Implementing community-based education in basic nursing education programs in South Africa

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Community-based education, nursing programmes, service learning, community health nursing programme

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Education of health professionals using principles of community-based education is the recommended national policy in South Africa. A paradigm shift to community-based education is reported in a number of nursing education institutions in South Africa. Reviewed literature however revealed that in some educational institutions planning, implementation and evaluation of Community-based Educational (CBE) programmes tended to be haphazard, uncoordinated and ineffective, resulting in poor student motivation. Therefore the purpose of this study was to analyse the implementation of community-based education in basic nursing education programmes in South Africa. Strauss and Corbin's (1990) grounded theory approach guided the research process. Data were collected by means of observation, interviews and document analysis. The findings revealed that collaborative decision-making involving all stakeholders was crucial especially during the curriculum planning phase. Furthermore, special criteria should be used when selecting community learning sites to ensure that the selected sites are able to facilitate the development of required graduate competencies. Collaborative effort, true partnership between academic institutions and communities, as well as government support and involvement emerged as necessary conditions for the successful implementation of community-based education programmes.

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Introduction

To address population needs and economic constraints, health care systems are changing in order to address equity, cost effectiveness and quality-related issues. Community-oriented primary care is attractive to many on a principled level because it envisions community participation in health care decisions (Mullan & Epstein, 2002:1749). This system of health care was developed by two physicians in South Africa during the 1940's, partially adopted by many other countries, and used by the World Health Organization in their definition of primary health care. In 1997, 3 years after the election of the first demographic government in South Africa, a policy paper (Transformation of the Health System in South Africa: 1) called for the re-orientation of health professionals' education to a comprehensive primary health approach and community-based education (CBE) as the method to implement this approach.

The education of health professionals must ensure that programmes are producing graduates who are prepared to serve in community settings (Nokes, Nickitas, Keida & Neville, 2005:44) as a result of the paradigm shift from fixed institutions, such as hospitals, to varied settings in the community (Frank, Adams, Edelstein, Speakman & Shelton, 2005:283). Community-based education is an educational pedagogy

that is used to link community service and students' learning. According to Salmon and Keneni (2004: 173), Community-based education takes place in the community where students are given an opportunity to apply theoretical knowledge in assessing, planning and participating in solving community health problems.

Background to the problem

An extensive review of the nursing education literature focusing on South Africa (Adejumo & Gangalimando, 2000:3, Fitchardt, Viljoen, Botma, & du Rand, 2000:86, Fitchardt and du Rand, 2000:3, Gwele, 1997:275, Madalane, 1997:67; McInerney, 1998:53, Nazareth & Mfenyane, 1999: 722, Uys, 1998: 19) found that the implementation of community-based nursing education varied in different settings. Similarities included: a) extensive use of the community as a learning environment, b) partnerships between communities and academic institutions, c) community involvement, d) use of a problem-based approach in teaching, e) application of principles of adult learning, f) facilitating the development of transferable life skills, and g) basing the curricula on a health to illness continuum, with the focus on individuals, families and communities. Differences included: a) types of course assignments, b) duration of time spent in the community during the entire educational program, c) timing of the first community exposure, d) organisation and sequencing of learning experiences in the curriculum, e) the degree to which the community was used as a learning environment, f) level of involvement in student experiences by members of the community, g) the level of involvement of other health team members and other members of the multidisciplinary team, h) the level of involvement from other sectors such as agriculture, economics, and political science, and I)teaching/learning approaches used. In addition, Madalane (1997: 67) examined the quality of facilitation and supervision of community based learning experiences and found that some preceptors were inadequately prepared for their roles and responsibilities and, in some settings, community health workers were the primary preceptors of nursing students. The study by Salmon and Keneni (2004: 173) revealed that in some educational institutions planning, implementation and evaluation of educational programmes tend to be haphazard, uncoordinated and ineffective, resulting in poor student motivation. Hence, the purpose of this study was to analyse the implementation of community-based education in basic nursing programmes in South Africa.

Objectives of the Study

The objectives of this study were to:

a) Analyse the process of implementing community-based education in basic nursing programmes in South Africa and

b) Describe CBE antecedents, context, action/interaction strategies, and intervening conditions under which the phenomenon CBE occurs in basic nursing education in South Africa.

Research Method

This study employed a qualitative design and a grounded theory approach. According to Chenitz and Swanson (1996) grounded theory makes its greatest contribution in areas where little research has been done and when new viewpoints or gestalts are needed to describe the familiar phenomenon that is not clearly understood (p.7). Grounded theory was thus appropriate in a study of this nature because very little has been done in terms of research aimed at understanding the phenomenon of CBE, either in South Africa or globally. Secondly, the grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon". The primary objective of grounded theory, then, is to expand upon an explanation of a phenomenon by identifying the key elements of that phenomenon, and then categorizing the relationships of those elements to the context and process of the experiment. Strauss and Corbin's (1990) grounded theory approach informed the study design, data collection, and analysis.

Research Settings

Using the published list of all basic nursing education programs in South Africa (N=37), the researcher accessed the web sites of these programs and determined whether they were implementing community-based education. Through this search, four university nursing schools running CBE programmes were identified and the staff of the South African Nursing Council (SANC) identified two additional nursing colleges which were using community-based curricula. One of those two colleges had six campuses and one sub-campus. The researcher selected one campus situated in an urban area and one in a rural area for a total of 7 settings.

Data Collection

Data collection in grounded theory is directed by theoretical sampling, with sampling that is based on theoretically relevant constructs to ensure that data is relevant to the research questions or objectives (Davidson, 2000:p1). The researcher initially employed open theoretical sampling to identify individuals and documents that will contribute significantly to the study. Later, during axial coding, the researcher adopted a systematic relational or variational sampling, with the aim of locating data that either confirmed the relationships between categories, or limited their applicability. The final phase of sampling generally involved discriminate sampling, which consists of the deliberate and directed selection of individuals, objects or documents to verify the core category and the theory as a whole, as well as, to compensate for other less developed categories, as stated in Davidson (2000:p1).

Multiple sources of data were used. They included conducting observations, analysis of documents and interviewing participants. Observations entailed observing learning in community and classroom settings, with the aim of discovering how classroom learning was informed by learning in community settings. Observations were conducted in the classrooms as well as in the community. Documents analysis included studying the institution's philosophy, mission statement, conceptual framework, programme structure, programme and level outcomes, content covered, teaching methodologies, the teaching/ learning process, as well as, the assessment of learning. The interviews were informed

by the data collected through observations and document analysis. The final sample for interviews included heads of schools (5) and/or CBE programme directors (2), level coordinators (11), facilitators (17) and policy makers; members of the SANC education Committee (6), and representatives from the National Department of Health Human Resources division (3), thus were making a total of 44 participants. Interviews were conducted in the offices of the interviewees, with their permission

Data analysis

Analyzing data involved three processes which were overlapping sometimes; open coding, axial coding and selective coding. Open coding involved breaking down, examining, comparing, conceptualizing and categorizing data often in terms of properties and dimensions. Data for open coding, as stated in Sarker, Lau, and Shay (2000:2) was selected in a form of theoretical sampling known as '*open sampling*', which involves identifying situations or portions of transcripts that lead to greater understanding of categories and their properties. Open coding in this study entailed line-by-line analysis of data collected, as well as holistic analysis of documents. Through this analytic process developing concepts were described in terms of their properties and dimensions. Some of the concepts were named from the words and phrases used by informants and some were derived from a pool of concepts the researcher knew from her academic subjects and professional reading. Strauss and Corbin (1990:68) refer to the later source of concepts as 'literature derived concepts'. Open coding included asking questions about data and making comparisons for similarities and differences between concepts. Similar events and incidents were grouped as categories. Guided by the premise that the study was aimed at uncovering the meaning of CBE in basic nursing education in South Africa, not to compare different institutions, the researcher, through the constant comparative method of data analysis, looked across all institutions that participated in the study to generate categories representative of all. Open coding; which was the initial phase of data analysis took place concurrently with data collection.

Open coding was followed by axial coding. Strauss and Corbin (1990:96) describes axial coding as the analytical activity for making connections between a category and its subcategories developed during open coding; that is, reassembling fractured data by utilizing a coding paradigm. This coding paradigm categorises data into antecedent conditions, context, action/interaction strategies, intervening conditions and consequences. During axial coding, deductive and inductive thinking was required to make connections between the developed categories and subcategories. Sarker et al. (2000:2) stated that during the process of axial coding, the '*relational and variational sampling*' is used where data is sought depending on its applicability to suggest relationships among a category and its subcategories, or its ability to support or falsify a plausible relationship of a category with its subcategories. CBE as the phenomenon of interest in this study was regarded as the main category and other categories, which were linked to the main categories, were viewed as subcategories.

Selective coding was the final phase of data analysis. This phase was directed at refining the developing theory. Selective coding involved verification of a core category around which the theory emerged. The theoretical sampling used at this phase was referred to as 'discriminate *sampling*'. Discriminate sampling is used to select appropriate data such that weak connections between categories can be inductively strengthened and relationships that have already emerged can be deductively tested (Sarker et al, 2000: 2). During this stage developed categories were further analyzed with an intention of finding those sharing similar characteristics and merging them to form higher order categories. Through selective coding diverse properties started to become integrated and the resulting theory began to emerge and eventually solidified. Selective sampling of literature to determine the 'fit' of findings from earlier studies and existing theories with the present findings was also conducted during the phase. The emerging theory was then validated against data to complete its grounding, as stated in Strauss and Corbin (1990:133) but this phase is not included in this article due to the specified length of the article.

Discussion of Results

In grounded theory, the core category can be compared to the sun and subsidiary categories are like the rays from the sun. The subsidiary categories linked to the core category (CBE) were CBE antecedent conditions, CBE context, CBE action/interaction strategies, intervening conditions and CBE expected outcomes. These subsidiary categories were further delineated into sub-categories. The CBE expected outcomes are not included in this paper.

Community-based Education antecedent conditions

CBE antecedent conditions were those conditions that led to the adoption of CBE in basic nursing programmes. Inadequacy of hospital-based nursing education emerged as a major category under antecedent conditions. This category had a number of subcategories which Subcategories under this category included use of *tertiary high technology well-resourced, ideal urban hospitals* as the main setting for the placement of the students, use of a *curriculum* that was *based on a biomedical model* which focused mainly on the curative aspect of care with little or no mention of health promotion and illness prevention, *content overloaded and fragmented curriculum*, use of *teaching methods* (lectures and demonstrations) which encouraged passiveness from the students, with the teachers dominating the teaching process and *neglect of adult learning principles*.

The findings revealed that nursing education institutions used *tertiary high technology well-resourced, ideal urban hospitals* as the main setting for the placement of the students. This however deprived the students of exposure to rural and under-resourced health settings which were serving a larger percentage of the population. Furthermore this led to the production of large quantities of highly skilled technical nurses, who were only able to serve the minority of the population that had access to and who could afford services rendered in high technol-

ogy hospitals. The major shortfall of this practice was poor retention of graduates in rural and under-resourced settings leading to skewed distribution of health personnel as in this extract;
The students after graduation experienced problems when expected to function in under resourced rural settings, which were nowhere near what the urban institutions had in terms of resources.

Content overloaded and fragmented curriculum emerged as another shortcoming in nursing education programmes that led to the adoption of CBE. According to the participants, the focus was on the mastery of the preselected curriculum content, not on the relevance of the curriculum content to the health needs of the community. In their view the old curricula was also fragmented with subjects viewed as standalone. According to the participants, CBE facilitated integration of subjects for students to get a comprehensive picture of the client's problem, as stated in this extract.

Traditional nursing education lacked comprehensive analysis of client's problems ... Courses such as anatomy, physiology, sociology, anthropology, psychology and many other subjects were offered separately.

The lecture method and demonstrations were the commonly used methods according to this study and these teaching approaches did not facilitate the development of the students holistically. They encouraged passiveness from the students, with the teachers dominating the teaching process. The participants reported that there was no engaging of students during the teaching/learning process. They only actively took notes which were prepared and dictated by the teacher. The students were not given an opportunity to actively listen and engage in dialogues that will facilitate the development of their critical, analytical thinking as well as problem solving skills. The findings in this study clearly pointed out that this retarded the students' academic and personal growth;
We had to adopt a CBE curriculum because in the old programme our students were not taught to problem-solve and to think critically.
Class sessions were note taking sessions where the teacher's role was to dictate notes.

Furthermore, nursing programmes were blamed for not observing *adult learning principles* regardless of the fact that nursing is attracting people who are adults with rich experiences.
... the teaching methods used were not synchronized with adult learning principles... and that crippled their personal development.

Community-based Education context

New policies backing up the transformation of the health care system, general and professional education, as well as public service emerged in this study as point of reference to those institutions that adopted CBE curricula. They formed part of the context within which CBE was implemented in South Africa. The 1997 national health policy with the emphasis on PHC, the 1997 national education policy in support of service learning, the SANC 1999 discussion document titled 'Education and Training of Professional Nurses in South Africa: Transforming Nursing Education' supporting PHC and community-oriented education, as well as the 1999 public service policy with the emphasis on Batho Pele principles served as framework to the adoption of CBE.
The 1997 White Paper on Higher Education has been highly influential in the promotion of social responsibility in the students. CBE policies in a number of higher education institutions are based on this Education White Paper.

Action/Interaction strategies

Action/interaction strategy refers to those processes which were involved in operationalisation of the concept community-based education. Two categories emerged under action interaction strategies; the CBE curriculum planning phase and the CBE curriculum implementation phase.

CBE curriculum planning phase

The findings in this study revealed three subcategories under the curriculum development phase; collaborative decision-making, ensuring congruence between expected graduate competencies and clinical learning settings, as well as development of stakeholders for the implementation of CBE. These emerged as crucial aspects to be considered in planning a CBE curriculum.

According to the study the support of the CBE programme by all stakeholders was fundamental and this was enhanced through collaborative decision-making. Nursing institutions invited input from all the stakeholders very early during the planning phase. Community meetings, public forums, as well as workshops were used to obtain input. The stakeholders contributed in making decisions regarding the nature of the curriculum that would be able to produce graduates who are competent in meeting the needs of the South African population. They also contribute in decisions regarding the competencies required from graduates on completion of the programme and the nature of clinical settings that will facilitate the development of required skills.
We invited staff from the neighbouring hospitals and clinics, representatives from the community as well as the non-governmental organizations...

Involving stakeholders was crucial because decisions had to be made concerning the priority problems to be addressed, as well as the competencies of the new graduates.

The findings also reveal that there should be congruence between expected graduate competencies and clinical learning sites to facilitate development of expected graduate competencies. According to the data obtained through interviews, the curriculum planners were guided by competencies required from the graduates in the process of selecting appropriate learning settings. Furthermore, curriculum developers took into consideration the levels in the health care system in South Africa (that is, primary, secondary and tertiary), as well as the underlying philosophy of the health care system (PHC) s in their process of selecting clinical learning sites. The students were therefore placed in a variety of clinical learning settings, including community settings, PHC clinics, district hospitals, referral hospitals and rehabilitation centres to ensure adequate exposure to all levels care within the health care system.
In CBE we say we want to produce graduates who will be able to serve

communities at all levels, especially under-resourced communities. This should then be reflected in our selection of community sites.

Development of stakeholders for the implementation of CBE

It emerged as crucial because CBE was an unfamiliar concept. The preparation of staff from the nursing education institutions, the health service personnel, the community, as well as, the students and their parents came up as the key to the successful implementation of CBE. The teachers were prepared through workshops, seminars, visiting well established local and international CBE programmes, attending CBE conferences and inviting experts to come and assist along the process of planning and initiating CBE programmes, as stated below.

An expert from an overseas university had to spend the whole year helping us by running workshops and demonstrating facilitation during the classroom sessions.

Two staff members from our school attended workshops in one of the overseas universities....

Health service personnel, as well as, communities were prepared mainly through workshops and community meetings. The process of preparing communities started with key figures who later invited communities to participate. During the negotiation of community entry, it was important for the academic staff to understand the community's culture, language and to obtain support of community structures, as stated in this quote.

I was specially employed to prepare the community because the academic staff of the school had a problem in understanding the language and the cultures of the surrounding communities. I worked with those communities for two years preparing them.

The preparation of students and their parents emerged as another important factor because the students were going to be placed in community settings, the unfamiliar environment characterised by a number of social as well as health problems, the environment considered as unsafe and uncomfortable. Meetings were held with parents in the beginning of the first community-based learning year, to allay their anxieties. Special blocks were planned for the students to orientate them to CBE, basic community health nursing and PHC concepts, and to introduce them to transcultural nursing and multi-disciplinary approach to learning.

Our students arrive before the university's scheduled opening time for a two week orientation block

Orientation includes introduction to CBE, cultural diversity, group dynamics, PHC, community entry, community participation, how to do a rapid appraisal and epidemiological studies, and learning contracts as means of promoting self-directed learning. The students then visit the community sites where they will be placed later for their community-based learning.

CBE Curriculum implementation phase

Five subcategories emerged as under this phase; determinants of the curriculum, the nature and sequencing of community-based learning experiences, teaching approaches, teaching/learning process, the nature of the teacher, and the nature of the learner.

Curriculum Determinants

The findings revealed four determinants that shaped the CBE curriculum: priority health needs/problems in the surrounding environment (the community in particular); students' learning needs; regulatory body (SANC) requirements and the national health as well as education policies. These determinants ensured relevance of the curriculum content, they ensured that the curriculum was contextualised, dynamic and community oriented, as stated in these quotes.

The curriculum content is determined by the needs of the community, the students' interests and the regulatory body.

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

The nature of learning experiences

Data reflected that the nature of learning experiences selected had to facilitate the development of expected graduate competencies. Community-based learning experiences in the context of this study included (a) conducting a community survey, planning, implementing and evaluating a community action plan, (b) conducting home visits and family studies, (c) epidemiological studies, (d) health education as part of health promotion and illness prevention, and (e) working in the community with the aim of provide service to the community while learning to understand how psycho-social, economic, political, cultural and other factors affected the health of individuals, families and the community. The students were also engaged in learning experiences which focused on what was referred to as GOBIFFFF strategy. This included **G**rowth monitoring, educating communities, families and individuals about **O**ral rehydration in cases of diarrhoea and dehydration, educating communities about the importance **B**reast feeding, **I**mmunizations, **F**amily planning, **F**ood supplementation to prevent malnutrition, **F**irst Aid at home and **F**emale literacy as a women empowerment strategy, as stated below.

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

Teaching/Learning approaches

A problem- focused approach appeared to be the main approach used in four of the seven institutions with the aim of developing problem solving skills. The other three institutions were still using the expository approach, mainly because they were still writing examinations set by a regulatory body. Of the four institutions, two were using paper problems and two were using authentic unstructured problems from real life settings. The teaching learning approaches used ensured integration of subjects across the disciplines and a process of generating context-based knowledge through students and educators engaging in a dialogue.

We use health problems as the basis in our teaching ...but we develop them into paper problems.

Problems used are real problems from clinical settings where our students

are placed…

Teaching/Learning Process

Active learning as promoted during the teaching/learning process. Active learning was facilitated through experiential learning, collaborative learning, and self-directed learning. The findings in this study pointed out a need to shift from the teacher-imposed education to encourage active learning in students. It was believed that active learning promote the development of a number of life skills such as self-directed learning, analytical and critical thinking skills, problem solving skills, communication skills, team work; the skill that are essential in graduates who are expected to function independently and within teams.

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

The Nature of the Teacher/ Learner

The characteristics of an ideal teacher in a CBE programme included the following characteristics in the context of this study; *commitment to CBE*, as CBE entails spending long hours in uncomfortable, unpredictable and sometimes less safe environments, working with people from different cultures and backgrounds; cognitive *modelling in an unpredictable learning environment* requiring an innovative, *creative and inquisitive person*, who is not afraid to explore new or unfamiliar situations, a person who is a fact and critical thinker who is able to come up with an alternative solution if the students plan fail; *democratic leader* in managing the learning environment, rather than actively engaging in teaching, a teacher *encourages students to learn actively*. It also came up that the facilitator serves as a consultant, a guide, a coordinator and manager of learning resources. The facilitator was viewed as resourceful in the selection of community learning sites, preparing communities for community-based learning activities, initiating and sustaining partnerships with communities, and negotiating

The role of the teacher changes completely in CBE because she takes an inactive role and encourages students to be actively involved.

… only serves as a resource person not a provider of information. … directs the students to where they can access relevant information that might be useful in working out the identified learning need.

The *ideal learner* was characterised as active in their learning; giver of input into the curriculum content in that their interests and needs contributed to the curriculum; a role player ensuring that the curriculum content is community oriented and is derived from the common problems in the surrounding community; a contributor to knowledge construction, actively engaged in the process of knowledge construction; a service provider, to those with limited access to health care services, in that he/she is willing to make home visits to render the best possible care; a change agent, views CBE as a force for social change and acts as a change agent playing an active role in influencing change in the society.

We design community-based learning experiences in such a way that when the students engage in them, they affect the community positively, challenging and equipping the community to deal with their problems.

Intervening conditions

Three categories were reflected under intervening conditions; collaborative effort among stakeholders, the practice of true partnership, and government commitment. The need for a closer relationship between the nursing education institution, community and service sector emerged as one of the critical conditions that determined the successful implementation of CBE and sustaining of the programme. This *collaboration* was characterized by an agreement between these three parties, written or unwritten shared vision, and sharing of responsibilities, as stated below.

In order for our community-university partnership to materialize, agreements were entered into by these three parties, the purpose of the partnership was clarified to all, and responsibilities of all members were tabled.

The nursing education institution in this partnership came out as proving expertise regarding the community-based educational experiences; coordinated learning experiences; provided teaching staff that would facilitate learning both in the community and classroom settings; provided learning resources such as libraries and clinical skills laboratories and expert advice to other partners regarding the implementation of CBE. Health services (hospitals and primary health care clinics) were responsible for providing suitable learning environment as well as competent personnel especially in the area of PHC and community health to assist in the learning of the students. Other provincial health departments supported CBE initiatives by providing transport to be used by students to community settings. The communities in the partnership contributed by providing safe learning environments and ensuring the safety of the students in their communities; information related to health needs/problems prevalent in the community; facilitating the process of developing working relations with other members of the community; and a context for learning, and transfer of knowledge and skills about the community to the students, academic and service partners.

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

Members of this community assist by giving our students information during community surveys, the information that forms part of the curriculum content in first year.

The common understanding of the concept '*partnership*' and the practice of true partnership emerged as an important factor in the successful implementation of CBE. The results in this study however revealed that partners did not understand this concept in the same way and that created some tension between partners. According to the data from interviews some voices were dominating and other were not heard, or were faintly heard, especially the voices of the communities. The rationale for this was that that the sources of funds were academic institutions, whose faculty had to account for how learning was taking place. It seemed as if academic institutions had more power and say than other partners.

We were literally chased out in one of

the communities because of our dominating nature as nurses in the community. This was one of the best sites when it came to learning experiences. It had very rich learning experiences. We did not mean for this to happen but it was a learning experience. Our programme was still new then.

Government commitment

The findings in this study suggested that there are concerns about the inadequate or lack of government involvement in the implementation of CBE, especially because CBE is a directive from the government. A need for financial support as well as support with transport to be used by students to community learning sites was verbalised. The data however revealed that the government was somehow supporting CBE initiatives and the education of nurses. One institution indicated that the government funded the building of an academic-community partnership structure in the community with a large sum of money. Some institutions indicated that the local government was supporting them with transport.

We have an agreement with the transport department. The government authorised that they provide us with buses to the community sites. This is helping a lot.

Discussion

This study suggested that successful implementation of CBE required collaboration amongst the stakeholders (academic institution, Health Service and Community); true partnership between academics and communities to ensure that all parties benefit mutually from the programme; financial commitment, as well as, philosophical commitment (that is, the vision, mission and programme outcomes to clearly state the commitment to CBE) to ensure sustainability of the programme; providing appropriate infrastructure to support the CBE initiatives. Most of the findings in this study were in line with Richard's (2003: 2-3) view about making community-based education programmes sustainable.

True partnership between communities and academic institutions came into sight as a major challenge in this study, as a result of differences in priorities. Just like in Roberts (1996, p.1259) learning came up as a priority for academic institutions whereas service provision emerged as a priority for the community. In this partnership communities seemed to have less power compared to academic institutions. The rationale was that academic institutions' primary responsibility is to ensure that students learn in community setting and provision of service was secondary to the students' learning. In support of this statement Quinn, Gamble and Denham (2001: 12) in their work on ethics and community-based education, pointed out that in the context of CBE, academic institution has an ethical obligation to see to the interests of the students first. The academic institution has to ensure that learning experiences and learning opportunities available in the community setting are more likely to contribute to the development of competencies expected from learners. This view however creates tension between communities and academic institutions because communities view service as a priority. It is acknowledged that true partnership between communities and academic institutions is important. In order to balance educational needs and with the needs of the community, Queen et al. (2001: 14) suggested that a guide for the relationship between the parties involved should be formulated during the partnership development stage, but bearing in mind that the academic institution's first ethical responsibility is to educate the students.

This study revealed that engaging all stakeholders is crucial in the sustainability of CBE programmes. They should be involved as early as possible in the planning phase to ensure that their voices are considered. In line with Hamad's (1999:383) view, the stakeholders should be full partners in all activities, with their representatives participating fully as members in the planning committees. Postmodernists refer to engaging all stakeholders as 'listening to different voices'. Postmodernism according to Beyer and Linston (1992: 9) emphasize listening to different voices, especially the voices of the 'other' (those who were regarded as not important) to make the newly developed curriculum representative of all. In the context of CBE, the voices of the 'other' are the voices of the community who were rarely consulted in the past during the process of developing a new curriculum. Beyer and Linston (1992) emphasize "We need a rainbow coalition to make sure that serious voices are not left out of the great conversation shaping the curriculum" (p.9). Bernal, Shellman and Reid (2004) also state that community-academic partnerships are missteps in CBE programmes and that creates tension and results in disjointed functioning (p.33). According to these authors academic partnerships are crucial and they are of the opinion that both parties while coming from different contexts, share an interest that allows them to work together for the mutual benefit. It is important to note that a true partnership albeit, not yet achieved in CBE in basic nursing education in South Africa, was nonetheless recognized by the participants of the study as a necessary condition for a successful CBE programme.

The findings revealed that learners' learning is more meaningful when they are actively involved in their learning and learning is taking place in setting resembling the workplace, or the place they are likely to work in when they graduate. It emerged that learning in such settings facilitated the development of analytical, decision making, problem-solving, communication and self-directed learning skills. The exposure to community settings as well as hands-on learning experiences allowed learners to act as professionals and they had an opportunity to challenge some workplace problems as they would as professionals. This is in line with Sandar's (2005) view that learners in work-based settings develop into what will be expected to them when they graduate (p.191). Furthermore, CBE attempts to reduce inequity in access to health services. Through service provision, as part of learning, CBE assists by expanding health services to underserved settings, as stated in Kristina, Majoor and van der Vleuten (2004: 511).

Conclusion

This study reflects that the process of implementation of community-based nursing education in South Africa was triggered by the production of inadequate prepared graduates who were unable to meet the health needs of the majority of population found in rural

Introduction and problem statement

Since 1997 the School of Nursing Science and the School of Psychosocial Behavioural Science, of a South African university, specifically the Department of Social Work, have been offering a variety of health care services to a disadvantaged community as part of their students' experiential learning. Wondmiku, Felcke and Tafete (2005:179) support service-learning as a valuable learning method that balances the service and teaching objectives. Maintaining the quality of both can be attained through carefully combining the objectives of both components.

The service-rendering by the students during experiential learning is especially directed to the disadvantaged community, and in line with the focus specified in the White Paper for the Transformation of the Health System of South Africa (South Africa, 1997b). The services provided by the students include work at primary health care (PHC) clinics and other government institutions, including rendering home-based care to people living with HIV and AIDS (PLWA) and other chronic patients, community projects (such as eco-circle gardens), health promotion through the Healthy Hester Health Education programme, group work, parent guidance (Botswadi), empowering of children, working with alcohol-related problems, investigating child neglect and abuse, planning foster care, and helping with grants and food parcels.

The White Paper for the Transformation of the Health System of South Africa (1997b:13) states that the health of all people in South Africa should be promoted and monitored, and that a caring and effective service should be provided through a PHC approach. Health teams and workers should not only be responsible for the patients who attend health facilities, but should also have a sense of responsibility for the health of the population and communities. The mission and objectives of the welfare system address the elimination of fragmented services and a stronger focus on a people-centred and community participation approach. Students are thus sensitised to this approach during their placement in the community for experiential learning.

The two schools offer health care services based on their students' required experiential learning, and on the needs of the disadvantaged community. Beytell (2002:17) states that communities, patients and their next of kin should play an active role in community health, through participation and empowerment, as efforts at solving problems require a holistic approach.

Over time a gradual trust relationship developed between community members and members of the two schools. However, no relationship developed between the lecturers of the two schools in relation to the planning of health care delivery due to the single discipline approach. Reagan and Brookins-Fisher (1997:4) mention that different fields of practice such as social work, nursing, psychology and allied medical groups consisting of theorists, clinicians, legislators and academics should be involved in providing multidisciplinary health care services. In contrast with this, each school was doing its own planning to provide the relevant services, with no multi-disciplinary linking or team work amongst the students.

Arrangements are made on an individual basis by the lecturers with people in the community identified as key people for the purpose of fulfilling the students' educational requirements, as well as where they think the greatest community needs exist. However, during their experiential learning the students are involved with many health-delivery organisations including non-governmental organisations (NGOs), faith-based organisations (FBOs), the Local AIDS Council (LAC) and various government departments (such as the Department of Health and the Department of Social Welfare). Goldman, Morrissey, Ridgely, Frank, Newman & Kennedy (1992:54) state that the related goals of integrating and co-ordinating services are relatively high on the agendas of professionals and policy analysts. Findings in a study in Potchefstroom within the AIDS Council system confirm that unnecessary duplication occurs at local level, while certain existing health care gaps are not addressed (Schutte, 2004:171-196).

Valuable health care services are thus offered with various health care delivery organisations, but without any multidisciplinary linkages and co-operation. A further disadvantage is that no feedback system exists to evaluate the true worth and quality of the delivered health care services. Neither the experiences of the students, nor the health care delivery organisations nor the patients have previously been explored. Effective communication, planning and coordination are needed to provide quality services, but this is also done on an individualised basis. It is thus important to ensure that students' service delivery will be done in a more co-ordinated manner and on a multi-disciplinary basis.

In the Education White Paper (1997c:7) a specific purpose of Higher Education was set as contributing to the socialization of enlightened, responsible and constructive critical citizens. The two schools are trying to ensure education of a student core that is ready to meet the challenges of the communities it is going to serve. Shaughnessy, Crisler, Schlenker, Arnold, Kramer, Powell and Hittle (1994:35-68) mention that with the rapid expansion and acceptance of medical services, nursing, social work and other services in the home setting, more systematic attention should be given to the specification and measurement of the goals and outcomes of home health care. It has thus become necessary to ensure that students' experiential learning enable them to meet the professional expectations of various professions.

Objectives

The implied research questions translated to the following objectives:

Firstly, to explore the experiences of the following role-players in providing health care services to a disadvantaged community during experiential learning:

- the senior nursing and social work students
- the health service delivery organisations
- the disadvantaged community members; and

The second objective was to investigate what apparent health communication models are used in the efforts to link the needs of the disadvantaged community with the provision of health services by students.

The final aim was to formulate guidelines to enhance quality multi-disciplinary health care service delivery to a disadvantaged community by the stu-

dents, as part of their experiential learning.

Literature review

Theoretical perspectives on health care service delivery to a disadvantaged community by students are discussed to contextualise the study within the context of literature reports about similar investigations.

Health care service delivery

The Oxford Advanced Learner's Dictionary (2005:690) defines *health* as "the state of being physically and mentally healthy". It is with this focus in mind that services are delivered to patients in the community. *Service* is also defined as "the system that provides what the public needs, organized by the government or a private company" (Oxford Advanced Learner's Dictionary, 2005:1335). Thus, *health care service delivery* in the context of this research indicates an organisation that is tasked with the maintenance and promotion of public health within a specific area and for a specific disadvantaged community.

The HIV/AIDS and STI Strategic Plan 2007-2011 (South Africa, 2007a:11), states that intensification of the multisectoral national response, with the focus on better coordination and monitoring, is necessary. The government, non-governmental organisations, community-based organisations, faith-based organisations, private sectors and the people living with HIV/AIDS (in this research, people in the community needing health service) should employ a joint effort and be involved at all levels of this Strategic Plan (Pelser, Ngwena & Summerton, 2004:308-309). Such a comprehensive approach to health-service delivery not only depends on one organisation or discipline, but on various role-players who must co-operate on a formal and informal level and in an integrated and co-ordinated manner as partners to render the health service. Within the context of this research the university can be regarded as the informal and the health service organisations as the formal role-players.

The Social Welfare Action Plan (National Welfare Department, 1998:121) further states that appropriate services should be provided to individuals and their families in communities who are unwell. The objective to achieve this goal is to develop home-based, family-oriented and community-based care strategies in collaboration with other stakeholders. A one-stop treatment service and a comprehensive district health and welfare service, which must collaborate to provide care, support and rehabilitation, is suggested by the White Paper for Social Welfare (1997b:88).

Disadvantaged community

According to the New Dictionary of Social Work (1995:18) and The Oxford Pocket Dictionary of Current English (2009) a *disadvantaged community* is a community functioning under unfavourable circumstances and which has been disadvantaged educationally, economically and/or socially as a result of inferior education, inadequate infrastructures and a lack of opportunities for growth.

People living in circumstances of poverty cannot contribute to maintaining their own health. They cannot purchase nutritional foodstuffs and this can lead to ill health, malnutrition and a high mortality rate (Bezuidenhout, 1998:161; Bradshaw, 2008:56; De Swardt & Theron, 2007:29). A higher prevalence of disease is listed among lower-income groups, including tuberculosis, diarrhoea and fever, while higher rates of mental and physical disability are found among the poor (Uys & Cameron, 2004:162). The infrastructure is not always there to address their health needs; for instance, there are few clinics in their area and there is no running water or sanitary facilities (Beytell, 2002:25).

More than one third of the South African population of 46 million is unemployed, with almost one third living below the poverty line (Statistics South Africa, 2006). Because of the high levels of unemployment and illiteracy in disadvantaged communities, they are to a large extent dependent on social grants. Currently the number of beneficiaries of grants and pensions is 12 million persons (South Africa, 2007b:4). Because of lack of money, their houses are inadequate, leak rain and dust, have weak foundations and are too small for the number of people living in them (Swanepoel & De Beer, 2006:4). Overcrowding can lead to a lack of privacy, irritation with one another and children who tend to wander (Bezuidenhout & Joubert, 2003:59). There are almost no appliances in the houses such as stoves or fridges, and there is also a shortage of clothes and furniture in these communities.

Because of the low level of education the members lack basic knowledge and skills, and the health care workers should develop programmes in which they could be trained in various skills. Income-generation and job-creation projects are some of the ways in which poverty issues could be addressed (Gathiram, 2005:127), because according to Bradshaw (2008:57) education plays a fundamental role in health.

There is a high incidence of HIV/AIDS in disadvantaged communities (Evian, 2003:21; Tladi, 2006:371; Uys & Cameron, 2004:162). According to Barnett and Whiteside (2006:296), poverty assists the spread of HIV and AIDS and forces people into poverty, or makes it harder for them to escape from it. The health care profession with its specialised knowledge, skills and training needs to take responsibility for psychosocial services, and education and training regarding HIV and AIDS (Spies, 2007:291). AIDS orphans have to be placed in foster care, which requires extensive administrative work. There is also the problem of child-headed families which requires attention (Evian, 2003:21; Schenck, 2004:159; Uys & Cameron, 2004:163.

Another issue the members from the disadvantaged community bring to the attention of the health care workers centres on family and marital problems. These include family conflict, domestic violence, and alcohol and drug abuse (Schenck, 2004:161). Economic deprivation increases the level of stress experienced by the parent and this, in turn, may negatively affect the parent's affective relationship with the child and his/her quality of parenting (Bezuidenhout & Joubert, 2003:58). Frederick and Goddard (2007:335) remark that child neglect is associated with poverty. In order for changes to occur in the circumstances of a disadvantaged community, health care workers should empower the community and provide community-based services (Strydom, 2008:68).

Students who deliver services to disadvantaged communities

Students should be equipped to face

these communities in a caring and understanding manner. Students should have particular personality traits in order to meet the needs of the people and to render effective services. In a study conducted in KwaZulu-Natal participants felt that service providers should be caring and tolerant, down to earth and able to understand people (Evian, 2003:313-314; Simpson, 2003:159). All people value respect and desired to be treated as worthy individuals (Simpson, 2003:159).

According to Simpson (2003:158) the experience of being accepted and understood makes for successful helping. She adds that good service providers are real people with whom patients can identify. According to Cummins, Sevel, and Pedrick (2006:49-50) this means that they need to acquire knowledge of a variety of cultural dimensions, such as attitudes, values, customs, community patterns and spirituality that define particular cultures in order to respond effectively to the needs of diverse populations. Skills such as empathic responses, genuineness and clarification are helpful in establishing therapeutic relationships across all cultural lines (Cummins, et al., 2006:49-50). In the study conducted in KwaZulu-Natal the participants mentioned that race was not a problem. They did feel, however, that it would be more helpful for the service provider to be able to speak the local language to improve communication between helper and patient (Simpson, 2003:158).

Communication

To create an integrated and coordinated health service there would be a need for effective health communication. It entails the process of sharing information according to a common system of symbols and language (Faulkner & Hecht, 2007:388). Communication is also conceptualised as a verbal and non-verbal human transactional interaction in the sense that it is a continuous, ever-changing process that involves reciprocal influences. Health communication is a subset of human communication and refers to any human communication, the content of which deals with health-related issues (Rogers, 1996:15).

Communication, though, is complex and entails more than the use of a specific language. Therefore models have been created to reduce the complexity of the transactional process. With regard to health communication, three possible models can be scrutinised to see how they portray communication: the therapeutic model, the Health belief Model and King's Interaction Model (Airhihenbuwa & Obregon, 2000:10-16; Northouse & Northouse, 1998:12; King, 1999).

- *The Therapeutic Model* is patient-centred and can be viewed as a communication skill that would help patients "adjust to their circumstances and to move in the direction of health and away from illness" (Northouse & Northouse, 1998:12). This model has its origin with Carl Rogers (1951) who believes that the helper should communicate with empathy, positive regard and congruence (Rogers, 1951; Afifi, 2007: 52-56).
- *The Health Belief Model* is more complex with a different focus. This model would like to explain the nature of individuals' health actions and consists of three major elements: Firstly, the patient's perception of vulnerability to and severity of the disease; secondly, the patient's perception of the benefits and stumbling blocks to taking preventive actions to control and/or prevent the disease; and thirdly, the cues available that would encourage the patient to sustain preventive health actions. So-called modifying factors such as age, sex, ethnicity and poverty can also influence the patient's perceptions and beliefs. Thus, the core of the model is to predict the likelihood of a patient to adopt certain behaviour (self-efficacy) as a function of the perceived threats and possible benefits. It focuses on the patient's perceptions of preventive measures rather that the transactional nature of the patient-helper interaction. (Glanz & Rimer, 1995:19; Airhihenbuwa & Obregon, 2000:10-16).
- *King's Interaction Model* em phasises the communication process between helper and patient within a systems perspective, with the focus on interpersonal systems. The interaction is dynamic, which includes a reciprocal interplay between the helper and the patient, resulting in a transaction established by both communicators as they co-operate. Shared meaning and feedback are important aspects in this transaction (King, 1981:144-161; Beach, 2007:333-349).

Major factors influencing health communication

Because of the unique nature of each communication interaction, it is not possible to classify each transaction solely under one of the mentioned models. According to Northouse and Northouse (1998:17-21) the three major factors within health communication that should be part of health communication are *relationships, transactions* and *contexts*.

- The *relationship* can be any one of many possibilities among many role-players. It may also include social networks that are involved with the patient, like family members, friends and co-workers. The multidimensional involvement of many role-players is especially important in collectivistic cultures where face-saving and harmony within the group, family or community are important (Dodd, 1998:92). If the role-players are of different ethnic origins, cultural issues should also be addressed with regard to the nature of the relationship.
- *Transactions* refer to any health-related interaction between participants during the process. This would include both the content (information) and the relationship dimensions of messages (Courtright, 2007:319-326). The nature of the relationship influences how the content should be interpreted. The continual feedback allows participants to make changes to the message and to adjust and readjust their communication according to many variables that may influence the participants and their messages.
- The *contexts* refer to the setting

and the systemic properties in which the communication takes place. The physical setting as well as the socio-economic environment and cultural issues have an important influence on communication. Different health care settings and the number of persons involved have differ ent effects on the dynamics of the transactions that take place within these settings (Courtright, 2007).

Methodology

Protection of Human Subjects

The research protocol was approved by the ethics committee of the university. Permission to conduct the study was also obtained from the provincial Department of Health. Participants were provided with information about the background of the study and were informed that participation was voluntary and that they could withdraw from participation at any time. Participants were also assured of confidentiality of information. Following this explanation, each participant signed a written consent form.

Research Design

A qualitative design was used to explore and describe (Mouton & Marais, 1996:45) the experiences of the role-players. Focus group discussions (Greeff, 2005:299) were conducted with the senior nursing and social work students as well as the health service delivery organisations and unstructured one-on-one interviews (Greeff, 2005:292) with disadvantaged community members.

Settings

The study was conducted in two schools of the Faculty of Health Sciences at the university concerned and in the disadvantaged community of the Potchefstroom district. Third-year B Cur. Nursing and fourth-year social work students were included as they had experienced experiential learning in the disadvantaged community concerned. Focus groups with the health service delivery organisations were done at a central location close to their workplace. The individual interviews were conducted with community members in their own homes or at the offices of the HSDO.

Populations and samples

Three populations were involved. The students consisted of the third-year nursing (22) and fourth-year social-work (20) students. The second population consisted of members from NGOs, FBOs, LAC and various government departments as health service delivery organisations. The last population consisted of disadvantaged community members who had received health care from the students concerned.

Sampling

Non-probability purposive voluntary sampling was used and data saturation use to determine the size. Four (4) focus groups (one per mentioned population) and nine (9) interviews were conducted with a total of 41 participants. Ten (10) third-year nursing students and eight (8) fourth-year social work students were included in the focus groups. Ten (10) members from health service delivery organisations where nursing students were involved and four (4) members from health service delivery organisations where social-work students were involved were included in the two focus groups with health service delivery organisations. Nine (9) patients were interviewed, six (6) of whom had received health care rendered by nursing students and three (3) by social-work students.

Data Collection

Participants were invited to come to the various settings or appointments were made with patients to visit them in their homes. According to Greeff (2005:299) focus groups are a means of gaining a better understanding of how people feel or think about an issue, product or service. All focus groups and interviews were conducted in Afrikaans and/or English and audio-taped. All participants were informed about matters of confidentiality, anonymity, privacy, risks, withdrawal and possible termination of their participation prior to completion of the data gathering processes.

In the case of the focus groups all the questions were evaluated beforehand by the research team and referred to experts for comment and a focus group conducted to evaluate the applicability of the questions. The estimated time of an hour for the focus group discussion was communicated to the participants when they were invited to participate. During the focus groups communication techniques (Okun, 1992:70-71) and group facilitation strategies (Greeff, 2005:307) were used to enhance participation. Communication techniques (Okun, 1992: 70-71) facilitated the interviews. The various focus groups were introduced with the following questions:

Nursing and social work students:

- How did you experience health care service delivery to the disadvantaged community?
- How did you experience communication with the people who made the arrangements for health care service delivery?
- How did you experience communication with the community?
- What would enhance health care service delivery to the disadvantaged community?

Health service delivery organisations:

- They were asked similar questions, focusing on their experiences and perceptions of health care delivery by the students.

The questions to the disadvantaged community members:

- How did you experience the service delivery rendered by the students to you?
- How did you experience the communication with the students as well as with the person who made the arrangements for them to deliver the service to you?
- How do you think this service delivery by students could be enhanced?

Field notes were taken at the end of each group or interview, focusing on personal, observational and methodological notes (Talbot, 1995:478; Polit & Hungler, 1997:307).

Data analysis

All the focus groups and interviews were transcribed verbatim and analysed using the open coding technique of Tesch (*in* Creswell, 2003: 153-155) to identify themes and sub-themes. The

though we were loosing hope. They uplifted our spirits ... Obtaining a grant provided outcome to the patient or the fact that the student did not lose hope gave them strength. It really meant a lot (obtaining a grant).

The HSDO also felt supported by the students as they indicated their concern for the burdens the students had to face. *They are interested and they want to know how are you handling all these people.* The students also provided much needed additional services that the HSDO could not provide or initiate due to time constraints. *They help with food parcels, administrative tasks, start new projects and do group work.*

Difficult to cope with student turn over

The patients found the changing of students less easy to cope with. The contact the patients had with the students varied from one to but a few contacts, making the building of relationships difficult. Contact was made in clinics, during home visits and during training programmes. *It is not one person coming. They change all the time. She is gone now and I am so heart sore and sorry. We get use to them.* However, this did not prevent them from talking to the student or wanting them to come back.

Students question their worth

The students initially questioned their worth but became more aware of their worth to the community as the discussions went along. *If I think about it, it is not enough. I think we do not always realise the difference we make. Just that little I give ... can help them along. You feel so small and helpless until the patient says thank you and you realise it was help.* They felt they had provided a meaningful foundation for further health education and focused on various aspects of health that could be transferred to the rest of the community.

Community comfortable with students

The community is comfortable with the students as they do not feel ashamed. *You see they feel comfortable. It is happiness.* Students are seen to be prepared to share their time with patients and be available. *They feel today somebody is coming to heel their wounds. There are at least people who care for me.*

The placement in the community became a very rich and rewarding experience for the students: *It has enriched my life. I gained more than I gave. We have received so much from them in the end.*

Experiences of students and health service delivery organisations with lecturers

Communication sometimes effective and sometimes less effective

The students experienced the communication with the lecturer, making the arrangements for service delivery as sometimes effective and sometimes less effective. Changes made by lecturers caused problems if the students were not informed. *It is difficult if arrangements are changed at short notice. Here the morning this has been changed.* Poor arrangements caused students to feel unwelcome in the practice area due to professional nurses not knowing that students were going to be there. Students verbalised the need to see lecturers more: *My lecturer did not come when I phoned her. We do not always see them (lecturers).*

HSDO's experiences varied from positive to negative

It seems as though the experiences of the HSDO with lecturers also varied from positive to negative. In the cases of well-planned and structured arrangements that were provided well in advance the HSDO appreciated this fact. *It is a set structure. In the most cases we are well informed.* They appreciated being aware of expectations, like when to expect students, what the expectations were concerning these students and what support was expected. They experienced the students as well prepared, making the placement more meaningful. *When the students arrive they are prepared and know exactly what is expected of them.*

HSDO felt lack of involvement

The HSDO experienced the lack of involvement in arrangements negatively. *They simply just place students there and that is the end.* It was difficult if no pre-arrangements were made and students only arrived in the clinical area, leading to people having to rearrange their schedule at short notice to accommodate the students. *Sometimes just to be told in the morning you have students and I have to change my plans.* The HSDO or the students did not see the lecturers on a regular basis. *The students need to see their tutors. We would like to see the tutor as well.*

Communication during the health care service delivery

As different aspects of communication are intertwined in the findings, the following is a synthesis focusing on communication only. It is done according to the theoretical context discussed earlier. In general it can be deduced that the communication tended to portray to some extent the therapeutic as well as King's Interaction Model rather than the Health Belief Model. The experiences of the students, and especially those of the patients, indicated that the students helped patients to adjust to their circumstances and provided them with valuable information to prevent possible illnesses: *They taught us how to care for our children and how to treat them. We learned a lot.*

The importance of interpersonal relationships and reciprocal interplay, which are core elements of King's model, also came to the fore in the experiences of all the role-players: *We could always speak to ... if we had problems. She had time to listen to us. She understood what I told her.*

The issue mentioned by the students about the possibility that some content would be lost due to the fact that the students did not understand Setswana indicated the concern of the students to share and properly understand meaning during communication. The following findings will be grouped according to the three major factors within health communication: *relationships, transactions* and *contexts.* One should realise that these aspects can be distinguished from each other, but in reality they do not function separately. They are crucial interrelated elements of the communication system that influence each other (Courtright, 2007:313-315).

Relationships

It is clear that many relationships are involved. There is positive evidence of good relationships in most instances, especially between the students and the patients, as reflected in the follow-

ing statements of patients regarding the students: *They really work nicely with us. The most important thing was the sympathy they gave. They give love and caring by playing with our kids. They are beautiful and you open your heart to them.*

The relationship between the university lecturers and the clinical staff seemed to be ambivalent. The cause of this sometimes strained relationship seems to be due to a lack of adequate and effective communication about schedules and dates, and also due to last minute changes to the scheduled programme. The relationship between the patients and the clinical staff/NGOs appears to be sound as no specific problems were mentioned during the interviews.

Transactions

Language

The concept *transaction* refers to the communication interaction during contact. In most instances the transactions experienced were positive. One problem, though, seems to be the fact that most students do not speak the mother tongue of most patients: *They (patients) know we will not understand them and then keep quiet. It is certain things you want to tell or show them ... now you can't.* An interpreter was of value but it did lengthen the time of communication. They did not always know whether the interpreter interpreted correctly. *Then someone has to talk on your behalf but you don't know that it is truly what you wanted to communicate.* The HSDO confirmed that language was a possible obstacle during health care delivery by students. The student's personality and emotional maturity played an important role in overcoming the language problem.

It is interesting to note that the students experienced the lack of speaking in the patient's mother tongue as a bigger problem than the patients themselves. Those patients, who experienced empathy, respect and honest involvement did not experience language as a major stumbling block. If empathy and respect were present it made it possible to overcome the language barrier. Patients said: *We did not struggle with language. We would talk to one another nicely. They are friendly people and we talk to them. They spoke with respect.* It is possibly attributed to the belief that good interpersonal relationships and trust are firstly of the utmost importance for effective communication within Afro-centric and collectivistic cultures. The presence of trust and good will during the interaction even without the necessary language skills is preferable to language proficiency without the essential *relationship of trust* and reciprocity.

Another aspect of the interaction seems to be the tendency of students, in their urge to help and do something immediately, to react verbally and nonverbally before they even know the patient well and know what the real needs of the patient are: *People's needs are very, very different. But if you actually find out what they need ... it is so small and basic what you give. I thought I wanted to change the whole place ... and then I realised they don't have those needs. Sometimes they only want to tell their story. If you listen they are more open to share information.*

Context

A variety of contexts are involved in the service of the students to the community. In most instances the role-players adjust well to different contexts. One issue that needs to be addressed, though, is the totally "new" and different cultural environment which the students have to accommodate in order to communicate optimally from the beginning (Littlejohn & Foss, 2005:147-153). The real life experiences such as poverty and death can be such a shock for the students that the help and support they are supposed to give can be negatively affected. The possibly uncontrolled emotions which the students might experience could interfere with the ideal of reciprocal communication during the interaction. *Specifically in your first year. You stay in your town and never go to the disadvantaged community. Now you have to. It is a big adjustment and a total new discovery ... I was so frightened I did not want to look out of the window when we travelled in the community.*

However, it seems that most students learned to adjust rather quickly. It is also evident that the students experienced more confidence within the context of a small group than a context where they had to interact on an interpersonal level. *Groups were easier as they help one another if they do not understand. Although the communication appeared to be relatively good in many instances, it can be improved to optimise the service delivery to the community.*

Conclusions

Although there are smaller differences in the experiences of the three groups, there are many similarities. Community outreach is built on a trust relationship, with empathy and respect as core elements. Both students and HSDO mentioned the initial shock experienced by students when they were confronted with the disadvantaged community for the first time. The students found circumstances in the disadvantaged community shocking and heartbreaking, as it was very different from their own protected environment as well as their more structured learning environment (the hospital). However, the students quickly overcame this challenge and adjusted to the situation.

Cultural differences existed but were overcome with understanding and respect from the side of the students. The needs of the community were vast and basic and the students felt that they could meaningfully contribute to this with the knowledge they had. Patients welcomed students in their homes. However, it was difficult to build a relationship of trust with students if they only went on home visits once or twice. The availability of students to listen to the stories of patients was a key factor to their successful acceptance by community members. Students realised that the community valued their presence and that there was a general trend of respect and appreciation.

The HSDO stated that the community experienced the students as compassionate and respectful. They felt that students were prepared to spend time with them. Communication with the lecturers varied from effective to less effective. Aspects like being involved and informed about plans and expectations were important aspects of a successful relationship between the university and the HSDO. Both students and the HSDO experienced language as a barrier but patients did not experience it as a stumbling block. Honest human caring and genuine interest bridged this gap. All the groups benefited from this deeply human experience and gained more than the initial goal had intended. There is a fine line between the goals of the required ex-

periential learning and meeting the specific needs of the disadvantaged community.

Limitations of the study

The following limitations were identified in this study:

- Only two professional student groups (Nursing and Social Work) were really active in the service delivery to the disadvantaged community through experiential learning.
- Nursing students were more active in the community, whereas social work students were providing service delivery at existing services. The two groups did not have contact with one another.
- Students often only had contact once with a patient. The latter lead to a lack of relationship building.
- Only three interviews were conducted with social work clients, but this was not a problem as data was saturated.
- Interviews with supervisors would have enriched the data.

Recommendations

Recommendations focus on the improvement of accompaniment by lecturers and possible training by communication specialists; extending health care service delivery to a multidisciplinary team approach by students; and recommendations to improve health care service delivery.

Students should be prepared for and informed about the different contexts they will be facing, either by students previously exposed to the situation (3rd and 4th years) or by the clinical staff members who are working in the community. They should be prepared for the harsh reality, problems and cultural beliefs and customs before their first community encounter. Students who participate for the first time should also visit the relevant sites before they actually become involved in the community.

Lectures in intercultural communication could help overcome cultural barriers. Ideally, these aspects should form part of the curriculum. Students should be helped to work through any preconceived and prejudged thoughts and feelings before they start to work in a disadvantaged community. Students who participate for the first time should initially be accompanied by more experienced students/HSDO. Any form of guidance would have enhanced the student's confidence and ability to communicate more effectively. Students should also be prepared by the lecturers or HSDO when the sessions shift from the clinical environment to the homes or informal settlements where the people are living, and often dying. A much more co-ordinated effort should be introduced to ensure quality health service delivery to a disadvantaged community.

With regard to different languages, lectures in the relevant language of the community would help to overcome the language barrier. The problem is that the necessary intercultural competencies, which involve more than just language proficiency, take time to acquire, but even a basic spoken knowledge of the language would be of great assistance. At the same time, students must be informed and prepared to, firstly, earn the trust of the patient by listening well and building a relationship before they, secondly, respond by saying and doing what would be congruent with the patient's needs.

The already good relationship between the students and the patients can be enhanced if it would be possible for the same student to help the same patients over a longer period of time. The relationship could grow in depth, and quality of help would benefit from the longer involvement. Well-structured arrangements should be made well in advance and communicated to the relevant parties. The problem is that the relationship between the students and the clinical staff can be jeopardised if the communication between the two organising role-players is lacking or not properly done, while the "innocent" students would be the role-players to suffer.

A system should be developed for both the patients and the students to evaluate the health services delivered. Debriefing sessions for students to overcome the experience of the harsh conditions in the community should be built into the programme. The ideal would be, as many requested, to send a multidisciplinary team of students to the community.

The knowledge gained from this research should be ploughed back into education, research and community outreach planning.

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