

**COMMUNITY-BASED EDUCATION AND SERVICE LEARNING:
EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE
UNIVERSITY OF THE FREE STATE**

By

SONET BEATRICE KRUGER

**Thesis submitted in fulfilment of the requirements for the degree
Philosophiae Doctor in Health Professions Education**

Ph.D. HPE

in the

DIVISION HEALTH SCIENCES EDUCATION

FACULTY OF HEALTH SCIENCES

UNIVERSITY OF THE FREE STATE

BLOEMFONTEIN

JUNE 2013

PROMOTER: PROF. G.J. VAN ZYL

CO-PROMOTER: PROF. DR M.M. NEL

DECLARATION

I hereby declare that the work submitted here is the result of my own independent investigation. Where help was sought, it was acknowledged. I further declare that this work is submitted for the first time at this university/faculty towards a Philosophiae Doctor degree in Health Professions Education and that it has never been submitted to any other university/faculty for the purpose of obtaining a degree.

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DEDICATION

I would like to dedicate this thesis to my family - your love, support, patience and faith in me have made this dream possible.

Particularly, to my loving parents, who both believed in me – there is no doubt in my mind that without their continued support I could not have completed this process.

I further dedicate this work to my daughters, Carli and Mika, who are the joy of my life. You were my reason for carrying on and without your unconditional love I would not have been able to complete this effort.

ACKNOWLEDGEMENTS

I would like to thank everyone who helped to make this thesis possible. I wish to express my sincere thanks and appreciation to the following persons:

- My promoter, Prof. Gert van Zyl, Dean: Faculty of Health Sciences, University of the Free State, for his guidance, valuable advice and financial support. Your patience and encouragement meant a lot to me.
- My co-promoter, Prof. Marietjie Nel, Head: Division of Health Sciences Education, Faculty of Health Sciences, University of the Free State, for her incredible support, mentorship, expert supervision and patience. Thank you for spending so many hours assisting me and believing in me.
- The undergraduate students in the Faculty of Health Sciences, University of the Free State who participated in the research - without your time, cooperation and valuable contributions, this project would not have been possible.
- Dr Rita van Heerden, Department of Occupational Therapy, Faculty of Health Sciences, University of the Free State, for her expert handlings as facilitator during the Nominal Group Discussions and for her aid and guidance in the planning, preparation and execution of the Nominal Group Discussions.
- Mr Cornel van Rooyen, Bio-statistician, Faculty of Health Sciences, University of the Free State, for the analysis of the quantitative research.
- Dr Luna Bergh (D.Litt. *et* Phil.), University of the Free State for the final language editing of the thesis.
- Ms Michelle de Klerk, for her support with references.
- Ms Elmarié Robberts, for the typing, editing and her meticulous attention to technical detail with this thesis.

- My parents, Piet and Lorraine Grove, who always believe in me no matter what I have attempted. Your love and support meant so much to me in the lonely hours at night while I was working.
- All my colleagues at the Division Health Sciences Education, Faculty of Health Sciences, Free State University. Thank you for your support, encouragement and assistance.
- Most importantly, My HEAVENLY FATHER, without the strength YOU gave me this project would have been impossible.

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LIST OF ACRONYMS

B.:	Bachelor's degree
B.Sc.:	Bachelor of Sciences degree
B.Soc.Sc.:	Bachelor of Social Sciences degree
CBE:	Community-Based Education
CE:	Community Engagement
CHESP:	Community Higher Education Service Partnerships
COME:	Community-Orientated Medical Education
CSL:	Community-Service Learning
DL:	Diensleer
<i>et al:</i>	et alii (and others)
FHS:	Faculty of Health Sciences
GBO:	Gemeenskapsgebaseerde Onderwys
GCSA:	Global Consensus for Social Accountability of Medical Schools
HE:	Higher Education
HEIs:	Higher Education Institutions
HEQC:	Higher Education Quality Committee
JET:	Joint Education Trust
M.B.,Ch.B.	Bachelor of Medicine degree
NCHE:	National Council of Higher Education
NGT:	Nominal Group Technique
PHC:	Primary Health Care
SA:	South Africa
SL:	Service Learning
SMS:	Short Message Service
SoAHP:	School of Allied Health Professionals
SoM:	School of Medicine
SoN:	School of Nursing
UFS:	University of the Free State
WHO:	World Health Organisation

SUMMARY

Key terms: Community-Based Education, Community Engagement, Experiences of students, Health Sciences Education, Higher Education, Mixed-methods design, Service Learning, Undergraduate education.

In this research project, an in-depth study was done by the researcher in view of providing recommendations, based on the experiences of Health Sciences students in Community-Based Education (CBE) and Service Learning (SL), to academic staff in the Faculty of Health Sciences (FHS), University of the Free State (UFS), as well as to all internal and external role players who are planning such initiatives in the future in order to enhance the effectiveness thereof.

The current challenge in the training of health professionals is that programmes should produce graduates who are prepared for work in community settings. CBE and SL are teaching approaches used in the FHS, at the UFS, in order to prepare undergraduate students for future professional work in rural and underserved communities.

The research problem revolved around determining what the experiences of Health Sciences students are during CBE and SL undertaken at the UFS. The overall goal of the study was to explore the students' views regarding CBE and SL initiatives in order to make recommendations to all stakeholders involved in these initiatives with the view to enhance the efficacy thereof for students. The aim of the study was to explore the experiences, views, attitudes and perceptions of Health Sciences students regarding CBE and SL at the UFS.

An exploratory mixed-methods design was used – a design in which the results of the first method (qualitative) can help develop or inform the second method (quantitative). The methods that were used and which formed the basis of the study comprised a literature review, and – as the empirical study – nominal group discussions and a questionnaire survey.

The purpose of the literature review was to provide background for the research problem, to establish the need for the research and to indicate that the researcher is

knowledgeable about the area. The literature review focussed on the contextualisation and conceptualisation of CBE and SL. The purpose of the nominal group discussions was to identify themes that occurred in the questionnaire survey. The purpose of the questionnaire survey was to identify the most commonly shared perceptions and attitudes that Health Sciences students have about CBE and SL and to identify whether there are certain factors that influence their experience of CBE and SL.

Recommendations were made on how to implement and manage CBE and SL within undergraduate Health Sciences programmes at the FHS in such a way that students benefit from the experience and as a result, the effectiveness thereof improve.

The study was done to make a contribution to the implementation and management of CBE and SL within undergraduate Health Sciences programmes in the Faculty of Health Sciences at the UFS, through describing how students currently experience CBE and SL in the FHS. The study provides recommendations to all stakeholders in the FHS, at the UFS that are currently involved in CBE or SL and to those who are planning such initiatives in the future.

A contribution is made and new knowledge is added through this study. By describing how undergraduate Health Sciences students experience CBE and SL in the FHS, at the UFS and by providing recommendations regarding the implementation and management of CBE and SL in such a way as to enhance the students' experience thereof, the identified gap is bridged. The sound research approach and methodology ensured the quality, reliability and validity of the research. The completed research can form the basis for future research. If the recommendations are followed when implementing and managing CBE and SL initiatives within undergraduate Health Sciences programmes, the students' experiences of these initiatives will improve, and ultimately the effectiveness of CBE and SL will improve for all stakeholders involved.

OPSOMMING

Sleuteltermes: Gemeenskapsgebaseerde Onderwys, Gemeenskapsbetrokkenheid, Ervarings van studente, Gesondheidswetenskappe-onderwys, Hoër Onderwys, Gemengde metodes ontwerp, Diensleer, Voorgaadse onderrig.

In hierdie navorsingsprojek is 'n diepgaande studie onderneem deur die navorser met die oog daarop om aanbevelings te maak, gebaseer op die ervarings van Gesondheidswetenskappe-studente in Gemeenskapsgebaseerde Onderwys (GBO) en Diensleer (DL), aan die akademiese personeel van die Fakulteit Gesondheidswetenskappe (FGW), Universiteit van die Vrystaat (UV) asook aan alle interne en eksterne rolspelers wat sulke inisiatiewe in die toekoms beplan om die doeltreffendheid daarvan te verhoog.

Tans is die uitdaging ten opsigte van die opleiding van professionele gesondheidswerkers dat programme gegradeerdes moet lewer wat voorbereid is om in 'n gemeenskapsopset te werk. GBO en DL is onderrigbenaderings wat in die FGW aan die UV gebruik word om voorgaadse studente voor te berei om professioneel in plattelandse en afgeskepte gemeenskappe te werk.

Die navorsingsprobleem was daarop gemik om vas te stel wat die ervarings van Gesondheidswetenskappe-studente is tydens GBO en DL aan die UV. Die oorkoepelende doel van die studie was om die studente se beskouings oor GBO- en DL-inisiatiewe te ondersoek om sodoende aanbevelings aan al die belanghebbendes ten opsigte van die inisiatiewe voor te lê om die doeltreffendheid daarvan vir studente te verbeter. Die oogmerk van die studie was om die ervarings, beskouings, houdings en persepsies van die studente rakende GBO en DL aan die UV na te vors.

'n Eksploratiewe, gemengde metodes ontwerp is gebruik – 'n ontwerp waarvolgens die resultate van die eerste metode (kwalitatief) die tweede metode (kwantitatief) kan toelig of help ontwikkel. Die metodes wat gebruik is en die basis van die studie uitgemaak het, was 'n literatuuroorsig en – as die empiriese studie – nominale groepbesprekings en 'n vraelysopname.

Die doel van die literatuuroorsig was om die navorsingsprobleem in konteks te plaas, die belangrikheid vir die navorsing aan te dui en om te toon dat die navorser goed op hoogte van die veld is. Die literatuuroorsig fokus op die kontekstualisering en konseptualisering van GBO en DL. Die doel van die nominale groepsbesprekings was om temas te identifiseer wat in die vraelysopname voorgekom het. Die doel van die vraelysopname was om die Gesondheidswetenskappe-studente se algemeenste persepsies en houdings oor GBO en DL te identifiseer en vas te stel of daar spesifieke faktore is wat hulle ervaring van GBO en DL beïnvloed het.

Aanbevelings is gemaak oor hoe om GBO en DL op so 'n wyse te implementeer en bestuur binne voorgraadse Gesondheidswetenskappe-programme van die FGW sodat studente by die ervaring baat en dat die effektiwiteit as gevolg daarvan ook toeneem.

Die studie is onderneem om 'n bydrae te lewer tot die implementering en bestuur van GBO en DL binne voorgraadse Gesondheidswetenskappe-programme van die Fakulteit Gesondheidswetenskappe aan die UV, deur te beskryf hoe studente tans GBO en DL in die FGW ervaar. Die studie bied aanbevelings aan alle rolspelers in die FGW aan die UV wat tans by GBO en DL betrokke is en aan diegene wat sulke inisiatiewe vir die toekoms beplan.

'n Bydrae is gelewer en nuwe kennis is toegevoeg deur hierdie studie. Deur te beskryf hoe voorgraadse Gesondheidswetenskappe-studente GBO en DL in die FGW aan die UV ervaar en aanbevelings te maak oor hoe GBO en DL op so 'n wyse geïmplementeer en bestuur kan word dat die studente se ervaring verbeter kan word, is die gaping wat identifiseer is, oorbrug. Die grondige navorsingsbenadering en metodologie verseker die kwaliteit, betroubaarheid en geldigheid van die navorsing. Die afgehandelde navorsing kan die basis vir verdere navorsing bied. Indien die aanbevelings in aanmerking geneem word by die implementering en bestuur van die GBO- en DL-inisiatiewe in die voorgraadse Gesondheidswetenskappe-programme, sal die studente se ervaring van hierdie inisiatiewe verbeter en sal die effektiwiteit van GBO en DL vir alle belanghebbendes verbeter.

COMMUNITY-BASED EDUCATION AND SERVICE LEARNING: EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE UNIVERSITY OF THE FREE STATE

CHAPTER 1

ORIENTATION TO THE STUDY

1. INTRODUCTION

In this research project, an in-depth study was done by the researcher with a view to provide information regarding the experiences of Health Sciences students in Community-Based Education (CBE) and Service Learning (SL) to academic staff in the Faculty of Health Sciences (FHS), University of the Free State (UFS) as well as to all internal and external role players who are planning such initiatives in future that can add value to curriculum development and the implementation of CBE and SL initiatives.

Higher Education Institutions (HEI) are shaped by their societies and history. If they aspire to be the creators of new knowledge and at the centre of political and social thought, new and changing contexts call for new approaches (Bawa 2003:49). If universities are regarded as the conscience of society and are meant to serve society, it is important to find the intrinsic nature of the university amidst the changing demands of society (Fourie 2006:20; Gibbons 1998:35). In order to become more relevant again and escape from absolutism, Higher Education (HE) has been striving for transformation during the last few decades.

In this regard innovative pedagogies, such as community engagement (CE) and an enhanced social contract, are increasingly crucial. CE refers to initiatives and processes through which the expertise of the HEI in the areas of teaching, research and service delivery are applied to address issues relevant to its community (HEQC 2006:17-23).

Universities in South Africa, including the UFS, have adopted a CBE and SL teaching approach for undergraduate Health Sciences students in order to prepare students for future professional work in rural and underserved communities.

According to Jordaan (2006:20) SL refers to a process which involves students in community work that makes a contribution to the community, enhances the students' academic understanding, adds to personal and career growth and also creates an understanding of current social issues in society. It is a structured, intentional process, carefully designed to meet the requirements of a specific academic programme from which students can earn academic credits. Students are actively engaged in critical and reflective thinking practices that enhance their understanding of academic content and social responsibility.

According to Wojtczak (2002:216) CBE is a form of instruction where trainees learn professional competencies in a community setting focusing on population groups as well as on individuals and their everyday problems.

This study can serve as a guideline to all role players, both internal and external, that are currently involved in CBE or SL or planning such initiatives in future on how to incorporate CBE and SL effectively into their programmes.

The aim of Chapter 1 is to orientate the reader to the study. It provides background to the research problem, followed by the problem statement – including research questions, the overall goal, aim and objectives of the study. This is followed by a demarcation of the study, which also highlights the significance and value of the study. Thereafter a brief overview of the research methods of investigation is presented. The chapter is concluded by a lay-out of the subsequence chapters and a short, summative conclusion.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Higher Education Institutions (HEIs) in the 21st century, and particularly those in South Africa (SA), are facing the challenge of globalisation, new knowledge societies, and complex issues of social transformation and diversity (Department of Education 2002:online; O'Brien 2005:65), which led to various changes already.

These changes urge HEIs to shift focus from knowledge to competence, from dichotomy to pluralism and diversity, as well as from closed systems based on canonical norms and collegial authority to open and permeable systems responsive to social interests (Kraak 2000:23). Evidence of this is seen in SA, with multiple policy imperatives and the increased use of CE as pedagogy attempts to realign the

relationship between HEIs and communities (O'Brien 2005:86).

The White Paper 3 on HE (Department of Education 1997:3) laid the foundation for SL (and CE) in HE. A call was made to demonstrate social responsibility and a commitment to the common good of all. From their mission and vision statements, it is clear that many HEIs have opted for SL as vehicles to formalise and organise their tripartite functions while repositioning themselves. In the preamble of the Community SL Policy of the University of the Free State (UFS), the UFS commits itself to proactive transformation in its strive to be an "excellent, equitable and innovative university" (UFS 2006:online).

In addition, the White Paper on the Transformation of the Health Care System in South Africa called for the re-orientation of health professionals' education to a comprehensive primary health care approach and CBE as the method to implement this approach (Department of Health 1997:34–36). The education of health professionals must ensure that programmes are producing graduates who are prepared for 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).

The Faculty of Health Sciences at the University of the Free State has adopted a CBE and SL teaching approach for undergraduate Health Sciences students in order to prepare them for future professional work in rural and underserved communities. CBE and SL are compulsory components of the curriculum of undergraduate students in the FHS and all students have to take part in these initiatives; however, the attitudes to and perceptions of CBE and SL vary significantly among these students. Some students are really excited to participate in CBE and SL, while others have a somewhat negative attitude towards it and only participate in these initiatives because it is compulsory for them to do so.

Attitudes will influence behaviour and therefore it will be valuable to investigate what attitudes, beliefs and opinions are held by groups of subjects with common traits (Black 1999:215). By surveying the attitudes, perceptions and opinions of students regarding CBE and SL, information can be collected that could shed light on how to best integrate CBE and SL into learning programmes so as to ensure successful integration.

1.3. PROBLEM STATEMENT AND RESEARCH QUESTIONS

The problem that was addressed in the current study is to determine what the experiences of Health Sciences students are during CBE and SL undertaken at the UFS.

After an extensive literature review, no recent study concerning the experiences of Health Sciences students during CBE and SL in South Africa could be traced. Research on the experiences of Health Sciences students on CBE and SL in South Africa is limited. Searches on the NRF's website and the NEXUS Database System (information regarding South African dissertations) did not produce relevant dissertations or research on the experiences of Health Sciences students on CBE or SL. However, a number of dissertations/theses were found on student experiences or perceptions and attitudes towards CBE and SL in other professions/disciplines. Examples of such scholarly work on CBE and SL include the following: Attitudes and perceptions about community SL among students in a teacher programme (Jordaan 2006); Experiences of staff and students of a SL project at a private HEI (Pearce 2006) and attitudes and perceptions of students towards community SL implication for implementation and management by programme heads (Pretorius 2007). The researcher also searched the MEDLINE, EMBASE ERIC, Academic Search Complete and CINAHL databases to identify relevant articles.

Some sections in dissertations/theses and articles were informative and helpful and are acknowledged and referenced as such.

In conclusion, there seemed to be no recent scientific literature on the experiences of students in Health Sciences on CBE and SL in South Africa.

In order to address the problem stated, the following research questions were asked:

1. *How can CBE and SL be conceptualised and contextualised as the theoretical framework of this study?*
2. *What are students' views regarding CBE and SL?*
3. *What are the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL?*

4. *Are there certain factors that influence Health Sciences students' experience of CBE and SL, and if so what are those factors and how do they influence students' experiences?*
5. *How can CBE and SL initiatives be effectively implemented in the Faculty of Health Sciences, UFS?*

The research was carried out and completed based on these five research questions.

1.4 OVERALL GOAL, AIM AND OBJECTIVES OF THE STUDY

1.4.1 Overall goal of the study

The overall goal of the study was to explore the Health Sciences students' views regarding CBE and SL initiatives in order to maximise the efficacy thereof for students by:

- Increasing their understanding of the theoretical work;
- Gaining a deeper understanding of the linkage between curriculum content and community dynamics;
- Fostering a sense of social responsibility and
- Enhancing their personal growth and professional development.

1.4.2 Aim of the study

The aim of the study was to explore the experiences of Health Sciences students, including their views, attitudes and perceptions regarding CBE and SL at the UFS.

1.4.3 Objectives of the study

To achieve this aim, the following objectives were pursued namely:

1. *Conceptualising and contextualising CBE and SL via a literature study, in order to compile a theoretical framework for the study.*
This objective addresses research question 1.
2. *To explore students' views regarding CBE and SL via the nominal group technique.*
This objective addresses research question 2.

3. *To identify the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL via a questionnaire survey.*

This objective addresses research question 3.

4. *To identify whether there are certain factors that influence Health Sciences students' experience of CBE and SL via a questionnaire survey.*

This objective addresses research question 4.

5. *To identify what the factors are that influence Health Sciences students' experience of CBE and SL via a questionnaire survey.*

This objective addresses research question 4.

6. *To determine how these factors influence Health Sciences students' experience of CBE and SL via a questionnaire survey.*

This objective addresses research question 4.

7. *To provide information and make recommendations to academic staff in the Faculty of Health Sciences, UFS, as well as to all internal and external role players who are planning such initiatives in future that can add value for curriculum development and the implementation of CBE and SL initiatives via the literature study, nominal group technique and questionnaire survey.*

This objective addresses research question 5.

1.5 DEMARCATION OF THE FIELD AND SCOPE OF STUDY

The research findings of this study will be provided to all stakeholders in the Faculty of Health Sciences, UFS that are currently involved in CBE or SL and to those who are planning such initiatives in future.

This study was done in the field of Health Professions Education (HPE) and belongs in the domain of CBE and SL in that it explores students' views regarding CBE and SL initiatives in order to maximise the efficacy thereof.

The participants in this study, for both the nominal group technique as well as the questionnaire survey, were undergraduate students from the Faculty of Health Sciences, UFS that were involved in CBE and SL during 2011.

In a personal context, the researcher in this study is a qualified Industrial Psychologist with a Master's Degree in Industrial Psychology and also an Honours Degree in General Psychology. She is currently employed in the division Health Sciences Education (HSE)

at the Faculty of Health Sciences at the UFS, where she is jointly responsible for student support in the Faculty. She developed a special interest in CBE and SL, with an emphasis on students' experiences, attitudes and perceptions in this regard. She is also a module leader in the Master's Programme in the Health Professions Education (HPE) programme and is responsible for Module HPE705 (Community Service Learning, Interdisciplinary Education and Primary Health Care).

As far as the timeframe is concerned, the study was conducted between August 2010 and January 2013, with the empirical research phase in 2011.

1.6 THE VALUE AND SIGNIFICANCE OF THE STUDY

The current educational practice in HEIs is to include CE so as to enhance academic learning. Previous researchers have looked at the result of CBE (Kristina, Majoor & van der Vleuten 2006; Mtshali 2009; Mwanika, Okullo, Kaye, Muhwezi, Atuyambe, Nabirye, Groves, Mbalinda, Burnam, Chang, Oria & Sewankambo 2011) and SL (Gillis & MacLellan 2010; Gitlow & Flecky 2005; Hoppes, Bender & De Grace 2005; Horowitz, Wong & Dechello 2010) on learning outcomes and understanding but little has been written about students' experiences of CBE and SL or included as an example their attitudes, beliefs, perceptions and opinions regarding it.

Black (1999:215) states that investigating what attitudes, beliefs and opinions groups of subjects with common traits hold is of value because these attitudes will influence behaviour. Uninformed students who participate in CE programmes could develop negative attitudes and participate unwillingly. Information about preconceived ideas gained by surveying the attitudes and perceptions students have about CBE and SL could shed light on how best to integrate it into learning programmes so as to ensure successful integration.

Furthermore, no study of this kind has as yet been done specifically for or amongst South African HEIs and Health Sciences' students. Although there is international literature (cf. Chapter 2) on the topic of community SL, very little research has been done nationally (cf. Chapter 2) and the South African educational environment has yet to explore its possibilities and benefits in formal studies. For this reason, this study would add value by providing insight into the students' experiences and understanding of the concept of CBE and SL.

The research findings of this study will be made available to all stakeholders in the Faculty of Health Sciences, UFS that are currently involved in CBE or SL as well as to internal and external role players who are planning such initiatives in future. Recommendations will be made on the implementation and management of CBE and/or SL within undergraduate Health Sciences programmes in order to make them more effective.

1.7 RESEARCH DESIGN OF THE STUDY AND METHODS OF INVESTIGATION

1.7.1 Design of the study

1.7.1.1 *Case study-design*

The research design adopted in this study was that of a case study. A case study design is used to gain an in-depth understanding of a single phenomenon, a particular group, social setting, event or programme and it involves extensive collection of data (Berge 2001:225; Burns 2000:460; McMillan & Schumacher 2001:391; Mouton 2001:149). In this study, the particular group of individuals were undergraduate students involved in CBE and SL initiatives in the Faculty of Health Sciences at the UFS with the focus on one issue, namely Health Sciences students' experiences of CBE and SL initiatives.

1.7.1.2 *Mixed-methods approach*

Authors such as Johnson and Onwuegbuzie (2004:online) and Creswell, Shope, Plano Clark and Green (2006:1) recommend that where quantitative and qualitative data complement each other, a mixed-methods approach applies. In this research project both qualitative and quantitative methods were employed by means of the nominal group technique (NGT) and a questionnaire to gather the required data from the students involved in CBE and SL initiatives.

According to Creswell and Plano Clark (2007:79-82) four basic types of mixed methods can be identified; namely embedded, explanatory, exploratory and the triangulation type. In this study, the exploratory type was used. The Exploratory Design is used when the results of the first method (qualitative) can help to develop or inform the second method (quantitative).

In this study the qualitative results from the nominal group technique identified themes/topics that were used to explore the views, attitudes, perceptions and opinions of Health Sciences students' on CBE and SL in the questionnaire survey.

The mixed-methods design followed in this study is described in more detail in Chapter 3.

1.7.2 Methods of investigation

The methods that were used and which formed the basis of the study comprised a literature review, and nominal group technique and a questionnaire survey.

This research included a literature study that focuses our understanding of the practice, outcomes, impact and quality of CBE and SL endeavours and the profile of the students who participate in these endeavours.

The literature study was succeeded by the nominal group technique that was used to identify themes/topics that were used to explore the experiences of Health Sciences students, including their views, attitudes and perceptions regarding CBE and SL at the UFS.

A questionnaire survey was also used to obtain demographic information of the participants, and explore students' experiences regarding CBE and SL. The information obtained through the nominal group technique was used in conjunction with the literature to formulate the questions in the questionnaire survey.

The results of the literature study, the nominal group technique and the questionnaire survey can be used to provide information and make recommendations to academic staff in the Faculty of Health Sciences, UFS, as well as external role players that could add value for curriculum development and the implementation of CBE and SL initiatives.

The detailed description of the population, sampling methods, data collection and techniques, data analysis and reporting and the ethical consideration are given in Chapter 3.

A schematic overview of the study is given in Figure 1.1.

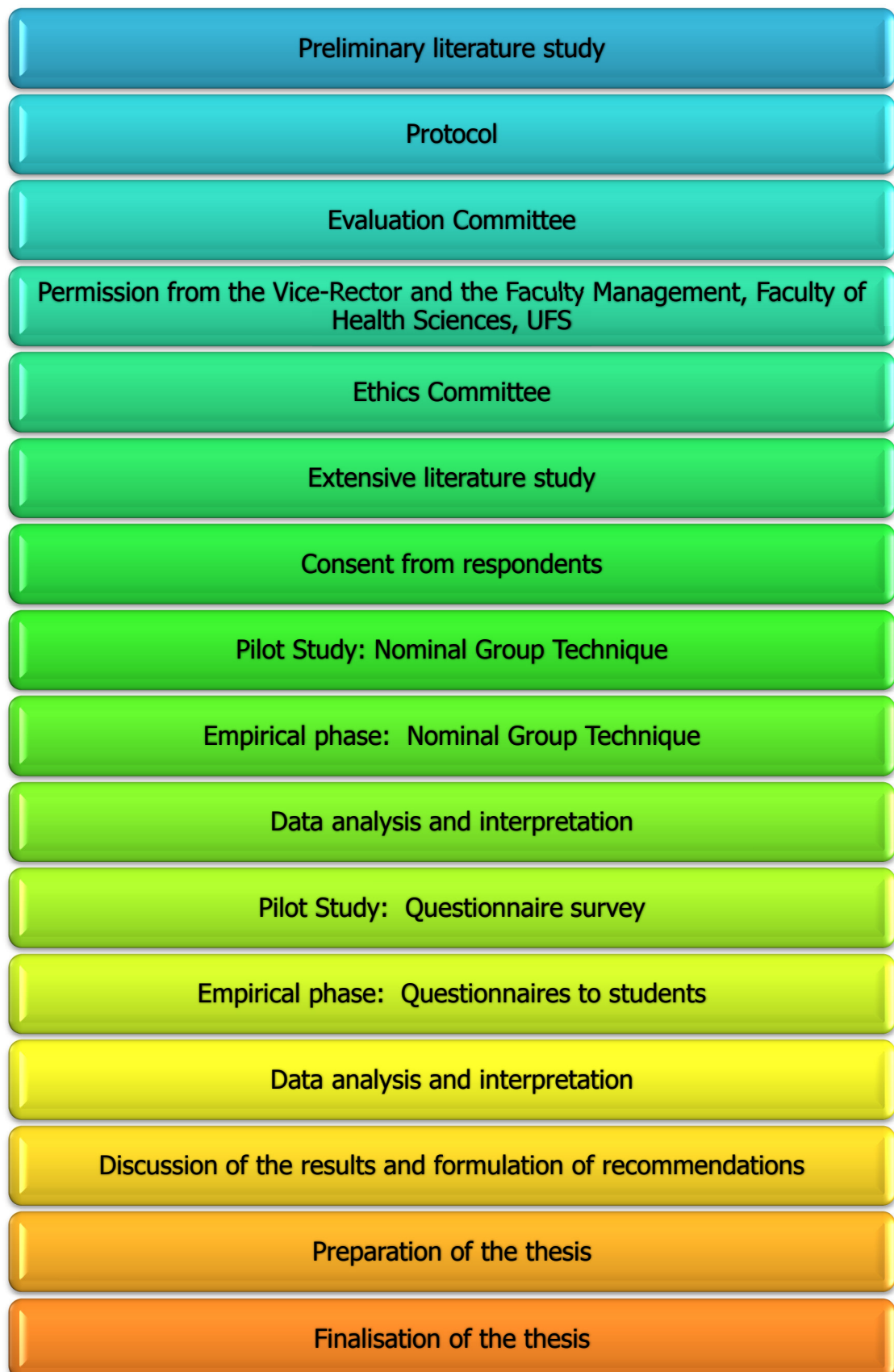


FIGURE 1.1: A SCHEMATIC OVERVIEW OF THE STUDY
[Compiled by the Researcher, Kruger 2011]

1.8 IMPLEMENTATION OF THE FINDINGS

This report containing the findings of the research will be brought to the attention of all stakeholders in the Faculty of Health Sciences, UFS that are currently involved in CBE or SL and to those who are planning such initiatives in future. The research findings will be submitted to academic journals with a view to publication, as the research will make a contribution on how to incorporate CBE and SL more effectively into programmes. The research findings will also be presented at conferences.

1.9 ARRANGEMENT OF THE REPORT

To provide more insight into the topic, the methods used to find solutions and the final outcome of the study will be reported on as follows:

In this chapter, Chapter 1, **Orientation to the study**, the background to the study is provided and the problem, including the research questions, is stated. The overall goal, aim and objectives are stated and the research design and methods that were employed are briefly discussed to give the reader an overview of what the report contains. It further demarcates the field of the study and the significance of the study for HE, CBE and SL.

In Chapter 2, **Conceptualisation and Contextualisation of CBE and SL**, the conceptualisation and contextualisation of CBE and SL are discussed. This chapter will serve as the theoretical framework for the study.

In Chapter 3, **Research Design and Methodology**, the research design and the methods applied are described in detail. The mixed-methods research design used is clarified, while the methods and procedures are also explained. The latter consist of the nominal group technique and the questionnaire survey. The research participants are described and the research techniques and data analysis are explained. In addition validity, reliability and trustworthiness of the measuring instruments are dealt with.

In Chapter 4, **Description and discussion of the findings of the nominal group technique**, an exposition of the findings of the nominal group technique is provided. Chapter 4 represents Phase I of the mixed-methods research design, namely an exploratory design.

In Chapter 5, **Description and discussion on the results of the questionnaire survey**, the results of the questionnaire as data collecting method employed in this study is reported and the findings are discussed. In this chapter, Phase II of the mixed-methods research design, namely an exploratory design, is presented.

In Chapter 6, **Health Sciences students' experiences of Community-Based Education and Service Learning**, the final outcome of the study is represented, including the incorporation of results from Phase I and II. The researcher makes use of the literature survey as well as findings from the nominal group technique and the questionnaire survey for the purpose of making recommendations on how to incorporate CBE and SL into an undergraduate curriculum in such a way that students benefit from the experience and consequently improve the effectiveness thereof.

In the final chapter, Chapter 7, **Conclusion, recommendations and limitations of the study**, an overview of the study, conclusion, recommendations and the limitation of the study is provided.

References and Appendices are included at the end of the thesis.

1.10 CONCLUSION

Chapter 1 provides background and introduction to the research undertaken regarding the experiences of Health Sciences students, at the UFS regarding CBE and SL. The experiences of Health Sciences students regarding CBE and SL are of great importance and this thesis contributes to informing academics in curricula inclusion of CBE and SL to make it more effective and worthwhile and in the same process address the needs of the community. The aim of the chapter was to orientate the reader to the study, by providing an overview of the research as a whole. This included a brief introduction and background followed by the problem statement and research questions. The overall goal, aim and objectives and hypotheses of the study were given, followed by an explanation of the demarcation of the field and scope of the study and its significance and value for the field of Health Sciences Education. This was followed by a concise description of the research design and methods of investigation used. Figure 1.1 was provided as a schematic overview of the study, followed by a brief discussion on the implementation of the findings.

The next chapter, Chapter 2, entitled **Conceptualisation and Contextualisation of CBE and SL**, will be a study on the relevant literature.

CHAPTER 2

CONCEPTUALISATION AND CONTEXTUALISATION OF COMMUNITY-BASED EDUCATION AND SERVICE LEARNING

2.1 INTRODUCTION

Earlier, colleges and universities played a significant role in developing civic knowledge and skills in undergraduates, but that role has declined in priority for the most part of the twentieth century. However, lately many Higher Education Institutions (HEI's) have recommitted to their public purpose and are presenting more opportunities for students to learn about and practice civic engagement (Lopez & Kiesa 2009:31).

In the 21st century, the greatest challenge for health professions education exists in the responsibility of educational institutions for a greater contribution to improving health systems performance and people's health status. This can only be accomplished by adapting educational programmes to focus on priority health problems and by a stronger involvement in anticipating health and human resources needs of a nation as well as by ensuring that graduates are employed where they are most needed delivering the most vital services (GCSA 2010:2).

In this regard the medical education literature has increasingly focused on Community-Based Education (CBE) and Service Learning (SL) as a means to achieve greater social accountability. In this chapter, CBE and SL are conceptualised and contextualised. The following issues are dealt with, namely, international and national changes in Higher Education (HE), community engagement (CE), the conceptualisation and contextualization of CBE and SL as well as attitudes and perceptions of students.

For a schematic overview of the different aspects that will be discussed and that will constitute the theoretical framework to the study, please see Figure 2.1.

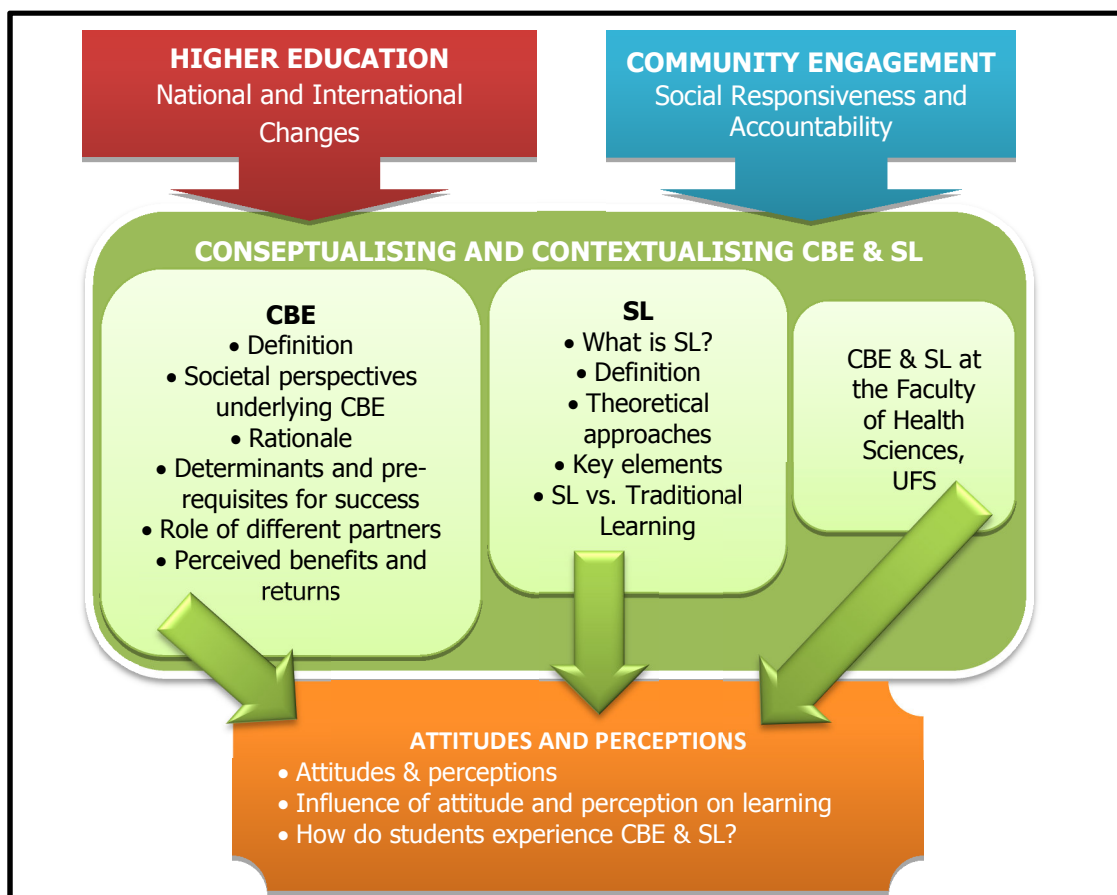


FIGURE 2.1: A DIAGRAMMATIC OVERVIEW OF THE DIFFERENT ASPECTS THAT WILL BE DISCUSSED

[Compiled by the Researcher, Kruger 2011]

2.2 THE CHANGING FACE OF HIGHER EDUCATION – AN OVERVIEW

HEIs worldwide face challenges such as globalisation, new knowledge societies and social transformation and diversity (Department of Education 2002:online; O'Brien 2005:65). In response to these challenges, HEIs realise the importance of developing holistic human beings with the ability of praxis, i.e. reflection and interaction with the world in order to transform it (Naudé 2007:1). Moreover, critical cross field / generic outcomes, such as participating as responsible citizens in the life of local, national and global communities are now considered essentials of HE (Department of Education 2002:online), and HEIs are urged to increase their community participation and social responsiveness (Department of Education 1997:3; NCHE 1996:online). According to Naudé (2007:1) the call for shaping citizens for a demographic society and the production of useful knowledge is heard louder than ever before. In this regard educational transformation (including innovative pedagogies), CE and enhanced social contract are increasingly crucial.

2.2.1 International changes in Higher Education

Rapid globalisation, democratisation and the emergence of a new and more open knowledge society mark the modern face of HE. In addition, the explosion of information technologies (which speeds up the access, rate and effectiveness of communication) and the commodification of knowledge (which implies that knowledge is driven by social and industrial processes and needs) are two current realities in HE (Bawa 2003:49; Kraak 2000:24; O'Brien 2005:66). Furthermore, Maurrasse (2001:14) explains that HE is no longer the upholder of the elite, but expected to be accessible to the masses. Gibbons (1998:33) and Van der Merwe (2004:128) concur, adding the following to the list of challenges facing HE: shifts in demographic tendencies and the social profiles of the student population, a broadening ethos of accountability and efficiency, and calls for education for the professions. These challenges lead to further necessary changes, such as diversification of function of the academic profession; teaching activities that shift from formal lectures to a variety of teaching modes; learning environments that facilitate lifelong learning; the move from mono- to multidisciplinary and increased sensitivity to societal needs (Gibbons 1998:34; Van der Merwe 2004:129).

From the above it follows that it is necessary for HEIs to engage with the community in order to move towards not only producing reliable knowledge through research, but also socially robust knowledge. This is done through contextualisation – when not only the scientists speak to society, but society speaks to the scientists. This engagement with the community is important in order to stimulate new, different kinds of knowledge, knowledge that is “valid beyond the laboratory, because tested in a range of other contexts” (Gibbons 2005:5).

Lazarus, Erasmus, Hendricks, Nduna and Slamat (2008:60-61), Naudé (2007:7-8) and the HEQC (2006:10-11) refer to the work of Ernest Boyer in this regard. Boyer (1990:16-25) proposes four forms of scholarship, namely the scholarship of discovery, the scholarship of integration, the scholarship of application and the scholarship of teaching.

The scholarship of discovery focuses on research and the generation of new knowledge, while the scholarship of integration is concerned with a more integrated

view of knowledge, looking at the actual meaning / significance of findings and interpreting the data in a larger, social context (Boyer 1990:18).

The scholarship of application is most closely linked with engagement. In this respect, Boyer refers to questions such as “How can knowledge be responsibly applied to significant problems? How can it be helpful to individuals as well as institutions? Can social problems *themselves* define an agenda for scholarly investigation?” (Boyer 1990:21).

Finally, the scholarship of teaching emphasises the transmission, transformation and extension of knowledge. In the scholarship of teaching, students do not only learn from academics, but academics can also learn from students and the community. According to Lazarus *et al.* (2008:60-61) and the HEQC document (2006:10) the combination of the four forms of scholarship together form the scholarship of engagement as illustrated in Figure 2.2.

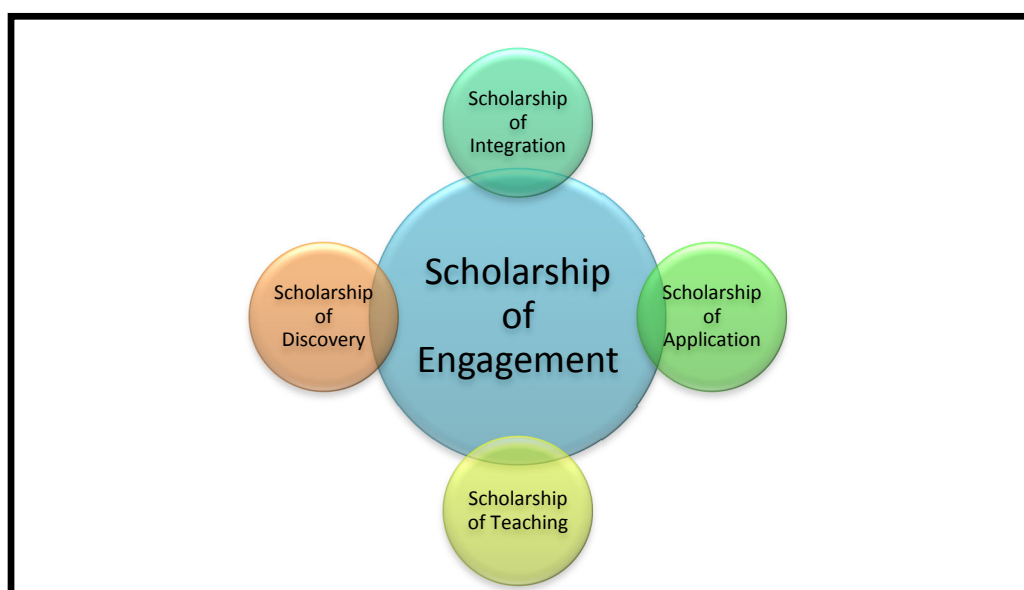


FIGURE 2.2: SCHOLARSHIP OF ENGAGEMENT
[Compiled by the Researcher, Kruger 2011]

Boyer (1996:14) and Kraak (2000:25) argue that although universities add to the development of different applied fields, HEIs are generally seen as more successful in the production of knowledge (Boyer’s scholarship of discovery) than in drawing creatively on existing knowledge or reconfiguring existing knowledge for the social good (Boyer’s scholarship of integration and application).

Universities were formerly seen as the home of discipline-based research; this implied the exclusion of inappropriate and illegitimate outside interference. Disciplinary structures advocated “good science”. Today, however, HEIs function in a new culture of accountability and relevance. The production of knowledge is shifted by societal demands from the production of knowledge that is only reliable to the production of knowledge that is also socially robust. When knowledge production reaches beyond the walls of the academy, boundaries become permeable, and societies are “allowed” to speak back to the academy. These new demands are more complicated than previous ones, because consensus across a broader range of social worlds is complex - calling for multidisciplinary approaches, “experts” from all spheres of society, boundary work, reverse communication, and transaction spaces where social worlds can interact (Gibbons 1998:35; 2005:6).

Gibbons supports the idea that universities should serve the public good and have closer engagement with society. He warns against withdrawing into the ivory tower and challenges HEIs to enter public spaces to move “beyond” - becoming sites of socially robust knowledge, engaged in the joint production of knowledge with their communities (Gibbons 2005:6).

2.2.2 Higher Education in South Africa

Enslin and Horsthemke (2004:547) argue that the South African HE discourse should be rooted in its’ own unique multicultural, multiracial, and multilingual context. After 1994, responding to transformation in general, but also in recognition of the importance of revival and development, the nation’s educational system reacted by introducing new policies and initiatives. HEIs positioned themselves in line with these policies and the practices that follow from them (Hay 2003:185; Subotsky 2000:74).

Increased participation, co-operative relationships and partnerships and greater responsiveness are the three pillars for HE transformation, as identified by the National Commission on HE (NCHE 1996:online). The aim of increased and broadened participation is to accommodate a larger and more diverse population. Equity and redress, diversification of programmes and multiple entry and exit points support a more flexible, accessible and less fragmented education system, which is not only accessible to the elite, but also for the masses (NCHE 1996:online).

It is claimed that a move away from self-reliance to the recognition of interdependence between multiple actors in HE will result in co-operative relationships and partnerships. This requires a move from closed to open knowledge systems, flexible boundaries and interactive perspectives integrated in the social context, which in turn could result in greater participation by all sectors and the incorporation of previously silenced groups. A more dynamic interaction between HE and society could lead to greater responsiveness to societal interests and needs. In order to meet the development needs of society and to address the learning needs and desires of individuals, HE have to undertake research across disciplines, generating knowledge that contributes to a better quality of life for all, as well as the socialisation of trained, open-minded and accountable citizens committed to citizenship and the common good (Department of Education 1997:4; Kraak 2000:26; NCHE 1996:online).

The White Paper on the Transformation of Higher Education (Department of Education 1997) laid the foundations for making CE an important part of South African HE. It calls on HEI to "demonstrate social responsibility ... and their commitment to the common good by making available expertise and infrastructure for community service programmes". It states that one of the goals of HE is "to promote and develop social responsibility and awareness among students of the role of HE in social and economic development through community service programmes". It shows receptiveness to "the growing interest in community service programmes for students" and gives in-principle support to "feasibility studies and pilot programmes which explore the potential of community service in HE".

Furthermore, there is a renewed political commitment in South Africa to develop primary care and a call for fundamental reform in medical education to support this. New challenges are posed to the education of future doctors with the increased focus on health rather than disease and the need for socially relevant training, changes in disease patterns and the redistribution of health care resources. Medical students will not be sufficiently competent to cope with these changes without the restructuring of current curricula in term of content as well as method of training (Mash & De Villiers 1999:725).

Over the past decade, numerous national organisations have been suggesting CE in health professions schools as an essential strategy for improving health professions education, achieving a diverse health force, increasing access to health care, and

eliminating health disparities. CE is now extensively seen as fundamental to the mission and purpose of health profession schools (Commission on Community-Engaged Scholarship in the Health Professions 2005:5). The re-orientation of health professions education to an inclusive primary health approach was called for in the White Paper on the Transformation of the Health Care System in South Africa (Department of Health 1997:34–36) and CBE is recommended as a strategy to implement this approach. Authors such as Frank *et al.* (2005:283) and Nokes *et al.* (2005:44) argue that the education programme for Health Professionals should deliver graduates who are prepared for community settings as a result of the move from fixed institutions, such as hospitals, to varied settings in the community.

According to Boelen (2008:52) the most important and difficult challenge in medical education is social accountability. Boelen and Woollard (2011:615) explain that the term *social responsibility* of an educational institution implies awareness of duties regarding society and the term *social responsiveness* is the engagement in a course of actions responding to social needs. The term *social accountability* adds a documented justification for the scope of undertaken actions and a verification that anticipated outcomes and results have been attained. While the goal of medical education is the care of the patient, education should be directed towards health priorities which the community identified. Yogeswaran, O' Mahony and Mfenyana (2011:287) affirm that although CBE can be implemented, there will be no benefit to society unless there is social accountability. Social accountability for medical schools can be defined as "The obligation of medical schools to direct education, research and service activities towards addressing the priority health concerns of the community, region or nation that they are mandated to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public" (GCSA 2010:15).

Health professionals should improve health care systems through education and be responsive to the needs of the population that they serve. A number of governments, including SA, have issued definite guidelines for changes in medical education to prepare graduates for work in health systems, to address the health needs of families and communities and to assist in improving access to health services in places and under conditions that advance general well-being. These guidelines require students to demonstrate abilities, perspectives and resourcefulness consistent with continuing education and capacity to promote health. They also require more attention to be

paid to building links between educational institutions and the health sector (Mennin & Petroni-Mennin 2006:91).

In summary, HEIs globally are confronted with the challenge of not only generating new and dependable knowledge through research, but socially vigorous knowledge as well. In this regard educational transformation, such as innovative pedagogies and CE become increasingly important. South Africa faces similar challenges within its own unique multicultural milieu and better relations between HE and society can lead to greater responsiveness to societal interests and desires. Furthermore, there is a fundamental call for the restructuring of medical education to achieve a more diverse health force, increase access to health care and to eradicate health inequalities. Crucial health concerns are to be identified together by governments, health care organizations, health professionals and the public.

2.3 COMMUNITY ENGAGEMENT

If HEIs wish to remain relevant and continue to contribute to the common good, the needs and challenges of communities need to be identified accurately, and addressed sustainably within the scope of scholarly engagement and in so far as their resources allow it. This will only be possible if HEIs purposely shape engagement to “make communities active participants in knowledge activities – in its creation, dissemination and utilisation” (Bawa 2003:48).

Well-coordinated CE will also include service sector partners (public or private service), who can contribute to the viability, sustainability and continued partnership within the CE endeavour.

The model depicted in Figure 2.3, adapted from Bringle (1999) and taken from Lazarus *et al.* (2008:21) suggests different ways in which HEIs may participate in scholarly CE.

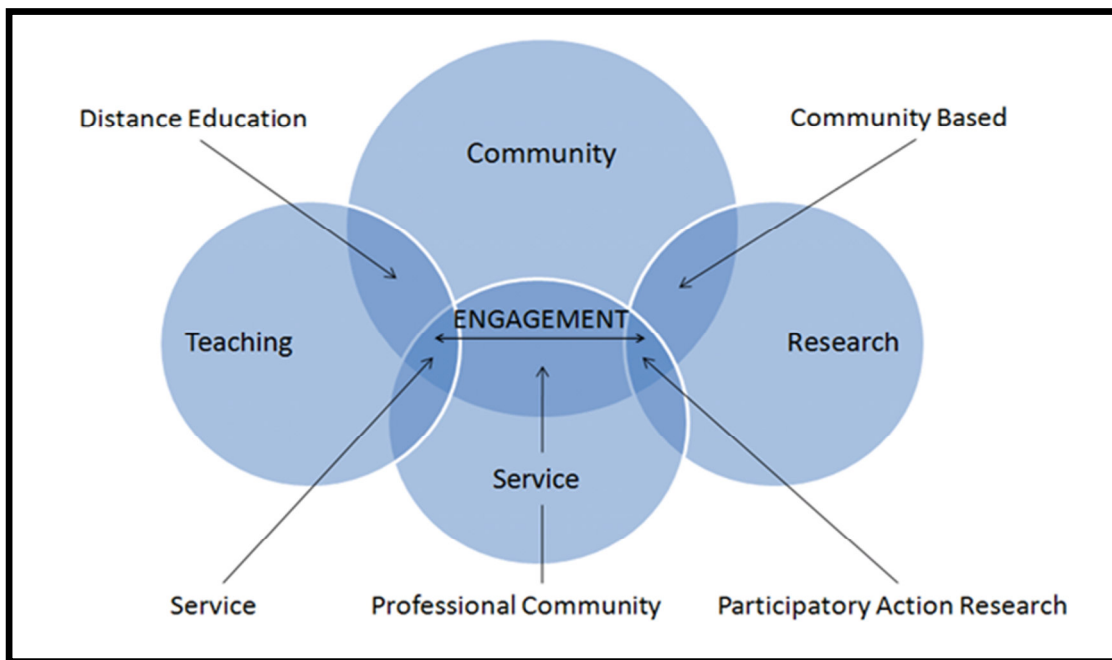


FIGURE 2.3: TYPES OF COMMUNITY ENGAGEMENT
 [Source: Lazarus *et al.* (2008:21)]

The following section provides a brief outline of the constitutional, policy and professional directives that guide CE. All the information was taken from HEQC (2006:1-12) unless stated otherwise.

- *Green Paper on Higher Education Transformation* (Department of Education 1996) pointed out that HEIs in South Africa do not contribute sufficiently to cultivating a culture of tolerance; neither is there sufficient consideration of and contribution to community needs. It calls for programs and teaching methods that are more **responsive to these needs** and that increases participation in HE.
- *Education White Paper 3: A Programme for the Transformation of Higher Education* (Department of Education 1997) requires HEIs to “**promote social responsibility** and awareness amongst students of the role of HE in social and economic development through community service programmes” and also promises support of development of community service.
- The Founding Document of the HEQC (2001) states that the key objective of the HEQC is to ensure the implementation and quality assurance of the three core functions of HEIs, these being teaching, research and **community service**.
- The HEQC Institutional Audit Framework (2004a) and Institutional Audit Criteria (2004b) call for the **integration of CE with teaching and research**. It calls HEIs to have policies in place, make resources available for SL and monitor the impact and effectiveness of SL programmes.

- The HEQC (2004c) Criteria for Programme Accreditation requires the integration of SL programmes into “**institutional and academic planning** as part of the institution’s mission and strategic goals” as well as the availability of “enabling mechanisms to support implementation of SL”.
- JET Education Services Survey (Perold & Omar 1997; Perold 1998) identified the common difficulties and **stumbling blocks** of HEIs in implementing SL.
- The JET-CHESP Initiative were launched in 1999 with the aim to **support, monitor, assess and research** the implementation of CE and SL programmes (HEQC 2006).
- Vice-Chancellor’s Meeting (JET 2000) highlighted the various roles of role-players in HEIs, but most importantly highlighted the purpose of HEIs as educating for good citizenship and striving for a **scholarship of engagement**.

In addition, the Community Service Policy of the UFS (2006:online) envisions CE in the form of a “pioneering approach that is increasingly integrated with teaching, learning and research”. The policy therefore indicates that CE does not stand alone, but with the traditional pillars of education at a HEI. The policy defines CE as “continuously negotiated collaborations and partnerships between the UFS and the interest groups that it interacts with, aimed at building and exchanging the knowledge, skills, expertise and resources required to develop and sustain society” (UFS 2006:online).

At the FHS at the UFS, SL and CBE together has become the “engagement tool” of choice for CE in order to address the needs of the community and to prepare students for future work in rural and underserved communities.

From the summary above it follows that CE is essential for HEI and that the needs and challenges of communities need to be identified correctly and dealt with effectively and sustainably. The different constitutional, policy and professional directives that guide CE in South Africa were summarised in this section.

2.4 CONCEPTUALISATION AND CONTEXTUALISATION OF COMMUNITY-BASED EDUCATION AND SERVICE LEARNING

2.4.1 Community-Based Education (CBE)

2.4.1.1 *Definition*

A term that is inseparable from CBE and needs to be explained first is Community-Orientated Medical Education (COME).

Community-Orientated Medical Education (COME)

Hamad (2000:15) states that COME is an approach to medical education, just as primary health care is an approach to the health system. White (1972) as quoted by Hamad (2000:15) defines COME as "relevant medical education, which takes into consideration in all aspects of its operations the priority health problems of the country in which it is conveyed". COME aims to focus health professions education on the priority health problems of the society in which the educational institution is based (Kristina, Majoor & Van der Vleuten 2004:511).

Community-Based Education (CBE)

The WHO (1987:11) and Kristina *et al.* (2004:511) define CBE as a means of implementing a community-orientated educational programme. It consists of learning activities that take place within communities and can be conducted wherever people live, be it in a rural, suburban or urban area (Hamad 2000:16; Howe 2002:9).

Since the difference between COME and CBE is not very clear, Magzoub and Schmidt (2000:27) made the following distinction: Community-orientation refers to the objectives of the school and their relevance to the community health needs and are reflected in the content of the curriculum. This means that the subject-matter studied by the students has direct relevance to the priority health needs of the society for which these students are trained. CBE, on the other hand, refer to the learning activities that take place in particular community settings. The activities undertaken in the community setting may, or may not be relevant to the communities' health needs.

A curriculum can thus be considered community-based without being community-orientated.

In addition, Wojtczak (2002:217) defines CBE in the context of medical education as a form of instruction where trainees learn professional competencies in a community setting focusing on population groups and also individuals and their everyday problems. Instruction may take place at a general practice, family planning clinic, community health centre or a rural hospital.

For the purpose of this study, the researcher concurs with Wojtczak's definition and defines CBE as a form of instruction where students learn professional competencies in community settings, focusing on individuals and groups and their everyday problems. At the Faculty of Health Sciences, UFS, CBE takes place at the National District Hospital as well as at various primary health care clinics.

2.4.1.2 *Societal perspectives underlying CBE*

In the following sections, the various perspectives that gave rise to the idea of COME and CBE will be discussed. These include ethical, social, political and educational perspectives.

Ethical perspectives

Beauchamp and Childress (1994:34) identify four principles in medical ethics including respect for autonomy, beneficence, non-maleficence and justice. These four prima facie principles include most of the moral issues that arise in health care and are mainly intended in individual patient's health care. "Prima facie," a term introduced by the English philosopher W.D. Ross, means that the principle is binding unless it conflicts with another moral principle - if it does we have to choose between them (Gillon, Lloyd & Williams 1994:830). Additionally, these principles can also serve as a good framework for the ethical issues that gave rise to COME.

Respect for autonomy means respecting people's thought, will, intention and action. In health care respecting people's autonomy has many prima facie implications; it necessitates health care workers to consult people and obtain their agreement before taking action and help them and involving them in decision-making. This involves good

communication skills to provide people with adequate information about any proposed intervention and for finding out whether people would like that intervention (Gillon *et al.* 1994:831; Morgan, Smedts, Campbell, Sager, Lowe & Strasser 2009:3).

Since people's needs are best expressed by themselves, continuous attempts are put into action to bring that goal into reality, by for example, active involvement of communities in primary health care and health professions education. According to Ezzat (1995:46) and Morgan *et al.* (2009:3) this role is being loudly promoted, which requires consultation of people in curriculum planning and response to their real community health needs. The communities are partners in prioritising health problems for educational purposes and share actively in planning, implementation and evaluation.

Gillon (1994:online) states that the traditional Hippocratic moral obligation of medicine is to offer medical benefit to patients with minimal harm - that is that beneficence with non-maleficence. According to him, it means that health professionals need accurate, effective and relevant education and training, both before and during their professional lives. This moral duty is self-explanatory and evident in the case of CBE which strives for relevance in health professions education to make it effective and responsive to real community health needs.

The fourth *prima facie* moral principle is justice and it can be subdivided into three subcategories, namely fair distribution of scarce resources (disruptive justice), respect for people's rights (rights-based justice) and respect for morally acceptable laws (legal justice). In reality this moral principle is not properly applied in many health systems all over the world, with large variations in health service provisions within geographical areas in both developed and developing countries (Kristina *et al.* 2004:511; Magzoub & Schmidt 2000:32).

Various authors (Farnsworth, Frantz & McCune 2012:5; Kristina *et al.* 2004:511; Magnus & Tollan 1993:252) agree that one of the primary goals of CBE is equitable distribution of health personnel and to graduate community-orientated health care professionals who are able and prepared to work in underserved areas. CBE uses many strategies to target fair distribution of health personnel and health services, including establishing medical schools in rural areas; training students in primary care settings

and rural area postings and, finally, selecting students from rural areas to be trained in the localities.

Social perspectives

According to Magzoub and Schmidt (2000:32) the WHO defined health “as a complete physical, mental and social well-being and not merely absence of disease or infirmity”. The social aspects of health are captured in this definition. The association between health and social issues is well-established and the differentiation in health services coverage among different social and ethnic strata is found all over the world.

Furthermore, cultural factors also play a significant role in health services utilisation and shaping behaviour and attitudes of people towards health interventions. In every community there are certain indigenous cultural forces that influence behaviour and attitudes towards choices on the available health services including self, traditional and modern health services (Hunt, Bonham & Jones 2011:246; Magzoub & Schmidt 2000:33).

During CBE students get the opportunity to recognize all these factors while they work and live in underserved communities and amongst ethnic minorities. As part of their training, students perform family visits and conduct community postings as well, where they consider all social and cultural factors that pertain to ill health. Some medical schools offer service to rural people while students are trained in the community, thus contributing to solving the problems of maldistribution of services even as early as undergraduate training (Hunt *et al.* 2011:246; Magzoub & Schmidt 2000:33).

Political perspectives

Ezzat (1995:46) explains that there has been a movement towards recognition of people’s rights in basic social services, including health during the past few decades. The empowerment of human rights and the democratic changes in developing countries gave rise to drastic social and political changes. According to the WHO (1977:9) the main medical and social target of countries should be the attainment of a level of health for all people that will allow them to live a socially and economically productive life. Countries who participated in Alma Ata are politically committed to primary health care to attain a level of equity and fair distribution of health services

(WHO 1977:9). For this goal to realise there must be good collaboration between government, universities and the communities. Several positive outcomes are anticipated from initiatives such as increased accountability of universities, relevance of health professions education, improvement of health services and promotion of communities' self-reliance and empowerment (Ezzat 1995:48; Farnsworth *et al.* 2012:5).

Educational perspectives

Traditional models of medical education are no longer suitable for graduating health professionals that are responsive to community health needs. According to Farnsworth *et al.* (2012:3) and Magzoub and Schmidt (2000:34) most medical schools had lost touch with the needs of society, focusing instead on hospital care and high technology rather than the patient, the social context in which treatment must occur and the health needs of the community. This lead to educational reform and change in medical education as well as in medical practice, that is aimed at education that is relevant to community health needs. Evaluation of many CBE programmes (Kristina *et al.* 2006:782; Wallace, Berlin, Murray & Southgate 2001:164) showed that graduates from such institutions are not less knowledgeable, but more advanced than others in terms of humanistic values.

2.4.1.3 Rationale for CBE

The rationale of CBE can be summarized as follows:

- i. According to Magzoub and Schmidt (2000:33) CBE can assist with the problem of inequity in service delivery. CBE is seen as an important approach to train doctors who are willing and able to work in underserved areas and particularly rural areas (Kristina *et al.* 2004:511; Magnus & Tolan 1993:250; Tavernier, Connor, Gates & Wan 2003:300). On the other hand, CBE does not only provide answers to the imbalance of health services by graduating health professionals who are committed to the community, but also provides health services to the community as soon as students begin to learn in the community (Farnsworth *et al.* 2012:1).
- ii. Farnsworth *et al.* (2012:1) and Magzoub and Schmidt (2000:35) argue that CBE presents students with unique opportunities to learn in an environment that typically resembles what students will come across in their later professional life,

which, in turn, will improve their performance. Furthermore, the authors argue that students understand, process and retrieve information better if they have the opportunity to elaborate on it. CBE provides an opportunity for students to elaborate on information, since the community will consider them as experts and ask them questions and discuss possible health problems with them.

- iii. CBE can equip students with possible competencies and skill which they might not have learnt otherwise e.g. leadership skills, the ability to work in a team and communication skills. Through CBE, students have the distinctive opportunity to apply these skills, which are essential for their professional life later (Magzoub & Schmidt 2000:35).
- iv. Farnsworth *et al.* (2012:1) add that students get exposed to a wider variety of patients with more opportunities to develop and practice clinical skills with greater continuity across a broader continuum of care.
- v. Student assessment may also improve through CBE, because the community setting provides an opportunity to assess student competencies in context, e.g. communication, management and leadership skills. The community is also a source of independent assessors for both students and the programme (Magzoub & Schmidt 2000:35).
- vi. Different authors (Magzoub, Magzoub & Saeed 1992:106; Hunt *et al.* 2011:248) affirm the importance of all health professionals working in a harmonious team. They further state that this cannot be achieved without mutual respect between team members and the recognition and appreciation of everybody's role. CBE offers students an opportunity to learn and work with other health professionals in for instance, primary care units.
- vii. Magzoub and Schmidt (2000:36) argue that according to the WHO (1987:13) health is defined as a complete physical, mental and social state of well-being and not merely the absence of disease. This definition implies a holistic and multi-disciplinary approach to health care as well as the contribution of other sectors to the improvement of the health status of the population. CBE offers students the opportunity to practice a multi-disciplinary and holistic approach to health care, while assigned to work in rural health facilities (Hunt *et al.* 2011:246).
- viii. CBE, in addition, renders opportunities for partnership between the community, university and government. This gives the university political and moral support to realise its objectives and to play an essential role in decision-making concerning the promotion of the health system and services in the community (Magzoub & Schmidt 2000:36; Morgan *et al.* 2009:3).

2.4.1.4 *Taxonomy of CBE*

The implementation of various CBE programmes across the world is quite diverse. Each institution has a unique approach to CBE, although it may share general goals and experiences with others. The main reason is that the learning is based in communities and communities can be quite different. Furthermore, the national educational system within which the school is operating, the administrative and political set-up of the institution and the resources allocated to CBE are all important factors in planning, implementing and eventually shaping CBE programmes (Magzoub & Schmidt 2000:103). A taxonomy of CBE is thus important to structure one's thoughts when discussing issues in relation to CBE. Prinsloo (2004:21) argues that the ultimate goal of CBE is to support the public health care approach by using a psychosocial approach in health care focusing on population-based public health. This, however, does not imply that CBE can only be done in public health care settings or only supports the public health care approach.

From the aforementioned differences it is clear that there is a need to classify CBE. According to Magzoub and Schmidt (2000:103) there are two reasons for the classification. First, one of the criticisms voiced against CBE is that this type of learning does not have a scientific basis. Secondly, classifying CBE can help develop guidelines for the implementation thereof. Earlier classification attempts differentiate between CBE, which is described as learning activities that utilize the community comprehensively throughout the educational experience, and community-based activity, which is short, isolated educational activities that occur in community settings (Magzoub & Schmidt 2000:103). The taxonomy for CBE, proposed by Magzoub and Schmidt (2000:105), is based on three main categories: It distinguishes between programmes that are primarily service-orientated, programmes that are research orientated and programmes that are training focused. In addition, it introduces six sub-classifications. The taxonomy is based on the nature of activities carried out by the student in the community as well as the level of faculty and community involvement in the programme (Figure 2.4).

Service-orientated programmes

Magzoub and Schmidt (2000:105) explain that the focus of service-orientated programmes are on service delivery through students and staff and the services range

from services in primary care units to broader community development services through community mobilisation. Services are usually based on prior needs and resources assessment. These programmes can further be subdivided into health intervention programmes and community development programmes.

Research-orientated programmes

In this category, staff and students are mainly involved in studying the problems of community health. The research aspires to address health care delivery problems and at making informed decisions. These programmes can be subdivided into community-based research programmes and health facility-based programmes and the only difference between them is the site for research (Magzoub & Schmidt 2000:105-109).

Training focused programmes

The focus of programmes in this category are on student training in the community setting, be it a primary care unit, a defined community or a working environment. The main challenge for these programmes is to produce health care professionals who are able to work in underserved areas. Training-focused programmes can further be divided into primary care-based programmes and community exposure programmes. Primary care-based programmes are largely for clinical training of students taking place in primary health care facilities. These programmes may offer some services through their students and staff and may contribute to the improvement of health facilities utilised by the programme. In community exposure programmes, time related to a community is minimal compared to other approaches and the students are mostly observers or might be involved in data collection of other tasks of limited duration e.g. measuring blood pressure of community members in a day or two (Magzoub & Schmidt 2000:105-109). The CBE component of the M.B.,Ch.B curriculum in the FHS, UFS could be classified as mainly a training-focused CBE programme with most of the CBE activities taking place in Primary Health Care (PHC) settings. There are, however activities in the curriculum that can be classified as services-orientated and research-orientated.

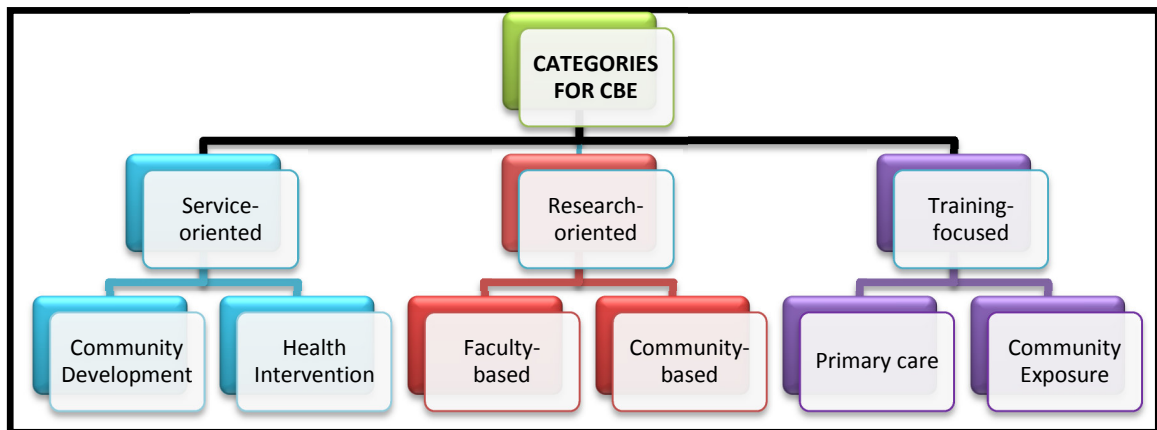


FIGURE 2.4: TAXONOMY OF CBE
 [Source: Magzoub & Schmidt (2000:106)]

2.4.1.5 *Determinants and pre-requisites for success in CBE*

There are various determinants and pre-requisites for success or failure of CBE. Prinsloo (2004:23) acknowledges that there are different role players involved in CBE partnerships including the student, the community, the services and the lecturers/faculty. A deficit or problem relating to one of these role players would ultimately influence the learning process. Each of these role players has its own objectives and terms of reference. The student wants to be trained to become a professional, the community needs services and the lecturer/faculty must teach and train professionals with the important knowledge, skills and attitudes to serve in a community they work in. Optimal involvement and satisfaction of all role players will enhance success (Prinsloo 2004:23).

2.4.1.6 *The roles of the different partners in CBE*

The role of the university

In order for CBE to be successful it is important that the vision and mission of the university should endorse public accountability. Policy guidelines regarding curriculum, funding, logistics and administration are essential to the success of CBE and therefore CBE will have limited success without the commitment from top management (Prinsloo 2004:23). The vision, mission and values of the FHS, UFS support CBE.

According to Bryant (1993:217) universities and medical schools should leave their protected environments and venture into the world to grapple with problems of society and take responsibility for the health of their local populations.

The role of the student

The role of the student in CBE, according to Prinsloo (2004:24), is to learn from all partners, conduct research, contribute towards community development programmes and to be an active partner in the planning and implementation of CBE.

The role of the community

The community is an essential partner in the CBE programme and when selecting communities to participate in CBE activities they should realise their responsibility. The university/faculty should also become conscious of and acknowledge the strengths and potential contributions that the community can offer, such as academic/service site identification, participating in planning programme activities, sharing resources, and mobilising community participation in service training planning (Prinsloo 2004:24).

According to Magzoub and Hamad (2000:247) sustainable community involvement is crucial and therefore it is vital to evaluate the community's satisfaction with the CBE process continuously.

The role of the health services

The services should participate in the planning and implementation of training. Service personnel contribute to the training of students by being involved in supervision of students, facilitation of multi-professional and multi-sectorial collaboration, providing maintaining and sustaining public health care facilities and services and providing policy guidelines at national and provincial levels (Prinsloo 2004:25).

2.4.1.7 *Perceived benefits and returns to partners*

Hamad (2000:18) affirms that one of the justifications of CBE arises from its perceived benefits to students, the faculty, the educational institution, the health services and the society at large.

Students have the opportunity of working together as a team and of applying their theoretical knowledge straightaway in real-life situations outside the class-room or teaching hospital into the community and in a continuing fashion, thus motivating them for learning. They learn how to communicate effectively on different levels within the community, how to make a community diagnosis, initiate action and involve and organise people in the service of health. In addition, students get to learn more about cultures and the multi-disciplinary team, which allows for recognition and appreciation of the role of each member. Students are also expected to develop more sense of responsibility and leadership than their peers in traditional medical education (Hamad 2000:18). Kristina, *et al.* (2004:511) argues that the breadth of exposure to different pathologies and cases are wider in primary healthcare facilities. There is a huge discrepancy between the types of patients seen by students in the clinical teaching hospital and the characteristics of patients who present to primary health care facilities, and the relevance of undergraduate medical education greatly improves when students are also exposed to health problems in different community settings.

Hamad (2000:18-19) further states that the faculty (teaching staff) gain experience in teaching and research that is relevant to their country through their full participation in CBE activities and programmes, while they also fulfil their responsibility to develop the community. The role and credibility of the educational institution become more visible to society, which in turn improves the image of the institution. At the same time, the institution acquires more in-depth information on the local community (and the country) which assists the institution in planning its educational and research programmes as well as any health-intervention activities.

The community contributes to its own development, as a result of being actively involved in the solution of its problems (identification, prioritisation, posing feasible solutions options, selecting appropriate intervention and planning, implementation, monitoring and evaluation of intervention). Furthermore, communities become aware of health and health-related matters and have the opportunity to become self-reliant, empower their community and for sustainable development (Hamad 2000:18). CBE may assist in expanding health services to target communities and eventually motivate graduates to work in health services for medically-underserved communities (Kristina *et al.* 2004:511).

2.4.1.8 Programme design and development

Key steps in the development of a CBE programme as summarised by Morgan *et al.* (2009:3) include:

Engagement with key partners and stakeholders

CE is the foundation stone of successful CBE programmes. A community consultation should be conducted with key partners and stakeholders at the onset of a new programme. The consultation process can be used to highlight the potential strengths and weaknesses of the programme, emphasise the importance of vertically integrated learning and also help determine the overall aims of the programme.

Establishment of the CBE team

Two key preliminary steps are to appoint an academic to develop and lead the new programme and the establishment of an inter-professional academic team that will be responsible for the supervision and training of students.

Development of aims and action plans

The aims of the CBE programme can be developed through the amalgamation of the relevant aspects, including the strategic aims of the Medical School, the respective curriculum, the findings of the consultation process and a review of the literature. Following the formulation of aims, a plan for the development and implementation of the new programme can be developed, consisting of the key objectives, actions and targets.

Development of a curriculum framework

Adaptation to the current curriculum is necessary to reflect the particular characteristics of the different locations and programmes. The development of a new framework for curriculum delivery, attempting to best match the required learning objectives with the available learning opportunities in each setting is necessary. This process needs to be done through consultation with all the stakeholders involved in the programme.

Multi-disciplinary teaching

One of the strengths of a CBE programme is to provide students with the opportunity to see the patient care pathway span a range of services and especially to experience teaching by non-medical teachers. Consequently the incorporation of a range of non-medical, professional community health care workers into the curriculum is recommended.

Recruitment of training placements

A recruitment process should be followed to recruit health care facilities where students can be placed. The health care workers at these recruited sites need to be trained on teaching skills, curricula and assessment skills.

Social responsiveness

Another aspect that influences curriculum development is the obligation to social responsiveness. This includes the development of an ongoing programme in the community which aims to provide complementary clinical health services to communities in order to address the most pressing health issue of the respective community.

Patient encounter log

In order to assess clinical exposure in community settings, a patient log book can be used to capture students' encounters with patients. Students are required to document the basic demographic profile, presenting symptoms, working diagnosis and management of the patient. Students can also be requested to identify the learning objectives from each encounter. Data can be used to support student learning, monitor attendance and as a tool for reflection and feedback.

2.4.2 Service Learning (SL)

2.4.2.1 *What is Service Learning?*

While reviewing the literature, the contested nature of SL became evident in the disagreement related to its terminology. Some researchers prefer SL while others

favour CSL (Community SL). According to Coetzee (2010:48) the difference lies only in the researcher's and practitioners' preference and the terms can be used interchangeably. The term used generally in the FHS at the UFS is SL.

SL is a form of experiential learning and can be seen as one way to integrate CE into the curriculum. Figure 2.5 shows the various forms of service programmes (of which SL is one) that can be used in experiential learning, as illustrated in Furco (2000:10).

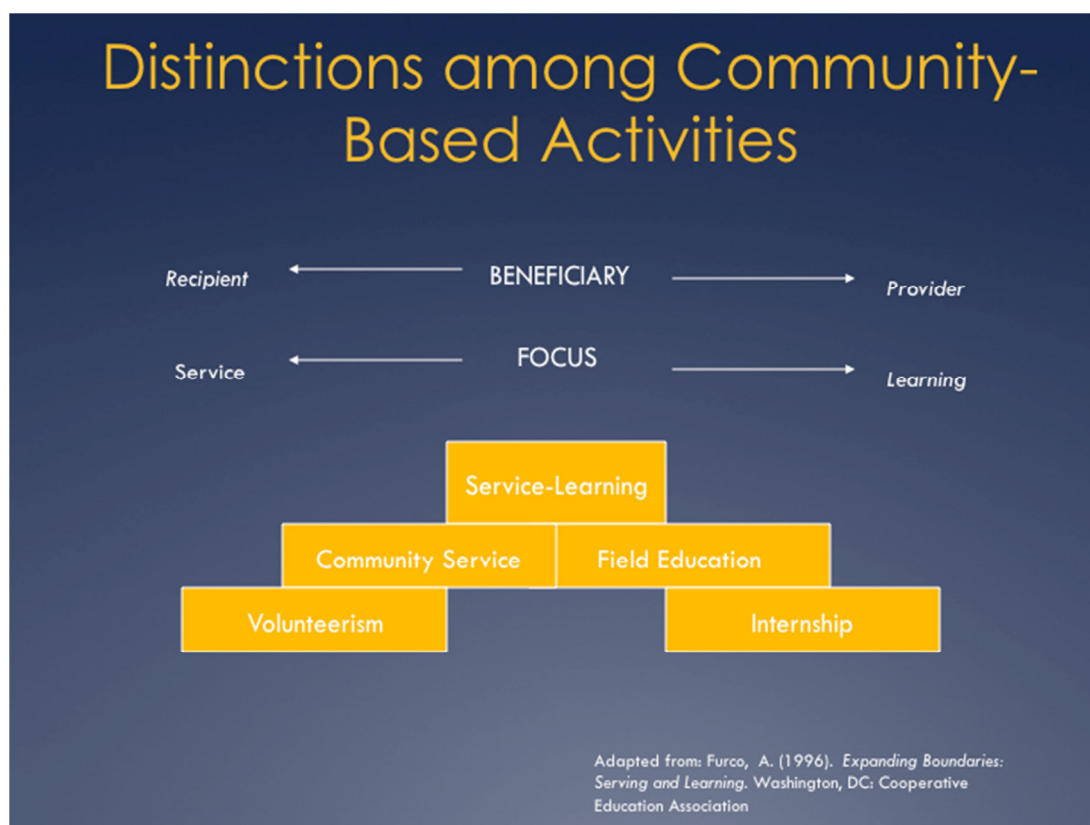


FIGURE 2.5: DISTINCTIONS AMONG SERVICE PROGRAMMES
[Source: Furco (2000:10)]

There are two key focal points in this typology. Firstly, who is receiving the benefits and secondly, where does the focus lie? Furco (2000:10-12) describes the difference between the programmes as follows:

Volunteerism, to the left of the typology, is a purely altruistic activity where the primary emphasis is on the service being provided and the primary intended beneficiary is the service recipient. The focus is on the service given and not on learning; if learning does occur it will be unintentional, not integrated into a module and not related to any specific learning outcome. During **community outreach** the main goal is to provide a service to the recipient/community, who then is the primary beneficiary. It differs from volunteerism in the sense that it is more structured and

generally initiated by a faculty or department in a HEI. Academically-based community outreach programmes are sometimes related to, and integrated with academic work (Furco 2000:10-12).

On the other extreme of the continuum, **internships** focus on activities that engage students in service activities primarily for the purpose of providing students with hands-on experience that enhances their learning or understanding of issues relevant to a particular area of study. The primary intended beneficiaries are the students and the primary goal is student learning. Internships are generally an integral part of the curriculum. In **co-operative education**, as with internships, the primary beneficiary is the student and the primary goal is student learning. It consists of co-curricular opportunities which are related, but not always fully integrated into the curriculum and mostly provides pre-professional opportunities in the industry to students (Furco 2000:10-12).

In the middle of the typology, representing the balance between the different goals and beneficiaries is **Service Learning**. It places equal focus on the service being provided and the learning that will take place and both the community, and the students are the main beneficiaries. Reciprocity is the central feature of SL (Furco 2000:10-12).

2.4.2.2 Defining Service Learning

The definition for SL from Bringle and Hatcher (1996:222) is the one cited most and they view SL as a "course-based, credit bearing educational experience in which students participate in an organised service activity that meets identified community needs and reflect on the service activity in such a way as to gain further understanding of course content, a broader appreciation of the discipline enhanced sense of responsibility".

Another popular definition of SL is provided by Eyler and Giles (cited in Mouton & Wildschut 2005:118): "...SL is a form of experiential education where learning occurs through a cycle of action and reflection as students work with others through a process of applying what they are learning to community problems and, at the same time, reflecting upon their experience as they seek to achieve real objectives for the community and deeper understanding and skills for themselves".

In the UFS policy, SL is defined as “an educational approach involving curriculum-based, credit-bearing learning experiences in which students (a) participate in contextualised, well-structured and organised service activities aimed at addressing identified service needs in a community, and (b) reflect on the service experiences in order to gain a deeper understanding of the linkage between curriculum content and community dynamics, as well as achieve personal growth and a sense of social responsibility. It requires a collaborative partnership context that enhances mutual, reciprocal teaching and learning among all members of the partnership (lecturers and students, members of the communities and representatives of the service sector)” (UFS 2006:9).

In this study SL will be defined according to the definition provided by the UFS.

2.4.2.3 *Theoretical approaches to understanding Service Learning*

SL is a form of experiential learning. This pedagogy was advocated by Dewey in the early 1900s and is based on the hypothesis that learning will occur more effectively if the learner is involved in the act of learning. Dewey did not use the term SL or CSL, but many of his thoughts can be related to the concepts (Saltmarsh 1996:15).

According to Saltmarsh (1996:15), Dewey’s educational philosophy laid the foundation for a pedagogy connecting practice and theory. He disagreed with the idea that the learner is a passive recipient of knowledge and that little regard should be given to past experiences and argued that all educational activities should involve the learner through active participation and in experiences that are linked to the knowledge that has to be acquired. The learner’s attitude to future experiences will then be influenced by these experiences and it will have an effect on the learner’s growth or stagnation. The learners should be taken outside the traditional classroom in order to be given the opportunity to interact with the natural environment. Dewey was also of the opinion that education should be linked to “social reconstruction” and viewed education as the primary means of transformation (Saltmarsh 1996:19).

In the 1980’s, a researcher in the field of experiential education, David Kolb, attempted an improved clarification of the integration of knowledge and experience as promoted by Dewey. Kolb (1984:41) defines learning as the process through which knowledge is created by means of transforming experiences. A combination of grasping experience

and transforming it thus results in knowledge. He proposed that learning takes place in a four-stage cycle involving four adaptive learning modes, namely concrete experiences, reflective observations, abstract conceptualization and active experimentation (Figure 2.6).

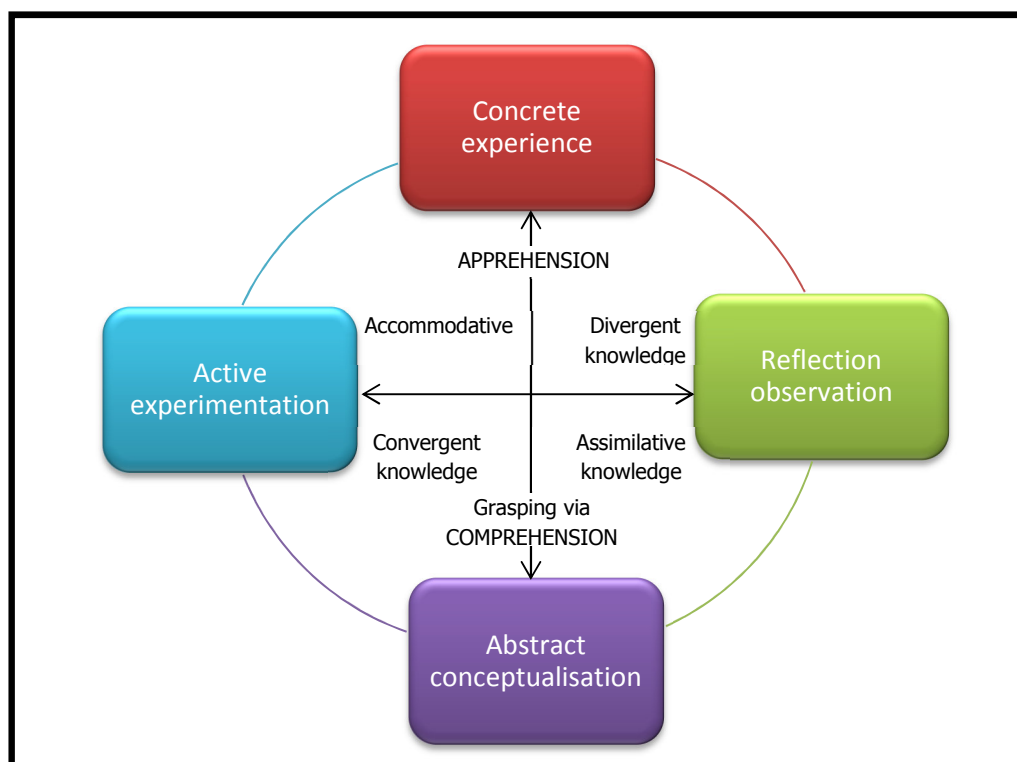


FIGURE 2.6: DAVID KOLB'S LEARNING MODEL
[Source: Kolb (1984:42)]

Kolb explains that in the learning cycle there are two opposing forms of prehension as well as two opposing forms of transforming prehension that result in four different forms of knowledge. Experience grasped through apprehension and transformed through intention results in divergent knowledge, while assimilative knowledge is gained through experience that is grasped through comprehension and transformed through intention. When experience is grasped through comprehension and transformed through extension, it results in convergent knowledge. And finally, experience grasped by apprehension and transformed by extension results in accommodative knowledge. Kolb is thus of the opinion that experience alone is not sufficient for learning; something must be done with it (Kolb 1984:42).

According to Kolb (1984:42) the sequence of learning is concrete experience; observation and reflection; the formation of abstract concepts and generalisations; and testing the implications and concepts in new situations.

Experiential learning theories form the underpinnings of SL and propose that learners remember more effectively when they actively do, or participate in the activities they are expected to learn about (Jordaan 2006:34).

2.4.2.4 *Key elements of Service Learning*

The HEQC (2006:25) summarises work by Howard (2001) as well as Stacy, Rice and Langer (2001) to identify four criteria that are essential for SL, namely relevant and meaningful service with the community, enhanced academic learning, purposeful civic learning and structured opportunities for reflection.

HEQC (2006:25) explains meaningful and relevant service to the community as service that meets an identified need which is relevant in improving the quality of life of the community and simultaneously assists in achieving module outcomes. The community should value students' interests and skills and they should view the service as worthwhile and necessary.

Enhanced academic learning means SL experiences must reinforce the achievement of learning outcomes. The HEQC (2006:25) elucidates that learning should not be incidental, but has to take place and should be clearly connected to the module objectives.

Purposeful civic learning refers to the preparation of students for community-based active public involvement in a diverse democratic society and therefore social responsibility (HEQC 2006:25). Mitchell (2008:50) reiterates the importance of linking classroom learning to concerns of social justice. SL 'serves as a vehicle' for connecting students and institutions to their communities and the larger social good.

The HEQC (2006:25) states that students need structured opportunities to reflect in order to relate community service experiences to the module. Reflection is a crucial element in transforming, clarifying, reinforcing and expanding concrete experience into knowledge and assists in gaining a deeper understanding of module content, a broader appreciation of the discipline and social responsibility.

2.4.2.5 *Service Learning vs. Traditional learning*

SL challenges educators to make a paradigm shift away from just teaching to learning. Some of the differences between traditional learning and SL are highlighted in the two tables below.

In Table 2.1 it is depicted that there is a clear distinction between the teacher and the learner in traditional learning. Students learn as a spectator from someone else's knowledge and learning occurs on an individual basis. Traditional learning is based on an objectivist epistemology. On the other hand, SL is portrayed in a different way, as students are viewed as participants who learn from theory, experience and personal knowledge. Co-operative learning is emphasised and there is a less hierarchical structure between students and teachers. SL is based on a connected/feminist epistemology.

TABLE 2.1: DISTINCTIONS BETWEEN TRADITIONAL LEARNING AND SERVICE LEARNING

TRADITIONAL LEARNING	SERVICE LEARNING
Theory	Theory and experience
Others' knowledge	Personal knowledge
Spectator	Participant
Individual learning	Co-operative learning
Distinction between teacher and learner	Blurred distinction between teacher and learner
Answers	Questions and answers
Certainty of outcomes	Heterogeneous outcomes
Ignorance avoided	Ignorance a resource
Objectivist epistemology	Connected/feminist epistemology

[Source: HEQC (2006:27) adapted from Howard 1993]

The differences between a traditional module and an SL module are also illustrated in Hay (2003:185). The focus of this researcher is somewhat different and is on aspects such as where the module takes place, the person teaching, preparation, how learning and assessment takes place and the architect of the module. This is shown in Table 2.2.

TABLE 2.2: SOME OF THE MOST DISCERNABLE DIFFERENCES INVOLVED IN SERVICE LEARNING PROGRAMMES

	TRADITIONAL COURSE	SERVICE LEARNING COURSE
Place	Classroom	Classroom, community, fieldwork-related experiences
Lecturers	Lectures on different levels	Lectures, supervisors, clients, peers, community leaders and other knowledgeable people
Preparation	Readings, previous courses	Expanded readings, previous courses, personal characteristics, site visits
Learning	Writing exams, cognitive short term, theoretical, passiveness, sequential, linear, structured learning, convergent thinking, deductive learning, usually assessed at the end of the course	Writing exams, cognitive and affective development for short and long term, practical, active, perplexity, non-linear, expansive and integrative, divergent thinking, inductive learning from experience, learning continues beyond the course
Assessment	Lectures on various levels	Lecturers, supervisors, self-assessment and even community leaders
Architect	Individuals	Teams comprising academics, members of the triad of students

[Source: Hay (2003:185)]

Hay (2003:25) compares traditional learning and SL by indicating where they share similarities and where they differ from each other in the above-mentioned aspects. In general, where there are similarities, SL has some additional aspects to the pedagogy, seemingly strengthening the choice of SL as a means of educating students. An example of this is where learning takes place. In traditional learning, the classroom is the focus and the area where learning takes place. In SL the classroom is also used for learning; however, it is not the only place where learning takes place as it can occur in the community and fieldwork-related experiences as well.

2.4.2.6 Benefits of Service Learning

According to Coetzee (2010:57) partnerships between academics (lecturer and students), the community and a service provider are formed during SL. Reciprocity is very important to the partnership and is based on the grounds that all members in the partnership are equal and that all work towards the same goals and receives benefits.

The benefits of SL for all partners involved can be summarised as follows:

Benefits for the University

- Enhanced teaching, research and outreach activities.

- Faculty and student engagement in local and state community issues.
- Opportunities to extend university knowledge and resources.
- Positive community relationships.
- Increased development and better preparation of university graduates.

Benefits for lecturers

- Inspiration for and invigoration of teaching methods.
- Increased contact with students through a greater emphasis on student-centred teaching.
- A new perspective on learning and an increased understanding of how learning occurs.
- Connection of the curriculum with the community and lecturers become more aware of the current societal issues related to academic areas of interest.
- Identification of areas for research and publication related to current trends and issues.
- Provision of authentic assessment opportunities.
- Redefinition of role from giver of knowledge to giver/facilitator of knowledge.
- Students are helped to structure knowledge and act on that knowledge.
- Enabling teaching to become more process-oriented.
- Interactive, involved students.
- Decreased at-risk student behaviour.
- Engagement of all learners.
- Improvement in students' academic achievement.
- Fewer disciplinary issues.
- Becoming more linked to the community.
- Making a difference in the community.

Benefits for students

- Use of hands-on skills and knowledge that increase the relevance of academic skills.
- Opportunities that accommodate different learning styles.
- Interaction with people of diverse cultures and lifestyles.
- Increased sense of self-efficacy and better analytical skills.
- Valuable and competitive career guidance and experience.

- Opportunities for meaningful involvement in the local community.
- Increased sense of civic responsibility.
- Students learn to apply principles from the module to new situations.
- Students develop a greater willingness to work towards the resolution of societal problems.
- Students develop problem-solving skills.
- Students gain competence by practising social-professional skills.
- Social development: increased interpersonal skills, indication of future CE.
- Academic/Cognitive: better grades and higher throughput rate.

Benefits for the community and service providers

- Students contribute to community development and renewal.
- Recipients benefit from direct aid.
- Students become invested in the communities.
- Communities have access to institutional resources.
- Positive relationships develop among universities and community.
- Community has an opportunity to contribute to the educational process.
- Community and service agencies receive an infusion of creativity and enthusiasm from students.
- The quality and efficiency of services offered to the community increase due to HEI assistance.
- The HEI, community and service agency build links.

(HEQC 2006:139; Stacey, Rice, Hurst & Langley 1997:33; Stacey, Rice & Langer 2001:28).

2.4.3 CBE and SL at the Faculty of Health Sciences, UFS

The Faculty of Health Sciences, UFS recognises the tremendous potential of CBE and SL to enhance health professions education, because both allow students to apply the information they learn in the classroom to real-world settings and provide an important venue for self-reflection. In addition, the FHS attempts to assist students in fully appreciating and embodying the very service ethic that underlies their chosen profession through CBE and SL and to produce graduates that are prepared to serve community settings.

CBE and SL contributed to the restructuring of clinical education in the FHS and various modules, utilising CBE or SL, are offered throughout the different study years across the different disciplines in the Faculty (cf. Table 3.1).

In summary, the concepts of CBE and SL were clarified in this section. These concepts were also contextualised and defined within the study to give the reader a clear picture of their relevance to the study. The terms CBE and SL clearly overlap and the themes of developing collaborative partnerships and finding opportunities to teach about community health and in community health care settings arose in the literature using both terms.

2.5 STUDENTS' EXPERIENCES OF CBE AND SL

2.5.1 Attitudes and perceptions

Throughout the history of social psychology, the term attitude has been defined in various different ways. Fabrigar, MacDonald and Wegener (2005:79) claim that central to most definitions is the idea that attitudes reflect people's evaluations of objects and vary from positive to negative. These authors further note that the most common understanding of attitudes is that it is the general evaluations people access from memory when called upon to do so, and it is temporary constructions, formed at the time people are asked to make attitudinal judgements.

Although attitudes are portrayed as simple object-evaluation associations, Fabrigar *et al.* (2005:80) explain that it may be part of bigger sets of knowledge structures. It can be illustrated with the following example: one might associate specific qualities with the presentation of the object and each of these qualities might in turn be associated with an evaluation. Similarly, one might link specific emotional reactions with an object and each of these reactions might be associated with an evaluation.

Attitudes are normally learned early in our lives, in social contexts; through an unconscious process and it influences our perceptions and views of certain things or processes (O'Donohue 1998:434).

Jordaan (2006:19) argues that an attitude is not consciously learned through instruction, but rather acquired by an individual over a period of time within a social

context and the environment in which a person lives. Lived experience influences an individual's attitude to objects and situations and has an effect on learning. Attitudes differ from person to person and cannot be manipulated, as they are also influenced by the personality traits that are individual attributes differing from one person to another. Positive people generally have a positive attitude, and negative people a negative attitude to things and the situations in which they may find themselves. Attitudes have a very definite influence on the outcomes of any learning programme or activities intended to take place in a social environment and aimed at effecting personal growth or social change. For this reason, attitudes have great significance for the implementation of such programmes or activities. Creating the conditions conducive to positive outcomes will have a positive influence on the attitudes and behaviour of the participants to the activities and in turn make a difference to the desired outcomes.

Meyer, Moore and Viljoen (2002:34) define perception as one of the basic elements of consciousness, describing it as the sensory perception that arises from all cognitive contents of consciousness. A perception as part of the cognitive person will therefore have a definite influence on the persons' cognitive contents and affect the person's behaviour.

As perceptions are also influenced by expectations and hypothesis, they are prone to error and may not always be correct (Eysenck & Keane 1995:45). Theorists generally take two approaches to the way they believe perceptions are formed: a top-down approach or conceptually driven process, as opposed to a bottom-up approach or data-driven process. Therefore, forming a perception is an active process which occurs through the stimulation of the senses and external experiences, and is the end product of such stimuli. A perception can be described as the information processing of cognitively received stimuli occurring in relation to the world one lives in. People are not all the same, and each individual views the world in a way that makes the most sense to him or her personally. The way we view the world is referred to as our perception. Perceptions have an influence on what we think, how we make decisions and define what we regard as most important (Eysenck & Keane 1995:66).

A person's attitude towards a construct and their perception thereof is unique and differ from individual to individual, but it is clear that it will ultimately have an influence on their experiences of that construct.

2.5.2 Influence of attitude and perception on learning

Learning is a cognitive process and will therefore be greatly influenced by the learners' attitude to and perception of a learning task, method or climate (Marzano 1992:online).

There is an intricate relationship between attitudes, perceptions and learning that has an effect on the students' ability to learn. If students have a negative perception of the learning environment, they will have a negative attitude to the learning that is anticipated to take place, which will inevitably result in less effort that is put into the tasks at hand and ultimately less learning that will occur. Students have little or no chance of learning effectively without positive attitudes and perceptions and therefore it is essential to establish positive attitudes and perceptions about the learning environment and the tasks that the students are required to perform (Marzano 1992:online). The author further states that positive attitudes and perceptions can be encouraged by creating a better classroom climate, ensuring the quality and quantity of resources and gaining the individual acceptance of the students.

2.5.3 How do students experience CBE and SL?

According to Elen and Clarebout (2004:267) students have two diverse perceptions of teaching. The first idea represents teaching as a didactic process of conveying knowledge, while the second view sees teaching as a process of facilitating learning - where the student takes responsibility for independent learning with the support of the teacher. These perceptions of teaching and learning will also have an influence on students' experience of the value of CBE and SL and will, in turn, determine their perceptions and attitudes towards this pedagogy.

Jordaan (2006:57) is of the opinion that students have to view the SL project as significant in order to be dedicated to and accountable in carrying out that project. Therefore it is important to understand the students' attitudes and perceptions when designing and coordinating SL and CBE courses/projects so that the maximum benefit

can be gained from this pedagogy.

According to Eyler and Giles (1999:287) participation in SL proved to be a factor that strengthens the attainment of course outcomes, while at the same time affecting students' attitudes towards social problems. In a study by Astin and Sax (1998:261), focusing on how undergraduates are affected by service participation, it was shown that undergraduate students' academic development, life skills development and sense of civic responsibility are substantially enhanced through participating in service activities. In general, the more time devoted to service, the stronger the positive effect.

Research by Bassi (2011:166) on undergraduate nursing students' perceptions of SL through a school-based project suggest that SL can contribute to students' growth and development while helping to teach the skills and values that students will need as they graduate and seek professional nursing roles. Students participating in the research reported that the SL project helped them link their theoretical knowledge about public health to actual practice, taught them community partnership skills and teamwork and introduced them to their role as a community-based nurse.

During a study on the experiences of final-year medical students during their exposure to primary health care, students stated that there was an improvement in their consultation skills; they had the opportunity to apply their theoretical knowledge; their capability to deal with undifferentiated patients increased; their confidence and self-esteem improved; they experienced the inefficiencies in the public health systems firsthand; developed an appreciation of primary health care and other disciplines; got exposed to community health problems and their innovation improved as a result of being involved in primary health care (Nyangairi, Couper & Sondzaba 2010:468-469).

In a study by Kaye, Mwanika, Sekimpi, Tugumisirize and Sewankambo (2010:50) on perceptions of newly-admitted undergraduate medical students on experiential training on community placements in rural areas of Uganda, many students gave positive views of CBE and were in favour of this being part of their medical training. Some of the reasons given were that it enables students to understand the medical conditions in rural areas, to see a variety of medical conditions (some of which are not seen in a teaching hospital) and to learn about the management of the health care system. Negative views on CBE included worries about absence of necessities, being cut off

from friends and colleagues, absence of guidance from faculty or any tutors, inadequate exposure to the variety of conditions which exists in a large teaching hospital and communication difficulties due to the inability to understand the local languages or cultures.

In summary, this section dealt with attitudes and perceptions and the influence they have on learning. The findings in a number of scholarly research articles on how students experience CBE and SL were also discussed in this section. The above-mentioned studies offer evidence that CBE and SL can be beneficial to students and their training and development as health care professions, but also recognise the challenges involved.

2.6 CONCLUSION

It is clear that integrating CBE and SL into a curriculum is not simply a matter of making students do some extra practical work, but entails intensive planning. CBE and SL could definitely add value to the training of health care professionals, provided that the pedagogy is understood and its value is recognised by students and academic staff alike.

In this chapter a literature study that was done to conceptualise and contextualise CBE and SL was discussed. In addition, the changes in HE, CE as well as students' experiences of CBE and SL were reported, providing a theoretical framework for the research questions at hand.

In the following chapter, Chapter 3, ***Research Design and Methodology***, the research design and methods applied will be discussed in detail.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter 3 provides an overview of the theoretical perspectives on the research design and methodology used to investigate what the experiences of Health Sciences students are during Community-Based Education (CBE) and Service Learning (SL) undertaken at the University of the Free State (UFS). In the first place, theoretical perspectives on the research design are provided. Thereafter, a discussion follows of the process of data collection, sample selection, pilot study and data analysis. Finally, issues of reliability, validity and trustworthiness as well as ethical considerations are discussed.

3.2 THEORETICAL PERSPECTIVES ON THE RESEARCH DESIGN

Before discussing the process followed to carry out this research, certain research terms that were used are explained. For the purpose of this study, the researcher explains three terms, namely, research design, research methodology and research approach.

In the case of a research design, the researcher agrees with Ebersohn, Eloff and Ferreira (2007:130) who state that a research design is a strategy of enquiry. The research design adopted in this study is a case study. In the case of the second term, research methodology, the researcher concurs with Mouton (2001:55) and Creswell and Plano Clark (2007:4) who describe this term as a process followed to conduct a study. The term research process is thus used in the context of this study to explain how the empirical investigation was conducted. Within this process, the term research approach is used to describe the quantitative and qualitative nature of the research referred to as a mixed-methods approach.

The research process that was followed in this study begins with a literature review followed by theory building. Thereafter, an empirical investigation, guided by the literature review and theory, was conducted. A nominal group technique and a questionnaire were used to collect data within a mixed-methods design. Subsequently,

quantitative and qualitative data were analysed separately by means of different approaches (cf. 3.3.2 and 3.3.3).

The following information is a description of the research design, theory building and research approach that was used, as well as how these were applied in the study.

3.2.1 Case-study design

Extensive collection of data are done to gain an in-depth understanding of a single phenomenon, a particular group, social setting, event or programme through a case-study design (Berge 2001:225; Burns 2000:460; McMillan & Schumacher 2001:391; Mouton 2001:149). Case studies can be selective, focusing on one or two topics that are essential to understanding the system being examined. The unit of analysis is a significant factor in a case study design, even though the analysis is focused on an individual or group of individuals, (Nieuwenhuis 2007:75). In this study, the particular group of individuals that will be studied are undergraduate students involved in CBE and SL initiatives in the Faculty of Health Sciences at the UFS with the focus being on one question, namely, how Health Sciences students experience CBE and/or SL in the FHS, at the UFS.

3.2.2 Theory building

According to Lynham (2002:online) theory building consist of two parts, with the first part being theoretical and the second part being the operational side of the cycle. This is seen as a continuous theory-research cycle. In the first part, the concepts of the theory are identified and these concepts represent variables whose interactions constitute the core of the theory. The next step in theory building is to specify how these concepts interact and relate to each other. Successful completion of the first part results in a conceptual or theoretical framework (Moagi-Jama 2009:80). In this study the conceptual or theoretical framework relied on literature as discussed in Chapter 2. The second part, namely the operational side of the cycle, included the empirical study and the findings and interpretation thereof.

3.2.3 Mixed-methods approach

According to Creswell and Plano Clark (2007:259) quantitative and qualitative research approaches differ in how knowledge is generated, but both these approaches can be applied to study the same research problem. In this study the research design that was used is a case study, which is a type of qualitative research (Babbie & Mouton 2001:279). However, according to Grix (2004:122) there is no reason why a researcher should not utilise methods associated with quantitative research in a case study. Data were collected, analysed and interpreted both quantitatively and qualitatively in this study. Both Johnson and Onwuegbuzie (2004:online) and Creswell, Shope, Plano Clark and Green (2006:online) state that where quantitative and qualitative data complement each other, a mixed-methods approach applies. In this research project both qualitative and quantitative methods were employed, by means of using the nominal group technique (NGT) and a questionnaire to gather the required data from the students involved in CBE and SL initiatives.

3.2.3.1 *Mixed-methods diagrammes and notations*

Authors such as Creswell and Plano Clark (2007:40) and Ivankova, Creswell and Plano Clark (2007:263) state that by using visual diagrammes and notation systems the nature of mixed-methods approach can be better understood. In visual diagrammes, the steps in the research process are shown by means of geometric shapes (boxes or ovals) and arrows that indicate the progression through steps. In the notation systems pluses (+) are used to indicate methods that occur at the same time and arrows (→) to indicate methods that occur in a sequence.

In addition, Johnson and Onwuegbuzie (2004:online), Creswell and Plano Clark (2007:40), and Ivankova *et al.* (2007:263), state that a notation system assigns the importance of the methods within the study, with the main method shown with uppercase letters i.e. QUAN or QUAL, and the resulting method indicated in lowercase i.e. quan or qual. For example, QUAN + QUAL indicate that both quantitative and qualitative methods are used concurrently during the research and both have equal weight. QUAL → quan indicate that qualitative and quantitative methods are used in sequence, with the qualitative method being used first and also emphasised (Creswell & Plano Clark 2007:40). The visual diagramme and notation system in this study will be explained in paragraph 3.2.3.3 of this chapter.

3.2.3.2 *Mixed-methods types*

Creswell and Plano Clark (2007:79-82) point out that a researcher has to consider factors such as timing, weighting and mixing when choosing a specific mixed-method. The timing decision involves the order in which data will be collected – it can either be collected simultaneously (concurrently) or sequentially with either the quantitative or qualitative first. The weighting decision refers to the equal or unequal weight (in terms of the importance or priority) of the quantitative and qualitative methods. Decisions as far as the weighting is concerned will be based on the literature cited, the purpose of the study and practical considerations (Creswell & Plano Clark 2007:79-82). In Figure 3.1 the Decision Tree for Mixed-Methods Design Criteria for Timing, Weighting and Mixing is given. The shaded boxes show the relevance as far as this study is concerned.

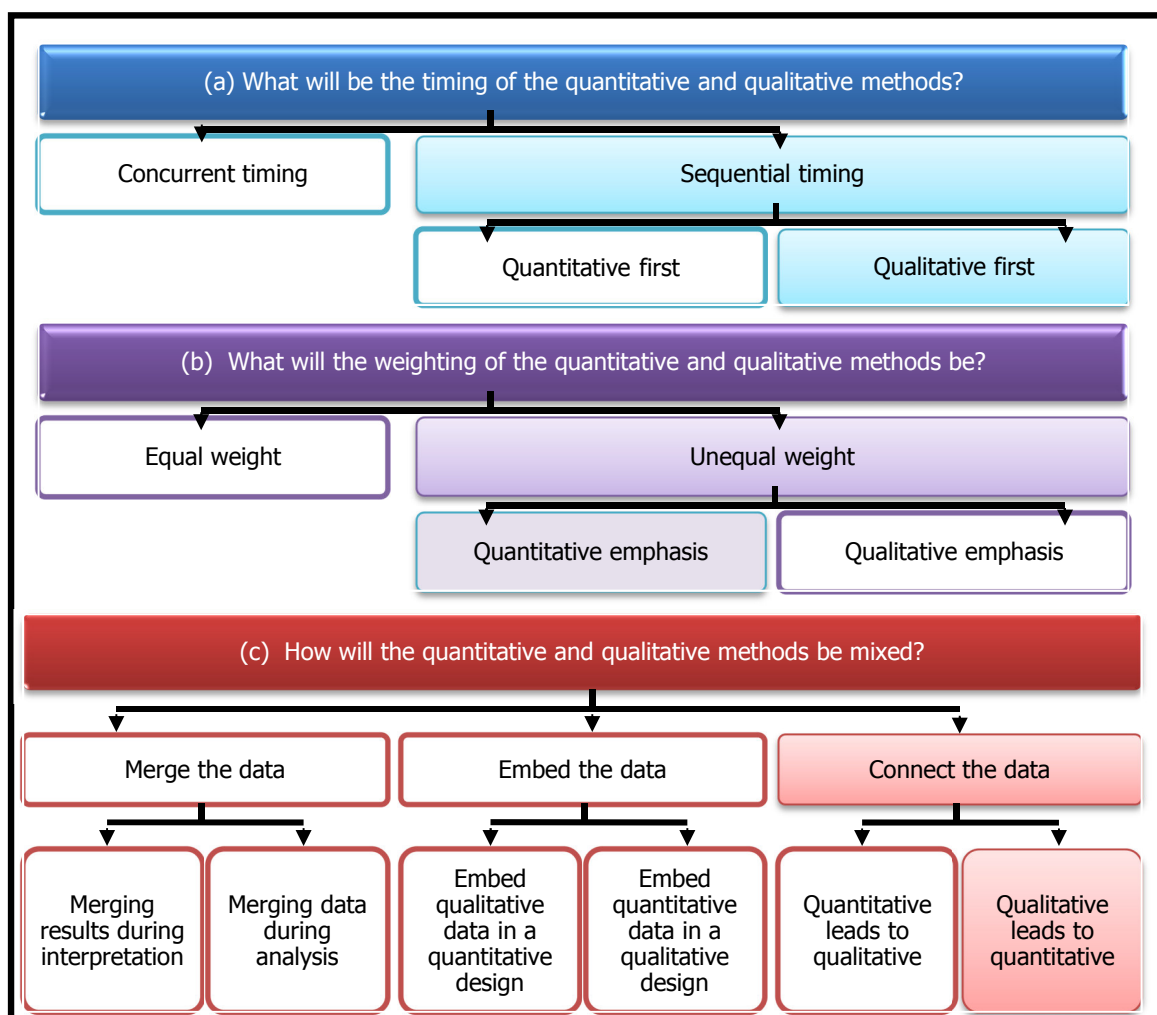


FIGURE 3.1: DECISION TREE FOR MIXED-METHODS DESIGN CRITERIA FOR TIMING, WEIGHTING AND MIXING [Based on Creswell and Plano Clark (2007:80)]

Four basic types of mixed-methods can be identified, namely embedded, explanatory, exploratory and the triangulation type.

The triangulation design is used to obtain different but complementary data on the same topic to best understand the research problem and is used when a researcher wants to compare and contrast quantitative statistical results directly with qualitative findings or to validate or expand quantitative results with qualitative data (Creswell & Plano Clark 2007:62).

The embedded design is a mixed-methods design in which one data set provides a supportive, secondary role in a study based primarily on the other data type (Creswell, Tashakkori, Jensen & Shapley 2003:68). It means that both quantitative and qualitative data are collected, but one of the data types plays a supplemental role within the overall type. This design is particularly useful when a researcher needs to embed a qualitative component within a quantitative design, as in the case of an experimental or correlation design (Creswell & Plano Clark 2007:67).

The explanatory type can be used when qualitative data is needed to explain or expand on the quantitative data. In such a type, quantitative results provide a general picture while the qualitative results refine, explain or extend the general picture (Creswell & Plano Clark 2007:72).

The exploratory design is used when the results of the first method (qualitative) can help to develop or inform the second method (quantitative) (Creswell & Plano Clark 2007:75). As the name suggests, this design permits a researcher to first explore a topic by identifying qualitative themes and generating theories, and then to use that exploration to guide subsequent quantitative examination of the initial qualitative results, such as to test theory or to develop a measurement instrument based on the qualitative results (Creswell & Plano Clark 2007:80).

3.2.3.3 *The mixed-methods approach used in this study*

The mixed-methods type used in this study is the exploratory type; the qualitative results from the nominal group technique identified themes/topics that were used to explore the views, attitudes, perceptions and opinions of Health Sciences students' on

CBE and SL in the questionnaire survey. The following diagramme with notations explains how these types were applied.



FIGURE 3.2: MIXED-METHODS APPROACH FOR THIS STUDY
[Compiled by the Researcher, Kruger 2011]

Figure 3.2 shows that the research was conducted in three phases. The nominal group technique (NGT) was used as primary data collection tool in Phase I. Nominal group interviews were conducted with the class leaders of each year of study in each discipline. The qualitative data gathered in this phase were analysed and interpreted by the researcher. In phase II a quantitative questionnaire (with a few qualitative elements) was given to the undergraduate Health Sciences students at the UFS. The questions in the questionnaire were formulated by using the data gathered in Phase I. In the final phase of the project the findings of Phase I and Phase II were used to explore students' views and attitudes regarding CBE and SL and to identify whether there are certain factors that influence students' experience of CBE and SL. This information was then used, in combination with the information gathered from the literature review, to make recommendations to the Faculty of Health Sciences at the UFS on the implementation of CBE and SL initiatives.

3.3 RESEARCH METHODS

3.3.1 Literature Review

The aim of a literature review is to contextualise a problem against related theory and research, while ensuring that the researcher is sufficiently knowledgeable about the subject of the research project (Singleton & Straits 1999:544). In this research project, the literature review provided the necessary background and context to the stated problem.

It was endeavoured to gain a deeper insight into our understanding of the practice, outcomes, impact and quality of CBE and SL efforts and the profile of the students who participate in CBE and SL. This provided the background information for the research project.

The themes that were discussed in the literature review mainly focused on:

- Conceptualising and contextualising CBE and SL;
- National and international students' experiences in CBE and SL initiatives.

3.3.2 The Nominal Group Technique

3.3.2.1 *Theoretical aspects*

The use of the nominal group technique (NGT) was first reported by Delbecq and his colleagues in 1975 (Delbecq, Van Den Ven & Gustafson 1975:466). Since then, the NGT has been employed as an evaluative tool in medicine, health care, nursing, engineering, information and systems, management and behavioural research to prioritise items and to identify areas requiring attention or needing changes.

Gallagher, Hares, Spencer, Bradshaw and Webb (1993:76-77) explain that NGT is a procedure that is used for gathering information from groups of people who have insight into the issue at hand. It is done in a structured way and its purpose is to generate ideas. Siegenthaler and Riley (2002:61) comment that the technique gives all participants an opportunity and helps prevent individuals from dominating the group

discussion. Respondent validation takes place within the process (MacPhail 2001:162) as participants themselves weigh the importance of items.

Summarising De Ruyter (1996:45), Gallagher *et al.* (1993:78-80), Siegenthaler and Riley (2002:61-62) and Taylor-Powell (2002:online) the following steps should be performed during a nominal group discussion: During step 1 an introduction takes place where participants are welcomed and the purpose, procedures and how results will be used are explained. Informed consent is obtained from all participants. In step 2, a question is posed to the group, then written on a flip chart, cards or paper and clarified if needed. During the 3rd step, participants are asked to reflect individually on the question and then write down as many ideas as possible, without discussing it with anybody. A time limit is given for listing ideas. Ideas are then recorded (the 4th step) one by one as participants read their ideas out loud. The idea will be noted on the flip chart to enable the entire group to see it. The process continues until all ideas have been recorded. If participants identify additional aspects that come to mind during the sharing of ideas, they are encouraged to share it with the group while the round robin sharing of ideas is taking place.

A group discussion can now be held as the 5th step, as up to now any discussion has been discouraged. It is only now, after all ideas have been shared, that participants are given the opportunity to explain their ideas further. A detailed discussion is still not needed; just an explanation or clarification of meaning. The significance or worth of ideas is not discussed. This aids with the review and aspects that are duplicated are eliminated from the list.

The ranking of items then takes place as the 6th step. Participants are asked to rank the items (individually to avoid dominance within the group) from most important to least important and each individual's ranks are then displayed on the chart. The ranks are then calculated resulting in a final ranking list.

A "third party" is included in the process in order to identify and rank issues identified by the group (Delbecq *et al.* 1975:8). The suggested size of a group of participants is five to ten and such a meeting usually lasts up to two hours (Delbecq *et al.* 1975:69; Potter, Gordon & Hamer 2004:126; Taylor-Powell 2002:online).

3.3.2.2 *The nominal group technique in this study*

In this study the NGT was used to identify themes/topics that were used to explore the experiences of Health Sciences students, including views, attitudes and perceptions regarding CBE and SL at the University of the Free State. The groups were held in Room A126 in the Francois Retief building and most students were familiar with this venue. The venue was quiet, with the necessary facilities (Creswell 1998:124).

The duration of the different sessions was between one hour thirty minutes and two hours each. In each session there were:

- Two Flipcharts;
- Pens;
- Paper to write on;
- Index cards; and
- Coloured pens to write on the flipchart.

An expert in the nominal group technique from the School of Allied Health Professions, UFS was used to guide the group and the researcher took field notes as observer (The Quality Toolbook: How to create a Nominal Group Technique 2002-2007a:online). At the start of the nominal group discussion an introduction took place where participants were welcomed and the purpose, procedures and how results will be used were explained. The information document (Appendix A1) was given to everybody to read and the opportunity was given to ask questions. The informed consent form (Appendix A2) was signed by all participants that were willing to take part in the study and thereafter data were collected. The groups were presented in either English or Afrikaans. A definition of CBE and SL were given to each student to ensure that they fully understand the concepts. The first research statement was completed first and thereafter the second research statement was handled.

The research statements were written on the flipchart in order for the students to be able to see it throughout the discussions (The Quality Toolbook: How to create a Nominal Group Technique 2002-2007a:online).

The research statements entailed the following (Appendix A3):

Each of the research statements was first formulated in English and then translated in Afrikaans to accommodate the Afrikaans-speaking students. The research statements were as follows:

As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a positive influence on your experience? / As student, watter aspekte van Gemeenskapsgebaseerde-Onderwys of Diensleer in die Fakulteit Gesondheidswetenskappe het 'n positiewe invloed gehad op jou ervaring?

As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a negative influence on your experience? / As student, watter aspekte van Gemeenskapsgebaseerde-Onderwys of Diensleer in die Fakulteit Gesondheidswetenskappe het 'n negatiewe invloed gehad op jou ervaring?

Students had the chance to write down all their ideas on a piece of paper in privacy. Each student then had the chance to voice their ideas (each student gave one idea and then it was the next student's turn). After clarifying each idea it was written on the flip chart and once all ideas were written down, the students had to vote for the five ideas they thought was the most important ones. The voting was done, once again as individuals, in private and written down on cards. The facilitator collected all the cards and counted the ideas. The five most important ideas were identified by the students in the group and consensus was reached this way.

3.3.2.3 *Sample selection*

According to Bowling (2002:187) sampling methods for research may be roughly divided into two groups, namely sampling for quantitative research and sampling for qualitative research. The methods, in each of these groups, can be further divided into random and non-random sampling, depending upon the purpose of the research. Random sampling would include methods such as simple random sampling, unrestricted random sampling, systematic random sampling, stratified random sampling, cluster sampling, as well as other techniques with minor deviations to the sampling methods. Random sampling is often used when the researcher wishes to draw conclusions on how the research would apply to the wider population.

Bowling (2002:187) further states that when research is conducted for the purposes of understanding complex phenomena and to generate hypotheses, rather than to apply findings to a wider population, non-random sampling is usually used. Non-random sampling methods are usually used in qualitative research and include methods such as convenience sampling, purposive sampling, snowballing and theoretical sampling.

The sample design in this study was purposive sampling, which is the sampling method most often applied in case studies (Maree & Pietersen 2007:178). It implies that participants are chosen with a specific goal in mind, with the purpose of gaining understanding of the specific phenomenon under investigation. This was the case in this study where undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing in the Faculty of Health Sciences (FHS) who participated in CBE and/or SL during 2011 were chosen.

Target Population

A target population consists of a group of individuals who possess and share certain specified characteristics (De Vos, Strydom, Fouché, & Delport 2005:14). The target population included all the undergraduate students in the FHS, UFS who participated in CBE and/or SL during 2011. This included first-year to final-year undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS.

The Faculty of Health Sciences consists of the School of Medicine, School for Allied Health Professions and School of Nursing. The School of Medicine offers a 5-year undergraduate programme for general practitioners (the degree M.B.,Ch.B.). The School for Allied Health Professions includes the Departments of Occupational Therapy offering a 4-year programme (degree B. Occupational Therapy), Physiotherapy offering a 4-year programme (degree B.Sc. Physiotherapy), Nutrition and Dietetics offering a 4-year programme for dietitians (degree B.Sc. Dietetics and Human Nutrition) and Optometry offering a 4-year programme for optometrists (degree B. Optometry). The School of Nursing offers a 4-year undergraduate programme for professional nurses (degree B.Soc.Sc. Nursing).

Table 3.1 represents the numbers of registered, undergraduate students who participated in CBE and/or SL in the Faculty of Health Sciences during 2011. It can be

seen in Table 3.2 that the target population included 1067 students in the Faculty of Health Sciences, UFS. Almost half of the total number of students was in the School of Medicine's M.B., Ch.B. programme.

TABLE 3.1: NUMBERS OF REGISTERED, UNDERGRADUATE STUDENTS WHO PARTICIPATED IN CBE AND/OR SL IN THE FACULTY OF HEALTH SCIENCES DURING 2011

STUDENTS	YEAR OF STUDY					TOTAL
	I	II	III	IV	V	
M.B., Ch.B.	127	0*	125	107	122	481
B. Occupational Therapy	46	35	34	38	NA	153
B.Sc. Physiotherapy	45	39	42	43	NA	169
B. Sc. Dietetics and Human Nutrition	0*	0*	0*	19	NA	19
B. Optometry	0*	0*	27	0*	NA	27
B.Soc.Sc. (Nursing)	78	55	34	47	NA	214
TOTAL	296	129	262	254	122	1063

* = no CBE/SL in these study years

NA = not applicable as these are four-year degree courses.

Source: Division Student Administration: Office of the Dean, Faculty of Health Sciences, University of the Free State, Bloemfontein, August 2011.

Survey Population

The survey population was selected from the above-mentioned target population through convenience sampling and included both the English and Afrikaans class leaders from the undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS. Due to the large size of the target population (1067 students), it was decided to include only the class leaders during 2011 for the NGT, providing representative data from a wide range of junior to senior students.

Sample size

All the class leaders were telephonically invited to the nominal groups and reminded about the sessions per sms. The sample included all the class leaders who turned up at the nominal groups and who signed the consent form to participate in the research. The sample amounted to 26 students. Table 3.2 represents the numbers of undergraduate student class leaders who participated in the NGT in the Faculty of Health Sciences, UFS, 2011.

TABLE 3.2: NUMBERS OF UNDERGRADUATE STUDENT CLASS LEADERS WHO PARTICIPATED IN THE NGT IN THE FACULTY OF HEALTH SCIENCES, UFS 2011.

STUDENTS	YEAR OF STUDY					TOTAL
	I	II	III	IV	V	
M.B., Ch.B.	1	2	0*	2	1	6
B. Occupational Therapy	2	2	1	2	NA	7
B.Sc. Physiotherapy	1	1	2	2	NA	6
B. Sc. Dietetics and Human Nutrition	0*	0*	0*	1	NA	1
B. Optometry	0*	0*	2	0*	NA	2
B.Soc.Sc. (Nursing)	0	2	2	0	NA	4
TOTAL	4	7	7	7	1	26

* = no CBE/SL in these study years

NA

= not applicable as these are four-year degree courses

Description of the sample

The sample comprised 26 students registered for the undergraduate degree programmes in the Schools of Medicine, Allied Health Professions and Nursing respectively, in the Faculty of Health Sciences, UFS and who were involved in CBE and/or SL during 2011. This included 13 Afrikaans and 13 English students of whom 9 were male and 17 females, representing different ethnic groups.

The pilot study

It is important to conduct a smaller version of the research study in order to identify possible problems and pitfalls in the proposed technique. This process is generally referred to as a pilot study.

According to Van Teijlingen and Hurdley (2001:online) the reason for conducting a pilot study could be for pre-testing a particular research instrument. By conducting a pilot study the researcher might be given advance warning about where the main research project could fail, where research protocols may not be followed or whether proposed methods or instruments are inappropriate or too complicated (Van Teijlingen & Hurdley 2001:online).

A pilot study was done by having the same nominal group discussion with five second-year medical students, which included three Afrikaans and two English-speaking students. These students were selected because they were previously (2010) involved in CBE or SL at the Faculty of Health Sciences, UFS, but were not involved at the time of the study (2011) and therefore did not form part of the target population. The

results of the pilot study are not included in the final research.

The pilot study was done to test the question that was asked during the discussion as well as to determine the duration of the session and to identify the number of priorities that need to be identified (Van Heerden 2009:91). The research question that was used during the pilot study was: What factors had an influence on your perception, attitude and experience of CBE and/or SL in the Faculty of Health Sciences, University of the Free State? / Watter faktore het 'n invloed gehad op jou persepsie, houding en ervaring van GBO en/of SL in die Fakulteit Gesondheidswetenskappe, Universiteit van die Vrystaat?

During the pilot study it became apparent that the question does not generate the required information and that the students get confused between the terms perceptions, attitudes and experiences. In addition, they tend to focus on either the positive or the negative aspects in CBE and SL and do not include both experiences. Consequently the research statement was changed to the following two questions:

As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a positive influence on your experience? / As student, watter aspekte van Gemeenskapsgebaseerde- Onderwys of Diensleer in die Fakulteit Gesondheidswetenskappe het 'n positiewe invloed gehad op jou ervaring?

As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a negative influence on your experience? / As student, watter aspekte van Gemeenskapsgebaseerde- Onderwys of Diensleer in die Fakulteit Gesondheidswetenskappe het 'n negatiewe invloed gehad op jou ervaring?

Data gathering

Four different nominal group discussions were held with a total of 26 students. Four different dates and times were arranged, according to the timetables of the individual students. Two of the discussions were held in English and the other two in Afrikaans and students were telephonically invited to the session that suited them best. All students who agreed telephonically to participate in the nominal group discussions were reminded again of the session via SMS.

In preparation for the nominal group discussion, a suitable venue was arranged that was large enough to accommodate participants at individual tables placed in a U-shape. Two flip charts was placed at the open end of the U and the necessary stationery was provided (Delbecq *et al.* 1975:41; Taylor-Powell 2002:online).

The nominal group discussion itself followed six steps.

- Step 1: Participants were welcomed, informed about the study and informed consent was obtained by the facilitator (in this case an independent person who has expertise in NGT).
- Step 2: The nominal question was put to participants.
- Step 3: The participants then generated ideas in silence and wrote them down on a card.
- Step 4: A discussion followed, namely the verbalising of their ideas in a round-robin fashion (Delbecq *et al.* 1975:67; Gallagher *et al.* 1993:78; Taylor-Powell 2002:online).
- Step 5: A discussion took place regarding the ideas generated, which created the opportunity to clarify any possible misconceptions.
- Step 6: Lastly, participants got the opportunity to prioritise ideas from the pool of ideas generated by all participants (Delbecq *et al.* 1975:8; Siegenthaler & Riley 2002:62).

During these mentioned data collection steps, the generating of the group's ideas and eventually the priority ranking of ideas was reflected on the flipcharts enabling all participants to keep track of the process (Delbecq *et al.* 1975:68; Sample 1984).

Data analysis

Data analysis refers to the systematic organisation and synthesis of research data, which allows the researcher to reduce, organise and give meaning to data (Polit & Beck 2006:498; Burns & Grove 2009:695). Even though the NGT can be seen as a mixed-method approach, using qualitative and quantitative methods in the analysis and reporting of results, the emphasis in this study will mainly fall on the analysis of the qualitative data provided by participants (Potter, Gordon & Hamer 2004:128).

The researcher used the guideline proposed by Van Breda (2005:4-11) to analyse the multiple NGT data. The analysis of data followed a stepwise process:

- Capture original data;
- Identify the priorities in each group;
- Analyse the content of the data according to categories and themes;
- Confirm the content analysis;
- Calculate combined ranks;
- Report the NGT data.

A detailed description and discussion of the findings of the nominal group technique is provided in Chapter 4.

3.3.2 The questionnaire survey

3.3.3.1 *Theoretical aspects*

The theoretical aspects and methodological bases for the use of a questionnaire are discussed in this section.

Gay and Airasian (2003:10) explain that survey research, also called descriptive research, involves collecting data to answer questions about the current status of issues or topics, followed by a quantitative description given in the form of statistics and numbers.

Questionnaire surveys are noted to be usually carried out to obtain information about the preferences, attitudes, practices, concerns and interests of some groups of people. Surveys are also regarded as an effective method for investigating educational issues (Gay & Airasian 2003:277).

According to Bowling (2002:58) questionnaires may be structured, semi-structured and unstructured. A structured questionnaire involves the use of fixed standardised questions and/or scales which are presented to the respondents in the same way, with no variations in question wording, and with mainly pre-coded response choices. Closed or structured questions are usually used when very specific information is required as well as for large-scale data collection (Goddard & Melville 2001:48). A

semi-structured questionnaire contains variations in question wording and may have variations in scales or presentation and open-ended questions may be included. The questionnaire in this research study (cf. Appendix B) falls mainly in the structured category with some open-ended questions in order to accommodate the views of all respondents.

The main benefit of the use of structured questionnaires is the ability to gather explicit and easy-to-count answers, leading to quantitative data for analysis. Because this method leads to straightforwardness of data collection and analysis, it is relatively economical and large numbers of people can be included (Bowling 2002:258).

One of the disadvantages of structured questionnaires is that the pre-coded response choices may not be all-inclusive and not all answers may be accommodated without difficulty. Some respondents may, therefore, be required to choose inappropriate pre-coded answers that might not fully represent their views (Bowling 2002:258).

Another weakness of structured questionnaires is that it presumes that the questions will be understood by the respondents, whereas a further difficulty is that respondents may not all share the same perspectives and understanding of the terms and concepts used (Bowling 2002:258).

3.3.3.2 CBE and SL questionnaire

No instruments could be found in the literature to obtain the data to address the hypotheses and aims of this study and it was therefore necessary to design a survey questionnaire specifically for this unique study and population.

The questionnaire survey in this study used a quantitative approach with elements of qualitative research. The aim of the questionnaire survey was to obtain demographic information of the participants, explore the students' views, attitudes and perceptions regarding CBE and SL and identify whether there are certain factors that influence students' experience of CBE and SL.

The questionnaire contained both open-ended and closed questions and was available in Afrikaans and English. The questions were compiled by the researcher who made use of the information gathered in the NGT as well as studying the literature on CBE, SL

and the assessment of student experiences (Astin & Sax 1998; Bringle & Hatcher 2005; Stukas & Dunlap 2002).

The first section of the questionnaire included the demographic questions, as a factual, non-threatening introduction to the questionnaire. The sections then followed a logical order and questions related to the same topic were grouped together. The wording of the questions was, as far as possible, clear, unambiguous, without double negatives and phrased neutrally without emotional language or intention to make the respondent feel guilty. The definitions of CBE and SL were given to respondents on the questionnaire to ensure that they understand the term as they are used in this study.

Various scaling methods were used in the questionnaire survey, for example nominal measurements were used in the demography section, while a Likert scale was used to obtain ordinal measurements from the close questions in the other sections. Sufficient open space was provided following the open questions so that respondents could write down their responses.

The questionnaire (cf. Appendix B) collected information in three sections, namely:

Section 1: Demographics

This section deals with the personal and academic profiles of the respondents.

- Personal profile
In the personal profile category, information on the age, gender and ethnic group was collected.
- Academic profile
In the academic profile category, information on the field of study and study year of respondents was collected.

Section 2: Experiences regarding community-based education and/or Service Learning

This section deals with issues related to the experiences regarding CBE and or SL.

The following aspects are included in the questionnaire:

- Experiences on a personal level;
- Value of CBE and/or SL for students;
- Community involvement and social responsibility;
- Organisation of CBE and/or SL at the Faculty of Health Sciences, UFS and
- Support/supervision during CBE and/or SL.

Section 3: Satisfaction from CBE and/or SL

This section deals with the reasons respondents enjoyed CBE and/or SL and with their suggestions for the improvement of CBE and/or SL at the Faculty of Health Sciences, UFS.

3.3.3.3 *Sample selection*

Target Population

The target population included all the undergraduate students in the Faculty of Health Sciences, UFS who participated in CBE and/or SL during 2011. This included first-year to final-year undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS.

Cf. Table 3.1 for the number of registered, undergraduate students in the Faculty of Health Sciences who participated in CBE and/or SL during 2011.

Survey Population

The survey population included all the students in the target population who voluntarily completed the anonymous questionnaire during an academic contact session. The researcher approached academic staff members who lecture to each student group to obtain permission to distribute the questionnaires during an academic contact session.

Sample size

In this study the whole population was studied to give more meaning to the findings. All registered undergraduate students in the Faculty of Health Sciences who participated in CBE and/or SL during 2011 and who complete the anonymous questionnaire were included in the study. The total sample included 792 students. Table 3.3 represents the numbers of registered, undergraduate students in the Faculty of Health Sciences, UFS that completed the questionnaire survey.

TABLE 3.3 NUMBERS OF REGISTERED, UNDERGRADUATE STUDENTS IN THE FACULTY OF HEALTH SCIENCES, UFS THAT COMPLETED THE QUESTIONNAIRE SURVEY (n = 792)

STUDENTS	YEAR OF STUDY					TOTAL
	I	II	III	IV	V	
M.B., Ch.B.	128	0*	99	54	76	357
B. Occupational Therapy	31	31	6	27	NA	95
B.Sc. Physiotherapy	40	33	38	30	NA	141
B. Sc. Dietetics and Human Nutrition	0*	0*	0*	18	NA	18
B. Optometry	0*	0*	23	0*	NA	23
B.Soc.Sc. (Nursing)	60	27	30	41	NA	158
TOTAL	259	91	196	170	76	792

* = no CBE/SL in these study years

NA = not applicable as these are four-year degree courses

Description of the sample

The sample consisted of all undergraduate students registered for the respective undergraduate degree programmes in the Schools of Medicine, Allied Health Professions and Nursing respectively, in the Faculty of Health Sciences, UFS who participated in CBE and/or SL during 2011. This included Afrikaans and English as well as male and female undergraduate students, representing White, Black, Coloured, Asian and Indian ethnic groups.

The pilot study

Peat, Mellis, Williams and Xuan (2002:123) list a number of aspects of a pilot study that may improve the proposed questionnaire and these aspects were summarised and reduced by Clarke-Farr (2005:221-222). These would aim to:

- “administer the questionnaire to pilot participants in exactly the same way as it will be administered in the main study;

- ask the participants for feedback to identify ambiguities and difficult questions;
- record the time taken to complete the questionnaire and decide whether it is reasonable;
- discard all unnecessary, difficult or ambiguous questions;
- assess whether each question gives an adequate range of responses;
- establish that replies can be interpreted in terms of the information that is required;
- check that all questions are answered;
- re-word or re-scale any questions that are not answered as expected;
- shorten, revise and, if possible, pilot again”.

A pilot study was conducted by administering the questionnaire to undergraduate students that were involved in CBE or SL at the Faculty of Health Sciences, UFS, previously (2010) but who were not involved at the moment (2011). These students do not form part of the target population. Students were approached during a “student’s voice” session, after the academic staff member responsible for that session had granted permission. Students were asked to voluntarily complete the anonymous questionnaires during the session. The time needed to complete the questionnaires as well as any confusing questions or misunderstanding was noted. Students completed the questionnaire comfortably within 20 minutes, and there were no difficulties during completion. Two questionnaires were included in the pilot study. Questionnaires were coded, but the data from the questionnaires in the pilot study were not included for analysis. No changes to the questionnaires for students were made after the pilot study.

Data gathering

Questionnaires were handed to the students directly after an academic contact session, once they had completed their respective CBE or SL initiatives. The researcher approached academic staff members who lecture to each student group to obtain permission to distribute the questionnaire after an academic contact session.

The questionnaires were filled in anonymously and no personal data were expected from the participants, apart from certain biographical data that were asked and used in the study. The students had 20 minutes to complete the questionnaire, which gave them adequate time to really think about their answers. After completion of the

questionnaires, the participants placed the questionnaires in a box, to ensure anonymity and confidentiality.

Data analysis

The data from the questionnaire surveys were analysed with the help of a biostatistician from the Department of Biostatistics, Faculty of Health Sciences, UFS. Quantitative data were analysed descriptively using frequencies and percentages for the categorical variables.

The qualitative data were analysed by the researcher by reading and reflection, identification of themes, establishment of patterns and connections as well as coding. An independent researcher was asked to check the themes, connections and patterns to ensure authenticity.

De Vos (2005a:337) states that it is important to read through respondents' statements several times in entirety and immersing oneself in the details to get a sense of the data before breaking the data into parts. Data can then be organised to discover patterns, themes, forms and qualities and connections can be formed. In this study the researcher identified recurrent themes, and reviewed and coded them (De Vos 2005a:333; Fossey, Harvey, McDermott & Davidson 2002:729).

A detailed description and discussion on the results of the questionnaire survey will be given in Chapter 5.

3.4 ENSURING THE QUALITY, RELIABILITY AND VALIDITY OF THE STUDY

There are different views about validity and reliability of data and results in the mixed-methods approach. Validity differs in quantitative and qualitative research, but in both approaches it serves the purpose of checking on the quality of the data and the results. In quantitative research, validity means that the researcher can draw meaningful inferences from the results to a population; reliability means that scores received from participants are consistent and stable over time (Creswell & Plano Clark 2007:133).

Creswell and Plano Clark (2007:134) state that in qualitative research, there is more of a focus on validity to determine whether the account provided by the researcher and the participants is accurate, can be trusted, and is credible.

There are different views about assessing the quality of mixed-methods research. In this study, the researcher followed the example of a mixed-methods study included in Maree (2007:297) in choosing terminology describing the quality in this research study.

3.4.1 Trustworthiness (reliability, dependability)

When applying mixed methods to research, the trustworthiness of data should include various topics discussed under both the quantitative and qualitative approaches. The term “trustworthiness” refers to the way in which the inquirer is able to persuade the audience that the research is of high quality and worth paying attention to (Golafshani 2003:online). In this study trustworthiness was established by providing a detailed outline of how quantitative and qualitative data were analysed and interpreted in the final research report.

Another way of establishing trustworthiness of results is by linking findings and conclusions to both data and theory (Westphal 2000:online). This way of establishing trustworthiness of results was used by linking the findings and conclusions made in the empirical investigation with the theory as found in the literature.

The term reliability is used in quantitative research, and dependability is used in qualitative research (Patton 2002:546). According to Creswell and Plano Clark (2007:133) reliability refers to the consistency and uniformity of results when observations or measurements are repeated under the same conditions or over time. In this study, the reliability of the questionnaire survey was ensured by using a well-constructed questionnaire, e.g. by “asking similar questions which should give similar answers” (Katzenellenbogen & Joubert 2007:119), by doing a pilot study, as mentioned in section 3.3.3.3, as well as making use of statistical analysis by an expert (Creswell & Plano Clark 2007:133).

According to Lincoln and Guba (in Patton 2002:546) dependability refers to a systematic process followed in a systematic way, while De Vos (2005b:346) sees it as an attempt “to account for changing conditions in the phenomenon chosen for study as

well as changes in the design created by increasingly refined understanding of the setting". Dependability in this study is ensured by the inclusion of both quantitative and qualitative questions in the questionnaire to incorporate perspectives which would lead to a more holistic picture (De Vos 2005b:346). Furthermore, the systematic process that was followed in the NGT increased dependability in this study.

3.4.2 Validity

3.4.2.1 *Credibility / Internal Validity*

The term credibility in qualitative research is equivalent to internal validity in quantitative research and as such means the degree to which methods that are used to generate the findings of a study can be trusted (Delport & Fouché 2005:353).

De Vos (2005a:346) describes credibility as the alternative to internal validity and states that the goal in credibility is to demonstrate that the research was conducted in such a manner as to ensure that the subject was accurately identified and described. In this study, the subject was accurately identified and described in the literature review.

In addition, credibility in this study was established by identifying the correct participants to partake in the nominal group discussions. All participants that were selected for the NGT were registered undergraduate students from the different year groups and degree courses in the Faculty of Health Sciences, UFS, and were involved in CBE and SL during 2011. The very structure of the NGT also further assisted the credibility of findings. All participants had an equal opportunity to partake in verbalising ideas through the usage of the round-robin technique, as well as the clarification of these ideas. Member checking forms part of the NGT in that participants themselves prioritised ideas and as a result are in agreement with research findings (Van Breda 2005:6). Furthermore, an expert in the NGT was used to gather the data, which also ensured credibility.

Credibility was further strengthened through the broad collaboration by means of which the research questionnaire was designed and the research design that was used, which is a case study, which will allow an in-depth exploration of the subject as well.

3.4.2.2 Transferability / Generalisation

Transferability refers to the extent to which findings can be transferred to other settings and the probability that the study findings add meaning to these settings (Polit & Beck 2006:511; Speziale & Carpenter 2007:49). The decision whether these findings are actually transferable or applicable in another setting, rests with the potential users of the findings and not with the researcher (De Vos *et al.* 2005:346; Speziale & Carpenter 2007:50).

The aim of this study is not to create transferable findings, but to explore the views, attitudes, perceptions and opinions of Health Sciences students regarding CBE and SL.

According to Burns (2000:474) and De Vos (2005a:352) when generalisations are made, they can be based on theoretical propositions and understandings. In this study, where generalisations were made, they were based on the theoretical understandings and perspectives discussed in Chapter 2.

3.4.3 Confirmability

Confirmability refers to the objectivity or neutrality of the data or the analysis and interpretation of this data (Polit & Beck 2006:497). This objectivity or neutrality of data can only transpire if documentation of research findings leaves an audit trail. This trial should consist of a recording of activities over time that another individual can follow. In this way the evidence and thought processes that lead to conclusions can be illustrated (Speziale & Carpenter 2007:49). The traditional concept of objectivity is thus captured, namely: Can the findings of the study be confirmed by another (De Vos *et al.* 2005:347)?

The approach that was followed during the NGT strengthened the confirmability of the results. The facilitator of the NGT was in a position to act objectively during facilitation of the discussion. The analysis of the data commenced by the participants themselves, with the researcher following a further structured process. Interpretation of the data was checked by an independent researcher to make sure that it was correct (Van Breda 2005:6).

3.5 ETHICAL CONSIDERATIONS

3.5.1 Approval

Approval to execute the research was obtained from the Vice-Rector (Academic) (cf. Appendix C2) and the Faculty Management of the Faculty of Health Sciences (cf. Appendix C1), UFS. Approval was also obtained from the Ethics Committee of the Faculty of Health Sciences (ETOVS number: 77/2011).

3.5.2 Informed consent

All respondents that participated in the nominal group technique had to sign a written consent before they were allowed to participate in the study. The consent form was available in both English and Afrikaans (cf. Appendix A2), according to the language policy of the UFS and the participants were given a description of the study and the anticipated duration of the study (cf. Appendix A1).

All sample subjects (for both the NGT and the questionnaire) knew that their participation was voluntary and that they had the choice of either participating or not. They were also informed that they could withdraw from the study at any given time, without being penalised in any way (cf. Appendix A1 & Appendix B).

3.5.3 Right to privacy

The information collected by means of the NGT as well as the questionnaire survey was dealt with in a strictly confidential manner and no names or personal information was made known. The information gathered during the questionnaire survey was also anonymous. Participants in the NGT were guaranteed that all information will remain confidential. No respondent's name appeared on any document. Only a code number was used, which will not be linked to any names. At no time were students mentioned by name as to the comments they made. Privacy was maintained at all times.

The information gathered during the questionnaire survey was anonymous and no names or personal information was made known by the researcher. The researcher's name and contact details were available to all participants at all times and participants will have access to the published results of the study.

3.5.4 Minimising of potential misinterpretation of results

Correct analysis of quantitative data was ensured by making use of a statistician from the Department of Biostatistics, Faculty of Health Sciences, UFS. The researcher is convinced that all possible measures were taken to ensure that the study complied with ethical standards (cross-referencing and scientific referencing).

3.6 CONCLUSION

Chapter 3 provided an overview of the research design and methodology involved in the study and the procedures that were followed. A mixed-methods approach comprising two main data collection tools was employed in this investigation, namely the nominal group technique (NGT) and a structured questionnaire on CBE and SL.

In the next chapter, Chapter 4, entitled **Description of and discussion on the findings of nominal group technique**, the findings of the nominal group technique as data collection method employed in the study will be reported and discussed. This chapter reports on the first phase of the mixed model research design used in the study.

CHAPTER 4

DESCRIPTION AND DISCUSSION OF THE FINDINGS OF THE NOMINAL GROUP TECHNIQUE

4.1 INTRODUCTION

This chapter reports on the first phase of the mixed methods approach used in this study, namely exploratory design (cf. Figure 3.2). The instrument used during this phase of the mixed-methods approach included nominal group interviews with the respective class leaders from the different year groups of undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS. The nominal group interviews were conducted in English and Afrikaans respectively.

An exploratory design (cf. 3.2) is used to first explore a topic by identifying qualitative themes and generating theories, and then to use that exploration to guide subsequent quantitative examination of the initial qualitative results, such as to test theory or to develop a measurement instrument based on the qualitative results. The aim of the Nominal Group Technique (NGT) in this study was to identify themes/topics that were used to describe the experiences of Health Sciences students, including views, attitudes and perceptions regarding Community-Based Education (CBE) and Service Learning (SL) at the University of the Free State (UFS) in order to develop a questionnaire that can be used in the second phase of the mixed methods approach. Data was obtained on the aspects of CBE and/or SL in the Faculty of Health Sciences (FHS) that had a positive and negative influence on students' experience thereof (cf. 3.3.2). Four different nominal group discussions were held.

The demographic description of the sample is presented first (cf. 4.2: Demographic information). The demographic information includes biographic data such as gender, field of study, study year and language group (cf. Table 4.1- 4.9).

Subsequently, the research findings are discussed (cf. 4.4: Discussion of the research findings). The responses obtained through the different nominal groups as well as the categorisation thereof are presented first (cf. Table 4.10) followed by the combined data for the two research statements respectively (cf. Table 4.11- 4.13).

Nominal group interviews three and four were conducted in Afrikaans and the students' responses were translated by the researcher. The Afrikaans responses of the students are shown in brackets and *italics* (cf. Tables 4.5, 4.6, 4.9, 4.10, 4.11 & 4.12).

4.2 DEMOGRAPHIC INFORMATION

Twenty-six undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS were involved in the Nominal Group Technique. The distribution of the different study fields and year groups are summarised in Table 4.1.

TABLE 4.1: DISTRIBUTION OF DIFFERENT STUDY FIELDS AND YEAR GROUPS

Field of study	Year of study					Total (n = 26)
	I	II	III	IV	V	
M.B., Ch.B.	1	2	N/A*	2	1	6
B. Occupational Therapy	2	2	1	2	-	7
B.Sc. Physiotherapy	1	1	2	2	-	6
B. Sc. Dietetics and Human Nutrition	N/A*	N/A*	N/A*	1	-	1
B. Optometry	N/A*	N/A*	2	0	-	2
B.Soc.Sc. (Nursing)	0	2	2	0	-	4
TOTAL (n = 26)	4	7	7	7	1	26

*N/A = No CBE/SL activities during 2011

From the results it can be seen that all the respective study fields and year groups that participated in CBE/SL during 2011 were represented in the nominal group discussions.

The distribution of language preference (Afrikaans or English) and gender in the different study fields are summarised in Table 4.2.

TABLE 4.2: DISTRIBUTION OF LANGUAGE PREFERENCE AND GENDER IN THE DIFFERENT STUDY FIELDS

Field of study	Language preference		Gender	
	Afr	Eng	Male	Female
M.B., Ch.B.	3	3	4	2
B. Occupational Therapy	3	4	0	7
B.Sc. Physiotherapy	3	3	1	5
B. Sc. Dietetics and Human Nutrition	1	0	0	1
B. Optometry	1	1	0	2
B.Soc.Sc. (Nursing)	2	2	2	2
TOTAL	13	13	7	19

The results show that there were an equal number of Afrikaans and English students participating in the nominal group discussions, with the majority of the students being

female. The professions of Nursing [SoN] and Occupational Therapy, Physiotherapy and Dietetics [SoAH] are traditionally and historically dominated by females, which may clarify the larger numbers of female students in the Schools of Allied Health and Nursing.

Four nominal groups were held, two in Afrikaans and two in English. Students had the opportunity to decide their preferred language in order to improve communication and to enable the students to understand the facilitator as well as the other group members accurately. There were 13 Afrikaans and 13 English students, of which seven were male and nineteen female students. All the students were class leaders for 2011 from the undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS.

The groups consisted of 26 undergraduate students from different year groups, providing representative data from a wide range of junior to senior undergraduate students. Six students were registered for the programme for general practitioners (degree M.B.,Ch.B.), seven for Occupational Therapy (degree B. Occupational Therapy), five for Physiotherapy (degree B.Sc. Physiotherapy), one for Nutrition and Dietetics (degree B.Sc. Dietetics and Human Nutrition), two for Optometry (degree B. Optometry) and four for the programme for professional nurses (degree B.Soc.Sc. Nursing), offering miscellaneous data from all the different study fields at the FHS, UFS.

4.3 PROCESS OF DATA ANALYSIS

On completion of the NGT-interviews the raw data, received from the flipcharts, were transferred to the computer and tabulated according to categories to simplify the reading thereof. The data were examined by two people (researcher and typist) to ensure that there were no mistakes during the transfer of the data.

The seven steps for the analysis of NGT-interviews according to Van Breda (2005:4-12) were used to analyse the data (cf. 3.3.2.3). Data were studied per group and the priorities of each group pertaining to the statements were determined – step 2 (Van Breda 2005:5) (cf. Tables 4.3 – 4.10). As suggested in step 3 and 4, the researcher and a co-data analyzer grouped the responses of the students in categories and

themes according to the two statements given to the students, namely positive or negative influence on their experience.

All the responses received from the different groups were used for the research findings. The students prioritised the different responses attained during the NGT-interviews by identifying the five most important statements and scoring them by giving a five to the most important statement and one to the statement they regarded as least important. All the data from the different groups were not only sensibly reduced by the categorisation, but also combined with regard to the two statements (Tesch 1990:138-139). (cf. Table 4.11 – 4.13)

4.4 DISCUSSION OF THE RESEARCH FINDINGS

The research findings are discussed according to the two statements (Appendix A3). Each statement is discussed per group and followed by a discussion of the combined data.

4.4.1 The research statements

Statement 1: As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a positive influence on your experience?

Statement 2: As a student, which aspects of CBE and/or SL in the Faculty of Health Sciences had a negative influence on your experience?

4.4.1.1 *Responses on statement 1 'positive influence on your experience'*

All the information obtained through the NGT is given and the responses as received from each group are discussed in short. None of the students' responses are edited and are thus given verbatim. The responses from the students in groups three and four, which were presented in Afrikaans, were translated, but not edited. The voting count points to the importance (priority) given to each response by the students. In tables 4.3 to 4.6 the results of the first statement are given.

TABLE 4.3: RESPONSES OF GROUP 1

Category/ Theme (n = 8)	Response	Voting count	Total voting count and averages	Priority
Personal growth (Growing)	Personal growth	1;3;4;4;4	16 (3.2)	1
Theory – practice (Application)	Apply theory to practice	5;5	10 (5)	2
Practical skills (Development)	Developing skills in practical settings	5;3;2	10 (3.3)	2
Exposure/ experience (Variety)	Variety of exposure	5;4;1	10 (3.3)	2
Patients (Human aspect)	Experience of human aspects of the patient	4;3	7 (3.5)	3
Personal growth (Strengths & weaknesses)	Discover yourself in terms of strengths and weaknesses	5	5 (5)	4
Social responsibility (Personal perception)	Personal perception of social responsibility	2;2	4 (2)	5
Theory – practice (Integration)	Integration of theory and practice in modules	3;1	4 (2)	5
Cultural diversity (Interaction)	Interacting with people outside your own environment	2;1	3 (1.5)	6
Feeling valued (Roles in community)	Expectations/ Role in different community settings	3	3 (3)	6
Guidance (Introduction)	Gradual introduction	2	2 (2)	7
Peer (Peer perspective)	Perspective of other year groups	1	1 (1)	8
Communities (Willingness)	People in the community have the willingness to help students	0	0	9
Interpersonal skills (Communication)	“Forced” different languages	0	0	9
Research (Needs analysis)	Needs analysis in the community	0	0	9
Guidance (Outcomes)	Outcomes are clear	0	0	9

Sixteen responses were received on the first statement in group one. The first five priorities in sequence of importance were personal growth, the application of theory in practice, development of practical skills, variety of exposure, the human/social aspect of the patient, discover strengths and weaknesses (personal growth), social responsibility and the integration of theory and practice in modules (theory – practice).

Priorities six, seven and eight included cultural diversity, feeling valued in terms of your role in the community, gradual introduction (Guidance).

Priority nine consists of four responses, which did not receive any votes during the prioritisation by students (students were asked to identify only the five most important items). This includes the attitude of the community in terms of their willingness to help, improvement of communication skills (interpersonal skills), research and clear outcomes (Guidance).

TABLE 4.4: RESPONSES OF GROUP 2

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 5)	Response	Voting count	Total voting count and averages	Priority
Exposure/ experience (acquiring)	Gaining of a lot of experience	4;5;5; 5;5;4	28 (4.6)	1
Social responsibility (serving)	Serving the community	1;3;5; 5;5	19 (3.8)	2
Health Care Professionals (collaboration)	Working with & learning from the MDT	1;1;3; 2;4	11 (2.2)	3
Professional Competencies (problem-solving skills)	Problem solving	4;3;4	11 (3.6)	3
Interpersonal Skills (communication skills)	Communication (<i>with group, patient, other professionals, etc</i>)	4;3;2;1	10 (2.5)	4
Theory – practice (application)	Put knowledge into practice	2;2; 2;2	8 (2)	5
Cultural diversity (awareness)	Learn more about cultures	4;3	7 (3.5)	6
Professional Competencies (time management skills)	Time Management	3;2	5 (2.5)	7
Cultural diversity (awareness)	Low socio-economic background of the community (<i>learn about diseases and problems and how to treat that</i>)	5	5 (5)	7
Interpersonal skills (people skills)	People skills (<i>interaction with other people</i>)	2;1;1	4 (1.3)	8
Personal growth (self-fulfilment)	Self-fulfilment	4	4 (4)	8
Personal growth (emotional intelligence)	Gaining Emotional Intelligence	3	3 (3)	9
Knowledge (from practice)	Gaining knowledge from practice	3	3 (3)	9
Resources (adapt)	Learning to adapt to minimum resources	1	1 (1)	10
Celebration (partners)	Celebration (<i>with the partners</i>)	1	1 (1)	10

Category/Theme (n = 5)	Response	Voting count	Total voting count and averages	Priority
Peer support (support)	Support from peers and support as a peer	0	0	11
Supervision (UFS & community setting)	Supervision from UFS & clinical side	0	0	11
Personal growth (self knowledge)	Improvement of self-knowledge	0	0	11
Feeling valued (knowledge & role)	Knowledge and role are valued in the community	0	0	11
Research (knowledge)	Researching the population beforehand (<i>gaining more knowledge than what is in the books</i>)	0	0	11
Resources (technology)	Using technology (<i>apparatus, ppt, etc</i>)	0	0	11
Interpersonal skills (social interaction)	Social interaction (not books)	0	0	11
Patient (progression)	Progression with patient (Dependant – independent - discharge	0	0	11

Twenty-three responses were received from the second group, which were divided into 11 priorities. Gaining experience (exposure/experience) was voted as the most important aspect and received 28 votes.

Priorities two to five include social responsibility in terms of serving the community, working in multi-disciplinary teams (health care professionals), improvement of problem-solving skills (professional competencies), improvement of communication skills (interpersonal skills) and put knowledge into practice (theory-practice).

The rest of the priorities were cultural diversity, improvement of time management skills (professional competencies), cultural diversity, improvement of people skills, self-fulfilment (personal growth), gaining emotional intelligence (personal growth), gaining knowledge from practice, learning to adapt to minimum resources and celebration with the different partners.

Priority eleven consists of eight responses which include the following categories: peer support, supervision (from the UFS and Clinics), personal growth, feeling valued, research, resources, interpersonal skills and patient.

TABLE 4.5: RESPONSES OF GROUP 3

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 8)	Response	Voting count	Total voting count and averages	Priority
Practical skills (development)	Practical skills in the community (<i>Praktiese vaardigheid in die gemeenskap</i>)	5;4;3	12 (4)	1
Job satisfaction	Job satisfaction (<i>Werkstevredenheid</i>)	5;5;2	12 (4)	1
Interpersonal skills (people skills)	"People skills"	4;2;1	7 (2.33)	2
Personal growth (self-confidence)	Self-confidence (<i>Selfvertroue</i>)	3;3	6 (3)	3
Practical skills (Practise)	Repetition of practical knowledge – can practise skills over and over (<i>Repetisie van praktiese kennis - kan vaardighede oor-en-oor oefen</i>)	3;2	5 (2.5)	4
Personal growth (appreciation)	Appreciation of what you have (<i>Dankbaarheid van wat jy self het</i>)	5	5 (5)	4
Cultural Diversity (Contact)	Contact with diversity (<i>Kontak met diversiteit</i>)	3;2	5 (2.5)	4
Interpersonal skills	Interpersonal skills improve (<i>Interpersoonlike vaardighede verbeter - komm, verhoudinge ens</i>)	4;1	5 (2.5)	4
Knowledge (gaining)	Theoretical knowledge grows – find out more about illnesses etc. (<i>Teoretiese kennis verbreed - vind meer uit oor siektes, ens</i>)	5	5 (5)	4
Personal growth (self- knowledge)	Self-knowledge improve (<i>Selfkennis verbreed</i>)	4	4 (4)	5
Social Responsibility (build relationships)	Build relationships inside the community (<i>Bou van verhoudinge binne die gemeenskap</i>)	4	4 (4)	5
Professional competencies (Time management skills)	Time Management (<i>Tydsbestuur</i>)	1;1;1	3 (1)	6
Resources (awareness)	Awareness to use resources – learn which clinics, etc do what (<i>Bewuswording om hulpbronne te gebruik - leer watter klinieke ens doen wat</i>)	2	2 (2)	7
Social Responsibility (Awareness)	Can make other aware of the needs in the community (<i>Kan ander bewus maak van die behoeftes in die gemeenskap</i>)	0	0	8
Interpersonal Skills (communication skills)	Other language skills – Sotho (<i>Ander-taal vaardighede - Sotho</i>)	0	0	8
Exposure/ experience (optometry health train)	Experience to see SA – Optometry health train (<i>Ervaring om SA te kan sien - Optometrie gesondheids- trein</i>)	0	0	8

Category/Theme (n = 8)	Response	Voting count	Total voting count and averages	Priority
Cultural diversity (compare diversity)	To compare diversity in different areas in SA (<i>Om diversiteit t.o.v verskillende Ostreke in SA te vergelyk</i>)	0	0	8
Health Care Professionals (role)	Role of the multi-disciplinary team (MDT) (<i>Rol van die MDS</i>)	0	0	8
Interpersonal Skills (communication skills)	Professional and "lay-mans' language improve (<i>Professionele en leke-taal verbeter</i>)	0	0	8
Feeling valued (Appreciation of community)	Appreciation of the less fortunate in the community (<i>Dankbaarheid van minderbevoorregtes in die gemeenskap</i>)	0	0	8
Sustainability (Project)	Sustainability of the project which is implemented (<i>Volhoubaarheid van die projek wat implimenteer is</i>)	0	0	8
Personal growth (Prepare for career)	SL prepare you for the following step in the learning process (<i>SL berei jou voor vir 'n vlg stap in die leerproses</i>)	0	0	8

The third group identified eight priorities of which practical skills and job satisfaction were rated as the most important. Priority two and three included the improvement of "people skills" (interpersonal skills) and self-confidence (personal growth).

Practical skills, appreciation of what you have (personal growth), cultural diversity, improvement of interpersonal skills and gaining knowledge about illnesses all received five votes and were graded as the fourth priority. Priorities five, six and seven included personal growth, building relationships in the community (social responsibility), time management (professional competencies) and awareness of resources.

The last nine responses (priority eight) did not receive any votes (students were asked to choose only the five most important items) and included the following: social responsibility, interpersonal skills in terms of learning other languages, exposure/experience, cultural diversity, health care professionals, interpersonal skills, feeling valued, sustainability and personal growth.

TABLE 4.6: RESPONSES OF GROUP 4

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 5)	Response	Voting count	Total voting count and averages	Priority
Personal growth (Growing)	Personal growth (<i>Persoonlike groei</i>)	1;5;4; 3;3;2	18 (3)	1
Professional competencies (problem-solving skills)	Problem solving skills improve (<i>Probleemoplossingsvaardighede verbeter</i>)	5;5;4	14 (4.6)	2
Social Responsibility (community needs)	See needs outside of your frame of reference (<i>Behoeftes buite jou verwysingsraamwerk raak te sien</i>)	1;5;2; 2;2;1	13 (2.16)	3
Theory – practice (application)	Theory apply in practice (<i>Teorie in praktyk toepas</i>)	1;3;4;5	13 (3.25)	3
Social Responsibility (difference in the community)	Difference you make to the community as professional person (<i>Verskil wat jy as professionele persoon in die gemeenskap maak</i>)	4;3;2; 2;1	12 (2.4)	4
Exposure/experience (From jnr years)	Practical experience from junior years (<i>Praktiese ervaring vanaf junior jare</i>)	5;3;1	9 (3)	5
Knowledge (Gaining)	Improve knowledge (<i>Verhoog kennis</i>)	4;4	8 (4)	6
Exposure/experience (Different pathologies)	Different pathologies where you can give an input as a team member (<i>Verskeie patalogieë waarby jy as spanlid 'n inset kan lewer</i>)	5;3	8 (4)	6
Health Care Professionals (Role)	Role of the multi-disciplinary team (<i>Rol van die multi-dissiplinere span</i>)	4;2;1	7 (2.33)	7
Feeling valued (professional member)	Appreciation of community of you as a professional member (<i>Waardering van die gemeenskap vir jou as professionele lid</i>)	5	5 (5)	8
Exposure/ experience (introduction to clinical work)	Informal way of introduction to clinical work (<i>Informeel wyse van bekenstelling aan kliniese werk</i>)	4	4 (4)	9
Interpersonal Skills (communication skills)	Communication skills improve (<i>Kommunikasievaardighede verhoog</i>)	3	3 (3)	10
Interpersonal Skills (communication skills)	Language skills in more languages (<i>Taalvaardighede in meer tale</i>)	3	3 (3)	10
Social responsibility (improve communities)	Knowledge improve of people involved in the community (<i>Betrokennes in die gemeenskap se kennis verhoog</i>)	2	2 (2)	11

Category/Theme (n = 5)	Response	Voting count	Total voting count and averages	Priority
Personal growth (motivation)	Motivation aspect – student motivated to complete studies (<i>Motiveringsaspek – motiveer student om te kwalifiseer</i>)	1	1 (1)	12
Health Care Professionals (being a team member)	Involvement of senior students as member of a team (<i>Betrokkenheid van senior studente as lid van 'n span</i>)	0	0	13
Experience/ exposure (encounter with patients)	First exposure to possible patients (<i>Eerste blootstelling aan moontlike pasiënte/klënte</i>)	0	0	13
Experience/ exposure (different illnesses)	Different illness profiles in different regions (<i>Verskillende siekte profiele in verskillende streke</i>)	0	0	13
Interpersonal skills (group dynamics)	Group dynamics (<i>Groepsdinamika</i>)	0	0	13
Social Responsibility (caring for others)	Caring for others (<i>"Omgee" vir ander</i>)	0	0	13

The fourth group identified 20 aspects that influenced their CBE/SL experience in a positive way. In the first place they identified personal growth and the improvement of problem-solving skills (professional competencies) as the second most important aspect.

Priorities three and four included the application of theory in practice and social responsibility in terms of seeing needs outside your own frame of reference and the difference you make in the community. Other priorities that were identified were gaining experience from your junior years (exposure/experience), knowledge improvement, exposure to different pathologies, health care professionals, feeling valued in the community, exposure/ experience in terms of introduction to clinical work, improvement of communication skills (interpersonal skills), knowledge improvement of the people working with the communities (social responsibility) and motivation (personal growth).

Involvement as member of the multi-disciplinary team, practical skills in terms of exposure to patients, learning about different illnesses, group dynamics (interpersonal skills) and caring for others (social responsibility) were also mentioned, but did not receive any votes during the prioritisation process.

4.4.1.2 Responses on statement 2 'negative influence on your experience'

The tables below show the responses of the students during the NGT interviews regarding the second statement. In tables 4.7 to 4.10 the statement 'which aspects of CBE and/or SL in the Faculty of Health Sciences had a negative influence on your experience' are discussed.

TABLE 4.7: RESPONSES OF GROUP 1

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 8)	Response	Voting count	Total voting count and average	Priority
Health Care Professionals (Unprofessional behaviour)	Lack of professional courtesy and communication	5;5;5	15 (5)	1
Organisation (Between UFS and community)	Poor organisation between UFS & Community setting	5;5	10 (5)	2
Health Care Professionals (unwillingness to help)	Unwillingness to help other professionals	4;2;1	7 (2.33)	3
Communication (Language barrier)	Language barrier	4;2	6 (3)	4
Peer support (Incompetency)	Incompetency of certain team members	4;1;1	6 (2)	4
Transport (How to get there)	Transport – not taking in consideration "how"	3;1	4 (2)	5
Organisation (no learning outcomes)	Wasting time – no learning outcomes	2;2	4 (2)	5
Resources (Lack of)	Lack of resources	4	4 (4)	5
Knowledge (Too little knowledge)	Too little knowledge as 1 st year – therapeutic value	4	4 (4)	5
Health Care Professionals (Lack of knowledge on other professions)	Lack of knowledge between multi-disciplinary teams	3;1	4 (4)	5
Health Care Professionals (Neglecting patients)	Neglecting of patients	3	3 (3)	6
Organisation (Privacy)	Privacy of reflections on blackboard	3	3 (3)	6
Resources (Ineffective use)	Ineffective use of resources	3	3 (3)	6

Category/Theme (n = 8)	Response	Voting count	Total voting count and average	Priority
Emotional exposure (Debriefing)	Expose to emotional things without knowing how to deal with it	2	2 (2)	7
Organisation (Time allocation)	Inappropriate allocation of time in academic roster	0	0	8
Peer support (Commitment)	Lack of commitment from certain students	0	0	8
Patients (Lack of participation)	Lack of participation from patients' side	0	0	8

During the first group session, eight priorities were identified regarding the second statement. Lack of professional courtesy and communication from other health care professionals was identified as the most important. Some of the other priorities were poor organisation between the UFS and the community, the unwillingness of health care professionals to help students, language barrier, incompetence of fellow students (peer support) and transport in terms of 'how' to get there. A lack of clear outcomes and too little knowledge as first-year student, lack of resources and health care professionals that do not have knowledge of other professionals were other important aspects. The fifth and sixth priorities included neglecting patients (health care professionals), privacy of reflections (organisation) and being exposed to emotional things without knowing how to handle it (emotional exposure).

The last three responses did not get any votes (students were asked to identify only the five most important items) and were organisation (poor time allocation), lack of commitment from students (peer support) as well as lack of participation from patients (patients).

TABLE 4.8: RESPONSES OF GROUP 2

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 5)	Response	Voting count	Total voting count and average	Priority
Resources (Lack of)	Limited resources	2;4;4; 5;5;4	24 (4)	1
Transport (How to get there)	Transport	5;3;3; 2;1	14 (2.8)	2
Health Care Professionals (unwillingness to help)	Unwillingness of staff to do their jobs	4;3;3;2	12 (4)	3
Emotional exposure (debriefing)	Emotional drain/ desensitising (cut off – too much to take in)	5;2;2	9 (3)	4

Category/Theme (n = 5)	Response	Voting count	Total voting count and average	Priority
Organisation (unfairness)	Inconsistent system – unfairness – getting something vs getting nothing	5;4	9 (4.5)	4
Communication (Language barriers)	Communication barriers	1;3;2;2	8 (2)	5
Work pressure (limited time)	Work pressure/ Limited time	1;5;1	7 (2.33)	6
Patients (unwillingness/rude)	Rude patients/ Unwillingness to co-operate	1;3;1;1	6 (1.5)	7
Unproductive (feeling inadequate)	Failed, can't help patients – can't reach the outcomes	5	5 (5)	8
Health Care Professionals (negative attitude)	Opinion as student not valued	5	5 (5)	8
Theory – practice (different from theory)	Adapt – seems wrong according to theory (do things different than in books)	4	4 (4)	9
Communities (Misconceptions)	Unreasonable demand set by communities (wanting a flat screen television)	3;1	4 (2)	9
Unproductive (feeling inadequate)	Feeling inadequate	4	4 (4)	9
Health Care Professionals (expectations)	Expectations from clinic staff	4	4 (4)	9
Emotional exposure (devastating circumstances)	Exposing to devastating circumstances	3	3 (3)	10
Safety (feeling unsafe)	Feel unsafe	2	2 (2)	11
Guidance (induction and initiation)	Orientation into the community (induction and initiation)	0	0	12
Health Care Professionals (negative attitude)	Aggressive personnel – defence mechanism (feel threatened by you)	0	0	12
Cultural diversity (time concept)	Time concept of communities	0	0	12
Unproductive (feeling in the way)	You are in the way (feeling that you are in the way)	0	0	12
Health Care Professionals (lack of communication)	Lack of communication between MDT members	0	0	12

Twelve priorities were determined by the second group and included 21 responses. Lack of resources was voted as the most important aspect and received 24 votes. The second and third priorities were Transport and Health Care Professionals (unwillingness to help). Other priorities were emotional exposure, inconsistency of the system (organisation), communication, work pressure, unwillingness of patients, unproductive

in terms of inability to help patients and the negative attitude of health care professionals.

The rest of the priorities were adaptation in the clinical environment (theory – practice), expectations of the community, feeling inadequate (unproductive), expectations from health care professionals, being exposed to devastating circumstances and feeling unsafe. The last priority, number 12, was guidance (induction and initiation), aggressive personnel (health care professionals), cultural diversity, feeling in the way and lack of communication between health care professionals.

TABLE 4.9: RESPONSES OF GROUP 3

[TABLE CONTINUES ON NEXT PAGES]

Category/Theme (n = 8)	Response	Voting count	Total voting count and average	Priority
Organisation (finance)	Financial aspects regarding projects (<i>Finansiële aspekte rondom projekte</i>)	4;3;1	8 (2.66)	1
Emotional exposure (debriefing)	Debriefing absent (" <i>Debriefing</i> " <i>ontbreek</i>)	5;3	8 (4)	1
Organisation (poor planning)	Poor planning in the rosters for community projects (<i>Swak tydsbeplanning in die rooster vir gemeeskapsprojekte</i>)	5;3	8 (4)	1
Organisation (time insufficient)	Time connected to projects is not enough (<i>Tyd gekoppel aan die projek is nie genoegsaam</i>)	5;2	7 (3.5)	2
Organisation (poor planning)	Poor planning and organisation of lecturers (<i>Swak beplanning en organisering van dosente</i>)	4;1	5 (2.5)	3
Organisation (different expectations)	Differences in the expectations in the clinical field – lecturers and clinical staff expect different things/ do things different (<i>Verskille in verwagtinge in die kliniese veld - dosente en kliniese personeel verwag verskillende dinge/ doen dinge verskillend</i>)	5	5 (5)	3
Unproductive (feeling inadequate)	Uncertainty in terms of the application of practical skills – feeling inadequate (<i>Onsekerheid t.o.v toepassing van praktiese vaardighede – voel onbekwaam</i>)	5	5 (5)	3
Organisation (lecturers not involved)	Lecturers take no effort to be involved in projects (<i>Dosente doen nie moeite om betrokke te raak by projekte nie</i>)	4	4 (4)	4

Category/Theme (n = 8)	Response	Voting count	Total voting count and average	Priority
Unproductive (feeling in the way)	Feeling in the way (<i>Voel in die pad</i>)	4	4 (4)	4
Knowledge (Too little knowledge)	Little knowledge about the basics bedside manners (<i>Min kennis oor basiese "bedside manners"</i>)	4	4 (4)	4
Cultural diversity (pace of things)	Pace in which things happen in the community (<i>Tempo waarteen goed in die gemeenskap gebeur</i>)	3	3 (3)	5
Organisation (poor choices of communities)	Poor choices of community – projects – communities who already have everything (<i>Swak keuse v gemeenskapsprojekte – plekke wat reeds alles het</i>)	3	3 (3)	5
Organisation (expectations unreasonable)	Expectations of lecturers in terms of knowledge and skills not always in line with year (<i>Verwagtinge van dosente t.o.v kennis en vaardighede nie altyd jaar-gepas</i>)	2;1	3 (3)	5
Communication (community)	Keep communication channels open – in the community (<i>Komm kanale oop te hou - in die gemeenskap</i>)	2	2 (2)	6
Health Care Professionals (poor notes)	Poor process-notes – Drs in the hospitals/clinics do not always write up everything (<i>Swak prosesnotas - Drs in hospitale /kliniek teken nie als aan</i>)	2	2 (2)	6
Communication (language barrier)	Language barrier (<i>"Language barrier"</i>)	2	2 (2)	6
Organisation (donations misuse)	Donations used wrongly (<i>Misbruik van skenkings</i>)	1	1 (1)	7
Organisation (unfairness)	Uneven distribution of work between groups (<i>Groepe met oneweredige werksverspreiding</i>)	1	1 (1)	7
Peers (conflict in projects)	Conflict in group projects (<i>Konflik in groepsprojekte</i>)	0	0	8
Transport	Transport (<i>Transport</i>)	0	0	8
Resources (low)	Low resources (<i>Lae hulpbronne</i>)	0	0	8
Community (co-operation)	Low co-operation of the community (<i>Lae samewerking van die gemeenskap</i>)	0	0	8
Organisation (too many groups in one community)	Too many groups at the same community (<i>Te veel groepe by dieselfde gemeenskappe</i>)	0	0	8
Health Care Professionals (communication)	Interdisciplinary communication (<i>Interdissiplinêre kommunikasie</i>)	0	0	8

Category/Theme (n = 8)	Response	Voting count	Total voting count and average	Priority
Unproductive (cannot do what you really want)	Disappointment in the undertaking of projects – cannot always do what you want (<i>Teleurstelling in die uitvoering van projekte - kan nie altyd doen wat wil nie</i>)	0	0	8
Cultural diversity (older patients – unwillingness)	Age gap – patients usually older – do not want to listen to youngsters) (<i>Ouderdomsgaping - pasiënte gewoontlik ouer – wil nie "luister" vir jonges</i>)	0	0	8
Organisation (time and resources)	Too little time and resources to learn the basic skills (<i>Te min tyd en bronne om nodige vaardighede aan te leer</i>)	0	0	8
Organisation (absence of lecturers)	Absence of lecturers in the learning of skills (<i>Afwesigheid van dosente in die aanleer van vaardighede</i>)	0	0	8
Organisation (time wasting)	Time-wasting activities (<i>Tyd mors aktiwiteite</i>)	0	0	8

Twenty-nine responses were received during the third group session, which were divided into eight priorities. Financial aspect (organisation), emotional exposure and poor planning in the rosters (organisation) were voted as the most important aspects. Insufficient time, poor planning of lecturers, different expectations from lecturers and clinical staff (organisation), feeling inadequate (unproductive), poor involvement from lecturers, unproductive in terms of feeling in the way as well as having too little knowledge were other priorities.

Priorities five, six and seven were cultural diversity, poor choice of communities (organisation), unreasonable expectations from lecturers (organisation), communication in the community, health care professionals in terms of poor note keeping, language barrier, misuse of donations and uneven work distributions between groups.

Eleven responses did not receive any votes (students were asked to identify only the five most important items) and made up the eighth priority. These were conflict in student projects (peers), transport, low resources, co-operation from the community, organisation in terms of too many groups in one community, interdisciplinary communication (health care professionals), disappointment because students cannot always do what they want with the projects (unproductive), age gap between students

and older patients (cultural diversity), too little time and resources, absence of lecturers and time-wasting activities.

TABLE 4.10 RESPONSES OF GROUP 4

[TABLE CONTINUES ON NEXT PAGE]

Category/Theme (n = 5)	Response	Voting count	Total voting count and average	Priority
Resources (lack of)	Resources/equipment limited to none (<i>Hulpbronne/toerusting beperk tot geen</i>)	1;3;3;4; 4;5;5;5	29 (3.63)	1
Organisation (poor learning environment)	"Learning environment" not being created (<i>"Omgewing van leer" word nie geskep nie</i>)	5;4;3;3	15 (3.75)	2
Health Care Professionals (negative attitude)	Negative attitude of health care workers (<i>Negatiewe houding van gesondheidswerkers</i>)	5;4;3	12 (4)	3
Community (great needs)	Need in the community is too big (<i>Nood in die gemeenskap is te groot</i>)	5;4	9 (4.5)	4
Health Care Professionals (unprofessional behaviour)	Unprofessional behaviour from members of the team (staff) (<i>Onprofessionele gedrag van lede van die span (personeel)</i>)	4;3;1	8 (2.67)	5
Health Care Professionals (ignorance of students' levels of knowledge)	Ignorance of clinical personnel regarding the expectations in specific year groups (<i>Oningeligtheid van kliniese personeel t.o.v. verwagtinge binne spesifieke jaargroepe</i>)	5;2;1	8 (2.67)	5
Emotional exposure (emotional overload)	Emotional overload (<i>Emosioneel oorlaai</i>)	5;2	7 (3.5)	6
Organisation (time consuming)	Time consuming (<i>Tydrowend</i>)	4;2	6 (3)	7
Organisation (poor communication between institutions)	Poor communication between the UFS and the community (<i>Swak kommunikasie tussen UV en gemeenskap</i>)	4;1	5 (2.5)	8
Health Care Professionals (cooperation between different professionals)	Cooperation between MDT (<i>Samewerking tussen MDS</i>)	2;2	4 (2)	9
Guidance (lack of orientation)	Orientation not adequate for the area you are going to work (<i>Oriëntering nie voldoende vir die area waar jy gaan werk</i>)	3;1	4 (2)	9
Organisation (poor management)	(<i>Swak bestuur binne instansies</i>) Poor management inside organisation	3;1	4 (2)	9
Organisation (meaningfulness of residency)	Meaningfulness of the residency (<i>Betekenisvolheid van die inwoning</i>)	3	3 (3)	10

Category/Theme (n = 5)	Response	Voting count	Total voting count and average	Priority
Transport How to get there)	Transport(<i>Vervoer</i>)	2	2 (2)	11
Community (misconceptions)	Misconception of the community regarding the MDT(<i>Wanpersepsie van die gemeenskap t.o.v die MDS</i>)	2	2 (2)	11
Organisation (poor management)	Unorganised institution (<i>Ongeorganiseerdheid in die instansie</i>)	1	1 (1)	12
Safety (Feeling unsafe)	Safety aspect(<i>Veiligheidsaspek</i>)	1	1 (1)	12
Organisation (poor service delivery)	Poor service delivery in certain institutions(<i>Swak dienslewering in sekere instansies</i>)	0	0	13
Patients (negative)	Negative attitude of certain patients(<i>Negatiewe houding van sekere pasiënte</i>)	0	0	13
Organisation (lack of control)	Low control over students(<i>Lae kontrole oor student</i>)	0	0	13
Organisation (poor guidelines)	Poor guidelines regarding expectations(<i>Vae riglyne t.o.v verwagtinge</i>)	0	0	13
Communication (language barrier)	Language barrier (" <i>Language barrier</i> ")	0	0	13
Health Care Professionals (respect towards students)	Respect for student (Staff) [<i>Respek teenoor student (personeel)</i>]	0	0	13
Knowledge (inadequate knowledge regarding role of MDT)	Ignorance of the jnr student about the role of the MDT (nobody teaches you) [<i>Onkunde van die jnr student oor die rol van die MDS (niemand leer jou nie)</i>]	0	0	13
Organisation (unrealistic rosters)	Unrealistic expectations regarding the setting out of practical service times (<i>Onrealistiese verwagtinge t.o.v uiteensetting van praktiese dienste</i>)	0	0	13

The fourth and last group produced twenty-five responses, which were divided into thirteen priorities. The first priority, which received a total of twenty-nine votes, is limited resources. Poor learning environment (organisation) and the negative attitude of the health care workers were classified as the second and third priority.

Further priorities included great need in the community, health care professionals (unprofessional behaviour and ignorance of students' level of knowledge), emotional exposure, time consuming and the poor communication between the UFS and

institutions. Priorities nine and ten included cooperation between the members of the MDT, lack of orientation, poor management in the institutions (organisation) and the meaningfulness of the residency.

The lower priorities included transport, misconceptions in the community, poor organisation, safety, poor service delivery (organisation), negative attitude of the patients, low control over students (organisation), poor guidelines, communication, respect towards students (health care professionals), little knowledge regarding other professionals and unrealistic rosters. From the discussions in the NGT it was clear that students are very positive about CBE and SL; however, there are a few aspects that have a negative influence on their experiences.

4.4.1.3 *Combined data*

The categories are given according to the processed average mark (Van Breda 2005:7-8) that each category obtained through the combined data of each statement (positive influence/negative influence). The categories are shown in italics and the themes are discussed underneath that.

Different NGT interviews were used to obtain the data and therefore Van Breda's (2005:7-10) method was used to obtain averages in order to determine the priorities (cf. Table 4.11 to 4.12). The combined data were obtained by adding the scores of the four different groups in relation to a specific theme. Only examples of the responses received from students in the NGT are reflected in Table 4.11 and 4.12. The complete responses are given in Tables 4.3 to 4.10. The original Afrikaans responses (given in brackets and *italics*) were translated in English.

TABLE 4.11: COMBINED DATA OF STATEMENT 1 'POSITIVE INFLUENCE ON STUDENTS' EXPERIENCE' [TABLE CONTINUES ON NEXT PAGES]

Category/Theme (n=26)	Responses (examples)
<i>Personal Growth (27.2)</i> <ul style="list-style-type: none"> - Growing (6.2) - Strength and weaknesses (5) - Self-fulfilment (4) - Emotional Intelligence (3) - Self-confidence (3) - Appreciation (5) - Motivation (1) 	<ul style="list-style-type: none"> - Personal growth - Discover yourself in terms of strengths and weaknesses - Self-fulfilment - Gaining emotional intelligence - Self-confidence (<i>Selfvertroue</i>) - Appreciation of what you have (<i>Dankbaarheid vir wat jy self het</i>) - Motivation aspect – student motivated to complete studies (<i>Motiveringsaspek motiveer student om te kwalifiseer</i>)

Category/Theme (n=26)	Responses (examples)
Exposure/Experience (18.9) <ul style="list-style-type: none"> - Variety (3.3) - Acquiring (4.6) - From junior years (3) - Different pathologies (4) - Introduction to clinical work (4) 	<ul style="list-style-type: none"> - Variety of exposure - Gaining a lot of experience - Practical experience from junior years (<i>Praktiese ervaring vanaf junior jare</i>) - Different pathologies where you can give an input as a team member (<i>Verskeie patalogieë waarby jy as spanlid 'n inset kan lewer</i>) - Informal way of introduction to clinical work (<i>Informele wyse van bekendstelling aan kliniese werk</i>)
Social Responsibility (16.36) <ul style="list-style-type: none"> - Personal perception (2) - Serving (3.8) - Build Relationships (4) - Community needs (2.16) - Difference in the community (2.4) - Improve communities (2) 	<ul style="list-style-type: none"> - Personal perception of social responsibility - Serving the community - Build relationships inside the community (<i>Bou van verhoudinge binne die gemeenskap</i>) - See needs outside of your frame of reference (<i>Behoeftes buite jou verwysingsraamwerk raaksien</i>)
Interpersonal skills (14.63) <ul style="list-style-type: none"> - Communication skills (8.5) - People skills (3.63) - Interpersonal skills (2.5) 	<ul style="list-style-type: none"> - Communication skills (with group, patient, other professionals, etc.) - People skills (interaction with other people) - Interpersonal skills <i>improve</i> (<i>Interpersoonlike vaardighede verbeter, kommunikasie, verhoudinge ens</i>)
Cultural diversity (12.5) <ul style="list-style-type: none"> - Interaction (1.5) - Awareness (8.5) - Contact (2.5) 	<ul style="list-style-type: none"> - Interacting with people outside of your own environment - Learn more about cultures - Contact with diversity (<i>Kontak met diversiteit</i>)
Theory – Practice (12.25) <ul style="list-style-type: none"> - Application (10.25) - Integration (2) 	<ul style="list-style-type: none"> - Apply theory to practice - Integration of theory and practice in modules
Knowledge (12) <ul style="list-style-type: none"> - From practice (3) - Gaining (9) 	<ul style="list-style-type: none"> - Gaining knowledge from practice - Theoretical knowledge grows – find out more about illnesses (<i>Teoretiese kennis verbreed – vind meer uit oor siektes, ens</i>)
Professional Competencies (11.7) <ul style="list-style-type: none"> - Problem-solving skills (8.2) - Time Management skills (3.5) 	<ul style="list-style-type: none"> - Problem solving - Time Management
Practical skills (9.8) <ul style="list-style-type: none"> - Development (7.3) - Practice (2.5) 	<ul style="list-style-type: none"> - Developing skills in practical settings - Repetition of practical knowledge – can practice skills over and over (<i>Repetisie van praktiese kennis – kan vaardighede oor en oor oefen</i>)
Feeling valued (6.5) <ul style="list-style-type: none"> - Roles in the community (1.5) - Professional member (5) 	<ul style="list-style-type: none"> - Expectations/Role in different community settings - Appreciation of the community of you as a professional member (<i>Waardering van die gemeenskap vir jou as professionele lid</i>)

Category/Theme (n=26)	Responses (examples)
<i>Health Care Professionals (4.53)</i> - Collaboration (2.2) - Role (2.33)	- Working with and learning from the MDT - Role of the MDT (<i>Rol van die MDS</i>)
<i>Job satisfaction (4)</i> - Job satisfaction (4)	- Job satisfaction (<i>Werkstevredenheid</i>)
<i>Patients (3.5)</i> - Human aspect (3.5)	- Experience the human aspects of the patient
<i>Resources (3)</i> - Adapt (1) - Awareness (2)	- Learning to adapt to minimum - Resources - Awareness to use resources – learn which clinics, etc do what (<i>Bewuswording om hulpbronne te gebruik – leer waste klinieke ens. doen wat</i>)
<i>Guidance (2)</i> - Introduction (2)	- Gradual introduction
<i>Peer (1)</i> - Peer perspective (1)	- Perspective of the other year groups
<i>Celebration (1)</i> - Partners (1)	- Celebration (with partners)

TABLE 4.12: COMBINED DATA OF STATEMENT 1 'NEGATIVE INFLUENCE ON STUDENTS' EXPERIENCE' [TABLE CONTINUES ON NEXT PAGES]

Category/Theme (n=26)	Responses (examples)
<i>Organisation (59.41)</i> - Between UFS and community (5) - Privacy (3) - Finance (2.66) - Poor planning (6.5) - Time insufficient (3.5) - Different expectations (5) - No learning outcomes (2) - Unfairness (5.5) - Lecturers not involved (4) - Poor choices of communities (3) - Expectations unreasonable (3) - Donation misuse (1) - Poor learning environment (3.75) - Time consuming (3) - Poor communication between Institutions (2,5) - Poor management (3) - Meaningfulness of residency (3)	- Poor organisation between the UFS and Community setting - Privacy of reflections on blackboard - Financial aspects regarding projects (<i>Finansiële aspekte rondom projekte</i>) - Poor planning in the rosters for community projects (<i>Swak tyds-beplanning in die rosters vir gemeenskapsprojekte</i>) - Time connected to projects are not enough (<i>Tyd gekoppel aan projek is nie genoegsaam</i>) - Differences in the expectations in the clinical field / lecturers and clinical staff expect different things / do things different (<i>Verskille in verwagtinge in die kliniese veld dosente en kliniese personeel verwag verskillende dinge/ doen dinge verskillend</i>) - Wasting time – no learning outcomes - Inconsistent system – unfairness – getting something vs. getting nothing - Lecturers take no effort to be involved in projects (<i>Dosente doen nie moeite om betrokke te raak by projekte nie</i>) - Learning environment not being created (<i>Omgewing van leer word nie geskep nie</i>) - Poor management inside organisation (<i>Swak bestuur binne instansies</i>)

Category/Theme (n=26)	Responses (examples)
Health Care Professionals (39.67) <ul style="list-style-type: none"> - Unprofessional behaviour (7.67) - Unwillingness to help (6.33) - Lack of knowledge on other professions (4) - Neglecting patients (3) - Negative attitude (8) - Expectations (4) - Poor notes (2) - Ignorance of students' level of knowledge (2.67) - Co-operation between different professionals (2) 	<ul style="list-style-type: none"> - Lack of courtesy and communication - Unwillingness to help other - Professionals - Lack of knowledge between MDT - Neglecting patients - Opinion as student not valued - Expectations from clinic staff - Ignorance of clinical personnel regarding the expectations in specific year groups (<i>Oningeligtheid van kliniese personeel t.o.v. verwagtinge binne spesifieke jaargroepe</i>)
Unproductive (18) <ul style="list-style-type: none"> - Feeling inadequate (14) - Feeling in the way (4) 	<ul style="list-style-type: none"> - Failed, can't help patients – can't reach the outcomes - Feeling in the way (<i>Voel in die pad</i>)
Emotional exposure (15.5) <ul style="list-style-type: none"> - Debriefing (9) - Devastating circumstances (3) - Emotional overload (3.5) 	<ul style="list-style-type: none"> - Expose to emotional things without knowing how to deal with it - Exposing to devastating circumstances - Emotional overload (<i>Emosioneel oorlaai</i>)
Resources (14.63) <ul style="list-style-type: none"> - Lack of (11.63) - Ineffective use (3) 	<ul style="list-style-type: none"> - Lack of resources - Ineffective use of resources
Communication (9) <ul style="list-style-type: none"> - Language barrier (7) - Community (2) 	<ul style="list-style-type: none"> - Language barrier - Keep communication channel open – in the community (<i>Kommunikasie-kanale oop te hou – in die gemeenskap</i>)
Communities (8.5) <ul style="list-style-type: none"> - Misconceptions (4) - Great needs (4.5) 	<ul style="list-style-type: none"> - Unreasonable demand set by communities (wanting a flat screen tv) - Need in the community too big (<i>Nood in die gemeenskap te groot</i>)
Knowledge (8) <ul style="list-style-type: none"> - Too little knowledge (8) 	<ul style="list-style-type: none"> - Too little knowledge as 1st year – therapeutic value
Transport (6.8) <ul style="list-style-type: none"> - How to get there (6.8) 	<ul style="list-style-type: none"> - Transportation – not taking into consideration "how"
Theory – practice (4) <ul style="list-style-type: none"> - Different from theory (4) 	<ul style="list-style-type: none"> - Adapt – seems wrong according to theory (<i>do things different than in books</i>)
Safety (3) <ul style="list-style-type: none"> - Feeling unsafe (3) 	<ul style="list-style-type: none"> - Feel unsafe
Cultural diversity (3) <ul style="list-style-type: none"> - Pace of things (3) 	<ul style="list-style-type: none"> - Pace in which things happen in the community (<i>Tempo waarteen goed gebeur in die gemeenskap</i>)
Work pressure (2.33) <ul style="list-style-type: none"> - Limited time (2.33) 	<ul style="list-style-type: none"> - Work pressure / limited time
Guidance (2) <ul style="list-style-type: none"> - Lack of orientation (2) 	<ul style="list-style-type: none"> - Orientation not adequate for the area you are going to work (<i>Oriëntering nie voldoende vir die area waarin jy gaan werk</i>)

Category/Theme (n=26)	Responses (examples)
<i>Peer support</i> (2) - Incompetency (2)	- Incompetency of certain peer members
<i>Patients</i> (1.5) - Unwillingness/rude (1.5)	- Rude patients/ unwillingness to co-operate

Only examples of the students' responses were repeated in the combined data.

TABLE 4.13: COMBINED RESULTS OF THE TWO STATEMENTS

Positive influence on students' experience	Negative influence on students' experience
Personal Growth (27.2)	Organisation (59.41)
Exposure/Experience (18.9)	Health Care Professionals (39.67)
Social Responsibility (16.36)	Unproductive (18)
Interpersonal skills (14.63)	Emotional exposure (15.5)
Cultural diversity (12.5)	Resources (14.63)
Theory – Practice (12.25)	Communication (9)
Knowledge (12)	Communities (8.5)
Professional Competencies (11.7)	Knowledge (8)
Practical skills (9.8)	Transport (6.8)
Feeling valued (6.5)	Theory – practice (4)
Health Care Professionals (4.53)	Safety (3)
Job satisfaction (4)	Cultural diversity (3)
Patients (3.5)	Work pressure (2.33)
Resources (3)	Guidance (2)
Guidance (2)	Peer support (2)
Peer (1)	Patients (1.5)
Celebration (1)	

Seventeen categories were identified for the statement "positive influence on students' experience". *Personal growth* was considered as the most important category, with an average voting count of 27.2. The themes that were identified in this category are growing, strengths and weaknesses, self-fulfilment, emotional intelligence, self-confidence, appreciation and motivation. Students were of the opinion that CBE and/or SL assisted them in developing personally on different levels. The second most important category was *exposure/experience* and students agreed that CBE and/ or SL expose them to multiple patients and that they acquire a lot of practical experience.

Social responsibility was also emphasised and students felt that their perception of community service and social responsibility changed during CBE and/or SL. Furthermore, students believed that there was an improvement in their *interpersonal skills* and that they gain knowledge on different cultures and became more aware of *cultural diversity*.

The sixth category that was identified was *theory-practice* and students were of the opinion that CBE and/or SL provided them the opportunity to apply and integrate their practical knowledge. In addition, they gained more *knowledge* as well. *Professional competencies* were also highlighted and students believed that their problem-solving and time management skills improved through CBE and/or SL.

Practical skills were also important to students and they said that they got the opportunity to develop their practical skills. Additionally, students regard *feeling valued* as an important aspect whereby they felt that the community appreciates their efforts. Students also emphasised that they benefit from working with other *Health Care Professionals* and experience a sense of *job satisfaction*.

The last five categories that were identified include *patients, resources, guidance, peers* and *celebration*. Students enjoyed the interaction with patients and learnt to adapt to the available resources. They experienced the gradual introduction to clinical experience from their first to final year as positive as well as the support they received from senior students. The celebrations with the communities on completion of CBE and/or SL were also enjoyable.

From the second statement "negative influence on students' experience" 16 categories were identified. The most important category that was identified was *Organisation* with a total voting count of 59.41. This category comprised of the following themes: between the UFS and the community, privacy, finance, poor planning, time insufficient, different expectations, no learning outcomes, unfairness, lecturers not involved, poor choices of communities, expectations unreasonable, donation misuse, poor learning environment, time-consuming, poor communication between institutions, poor management and meaningfulness of residency. All of these themes relates to the management or organisational aspects regarding CBE and/or SL.

The second category was *Health Care Professionals* and students were of the opinion that certain Health Care Professionals are unprofessional, have a negative attitude towards students and/or patients; they do not have sufficient knowledge of other professions and do not want to work with them; they have poor patient notes and are not always familiar with what the students' level of knowledge are for the different study years and disciplines. Thirdly, students emphasised *unproductive* and felt they

were sometimes in the way and did not have adequate knowledge to treat patients sufficiently.

Emotional exposure was identified as the fourth important category and students thought that CBE and/or SL expose them sometimes to emotional aspects that they were not ready to handle and emphasised that debriefing is an important component of CBE and/or SL. Lack of *resources* had a negative impact on students as well as the *communication* barrier, in that patients/members of the communities and students do not always understand each other.

The misconception in the *communities* regarding the roles and expectations of students as well as the great needs made a negative impression on students and they felt that they sometimes do not have sufficient *knowledge* to treat the patients. A few students mentioned *transport* difficulties as a constraint and there were also students that thought that things were done differently in practice than in theory and it confused them (*theory-practice*).

Safety was also mentioned as an important factor and students did not always feel safe during CBE and/or SL. *Cultural diversity* and *work pressure* were emphasised and it was mentioned that the pace in which communities function differ from what students are used to and that they are sometimes pressured to complete projects in a limited time.

Guidance, *peer support* and *patients* were identified as the last three categories and students felt that they did not always receive the necessary guidance from lecturers and that their peers are not always competent to support them during CBE and/or SL activities. Patients are also not always willing to co-operate with students.

4.5 CONCLUSION

In this chapter the findings of the NGT that were held with the class leaders from the different year groups of undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS were described. Different aspects that had a positive and negative influence on the students' experience of CBE and/or SL were identified and divided into 17 "positive" and 16 "negative" categories and discussed by the researcher.

The aim of the NGT was to identify the most important aspects that have an influence on the way students experience CBE and SL to assist in the development of a questionnaire. All the different categories that were identified during the NGT were included in the questionnaire that was administered to all the undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS.

In Chapter 5, **Description and discussion on the results of the questionnaire survey**, the results from the undergraduate students' questionnaire surveys conducted as part of this study will be discussed. The questionnaire survey yielded both quantitative (numerical) and qualitative (text) data from closed and open-ended questions respectively. This chapter reports on the second phase of the mixed model research design used in the study.

CHAPTER 5

DESCRIPTION AND DISCUSSION ON THE RESULTS OF THE QUESTIONNAIRE SURVEY

5.1 INTRODUCTION

This chapter presents the results of the undergraduate students' questionnaire survey conducted in the Faculty of Health Sciences, University of the Free State (UFS) as part of this study. The questionnaire survey yielded both quantitative (numerical) and qualitative (text) data from closed and open-ended questions respectively. This chapter reports on the second phase of the mixed methods approach used in the study, namely exploratory (cf. Figure 3.2). The instrument used during this phase of the mixed methods study included the Community-based Education and Service Learning Questionnaire that was available in both English and Afrikaans (Appendix B).

The questionnaire was designed to obtain demographic information of the participants, explore the students' views, attitudes and perceptions regarding CBE and SL and identify whether there are certain factors that influence students' experience of CBE and SL. As elucidated in Chapter 3 (cf. 3.3.3.2), the statements included in the questionnaire were based on the information gathered in the NGT as well as studying the literature on CBE, SL and the assessment of student experiences.

The demographic description of the sample is presented first (cf. 5.2: Demographic information). The demographic information includes biographic data such as age, gender, field of study, study year and ethnic group.

The second section of the questionnaire deals with the students' experiences regarding community-based education and/or Service Learning (cf. 5.3: Experiences regarding community-based education and/or Service Learning). This section is divided into five sub-sections, namely personal level, value of CBE and/or SL, community involvement and social responsibility, organisation and support/supervision during CBE/SL.

The third section of the questionnaire deals with satisfaction from CBE and/or SL and included reasons why students enjoy CBE and/or SL and what can be done to improve CBE and/or SL in the FHS, UFS (cf. 5.4: Satisfaction from CBE and/or SL).

In this chapter, the percentages have been worked out to the second decimal figure. Therefore, the percentages would not add up to 100% in some cases. This is applicable to all figures and tables in this chapter where percentages have been worked out.

5.2 DEMOGRAPHIC INFORMATION

[Please compare Section 1 of Questionnaire (Appendix B)]. Respondents were asked to give information on their age, gender, field of study, study year and ethnic group.

5.2.1. Age distribution of students in the sample

Figure 5.1 indicates the age distribution of the sample. All the respondents answered the question on age.

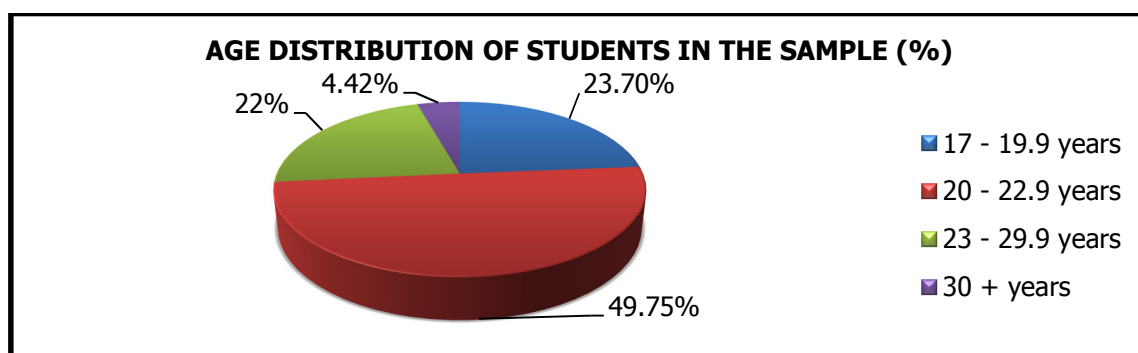


FIGURE 5.1: AGE DISTRIBUTION OF STUDENTS IN THE SAMPLE (%)
(Question 1, Section 1 of Questionnaire) [n=792]

Discussion: Of the respondents 23.74% were between 17-19.9 years, 49.75% were between the ages 20 – 22.9 years, 22.10% were between 23 – 29.9 years and only 4.42% were above 30 years of age.

Figure 5.2 indicates the age distribution in the Schools of Medicine, Nursing and Allied Health Professions respectively.

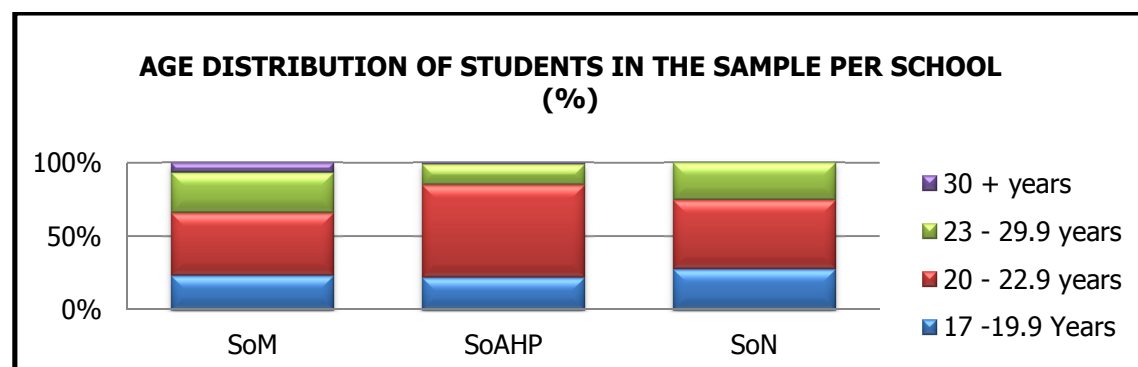


FIGURE 5.2: AGE DISTRIBUTION OF STUDENTS IN THE SAMPLE PER SCHOOL (%)
(Question 1, Section 1 of Questionnaire) [n=790]

Discussion: In both the Schools of Medicine and Nursing nearly half of the students were between the ages of 20 – 22.9 years and a quarter of the students between 17 – 19.9 years and 23 – 29.9 years respectively, with only a few students above the age of 30. Almost two thirds of the students in the School for Allied Health Professions fell in the age group 20 – 22.9 years, nearly one fifth were between 17 – 22.38 years and the rest were older than 23 years. The findings indicate that there is a good distribution as far as age of respondents is concerned with most respondents in the age bracket of their early twenties. It appears, therefore, that most students entered their degree courses immediately after completing their schooling.

5.2.2 Gender distribution of students in the sample

The gender distribution for all the students in the sample population from the Faculty of Health Sciences is represented in Figure 5.3. Of the respondents, 790 indicated their gender, while 2 students omitted this answer.

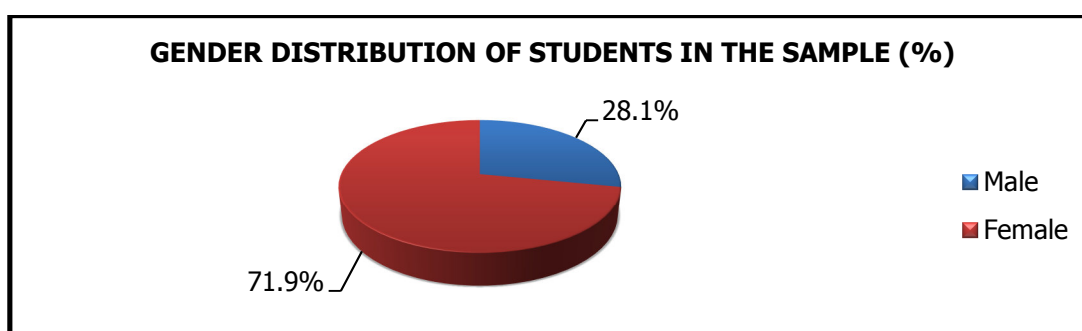


FIGURE 5.3: GENDER DISTRIBUTION OF STUDENTS IN THE SAMPLE (%)
(Question 2, Section 1 of Questionnaire) [n=790]

Figure 5.4 indicates the gender distribution in the Schools of Medicine, Nursing and Allied Health Professions respectively.

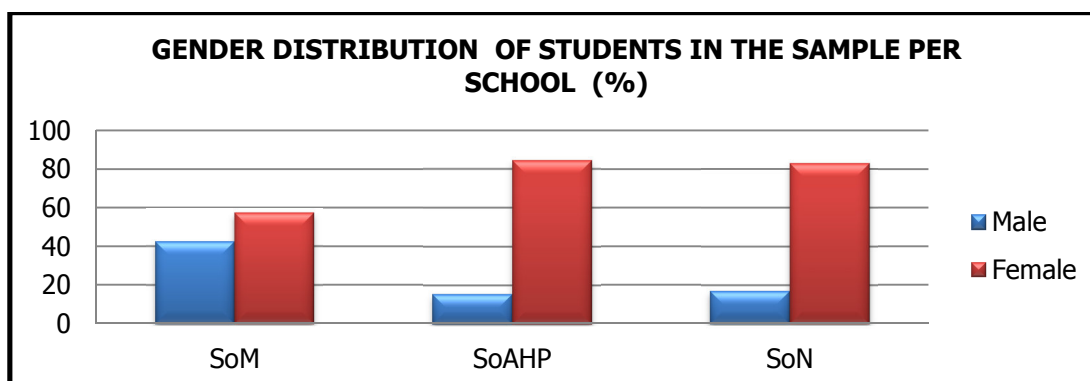


FIGURE 5.4: GENDER DISTRIBUTION OF STUDENTS IN THE SAMPLE PER SCHOOL (%)
(Question 2, Section 1 of Questionnaire) [n=790]

Discussion: In the School of Medicine, there is a slight difference in the gender distribution (42.43% male, 57.3% female); while in both the Schools for Allied Health Professions (15.58% male, 84.42% female) and Nursing (17.09% male, 82.92% female), female students made up the majority of the groups. In the SoM, the selection process ensures that equal numbers of male and female students are admitted to the M.B., Ch.B. programme (Selection Policy 2010, FOHS, UFS); however, it does not mean that equal numbers of males and females necessarily complete their degrees, which may explain the difference in gender in the SoM. The professions of Nursing [SoN] and Occupational Therapy, Physiotherapy and Dietetics [SoAHP] are traditionally and historically dominated by females, which may clarify the larger numbers of female students in the Schools for Allied Health and Nursing.

5.2.3. Study field distribution of the students in the sample

The study population (n = 792) included students from the Schools of Medicine (SoM), Allied Health Professions (SoAHP) and Nursing (SoN) in the Faculty of Health Sciences (FoHS), UFS, who participated in CBE and/or SL during 2011 and voluntarily completed an anonymous questionnaire during an academic contact session. Figure 5.5 indicates the different study fields of the students in the sample.

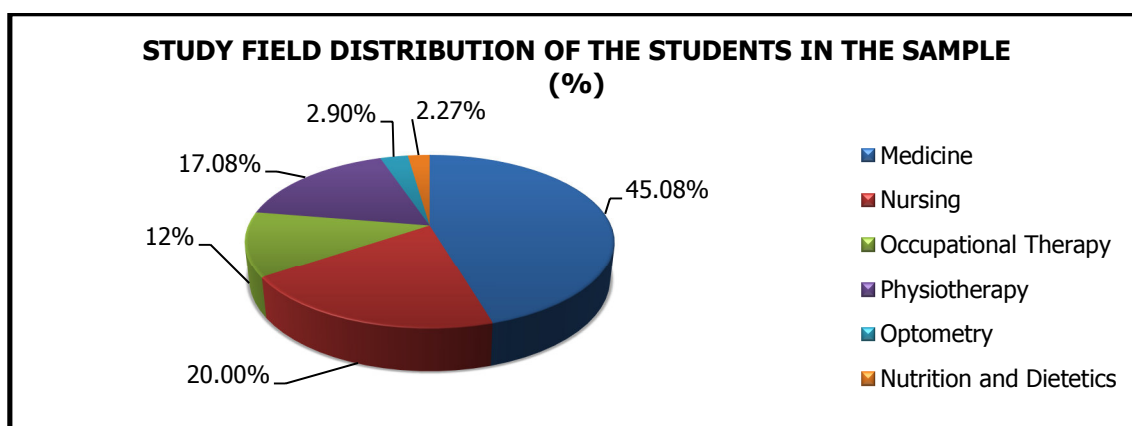


FIGURE 5.5: STUDY FIELD DISTRIBUTION OF THE STUDENTS IN THE SAMPLE (%) (Question 3, Section 1 of Questionnaire) [n=792]

Discussion: Approximately 50% of the students were studying Medicine and 20% of the students Nursing. The distribution of students in the School for Allied Health Professions include 12% Occupational Therapists, 17.08% Physiotherapists, 2,90% Optometrists and 2,27% Nutrition and Dieticians. Only students who participated in CBE and/or SL during 2011 were included in the study, which means that only one

year group from Optometry (3rd years), and Nutrition and Dietetics (4th years) were included, which explains the small numbers in these study fields.

5.2.4 Study year distribution of students in the sample

Figure 5.6 indicates the academic year of study of the students in the sample population. As stated in Chapter 3 [Methodology and Research Design], the sample population included all the undergraduate students in the Faculty of Health Sciences, UFS who participated in CBE and/or SL during 2011. This included first-year to final-year undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS.

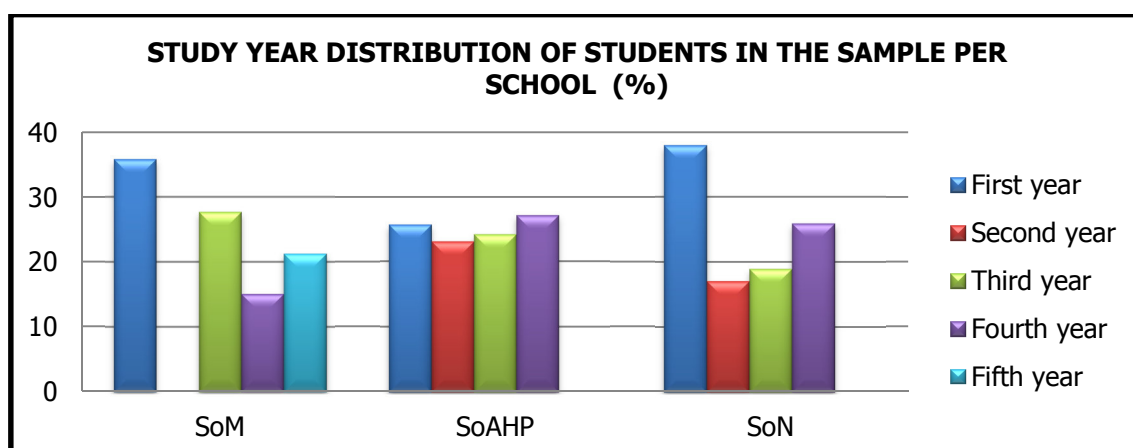


FIGURE 5.6: STUDY DISTRIBUTION OF STUDENTS IN THE SAMPLE PER SCHOOL (%)
(Question 4, Section 1 of Questionnaire) [n=792]

Discussion: Students who did not participate in any CBE and/or SL activities during 2011 include the second-year students in the School of Medicine, the first, second and fourth year Optometry students (School for Allied Health Professions) and the first, second and third year Nutrition and Dietetics students (School Allied Health Professions) and therefore these students were excluded from the study.

There were 35.85%, 25.63% and 37.97% first-year students in the Schools of Medicine, Allied Health Professions and Nursing respectively. In the School for Allied Health Professions 23.1% and in the School of Nursing 17.09% of the students were in their second year of study. The third-year students comprised 27.73% students in the School of Medicine, 24.19% of students in the School for Allied Health Professions and 18.99% in the School of Nursing.

A total of 15.12%, 27.07% and 25.95% of the students were in their fourth year of study in the respective Schools of Medicine, Allied Health Professions and Nursing, while 21.29% of the students in the School of Medicine were in their fifth (final) year of study.

The findings indicate that there is a good distribution as far as study years are concerned, with almost equal numbers of junior and senior students included in the study.

5.2.5 Ethnicity of the students in the sample

Figure 5.7 indicates the ethnic groups that students in the sample belong to (n= 780), as indicated by students in the questionnaire survey.

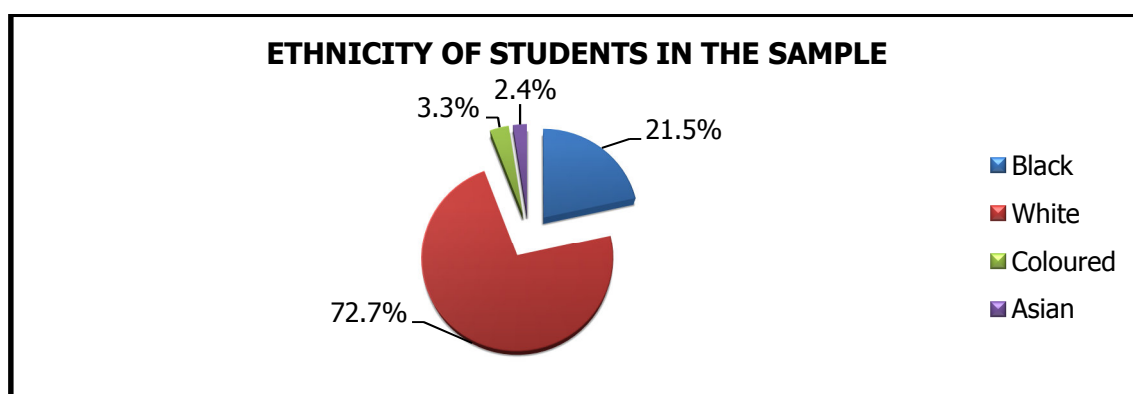


FIGURE 5.7: ETHNICITY OF STUDENTS IN THE SAMPLE (%)
(Question 5, Section 1 of Questionnaire) [n=780]

Figure 5.8 indicates the ethnic groups that students in the sample belong to (n= 780 in the Schools of Medicine, Allied Health Profession and Nursing respectively).

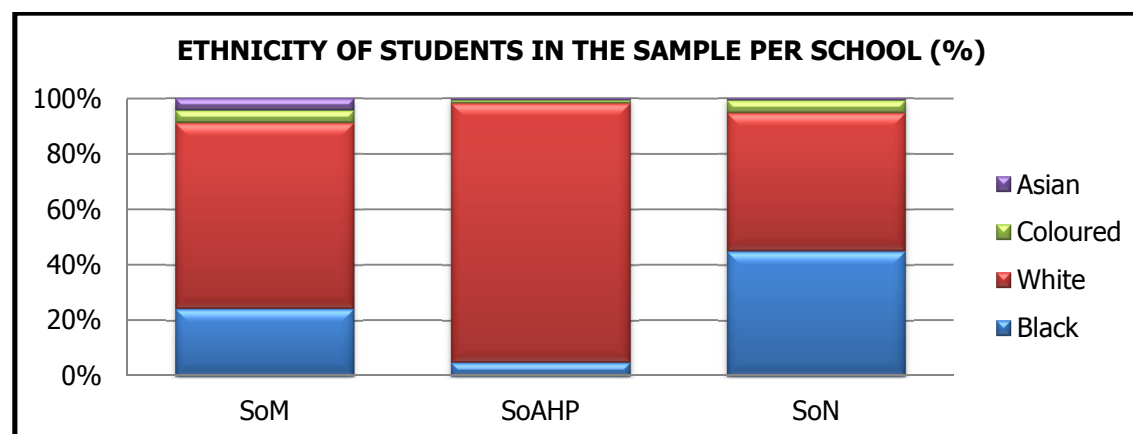


FIGURE 5.8: ETHNICITY OF STUDENTS IN THE SAMPLE PER SCHOOL (%)
(Question 5, Section A of Questionnaire) [n=780]

Discussion: The majority of students in the SoM (66.86%) and SoAHP (93.12%) were White, while 50% of students in the SoN were White. The rest of the students were Black (SoM 24.29%, SoAHP 5.07%, SoN 44.81%), and only small numbers of students represented other ethnic groups. In the SoM, 4.57% of the students were Coloured, and 4.29% were Asian, while in the SoAHP, 1.08% were Coloured and 0.72% Asian respectively. In the SoN, 4.55% of the students were Coloured students, and 0.72% Asian. From these results, it appears that this cohort of students represents mostly White students, while almost one third and half of the students in the SoM and SoN respectively were Black.

5.3 RESULTS OF QUESTIONNAIRE SURVEY SECTION 2 [EXPERIENCES REGARDING COMMUNITY-BASED EDUCATION AND SERVICE LEARNING]

[Please compare Section 2 of Questionnaire (Appendix B)].

Section 2 of the questionnaire focuses on students' experiences during CBE and/or SL. This was determined by means of undergraduate students' responses on statements in five different sub-sections, namely personal level, value of CBE and/or SL, community involvement and social responsibility, organisation and support/supervision during CBE/SL. Data collected include quantitative (statistical) data in the form of responses on a Likert scale to closed questions. Students were asked to indicate their agreement or disagreement with the given statements on a Likert scale of 1 – 5, where 1 = strongly disagree, 2 = disagree; 3 = neutral, 4 = agree and 5 = strongly agree.

5.3.1 Personal Level

Table 5.1 indicates the quantitative results for the statements reflecting how students experience CBE and/or SL on a personal level, in each of the three Schools in the FoHS. In the table the responses 1 and 2 on the scale are grouped together to represent disagreement, response 3 indicates neutral, while responses 4 and 5 are grouped together to represent agreement with each statement.

TABLE 5.1: STUDENTS' AGREEMENT/DISAGREEMENT WITH STATEMENTS REGARDING EXPERIENCE OF CBE AND/OR SL ON A PERSONAL LEVEL
(Question 2.1, Section 2 of Questionnaire) [Table continues on next page]

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
When I serve another person, I am thankful for the opportunity to help (n = 788)	(6) 1.69	(0) 0	(3) 1.91	(41) 11.58	(23) 8.30	(15) 9.55	(307) 86.72	(254) 91.70	(139) 88.54
During CBE and/or SL I discovered my own personal strengths (n = 790)	(40) 11.24	(14) 5.07	(10) 6.33	(127) 35.67	(86) 31.16	(36) 22.78	(189) 53.09	(176) 63.77	(112) 70.89
During CBE and/or SL I discovered my own personal weaknesses (n = 785)	(43) 12.18	(11) 3.99	(12) 7.69	(122) 34.56	(96) 43.78	(37) 23.72	(188) 53.26	(169) 61.23	(107) 68.59
I experienced a sense of self-fulfilment during CBE and/or SL activities (n = 787)	(29) 8.22	(16) 5.80	(8) 5.06	(112) 31.73	(67) 24.28	(40) 25.32	(212) 60.06	(193) 69.93	(110) 69.62
CBE and/or SL helped me to grow as a person (n=791)	(25) 7.02	(8) 2.89	(7) 4.43	(129) 36.24	(80) 28.88	(50) 31.65	(202) 56.74	(189) 68.23	(101) 63.92
CBE and/or SL exposed me to emotional experiences that I did not know how to handle (n = 785)	(115) 32.39	(50) 18.25	(20) 12.82	(109) 30.70	(87) 31.75	(38) 24.36	(131) 36.90	(137) 50.00	(98) 62.82
I sometimes felt that I failed the patients/ community, because I could not help them efficiently (n = 788)	(79) 22.25	(49) 17.75	(31) 19.75	(134) 37.75	(113) 40.94	(44) 28.03	(142) 40.00	(114) 41.30	(82) 52.23
CBE and/or SL was a waste of my time (n = 781)	(250) 70.42	(204) 75.28	(104) 67.10	(82) 23.10	(45) 16.61	(32) 20.65	(23) 6.48	(22) 8.12	(19) 12.26

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAH	SoN	SoM	SoAHP	SoN
CBE and/or SL have no value in the junior years, because students have too little knowledge in their field (n = 789)	(182) 51.27	(149) 53.99	(77) 48.73	(80) 22.54	(71) 25.72	(40) 25.23	(93) 26.20	(56) 20.29	(41) 25.95
CBE and/or SL was emotionally draining and took too much of me as a student (n = 787)	(171) 48.17	(107) 38.91	(37) 23.57	(97) 27.32	(92) 33.45	(44) 28.03	(87) 24.51	(76) 27.64	(76) 48.41
The devastating circumstances of some of the people in the community that I was exposed to during CBE and/or SL really upset me (n = 787)	(76) 21.47	(51) 18.48	(28) 17.83	(107) 30.23	(90) 32.61	(57) 36.31	(171) 48.31	(135) 48.91	(72) 45.86
I sometimes felt in the way of other clinical staff during CBE and/or SL activities (n = 784)	(89) 25.36	(91) 32.97	(38) 24.20	(108) 30.77	(89) 32.25	(46) 29.30	(154) 43.87	(96) 34.78	(73) 46.50
I usually leave a CBE and/or SL activity with ideas for additional ways that I can be involved in future (n = 784)	(58) 16.43	(27) 9.85	(18) 11.46	(160) 45.33	(127) 46.35	(72) 45.86	(135) 38.24	(120) 43.80	(67) 42.86
As a result of my community involvement (in the Faculty), the direction of my life has dramatically changed (n = 791)	(113) 31.74	(56) 20.22	(34) 21.52	(170) 47.75	(139) 50.18	(49) 31.01	(73) 20.51	(82) 29.60	(75) 47.47

Discussion: Only statements that 50% or more of the students agreed or disagreed on (cf. Table 5.1. marked in bold) are discussed below; for the rest of the results cf. Table 5.1.

Being thankful for the opportunity to serve other people appears to be the most important factor that has a positive influence on students' experience of CBE and/or SL on a personal level and of the respondents 86.72% (SoM), 91.70% (SoAHP) and 88.54% (SoN) agreed with this statement. Of the respondents 53.09% (SoM), 63.77% (SoAHP) and 70.89% (SoN) agreed that they discovered their own personal strengths during CBE and/or SL, while 53.26% (SoM), 61.23% (SoAHP) and 68.82% (SoN) agreed that they were also able to discover their personal weaknesses during CBE and/or SL.

Additionally, 60.06% (SoM), 69.93% (SoAHP) and 69.62% (SoN) of the respondents agreed that they experienced a sense of self-fulfilment during CBE and/or SL activities and 56.74% (SoM), 68.23 (SoAHP) and 63.92% (SoN) of the respondents agreed that CBE and/or SL helped them grow as a person.

Of the respondents 50.00% (SoAHP) and 62.82% (SoN) agreed that CBE and/or SL exposed them to emotional experiences that they did not know how to handle; however, only 36.90% of the respondents from the SoM agreed with this statement.

In the SoN 52.23% of the respondents felt that they sometimes failed the patients/community because they could not help them efficiently, while only 40.00% (SoM) and 41.30% (SoAHP) felt the same.

Furthermore, 70.42% (SoM), 75.28% (SoAHP) and 67.10% (SoN) of the respondents did not agree with the statement that CBE and/or SL are a waste of their time. Approximately half of the respondents from all three schools (51.27%, 53.99% and 48.73%) respectively did not agree with the statement that CBE and/or SL had no value in the junior years, because students have too little knowledge in their field.

It is clear from these findings that the students experience CBE and/or SL positively as far as their personal growth is concerned. They experience a sense of self-fulfilment, grow as a person, discover their own personal strengths and weaknesses and they are thankful for the opportunity to serve other people and do not experience it as a waste

of time. Furthermore, they do feel that CBE and/or SL has value in the junior years; however, some of the students, especially in the Schools of Allied Health Professions and Nursing felt that they are exposed to emotional circumstances that they did not know how to handle.

5.3.2 Value of CBE and/or SL

Table 5.2 indicates the quantitative results for the statements reflecting what the students believe the value of CBE and/or SL are, in each of the three Schools in the FoHS. Responses 1 and 2 on the scale are grouped together to represent disagreement, response 3 indicates neutral, while responses 4 and 5 are grouped together to represent agreement with each statement in the table.

TABLE 5.2: STUDENTS' AGREEMENT/DISAGREEMENT WITH STATEMENTS REGARDING THE VALUE OF CBE AND/OR SL
(Question 2.2, Section 2 of Questionnaire) [Table continues on next page]

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
CBE and/or SL helped me to experience the "human aspect" of patients as opposed to only the theory (n = 789)	(16) 4.49	(5) 1.81	(14) 8.97	(55) 15.45	(39) 14.08	(30) 19.23	(285) 80.06	(233) 84.12	(112) 71.79
I got exposed to a variety of conditions/cases relevant to my field of study during CBE and/or SL (n = 789)	(40) 11.27	(13) 4.69	(5) 3.18	(80) 22.54	(46) 16.61	(27) 17.20	(235) 66.20	(218) 78.70	(125) 79.62
CBE and/or SL helped me put my knowledge into practice (n = 791)	(42) 11.76	(14) 5.05	(5) 3.18	(92) 25.77	(54) 19.94	(28) 17.83	(223) 62.46	(209) 75.45	(124) 78.98
CBE and/or SL provided me with hands-on use of skills that increased the relevance of academic skills (n = 791)	(40) 11.20	(12) 4.33	(6) 3.82	(103) 28.85	(66) 23.83	(33) 21.02	(214) 59.94	(199) 71.84	(118) 75.16

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
CBE and/or SL provided me with hands-on use of knowledge that increased the relevance of academic skills (n = 789)	(33) 9.27	(17) 6.14	(8) 5.13	(106) 29.78	(71) 25.63	(37) 23.72	(217) 60.69	(189) 68.23	(111) 71.15
CBE and/or SL taught me the roles and value of the multi-disciplinary team (n = 787)	(30) 8.45	(31) 11.23	(12) 7.69	(58) 16.34	(67) 24.28	(39) 25.00	(267) 75.21	(178) 64.49	(105) 67.31
Exposure to certain diseases/cases during CBE and/or SL "forced" me to search for additional information with a view to learn extra things, which I would not have done otherwise (n = 791)	(52) 14.57	(36) 13.00	(9) 5.73	(93) 26.05	(85) 30.69	(36) 22.93	(212) 59.38	(156) 56.32	(112) 71.34
Through CBE and/or SL I learned a lot about other cultures (n = 790)	(47) 13.20	(35) 12.64	(8) 5.10	(114) 32.02	(81) 29.24	(37) 23.57	(195) 54.78	(161) 58.12	(112) 71.34
CBE and/or SL improved my self-confidence (n = 786)	(45) 12.68	(29) 10.51	(20) 12.90	(105) 29.58	(75) 27.17	(37) 23.87	(205) 57.75	(172) 62.32	(98) 63.23
CBE and/or SL improved my interpersonal communication skills (n = 789)	(39) 10.96	(20) 7.22	(11) 7.05	(90) 25.28	(53) 19.13	(32) 20.51	(227) 63.76	(204) 73.65	(113) 72.44
My problem-solving skills improved as a result of CBE and/or SL (n = 790)	(44) 12.36	(15) 5.42	(12) 7.64	(115) 32.30	(78) 28.16	(48) 30.57	(197) 55.34	(184) 66.43	(97) 61.78
My time management skills improved during CBE and/or SL (n = 789)	(83) 23.31	(42) 15.22	(24) 15.29	(134) 37.64	(93) 33.70	(47) 29.94	(139) 39.04	(141) 51.09	(86) 54.78

Discussion: Only statements that 50% or more of the students agreed or disagreed on (cf. Table 5.2. marked in bold) are discussed below, for the rest of the results cf. Table 5.2.

To be able to experience the “human aspect” of patients as opposed to only theory appears to be the most valuable experience students gained from CBE and/or SL and 80.06% (SoM), 84.12% (SoAHP) and 71.79% (SoN) of the respondents respectively agreed with this statement.

Furthermore, the students agreed that CBE and/or SL exposed them to a variety of conditions/cases relevant to their field of study [66.20% (SoM), 78.70% (SoAHP) and 79.62% (SoN)] and that it helped them put their knowledge into practice [62.46% (SoM), 75.45% (SoAHP) and 78.98% (SoN)]. Of the respondents, 59.94% (SoM), 71.84% (SoAHP) and 75.16% (SoN) respectively agreed that CBE and/or SL provided them with hands-on use of their skills that increased the relevance of academic skills, while 60.69% (SoM), 68.23% (SoAHP) and 71.15% (SoN) respectively agreed that CBE and/or SL provided them with hands-on use of their knowledge that increased the relevance of academic skills.

Additionally, 75.21% (SoM), 64.49 % (SoAHP) and 67.31% (SoN) of the students agreed that CBE and/or SL taught them the roles and value of the multi-disciplinary team. Of the respondents, 59.38% (SoM), 56.32% (SoAHP) and 71.34% (SoN) agreed with the statement that exposure to certain diseases/cases during CBE and/or SL “forced” students to search for additional information with a view to learning extra things, which they would not have done otherwise. Another valuable experience CBE and/or SL gave students was the opportunity to learn about other cultures [54.78% (SoM), 58.12% (SoAHP) and 71.34% (SoN)] and students were also of the opinion that it improved their self-confidence [54.78% (SoM), 58.12% (SoAHP) and 71.34% (SoN)].

The students furthermore believed that CBE and/or SL improved certain professional competencies and agreed that their inter-personal communication skills [63.76% (SoM), 73.65% (SoHA), 72.44% (SoN)], problem-solving skills [55.34 % (SoM), 66.43% (SoAHP), 61.78% (SoN)] and time management skills [51.09% (SoAHP), 54.78% (SoN)] improved.

From the above findings it is clear that students are of the opinion that CBE and/or SL is a valuable experience. They agreed that through CBE and/or SL they had the opportunity to experience the “human aspect” of patients as opposed to only theory; they were exposed to a variety of conditions/cases that are relevant to their field of study; they could put their knowledge into practice; and had the opportunity to practice their skills and apply their knowledge. Furthermore, they learnt about the roles and values of the multi-disciplinary teams, were forced to seek additional information which they would not have done otherwise and they learnt about other cultures. CBE and/or SL improved their self-confidence, interpersonal communication skills, problem-solving skills as well as their time management skills.

5.3.3 Community involvement and social responsibility

Table 5.3 indicates the quantitative results for the statements reflecting how students, in each of the three schools in the FHS, experience CBE and/or SL as far as community involvement and social responsibility is concerned. In the table, responses 1 and 2 on the scale are grouped together to represent disagreement, response 3 indicates neutral, while responses 4 and 5 are grouped together to represent agreement with each statement.

TABLE 5.3: STUDENTS’ AGREEMENT/DISAGREEMENT WITH STATEMENTS REGARDING COMMUNITY INVOLVEMENT AND SOCIAL RESPONSIBILITY
(Question 2.3, Section 2 of Questionnaire) [Table continues on next page]

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
Students who participate in CBE and/or SL can make a positive impact on community development (n = 790)	(13) 3.65	(7) 2.53	(8) 5.10	(59) 16.57	(25) 9.03	(37) 23.57	(284) 79.78	(245) 88.45	(112) 71.43
I have an obligation to serve the community (n = 789)	(20) 5.62	(19) 6.86	(17) 10.90	(53) 14.89	(62) 22.38	(45) 28.85	(283) 79.49	(196) 70.76	(94) 60.26
I enjoyed serving the community (n = 784)	(6) 1.70	(11) 3.79	(15) 9.68	(78) 22.16	(50) 18.05	(39) 25.16	(268) 76.14	(216) 77.98	(101) 65.16
CBE and/or SL increased my desire to help or care for others (n = 783)	(16) 4.57	(9) 3.25	(9) 5.77	(74) 21.14	(66) 23.83	(36) 23.08	(260) 74.29	(202) 72.92	(111) 71.15

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
CBE and/or SL helped me understand the problems and diseases that the community experiences (n= 785)	(18) 5.08	(14) 5.05	(7) 4.55	(86) 24.29	(74) 26.71	(36) 23.38	(250) 70.62	(189) 68.23	(111) 72.08
CBE and/or SL helped me realise my responsibility towards the people in the community (n = 787)	(24) 6.76	(10) 3.61	(11) 7.10	(90) 25.35	(71) 25.63	(43) 27.74	(241) 67.89	(196) 70.76	(101) 65.16
I enjoyed the interaction with people from different cultures during CBE and/or SL (n = 789)	(16) 4.51	(19) 6.86	(8) 5.10	(96) 27.04	(70) 25.27	(41) 26.11	(243) 68.45	(188) 67.87	(108) 68.79
The community valued the services that students offered during CBE and/or SL (n = 784)	(36) 10.20	(14) 5.05	(10) 6.49	(124) 35.13	(54) 19.49	(41) 26.62	(193) 54.67	(209) 75.45	(103) 66.88
The difference in languages made it difficult to communicate with the people in the community (n = 787)	(53) 14.97	(33) 11.91	(35) 22.44	(87) 24.58	(62) 22.38	(42) 26.92	(214) 60.45	(182) 65.70	(79) 50.64
CBE and/or SL helped me understand how to treat the problems and diseases that the community experiences (n = 786)	(44) 12.43	(25) 9.06	(9) 5.77	(108) 30.51	(86) 31.16	(45) 28.85	(202) 57.06	(165) 59.78	(102) 65.38
I will probably continue to volunteer in the community in future (n = 786)	(40) 11.33	(30) 10.83	(35) 22.44	(84) 23.80	(75) 27.08	(44) 28.21	(229) 64.87	(172) 62.09	(77) 49.36
The people in the community were rude and unwilling to co-operate (n = 785)	(213) 60.00	(176) 63.77	(96) 62.34	(107) 30.14	(79) 28.62	(47) 30.52	(35) 9.86	(21) 7.61	(11) 7.14

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
The people in the community were always willing to help the students during CBE and/or SL (n = 789)	(92) 25.84	(51) 18.41	(34) 21.79	(116) 32.58	(106) 38.27	(40) 25.64	(148) 41.57	(120) 43.32	(82) 52.56
It was difficult to work in the communities because of the cultural differences (n = 787)	(92) 25.84	(96) 34.78	(53) 34.19	(125) 35.11	(99) 35.87	(43) 27.74	(139) 39.04	(81) 29.35	(59) 38.06
The patients were not always willing to participate in the activities/treatment that the students offer during CBE and/or SL (n = 790)	(99) 27.81	(52) 18.77	(61) 38.85	(106) 29.78	(91) 32.85	(38) 24.20	(151) 42.42	(134) 48.38	(58) 36.94
The communities had realistic expectations/ demands from the students (n = 783)	(105) 29.75	(43) 15.58	(34) 22.08	(116) 32.86	(107) 38.77	(47) 30.52	(132) 37.39	(126) 45.65	(73) 47.40

Discussion: Only statements that 50% or more of the students agreed or disagreed on (cf. Table 5.3. marked in bold) are discussed below; for the rest of the results cf. Table 5.3.

The majority of the students believe that they make a positive impact on community development through participation in CBE and/or SL and of the respondents 79.78% (SoM), 88.45% (SoAHP) and 71.43% (SoN) respectively agreed with the statement. Students are of the opinion that they have an obligation to serve the community [79.49% (SoM), 70.76% (SoAHP) and 71.43% (SoN)]; furthermore they enjoy serving the community [76.14% (SoM), 77.98% (SoAHP) and 65.16% (SoN)].

CBE and/or SL increased the students' desire to help or care for others and 74.29% (SoM), 72.92% (SoAHP) and 71.15% (SoN), of the respondents agreed with this statement. Additionally, 70.6% (SoM), 68.23% (SoAHP) and 72.08% (SoN), of the respondents agreed that CBE and/or SL helped them understand the problems and diseases the community experience and 67.89% (SoM), 70.76% (SoAHP) and 65.16% (SoN) of the respondents agreed that CBE and/or SL helped them realise their responsibility towards people in the community.

Furthermore, approximately 68% of all the respondents agreed that they enjoyed the interaction with people from different cultures during CBE and/or SL and 54.67% (SoM), 75.45% (SoAHP) and 66.88 (SoN)% of the students were of the opinion that the community valued the services that students offer during CBE and/or SL.

Of the respondents, 60.45% (SoM), 65.70 (SoAHP) and 50.64% (SoN) agreed that the difference in language made it difficult to communicate with the people in the community. The reason why fewer students from the SoN experienced difficulties with the language difference might be due to the fact that there are more black students in the SoN (44.81%), than in the other two Schools and the majority of the people in the communities are black as well. In addition, 57.06% (SoM), 59.78% (SoAHP) and 65.38% (SoN) of the respondents agreed that CBE and/or SL helped them to understand how to treat the problems and the diseases the community experience and 57.06% (SoM), 59.78 (SoAHP) and 65.38% (SoN) of the students were of the opinion that they would probably continue to volunteer in the community in future.

Students experienced the people in the community as pleasant and co-operative and 60.00% (SoM), 63.77% (SoAHP) and 62.34% (SoN) of the students respectively did not agree with the statement that people in the community were rude and unwilling to co-operate.

In general, students experienced CBE and/or SL positively in terms of community involvement and social responsibility. They agreed that their participation in CBE and/or SL gave them an opportunity to make a positive impact on community development; increased their desire to help or care for others; helped them understand the problems and diseases in the community and helped them to understand how to treat the problems and diseases that the community experience. Furthermore, they felt that they have an obligation to serve the community, enjoyed serving the community as well as the interaction with people from different cultures and they realise their responsibility towards the people in the community and will probably continue to volunteer in the community in future. Students thought that the communities valued the services offered through CBE and/or SL and they believed the people in the community had a positive attitude as well. However, the difference in languages made it difficult to communicate with the people in the community.

5.3.4 Organisation

Table 5.4 indicates the quantitative results for the statements reflecting how students, in each of the three schools in the FHS, experience CBE and/or SL as far as organisation is concerned. In the table, responses 1 and 2 on the scale are grouped together to represent disagreement, response 3 indicates neutral, while responses 4 and 5 are grouped together to represent agreement with each statement.

TABLE 5.4: STUDENTS' AGREEMENT/DISAGREEMENT WITH STATEMENTS REGARDING ORGANISATION
(Question 2.4, Section 2 of Questionnaire) [Table continues on next page]

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
Orientation/induction before going to the community sites is important (n = 784)	(7) 1.98	(5) 1.81	(3) 1.94	(39) 11.05	(35) 12.68	(26) 16.77	(307) 86.97	(236) 85.51	(126) 81.29
The lecturers prepared us well for CBE and/or SL so that I knew exactly what to expect (n = 785)	(123) 34.75	(74) 26.71	(43) 27.92	(114) 32.20	(111) 40.07	(42) 27.27	(117) 33.05	(92) 33.21	(69) 44.81
It is important to have clear outcomes of the CBE and/or SL activities (n = 785)	(9) 2.54	(7) 2.54	(1) 0.65	(54) 15.25	(65) 23.55	(31) 20.00	(291) 82.20	(204) 73.91	(123) 79.35
CBE and/or SL activities in my course always had clear outcomes so that I knew exactly what to do (n = 784)	(104) 29.63	(59) 21.30	(30) 19.23	(128) 36.47	(116) 41.88	(44) 28.21	(119) 33.90	(102) 36.82	(82) 52.56
I had clear guidelines on which aspects I am going to be assessed during CBE and/or SL (n = 783)	(89) 25.36	(63) 22.83	(16) 10.26	(114) 32.48	(109) 39.49	(49) 31.41	(148) 42.17	(104) 37.68	(91) 58.33
Reflecting on CBE and/or SL activities helped me to learn more (n = 785)	(53) 14.97	(35) 12.68	(22) 14.19	(139) 39.27	(100) 36.23	(44) 28.39	(162) 45.76	(141) 51.09	(89) 57.42
I felt unsafe during CBE and/or SL activities (n = 784)	(197) 55.56	(173) 62.45	(72) 47.06	(94) 26.55	(78) 28.16	(53) 34.64	(63) 17.80	(26) 9.39	(28) 18.30
Students' attendance was well-monitored during CBE and/or SL (n = 784)	(108) 30.51	(79) 28.52	(23) 15.03	(113) 31.92	(81) 29.24	(41) 26.80	(133) 37.57	(117) 42.24	(89) 58.17

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
It will be nice to celebrate the success of a community partnership at the end of the year (n = 783)	(29) 8.26	(16) 5.78	(11) 7.10	(103) 29.34	(79) 28.52	(44) 28.39	(219) 62.39	(182) 65.70	(100) 64.52
All students put in the same amount of effort during CBE and/or SL and contributed equally to the success of the activities (n = 784)	(199) 56.37	(130) 46.93	(74) 48.05	(81) 22.95	(64) 23.10	(40) 25.97	(73) 20.68	(83) 29.96	(40) 25.97
The CBE and/or SL activities were always well-organised between the UFS and the community (n = 784)	(104) 29.55	(96) 34.66	(36) 23.23	(111) 31.35	(89) 32.13	(44) 28.39	(137) 38.92	(92) 33.21	(75) 48.39
Time allocated at community sites was enough to really make a difference (n = 785)	(138) 39.09	(84) 30.32	(35) 22.58	(113) 32.01	(90) 32.49	(58) 37.42	(102) 28.90	(103) 37.18	(62) 40.00
I experienced transport difficulties during CBE and/or SL (n = 785)	(191) 53.95	(129) 46.57	(56) 36.36	(58) 16.38	(60) 21.66	(27) 17.53	(105) 29.66	(88) 31.77	(71) 46.10
The lack of supplies/resources at the hospitals/clinics etc. made it difficult to perform my CBE and/or SL activities (n = 786)	(89) 25.14	(67) 24.19	(31) 20.00	(125) 35.31	(99) 35.74	(52) 33.55	(140) 39.55	(111) 40.07	(72) 46.45
Reflection is a private issue and should not be shared with everybody (n = 782)	(89) 25.50	(65) 23.47	(31) 19.87	(124) 35.53	(93) 33.57	(47) 30.13	(136) 38.97	(119) 42.96	(78) 50.00
The CBE and/or SL activities were planned in our rosters at times when it suited us best (n = 782)	(91) 26.00	(73) 26.35	(33) 21.29	(109) 31.14	(88) 31.77	(60) 38.71	(150) 42.86	(116) 41.88	(62) 40.00

Discussion: Certain important aspects (mostly responses that 50% or more of the students agreed/disagreed on) regarding the organisation of CBE and/or SL are highlighted (cf. Table 5.4. marked in bold) and discussed; for the rest of the results cf. Table 5.4.

Students regard orientation/induction before going to the community sites as important and 86.97% (SoM), 85.51% (SoAHP) and 81.29% (SoN) of the respondents agreed with this statement; however, only 33.05% (SoM), 33.21% (SoAHP) and 44.81% (SoN) believed that the lecturers prepared them well for CBE and/or SL so that they knew exactly what to expect. Furthermore, 82.20% (SoM), 73.91% (SoAHP) and 79.35% (SoN) of the respondents agreed that it is important to have clear outcomes of the CBE and/or SL activities, but only 33.90% (SoM), 36.82% (SoAHP) and 52.56% (SoN) of the respondents agreed that the CBE and/or SL activities in their course always had clear outcomes so that they know exactly what to do.

Of the respondents, 42.17% (SoM), 37.68% (SoAHP) and 58.33% (SoN) agreed that they had clear guidelines on which aspects they are going to be assessed during CBE and/or SL. Reflection seems to be important and 45.76% (SoM), 51.09% (SoAHP) and 57.42% (SoN) of the students agreed with the statement that "reflecting on CBE and/or SL activities helped me to learn more". The majority of the students felt safe during CBE and/or SL activities and 55.56% (SoM), 62.45% (SoAHP) and 47.06% (SoN) did not agree with the statement that they feel unsafe during CBE and/or SL activities.

The students in the different Schools had mixed feelings regarding the monitoring of student attendance and 37.57% (SoM), 42.24% (SoAHP) and 58.17% (SoN) agreed with the statement that students' attendance was well monitored during CBE and/or SL. Of the respondents, 62.39% (SoM), 65.70% (SoAHP) and 64.52% (SoN) agreed that it would be nice to celebrate the success of a community partnership at the end of the year.

From these findings it is apparent that students have mixed feelings regarding the organisational aspect surrounding CBE and/or SL. Students are of the opinion that it is important to have induction/orientation before going into the communities and to have clear outcomes during CBE and/or SL; however, it seems that it is not always done. Some of the students are also unsure regarding which aspects they are going to be assessed during CBE and/or SL activities. Furthermore, students regard reflection during CBE and/or SL as important; they did not feel unsafe and would like to celebrate the success of a community partnership at the end of the year. Students' opinions regarding the monitoring of students during CBE and/or SL differ across the three Schools in the FHS.

5.3.5 Support / supervision during CBE and/or SL

Table 5.5 indicates the quantitative results for the statements reflecting how students, in each of the three schools in the FHS, experience CBE and/or SL as far as supervision is concerned. In the table, the responses 1 and 2 on the scale are grouped together to represent disagreement; response 3 indicates neutral, while responses 4 and 5 are grouped together to represent agreement with each statement.

TABLE 5.5: STUDENTS' AGREEMENT/DISAGREEMENT WITH STATEMENTS REGARDING SUPPORT/SUPERVISION DURING CBE AND/OR SL
(Question 2.5, Section 2 of Questionnaire) [Table continues on next page]

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
The staff at the community setting was helpful and friendly (n = 787)	(56) 15.82	(29) 10.47	(22) 14.10	(87) 24.58	(81) 29.24	(54) 34.62	(211) 59.60	(167) 60.29	(80) 51.28
The staff at the community setting was knowledgeable and taught me a lot (n = 786)	(66) 18.70	(42) 15.16	(15) 9.62	(125) 35.41	(81) 29.24	(59) 37.82	(162) 45.89	(154) 55.60	(82) 52.56
The expectations of the staff/ supervisors regarding students' abilities during CBE and/or SL were reasonable (n = 787)	(60) 16.95	(25) 9.03	(21) 13.46	(124) 35.03	(99) 35.74	(52) 33.33	(170) 48.02	(153) 55.23	(83) 53.21
There was adequate supervision during my CBE and/or SL experiences (n = 785)	(87) 24.65	(66) 23.83	(22) 19	(116) 32.86	(101) 36.46	(46) 29.68	(150) 42.49	(110) 39.71	(87) 56.13
There was a good working relationship between members of the multi-disciplinary team and everybody assisted us (n = 787)	(63) 17.80	(61) 22.02	(24) 15.38	(133) 37.57	(85) 30.69	(58) 37.18	(158) 44.63	(131) 47.29	(74) 47.44

Statements	Disagreement (n) %			Neutral (n) %			Agreement (n) %		
	SoM	SoAHP	SoN	SoM	SoAHP	SoN	SoM	SoAHP	SoN
My peers and/or senior students supported me a lot during CBE and/or SL activities (n = 787)	(82) 23.16	(39) 14.08	(30) 19.23	(108) 30.51	(81) 29.24	(54) 34.62	(164) 46.33	(157) 56.68	(72) 46.15
CBE and/or SL sites are conducive environments for learning – clinical staff were willing to assist students (n = 786)	(60) 17.00	(34) 12.27	(27) 17.31	(126) 35.69	(94) 33.94	(45) 28.85	(167) 47.31	(149) 53.79	(84) 53.85

Discussion: All of the statements in this section are discussed below. Of the respondents 59.60% (SoM), 60.29% (SoAHP) and 51.28 % (SoN) were of the opinion that the staff at the community settings are helpful and friendly and 45.89% (SoM), 55.60% (SoAHP) and 52.56% (SoN) of the students agreed that the staff was helpful and taught them a lot. Approximately half of the respondents [48.02% (SoM), 55.23% (SoAHP) and 53.21% (SoN)] believe that the expectations of the staff/supervisors regarding students' abilities during CBE and/or SL were reasonable.

The students had mixed feelings regarding the supervision during CBE and/or SL and 42.49% (SoM), 39.71% (SoAHP) and 56.13% (SoN) of the students agreed with the statement that there was adequate supervision. Slightly less than half of the students, 44.63% (SoM), 47.29% (SoAHP) and 47.44% (SoN), thought that there was a good working relationship between members of the multi-disciplinary team and that everybody assisted them, while 46.33% (SoM), 56.68% (SoAHP) and 46.15% (SoN) of the respondents felt that their peers and/or senior students supported them a lot during CBE and/or SL activities.

Students' thoughts about whether CBE and/or SL sites are effective environments for learning and whether clinical staff was willing to assist students varied between 47.31% (SoM), 53.79% (SoAHP) and 53.85% (SoN).

Many students had a positive experience with the staff at the community settings and experienced them as friendly, helpful, knowledgeable and thought their expectations from students were reasonable. Students' opinions regarding amount of supervision at

the CBE and/or SL sites, working relationship with members of the multi-disciplinary team and support from their peers/seniors varied amongst the three Schools, but in general less than half of the students had a positive experience in this regard. Approximately half of the students felt that CBE and/or SL sites are effective environments for learning. In general, students experienced CBE and/or SL with regards to support/supervision less favourable than the other sections.

5.3.6 Satisfaction from CBE and/or SL

Respondents were asked to indicate why they enjoy CBE and/or SL and nine different options were given to them (cf. Question 3.1 A, Section 3). They could choose more than one option and they could also add additional reasons (cf. Question 3.1 B, Section 3). The quantitative data are presented in Table 5.6 with a short discussion, followed by a description of the open question (qualitative data).

TABLE 5.6: REASONS WHY STUDENTS ENJOY CBE AND/OR SL
(Question 3.1 A, Section 3 of Questionnaire) [Table continues on next page]

I enjoy CBE and/or SL:	SoM		SoAHP		SoN	
	Number of Respondents (N)	Number of Respondents (%)	Number of Respondents (N)	Number of Respondents (%)	Number of Respondents (N)	Number of Respondents (%)
To help other people	318	89.08	266	96.02	137	86.71
To develop new skills	295	82.63	239	86.28	131	82.91
To enhance my academic learning	266	74.50	193	69.68	120	75.95
To improve my community	238	66.67	187	67.51	103	65.19
To improve society as a whole	213	59.66	156	56.32	81	51.27
To work with people that are different from me	205	57.42	181	65.34	96	60.76
To feel personal satisfaction	198	55.46	174	62.82	86	54.43
To fulfil my civic or social responsibility	175	49.01	124	44.77	73	46.20
To enhance my resume	112	31.37	81	29.24	60	37.97

Discussion: The respondents were asked what the reasons are why they enjoy CBE and/or SL. Only the three most and the three least important factors are discussed below (marked in Bold).

“To help other people” emerges as the most important reason and of the respondents 89.08% (SoM), 96.02% (SoAHP) and 86.71% (SoN) indicated that it is important. The second most important factor is to develop new skills [82.63% (SoM), 86.28% (SoAHP) and 82.91% (SoN)] and to enhance my academic learning was voted as the third most important factor [74.5% (SoM), 69.68% (SoAHP) and 75.95% (SoN)].

The factors that received the least votes were: to feel personal satisfaction [55.46% (SoM), 62.82% (SoAHP) and 54.43% (SoN)], to fulfil my civic or social responsibility [49.01% (SoM), 44.77% (SoAHP) and 45.20% (SoN)] and to enhance my resume [31.37% (SoM), 29.24% (SoAHP) and 37.97% (SoN)].

The quantitative findings indicate that students enjoy CBE and/or SL mostly because it enhances their learning and skills and they get the opportunity to help other people; furthermore, they are not of the opinion that CBE and/or SL leads to personal satisfaction and enhances their resume. Unfortunately they do not see CBE and/or SL as an opportunity to fulfil their civic or social responsibility, which is one of the aims of SL (cf. 2.4.2.2).

Students were asked to give any other reason why they enjoy CBE and/or SL (cf. Question 3.1 B, Section 3 of Questionnaire). The data were analysed by the researcher herself by reading and reflection, identification of themes, establishments of patterns and connections as well as coding the data (cf. Chapter 3, 3.3.3.3 Data analysis). To ensure trustworthiness, the direct words of the respondents are quoted.

From the research, twelve additional reasons were identified. The reasons are given below together with examples of the students’ responses to support the respective reason. Responses are quoted verbatim. Afrikaans quotes were translated by the researcher, with the verbatim Afrikaans quotes given in brackets and *italics* where applicable. The students’ responses in all three Schools were similar and are therefore presented together.

i. To learn about other cultures

- “Working with different cultures”
- “Give insight into other cultures”

ii. To grow as person

- "It helped me to grow as person which made me more competent in my personal life" (*Dit het my gehelp groei as mens wat my vaardiger in my persoonlike lewe maak*)
- "Personal growth and development"
- "To see what areas am I lacking in and improve upon these"
- "Because it is on our knowledge level and not great specialities which made you feel that you can be a doctor and it builds your self-confidence" (*Want dit is op ons kennisvlak en nie erge spesialiteit nie wat jou regtig laat voel jy kan 'n dokter wees en dit bou jou selfvertroue op*)
- "Took me out of my comfort zone and I learned new competencies" (*Het my uit my comfort zone gevat en ek het nuwe vaardighede geleer*)
- "It is a way of finding out how much you know and how much you still have to learn"
- "I enjoyed seeing how it differs from other places (hospitals) where I have worked. You were on your own a lot. Have to make decisions yourself and bear responsibility, I enjoyed it" (*Ek het geniet hoe om te sien hoe verskil dit van ander plekke (hospitale) waar ek gewerk het. Jy was baie op jou eie. Moes self besluit maak en verantwoordelikheid dra, ek het dit geniet*)

iii. To prepare for future role as healthcare professional

- "Better guidelines as to what is expected of one"
- "It gives one a viewpoint of how things in the future in your career can work and what can be improved" (*Dit gee mens 'n siening van hoe dinge in die toekoms in mens se beroep kan werk en wat verbeter kan word*)
- "It gave me a bigger picture of what we study and how everything fits together" (*Dit het my 'n groter prentjie laat sien oor wat ons studeer en hoe alles bymekaar inpas*)
- "It gave me a sense of purpose to the course that I've chosen"
- "To see how the multi-disciplinary team works and experience the hospital environment"
- "It helps to learn more about other fields" (*Dit help om meer oor ander rigtings te leer*)

iv. To make a difference

- "There it feels like I am actually making a difference" (*Daar voel dit of EK eintlik 'n verskil maak*)
- "Feeling useful to the community"
- " It makes me feel that I can make a difference in somebody's life, it does not matter how small it is" (*Dit laat my voel dat ek wel 'n verskil kan maak in iemand se lewe maak nie saak hoe klein nie*)

v. To gain life experience

- "Gives a sense of realistic approach to life"
- "It gives one a greater sense of purpose"
- "It gave me a new perspective and challenged me to develop creative solutions for some problems"

vi. For groupwork

- "To be able to learn and experience with my fellow-students" (*Om saam my mede-studente te kan leer en ervaar*)
- " It was nice for me to work with friends in a group, we learned how to deal with difficult situations together" (*Dit was vir my lekker om saam vriende in 'n groep te werk, ons het geleer hoe om moeilike situasies saam aan te pak*)
- "To enhance personal relations with my peers and other professionals"
- "Working together with a group of my fellow students taught me a lot about them as well as about myself. I enjoyed working together to try to make a difference in the community because we achieve more when we work together"

vii. To see different patients

- "Diversity of the patient profiles"
- "It is challenging. There is a huge variety in the patients"
- "It gives you the time to learn about patients and pathologies without the stress of being assessed while doing so - it is fun but still a valuable learning session"

viii. To gain experience

- " It is nice to experience everything practical and not only to learn the theory" (*Dis lekker om als prakties te ervaar en nie net die teorie te leer nie*)
- "Challenging. Learn a lot more through experience"

ix. To get appreciation from the community

- "It was nice to see how thankful the less fortunate was/is for the help that they receive" (*Dit was lekker om te sien hoe dankbaar minder bevoorregtes was/is vir die hulp wat hulle ontvang*)
- "It is nice to do something where you see the appreciation in other people and that you know you can make a difference in others' lives, even how small or big" (*Dis lekker om iets te doen wat jy die waardering in ander mense sien en dat jy weet jy kan 'n verskil in ander se lewens maak, al was dit hoe klein of groot*)
- "To see how thankful the people are afterwards"

x. To appreciate what I have

- "It was a privilege to work with people that live a different life than myself. Seeing how other people suffer was humbling"
- "Made me realise once more how fortunate I am" (*Het my weereens laat besef hoe bevoorreg ek is*)
- "Make one a better person; appreciate small things more. Open/broadens one's perspective on things"

xi. To have fun

- "It was fun and enjoyable"
- "I enjoyed it to work in another environment that usually" (*Ek het dit geniet om in 'n ander omgewing as normaalweg te werk*)
- "It's not in the lecture halls"
- "It is a more relaxed environment where evaluation is not so strict in the area itself" (*Dis 'n meer ontspanne omgewing waar evaluasie nie so streng in die area self is nie*)

xii. To mentor junior students

- "To act as a mentor for younger students and to help and guide them in their journey in CBE/SL" (*Om as mentor op te tree vir jonger studente en hul te help en rig in hul 'journey' by GBO/DL*)
- "I enjoyed it to mentor the first years. To give them advice and to make them realise the value of the activity" (*Ek het dit geniet om die eerstejaars te mentor. Om vir hulle raad te gee en die waarde van aktiwiteit te laat besef*)

The quantitative and qualitative findings in this study show that students do enjoy CBE and/or SL for different reasons, which fluctuate between reasons for personal gain/growth, academic learning and improving/helping communities.

5.3.7 Improving CBE and/or SL in the Faculty of Health Sciences, UFS

This question (cf. Question 3.2, Section 3 of questionnaire) deals with the improvement of CBE and/or SL in the Faculty of Health Sciences, UFS. The respondents had to answer an open-ended question in this regard, namely:

"What can be done to improve CBE and/or SL in the Faculty of Health Sciences, UFS?"

The data was analysed by the researcher by means of reading and reflection, identification of themes, establishment of patterns and connections and coding (cf. Chapter 3, 3.3.3.3 Data analysis). Trustworthiness is ensured by quoting the direct words of the respondents.

A total number of 491 of the respondents completed the question and made recommendations on how to improve CBE and/or SL in the FHS. Of the respondents, 88 were from the School of Nursing, 204 from the School of Medicine and 199 from the School for Allied Health Professions. The results from the three Schools vary and will therefore be discussed separately (cf. 5.3.6.1 – 5.3.6.3). A summary of all the themes identified is presented in Table 5.7 (cf. 5.3.6.4).

5.3.7.1 Results from the School of Nursing

Twelve themes emerged from the data from the School of Nursing. Discussions on these themes are given below together with examples of the students' responses to support the respective theme. Responses are quoted verbatim. Afrikaans quotes were translated by the researcher, with the verbatim Afrikaans quotes given in brackets where applicable.

- **Communication:** Good/better communication should exist between all the parties involved in CBE and/or SL, namely the students, the university, the clinical facility and the community. There appears to be some confusion about what is expected from the students during CBE and/or SL. In the words of some respondents:

"Better communication amongst us all"

"Better communication between students and lecturers" (Beter kommunikasie tussen student en dosente)

"Better communication between the clinical facilitators of the UFS and the personnel where the practicals are done regarding what is expected from the students" (Beter kommunikasie tussen kliniese fasiliteerders van die UFS en personeel waar prakties gedoen word oor wat van student verwag word om te doen)

- **Exposure:** Students should be exposed to more patients in order to ensure that they get a variety of experience as well as to assist the community even more. Some of the comments included:

"It can be done on a more regular basis and on a wider spectrum" (Dit kan op 'n meer gereelde basis gedoen word op 'n wyer spectrum gedoen word)

"More opportunities can be created to serve the community in this way"

- **Healthcare personnel:** The approach of the staff at the healthcare institutions plays an important role in the way students experience CBE and/or SL. Students are of the opinion that the healthcare staff display a negative attitude towards the students and that they are not helpful or friendly. Responses included:

"The permanent personnel can be more thankful to have us there and be less rude" (Die permanente personeel kan meer dankbaar wees om ons daar te hê en minder ongeskik wees)

"Deal with nurses who are rude and disrespectful to students and patients"

"Student friendly staff!! Appreciation for our work!!"

- **Organisation:** CBE and/or SL should be well organised. The students are of the opinion that the personnel at the clinical sites are not always prepared for them and furthermore they do not always get sufficient learning opportunities during CBE and/or SL, which results in them wasting their time. In the words of the respondents:

"Be more organised"

"To inform the wards on how our programme works and to be available always" (Om die sale in kennis te stel hoe ons program werk en om altyd beskikbaar te wees)

"Place the students where there are learning opportunities other than being on a place yet you have nothing to do than walking around the place like a 'security' and clinicians think we are lazy as we do that"

- Orientation:** Students need to be prepared/orientated before entering the community. Many respondents felt that they were not adequately prepared to go to the healthcare institutions. They did not know what to expect or what was expected of them during CBE and/or SL. Examples of the responses are:

"..... and provide more orientation surrounding the practical setting and what to expect"

"Examples should be given"

"Better explanation on the expectations of everybody and the importance of CBE and/or SL" (Beter verduidelik wat is die verwagting van almal en die redes vir GBO en/of DL)
- Outcomes:** Comprehensive outcomes and guidelines of what is expected from the students should be set for CBE and/or SL. These outcomes should be clear and available to students as well as healthcare personnel beforehand in order for everybody involved to understand what their roles are. Some of the comments in this regard included:

"Objectives and outcomes the students need to do should be explained to the staff in the hospitals"

"Make objectives clear beforehand"

"Proper layout of goals and time around activities are needed" (Behoorlike uiteensetting van doelwitte en tyd rondom aktiwiteite word benodig)
- Planning:** CBE and/or SL should be planned properly. The activities should be planned in timeslots that fit the students' time schedules and they should be informed of these activities well in advance. Furthermore, the community settings/ healthcare institutions should be evaluated in order to ensure that the students receive appropriate exposure during CBE and/or SL and that the community benefit from it as well. Responses included:

"Placements for SL should be given out early so that students can plan"

"More efficient outings that will ensure that you go out to community less (save time)" (Meer doeltreffende uitstappies, wat veroorsaak dat jy minder na die gemeenskap gaan – tyd te bespaar)

"Better management of times at institutions. Fairness in allocations"
- Reflections:** Students should have the opportunity to reflect more on their experiences. This will provide valuable information to the lecturers on where they can support students more and it will give them an opportunity to give feedback and advice to the students on their progress. Comments in this regard included:

"Have meetings with staff at which students will be allowed to inform them about student needs; like encouragement, advising, asking of stimulating questions and continuous supervision if possible"

"Students must be asked to submit a weekly reflection report on what they have learned in order to improve their reflection skills based on the facilitator's advice"

"Ask students about their experiences during Service Learning and take note to what they say"

- **Supervision:** The respondents feel that there should be more supervision at the CBE and/or SL sites in order to train, evaluate and assist the students. Some of the comments in this regard included:

"The lecturers should be involved more at the clinics in order to give clear demonstrations in the clinics" (Die dosente moet meer betrokke wees by die kliniek sodat alle demonstrasies mooi duidelik in die kliniek gegee kan word)

"Make more mentors and clinical facilitators available in practical and community settings"

"More facilitators to evaluate"

- **Time:** Students recommend that longer hours should be spent in the communities during CBE and/or SL. This will be more beneficial to the communities and will really make a difference to them. Comments in this regard include:

"Give more time to actually make a difference"

"They can extend the time for it so that it can really make a difference in people's lives"

"More time spent in the community" (Meer tyd spandeer in die gemeenskap)

- **Transport:** There is a great need for transport to and from the CBE and/or SL sites. Not all the students have their own transport and have to make use of public transport, which place a financial burden on them and they do not always feel safe while making use of public transport. In the words of the students:

"That we have transport to go to different settings"

"They should consider more in terms of cost of transport" (Hulle meer in ag neem ten opsigte van koste vir vervoer)

"Formal transport for students to different experiential learning institutions would make a huge difference in the way that we won't feel insecure anymore going to the station which appeared very 'dodgy' and has bad history of hijacks"

"Transport is the main concern; provide us with transport to go to hospitals and clinics"

"Provisioning of transport to clinical facilities" (Voorsiening van vervoer na kliniese fasiliteite)

- **Other:** The last theme includes all the suggestions and comments students made that did not fit into any of the other themes, such as remarks on CBE and/or SL in general, suggestions that students and the community should be financially compensated for their time and that food should be provided. Some of the responses included:

"Give students a payment every month of at least R1500 to help with their needs"

"Overall the programme is very good"

"Terminate it, or provide an alternative. Some of us hate community work and will probably never work in the community. Call me cruel but that is just how I feel. It's torture!!"

"To give the community something in return of their time"

"Provide us with food/lunch"

The main concerns that emerged in the School of Nursing are transport, orientation and planning. These topics seem to play an important role in the way students experience CBE and SL and they received 30, 13 and 12 comments respectively.

5.3.7.2 Results from the School for Allied Health Professions

Seventeen themes emerged from the data from the School for Allied Health Professions. Discussions on these themes are given below together with examples of the students' responses to support the respective theme. Responses are quoted verbatim. Afrikaans quotes were translated by the researcher, with the verbatim Afrikaans quotes given in brackets where applicable.

- **Assessment:** The respondents recommended that there should be more opportunities for assessment during CBE and/or SL. Furthermore, they would like to have more guidance and supervision while assessing patients. Some of the responses include:

"More opportunities to evaluate and treat patients for marks" (Meer geleenthede om pasiënte vir punte te evalueer en behandel)

"Better assessment guidance"

"Having more than one person in charge of you or responsible for evaluating you as a student, because marks are too subjective"

- **Communication:** Better communication should exist between all the parties involved in CBE and/or SL, namely the students, the university, the clinical facility and the communities. There appears to be some confusion about what is expected from the students during CBE and/or SL and furthermore the clinical areas are not always ready or aware that the students are going there. In the words of some respondents:

"Better communication between UFS and clinical areas"

"Better communication with students" (Beter kommunikasie met student)

"Communication between students and the UFS must improve so that we know exactly what to do"

"The communication between the UFS and the areas can improve. Sometimes the therapists is absent in the areas" (Die kommunikasie tussen die UV en die areas kan verbeter word. Soms is die terapeute afwesig in die area)

- **Exposure:** The students would like to have more exposure in all the different year groups to hospitals, clinics and communities and they would like to be exposed to projects of students in other health professions as well. Furthermore, they want to be exposed to a greater variety of patients and diseases. Some of the comments included:

"It would be nice if you can be exposed to the types of activities/projects that are carried out by other disciplines" (Dis sal ook lekker wees as ons blootgestel kan word aan die tipe aktiwiteit/projekte wat deur ander dissiplines uitgevoer word)

"More exposure to CBE/SL activities"

"In the fourth year more time can be given" (In die 4de jaar kan daar dalk bietjie meer tyd daaraan afgestaan word)

"To do it more often"

"As 1st years, we could see more clinical procedures by 3rd and 4th years to know what to expect"

"Implementation from earlier on in one's degree"

"More rotation in community areas – one would like to have more exposure and experience at more than one area" (Meer rotasie onder gemeenskapsareas – mens wil by meer as een area blootstelling ontvang en ondervinding opdoen)

- **Financial aid:** Students would like to have more funds available to complete their CBE and/or SL projects as well as funds to help them to carry some of the extra costs they have to incur during CBE and/or SL, for example transport, accommodation and meals. Comments in this regard include:

"The University should set aside funds for community projects, as sponsorships is the primary reason why we as students struggle to complete the tasks which we would like to"

"Financial aid to help with community project"

"More funds can be made available for students. We had to cover a lot of the expenses ourselves" (Meer fondse kan vir studente beskikbaar gestel word. Ons moes baie uitgawes self dek)

"Expenses: Students spent a lot of money to get to the areas" (Uitgawes: Studente spandeer baie geld om by areas uit te kom)

"Grant more money to students for meals and provide a more desirable place to stay in order to enjoy the experience more"

- **Healthcare personnel:** Healthcare personnel should treat students with the necessary respect and patience and they should be willing to support students. They do not always know what are expected of the students and be available to the students to offer assistance and to facilitate their learning. In the words of the respondents:

"Regarding the nurses, we are always in their way and we must learn new skills, but you feel in the way"

"Clinical staff should be on the same page and each one with their own way. Confuse students to learn how each clinical staff member like to do things (clinical procedures)"

"Support from personnel, they are rude and not helpful (nurses and sometimes doctors)" (Ondersteuning van personeel, hul is so ongeskik en glad nie hulpvaardig nie – verpleegpersoneel en soms dokters).

- **Multi-disciplinary teams:** Students would like to have more interaction with multi-disciplinary teams in order to learn what the other disciplines do as well and to learn how to work together in a team. Some of the comments in this regard included:

"Interdisciplinary interaction more" (Interdissiplinêre interaksie meer)

"Maybe combine different groups in one area, for example Fisio's, OT's and doctors together in one area" (Dalk verskeie groepe meng in 'n area bv. Fisio's, OT's, dokters ensv saam sit in een area)

- **Monitoring:** Student attendance should be monitored well and there should be better control measures to ensure that all students participate in CBE and/or SL. Comments in this regard are:

"Better control over students and activities" (Beter kontrole oor student en aktiwiteite)

"All students should do it and not only a few"

- **Organisation:** The students are of the opinion that a lot of improvement is needed as far as the organisation of CBE and/or SL is concerned. The personnel at the clinical sites are not always expecting the students and furthermore they are not prepared for them. CBE and/or SL needs to be more organised and structured to ensure that the students get the best possible learning experience. In the words of the respondents:

"Make sure the organisation of the day is efficient"

"Adequately organised" (Voldoende gereël word)

"There is serious disorganisation of the clinical. I was in a group that was turned away at one of the places, because nothing was organised. It will also happen that you organise an activity for a patient and the next time you get there, the patient is discharged and you get a new patient for which the activity is not suitable. The lecturer will on top of it criticise you, because the activity is not suited for the patient" (Daar is erge disorganisasie van klinies. Ek was in 'n groep wat by een van die plekke weggewys was omdat daar niks gereël was nie. Dis sal ook gebeur dat jy 'n aktiwiteit vir 'n pasiënt beplan en die volgende keer as jy daar aankom is die pasiënt weg/ontslaan en jy kry 'n splinternuwe pasiënt vir wie die aktiwiteit nie gepas is nie. Die dosent sal jou boonop kritiseer omdat jou aktiwiteit ongepas is)

"We did not have enough time. Lunchtimes were scheduled during SL times and we never had enough time to do anything with the residence. The amount of sessions were also not enough – personally I did not learn anything academically"

Ons het nie genoeg tyd gehad nie. Etes was geskeduleer in die DL tyd en dus het ons nooit genoeg tyd gehad om iets met die inwoners te doen nie. Die hoeveelheid sessies was ook nie genoeg nie – persoonlik het ek glad nie akademies gewys iets geleer nie)

- **Orientation:** Students should be prepared on what to expect during CBE and/SL. They are unsure what to expect of them and what they are supposed to do. Some of the comments include:

"Better preparation on what to expect"

"Perhaps more information can be given to students on what it entails" (Dalk meer inligting deurgee aan student oor wat dit behels)

"Orientation to areas can be beneficiary"

"Give us more practical examples before we go into the community to ensure that we are more at ease on what to expect and how to do that. Just more orientation and examples on real patients in order for us to learn" (Vir ons meer praktiese voorbeelde te gee voordat ons in die gemeenskap ingaan om seker te maak dat ons meer gerus is van wat verwag word en hoe ons dit moet doen. Net meer oriëntering en voorbeelde op regte pasiënte sodat ons so kan leer)

- **Outcomes:** Clear allocated goals and outcomes should be given to all the stakeholders involved in CBE and/or SL in order for everybody to know exactly what is expected from the students. Outcomes should also be realistic in terms of what can be done at a certain area. Comments from the respondents include:

"Clear allocated goals so that everybody works equally hard"

"Clear outcomes for future students might be helpful"

"You should understand better what is exactly expected of you" (Jy moet beter verstaan wat van jou verwag word presies)

"Rosters should be set out on what must be done in each session" (Roosters moet uiteengesit word van wat gedoen moet word elke sessie)

"More prominent outcomes"

- **Planning:** CBE and/or SL should be well planned and students' academic rosters should be taken into account and they should be informed well in advance in order for them to make the necessary arrangements. Activities should also be planned to be effective and relevant for the respective students' level of knowledge and for the community involved. Furthermore, communities should be evaluated and carefully chosen in order to ensure that there is a need that the students can fulfil. In the words of the respondents:

"Give a well organised (fair) roster beforehand so that proper plans can be made and not 2 days before"

"A clear schedule that is planned well in advance"

"The sessions of SL this year was very short and therefore we could not complete our projects"

"The lecturer can maybe check out the area and provide maps in order for her to understand the situation and environment" (Die dosent kan dalk net die area gaan uitkyk en padkaarte verskaf sodat sy kan verstaan hoe die situasie en omgewing lyk)

"Better planning"

- **Reflection:** Reflecting on the CBE and/or SL activities are crucial to students and they would like to do more reflections. Reflections should however be done

privately and not on a public forum, such as Blackboard. Comments in this regard were:

"Would like to do more reflections and more specific reflections in writing instead of electronically" (Sal graag meer refleksies wil doen en meer spesifieke refleksies skriftelik in plaas van elektronies)

"Please no reflections on Blackboard" (Asb nie refleksies op Blackboard)

- **Resources:** There should be sufficient resources and supplies available at the CBE and/SL sites. Some of the comments included:

"Organise supplies"

"More resources" (*Meer hulpbronne*)

"Service and maintenance of clinical equipment"

- **Supervision:** Adequate supervision, direction and support should be available to the students in the CBE and/or SL areas. Supervisors should be resourceful and able to assist and guide students. Responses in this regard:

"More qualified physiotherapists at MUCPP that can help during treatments" (*Meer gekwalifiseerde fisioterapeute by MUCPP wat kan help tydens behandelinge*)

"More supervision"

"Involve sufficient healthcare workers"

"Organise professional supervision" (*Reël professionele toesig*)

"Guidance and supervision"

- **Support:** Students would like to get more guidance from lecturers as well as emotional support during academic contact sessions as well as in the clinical areas. In the word of the respondents:

"Better involvement from lecturers at the different sites" (*Beter betrokkenheid van dosente by verskillende areas*)

"A more comprehensive form of emotional support"

"Class guidance" (*Klasleiding*)

- **Time:** Students feel that they should spend more time on CBE and/or SL in order to complete their projects and to really make a difference in the communities. The number of sessions as well as the time of each session can be increased. Comments include:

"More time allocation"

"Must make it longer, say for a whole day"

"More time on a daily basis in order to see a difference" (*Meer op 'n daaglikse basis op een plek te werk om verbetering te kan sien*)

- Transport:** Transport or financial aid for transport should be available to students, because it costs a lot of money to travel to the different CBE and/or SL sites and public transport is not always safe. In the words of the respondents:

"Travel compensation/busses"

"Transport also needs to be improved, because not everybody have and it is not calculated in their budgets"

"Organise professional transport" (Reël professionele vervoer)

"Transport should also be given and some places are far and it is expensive and not safe"
- Other:** The last theme includes all the suggestions and comments students made that did not fit into any of the other themes. This includes remarks on CBE and/or SL in general, suggestions that there should be more interaction during CBE and/or SL, debriefing after traumatic incidences during CBE and/or SL and issues on accommodation and safety. Examples of these suggestions include the following responses:

"Psychologists for emotional stress of CBE and SL"

"More student interaction"

"Better accommodation" (Beter verblyf)

"Are presented very good" (Word baie goed aangebied)

"I am first year, don't have enough to say"

"Security! For girls it is risky to go to certain areas and townships"

The main concerns that emerged in the School for Allied Health Professions are planning, exposure and organisation. These topics seem to play an important role in the way students experience CBE and SL and they received 36, 35 and 30 comments respectively.

5.3.7.3 Results from the School of Medicine

Nineteen themes emerged from the data from the School of Medicine. Discussions on these themes are given below together with examples of the students' responses to support the respective theme. Responses are quoted verbatim. Afrikaans quotes were translated by the researcher, with the verbatim Afrikaans quotes given in brackets where applicable.

- **Applicability:** Students recommended that the content of CBE and/or SL should be applicable to the theory that they learn in class. Furthermore, they feel that the activities do not always benefit the community and /or the students and that it should be based on the needs of the community, but on the practical skills that the students need to practice as well. In the words of the respondents:

"Theory in class does not match the practical aspects"

"Give less work that is really irrelevant and make it more practical" (Minder werk gee wat regtig irrelevant is en om dit meer prakties te maak)

"Make it more interactive with the community. I don't see the use of the expo, as I do not feel it truly reach out to the community"

"Visits with relevance to academic learning"

"More applicable" (Meer toepaslik maak)
- **Assessment:** The assessment of the community projects should be fair and based on the actual work put into the project and the difference it made to the community. Assessment in group context also creates problems, because not all group members work equally hard. The comments in this regards, include:

"Marks shouldn't be allocated for fancy and pretty presentations, rather the actual work done in the specific community"

"The system in the Faculty of Health Sciences particularly MEX does not protect better skilled students from being exploited by students that are less well skilled and don't pull their weight. This is justified 'group work' and is the umbrella term that ends up in victimisation of an individual. The faculty must find a way of keeping students accountable, even in a group work setting, for their individual effort and contribution – SL almost cost me my academic year"
- **Communication:** The communication between the students, the community settings and the UFS should improve. All the stakeholders should be well informed about the students' schedules as well as what to expect from the students. Furthermore, the students find it difficult to communicate to the community, because of the language difference. Comments in this regard, include:

"An effort to communicate better with students as to the state of affairs"

"Better communication between the different NGO's and the UFS" (Beter kommunikasie tussen verskillende NGO's en UV)

"Communication between the faculty and the skill providers at the CBE facilities needs to be improved with regard to the expectation of all role players as well as their responsibilities"

"Learn Sesotho"

"Translators in clinics"

- **Evaluation of communities:** Students believe that only communities that truly have needs should be selected for CBE and/or SL. They are of the opinion that some of the communities that the UFS currently serve do not really need it, which make it very difficult for students to identify projects in those specific communities. In the words of the respondents:

"Community projects should not always go to the same NGO's. There are many new projects that can benefit from student assistance"

"Institutions should be changed regularly, because certain institutions see the CBE and/or SL as a right and not a privilege" (Instansies moet gedurig verander word, want sommige instansies sien GBO en/of DL as 'n reg en nie 'n voorreg nie)

"NGO's used during projects should be carefully picked out"

- **Exposure:** Students would like to be exposed to a greater variety of diseases in the community. Comments were received from all the different year groups that more time should be allocated to CBE and/or SL – exposure should start form early in the programme and should continue throughout the programme. Comments in this regard:

"More opportunities can be created" (Meer geleenthede kan geskep word)

"Early onset of community service to get us used to things to come"

"There is not a lot of CBE, we only went out at the beginning of the year then not anymore"

"To maybe include more CBE and/or SL activities in Phase II"

"All students should perhaps be exposed to a various types of health care services instead of one"

"There can be more exposure to clinical things in order for students to see in practice what they have learned in theory" (Daar kan bietjie meer blootstelling aan kliniese dinge wees sodat student kan sien dat dit wat hulle leer in die praktyk toegepas word)

- **Financial aid:** Financial support from the Faculty will assist students in their community projects. In the words of some respondents:

"The faculty should organise sponsors for all groups and give a budget"

"Financial" (Geldelik)

"Get contacts and willing sponsors for CBE"

- **Healthcare personnel:** The healthcare personnel at the community settings and hospitals/clinics display a negative attitude towards the students and they are not always willing to assist them. Comments in this regard:

- "Friendliness of staff"*
- "They should be more student-orientated and organised"*
- "The staff at the community centres should be encouraged to be more willing to teach"*
- "Only staff that is willing to work with students should be involved"* (Daar moet slegs personeel betrek word wat gewillig is om met studente saam te werk)
- Lecturers:** Students are of the opinion that the lecturers responsible for CBE and/or SL should be more involved with the projects and visit the community sites. In the words of the respondents:

"The fact that the lecturer NEVER came to see the project was very bad. They give us marks for project that they show no interest in" (Die feit dat dosente NOOIT by die projek self kom kyk het nie was vir my baie afsittend. Hulle gee ons punte vir projekte waar hul nie eens self belangstelling toon nie)

"Lecturers should actually visit the specific areas"
 - Monitoring:** Monitoring of students at CBE and/or SL sites should be enhanced. Some students do not participate in CBE and/or SL activities. Some respondents remarks in this regard were:

"Monitor student's attendance regularly. It's bad that some students never attend the community sessions, but lie and get away with it. Ensure each member participates in the group"

"Better monitoring at CBE's"
 - Organisation:** The organisation of CBE and/or SL should improve. Students do not always have clear directions to the community sites, they do not know what to do there and the communities are also not well prepared to receive the students, which results in students wasting their time. Comments in this regard:

"To have set out schedules/time tables to minimise time wastages"

"Better organisation"

"Better maps/directions to clinics" (Beter padkaarte/adresse na klinieke)

"Communicate with the sites at which SL takes place to prepare them to be expecting students and what to do with the students"

"Effectiveness. Organisation from all spheres"
 - Orientation:** Students need to be well-orientated before they start CBE and/or SL. They are not prepared before they go out into the communities and they do not know what to expect. Remarks from some of the respondents include:

"Enough training beforehand should be conducted"

"Maybe prepare students in depth on exactly what are expected of them" (Dalk net studente voorberei in diepte oor presies wat van hulle verwag word)

"Orientation before a residency is vital"

"More information can be given to students before CBE and/or SL are done" (Meer informasie moet gegee word aan studente voordat GBO en/of DL gedoen word).

- **Outcomes:** Clear instructions and guidelines should be given to students on what to do during CBE and/or SL. Outcomes should be communicated to the healthcare workers and the students in order for all stakeholders to have the same expectations. Comments in this regard include:

"More clear guidelines"

"Better and clearer instructions"

"State clear objectives as to what is exactly expected of students"

"Better guidelines could be stated on what is expected of students" (Beter riglyne kon gestel word oor presies wat van studente verwag word)

- **Planning:** CBE and/or SL should be carefully planned and students' academic schedules should be taken into account, e.g. test/exam schedules and lecture times. CBE and/or SL activities should also be planned in such a way that the students gain experience from it and not only to deliver a service to the community. Healthcare organisations should be informed about what the students need to do. In the words of some of the respondents:

"Time management – it is unreasonable to be on call every third evening during a test week" (Tydsbeplanning – dit is onredelik om elke derde aand op roep te wees in toetsweek)

"Must be scheduled in the the most suitable time so that students will be able to participate without thinking about their studies"

"It should not interfere with our tests please"

"The activities should not be done directly after the holidays, it makes planning difficult" (Die aktiwiteite moet nie direk na 'n vakansie geskied nie, dit maak beplanning moeilik)

"Make it more medical orientated according to our course work"

"PLANNING. Make the organisations aware of what we have to do. We do not have the time to do everything that they want us to do" (BEPLANNING. Maak die organisasies bewus van wat gedoen moet word. Ons het nie heeldag tyd om alles te doen wat hulle wil hê)

- **Resources:** There should be an adequate amount of resources and equipment available at the hospitals and clinic in order for students to be able to perform CBE and/or SL. Comments in this regard:
 - "Improve hospital conditions"*
 - "The stock at the clinics also needs to be looked at"*
 - "The clinics need proper equipment"*
- **Security:** CBE and/or SL sites need to be safe for students, especially when students have to work in the evenings. Comments in this regard include:
 - "Security – especially being on night call"*
 - "Improve safety"*
- **Supervision:** There should be sufficient supervision from experienced healthcare personnel in order for students to gain the necessary experience and to learn how to perform the correct procedures. Senior students can also be used to supervise junior students. Some of the responses in this regards, included:
 - "To be taught by senior staff and to do procedures with them, to learn how to do that"*
 - "Supervision from medical staff"* (Toesig van mediese personeel)
 - "It would have been better had we as 1st years medical students, had some senior medical students accompanying us"*
- **Time:** Students would like to spend more time on CBE and/or SL in order for them to gain more experience and to be exposed to a greater variety of clinical cases. Comments included:
 - "Increase the time exposure – at least for two years"*
 - "More time necessary"* (Meer tyd nodig)
 - "Perhaps allow the students more time to experience the hospitals and see practical cases of what they are learning"*
 - "More time necessary to see a variety of fields"* (Meer tyd nodig gehad het om 'n verskeidenheid van velde te sien)
- **Transport:** Students experience problems with regard to transport to and from the CBE and/or SL sites. Comments in this regard:
 - "Transport must be available"*
 - "Not all students have cars, so transport should be organised"*
 - "Transport"* (Vervoer)
- **Other:** The last theme includes all the suggestions and comments students made that did not fit into any of the other themes and include remarks on CBE and/or SL in general, suggestions that there should be more support to students during CBE

and/or SL, debriefing after traumatic incidences during CBE and/or SL, collaboration with other faculties and suggestions on food and clothing. Examples of these suggestions include the following responses:

"The necessary debriefing after traumatic experiences" (Die nodige 'debriefing' na traumatiese gebeure)

"Collaborate with other faculties, such as social work, this way students learn more and also get to see how other students make a difference in the communities"

"Please provide a snack"

"Uniform in order to identify each other"

"It gets overwhelming in the final year and there is very little support on the students, it gets very depressing and tiring at this time"

The main concerns that emerged in the School of Medicine are exposure, organisation and outcomes. These topics seem to play an important role in the way students experience CBE and SL and they received 51, 30 and 24 comments respectively.

5.3.7.4 Summary of the results from all three Schools

Table 5.6 display all the themes that were identified by the three Schools respectively as well as the number of comments received on each of these themes.

TABLE 5.7: IDENTIFIED THEMES ON THE IMPROVEMENT OF CBE AND/OR SL AT THE FHS, UFS
[Table continues on next page]

Themes SoN	Number of comments	Themes SoAHP	Number of comments	Themes SoM	Number of comments
Transport	30	Planning	36	Exposure	51
Orientation	13	Exposure	35	Organisation	30
Planning	12	Organisation	30	Outcomes	24
Other	11	Supervision	23	Healthcare personnel	21
Organisation	10	Outcomes	20	Other	19
Supervision	7	Transport	20	Time	18
Communication	5	Communication	19	Orientation	18
Time	5	Other	17	Planning	16
Healthcare Personnel	4	Orientation	14	Evaluation of communities	13
Outcomes	4	Time	11	Applicability	13
Reflection	3	Healthcare personnel	9	Transport	12
Exposure	3	Financial Aid	9	Supervision	12
		Resources	6	Communication	9
		Support	8	Financial Aid	9

Themes SoN	Number of comments	Themes SoAHP	Number of comments	Themes SoM	Number of comments
		Multi-disciplinary teams	5	Resources	8
		Assessment	4	Monitoring	8
		Monitoring	3	Security	7
		Reflection	2	Lecturers	3
				Assessment	2

Twenty two different themes have been identified from the results. Eleven of the themes emerged in the data from all three Schools, namely communication, exposure, healthcare personnel, organisation, orientation, other, outcomes, planning, supervision, time and transport and seems to be important issues that influence the students' experiences of CBE and/or SL throughout the Faculty of Health Sciences.

Five of the themes emerged in data from only two of the Schools (SoM & SoAP), namely assessment, financial aid, monitoring resources and reflection and appears to be significant matters surrounding CBE and/or SL for the majority of the students in the Faculty of Health Sciences. The remaining six themes, namely applicability (SoM), evaluation of communities (SoM), lecturers (SoM), multi-disciplinary teams (SoAHP), security (SoM) and support (SoAHP) appeared at only one of the Schools and gives the impression that it is more School-specific issues regarding CBE and/or SL and do not affect the majority of the students in the Faculty.

5.4 CONCLUSION

In this chapter, the results of the questionnaire survey that was administered to all the undergraduate students registered for degree courses offered in the Schools of Medicine, Allied Health Professions and Nursing at the FHS, UFS involved in CBE and/or SL during 2011 were discussed. The aim of the questionnaire survey was to explore the way students experience CBE and SL in the Faculty of Health Sciences, UFS.

In Chapter 6, **Health Sciences students' experiences of Community-Based Education and Service Learning**, the researcher will combine the findings from the nominal group technique and the questionnaire survey as well as the literature in order to make recommendations on how to implement and manage CBE and SL into an undergraduate Health Sciences programme in such a way that students benefit from the experience and consequently improve the effectiveness thereof.

CHAPTER 6

HEALTH SCIENCES STUDENTS' EXPERIENCES OF COMMUNITY-BASED EDUCATION AND SERVICE LEARNING

6.1 INTRODUCTION

In this chapter the discussion revolves around the combined findings from both the quantitative and the qualitative results of the mixed-methods research design as described in Chapter 4, *Results and discussion of findings of the Nominal Group Technique* and Chapter 5, *Results and discussion of findings of the Questionnaire survey* as well as information obtained through the literature review, Chapter 2, *Conceptualising and Contextualising Community-Based Education and Service Learning*.

This will be done with the view to describe Health Sciences students' experiences of CBE and SL and to make recommendations to academic staff in the FHS, at the UFS as well as to all internal and external role players on the managing of CBE and SL initiatives within undergraduate Health Sciences programmes. This chapter is the conclusive step of Phase III in the mixed-methods design used in this research, namely exploratory design (cf. *Figure 3.2. Mixed-methods approach for this study*).

Students' ability to learn is to a great extent affected by their perception of the specific learning environment. A multifaceted relationship exists between attitude, perception and learning. If students have a negative perception of the learning environment, they will have a negative attitude towards the learning that is expected to take place, which will inevitably result in less effort put into the task at hand and ultimately less learning that will take place. Positive attitudes and perceptions can be encouraged by creating a better classroom climate, ensuring the quality and quantity of the resources and gaining individual acceptance of the students (Marzano 1992: online).

In order to be devoted and responsible when carrying out CBE and/or SL activities, it is imperative for undergraduate Health Sciences students to have an optimistic attitude to and perception of CBE and/or SL. Therefore, it is of utmost importance to understand the students' attitudes and perceptions of CBE and/or SL when designing

and coordinating such initiatives to ensure that maximum benefit can be obtained from this pedagogy.

The theoretical framework for CBE and SL as emerged from the literature will be given, followed by a description of the experiences of undergraduate Health Sciences' students towards CBE and SL by means of discussing the themes that emerged from the research. Subsequently, recommendations will be made on the important aspects to consider when implementing CBE and SL endeavours in order to create conducive learning environments for students and have a positive influence on their attitudes and behaviour, which will make a difference to the desired outcomes.

6.2 THEORETICAL FRAMEWORK UNDERLYING CBE AND SL

The theoretical framework pertaining to CBE and SL, including the changes in Higher Education that lead to the implementation of CBE and SL, community engagement and contextualising and conceptualising of the terms CBE and SL as proposed by the researcher through the literature study, will be discussed.

6.2.1 Changes in Higher Education

In Chapter 2, *The conceptualisation and contextualisation of Community-Based Education and service learning, The changing face of higher education* (cf. 2.2) both international (cf. 2.2.1) and nationally (cf. 2.2.2) were highlighted, followed by a discussion on the term *community engagement* (cf. 2.3) which laid the foundation for CBE and SL.

It is evident that HE faces the challenge of shaping holistic human beings. Universities should not only be focused on the world of work, but also on shaping caring and responsible citizens. Students and graduates should make a difference in the workplace but also in the community. This challenge leads to necessary changes, such as diversification of function of the academic profession, teaching activities that include a variety of modes, learning environments that facilitate lifelong learning, the move towards multidisciplinary training and increased sensitivity to societal needs.

The education of good, responsible and critical people for a future SA is emphasised at national level with the White Paper on the Transformation of Higher Education

(Department of Education 1997). It calls on HE institutions to demonstrate social responsibility and their commitment to the common good by making available expertise and infrastructure for community service programmes.

Health Sciences education is also affected by these challenges and should be directed towards health priorities in the communities. Additionally, graduates from Health Sciences graduates should be prepared to work in health systems, to address the health needs of families and communities and to assist in improving access to health services in places and under conditions that advance general well-being.

For the achievement of this ideal, it is necessary for HEI to engage with the community and to make communities active participants in knowledge activities - in the creation, dissemination and utilisation thereof. In the FHS at the UFS, CBE and SL became the "engagement tool" of choice for the attainment of this ideal.

6.2.2 Conceptualisation and contextualisation of CBE and SL

In Chapter 2, *The conceptualisation and contextualisation of CBE and SL*, the term **Community-Based Education** (cf. 2.4.1) was discussed. This included a definition of CBE (cf. 2.4.1.1 *definition*) as well as the underlying perspectives (cf. 2.4.1.2 *societal perspectives underlying CBE*) and the foundation of CBE (cf. 2.4.1.3 *rationale for CBE*). Following that, the classification of CBE (cf. 2.4.1.4 *taxonomy*) and the roles (cf. 2.4.1.6 *the roles of the different partners in CBE*) and benefits (cf. 2.4.1.7 *perceived benefits to partners*) of the different role players were examined. Lastly, *programme design and development* (cf. 2.4.1.8) were discussed.

Subsequently the term **Service Learning** (cf. 2.4.2) was also discussed. This discussion included *what is service learning* (cf. 2.4.2.1) and a *definition of service learning* (cf. 2.4.2.2). It was followed with a discussion of the *theoretical approaches to understand service learning* (cf. 2.4.2.3) and the key *elements of service learning* (cf. 2.4.2.4). Lastly, the difference between service learning and traditional learning (cf. 2.4.2.5 *service learning vs. traditional learning*) was clarified and the benefits *of service learning* (cf. 2.4.2.6) was discussed.

6.2.2.1 Community-Based Education

To recap, the researcher defines CBE in this research study as a form of instruction where students learn professional competencies at the National District Hospital level as well as various Primary Health Care (PHC) clinics based in the Free State; this is done by focusing on individuals and their everyday problems.

CBE programmes should consider the basic moral issues that arise in Health Care, such as respect for people's rights, offering medical benefits to patients with minimum harm and compliance with the justice system. Furthermore, CBE programmes should recognise communities as complete physical, mental and social well-beings and not focus on the absence of disease only. Various societal perspectives underpin CBE (cf. **2.4.1.2 Societal perspective underlying CBE**), which include ethical, social, political and educational perspectives. All of these perspectives should be taken into account when designing a CBE programme.

For a complete discussion on the rationale for CBE refer to **2.4.3.1 Rationale for CBE**. The main drive of CBE at the FHS, at the UFS, is to assist with the problems of inequity in health service delivery, to prepare undergraduate health sciences students for their future career by exposing them to opportunities to learn in an environment that resembles what they will encounter in their later professional life and to render opportunities for partnership between the UFS, government and the community.

The CBE component in the FHS, at the UFS, can be classified as mainly training-focused with most of its activities taking place at PHC settings. However, there are activities in the respective curriculums that can be classified as service-orientated and research-orientated. The main focus is on students training in community settings in order to produce Health Care professionals who are able to work in underserved areas (cf. **2.4.1.4 Taxonomy of CBE**).

It is imperative for the success of CBE programmes that each of the stakeholders involved in CBE fulfil their respective roles. The University should implement policy guidelines, provide the necessary funding, logistics and administration with regards to CBE; the students and communities should be active, responsible and accountable participants in CBE, while the health services should contribute to the training of students by being involved in supervision, facilitation, multi-disciplinary team

collaboration and providing and maintaining PHC facilities (cf. **2.4.1.6 *The roles of the different partners in CBE***).

The justification of CBE arises from its perceived benefits to students, the faculty, the institution, the health services and the society at large (cf. **2.4.1.7 *Perceived benefits and returns to partners***). The most important benefits of CBE for undergraduate health sciences students at the UFS are to gain practical experience, skills, competencies and knowledge. The public image of the UFS improves through CBE and the institution becomes more visible to the society, while the communities involved in CBE contributes to its own development and their health services expand.

Morgan *et al.* (2009:3) proposed key steps when designing a CBE programme (cf. **2.4.1.8 *Programme design and development***). The researcher concurs with this and is of the opinion that it is important to include all of these elements when implementing CBE in the Faculty of Health Sciences (cf. **6.5 *Implementing CBE and/or SL into undergraduate health sciences programmes***).

6.2.2.2 *Service Learning*

Service Learning in this study can be defined as curriculum-based, credit-bearing learning experiences in which students participate in well-organised and structured activities aimed in addressing the needs in the community and reflect on the service experience in order to gain an understanding of the linkage between theory and community dynamics as well as achieve personal growth and a sense of social responsibility. SL requires collaborative partnerships between the UFS, students, community and service sector. For more definitions of SL refer to **2.4.2.2 *Defining Service Learning***.

SL is a form of experiential learning (cf. **2.4.2.3 *Theoretical approaches to understand Service Learning***) that occurs in the community and place equal focus on the service being rendered to the community and the learning that will take place.

The popularity of SL in the past decades is due to its sound pedagogic principles (i.e. active learning, practical application, collaboration and frequent feedback), the effective learning environment it creates, and the more interdisciplinary focus on the holistic development of individuals (with regard not only to cognitive, but also

affective, social and attitudinal development) (cf. **2.4.2.4 Key elements of Service Learning**).

The main distinction between SL and traditional learning is that in traditional learning students are seen as listeners of someone else's knowledge and individual learning occurs individually, while students are viewed as active contributors who learn from theory, experience and personal knowledge in SL and co-operative learning is emphasised (cf. **2.4.2.5. Service vs. Traditional Learning**).

As with CBE, the success of SL lies in the benefits to students, the faculty, the institution, the health services and the society at large (cf. **2.4.2.6 Benefits of service learning**). The most important benefits of SL are similar to those for CBE and for the undergraduate health sciences students at the UFS it is to gain practical experience, skills, competencies and knowledge. For the UFS, the public image of the institution improves and for the communities involved in SL the benefit is that they can contribute to their own development and their health services expand.

The researcher is convinced and recommends that all the above mentioned factors should be considered when designing and implementing CBE and SL into the curriculum to ensure the success of the programme. The institution should ensure that CBE and SL initiatives are carefully planned before entering the community and be wary not to merely jump on the bandwagon unsighted and unprepared. Throughout and after the CBE and SL endeavours certain actions should be taken to ensure the success thereof (cf. **6.5 Implementing CBE and/or SL into undergraduate Health Sciences programmes**).

6.3 A SUMMATIVE DISCUSSION OF FINDINGS

A summative discussion will be given on the combined significant findings from both Phases I and II of the research design used in this mixed-methods approach. This discussion will include all the aspects that had a positive as well as a negative influence on the way students experienced CBE and/or SL in the FHS, at the UFS and will be done by means of discussing all the important themes that emerged from the research data.

This is based on the findings from Chapter 4, ***Results and findings of the nominal group technique*** and Chapter 5, ***Results and findings of the questionnaire survey***. The themes that were identified will also be reinforced with relevant literature as discussed in Chapter 2, ***The conceptualisation and contextualisation of Community-Based Education and service learning*** where applicable.

6.3.1 Factors that had a positive influence on students' experience

6.3.1.1 Personal growth

According to the definition of SL, the achievement of personal growth is one of the aims of SL (cf. ***2.4.2.2 Defining Service learning***) and gaining self-confidence is a benefit to the students that arises from SL (cf. ***2.4.2.6 Benefits of Service Learning***).

The undergraduate students from all three Schools in the FHS agreed that CBE and/or SL helped them grow as a person. Students got the opportunity to identify their own personal strengths and weaknesses through the CBE and/or SL activities they undertook and they experienced a sense of self-fulfilment. The majority of the students indicated that their self-confidence improved as a result of participating in CBE and/or SL.

6.3.1.2 Exposure / Experience

Encountering patients in their own environments illustrates to the students the complex interplay between physical, psychological, social and environmental factors, while they also get the opportunity to learn in diverse areas and to experience different health problems facing the members of the community, which prepare them for their future careers. The majority of the students were in agreement that CBE and/or SL exposed them to the "human side" of patients and furthermore they agreed that they were exposed to a variety of conditions/cases in their respective fields of study during CBE and/or SL.

This corresponds with one of the aims of CBE (cf. ***2.4.1.3 Rationale of CBE***) and to the perceived benefits of CBE (cf. ***2.4.1.7 Perceived benefits and returns to partners***) and SL to the students (cf. ***2.4.2.6 Benefits of service Learning***).

6.3.1.3 *Social responsibility*

Delivering relevant and meaningful service to the community is one of the key elements of both CBE and SL (cf. **2.4.1.3 *Rationale of CBE***; cf. **2.4.2.4 *Key elements of service learning***), while training social responsive and accountable students, who are willing and prepared to work in rural and underserved communities, is one of the aims of CBE (cf. **2.4.1.3 *Rationale of CBE***) and of SL (cf. **2.4.2.2 *Defining Service learning***).

In the FHS, at the UFS, CBE and/or SL enhance students' sense of social responsibility. Almost all the students in the FHS agreed that students who participate in CBE and/or SL can have a positive impact on community development; they enjoyed serving the community and they have an obligation to serve the community. Their desire to help or care for other people increased as a result of CBE and/or SL and they have a better understanding of the problems, diseases and needs in the community. CBE and/or SL furthermore helped students realise that they have a responsibility towards the people in the community.

There were some differences between the students in the FHS's opinions on whether they would continue to volunteer in the community in future. Two thirds of the students from the SoAHP and SoM were of the opinion that they will probably continue to volunteer in the community in future, while only half of the students in the SoN agreed with that. The researcher is of the opinion that although students from the different Schools differ in their opinion of whether they would like to continue to volunteer in the community in future, the majority of the students agreed that they would probably continue to work in the community in future, which is an indication that they do realise their obligation to serve the community and that they are willing to do so.

6.3.1.4 *Interpersonal skills*

Most of the students believed that their interpersonal communication skills improved as a result of the interaction they have with other role players during CBE and/or SL. CBE and/or SL provided students with the opportunity to interact with different patients, Health Care personnel and other members of the community, which helped them to

practice their interpersonal communication skills and thus prepare them for their future as Health Care professionals.

This corresponds with one of the rationales of CBE as well as a benefit to students in both CBE and SL, namely to equip students with competencies and skills which they might not have learnt otherwise e.g. communication skills (cf. **2.4.1.3 Rationale of CBE**, cf. **2.4.1.7 Perceived benefits and returns to partners**, cf. **2.4.2.6 Benefits of Service Learning**).

6.3.1.5 Cultural diversity

The majority of the students agreed that they enjoyed the interaction with people from different cultural backgrounds and that CBE and/or SL helped them understand how to treat the problems and diseases that the community experience. They generally experienced the community members to be friendly and willing to co-operate with the students. The researcher affirms students learn new skills and knowledge in caring for community's health, which involve the patient, family and the bigger community. CBE and/or SL force students to interact with people from different cultures and it presents them with the opportunity to learn more about cultures that are different from theirs, whether it is intentional or happening as part of their interaction with the patient.

One of the potential benefits to students is that both CBE and SL provide them with opportunities to interact with people of diverse cultures and lifestyles and to have meaningful involvement with the local community (cf. **2.4.1.7 Perceived benefits and returns to partners**, cf. **2.4.2.6 Benefits of Service Learning**).

6.3.1.6 Theory-practice

A perceived benefit of CBE is to present students with the opportunity to apply their theoretical knowledge in real life situations directly (cf. **2.4.1.7 Perceived benefits and returns to partners**). Some of the benefits to students during SL are the use of hands-on skills and knowledge to increase the academic skills. Students also learn to apply principles from the module to new situations (cf. **2.4.2.6 Benefits of Service Learning**).

Most of the students were in agreement that CBE and/or SL helped them put their knowledge into practice and provided them with hands-on use of the skills that increased the relevance of their academic skills. Furthermore, CBE and/or SL force students to integrate the knowledge that they have in order to form a holistic picture of the patient/disease. The researcher concurs that during CBE and/or SL in the FHS, at the UFS, students have access to a wide variety of patients, which provides them with the opportunity to develop and practice their clinical skills with greater continuity and across a broad continuum of care.

6.3.1.7 Knowledge

Students from all three Schools in the FHS were of the opinion that exposure to certain diseases/cases during CBE/SL "forced" them to search for additional information with a view to learn extra things, which they would not have otherwise. Furthermore, the majority of the students were of the opinion that CBE and/or SL provided them with hands-on use of the knowledge that increased the relevance of their academic skills.

The enhancement of knowledge and academic learning is one of the perceived benefits of both CBE (cf. **2.4.1.7 Perceived benefits and returns to partners**) and SL (cf. **2.4.2.6 Benefits of Service Learning**). CBE and/or SL enable students to integrate the theory and practical aspects, as well as the basic professional aspects of their training. Learning is based on real-life contexts and students are forced to search for new information and to learn new skills in order to successfully complete their CBE and/or SL endeavours.

6.3.1.8 Professional competencies

Students in all three Schools in the FHS indicated that their time management- and problem-solving skills improved as a result of CBE and/or SL. However, there was a difference in opinion as to the level of improvement between the students from the different Schools. More students from the SoN thought their time management- and problem-solving skills improved through CBE and/or SL as opposed to the students from the SoAHP, while only a small number of students from the SoM thought that CBE and/or SL contributed to the enhancement of their time management- and problem-solving skills.

Generally of the benefits of SL for students is the development of problem-solving skills (cf. **2.4.2.6 *Benefits of Service Learning***), while the development of time management skills is not mentioned as a benefit in either CBE or SL per se.

During CBE and/or SL students learn new skills and professional competencies, which they would not have done in hospital settings and these skills and competencies will enable them to participate in a meaningful way in the clinician-patient interaction and will prepare them for their future role as professionals.

6.3.1.9 *Feeling valued*

One of the aims of CBE is that it provides students with the opportunity to elaborate on information, since the community will consider them as experts and ask them questions and discuss possible health problems with them (cf. **2.4.1.3 *Rationale of CBE***), while one of the key elements of SL is that the community should value the students' interests and skills and they should view their services as worthwhile and necessary (cf. **2.4.2.4 *Key elements of service learning***).

The majority of the students in the Schools of Nursing and Allied Health Professions believed that the community valued their services during CBE and/or SL, while only half of the students in the SoM shared this belief. The researcher is of the opinion that students will feel valued and will perceive their service as meaningful if they can see the difference that it made to the community. It is therefore of utmost importance to base the CBE and/or SL activities on the real health needs of the community.

6.3.1.10 *Health Care Professionals / Multi-disciplinary Team*

More than half of the students from all three Schools in the FHS agreed that the staff at the respective community settings were helpful and friendly. The majority of all the students were of the opinion that they enjoyed the interaction with the members of the multi-disciplinary team and learned a lot from and about the different people working in the multi-disciplinary teams. One of the perceived benefits to students, as well as one of the rationales of CBE, is to offer students the opportunity to practice a multi-disciplinary and holistic approach to Health Care and to work together in a team and to *learn from each other* (cf. **2.4.1.7 *Perceived benefits and returns to partners***, cf. **2.4.1.3 *Rationale of CBE***).

The researcher wishes to highlight that one of the strengths of CBE and/or SL is to provide students with the opportunity to see the patient care pathway span a range of activities. This enables students to learn not only their own discipline, but the role of the multi-disciplinary team as well.

6.3.1.11 *Gradual introduction*

Approximately half of the students were of the opinion that CBE and/or SL have value in the junior years of their programmes, while about a quarter of the students disagreed with this statement and the other quarter were neutral. It seems, therefore, that students' perspectives in this regards differs, but that many of the students enjoyed the early exposure to the clinical setting.

In the literature consulted during this study, no specific guidelines or recommendations could be found as to whether junior students should be involved in CBE and/or SL or not. The researcher is of the opinion that early exposure to clinical areas will gradually introduce the students to environments that are similar to their future working environments and that it will be to their benefit. CBE and/or SL activities in the junior years should be planned carefully to ensure that students, as well as the community, can benefit from these activities.

6.3.2 Factors that had a negative influence on students' experience

6.3.2.1 *Organisation*

The majority of the students throughout the FHS believed that CBE and/or SL is not well-organised and that this has a negative impact on their experience. Approximately two thirds of the students agreed that it is important to have clear outcomes of the CBE and/or SL activities. The students had different views of whether there are clear outcomes with regards to CBE and SL in their respective programmes; in the SoN 50% of the students thought that there were clear outcomes to their programme, while only 30% from the SoM and SoAHP believed that there were clear outcomes in their respective programmes. The development of key learning objectives, actions and targets that best match the learning opportunities are one of the key steps in the development of a CBE programme (cf. **2.4.8.1 *Programme design and development***), while one of the key elements of SL is that service learning

experiences must reinforce the achievement of learning outcomes (cf. **2.4.2.4 Key elements of service learning**).

Students in the three Schools had different views regarding the monitoring of student attendance during CBE and/or SL. Sixty per cent of the students in the SoN believed that student attendance were monitored well, while about 40% of the students in the SoM and SoAHP believed that student attendance is well monitored in their respective Schools. CBE and/or SL represent a compulsory component of all the programmes in the FHS and it is imperative that all students should participate in these activities and therefore attendance should be well-monitored.

The students had different opinions with regard to the organisation between the University and the respective Health Care facilities/communities; however, in general the students felt that the CBE and/or SL activities were not well-organised between the UFS and the communities. It seems that the Health Care facilities or communities were not always expecting the students and were not organised to receive and assist them. Furthermore, they were sometimes unsure of what the students need to/are able to do. It happened at times that the community had unrealistic expectations from the students and were not willing to co-operate in the activities. A collaborative partnership and good communication between all stakeholders in the partnership is emphasised in both CBE (cf. **2.4.1.6 The roles of the different partners in CBE**) and SL (cf. **2.4.2.4 Key elements of service learning**).

Some of the students felt that the needs of the communities should be determined more accurately before the onset of CBE and/or SL, because some of the communities that were part of CBE and/or SL did not really need the service provided to them and other communities that do need the same services were omitted. One of the most important criteria for CBE and SL to be successful is to provide relevant and meaningful services to the community and to focus on identified needs in the community (cf. **2.4.1.2 Societal perspectives underlying CBE**, cf. **2.4.1.3 Rationale of CBE**, cf. **2.4.2.4 Key elements of service learning**).

Less than 40% of all the students felt that the time allocated at community sites was enough to really make a difference. It is imperative for the success of CBE and/or SL to plan activities and allow sufficient time in the communities (cf. **2.4.1.8 Programme design and development**, cf. **2.4.2.4 Key elements of SL**) in order for students to

be able to perform those activities to the best of their abilities and to meet the required outcomes of the sessions. Too little time allocated to activities can lead to increased learning for students and the needs of the communities might not be met.

Additionally, many (60%) of the students were of the opinion that CBE and/or SL activities were planned in their rosters at times which did not suit them best. To ensure that students benefit optimally from the experiences, it is imperative to ensure that the CBE and/or SL activities/projects are scheduled at the most suitable times possible for the students, in order for them to be able to devote their undivided attention and time to the activity/project. These initiatives should preferably not be scheduled during tests or exams.

6.3.2.2 Health Care professionals

The students had different opinions regarding the Health Care professionals at the community settings/ Health Care facilities. Almost half of the students felt that the staff at the community settings were not knowledgeable and did not teach them a lot.

Furthermore, the students are generally of the opinion that a good working relationship does not exist between the members of the multi-disciplinary team and that not everybody assisted them. The role of the Health Care Personnel is to contribute to the training of students by being involved in supervision of students, facilitation of multi-professional and multi-sectorial collaboration and to provide, maintain and sustain PHC facilities and services (cf. **2.4.1.6 The roles of the different partners in CBE**) and it is clear that not all Health Care personnel involved in CBE and/or SL fulfil these roles satisfactory.

In addition, half of the students were of the opinion that the expectations of the staff/supervisors regarding the students' abilities during CBE and/or SL were not reasonable and that there was not adequate supervision during CBE and/or SL. Good supervision is imperative for the success of CBE and/or SL (cf. **2.4.1.6 The roles of the different partners in CBE**, cf. **2.4.1.8 Programme design and development**, cf. **2.4.2.2 Defining Service Learning**, cf. **2.4.2.4 Key elements of SL**).

The researcher needs to emphasise that dedicated Health Care personnel who uphold and practice the ideal of public service and ethics of social responsibility in medicine and are willing to supervise students during CBE and/or SL are one of the key components to the success of CBE and/or SL. It is, however, difficult to find such supervisors and they need to be identified, nurtured and rewarded in order to retain them.

6.3.2.3 *Unproductive*

A large number of the students, especially in the SoN (50%), were of the opinion that they sometimes felt that they failed the patient/community, because they were not able to help them effectively. In addition, the students, in varying degrees, sensed that they were in the way of the Health Care staff at times (SoN 46%, SoM 43% and SoAHP 35%). The majority of the students, however, believed that CBE and/or SL are not a waste of their time. It is important to plan CBE and/or SL activities according to the level of knowledge and experience that the respective student has at that particular time, in order to ensure that they are able to perform the expected activity effectively (cf. **2.4.1.8 *Programme design and development***, cf. **2.4.2.4 *Key elements of SL***).

6.3.2.4 *Emotional exposure*

Students had different perspectives on whether CBE and/or SL exposed them to emotional experiences that they did not always know how to handle. Many of the students in SoN and SoAHP were of the opinion that they were exposed to emotional experiences that they did not know how to handle, while the students in the SoM had a different opinion.

On the other hand, approximately half of the students were disturbed by the devastating circumstances in the communities that they were exposed to. Hence, it is of utmost importance to debrief the students after CBE and/or SL, especially if they were exposed to traumatic experiences. One possible way of assisting students to deal with the emotional experience is through reflection (cf. **2.4.1.8 *Programme design and development***, cf. **2.4.2.4 *Key elements of SL***).

6.3.2.5 Resources

Students had different opinions regarding the availability of resources at the Health Care facilities, but generally the students were of the opinion that the lack of resources at the hospitals/clinics made it difficult for them to perform their CBE and/or SL activities.

6.3.2.6 Language

The language difference between some of the students and the members of the community made communication difficult and the majority of the students agreed that the language difference created difficulties.

6.3.2.7 Transport

Some of the students experienced transport problems, especially in the SoN. One of the roles of the University is to provide the necessary support to the students to be able to perform their activities (cf. **2.4.1.6 The roles of the different partners in CBE**).

6.3.2.8 Orientation

Students view orientation/induction before entering the communities as crucial, but felt that they do not always receive proper orientation/induction beforehand. None of the literature consulted reminisce the importance of orientation or induction for the students before embarking on CBE and/or SL.

The researcher is of the opinion that CBE and/or SL activities should be well-structured and -designed and lecturers should ensure that all students are prepared to embark on CBE and/or SL and know exactly what is expected of him/her. The assessment criteria should also be explained beforehand to the students in order for them to fully understand what the important aspects of the specific activities are.

6.3.2.9 Reflection

Approximately half of the students agreed that reflecting on CBE and/or SL activities helped them learn more and they were also of the opinion that reflection should be a private matter and that it should not be done on public forums, e.g. Blackboard. Reflection is an integral part of SL (cf. **2.4.2.2 Defining Service Learning**, cf. **2.4.2.4 Key elements of Service Learning**) in order for the students to enhance their learning.

6.4 RECOMMENDATIONS RELATING TO THE IMPROVEMENT OF CBE AND/OR SL IN THE FACULTY OF HEALTH SCIENCES AT THE UFS

Based on the previous discussions (cf. Points 6.2 & 6.3) the following recommendations are made with regard to the improvement of CBE and or/SL in the FHS, at the UFS with a view to enhance the experience of undergraduate Health Sciences students.

The recommendations will be based on all the elements that had a negative influence on the experiences of students with regards to CBE and SL, while at the same time including those aspects that had a positive influence on students' experiences.

The researcher proposes that the following elements and actions are included when implementing CBE and/or SL into undergraduate Health Sciences programmes in order to:

- Ensure that students acquire an understanding of the current health needs and challenges facing communities;
- Provide students with an opportunity to learn in an environment that resembles what they will come across in later professional life;
- Ensure that students get the opportunity to apply their theoretical knowledge;
- Equip students with competencies and skills which they might not have learnt otherwise e.g. communication skills, leadership skills, team work, etc.;
- Expose students to a wide variety of patients in order to develop their practical and clinical skills across a broad continuum of care;
- Offer students the opportunity to practice a multi-disciplinary and holistic approach to Health Care;

- Develop health professionals that are prepared to deliver optimal health care in an environment that inherently provides unequal access to health care and instil a sense of social responsibility, which will in turn contribute to health promotion of the country, and
- Ensure that CBE and/or SL initiatives benefit the community as well.

The following recommendations are made with the view to improve CBE and/or SL activities in the FHS, at the UFS.

6.4.1 Organisation

6.4.1.1 *Develop module outcomes*

Academic staff must clearly indicate the integration of CBE and/or SL within a module. In order for CBE and/or SL to be truly effective, CBE and/or SL must be well-planned and integrated into the module outcomes, with a clear outline of the CBE and/or SL component, what the activities entails, why these activities are being employed in this particular module and how is it integrated with academic learning.

CBE and SL are academic endeavours, which require that the activities should be linked to the respective theoretical components in the different modules. CBE and SL should entail service activities that are directly accountable to community-identified needs and it should have explicit learning outcomes for the students.

Learning outcomes should be clear, specific, and action-orientated and it should be linked to the academic issues that emerge when students meet the specific health needs of the chosen community. At the same time the outcomes should be broad enough to clarify the social, economic, cultural and political issues underlying the source of the community need, while encouraging students to think about questions of moral, ethical and social responsibility. Outcomes should be explicit in showing students how to relate CBE and SL experiences to module content.

CBE and/or SL learning outcomes should include:

- *Enhanced understanding of curriculum content and improved application of curriculum content*

As the students follow the learning outcomes in this module they should be able to identify and describe the links between the theoretical components on the one hand and their experiences in the communities and Health Care facilities on the other hand. Furthermore, they should be able to apply the theoretical concepts in the context of their CBE and/or SL experiences, analyse the module content in light of their experiences and evaluate their own understanding of the module content.

- *Personal growth*

Learning outcomes should also attempt to capture learning related to students' personal characteristics. While attempting these learning outcomes, students should become aware of their own personal characteristics, for e.g. their strengths and weaknesses, their sense of identity, their own assumptions and beliefs. They should be able to apply this deepened awareness of themselves in the context of their CBE and/or SL experience as well as in their lives and they should be able to evaluate their strategies for personal growth in accordance with what they are learning about themselves.

- *Deeper appreciation of social responsibility*

These learning outcomes attempt to capture learning related to citizenship, how individuals act in their specific profession in social responsive ways or collective action towards change and improvement. Furthermore, the aim is to ensure that students become educated in the problems of society, experience and understand the social, health and political issues in the communities and gain experience and skills on how to act on these issues.

As a starting point, a wide range of service learning outcomes (as discussed above) can be set and from there academic staff can formulate specific learning outcomes that are clear and measurable. Furthermore, learning outcomes should be in writing and included in the module guides of students. Learning outcomes should also be carefully selected with consideration for the well-being of the community involved.

Once learning outcomes have been formulated, CBE and/or SL tasks and activities should be planned to address the specific outcomes. These tasks and activities should be planned in collaboration with the community partners and Health Care facilities. Academic staff should ensure that the CBE and/or SL experiences are designed around

the health needs of the identified community and are applicable to the module outcomes and specific levels of knowledge and skills of the students. Precise teaching methods can then be matched to the different tasks and activities; for example, teaching clinical skills require demonstration and practice under observation.

Another vital element is to link academic credits to CBE and/or SL activities and to establish assessment criteria in order to ensure that academic learning take place. It is important that assessment should not be based on the actual service that is performed, but rather on the student's demonstration on how they are integrating the service experience with the module content. Forms of assessment can include practicals, reflective journals, compilation of portfolio's, etc.

The researcher wants to emphasise the importance of designing CBE and/or SL programmes around the health problems identified in collaboration with the communities in order to enhance the effectiveness of CBE and/or SL. Students will provide the required health services to the community as soon as they enter the community, which will assist with the imbalances of health services in the country and fulfil one of the aspirations of the WHO. Conversely, students will obtain more personal satisfaction from CBE and/or SL when they perceive that their efforts truly make a difference in the lives of the communities, which will result in creating social responsive graduates who are able and willing to work in underserved communities.

6.4.1.2 *Selecting appropriate communities and Health Care facilities*

Community settings and Health Care facilities should be evaluated in order to ensure that the correct placements are made for the CBE and/or SL activities. Academic staff should meet with the surrounding communities and Health Care facilities to identify the different health- and social needs of the different communities. Only the community settings and Health Care facilities and the requirements that will be met by the specific learning outcomes and CBE and/or SL activities should be selected. Students should be able to deliver a service to the community during CBE and/or SL that will truly benefit the members of the community.

Academic staff should also ensure that the selected community settings and Health Care facilities are able and willing to accommodate the different students and that they have sufficient resources to be able to provide a favourable learning environment to

the students. Additionally, the researcher affirms that it is important that students are exposed to as many as possible different pathologies and patients during CBE and/or SL in order to provide them with the opportunity to practise their clinical skills. Academic staff should bear this in mind when selecting appropriate community settings and Health Care facilities for CBE and/or SL.

6.4.1.3 *Monitoring of students' attendance*

CBE and/or SL form a compulsory component of the undergraduate programmes in the FHS at the UFS and it is imperative that student attendance should be well-monitored during CBE and/or SL. Student logbooks can be used for this purpose, where students need to document their encounters with the different patients that they see during CBE and/or SL. Student reflections and attendance registers are additional tools that can also be used.

6.4.1.4 *Communication between all role players*

The researcher wishes to highlight that open communication between all role players in CBE and/or SL is vital to the success thereof. To ensure open communication, the researcher proposes that before the onset of CBE and/or SL activities an initial consultation be coordinated between the community settings and Health Care facilities where students need to perform the CBE and/or SL activities.

During these consultations, academic staff should inform the role players in the community settings and Health Care facilities of the overall aim of the CBE and/or SL activities, the learning objectives and the specific learning outcomes of the module. The CBE and/or SL activities should address the needs of the chosen communities and Health Care facilities. Furthermore, the roles and responsibilities of the different role players as well as the potential benefits to the community should be highlighted. Academic staff should also provide a schedule of the CBE and/or SL activities to the community settings and Health Care facilities and it should be ensured that this schedule will suit the community and Health Care facilities and that they will be able to accommodate students during these times.

Additionally, it is recommended that during CBE and/or SL endeavours regular meetings should be held with community settings and Health Care facilities to discuss

potential challenges and problems and solutions. During these meetings, community settings and Health Care facilities should have the chance to provide feedback on the activities and on their experiences thereof. Academic staff will then have the opportunity to make adaptations to the schedules and activities if necessary.

Furthermore, academic staff should regularly communicate with community settings and Health Care facilities to ensure that scheduled activities can still continue and that students will have the best possible opportunity to carry out the CBE and/or SL activities and tasks.

It is suggested that academic staff should have regular discussions with students during CBE and/or SL endeavours. These discussions can be used to identify and discuss possible problems and solutions as well as to provide students with feedback on reflections and debriefing opportunities if necessary.

6.4.1.5 *Scheduling CBE and/or SL activities*

Academic staff should ensure that the time allocated at community sites and Health Care facilities are sufficient for students to be able to complete the different CBE and/or SL activities assigned to them and that they are able to reach the module outcomes. Students should receive the opportunity to be exposed to a variety of patients and cases during CBE and/or SL and to gain adequate experience.

The researcher wishes to highlight the importance of scheduling CBE and/or SL activities into the academic rosters of students well in advance to ensure that enough time can be allocated to CBE and/or SL. When planning these activities into the academic rosters of students it is imperative to take test and examination schedules of students into account. The researcher argues that CBE and/or SL activities should be scheduled at times during which students can focus optimally on these activities and do not have to study for other modules. This will ensure that they spend all their time and effort on the CBE and/or SL activities and make optimal use of the learning opportunities presented to them.

The researcher realises, however, that the scheduling of CBE and/or SL activities is a complex task and can produce many challenges. Community settings and Health Care facilities schedules also need to be taken into account and they will not be able to

accommodate the students at all times. It is suggested that time schedules of CBE and/or SL activities should be made available to students well in advance in order for them to be able to fit it into their academic schedules and to plan well in advance for these activities.

6.4.2 Health Care Personnel

Appropriate Health Care personnel should be recruited and/or appointed to supervise students during CBE and/or SL activities. The Health Care personnel should be from a variety of Health Care disciplines to ensure that students get exposed to the different disciplines involved in Health Care, furthermore they should be knowledgeable in their respective fields and they should be willing and able to supervise and support students.

The researcher is of the opinion that it will be ideal to appoint one Health Care personnel member at each community setting and Health Care facility where students will be placed, to coordinate the CBE and/or SL activities at the specific location. A team of Health Care personnel can subsequently be appointed at the different sites to provide the necessary supervision and support for students during CBE and/or SL activities.

It should be stressed that it is vital that the Health Care personnel are trained on the specific module outcomes that students need to meet, on the different activities that students need to perform and on their roles and responsibilities during these activities. Health Care personnel should also be familiar with the different levels of knowledge and skills that the different students have at a particular time to ensure that they do not expect of them to perform activities and duties that they are not able to do, but on the other hand the activities and duties should also not be too easy and it should present students with a challenge and provide a learning opportunity to enhance their practical skills and abilities. In order for CBE and/or SL endeavours to be successful, students should have the opportunity to apply their theoretical knowledge in assessing, planning and participating in solving real community health problems. The researcher therefore emphasises the importance of training Health Care personnel to be able to assist and supervise students effectively.

In addition, it is recommended that regular meetings be held with these Health Care personnel to ensure that everybody is still working towards the same goal and that all

challenges and problems that arise during CBE and/or SL activities can be addressed. It is crucial to the success of CBE and/or SL that students need to be supervised at all times and that they receive the necessary support when performing CBE and/or SL activities.

6.4.3 Emotional exposure

CBE and/or SL can expose students to experiences and situations that are traumatic to them and that they do not know how to handle, for example critically ill patients; patients that pass away; devastating circumstances in which the people in the community live. It is very important to recognise these experiences and to assist students in dealing with their emotions. Traumatic experiences and situations can be identified through student reflections and academic staff members should arrange for discussions and debriefing sessions when necessary.

The researcher proposes that a professional counsellor or psychologist is available to students, when they are not able to cope with their emotions that arise as a result of CBE and/or SL activities. Students should be informed that such a service is available to them and that they can arrange for counselling if necessary.

6.4.4 Resources

The researcher argues that although it is the responsibility of the administration of the Health Care facilities and community settings to obtain and maintain the necessary health resources to treat their patients (community), academic staff members should ensure that all the necessary resources are available for the students to perform their respective CBE and/or SL activities. Medical equipment is not always available or in a working condition at community settings and Health Care facilities and the necessary health supplies are also not available at all times and therefore academic staff should ensure that the necessary equipment and resources are available in order to ensure that students receive the best opportunity to practice their clinical skills.

Through regular communication, the availability of the necessary health resources can be monitored and alternative arrangements or adaptations to the activities should be made to ensure that the required equipment and resources are available to students when they need to perform their activities.

6.4.5. Language

In order to prevent communication problems between students and the members of the communities it is recommended that students perform CBE and/or SL activities in groups and that academic staff members attempt to divide students in groups that are multi-cultural and that the groups are comprised of students from different language groups. Students can assist each other when performing their CBE and/or SL activities to ensure proper communication.

The researcher furthermore argues that it is important that students are taught the basic terms that they need to know in order to perform a consultation in English, Afrikaans and Sesotho, which are the majority languages spoken in the Free State. These basic terms can be taught to students early on in their respective programmes, before they enter the communities, as they progress in their studies more advance terms and phrases can be taught which will enable them to perform the necessary duties in the communities.

6.4.6 Transport

Some of the community settings are far from the UFS and it will therefore be favourable to arrange transport for the students. The ideal will be if the FHS can arrange for public transportation that can carry students from the UFS to the different community settings and Health Care facilities. This transport facility can be voluntarily and students who still prefer to travel on their own will be able to do so, though they will not be compensated for that. Academic personnel should provide the different schedules for CBE and/or SL activities at an early stage in order for the FHS to coordinate the different trips. If it is not possible to provide public transport to a specific location, students can be reimbursed for the costs that they have to incur to travel to the community setting or Health Care facility.

In addition, the researcher suggests that the FHS should arrange accommodation for students when CBE and/or SL locations are far-off and it is necessary for students to spend more than one day at the specific location. This will reduce the transport costs and save students travelling time. Students from different programmes that work in the same area can share the accommodation facilities, which will also reduce the expenditure.

6.4.7 Orientation

The researcher wishes to highlight the importance of adequate orientation to prepare student for CBE and/or SL activities. It is recommended that orientation of students take place at the onset of the module, before students go out to the community settings and Health Care facilities. Students should be orientated on the following issues:

- Importance, aims and objectives of CBE and/or SL;
- Background of the communities they will visit;
- Location and clear directions of the community settings and/or Health Care facilities;
- Health- and social needs of the community;
- Module outcomes related to CBE and/or SL;
- Specific activities they need to perform in the community;
- Dividing students into groups;
- Assessment criteria;
- Roles, responsibilities and expectations of students;
- Professional behaviour and ethical issues;
- Problem-solving around difficult situations that may arise;
- Record keeping, supervision and accountability;
- Time schedules of activities; and
- Available support services – such as transport, counsellor/psychologist and supervisors.

During the orientation session, academic staff needs to discuss issues of confidentiality and professional ethics. Students need to get clear guidelines on what is expected of them on how to perform the specific required activities and they should also be acquainted with the specific operating procedures of the community setting or Health Care facility. Students should also receive emergency contact numbers of module leader(s), supervisor on site, transport officer, counsellor / psychologist and any relevant other.

The researcher argues that if students are not well prepared for CBE and/or SL endeavours, they do not know what to expect and how to perform the activities, which will have a negative impact on the way they perceive CBE and/or SL and their attitude

towards it, which will in turn negatively influence the learning that are suppose to take place.

6.4.8 Reflection

The researcher would like to accentuate the importance of reflection as a component of CBE and/or SL whereby students get the opportunity to think critically about their experiences. It provides an opportunity to them to look back on their experience and to determine what has been gained, lost or achieved during the particular CBE and/or SL experience. Students can examine and question their beliefs, opinions and values; they can ask questions and put facts, ideas and experiences together to derive new meanings. Furthermore, reflections provide them with the opportunity to examine the critical issues related to CBE and/or SL and they can connect the service experience to the module content, while enhancing social responsibility and accountability and assisting students in finding the personal relevance of their work.

Academic staff should structure reflection in such a way that students can improve their learning and personal growth as a result thereof. Reflections should be structured around the module outcomes to ensure that students meet the set objectives of CBE and/or SL. Furthermore, academic staff should decide on the frequency and timing of the reflections and ensure that students receive the opportunity to reflect on their activities during and after their experiences.

Reflection can take on different forms – it can be done in the form of group discussions, individual writing reflections, journals, portfolios, electronic forums, etc. It is recommended that academic staff employ a number of different forms of reflections in order to provide students with as much as possible opportunities to think about and analyse their CBE and/or SL experiences.

Regular and ongoing feedback may be required to prompt students to think further about issues, and to consider other related issues and perspectives. Academic staff must also make decisions about how to assess and allocate marks to reflections and communicate that to students.

It is important to highlight that CBE and/or SL activities alone do not always lead to transformation of students. To really enhance students' academic achievement,

personal growth and to foster social responsibility, students should have the opportunity to critically reflect on their CBE and/or SL experiences.

6.4.9 Evaluation

Evaluating CBE and/or SL is the final important constituent in the process. Evaluating CBE and/or SL consists of two parts, the first is to celebrate the completion of CBE and/or SL and the second part is to evaluate and review the module for improvement.

Celebrate the completion of the module

It is important to celebrate the end and the success of the CBE and/or SL initiative by having a function at the completion of the CBE and/or SL initiative in the community. Celebrate the students' accomplishments and acknowledge their involvement in the community. Additionally the community partners, Health Care facilities and Health Care personnel can be thanked for their input and assistance during CBE and/or SL activities.

Celebration functions can be combined for all the students in the FHS who have worked in the same community and during these celebrations students can be given the opportunity to present their projects to their fellow students and to share the experiences.

Evaluate and review the module for improvement

Investigating the impact of CBE and/or SL on students is imperative. Students' cognitive understanding of the module content, personal growth and social responsibility are essential factors to consider when assessing the complete CBE and/or SL experience. Evaluation questionnaires can be given to students on completion of the respective CBE and/or SL initiatives to determine the students' views thereon. Evaluation can then be used to adapt the CBE and/or SL activities in future to ensure that the outcomes of CBE and/or SL are met.

6.5 IMLEMENTING AND MANAGING CBE AND/OR SL WITHIN UNDERGRADUATE HEALTH SCIENCES PROGRAMMES

The researcher proposes that the following steps and actions are pursued when implementing and managing CBE and/or SL within undergraduate Health Sciences programmes in order to ensure that students experience CBE and/or SL in a positive manner. When implementing CBE and/or SL initiatives within undergraduate Health Sciences programmes thorough *planning* is imperative for the success of the initiatives. After implementation careful management of the process is important *during* CBE and/or SL endeavours and *afterwards* the entire process needs to be evaluated and adapted if necessary.

6.5.1 Planning CBE and/or SL endeavours

The researcher is of the opinion that there are a number of important steps that need to be taken when planning CBE and/or SL endeavours. The first important step when planning CBE and/or SL activities is to set clear module outcomes beforehand. It is crucial to ensure that these outcomes address the health needs of the community; clarify social, economic, cultural and political issues underlying the source of the community need; enhance academic learning, personal growth and social responsibility of students; and they are clear, action-orientated and measurable.

The second step is to assign tasks to the learning outcomes that are applicable to the students' level of knowledge and skills, in line with the outcomes and achievable in the community. Teaching methods can now be assigned to the different tasks (Third step). These teaching methods should be in the correct combination and level of students' knowledge and skills to facilitate and support learning from communities and integration of experiential learning. The fourth and fifth steps are to assign assessment criteria and academic credits to the activities.

Steps six to eleven can be done in any particular order or simultaneously and not necessarily in the proposed order. Appropriate community service placements should be selected. The selected community settings' health needs should relate to the set module outcomes and students should have the appropriate skills and knowledge to address these needs. Furthermore, community settings should provide students with exposure to a variety of pathologies, they should be able to accommodate the students and have the necessary resources.

Academic staff should plan the duration of the CBE and/or SL activities and ensure that reasonable timeframes are given to successfully complete the activities. Health Care personnel have to be recruited and appointed that are knowledgeable, willing and able to supervise students. Health Care personnel should be from multiple disciplines and they should be trained on their roles and responsibilities and on the module outcomes.

CBE and/or SL activities should be scheduled in terms of the academic rosters of the students. Consideration should be given to test and examination times of students, availability of community settings and supervisors.

Academic personnel should ensure that there is transport available to the community settings and a professional counsellor or psychologist should be available to assist students with traumatic emotional experiences.

The final step that needs to be taken when planning CBE and/or SL is to orientate the students. Orientation should include the following elements:

- Introduce concept of CBE and/or SL
- Emphasise the importance of CBE and/or SL
- Prepare students on what to expect during CBE and/or SL
- Orientate students to module specific content
- Explain what is expected of students
- Explain assessment criteria
- Discuss student reflections and indicate the frequency, format and content
- Inform students about support services (transport, psychologist, etc.)
- Divide into groups (multi cultural and different languages)
- Hand out CBE and/or SL schedules
- Provide clear directions to CBE and/or SL sites
- Inform students about professional courtesy, ethics, their rights and responsibilities
- Discuss the different activities that they need to perform
- Discuss possible challenges and problems that they can encounter as well as possible solutions.

Figure 6.1 presents a schematic outline of all the steps that need to be taken into account when planning a CBE and/or SL initiative in order for students to have a favourable experience and to create an environment that is conducive to learning.

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6.5.2 Actions during CBE and/or SL endeavours

The researcher proposes that the following actions are executed on a continuous basis throughout the duration of CBE and/or SL initiatives. The first important action is that students' attendance should be strictly monitored at all times.

Secondly, regular communication should take place between all stakeholders involved in CBE and/or SL throughout the duration of the activities. This includes consultations with the community setting and Health Care facilities at the beginning of CBE and/or SL endeavours to identify the broad health needs of the community, inform them of the planned CBE and/or SL activities as well as the aims and objectives of the activities, highlight the potential benefits it will have for the community and emphasise the importance of mutual respect and co-operation from everybody.

Other important actions is that academic personnel should have meetings all the way through the duration of the CBE and/or SL activities with, respectively, the community settings and Health Care facilities, the different supervisors and the students to ensure that everybody is still working towards the same goal and objectives, confirm schedules for future CBE and/or SL activities and to identify problems and challenges and discuss possible solutions. It should also be confirmed whether the necessary resources are still available at the different sites where CBE and/or SL activities are planned.

Figure 6.2 provides a schematic representation of all the essential actions to be taken throughout CBE and/or SL initiatives in order to make sure that students gain the maximum benefit from the experience.

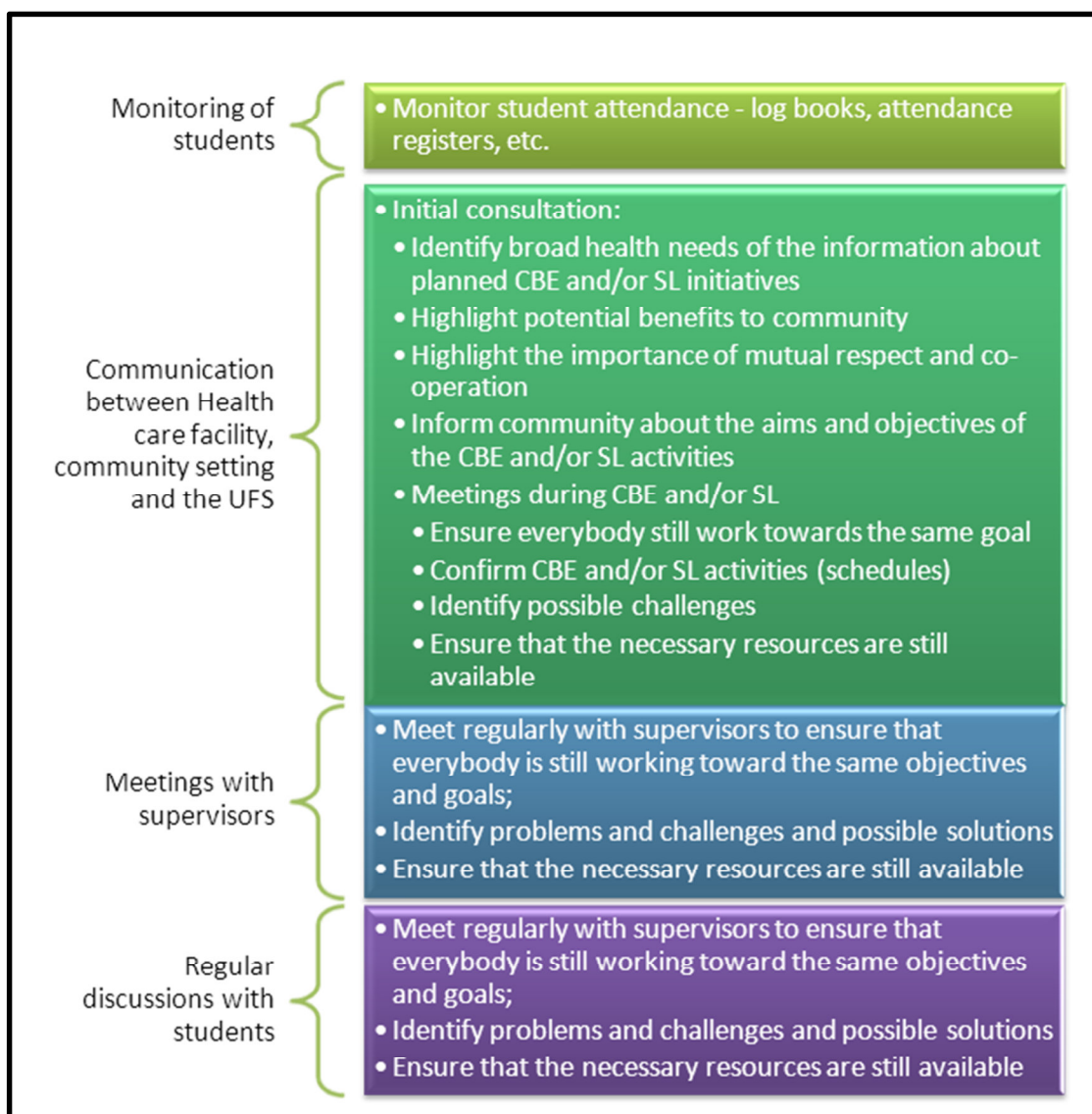


FIGURE 6.2: ACTIONS TO BE TAKEN DURING CBE/SL [Compiled by the Researcher, SB Kruger: 2012]

6.5.3 Following CBE and/or SL endeavours

On completion of the CBE and/or SL endeavours there are three important actions to be executed. Firstly, it is important to celebrate the success of the initiatives with all the relevant role players and to show appreciation for their respective inputs in the success of the initiative.

The second important action is to allow students to evaluate CBE and/or SL initiatives and to receive their inputs and feelings on the experience. It is important to evaluate whether module outcomes have been met and whether students' personal growth and social responsibility has increased. Thirdly, these evaluations and recommendations

can then be used to make adaptations to the CBE and/or SL activities if deemed necessary.

Figure 6.3 is a schematic outline of the actions that need to be taken after CBE and/or SL activities to ensure that students regard the experience as positive.

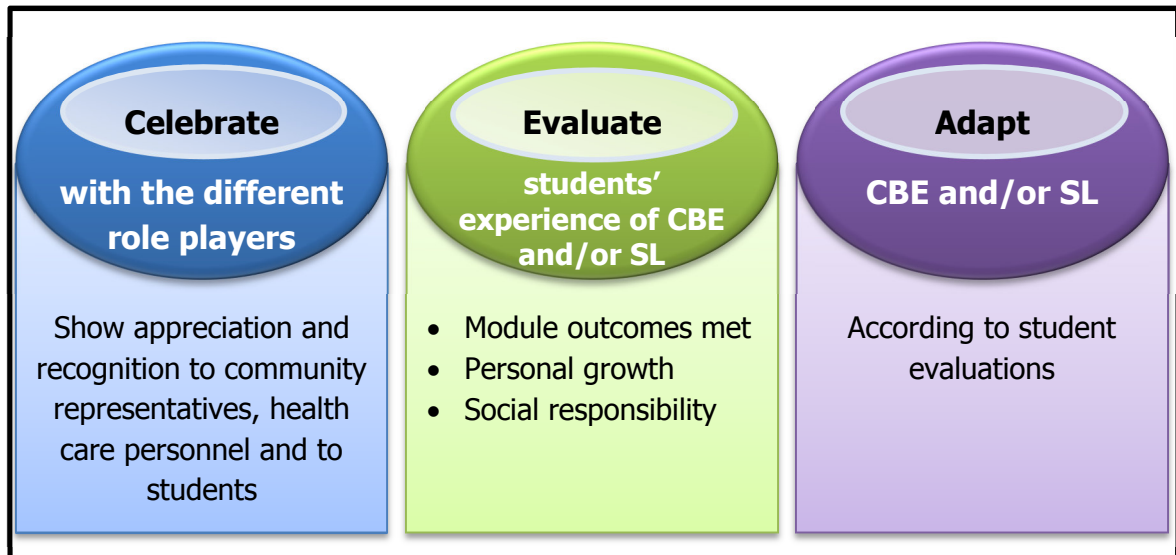


FIGURE 6.3: ACTIONS TO BE TAKEN AFTER CBE/SL [Compiled by the Researcher, SB Kruger: 2012]

Figure 6.4 provides an overview of the entire process on how CBE and/or SL can be implemented and managed within undergraduate Health Sciences programmes to ensure the success thereof.

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FIGURE 6.4: OVERVIEW OF THE PROCESS TO IMPLEMENT AND MANAGE CBE AND/OR SL WITHIN UNDERGRADUATE HEALTH SCIENCES PROGRAMMES
[Compiled by the Researcher, SB Kruger: 2012]

6.6 CONCLUSION

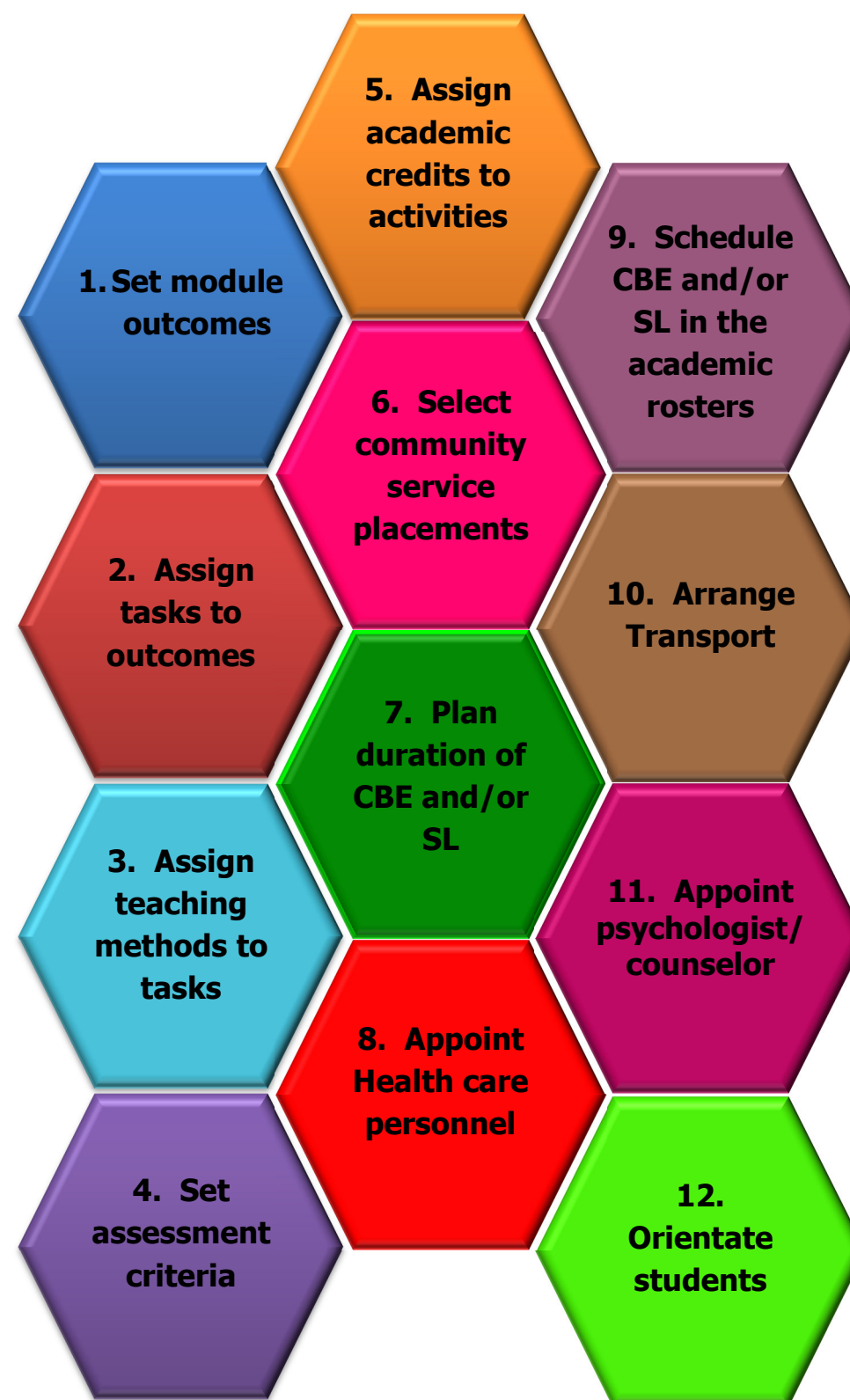
Chapter 6 provided recommendations for the implementation and management of CBE and/or SL initiatives within undergraduate Health Sciences programmes at the UFS to enhance the students' experience, as a final outcome of the study through synthesising the literature review, the results from nominal group discussions and the questionnaire survey.

The aspects that were dealt with were the changes in HE, conceptualisation and contextualisation of CBE and SL, factors that had a positive influence on the students' experience, the factors that had a negative influence on the students' experience, recommendations on the improvement of CBE and/or SL at the FHS, at the UFS and the implementation and management of CBE and/or SL within undergraduate Health Sciences programmes at the UFS.

In the next chapter, Chapter 7, ***Conclusion, recommendations and limitations of the study***, a summative discussion, limitations of the study, conclusion, and recommendations from the study will be provided.

PLANNING CBE AND/OR SL

1. Set module outcomes that:
 - Address health need of the community;
 - Clarify social, economic, cultural and political concerns underlying the need of the community;
 - Enhance academic learning, personal growth and social responsibility;
 - Are clear, action-orientated and measurable
2. Assign tasks to outcomes that are:
 - Applicable to students' level of knowledge and skills;
 - In line with academic outcomes;
 - Achievable in communities
3. Assign teaching methods to tasks that are in the correct combination and level of students' knowledge and skills to facilitate and support learning from communities and integration of experiential and academic learning
4. Set assessment criteria to activities
5. Assign academic credits to CBE and/or SL activities
6. Select community service placements:
 - Health needs relate to module outcomes;
 - Students have appropriate skills and knowledge to address health needs;
 - Students get exposure to a variety of pathologies;
 - Community is able to accommodate students
 - Ensure the availability of resources
7. Plan duration of CBE and/or SL
 - Reasonable timeframes to successfully complete all activities
8. Appoint Health care personnel:
 - Recruit Health Care Personnel that are knowledgeable, willing and able to supervise students;
 - Ensure that supervisors are from multiple disciplines;
 - Train supervisors on their roles and responsibilities and inform them of the module outcomes



9. Scheduling CBE and/or SL in the academic rosters
 - Consider test/exam times;
 - Availability of community setting/ Health Care facility;
 - Availability of supervisors
10. Arrange necessary transport to and from community settings
11. Appoint a psychologist/counselor to assist the students with traumatic experiences
12. Orientate students:
 - Introduce concept of CBE and/or SL
 - Emphasise the importance of CBE and/or SL
 - Prepare students on what to expect during CBE and/or SL
 - Orientate students to module specific content
 - Explain what is expected of students
 - Explain assessment criteria
 - Discuss student reflections and indicate the frequency, format and content
 - Inform students about support services (transport, psychologist, etc.)
 - Divide into groups (multi-cultural and languages)
 - Hand out CBE and/or SL schedules
 - Give clear directions to CBE and/or SL sites
 - Inform students about professional courtesy, ethics, their rights and responsibilities
 - Discuss the different activities that they need to perform
 - Discuss possible challenges and problems as well as solutions

FIGURE 6.1: STEPS TO BE TAKEN WHEN PLANNING CBE/SL [Compiled by the Researcher, S Kruger: 2012]

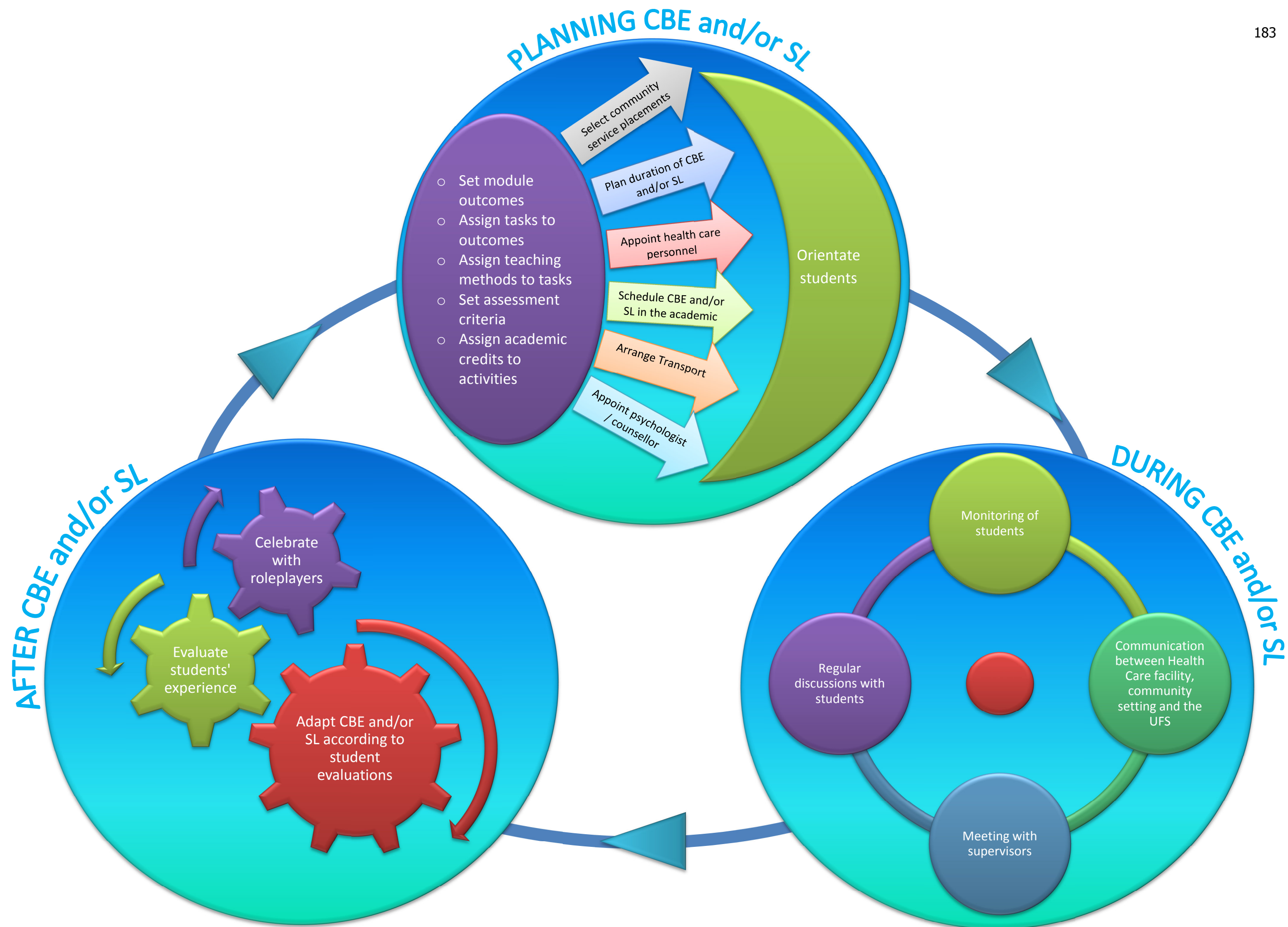


FIGURE 6.4: OVERVIEW OF THE PROCESS TO IMPLEMENT AND MANAGE CBE AND/OR SL WITHIN UNDERGRADUATE HEALTH SCIENCES PROGRAMMES
[Compiled by the Researcher. SB Kruger: 2012]

CHAPTER 7

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

An in-depth study was done by the researcher with the intention to make recommendations on the implementation and management of CBE and/or SL within undergraduate Health Sciences programmes. These recommendations were made with the aim of providing an environment conducive to learning for students in order to enhance the desired outcomes thereof for particularly students, but also for the institution, faculty and communities involved.

Various CBE and/or SL initiatives are implemented throughout the different undergraduate academic programmes in the FHS, at the UFS. Students view CBE and/or SL differently and their viewpoints are based on their previous exposure to CBE and/or SL activities and tasks. There are various elements of CBE and/or SL activities that have either a positive or negative impact on the way students experienced these activities, which in turn influence their ability to learn from the experiences.

7.2 OVERVIEW OF THE STUDY

The research was approached and completed based on five explicit research questions. These questions arose as a result of an identified gap in current knowledge regarding the experiences of Health Sciences students with regards to CBE and/or SL. Building on a conceptual framework from engaging with the literature, and making use of suitable research design and methodology, data were collected and results represented. From the research findings as well as engagement with theory, the research questions were answered and conceptual conclusions made, which served to provide recommendations on how to manage CBE and/or SL within the undergraduate programmes in the FHS, UFS in order to ensure that students view CBE and/or SL initiatives as positive endeavours and benefit optimally from it.

In Chapter 1 (cf. **1.3 Problem Statement and Research Questions**) an outline of the five research questions was presented. The research questions guided the study

and shaped the final outcome. In point 7.2.1 to 7.2.5 the research questions are reviewed and the main findings of each research question are given.

7.2.1 Research Question One

The first research question was stated as follows:

How can CBE and/or SL be conceptualised and contextualised as the theoretical framework of this study?

The following objective was pursued:

Conceptualising and contextualising CBE and SL via a literature study, in order to compile a theoretical framework for the study.

This research question aimed to provide the background of the study and was pursued by means of a literature study. In Chapter 2, CBE and SL were conceptualised and contextualised. The following issues were dealt with, namely, an overview of the changing face of Higher Education, community engagement, conceptualisation and contextualisation of CBE and SL, CBE and SL at the Faculty of Health Sciences, UFS and students' experiences of CBE and SL.

To understand where CBE and SL fit into HE it was important to discuss the **international changes in higher education** (cf. 2.2.1), **higher education in South Africa** (cf. 2.2.2) and **community engagement** (cf. 2.3). During the conceptualisation and contextualisation of CBE, the term CBE was defined (cf. **2.4.1.1 definition**) following by a discussion of the perspectives that underpin CBE (cf. **2.4.1.2 the societal perspectives underlying CBE**), the aim thereof (cf. **2.4.1.3 the rationale of CBE**) and a description of the classification of CBE (cf. **2.4.1.4 taxonomy of CBE**). Furthermore, the **determinants and pre-requisites for success in CBE** (cf. 2.4.1.5), **the roles of the different partners in CBE** (cf. 2.4.1.6), **perceived benefits and returns to partners** (cf. 2.4.1.7) and **programme design and development** (cf. 2.4.1.8) were also discussed.

To conceptualise and contextualise SL the following concepts were defined and discussed; namely, **what is service learning** (cf. 2.4.2.1), **defining service**

learning (cf. 2.4.2.2) and the **theoretical approaches to understand service learning** (cf. 2.4.2.3). This was followed by a discussion of the important components of SL (cf. **2.4.2.4 key element of service learning**), a distinction between SL and traditional learning (cf. **2.4.2.5 service learning vs. traditional learning**) and the **benefits of service learning** (cf. 2.4.2.6) for the different role players involved.

This provided the background to developing an understanding of CBE and SL, particularly in Health Sciences Education, in order to evaluate the experiences of Health Sciences students with regards to CBE and SL. A discussion on **CBE and SL at the Faculty of Health Sciences, UFS** (cf. 2.4.3) followed so as to indicate how CBE and SL are incorporated into undergraduate Health Sciences programmes at the UFS.

To be able to understand how **students' experiences of CBE and SL** (cf. 2.5) affect the students ability to learn from these opportunities, **attitudes and perceptions** (cf. 2.5.1) were defined and discussed as well as the **influence of attitude and perception on learning** (cf.2.5.2). In the last section, **how do students experience CBE and SL?** (cf.2.5.3) the perceptions, attitudes and experiences of undergraduate students with regards to CBE and SL were highlighted. An outline of Chapter 2, in the form of a diagrammatic overview, is included in Figure 2.1.

7.2.2 Research Question Two

The research question was stated as:

What are the students' views regarding CBE and SL?

The following objective was pursued:

To explore the students' views regarding CBE and SL via the nominal group technique.

This objective was pursued by means of nominal group discussions with the respective class leaders from the different undergraduate year groups enrolled for degree programmes in the FHS, at the UFS. In responding to research question 2, Chapter 4 **described and discussed the findings of the nominal group technique.**

The **introduction** (cf. 4.1) was followed by a description of the **demographic information** (cf. 4.2) of the students in the study population and the **process of data analysing** (cf. 4.3). The findings of the NGT were presented (cf. 4.4 *Discussion of the research findings*) by discussing the responses given by the students on the two research statements (cf. Tables 4.3 – 4.10). This was followed by a summative discussion of the combined data from the NGT (cf. Tables 4.11 – 4.13).

A total of 33 different themes were identified for the two research statements in the NGT which were used in the development of the questionnaire survey.

7.2.3 Research Questions Three and Four

The research questions were stated as:

What are the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL (Research question 3)?

Are there certain factors that influence Health Sciences students' experience of CBE and SL, and if so what are those factors and how do they influence the students' experiences (Research question 4)?

The following objectives were pursued:

To identify the most commonly shared/common perspectives and attitudes that Health Sciences students have about CBE and/or SL via a questionnaire survey. This objective addresses research question 3.

To identify whether there are certain factors that influence Health Sciences students' experience of CBE and SL via a questionnaire survey. This objective addresses research question 4.

To identify what the factors are that influence Health Sciences students' experience of CBE and SL via a questionnaire survey. This objective addresses research question 4.

To determine how these factors influence Health Sciences students' experience of CBE and SL via a questionnaire survey. This objective addresses research question 4.

These objectives were perused by means of a questionnaire survey. Chapter 5 represented the **results and discussion of the questionnaire survey** for undergraduate health sciences students. The **introduction** (cf. 5.1) was followed by a discussion on the **demographic information** (cf. 5.2) of the undergraduate students who participated in the questionnaire survey. An overview of the students' experiences during CBE and/or SL in the FHS, at the UFS was presented based on the different sections of the questionnaire survey (cf. Table 5.1 – 5.6), namely **personal level** (cf. 5.3.1), **value of CBE and SL** (cf. 5.3.2), **community involvement and social responsibility** (cf. 5.3.3), **organisation** (cf. 5.3.4), **support/supervision during CBE and/or SL** (cf. 5.3.5) and **satisfaction from CBE and/or SL** (cf. 5.3.6).

Following by a discussion of all the different reasons why students gain **satisfaction from CBE and/or SL** (cf. 5.3.6) as well as their recommendations on the **improvement of CBE and/or SL in the Faculty of Health Sciences, at the UFS** (cf. 5.3.7).

7.2.4 Research Question Five

The research question was stated as:

How can CBE and SL initiatives be effectively implemented in the Faculty of Health Sciences, UFS?

The following objective was pursued:

To provide information and make recommendations to academic staff in the Faculty of Health Sciences, UFS, as well as to all internal and external role players who are planning such initiatives in future that can add value for curriculum development and the implementation of CBE and SL initiatives via the literature study, nominal group technique and questionnaire survey. This objective addresses research question 5.

In Chapter 6, a detailed **discussion on Health Sciences students' experiences of CBE and/or SL** was provided. It includes the **theoretical framework underlying CBE and SL** (cf. 6.2), **discussion of the findings** (cf. 6.3), **recommendations relating to the improvement of CBE and/or SL at the FHS, at the UFS** (cf. 6.4)

and the implementation and management of CBE and/or SL within undergraduate Health Sciences programmes at the UFS (cf. 6.5).

The researcher endeavoured to make a number of recommendations with regard to implementing and managing CBE and/or SL activities within the undergraduate programmes at the FHS, UFS in order to ensure that CBE and/or SL benefit the student, the faculty, the institution, health services and society at large.

If CBE and/or SL can be implemented and managed successfully and students regard it as positive learning experiences they will acquire an understanding of the current health needs and challenges facing the communities, get the opportunity to apply their theoretical knowledge and learn in an environment that resembles their future professional career. Moreover, they will be equipped with a number of professional competencies and skills, experience the multi-disciplinary teams working together, interact with different cultures and their social responsibility will be enhanced.

The teaching staff in the FHS will gain experience in teaching and research that is relevant to their country, while they fulfil their social responsibility. At the same time the institution acquires more in-depth information on the local community, which can assist the institution in planning its educational and research programmes as well as other health intervention activities and the Institution will become more visible in the society as well.

When CBE and/or SL are properly implemented and managed and the community plays an active part in the process, the community will be developed, their members will have access to health services and become more aware of health and health-related matters and have the opportunity to become self-reliant.

Figure 6.4 provide an overview of how CBE and/or SL can be implemented and managed within undergraduate Health Sciences programmes to ensure the success thereof.

7.3 CONCLUSION

No recent study concerning **undergraduate Health Sciences students' experiences with regards to CBE and/or SL** in South Africa has been traced.

Research on the improvement of CBE and/or SL with regards to students' experiences is limited. This study is based on the **recognition and acknowledgement that a gap existed in the way CBE and/or SL is implemented and managed in undergraduate Health Sciences programmes in order to maximise the efficacy thereof for students, communities and the institution.**

To **bridge this gap**, the researcher conducted an in-depth study on the way undergraduate Health Sciences students at the FHS, UFS experience CBE and/or SL and made recommendations based on these experiences in order to improve CBE and/or SL experiences for the students, which will, in turn, enhance the success of CBE and/or SL as well as the benefits to the different role players.

A **combination of methods** was used to generate data and these **findings were interpreted** to form the **basis for the recommendations on the improvement of CBE and/or SL**. During **Phase I** of the mixed-methods research design, data were collected by means of **NGT**. Nominal group discussion were held with the class leaders from all the different year groups registered for degree programmes in the FHS, at the UFS who participated in CBE and/or SL during 2011. Nominal group discussion were held to identify possible themes/topics that can be used to describe the experiences of Health Sciences students with regard to CBE and/or SL. These themes and topics were included in the **questionnaire survey**, which formed **Phase II** of the research.

The questionnaire survey was handed to all the undergraduate Health Sciences students who were registered for a degree programme during 2011 and participated in CBE and/or SL initiatives. A detailed description of the **factual aspects** was given in Chapter 4 and 5.

In Chapter 6 the **interpretations**, as scientific evidence, converged to make recommendations, **Phase III** of the research. This was also discussed in detail. It is clear that most of the undergraduate Health Sciences students are of the opinion that careful **planning**, including setting of **module outcomes** and **assessment criteria**, **selection of community placements**, the appointment of trained **Health Care personnel** and **orientation** of students is imperative before the onset of CBE and/or SL. **During** CBE and/or SL student **attendance** should be **monitored** and regular **communication** between all role players should be involved in CBE and/or SL initiatives should exist and thorough **evaluation** of CBE and/or SL experiences should

take place at the end of CBE and/or SL. These actions are necessary to ensure that CBE and/or SL experiences benefit the student, the faculty, the institution, the health services and the society at large.

The **theoretical perspectives**, based on a thorough literature study and linked to various scholarly contributions of different authors, helped to develop a **conceptual framework** on which the research was based. At the **conceptual level** it became apparent that a clear definition of both CBE and SL as well as an understanding of the perspectives underpinning CBE and SL is important before implementing these initiatives in any institution.

Furthermore, it is crucial to understand who the different role players in CBE and SL are and what their roles and responsibilities are to ensure that they are all active participants in the entire process. The value and benefits of CBE and SL for all role players concerned should be taken into account when implementing and managing CBE and/or SL in order to ensure the efficacy thereof.

An in-depth study on the way students experience CBE and/or SL activities and subsequently offering recommendations on the implementation and management of CBE and/or SL within Health Sciences programmes, specifically to enhance the students' experience is a **first step in this direction**.

7.4 LIMITATIONS OF THE STUDY

The researcher recognises the following limitations in the study:

Although the study was clearly demarcated, it became a comprehensive study. In order to get a clear picture of the way undergraduate Health Sciences students experience CBE and/or SL, all undergraduate students in the FHS, at the UFS involved in CBE and/or SL during 2011 were included in the study, which resulted in a survey population of 791 students. The questionnaire survey extended over various fields and focused on a large number of aspects. Therefore, the study resulted in a number of **research findings so comprehensive in quantity and quality** that it was not achievable to discuss it in full. These aspects could be addressed when **publications** are prepared.

7.5 CONTRIBUTION TO RESEARCH

The study provided evidence based on a comprehensive array of research data findings that was used in the formulation of recommendations to ensure the successful management of CBE and SL within undergraduate Health Sciences programmes. The researcher is of the opinion that the research made a **valuable contribution** by adding new facts and understanding to the existing body of knowledge concerning the experiences of undergraduate students regarding CBE and SL in the Health Sciences education environment.

By discussing the undergraduate Health Sciences students' experiences on CBE and/or SL and by making recommendation on the improvement thereof, the identified gap is bridged. The sound research approach and methodology ensured the quality, reliability and validity of the research. In addition, the development of the questionnaire survey instrument as the data collection method as well as the completed research can be **utilised for further research** in the field of Health Sciences Education, both locally and internationally, as well as in higher education in general.

The overall goal of the research was to **explore** the Health Sciences students' views regarding CBE and SL initiatives in order to **maximise the efficacy** thereof for students and subsequently also for the Faculty, institution and the contributing communities. The **value of the study** will be realised in the contribution it will make via recommendations with regard to the **management of CBE and SL initiatives within undergraduate Health Sciences programmes** in order to make it more effective and to provide maximum opportunities and benefits for students, communities and the institution.

The **significance** of this research lies in its contribution to the body of **scientifically-based knowledge** regarding the **scholarship of engagement** and **best evidence medical education**, as well as its **value** in terms of **creating awareness** and providing guidelines and recommendations which will **enhance best practice** in **Health Sciences Education**.

7.6 RECOMMENDATIONS ON THE OUTCOME OF THE STUDY

In order for the study to yield **significant and valuable** results, the researcher takes the liberty to recommend the following:

- Presentation of the recommendation made for implementing and managing CBE and/or SL within undergraduate Health Sciences programmes, as formulated in this study to the FHS Management Board, as well as the appropriate Faculty Committees involved in CBE and SL for consideration and possible implementation in the Schools of Medicine, Allied Health Professions and Nursing in the FHS when planning and executing CBE and/or SL endeavours. The overview of all the steps and actions that need to be taken into account when implementing and managing CBE and/or SL within undergraduate Health Sciences programmes to ensure the success thereof (cf. **Figure 6.4**) provide the point of departure for such a presentation.
- Submission of a report about the experiences of Health Sciences students regarding CBE and SL generated from these data to the respective Module Leaders in the FHS, who are involved in CBE and/or SL activities.
- Dissemination of the research findings by submitting publications to accredited subject journals. The publications must be aimed at including the phases of the mixed-methods research design, the experiences of Health Sciences students concerning CBE and/or SL generated from the findings and the recommendations made for planning, execution and evaluation of CBE and/or SL endeavours with the view to enhance the experience for students and consequently improve the outcomes thereof for all role players involved.
- To present research results and findings at relevant educational forums at national and international conferences.
- To do further research on the experiences of undergraduate Health Sciences students with regard to CBE and SL once the proposed recommendations have been implemented.
- Creating awareness amongst staff members in the FHS regarding the necessity to thoroughly plan CBE and/or SL initiatives and effectively manage it during implementation and to evaluate the endeavours afterwards by means of staff development opportunities.
- The description of the experiences of undergraduate Health Sciences students concerning CBE and SL generated from this study may be generalised beyond its

local application as it may be applicable to other situations and groups. Therefore, the researcher proposes expansion of the use of the survey instrument developed for the purpose of this study by other Faculties at the UFS, as well as by other Faculties of Health Sciences, both locally and internationally, as a means of generating comprehensive information regarding students' experiences regarding CBE and SL in other settings as well as encouraging future research in this regard.

7.7 CONCLUSIVE REMARK

The focus of effective implementation of CBE and SL should be on providing students with a favourable learning environment, which will have a positive influence on their attitudes and behaviour to the activities and in turn make a difference to the desired outcomes thereof for students, the institution, the faculty, the community and ultimately to the society as a whole.

'We must do all that we can, to give our children the best in education and social upbringing - for while they are the youth of today, they shall be the leaders of tomorrow.'

-John F. Kennedy (1917 – 1963)

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APPENDIX A

**APPENDIX A-1: LETTER OF REQUEST FOR PARTICIPANTS OF THE
NOMINAL GROUP TECHNIQUE (NGT)**

**APPENDIX A-2: BRIEF OM VERSOEK VIR DEELNEMERS IN DIE
NOMINALE-GROEPTEGNIEK (NGT)**

**LETTER OF REQUEST FOR PARTICIPANTS OF THE NOMINAL GROUP
TECHNIQUE (NGT)**

Dear Student

**Request to participate in a Ph.D. study titled: COMMUNITY-BASED
EDUCATION AND SERVICE LEARNING: EXPERIENCES OF HEALTH
SCIENCES STUDENTS, AT THE UNIVERSITY OF THE FREE STATE.**

I am currently occupying the position of Junior Lecturer in the Division Health Sciences Education, Faculty of Health Sciences at the University of the Free State. I am mainly responsible for student support and development as well as staff development.

I am in the process of writing a thesis to obtain the Ph.D. degree in Health Sciences Education in the Faculty of Health Sciences at the University of the Free State (Student number 2000041117). The title of my research is **COMMUNITY-BASED EDUCATION AND SERVICE LEARNING: EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE UNIVERSITY OF THE FREE STATE.**

My supervisors are:

Promoter:	Prof. GJ. van Zyl Dean: Faculty of Health Sciences University of the Free State Bloemfontein, SOUTH AFRICA
Co-promoter:	Prof. M.M.Nel Head: Division Health Sciences Education Faculty of Health Sciences University of the Free State Bloemfontein, SOUTH AFRICA

The **problem** that has to be addressed is to determine what the experiences of Health Sciences students are during CBE and SL undertaken at the University of the Free State.

The overall **goal** of the study would be to explore the students' views regarding CBE and SL initiatives in order to maximise the efficacy thereof for students and inform the sustainability of teaching and learning practice.

The **aim** of the study is to explore the experiences of health sciences students, including views, attitudes and perceptions regarding CBE and SL at the University of the Free State.

To achieve this aim, the following **objectives** will be pursued, namely:

- To explore the students' views regarding CBE and SL;
- To identify the most commonly shared/ common perceptions and attitudes that Health Sciences students have about CBE and SL;
- To identify whether there are certain factors that influence Health Sciences students' experience of CBE and SL;
- To identify what the factors are that influence Health Sciences students' experience of CBE and SL;
- To determine how these factors influence Health Sciences students' experience of CBE and SL;
- To provide information to academic staff in the Faculty of Health Sciences, UFS, that could add value for curriculum development and the implementation of CBE and SL initiatives.

The **methods** that will be used in this study are, firstly, a comprehensive literature study that will address issues within the domain of CBE and SL. Secondly, nominal group discussions will be held with a sample of undergraduate students, from the three respective schools in the Faculty of Health Sciences that are involved in CBE and SL during 2011 to identify themes/topics that will be used to explore the views, attitudes, perceptions and opinions of Health Sciences students' on CBE and SL. Thirdly, questionnaires will be given to all undergraduate students in the Faculty of Health Sciences, UFS to identify the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL and to identify whether there are certain factors that influence Health Sciences students' experience of CBE and SL.

For the **purpose** of this part of the study, Nominal Groups will be formed, which falls under the category of qualitative research approach. The nominal group discussion itself will follow six steps. Participants will be welcomed, informed about the study and informed consent will be obtained by the facilitator (in this case an independent person who has expertise in NGT). Thereafter, the nominal question will be put to participants. They will then generate ideas in silence and write them down on a card. The fourth step of the discussion will follow, namely the verbalising of their ideas in a round-robin fashion. In the fifth step, a discussion of ideas generated will create the opportunity to clarify any possible misconceptions. Lastly, participants will get the opportunity to prioritise ideas from the pool of ideas generated by all participants.

You have been chosen as one of the students to participate in the nominal group discussions. I respectfully request your co-operation by consenting to take part in the nominal group discussions for this project. I am aware that time is a valuable commodity. The nominal group discussions will take approximately 60-90 minutes. Should you have any questions regarding the study or nominal group discussions, I can be contacted at:

Telephone: 051 – 405 2846
 Cellular phone: 082 771 4709
 Email address: krugersb@ufs.ac.za

The nominal group discussions are scheduled to take place during the period 01 August – 15 September 2011. Should you be willing to participate, please complete the accompanying consent form and return it to me as soon as possible.

Thank you for taking time to read this communication. I will appreciate your contribution to the project.

Sincerely,

A handwritten signature in dark ink, appearing to be 'S.B. Kruger', written on a light blue background.

Ms S.B. Kruger
Faculty of Health Sciences
University of the Free State
Bloemfontein

ETOVS nr: 77/2011

BRIEF OM VERSOEK VIR DEELNEMERS IN DIE NOMINALE-GROEPTEGNIK (NGT)

Geagte Student

Versoek om deelname aan 'n Ph.D.-studie getiteld: COMMUNITY-BASED EDUCATION AND SERVICE LEARNING: EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE UNIVERSITY OF THE FREE STATE.

Ek beklee tans die posisie van Junior Dosent in die Afdeling Gesondheidswetenskappe-onderwys, Fakulteit Gesondheidswetenskappe, aan die Universiteit van die Vrystaat. Ek is hoofsaaklik verantwoordelik vir die studente-ondersteuning en -ontwikkeling, asook personeelontwikkeling.

Ek is in die proses om 'n tesis te skryf om die Ph.D.-graad in Gesondheidswetenskappe-onderwys aan die Fakulteit Gesondheidswetenskappe by die Universiteit van die Vrystaat te ontvang (studentenommer 2000041117). Die titel van my navorsing is **COMMUNITY-BASED EDUCATION AND SERVICE LEARNING: EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE UNIVERSITY OF THE FREE STATE.**

My toesighouers is:

Promotor:	Prof GJ van Zyl Dekaan: Fakulteit Gesondheidswetenskappe Universiteit van die Vrystaat Bloemfontein, SUID-AFRIKA
Mede-promotor:	Prof MM Nel Hoof: Afdeling Gesondheidswetenskappe-onderwys Fakulteit Gesondheidswetenskappe Universiteit van die Vrystaat Bloemfontein, SUID-AFRIKA

Die **probleem** wat aangespreek moet word, is om vas te stel wat die ervarings van gesondheidswetenskappe-studente is tydens GBO en DL, onderneem by die Universiteit van die Vrystaat.

Die algehele **doel** van die studie is om die studente se sieninge oor GBO- en DL-inisiatiewe te verken ten einde die doeltreffendheid daarvan vir studente te maksimaliseer en die onderhoubaarheid van onderrig- en leerpraktyk in te lig.

Die **mikpunt** van die studie is om die ervarings van gesondheidswetenskappe-studente te verken, insluitend die sieninge, houdings en persepsies aangaande GBO en DL aan die Universiteit van die Vrystaat.

Ten einde hierdie mikpunt te bereik, word die volgende **doelwitte** nagestreef:

- Om studente se sieninge rondom GBO en DL te verken;
- Om die mees algemeen gedeelde / mees algemene opvattinge en houdings van gesondheidswetenskappe-studente oor GBO en DL te identifiseer;
- Om te identifiseer of daar sekere faktore is wat gesondheidswetenskappe-studente se ervaring van GBO en DL beïnvloed;
- Om die faktore te identifiseer wat die gesondheidswetenskappe-studente se ervaring van GBO en DL beïnvloed;
- Om vas te stel hoe hierdie faktore gesondheidswetenskappe-studente se ervaring van GBO en DL beïnvloed; en
- Om inligting aan akademiese personeel in die Fakulteit Gesondheidswetenskappe, UV, te voorsien wat waarde kan toevoeg tot die kurrikulumontwikkeling en die implementering van GBO- en DL-inisiatiewe.

Die **metodes** wat in hierdie studie gebruik gaan word, is eerstens 'n omvattende literatuurstudie wat sake sal aanspreek binne die domein van GBO en DL. Tweedens sal nominalegroepbesprekings gehou word met 'n steekproef van voorgraadse studente van die drie onderskeie skole binne die Fakulteit Gesondheidswetenskappe, wat betrokke is in GBO en DL tydens 2011, om temas/onderwerpe te identifiseer wat gebruik sal word om die sieninge, houdings, opvattinge en menings van gesondheidswetenskappe-studente oor GBO en DL te verken. In die derde plek sal vraelyste aan alle voorgraadse studente in die Fakulteit Gesondheidswetenskappe, UV, gegee word om die mees algemeen gedeelde / mees algemene opvattinge en houdings van gesondheidswetenskappe-studente jeens GBO en DL te identifiseer en om te identifiseer of daar sekere faktore is wat gesondheidswetenskappe-studente se ervaring van GBO en DL beïnvloed.

Vir die **doel** van hierdie gedeelte van die studie sal nominalegroepbesprekings gehou word, wat val onder die kategorie van 'n kwalitatiewe navorsingsbenadering. Die nominalegroepbespreking self sal ses stappe volg. Deelnemers sal verwelkom word, ingelig word oor die studie, en ingeligte toestemming sal deur die fasiliteerder verkry word (in hierdie geval 'n onafhanklike persoon wat 'n kenner is in NGT). Daarna sal die nominale vraag aan deelnemers gestel word. Hulle sal dan in stilte idees genereer en dit op 'n kaart neerskryf. Die vierde stap van die bespreking sal volg, naamlik die verbalisering van idees in 'n rondomtalie-wyse. In die vyfde stap sal 'n bespreking van idees gegenereer die geleentheid skep om enige wanopvattinge uit te klaar. Laastens sal deelnemers die geleentheid gegun word om idees vanuit die poel idees deur alle deelnemers gegenereer te prioritiseer.

U is as een van die studente gekies om aan die nominalegroepbesprekings deel te neem. Ek versoek hiermee eerbiedig u samewerking deur in te stem om deel te neem aan die nominalegroepbesprekings van hierdie projek. Ek is bewus daarvan dat tyd 'n waardevolle kommoditeit is. Die nominalegroepbesprekings sal ongeveer 60-90 minute duur. Sou u enige vrae aangaande die studie of die nominalegroepbesprekings, kontak my by:

Telefoon: 051 405 2846
Selfoon: 082 771 4709
E-posadres: krugersb@ufs.ac.za

Die nominalegroepbesprekings is geskeduleer om plaas te vind in die periode 01 Augustus tot 15 September 2011. Indien u gewillig is om deel te neem, voltooi asseblief die aangehegte toestemmingsvorm.

Dankie vir u tyd om hierdie kommunikasie te lees. Ek sal u bydrae tot die projek waardeer.

Die uwe



Mev SB Kruger
Fakulteit Gesondheidswetenskappe
Universiteit van die Vrystaat
Bloemfontein

ETOVS nr: 77/2011

APPENDIX B

**APPENDIX B-1: COMMUNITY-BASED EDUCATION AND SERVICE
LEARNING QUESTIONNAIRE**

**APPENDIX B-2: GEMEENSKAPSGEBASSEERDE ONDERWYS- EN
OPLEIDINGS- EN DIENSLEERVRAELYS**

ENGLISH

COMMUNITY-BASED EDUCATION AND SERVICE LEARNING QUESTIONNAIRE

You have been asked to participate in a research study. Please complete the following questionnaire regarding Community-Based Education (CBE) and Service Learning (SL). It will take you approximately 20 minutes to complete the questionnaire and there are no costs involved for you to participate in this study.

Please note that by completing this questionnaire you are voluntarily agreeing to participate in this research study and you may withdraw from this study at any given moment. You will remain anonymous and your data will be treated confidentially at all times. You will not receive any compensation for completing the questionnaire.

The purpose of this questionnaire is to give you as a student the opportunity to contribute to the improvement of CBE & SL at undergraduate level.

Your feedback will remain confidential and will be used for research purposes only. The results of this research project may be published and/or presented at forums and congresses.

QUESTIONNAIRE

SECTION 1 – DEMOGRAPHIC INFORMATION

Office use only

☐ ☐ ☐ 1 - 3

1.	What is your age?	(a) 17 – 19.9 years	1	<input type="checkbox"/> 4
		(b) 20 – 22.9 years	2	
		(c) 23 – 29.9 years	3	
		(d) 30 + years	4	
2.	What is your gender?	(a) MALE	1	<input type="checkbox"/> 5
		(b) FEMALE	2	
3.	What is your field of study?	(a) Medicine	1	<input type="checkbox"/> 6
		(b) Nursing	2	
		(c) Occupational Therapy	3	
		(d) Physiotherapy	4	
		(e) Optometry	5	
		(f) Dietetics	6	
4.	In which study year are you currently?	(a) One	1	<input type="checkbox"/> 7
		(b) Two	2	
		(c) Three	3	
		(d) Four	4	
		(e) Five	5	
5.	To which ethnic group do you belong?	(a) Black	1	<input type="checkbox"/> 8
		(b) White	2	
		(c) Coloured	3	
		(d) Asian	4	

DEFINITIONS:

Community-Based Education (CBE) - is a form of instruction where trainees learn professional competencies in a community setting focusing on population groups and also individuals and their everyday problems. Instruction may take place at a general practice, family planning clinic, community health centre or a rural hospital. For the purpose of this study all education and training that took place at **Universitas and Pelonomi Hospitals** is **excluded**, but education and training that took place at **National Hospital** as well as the **clinics at all 3 hospitals** is **included**.

Service Learning (SL) – is an educational approach involving curriculum-based, credit-bearing learning experiences in which students (a) participate in contextualised, well-structured and organised service activities aimed at addressing identified service needs in a community, and (b) reflect on the service experiences in order to gain a deeper understanding of the linkage between curriculum content and community dynamics, as well as achieve personal growth and a sense of social responsibility. It requires a collaborative partnership context that enhances mutual, reciprocal teaching and learning among all members of the partnership (lecturers and students, members of the communities and representatives of the service sector)

SECTION 2 - EXPERIENCES REGARDING COMMUNITY-BASED EDUCATION AND/OR SERVICE LEARNING

2.1. PERSONAL LEVEL

<i>Please circle the appropriate number reflecting your response</i>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
CBE and/or SL helped me to grow as a person	1	2	3	4	5	<input type="checkbox"/> 9
During CBE and/or SL I discovered my own personal strengths	1	2	3	4	5	<input type="checkbox"/> 10
During CBE and/or SL I discovered my own personal weaknesses	1	2	3	4	5	<input type="checkbox"/> 11
CBE and/or SL exposed me to emotional experiences that I did not know how to handle	1	2	3	4	5	<input type="checkbox"/> 12
CBE and/or SL was emotionally draining and took too much of me as a student	1	2	3	4	5	<input type="checkbox"/> 13
The devastating circumstances of some of the people in the community that I was exposed to during CBE and/or SL really upset me	1	2	3	4	5	<input type="checkbox"/> 14
I sometimes felt in the way of other clinical staff during CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 15
I experienced a sense of self-fulfilment during CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 16
When I serve another person, I am thankful for the opportunity to help	1	2	3	4	5	<input type="checkbox"/> 17
I sometimes felt that I failed the patients/community, because I could not help them efficiently	1	2	3	4	5	<input type="checkbox"/> 18
CBE and/or SL have no value in the junior years, because students have too little knowledge in their field	1	2	3	4	5	<input type="checkbox"/> 19
CBE and/or SL was a waste of my time	1	2	3	4	5	<input type="checkbox"/> 20

I usually leave a CBE and/or SL activity with ideas for additional ways that I can be involved in future	1	2	3	4	5	<input type="checkbox"/> 21
As a result of my community involvement (in the Faculty), the direction of my life has dramatically changed	1	2	3	4	5	<input type="checkbox"/> 22

2.2. VALUE OF CBE AND/OR SL

<i>Please circle the appropriate number reflecting your response</i>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
CBE and/or SL helped me put my knowledge into practice	1	2	3	4	5	<input type="checkbox"/> 23
CBE and/or SL provided me with hands-on use of skills that increased the relevance of academic skills	1	2	3	4	5	<input type="checkbox"/> 24
CBE and/or SL provided me with hands-on use of knowledge that increased the relevance of academic skills	1	2	3	4	5	<input type="checkbox"/> 25
Exposure to certain diseases/cases during CBE and/or SL "forced" me to search for additional information with a view to learn extra things, which I would not have done otherwise	1	2	3	4	5	<input type="checkbox"/> 26
My problem-solving skills improved as a result of CBE and/or SL	1	2	3	4	5	<input type="checkbox"/> 27
My time management skills improved during CBE and/or SL	1	2	3	4	5	<input type="checkbox"/> 28
CBE and/or SL improved my interpersonal communication skills	1	2	3	4	5	<input type="checkbox"/> 29
CBE and/or SL improved my self-confidence	1	2	3	4	5	<input type="checkbox"/> 30
I got exposed to a variety of conditions/cases relevant to my field of study during CBE and/or SL	1	2	3	4	5	<input type="checkbox"/> 31
CBE and/or SL taught me the roles and value of the multi-disciplinary team	1	2	3	4	5	<input type="checkbox"/> 32
CBE and/or SL helped me to experience the "human aspect" of patients as opposed to only the theory	1	2	3	4	5	<input type="checkbox"/> 33
Through CBE and/or SL I learned a lot about other cultures	1	2	3	4	5	<input type="checkbox"/> 34

2.3 COMMUNITY INVOLVEMENT AND SOCIAL RESPONSIBILITY

<i>Please circle the appropriate number reflecting your response</i>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
Students who participate in CBE and/or SL can make a positive impact on community development	1	2	3	4	5	<input type="checkbox"/> 35
The people in the community were always willing to help the students	1	2	3	4	5	<input type="checkbox"/> 36

during CBE and/or SL						
I enjoyed the interaction with people from different cultures during CBE and/or SL	1	2	3	4	5	□37
I have an obligation to serve the community	1	2	3	4	5	□38
It was difficult to work in the communities because of the cultural differences	1	2	3	4	5	□39
The patients were not always willing to participate in the activities/treatment that the students offer during CBE and/or SL	1	2	3	4	5	□40
CBE and/or SL helped me to realise my responsibility towards the people in the community	1	2	3	4	5	□41
The community valued the services that students offered during CBE and/or SL	1	2	3	4	5	□42
The people in the community were rude and unwilling to co-operate	1	2	3	4	5	□43
I enjoyed serving the community	1	2	3	4	5	□44
CBE and/or SL increased my desire to help or care for others	1	2	3	4	5	□45
The difference in languages made it difficult to communicate with the people in the community	1	2	3	4	5	□46
The communities had realistic expectations/demands from the students	1	2	3	4	5	□47
CBE and/or SL helped me understand the problems and diseases that the community experiences	1	2	3	4	5	□48
CBE and/or SL helped me understand how to treat the problems and diseases that the community experiences	1	2	3	4	5	□49
I will probably continue to volunteer in the community in the future	1	2	3	4	5	□50

2.4 ORGANISATION

<i>Please circle the appropriate number reflecting your response</i>	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
I experienced transport difficulties during CBE and/or SL	1	2	3	4	5	□51
All students put in the same amount of effort during CBE and/or SL and contributed equally to the success of the activities	1	2	3	4	5	□52
Orientation/induction before going to the community sites is important	1	2	3	4	5	□53
The lecturers prepared us well for CBE and/or SL so that I knew exactly what to expect	1	2	3	4	5	□54
The CBE and/or SL activities were always well organised between the	1	2	3	4	5	□55

UFS and the community						
Time allocated at community sites was enough to really make a difference	1	2	3	4	5	<input type="checkbox"/> 56
Reflecting on CBE and/or SL activities helped me learn more	1	2	3	4	5	<input type="checkbox"/> 57
I felt unsafe during CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 58
Students' attendance was well-monitored during CBE and/or SL	1	2	3	4	5	<input type="checkbox"/> 59
The lack of supplies/resources at the hospitals/clinics etc. made it difficult to perform my CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 60
It is important to have clear outcomes of the CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 61
CBE and/or SL activities in my course always had clear outcomes so that I knew exactly what to do.	1	2	3	4	5	<input type="checkbox"/> 62
Reflection is a private issue and should not be shared with everybody	1	2	3	4	5	<input type="checkbox"/> 63
It will be nice to celebrate the success of a community partnership at the end of the year	1	2	3	4	5	<input type="checkbox"/> 64
The CBE and/or SL activities were planned in our rosters at times when it suited us best	1	2	3	4	5	<input type="checkbox"/> 65
I had clear guidelines on which aspects I am going to be assessed during CBE and/or SL	1	2	3	4	5	<input type="checkbox"/> 66

2.5 SUPPORT/SUPERVISION DURING CBE AND/OR SL

The staff at the community setting was helpful and friendly	1	2	3	4	5	<input type="checkbox"/> 67
The staff at the community setting was knowledgeable and taught me a lot	1	2	3	4	5	<input type="checkbox"/> 68
The expectations of the staff/supervisors regarding students' abilities during CBE and/or SL were reasonable	1	2	3	4	5	<input type="checkbox"/> 69
There was adequate supervision during my CBE and/or SL experiences	1	2	3	4	5	<input type="checkbox"/> 70
There was a good working relationship between members of the multi-disciplinary team and everybody assisted us	1	2	3	4	5	<input type="checkbox"/> 71
My peers and/or senior students supported me a lot during CBE and/or SL activities	1	2	3	4	5	<input type="checkbox"/> 72
CBE and/or SL sites are conducive environments for learning – clinical staff were willing to assist students	1	2	3	4	5	<input type="checkbox"/> 73

SECTION 3 – SATISFACTION FROM CBE AND/OR SL

3.1 I enjoy CBE and/or SL: <i>A .Please tick all statements that apply to you</i>	(a) To help other people	1	<input type="checkbox"/> 74
	(b) To feel personal satisfaction	2	<input type="checkbox"/> 75
	(c) To improve my community	3	<input type="checkbox"/> 76
	(d) To improve society as a whole	4	<input type="checkbox"/> 77
	(e) To develop new skills	5	<input type="checkbox"/> 78
	(f) To work with people that are different from me	6	<input type="checkbox"/> 79
	(g) To enhance my academic learning	7	<input type="checkbox"/> 80
	(h) To fulfil my civic or social responsibility	8	<input type="checkbox"/> 81
	(i) To enhance my resume	9	<input type="checkbox"/> 82

B. Please give any other reason why you enjoy CBE/SL	<input type="checkbox"/> 83 <input type="checkbox"/> 84
	<input type="checkbox"/> 85 <input type="checkbox"/> 86
	<input type="checkbox"/> 87 <input type="checkbox"/> 88

3.2. What can be done to improve CBE and/or SL in the Faculty of Health Sciences, UFS?

	<input type="checkbox"/> 89 <input type="checkbox"/> 90
	<input type="checkbox"/> 91 <input type="checkbox"/> 92
	<input type="checkbox"/> 93 <input type="checkbox"/> 94

PLEASE MAKE SURE THAT YOU FILLED IN ALL 6 PAGES!!!!!!

THANK YOU FOR YOUR TIME!!

AFRIKAANS
GEMEENSKAPSGEBASEERDE ONDERWYS- EN OPLEIDINGS- EN DIENSLEERVRAELYS

U is versoek om aan 'n navorsingstudie deel te neem. Vul asseblief die volgende vraelys met betrekking tot Gemeenskapsgebaseerde Onderwys (GBO) en Diensleer (DL) in. Dit sal ongeveer 20 minute neem om die vraelys in te vul en daar sal vir u geen koste verbonde wees indien u aan die studie deelneem nie.

Let asseblief daarop dat u, deur hierdie vraelys in te vul, vrywillig instem om aan hierdie navorsingstudie deel te neem, en u mag te enige tyd uit die studie onttrek. U sal anomien bly en u data sal te alle tye vertroulik hanteer word. U sal geen vergoeding vir die invul van die vraelys ontvang nie.

Die oogmerk met hierdie vraelys is om u as student die geleentheid te gee om tot die verbetering van GBO & DL op voorgraadse vlak by te dra.

U terugvoering sal vertroulik bly en sal slegs vir navorsingsdoeleindes gebruik word. Die resultate van hierdie navorsingsprojek mag gepubliseer word en/of by forums of kongresse aangebied word.

VRAELYS

AFDELING 1 – DEMOGRAFIESE INLIGTING

Slegs vir kantoorgebruik ☐☐☐ 1 - 3

1.	Wat is u ouderdom?	(a) 17 – 19.9 jaar	1	<input type="checkbox"/> 4
		(b) 20 – 22.9 jaar	2	
		(c) 23 – 29.9 jaar	3	
		(d) 30 + jaar	4	
2.	Wat is u geslag?	(b) MANLIK	1	<input type="checkbox"/> 5
		(b) VROULIK	2	
3.	Wat is u studieveld?	(a) Medies	1	<input type="checkbox"/> 6
		(b) Verpleging	2	
		(c) Arbeidsterapie	3	
		(d) Fisioterapie	4	
		(e) Optometrie	5	
		(f) Dieetkunde	6	
4.	In watter studiejaar is u tans?	(a) Een	1	<input type="checkbox"/> 7
		(b) Twee	2	
		(c) Drie	3	
		(d) Vier	4	
		(e) Vyf	5	
5.	Aan watter etniese groep behoort u?	(a) Swart	1	<input type="checkbox"/> 8
		(b) Wit	2	
		(c) Bruin	3	
		(d) Asiër	4	

DEFINISIES:

Gemeenskapsgebaseerde Onderwys (GBO) - is 'n vorm van onderrig waar leerlinge professionele vaardighede in 'n gemeenskapsopset aanleer met die fokus op bevolkingsgroepe en individue en hul alledaagse probleme. Onderrig mag by 'n algemene praktyk, gesinsbeplanningskliniek, gemeenskapsgesondheidsentrum of landelike hospitaal plaasvind. Vir die doeleindes van hierdie studie is alle onderwys en opleiding wat by **Universitas en Pelonomi Hospitale** plaasgevind het **uitgesluit**, maar onderwys en opleiding wat by **Nasionale Hospitaal** en die **klinieke by al 3 hospitale** plaasgevind het is **ingesluit**.

Diensleer (DL) – is 'n opvoedingsbenadering wat kurrikulumgebaseerde, kredietdraende leerervarings behels waar studente (a) aan gekontekstualiseerde, goed gestruktureerde en georganiseerde diensaktiwiteite deelneem wat op geïdentifiseerde diensbehoefte in 'n gemeenskap gemik is, en (b) reflekteer oor dienservarings ten einde 'n meer diepgaande begrip te vorm van die verband tussen kurrikuluminhoud en gemeenskapsdinamika, asook om persoonlike groei en 'n gevoel van maatskaplike verantwoordelikheid te bereik. Dit vereis 'n samewerkende vennootskapskonteks wat wedersydse, wederkerige onderwys en opleiding onder alle lede van die vennootskap (dosente en studente, lede van die gemeenskap en verteenwoordigers van die dienssektor) vergroot.

AFDELING 2: ERVARINGS TEN OPSIGTE VAN GEMEENSKAPSGEBASEERDE ONDERWYS EN/OF DIENSLEER

2.1. PERSOONLIKE VLAK

<i>Omkring asseblief die toepaslike nommer wat u antwoord verteenwoordig</i>	Verskil skerp	Verskil	Neutraal	Stem saam	Stem ten sterkste saam	
GBO en/of DL het my as persoon gehelp om te groei	1	2	3	4	5	<input type="checkbox"/> 9
Ek het my eie persoonlike sterk punte tydens GBO en/of DL ontdek	1	2	3	4	5	<input type="checkbox"/> 10
Ek het my eie persoonlike swak punte tydens GBO en/of DL ontdek	1	2	3	4	5	<input type="checkbox"/> 11
GBO en/of DL het my blootgestel aan emosionele ervarings wat ek nie geweet het hoe om te hanteer nie	1	2	3	4	5	<input type="checkbox"/> 12
GBO en/of DL was emosioneel uitputtend en het te veel van my as 'n student geëis	1	2	3	4	5	<input type="checkbox"/> 13
Die vernietigende omstandighede van sommige van die mense in die gemeenskap waaraan ek tydens GBO en/of DL blootgestel is het my werklik ontstel	1	2	3	4	5	<input type="checkbox"/> 14
Ek het soms tydens GBO en/of DL in ander kliniese personeel se pad gevoel	1	2	3	4	5	<input type="checkbox"/> 15
Ek het tydens GBO en/of DL-aktiwiteite 'n gevoel van vervulling ervaar	1	2	3	4	5	<input type="checkbox"/> 16
Wanneer ek 'n ander persoon kan dien voel ek dankbaar dat ek die geleentheid gekry het om te help	1	2	3	4	5	<input type="checkbox"/> 17
Ek het somtyds gevoel ek laat die pasiënte/gemeenskap in die steek omdat ek hulle nie behoorlik kon help nie	1	2	3	4	5	<input type="checkbox"/> 18
GBO en/of DL het geen waarde in die junior jare nie omdat studente te min kennis in hulle veld het	1	2	3	4	5	<input type="checkbox"/> 19
GBO en/of DL was 'n vermorsing van my tyd	1	2	3	4	5	<input type="checkbox"/> 20
Ek gaan gewoonlik by 'n GBO en/of DL weg met idees vir nog maniere waarop ek in die toekoms betrokke kan wees	1	2	3	4	5	<input type="checkbox"/> 21
As gevolg van my gemeenskapsbetrokkenheid (in die Fakulteit) het my lewe 'n drasties ander rigting ingeslaan	1	2	3	4	5	<input type="checkbox"/> 22

2.2. WAARDE VAN GBO EN/OF DL

<i>Omkring asseblief die toepaslike nommer wat u antwoord verteenwoordig</i>	Verskil skerp	Verskil	Neutraal	Stem saam	Stem ten sterkste saam	
GBO en/of DL het my gehelp om my kennis prakties te gebruik	1	2	3	4	5	<input type="checkbox"/> 23

GBO en/of DL het my die geleentheid gegee tot eerstehandse gebruik van vaardighede wat die toepaslikheid van akademiese vaardighede vergroot het	1	2	3	4	5	<input type="checkbox"/> 24
GBO en/of DL het my die geleentheid gegee tot eerstehandse gebruik van kennis wat die toepaslikheid van akademiese vaardighede vergroot het	1	2	3	4	5	<input type="checkbox"/> 25
Blootstelling aan sekere siektes/gevalle tydens GBO en/of DL het my "gedwing" om bykomende inligting te soek met die oog daarop om ekstra goed te leer, iets wat ek nie andersins sou gedoen het nie	1	2	3	4	5	<input type="checkbox"/> 26
My probleemoplossingsvaardighede het as gevolg van GBO en/of DL verbeter	1	2	3	4	5	<input type="checkbox"/> 27
My tydsbestuurvaardighede het tydens GBO en/of DL verbeter	1	2	3	4	5	<input type="checkbox"/> 28
GBO en/of DL het my persoonlike kommunikasievaardighede verbeter	1	2	3	4	5	<input type="checkbox"/> 29
GBO en/of DL het my selfvertroue laat groei	1	2	3	4	5	<input type="checkbox"/> 30
Ek is tydens GBO en/of DL aan 'n verskeidenheid toestande/gevalle blootgestel wat betrekking op my studierigting het	1	2	3	4	5	<input type="checkbox"/> 31
GBO en/of DL het my die rolle en waarde van die multidissiplinêre span geleer	1	2	3	4	5	<input type="checkbox"/> 32
GBO en/of DL het my gehelp om die "menslike aspek" eerder as slegs die teorie van pasiënte te ervaar	1	2	3	4	5	<input type="checkbox"/> 33
Ek het deur GBO en/of DL baie oor ander kulture geleer	1	2	3	4	5	<input type="checkbox"/> 34

2.3 GEMEENSKAPSBETROKKENHEID EN MAATSKAPLIKE VERANTWOORDELIKHEID

<i>Omkring asseblief die toepaslike nommer wat u antwoord verteenwoordig</i>	Verskil skerp	Verskil	Neutraal	Stem saam	Stem ten sterkste saam	
Studente wat aan GBO en/of DL deelneem kan 'n positiewe impak op gemeenskapsontwikkeling maak	1	2	3	4	5	<input type="checkbox"/> 35
Die mense in die gemeenskap was altyd gewillig om studente tydens GBO en/of DL te help	1	2	3	4	5	<input type="checkbox"/> 36
Ek het die interaksie met mense van verskillende kulture tydens GBO en/of DL geniet	1	2	3	4	5	<input type="checkbox"/> 37
Ek het 'n verpligting om die gemeenskap te dien	1	2	3	4	5	<input type="checkbox"/> 38
Dit was weens die kulturele verskille moeilik om in die gemeenskappe te werk	1	2	3	4	5	<input type="checkbox"/> 39

Die pasiënte was nie altyd gewillig om aan die aktiwiteite/behandling wat studente tydens GBO en/of DL bied deel te neem nie	1	2	3	4	5	<input type="checkbox"/> 40
GBO en/of DL het my gehelp om my verantwoordelikheid teenoor die mense in die gemeenskap te besef	1	2	3	4	5	<input type="checkbox"/> 41
Die gemeenskap het die dienste wat die studente tydens die GBO en/of DL gelewer het waardeer	1	2	3	4	5	<input type="checkbox"/> 42
Die mense in die gemeenskap was ongeskik en onwillig om saam te werk	1	2	3	4	5	<input type="checkbox"/> 43
Ek het dit geniet om die gemeenskap te dien	1	2	3	4	5	<input type="checkbox"/> 44
GBO en/of DL het my behoefte om ander mense te help en hulle te versorg vergroot	1	2	3	4	5	<input type="checkbox"/> 45
Die taalverskille het dit moeilik gemaak om met die mense in die gemeenskap te kommunikeer	1	2	3	4	5	<input type="checkbox"/> 46
Die gemeenskappe het realistiese verwagtinge/eise van die studente gehad	1	2	3	4	5	<input type="checkbox"/> 47
GBO en/of DL het my gehelp om die probleme en siektes wat die mense in die gemeenskap ervaar, te verstaan	1	2	3	4	5	<input type="checkbox"/> 48
GBO en/of DL het my gehelp om te verstaan hoe om die probleme en siektes wat die gemeenskap ervaar te behandel	1	2	3	4	5	<input type="checkbox"/> 49
Ek sal in die toekoms waarskynlik steeds vrywillige werk in die gemeenskap verrig	1	2	3	4	5	<input type="checkbox"/> 50

2.4 ORGANISASIE

<i>Omkring asseblief die toepaslike nommer wat u antwoord verteenwoordig</i>	Verskil skerp	Verskil	Neutraal	Stem saam	Stem ten sterkste saam	
Ek het vervoerprobleme tydens GBO en/of DL ervaar	1	2	3	4	5	<input type="checkbox"/> 51
Alle studente het ewe veel moeite tydens die GBO en/of DL gedoen en het ewe veel tot die sukses van die aktiwiteite bygedra	1	2	3	4	5	<input type="checkbox"/> 52
Oriëntering/induksie voordat daar na die gemeenskap gegaan word is belangrik	1	2	3	4	5	<input type="checkbox"/> 53
Die lesings het ons goed op GBO en/of DL voorberei en dus het ek presies geweet wat om te verwag	1	2	3	4	5	<input type="checkbox"/> 54
Die GBO- en/of DL-aktiwiteite was altyd goed georganiseer tussen die UV en die gemeenskap	1	2	3	4	5	<input type="checkbox"/> 55
Tyd wat by gemeenskapsterreine toegeken is was genoeg om regtig 'n verskil te maak	1	2	3	4	5	<input type="checkbox"/> 56

Dit het my gehelp om meer te leer deur te reflekteer oor GBO- en/of DL-aktiwiteite	1	2	3	4	5	<input type="checkbox"/> 57
Ek het onveilig tydens GBO- en/of DL-aktiwiteite gevoel	1	2	3	4	5	<input type="checkbox"/> 58
Studente se bywoning is goed tydens GBO en/of DL gemonitor	1	2	3	4	5	<input type="checkbox"/> 59
Die gebrek aan voorraad/hulpbronne by die hospitale/klinieke ens. het dit moeilik gemaak om my GBO- en/of DL-aktiwiteite uit te voer	1	2	3	4	5	<input type="checkbox"/> 60
Dit is belangrik om duidelike uitkomst van die GBO- en/of DL-aktiwiteite te hê	1	2	3	4	5	<input type="checkbox"/> 61
GBO- en/of DL-aktiwiteite in my kursus het altyd duidelike uitkomst gehad sodat ek presies geweet het wat om te doen	1	2	3	4	5	<input type="checkbox"/> 62
Refleksie is 'n privaat aangeleentheid en behoort nie met almal gedeel te word nie	1	2	3	4	5	<input type="checkbox"/> 63
Dit sal aangenaam wees om die sukses van die gemeenskapsvennootskap aan die einde van die jaar te vier	1	2	3	4	5	<input type="checkbox"/> 64
Die GBO- en/of DL-aktiwiteite is sodanig op ons rooster beplan dat dit ons die beste gepas het	1	2	3	4	5	<input type="checkbox"/> 65
Ek het duidelike riglyne gehad ten opsigte van die aspekte waaroor ek tydens die GBO en/of DL ge-evalueer sou word	1	2	3	4	5	<input type="checkbox"/> 66

2.5 ONDERSTEUNING/TOESIG TYDENS GBO EN/OF DL

Die personeel by die gemeenskapsterrein was behulpzaam en vriendelik	1	2	3	4	5	<input type="checkbox"/> 67
Die personeel by die gemeenskapsterrein was kundig en het my baie geleer	1	2	3	4	5	<input type="checkbox"/> 68
Die verwagtinge wat die personeel/toesighouers van studente se vermoëns tydens GBO en/of DL gehad het was redelik	1	2	3	4	5	<input type="checkbox"/> 69
Daar was voldoende toesig tydens my GBO- en/of DL-ervarings	1	2	3	4	5	<input type="checkbox"/> 70
Daar was 'n goeie werksverhouding tussen lede van die multidissiplinêre span en almal wat ons bygestaan het	1	2	3	4	5	<input type="checkbox"/> 71
My portuur en/of senior studente het my baie tydens GBO- en/of DL-aktiwiteite bygestaan	1	2	3	4	5	<input type="checkbox"/> 72
GBO en/of DL-terreine is gunstige leeromgewings – kliniese personeel was gewillig om studente by te staan	1	2	3	4	5	<input type="checkbox"/> 73

AFDELING 3 – TEVREDENHEID MET GBO EN/OF DL

3.1 Ek geniet GBO en/of DL: <i>A: Merk asseblief alle stellings wat op u van toepassing is</i>	(j) Om ander mense te help	1	<input type="checkbox"/> 74
	(k) Om persoonlike bevrediging te ervaar	2	<input type="checkbox"/> 75
	(l) Om my gemeenskap te verbeter	3	<input type="checkbox"/> 76
	(m) Om die gemeenskap as geheel te verbeter	4	<input type="checkbox"/> 77
	(n) Om nuwe vaardighede te ontwikkel	5	<input type="checkbox"/> 78
	(o) Om met mense te werk wat anders as ek is	6	<input type="checkbox"/> 79
	(p) Om my akademiese leer te verskerp	7	<input type="checkbox"/> 80
	(q) Om my burgerlike of maatskaplik verantwoordelikheid na te kom	8	<input type="checkbox"/> 81
	(r) Om my curriculum vitae te verbeter	9	<input type="checkbox"/> 82

B. Verskaf asseblief enige ander rede waarom u GBO en/of DL geniet	<input type="checkbox"/> 83 <input type="checkbox"/> 84
	<input type="checkbox"/> 85 <input type="checkbox"/> 86
	<input type="checkbox"/> 87 <input type="checkbox"/> 88

3.2 Wat kan gedoen word om GBO en/of DL in die Fakulteit Gesondheidswetenskappe, UVS, te verbeter?

	<input type="checkbox"/> 89 <input type="checkbox"/> 90
	<input type="checkbox"/> 91 <input type="checkbox"/> 92
	<input type="checkbox"/> 93 <input type="checkbox"/> 94

MAAK ASB SEKER DAT U AL 6 BL INGEVUL HET!!!
DANKIE VIR U TYD!

APPENDIX C

APPENDIX C-1: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON COMMUNITY BASED EDUCATION (CBE) AND SERVICE-LEARNING (SL) IN THE FACULTY OF HEALTH SCIENCES AT THE UNIVERSITY OF THE FREE STATE (ECUFS NR 77/2011)

APPENDIX C-2: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON COMMUNITY BASED EDUCATION (CBE) AND SERVICE-LEARNING (SL) IN THE FACULTY OF HEALTH SCIENCES AT THE UNIVERSITY OF THE FREE STATE (ECUFS NR 77/2011)

Appendix C-1



Afdeling Gesondheidswetenskappe-onderwys/ Division Health Sciences Education
Kantoor van die Dekaan / Office of the Dean
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Tel: (051) 405-2846
Faks/Fax: (051) 405-3095
E-pos/E-mail: KrugerSB@ufs.ac.za

15 August 2011

Faculty Management
Faculty of Health Sciences
University of the Free State

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON COMMUNITY BASED EDUCATION (CBE) AND SERVICE-LEARNING (SL) IN THE FACULTY OF HEALTH SCIENCES AT THE UNIVERSITY OF THE FREE STATE (ECUFS NR 77/2011)

Dear Chairperson

I am in the process of writing a thesis to obtain the Ph.D. degree in Health Sciences Education in the Faculty of Health Sciences at the University of the Free State (Student number 2000041117). The title of my research is **COMMUNITY-BASED EDUCATION AND SERVICE-LEARNING: EXPERIENCES OF HEALTH SCIENCES STUDENTS AT THE UNIVERSITY OF THE FREE STATE**

My supervisors are:

Promoter:	Prof GJ van Zyl Dean: Faculty of Health Sciences University of the Free State Bloemfontein, SOUTH AFRICA
Co-promoter:	Prof MM Nel Head: Division Health Sciences Education Faculty of Health Sciences University of the Free State Bloemfontein, SOUTH AFRICA

The **problem** that has to be addressed is to determine what the experiences of Health Sciences students are during CBE and SL undertaken at the University of the Free State.

The overall **goal** of the study would be to explore the students' views regarding CBE and SL initiatives in order to maximise the efficacy thereof for students and inform the sustainability of teaching and learning practice.

The **aim** of the study is to explore the students' views, attitudes and recommendations regarding CBE and SL undertaken by health sciences students at the University of the Free State.

To achieve this aim, the following **objectives** will be pursued namely:

- To explore the students' views regarding CBE and SL;
- To identify the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL;
- To identify whether there are certain factors that influence Health Sciences students'

- experience of CBE and SL;
- To identify the factors that influence Health Sciences students' experience of CBE and SL;
- To determine how these factors influence Health Sciences students' experience of CBE and SL;
- To provide information to academic staff in the Faculty of Health Sciences, UFS, that could add value for curriculum development and the implementation of CBE and SL initiatives.

The **methods** that will be used in this study are, firstly, a comprehensive literature study that will address issues within the domain of CBE and SL. Secondly, nominal group discussions will be held with a sample of undergraduate students, from the three respective schools in the Faculty of Health Sciences, that are involved in CBE and SL during 2011 to identify themes/topics that will be used to explore the views, attitudes, perceptions and opinions of Health Sciences students' on CBE and SL. Thirdly, questionnaires will be given to all undergraduate students in the Faculty of Health Sciences, UFS to identify the most commonly shared/common perceptions and attitudes that Health Sciences students have about CBE and SL and to identify whether there are certain factors that influence Health Sciences students' experience of CBE and SL.

I hereby apply to conduct research as approved by the Ethics Committee (Faculty of Health Sciences) on CBE and SL in the Faculty of Health Sciences at the University of the Free State.

Yours faithfully



Ms SB Kruger
Junior Lecturer
Office of the Dean Health Sciences Education
Francois Retief Building, Block A, Room 131(E)
Tel. (051) 405 2846



Afdeling Gesondheidswetenskappe-onderwys/ Division Health Sciences Education
Kantoor van die Dekaan / Office of the Dean
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Tel: (051) 405-2846
Faks/Fax: (051) 405-3095
E-pos/E-mail: KrugerSB@ufs.ac.za

15 August 2011

Prof D. Hay
Vice-Rector: Academic
UFS

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON COMMUNITY BASED EDUCATION (CBE) AND SERVICE-LEARNING (SL) IN THE FACULTY OF HEALTH SCIENCES AT THE UNIVERSITY OF THE FREE STATE (ECUFS NR 77/2011)

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I hereby apply to conduct research as approved by the Ethics Committee (Faculty of Health Sciences) on CBE and SL in the Faculty of Health Sciences at the University of the Free State. Permission is required to use staff and students to participate in the research project.

Yours faithfully



Ms SB Kruger
Junior Lecturer
Office of the Dean Health Sciences Education
Francois Retief Building, Block A, Room 131(E)
Tel. (051) 405 2846