

**The Nature and Dynamics of Learning among Caregivers in a  
National Certificate Training Programme**

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requirements for the degree Master of Education (M.Ed)

University of the Western Cape

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.

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**Key Words**

Adult Learning

Experience

Participation

Learning

Situated Learning

Socio-Cultural Theory

Context

Community of Practice

Change

Care-giving



## **Abstract**

In this research study I investigate the nature and dynamics of learning amongst learners in a National Certificate Training Programme for community health workers who are caregivers in a home-based care programme. The study analyses the relationship between experience, participation and learning and seeks to establish how the experience of adult learners can be mobilised through active participation and how situational conditions can either facilitate or inhibit participation and learning amongst the learners. Another dimension of the study seeks to establish what caregivers learn and the processes through which they learn and how such learning contributes to changes in behaviour and relationships. In this study, the nature and dynamics of learning amongst adult learners in the NCTP programme at community level is explored as an example of socio-cultural theory and situated learning which hold that learning results from participation in various socio-cultural situations – the act of participation is seen as crucial in the learning. The study focused on a group of 10 learners in the National Certificate Training Programme for community health workers who are also caregivers in the Nokuthembeka Home-based Care Programme in New Crossroads in the Cape Town metropole and used a qualitative research design and interpretive approach to understand the situations in which they learn. An interpretive approach allowed for deeper insight into the socio-cultural contexts that influence the social interactions of caregivers with peers as well as their learning. In the study I argue that the experience of caregivers forms a critical resource and the foundational basis for learning. The research study confirmed that the training programme in which caregivers interact and engage with peers and facilitators creates a learning context and that active participation in the situation facilitates learning. The study further confirmed that the informal settings of the home and community are important sites for learning and gaining experience and that situational conditions such as language, personal attributes and culture of learning/teaching can influence participation and learning.

**Declaration**

I declare that *The Nature and Dynamics of Learning Amongst Learners in a National Certificate Training Programme* is my own work, that it has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

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Nomvula Dlamini (Ms)

November 2009



**Dedication**

This research paper is dedicated to the memory of my mother and brother who I sadly lost in the course of my learning journey.

I also wish to honour the many women and men who work tirelessly as home-based caregivers to serve communities with dedication, commitment, integrity and care.

**Acknowledgements**

Throughout this learning journey I have been supported by many people in different ways, particularly during those moments when I experienced setbacks. I am particularly thankful to those who have contributed to my thinking, ideas and writing for this mini-thesis. I am particularly thankful to the women in New Crossroads who participated in the focus group and interview sessions, the community home-based care programme that offered me access to the women and the Adult Learning Network that introduced me to the women who made this research possible. My supervisor, Prof. Zelda Groener, whose constant encouragement, unwavering support, love for learning and insightful guidance motivated me and helped me to persevere even during the most difficult moments of this journey. My colleagues, Desiree Paulsen, Vernon Weitz, Shelley Arendse, Marie Corcoran-Tindill for encouragement throughout and Miriam Louw, friend and confidante, for your belief in me. My organisation, the Community Development Resource Association for providing a stimulating, thought provoking learning environment that promotes cultivation of a reflective practice. Lecturers and the learning community of the Inter-Continental Masters programme for contributing towards expanding and challenging my thinking, opinions and perspectives. To my sisters, Nompukazana, Nodaka, Nontsikelelo and Nomama your love for learning has always inspired and sustained me.

## **SECTION ONE**

### **1. OVERVIEW OF THE STUDY**

#### **1.1 Introduction**

In South Africa, similar to many other countries in the world, reform of the health care system post-1994 ushered in a shift in the provision of health care support away from institutions to communities. This shift resulted in the introduction of home-based care practices and the involvement of large numbers of ordinary community people in the provision of health care at community level and so complementing the statutory institutional health care services.

The shift in health care support from institutions to communities has seen more responsibility transferred to community home-based caregivers, lay persons providing a community-based health service for which they are trained. Generally, community home-based caregivers are trained over a shorter period than health professionals. Where such home-based care programmes exist, they are often supported by the health care institutions but are not necessarily part of its organisation. Various studies, in South Africa and elsewhere, have revealed that such caregivers are mostly women.

Through my work in the non-governmental organisation sector and particularly with community-based organisations I have become aware of an increase in the number of home-based care programmes and this can be attributed to: 1) reforms in the health care system, 2) the growing prevalence of HIV and Aids has resulted in a growing demand for health care support, 3) the devastating effects of HIV and Aids have rendered vast numbers of children vulnerable and in need of care and support 4) the growing numbers of support groups through which sick people have cared for each other. This research



study is therefore grounded in my own practical experiences of facilitating learning processes for community-based organisations and community workers.

While many of these home-based care programmes start as informal, small support groups initiated by one or two people, over time many have evolved into community structures, projects and organisations that are well-coordinated and are increasingly recognized by provincial government departments, municipalities, business, donor agencies and communities as playing a critically important role in taking care of sick people and thus contributing towards the well-being of communities.

Many home-based care programmes have thus become registered entities in line with the Non-Profit Organisation Act of 1997 and this makes them compliant with the requirements and regulations. In the last while we have seen them increasingly play a role in the provision of health care and welfare services to poor communities; home-based care programmes are increasingly recognized as an important vehicle through which poor communities can access health care support and services. This assertion is substantiated by Wolvaardt, Van Niftrik, Beira, Mapham and Stander (2008:229-230) who maintain that “CBOs<sup>i</sup> are becoming major contributors at grassroots level, especially in providing home based care services and caring for the terminally ill. There has been substantial investment in developing the role of these organisations/projects by government and donors”. These authors go on to say that “In South Africa, there is a plethora of non-medical institutions, organisations and projects that are contributing to the promotion of mental, emotional and spiritual well-being including NGOs<sup>ii</sup> , community home-based care projects and various support groups (Wolvaardt, Van Niftrik, Beira, Mapham and Stander 2008:230). According to Clarke, Dick and Lewin (2008:680), “South Africa has

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<sup>i</sup> CBO: community based organisation

<sup>ii</sup> NGO: non-governmental organisation

now identified generalist Community Health Workers as having an important role to play in meeting the health and social needs of the majority of its people”.

In line with such recognition, important linkages have been established between health care institutions and community home-based care programmes to provide support to sick people in poor communities in ways that are more sustainable. Through such linkages, their access to such services is better coordinated.

According to Burns (2001:6), “learning is always socially situated, socially constructed and socially validated within social settings which exist as contextual settings”. Drawing on this perspective, community-based care-giving takes as its point of reference community-based learning and education; knowledge and practices that are non-formally and informally produced through social interaction - the core practices of community caregivers are therefore associated with non-formal and informal learning. My research study draws on this viewpoint to inquire into and establish how learning among caregivers contributes towards building their knowledge and competence. “Caregivers”, Uys (2002:99) maintains, “play an important role in correcting misconceptions about HIV and Aids; a great deal of what they have come to know about taking care of people living with HIV and Aids has been learned through training programmes that aim to equip them with knowledge and provide guidance for participation in real-life situations”. On a daily basis, caregivers participate in activities in settings where they perform core practices and interact with patients and their family members. For caregivers, ‘doing’ and ‘learning’ are therefore intertwined.

## **1.2 Focus of the research study**

The broad field of my research study is adult education and learning and the area of focus is situational learning. The study investigated “the nature and dynamics of learning” among a group of caregivers who provide palliative care and counseling support to patients of HIV and Aids, tuberculosis and other chronic illnesses at community level.

The study was guided by questions to provide insight into the nature and dynamics of learning amongst caregivers.

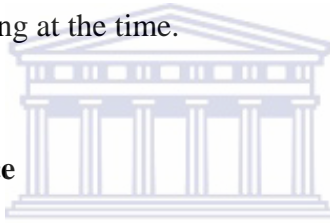
Towards this, one dimension of the study investigated how the experience of caregivers, as a resource and basis for further learning, influences their participation and learning in the training programme. The study further explored the concepts 'experience', 'participation' and 'learning' and the relationship between them in order to throw more light on the nature and dynamics of learning among caregivers who work at community level.

My study is premised on the experiences of a group of community caregivers who work for a registered home-based care programme. As a result the study is grounded in the lived experiences of a group of 8 women and 2 men of the Nokuthembeka home-based care programme as well as those of the 2 retired nursing professionals who coordinate the activities of the caregivers. Although caregivers are based outside of health institutions, they continue to have linkages with the health care system through the clinics, hospitals and hospices that offer them to undertake practical sessions and the referral system. The connection to these institutions enables them to offer support to communities that is much better coordinated while providing them with a platform for learning and ongoing development.

Although my research study focused on the nature and dynamics of learning among community level caregivers, it is important to mention that the emphasis was not on the care-giving practice but rather on the aspect of learning within the context of a training programme. The research group comprised of men and women who are learners in a four-year accredited National Certificate Training Programme for community health workers; the study investigated the nature and dynamics of learning as they participate as learners in a training programme. The sample group of 10 was in their second year of training and I investigated how their participation in a training programme facilitated learning that leads to change. Although the training programme makes use of

participatory methodologies, the study focused on the learners' perceptions/experiences of participation and how this facilitates learning that leads to change.

The National Certificate Training Programme has specifically been developed for community level caregivers to contribute towards the professionalisation of care-giving. The training programme has only been introduced over the last two years by the Department of Health in line with the broad skills development agenda and ensuring people who provide health care support at community level are adequately skilled to ensure sustained support outside of the formal health care facilities and system. Although the training programme makes use of participatory methodologies, I investigated participation from the learners' perceptions/experiences and not from those of the facilitators. My research study focused on learners in the second year of study because they were not involved in training at the time.



### **1.3 Motivation and Relevance**

Research studies in South Africa and elsewhere, have revealed that common issues among home-based caregivers have to do with the burden of care-giving responsibilities – a great deal of emphasis is placed on their need for relief care, appropriate information on how to provide care more effectively and how to match the shift away from institutions to community with a resource input. However, not many studies that provide insightful information on the learning aspect of the practice of home-based care have been undertaken.

In South Africa it is only in the last few years that the role of home-based caregivers as primary health care support in poor communities is being recognised, appreciated and valued. Clarke, Dick and Lewin (2008:1) remind us that “using lay members in the community to provide health care is a practice with a long history in South Africa. The development and implementation of community health worker programmes grew during the 1970s and 1980s in response to the inadequate provision of primary health care under apartheid”. Home-based care is linked to this history and practice of community health

workers and the practice of home-based care is increasingly being used and recognized in health care policy processes and programme planning. However, to ensure that the practice of home-based care contributes effectively to the learning of the healthcare system, it is important that the experiences and knowledge of community-based caregivers be harnessed and used for improving support services – such experiences should be viewed as an essential ingredient for home-based care policy development, programme planning and treatment choices.

Community caregivers therefore, in order to provide effective care to patients, need to be supported to deal with the practical and theoretical aspects of the care-giving roles and responsibilities. This requires that the learning aspect – the processes through which their experiences and knowledge are enhanced – pertaining to their roles and responsibilities have to be harnessed so as to further shape and inform HBC practice. Through focusing on the learning aspect of home-based care practice, the sustainability of a community-based health care system that relies on volunteer caregivers can be ensured.

While there are many situations in which caregivers engage, in this study I focused on their participation in the National Certificate Training Programme in which they interact with peers and facilitators of the training and explored how such interactions and participation contributed to their learning and the creation of new knowledge. While caregivers see their role as mediators or advocates between communities and professional health care practitioners, on a broader level the practice of care-giving seeks to ensure the well-being of communities; it is seen as contributing towards sustainable health care and HIV and Aids prevention. Given the role of care-giving in communities, there is a need for this practice to be developed into an occupation that requires not only better training, but also requires that their experiences and learning be harnessed. For this to happen, the value of the participatory processes through which they learn and the experience they bring should be established and investigated, and insights drawn from these.

There is a great deal of unintentional, unconscious and unplanned learning that happens as caregivers perform their daily tasks, participate in activities and interact with people in

the community, with peers and professional health care practitioners. This kind of learning that happens informally and incidentally is sometimes conscious and has intention to it. However, more often this learning is unconscious and is not recognized as learning by those involved in the activities or even by others – it is often not regarded as meaningful, beneficial and valid. As a result, this kind of learning is often not harnessed and used to improve the knowledge and understanding of those involved (Marsick and Watkins, 2001:25-26).

Learning through participation has the ability to blend the non-formal and informal dimensions of learning; for adult learners, most learning situations have dimensions of non-formal and informal learning and the relationship between these can only be understood within a particular context (Marsick and Watkins, 2001:25). At community level, caregivers work in environments where there is not much structure or facilitation; they essentially have to take responsibility for their work – they engage in activities and participate in situations through which they learn. The experiences of caregivers are formed by the situations in which they work; the activities they participate in and their daily interactions. On a daily basis they are faced with interpreting these situations and how they do this contributes to their personal knowledge. Though informal and unplanned, they also learn from these situations.

The different situations in which caregivers participate provide them with challenges but also with opportunities to learn, grow and develop. For example, they care for patients, interact with family members and health care professionals at health facilities and these situations provide them with learning opportunities. However, their own awareness of the learning opportunities in such situations is often not awakened and as a result they can not fully take advantage of such opportunities. Also, there are no guidelines or instruments to help them become more proactive and self directed in terms of their learning. Most people who venture into care-giving do not do so out of a strong desire to learn – learning is not the initial impetus that drives them. As a result, they do not link learning to the everyday activities and situations in which they participate and therefore do not become self-directed learners.

Critical literature on adult learning perspectives maintain that experiences that individuals bring to situations in which they participate can be mobilised through participation and that these situations provide opportunities for learning. It is only by creating awareness about linking learning to the situations in which they participate that caregivers can be awakened and stimulated to take responsibility for their own learning and for influencing the learning of the home-based care programmes of which they are a part.

#### **1.4 Aim of the research study**

The research study aimed to explore and investigate the “*Nature and Dynamics of Learning Amongst Caregivers in a National Certificate Training Programme*”. The following questions were formulated and posed to guide the investigation:

- How does the experience of learners influence their participation in the learning activities?
- What do the caregivers learn through participation in the training programme and how do they learn it?
- What situational conditions influence their participation and learning?
- How does participation in a training programme facilitate learning that results in change?

#### **1.5 Section outline**

Section Two is the literature review which is entitled “Socio-cultural Theory and Situated Learning”. The purpose of this section is to provide an epistemological basis and theoretical/conceptual framework for understanding the nature of adult learning processes at community level. The section seeks to translate the theoretical perspectives and provide insight into and an analysis/interpretation of the nature and dynamics of learning amongst community-based caregivers who are learners in a National Certificate Training Programme.

Section Three explains the research methodology. It starts off by sketching the methodological framework and goes on to explain the qualitative methods and the reasons for using these. The rationale for using a qualitative research methodology and particularly the use of focus groups and face-to-face interviews as methods is explained. The use of focus groups and face-to-face interviews are discussed with description of the processes and a reflection on the use of these methods. The section ends with the ethical guidelines and limitations of the study.

Section Four provides data/information on the core concepts covered in the study that give expression to the nature and dynamics of learning amongst caregivers. Further, the section seeks to provide an analysis and interpretation of the data. Throughout the section, I have tried to ensure that the voices of interviewees and my own interpretation remain interwoven in a meaningful way.

Section Five presents a summary of the key findings, conclusions and recommendations. The purpose of this chapter is to provide a synthesis of the central arguments of this research study and an interpretation of the relationship between experience, participation and learning.



## **SECTION TWO**

### **2. SOCIO-CULTURAL THEORY AND SITUATED LEARNING**

The purpose of this section is to provide an epistemological basis and theoretical/conceptual framework for understanding the nature of adult learning processes at community level. The section seeks to understand, translate the theoretical perspectives and provide an analysis and interpretation of the nature and dynamics of learning amongst community-based caregivers who are learners in the National Certificate Training Programme.

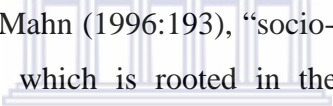
The epistemological basis of my research study makes use of socio-cultural theory and situated learning to help understand the nature and dynamics of learning amongst caregivers in the National Certificate Training Programme. The literature review starts by exploring learning as a socially situated process and looks at the importance of social interaction in learning processes. It then moves on to explore the concepts of participation and experience as they relate to the theoretical focus of my research study and ends in highlighting the relationship between experience, participation and learning in the context of the research questions posed.

#### **2.1 Learning as a socially situated process**

John-Steiner and Mahn (1996:192), two contemporary protagonists of socio-cultural theory, help us to understand that socio-cultural approaches to learning and development were first systematized and applied by Vygotsky and his collaborators in Russia in the 1920s and 1930s. According to John-Steiner and Mahn (1996:192) “socio-cultural approaches are based on the concept that human activities - including learning - take place in socio-cultural situations, are mediated by language and other cultural variables and can be best understood when investigated in their historical development”. Through their work, these theoreticians helped us to understand that Vygotsky developed a rich,

multifaceted theory through which he examined a range of subjects including language and thought, learning and development and the socio-cultural situation in which the learning happens.

Since the time of Vygotsky, socio-cultural approaches to learning have gained increasing recognition and have been further developed by scholars in many different parts of the world. Contemporary interpretations and reinterpretations of Vygotsky's and his collaborators' work reflect the visibility and obscurity of this theory's seventy-year existence. The expansions and interpretations of their work have led to diverse perspectives on socio-cultural theory. The dissemination of Vygotsky's ideas and the application of his work in diverse contexts have remained influential and have contributed substantially to ideas pertaining to socio-cultural approaches to learning throughout the world.



According to John-Steiner and Mahn (1996:193), “socio-cultural theory regards learning as a socially situated process which is rooted in the situation in which a person participates” - the emphasis is on learning-in-context. This theoretical perspective essentially views learning as a social process; it holds that human beings learn from interaction with other social beings as well as with the external world in which they participate. This external world can include ideas, beliefs and perspectives within that situation. This perspective therefore does not see learning as an activity that is separate from interaction in the situation – the learning is rooted in interaction with others and with other objects in that situation.

In citing Vygotsky (1978), John-Steiner and Mahn (1996:193) maintain that “socio-cultural approaches to learning emphasize the interdependence of the social and the individual processes in the co-construction of knowledge”. According to John-Steiner and Mahn (1996:193), “Vygotsky emphasized the importance and primacy of social interaction in human learning and development processes”. From this, it can be deduced that in any situation, social interaction in whatever form is critical for the learning.

John-Steiner and Mahn (1996:195), maintain that according to socio-cultural theory:

- 1) Learning happens in the relationships between people and requires full participation
- 2) The nature of the socio-cultural situation does impact significantly on the process of learning and meaning creation – it can either enhance or inhibit the processes of learning and meaning creation
- 3) Since learning happens through participation and interaction, meaning creation is not seen as an individual, subjective process – meaning is shaped by the collective and happens through active participation.

Wenger (1998:7), also an advocate of socio-cultural theory asserts that “learning takes place through engagement in actions and interactions and embeds this engagement in culture and history. Through local actions and interactions, learning reproduces and transforms the social structure in which it takes place”. Wenger’s perspective focuses on the individual’s actions and interactions with others in the process of learning and meaning construction. Wenger (1998:7) asserts that “for individuals it means that learning is a process engaging in and contributing to the practice of their communities”. While Wenger concurs with the ‘socially situated nature of learning’, he highlights the transformative nature of learning. This means that learning changes the individuals as well as the situation in which it happens.

Stein (1998:1) asserts that situated learning “conceives of learning as a socio-cultural phenomenon rather than the action of individuals acquiring general information from a de-contextualized body of knowledge”. In other words, knowledge is not perceived as existing separate from the situation in which the learning happens. According to Shor (1987) as cited in Stein (1998:1), “as an instructional strategy, situated learning has been seen as a means for relating subject matter to the needs and concerns of learners. Learning is therefore essentially seen as a matter of creating meaning from the real activities of daily living”.

Stein (1998:1) further maintains that “for adult learners, to situate learning means: 1) to place thought and action in a specific place and time, 2) to involve other learners, the situation and the activities to create meaning, 3) to locate in a particular setting the thinking and doing processes used by experts to accomplish knowledge and skill tasks and 4) to create the conditions in which participants will experience the complexity and ambiguity of learning in the real world”. According to Stein (1998:1), “participants will create their own knowledge out of the raw materials of experience i.e. the relationships with other participants, the activities, the cues from the situation, and the social organization that the community develops and maintains”.

“Situating learning”, according to Stein (1998:2), “places the learner in the centre of a process of instruction which consists of: 1) the content – the facts and processes of the task 2) the situation – people, values, beliefs, ideas/thoughts and environmental cues by which the learner gains and masters content 3) the learning community – the group with which the learner will create and negotiate meaning of the situation and 4) participation – the process by which learners working together and with experts in a social organization solve problems related to everyday life circumstances”. He refers to these as the elements of situated learning.

Therefore, for protagonists of this theory, learning becomes a social process dependent upon transactions with others within a situation that resembles as closely as possible the practice environment. As a result, according to Stein (1998:2) “situated learning in the classroom environment integrates content, context, community and participation”.

Marsick and Watkins (2001:29) maintain that “the context within which the experience occurs, the personal, social, business and cultural context for learning that plays a key role in influencing the way in which people interpret the situation, their choices, the actions they take, and the learning that is effected”. From this viewpoint, learning, whether conscious or unconscious, leads to a change in actions and choices. It can therefore be deduced that, irrespective of the circumstances under which it happens, human learning does seem to have outcomes attached to it and that such ‘outcomes’

could include increased knowledge, understandings, resourcefulness, consciousness, self-awareness, enhanced opinions, increased personal influence and capacity to decide or make choices.

## **2.2 Significance of the learning situation or context**

Socio-cultural theory perceives the situation or context in which the learning happens as critical. Various theorists describe this situation, context or environment as including objects, people, beliefs, perceptions, perspectives, ideas and thoughts. The learning situation is therefore seen as the objects, people, perspectives, thoughts, beliefs and perceptions contained in the space that the learner interacts and engages with directly or indirectly.

According to Hager, Johnsson and Halliday (2006:1), the socio-cultural situation refers to “the environment, background, setting, circumstances, situation or site in which the learning happens”. These authors see the socio-cultural situation as an important part of both the learning process and its outcomes. They assert that “the situation in which the learning happens changes both learners and the nature of their relationships with others”. This concurs with Wenger’s idea that “learning transforms the social structure” (Wenger1998:96).

The authors maintain that the learning situation allows for interaction/transaction and that such interaction/transaction changes both the relationship between the learners and the substance (subject matter). The authors conclude that learning becomes a transactional relationship in which learners, the situation, the learning process and outcomes change; they maintain that learners and situation or context are intertwined; they change each other. These authors further maintain that the situation shapes collective learning as it leads to shared understanding that stems from interaction with others. As a consequence, connection or relationship to others in the situation is therefore important.

Hager, Johnsson and Halliday (2006:2) do caution that “the situation should not be limited to merely the descriptive setting within which learning occurs. The danger of this view”, they maintain, “would simplify transferability as learning process and knowledge as learning product”. According to them, “the situation helps to problematise learning as the situational conditions help with interpretation and guide choices for actions”. They further assert that “the situation enables the development of an adaptive capacity to manage change and differences that contribute to collective competence. Therefore, interaction with others provides experiential opportunities to negotiate and refine frames of reference that form motivations and basis of action”.

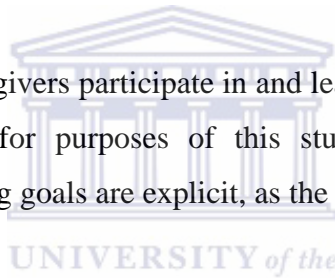
These authors therefore see the situation in which the learning happens as contributing to and emerging from collective actions, it presents the conditions that must be judged and acted upon together with others. For this reason, they see the situation or context as “helping to create knowledge that emerges from participation with others and results in knowing from participation with others”. They further maintain that “the situation or context in which learning happens provides the specifics in the immediate present that helps to shape past experiences and that through participation in a particular context, participants and the situation are transformed” (Hager, Johnsson and Halliday 2006:1). From this, it can be concluded that past experiences can be mobilized through participation and such facilitate learning.

According to Dey, Abowd et al (1999:3) the learning context can be understood as “the situation in which the individual or group of learners find themselves”. These authors define it as “any information that can be used to characterize the situation of a person, place or object considered relevant to the interaction”. According to them, awareness of the situation therefore helps with understanding the factors that influence learning. Dey, Abowd et al (1999:3) assert that “the situation in which the learning happens helps people make sense of things; it enables learners to integrate input from diverse sources and construct knowledge from that”. The authors further maintain that “knowledge/skills are best acquired in the situation and that the latter gives meaning to learning”. They

emphasize that it is important, in any learning event, to design an effective and meaningful learning situation or environment to facilitate learning.

Stein (1998:3) asserts that “the situation in which learning happens embraces notions of power relationships, politics, competing priorities, culture and the learner’s interaction with values, norms, culture of a community, organisation or family”. Stein (1998:3) further maintains that “the learning situation enables us to see the learner in “a social, psychological and material environment”. In seeing the situation in this way, it allows learners to re-experience the learning event from multiple perspectives (not only from one perspective). The situation, therefore, provides the setting for examining experience, feelings, perspectives and values. Within the situation, interaction with peers or members of the social community is what shapes the learning of individuals and the collective.

While I recognize that the caregivers participate in and learn from different socio-cultural situations on a daily basis, for purposes of this study I focused on the training environment, where the learning goals are explicit, as the main learning context.



Marsick and Watkins (2001) provide a basis for understanding how “meaning making progresses as people begin to make sense of a situation” (Marsick and Watkins 2001:29). According to them, “there are conditions within the socio-cultural situation that can enhance learning; making it more visible and rigorous”. Marsick and Watkins (2001:30) further maintain that “learning grows out of everyday encounters while working and living in a given situation”. According to them, “many contextual factors influence the ability to learn well enough to successfully implement the desired solution”(Marsick and Watkins 2001:30).

Vygotsky (1978) as cited in John-Steiner and Mahn (1996:194) postulated that “the situation in which an individual lives is the arena which provides challenge and development”. Further, “the learner’s environment is an important variable in the process of learning” (Vygotsky 1978:64-65). Duffy and Cunningham (2001:3) maintain that “the situation as a whole must be examined and understood in order to understand the

learning”. According them, “learning must be viewed as the activity in context” (Duffy and Cunningham 2001:3). Brown, Collins and Duguid (1989) as cited in Behrman (2002:27) concur with Vygotsky and maintain that “learning is also influenced by the physical setting and its available tools or resources”. According to Doolittle (1999:5), “variables such as language, politics, culture and economic aspects are therefore important tools that have an impact on learning and the creation of meaning/knowledge”. From this viewpoint, it can be deduced that the socio-cultural situation is critical for learning and it contains the tools that can be used for mediating/facilitating learning.

Nelson (1998: 120) maintains that “the mediating role of language involves its capacity to convey knowledge about the world, about other people, about social and cultural interpretations of situations and events, and about imagined possibilities, plans, mythologies and theories”. Although the role of language in regulating interactions between people is generally acknowledged by socio-cultural theorists, Nelson (1998: 120) goes on to assert that “in this role, language serves a different meta-function than that of regulating interactions between people”. She emphasizes that “language must be well developed in order to serve the full range of its mediating/facilitating functions (Nelson, 1998:120).

Because socio-cultural theory views the situation as important for learning, the implication is that the creation of meaning and knowledge are therefore bound to the space and time where the social engagement is happening. Further, given that protagonists of this theory view the learning situation as providing the tools that support/facilitate learning and help to create meaning, situational resources such as people, language, knowledge, ideas/thoughts and feelings therefore become important in this regard; they are seen as either enhancing or inhibiting learning. Although socio-cultural theory sees the situation as critical for learning; it recognizes that the situation is changeable and does not exist separately from the learner. In my study I took into consideration the dynamism and changeable nature of the situation and the influence it exerts on the learning process.



### 2.3 Exploring Experience and Participation

In this section ‘experience’ and ‘participation’ are explored as key concepts covered by my study.

Wikipedia ([www.wikipedia.org](http://www.wikipedia.org)) describes experience as “a general concept comprising knowledge of or skill in or observation of some thing or some event gained through involvement in or exposure to that thing or event. The concept refers to know-how or procedural knowledge, rather than propositional knowledge”. This description underscores the fact that experience can be gained through direct involvement in or exposure to a thing, a situation or event.

In critical adult learning literature, researchers and theoreticians support the importance of experience and creation of knowledge from such experience. According to Brookfield (in Tuinjmán (ed.) 1995:1) “experience should not be thought of as an objectively neutral phenomenon, a river of thoughts, perceptions and sensations into which we decide, occasionally, to dip our toes”. Brookfield (in Tuinjmán (ed.) 1995:1) asserts that “experience is culturally, morally and ideologically framed and shaped and that it is central to how we interpret what happens to us, our interaction with the world and how we act upon that world”.

According to Foley (1993) as cited in Sparks (2002:60), “much of adult learning is not acquired through formal education but is gained through experiences, through participation in an aspect of social life such as a learning group, family, community or work”. Foley (1993), as cited in Sparks (2002: 60) defines learning as “tacit or implicit; it is embedded in routine activities and is not automatic or inevitable”. There are different definitions of learning from experience, but in the early 1980’s Mezirow and Freire stressed that “the heart of all learning lies in the way we process experience, in particular our critical reflection on experiences”. At the time they spoke of learning as “a cycle that begins with experience, continues with reflection and later leads to action, which of itself becomes a concrete experience for reflection”

Although there are strong arguments by theorists and researchers that learning should be grounded in experience, the latter “should not be seen as an objectively neutral phenomenon. Experience is culturally framed and shaped and our reading of this changes according to the language, categories of analysis, cultural, moral and ideological factors” (Brookfield in Tuijnman (ed.) 1995:1). He reminds us that, when investigating experience, “our individual structures of understanding and perceptual filters are culturally embedded and our experiences therefore, are not free from the cultural contradictions that inform them” (Brookfield in Tuijnman (ed.) 1995:1).

In educational learning institutions, the situated learning perspective poses challenges to educators as they constantly have to create a learning environment that will ensure the social engagement produces the proper context in which such experience can be interrogated, investigated and understood. Looking at it from this perspective, experience is integrally linked to context and meaning is mediated through experience. In summary, experience is gained through participation and engagement in daily life, as part of a social community (family, peers) or through observation of a situation. Experience, therefore, is not bound to a place or time.

Merriman (2001:5) reminds us that “the five assumptions underlying andragogy - the art and science of helping adults learn - describe the adult learner as someone who has accumulated a reservoir of life experiences that is a rich resource for learning and is motivated to learn by internal rather than external factors”. From these assumptions, it is evident that any study focusing on adult learning processes and practices should take as a key point of reference the ‘reservoir of life experiences that serve as a source of learning’ that adult learners bring into any learning or instructional situation. A dimension of this study explored and investigated the experience that learners bring into the training programme and aimed to establish how such experience is mobilized through active participation.

Moving to the concept of participation, according to Stein (1998:3), “participation describes the interchange of ideas, attempts at problem solving and active engagement of learners with each other and with the materials of instruction. It is the process of interaction with others that produces and establishes meaning systems among learners”. From a situated learning perspective, Lave and Wenger (1998:4) maintain that, “learning involves participation in a community of practice”. Lave and Wenger (1998:4) go on to assert that, “learning is, thus, not seen as the acquisition of knowledge by individuals so much as a process of social participation”. They further maintain that “learning becomes a process of reflecting, interpreting and negotiating meaning among the participants of a community” (Lave and Wenger 1998:5).

Wenger (1998:51) asserts that “meaning is constructed through interaction by participating in a social community of practice”. He advocates that “participants help to shape each other’s experience of meaning and that the act of participation is crucial in the creation of meaning”. Wenger (1998:56) describes participation as “the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises”. According to Wenger (1998), “participation is both personal and social. It is a complex process that combines doing, talking, thinking, feeling and belonging; it involves our whole person, including our bodies, minds, emotions and social relations - participation is an active process” (Wenger 1998:56). From this it can be deduced that participation and social engagement enable the processing of experience which is vital to learning.

Behrman (2002:27) maintains that “learning is intermeshed with the social and physical situations and it occurs through active participation in a community of practice”. He asserts that “the learners’ manner of participation is more important than the activity itself”. Drawing on Behrman’s perspective, socio-cultural theory therefore emphasizes interaction with others and collective sense-making or meaning creation - it holds that interaction with others in a particular situation when making sense of the world is critical. This perspective emphasizes that “learning depends on the ability of individuals to

contribute to the collective production of meaning and knowledge and that it is by this process that competence is further developed” (Behrman 2002:26-32).

Drawing on the perspectives of Stein (1998:1-2), who advocates that “situated learning uses participatory teaching and learning methods as the means for acquiring knowledge and that knowledge is created through the interactions of the learner with others and the environment”. Subject matter is perceived to emerge from the cues provided by the situation and from the dialogue among those involved in the learning process. According to Stein (1998:1), “learning is implicit in the experience rather than in the subject matter (the what) presented by the instructor or facilitator”. This means that learning is implicit in the experience of interaction rather than in the subject matter (the content).

Many protagonists of situated learning insist that learning and knowledge are rooted in the process of participation – for situated learning theorists learning and knowing are defined as the “changing processes of human activity in a particular community” Lave and Wenger (1998:2). Lave and Wenger (1998:4), foremost among the proponents of this school of thought, contend that “participation in a situated learning context constitute a community of practice” (Lave and Wenger 1998:3). “Learning”, they argue, “is a social activity that emerges from our experience of participating in daily life” (Lave and Wenger, 1998:7). Wenger (1998) further maintains that “learners” occupy different roles depending on the structure of the community of learning; these may either be at the core or on the periphery of the learning community. But, regardless of where learners are located, the resultant learning becomes a shared enterprise” (Wenger: 1998:86).

In addition, situated learning uses cooperative and participative teaching methods as the means of acquiring knowledge. Knowledge is created or negotiated through the interactions of the learner with others and the environment. Subject matter is perceived to emerge from the cues provided by the environment and from the dialogue among the learning community. Applied to learning environments, situated learning is not only reflecting upon and drawing implications from previous experiences but is immersion in and with the experience (Stein 1998:2).

## **2.4 Relationship between experience, participation and learning**

The literature review highlights the fact that all human activities are socially situated and that learning, as a human activity, should be understood and engaged with from a social and cultural perspective and that learning happens through interaction with other social beings and also with objects in the world such as beliefs, ideas, perspectives and opinions. From the literature review, learning, as a human activity is therefore not confined to a particular setting, it happens in any situation where there is interaction between social beings.

In my research study, the participation of the learners in the training programme is a human activity that brings them into interaction with their peers as well as with the facilitators; there is therefore an interdependent relationship between the individual learner and their peers and facilitators in the training programme. The training environment provides the learners with a social situation in which they interact with their peers and also with the ideas, beliefs, opinions and problems they hold and come with into the training environment. Through the use of participatory methodologies they share ideas, stories, problems and challenges – the learners participate in group activities through which they work together and solve problems. In the context of the group, participation and the peers become important.

An important concept highlighted in the literature review is the importance of experience that individuals bring into new situations and interactions; the literature review emphasizes that such experience is acquired through involvement or participation in an activity or event. The literature emphasizes that experience grows through such involvement or participation and it informs how individuals interact with others in situations. In any learning situation, it is of critical importance to have participatory and interactive processes to enable the processing of such experience. The process of learning, therefore, becomes about processing such experience.

The literature review highlighted the fact that in order to meaningfully process such experience, it requires active participation on the part of the learner. Participatory processes are therefore seen as central to meaningful processing of experience; participatory processes allow individuals to interpret, reflect on and share their experiences and stories through interaction with others. This sense making of experience, according to the literature review, happens in a collective, in a social setting. As a result, it is important that those responsible for designing learning activities ensure the integration of participatory processes to ensure the creation of an environment that is conducive for such experience to be investigated, stimulated, interrogated and understood.

One of the main elements of situated learning is the socio-cultural situation or context in which the learning happens; the literature review highlights the fact that the socio-cultural situation provides an important context for learning. However, for the learning to happen requires full participation by those involved. In addition, the socio-cultural situation provides an important space for learners to examine their values, experience, feelings and perspectives through interaction with peers. The literature review highlights an important point about how, through participation, the situation changes the learners as well as their relationships with others. The transformative nature of the social situation is therefore highlighted by the literature. The literature review highlights the fact that the process of learning is not separate from interaction within the situation and participatory processes or methodologies can facilitate such interaction.

The National Certificate Training Programme makes use of participatory methodologies and the responsibility to ensure meaningful participation rests mainly with the facilitators of the training programme. One of the weaknesses of participatory processes or methodologies is that there are instances where the educators or facilitators are not able to re-create authentic situations in order to engage learners fully – this then does not lead to learning that results in change. One of the questions guiding this research study is whether participation in the training programme facilitates learning that results in change;

it explores whether their participation in the training programme facilitates learning that is transformative.



## SECTION THREE

### 3. RESEARCH METHODOLOGICAL FRAMEWORK

Socio-cultural theory and Situated Cognition both encourage approaches to learning that see people as active participants in their processes of learning, meaning making and knowledge creation. As a result, any research study which seeks to investigate activities of participation and its connection to experience, learning and knowledge creation has to acknowledge that these are complex concepts or phenomena which entail studying human behaviour, habits and preferences and for which quantitative measures are not adequate to interpret often very complex situations. For this reason a qualitative research design and methodological framework was favoured and used as overall framework to cater for qualitative observations of behaviours, habits and preferences and to allow for explanation, interpretation and description of what was observed, seen and related.

#### 3.1 Qualitative research methodology

The study was informed by a qualitative research methodology within which two particular qualitative methods, focus group and semi-structured interviews were used. Within this methodology an interpretivist approach was used to try and understand the nature and dynamics of learning among caregivers in a National Certificate Training Programme. The aim of the research study was to explore the nature and dynamics of learning among caregivers and as a result data that reflected their perceptions, opinions and thinking was required and a qualitative methodology was better suited to this kind of exploratory study. A qualitative research methodology also allowed for investigation and exploration of a topic about which very little is known. My preliminary literature searches provided very little information about the learning processes of caregivers within the South African context and use of a qualitative design enabled me to gain in-depth information about the nature and dynamics of learning among caregivers that would have been difficult to convey quantitatively.



In contrast to quantitative research, Lazar in Seale (2004:14) maintains that “researchers favour qualitative methodologies rather than quantitative ones because they find that people’s words provide greater access to their subjective meaning than do statistical trends”. According to Lazar in Seale (2004:14), “making use of a qualitative methodology allows for understanding of the socio-cultural context in which people operate and learn”. For purposes of this study, making use of qualitative methodologies and methods helped to give deeper insight into the factors that influence the learning of caregivers as well as their interactions with peers and facilitators in the learning community of which they are a part. Use of a qualitative design helped me to understand how participation can facilitate learning in a context-specific setting – it helped to illuminate the conditions that enable active participation and those that hinder or interfere with participation.

Drawing on the ideas of Lazar, Tonkiss and Byrne in Seale (2004:99-204), making use of qualitative methodologies helped with surfacing and identifying contextual factors such as language and the culture of learning/teaching and exploring how these facilitated or inhibited learning and the interaction among learners and between learners and facilitators of the training programme. In this study, making use of qualitative methodologies enabled penetration of the experiences of caregivers as learners in a training programme and the interrogation of how such experiences are mobilized by participatory activities and interaction with peers and facilitators of learning within the learning community.

### **3.2 Use of an interpretive approach**

In this section I briefly talk about my experiences during the data collection phase and relate these to the use of an interpretive approach in collecting the data. According to Lazar (Seale, 2004:14), “broadly speaking, interpretivists tend to favour qualitative rather than quantitative methods. This is because, on the whole, researchers find that people’s words provide greater access to their subjective meaning than do statistical trends”.

Using an interpretive approach helped with avoiding objectification of caregivers who served as the primary informants; it enabled me to explore the meaning or meaningfulness of their experiences and how such experiences can be mobilized through participatory activities. An interpretive approach relies on first-hand accounts - through use of an interpretive approach, the experiences and the stories that flowed from these provided access to the subjective meaning they have derived from such experiences. Through interpretation of their experiences and perceptions, an attempt was made to achieve clarity about the nature and dynamics of their learning processes and the meaning these hold for them.

Through use of an interpretive approach, I was able to discover the meaning different experiences had for individuals - interpretation of such meanings for different individuals was the responsibility of the researcher. An interpretive approach therefore allowed for continuous meaning making of responses by the researcher. At the same time, it demanded of the researcher to recognize that interpretations of meanings are context-specific and that such meanings would change from context to context.

The study recognizes that objectivity cannot be fully achieved in a study of this nature and Weber (1978), cited in Seale (2004:14) concurs with this. Weber (1978) is emphatic that persuasive interpretation of social action is necessary but not sufficient: "Every interpretation attempts to attain clarity and certainty, but no matter how clear an interpretation as such appears to be from the point of view of meaning, it cannot on this account claim to be the causally valid interpretation. On this level it must remain only a peculiarly plausible hypothesis" (1978: vol. 1:9). For purposes of this study, there was need to verify the subjective meanings of the caregivers - this was achieved through brief follow-up interviews that allowed for cross-checking of meanings, perceptions, opinions and explanations.

In using an interpretive approach, the researcher is challenged to develop listening and interpretive research skills. Terre Blanche and Kelly (1999:126) point to the importance of developing listening skills particularly for using an interpretive approach.

### **3.3 Sample size**

The study focused on 10 caregivers of the Nokuthembeka HBC programme who are also learners in the NCTP. These caregivers work in an urban community setting in the township and provide care to HIV/Aids and other chronically ill patients who require educational and counseling support. The Nokuthembeka home-based programme operates in New Crossroads in the Cape Town Metropole and comprises of 45 caregivers and 20 volunteers who are supervised by 2 retired health care professionals (nurses). Although the initial intention was to focus on women caregivers as previous research has established that it is largely women who venture into care-giving, two of the caregivers were men. From working with this group, it became evident that due to unemployment, the number of men who are considering care-giving as an occupation option is growing. However, this is still not at the same pace as women. This group of 10 was therefore representative in terms of gender, age, educational and family background – the broader group of caregivers consists of more women than men and a mix of older and younger women from different educational and family backgrounds.

The study focused on caregivers who had been involved in care-giving for between 2-5 years and had a good working knowledge and understanding of the community. Such knowledge and understanding of the community contributed towards informing the contextual dynamics and reality. It was important to involve interviewees who had a good and substantial experience in care-giving; this enabled them to speak with authority about the practice and to share from an informed place.

Working with a group that provided support and care in the same communities and who regularly engaged and interacted with professional health care practitioners enabled me to do a profile of the community and to identify the socio-cultural factors that influence and have an impact on their learning processes as well as on their work as caregivers.

Since the study was time-bound, the group that was selected to participate had the benefit of the support of the home-based care programme. Given that the interviewees were all Level 2 learners in their second year of learning, their involvement in the research study happened during the period when they were undertaking practical sessions at various health facilities and were doing patients visits in communities. The study surfaced issues pertaining to the methodology used in the training programme and ongoing support to learners and how their experiences and knowledge can be harnessed. It is envisaged that results from the study can be used to inform participatory and situated learning approaches to adult learning processes and how learning among caregivers can contribute towards sustainable health care at community level as well as to the well-being of communities.

### **3.4 Research methods**

#### **3.4.1 Focus group**

An aspect of the research entailed conducting a focus group discussion with 7 of the 10 interviewees from the sample group. The sample group, chosen from a total of 25 learners in their second year of training was representative in terms of gender, age, educational background, knowledge/understanding of the community and care-giving experience. Due to domestic problems 3 of the interviewees could not participate in the focus group discussion.

The focus group discussion was scheduled before the individual interviews so as to afford the researcher an opportunity to develop a good overview of the home-based care programme, connect with the interviewees on a personal level, build rapport with them and observe how they relate to each other. A group of this size was sufficiently small; it enabled all members to participate in the discussion and allowed for a variety of perspectives to be shared and captured. The focus group was a once-off process that helped to foreground the individual interviews.

According to Tonkiss in Seale (2004:194) “a focus group is, quite simply, a small group discussion focused on a particular topic and facilitated by a researcher. Focus groups originated in market research during the 1920s, and have been used within social science since at least the 1940s. There has, however, been increasing interest since the 1980s in the use of focus groups across different fields of social, cultural and policy research. These include media and communications research (especially audience studies), sociology and social psychology, policy consultation and evaluation, organisational studies, environmental studies, health research and research into public attitudes”.

The focus group and subsequent interviews were all conducted in a church in New Crossroads, a venue where the caregivers gather daily with the programme coordinators. This church is their meeting place and bears a certain familiarity for all the caregivers and conducting the focus groups and interviews at this venue enabled me to work with them in their own context. As an interpretive researcher it was my intention to meet the interviewees in their own context and what is regarded as their natural setting. In such a setting, the intention was to make them feel comfortable and relaxed. This intention was confirmed by Terre Blanche and Kelly (1999:127) when they assert that “interpretive researchers want to make sense of feelings, experiences, social situations and phenomena as they occur in the real worlds, and therefore want to study them in their natural setting”.

As is expected with many of the home-based care programme and caregivers, due to time constraints, the focus group discussion was limited to 1 hour 30 minutes – the caregivers were adamant that they could not miss out on visits with patients and this would affect their monthly stipend. Using the church as the venue for the focus group discussion brought a certain serenity to the discussion – there was a certain reverence in the group. This space provided us opportunity to have an uninterrupted discussion – I think being in a familiar space allowed the group members to relax, feel comfortable and in the absence of their coordinators they were able to share freely.

The focus group consisted of women only – at the start of the discussion, the younger women were initially shy and were not forthcoming; they were hesitant in responding and deferred to the more mature women. However, with the proper encouragement they opened up and towards the end of the discussion they spoke freely, enthusiastically and with ownership. In the focus group discussion, the more mature women spoke with authority and were less hesitant to ask questions and raise contentious issues. The focus group was very helpful; not only did it help me to build rapport with the women and it helped me to get to know them as individuals, to assess their proficiency of the English language.

Tonkiss in Seale (2004:194) further asserts that “focus groups offer a distinctive method for generating qualitative data on the basis of group interaction and discussion”. Tonkiss maintains that “although the interactive quality is the key feature of the focus group research, the unit of analysis is the group rather than the individuals taking part in the discussion and they should not be seen simply as a means of interviewing several people at the same time; rather, they are concerned to explore the formation and negotiation of accounts within a group context, how people define, discuss and contest issues through social interaction” (Tonkiss in Seale, 2004: 194).

Tonkiss in Seale (2004:194) further states that “underlying this approach is an assumption that opinions, attitudes and accounts are socially produced – shaped by interactions with others – rather than being discretely formed at the level of the individual. Moreover, the group context makes visible how people articulate and justify their ideas in relation to others. Whereas a survey questionnaire can elicit what someone says they think about a specific topic, and an interview can describe how an individual accounts for their views, group discussions show how such accounts emerge through a communicative process. Beyond their status as a practical strategy for generating data, then, focus groups involve a stronger methodological assertion that the group context is important (and not just handy) for exploring the way social and cultural knowledge and meanings are produced (Tonkiss in Seale, 2004:194).

In this particular study, a focus group discussion proved relevant and helpful for exploring the experience, perceptions and perspectives of the members of the group working as caregivers working at community level. From the focus group discussion, I was able to develop an overall sense of their care-giving experiences and their perceptions about the National Certificate Training Programme – while some members of the group saw the training programme as an opportunity to advance themselves, others were concerned about the fact that this was a four-year programme for which they were not certain about their own staying power.

For purposes of this study, the focus group was used to generate qualitative data and to explore the attitudes, opinions and perceptions of the interviewees (learners) pertaining to the practice of care-giving, HIV/Aids prevention, management of the programme, their experiences, the training programme and their relationship to the communities they serve. The focus group was also a good platform for observing the group – the relationships, behaviours and tensions. Having the sessions in their own venue and setting gave me a sense of the context in which they work on a daily basis – it gave me a glimpse into their personal struggles, the challenges they face on a daily basis and where they live. The focus group enabled me to hear the voices of the women, to experience them as a group and to observe their discussion as a collective. Although this was not a specific focus of the focus group, the introductory activity enabled me to hear a little bit about the lives of the women and some background information on their families and struggles.

Through the focus group discussion, a broad perspective on the historical background of the Nokuthembeka Home-based Care Programme, attitudes towards care-giving and the impact of HIV/Aids on communities was attained. The focus group also revealed the perceptions of group members on various issues pertaining to their work in communities, their interactions with health care professionals and their own participation in the programme. As an interpretive researcher, the use of focus groups enabled me to pay particular attention to the relationships within the group – who was responding to whose questions and how they were addressing each other, how they articulated their perceptions and perspectives pertaining to the home-based care programme, the National

Certificate Training Programme and the foundational experiences/knowledge that they came into the programme with. The fact that it was a small group enabled me as researcher to relax, to observe the group closely, to reflect on their responses and to probe some of the issues.

Using focus groups and open-ended questions allowed for a conversational tone and enabled me as researcher to focus on the emergent process – it allowed me the space and opportunity to ask new and additional questions as they emerged during the conversation. In this way, using focus groups allowed for flexibility in this regard. The methodology was empowering, it gave voice to the women and allowed them to express themselves in ways that were comfortable and allowed them to share their ideas and thoughts. By sharing their ideas and thoughts they were able, though in a limited way, to build onto each others ideas, thoughts and to question the opinions and perspectives of others. Through sharing and discussion, they were able to learn about each other's experiences and struggles.

However, it has to be mentioned that during the focus group discussion the women did not share as deeply about their personal lives as they did in the individual interviews – they were cautious and took their cue from others.

### **3.4.2 Individual interviews**

To complement the focus group, individual interviews were used as the primary method for gathering data. Individual interviews were conducted with 10 interviewees (sample group) chosen from a total of 25 learners in their second year of training. As an exploratory study, the research attempted to inquire into and understand the social reality of learners in a training programme; it explored the nature and dynamics of learning as a social process among caregivers in a particular socio-cultural setting. The study investigated how caregivers learn through participation and interaction with others and how such learning contributes towards reinforcing the knowledge, performance, attributes and contributes towards their developmental roles as caregivers. Combining



qualitative research methods such as focus group discussion and individual interviews allowed for dialogic exchanges; this enabled caregivers to share their experiences through conversation with the social researcher and their peers.

According to Byrne in Seale (2004:180), “qualitative interviewing is characterized by being flexible and dynamic”. She furthermore suggests that it “enables the social researcher to access complex issues such as values and understanding”. The structure of such interviews will follow guidelines which remain relatively open and allow interviewees to speak about what they feel is relevant to the topic or issue, and which might be adapted in the course of the study.

Byrne in Seale (2004:180) further maintains that “the qualitative interview, as a tool of social research, has flexibility and is dynamic in that it can be used in conjunction with other techniques - as a means of extracting different forms of information it allows for conversation between researcher and informant as equals rather than a question-answer exchange. She goes on to say that “as a mode of face-to-face questioning and encounter between the social researcher and informants, this method is directed towards understanding informants’ perspectives on their lives, experiences or situations expressed in their own words and it allows for the researcher to access complex issues such as the attitudes, values and understanding of the informants – these are not easily established or observed in formal, structured interviews. It allows for interviewees to speak in their own voices and with their own language”. The method seeks to encourage interviewees to talk about a range of issues in their own language and voice.

Using qualitative questioning in this study allowed for investigation of situated learning among caregivers at community level; it allowed for analysis and understanding of how participation leads to learning in a particular situations, how the learning context enhances or inhibits learning, how knowledge/meaning is created and to understand how such learning contributes towards enhancing the performance of learners as well as the well-being of communities. According to Rubin and Rubin (1995: 43) as cited in Babbie & Mouton (2001:289), “qualitative interviewing is characterized by being flexible,

iterative and continuous, rather than prepared in advance and locked in stone”. They furthermore suggest that the “questioning is redesigned throughout the project”. Thus, the structure of the interviews followed question guidelines, which remained relatively open and allowed interviewees to speak about what they feel is relevant to the topic, and which might be adapted in the course of the study.

While the qualitative interviews enabled penetration of the subjective meanings and understanding of their experience, perceptions of how they participate in the training programme and how they learn, I developed open-ended and flexible questions to get more considered responses. Open-ended flexible questions provided better access to the views of interviewees, their interpretations and understandings. The individual interviews observed strict confidentiality and I engaged interviewees in isi-Xhosa, a language that they are confident with and using English in instances where the interviewees switched to this. In addition to the learners, I also interviewed one of the coordinators to gain better understanding of how the caregivers (learners) are supported in their daily work in the community.

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The individual interviews were also conducted in the same church venue and during these, the women ventured to share more deeply about their personal lives than they were prepared to do in the focus group discussion. For the more mature women it provided opportunity to discuss some personal problems as well as to share some of their aspirations pertaining to their lives.

### **Preparation for the focus group discussion and individual interview sessions**

In preparing for these sessions, I consulted various books and articles on social research methodology, Seale (2004); Terre Blanche and Durrheim (1999) and Patton (1990) – in developing my methodological framework, I found Seale (2004) very informative and helpful. Through consulting the literature, I was helped in preparation of my interview guide, the conceptual framework and the advantages and disadvantages of certain methodological designs and frameworks.

I also drew on the knowledge I acquired from the module on research that was part of the structured programme of my studies. I further drew on my experience as a development practitioner, facilitator and evaluator of development projects, programmes and organisational activities. In my work as development practitioner, facilitator and evaluator I have experience in and have developed my faculties and skills in conducting interviews, facilitating focus group discussions, data analysis, taking field notes, working with groups and establishing rapport with individuals during interview sessions. A big part of my work as a development practitioner is about facilitating individual and group processes, listening and helping others make meaning or sense of their respective situations – the work entails analysis of information and interpretation of situations. At the time of undertaking my research study, my own organisation was exploring integrating research into its own practice – this provided me opportunity to engage with and learn from our internal researcher.

I deterred from using a tape recorder as this has the tendency to be intrusive and makes people less comfortable. I therefore relied on my listening skills and note-taking ability to capture the conversations as fully as possible – after each interview I created space to develop my notes and to reflect on each interview. However, not using a tape recorder meant that I could not readily play back the interviews at a later stage and to listen to them away from the actual interview.

### **3.4.3 Observations**

As a way of facilitating access to the programme, I was afforded permission by the programme manager to meet with the coordinators and caregivers to introduce myself to the group and to explain the purpose/process of the research study. I used my two meetings with the group as an opportunity to observe the social organisation and relationships within the setting. Towards this I attended two daily gatherings whose purpose is to 1) take a register of attendance 2) give caregivers an opportunity to share problems/challenges encountered during home visits and 3) give coordinators an opportunity to offer caregivers advice where needed.

While the first gathering helped me gain an understanding of the home-based care programme and the work of the caregivers, the second gathering afforded me opportunity to observe the social interaction between the coordinators and the caregivers. While the first occasion allowed me an opportunity to interact with the group, on the second occasion my social interaction with the group was limited.

Although this setting posed a limit on what I could observe, it helped me 1) develop insight into the programme 2) gain insight into the challenges/problems caregivers encounter in the field and 3) gain insight into the relationship between coordinators and caregivers. The value of such observations is substantiated by Walsh in Seale (2004:232) who asserts “essentially ethnography entails a learning role in which the observer is attempting to understand a world by encountering it first-hand”.

My observations of the two sessions gave me first-hand experience of how the coordinators addressed the caregivers and how the latter in turn address them. For example, while the coordinators address the caregivers by first names, the caregivers address them formally using their professional designation (because they are professional nurses they refer to them as “sister”). Another thing I observed was in the seating arrangement – the two coordinators sat at a table at the front and the caregivers sat a distance away from them.

Initially the group was suspicious of me. However, after I had introduced myself and explained my role as researcher, there was less suspicion. It became evident from their questions that the caregivers had experience of engaging with researchers prior to this experience, and this helped to make them less suspicious of me. In addition, when they learned that I was not there to evaluate their work they became less suspicious and began to relax. While the group appeared conscious of my presence on the first occasion, on the second occasion not much attention was paid to me. My observations of the social setting complemented the focus group discussions and individual interviews.

### **3.5 Research instrument – use of an interview guide**

During the preparation phase I developed an Interview Guide – see Appendix 1), based on the main concepts – learning situation, experience and participation that I explored in my study and this provided me with a framework for the interviews as well as for analysis of the data. I developed questions under each of these concepts and I explored these during each interview. The concepts provided me with predetermined inquiry areas while not allowing for predetermined responses. I used this guide for each interview with the intention to obtain the same information. Given that I used face-to-face interviews, this allowed me the freedom and flexibility to probe and explore within the predetermined inquiry areas.

Given that the interviewees could generally not give me additional time, the use of an interview guide allowed me good use of our interview time – this helped me to keep my interactions with interviewees focused and contained. At the same time it helped me to interview them around multiple concepts – learning context, experience and participation and this made the interviews more systematic and comprehensive. The interview guide was a good instrument for helping me modify questions over time and to focus attention on important areas. With time I was able to identify the less helpful questions and did not ask these in subsequent interviews.

The development of the interview guide itself was a learning process, it proved extremely challenging to identify the right questions and to establish with certainty how these connected to the questions guiding this investigation. In the beginning I developed a long list of questions which I then needed to pare down guided by my research questions. As I started to use the interview guide, it proved effective in helping me make a distinction between important questions and those that were less helpful. I also worked closely with my supervisor to focus and sharpen my questions for purposes of this study.

While the interview guide provided me with the framework for data collection and analysis, to a large extent, it also helped me to see the interconnections between the

concepts experience, participation and learning. In the beginning I tried to keep the central concepts separate. However, as the interviews progressed I discovered that it was hard to keep these concepts completely separate as they would touch on their 'experience' when I was exploring the action of 'participation'. In this way, the interview guide made the interconnections and relationships between the concepts more evident and explicit.

### **3.6 Ethical considerations**

All participants in the research study were respected in their right to privacy and confidentiality; no data was collected without permission of those involved. The Nokuthembeka HBC programme was identified through organisational networks and the 10 caregivers identified were selected through the support of the coordinators. Permission to work with the programme was sought from the manager as well as that of the healthcare professionals who coordinate the caregivers. An introductory session was held to introduce myself to the group and to inform them about the scope of the research and to request their permission prior to embarking on the study. The identities of the learners in the training programme as well as that of the facilitators involved will remain confidential. The names will remain confidential if they request it, but will otherwise be stated.

I used a qualitative research design and interpretive approach to understand the reality of the caregivers. Such an approach enabled me to avoid objectification of caregivers who served as the primary source of information – I engaged with the totality of their experiences including their rational thoughts, feelings/emotions as well as their will. In addition, I interpreted the meaning they were making of their own situations and how such meaning was articulated, explained and described became a critical part of the study. A qualitative research design allowed me to understand the socio-cultural context in which the caregivers function and it gave me deeper insights into the contextual factors that influence not only their learning but, also their interactions and relationships with others in their social community.

The experiences of the caregivers and the stories that flow from these provided access to the subjective meaning they have derived from such experiences. Through interpretation of their experiences I tried to achieve clarity and certainty about their learning processes and practices. Although objectivity cannot be fully achieved in a study of this nature, there was need for me to verify these subjective meanings. It was not easy to secure follow-up interviews or focus group discussions to triangulate and cross check meanings and explanations.

This was largely undertaken as a qualitative, exploratory study and made use of qualitative interviews and a focus group discussion as methods of inquiry. As an exploratory study, it sought to search for and try and understand the social reality of caregivers – it explored the nature and dynamics of learning among caregivers who are learners in a training programme and to explore how this learning results in change. By combining qualitative interviews with a focus group discussion allowed for dialogic exchanges – it enabled caregivers to share their experiences through dialogue with the researcher and their peers.



Both qualitative interviews and focus groups are methods that will surface different perspectives pertaining to learning and educational interventions. While the qualitative interviews enabled penetration of the subjective meanings and understandings they have of their experience and participatory processes, the focus group discussion allowed for different perspectives pertaining to their own participation and learning to be surfaced, explored and investigated.

In Seale (2004:116) Ali and Kelly mention that “the decision to conduct a particular study is about making a choice about a grouping to investigate and that this may have ethical implications”. My choice to work with caregivers and investigate the nature and dynamics of learning among them certainly has ethical implications. Caregivers for HIV and AIDS patients constantly encounter issues of stigmatization, exclusion and marginalization not necessarily for themselves but, for those they support and care for.

The environment in which they work is not only complex, it is emotionally-charged and therefore requires sensitivity, care and respect.

In addition, caregivers who work at community level are mainly volunteers who generally do not enjoy a lot of status in society – they are perceived to be at the lower end of the spectrum of society. They experience powerlessness and their work is not recognized and appreciated. Working with such a group required sensitivity, respect and humility.

In the introductory session I provided the reasons for undertaking this study. In my engagement with caregivers, I indicated that some of the questions are personal and that they are under no obligation to answer if they are not comfortable. Their right in this regard was respected and observed. While I recognized the importance of making notes from the qualitative interviews, I also respected the right of caregivers not to include aspects of the conversations in the report. In my interviews, I therefore created opportunity for individuals to let me know of anything that they think should be included after the formal interview slot.

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No identifying information about the care-givers was included in any written material about the research. However, I quoted participants throughout the research so that their voices come through. I tried to do so in a way that was sensitive and that ensured no identifying material is included in any quotes. The notes from the interviews were not shared with others. It was important for me to sign agreement forms with information about the aims and approach of the report and I ensured that the report from this research benefits and informs the broader learning processes of the Nokuthembeka Home-Based Care programme and caregivers who participated in this study.

### **3.7 Analysing the data**

In analysing the data, I made use of the steps provided by Terre Blanche and Kelly in Terre Blanche and Durrheim (1999:141) – they maintain that “these steps are useful for



analysing data within an interpretive, phenomenological research design”. These analytical steps fall between the two extremes with the first being quasi-statistical styles using predetermined categories and codes that are applied to the data in a mechanistic way to yield quantifiable indices and immersion styles that involves becoming familiar with a phenomenon, carefully reflecting on it and then writing an interpretation. The authors warn that “in reality, interpretive analysis rarely proceeds in as orderly a manner as may be suggested by our step-wise presentation, but it can be a helpful point”.

#### Step 1: Familiarisation and immersion

The authors refer to this as the step in which you are working with the field notes or transcripts to familiarise yourself with the material, reading through it and getting to know your data by making rough notes and drawing diagrams. They indicate that by the time you have completed this step, you should be able to know your data fairly well to start the process of interpretation (Terre Blanche and Kelly, 1999:141).

During this stage of the analysis, I found it very helpful to read through my field notes and to expand some of the comments I had made during the interviews and focus group discussions. I used note books and cards of different colours to organise the information and make it easily identifiable.

#### Step 2: Inducing themes

Terre Blanche and Kelly (1999:141) indicate that this process involves looking at the material and trying to determine the organising principles that underlie the material. They provide pointers about using the language of the interviewees rather than abstract theoretical language. They suggest that the researcher should then move beyond merely summarizing content and encourage the researcher to think in terms of processes, functions, tensions and contradictions. The authors indicate that themes should arise naturally from the data and should have bearing on the research question (Terre Blanche and Kelly, 1999:141).

In my study this step became automatic as I was guided by the themes of context, experience, participation and knowledge that were core concepts in my research study. I read through my field notes and collected what was emerging in relation to these themes. Given the inter-relatedness of these themes, it proved difficult in some instances to separate issues that overlapped with one or more themes.

### Step 3: Coding

Terre Blanche and Kelly (1999) refer to coding as “breaking up the data in analytically relevant ways”. With regard to this step, they provide some helpful hints such as discussing with others as a way of checking your interpretation (Terre Blanche and Kelly, 1999:144). The authors however, warn that it is important to have discussions with people who know a lot about the themes as well as those who don’t, but are able to consider it from a fresh perspective.

In my research study I used coloured cards to group relevant information under the core concepts in my research study. This provided me with the opportunity to stand back from my information and to begin to engage with it critically with the intention to become clearer and to enhance my understanding. I spent a great deal of time reading through the information and worked with an independent practitioner to help to clarify my own ideas. It is also at this point where I participated in a workshop focusing on data analysis and making sense of information – this was immensely helpful in my process of data analysis.

### Step 4: Elaboration

Terre Blanche and Kelly (1999:146) describe this as the phase of moving beyond seeing the data in a linear, chronological order. The authors indicate that in this stage, the researcher should be able to see the data through fresh eyes and start seeing different ways of re-organising the themes. This provides opportunity to re-group information under different themes.

In my study I was able to look at the information with fresh eyes after I had reconnected with the literature and was seeking connections between my findings and the theory. The

literature provided me with the hangers to structure my data, analyse and interpret it in a fresh, meaningful way. The literature enabled me to frame the critical areas in a way that supported my arguments in a logical way.

#### Step 5: Interpretation and checking

Terre Blanche and Kelly indicate that this step involves going through the interpretation thoroughly and strengthening the weaker areas. The authors mention that this provides the researcher with an opportunity to look at and identify contradictions in the data, in your interpretation or where you have not adequately substantiated.

In this final stage I spent time reading through my interpretation and checking the information. I once again returned to the literature but this time to strengthen and finalise my literature review section. This enabled me to look at my analysis with a refined perspective and ensuring that my conceptual foundation was coherent.

Throughout these stages, I ensured that the voices of the interviewees are not lost; in my analysis I tried very hard to ensure that my voice and their voices are intertwined in a meaningful way.

### **3.8 Possible limitations of the study**

The fact that no interviews were undertaken with facilitators of the training programme could certainly be viewed as a limitation of this study – it does not take into consideration their viewpoints, perceptions and perspectives pertaining to the concepts that are the focus of this study. Insights and conclusions pertaining to participation and how this facilitates or inhibits learning were arrived at purely on the perceptions of the interviewees (learners) involved in the study. Gaining insight into the perceptions and experiences of caregivers (learners) was the focus of my study.

Interviewing some of the facilitators would have brought in another dimension pertaining to perceptions of how the action of participation can enhance or limit learning – this would have allowed for comparison of the perceptions of the learners to those of the facilitators. Interviewing some of the facilitators would also have brought in a cultural dimension to how participation, experience and knowledge are viewed by persons of different cultural and educational backgrounds.

The study did not interview the coordinators of the home-based care programme, in this way it does not represent their views and perceptions. Although conversations were conducted with some staff of the Adult Learning Network, the information from such conversations was largely used to try and understand the structure of the training programme and the participatory methodologies used by the programme. Given that I examined the training materials for only one of the modules, failure to examine the training materials for all the modules for the four-year programme did not result in a good overview of the content of the training programme. As a result, I did not have access to the complete curriculum that describes the methodologies in-depth. This would have provided deeper insight into the participatory methodologies used in the training programme.

## **SECTION FOUR**

### **4. DATA ANALYSIS**

In this chapter I commence with a description of the Home-Based Care Programme, the work-place from which caregivers are assigned patients - this helps to create a picture of their reality and the challenges they face. This is followed by a description of the National Certificate Training Programme which provides the learning context in which caregivers participate as learners and in which the experience, participation and learning of respondents is located and investigated. I then move on to provide a profile of the research group. The chapter concludes by providing an analysis and interpretation of the data on the core concepts covered by my study.

#### **4.1 Description of the Home-Based Care Programme**

The home-based care programme is based in New Crossroads, a township in the Cape Town metropole that lies about 20 km from the city centre. The community of New Crossroads is plagued by poverty, unemployment, crime, HIV and Aids and many other social problems. The area has minimal infrastructure – schools, clinic, government facilities, crèches and churches. Although the community has benefited to some extent from the provision of Reconstruction and Development Programme housing, there are still people from the community who live in informal settlements that are without water, sanitation and electricity.

For those people who are employed, they have to travel vast distances to their places of employment. As a consequence, people spend a great deal on transportation. The majority of the people rely on public forms of transportation – there is a bus service through the area as well a taxi service. Many people have been hugely affected by the

increases in fuel/petrol tariffs – such increases have resulted in increased transportation costs and the increasing food prices have seen many people struggling to feed their families. There are many people in the community who try to sustain themselves through small income-generation activities such as selling fruit/vegetables on street corners and operating sites for repair of motor vehicles. The majority of the people speaks isi-Xhosa and for some family roots go back to the Eastern Cape from where they have moved in search of employment and a better life.

The home-based care programme was started in 1997 as an initiative of the Ministers Fraternal, an organisation of various church denominations that initiates development projects and programmes linked to the churches. Most of the development projects and programmes initiated through the Ministers Fraternal are managed by the pastors of the various church denominations. Similar to many other programmes at community level, this one was started in response to the growing incidence of HIV and Aids in communities which necessitated the need for additional people to provide health care and support to sick people in communities impacted by the pandemic. The programme started as a small initiative that was born out of communities increasingly taking responsibility for the care of sick people with little support from the health authorities and facilities.

Currently, the home-based care programme is registered as a non-profit organisation that provides community-based palliative care, counseling support and advice to patients of HIV and Aids, tuberculosis and other chronic illnesses. Although the patients are the primary focus, caregivers engage family members in an attempt to ensure that they become involved in and also take responsibility for the provision of care and support. However, the programme experiences many challenges in this regard and there remains a need for ongoing education of families and communities.

The home-based care programme does not do active recruitment in the different communities; information about it spreads by word of mouth through the various church congregations. The programme generally attracts unemployed women of varying ages, backgrounds and experience in care-giving. Although most of the women who become

involved are unemployed; employment is not the primary reason for their involvement. Most of the women who become involved in the programme see this as an opportunity to help others and contribute to building a healthy community.

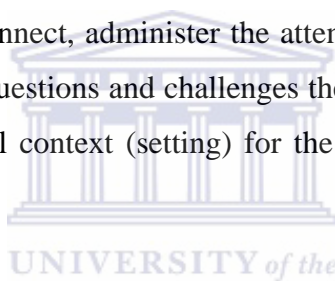
The programme comprises of 45 full-time caregivers, 20 volunteers, one manager, an office assistant and 2 coordinators. The manager, a pastor of one of the churches is responsible for overall management, resource mobilisation and liaison with government departments, donor agencies and various support organisations. The office assistant takes care of the day-to-day administrative responsibilities and 2 coordinators, retired nursing professionals, whose primary responsibility is to provide professional support to the caregivers and 20 volunteers and to supervise them. In addition, the coordinators liaise with professional health practitioners at the health facilities (clinics, hospitals and hospices) where caregivers undertake practical sessions, play a critical role in referring ill patients to health facilities for proper attention and treatment and they monitor the work of caregivers through regular follow-up visits to patients. To ensure patients are attended to properly and on a regular basis, the coordinators administer a daily attendance register and in the event where caregivers are absent due to unforeseen reasons, they allocate responsibilities to available volunteers and or undertake such visits themselves.

Caregivers from the programme provide care and support to patients in the townships of New Crossroads and Guguletu (adjacent to New Crossroads). Caregivers come from the following places of residence: Guguletu, Phillippi, KTC, New Crossroads and Delft – some have to travel some distance to the church in New Crossroads where the group gathers every morning. Until recently caregivers were allocated 3 patients to take care of and provide support for. Unfortunately the Department of Health (DoH) has introduced a new regulation that requires each caregiver to have 10 patients. Caregivers expressed concern about the new requirement in terms of patient numbers, they fear that this will put pressure on them and affect the quality of service.

Caregivers work 5 days a week from 09h00 to 13h30 and each caregiver is partnered with a volunteer who has experience in care-giving. Volunteers are required to work for two

years before they are considered as full-time and during this period they are not given consideration for participation in training courses. Although some volunteers come with care-giving experience, many learn about this from working alongside the full-time, more experienced caregivers – a lot of this happens through close observation of their peers and through informal sharing of knowledge. At the time the study was conducted, full-time caregivers received a monthly stipend of R860.00 and a uniform allowance of R500.00 per year and volunteers received a monthly stipend of R500.00 and no uniform allowance. Caregivers are required to submit a monthly report which gives an update on the status of each patient – these reports are compiled into a composite report by the coordinators and submitted to the health authorities.

The caregivers, volunteers and the 2 coordinators gather every morning for between one and one and a half hours to connect, administer the attendance register and create space for caregivers to raise issues, questions and challenges they encounter in their work. This daily gathering creates a social context (setting) for the group to engage, dialogue and problem-solve.



Depending on the nature of the issue, question or challenge raised, caregivers either enter into one-on-one consultations with the coordinators or the latter facilitate discussions that involve the broader group. Socio-cultural theory and situated cognition protagonists such as Wenger (1998:47-50), Stein (1998:3) and John-Steiner and Mahn (1996:193) emphasize the importance of the socio-cultural context in which individuals engage and participate. They see this context as critical and highlight that the nature of the social setting in which people engage has bearing on their learning. Although these group sessions do not explicitly have a learning objective, they inevitably provide caregivers opportunity to learn from each other's experience, questions and challenges.

The caregivers also utilise this space to connect with and engage with peers, to solicit information about developments in the programme from the coordinators and to update the coordinators on the status of patients who are critically ill. The engagement with peers is informal, it is not structured conversations but nevertheless, it serves as a source



of support and learning for many of them. Although one may initially get the impression of chaos, observing the situation more than once revealed a system. Those caregivers who desire one-on-one consultations move up to the table and have conversations with the coordinators. In instances where questions are posed to the coordinators from the broader group, a discussion is facilitated and solutions are provided to some of the problems raised.

The relationship between the coordinators and the caregivers is formal; the former are addressed by the caregivers as “sister” (given that they are nursing sisters) – this is in recognition of their professional status. Addressing them in this manner is also a sign of respect – both coordinators are elderly women who are retired. The coordinators in turn address the caregivers by name irrespective of their age. The relationships among the caregivers are informal and warm – there is a familiarity among some members of the group. In terms of language, isi-Xhosa is generally used by the caregivers but the coordinators tend to use both English and isi-Xhosa. All caregivers have a working understanding of English – they are expected to complete their report forms in English. The use of isi-Xhosa allows for caregivers and volunteers to express themselves freely and fully; given that they speak in their mother-tongue they are able to articulate their questions and challenges clearly.

The social situation is designed such that the coordinators sit at a table at a distance away from the caregivers who sit on chairs arranged in rows (similar to a classroom situation) – this denotes a relationship of power and caregivers only move up to the table on the instruction of the coordinators. The volunteers, younger caregivers and men generally sit together in their groupings and the women, in comparison to the men, speak more freely and appear more confident in asking questions and raising issues. Although not much space is created for interaction and engagement, the caregivers raise questions and draw their peers into the conversation by asking for their opinions and viewpoints – this helps to facilitate interaction and engagement.

Within the group, caregivers who have been longer with the programme express themselves with greater confidence than those who have been with the programme for shorter periods – these women are also more vocal than others. Although there is an unequal relationship of power between coordinators and caregivers, there is the confidence among caregivers to raise questions and in some instances to challenge the authority of coordinators. However, overall, this relationship is characterised by inequality and subservience – the caregivers treat the coordinators with an obvious respect on the basis of their professional standing and economic status.

#### **4.2 Description of the National Certificate Training Programme**

The interviewees involved in the research study work as caregivers in a community-level home-based care organisation and at the same time are learners in a training programme that was developed in response to the need for skills development for community home-based caregivers in order to alleviate the pressure on existing health facilities and professionals created by the growing prevalence of HIV and Aids and the impact of the pandemic on communities. Over the years, as home-based care became institutionalised, the training of caregivers has evolved and attempts have been made to professionalise home-based care and bring the training and skills development of caregivers into line with the requirements of the National Qualifications Framework.

The National Certificate Training Programme for community health workers is a 4-year programme that is implemented by the Adult Learning Network<sup>iii</sup> in partnership with the national Department of Health, the Health and Welfare Sector Education Training Authority and health care facilities such as clinics and hospices in the communities. The unit standards for the training programme are developed by the Health and Welfare training authority in line with the requirements of the National Qualifications Framework. The Department of Health is responsible for recruitment and provision of resources for the programme and the Adult Learning Network is responsible for developing the

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<sup>iii</sup> The Adult Learning Network is a non-profit organisation that was established in 2001 and provides a national networking structure for organisations working in the field of adult learning, basic education and development. It advocates and mobilises for adult and lifelong learning and seeks to promote redress and transformation in South African society.

learning materials. The training is a structured, cumulative learning programme that enables learners to exit at NQF levels 1, 2, 3 or 4 and allows for differentiated career paths. The first two years of the programme, the General Education Training Certificate is the equivalent of Grade 9 and 10 and allows learners to exit with a qualification as an Ancillary Health Care<sup>iv</sup> practitioner. Year 3 and 4 of the training programme is the National Certificates for Community Health Workers and is the equivalent of Grade 11 and 12 respectively.

For each year of study, learners participate in a 6-month formal learning programme where they are introduced to the theoretical aspects. Over this period, the formal theoretical learning is complemented by practical sessions which caregivers are required to undertake at health facilities - clinics, hospices, hospitals - under the supervision of and supported by professional health practitioners. During the 6-month period, learners spend 2 weeks focusing on the theory, 1 week in practical sessions and 1 week back in their place of work. During the practical sessions learners interact and engage with professional healthcare practitioners in the context of a health facility – within such a context, learners have an opportunity to apply the theoretical knowledge to real-life situations. Each learner works closely with and is supervised by a health care practitioner who guides and supervises them.

With regard to this training programme, the responsibility for recruitment of learners rests with the Department of Health and the only requirement is that learners are expected to have 2 years' experience in care-giving at community level to qualify. There is no requirement pertaining to formal education and as the implementer of the training, the Adult Learning Network has only recently embarked on developing an instrument for assessing prior experience of learners so as to help the organisation develop a programme that adequately meets the needs of learners.

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<sup>iv</sup> At the time when the study was undertaken the nature of the qualification was not clear and this was a source of tension for many of the learners

According to Toseland and Smith (2002:1), “programmes designed to educate, train and support caregivers should give consideration to the unique needs, specialized information/knowledge they require – such programmes should ensure impartation of specialized knowledge, information and support”. The National Certificate Training Programme is designed to equip the learners with specialised information and knowledge in order to perform their development roles at community level - it is a modular programme that seeks to equip learners with specialist knowledge on palliative care, HIV and Aids awareness, prevention and treatment, primary health care, tuberculosis prevention/treatment, first aid and community development.

The training programme is pitched at a general level and equips learners with knowledge, skills and information to enable them to provide general care in diverse community contexts and to properly manage the relationship between themselves and the patients who are recipients of the care they provide. As caregivers, they enter into relationships with patients and their families and a huge part of their responsibility is to manage such relationships in a way that enables them to be effective.

### **4.3 Participatory methodologies used by the programme**

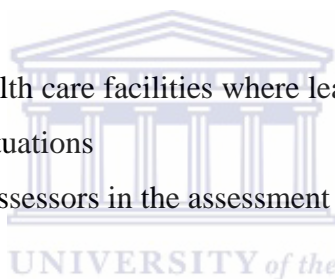
The training environment constitutes the learning situation or context for the learners – it is within this situation that they interact with peers and facilitators for the duration of six months. Information pertaining to the methodology used in the National Certificate Training Programme was not attained from in-depth examination of the training programme curriculum and methodology materials, it was attained from conversations with the staff of the Adult Learning Network and from interviews with the learners (Interviews 22 August and 8 September 2008). From these conversations, I was able to establish that the training takes the form of face-to-face facilitation and is conducted in a venue away from the communities where the learners work as caregivers. I gathered that, overall, the venue is comfortable, safe, spacious and conducive to learning.

The training programme uses participatory methodologies that are learner-centred and require of learners to take responsibility for their own learning. The participatory

methodologies used draw on the existing knowledge, understanding and experience of the learners – particularly knowledge and understanding about their communities, patients they support/care for and the kinds of challenges they encounter as caregivers working in communities.

From the conversations with the staff of the Adult Learning Network and the learners it became evident that facilitators make use of the following participatory methodologies to engage learners:

- 1) theoretical input given in an interactive way
- 2) small group work that draws on the personal experiences of learners
- 3) writing summaries at the end of each study unit
- 4) use of study materials
- 5) asking questions,
- 6) practical sessions at health care facilities where learners have opportunity to apply the theory to real-life situations
- 7) interact with qualified assessors in the assessment of own performance



From the conversations with the staff of Adult Learning Network and interviews with learners, I was able to deduce that although facilitators give theoretical input, the discussions, interactions and exchanges in small groups as well as in the larger group constitute an important aspect of the learning. Although not a focus of this study, it has to be recognized that other activities such as writing summaries, interaction with assessors, working through the study materials and interaction with health care practitioners at the sites where the practical sessions are undertaken also contribute in major ways to the learning of caregivers – their participation in these activities also contributes their overall learning.

Given that the training programme aims to equip learners with knowledge, skills and attitude to fulfill their roles as caregivers, the facilitators recruited to facilitate the training/learning are generally health care professionals (nurses) or individuals with specialist knowledge in the areas of specialisation such as first aid, HIV and Aids,

community development, mathematical literacy or risk management. The areas of specialisation are determined by the study units which are in turn aligned to the specific unit standards. In recruiting facilitators, the emphasis is placed on bringing in people with a good understanding of the subject matter who have at least 2 year's experience in facilitating training courses.

#### **4.4 Profile of the interviewees**

An investigation into the lives of the research group revealed that unemployed women and men of all ages have ventured into home-based care and consider it as an occupation that contributes to building healthy communities. This investigation further revealed that through involvement in a home-based care programme caregivers are provided with the opportunity to learn and deepen their knowledge and understanding of palliative care, counseling support, HIV and Aids, tuberculosis and other chronic illnesses. The research study revealed that the experience of caregivers forms a critical resource on which to build and this [experience] influences their participation in different socio-cultural settings that create a learning context.

Although the group of 10 caregivers who participated in the study was suggested by the coordinators of the home-based care programme, they were given the choice to indicate whether they were willing to participate. The decision to involve learners in the second year of training was informed by the fact that at the time of undertaking the research, learners in the first and third years were in training – learners in the second year of training had just completed their 6-month training for the year and started their practical and assessment sessions. In this study I refer to this as the research group and in order to protect their identities, pseudonyms which reflect their cultural backgrounds are used. Also, the caregivers were not comfortable to reveal their actual ages so these are given as twenty-, thirty- and forty-something.

Sivuyile is a vibrant 30-something year old woman who lives with her mother in Phillippi, a township in the Cape Town metropole. She is warm, confident and helpful.

She became involved in the Nokuthembeka HBC in 2006 after she was introduced to the programme by another young woman who was already involved as a caregiver. Although she had no 'formal' care-giving experience, she had helped her mother to take care of her grandmother before she passed away – this helped her gain experience in care-giving and was the main motivation for becoming interested in HBC. Due to financial circumstances, Sivuyile's family was not able to provide for her to complete her schooling and she dropped out in Grade 11. She has a strong desire to complete Grade 12 and train to become a nurse. Prior to becoming involved in the HBC programme she was unemployed; she sees this programme and the training as an opportunity to acquire a formal qualification and occupation. She came across as attentive, interested and although she enjoys the care-giving, she mentioned that it is hard work and, sometimes, with little gratitude expressed by families. Sivuyile presented herself as a confident, responsible and dependable woman who is committed to the work she does. She is curious and is not afraid to ask questions pertaining to her work. She has had no previous training in care-giving and therefore spent the first year in the programme as a volunteer.

Nomonde is a feisty 20-something year old young woman who lives in KTC, an informal settlement adjacent to New Crossroads. Her family moved to Cape Town from the Eastern Cape many years ago and she learned about care-giving from a crisis in her own family. She had to take care of her own mother during her recovery and rehabilitation and, given that the family did not have the money for doctors and treatment, they had to take responsibility for taking care of their mother. Nomonde became involved in the HBC programme in 2006 as a volunteer with no previous training and only the experience that she had acquired taking care of her mother. Prior to becoming involved in the HBC programme she was unemployed and had dropped out of school at Grade 11 due to financial struggles in her family. Nomonde ventured into care-giving mainly due to seeing the impact of HIV and Aids in communities and she was moved to become involved in some way and try and help those infected and affected by the pandemic. She was also moved by the fact that many people could not afford treatment but still needed to be assisted and taken care of. Nomonde came across as articulate, forceful and determined – she expressed strong concern for the absence of compassion in communities

and the neglect of sick people by their families. She expressed a strong desire to educate families and communities about the role of HBC programmes and caregivers – she is deeply touched by the way in which caregivers are abused by the families of patients.

Phinda is an articulate, determined and vocal 20-something young woman who lives in Delft and has always had very strong desires to become a nurse. She became interested in care-giving and nursing from watching programmes on television and helping to take care of sick family members. Phinda became involved in the Nokuthembeka HBC programme in 2006 after learning about the programme from a woman who was already involved in it and she spent the first year as a volunteer. She came into the programme having had some training provided by other service providers and with some experience in care-giving acquired from a previous programme where she had worked as a volunteer. Due to family circumstances Phinda had to drop out of school in Grade 11 and was always looking for opportunities to further her studies and acquire an occupation. Phinda comes across as confident, energetic, determined and excited about the opportunity to learn – she speaks with excitement about her engagement with health care professionals during the periods when they undertake their practical sessions at clinics, hospitals and hospices. She does not hesitate to question and in the daily gatherings she does not hesitate to ask questions and challenge situations and she expresses strong feelings about professional health care professionals who are sometimes not willing to support them and answer their questions during their practical sessions.

Nomsa is a 40-something year old woman who lives in Guguletu, a township adjacent to New Crossroads. She was motivated by her mother who was a nursing professional and became interested in care-giving from observing her mother and by helping her mother take care of sick family members. Nomsa became involved in the Nokuthembeka HBC programme in 2004 and, in addition to the experience gained from helping her mother, she was further exposed to care-giving by helping others in the community. Nomsa expressed concern about the growing incidence of HIV and Aids and the impact the pandemic is having on communities – she is concerned by the devastation the pandemic is having on communities. Although Nomsa was a high school drop-out, she has



subsequently completed her Grade 12 through taking classes at an adult learning centre. She comes across as a responsible, warm and caring person who listens attentively to others and is committed to her patients and their families. Nomsa is a strong woman who is inquisitive and challenging – she is not afraid to speak her mind and does not hesitate to question situations that she is not happy about. She is extremely neat in appearance, professional in her conduct and is polite towards her peers and coordinators. She has a strong desire to complete the training programme and move on to pursuing her studies towards become a nursing professional - something she reckons will make her departed mother very happy. She comes across as deeply spiritual, caring and enjoys providing counseling support to patients and their families.

Lesedi is a 30-something year old woman who lives in New Crossroads. She is of a quiet disposition, soft-spoken and was motivated by members of her support group to become interested in care-giving and involved in the HBC programme. She gained experience in care-giving from observing the caregivers who took care of her when she was sick and home-bound. Lesedi had to drop out of school at Grade 7 due to family circumstances and was unemployed prior to becoming involved in the HBC programme in 2006. During her first year in the programme she worked as a volunteer and it was during this time that her interest in care-giving grew. Lesedi comes across as a quiet but strong woman who is determined to improve her education and sees the training programme as an opportunity to develop herself and hopefully acquire a qualification through which she would be able to earn a living and improve her life.

Nolwandle is a 30-something year old woman who lives in with her husband and 5 children in Delft, a township for poor communities. She is a strong woman who, prior to becoming involved in the HBC programme, was unemployed. Her family is originally from the Eastern Cape and she and her husband moved to Cape Town some years ago to try and give their children better opportunities in terms of furthering their education. She is, however, considering moving back home to the Eastern Cape but would like to complete the training programme prior to doing so. Nolwandle joined the HBC programme in 2006 and has been on various training courses in home-based care and

gained experience in care-giving from being involved with Grandmothers Against Aids where she learned a great deal about HIV and Aids – this motivated her to venture into care-giving. She comes across as insightful, passionate and deeply devoted to helping others – a few years two of her children got burned in shack fires and she had to take responsibility for caring for her children. It is through this traumatic experience that she acquired the skills to care for sick people – when her children were in hospital she learned from observing them closely and applying the knowledge when she had to care for the children when they came home.

Zanele is a 30-something year old woman who lives in Phillippi, a township not far from New Crossroads. She was motivated by the growing incidence of HIV and Aids to venture into home-based care; the devastating impact of HIV and Aids on communities moved her to become involved in supporting and helping sick people. Zanele was not comfortable to divulge her formal education level; she simply mentioned that she did not complete her secondary education due to family circumstances but expressed great appreciation for the experience and knowledge she has gained over the years from being involved in community activities and projects. Prior to becoming involved with Nokuthembeka HBC programme in 2004, she has been involved in various community home-based care programmes since 2002 and came into the programme with substantial service providers such as St John Ambulance. Zanele comes across as articulate, confident and is not afraid to speak her mind – she brings strong leadership to the group and has developed her own systems for caring for her patients. She is committed, passionate and inquisitive.

Ayanda is a 20-something year old young man who lives in New Crossroads. He was unemployed prior to venturing into care-giving and becoming involved in the Nokuthembeka HBC programme in 2006 – he was invited by one of the women to become involved in the programme and the motivation was that it offered him some occupation and the opportunity to become involved in something that contributes towards the well-being of the community. He is soft spoken and due to family circumstances he was not able to complete his secondary education – he was not comfortable to disclose at

what level he dropped out. Ayanda does see his involvement in care-giving as a temporary measure and an opportunity to gain experience and acquire a formal qualification.

Lebo is a 30-something year old woman who lives in Phillippi. She has been involved in the Nokuthembeka home-based care programme since 2006 and was invited by one of the women to become involved. Lebo has always had a strong desire to be a nurse and this is what motivated her to venture into care-giving. Prior to becoming involved in the programme, she was involved in helping and supporting people in the community and is particularly concerned about the high prevalence of HIV and Aids in communities and reckons that such programmes contribute towards the health and well-being of communities and provide an opportunity for the rehabilitation of sick people outside of formal institutions. Lebo comes across as confident, strong, ambitious and determined – she has expressed interest and determination in completing the training and thereafter pursuing studies towards qualifying as a nurse.

Themba is a 30-something year old man who lives in New Crossroads. He became involved in the programme in 2006 having learned of it from some of the women. Prior to becoming involved in the programme Themba was unemployed and although he is committed to care-giving, he became interested as it offered him an opportunity for training and acquiring a qualification. Themba was not comfortable to reveal his formal educational level and indicated that he ventured into care-giving with little previous experience.

In the next section I discuss the information received from individual interviews and the focus group under the headings 1) significance of experience 2) learning processes: what and how do caregivers learn 3) situational conditions that influence learning and 4) relationship between participation and learning. I draw on the views/perspectives of socio-cultural theory protagonists and situated learning theorists to substantiate, corroborate or emphasise the insights I arrived at in my study.

#### 4.5 Significance of experience

In my research study, I developed an interview guide for the face-to-face interviews with learners to explore and establish what experience in palliative care, counseling and community work they came into the programme with. I then moved on to investigate how such experience is mobilised, stimulated, drawn on and utilised by the training programme.

Initially, in seeking to establish what experience learners come with into the training programme, they all responded that they bring no experience. In pursuing the responses, it was revealed that the interviewees assumed that the concept of 'experience' only referred to knowledge and skills acquired in formal work situations or contexts. It is only after pursuing the issue through further questioning that they confirmed that they come with some level of experience in care-giving, knowledge of HIV and Aids prevention and knowledge/understanding of their communities into the training programme. Their initial responses to the questions pertaining to the experience they come with revealed that they did not particularly acknowledge, appreciate, value and attach importance to their own experiences that were not acquired in formal work or learning environments.

The following response from Zanele illustrates: *I came into the training programme with experience in home-based care and some knowledge in the prevention of HIV and Aids from working with support groups in the community and from training received from St John Ambulance. I also learned about HIV and Aids prevention through the women's group in the church where we were regularly given talks by other women. These talks always emphasised that the growing incidence of HIV and Aids requires that we take responsibility for ourselves and as a result we have to learn about HIV and Aids* (Interview: 8 September 2008).

Also by this response from Nomsa: *I came with experience in HIV and Aids prevention and care-giving that I gained from observing my mother as she took care of sick family members in our home. As my mother was a nurse, I often had opportunity to ask her*

*questions and a great deal of my knowledge in care-giving was acquired through my interactions with her* (Interview: 22 August 2008)

The study provided evidence that learners came into the training programme with different levels of experience in the provision of palliative care, community level home-based care, knowledge in HIV and Aids prevention. This insight can be substantiated by Boud (1994:20) who states that “adult learners bring with them to any situation their personal foundation of experience – they bring with them their embodied life history and this experience profoundly affects their perceptions of what does and does not count as important and also makes them sensitive to some features of the situation or environment in which they learn”.

Regarding the acquisition of such experience, the study provided evidence that the experience the interviewees came with into the training programme was acquired in the informal home and community settings through taking care of sick people in their families, involvement in community projects or through living through such situations in their homes. This insight is corroborated by Foley (1993) as cited in Sparks (2002:59-68) who maintains that “much of adult learning is not acquired through formal education but is gained through experiences, through participation in an aspect of social life such as a learning group, family, community or work”.

Brookfield (in Tuinjmans (ed.) 1995:1) also highlighted the central importance of experience in adult learning processes: He maintains that “experience should not be thought of as an objectively neutral phenomenon, a river of thoughts, perceptions and sensations into which we decide, occasionally, to dip our toes. Experience is culturally, morally and ideologically framed and shaped and it is central to how we interpret what happens to us, our interaction with the world and how we act upon that world. When investigating experience, our individual structures of understanding and perceptual filters are culturally embedded and our experiences therefore, are not free from the cultural contradictions that inform them (Brookfield in Tuinjmans (ed.) 1995:1). Most of the interviewees indicated that, in their home setting, they had a moral obligation to support

and care for sick family members and their experience was also shaped by the cultural expectations of their families and communities. The importance of experience is further emphasised by Merriman (2001:5) who describes the adult learner as “someone who has accumulated a reservoir of life experiences that is a rich resource for learning”.

In exploring whether the training programme is set up in a way that draws on and utilises their experience, the interviewees responded positively – they indicated that they draw on their experience when they share and exchange experiences with peers in small group discussions and during practical sessions at health facilities (hospitals, clinics and hospices) where they interact with health care professionals. This experience, they indicated, comes in useful when they are faced with challenges in real life situations at the health care facilities – this is illustrated by the following response from Nolwandle:  
*When I encounter challenges in real life situations, like when I go for practicals, I find myself drawing on my experience. The situations I face force me to remember something that I observed someone else doing or an activity in which I participated. Often, when I am faced with real-life situations, I draw on the experience acquired from observing the nurses who cared for my children during the time they were treated for burns* (Interview: 8 September 2008).

Therefore, the study provided evidence that the training programme is designed and set up in a way that draws on and utilizes the experience of learners and that such experience is mobilised to facilitate learning. This is substantiated by the views of Stein (1998:1) who states that “participants will create their own knowledge out of the raw materials of experience i.e. the relationships with others, the activities, the cues form the situation and the social organisation that the community develops and maintains”. Drawing on the views of Stein (1998:1), experience is the “foundational basis” for learning.

In exploring with the interviewees whether the programme had a mechanism to assess what past experience they came with into the programme, interviewees were quick to indicate that the training programme had no mechanism to assess this. The following illustrates Nolwandle: *Although they asked some questions before I came into the training*

*programme, in my view it was not a very thorough way of assessing the experience I came with; there was no structured process to properly determine what I knew or what I was able to do. I was just asked a few questions and thereafter the programme coordinators seemed satisfied with what I indicated I knew and was able to do. I would have liked it to be a more thorough process that assessed what other knowledge, qualities and abilities I possessed for doing this kind of work. They seemed satisfied that I knew something about HIV and Aids – however, they did not pay attention to whether I had the compassion to care for sick people or whether I was able to write a report (Interview: 8 September 2008).*

Given the interaction with peers in the training programme, interviewees indicated that the experience of peers had influenced their own thinking about care-giving, HIV and Aids prevention and working with communities. They recognised that, over and above what they learned from the facilitators, they also learned from their peers, patients, nursing staff at the clinics and from other people in the community. They acknowledged and recognised that the differences in experience among them as caregivers provided an opportunity to learn from each other and that the level of experience of an individual can make them feel more confident. They indicated that they learn from peers through sharing and comparing stories and experiences. This is illustrated by the following response from Nomsa: *I have become aware that people know different things and one can not judge what others know. You have to be open to listen to others – my peers and even the patients we help and support. Often when I visit patients they will tell me that they are not in the mood for certain things – sometimes they just want to talk and be listened to – if I am not sensitive I will impose myself on the patient and overlook what they need and feel like. My experience has also taught me that you can only provide care in the context of a relationship of trust and it takes time to build such a relationship – where you have achieved to have a relationship of trust you have to be respectful of the wishes and desires and needs of others – you can not impose yourself because you think you know everything. No one person can know everything – we have to bring together our minds and experiences in order to resolve problems (Interview: 22 August 2008).*

Although the training programme is designed in a way that draws on and utilises the experience of the learners, there was a strong perception among the learners themselves that the kind of experience they bring is not immediately valued and recognised by others. Many of the interviewees mentioned that they did not imagine that what they had acquired in community settings is valuable, important and that it can even be appreciated. Many of the interviewees indicated that they had been under the impression that it is only knowledge, skills and experience acquired in formal work or learning situations that matters. From their responses, it became evident that they did not recognise their own experience as important and valuable and this is illustrated by the following response from Phinda: *I have never thought of what I learn when doing work in the community as important. I have always thought that it is only experience gained in formal work and learning settings that counts. As a result, given that I have been unemployed I have always regarded myself as having no experience* (Interview: 22 August 2008).

From the conversations with staff members from ALN, I was helped to understand that the training programme uses a participatory approach and methodology to learning, the programme is explicitly designed and set up to allow for active participation by learners. Notwithstanding this, in exploring with the interviewees what enabled them to participate actively, they indicated that when they have experience in and knowledge of the topics under discussion they feel more confident to participate. When they have little or no knowledge of and experience in the topic they become hesitant to participate in the discussions. This is illustrated by the following response from Phinda: *When I am certain of my knowledge on a topic I feel much more confident to participate in the discussions and to share and engage with others* (Interview: 22 August 2008).

From the interviewees, it became evident that the level of experience in care-giving and that of maturity of an individual can lead to more active participation in the discussions, interactions and exchanges. This is illustrated by the following response from Nomsa: *Being older and more mature makes me less hesitant to participate in the discussion. Also, having gained more work experience at community level gives me the confidence to*



*participate – I have an understanding of how things work at community level so I feel I can contribute to the discussions (Interview: 22 August 2008).*

This insight is substantiated by Wenger (1998:55) who describes participation as “the social experience of active involvement in social enterprise ...it is a complex process that involves our whole person (including level of experience and maturity)”. According to Wenger (1998:56), “participation is an active process”.

#### **4.6 Learning process: what and how do caregivers learn?**

Another dimension of the research study explored what caregivers learn and how they actually learn. From the interviews, I was helped to understand that there are different processes through which they learn and that these have significance in different circumstances. This is illustrated by the following responses from the interviewees:

Nomsa: *Before coming on the programme, I learned a great deal about caring for sick people by simply watching my mother taking care of sick family members – I observed her closely and paid attention to what she did when she bathed or fed them. I also watched how she gave them medication and spoke to them when they were not particularly feeling well (Interview: 22 August 2008).*

Nolwandle: *I have learned how to care for sick people by watching the nurses at the clinic when I go for practicals – I see how they handle them and when I visit my patients in the community I remember and do what I had seen them do. I improved by practising what I had seen the nurses do. Over time, I could see how I was improving in what I was doing (Interview: 8 September 2008).*

Nomsa: *When we get together during the training, I learned a great deal from my peers – we shared stories of our struggles and how we do things when we visit patients in the communities. I learned a great deal from the experiences of others and when I return to my patients, I try these things out (Interview: 22 August).*

Phinda: *I enjoyed going to the clinic because there was one doctor who took the time to show us and explain to us what he was doing. I used to watch him closely and that is how I learned a lot of what I know about caring for sick people* (Interview: 22 August 2008)

Nolwandle: *Although I knew about HIV and Aids before coming on the programme, the facilitators helped me to learn the right words to describe certain conditions of the patient. Before that, I always just mentioned that someone was sick. From the training, I learned to use the right words to describe the condition of the patient* (Interview: 8 September 2008).

The study highlighted and provided evidence that the learners learned through interaction with peers, through observing others and through being directly involved in doing. From the interviewees it was highlighted that they learned through interaction with peers and family members. Further, the study provided evidence that they learned more about themselves and not only factual knowledge and information. This, however, does not mean that no factual knowledge or information was learned or acquired – learners indicated that on many occasions, knowledge that they already possessed was re-confirmed or affirmed or they were helped to develop a new perspective on what they already knew.

This insight is corroborated by Stein (1998:2) who advocates that “situated learning uses participatory teaching and learning methods as the means of acquiring knowledge and that knowledge is created through the interactions of the learner with others and the environment”. The views of Lave and Wenger (1998) further substantiate this. According to Lave and Wenger (1998:7) “learning occurs in a social setting through dialogue with others in the community”. They go on to assert that “learning becomes a process of reflecting, interpreting and negotiating meaning” (Lave and Wenger 1998:7).

The interviewees indicated that, through participation in the training programme they mainly learned about themselves; how they interact with others, how they ask better questions, how they express their own ideas and thinking, how they relate to peers. They acknowledged that this learning influenced their thinking, their work performance in

communities, the quality of support they give patients and their relationships with peers and facilitators. Some even indicated that through participation in the training programme they were able to share information and knowledge with their families.

In terms of how they learn, some of the interviewees indicated that they still rely on rote learning – trying to memorise the information and then recall what they learned. The interviews highlighted the fact that the way some of the caregivers learn now is not much different from their way they learned when they were still in primary and secondary school. However, some of the interviewees indicated that they try to understand what is being taught – so, they ask questions of the facilitators and peers questions to make sure that they understand what is being. This is illustrated by the following from Lesedi: *I like to understand things as a result I ask questions to make sure that I do understand what is being said. If I do not ask the facilitators, I ask my peers afterwards especially those who are good in English and can speak it better than me. I like to understand things very well so that when I go to do my practical sessions and when I work in the community I have a good understanding of what I am doing.* (Interview: August 2008)

The study provided evidence that the interviewees learned through sharing, exchanging and comparing experiences, doing and from the interactive input by facilitators. From the data, it became evident that sharing, exchanging and comparing experiences had the strongest impact on the learning of the caregivers. This insight points to the importance of social interaction which is emphasised by John-Steiner and Mahn (1996:193) who, in citing Vygotsky, assert that “Vygotsky emphasised the importance and primacy of social interaction in human development”.

#### **4.7 Situational conditions that influence learning**

Situated learning theorists such as Stein (1998:3), Hager, Johnsson and Halliday (2006:1) and John-Steiner and Mahn (1996:193) highlight that learning opportunities for adults exist in a variety of situations or settings such as formal institutions, work places, communities and non-formal training processes. They point out that, irrespective of the

nature of the setting, it is important to understand the socio-cultural situation or context in which the learning happens. They emphasize that understanding the situation or context is important for the following reasons:

- 1) It enables facilitators of learning to develop appropriate support systems for learners
- 2) It can, depending on design, enhance or inhibit the interaction among learners and between learners and facilitators
- 3) It provides the tools that guide the participation of learners and supports their learning
- 4) It creates an environment in which their past experiences and knowledge can be drawn on and utilised.

Hager, Johnsson and Halliday (2006:1) maintain that “there are a multitude of variables/conditions in any socio-cultural situation that can influence the learning”. From my study the data revealed that language and level of confidence are important tools or conditions that can influence interaction and participation and subsequent learning. The data revealed that the use of a common language allowed for expression and sharing of experiences among the learners in the group influenced the act of participation and thus the learning. This is corroborated by Doolittle (1999:2) who concurs with Vygotsky that “learning should take place in authentic real-world environments and should involve negotiation and mediation”. Doolittle (1999:5) goes on to assert that “learning as a social, dialogical process happens through using tools - such as language – as a medium through which knowledge/understanding are constructed in social situations”.

All the interviewees involved in the research study use isi-Xhosa as vernacular (mother tongue); it is the language they use on a daily basis in their interactions with peers, patients and family. They also write and read isi-Xhosa very well. For all the interviewees English is the second or even the third language and although most speak it, they only use it in situations where they communicate with persons who do not understand and cannot speak their mother tongue. The medium of instruction for the training programme is English – it is the main language used by the facilitators for delivering the training. The learning materials which are specially designed for the training course are developed in English and each study unit has clear objectives and

exercises and activities are illustrated with diagrams. The interviewees indicated that although they can speak English, they generally struggle with reading and writing in English.

The interviewees indicated that they have stronger relationships with those peers and facilitators who speak the vernacular (mother tongue) – they indicated that having a shared language enables them to ask questions and share problems/experiences with ease. The majority of the interviewees indicated that they feel freer to share their personal learning struggles and challenges with those peers and facilitators who speak the vernacular. As a result, they find that they interact more with those people who speak the vernacular and this is illustrated by the following from Nomsa: *I feel closer to the peers with whom I share the vernacular; I find it easier to share with and relate to them. I feel free and can share with them on a deep, personal level. I am certain that they will understand my problem and will help me in my learning. I find that I interact more with those people who speak the vernacular and mainly engage with them when I have learning problems* (Interview: 22 August 2008)

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This insight is emphasised by Nelson (1998:120) who maintains that “the mediating role of language involves its capacity to convey knowledge about the world, about other people, about social and cultural interpretations of situations and events, and about imagined possibilities, plans, mythologies and theories”. Nelson further emphasises that “language must be well developed in order to serve the full range of its mediating/facilitating functions” (Nelson, 1998:120). My study provided evidence that language certainly played a role in facilitating and mediating sharing, exchanging and learning.

Interviewees indicated that when using the vernacular they are able to express their thoughts and ideas much easier and know that peers and facilitators who speak the vernacular will understand them without difficulty and this helps them to learn and leads to a better understanding of the theoretical concepts – this is confirmed by the following from Nomsa: *When I speak in the vernacular I am able to express my thoughts and ideas*

*much clearly and when I get the facilitator to explain concepts in the vernacular I understand much better.* (Interview: 22 August 2008).

The data revealed that use of the vernacular makes it easier for learners to make the connection between the theory and their own experience and this helps them a great deal when they go for practical sessions. This is illustrated by the following from Nomonde: *When things are only explained in English I struggle to see how it connects to my own experience – also, I find it difficult to fully explain what experience I have. However, when I am helped by those facilitators who can speak the vernacular it helps me to understand better and this helps me to make connections to experiences that I gained in the community.* (Interview: 22 August 2008). This further emphasises the mediatory role of language mentioned by Nelson (1998:120).

Many of the interviewees indicated that, although they understand English, they do not feel confident when having to express themselves using English. This makes them uncertain to express their ideas and share these with others. Often, because they struggle with the language they hesitate to share in group discussion as is illustrated by the following from Nomonde: *Sometimes because I am not certain of the language I hesitate to share my thoughts and ideas – this becomes a problem in my learning as I can not test my understanding of things.* (Interview: 22 August 2008).

Although this aspect was not a focus of the study, it became evident that the culture of teaching and learning that the learners were accustomed to from their past schooling, was a critical condition that influenced their participation and learning. All the interviewees indicated that they come from a culture of rote memorisation, formal examinations, passing things on by word-of-mouth and classroom teaching. As a result, in the training programme, how they learn and what they expect of facilitators is strongly influenced by this past culture of teaching and learning. As a result, attempting to memorise information remains a strong aspect of how they learn as illustrated by the following response from Themba: *I still try to memorise the information and this sometimes works*

*for me. At other times I struggle and given that we do not write exams, I am sometimes uncertain of how much I have learned and understood* (Interview: 22 August 2008).

The majority of the interviewees indicated that although they understood the content better when it was explained in detail first by the facilitator, when expected to work through the content in the learning materials on their own, they felt very uncertain about how much they understood or learned. Many indicated that they found it much easier to learn using the learning materials once the ‘teaching’ had happened. The following from Lesedi illustrates: *I learn much better when the facilitator explains the concepts during the sessions as this makes me to think. When I am taught I find it easier to connect what is said to what I already know or have heard before. Once it has been explained, I find it easier to go back to the study guide and read and work on the tasks. I also find that I can even enjoy working through the tasks after things have been explained during the sessions* (Interview: August 2008).

Some of the interviewees indicated that, even though the facilitators explained things very well during the session, they still preferred to engage their peers in re-explaining to them using the vernacular to ascertain whether they have truly understood what was said by the facilitator. This is illustrated by the following from Themba: *Even though I understand what has been explained during the sessions, afterwards I still go to my peers with whom I share a language and I ask them to re-explain it to me. In this way I can be sure that I really understand what was taught* (Interview: August 2008).

From the interviewees, it became evident that the responsibilities, obligations and expectations of their families and communities influenced the learning process of caregivers in one way or another. The majority of the interviewees indicated that such responsibilities/obligations/expectations, often underpinned by values of care, love and human dignity, was a critical factor in getting them to become involved in caring for sick people - they were expected to provide support, care and love for family members who ended up sick and incapacitated. The following from Nomsa illustrates: *Although this was never discussed, there was an obligation and responsibility to help my mother take*

*care of my grandmother and other members of the family when they became sick. It was not an issue that was discussed, somehow everyone was expected to help out and do your bit* (Interview: 22 August 2008).

Although the learners acknowledged that not too much attention was paid to evaluating the processes through which such experiences were acquired, it was evident that the experiences of others provided a resource for learners. Sharing and exchanging experiences proved helpful in shaping the thinking of individual learners as it enabled them to compare their own thinking to that of others, they learned from the ideas of others. This is substantiated by Hager, Johnsson and Halliday (2006:2) who maintain that “interaction with others provides experiential opportunities to negotiate and refine frames of reference that form motivations and basis of action”.

Some interviewees indicated that curiosity and willingness to learn and encouragement by peers influenced their participation in the programme – this is illustrated by the following from Phinda: *I am naturally curious so I ask a lot of questions in the sessions and this gives me chance to participate actively. Also, I am not hesitant to share what I know* (Interview: 22 August 2008). This is further illustrated by Sivuyile: *When my peers participate actively in the sessions I become encouraged by that and then feel comfortable to participate and share my ideas and thoughts* (Interview: 22 August 2008).

The interviewees indicated that the actions and behaviours of peers also influenced their participation. Such behaviours, they indicated, can either encourage or discourage their participation in the situation as illustrated by Lesedi: *When my peers encouraged me to speak, I was more willing to participate in the discussions. However, when they laughed at what I said, I become hesitant and withdrew from the discussions and sharing what I knew – this made me to doubt my own understanding and knowledge of things* (Interview: 22 August 2008).

Although the learners appreciated the assessment system which they experienced as less stressful, many indicated that the schooling system had made them used to writing formal



examinations and, as a result, they were not very certain about this new assessment system. According to many of them, the formal examination system gave them ‘a better sense of what they know’ – the new assessment system does not give them ‘a good sense of what they know’. Many indicated that they have to be helped to properly understand how the assessment process works and this is illustrated by the following from Themba: *I am used to writing examinations and this always gave me a sense of how much I know. With the assessment system, I am not sure how much I know. However, the assessment system is not as stressful as examinations but I need to understand more about what is my responsibility in making these assessments work. I need to understand better how the assessment works so I can do my best during my participation in the training course* (Interview: 22 August 2008).

#### **4.8 Relationship between Participation and Learning**

Referring to the theory, socio-cultural theory and situated learning view participation as central. Wenger (1998:57), amongst others, maintains that “the manner of participation of learners is more important than the various activities in which they participate”.

The investigation provided evidence that in the social setting, the importance of interaction with others for the collective production of meaning or knowledge and active participation is regarded as critical. This insight is emphasised by John-Steiner and Mahn (1996:193) who maintain that “learning is a socially situated process which is rooted in the situation in which a person participates”. They emphasise interaction with others and participation.

Drawing on the views of situated learning theorists, the process of learning, whether conscious or unconscious, results in a situation where human beings are allowed access to a broader range of choices and ways of changing themselves, their situations and environments. From this, it can be deduced that irrespective of the circumstances under which it happens, learning does seem to have changes attached to it and that such changes could include increased knowledge, understanding, consciousness, self-awareness,

resourcefulness, enhanced opinions and capacity to decide or choose. Marsick and Watkins (2001:29) support this insight. They maintain that “the process of learning, whether conscious or unconscious, results in a situation where human beings are allowed access to a broader range of choices and ways of changing themselves, their mental models, situations and their environments”.

In this study, I explored and investigated whether participation facilitated learning that resulted in changes in actions; the intention was to establish whether participation in a training programme facilitates learning that results in change. In exploring what they learned through interaction with peers, the interviewees indicated that over and above the knowledge on palliative care and HIV and Aids prevention, they learned a great deal about themselves. The majority of the interviewees indicated that by participating in the training programme, their thinking, actions and relationships had been influenced. Many of them indicated that, since participating in the training programme they had started to question their own ideas and thinking more, being in the training programme has made them to listen more and pay closer attention to others when interacting with them.

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Some of the interviewees indicated that participating in the programme has made them to work harder on their assignments and to assert themselves more when going for practical sessions at the clinic or hospital. For others, participation in the training programme has helped to stimulate their sharing – they find that they share more and feel much freer than before to articulate their own thoughts, ideas and opinions. The following illustrates Nomonde: *I have become more confident in asking questions and I have started to question my own ideas and thoughts more. Before participating in the programme, I used to be scared to ask questions and felt that it made me ‘stupid’. Since I have come onto the programme, I have come to see that it is a good thing to ask questions – by asking questions one learns more and you get to test your own ideas* (Interview: 22 August 2008).

The information revealed that through interaction with peers, the learners learn how to better express their own thoughts, ideas and opinions. They also learn how to ask the

right questions, how to relate to others and also to respond to the ideas, questions and perspectives of others. This is illustrated by the following response from Phinda: *Although I am gaining a lot of knowledge about palliative care, prevention of HIV and Aids, risk management and working with communities, at the same time I am learning about myself. I am learning a lot about how I relate to others and how I respond to their ideas/thinking. Interacting with others helps me to see myself, my relationships with others and how I express and articulate my own ideas and thoughts. I can see when I am not confident. I am learning about my own weak point* (Interview: 22 August 2008).

Further, the investigation highlighted that interaction with peers provides a context for learning in that it allows for sharing and exchange of ideas, experiences and knowledge and provides learners with a diverse range of perspectives that challenges their own thinking and provides them with options for approaching problems. Interviewees indicated that they learn through sharing and exchanging experiences, through observing others and asking questions. This is illustrated by the following - Nomonde: *I am learning a great deal about myself and how I relate to others. I find that I listen more closely and carefully to others when discussing with them. Sometimes I get scared when they ask me questions but, since coming onto the training programme I have become less scared of being asked questions* (Interview: 22 August 2008).

Interviewees indicated that, over time, their participation in the sessions and discussions have improved and that this is attributable to their own growing confidence. As they have gained knowledge and have started to feel secure within themselves, they have participated more strongly and shared more freely with peers in group discussions. For example the following response illustrates Sivuyile: *With time I have become less afraid to share my thoughts and ideas and I have become more open about what I know and do not know. The more I have learned the better I have become at participating in the sessions – my knowledge in care-giving has certainly contributed towards this* (Interview: 22 August 2008).

The data provides evidence that the level of experience is linked to personal self-concept and confidence; learners with vast experience in care-giving had higher levels of confidence. Due to the higher levels of confidence, they were more willing and prepared to participate, interact, exchange and compare experiences.

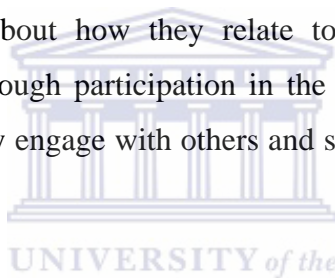
Some interviewees indicated that interaction with peers has not only improved their participation in the training session and small group work, it has also strengthened their relationships with peers. This is illustrated by the following response from Nomsa: *As I have learned from peers I have developed stronger relationships with them – I trust them more and this has made to feel freer to speak and participate in the sessions:* (Interview: 22 August 2008). The notion of strengthening relationships with peers is related to thoughts/ideas of Hager, Johnsson and Halliday (2006:2) that “the situation in which learning happens changes both learners and the nature of their relationships with others”.

The study highlighted and concurred with the views of Wenger (1998:56) that “participation in a learning activity is not a single act; instead participation becomes the result of a chain of responses that are based on an evaluation of the position of the individual in his or her environment”. The learners acknowledged that their level of participation was not the same at the beginning of the training programme as it was at the end of the 6-month training period. The investigation highlighted that, at the start of the training programme the participation of learners was less active and meaningful. With time, however, their participation has become more active. From the interviews, it became evident that, over time, due to increases in levels of confidence, a growing ability to question and engage with the ideas and viewpoints of others and a growing ability to pay close attention to others, the learners participated more actively and meaningfully in the learning activities.

The interviewees indicated that participating in the training programme has positively influenced their thinking; according to them, it has broadened their thinking and knowledge of HIV and Aids prevention, increased their awareness about personal responsibility regarding prevention of HIV and Aids and has contributed towards making

them more empathetic towards their patients. The following response illustrates Nomsa: *What I learned through interaction with peers has certainly broadened my understanding of HIV and Aids prevention, and the importance of education and personal responsibility regarding HIV and Aids prevention. Better understanding of issues has made me more empathetic towards my patients. I find that I listen more and try harder to understand the perspective of the sick people I support* (Interview: 22 August 2008).

In exploring what new knowledge they gained through participation, interviewees indicated that participating in the training programme has broadened their knowledge and understanding of care-giving and prevention of HIV and Aids. However, many indicated that over and above this, from participating in the training programme, they learned a great deal about themselves – many indicated that from participating in the programme, they actually learned more about how they relate to their peers. The majority of interviewees indicated that through participation in the programme, they have become more conscious about how they engage with others and share their own ideas/thinking in the sessions.



Participating in the training, they emphasized, has helped to broaden their own thinking and has made them less fearful of engaging with the ideas, thinking and perspectives of others. The following illustrates - Nolwandle: *Through participation in the sessions, I find myself listening more to the different viewpoints of others – I have become more attentive to what others says*: (Interview: 8 September 2008). And also by the following from Zanele: *Through participation in the sessions I have been exposed to the ideas and thinking of others –in the beginning I was always overwhelmed by the ideas and thinking of others but not, I see it as opportunity to test my own thinking/ideas against those of others*: (Interview: 8 September 2008).

The investigation highlighted that, more than new knowledge about HIV and Aids prevention, interviewees indicated that they experienced a shift in their own thinking about HIV and Aids prevention and the provision of palliative care to patients. The following responses illustrate - Sivuyile: *I don't think we have created new knowledge*

*through engagement with peers; instead I think I have been helped to see that HIV and Aids prevention is a complex thing that requires a lot of education (Interview: 21 August 2008). And from Lesedi: While I have not learned anything new, I think a lot of things regarding HIV and Aids prevention have been confirmed. However, something important that I have been helped with is the importance of education and personal responsibility regarding HIV and Aids prevention. I think my thinking about HIV and Aids has changed –I have become more cautious about talking to people about HIV and Aids prevention (Interview: 22 August 2008).*

From the study, most of the interviewees indicated that their own thinking changed because of the influence of the ideas and thinking of others – through interaction with others their own ideas were challenged and they have become more aware of their own actions in situations of care-giving. The following illustrates - Lesedi: *The interaction with peers has forced me to think a great deal about what I know – I have become more critical about what I know, about my own ideas. Also, I have become more aware of what I do in situations where I care for patients (Interview: 22 August 2008).*

Wenger (1998:55-58) emphasised the centrality of participation as a core concept in socio-cultural theory and situated learning approaches. According to him, “meaning is constructed through interaction by participating in a social community of practice - participants help to shape each other’s experience of meaning and that the act of participation is crucial in the creation of meaning. Participation is the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises. Participation is both personal and social. It is a complex process that combines doing, talking, thinking, feeling and belonging. It involves our whole person, including our bodies, minds, emotions and social relation - participation is an active process” (Wenger, 1998: 55-58). It can therefore be deduced that participation and social engagement therefore provide experience that is vital to learning

While their growing confidence and knowledge enhanced participation, the study provided evidence that the behaviour of peers also contributed to how learners

participated in the learning activities. The majority of interviewees acknowledged that there was a connection between the kind of feedback from peers and their participation. From their responses, it became evident that encouragement and positive feedback from peers generally had a positive influence on their participation in learning activities. In a way, the positive feedback reinforced active and meaningful participation and this enhanced their learning. This concurs with the viewpoints of Stein (1998:3) who maintains that “interaction with peers or members of the community is what shapes the participation and learning of individuals and the collective”.



## SECTION FIVE

### 5. SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Summary of Findings

The investigation brought me to significant findings and conclusions regarding the focus and core concepts covered in this study. I envisage that these findings may contribute to and inform the practices of training programmes similar to the National Certificate Training Programme in which the learners participated. Further, I envisage that the findings will also inform my own practice as a facilitator of learning and change processes with adult learners.

The focus of my study was “*The Nature and Dynamics of Learning Amongst Caregivers in a National Certificate Training Programme*” and the following questions were posed to guide the investigation:

- 1) *How does the past experience of learners influence their participation in the training programme?*
- 2) *What do the caregivers learn through participation in the training programme and how do they learn it?*
- 3) *What situational conditions influence their participation and learning?*
- 4) *How does participation in the training programme facilitate learning that results in change?*

The following findings of the study have emerged and brought me to important insights with regard to the focus of my research:

- 1) The learners came into the training programme with different levels of experience in care-giving, HIV and Aids prevention, counseling skills and working with communities and that such experience was acquired or gained from informal settings in the home and community.



- 2) This past experience of learners served as an important resource for learning in other settings or environments. In the training environment, the past experience that learners came with into the programme was mobilized through their interaction with peers and facilitators - the training programme environment provided the learners with a space to connect to, process, draw on, utilise and learn from their past experience.
- 3) The training environment provided learners with a safe environment to share experiences, express their ideas without fear and to draw support from others - the interaction with peers provided them with a context for learning and enabled the sharing and exchanging of experiences and stories.
- 4) Through participation in the training programme, the caregivers learned primarily about themselves and the content of the training programme became secondary. Although the content of the training programme helped the caregivers learn about HIV and Aids prevention, counseling skills and palliative care, through interaction with peers they learned mainly about themselves and such learning resulted in increased levels of confidence, stronger relationships with peers, enabled them to ask better questions, increased their ability to articulate their own ideas and increased their willingness to share experiences with peers.
- 5) The use of participatory methodologies by the training programme - for example small groups - enabled learners to use their own experience as 'raw materials' for interaction with peers and helped to strengthen relationships with peers.
- 6) Although the use of participatory methodologies enabled sharing and exchanging of experiences and stories, this study was not able to establish with certainty whether deeper learning was truly achieved.
- 7) Language was a significant means for sharing experiences, establishing meaning and for strengthening relationships with peers. The study revealed that learners found it easier to share with those peers with whom they shared a language – they also enjoyed stronger relationships with them.
- 8) By involving learners in processes of self assessment, creates opportunity for them to take responsibility for and track their own learning and to assess how the learning contributes towards their competence and performance. Involving the

learners in the self assessment processes, they were forced to take responsibility for their own learning.

- 9) In the training programme, interaction with peers provided the space and opportunity to exchange and compare experiences, ideas, knowledge and information and it is through such interaction that collective learning was achieved.
- 10) Due to the absence of an appropriate mechanism or instrument for assessing prior experience, the organisation implementing the training programme was unable to properly determine/assess the prior experience learners bring and to use such experience to inform the learning objectives of the programme.

## 5.2 Conclusions

My research study confirmed that:

- 1) Informal settings such as community and home environments are important and powerful learning sites for adult learners – they shape/frame the learner's experience. In such settings, observation of and direct involvement in events and activities are essential processes through which people learn.
- 2) Increasing levels of confidence in adult learners can enable more meaningful participation in learning activities and interaction with peers.
- 3) Active participation in learning activities does not happen merely through the use of participatory methodologies; it is important for those who design training and learning programmes to ensure proper integration of situational learning approaches.
- 4) This study confirmed that knowledge of self is different from factual knowledge (pertaining to content) – knowledge of self is facilitated by interaction with others.
- 5) Situational conditions or variables and tools such as language, culture of learning/teaching, personal attributes, curiosity and willingness to learn can influence participation and learning positively as well as negatively.

- 6) Learning among caregivers has a social dimension to it and is not confined to a particular situation; it happens in any situation where there is interaction. In this instance, it happens through interaction with peers and facilitators.
- 7) The extent to which participation facilitates learning in any situation depends on the extent to which learners are able to overcome the various situational, institutional and dispositional (personal attributes) barriers to learning.
- 8) The absence of a mechanism to assess or determine the prior experience of the caregivers is a weakness of the training programme.

### **5.3 Recommendations**

Although my research study focused on the National Certificate Training Programme for community health workers, the recommendations are a generalisation to similar training programmes aimed at professionalising home-based care practice.

As the National Certificate Training Programme targets adults in communities, the organisations that implements training programmes could benefit from developing an instrument for assessing/determining the prior experience of its learners in order to ensure that the learning goals of the programme are aligned to the learning needs and expectations of the learners.

It is further recommended that, when dealing with adult learners, it is not sufficient to simply use participatory methodologies as these can result in superficial learning; it is important that situational learning approaches are fully integrated into the programme to ensure deep learning.

Lastly, harnessing this kind of learning among caregivers can help to bring focus to the professionalisation of what is becoming an established occupation and practice; engaging with such learning processes can ensure that the care-giving practice is informed and shaped by lessons from the experiences of existing training and home-based care programmes.

#### 5.4 In closing

In closing, I would like to return to my topic which reads “*The Nature and Dynamics of Learning Amongst Caregivers in a National Certificate Training Programme*”. The conceptual framework has enabled me to establish that the nature of learning amongst caregivers brings their experience acquired in the informal settings of home and community into the learning activities of the training programme environment in a way that mobilises, stimulates, draws on and utilises such experience. The learning, the study established, is triggered by how this experience is mobilised, stimulated, drawn on and utilised.

Further, the conceptual framework enabled me to establish that within the training environment, participation facilitated learning that resulted in change. However, it helped to highlight that the learning did not necessarily contribute towards the creation of new factual knowledge but, instead helped the learners learn about self. The conceptual framework also enabled me to establish that the training environment provided caregivers with a learning context – it provides them with the space and opportunity to engage and interact with peers and facilitators and to share, exchange and compare experiences, ideas, knowledge and skills and learn through interaction. Through such interaction learning was collectively generated.

A weakness in the conceptual framework is that it did not highlight barriers that can either enhance or limit participation and learning in any situation. Although I did not anticipate these barriers in the conceptual framework, John-Steiner and Mahn (1996) distinguish between situational, institutional and dispositional barriers. According to **John-Steiner and Mahn (1996:198)**, “situational barriers are those arising from the learner’s own situation at a given time – they include things such as time and money factors and also issues of language. Institutional barriers refer to practices and procedures that exclude or discourage adults from participating – they include things such as relevance of programme, inconvenient schedules and assessment and practical processes. Dispositional barriers are those related to attitudes and perceptions about self as a learner and they include things such as confidence levels, feeling old, poor previous educational

performance and achievements, attitude towards learning (low motivation and or desire to learn)”.

In my study I found significant differences between the strength of these barriers – the dispositional barriers proved to be the most significant in terms of their impact on participation and learning among the learners. From the interviews, it was evident that where learners had a positive self concept and felt confident this translated into meaningful participation in small group discussions and this facilitated learning in a significant way. The study highlighted that the situational and institutional barriers were less significant in terms of their impact on participation and learning. However, to develop an in-depth understanding of the impact of these barriers on learning would require further research.



## BIBLIOGRAPHY

Bak, N. (2001). *Research Proposal Guide: Developing and submitting a research proposal*. University of the Western Cape: Cape Town.

Behrman, E.H. (2002). *Community-based literacy learning*: International Journal of Lifelong Education. Vol 20, No3, Issue 1, April 2002, pp 26-32.

Brookfield, S. Adult Learning: An Overview. In Tuinjmman, A. (1995) *International Encyclopedia of Education*, Oxford, Pergamon Press.

Burns, G.E. (2001). *Towards a redefinition of formal and informal learning: Education and the Aboriginal People*, WALL Working Paper No. 28, 2001

Byrne, B. Qualitative interviewing. In Seale, C (ed) (2004). *Researching Society and Culture*, Sage Publications: London

Clarke, M., Dick, J. and Lewin, S. (2008). *Community health workers in South Africa: Where in this maze do we find ourselves?* South African Medical Journal, September 2008, Vol. 98, No. 9. pp 680-681.

**Dey, A., Abowd, G. et al (1999). *Towards a better understanding of Context and Context Awareness*. Lecture notes in computer science; Vol. 1707. Proceedings of the 1<sup>st</sup> international symposium on Handheld and Ubiquitous Computing, Karlsruhe, Germany, September 27<sup>th</sup> to 29<sup>th</sup> 1999.**

Doolittle, P. (1999). Constructivism and Online Education. In *1999 Online Conference on Teaching Online in Higher Education*, pp 1-13.

Duffy, T.M. and Cunningham, D.J. (2001). *Constructivism: Implications for the Design and Delivery of Instruction*. AECT. The Handbook of Research for Educational Communications and Technology.

Retrieved from <http://www.aect.org/Intranet/Publications/edtech/07/index.html>.

Fenwick, T. (2001). *Experiential Learning: A theoretical critique from five perspectives*. ERIC Clearinghouse on Adult, Career and Vocational Educational Center on Education and Training for Employment. College of Education, The Ohio State University.

Retrieved May 2004 from [www.cete.org/acve/mp\\_fenwick\\_01.asp](http://www.cete.org/acve/mp_fenwick_01.asp)

Foley, G. (1999). *Learning in social action: A contribution to understanding informal education*. London: Zed Books.

Hager, P., Johnsson, M. and Halliday, J (2006). *Examining contexts in collective learning: A cross-case analysis* (a paper examining the role of context in collective learning across three empirical workplace cases - first appeared in Hager, P. & Halliday, J. (2006). *Recovering informal learning: Wisdom, judgement and community*. Lifelong Learning Book Series 7. Springer, Dordrecht, The Netherlands

Retrieved from <http://www.eric.ed.gov>

John-Steiner, V. and Mahn, H. (1996). *Sociocultural Approaches to Learning and Development: A Vygotskian Framework*. Educational Psychologist, Vol. 31 Issue 3 & 4 June 1996 pp191-206.

Kelly, M. Research Design and Proposals. In Seale, C. (ed.) (2004). *Researching Society and Culture*. Sage Publications: London

Lave, J. and Wenger, E. (1998). *Communities of practice*

Retrieved from [http://www.infed.org/biblio/communities\\_of\\_practice.htm](http://www.infed.org/biblio/communities_of_practice.htm)

Lzar, D. Selected issues in the philosophy of social science. In Seale, C. (ed.) (2004). *Researching Society and Culture*. Sage Publications: London

Marsick, V.J. and Watkins, K. (2001). *Informal and Incidental Learning*, New Directions for Adult and Continuing Education. No. 89 Spring 2001. Jossey-Bass. pp25-34.

Marton, F.(1995) *Cognoso ergo sum: Reflections on reflections*. Nordisk Pedagogik, Vol.4, Number 3. 1995.

Marton, F. (1999) *Variatio mater est studiorum*: Keynote address to the European Association for Research on Learning and Instruction (EARLI) Goteborg, 1999.

Mezirow, J. (1981). A Critical Theory of Adult Learning and Education *Adult Education: Vol. 32 No.1. Fall 3-24*.

Nelson, K. (1998). *Language in Cognitive Development: the emergence of the mediated mind*. Cambridge University Press: United Kingdom.

Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods* (2<sup>nd</sup> edition). Newbury Park, CA: Sage Publications Inc.

Seale, C. (ed.) (2004) Coding and analysing data. In *Researching Society and Culture*. Sage Publications: London.

Sparks, B. (2002) Adult Literacy as Cultural Practice. In Alfred, M.V. (ed.) *Learning and sociocultural contexts: Implications for adults, communities and workplace education*. New Directions for Adult and Continuing Education, Volume 2002, Issue No. 96 San Francisco: Jossey Bass, pp59-68.

Stein, D. (1998). *Situated Learning in Adult Education*. Eric Digest.

Retrieved September 2008 from <http://www.ericdigests.org/1998-3/adult-education.html>

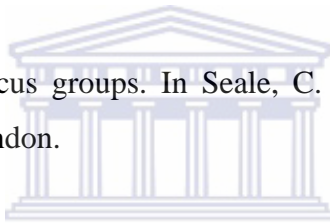


Tennant, M. (2003). Undisciplining psychology through pedagogy: an autobiographical case study of working knowledge. In Chapell, C.; Solomon, N.; Rhodes, C.; Tennant, M. and Yates, L. *Reconstructing the lifelong learner: Pedagogy and identity in individual, social and organisational change*. Retrieved April 2004 from: [http://blackboard.liu.se/bin/common/course.pl?course\\_id=455\\_1&frame=top](http://blackboard.liu.se/bin/common/course.pl?course_id=455_1&frame=top)

Terre Blanche, M. & Durrheim, K. (eds). (1999). *Research in Practice: applied methods for the social sciences*. Cape Town: UCT Press.

Tonkiss, F. (2004). Analysing text and speech: content and discourse analysis. In Seale, C. (ed.). *Researching Society and Culture*. Sage Publications: London.

Tonkiss, F. (2004). Using focus groups. In Seale, C. (ed.). *Researching Society and Culture*. Sage Publications: London.



Toseland, R.W. and Smith, T. (2002). *Supporting Caregivers through Education and Training*. National Family Caregiver Support Programme (NFCSP). Selected Issue Brief No. 5. Retrieved 18 February 2007 from <http://www.nasua.org/family/caregiver/careprof/conferences/Toseland>.

Trigwell, K.(2000). Phenomenography: Variation and Discernment. In C. Rust (ed.). *Improving Student Learning, Proceedings of the 1999 7<sup>th</sup> International Symposium*, Oxford Centre for Staff and Learning Development: Oxford pp75-85.

Uys, L.R. *The practice of community care-givers in a home-based HIV and Aids project in South Africa*. Journal of Clinical Nursing 2002; 11(1) pp 99-108.

Vygotsky, L. (1978). *Interaction between learning and development, Mind in society: The development of higher psychological processes*, Cambridge:Harvard University Press. Retrieved from <http://www.marxists.org/archive/vygotsky/works/mind/Chap6.htm>

Walsh, David (2004). Doing Ethnography. In Seale (ed.). *Researching Society and Culture*. Sage Publications: London.

Wenger, E. (1998). *Communities of Practice: Learning, Meaning and Identity*. Cambridge: Cambridge University Press.

Wikipedia

[www.wikipedia.org](http://www.wikipedia.org)

Wolvaardt, G., Van Niftrik, J., Beira, B., Mapham, W. and Stander, T. (2008). *The Role of Private and Other Non-Governmental Organisations in Primary Health Care* in South African Health Review 2008. Published by the Health Systems Trust 2008.

Retrieved from <http://www.hst.org.za/publications>



## **APPENDIX 1: INTERVIEW GUIDE**

### **Profile**

1. Name and age
2. Training (non-formal)
3. Level of formal education
4. Motivation for venturing into care-giving

### **Aspects to be covered**

#### **Learning Situation (Context)**

- Purpose of the training programme
- Description of the nature, quality and pattern of relationships within the training group
- How is the situation designed to facilitate interaction and participation?
- What situational conditions influence participation and learning?

#### **Experience**

- What experience in care-giving, counseling and community work do you think you come with into the training programme?
- Is the programme set up in a way that draws on and utilizes your experience?
- In what circumstances do you draw on your experience?
- Is your experience used in a way that contributes to learning within the group?
- How has your own experience sensitized you to the thinking and understanding of others peers and facilitators?
- How does your experience guide how you interact and engage with peers and facilitators?
- How has the experience of peers and facilitators helped to influence your own understanding and thinking about HIV/Aids prevention and care-giving?

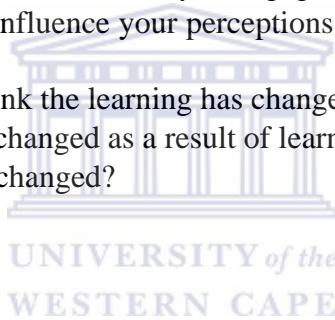
#### **Participation**

- Is the situation set up to allow for participation?
- If the situation is not explicitly set up to allow for active participation, what enables this?
- What knowledge and abilities enable you to participate in the situation?
- Does participation in the situation lead to questioning your understanding and knowledge of HIV/Aids prevention and the practice of care-giving?
- How do the actions/behaviours of peers influence your participation?

- What new information and knowledge on HIV/Aids prevention and care-giving have you gained through participation in these sessions?
- In what ways has your participation in these sessions improved over time and what has enabled this?
- How has interaction with peers contributed to improving your participation?
- How has your thinking and behaviour changed since participating in the training sessions?
- How do your perceptions about HIV/Aids prevention influence your participation?

### **Learning**

- What are you learning through interaction with peers?
- How are you learning it?
- How does the interaction with peers provide a context for learning?
- How does the interaction with peers help you in your learning?
- How does the learning influence how you participate in the sessions?
- How does the learning influence how you engage with and relate to others?
- How does the learning influence your perceptions about HIV/Aids prevention and care-giving?
- In what ways do you think the learning has changed you?
- Do you think you have changed as a result of learning?
- In what ways have you changed?



## APPENDIX 2: FIELD NOTES

### Theme: Experience

#### What experience did respondents bring?

Sivuyile: I brought experience in care-giving that I gained through observing my mother take care of my grandmother when she was sick – I also gained experience in care-giving by caring for my grandmother when my mother was at work – I had to wash and feed her. I gained experience in the prevention of HIV and Aids mainly from the media (television, radio, newspapers) and from interacting with other people.

Lesedi: I came into the programme with experience in care-giving and HIV/Aids prevention which I gained from observing the care-givers who looked after me when I was sick – I closely observed them as they bathed, clothed and fed me. I gained experience in the prevention of HIV and Aids from the members of the support group of which I was a part.

Nomsa: I brought experience in HIV/Aids prevention and care-giving that I gained from working with people in the community and from observing my own mother as she took care of sick family members. Also, my mother was a nurse and I had opportunity to ask her questions and gained knowledge through engaging with her.

Phinda: I came with experience in HIV/Aids prevention and care-giving which I mainly gained from the media – watching programmes on television, reading newspapers, from interaction with people in community projects.

Nomonde: I brought experience in HIV/Aids prevention which I gained from interacting with my friends and sick people in communities. My experience in care-giving I acquired from taking care of family members in my home situation – it was common to have a family member who was sick who needed attention and we had to help and support those who were sick.

Nolwandle: I came into the programme with experience in care-giving gained from taking care of my two children who had suffered burns during a shack fire some years ago – I was able to take care of them because while they were in hospital I closely observed the nurses who cared for them. I gained knowledge of the prevention of HIV and Aids from participating in community projects that supported sick people and from the training courses that I had the privilege of participating in before I became involved in Nokuthembeka HBC programme.

Zanele: I came with experience in care-giving and HIV/Aids prevention which I gained from working with people in the community and from the training I received from St John Ambulance before I became involved in this programme. I also acquired knowledge on HIV/Aids prevention from the church and through interacting with other women in the congregation. The growing incidence of HIV and Aids has forced as individuals to take responsibility for ourselves and this required that one learn about HIV and Aids.

Lebo: I came with experience in HIV/Aids prevention and care-giving which I gained by working in the community and interacting with people in the community and from observing health professionals at the clinic.

Ayanda: I brought experience which I gained mainly from interacting with people in the community and from observing others.

Themba: I came with experience in HIV/Aids prevention which I gained from interaction with others in the community.

Nolwandle: In real-life situations you find yourself drawing on your experience; the situation you face forces you to remember something that you participated in or observed someone else doing. Often, when I have to do dressings for the patients, I draw on what I observed when my own children were being treated for burns.

Sivuyile: During patient visits I often draw on what I remember my mother doing when we were taking care of my grandmother when she was sick and needed special care.

Nolwandle – in my view it was not a very thorough way of assessing our experience; there was not structured mechanism or process – I was just asked a few questions and thereafter they [the coordinators] seemed satisfied with what I indicated I knew. I would

have liked it to be a more thorough process – I would have liked them to assess whether I possess other qualities for doing this kind of work (patience, compassion, trustworthy, caring)

Nomsa – I was just asked if I had taken care of sick people before and when I responded positively, I was allocated patients that I immediately had to start taking care of. I think the fact that I was more mature and had been involved in HBC before probably made the coordinators decide that I could be allocated patients immediately.

**How has your own experience sensitised you to the thinking and understanding of others (peers, patients, family members)?**

Nolwandle: I have become aware that people know different things and this makes it easier for us to learn from each other. The nursing professionals at the clinics and hospitals are people from whom we as community caregivers can learn a lot – however, they can also learn a lot from us as we work in different situations. For instance sometimes colleagues complain about the nursing professionals and tell us how difficult some of the nurses are. Although I listen to my colleagues I try that their thinking should not influence my perception of the nursing professionals – I try to go in with an open mind to give me an opportunity to learn from the nursing professionals.

Zanele: My own experience has helped me to try and see the thing from the point of view of others – sometimes it is not about right or wrong but about seeing the thing or situation from another point of view. Also, it has helped me to see that in this line of work there is no one right way – different situations demands different approaches. It is for this reason that I have developed my own systems – things that work for me and the patients I take care of. However, I can not impose this system on others because it might not work for them. Also, when I go for my practical sessions at the clinic or hospice I try to remain open to learning from others.

Nomsa: I have become aware that people in different situations know different things and one can not judge what others know. Although it is difficult, you have to be open to listen to others – even the patients we help and support. Often when I visit patients they will tell me that they are not in the mood for certain things – sometimes they just want to talk and be listened to – if I am not sensitive I will impose myself on the patient and overlook

what they need and feel like. My experience has also taught me that you can only provide care in the context of a relationship of trust and it takes time to build such a relationship – where you have achieved to have a relationship of trust you have to be respectful of the wishes and desires and needs of others – you can not impose yourself because you think you know everything. No one person can know everything – we have to bring together our minds and experiences in order to resolve problems.

**How does your experience guide how you interact and engage with peers and patients?**

Sivuyile: It has made me aware that it is important to listen to others – with patients you have to take their feelings/emotions into consideration and not impose yourself.

Lesedi: I have become aware that we have to work in a way that respects the humanity of others – we can not bring our own experience in a way that undermines the humanity of others.

Zanele: You have to be aware that we are working with human beings who have feelings and you have to be careful not to behave in a way that will hurt others.

Nolwandle: You have to use your head and your heart all the time; the work demands that we be compassionate and realise that what you might only see as a task is actually somebody else's life. Sometimes when we work alongside volunteers we have to remember not to make them feel ignorant but rather use our experience to help them to learn. When we interact with the nursing professionals we have to do so in a way that helps them to understand the situation in communities and the challenges that we encounter on a daily basis instead of making them feel their work is less important.

Nomonde: I try at all times not to make people feel inferior because of what I know; after all I do not know everything – there is no one person who knows everything. We have to respect what others know and can share with us – we also have to respect the feelings of others.



**How has the experience of others helped to influence your own understanding and thinking about HIV and Aids prevention?**

Nolwandle: Through engaging with patients, I have learned that the biggest problem we face in communities is that of stigmatisation and that there is need for ongoing education to address this issue.

Nomonde: There is a high level of personal responsibility around the prevention of HIV and Aids but sometimes it seems that many people do not understand it – often we expect others to take responsibility. This is particularly so for us young women – we have to learn that it is our responsibility and we should not leave it to others [men] to make decisions and take responsibility for us.

Sivuyile: By engaging with peers and patients I have learned that prevention of HIV and Aids is everybody's responsibility – those infected and those who are not infected – in fact it is the responsibility of the entire community, the entire South Africa.

Phinda: I have seen people living with HIV and Aids who have very strong spirits – they try not to have regrets or live with blame and this takes a lot of courage. Through talking to people I have also become aware that it is not only about condom use; HIV and Aids prevention is a lifestyle – it is about the quality of life you wish to enjoy. It is also about self respect and loving yourself.

Zanele: Through the experiences of others I have learned that the prevention of HIV and Aids is a huge thing – often we tend to focus on condom use and yet it goes much deeper than that. Sometimes I feel this pandemic has affected the quality of life in our communities and that we need to be much more aggressive about addressing the issue. Often when it comes to HIV/Aids prevention we tend to look and shout at government – working as a community caregiver has helped me realise that we need to take personal responsibility as well as collective responsibility as a community to stem the spread of the pandemic.

Zanele: As my experience as a caregiver has grown I have become more confident in asking questions in the big group – I am not always sure how this helps others to learn until some colleagues come and indicate that the questions was helpful. Sometime those

with more experience can undermine the learning in the group when they use their experience to ‘show off’ or to make others feel ignorant.

Nomsa: It is often not easy to say as learning in the group is often not a conscious thing ... but you know, learning is a funny thing – we learn more from situations that we do not immediately see as learning opportunities. In fact I think we learn from everything we do ...from arguing with someone, from asking a question, from observing a situation.

Phinda: I think there is more we could learn in the group – sometimes I feel not enough opportunity and space is created to allow for learning in the group. Sometimes we focus too much on what needs to be done by caregivers and not much time is devoted to establish what we are learning from our every day work.

**How does your experience compare to the experiences of others?**

Lesedi: What is nice in the group is that we have different experiences – this enables us to share and learn from each other.

Ayanda: Those who have done this work for longer clearly have a lot more experience; however, one has opportunity to grow one’s experience on a daily basis.

Sivuyile: I know there are others who know more and have worked in many different situations.

Zanele: Although I have done this work for some time now, everyday gives me opportunity to increase my experience and to grow as a person.