

Community members' views on Addis Ababa University's rural community health training program: A qualitative study

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Abstract

Background: Community-Based Education (CBE) is an educational process aiming to ensure educational relevance to community needs, thereby contributing to improved community health needs. Addis Ababa University runs a six-week long Rural Community Health Training Program at Adami Tulu District, East Shoa Zone. In the program, the final year medical students are attached to the community to apply their theoretical training and address the community's health problems. This study explored views of the local community about the program.

Methods: A descriptive qualitative study was carried out in Adami Tulu District of East Shoa Zone – the district is the site of the training program. Data was collected from community members, local administrators, health extension workers, school principals and opinion leaders selected from three kebeles within the attachment area. A total of five FGDs and six key informant interviews were conducted using a semi-structured interview guide. The audio-taped data was later transcribed verbatim and translated into English. Themes were developed guided by the objective of the study with the application of Open Code Version 4.02.

Results: The finding of the study revealed that the local community, beyond recognizing the participants as some kind of medical professionals from Addis Ababa University, knew very little about the program and its objectives. For example, the only benefit all the participants rightly mentioned in common, as evidence of their knowledge the program is free treatment for sick children by the students. Lack of communication between the university and local administration; absence of community involvement in the planning, execution and evaluation of the program; and problems related to language were identified as key areas for improvement.

Conclusion: The Rural Community Health Training Program (RCHTP) is an important resource for both the university and the local community. It is therefore important that the university take proactive measures and optimize the involvement of local leaders and community members to enhance their sense of ownership of the program. [*Ethiop. J. Health Dev.* 2018;32(1):10-17]

Key words: Community health, rural attachment, RCHTP, Ziway

Background

Community-Based Education is an educational process used to achieve educational relevance to meet community's needs. Community-Based Education consists of learning activities that extensively use the community as a learning environment. Students, teachers, members of the community, and other sectors are actively engaged in community-based education throughout the educational experience (1-3). The community-faculty apprenticeship model of clinical education provides students with an opportunity to realize patients' involvement in their own care process. The clinical education program also requires the students to be closely supervised in the process of the development of their competence as physicians (4).

Community-Based Education (CBE) programs follow such principles as community focus, community participation, intersectorial collaboration, multifaceted interventions, and community wide outcomes (5, 6). In the cases where the community seeks benefits from Community-Based Education programs in developing countries, the success of such programs have been documented (1,7). To date, community-based education is recognized as an important educational process in

medical education. It empowers graduates with skills and experience of community level health problems and ways to deal with them (3). Recent research findings from Sub-Saharan Africa indicate that many teaching institutions have plans to develop new technologies such as mobile platforms and eLearning to enhance teaching learning at CBE sites and facilitate rotations (8).

Rural Community Health Training Program of AAU at Ziway has been in operation for more than 40 years. The training program offers community-oriented education to prospective graduates of medicine. The general objectives of the program are to offer an integrated series of learning experiences which will sensitize medical students to health problems and prepare them to serve in a rural community setting. The program was also designed to enable medical students and other students of health sciences (such as pharmacy and laboratory technology) with the capacity to identify and prioritize community health problems, and plan appropriate interventions with the involvement of local community (9).

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The Rural Community Health Training Program is a six-week attachment where students get introduced to field activities in the areas of: community census; maternal and child health; nutrition and morbidity assessment; school surveys; research methods; and involvement in special health sector programs (such as TB/HIV and malaria control) within the locality. In addition, the program creates opportunities for the students to conduct group research using primary or secondary data (9).

In spite of the benefits of the field attachment to students and the community, very little has been done so far to explore the views of the local community about the program. This means that not much is known about what members of the community think and know about the purposes, benefits and challenges of the attachment program. This study has been designed in recognition of this lack. The objective of this study was therefore to explore views of the community living around the Health Training Program.

Methods

Study Approach and Setting: A qualitative descriptive study was carried out in Adami Tulu district of East Shoa. This district has been the site for AAU's RCHTP during the last four decades. The district is about 165 km south of Addis Ababa. The study focused on three purposely-selected non-adjacent villages within the district: Abune Germama, Buchesa and Edo Gojola.

Participants and Recruitment: Participants were chosen based on their permanent residence in the area for at least five years. They were among the people believed to know well about their community irrespective of their gender. The technique used for selecting the participants was a snowballing technique (10). Trained research assistants, guided by field facilitators from Batu Campus of Addis Ababa University, visited the villages and selected the participants from the three kebeles. Accordingly, local administrators, health extension workers, school principals, and community elders were among the participants used as data sources.

Data Collection: A total of five focus group discussions (i.e., three with male and two with female) were conducted during the data collection period. Participants were residents selected from the villages considered in the study. In addition, six key informant interviews with HEWs, school principal, and kebele administrators were conducted. The interview questions were mainly semi-structured, but some open-ended questions were occasionally used for further probing of responses.

Amharic was the language used during the interview. All the focus group discussions and interviews were carried in fairly noise-free places in the communities. The interviews and the FGDs were all audio-recorded, and later transcribed. Appropriate notes were also taken to capture things the audio machines could not pick up during the interviews and the group

discussions. Translators were used whenever respondents wished to use Afan Oromo, which is the language of the study setting. Debriefing was conducted at the end of each data collection day with data collectors to share preliminary findings and identify areas that needed further exploration.

Data Validation: The audio-recorded data was transcribed verbatim and later translated into English. The transcripts and translations were cross checked for accuracy and consistency. Translated notes were read and re-read by two independent coders who had qualitative research experience. Later, guided by the objective of the study, the coders identified themes and sub-themes from the data. Thematic analysis was applied using Open code version 4.02 software. Rigour of the findings were ensured following different approaches. For example, data were generated from different sources. Different data gathering instruments were also used. In addition, there were debriefing sessions every day during data collection. Efforts were also made to ensure consistency between the data before and after translation. The involvement of two independent coders to read the data and identify themes can also be mentioned among the efforts made to ensure validity of the data (11). A draft report of the research was sent to participants who served as supervisors during data collection. Comments obtained from the supervisors were considered in the final version of the report. Data reflecting common views of FGD participants were quoted verbatim. References were made to the sources of the excerpts extracted from the data.

Ethical Considerations: Ethical clearance was secured from the Research and Ethical Committee (REC) of School of Public Health, and verbal consent was obtained from each of the participant in the study. The objectives and importance of the study were explained to the participants before the the interview and the FGD discussions. All interviews were conducted in areas where the privacy of the study participants was maintained.

Findings

Participants' Background: The study participants vary in terms of age, sex, educational background, and occupation. The ages of the study participants vary from 24 to 68 years, 42 being the mean age of the participants. Other than one participant, all were married. The average family size of the participants was seven. Around two-thirds (26 out of 42) of the participants were male. All community representatives were farmers by occupation while others were health extension workers, kebele administrators, and school principals. With the exception of one participant, all the other community members who participated in the study did not either attend formal education or completed primary schools. Kebele administrators, however, had high school level educational background. Health Extension Workers (HEWs) and school principals who participated in the study had a diploma from TVT colleges.

The findings of this study are categorized and reported under four major themes: what is known about the Health' Training Program, perceived benefits of the program, impressions of the community about the Health' Training Program and areas of the program that need improvement.

What the People Know about the Program: What the participants know about the program in terms of the objectives, the timing or the schedule of the program and the students' activities during attachment are explained in the next sections.

The program and its Objectives: About two-thirds of the participants said that students from AAU visited the village to teach the community about health. However, one in ten participants considered the program as a routine government program in the locality while about three out of ten participants considered the health-training program as a research project from the University. One of the participants noted that; *"I know students from Addis Ababa University come to this village and educate us about health"*. (Male FGD participant). Similarly one of the participants pointed out that; *"I know students who come from Addis Ababa University treat children, in our children, who have such diseases as eye diseases"*. (Female FGD participant)

Yet another female study participant replied that the students' visited the community to assess community health status, identify health problems and give treatments. This was found to happen once a year. It was further argued that; students come to Ziway to practice what they learned in theory; *"I think their objective is to assess the health status of the local community and practice what they learn in classrooms. So, their activity in the community is mainly for their own educational purpose while they may also give some health service to community members mainly children"*. (HEW KII)

The finding revealed that the participants could not talk in detail about the type of the program, who the students were and where (i.e., the institution) they came from. The respondents' lack of adequate information about the type of the health training program and its objectives can also be inferred from the data cited next. *"What I think about their objective is that they come to see the health status of the community and how we live and also to see the water points; whether our water sources are protected or if it caused any health problem"*. (Male FGD participant).

Another respondent had this to say: *"I don't know the name of the university they come from and what the students are concerned about. I remember there were students who came to our Kebele last year"*. (KII, Kebele administrator). Similarly, one of the participants pointed out that; *"Sometimes I see them when they come to our village, but I don't have detail information about what they do since I do not work with them"*. (HEW KII)

There are also community members who did not know about the objective of the program and its benefits to the community beyond thinking that the government sent the students to help improve community health. One respondent in particular appears to have some idea about the objective of the program although he sounded not certain enough when he said: *"Though the students have their objective to come to our village, our community in most cases does not know the objectives including the students' professional background. Our feeling is they are sent here by the government"*. (Male FGD participant)

A kebele administrator, an authority expected to have sufficient information and understanding about the program, does not seem to be in a better position than the other members of the community; *"We don't know why they come. I have been here as a leader for four years and they have come to me (my office) only once. That was the time when they told me they were students in the health field"*. (KII, Kebele Administrator)

The study participants had different opinions about the professional background of the students, who visited their village. Some participants had the opinion that the students were just from Addis Ababa. They did not know anything more about the students. Others said the students were from Addis Ababa University. One FGD participant explained that: *"We only know that students are from Addis Ababa University but we don't know their professional background although we kenw they are from the health field"*. (Female FGD participant)

Another participant who seems to have a better understanding about the program and the students had this to say: *"The students are nurses learning at the University. They come to practice their future career before they graduate"*. (Male FGD) Similar response was reiterated; *"I don't know who they are except hearing them talking about child health"*. (Female FGD participant)

Timing of the Health Training Program: As regards the schedule of the training program, differences were observed among the respondents' opinion in that some said the training was during the rainy season while others thought the training program was just after the rainy season. Nonetheless, over three-fourths of the respondents shared a common view that the attachment took place between August and October. In fact, all agreed that the students went to the village every year. School principals did not see any problem with the timing of the training, but community members and local administrators felt farming season (June to August) and harvesting season (November to January) were not suitable time for farmers. An excerpt taken from the data obtained from one FGD participant confirms this: *"We are busy during farming and harvesting and have no time to spend with students. We do not have time even to look after our family members if they get sick during such times"*. (Male FGD participant)

The farmers' hectic schedule during farming and harvesting seasons and the difficulty in requesting them for involvement in another schedule is stated by KII, Kebele administrator as follows: *"Our farmers do not want extra responsibility during farming and harvesting seasons. We do not even call them for a meeting during such times"*. (KII, kebele administrator)

Activities during Attachment: Questions on what students did in the community during their attachment generate various responses. The following are among the activities the respondents mentioned: visiting households and asking them about health related problems, diagnosing children's illness, advising sick persons to visit a health care facility, and providing health information and giving advice. The treatment of sick children during the attachment program was the students' activity most commonly mentioned during the discussion as revealed in the next excerpt: *"They examine sick children and give treatment if they have medicines and advise parents to take the children to a health centre for further treatment. That is what we know about their role in the community"*. (Female FGD participant). Furthermore, another participant has emphasized that;

When they come, they visit every household and ask questions about various issues related to our family and health problems. After examining children's, stool, they give medication if problem is found. They may also advise parents to visit the nearest health facility based on their examination". (Male FGD participant). Another participant pointed out that; *"They also go to the school in the village and educate school children on good nutrition"*. (Female FGD participant)

Perceived Benefits of the Program: Although there are no shared feelings among community members on the benefits of the program, the provision of free drugs/medication for sick children was commonly mentioned as a major benefit of the program. One of the participants, for example, pointed out that: *"When students come to our village they help sick children by giving them medicines, and this, is useful to us"*. (Female FGD participant).

A similar benefit, quoted next, was mentioned by one health extension worker: *"Students provide medications for sick children in the village during their stay in the community. Now community members have recognized the students' support, and children are taken to them when the students are here"*. (KII, Health Extension Worker).

According to the data gathered from participants in the FGDs, advice and health information given by students in the attachment program has generally resulted in improvements in child health, institutional delivery, sanitation and waste management. Improvements have also been seen in the communities' overall awareness about health care – including awareness about toilet construction and utilization. One of the participants

clearly explained that; *"I can also tell you that there is a change in my house regarding hygiene and sanitation following the education I got from the students. There is much improvement in the practice of personal hygiene. And, we are happy"*. (Female FGD participant) Another example on the benefits of students' attachment was explained that; *Previously sick children in this area were not immediately taken to health facility. They are kept at home longer without getting treatment. Now in our community, due to the awareness we got from the students, we take children to health facility as soon as any symptoms of illness are seen.* (Male FGD participant).

A school principal has further illustrated the benefit of student's activity in his school; *"The status of school hygiene has improved may be due to students visit to schools. Our students are now motivated to keep their class clean. Our school is also trying hard to attend to the advice of the students in the attachment program in constructing separate rest room for girls and boys"*. (School principal KII).

Despite such recognition of the contributions of students by most of the study participants, one kebele administrator did not attribute changes to attachment students' intervention. This can be understood from the extract cited next: *"It is very difficult to attribute health related changes to the students since our health extension workers are also actively working on health both at household, community and school levels"*. (KII, Kebele administrator).

Community's Impressions about Health Training Program: Participants of the study reflected that the local community is happy and has positive impression about the program, the services the students offered and the behavior of the students' during the attachment program. Overall, members of the community were happy and satisfied with the program. One of the participants explained that; *"We want to see the program improved; we want the necessary medical equipment to be fulfilled and the program continue. We are satisfied; we do not want the program to discontinue"*. (Male FDG participant)

The school principal as participant in this study shared similarly that ; *"I think the community members are very happy with the activities of the students in the Kebele. The students treat our children; they also give us education and advice."* (School principal KII)

However, a community participant appears to have some reservation about the type of the background of the students and their professional competence. *"Some individuals say that these are students without completing their training and they use us for learning and doing research"*. (Male FGD participant)

Participants were also asked about the behavior of the students and their approach to the community during their delivery of services to the community. As revealed in the next quotation, the respondents reported

not observing any misbehavior: *“The behavior of the students’ in the attachment program is good; all behave well when they visit us”*. (Male FGD participant).

Areas for Improvement: The survey finding shows those community members both at leadership and individual level had no specified role in the program. The survey participants’ responses to questions asked to see whether or not the community had any stake in the planning, implementation, and evaluation of students’ activities in the community revealed that, beyond hosting the students, the community had no involvement in the program. One of the participants said this as follows: *“No one asked us for participation. We only see students coming to the village and going back when the attachment program is over. We only assume that the government sends them. We know only from what they tell us that they are students”*. (Male FGD participant).

The finding of the study also indicates a communication gap between the body that sends the students and the local administration. Data from the participants shows the need to inform the community and other stakeholders in the community (such as school principals and health extension workers) about the plan of the health attachment program. This concern is reflected in the excerpt cited next. *“When students arrive, they go to households without informing local administration about why they are here. Even at household level, they do not explain about their objectives and what support they can give to the household they visit.”* (kebele administrator KII).

Lack of communication about the program among local leaders and the community makes the plan a one-sided one and ineffective. During the interview session, one school principal had this to say in this regard. *Students often make a surprising visit to our School. We don’t have prior information about their coming. This may affect their own plan since we may not be around the school when they visit our school. Their sudden visit to our school may also disrupt our lesson time, as students may be learning at the time of the visit. This has happened several times. Prior communication and mutual agreement are important things that can facilitate their activities.*

As reflected in the next extract, a similar problem was reflected at health extension worker’s level: *“I hear about the program and what students do from women at household level. This is because the students in the attachment program have never come to my office to discuss this with me or with other health extension workers.”* (KII, Health Extension Worker).

The community’s inadequate engagement in the planning of the attachment program and the local leaders’ lack of communication about the program are important areas of the training program that need improvement. Another area for improvement arises from the language used in the attachment program.

Many students in the program speak Amharic and cannot communicate with the community using the local language. On the other hand, most community members do not know any language other than their own language, which is Afan Oromo. It was noted in the finding that mothers often failed to explain to the students the symptoms of their children’s illness in Amharic. The next extract shows this: *“Since most students speak Amharic, we sometimes find it too difficult to communicate with them. For example, when they ask us questions about symptoms of our children’s illness, we ask for someone to translate their questions into our language. Translators, however, may not be available at the time the need for them arises”*. (Male FGD participant)

Discussion

Addis Ababa University has been running the RCHTP at Ziway for over four decades. The present study revealed that community members do not have adequate information about the program, its objective, and information about the students’ activities during the attachment. The community’s lack of adequate information about the attachment program is a barrier to the contribution the community and its administration can make towards the smooth running of the program. However, it should be noted that the degree to which a medical training involves community members in planning, implementation and evaluation tells us the success of all the stakeholders- students, the university and the community at large (12).

In the objectives of the program, as outlined in the AAU’s RCHTP Handbook, the roles of the community and the modalities of communication between the local leadership, the community and the university have not been clearly stated (9). Such a lack of communication is a cause for an inadequate community engagement. Establishing proper understanding of the differences between what HEWs do at community level and the purpose of the students’ community health attachment is yet another area that needs improvement. Rural community attachment of health students is believed to be of some benefit to the students and the university’s teaching-learning process, and to the host community (9). This means that any partner’s lack of understanding about the program heavily jeopardizes the potential benefits of all involved.

Findings of a study carried out at Jimma University documented a lack of awareness by over one-third of community respondents about rural community attachment of health students (13). This clearly shows that teaching institutions did not engage host community in the design, planning, implementation and evaluation of their community attachment program.

Although participants often mentioned what students did when they stayed in the community, none of them mentioned details of students’ activities in the community. Participants were also observed to face difficulty in differentiating the routine health extension

workers' health activities and the activities of the students in the attachment program. No clarification or guidance was provided in the handbook about the differences between the students activities and the activities of health extension workers (9). Running community-oriented teaching requires considering the local resources, including human resource in the program (13). This is a missing piece in the Rural Community Health Training Program run by Addis Ababa University at Adami Tulu District, East Shoa Zone.

Community members felt the benefit of the program in terms of getting free treatment for sick children. Changes in school children's hygiene and school sanitation were also cited as useful contributions of the program. Another study reported that community based education and services contribute to a change in health seeking behavior and improvements in the community's health awareness (7). However, one can argue about the difficulty of ascertaining this, as such improvements might also come as a result of health extension workers interventions. The way the participants expressed the felt benefits as a recent changes might support this as the RCHTP has been in place for over 40 years.

In the broader recognition of child health care, it is interesting to note that the care and advice given by the students on children's health can draw much attention. The information can also be easily disseminated among the community and improve the community's perception of the student's attachment. This is an expression of the community's positive impression about the program. Other studies have also reported that host communities of rural attachment programs have positive impressions of Community Based Education (14-16). The community's positive impressions suggest that the community still sees value in the attachment program and suggest the need for its continuation even when the contribution of the program is agreed to be limited.

Community based education has a strong role in improving the competence of the students in the attachment program. In particular, it helps them link theories with practice and find solutions to problems. The presence of the students in the community can also serve as additional workforce to solve community health problems. The students can identify the community's health needs and help in finding ways of addressing the needs (7).

The presence of the program obviously contributes to the overall local development programs (13). This, however, requires careful designing of the program. Careful designing primarily requires adequate involvement of the host community. Bilateral ownership of the program may enhance its sustainability and usefulness.

The AAU's RCHTP Handbook specifies end of August or beginning of September to January as the schedule

of the attachment (9). These are, however, times when community members are very busy with their agricultural activities. Consulting the community at the design phase of the program may result in an agreed schedule of the attachment program.

Other barriers against the participation of the community in the design and planning of the program include a lack of prior communication and scheduling, low level of community awareness about the program, and language differences between students and the community. The lack of communication about programs where the community has a stake has also been shown to be a challenge as reported by a study in South Africa (17). Lessons could be gained from other community-based health programs where community members play important roles as members of the steering committee. They can also take the responsibility of facilitating the mobilization of the community and the local resources in an effort to improve the health of the community (18).

Quality communication, within the context of community based education, needs to be sustainable. Sustainable quality communication can perhaps be achieved using corrective feedback obtained from the communities. Dialogues with the community at both the beginning and end of each intervention can be useful mechanisms of obtaining community feedback. Sharing findings from the attachment and accomplishments as well as challenges encountered may also serve as tools to improve the design of the program. It is also essential for the attachment program to establish a strong partnership with different stakeholders such as schools, public and private sectors in the community (15).

One of the other major pitfalls observed in the program under study was the program's failure to integrate its activities with the activities of the local health extension program. The findings of the survey indicate that HEWs who stay in the community and are responsible for health services at the level are not well aware of the RCHTP. This may lead to duplicating efforts both at community and school levels. Needless to say, this is wastage. Establishing a clear line of relationship between the program and health institutions and relevant resources at community level is thus believed to have important implications not only for the success of the program but also for the overall improvement of health of the local community (16).

The discussions so far imply that there is a need for a formal evaluation of the student attachment program in terms of design, implementation, accomplishments, and challenges. The finding of the needed study may lead to redesigning the program following a model that draws lessons from previous studies (16, 20) including the review of community-based education curriculum. Besides, the designing of strategies and tools may need to be considered for improved role of attachment both for the students and for the community of concern (8).

The redesign of the program may have to pay attention to all stakeholders at different levels in the program instead of keeping them as passive recipients of whatever services the program may offer. The implementation of the program and the activities carried in the community may have generated useful lessons that may contribute to routine classroom teaching. It needs to be investigated if and whether the rural attachment has ever contributed to the teaching in classroom (21).

Strengths and Limitations of the Study: As an explorative study, the present study may contribute to opening up the issue for further more comprehensive studies of the various aspects of the RCHTP. The application of different methods to generate evidence and the participation of different sources of information can be mentioned as strengths of the study. On the other hand, this study cannot claim to have answered all the issues related to the program. In addition, the absence of quantitative data to substantiate the finding remains to be the weakness to be mentioned.

However, the study has shed some light on major themes for further investigation in addition to the attempts it made to give a fairly accurate description of the present status of the community based education program of the Rural Community Health Training Program run by Addis Ababa University.

Conclusion and Recommendations

This study revealed that members of the host community, including community leadership and other community members whose occupation is related to health in the community, were not adequately informed about the program. The program, in general, seems to be unilaterally owned by the university- with the community having either no or very little awareness about the health attachment program. Students are also attached to kebeles and households without the kebeles' and the households' getting prior information about the intervention program. Equally important is the fact that the attachment program begins in the community without the knowledge of the community members and leaders. This is a critical issue. It may also have ethical implications.

Despite some limitations, the program has been appreciated for intervening in childhood problems. This recognition may be used as an opportunity for improving and expanding the program.

The study team recommended the need for planning and implementing a comprehensive evaluation of the program. This may generate additional evidence that may help in the revision and redesigning of the attachment. In the mean time, students should be trained on how to be more ethical in collecting and collating evidence from the community and on how to use the evidence.

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Authors Contributions

MT and MG contributed to the conception, design and acquisition of data. All of the authors of this report were involved in analyzing and interpreting the data. All were also involved in approving and writing the final manuscript.

Final Note

The authors report having no conflict of interest.

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