involved the Municipal council of the area, the community structures like SANCO, churches and other organizations such as women's organizations in these communities. Getting these community structures to support our new programme was our main priority.

Participants highlighted that in CBE the preparation of **the students** as well as their parents or significant others was important, because the students in CBE are exposed to an unfamiliar environment which is considered by many to be unsafe and uncomfortable. According to the participants, this preparation does not take place during the curriculum planning process, but only takes place when the students have been accepted into the programme. It was included under this section because it fell under preparation of those who would be involved in CBE. The following extract explains how the students were prepared in one institution:

At the beginning of the year, towards the end of February, we call a parents' meeting where we explain our programme to them. Usually one finds that they are not happy about the placement of the students (their children) in the community because they consider the communities used as unsafe. We try to allay their anxieties and we even invite students from the previous groups who have been through those communities to share their experiences. We show them pictures of

the community sites and we inform them that community police stations are always informed about the students in the communities.

With regard to the preparation of students, it was reported that the process of preparing them for a community-based curriculum began before the scheduled university opening time. Orientation included preparing students for community-based learning experiences in the community, and assisting them in learning how to learn, as self-directed learning is promoted throughout the programme. In response to how students were prepared for community-based learning one respondent stated that:

Our students arrive before the university's scheduled opening time. At this time they are orientated to the programme and this includes telling them about the learning sites used especially the community, and telling them about the study methods which are promoted in our curriculum. We orientate them to CBE and problem-based learning. We give them handouts on basic learning skills, how they are going to work in groups, and we have a simple scenario with something like people living in an informal settlement and we take them through different steps to familiarize them with the problem-solving approach dominating our programme.

Orientation takes about two weeks and it includes orientation to CBE, cultural diversity, group dynamics, PHC, community entry, community participation, how to do a rapid appraisal and epidemiological studies, and learning contracts as means of promoting self-directed learning. The students then visit the community sites where they will be placed later for their community-based learning experiences, to view these sites in preparation for conducting community surveys. Videos are provided in the clinical skills laboratory where they learn basic skills they are likely to need in the community, such as temperature taking, BP checking, urine testing, blood sugar level monitoring and many other skills. They

also learn more about some of the activities that will be taking place in the communities, activities such as doing home visits, conducting family studies, monitoring of growth in a child and assessment of the nutritional status of a child less than five years of age.

In view of the data presented on the preparations important in the adoption of a new CBE curriculum, one can conclude that adoption of a CBE curriculum requires the preparation of faculty who will be involved in the facilitation of learning; it includes preparation of staff from the health care settings as well as the community. Furthermore parents and the students are prepared for the paradigm shift from the hospital environment that is considered to be safe, to the community environment which is assumed to be unsafe.

CBE Curriculum Implementation

Subcategories that emerged under the implementation of a CBE curriculum included (a) determinants of the curriculum, (b) the nature and sequencing of community-based learning experiences, (d) teaching approaches, (e) teaching/learning process, (f) the nature of the teacher, and (g) the nature of the learner.

Determinants of the curriculum. Participants highlighted that a CBE curriculum does not have a preset content. The participants repeatedly mentioned three sources of curriculum content, which were the clinical learning environment (the community in particular), the students and the regulatory body (SANC). The following participant summarises this:

The curriculum content is determined by the needs of the community, the students' interests and the regulatory body. The students' interests emanate from the problems identified in the learning settings, the problems they do not know

and need to know. The nursing council, on the other hand, as a regulatory body, gives directives on the important issues to be considered in the curriculum.

The learning environment was used as the source of the curriculum content.

Participants stated that problems identified in these learning settings provided the basis on which to organize the curriculum content. Students were placed in community settings as part of their learning, to conduct needs assessment. During that process they identified problems which were taken back to class, and served as the basis on which to build the curriculum content. The determinants of health in the community were used to analyze these problems. Some participants stated that drawing problems from the community to form the curriculum content gives a community-oriented focus and relevance to the curriculum, as stated in the following extract:

We expose the students to the community first to assess the needs of the community and the identified needs and problems form part of the curriculum content. The identified needs or problems are current, and are from real life settings. That causes our curriculum to have relevant and up to date content. More importantly, the curriculum becomes community-oriented.

With regard to the regulatory body as another source of the curriculum content, participants stated that the directives from the SANC were taken into consideration. The example provided was that of PHC policy serving as the basis for most of the schools' curricula, as stated in the following excerpt:

We also try and relate these problems (problems identified in the community) to the SANC requirements, as the Council has got its own expectations. We try to link them to PHC, as it is the directive from the SANC.

From the findings presented on the sources of the curriculum in CBE, it is clear that there are three main curricula sources, the clinical learning environment (the community in particular), the students, and the regulatory bodies. The directives from the regulatory body are used as a point of reference in the relevancy of the curriculum content to the needs of the community and the health care system.

The nature of learning experiences. Data sources highlighted that in a CBE curriculum there are learning experiences that characterize a CBE curriculum. Community-based learning experiences emerged as important concepts under learning experiences.

Regarding the **nature of community-based learning experiences** participants mentioned that community-based learning experiences are dominant in first and second year in the programme. As a result, learning experiences characterizing community-based education are found in those first two years. According to the participants those learning experiences differentiate CBE from traditional education because of the nature of the environment where they take place:

Learning activities distinctive of CBE are those found in first and second year in our programme. They characterizes CBE because they take place in the environment which is viewed as the main environment in CBE, the community

According to data sources the students in community settings participated in the following community-based learning experiences (a) community surveying and action plan, (b) home visits and family study, (c) epidemiological studies, (d) health education as part of health promotion and illness prevention, and (e) working in the community to provide service to the community and to understand how psycho-socio economic factors affected

the health of individuals, families and the community. Elaborating on community surveying and action plan one participant stated that:

Community surveying is the first community-based learning experience that is conducted following the orientation block. Problems identified are analyzed in class and one of these problems is selected to act on. What is important in this learning activity is to ensure that students are working in partnership with the community, otherwise their project is likely to be unsuccessful. Implementation of the action plan is followed by the evaluation of the effectiveness of the action plan.

Experiences related to the programme called the 'Child survival development revolution' which is part of the Health for All programme started by the United Nation's Children's Fund (UNICEF) and WHO were observed in all settings. The students were observed by the researcher in the community settings, during home visits and at the PHC clinic engaged in activities such as growth monitoring, immunizations, family planning, breast feeding promotion, promotion of the use of oral rehydration therapy at homes in cases of dehydration due to diarrhoea and vomiting, education on nutrition, especially in children, with the emphasis on food supplementation or planting vegetable gardens, and education of family members on first aid during homes visits. While in the community, the researcher visited some of the community projects which were initiated by the students in partnership with the women in the community to empower them with life skills. Projects such as sewing, baking, and gardening, which were cash generating projects initiated by the students, were visited. These projects were at the stage where the women themselves sustained them. Participants referred to these learning experiences as GOBIFFFF, which in full means Growth monitoring, Oral rehydration, Breast feeding, Immunizations, Family

planning, Food supplementation, First Aid and Female literacy. Regarding the PHC focus in learning experiences one participant stated that:

Most of our learning activities focus on the GOBIFFFF because we are preparing graduates who are supposed to be PHC competent. They engage in these activities during home visits, at the clinics and sometimes as part of their community intervention projects.

Teaching/learning approach. A **problem- focused approach** appeared to be the main teaching/learning approach used in four of the seven institutions that participated in this study. The other three institutions were still using the expository approach, mainly because they were still writing examinations set by a regulatory body. A problem-focused approach was regarded as important because the preparation of students in CBE was aimed at developing students in the area of handling patients' or clients' problems in all health care settings. In response to the question about why the use of problems was important, one participant stated that:

We use problems as the basis in our teaching because we are preparing graduates who should be able to deal with problems of individuals and communities in practice. Problems used are real problems from clinical settings where our students are placed.

From the four institutions which were using authentic clinical learning experiences as the basis for content selection as well as the process of learning, two approaches emerged, (a) paper problems, and (b) authentic clinical problems. Paper problems in the context of this study were community problems which were presented on paper in a form of short scenarios, for learning purposes. Presenting problems on paper according to the

participants, gave structure to what was being learned. Authentic clinical problems refer to real life problems drawn from the community setting and presented in the classroom as they are for learning purposes.

Some of the participants who had reservations about the adequacy of the content covered through the use of authentic problems direct from the clinical settings were using **'paper problems'** because they were more structured than the use of problems arising from the clinical environment. According to the participants, paper problems were organised in a more systematic way, directing the learning process towards ensuring that the important content was covered. The participants believed that reasonable content was covered through paper structured problems cases and at the same time the students were developed in a number of life skills, including problem-solving skills. This participant reported on their school's experience with regard to the use of both paper problems and authentic problems:

Initially when CBE was introduced we used problems direct from the community for a year, but we were not comfortable with the breadth of the content that was covered. This approach to teaching only focused on the depth of the issue of the interest at that time, not the breadth. As we have a regulatory body that set standards, as a school we felt that the content we were covering was nowhere near the minimum requirement by the SANC. Consequently, we changed to paper problems.

To ensure relevance of the paper problems used, the institutions reported that they based those cases on common problems in the community, and they revised them every year, taking into consideration current problems and current changes in the community. A participant explained how relevance of the cases was maintained in their institution:

During the orientation block, at the beginning of the year, our students are given a workbook with paper problems, which is reviewed yearly by the school of nursing in partnership with other faculties, depending on the subjects of interest integrated in that case. Reviewing the cases yearly is very important taking into consideration the needs of the surrounding community, prevalent conditions in the community and current health policies. We review these cases yearly to keep them up to date.

Participants emphasized the importance of a multi-disciplinary team approach in developing and reviewing of these cases. One participant made an example of a nutrition case that required input from nurses, a nutritionist, physicians, dermatologist and an agriculturalist. The case was developed by all these specialists focusing on their areas of speciality. With regard to a multi-disciplinary approach in case studies, this participant stated that:

We use a multi-disciplinary approach in developing our cases because it is not possible to have specialists from other disciplines to teach our students as we would like to owing to how the university functions. So, in order to introduce our students to that multi-disciplinary approach we develop cases and we involve other schools. These schools have their input into our cases. Through these cases our students learn to understand how other members of the team contribute in the management of a certain problem, through a paper problem.

According to the participants from institutions using paper problems, these are used mainly as triggers for further discussion in class. Following a problem-solving process that has seven steps, the students analyse these cases. Sometimes the facilitator presents an illustration or a picture which relates to what is taking place in the real world or community setting. A short scenario related to the picture presented accompanies this illustration. The

students are then expected to analyse the illustration or the picture. The researcher, during observations, witnessed the use of both the short scenarios and illustrations. These triggers stimulate the discussion in class and the process of knowledge construction. One participant explaining the use of short paper problems and illustrations in class stated that:

As you have seen in class today we use illustrations, pictures and short paper problems closely resembling situations that confront the students in community settings. The illustration of a rural community that was used in class had a number of social problems that were likely to influence the health of community members. Such activators or triggers stimulate students to think deeply about what they see in community or clinical settings.

Two of the four institutions that were using a problem-focused approach in teaching and learning indicated that they were using **authentic clinical problems**, not paper problems as the other two institutions were. The important concepts that emerged from data obtained from nursing education institutions that used authentic clinical learning experiences as the basis for curriculum content selection as well as the process of learning were (a) experiential learning, and (b) use of the problem-solving approach.

Experiential learning was identified as one of the strategies used for teaching and learning in a problem-focused approach. The students were placed in clinical settings first to identify problems independently, with some guidance from the facilitator as and when the need arose. That process was followed by the analysis of the identified problems, selecting one problem and working on appropriate intervention strategies, implementing the selected strategy and evaluating it. Embarking on these learning experiences independently promoted learning through experiences as indicated in the following statement:

Experiential learning is dominating, especially in community-based learning activities. When students are placed in settings where they will be required to perform some nursing skills they learn through experience in the clinical skills laboratory first, before engaging in performing those skills with real patients

The students only attend an orientation block which prepares them for life in the communities out there. Thereafter they learn through experience and the process continues up to the end of their community development process.

What emanated from the data was that the process of experiential learning goes together with engaging in authentic learning activities. Community-based learning experiences were organized in such a way that the students had to act on their experiences to make learning more meaningful, as indicated in the following statements:

We place our students in real life settings, to learn through dealing with these problems. We believe that learning takes place through the process of problem-solving and the knowledge acquired during the process is current and relevant to the situation dealt with.

One of the objectives in our community module is for the students to be able to conduct a community survey. We do not stand up in class to teach them how to conduct a community survey. We place them in their community to learn by actually doing a community survey in real settings, identifying real needs and problems in that particular community.

The process of learning through experience was coupled with reflective learning, as students were expected to reflect on their learning experiences, and on the kind of learning that took place from learning through experience. What was observed in the nursing institutions that participated in this study was that community-based placement was

followed by a feedback session or a post clinical conference that was used as a platform to reflect on learning experiences encountered in the community settings. Reflecting in post clinical conferences was also confirmed through interviews, as stated in this extract:

We end each community-placement day with a post clinical conference. In these post-clinical conferences the students get an opportunity to reflect on their experiences in the community, telling us about the problems they identified in the community, how they dealt with those problems and what learning took place during the process of solving those problems.

Experiential learning was reported to be coupled with problem-solving. Problem solving activities were introduced in the programme as early as possible to facilitate early development of the problem-solving skills which are crucial in a CBE graduate. The students were placed in community settings where they were confronted with problems to address. The process of problem-solving, however, began with problem identification. Some participants shared with the researcher how the problem-solving approach was applied in community-based learning activities:

Students are placed in the community at the beginning of the year to assess the needs of the community. Thereafter they analyze the identified problems, decide which one to deal with. They follow the process of problem solving, as you can see it in our conceptual framework. They complete the whole learning experience by the evaluation of the whole process at the end of the year.

The following participant stated how a problem solving approach was used in the classroom;

The students compile a list of problems identified in the community settings. From that list we select one and we analyse it following the problem-solving steps.

Information needed to deal with a problem comes from many sources. The students are therefore expected to go and research further on the identified problem. They then later come back to present their findings.

In one of the documents which were reviewed the problem-solving approach was defined as:

A systematic and substantive process of meaningful learning. The steps involved include sensing the problem, formulating a list of problems, analysing the identified problems, prioritising problems, searching for intervention strategies, selecting one feasible strategy, implementing and evaluating it.

One of the reasons for the use of the problem-focused approach which was repeatedly mentioned by the participants was that it facilitated the integration of theory and practice. It was reported that the problems identified in the clinical settings were dealt with in class with the intention of correlating what was taking place in the practical settings to the theory taught in class. Facilitation of correlation of theory and practice through the problem-focused approach was highlighted in the following extract:

The correlation of theory and practice has been a missing component in nursing education. As a result we had been producing highly skilled nurses who, however, could not link what they were practising to the theory they had learned. The identification of problems in the community and taking them to the classrooms for further analysis, using literature and other sources, facilitates the integration of knowledge and that makes learning more meaningful.

Other participants asserted that through PBL the students learn to identify problems in real life settings and actively work out solutions to them. They believed that this exercise

prepared the students for their practice after graduation. This view was expressed in the following statement:

In the classroom and in the community settings our students engage in problem identification and solving activities with the aim of preparing them for their responsibility after graduation. In the communities they engage in a community development project which takes almost a year to be completed, beginning with problem identification, working out a solution to that problem, implementing and evaluating that project.

Some of the rationalization provided for the use of PBL was that it facilitated the development of knowledge which is usable, relevant and current, as was indicated by this participant:

These days there is emphasis on relevance, currency, and practical usefulness of knowledge and that is possible through the use of a problem-solving approach in teaching.

The selection of priority problems to be included in the curriculum emerged as important in a problem-focused approach because of the large numbers of problems encountered in the clinical settings. In response to how a decision was reached on the problems to be dealt with, participants stated that a specific criterion was used. One participant stated that:

These criteria facilitated the selection of priority problems to be included in our curriculum. In the clinical settings the students come across a number of problems. What we do is that they compile a list of all the problems identified and we check the frequency of these problems as well as what contribution they could make to the learning of the students.

In selecting priority problems, firstly, the students, together with their facilitators, decide on the common problems in the community and the most prevalent ones are dealt with first. Secondly, a problem, although rare, may be included if it is a good model of study, when it is believed that the students might benefit most from the inclusion of that problem. The example that was provided was that of Malaria, because it is a major problem in neighbouring countries that use some of the hospitals in South Africa as their referral hospitals. In other words the prototype value of the problem is important in the selection of priority problems. Thirdly, problems which are regarded as requiring immediate intervention at the time of presentation, and which might lead to death if not attended to early are included. The example which was provided was that of Ebola Fever. Fourthly, problems that promoted an interdisciplinary input were considered to be important especially in institutions that used a multi-disciplinary approach. For example, in one institution the researcher observed students from a number of disciplines in a class session meeting for a case management. These students were from the schools of nursing, medicine, physiotherapy, social work, psychology, anthropology, nutrition, and natural environment and community health. The case that was presented had multiple problems that required a team approach. This was a case of a female widowed client, who was the only source of income, with four young children. She sustained burns from the stove in her home in an informal settlement. In explaining how this particular problem was identified as a priority because it was not a common problem, the facilitator told the researcher that:

Burns from a stove are important but are not a priority. They are dealt with in third year which is hospital-focused. What is unique about this case is that it was identified by the students in the community setting as having multiple problems; it required input from other disciplines. The students collected information with the

help of the facilitator who was with them on that day and that information is the one that was presented today. The problem is analyzed by all the students and they planned together how as a team they could contribute in the management of this problem.

Teaching/learning process. Active learning emerged as the major concept under the teaching learning process. Active learning was reported to be facilitated through a number of processes such as (a) collaborative learning, and (b) self-directed learning. Active learning was observed by the researcher both in the classrooms and community settings where the students took an active role in their learning, with the teacher facilitating the process. Explaining that active learning was promoted during the teaching/learning process the participants stated that:

In this day and age learners have to be involved in their learning. They should actively participate. We need to run away from the teacher-imposed education and encourage the use of strategies encouraging active learning in students. Active participation promotes self-directed learning, the skill that is essential in graduates who are expected to be lifelong learners.

We use a combination of strategies that promote active learning, strategies such as group-based learning, experiential learning, self-directed learning, and problem-based learning.

Some of the participants linked active learning to adult education, as nursing students were regarded as adults. According to these participants the students, as adults, preferred to be actively involved in their learning especially because they believed in meaningful learning. Moreover, these students like to contribute to the learning process, owing to their rich background of life experiences. Some of the students were reported to

have some background in nursing, which they used as a foundation to build on. The following were the responses of some of the interviewees regarding active learning and nursing students as adults:

In our programme we regard students as adults because they have gone past formal education years, they are in a tertiary institution. As adults, they have a very rich background that cannot be ignored as they also like sharing their past experiences to contribute to their present learning. More importantly as CBE takes place in the community which is their familiar environment, they like sharing their life experiences to clarify some of the issues identified from the community.

We are dealing with adult students who believe in active learning. Some of them have been working as enrolled nurses, so they have a rich nursing background to be shared with other students. Encouraging them to share their experiences makes learning more meaningful to them and to their colleagues. Learning becomes more meaningful if they also contribute from their previous experiences to the present.

Collaborative learning emerged as an important essential in CBE, as the students were being prepared to function in teams. Collaborative learning was characterised by (a) heterogeneous groups, and (b) democratic instruction which was reported to be in small heterogeneous groups in order to learn to understand each other, as they were from different cultural backgrounds, different age groups and were of different genders. These heterogeneous groups were learning and working together throughout the year. Collaborative learning was observed in the classroom settings and in the community settings. It was more pronounced in community-based learning activities where groups engaged jointly in community needs assessment, analysis, planning, implementation and

evaluation of community-based projects that were in line with an identified need, during needs assessment, as stated in the following excerpts:

We have a group of about 75 first year students. We divide them into smaller groups for learning purposes. They work together in those groups throughout the year, both in the community and classroom settings. They really grow from that experience as our groups are mixed culturally, age-wise and they consist of both males and females. Working in groups is not easy but they learn to work together, to support each other and to respect each other. In that way they are able to learn well in their groups.

Data sources also revealed that collaborative learning was characterised by democratic instruction. A reciprocal relationship between the team members and teachers was promoted to facilitate a dialogue during the learning process. Dialogue was viewed as the basis for successful and meaningful learning. The learning process encouraged the students within their teams to question answers provided to their questions, not to accept them as they are, as was the case when expository methods were still dominant. They were encouraged to question and debate responses provided in order to understand the issue of interest and its context better, from multiple perspectives, as in the following statements indicate:

As we are promoting active learning in our programme, active learning requires a partnership between the teachers and the students, a relationship that is two-way, unlike in traditional education where the teacher dominated the learning process. The teacher in our new programme is part of the team but with an added responsibility of overseeing all the learning activities. As we learn in groups we encourage open communication with all members contributing to the lesson of that day.

When facilitating learning in groups one ensures that there is an exchange of ideas to promote active engagement of all students in learning. The students are encouraged to question the answers provided to them as we are trying to develop critical thinkers. The why question is a famous question in our classrooms because the students need to understand the context of the issue of interest at that time.

It also surfaced from the data sources that power sharing was important in democratic instruction, sharing of power among the team members themselves and also with the facilitator. Power sharing was reported in handling group issues and learning activities that required joint decision-making. Issues regarding group rules, learning experiences of importance, how to approach learning activities, time to be spent on certain learning activities, were discussed by all team members until agreements were reached.

Effective implementation of CBE requires the sharing of authority between the facilitators and learners. Together they decide on group activities, learning issues to be dealt with, time to be spent on each learning activities. They as a team set group rules which serve as a reference if and when there is a need to discipline one of the group members.

Self-directed learning also emerged from the data sources as an important concept in active learning, especially because the programmes were aiming at producing lifelong learners, who were able to self-direct their learning needs.

The education system today requires students who are active in their learning for learning to take place. To be life-long learners they need to develop a culture of being responsible for learning, as learning is a lifelong process. Promoting active

learning facilitated the development of self-directed learners who are likely to be self-directed throughout their lives.

The nature of the teacher. Data sources revealed the following characteristics describing the nature of a teacher in CBE; (a) commitment to CBE, (b) cognitive modelling in an unpredictable learning environment, (c) democratic leadership in managing the learning environment, (d) coordinator and manager of learning resources.

Commitment of the teacher to CBE emerged as crucial, especially because community-based learning was reported to be taking place in an environment which was assumed to be uncomfortable. According to the participants, the commitment of the teacher to CBE was crucial because of the nature of the clinical learning setting used, the community. Unlike in hospital based nursing education where teachers spend most of the time in doors, the teacher in CBE spent long hours in unpredictable weather out there in the community, in an environment considered to be unsafe, mixing and working with multi-cultural groups from different strata of life, and expected to learn different languages and cultures in the community. Handling such situations was reported to require a teacher with a passion for working with communities, as the following quotation illustrates:

CBE is not an easy road. We have met a lot of challenges out there and some of us who felt we were not tailor made for the life in the community resigned. One must have passion to work in an open environment out there which is regarded as unsafe. The weather out there changes, you find that it is hot in the morning, and by twelve midday it is raining. Those who are used to offices with air conditioners find it hard out there. There are multi-cultural issues, including different languages to be understood in the community. If one is not prepared for this it becomes a problem.

Cognitive modelling in an unpredictable learning environment emerged as another important characteristic in the nature of the teacher. The teacher in a CBE programme was described as an innovative, creative and inquisitive person, who is not afraid to explore new or unfamiliar situations. These qualities emerged as important because teachers who were facilitating learning were placed in an unpredictable environment, where there were no preset learning experiences. They were therefore expected to model for their students special attitudes of learning as you go. The students were learning from what emerged as a learning experience on that day. Participants stated that in order to cope with those unpredictable situations the teacher should be a fast thinker, with alternative solutions, as the following extract indicates:

As students learn through experience in real life settings, the facilitator guiding them should have creative and innovative ideas, be supportive, flexible and adaptable to facilitate the development of the same skills in her students. The facilitator should be able to intervene if the need arises, as students in clinical settings learn through trial and error.

Democratic leadership in managing the learning environment was seen as one of the salient features of a CBE teacher. Participants highlighted that rather than the teacher actively engaging in teaching, he/she is expected to encourage the students to learn actively. The teacher is there to facilitate the learning process both in the community and in the classroom, allowing the students to take a lead role in their learning, as stated in the following extracts:

The teacher is there to facilitate learning. The role of the teacher changes completely in CBE/PBL because she takes an inactive role and encourages

students to be actively involved. She encourages the students to be in charge of their learning.

Unlike in the old curriculum where the teacher directs everything, in CBE the teacher allows the students to take the driver's seat. Taking a back seat as a teacher is not easy but it is good in developing students to be responsible for their own learning. While on that back seat the teacher does not sit quietly, she assesses continuously if learning is taking place.

As a democratic teacher who facilitates learning rather than providing knowledge, the teacher serves as a resource person. Because of her/his level of knowledge the teacher is consulted by the students when they identify the need to draw from his/her expertise. Otherwise, if there is no need to consult the teacher, the students remain in control of their learning.

When our students encounter problems regarding their learning needs we encourage them to identify human as well as material sources that can be useful in handling that problematic situation. The teacher in this case only serves as a resource person not a provider of information. The teacher does not just dish out information because she/he is a resource person but he/she directs the students to where they can access relevant information that might be useful in working out the identified learning need.

As a **coordinator and manager of learning resources**, the teacher was reported to be involved in a number of activities concerning learning resources. These activities included (a) selection of communities, (b) preparing communities for community-based learning activities, (c) initiating partnerships with communities, negotiating and (d)

facilitating community entry. The following was shared by one of the participants regarding the teacher's responsibility:

On initiation of the new programme I was appointed to prepare the learning sites and to facilitate learning especially in community settings. I was working as a link between the school, the university and the community. Now that the programme is stable I am just linking facilitators with their new communities after negotiating with the key figures in that community.

As a person who was responsible for coordinating community-based learning activities, I was responsible for selecting appropriate communities, initiating community partnerships, facilitating community entries. I must say, this was not an easy task but it was crucial in the implementation of CBE.

According to the participants, part of the teacher's responsibilities also included making learning resources available to the students. She had to ensure that the library facility had relevant and current resources, that would be of value to students when working on their learning needs. Participants from the institutions that had clinical skills laboratories mentioned that the teacher also had the responsibility of ensuring that learning resources were available in the clinical skills laboratory to assist students in their research, as reported in the following extracts:

CBE is demanding when it comes to learning resources because now and again our students use the library in working out learning issues identified during the learning process. We as staff have to ensure that the library is well resourced to meet the students' learning needs.

We encourage our students to identify their learning needs and to work on their identified needs. Our role is to ensure that learning resources in library and in the

clinical skills laboratory are available to help them. We use the money budgeted for learning resources in updating our learning resource centres.

In six of the seven institutions that participated in this study, organizing transport to the community learning sites surfaced as another responsibility of the teacher. The transport in these institutions was either provided by the university, or the hospital which is in partnership with the school, or the local government transport department. In one of these nursing education institutions, transport was hired from a private company. The agreement with the transport providers was that transport had to be booked well in advance, and the school was required to keep reminding the transport unit of the dates for the transport. One of the participants stated that;

Part of our responsibility is to book the buses in advance; if we do not do that early we do not get them. We need to book them timeously. The coordinator or facilitator provides the transport department with a copy of our year plan where days scheduled for our community based learning activities are highlighted. Submitting the copy of a year plan is not enough, as facilitators we have to remind them when the days draw nearer.

The nature of the learner. The learner emerged as (a) a source of the curriculum, (b) contributor to knowledge construction, (c) service provider, (d) change agent, and (e) responsible for own learning. Data resources revealed that as CBE facilitates active involvement of the students in their learning, the students in a CBE curriculum appeared to have great input into the curriculum content, in that their interests and needs contributed to the curriculum. The students also had an important role to play in ensuring that the

curriculum content was community oriented and was derived from the common problems in the surrounding community.

In our old curriculum the students had nothing to do with the decisions regarding what should be included as part of the curriculum. With this new curriculum the students are the ones bringing to class raw material from the community sites that forms the major part of the curriculum. The students are also regarded as sources of the curriculum content.

The students we are having now are different in that they play an important role in decisions regarding the curriculum content. They are the ones identifying problems from the surrounding community, to ensure that the curriculum content is community-oriented.

CBE programmes promote self-directed learning. We then encourage our students to identify their learning needs and interests that form part of the curriculum. Furthermore they play an active role in identification and selection of community problems and needs which are used as part of the curriculum content. The student has a major responsibility in contributing to the curriculum content, unlike in traditional education where the curriculum content was the sole responsibility of the teacher.

The student emerged as a **constructor of knowledge** in a CBE curriculum. The teacher no longer serves as the main source of knowledge. The students actively participate in the process of knowledge construction. Participants pointed out that following the identification of major problems that form the major part of the curriculum content, the students engage in an intensive process of analysing these identified problems, with the purpose of developing grounded knowledge:

We no longer stand in front of the class and provide students with knowledge. The students are the ones actively engaged in the process of knowledge construction. The classrooms are used as a platform for constructing knowledge, with the teacher facilitating the process. The students in CBE engage in a process of identifying major problems in the community, which are then processed in class by the students with the purpose of producing grounded and relevant knowledge.

The student is viewed as a constructor of knowledge, in that, PBL and experiential learning used during the learning process allow the students to engage actively in knowledge development, the knowledge that is grounded on the identified needs.

In one of the CBE programme documents the student was described as an:

Aggressive seeker of knowledge, a retriever of knowledge, who views learning as a natural and enjoyable process.

The student also emerged as **change agent**, influencing changes in how the individuals, families and community viewed their health and the issues influencing their health. The students had a responsibility to help communities believe in themselves, not on health professionals, with regard to their health issues. This change in the community was facilitated through community-based learning activities in which students were engaged. Through these activities the students were described as able to diagnose needs and problems confronting communities, while at the same time making the communities aware or conscious of their needs and problems and how these needs and problems might affect their health. As change agents, the students were described as facilitators of the process of dealing with some of the community needs and problems, where the community had to take

an active role in solving these problems. The students in a number of nursing education institutions were reported to have initiated community empowerment projects in partnership with communities which were ultimately aimed at improving the health status of the community. The projects were sustained by community members. These views on students as change agents are illustrated in the following extracts:

I view CBE as a force for social change with the students playing an active role in influencing this change in the society. We design community-based learning experiences in such a way that when the students engage in them, they affect the community positively, challenging and equipping the community to deal with their problems.

CBE changed the focus of nursing education institutions to that of functioning as instruments for change in the surrounding communities. We place our students in communities where they engage in partnership empowerment projects with the community, projects based on needs and problems identified during community surveying. Through these small community initiatives the students influence change in the community, on a smaller scale. It might look small but we hope that the impact it has on the health of the community is more than we see.

The student also emerged as a **service provider**, as community-based learning experiences were described as having a dual purpose; that of learning and that of service provision. According to the participants, part of the bargain for using the community as a learning environment was to provide the community with some form of service. The students were therefore learning through providing service to the community, depending on the identified need.

When entering into partnerships with communities, communities want to know what is in it for them. As health care providers we have been abusing

communities with our one-sided focus, focusing on using communities for our learning purposes. In our new partnerships with the communities our students have an obligation to learn through providing service to them.

All along the community was used for the benefit of the students and the school. Communities were used as the learning laboratories. Now that we have a formal agreement with the community we have an obligation to contribute something to the community. That might be in a form of knowledge, small community projects that will contribute to the betterment of the community life or by providing nursing care where there is a need, especially during home visits.

CBE should not only be looked at as the placement of students in the communities but as a process of reaching out to the communities, whose health is compromised because our health care system cannot cater for their needs. This is where students from CBE programmes serve as some means of giving these people access to health care. The students provide some form of service to these communities; a service which is a form of relief to the needs of the community.

PHC that forms the basis of our CBE curriculum emphasizes that services should be taken to the people, and they should be accessible, available, effective etc. The students through their community-based learning experiences provide the service to the community.

As CBE programmes promote active learning, the students were reported to be **self-directed** in that they were responsible for their learning, making decisions on what to learn, when, and how, with the facilitator facilitating the learning process. One of the participants stated that the students had a primary responsibility for planning their own learning, depending on the identified needs they carry out and evaluating their learning process with

the assistance of the facilitator. In one nursing education institution participants stated that, at the beginning of the year, the students were furnished with a list of competencies to be achieved by them in the community settings. The students were given autonomy to manage their own learning process under the direction of the facilitator:

We are aiming at producing self-directed and lifelong learners, who will be able to identify their own limitations, confront those limitations by working on them independently.

We try to promote self-directed learning as much as possible in our CBE curriculum because we are expected to produce graduates who should be able to function autonomously when the need arises. At each level in the curriculum there are competencies to be achieved. We make this information available to the students early in the year, and we leave them to decide on how to work on these required competencies. As facilitators we only monitor the process and act as resource persons when the need arise.

Intervening Conditions

Data sources revealed that the successful implementation of CBE in basic nursing programmes was influenced by a number of conditions, such as (a) collaborative effort, (b) practice of true partnership, and (c) government commitment.

Collaborative Effort

A need for a closer relationship between the academic/nursing institution, community and service sector emerged as one of the conditions that determined the

successful implementation of CBE and sustaining of the programme, as the following participant indicated:

Successful implementation and sustenance of CBE programmes depends on the working relationship between these three parties, the school, the health care providers and the community. If the relationship between these partners is well maintained, the implementation is more likely to be successful. It is believed that all these parties have a great contribution in moulding the ideal CBE graduate, with each party having its own responsibilities which are in line with preparing this special graduate.

Another participant who shared a similar view stated that:

CBE needs an integrated approach where service providers together with the community join hands with the school of nursing. Together they decide on who is going to do what and when. The success of CBE depends on this partnership because they all know the type of product they expect from a CBE programme.

This collaboration, according to the participants, was characterized by three properties: (a) an agreement between these three parties (b) a shared vision, and (c) sharing of responsibilities, as the following statement illustrates:

With the help of the Kellogg Foundation, the university entered into a partnership with the nearby community and the surrounding health service institution. In order for our community-university partnership to materialize, agreements were entered into by these three parties, the purpose of the partnership was clarified to all, and responsibilities of all members were tabled.

Regarding **agreements** between these three parties, data revealed that the agreements which were entered into to were either formal or informal. The university/

faculty entered into the tripartite partnership on behalf of all the schools who were using communities as their learning sites. Representatives from all the faculties that required the placement of the students in the community formed part of the university team. The following statement was made by the director of one of the Partnership in Health Personnel Education programmes which coordinated activities of all the three parties:

We are not working with the school of nursing per se. We are working with almost all faculties at the university. We are working with the whole Faculty of Health Sciences with the aim of exposing the students as a team to the realities of life out there in the community. We bring together experts from academic institutions, community and service personnel to contribute to the education of students.

The working relationship between this collaboration was reported to be directed by all members sharing a common goal, a goal of producing graduates with competencies relevant to meet the needs of the surrounding communities of the health care system. This appeared as the long-term goal in this partnership which contributed to keep all these partners focused. The short-term goal which was shared by one participant was that;

This partnership in health personnel education was established to influence the health of the people of this community and surrounding areas, by providing health personnel with appropriate education through partnerships between the community, local services and training institutions in a model primary health care setting. All these partners, using ideal primary health care settings, work in partnership with the intention of producing this ideal graduate.

All institutions were reported to have some form of working agreements with the community and health service centres. Some of the institutions had informal agreements, in that there was nothing formal or written on paper binding their partners. Participants

reported that the informal agreements between the nursing education institutions and communities only enabled the students to conduct their community-based learning activities with nothing binding the community to contribute. Their contribution was voluntary as the participant reported:

The community is helping us because it wants to, there is nothing forcing them to. As a way of appreciating their contribution to the learning of our students we make sure that they benefit from community-based learning activities. The same applies to the health service centres used for the placement of our students. There was no formal contract which was entered into. The school made arrangements with these settings and they are assisting because they also have a vested interest in our students.

From the documents and from interviews it emerged that all partners in this collaboration had specific roles or responsibilities. From interviews it was established that the **nursing education institution** in this partnership provided expertise regarding the educational experiences that would meet the needs of the students and the needs of the surrounding community. Secondly, it had a responsibility to coordinate the learning experiences of the students, Thirdly, it was responsible for the provision of staff who would facilitate learning both in the community and classroom settings. Lastly, the school had to provide learning resources such as libraries and clinical skills laboratories. This was confirmed from statements which were documented in the following manner under the title 'Responsibilities of each partner':

The academic sector is responsible for:

(a) Curriculum transformation in response to identified community needs to implement national policies, (b) transfer of knowledge and skills on community

based, service oriented education to students, community and service partners, and (c) provision and maintenance of learning resources.

From interviews the **service sector** (hospitals and primary health care clinics) was responsible for providing the learning environment as well as personnel to assist in the learning of the students. In three institutions the service sector also assisted by providing transport for students when they were placed in the community settings. From one of the institutions the following responsibilities were documented:

The service sector is:

(a) responsible for the provision of comprehensive PHC settings to implement national policies, and (b) responsible for the transfer of knowledge and skills on the delivery of comprehensive PHC to students, academics and community partners.

Communities contributed by providing safe learning environments and by ensuring the safety of the students in these communities, as reported during interviews. During community surveys they provided information related to health needs of the community. It was also established from interviews that community leaders/key figures and/or community health workers facilitated the process of developing working relations with other members of the community. One participant indicated how the community contributed to their programme by stating:

We are using a community that was adopted more than 10 years ago by the university. Members of this community assist by giving our students information during community surveys, the information that forms part of the curriculum content in first year.

The data on the responsibility of the community was also obtained from the documents:

The community

(a) provides the context for learning, and (b) is responsible for the transfer of knowledge and skills about the community to the students, academic and service partners.

One participant further stated that the community was involved in the assessment of learning in the community:

The community is also involved during the feedback days when the students present their community projects and other learning experiences in the community. More importantly, we get feedback from the community regarding the students' behaviour out there in the community, of whether they involved them (community members) when they were doing community needs assessment, and in planning and implementing their community intervention projects.

Community health workers participated in CBE as representatives of the community in other institutions. In some institutions they were reported to assist in selecting of homes with rich learning experiences relevant to a specific module in which the students were engaged in, as this participant stated:

We have a long working relationship with our community workers. They are now familiar with our programme as we involved them in facilitating learning and in our curriculum reviews. With the training they had from Border Institute for Primary Health they are very helpful in selecting homes that have learning experiences required in specific modules. As I am involved in a psychiatry course, community health workers assist us by selecting homes with clients who are mentally ill. They even know those who have defaulted and they direct us to their homes.

Community health workers were given an opportunity to facilitate learning in activities such as home visits, growth monitoring at home, health education, and were involved in planning and implementing community intervention projects. The main reason that was put forward for the involvement of community health workers in facilitation of learning in the community was that they were very knowledgeable in community issues as it was their familiar environment. Another reason was the limited number of facilitators. Breaking down groups of students to smaller groups required more facilitators, who were not available. Rather than having the students engaging in community-based learning activities on their own, community health workers were approached to assist. The following extract was a response to a question on the involvement of community workers who were observed by the researcher while they were facilitating learning of students during home visits in a rural community:

In other instances community health workers assist in facilitating learning owing to the shortage of facilitators. Breaking groups of students into smaller groups in the community requires more facilitators. Rather than leaving students to be on their own, or to walk as large groups, which are not welcome in most homes, we use community health workers to assist us with activities such as home visits.

One participant summarised the responsibilities of all the partners in the following manner;

The success of CBE really depends on working in collaboration with other sectors, as it is very expensive, time consuming and requires large numbers of staff. The community contributes significantly in our programme because the curriculum content depends on their willingness to share the information with our students. Owing to the shortage of facilitator,s community health workers assist by facilitating learning in some groups of students in the community. They

know about our programme and they have been part of our curriculum review. The hospitals and the clinics provide us with learning sites and staff to assist in the learning of our students. We wish the government could contribute by assisting us with transport, but we know it will take sometime before this materialises.

In conclusion one participant on the issue of collaboration emphasized that:

A strong commitment from all parties involved is essential otherwise our programmes will not be successful in meeting their primary goal.

The Practice of True Partnership

The understanding of the concept ‘partnership’, and the practice of true partnership in reality emerged as an important factor in the implementation of CBE. This term was viewed as important because partnership in CBE is reported in multi-disciplinary teams which were formed by students from a number of schools. It was also reported in collaboration between the academic institution, health services and the community.

According to the participants, the concept was therefore critical in the success of CBE. One participant stated that:

The concept partnership is not understood in the same way by all partners and that creates some tensions between those who regard themselves as being in partnership.

When asked to explain further the term ‘partnership’ one participant stated that:

I regard the term ‘partnershi’p as the cornerstone in CBE because one party cannot successfully implement CBE. In my understanding partnership is characterised by sharing of common interest, respect, equal power sharing,

mutual benefits, empowerment of all parties and joint decision-making. No party is supposed to dominate or have more power in a true partnership.

In the analysis of what takes place in academic, community and service partnerships one participant asserted that from discourse analysis the academic voice is dominating and other people's voices are not heard, or are faintly heard, especially the voice of the community. One of the reasons that was put forward was that funds came from the university, and as a result it seemed they had more power than other partners. This statement was made by one of the participants regarding problems associated with the meaning of the concept partnership:

The understanding of the concept 'partnership' especially in real life settings is not understood in the same way by members of the partnership. Through discourse analysis the academic voice is the dominant voice in this partnership. Finances are from the university. Unconsciously that makes partners from the university think that they have more power than other members. To be honest, sometimes one fails to locate partnership from what is called a partnership programme and that might have a negative impact on the implementation of CBE programmes.

One of the participants shared her views with regard to partnership in multi-disciplinary teams as their students were exposed to such teams in community-based learning experiences and in case management seminars.

In multi-disciplinary teams we keep referring to partnerships among members of the team. Partnership in the true sense of partnership is not observed in these teams. The problem starts with the facilitators from different disciplines. I think the problem with their attitude to other members of the team is influenced by the fact that they are the products of the old programmes. They then transfer that

attitude to their students and the meaning of true partnership is lost. You can see what I am talking about in case-management sessions and when students from different disciplines are engaged in the same community-based activity.

One participant indicated how the lack of working together as equal partners affected their CBE programme:

As a result of having other partners dominating in a team, those who feel dominated either become passive in a partnership or they pull out. We cannot afford to have such in CBE. We were literally chased out in one of the communities because of our dominating nature as nurses in the community. This was one of the best sites when it came to learning experiences. It had very rich learning experiences. We did not mean for this to happen but it was a learning experience. Our programme was still new then.

Government Commitment

Government commitment emerged as another important condition in the successful implementation of CBE. Participants expressed concern about the lack of government involvement in the implementation of CBE, as it is a directive from the government. Participants were hoping that the government would support their effort financially or with transport which was the main problem in all the institutions.

CBE is a very expensive exercise. One cannot cope with the resources which were used in traditional programmes. We are hoping that the government one day will realize this and help us at least with transport.

CBE is good and we can see that the results are good. But we are really struggling for resources to implement CBE. Some of the institutions started the programmes but discontinued them because of resources. Maybe if the government can provide assistance of some sort, it will provide some relief. CBE is very expensive

especially the transport and getting extra staff to facilitate learning in community sites.

On the issue of support from the government, one participant stated that:

Whether the government will ever be involved is a big question and that may delay the process of transformation in nursing. If we wait for the government we will be behind with the changes which are taking place in the country. The government however should assist because running CBE programmes is very expensive. As initiators of this we are owed some assistance.

Some of the participants, though not many, voiced their concerns regarding the time, effort and money spent preparing students through CBE when there was no provision made by the government for these graduates on completion of the programme. According to these participants, PHC oriented graduates were still going back to serve in high technology institutions, leaving the majority of the population they were mainly prepared to serve.

What I am saying has no direct effect on the actual implementation of CBE but may be in the long run it will have an impact. The government gave us a directive to prepare PHC competent graduates who will be able to work with individuals in different types of communities and at all levels of health care, mainly focusing on health promotion and illness prevention. Our graduates are frustrated where they are practising because they are applying very little of the competencies they have.

Another participant highlighted how the functioning of PHC competent graduates in tertiary institutions was against the government's philosophy, and how that might later impact on those supporting CBE programmes because of the purpose of education.

My concern about the graduates we are producing is that they are not functioning where they were prepared to function because there is no provision made for them

in practice. The community out there needs them but no one is prepared to pay a salary for a person who is just out there in the community. Having more health personnel placed in tertiary health care services rather than in settings where they will be engaged in activities directed towards promoting health is against the government's philosophy. Such issues might have an influence on those institutions or organisations funding CBE programmes because I believe they support these programmes because of their purpose.

Expected CBE Consequences

Responding to the question on the consequences of CBE was not easy because, according to the participants, it was still early for this, taking into consideration that CBE in basic nursing programmes is not even 10 years old. In view of that the focus changed to the expected outcomes of CBE which were categorised into three (a) nursing education, (b) community, and (c) health service.

Expected Outcomes in Nursing Education.

From the analysis of data it emerged that expected CBE outcomes in nursing education were (a) educational relevance, (b) responsiveness to National Policies, (c) PHC graduates, and (d) open communication between communities and nursing education institutions.

Educational relevance. According to the participants, it was hoped that with the adoption of CBE the education of nurses would change from producing large numbers of highly qualified and highly skilled nurses to the production of nurses who would be able to meet the needs of the community and the new comprehensive health care system.

Participants indicated that educational relevance could not be achieved by teaching the

students in class but by placing the students in dynamic community settings where they would learn to appreciate the client's context. **Contextualization** of learning emerged as significant in ensuring that graduates attain competencies which are in line with the needs of the health care system and those of the community;

In our old programmes we aimed at producing highly skilled technical nurses who could function well in high technology institutions. With CBE all that changed because CBE is aimed at meeting the needs of all the communities. Relevance of nursing education to the needs of the majority of the population that does not have adequate access to health care is our priority now. Our programmes are directed towards achieving that goal.

We are hopeful that in view of how we prepare our students, relevance of nursing education to the needs of all communities will be enhanced. We believe that as time goes on the curriculum will be totally community oriented, as the community serves as the source of our curriculum content and this content changes according to the changes taking place in the community.

Now that CBE is in place, although there are a lot of challenges, we are hoping that the concern about the irrelevance of nursing education to the needs of the South African population will be addressed, as this has been a major cry.

Responsiveness to national policies. What emerged as another expected outcome in nursing education was the responsiveness of nursing education to the national policies, that called for a change in preparation of health professional to be able to meet the needs of all communities. The implementation of a PHC policy in nursing education curricula was given as an example of what was expected in community-based nursing education. It was

hoped that nursing education would work towards fostering the understanding and the implementation of national health policies.

The new curriculum took into consideration a number of National policies, such as PHC policy, Higher education policy on service learning as well as the Bathopele principles. These policies also served as reference to the SANC's (1999) policy on nursing education. Through CBE we are hoping to see nursing education responding to a number of national policies that are aimed at improving the health status of the South African population.

In one of the documents a programme outcome was given as:

Through community-based education the school wants to foster the understanding of public policy issues.

One participant also stated:

The understanding and implementation of health policies was not catered for in our old nursing education. We are seeing this for the first time in community-based nursing education programmes and it is a good move in nursing education.

PHC competent graduates. According to the data sources CBE was aimed at producing PHC competent graduates, with relevant knowledge, skills and attitude to serve the South African community and health care system. Some of the participants viewed the production of PHC graduates as an obligation to the government and the South African population as stated in the following extract:

As a school we have an obligation to the government and to the South African population to produce graduates with relevant competencies. Relevant competencies in our South African context are competencies, which are PHC

related. We therefore have a responsibility to train our students so they are PHC competent.

The following information was stated in one of the CBE programme documents with regard to the aims of the CBE programme:

To ensure socialization of students to PHC and to the understanding of diverse social, economic, cultural and environmental factors that impact upon health and development of individuals, families and the community, with the aim of facilitating the development of knowledge, skills and attitudes relevant to comprehensive PHC, the skills required from PHC graduates.

Open communication between communities and nursing education institutions.

Some of the participants highlighted that through CBE, nursing education institutions, especially those situated in universities, would be more accessible to communities.

According to the participants these institutions were not accessible to the public or surrounding communities as they were viewed as ivory towers for academics, that had nothing to do with the community. With the move of nursing education to community, communities have access to academics from these institutions and lines of communication between these two are opening up. It is hoped that in the near future communities will be more involved in nursing education of students. In line with this view one of the participants stated that:

CBE has assisted in changing the image of academic institutions. Right now the university is no longer seen as 'that building' where nobody knows what is going on in it, the building where learned people are, people who do not go to the community. Now universities belong to the community and the community to the university. In fact the university is now a community project itself.

Working partnerships between nursing education institutions and communities are opening up new possibilities, where communities have access to the traditionally well-respected academic institutions; they have an opportunity to be involved in the education of nurses. We are hoping that this will continue because the input of the community is important to the success of CBE programmes.

Expected Outcomes in the Community

Self-determined and self-reliant communities. The main outcome of CBE in the community was that of having self-determined and self-reliant communities who could take responsibility for their health and use available resources economically. In defence of having self-reliant communities through CBE, one participant stated that:

One cannot have fully or 100% self-reliant communities but one may be successful to a certain degree. The rate of success differs from community to community. Having self-reliant communities is going to take time but it might eventually work. There are communities that might approximate to self-reliance, who might reduce the risk of getting diseases with the knowledge and skills they have.

One of the means of working towards developing self-reliant communities was that of raising their consciousness of the problems in the community, and developing in them the culture of being able to sense problems and deal with them using the available or accessible resources.

Communities should be conscientized about issues in their communities that might impact on their health. They need to be made aware that they should to rely on themselves; they do not need a nurse to be able to go on with their lives or to take care of their families. They should learn to identify and deal with problems in their communities or families.

One of the participants viewed knowledge given to communities on promotion of health and prevention of illness as one way of promoting self-reliance, if the community passes it on to other community members and at the same time utilizes it.

Our programme should contribute something to the community by giving them knowledge on health promotion and prevention of illness, healthy life styles. This looks like a minor benefit to the community right now, but in the long run, if they continue to pass this knowledge to others and apply it in their families, the outcome might be good in that the community can deal with its own problems. Even the health status of the community is more likely to be improved because of the health promotion programme by the students in these communities.

Some of the participants viewed income-generating projects initiated in by the community with the assistance of the students as one of the ways of promoting self-reliance if the projects are sustained well.

Our students have initiated a number of income generating projects in the community. Some have been successful and some were not well sustained. If communities can sustain these projects they can stand on their own.

Expected Outcomes for the Health Care System

According to the participants it was hoped that, through CBE, health service institutions would be equipped with personnel competent to serve at all levels of health care irrespective of where the health service was situated. More importantly, the health care system would be responsive to national health policies which are in line with the promotion of the health of all people in South Africa, as the following statement indicates:

Health services have been heavily criticised for being inadequate in meeting the needs of all people. With CBE, where students are placed in a balanced variety of

settings, we are hoping that the health care institutions at all levels will be staffed with graduates who can competently function in those areas.

CBE is one promising solution to the problem of skewed distribution of nurses and poor retention of nurses in under-resourced settings.

Conclusion

This conclusion focuses on the main categories and the subcategories that emerged in this study, as presented in **Figure 6**. The formulation of these categories was influenced by Strauss and Corbin's framework, as indicated earlier on. Firstly, CBE was a phenomenon of interest in this particular study. This phenomenon (CBE) was conceptualised in terms of four discriminatory variables, which are (a) the community setting where learning takes place, (b) timing of the first community-based learning experience, (c) duration, frequency and sequencing of community-based learning experiences, and (d) education for service.

Secondly, two conditions emerged as CBE antecedents; conditions that led to the adoption of CBE in basic nursing programme. These conditions included (a) irrelevance of nursing education owing to the nature of how graduates were prepared, and (b) political changes in the country that took place in the early 1990s including the 1994 democratic elections. As a result of these conditions, nursing education institutions had to revisit how they were preparing their students, with the intention of ensuring that graduates produced were able to serve in all community settings and at all levels of health care, including serving in institutions with limited resources. Thirdly, the new national policies provided a context in which CBE as a phenomenon responded. These policies included a PHC health policy, Service Learning Policy from Higher Education, Bathopele Principles from the

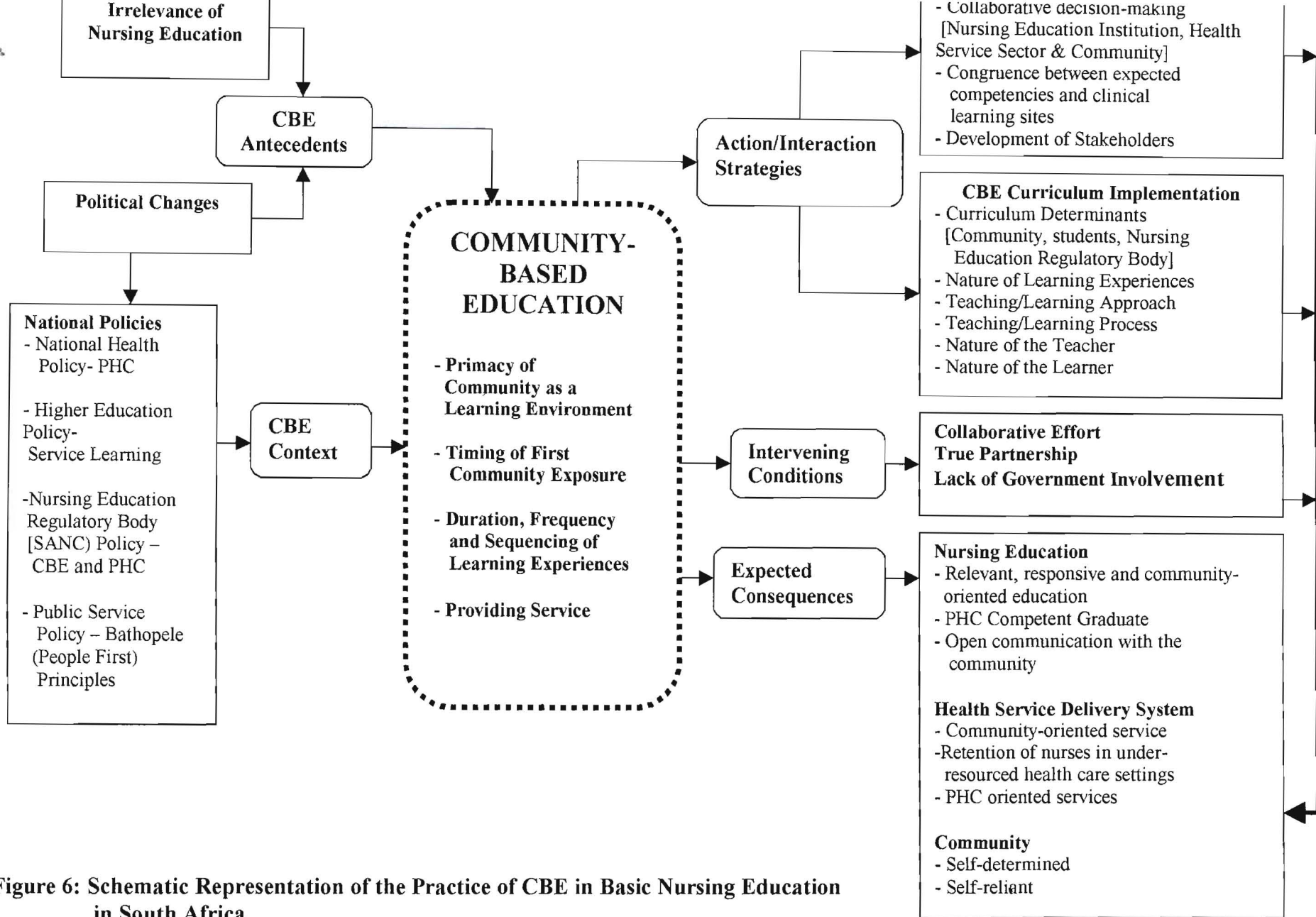


Figure 6: Schematic Representation of the Practice of CBE in Basic Nursing Education in South Africa

Public Service Policy and the SANC PHC and CBE policies, which were based on the National Department of Health's policy on PHC.

Fourthly, the realization of CBE was ensured through what emerged as action/interaction strategies, according to Strauss and Corbin (1990). Action/interaction strategies in this study included CBE curriculum planning and curriculum implementation. CBE curriculum planning incorporated (a) collaborative decision-making regarding the adoption of a new curriculum and collaborative designing of a new curriculum, (b) selection of clinical learning sites which were congruent to expected graduate competencies, and (c) development of stakeholders for their new roles (that is, the teaching staff, the health service personnel, communities, as well as students and their parents). CBE curriculum implementation surfaced as a second category under action/interaction strategies. Subcategories that emerged under CBE curriculum implementation were (a) determinants of a CBE curriculum which were the community, the students, and the SANC, (b) the nature of learning of community-based learning experiences, (c) teaching/learning approaches with a problem focused approach dominating, where other nursing education institutions were using paper problems and others using authentic clinical learning problems, (d) teaching/learning process, with active learning governing the teaching/learning process (e) the nature of the teacher, and nature of the student.

Fifthly, conditions that influenced the successful implementation of CBE included (a) collaborative effort between the nursing education institution, health service, and the community, characterized by some form of agreement between partners, a common goal and clearly spelt responsibilities of each partner, (b) lack of government support on the implementation of CBE appeared as another intervening condition, the main concern being

the need for government's support of CBE programmes with human and material resources, and (c) lack of common understanding of true partnership emerged as another intervening condition.

Lastly, expected CBE consequences that surfaced in this study included consequences for nursing education, which were (a) relevance of nursing education to the needs of the South African population and health care system, (b) responsiveness to national policies (c) PHC competent graduates and (d) open communication between communities and nursing education institutions. CBE was also expected to have an impact on the communities which were used for learning purposes. The findings in this study suggested that communities would be self-reliant and self-determined. Expected consequences included health services equipped with graduates competent in serving at all levels of health care. It was also hoped that there would eventually be a balanced distribution of nurses, and retention of nurses in under-resourced health care settings.

CHAPTER 5

DISCUSSION OF RESULTS

Introduction

Taking into consideration the purpose of the study, which was to discover a shared meaning of the phenomenon CBE in basic nursing education within the South African context, it is believed that in order to establish meaning one needs to interpret the results of the study within the context of relevant literature. In line with this understanding, Tanner and Tanner (1995) stated that attaching meaning to what is practised as education requires more than a 'common sense outlook' on educational and curriculum matters, it requires philosophical considerations guiding the means and ends of education. In order to attach meaning to what is practised as CBE in basic nursing education in South Africa, the discussion and interpretation of results therefore, included drawing from some of the educational philosophies which appeared to be relevant to this study. It is also important to note that new literature which was not presented as part of the literature review, was used in this chapter to discuss new concepts that emerged from this particular study and to develop a better understanding of the emerging concepts. As indicated in Stern (1980) because of the nature of the study (grounded theory study), at this phase of the research process the researcher conducts selective sampling of literature focusing on those new concepts pertinent to the study. According to Stern, Allen and Moxley (1982), literature reviewed at this level of the study helps expand the theory and relate it to other theories, and can also fill in gaps/missing pieces in the emerging theory, and add completeness to the theoretical description.

Conceptualisation of CBE

In the context of this study it emerged that CBE had four core characteristics which were regarded as discriminatory dimensions of CBE in basic nursing education in South Africa. These core characteristics included (a) the primacy of the community setting as a learning environment, (b) timing of the first community exposure, (c) duration, frequency and sequencing of community-based learning experiences, as well as (d) education for service.

The Primacy of the Community as a Learning Environment

According to the findings in this study, CBE was conceptualised as learning which was taking place in the community settings, beyond the confines of the classroom and the hospital. The community setting, in all clinical learning environments used in CBE, surfaced as the clinical learning environment characteristic of CBE. As a result CBE was conceptualised in terms of this setting. Defining CBE in terms of the setting where learning takes place supported the definitions by the WHO (1983; 1993), Magzoub and Schmidt (1998) and Margolis (2000). According to these authors, CBE is distinguished by the extensive use of the community as a learning environment, a rationalization that was provided in this study for defining CBE in terms of one setting (the community) in a variety of settings (hospitals, PHC clinics) used.

From the findings of this study, it unfolded that the community setting is more than just a learning space, as was the case in traditional nursing education. The community setting is one that exposes students to live dynamic contexts, to conscientize them about the socio-political, economic and cultural factors that influence health. As students were

reported to be learning by exploring these issues, they developed a better understanding of them, which equipped them to deal with such issues/problems. Consciousness raising education is associated with critical theorists, especially Paulo Freire (Wallerstein, Sanchez-Merki & Dow, 1999). Freire (1972) believed that society provides an environment that exposes students to social issues that impact on the lives of individuals in that society, especially issues of inequality and injustices. According to Hall (1999), these issues, if not addressed, prohibit people from reaching their full potential. Rodgers (2001) also highlighted that the students, by being exposed to the issues of this nature in the community setting, develop deeper knowledge of the needs of the vulnerable and underserved groups. This aspect was lacking in traditional nursing education, as was indicated earlier on in this study.

The understanding of the community as an important learning environment was also stressed by Harden, Sowden and Dunn (1984). These authors asserted that the community exposes the learners to the social cultural, political and economic aspects of health, which are part of the client's context and their finding was also reflected in this study. According to the results of this study, understanding all these important aspects of health gives a holistic view of the client, as Boaden and Blight (1999) advocated. Boaden and Blight pointed out that a community learning setting is one that provides a complete, holistic view to health and illness. They further maintained that the hospital environment, independent of or without the inclusion of, the community setting, provides only a narrow view of health problems. This community environment, according to Boaden and Blight, provides a broader approach to learning about individuals, and it provides a holistic, comprehensive and more preventative approach to health issues. In Harden et al. (1984), the community as

a unique learning environment provides some aspects of health which can only be taught adequately in community settings, such as effects of illness in the family, the early signs of the disease and many other aspects. The community setting provides a spectrum of problems which are normally not seen in other clinical learning settings.

Concluding the conceptualisation of CBE in terms of the setting where learning takes place, the results in this study corroborate the views of the authors mentioned above about the place of the community in education. The similarities between the views of these authors, and those of the participants in this study can be attributed to what appears to be global dissatisfaction with conventional education in the health professions in particular (WHO, 1987).

Timing of First Community Exposure

One of the fundamental features of CBE that emerged from the results of this study was the timing of the first community exposure. The results showed that CBE was characterised by early exposure of students to community settings, where they (students) were introduced to PHC. The study by Magzoub and Schmidt (2000) also yielded similar results. According to Magzoub and Schmidt (2000), early exposure to community-based learning experiences is crucial in a CBE curriculum in producing graduates who are community oriented, as the interest developed so early in serving in PHC and community settings will influence their career choices after graduation.

The reasons which were associated with the significance of the early exposure of students to community settings in this study included that early exposure facilitated the building of a good PHC foundation, as it was believed that the community setting

facilitated the realization of PHC. In fact, some of the participants in this particular study referred to this process as “early indoctrination” of the students to PHC as the purpose of the programme was to develop graduates who would be competent in PHC settings. These findings were congruent with those reported by Mattock and Abeykoon (1993) where early exposure was regarded as important in laying the foundation that is likely to have an influence on the interest to serve in community settings. According to the findings in this particular study, students were likely to develop an early interest in serving in community settings, especially the rural and under-resourced communities, which made more likely their choice to serve in such settings after graduation. The rural and under-resourced settings are particularly subject to problems of staff retention and turnover. Simoni and McKinney’s (1998) study showed similar results, endorsing the fact that early exposure to community settings had an influence on the interest to serve in community settings later on. In line with these findings was the view by Al-Refai (1995) that early exposure to real problems in community settings maintains students’ motivation and creates in them interest in these settings. More importantly, it was motivating to the students, because they were able to see the relevance of what they were studying to what they would do after graduation.

Duration, Frequency and Sequencing of Community-based Learning Experiences

The duration, frequency and sequencing of community- based learning experiences surfaced as another important discriminatory dimension in the understanding of CBE. According to the findings in this study, it was assumed that the more time spent in community-based learning experiences, the better were the chances of producing graduates

who were PHC competent and more likely to be interested in serving in community settings. Simoni and McKinney's (1998) study also suggested the same. According to the findings in Simoni and McKinney, a difference was noted in the long-term goals of first and fourth year students. The goals of a number of fourth year students were to participate in PHC after graduation, and this was attributed to the influence of the duration the students had been exposed to community settings. The first year students in Simoni and McKinney's (1998) study preferred hospital employment, and it was assumed that this preference arose from their still being new in the programme, having had only minimal exposure to community-based learning experiences.

The WHO (1987) and Schmidt et al. (2000) also maintained that in order to produce graduates who were willing and able to work in community settings, community-based learning experiences should be spread throughout the duration of the programme, to ensure that students would have adequate exposure to facilitate the development of skills and interest in serving in community-based settings. The finding in this study suggested that the ideal percentage of the time to be spent in community-based learning experiences was 50%. The WHO (1987; 1993) and Schmidt et al. (2000), on the other hand, in their description of CBE and the time to be spent in community-based learning activities, were not specific about the percentage ideal of community placement, but suggested that an appropriate number of learning experiences should be spent in a balanced variety of settings. The WHO (1987) emphasised that community based learning experiences should be dominant in a CBE curriculum.

What was noted from this study, however, was that it was not always possible to have about 50% of the time spent on community-based learning experiences. The findings

revealed that, in reality, community-based learning experiences in CBE curricula were nowhere near 50%. For example, it emerged from the data that in most of the institutions CBE was dominant in one year of the whole programme, with isolated learning experiences in other parts of the curriculum. In one institution, in the year where CBE was dominant, the students were only placed in community settings during vacation times and some of the community-based learning experiences were found in fourth year, in a module that was running over one semester. During that semester the students were involved in other activities (orientation block, placement in mental care clinics, in tertiary health care clinics, class interaction days as well as examinations), which were part of that module including community-based learning experiences. Gwele (1999) also reported on one nursing education institution that was using vacations for community-based learning experiences. In some of the nursing education institutions, community-based learning experiences only formed part of a community health module, which was one of the four (general nursing, community, psychiatry, and midwifery) main modules in a comprehensive basic nursing programme. In some of the institutions community-based learning experiences (placement in the community, family, PHC clinics as well as specialised clinics) were dominant in the first two years. Within those two years the students were spending some of the time in hospital settings, learning basic nursing skills that might make it possible for the student to enrol as nurses in case there was a need for them to exit either at first or second year level. This arrangement was as a result of the nursing education regulatory body demands that there should be exit levels in the programme (SANC, 1999). Some of the time in those first two years dedicated to community-based learning had to be spent preparing graduates in those competencies required at each exit level, most of which were found in hospitals.

These afore-mentioned examples of time spent on community-based learning experiences support the view that the ideal percentage of community-based learning experiences suggested in this study might not always be feasible for a number of reasons, including realities of the shortage of health personnel and the need to ensure that learners, who for whatever reason, have to leave a four year programme at the end of one or two years, can still find employment in the health sector. The study by Magzoub and Schmidt (2000) also suggested that time spent on community-based learning experiences varies from institution to institution. According to Magzoub and Schmidt (2000), the percentage of community-based learning experiences in 32 programmes that they studied varied from 5% to 50%. The findings of the study by Richards et al. (1994) suggested the same. Although these authors were not specific about percentages spent on community-based learning experiences, they reported that of the 10 schools surveyed, five of the schools managed to provide their students with a considerable amount of community experience, two school provided only a fair number of experiences and three schools managed to provide only a few. In the other two schools community-based learning experiences were reported to be isolated in the curriculum, with no continuity. The study by Richards (2001) also yielded similar results, where the total percentage of learning experiences reported in a CBE programme was 30%. These findings suggest that the length of community exposure in the programme varies for a number of reasons, although community-based learning experiences should be dominant in a CBE programme.

Regarding the understanding of CBE by sequencing of community-based learning experiences, the findings uncovered that CBE is distinguished by the way learning experiences were sequenced. From the findings it emerged that learning experiences were

sequenced systematically to ensure continuity in learning, from healthy individuals in their natural settings to hospitalized sick clients. They were also sequenced so that students were placed in primary health care settings first, then in secondary and later in tertiary health care settings. Such sequencing of learning experiences allowed for the development of competencies required at each level, ensuring that students built on previous experiences in their increasingly complex learning experiences. In Snadden and Mowat's (1995) model of community-based teaching, sequencing learning experiences from the healthy individuals to the sick was regarded as a key to meaningful teaching/learning in community-based learning. Vertical organisation of learning experiences in a CBE curriculum was essential in a programme which was aimed at producing graduates who were able to render comprehensive health care, at all levels. Such sequencing ensured that the students had an opportunity to develop competencies required at each level in the health care system in preparation for practice at all levels.

Education for Service

CBE was also conceptualised in terms of the service provided during the learning process in the community. What was notable from the findings was that the service that was provided had a clear educational focus, and learning was the main purpose of service provision. Engaging in such learning experiences promoted learning that was more meaningful in that the students developed a better understanding of what was expected in their future careers. It was during the process of providing service that the students developed work-related competencies because of the nature of activities in which they were engaged in. The activities were reported to be closely in line with the activities of

professionals who are in practice. Although Dewey (1916) was referring to general education, he believed in preparing learners through occupations, as that made learning more real, more practical and relevant to future occupations. Rodgers (2001) pointed out that learning through providing service in communities promoted relevance in learning as students were offered an opportunity to practise their nursing skills. Dewey (1916) asserted that “ the only adequate training for occupation is through occupations” (p. 362) as education through occupations consequently combines within itself more of the factors conducive to learning than any other method.

Rodgers (2001) and Wade (2001) revealed that learning through providing service goes beyond learning cognitive and behavioural skills; it also facilitates the development of the affective aspect in students, which was in line with the findings in this particular study. The results revealed that learning by providing service to the community, especially in underdeveloped communities facilitated the development of a sense of commitment to service, that is required in practice. Kulenwicz (2001), sharing a similar view, stated that the idea of learning through service encourages active learning to fulfil social responsibilities. As the students engage in community-based learning experiences, they learn to contribute to the good of the community and they develop a special interest in serving under-resourced communities.

From the results of this study it also emerged that exposing students to realities in community learning settings and working in partnership with community members facilitated the development of a number of important nursing values, which according to Kulewicz (2001) included the development of values, such as respect, autonomy, working with other people in partnership, altruism and social justice. Supporting the findings in this

study, Kulewicz (2001) also stated that, unaware, the students through learning by providing service learn to apply a number of nursing values while interacting with the community. These core values include human dignity, respect, altruism, autonomy, integrity and social justice. According to this author, during the process of learning and providing service, the development of students' moral judgement, civic duty and cultural competence is fostered.

According to the findings in this study, the service provided by students during the learning process increased access to health care, especially in under-resourced communities and at the same time, the students' experiences in under-resourced communities facilitated the development of interest in social justice issues. According to Asbury (2002), as they become involved in the community, confronting community issues, they often want to know more about social issues prevalent in the community. They develop interest in social issues such as poverty, homelessness, domestic violence, the AIDS epidemic and many other contemporary social issues. As they learn through exploring these issues they develop a better understanding of them and how they impact on the lives of individuals in the community. In Asbury's view, because of the interest developed in social issues, when students provide service, they provide it with compassion, a service that has a meaning to both the provider and the receiver of the service.

Magzoub and Schmidt (2000) in their classification of CBE programmes pointed out that CBE in other institutions, over and above learning, has a service-oriented focus as was the case in this study. According to these authors the programmes from some institutions have a strong research focus and others have a strong focus on training. Rodgers (2001) warned that the service aspect should not outweigh learning in CBE, as the findings

in the study highlighted that learning should be the focus of service provided.

What is emerging from CBE and service is the understanding that CBE is education that facilitates the promotion of social justice through community-based learning activities. Learning experiences in the community promote the development of commitment to social justice issues and in some students enhance commitment to being agents of social change.

Wade (2001a) pointed out that **social justice** is a term often referred to but rarely defined. This term, according to Gilligan cited in Wade (2001a), cannot be thought purely in intellectual terms as it also encompasses care, relationships and responsibility. Social justice is therefore some sense of appropriate structure and respectful relationships among persons without regard to race, ethnicity, religion, age, physical ability or sexual orientation. Social justice in Wade's view is a core value in a democratic society . Wade (2001b) described the term 'education for social justice' as closely connected with democratic education. Central to this type of education is the analysis of concepts power, oppression, marginalization, exploitation, powerlessness, violence and liberation. In Kuo's (2000) view students in social justice education move beyond studying the existing social problems to the exploration of the primary causes of these social problems. The focus in this education is to question why the problems exist, what perpetuates them and what steps citizens can take individually and collectively to effect change (Wade, 2001b).

In line with Wade's (2001b) view Adam, Bell and Griffin (1997) stated that in social justice education students are encouraged to criticise the status quo, examine underlying values and assumptions, and explore their own role in relation to dealing with prevailing social problems. Bigelow, Christiansen, Karp, Miner and Peterson (1994) pointed out that the teacher in education of this nature encourages students "to develop their

democratic capacities: to question, to challenge, to make decisions, to collectively solve problems” (p. 4). Bigelow et al believed that making students critique the status quo is the first step in creating social change.

In this particular study it emerged that in the classrooms exploration and discussion of root causes of problems in the communities was not well promoted. Concepts such as marginalization, oppression and liberation did not emerge in this study as concepts which formed part of the curriculum content. According to Gwele (2002) this could be attributed to the fact that democracy in South Africa is still new, and discussion of oppression and marginalization is still not a comfortable topic for conversation. This view is in line with what was stated by Wade (2001b) that discussing social justice issues in the classroom can be difficult, given their controversial nature.

Nursing education institutions in South Africa, according to the findings in this particular study are still at the level where their focus is more on service provision. As CBE is one of the means of bringing about social justice and social change, nursing education institutions have to move beyond service provision to the level of exploring primary sources of the problems in communities in preparing students for their social responsibility after graduation. Wade (2001) stated “ in the context of working for social justice, teachers should involve students in going beyond serving individual needs. Too often, service learning projects stop short of questioning why those needs exist in the first place” (p.4). The root causes of the problems should be analysed and actions taken to change the root cause of the problem.

CBE Antecedents

The irrelevance of earlier nursing education to the needs of the community and needs of the health care system, as well as the political changes in South Africa in the early 1990s surfaced as antecedents of CBE in basic nursing education.

Irrelevance of Traditional Nursing Education

From the findings in this study a number of factors were identified as contributory to the irrelevance of past nursing education. The findings showed that the hospital setting where learning was taking place contributed significantly to the inadequate preparation of nurses in meeting the needs of the South African population. Nurses were inadequately prepared in that the focus of **hospital-based education** was on the curative aspect not health promotion and illness prevention. Inadequacy of the preparation of nurses owing to hospital-based education was also identified by a number of authors (Cohen, 1999; Garcia-Barbero, 1995; Mattock & Abeykoon, 1993; McWhinney, 1980; WHO, 1985; 1993) as a contributory factor to the irrelevance of nursing training to reality. In Cohen's (1999) view the processes and products of health professionals' education were not in line with the needs of the population because nurses were prepared in hospital settings. According to the WHO (1985; 1993) hospital-based education limited graduates in that they were not appropriately trained for the tasks they were expected to perform in the community, and inappropriately trained to serve in the health care system founded on a PHC philosophy. As was indicated in this study, as well as the study by McWhinney (1980) hospital-based training offered graduates little training in the wider aspects of health, and thus limited

ability to address the social, economic and political forces affecting health. McWhinney (1980) also asserted that hospital-based training exposed students to training that isolated the patient/client from his/her context of illness, namely family and community dimensions of ill health. Sharing the same view that hospital-based learning contributed to the irrelevance of nursing education, Buttriss, Kuipper and Newbold (1995) stated that the hospital as a clinical learning environment isolated nursing students from the populations at risk outside the hospital or clinic and this distanced nursing from the group in need. According to the results in this present study, a large percentage of the population was isolated because of limited access to the tertiary high technological, very expensive institutions. Nurses in traditional nursing education programmes were equipped to serve only the few who could afford and access such services, neglecting those communities in desperate need of nursing services.

From this present study it emerged that traditional nursing education was inadequate in that it was based on a bio-medical model and it focused on a curative aspect of health, with little attention, if any, to health promotion and illness prevention. In line with these findings was what Stewart (1990) pointed out, that the hospital context socialized students in the expert provider role, which was associated with the bio-medical model, leaving out the most important aspects of health promotion and illness prevention. Peabody (1999) also highlighted that hospital-based training, with its curative focus, was not in line with the everyday demands of the clinical environment, especially the demands of under-resourced settings, which were accessible and affordable to the majority of the population. Clarke and Cody (1994) Stewart (1990) and Peabody (1999) asserted that, as most of the clinical learning experiences in traditional education were conducted in high technological urban

hospitals, such education gave an impression that graduates were prepared to cope with an escalating array of technical tasks and hospital driven competencies, where a minority of the population was served. The nurses, as a result, developed the mentality of a specialist, not the mentality of a server of needs of the community.

From the findings of this study the biomedical model focused education only on physical and psychological aspects of health, with no effort to include other determinants such as economic, socio-political and cultural determinants of health. These determinants of health in the context of this study were regarded as essential to serve in a health care system that is based on a PHC philosophy. This study found that these aspects were important, in order to raise the consciousness of students to issues of social injustices which have an impact on health of individuals, families and the community. Peabody (1999) convincingly asserted that hospital focused traditional education led to apolitical or politically naive graduates with limited understanding, if any, of social and political factors influencing health. Maxwell (1997) also recommended emancipatory nursing, which calls for the understanding of health in relation to physical, psychological and socio-political dimensions of health.

According to Maxwell (1997), the limitation of the use of a bio-medical model in nursing education was that it focused on the physical and psychological aspects of health, as indicated in this present study, leaving out other important aspects of health, such as social, political, economical, cultural, and many others. Butterfield, cited in Maxwell (1997), aligned traditional nursing education with a bio-medical model, because traditional nursing education focused only on the physical and psychological aspects of health, with little or no acknowledgement of the broad socio-political dimensions of health. Butterfield

felt that only these two aspects of health contributed significantly in making education less relevant to the needs of the community. Limitations of a bio-medical model, according to Guilbert (1995) were that it keeps health in a biological context, excluding the psychosocial and political context that offers a broader perspective or macroscopic view of health. Guilbert further stated that according to this model the nature and causes of health and disease can be traced to a specific aetiology (or origin) such as a virus, parasite or bacterium, whereas the understanding of the complexity of factors involved in the disease process call for a comprehensive view, integrating the client's physical, psychological as well as social well being. The participants in this study maintained that hospital-based education limited students in understanding the dimensions that influence health, as their nursing education focused only on the physical and psychological aspects of health. A need for a paradigm shift from a disease-oriented focus was identified in this study as important in ensuring the relevance of education to the needs of the community at all levels of life.

Hospital based education was also criticised in this study, for contributing significantly the problem of poor retention of graduates in rural and under-resourced settings, as their preparation was way out of what they were confronted with in these settings. These findings supported the studies by Mattock and Abeykoon (1993), Pathman et al.'s (1998), and Schmidt at al. (2000), which concluded that the preparation of graduates in urban well-resourced institutions contributed to the graduates' lack of interest and commitment in serving in under- resourced settings, mainly because they were not equipped for serving in health care settings of this nature. This lack of interest in under-resourced settings resulted in the skewed distribution of health professionals with rural and under-resourced communities being the ones most affected.

The problem of **content overloaded curricula** was identified from the findings in this study as another shortcoming in traditional education, in that the focus was on the curriculum content to be covered, not on the relevance of the curriculum content to the needs of the community to be served. Ironside (2001) showed that a content-driven curriculum in traditional nursing education was one of the factors that contributed to the poor preparation of students because rather than focusing on the relevance of the curriculum content, teachers worked hard to cover pre-determined large amounts of content in each course. According to Ironside the poor preparation of nurses with some irrelevant competencies was made increasingly obvious by the contemporary challenges in nursing education, in health care and in higher education. In Ironside's view focusing on pushing the content, with students passively taking notes, crippled students in developing to be active participants in their learning in preparation for their practice after graduation.

The **teaching/learning process**, with its heavy reliance on the lecture method also emerged as one of the reasons for the irrelevance of traditional nursing education. According to Paulo Freire (1972), supported by Bevis and Murray (1990) teaching is a political activity within which are embedded hidden messages. The findings in this present study highlighted the limitations of using the lecture method as a dominant method of teaching in nursing education as it limited active participation in class, and the development of essential skills associated with student involvement in their learning. The findings suggested that there are embedded messages of oppression in the lecture method as Freire, cited in Bevis and Murray (1990) indicated. Maxwell (1997) also aligned traditional nursing education with oppression, as traditional nursing education prepared graduates not to question the status quo but to align with the oppressors. Bevis and Murray described the

lecture method as one instrument of oppression which was teaching graduates to do the same (oppress) to those less powerful, as was indicated by the results of this study.

Graduates in dealing with their clients in health care settings, unaware, demonstrated some actions of oppressing those regarded as less knowledgeable and less powerful than the graduates were. Elaborating on how the lecture method was oppressive, Bevis and Murray (1990) argued that it does not teach students how to learn, how to critique and how to come to their own meaning of what they are learning during the learning process. Furthermore, it is unable to promote active learning by the students as the teacher is dominating the teaching/learning process. According to Scarry (1999) the norms and values instilled during the students' preparation, socialise the to behave or expect the same response from their clients.

Closely related to the use of the lecture method and its limitation in promoting active learning, the findings of this study also indicated that principles of adult learning during the teaching/learning process were not observed because of the teaching approaches used. The findings revealed that these principles were hardly promoted in conventional nursing education, thus limiting the development of students in skills required in practice. Fitchardt, et al. (2000) also showed concern about traditional nursing education, that teaching methods were not synchronised with the principles of adult learning and promoted passive academic behaviour in students. In Fitchardt et al.'s view, the students were deprived of the opportunity to develop problem solving and critical thinking skills, the skills which according to Reefat et al. (1989), are crucial in practice and in a community-oriented graduate.

Kaufman (1999), in connection with the irrelevance of health professionals'

education posited that health professionals' curricula should be relevant and responsive to the priority needs of the community. In defining a responsive curriculum Kaufman (1999) defined it as a curriculum, that is measured by the degree to which it reflects community needs, exposes students to the full spectrum of health related problems of local communities, and challenges students to address these needs as they would address health problems found in practice. In a nutshell, the findings in this study indicated that the misdirected preparation of nurses in traditional education contributed significantly to the irrelevance of nursing education to the priority health needs of local communities and to the priority health needs of the country.

Political Change in the National Government

According to Ornstein and Levine (1997), education is highly influenced by social and political changes, and this view was also endorsed in this particular study. Political changes that took place in South Africa in the early 1990s contributed significantly to the transformation in nursing education. Fitchardt and du Randt (2000) and Fitchardt et al. (2000) pointed out that political changes in South Africa had a great influence on the adoption of CBE in basic nursing programmes in South Africa. The change to democracy brought about a lot of changes impacted on the health care delivery system, as well as the preparation of graduates to serve in the new health care system. Van Niekerk (1999) also pointed out the influence of political changes on the changes in health professionals' education in South Africa. According to Van Niekerk (1999) health professionals' education institutions in South Africa were profoundly affected by the 1990s social reforms in that they had to review their missions in order to meet the social imperatives especially

because of the government initiatives to redress inequalities of the past. Gwele (1999) also asserted that changes in the health care delivery system in South Africa necessitated a different kind of health care professional who would be responsive to the needs of the community.

CBE Context

National Policies

It emerged from the findings that national policies (Health, Education, Public Service and SANC policies) provided the context on which CBE was based. Nursing education institutions had to respond to these changes and national policies. The main policy that seemed to dominate was a PHC policy, in that even the SANC's policy was based on the Department of Health's PHC policy. The PHC policy according to Fitchardt and du Rand (2000) was aimed at improving and maintaining the health of the South African population, especially those in underserved communities. The new PHC policy demanded a change in the education of health professionals so as to have graduates with competencies relevant to serve all communities.

Jinadu (2002), sharing the Nigerian experience on the adoption of CBE with regard to political changes, stated that the founding of the National Health Care System in the PHC policy challenged the health professionals' education to respond to this national policy by revisiting how graduates were prepared to serve in such a health care system as they had a major role to play. In Nigeria, just like in South Africa PHC is a policy on which CBE is founded.

The conclusion can be drawn that CBE in basic nursing education is a relevant and

responsive education, in that it emerged as a response to the needs of the surrounding communities, the needs of the South African population at large, as well as a response to national policies in South Africa which were aimed at improving the relevance of nursing education. From the interpretation of the findings on CBE as a response to national policies and as facilitating the realisation of national policies, one might conclude that CBE is **responsive education**, and is also a **political instrument** to influence change in the country as a whole and in individual communities. According to the results of this study, CBE contributes towards the realisation of some of the government policies, such as the PHC policy.

Action/Interaction Strategies.

Action/interaction strategies were those actions that facilitated the implementation of CBE in basic nursing education. Some of these actions focus on the curriculum planning process and others focus on the curriculum implementation process.

Curriculum Planning Process

The findings in this study revealed three main concepts in the curriculum planning process; (a) collaborative decision-making, (b) congruence between graduate competencies and clinical learning environment, and (c) the development of stakeholders.

Collaborative decision-making. From the findings of the study it was apparent that collaborative decision-making was fundamental in and crucial to the process of curriculum transformation, especially because the success of CBE in this particular study depended on the collaborative effort between stakeholders (nursing education institutions, health service

sector, and the community). According to Jolly and Rees (1998) a curriculum that is supposed to be socially responsive is a very complex curriculum, therefore it cannot be designed by a small group of the privileged few. In Jolly and Rees' view the curriculum should be "designed by a consensus, involving wide representation from interested parties, and taking particular cognisance of the uses to which the skills and knowledge gained in training will be put" (p.23). The results of this study concurred with Jolly and Rees' view on collaborating in the process of change.

Gastel (1999) asserted collaborative decision-making in curriculum planning and development was critical in that it enhances the relevance and social responsiveness of the curriculum. This author further asserted that one of the pre-requisites for successful CBE is the close linkage between education and service delivery, involving the community in the process of change as early as possible. According to this author, the curricula of health professionals are too often shaped by the teaching staff, according to their traditional standards and without concern for the needs and demands of the community in which graduates will practice. In Koch-Weisser's view such an approach to curriculum planning and/or development is not fair to the community members because final competencies will be used in serving consumers who were not involved in decisions regarding graduate competencies. This study posited that as graduates of the new programme will serve the community and health service sector after graduation, involving them in the process of decisions regarding graduates' competencies was crucial. According to Koch-Weisser all stakeholders should be involved in the education and training of graduates who are to function competently in community settings and in health care delivery systems. The stakeholders should be involved both in the planning and implementation of a new

community oriented curriculum.

Hamad (1999), in describing the setting of a stage for innovation, emphasized that innovation in essence should be a shared responsibility between those who educate and produce human resources (academic institution) and those who utilise the academic institution's product (the health sector). Hamad suggested that health services should be full partners in all activities, with their representatives participating fully as members in the planning committees, which was what the results of this study revealed. Refaat et al. (1989) pointed out that the community should be fully involved from the beginning of the curriculum-planning phase and even be represented in a core curriculum committee for the curriculum to be responsive and relevant to the needs of the community.

The representation of all stakeholders was in line with what the postmodernists refer to as 'listening to different voices'. Beyer and Linston (1992) pointed out that postmodernists believe in listening to different voices, especially the voices of the 'other' (those who were regarded as not important) when developing a curriculum that is representative of all. Beyer and Linston further stated, "We need a rainbow coalition to make sure that serious voices are not left out of the great conversation shaping the curriculum" (p.9). The inclusion of the 'other' emerged from Foucault's (1980) ideologies that the voice of the other is always pushed aside, marginalized, forcibly homogenized, and devalued. Foucault emphasized the importance of the voice of those who have been oppressed and their voices not heard.

Cahoone (1996) also posited that postmodernists turn their attention away from the well known, openly announced themes in text towards the seldom mentioned, the virtually absent, because they believed that presence (referring to the quality of the present

experience and to the objects thereby immediately presented) is constituted by the absent. In other words the quality of present experience depends on those themes in text, which are overlooked, not knowing the quality of their input into the present. In the context of the present study, the voices which were not heard, and the text which was seldom mentioned were those of the community, and sometimes the voice of the health service sector. Inclusion of all stakeholders according to the findings in this study was regarded as crucial to the process of change, and in adopting, developing and implementing a new CBE curriculum.

It emerged from the findings of this study that collaborative decision making was crucial in ensuring that the curriculum (a) was acceptable to all stakeholders, (b) was likely to produce competent graduates in terms of stakeholders needs and (c) could be implemented in the locality where it was supposed to be put into action. The above mentioned features were reported to be important in measuring the acceptability and feasibility of a new curriculum, as, according to Jolly and Rees (1998), it is not possible to have a correct or ideal curriculum but at least it should meet some general specifications, which in his view are (a) plausibility, (b) fitness for purpose, and (c) implementability.

Involvement of all stakeholders in the process of change as indicated by the findings in this study, was one way of dealing with the possible barriers to change. Habbick and Leeder (1996) highlighted a similar approach to change and strategies used to deal with possible barriers to change. These strategies included the developing ownership of the proposed innovation, winning converts by inviting participation rather than intellectual discussion, forming new alliances to broaden the base of support, and sharing rewards of change widely.

CBE in the context of this study requires collaborative decisions on the curriculum, where all stakeholders become part of the decision making team regarding the adoption of a CBE curriculum, the priority issues to be addressed in a curriculum, as well as competencies required from graduates. Collaboration in CBE enhances the relevance of the curriculum.

Congruence between expected graduate competencies and clinical learning sites. According to Brazansky, cited in Refaat et al. (1989), health professionals' education is influenced by the training settings where students can observe and master defined competencies, particularly relevant to serving in those clinical learning settings, and that is what the findings in this study also suggested. The findings revealed the importance of selecting clinical learning environments that would facilitate the development of competencies expected from the graduates, as students learn in these real life settings through authentic learning activities which are similar to those in which health professionals engage. They supported Oneha et al.'s (2001) findings, that learning sites were the key in promoting the development of competencies required from graduates. According to the findings in this study, the clinical learning sites used should closely resemble those in which the graduates are more likely to practise, as the WHO (1987) recommended.

Learning experiences in the clinical learning settings emerged as facilitating the development of some of the skills and competencies required from CBE graduates. According to the findings in Simoni and McKinney (1998) which were also in line with the findings in this study the community learning environment facilitated important life skills such as problem solving skills, life long learning, critical thinking skills as well as

competencies such as the ability to respond to the changing needs of the community, to care for the community's health, collaborative working in partnership with community, the ability to identify, plan, and implement and evaluate health promotion and disease prevention interventions.

Regarding the selection of community learning sites, the results showed that specific criteria were used. Nooman (1989) also published criteria that had factors close to those which were identified in this study. It was found in this study that the following criteria were used for selection of clinical learning sites (a) there should be community-based organizations and health care settings whose practice is based on a PHC philosophy, (b) feasibility and accessibility in relation to transport were necessary, and (c) the community should need and appreciate the service by the students. Other important factors which were identified in this particular study were that the community should (a) have a history of being used by other academic institutions or schools, (b) have relevant learning experiences that would facilitate the development of required skills and competencies, and (c) be reasonably safe.

There are some reservations, however, about the use of a community that has a history of being used by a university or faculty placing its students in that particular community, because the students should be exposed to working with students from other disciplines. Looking more closely at this arrangement, such communities may be over utilized by the students. They may also, be overpopulated by students leading to competition over available resources and limited access to relevant learning experiences. Placing students in a community that has a number of students from other disciplines was contradictory to the view in Habbick and Leeder (1996) that CBE encourages the use of

untapped resources and resources where the services offered by the students are likely be highly appreciated. Focusing on one community can deprive other communities which could offer rich learning experiences, of the opportunity to have access to service provided by the students. All communities, especially the under-resourced communities have a right to have access to health care.

Development of stakeholders. It was apparent in this study that CBE brought in a new culture in teaching and learning. Changing to a new culture meant preparing all stakeholders, including the students and their parents, in line with the requirements of this new and unfamiliar education. The development of stakeholders for their new roles and responsibilities surfaced as essential, because they had important roles in the process of change.

The **preparation of teaching staff** in this study appeared to be crucial as they were regarded as a driving force behind the successful implementation of CBE. In support of this finding, Des Marchais and Chamberland (2000) pointed out that staff development is one of the essential components of any good quality programme, as no one was born a great teacher/superb educator. DesMarchais and Chaput (1997) also asserted that the teaching staff, as the backbone of the innovation, require to be prepared properly for the change, as this preparation is the key to the adoption of a new curriculum

Preparing staff in this particular study required the use of a variety of strategies, which included workshops, attending conferences, site visits to observe facilitation of learning, and inviting experts to assist them along the process of change. DesMarchais and Chaput (1997) maintained that it is not easy to retrain experienced educators, therefore a single workshop on staff development was not adequate, because of the nature of the

teaching/learning process and teaching/learning approaches used. This view was supported by the findings in this particular study. According to Des Marchais and Chamberland (2000) the teachers require a thorough preparation on a student-centred approach which is dominant in CBE. Des Marchais and Chaput (1997) suggested comprehensive training that should extend across sufficient time and be continuous, as was reported in this particular study, where staff preparation in some nursing education institutions took more than two years. Spending more time preparing staff was viewed by Okella, Ovunga and Luboga (1993) as time well invested because of the possible resistance from the staff if they were not well prepared for the change.

Elaborating on what the preparation of teaching staff means for the innovation, Irby in Hitchcock and Mylona (2000), stated that preparing staff for the innovation is like challenging the cherished beliefs about teaching that staff have developed over the years. It means redefining relationships with students because of the student-centred approach in CBE, and redefining relations with other teaching staff. It also means the teaching staff have to develop an array of skills required to respond to learners' needs. Because of the criticality of the preparation of teaching staff, Hamad (1999) suggested the use of all possible opportunities to prepare staff and, if financially possible the teaching staff visiting other institutions, as models of CBE, which was in accordance with the findings in this particular study.

CBE requires good **preparation of health service personnel and community members**. Des Marchais and Chamberland (2000) asserted that good preparation of health service personnel and community members is the key element in fully realizing the educational potential of the community/clinical setting. Part of the preparation of

community and health service staff included holding meetings with them, where they were expected to participate actively. These stakeholders were developed through workshops which focused on their roles and responsibilities in CBE.

According to the findings in this study the process of preparing communities took longer than that of preparing service personnel, because of the hierarchy to be observed and respected in the community. The need to win the trust of some community members prolonged the process of developing communities for their roles. Truglio-Londrigan et al (2000) reported the same in their institutions. These authors stated that preparing and developing partnerships with communities was a challenge because of the careful process that had to be followed in order to be acceptable in those communities.

In this study **students** were treated as primary stakeholders, especially because CBE was about preparing them for their careers. Their preparation included an orientation block that introduced them to important concepts such as community, community assessment, determinants of health, PHC, epidemiology, community partnerships, group dynamics, learning how to learn and other important concepts. Part of the orientation given introduced students to the realities in the community settings. Preparing students for group dynamics as stated in Solomon and Finch (1998), was important because of group learning which was practised in all institutions. According to Solomon and Finch (1998) preparing students for group learning is essential because learning collaboratively in small groups tends to bring unique stressors rather than a cooperative attitude. The students tend to compete rather than to work collaboratively.

In the context of this study the preparation of all stakeholders for their new roles and responsibilities was seen as crucial because they all had major roles to play in the

successful implementation of CBE. Time and effort spent on the preparation of stakeholders was regarded as an investment because of the need to ensure that all stakeholders participated and contributed positively to the preparation of students, including the students themselves.

Curriculum Implementation

A number of concepts emerged from the data on curriculum implementation, which included (a) curriculum determinants, (b) the nature of community-based learning experiences, (c) the teaching/learning approach, (d) the teaching/learning process, (e) the nature of the teacher, and (f) the nature of the student.

Determinants of the curriculum. The findings in this study revealed that there are three main determinants of the curriculum (a) the community, (b) the students, and (c) the nursing education regulatory body (SANC). The purpose of having a **community** as a source of the curriculum in this particular study was to ensure curriculum relevance to priority needs of the community. The CBE curriculum, because of the use of community problems as part of the curriculum, was described as contextualised, dynamic, adaptable, community oriented, and unique, as problems used were derived from the surrounding community. What was regarded as knowledge in a CBE curriculum, according to the findings in this study, was generated mainly from the community problems and needs. The generated knowledge was described as grounded, authentic, contextualised and constructed with information from a number of disciplines to give a holistic view of an issue of interest.

Relevance of the curriculum, which was measured by having the community as the source of the curriculum content, concurs with the views of a number of authors (Boaden &

Blight, 1999; Cohen, 1999; Magzoub & Schmidt, 1998; WHO, 1987; 1993), that the relevance of the curriculum is mainly determined by the curriculum's orientation to the community's problems. Schmidt et al (1991) described a community-oriented curriculum as a contextualised curriculum, in that it is based on the needs of the surrounding community. In Schmidt et al's (1991) view such curricula are likely to be different as they are based on the needs of the surrounding community. These curricula are dynamic because of the changes taking place in the community, in that the community-oriented curricula are likely to have new content introduced every year, depending on the prevalent or priority problems in the surrounding community.

The CBE curriculum shares some of the characteristics of postmodernists and instrumentalists curricula, in that it is contextualised as it is grounded on realities in the community, it is dynamic, it changes depending on the priority community needs. From the postmodern and instrumentalists' view, a curriculum should be immediate, relevant and changing with time and context, as stated in Reed (1995) and Klages (2000) According to those subscribing to instrumentalism, a democratic society must be the basis of the curriculum (Haque, 2002) as the findings suggested in this study. The community setting provides a raw content material which is refined by the students with the help of the facilitator during class interactions, in order to develop the material into curriculum content. The instrumentalists (Haque, 2002) and postmodernists (Reed, 1995) refer to this process as a process of knowledge construction. Postmodernists, according to Klages (2000), believe that knowledge should be functional, one should learn things not only to know them but also to use the knowledge gained, which is in line with the findings in this study. Regarding relevance of the curriculum, Barnett, cited in Preece (2001) maintained that the curriculum

should be contextualized he/she described a curriculum as a study of issues of the here and now, which provided an opportunity to move beyond the subject matter confined by the limits of existing authoritative knowledge.

The students also emerged as one of the important determinants of the curriculum in that their interests and learning needs, which were in line with programme outcomes, were taken into consideration. The use of students' interest is common in general education. Philosophers such as progressives, social reconstructionists, critical theorists and postmodernists believe in a curriculum in which students have an input, as stated in Ornstein and Levine (1997). According these authors the students' interests and needs form an emerging curriculum.

From the preceding discussion it is argued that a CBE curriculum has four main voices, the voices of the students, the community, the academic institution and of the body regulating nursing education. It appears however, that because of the contract between the learner and the academic institution, and the economic power vested in the university, at least in South Africa, the academic institutions' voice is likely to remain the most influential in education.

The nature of learning experiences. The nature of learning experiences in this study were similar to those reported by a number of authors (Habbick & Leeder, 1996; Hamad, 1991; 1999; Towle, 1992; WHO, 1987) as the main community-based learning experiences in a CBE curriculum. These community-based learning experiences included (a) conducting a family study, (b) conducting a community survey, and playing an active role in planning, implementing and evaluating an action plan, (c) participating in health promotion and illness prevention, (d) working in a variety of community settings with the

intention of providing service and at the same time conceptualising how psycho-social, economic, cultural and political factors affected the health of individuals, families and communities. Over and above learning experiences reported by these authors, epidemiological study emerged as another important community based learning experience in basic nursing curricula. From the findings it was established that learning experiences in the community focused on implementing PHC goals, principles and strategies, as many authors (Habbick & Leeder, 1996; Richards & Fulop, 1987; Towle, 1992) indicated. In most cases this was taken for granted as CBE is founded on a PHC philosophy.

Teaching/learning approach. The results in this study revealed that a problem focused approach to teaching/learning was a dominant approach in developing problem solving skills, which were regarded as essential skills in practice, as Reefat et al (1989) asserted. According to these authors problem-solving activities in CBE served as means to prepare graduates who would be able to address the major health problems of their community. According to Barrows and Tamblyn, cited in Garcio-Barbero (1995), learning by using problems goes beyond learning to problem solve, to the level of understanding the causes of these problems, as was also indicated in this study.

The findings revealed that some of the nursing education institutions were using **paper problems**. These were presented as triggers to problem solving activities. These triggers were either in the form of illustrations, pictures or a short scenario to be analysed by the students. In Freire's (1972) pedagogy, such an approach to teaching/learning is referred to as a problem-posing approach as the students are presented with a problematic image or scenario to identify problems and analyse them. Freire refers to images and short scenarios used as 'codifications'. Wallerstein et al (1999) pointed out that codifications

mediate reality and its theoretical context; the students learn to link what is taking place in reality to theory. The teaching/learning process in this particular study was characterised by dialogue among all those involved.

The results also revealed that some of the nursing education institutions were using authentic clinical problems. These authentic learning problems served as the basis for content selection. Experiential learning as well as problem solving methods emerged as the main methods of teaching/learning in these nursing education institutions. According to Magzoub Ahmed and Salih (1992), learning through solving authentic problems in real life settings developed students for practice because they developed an important life skill (problem-solving skill). In Jinadu's (1992) experiential learning model, experiential learning was presented as a unique way of educating health professionals towards relevance, as experiential learning required the active participation of students in learning experiences which were consciously and systematically organised in real life settings. According to Jinadu (1992) the experiential model encouraged students to explore what they encountered in the environment, promoting deeper learning, and developed students in working on health problems identified in the community settings, as was also reported in this particular study.

Students were reported to be growing academically and personally from learning through experience and through problem solving. According to Jinadu (1992) such a process of learning (experiential learning), coupled with reflective learning accounted for the academic and personal growth reported in students, as was also reported in this particular study. The studies by Dana and Gwele (1998), Gwele (1999) and Madalane (1998) reported the findings that were in congruence with the findings in this study with

regard to growth resulting from experiential learning. The studies by the above mentioned authors revealed that students grow academically and personally from the process of learning through experience in community learning sites. They develop a number of life skills such as problem solving skills, thinking and critical thinking skills, independent learning, self-directed learning, communication skills, leadership skills, interpersonal skills, as well as community oriented skills such as negotiating skills, partnership building, maintaining and terminating skills.

Experiential learning can be traced mainly in education programmes influenced by experimentalism or instrumentalism. One of the well-known instrumentalists (Dewey, 1916; 1933; 1938), although his thoughts were in general education, believed in a problem solving approach. According to the instrumentalists' view a problem solving approach allowed students to be involved actively and to take responsibility for their learning, and through that process growth took place. Dewey believed that the problem solving approach, experiential learning and reflective learning facilitated growth in students. In Dewey's (1938) view "all genuine education comes through experience" (p.25), and 'reflection' which was repeatedly reported in this particular study, following experiential learning, is central to learning experiences that are educative.

In the context of this particular study the problem solving approach and experiential learning surfaced as important approaches to teaching/learning. According to Schmidt (1989), teaching approaches used in CBE promote a deep level approach in learning. Schmidt (1989) described deep approach learning as an approach that attempts to integrate what is learned with what is already known, on the pursuit of 'meaning' in the material learned. Superficial learning, on the other hand, was described as largely characterized by a

rote-learning tendency, aimed at literal reproduction of the material, and the use of extensive memorization procedures. In the context of CBE, deep learning results mainly from the problem solving and experiential learning approaches used. The use of a community as a learning environment and the use of issues confronting students in a community environment also facilitated a deep-level approach, as indicated in Schmidt (1989). Community-based learning experiences according to Schmidt (1989), fostered in the students an inquisitive style of learning.

Teaching/learning process. Active learning, collaborative learning and self-directed learning emerged as important in the teaching/learning process in this study. The findings revealed that active learning mainly dominated in the teaching/learning process, as CBE required a lot of participation by student.

Sivan, Leung, Woon and Kember (2000) pointed out that terms such as **active learning**, experiential learning and hands-on-learning are often used interchangeably. In their view that may be attributed to the understanding that active learning lacks a common definition, in that most educators when wanting to use this term establish their own working definitions. Active learning in the context of this study, thus refers to learning where students move away from being passive recipients of knowledge to being active participants doing most of the work, learning through experience, engaging in problem solving activities and knowledge construction exercises, as well as in application of what has been learned, with teachers facilitating and directing the process of learning.

In this particular study the reason for promoting active learning, both in the community settings and classroom settings, was to facilitate the development of skills such as communication skills, problem solving skills, independent learning, thinking skills and

ability to interact with other students and with teachers. These findings concurred with the results in Sivan et al's (2000) study on implementation of active learning and its effects on the quality of student learning. The findings in this particular study also highlighted that active learning created interest in the curriculum to prepare the students for their future careers. Furthermore, authentic activities for learning purposes affected the quality of student learning by shaping the way students met the desired learning outcomes and developed the skills required in practice, the skills which according to Sivan et al (2000) help graduates cope with future changes of their professional roles.

Collaborative learning also emerged as important during the teaching/learning process, as most of the learning experiences were confronted as a team, in both the community and classroom settings. According to Okasha (1995) team learning in community-based learning enhances early professional socialization and provides opportunities for development of leadership skills. Collaborative learning is aimed at achieving the outcome of being able to work harmoniously in a team as according to Okasha, team learning promotes respect for other team members and community/clients.

The finding on **self-directed learning** revealed that although significant in CBE, self-directed learning was not used in isolation as a teaching/learning method. It was interlaced with other teaching/learning methods, but the main purpose of self-directed learning was to produce lifelong learners, who were able to direct their own learning, depending on the learning needs identified. Encouraging self-directed learning in this particular study harmonized with Della-Dora and Wells' (2001) view that education should go beyond teaching the basics required in traditional education. It should also teach the basics for survival in a democratic world. According to these authors "the distinguishing

features of education in a democracy should be to teach people how to exercise their individual and group rights in a responsible manner". There should be evidence that students learn to be more self-responsible and more self-directed as they progress with their education.

The nature of the teacher. Regarding the nature of the teacher in CBE, the findings suggested that the teacher is characterized by (a) a commitment to CBE, (b) cognitive modelling in an unpredictable learning environment, (c) democratic leadership in managing a learning environment, (d) ability to coordinate and manage of learning resources. The characteristics portrayed by the teacher in CBE are in line with those presented in Faller, Dowell and Jackson (1995). According to these authors, the paradigm shift in learning sites used for teaching/learning purposes, as well as the change in the teaching responsibility of teachers, including practising in community settings, poses a serious challenge as the teaching responsibility incorporates both teaching students and providing service to community members. Providing service to community members during the teaching/learning process, an aspect that was not important in traditional education, adds to the responsibilities of the teaching staff. In view of the changes accompanying the adoption of community-based learning, Faller et al. (1995) contended that the success of community-based learning does not require expertise in community health nursing but it requires enthusiastic teaching staff who value nursing in community, not just nursing in the health care organisations, and the findings here also indicated that the teacher should be committed to CBE. According to Faller et al. (1995) the teacher should be passionate about functioning in the community.

The results in this study further revealed that teachers in CBE should be comfortable

with the paradigm shift in their roles and responsibilities, and have an interest in community-based learning activities. The teacher of this nature was found to be in accordance with the description of the teacher in Faller et al. (1995), that teaching staff in CBE must value the concept of empowerment of others, either communities or students to meet self-identified needs, as CBE is mainly about empowerment. Teaching staff should be comfortable with the lack of structure in community settings and should be creative in using scarce resources, they should be willing and comfortable when working collaboratively, including joint decision-making, and they should not be threatened by the beliefs of others.

Lindermann, in Elias and Merriam (1995), described a teacher of this nature as a 'teacher with a new function', the teacher who is no longer the main source of knowledge but who is there only to facilitate learning and manage the learning process and resources. The teacher in CBE is more in keeping with the progressive teachers (experimentalist/instrumentalists), postmodernist teachers and teachers subscribing to critical theories (Freire's pedagogy, social reconstructionism). Ornstein and Levine (1997) asserted that the social reconstructionists teacher should believe and be committed to social change, as he/she is supposed to facilitate the process of developing students to be change agents. A critical theorist teacher, according to Brameld (1928), is a transformative intellectual with the potential to facilitate socio-cultural change towards realizing a better society. The teacher should be aware of the problems that affect the society, and should have a passion to confront them.

The findings in this study also revealed that because of the important aspect of raising consciousness of the students to socio-political, economic and cultural issues, the teacher has to be able to facilitate this aspect of learning, which, according to critical

theorists in education, is learning aimed at consciousness raising. According to Levine and Ornstein (1997), the teacher therefore has to direct the students to focus on significant socio-economic problems and develop them in challenging the status quo. Ryan and Cooper (1998) further pointed out that the teacher in consciousness-raising education guides the students in their efforts in implementing social reform and assists them with choices and support. CBE in this study was aligned with consciousness-raising pedagogy in the understanding that CBE conscientizes students to realities in the community environment, and students are engaged in activities aimed at addressing some of the health problems related to social justice issues. Under the guidance of the teacher, the students as change agents, engaged in consciousness raising activities in the community in order to help the community improve its own health.

The nature of the learner. The results characterised the student as a primary stakeholder in CBE, determinant of the curriculum, constructor of knowledge, change agent, service provider, and responsible for own learning (self-directed). The student was described as an aggressive seeker of knowledge, who takes charge of his/her learning, and who views learning as a natural and enjoyable process and actively engages in the process of curriculum and knowledge construction. Such a student has the qualities of an experimentalist/ instrumentalist student, and some of the qualities related to the qualities of a postmodernist and critical pedagogy student as outlined by a number of authors (Elias & Merriam 1995; Freire, 1972; Ornstein & Levine, 1997; Rather, 1994; Slattery, 1995; Tanner & Tanner, 1995). These philosophers view the learners as active, taking charge of their learning (self-directed), problem solvers, independent thinkers, socially responsible democratic citizens, and knowledge constructors. The students in this study were also

described as the determinants of the curriculum and the primary constructors of knowledge, with an ability to grow from their learning experiences. According to Tanner and Tanner (1995), experimentalists also described a student as an organism in biological continuity with nature as education in its process. The students should grow continually, never reaching a point where they say they have completed education, as learning is viewed as a lifelong process.

Intervening Conditions

The findings indicated that CBE in basic nursing education in South Africa has three main intervening conditions which were (a) collaborative effort, (b) practice of true partnership and (c) lack of government commitment.

Collaborative Effort

This study showed that as education is decentralized, with a strong sharing of educational responsibilities, as highlighted in Habbick and Leeder (1996), the need for collaborative effort among nursing education institutions, the community and health service sector emerged as crucial to ensure the successful implementation of CBE. This tripartite partnership, according to this study, was characterized by a strong commitment from all members towards a common/shared vision, formal/informal working agreement between the parties, and sharing of responsibility, with each member having its own responsibilities.

The **nursing education institution** was responsible for (a) leading curriculum transformation in response to identified priority health needs and National policies, (b) providing expertise regarding community-based educational experiences, (c) providing

teaching staff to facilitate the learning of students, (d) providing and maintaining learning resources, and (e) ensuring smooth running of the programme.

The **community** had the responsibility of (a) providing an environment/ context for learning, (b) facilitating community entry, (c) ensuring the safety of the students in the community, (d) providing information that forms part of the curriculum content, (e) sharing knowledge and skills on handling realities in the community, and (f) facilitating some of the learning experiences in the community which lie within their level of expertise.

Shipengrover and James (1999) as well as Worley et al. (2000) in their studies that measured instructional quality in community-based settings where community members were also involved in the teaching of students, pointed out that there was a concern about the credibility of community members in the area of teaching students especially because they have not undergone any preparation in the teaching of health professionals. In contrast to this view the case study by Seabrook et al. (1999) on the teaching of community-based courses, the findings revealed the importance of community involvement in teaching students in community settings because they have in-depth knowledge and lived experiences regarding problems and needs of the community. They are rich resources in that area of community-based needs and problems. It was recommended, however, in Seabrook et al. that community members undergo some form of preparation for their role as teachers. The study by Stacey and Spencer (1999) acknowledged the question of credibility of community members in teaching students but pointed out that community members have a valuable contribution to make in community-oriented programme.

Acknowledging the community members' in-depth knowledge and experience in the facilitation of learning of community-based problems and needs is in line with

postmodernists' belief that in learning communities all members are educators and educands depending on who is in possession of more knowledge and experience on that particular subject. All members are regarded as having a potential to share what they know with the members of the group and take a leading role at that time (Wilson & Ryder, 1998).

The results in this study also revealed that the **health service sector** had the responsibility of (a) providing clinical learning environment, (b) providing personnel to assist in the facilitation of learning in the clinical learning environment, (c) facilitating learning in the clinical learning environment, and (d) sharing knowledge and expertise on the delivery of comprehensive PHC, sharing it with the students and other partners. Each member in this partnership had its particular roles and responsibilities, which were different from those of others, but they were all linked and interdependent, contributing to the successful preparation of CBE graduate. These partners needed each other to produce competent graduates to serve in all levels of health care.

Practice of True Partnership

True partnership was revealed from the results as one of the factors influencing the successful implementation of CBE. From the discourse analysis it emerged that there were voices which were more powerful than others, which affected the working relationship between those in a partnership. Lack of true partnership was in line with what was reported by Williams, Reid, Yeni, Pitt, and Solarsh (1999). These authors pointed out that lack of true partnership might be a shortcoming of CBE. According to Williams et al. (1999), the concern about true partnership is more common when it comes to community involvement. In principle, the community in CBE should be involved as an active partner in all the

activities (WHO, 1987; 1993) not only as a partner when needed for the benefit of other parties. Williams et al. (1999) reported that, what has been observed is that the community in a partnership receives very little when it comes to benefits, but the greater benefits are to the students and education institutions.

Investigating why other partners dominated in a community-academic partnership, Blumenthal (1990) stated that members in a partnership might not always have common objectives and interests. The academic institution has a responsibility to ensure that the students learn, as indicated in this study, whereas the other parties' vested interests might be the service by the students. The differences in the priorities and values might be the source of finding some partners dominating in a relationship at certain situations.

One of the concerns raised in this study was about equal power sharing, where those regarded as more educated were viewed as dominating in a partnership. Regarding equal power sharing between the community and the university, Quinn, Gamble and Denham (2001) in their work on ethics and community-based education, pointed out that in the context of community-based education of students, the academic institution and the teaching staff are the key stewards of the relationship between the community and the academic institution. In their view, in this relationship the academic institution, however, in general has greater fiscal and political power than the community because ethically the university has an obligation to see to the interests of the students first in community-based learning experiences. The academic institution has to ensure that learning experiences and learning opportunities available in the community setting are more likely to contribute to the development of competencies required. Service to be provided by the students to the community, which is of interest to the community, should be secondary to the learning

needs of the students. This is likely to strain the relationship between the two parties but according, to Quinn et al. (2001) the academic institution, regarded as more powerful because of its ethical obligation to the students should ensure that the needs of the students are the priority. Yoder, Cohen and Gorenberg (1998) also supported the understanding that the relevance of learning experiences to graduates' outcomes should be a priority before the service to be provided to the community and the academic institution must ensure this is taken into consideration.

Quinn et al. (2001) asserted that although the goal should be to develop a relationship that is a true partnership between the academic institutions and the community, it is important to acknowledge that power is a critical characteristic that can not be ignored, and carries with it responsibility towards stewardship. Rodgers (2001) also warned that community needs for service must not dominate the requirements of learning, as learning is a priority in CBE, In his view, the value of learning through service must not only be judged by the value of the service the community receives but more importantly by the learning that takes place. Quinn et al. suggested that in order to balance educational needs with needs of the community, a guide for the relationship between the parties involved should be established. Quinn et al, however, emphasized that the missions of the academic institutions are primarily education and research. Thus, one must consider that the first ethical obligation is to educate the students.

It is important to note that a true partnership, albeit not yet achieved in CBE in basic nursing education in South Africa, was nonetheless recognized by the participants of the study as a necessary condition for a successful CBE programme.

Lack of Government Commitment

Lack of government support was another main concern voiced in the study with regard to the successful implementation of CBE, particularly as CBE emerged as a policy from the government in this study. The government, according to nursing education institutions, had a responsibility to assist in the implementation of CBE. From the analysis of data, however, it could be argued that the government and the nursing education institutions did not have a common understanding about the contribution of the government to CBE, as participants themselves highlighted some form of the assistance their institutions were receiving from the government. For example, it was reported in some of the institutions that the government was providing transport to take students to community settings. In one province the government contributed a large sum of money to the building of a Community-Academic Partnership Centre, that was used for all CBE activities. In another province the government was reported to be providing bursaries for students, who were spending two years in the community settings, not providing service in hospital settings. The government was also reported to assist in organising and funding capacity building initiatives for teachers in some provinces.

The participants' views regarding government support of CBE programmes and what the government is doing to support the education of basic nurses indicate that the expectations of the CBE curriculum implementers may be different from those of the government. One can assume that the government was assisting as thought best, depending on the available resources in that particular province or setting. This study makes clear that there is a need for nursing education institutions together with the government to work towards developing a common understanding on the support to be provided by the

government to CBE programmes.

Expected CBE Consequences

The results showed that CBE consequences were expected in nursing education, in the health care delivery system and in the wider community. It was hoped that, through CBE, nursing education will (a) have a community-oriented curriculum, that is relevant to address the priority health problems in South Africa, (b) produce socially responsive, PHC competent graduates, (c) facilitate the realization of national policies, by preparing graduates with a curriculum that is based on these national policies, and (d) have open relationships with community members to such an extent that there would be sharing of resources required for preparing students.

According to the findings in this study, one of the expected outcomes of CBE was the production of PHC competent nurses, which was in line with the results in Kumpusalo et al (2000). These authors showed that CBE graduates were equipped to serve in PHC settings and were likely to be willing and able to cope with serving in under-resourced and rural health care settings. According to their study graduates who were prepared through CBE were confident that they had relevant competencies to serve in PHC settings and most of them were more willing to serve in such settings than graduates from conventional health education programmes.

With regard to the impact of CBE on the health care system, the finding revealed that the health care system was more likely to provide relevant health care service and be responsive to national priority issues because of the nature of graduates serving in the health care settings. These findings supported the findings in Kumpusalo et al.'s (2000)

study. These authors reported on the state of the health care system before the adoption of CBE in health professionals' education. According to these authors, their country (Finland) suffered a serious shortage of health professionals, particularly in under-resourced and rural community health care services. According to Kumpusalo et al., a number of years after the implementation of CBE, their country had enough health professionals for both public and private sectors and the health services had improved as a result being staffed by PHC competent graduates who were the products of CBE programmes. This is in line with the expected outcomes of CBE on the health care system here.

The study by Magzoub and Schmidt (2000) however, differed slightly from the findings in this study and the findings in Kumpusalo et al.'s (2000) study. Although the purpose of this presented study was not to compare graduates from conventional nursing education programmes to CBE graduates, it was clear from the expected outcomes that nursing education programmes are expected to produce PHC competent graduates, as it was a major concern that graduates produced from conventional programmes were not PHC competent. The expectations in this particular study on graduates differed from Magzoub and Schmidt's study. The study by Magzoub and Schmidt showed that community oriented programmes produced graduates with similar knowledge and skills as compared to graduates from conventional programmes. The difference was only in their career choices. The graduates from COE programmes chose a career in PHC to a larger extent.

According to Felletti et al. (2000), community-based learning activities have a more long term and a broader scope, as they are aimed at improving the chances of the community taking care of their problems. The participants in this study also shared the view that the impact of CBE might not be obvious in short term, but CBE is a long-term lifetime

investment in the community. In this study the results showed that it was hoped communities would become self-reliant and self-determined so that they would be able to take responsibility for their own health needs and use available resources economically for the benefit of the community. The results also revealed that although it is not possible to have completely self-reliant communities, they have a potential of approximating to self-reliance.

It is important to note that there was limited literature on the impact or expected outcomes of CBE on the community to adequately support the findings in this present study on the expected outcomes of CBE in the community. According to Magzoub, Schmidt, Ilyas and Lewis (2000) literature is limited in this area because the attention is being paid to this aspect of CBE. The WHO (1993) stated that the reason for limited reporting on CBE in the communities was that evaluations of innovations in education commonly concentrated on the effects on students and teacher, with less attention paid to the effects on practice patterns and very little to the effect on the community. The WHO (1993), however, pointed out that outcomes of CBE in the community might be difficult to measure because of many factors interacting to influence the health status of the population. Pinning down the outcomes to CBE might be a challenge, but it would be a worthwhile attempt because the community is the focal point of CBE.

Conclusion

The discussion in this study shed light on that what is practised as CBE in basic nursing education in South Africa. The discussion indicated that CBE in nursing education shared some similarities with what was practised in other parts of the world. For example,

as in other countries, CBE was aimed at ensuring that nursing education was relevant to the needs of the community and needs of the health care system. It was also aimed at conscientising students and community members on the socio-political, economic and cultural factors that had an influence on the health of individuals, families and the community. What was notable in basic nursing education in South Africa, however, was that there was a strong emphasis on PHC, all activities, from the planning phase to the implementation phase, were directed at producing a PHC competent graduate. CBE was therefore used as an instrument to socialise students, consciously and deliberately, to PHC. It is also important to note that a number of important concepts were illuminated in this chapter. Those concepts will be further analysed in the following chapter as they contributed to building a middle range theory on CBE in basic nursing education.

CHAPTER 6

A MIDDLE-RANGE THEORY OF COMMUNITY-BASED EDUCATION

Introduction

The purpose of this study was to analyze CBE in basic nursing education in South Africa with the aim of discovering the shared meaning of this phenomenon and to develop a middle range theory grounded on what is practised as CBE. This chapter presents a middle-range theory of CBE that emerged from what is conceptualised as CBE in basic nursing education in South Africa. A middle range theory in the context of this study is a theory that is made up of limited concepts and propositions, written at more concrete and specific levels. It encompasses a limited scope with a number of variables, which are testable in a direct manner. In the theory of this nature propositions are clear, and testable hypotheses can be derived (Merton in Wilson, 1989).

The theory presented in this chapter builds on the theoretical schema provided in the previous two chapters. It provides an interpretive explanation of the phenomenon CBE in nursing education in the South African context. Neumann (2000) maintained, “the purpose of *interpretive explanation* is to foster understanding” (p. 58). This is precisely what the researcher attempts to achieve in this study.

Glaser (1992) warned that when using Strauss and Corbin’s grounded theory approach the results might yield full conceptual descriptions at the expense of theory development. Kendall (1999), from her own experience, also cautioned researchers that Glaser’s concern about using Strauss and Corbin’s paradigm model might be true. According to Kendall (1999), to avoid ending up with conceptual descriptions rather than a

theory, researchers should move beyond fitting categories in Strauss and Corbin's paradigm model, into conceptualisation and theorizing.

To ensure the quality of an emergent theory, the researcher strived to make certain that the developed theory meets Strauss and Corbin's (1990) four central criteria for a good theory (fit, understanding, generality, and control). According to Strauss and Corbin (1990), the theory should (a) fit the area of study, provided it has been carefully derived from diverse data and is faithful to the everyday reality of the area, (b) provide understanding, and be comprehensible to both the persons studied and others involved in the area, (c) provide generality, given that the data are comprehensive, the interpretation conceptual and broad, the theory includes extensive variation, and is abstract enough to be applicable to a wide variety of contexts in the area, and (d) provide control, in the sense of stating the conditions under which the theory applies and provides a basis for action in the area.

According to Chinn and Jacobs (1987) "not all things labelled 'theory' qualify as theory by any reasonable definition, and what is accepted as a theory in one discipline may not be considered theory in another" (p. 115). According to these authors it is therefore important to provide a definition of the term 'theory' in relation to the context within which it is used. In the context of this study the researcher used Chinn and Jacob's (1987) definition; "A theory is a set of definitions, concepts, and propositions that project a systematic view of a phenomenon by designating specific interrelationships among concepts for purposes of describing, explaining and predicting" (p. 115).

Embedded in Chinn and Jacobs' (1987) definition of the term 'theory' are six components of a theory, which include (a) goals of a theory, which are described as the general purposes for which the theory is developing, and suggested boundaries to which the

theory applies, (b) concepts, which are described as symbolic representations of reality, serving as building blocks of a theory, (c) definition, defining concepts to clarify their meaning in relation to the developed theory, (d) relationship statements, the statement providing linkages between concepts, (e) theory structure, which gives the overall form to the conceptual relationships within it, and (f) assumptions, which are basic givens, or accepted truths, that are fundamental to theoretical reasoning. According to Chinn and Jacobs (1987) and Fawcett (1984) the components of a theory are useful in the analysis of the existing theory, as they are embedded within a theory when it is being developed. In other words, when these concepts are used for analysis purposes, the theory is broken down looking for these components. In this chapter the researcher attempted to present the CBE theory in an understandable manner. Struebert and Carpenter (1995) asserted, “ A good report reflects a theory in ways that allow the outsider to grasp its meaning and apply its concepts” (p.159)

According to Fawcett (1984), each discipline singles out its own meta-paradigm, which is used in developing a theory in that specific discipline. This paradigm consists of specific concepts or themes around which the theory is developed. In this particular study, the framework for educational analysis presented by Tanner and Tanner (1995), which includes (a) nature of the curriculum, (b) nature of knowledge, (c) teaching/learning process, (d) nature of the teacher, and (f) nature of the learner is used to explicate the educative process.

The Goals of a CBE Model in Basic Nursing Education

The community-based education theory in this study is aimed at providing a

framework to guide the practice of CBE in basic nursing education in South Africa. As an explanatory theory, it is aimed at providing an explanation of CBE in basic nursing education in South Africa. This theory could be used to guide the efforts of those nursing education institutions planning to initiate CBE programmes, as most of the existing programmes, according to the participants in this study, were developed through trial and error. It could be used to evaluate the existing CBE curricula. It could also contribute to the limited theoretical or scientific body of knowledge in CBE as reported by many authors (Hamad, 1991; Jinadu, 1992; Magzoub & Schmidt, 2000; Towle, 1992).

The Concepts of a CBE Theory

Regarding the definition of concepts, Chinn and Jacobs (1987) stated that theorists define words or concepts by how they are utilized within a theory (relatively associative definition) and other theorists define terms specifically by what they mean (relatively specific definition). The researcher in this theory defined the substantive concepts of CBE in a relatively associative manner in order to bring an understanding of how CBE is conceptualised in this particular CBE theory.

CBE in Basic Nursing Education

As the phenomenon of interest in this study, CBE in basic nursing education is treated as the main concept in this theory, with all other major concepts linked to it. The major concepts which were linked directly to CBE included (a) relevant education, (b) responsive education, (c) education for social justice, (d) education as a conscious and deliberate PHC socialization process, and (e) a process-outcomes oriented education. The

first four major concepts developed as characteristics of CBE in basic nursing education in South Africa. CBE as a process-outcomes oriented education, as another major concept, developed as having a crucial role in the realisation of the phenomenon CBE in basic nursing education: it describes an educative process that needs to be in place for any nursing education programme worthy of the term CBE programme in SA. **See Figure 7.**

CBE as Relevant Education

CBE is education that promotes **relevance** in nursing education, in that through CBE basic nursing education is able to produce graduates with relevant knowledge, skills and attitude to meet the needs of all communities and the needs of the health care system. It is able to produce graduates who are equipped to serve in PHC settings, and are likely to be willing to serve in rural and under-resourced health-care settings. Through a conscious and deliberate socialisation of nursing students, very early and throughout the duration of the education programme, it is hoped that the outcome will be the production of PHC competent graduates.

CBE as a Conscious and Deliberate PHC Socialization Process

Although conceptualisations of CBE vary in basic nursing education in South Africa, there are, however, four common core characteristics distinguishing CBE in basic nursing education. These incorporate (a) the primacy of the community as a learning environment, (b) timing of first community exposure, (c) frequency, duration and sequencing of community based learning experiences and (d) service provision. The latter has already been dealt with under the subsection 'Education for social justice'.

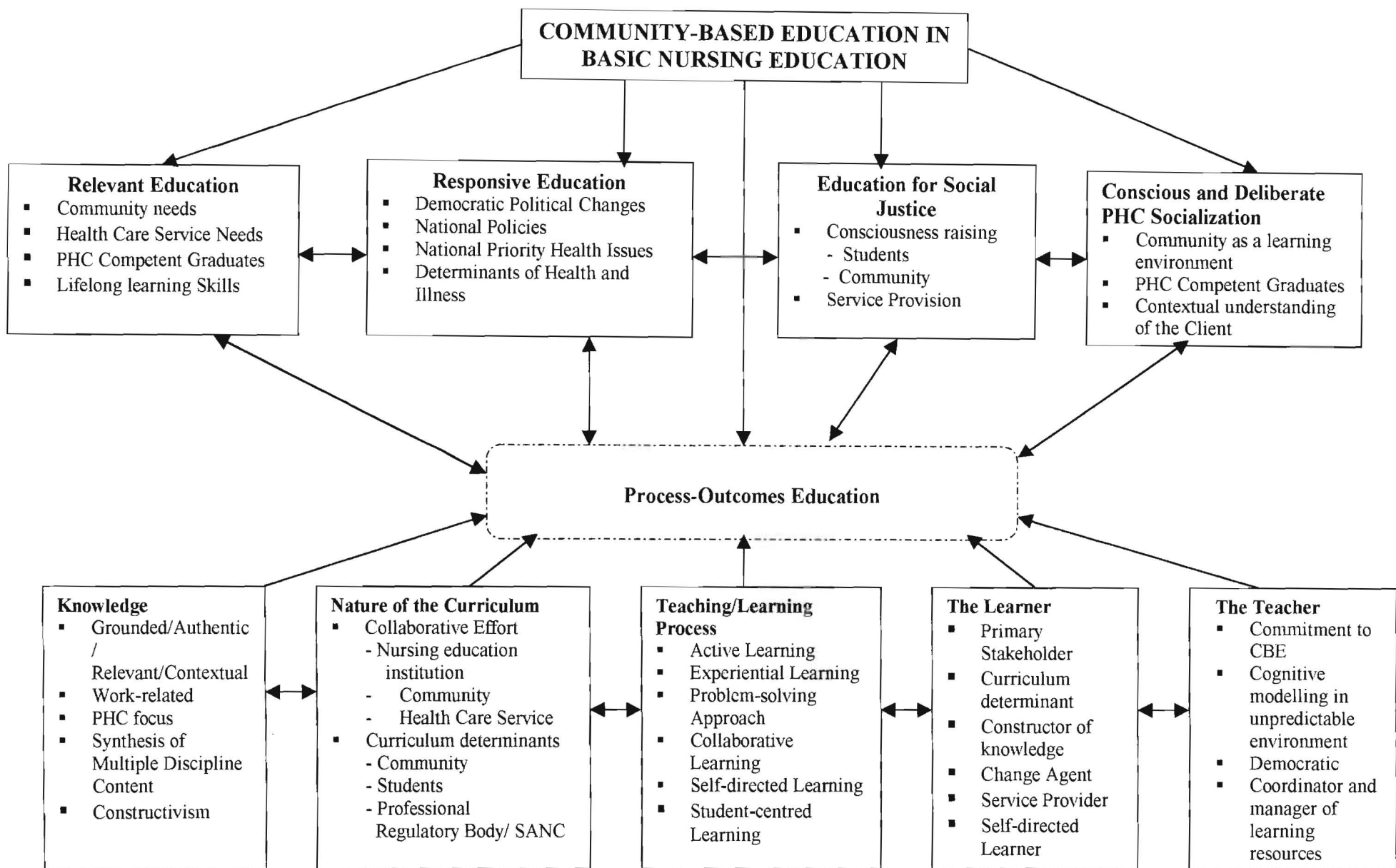


Figure 7: A Conceptual Model of Community-Based Nursing Education In South Africa

Firstly, regarding the primacy of the community as a learning environment. This learning environment provides the setting where the consciousness of students and community members on socio-political, economic and cultural issues in the community impacting on health is raised. The students in this clinical learning environment are exposed to those learning experiences, which are only found in community settings. This learning environment provides a holistic and contextualised view of a client, who is met in his/her natural setting. The community settings used (under-resourced settings) facilitate the conceptualisation of PHC as they provide a rich environment for PHC learning experiences. Secondly, CBE is characterised by early exposure to community settings to ensure early socialisation of students to realities in the community and to PHC. It is believed that at this early stage in the programme the students are more receptive to changes and new ideologies. This is the phase in the curriculum where students are still able to identify with the community's perspective on issues, and where the students have not been introduced to curative focused care. It is hoped that students would develop early the interest in working in these settings, especially because the community settings selected are those where services provided by the students are highly appreciated.

Thirdly, CBE is distinguished by the duration, frequency and sequencing of community-based learning experiences. The students in a CBE curriculum should be repeatedly exposed to community settings to familiarise them with the environment where they are prepared to practice after graduation, to build and reinforce a strong PHC foundation and to develop in them an interest in practising in such settings. Further, the students' understanding of the socio-political, economic and cultural factors influencing

health is enhanced through repeated exposure. Sequencing of learning experiences in a CBE curriculum gives a holistic view of the client, from the healthy client in the community or primary health care settings, to secondary and tertiary health care settings. Following the client through all these settings develops the students in such a way, that by the time they are placed in hospitals, they are able to provide relevant care and health education. Sequencing of learning experiences allows for the placement of the students at all levels of health care, facilitating the development of competencies required at each level of health care. Such sequencing of learning experiences also facilitates the understanding of how the health care system in South Africa operates or functions.

CBE as Responsive Education

In the context of this model CBE as responsive education is education that responds to the national policies, national priority health needs and prevalent community needs. It is able to respond to the needs of individuals and their families, and to community needs, but it is determined by the nature of the educative process, that is, the nature of the curriculum, the teaching learning process, the nature of the teacher and the nature of the learner. A responsive nursing education curriculum is derived from the context in which it operates, the national health and education policies, the community, the learner and the requirements of the professional regulatory body. In this sense, CBE as responsive education is used as a government instrument to facilitate the implementation of national policies and to bring about change in the country, in the surrounding communities and in the health care systems. The teacher and the students in such education are regarded as change agents. CBE is viewed as a means to bring about transformation in nursing education to ensure that it is in

line with the policies of the government, for example the current national PHC policy in South Africa.

CBE as Education for Social Justice

CBE is depicted as education for social justice as a result of its strong emphasis on service provision and learning through serving communities. By providing service to under-resourced and rural communities, the students are exposed to social injustices which arise mainly from the issues of inequality, issues that are regarded as undeniably linked to health problems prevalent in the communities. In Freire's (1972) language, in this type of education, the students in community settings engage in emancipatory inquiries, that are aimed at seeking to understand oppression from the community's perspective, not to understand oppression from a book's perspective. This process is aimed at bringing about change, which is the goal of emancipatory inquiry according to Freire. Oppression in the context of this study may be in a form of social or health problems as a result of unequal distribution, or lack of resources due to social injustices, it might be lack of information or illiteracy on health issues, and lack of knowledge of those factors (psycho-socio, political, economic, and cultural factors) contributing to health and disease in the community due to illiteracy as a consequence of social injustices, or may be due to fear of challenging the status quo. The students have a responsibility to make the community members aware of these issues affecting their health, and to assist the communities in changing these situations.

CBE therefore raises the consciousness of students to issues confronting communities; issues such as poverty, homelessness, high crime rate, malnutrition, teenage

pregnancies, child abuse, drug and alcohol abuse, and many other contemporary issues which impact on health. As the students explore these issues, they are also being equipped to raise the consciousness of the community members to them, with the intention of influencing the community to confront these situations in order to have better communities. Interacting with the affected communities, and learning through providing service to them facilitates the development of interest in social justice issues, and some students are likely to develop commitment and compassion in serving such communities.

The preceding paragraphs illustrate the meaning of CBE in basic nursing education in South Africa. Essentially it is believed that none of the concepts presented as core concepts of the concept CBE is independent. Instead they are all linked to constitute what is practised as CBE in nursing education in the country. Nevertheless, as noted in the previous two chapters, educational relevance, education for social justice and educational responsiveness are only possible when educational programmes place emphasis on both the process and outcomes. The following is an explanation of the educative process in CBE. The major concept emanating from the data regarding the nature of a CBE educative process was education as process and outcomes.

Education as Process and Outcomes

CBE as process-outcomes driven education implies that both the process of learning and the outcomes of education are important. The sub-concepts that constitute the educative process in CBE include collaborative curriculum decision-making, grounded knowledge, active learning, skills development.

The meta-paradigm for educational theorizing, that is, (a) the nature of curriculum,

(b) the nature of knowledge, (c) the teaching/learning process, (d) the nature of the learner and (e) the nature of the teacher, is used to explain the sub-concepts emanating from the data on the educative process in CBE.

The nature of the curriculum. With regard to the **nature of the curriculum**, the curriculum is explained in terms of how it developed, the determinants of the curriculum, and the focus of the curriculum. The curriculum is a **collaborative effort** by all major stakeholders; the academic institution, the health care system and the community, to ensure that the developed curriculum is plausible, is fit for the purpose, and is implementable. It is crucial that the stakeholders have an input into the priority health issues to be included in the curriculum, are involved in decision-making regarding the competencies expected from the CBE graduate, and to have input into relevant learning experiences, as well as clinical learning sites where the expected competencies from the graduates will be developed. Involving the community and health service sector is essential because graduates of the CBE programmes will be serving in these settings. This theory of CBE Collaborative effort in curriculum planning and implementation is an effort to enhance social responsiveness and relevance of the curriculum to the national priority health issues, including the needs of the surrounding community and health care service. Furthermore, the curriculum is structured in such a way that a health to illness continuum is followed, that is, understanding the healthy individuals first in their natural environment, the family and community, and then individuals at secondary levels of health care, and later in tertiary levels of health care level with the focus on sick individuals.

The **curriculum determinants** in this model include (a) the community, (b) the students, and (c) the nursing education regulatory body (SANC). The community as one of

the curriculum determinants has an outstanding role in a CBE curriculum that is aimed at orientating and socializing the students in understanding community needs and problems from the community's perspective. The input from the community (a) enhances the relevance of the curriculum to the priority needs of the surrounding community, (b) ensures that the curriculum content is contextualised and unique as it is based on the needs of the surrounding community, and (c) ensures that the CBE curriculum is dynamic, and is based on the present, because of the changes taking place in the community. Involving community members as the source of a community-oriented curriculum is important, in that they are competent to identify their priority needs and problems, which might be different from those viewed by health professionals as priority issues. The input from the community ensures that problems and needs forming part of the curriculum are real problems and felt needs in the community.

The students are also regarded as sources of the curriculum, as their needs and interests are taken into consideration, thus making the curriculum a responsive one. It is, however, important to note that not all students' interests are taken into consideration in a CBE curriculum, but only those in line with the expected learning outcomes at a particular level, or those in line with graduate competencies.

The SANC as a nursing education regulatory body is another important determinant of the curriculum, and ensures that their policy directives are taken into consideration in a CBE curriculum so that it is relevant and responsive to the priority needs of the country. According to this particular CBE theory, the SANC works closely with the Department of Health to ensure that the priority needs of service are catered for in basic nursing education curricula. For example, the current SANC policy on PHC is in line with the Department of

Health's current policy on PHC. Hence, the emphasis in a CBE curriculum is on **PHC**, especially the health promotion and illness prevention aspects, as PHC is a priority issue in South Africa's health care system.

The teaching/learning process. In CBE, the teaching/learning process is characterised mainly by active learning, self-directed learning and collaborative learning. To reiterate, active learning in the context of this study refers to learning where students move away from being passive recipients of knowledge, to being active participants doing most of the work, learning through experience, engaging in problem-solving activities and knowledge construction exercises, as well as in the application of what has been learned, with teachers facilitating and directing the process of learning. Active learning makes a valuable contribution in developing transferable life skills highlighted under skills in

Figure 6.

Collaborative learning as part of the teaching/learning process, where students learn in groups, socialises the students to their professional roles in working in a team. It provides opportunities for the development of leadership skills and facilitates the understanding of different personalities encountered when functioning in teams.

The nature of knowledge. Knowledge in this CBE theory is regarded as knowledge if it is grounded on real life experiences in a clinical learning environment. Knowledge in the context of this CBE theory is socially constructed in communities of learning by the students under the guidance of the facilitator. Social constructivism is the dominant theory when it comes to knowledge construction. Factors contributing to the development of grounded knowledge include (a) rich authentic environments, such as community settings,

(b) communities of learning, as students learn in teams or small groups, and (c) authentic learning activities, real learning activities taking place in real life communities.

The clinical learning environment provides the context on which to base the knowledge: for example, the under-resourced communities provide a rich source of knowledge. The students, as part of their learning experiences, identify problems and needs in the community which are viewed as raw curriculum content to be refined in classroom setting through the process of knowledge construction. Grounded knowledge is socially constructed in that students analyse raw information direct from community learning environments in their small groups, sharing and exchanging ideas. The success of knowledge construction depends on dialogue, as all members of the team are expected to participate actively in this process so as to own the constructed knowledge.

As CBE is preparing students for their occupations through service rendering, learning activities both in the clinical learning environments and in the classrooms facilitate the development of **work-related knowledge**, especially because learning experiences have a PHC focus. Work-related knowledge is developed through authentic learning activities in which the students engage, activities such as health screening, health education, participation in immunisation programmes, growth monitoring programmes, nutrition programmes, and many other work related activities. Work-related knowledge is developed from the process of engaging in service rendering activities and later reflecting on those learning experience either in classrooms or during feedback sessions, to show learning that has taken place and gaps to be filled, if there are any. In this particular theory, knowledge developed is characterised by the synthesis of content from multiple disciplines in order to have a complete picture of the phenomenon of interest.

The nature of the learner. The learner in this theory is characterised by being a source of the curriculum, contributor to knowledge, service provider, change agent and a self-directed learner. The learners in this theory are regarded as primary stakeholders, as all CBE activities revolve around them, aiming at ensuring that the type of education provided to them is relevant, is responsive, prepares them for issues of social injustice, and give them a solid PHC foundation. Learners with such responsibilities are expected to be actively involved in learning and to be self-directed. As self-directed learners, they are expected to take responsibility for their own learning, with the teacher facilitating the learning process.

The nature of the teacher. The nature of the learning environment (community) used for teaching/learning purposes in this theory requires a teacher with a commitment to CBE, because of the unfamiliarity of this learning environment, as well as the changes in the responsibilities of the teacher as a result of the use of this learning setting. The teacher is characterised by cognitive modelling in an unpredictable learning environment, where learning depends on what emerges as a learning experience at that particular time. The teacher is therefore expected to be an innovative, creative and inquisitive person, who is a fast and critical thinker, with alternative solutions when the need arises, especially because the students learn through experiential learning.

The nature of the learner and the nature of the educative process require the teacher to demonstrate democratic leadership in managing the learning environment. Rather than actively teaching, this teacher encourages learners to learn actively, and to take a leading role in the teaching/learning process. Rather than providing knowledge the teacher,

facilitates the process of knowledge construction and only serves as a resource person, not a giver of information. The learners draw from his/her knowledge and expertise.

The teacher in this theory also has a responsibility to coordinate and manage learning resources. Responsibilities of the teacher in this regard include (a) selection of communities, (b) preparing communities for community-based learning activities, (c) initiating partnerships with communities, (d) negotiation and facilitating community entry, (e) ensuring that learning resources are readily available to the learners, and that they are relevant to their learning needs, (f) communicating with other partners who are assisting in the learning of the students.

The teacher in this theory has a major contribution in the educative process. This teacher has an influence on the nature of the curriculum as he/she ensures that the content is relevant, and is drawn from community needs and problems. This teacher facilitates the process of knowledge construction, to ensure that the knowledge constructed meets the criteria of the nature of knowledge in a CBE curriculum. The success of a teaching/process depends heavily on the nature of the teacher, with the teacher working in partnership with the learner.

Basic Assumptions

A number of assumptions presented below formed the basis of the presented theory of CBE in basic nursing education.

Education is a Social Instrument

Education as a social instrument addresses social needs and problems, with the intention of bringing about change in society. Central to education, as a social instrument, is

the social relevance of education and social responsibility. Social relevance in such education is viewed in terms of education addressing the needs and problems of society. The learners are socialized in being socially responsible; in developing knowledge, skills and attitude required as responsible citizens, such as appreciating diversity, valuing cultural differences, solving problems cooperatively, thinking creatively and critically and making responsible decisions and accounting for them.

Education is a Political Instrument

Education is a powerful political instrument used to bring about change in the country, in the health care system and in communities. As politics is associated with power, those in power fulfil their visions and missions through education, using learners and teachers as change agents. In education there is a high possibility of being unaware of subliminal indoctrination, because it is a given fact that education of this nature has to be in line with the policies of the government of the day. Education as a political instrument facilitates the implementation of national policies, enhances knowledge and understanding of the workings of the political system, and, in a democratic country, promotes democratic values and practices. The ultimate aim of education as a political instrument is to serve the interests of the government of the day.

Education is a Collaborative Effort

Education is a collaborative effort with all stakeholders represented, the community, the academic institution, and the health service sector. Collaboration, along

with the emphasis on community involvement, is the centre of community-based education. Collaboration improves the quality of education and the quality of the graduate produced.

Education is a Process and an Outcome

As a process-oriented education, CBE facilitates the development of skills essential to a satisfying and productive life, which will benefit individuals themselves, as well as society. An education of such nature facilitates the development of skills fundamental in dealing effectively with different situations and events in a variety settings. Acquisition of skills is regarded as essential in a world where it is impossible to cope with knowledge explosion, where societies and their needs and problems are changing rapidly, where individuals are expected to serve societies with diverse needs. Process-oriented education, therefore, enables individuals to adapt to these life demands, as skills are regarded as more widely applicable than knowledge and information, and the more the individuals use their skills the better is the service they provide, unlike knowledge that becomes obsolete after some time.

Knowledge is a Tentative, Subjective, Dynamic and Contextualised Information with a Utilitarian Value at a specific time and in a Specific Situation

According to this CBE theory knowledge is knowledge only if it is grounded on experience, contextualised, socially constructed, and meaningful to the constructors of knowledge. Knowledge arises from the process of meaning-making, otherwise, if it is transmitted to passive conformist learners, it is regarded as information. Knowledge results from engaging in a process of meaning-making, which according to Cole (1976) is the act

of applying one's skills to the organization of information, experience, and behaviour.

According to this author, this act of meaning-making includes exploring, experiencing, problem-solving, and building content and knowledge from experience. The end product of this act is what is viewed as knowledge.

Education is also outcomes oriented, as it places more emphasis on the outcomes, the nature of the graduate to be produced. In order to achieve the desired exit outcomes, all learning activities are organised in such a way that they build on others, advancing at each level in the programme. Level or unit outcomes are developed to fit into the larger picture of exit outcomes. As a learner progresses in the programme the learning outcomes also advance to show the level of growth. The process of learning is regarded as important because it facilitates development and growth of the learner as he/she is working towards achieving the desired outcomes. The learner in education of this nature participates actively in the learning process and directs his/her own learning, with the teacher facilitating the learning process.

The Curriculum Has a Capacity to be Relevant.

The curriculum may possibly have personal relevance, social relevance and political relevance. Relevance is determined by needs addressed in that curriculum. The needs may be the needs of society, government, individuals and/or learners.

Learning is a Natural and a Creative Process

The intrinsic motivation to learn makes learning natural, as one has that natural inclination to engage in an investigative action, seeking meaning from the new experience,

as stated in Cole (1976). Relevance, especially personal relevance, contributes to making learning more natural, in that what is to be learned has a personal value to the individual, who therefore has a strong desire to explore.

Creativity comes forth during the process of knowledge construction and meaning-making, where students take an active role, with the teacher in the background facilitating and directing learning. As the students interact, engage in a dialogue, thinking through unfamiliar concepts, taking context into consideration, with all members of the team actively participating, drawing from their pool of previous experience, integrating the past with the present, utilizing information from a number of disciplines, and applying information from cultural heritage to the present to create meaning, learning becomes a creative process. The outcome of this process is a unique product (knowledge) creatively constructed by the community of learners.

Skills are the Basis for Learning During the Learning Process

In the context of meaning making, skills serve as means by which individuals construct responses and purposeful actions towards the goals of meaning making. They use skills such as problem-solving, creative and critical thinking, communication skills, and many other important skills. Preparing learners for such learning processes requires them to acquire skills in identifying resources and accessing information independently from those identified resources.

The nature of learning experiences, and the clinical learning environment used, have a direct influence on the graduate produced. The nature of the educative process is closely in line with the outcomes of education.

Further Recommended Research

As this was a groundbreaking study on the meaning of CBE in basic nursing education in South Africa, a number of possibilities for further research were acknowledged.

The newly developed tentative theory in this study requires testing to ensure its validity. As the purpose of this study was to develop a theory to guide the practice of CBE in basic nursing education in South Africa, and to contribute to the body of knowledge in this area nationally and internationally, testing of this theory might open an opportunity for this tentative theory to move to a higher level of a substantive theory, where it can be recognised and used in practice settings.

The study revealed that the participating nursing education institutions were assisted by experts from abroad in the process of adopting CBE. Involvement of experts from abroad might have an influence on the current meaning attached to what is practiced as CBE in basic nursing education in South Africa. There is a need for a study that will include those institutions that were assisted by local universities in their process of change, especially because the universities that assisted in these new CBE programmes had experiences of what did not work in their institutions, different from those experiences introduced by international experts.

The researcher in this particular study used Strauss and Corbin's grounded theory approach. As there is another grounded theory approach by Glaser that has outstanding differences from that of Strauss and Corbin, a study using Glaser's grounded theory approach might contribute significantly in the area of CBE in basic nursing education in South Africa.

This study included only nursing education institutions and policy makers, community members, students and/or CBE graduates were not involved. Although a study of this nature and capacity would demand more funding, a collaborative team of researchers, and more time, it would have the potential to provide richer findings and suggest future directions for CBE inclusive of the views of all stakeholders.

This study showed that there is concern about the understanding of true partnership in the context of CBE in South Africa. Investigating experiences and epistemological understanding of true partnership in the context of CBE might contribute significantly because partnership is the core of CBE.

The results also showed that CBE is a governmental policy, but the role of the government is not well defined when it comes to the implementation of CBE. From the discussion of results it became clear that local governments assisted in the best way they knew how. A small-scale study that could focus on the role of different stakeholders, including the government and the students might assist in the implementation of CBE.

The findings in this study pointed out other important issues which were however not addressed in this particular study because they were not a primary focus in this study. For example there was an issue of (a) sustainability of CBE in a multi-lingual and multi-cultural society such as South Africa, as CBE requires close working relationships with the surrounding multi-cultural and multi-lingual communities, (b) cost effectiveness of CBE, especially in a developing country such as South Africa, as it was reported that other institutions had to employ academic staff that had an understanding of the language and culture of the surrounding community to assist in preparing these communities for their roles in CBE, (c) quality measurement systems in place especially in academic institutions

relying on the use of community health workers in community-based learning settings. An investigation on how the quality of education is ensured in these institutions is recommended because academic institutions have an obligation and a responsibility to provide quality education to the students.

Limitations of the Study

According to Burns and Grove (1997) limitations of a study “are restrictions in a study that might decrease the generalizability of the findings” (p.49). These restrictions may be either theoretical or methodological. In this report they are categorised into limitations with regard to (a) relevant literature, (b) methodology, (c) participants, and (d) data collection.

Limitations with regard to relevant literature. Obtaining relevant empirical literature on CBE presented a problem locally and internationally, as CBE is still a new phenomenon that is not yet well researched. There was scanty literature with in-depth knowledge, yet such is required to provide a broad background and understanding of the phenomenon of interest in this study. Most of the literature provided only descriptions of existing CBE programmes and other articles were position papers on CBE.

Limitations regarding the methodology. There is a limited number of experts in the area of grounded theory research. Accessing available experts as and when there was a need posed a problem because of their busy work commitments. It was, however, possible to access the experts when they were available.

Limitations regarding data collection. Firstly, the placement of the students in communities for their community-based learning experiences varied in different

institutions. As a result the researcher had to ignore her scheduled work plan on when to do observations, and visit the institutions at times suitable to them. Secondly, participants in other institutions had problems in honouring their appointments because of their busy work schedule. They only managed to fit in the researcher when they had time and sometimes they were interrupted during interviews. In such instances the researcher had to re-schedule appointments with the participants for other suitable times. Thirdly, in some of the nursing education institutions, owing to high staff turnover there were new recruits who had only limited information on the phenomenon of interest. In such cases, minutes of meetings that were held on the introduction of the programme, as well as old programme documents which were used on inception of the programme and periodic reports on the programme were used to verify information provided by new recruits who participated in the study.

Language. Language barrier was another limitation, especially in community settings, as South Africa has more than eleven official languages. In some community settings the students were communicating with community members in SeSotho, SeTswana, Afrikaans, Shangane, SiPedi, Xhosa, and many other languages. That posed a problem to the researcher as it was possible for her to miss out on some important information. The facilitators and the students, however, assisted by explaining some aspects of the conversation which were not clear to the researcher. This might weaken the findings in this study if some of the information was not properly interpreted to the researcher.

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ANNEXURE A

Research Permission from Policy Makers

School of Nursing
Faculty of Community and Development Disciplines

Durban 4041 South Africa
Telephone: +27 (0)31 260 2499
Facsimile: +27 (0)31 260 1543

21 June 2001

The President
South African Nursing Council
602 Pretorius Street
Acadia, Pretoria
0001

Dear Madam

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

I am a Ph. D. student at the University of Natal, School of Nursing. I am requesting permission to have access to the SANC education committee members. The title of the proposed research study is "A Grounded Theory Analysis of the meaning of Community-based education (CBE) in basic nursing education in South Africa".


Included within this mailing is an abridged research proposal and ethical clearance from the University of Natal's Research Ethics Committee. If the SANC grants me the permission to conduct this proposed study, I would appreciate having the Education Committee meeting dates so as to know the dates that may be convenient for data collection. I have planned to initially interview the chair of the education committee and then all those that may contribute in this study.

I guarantee that participation will be voluntary, anonymity and confidentiality will be maintained throughout.

It will be highly appreciated if my request receives your favorable consideration

Yours sincerely

Ntombifkile Gloria Mtshali



Research Supervisor: Prof. N.S. Gwele



The South African

NURSING COUNCIL

Your ref:
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12791976

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*The Nursing Council was
established under the
Nursing Act, 1978*

15 November 2001

Ms N G Mtshali
University of Natal School of Nursing
Faculty of Community and Development Disciplines
DURBAN
4041

Dear Ms Mtshali

**APPLICATION FOR PERMISSION TO CONDUCT
RESEARCH**

Your letter dated 18 September 2001 has reference.

Council at its meeting held on 7 November 2001 granted you permission to conduct your proposed research i.e. conducting interviews during Education Committee Meetings.

It might not be feasible to conduct interviews during meetings. Perhaps you should consider interviewing Council members the evening prior to the first day of the meeting or after the first day of the meeting.

Education Committee meetings will be held on the following dates:

- ◆ 9 - 10 January 2002
- ◆ 12 - 13 February 2002
- ◆ 3 - 4 April 2002
- ◆ 7 - 8 May 2002
- ◆ 18 - 19 June 2002
- ◆ 20 - 21 August 2002
- ◆ 17 - 18 September 2002

The following Council members constitute the Education Committee. It might be useful to communicate directly with them in order to make the necessary arrangements:

1. Prof M J Viljoen (Chairperson)
Tel: (051) 401 2247

2. Mrs L J Maqqa (Deputy Chairperson)
Tel: (043) 709 2049
2007.

3. Mrs G E Babuseng
Tel: (053) 8300 828

4. Mrs N E Bhengu
Tel: (011) 355 3450

5. Mr S Mafanya
Tel: (040) 609 2751

6. Mrs T S Manganye
Tel: (012) 312 0727

7. Ms V M P Mentor
Tel: (053) 830 1600

8. Prof L Uys
Tel: (031) 260 2075

Wishing you success in your studies and wishing you a Merry Xmas and a Prosperous New Year.

Kind regards



DR GRACE RAMADI
DEPUTY REGISTRAR

ANNEXURE B

Research Permission from Nursing Education

Institutions

13 June 2001
The Head of the School
University of Free State
P. O. Box 339
Bloemfontein
9300

Dear Madam

**APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN
YOUR DEPARTMENT**

I am a Ph. D. student at the University of Natal, School of Nursing. I am requesting a permission to conduct a research project in your department. The research title of the proposed study is "A Grounded Theory Analysis of the meaning of Community-based education (CBE) in basic nursing education in South Africa". The selection of participants in the study will depend on how your department's CBE programme is structured. I have planned to initially request level or subject coordinators and CBE programme director or the head of the nursing school to participate in the study, then if the need arise to collect data from all those who can contribute in this study.

Included within this mailing is an abridged research proposal and ethical clearance from the University of Natal's Research Ethics Committee. If your school grants me the permission to conduct this proposed study I would appreciate having your school's CBE programme structure, the timing of the placement of the students in the community and the nature of community-based learning activities. Having such information will enable me to plan when to collect data in your institutions.

I guarantee that participation will be voluntary, anonymity and confidentiality will be maintained throughout.

It will be highly appreciated if my request receives your favorable consideration

Yours sincerely

Ntombifikile Gloria Mtshali

Prof. N.S. Gwele

Research Supervisor

13 June 2001

The Head of the School
University of Natal, School of Nursing
P/Bag X10
DURBAN
4010

Dear Madam

**APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT IN
YOUR DEPARTMENT**

I am a Ph. D. student at the University of Natal, School of Nursing. I am requesting a permission to conduct a research project in your department. The research title of the proposed study is "A Grounded Theory Analysis of the meaning of Community-based education (CBE) in basic nursing education in South Africa". The selection of participants in the study will depend on how your department's CBE programme is structured. I have planned to initially request level or subject coordinators and CBE programme director or the head of the nursing school to participate in the study, then if the need arise to collect data from all those who can contribute in this study.


Included within this mailing is an abridged research proposal and ethical clearance from the University of Natal's Research Ethics Committee. If the school grants me the permission to conduct this proposed study I would appreciate having your school's CBE programme structure, the timing of the placement of the students in the community and the nature of community-based learning activities. Having such information will enable me to plan when to collect data in your institutions.

I guarantee that participation will be voluntary, anonymity and confidentiality will be maintained throughout.

It will be highly appreciated if my request receives your favorable consideration

Yours sincerely

Ntombifikile Gloria Mtshali


Prof. N.S. Gwele


Research Supervisor



14th January 2002

Ms NG Mtshali
School of Nursing
University of Natal
Durban
4041
Facsimile: 031-2601543

Dear Ms Mthali

PERMISSION TO CONDUCT A RESEARCH PROJECT.

Your application for permission to conduct a research project, dated 9th November 2001 refers:

Permission is hereby granted to conduct the research project at the Department of Nursing Education, University of the Witwatersrand. The person to contact is Mrs Gayle Langley (011) 488-4270 who will assist you with coordination at Wits.

Best wishes with your study.

Yours sincerely,

Professor HC Klopper
Head: Department of Nursing Education

School of Nursing
Faculty of Community and Development Disciplines

Durban 4041 South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

4th December, 2001

Ms N G Mtshali
School of Nursing
University of Natal
DURBAN
4041

Dear Ms Mtshali

PERMISSION TO CONDUCT RESEARCH

Your request to conduct research "A grounded theory analysis of the meaning of Community-based Education in basic nursing education in South Africa" pertains.

As far as I am concerned, we would gladly participate in the study. Please approach individual staff members to request their involvement. They have a choice to participate or not, as have the students.

Best wishes for your research.

Sincerely

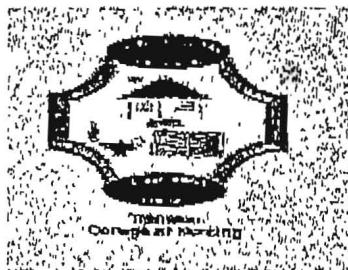


PROFESSOR L R UYS
(HEAD OF SCHOOL)

HEALTH & WELFARE UMTATA
NO. 607

**EASTERN CAPE GOVERNMENT
DEPARTMENT OF HEALTH
TRANSKEI COLLEGE OF NURSING**

TEL : 047 - 5314288
FAX : 047 - 5311158



PRIVATE BAG X5064
UMTATA
EASTERN CAPE
5100

Date: ...24.01.2002.

**TRANSKEI COLLEGE
OF NURSING**

2002 - 24

P/BAG X5064, UMTATA 5100

Ms N.G. Mtshali
School of Nursing
Faculty of Community and development Disciplines
DURBAN
4041

Madam

**APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT
AT TRANSKEI COLLEGE OF NURSING + CAMPUSES : MS N.G. MTSHALI.**

I hereby acknowledge receipt of your letter.

The College is agreeable to your request.
The Provincial Office at Bisho has been notified, No Objection.
Kindly furnish us with the dates of your visit.

Yours faithfully


P.MIZA : PRINCIPAL
TRANSKEI COLLEGE OF NURSING

ATTENTION Ms MTSHALI

PROVINCE OF THE EASTERN CAPE

Department of Health (Eastern Region)		Isebe LeZempilo Private Bag X5014 UMTATA
Ref No.	Enquiries: <i>K. Nonxuba</i>	UMTATA GENERAL HOSPITAL Tel. (047) 5013284 Date: 06.03.2002 Fax. (047)

**The Principal
Transkei College of Nursing
UMTATA**

Dear Madam,

Ms MTSHALIS VISIT :- C.B.E. :- UMTATA CAMPUS:

I hereby wish to report that 2nd year students will be going out to the Community in March and April '2002', The 24 and 25 April is considered convenient for Ms Mtshalis visit.

May I also take this opportunity to report that towards end of '2001' the Campus started off a fresh community entry with Dosi Location, in view of problems encountered with Payne Location.

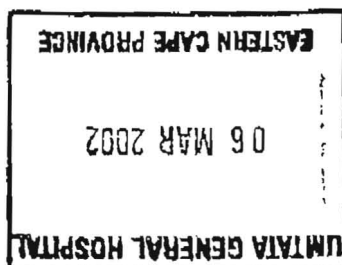
Dosi Location is under Lindile Administrative Area.

Umtata Campus students will now use this Community, from April '2002'. This change has been highlighted in the annual report.

Yours faithfully,

K.N. Nonxuba

K.N. Nonxuba R.T.



TRANSKEI COLLEGE
OF NURSING
2002 -03- 14
P/BAG X5064, UMTATA 5100
RECEIVED

Province of the Eastern Cape / Iphondo Lempuma Koloni
Department of Health / Isebe LeZempilo

ST BARNABAS' HOSPITAL / ISIBHEDLELE (NTLAZA)

TEL: (047) 555 1010/1/2
FAX: (047) 555 1013
EMAIL: nava@venturenet.co.za

ENQUIRIES : Ms Ntloko

REF. NO. :



ST BARNABAS HOSPITAL ^{CAMPUS}
P.O. BOX 15
ISIBHODE
5160

DATE: 17.04.2002.....

The Principal
Transkei Nursing College
UMTATA
5100

Madam

Re-VISIT BY RESEARCHER MS MTSHALI

St. Barnabas Campus would like the researcher to visit us on the 25 April 2002.

Thank you.

Yours faithfully

F.V. Ntloko (Act. Campus Head)

[Handwritten signature]
02/04/19

TRANSKEI COLLEGE
OF NURSING
2002-04-19
P/BAG X5054, UMTATA 5100
RECEIVED



Iphondo Lwempuma-koloni Province of the Eastern Cape Provinsie Oos -Kaap
ISEBE LEZEMPILO : DEPARTMENT OF HEALTH
DEPARTMENT VAN GESONDHEID
Ingxowa Eyodwa Private Bag/ Privaatsak X6038, BISHO 5605 SOUTH AFRICA

BATHO PELE
(Abantu Kuqala, People First)

Ireferensi :
Ref. No. :

Imibuzo :
Enquiries : Mrs Sitsha

Tel. No. : 040-6093436

Fax No. : 040-6351132

Cell no. : 082 5701346
e mail: sitshan@impilo.ecape.gov.za

Ingxowa Eyodwa
Private Bag x0038
BISHO 5605
10 July 2001

Ms N.G. Mtshali
School of Nursing
University of Natal
DURBAN 4041

Dear Ms Mtshali

PERMISSION TO CONDUCT RESEARCH

Your application for permission to conduct research at Frere Nursing College is acknowledged.

The application is approved.

It will be greatly appreciated when, at the completion of your studies, a copy of the thesis is made available to the department.

ACTING DIRECTOR: NURSING

IPHONDO LEMPUMA KOLONI

PROVINCE OF THE EASTERN CAPE

OFFICE OF M.E.C. FOR HEALTH AND WELFARE



FRERE NURSING COLLEGE

Private Bag X 9023

EAST LONDON

5200

Telephone: (043) 7092136

Fax: (043) 7434265

7092173

FAX FORM

TO: MRS. Mtshali

FAX NO: 031 260 1543

ATTENTION: Mrs. Mtshali

FROM: Felicia Mazwi

NUMBER OF PAGES: 2 DATE: 30.01.02

Mrs Mtshali
University of Natal

Fax : 031-2601543

Dear Mrs Mtshali

PERMISSION TO CONDUCT A RESEARCH PROJECT

It gives me pleasure to inform you that the College Management has agreed to give you permission to conduct a research project in our Institution.

Attached please find dates that you could choose from.

Thank you

Mrs F Mazwi
Acting College Head

ANNEXURE B

Research Permission from Nursing Education Institutions

NURSE EDUCATORS' INTERVIEW GUIDE

1. What were the driving forces behind the adoption of CBE in this institution?
2. What is the nursing education institution aiming to achieve with this new programme?
3. What competencies are expected from the graduate of this new programme?
4. What learning experiences facilitate the development of these competencies?
5. Regarding teaching/learning, what is the role of the facilitator, student and the community?
6. Tell me more about the new CBE curriculum/programme.
7. Tell me about other stakeholders who are involved in your school's CBE programme.
8. What is your understanding of this term, CBE?
9. What are your comments about the existing CBE curricula?

SANC EDUCATION COMMITTEE INTERVIEW GUIDE

In the 1999 Discussion Document on "Education and Training of Professional Nurses in South Africa: Transforming Nursing Education" the SANC referred to CBE as the key to the call for nurses who can provide PHC effectively as required by the Department of Health.

1. What was the meaning of this statement?
2. When the SANC refers to a CBE what does it mean?
3. What was the reason behind the SANC's call for nursing institutions to the change from hospital-based education to CBE?
4. What competencies is the SANC expecting from the CBE graduates.
5. How do you view the existing community based nursing education programme?

ANNEXURE B

Research Permission from Nursing Education Institutions

APPENDIX D.

NVivo revision 1.2.142

Licensee: ltd UND

Project: Meaning of CBE

User: Mtshalin3

Date: 2002/09/19 - 08:31:54

DOCUMENT CODING REPORT

Document: 5

Created: 2002/08/14 - 04:11:36

Modified: 2002/09/19 - 08:30:49

Description:

INTERVIEWEE 5: 09H15 10H00

Nodes in Set: All Free Nodes

Node 1 of 144 **CBE as learning in the community**

3: CBE is learning that takes place in the community.

Node 2 of 144 **CBE Context**

9: but it is a policy directive from the Government the National Health Policy that calls for the change to a PHC approach. CBE is one vehicle which can be used to implement PHC in our communities.

Node 3 of 144 **CBE Learning sites**

3: The learning site is important. It involves learning with the community.

Node 4 of 144 **Community involvement**

3: The communities are involved in the assessment of their needs.

Passage 2 of 4 Section 1, Para 7, 85 chars.

7: CBE says it is critical that we need to find out from the community what they need. *Passage 3 of 4* Section 1, Para 9, 162 chars.

9: the same applies to the communities; nurses as experts should not impose their ideas on the communities but should establish the needs of the community from them.

Passage 4 of 4 Section 1, Para 9, 92 chars.

9: communities should actively participate in the education of the nurses who will serve them.

Node 5 of 144 **Student Involvement**

Passage 1 of 1 Section 0, Para 3, 106 chars.

3: What is required in CBE is the involvement of the learners with the community identifying learning needs.

4: Node 6 of 144 **CBE Definition**

3: CBE is learning that takes place in the community.

Node 7 of 144 **Collaborative learning**

Passage 1 of 2 Section 0, Para 3, 51 chars.

3: Both the community and the learners are educands.

Passage 2 of 2 Section 0, Para 3, 96 chars.

3: Both participate in need assessment and they learn to deliver according to the identified needs.

Node 8 of 144 **Active learning**

Passage 1 of 1 Section 0, Para 3, 64 chars.

3: There are no imposed ideas to both the students and the learners

Node 9 of 144 **Respect-nursing value**

Passage 1 of 1 Section 0, Para 3, 119 chars.

3: The students do not impose their ideas on the community because the communities are not likely to accept imposed ideas.

Node 10 of 144 **Partnership**

Passage 1 of 1 Section 0, Para 3, 98 chars.

3: Both participate in need assessment and they learn to deliver according to the identified needs.

Node 11 of 144 **CBE Antecedent condition**

Passage 1 of 1 Section 1, Para 7, 273 chars.

7: CBE came as the realization that what has been happening was incorrect. Health professionals thought they knew the needs of the community, as a result prepared students based on what they thought were the needs of the community without any consultation with the community.

Node 12 of 144 **Irrelevance of nursing education**

Passage 1 of 2 Section 1, Para 7, 273 chars.

7: CBE came as the realization that what has been happening was incorrect. Health professionals thought they knew the needs of the community, as a result prepared students based on what they

thought were the needs of the community without any consultation with the community.

Passage 2 of 2 Section 1, Para 7, 98 chars.

7: Experts might bring what the community does not need and the disappointed when it is not accepted.

Node 13 of 144 **Importance of context**

Passage 1 of 1 Section 1, Para 7, 59 chars.

7: We do not go to the communities with pre conceived ideas. We need to learn from what is taking place in the community, so as to understand our client's context, and how it influences their health.

Node 14 of 144 **Student active involvement**

Passage 1 of 1 Section 1, Para 9, 140 chars.

9: Learners have to be involved in their learning. They need to actively participate. We need to run away from the teachers imposed education

Node 15 of 144 **CBE- Co learners**

Passage 1 of 1 Section 1, Para 9, 145 chars.

9: According to the traditional route the teacher knows everything but in CBE everyone is learning. The teachers also have things they do not know.

No other nodes in this set

code this document.