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ASSESSMENT OF AWARENESS, ATTITUDE AND IMPLEMENTATION OF COMMUNITY BASED TRAINING PROGRAMME FROM THE PERSPECTIVE OF JIMMA UNIVERSITY MEDICAL STUDENTS, JIMMA, SOUTH WEST ETHIOPIA, 2017

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ABSTRACT

This institution based cross sectional study conducted from July to August 2017 at Jimma University, assessed the awareness and attitude towards relevance and implementation of Community Based Training Program (CBTP) from the perspective of medical students in the University. Data was collected from three hundred and nine (309) medical students using pre-tested structured self-administered questionnaire. The data was checked for completeness, edited, coded and entered in to SPSS version 23 for statistical analysis. Descriptive statistics (frequencies, percentages) was computed to show picture of the data. Chi-square test, where necessary, was used to test the association among variables. P-value of < 0.05 was used as a measure of statistical significance. Results showed a significant association between awareness of objectives of CBTP and attitude towards relevance of CBTP in future career (p-value=0.04). It also indicated that the supervision of CBTP activities was inadequate and implementation of action plan and evaluation of intervention was low; suggesting that CBE shall foster CBTP supervision and implementation of action plan drawn at the end of each phase of CBTP.

Key words: Community Based Training Program, Awareness, Attitude, South-West Ethiopia

INTRODUCTION

Community–Based Education (CBE) is not a new idea. The recognition of the importance of community based training as community development problem solving mechanism has been documented since 1940s (WHO, 1987 and Tristole, 1986). Community based education (CBE) is a way of achieving educational relevance to the community needs and consequently, of implementing community oriented educational program**(**COEP) , CBE as educational philosophy aims at developing professionals with problem identifying and solving skills and positive attitude to serve the society. Jimma University (JU) is the national pioneer of community based higher education (www:http//:ju.edu.et.). It has been nearly 30 years since CBE was introduced in JU's education system (Jimma Univesity, 2010).The university's CBE implementation guideline clearly positioned CBE as means of achieving educational relevance to community needs and consequently of implementing a community-oriented education program .It consists of learning activities that utilize the community extensively as a learning process where students use the community through problem identification, prioritization, implementation and evaluation of interventions in relation to the benefits reached to community and students in the learning (JU, 2010; JU, 2013).

The ultimate purpose of including CBE in to JU's curricula is to produce competent professionals who are responsive to the felt needs of the community through a developmental approach that contributes to improve the livelihood of the society by involving

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the community and stakeholders in community development. In order to achieve these objectives, the university has devised major categories of courses and included them in a curriculum as implementation strategies. These are:

Community Based Training Program (CBTP), which is implemented in all undergraduate programs of the university in *n-1* formula where *n* represents the duration of the program in years. Team Training Program (TTP), whose implementation is limited to undergraduate programs of college of public health and medical sciences. Developmental Team Training Program (DTTP) ,which is implemented at post graduate level including terminal degree programs and Students Research Project (SRP), which is undertaken at final year of each training program (JU, 2013; Assefa, 2000).

CBE evolved from the field of community development that grew in the industrialization model of the mid-1990 (Maser,1997).The concept of formal education particularly tertiary education contributing towards social & economic development is being challenged in Africa, most particularly in Ethiopia (Thompson, 1981; Devi , 2003; Amare and Temechegn, 2002).

It has been argued that, higher education in Africa didn't go further than producing trained public servants needed to meet the requirement of bureaucratic hierarchy (Meseret, 2005). The competence and commitment of graduates to serve the community and bring a meaningful change for economic development is also challenged. These could be attributed to insufficiency of the curricula for practical training in the community. In this regard, Burgess (Burgess *et al*., 2010) argued that, the focus on teaching in higher education is lecture method that has jeopardized the students' capability required in community development.

The international trend in the early 70s has compelled Ethiopia to think and introduce CBE. Hence, Addis Ababa University issued its manifesto that declares its commitment to enhance education to serve the interest of the Ethiopian people through that integration of education, research and services in 1975.These national and international trends on CBE motivated to pick and implement CBE in Jimma Institute of Health (JIHS) since 1983 (Office of Senior Director of Research, Community Based Education and Graduate Studies, 2013).

The effectiveness of CBE demands active engagement of students in real, authentic and attractive environment. Teachers are expected to make use of various active learning methods and create attractive learning environment in which students learn with high motivation and interest (WHO, 1987; Assefa, 2000).

As CBTP is joint venture the evaluation is done by supervisors, students and other stakeholders. However, despite of the commitment of the university to ensure quality in CBTP implementation little is known about state of affairs (strengths, weaknesses, threats and opportunities) (Tegegne *et al*., 2000). End-of –program evaluations seem to be inadequate to give a complete picture about how the program is going. Thus, conducting a research on nature of CBTP implementation i.e. strengths and weaknesses appears necessary. This research attempts to examine the strengths and weaknesses in implementation of CBTP with the perspective of the students and also tries to examine the views of the students regarding the relevance of CBTP. Particularly, the following basic questions are raised:
–what is the view of students regarding relevance of CBTP
–what is the weakness in implementation of CBTP from the perspective of the students
Therefore, this study will identify the strengths and weaknesses in implementation of CBTP.

METHOD OF STUDY

Study Area: The study was conducted in Jimma University, the campus of which is located in city of Jimma, situated around 352 kilometers southwest of Addis Ababa, Ethiopia. Its grounds cover some 167 hectares. JU is Ethiopia's first innovative community-oriented institution of higher learning, with teaching centers for health science students in Jimma, Omo Nada, Shebe, Agaro, Asendabo and Limmu. JU has academic and scientific collaboration with numerous national and international partners.

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The study was conducted from July to August 2017 G.C.

Subjects: Source population was randomly selected medical students of Jimma University in 2nd -6th year.

Inclusion and Exclusion Criteria: Those medical students who had took part in CBTP at least once i.e. medical students from PC-II to internship, were included in the study. While those medical students who didn't fulfill this inclusion criteria i.e. those in pre-medicine & PC-I, were excluded.

Ethical consideration: Before data collection letter of permission was taken from Jimma University. Verbal consent was obtained from each respondent after explaining the objective of the study. To maintain confidentiality, the name of subjects was not be registered on the questionnaire.Further more, the study participants involvement in the study was based on their willingness.

Study design: An institution based cross sectional study design was used.

Sampling technique and Sample Size: Systematic random sampling technique was employed to conduct the research. The sample size is determined by single proportion formula.

$$ni = \frac{(Z\alpha/2)^2 P(1-P)}{d2} = \frac{(1.96)^2 \quad (0.5)^2}{(0.05)^2} = 384.16$$

Where – $\mathbf{z_{\alpha/2}}$-the standard normal variable at 95% confidence interval

z = 1.96
n = the minimum sample size required
p = the estimated proportion (p=0.5)
d = the margin of sampling error tolerated (0.05)
N = the total number of medical students (2nd -6th year) = 1,572

Since total number of medical students is less than 10,000 correction formula is employed to determine the corrected sample size.

$$\text{Hence, } nf = \frac{n}{1+\frac{n}{N}} = 384^* (1+384/1572) = 309$$

Where n_f = final sample size
n=study sample
N=source population

The calculated sample size (309) was allocated among medical students from PC-II to internship using proportion method. Selection was made from up dated list of students of each class using systematic random sampling.

Table 1: Proportion of study subjects from each academic year

Year II	Year III	Year IV	Year V	Year VI
431	236	346	306	253
n1 =85	n2=46	n3=68	n4=60	n5=50
Nt = n1 +n2+n3+n4 +n5 = 309				

Where N_t = total sample size of students.

Data collection: Data collection instrument: Structured questionnaire was developed in such a way that all the necessary variables to be assessed were included in the questionnaire. Pretest of this questionnaire was done in medical interns. Structured self-administered questionnaire was the data collection instrument employed.

Data collection technique: Medical students from PC-II to internship were selected randomly from

students` list sheet so as to be included in the study. Data was collected from these randomly selected respondents using structured self-administered questionnaire.

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Data quality control: The collected data was carefully checked for completeness.

Data analysis & Interpretation: The collected data was edited, coded and entered in to SPSS version 23 for statistical analysis. Descriptive statistics (frequencies, percentages) was computed to show the picture of the data. Chi-square test, where necessary, was used to test the association among variables. P-value of < 0.05 was used as a measure of statistical significance. Results are then presented using tables, graphs and text description.

Operational Definition: Community Based Training Program (CBTP):-is educational activity outside class room, in the community with clear correlation with class room activities and clear benefit to the student, community and other sectors. Number of phases of CBTP= n-1

Awareness: -is information and understanding that one has gained, especially through learning or experience, the degree of which is rated by the respondents themselves.

Motivation:-the degree of interest to participate in CBTP, which is rated by the students themselves.
Attitude: -A way of feeling or thinking about something which influences ones behavior.

Often: - supervision activity of 3-4 days per week of activity

Always:-Supervision activity of all 7 days of the week of activity

Occasionally:-Supervision activity during special occasions (Symposium, rehearsal, orientation).

RESULTS

A total of 309 students were included in the study and only 280 students filled in the questionnaire completely. The highest response rate was obtained from year IV (95.6%) and followed by year V (95%) & year VI (94%) as depicted in the following table.

Table 2: Response rates of Jimma University medical students, 2017

Category		No Proposed	Respondents	Response rate(%
Class year	II	85	76	**89.4**
	III	46	39	**84.8**
	IV	68	61	**95.6**
	V	60	57	**95**
	VI	50	47	**94**
	Total	**309**	**280**	**90.6**

Majority of the respondents were in the age group 20-24 years (making up 82.9% of the respondents). Large proportion of the respondents were males 150(53.6%).Most of the students involved in the study are from urban areas constituting 143(51.1%) and students from the rural areas make up about 108(38.6 %) of the respondents.141(51.1%) of the respondents are originally from urban area, while 108(38.6%) of them are from rural areas.

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Table 3: Socio-demographic characteristics of Jimma University medical students, 2017

S. No	Variables		Frequency	Percentage
1.	Age	15-19	4	**1.4**
		20-24	232	**82.9**
		25-29	44	**15.7**
		>30	0	**0**
2.	Sex	Female	130	**46.4**
		Male	150	**53.6**
3.	Address (Place of Origin)	Urban	143	**51.1**
		Rural	108	**38.6**
		Semi- urban	29	**10.4**
		Total	**280**	**100**

Most of the respondents rated their awareness on the objectives of CBTP to be average (53.9%) & about 38.9% of the students involved in the study rated their awareness on the objectives of CBTP to be high & the rest 7.1% of them rated it to be low.

Table 4: Awareness rating of Jimma University medical students with regard to the objectives of CBTP, 2017

		Awareness			Total
		High	Average	Low	
Class year	II	18(23.7%)	46(60.5%)	12(15.8%)	76
	III	7(18%)	30(76.9%)	2(5.1%)	39
	IV	30(49.2%)	28(45.9%)	3(4.9%)	61
	V	18(31.6%)	37(64.9%)	2(3.5%)	57
	VI	36(76.6%)	10(21.3%)	1(2.1%)	47
Total		109	151	20	280
	Percentage	38.9	53.9	7.1	100

Table 5: Number of phases of CBTP participated by rating of awareness of objectives of CBTP of Jimma University medical students cross tabulation, 2017

		Rating of awareness of objectives of CBTP				Chi-square	p-value	Correlation
		High	Average	Low	**total**		**0**	**0.56**
No_ of phases of CBTP participated	CBTP phase I	18	46	12	76	32.982	0.00	0.56
	CBTP phase II	7	30	2	39			
	CBTP phase III	30	28	3	61			
	CBTP phase IV	54	47	3	104			
Total		109	151	20	280			

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The above chi-square test clearly depicts that there is significant association (p-value=0) between the number of CBTP phases the student took part in & his awareness of the objectives of CBTP with positive correlation (correlation=0.56). Large proportion of the respondents constituting 60.7% rated the adequacy of CBTP orientation to be good and about 23.9% the respondents rated the adequacy of CBTP orientation to be very good.

Table 6: Frequency distribution of Jimma University medical students' rating of adequacy of CBTP orientation, 2017

		Class year					Total	%
Category		**II**	**III**	**IV**	**V**	**VI**		
Adequacy of CBTP orientation	Very good	13(17.1%)	9(23.1%)	20(32.8%)	15(26.3%)	10(21.2%)	67	23.9
	Good	40(52.6%)	28(71.8%)	38(62.3%)	36(63.2%)	28(59.6%)	170	60.7
	Poor	19(25%)	2(5.1%)	3(4.9%)	6(10.5%)	4(8.5%)	34	12.1
	Very poor	4(5.3%)	0(0%)	0(0%)	0(0%)	5(10.6%)	9	3.2
	Total	76	39	61	57	47	280	100

Vast majority of the respondents (54.2%) said that only one supervisor was attending CBTP & 5% of the respondents said that no supervisors were attending CBTP field activity. Large proportion of the supervisions (about 74.6%) were occasional (during rehearsal, orientation & symposium).Only 5.4% of the respondents said that they always had supervision.

Table 7: Pattern of supervision of CBTP activities from the perspective of Jimma University medical students, 2017

S. No	Variables		Class year					Total	%
			II	III	IV	V	VI		
1.	No of Supervisors	1	48(63.2%)	20(51.3%)	37(60.6%)	30(52.6%)	17(36.2%)	152	**54.2**
		2-3	19(25%)	16(41%)	22(36.1%)	25(43.9%)	27(57.4%)	109	**38.9**
		4-5	1(13.2%)	1(2.6%)	1(16.4%)	2(3.5%)	0(0%)	5	**1.8**
		Non	8(10.5%)	2(5.1%)	1(16.4%)	0(0%)	3(6.4%)	14	**5**
2.	Frequency of Supervision	Always	5(6.6%)	2(5.1%)	4(6.6%)	3(5.3%)	1(2.1%)	15	**5.4**
		Often	18(23.7%)	2(5.1%)	4(6.6%)	6(10.5%)	16(34%)	46	**16.4**
		Occasional	48(63.2%)	33(84.6%)	53(86.8%)	48(84.2%)	27(57.4%)	209	**74.6**
		Non	5(6.6%)	2(5.1%)	0(0%)	0(0%)	3(6.4%)	10	**3.6**
		Total	**76**	**39**	**61**	**57**	**47**	**280**	**100**

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Vast majority of the respondents (47.1%) said that identifying socio demographic data is the most commonly achieved activity followed by identifying community health problem (29.1%). Implementation of action plan & evaluation of intervention was least achieved (3.9%).

Table 8: Percentage distribution of the most achieved activities of CBTP from the perspective Jimma University medical students, 2017

Activities	Frequency		Total	(%)
	Male	Female		
Identifying socio-demo graphic data	64(48.4%)	68(51.6%)	132	**47.1**
Data analysis & drawing action plan	36(66.6%)	18(33.3%)	54	**19.3**
Implementing action plan & evaluating interventions	7(63.6%)	4(36.4%)	11	**3.9**
Identifying community health problem	42(51.2%)	40(48.8%)	82	**29.3**
Other	1(100%)	0(0%)	1	**0.4**
Total	**150**	**130**	**280**	**100**

41.1% of the respondents identified community fatigue and waste of resource as a weakness of CBTP and 35.7% of the respondents labeled lack of implementation of action plan and evaluation of intervention.

Table 9: Perceived pitfalls of CBTP from the perspective of Jimma University medical students, 2017

Short comings	Frequency		Total	%
	Male	Female		
Lack of implementing the action plan & evaluation the intervention	59(59%)	41(41%)	100	**35.7**
Inadequate coordinating & supervision	13(56.5%)	10(43.5%)	23	**8.2**
Community fatigue &waste of resource	56(48.7%)	59(51.3%)	115	**41.1**
Dominance of the group by individual students	11(42.3%)	15(57.7%)	26	**9.3**
Short practice time	11(68.8%)	5(31.2%)	16	**5.7**
Total	**150**	**130**	**280**	**100**

As illustrated in the table below majority of the respondents (59.6%) agreed up on the adequacy of time allocated to CBTP, while 33.2% of the respondents claimed that the time allocated to CBTP is long. 56.8% of the respondents suggested that CBTP needs to continue with modification , while

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35.7% of the respondents said CBTP has to stop completely. Most of the respondents agreed that there is correlation between CBTP field activities & class activities. Students were inquired if they think CBTP solves the real problem of the community and majority of them (68.6%) disagreed.

Table 10: Frequency distribution of attitude of Jimma University medical students, 2017

S/No	Attitude		Class Year					Total	%
			II	III	IV	V	VI		
1.	Time allocated for each phase of CBTP	Adequate	50(65.8%)	25(63.1%)	36(59%)	32(56.1%)	24(51.1%)	167	**59.6**
		Short	9(11.8%)	0(0%)	8(13.1%)	0(0%)	3(6.4%)	20	**7.1**
		Long	17(22.4%)	14(35.9%)	17(27.8%)	25(43.9%)	20(42.6%)	93	**33.2**
2.	Continuity of CBTP	Continue with Modification	40(52.6%)	23(59%)	40(65.6%)	31(54.4%)	25(53.2%)	159	**56.8**
		Stop completely	28(36.8%)	14(35.9%)	15(24.6%)	25(43.9%)	18(38.3%)	100	**35.7**
		Continue with current status	8(10.5%)	2(5.1%)	6(9.8%)	1(1.8%)	4(8.5%)	21	**7.5**
3.	Level of correlation of CBTP field & class activities	Agree	24(31.6%)	9(23.1%)	24(39.3%)	22(38.6%)	19(40.4%)	98	**35**
		Disagree	29(34.2%)	24(61.5%)	28(45.9%)	19(33.3%)	24(51.1%)	124	**44.3**
		Neutral	23(30.3%)	6(15.4%)	9(14.8%)	16(28%)	4(8.5%)	58	**20.7**
4.	CBTP solved the real problems of the community	Agree	911.8%)	0(0%)	4(6.6%)	7(12.3%)	9(19.1%)	29	**10.4**
		Disagree	48(61.2%)	30(76.9%)	48(78.7%)	37(64.9%)	29(61.7%)	192	**68.6**
		Neutral	19(25%)	9(23.1%)	9(14.7$)	13(22.8%)	9(19.1%)	59	**21.1**
		Total	**76**	**39**	**61**	**57**	**47**	**280**	**100**

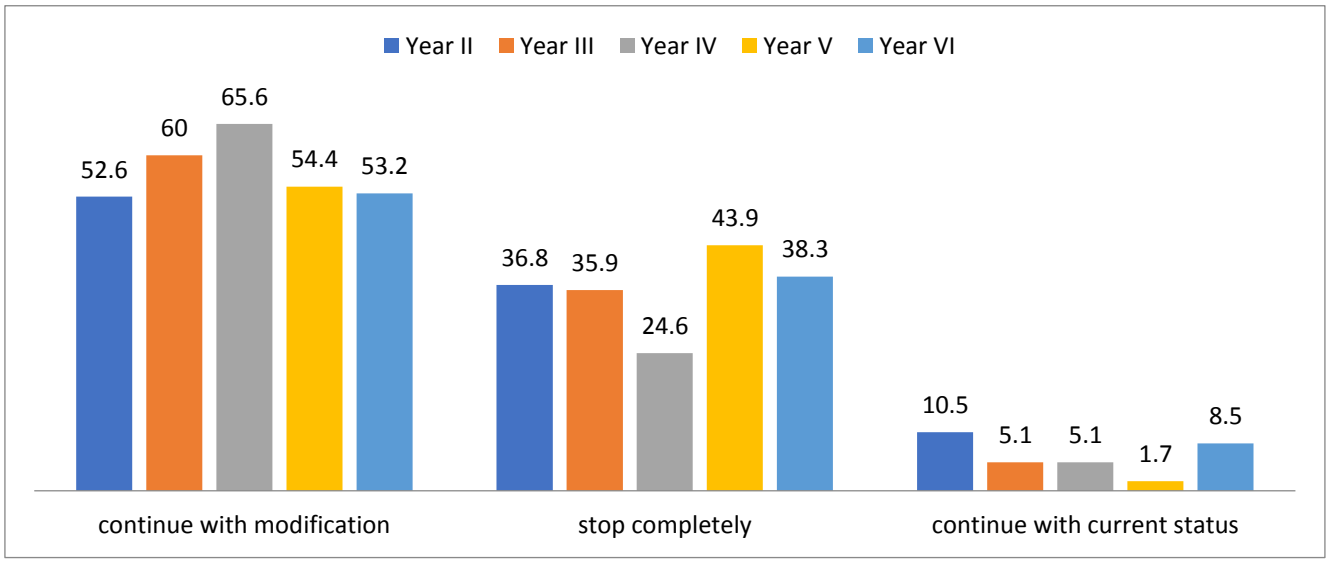

Fig 1- Attitude of Jimma University medical students to the continuity of CBTP, 2017

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As depicted in the table below vast majority of the respondents (63.9%) rated their motivation and interest to participate in CBTP activities to be average.

Table 11: Rating of motivation and interest of Jimma University medical students to participate in CBTP activities, 2017

Category		Class year					Total	%
		II	III	IV	V	VI		
Level of motivation and interest	High	5(6.6%)	6(15.4%)	14(23%)	17(29.8%)	4(8.5%)	46	**16.4**
	Average	46(60.5%)	23(58.9%)	37(60.6%)	37(64.9%)	36(76.6%)	179	**63.9**
	Low	20(26.3%)	10(25.6%)	9(14.8%)	3(5.3%)	7(14.9%)	49	**17.5**
	Very low	5(6.6%)	0(0%)	1(1.6%)	0(0%)	0	6	**2.1**
	Total	**76**	**39**	**61**	**57**	**47**	**280**	**100**

Table 12: Attitude towards relevance of CBTP in future career by rating of of awareness of Jimma University medical students cross tabulation, 2017

		Rating of awareness of objectives of CBTP			Total	Chi-square	p-value
CBTP is helpful in future career		High	Average	Low			**0.04**
	Yes	88	96	11	195	10.99	0.04
	No	21	55	9	85		
	Total	109	151	20	280		

The above chi-square test clearly depicts that there is significant association between awareness of the objectives of CBTP and attitude towards relevance of CBTP in future career (p-value=0.04).

Most of the respondents (69.6%) reflected that they think their participation in CBTP is helpful in their future career. In spite of this 61.8% of the respondents revealed that there is dominance of CBTP activities by individual members such as the rapporteur & leader.

In addition large proportion of the respondents (72.9%) revealed that they have encountered students who fill in the questionnaire by themselves without asking the study population. The respondents pointed out that students do so for numerous reasons as depicted in the pie chart below.

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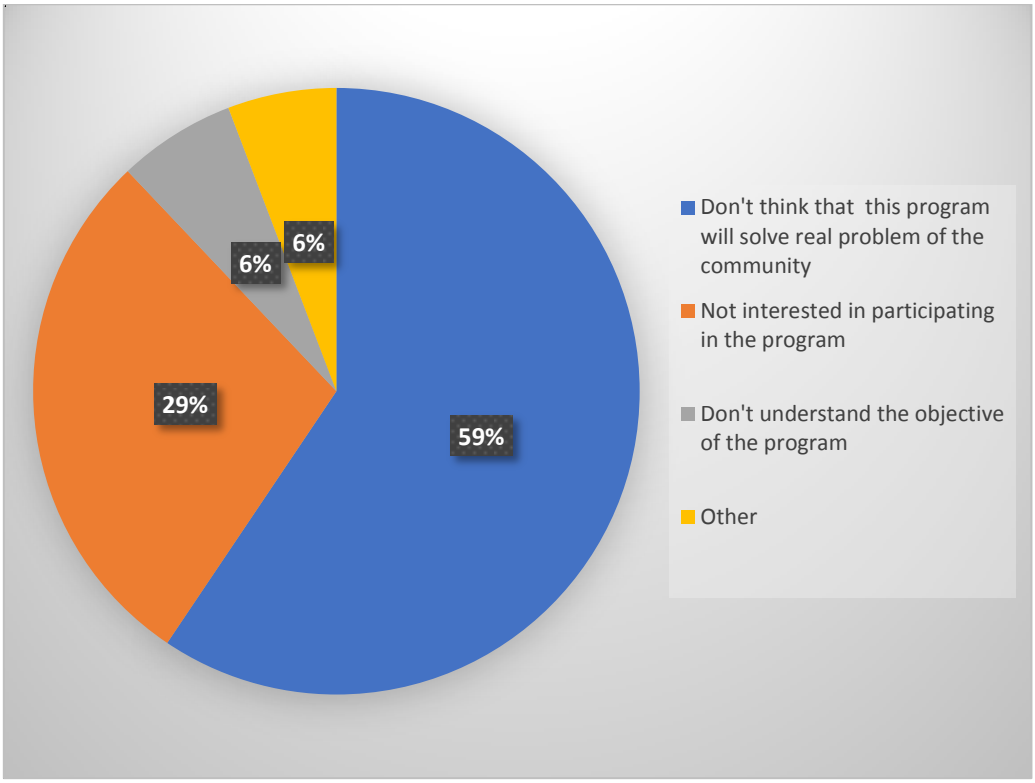

Fig. 2: Pie chart showing speculated reasons for Jimma University medical students to fill the questionnaire by themselves without asking the study population, 2017

In response to measures that can be taken to improve the effectiveness of CBTP majority of the students (56.4%) emphasized on strengthening the intervention part of CBTP, while 26.4% of the respondents suggested that supervision of CBTP activities needs to be consolidated.

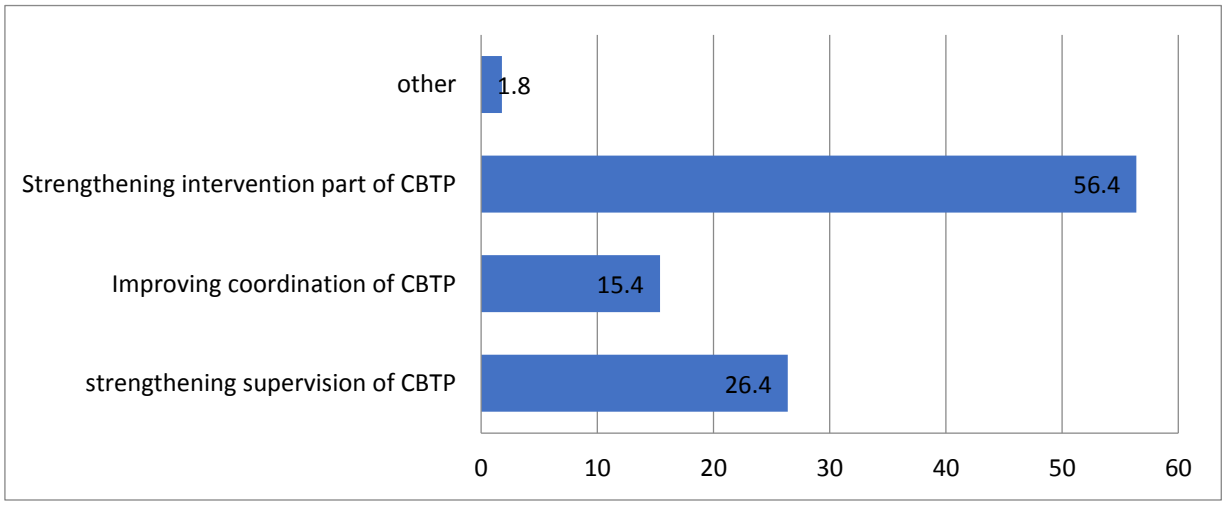

Fig 3: Measures speculated by Jimma University medical students to improve the effectiveness of CBTP, 2017

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DISCUSSION

The overall response rate of the respondents was 90.6% which is comparable to the previous study done in Jimma University in 2004 G.C (Alemayehu *et al*., 2004).

At each phase of CBTP before departing to the particular community of their assignment a one day orientation will be given to students and supervisors .The orientation include about the philosophy of CBE in general and CBTP phase objective & activity in particular. In addition, students & supervisors will be oriented about their roles & responsibilities, the time required to complete the phase (JU, 2013). In this study majority of the respondents (60.7%) rated the adequacy of CBTP orientation to be good.

Supervisors play an important role in facilitating learning in CBE. They demonstrate practice, encourage students, orient to placements and monitor students' work (Macke, 1992).In this study I found out that supervision activity was inadequate. 54.2% of the respondents reported that there was there was only one supervisor attending CBTP field activities. But normally,3-5 supervisors are assigned for each group of students (Department of Community Health,1987). Majority of supervisions (74.6%) were occasional that is during orientation, rehearsal,& symposium. Previous study done in JU showed that the overall effort to make CBTP fruitful was low (Tegegne, M., M.Assefa, F.Tessema and K.Kebede, 2000). Another study done in Uganda showed that about 70% of institutions had neither formal criteria for selection nor formal training of supervisors (Dank kaye, Wilson W. Muhewzi lesso ,2011).This might hold true in our institution.

In general the main objectives of CBE are training professionally competent, confident & committed professionals, undertaking problem based researches, encouraging team approach in treating societal problems and working with local communities (www:http//:ju.edu.et.) we found that 53.9% of the respondents rated their awareness on the objectives of CBTP to be average and 38.9% of them rated their awareness to be high.

During CBTP students are expected to follow and pass through problem solving steps. They have to gather data, process and analyze, identify and prioritize problems, draw action plan, carry it out evaluate the interventions (www:http//:ju.edu.et.) In this study we found out that identifying socio-demographic data (47.1%) & identifying community health problem (29.1%) are most commonly achieved as claimed by the respondents; while implementation of action plan & evaluation of intervention was least achieved(3.9%).This finding is similar with previous study done in 2004 G.C (Alemayehu *et al*., 2004).

Lack of implementation of action plan & evaluation of intervention was mentioned to be weakness of CBTP by 35.7% of the respondents and community fatigue and waste of resource mentioned to be weakness by 41.1% of the respondents. Some respondents speculated that "The work of CBTP ends up in drawing action plan & reporting it" a similar saying with a previous study (Alemayehu *et al*., 2004).

This study showed that the time allocated to CBTP was adequate as reported by most (59.6%) of the respondents. With regard to continuity of CBTP majority of the respondents (56.8%) emphasized that CBTP needs to continue with modification. Similarly in a study done in 2000 about 90% of medical students depicted need of modification of CBTP while only 2.2% of them stated the discontinuation of CBTP at all (Tegegne *et al*, 2000). 44% of the respondents disagreed on the correlation between CBTP field & class activities while 35% of the respondents agreed. Vast majority of students (68.6%) disagreed that CBTP solved real problems of the community. This might be due to poor implementation of action plan.

There is significant association between awareness of the objectives of CBTP and attitude towards relevance of CBTP in future career(p-value=0.04).There is significant association (p-value< 0.05) between the number of CBTP phases the student took part in & his awareness of the objectives of CBTP with positive correlation(correlation=0.56).

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Most of the respondents (69.6%) reflected that they think their participation in CBTP is helpful in their future career. Despite of this 61.8% of the respondents revealed that there is dominance of CBTP activities by individual members such as the reporters& leader. In a study done in 2004 in JU dominance of the group by individual students was identified as hindering factor to learning in CBE (Alemayehu *et al*., 2004).

This study revealed that 72.9% of the respondents have encountered students who fill in the questionnaire by themselves without asking the study population. Majority (59%) the respondents speculated that students do so because they don't think that this program will solve the real problem of the community. Majority of respondents emphasized on strengthening the intervention part of CBTP (56.4%) i.e. bringing the drawn action in to tangible practical activities in to the ground. The other 26.4% stressed on strengthening supervision of CBTP & 15.4% of them suggested improving coordination of CBTP.

LIMITATION OF THE STUDY

Only medical students are included in the study, this limits generalization of findings of the study.

CONCLUSION AND RECCOMENDATION

As far as the main objective of this study is concerned, which is aimed at assessing the awareness, attitude towards relevance and implementation of CBTP from the perspective of medical students, we have came up with the following conclusions based on the result of the study.

1. Most of the students are aware of the objectives of CBTP.
2. Most of the respondents think that their participation in CBTP is helpful in their future career.
3. Adequacy of orientation is good.
4. Supervision of CBTP activities is poor, for only one supervisor attends CBTP activity and supervision was occasional.
5. Implementation of action plan and evaluation of intervention part of CBTP is low.
6. Identifying socio-demographic data is most achieved activity of CBTP.
7. Time allocated to CBTP is adequate.

RECCOMENDATION

Based on the above conclusion and other findings of the study, we would like to make the following recommendations to JU, CBE office, students and other responsible bodies to improve the effectiveness of CBTP to achieve the intended goals.

1. CBE shall make sure that CBTP activities are well supervised.
2. CBE shall give priority to implementation of action plan drawn at the end of each phase of CBTP if not CBTP activities will be futile.
3. CBE office of JU have to play an active role in modification of CBTP , for CBTP needs to continue with modification so as to make it fruitful for both the students involved in it & members of the community.
4. CBE of JU have to support further studies to be conducted on the assessment of CBTP effectiveness & ways of further improvement.
5. Students have to develop internal motivation and need to actively participate in CBTP activities, in order to benefit from this involvement in their future career.
6. Other researchers shall conduct further studies in broad context involving community and students from other departments.

CONFLICTS OF INTEREST

The authors have no any conflict of interests.

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AUTHOR'S CONTRIBUTIONS

MST & WGT: contributed in the conception of the research idea, study design and proposal development, collection and ensured quality of data , made a substantial contribution to the design, conduct, analysis, interpretation and report writing , critically reviewed the manuscript and gave final approval of the paper to be published .MST- has the responsibility to submit manuscript for publication.

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