

UNIVERSITY OF KWAZULU-NATAL

**AN EXPLORATION OF NURSING STUDENTS' EXPERIENCES OF A
COMMUNITY-BASED HEALTH PROMOTION AND ILLNESS
PREVENTION PROGRAMME IN A SELECTED SCHOOL OF NURSING
IN KWAZULU-NATAL**

By

Agathe UWITONZE

2017

**AN EXPLORATION OF NURSING STUDENTS' EXPERIENCES OF A
COMMUNITY-BASED HEALTH PROMOTION AND ILLNESS
PREVENTION PROGRAMME IN A SELECTED SCHOOL OF NURSING
IN KWAZULU-NATAL**

Dissertation submitted in partial fulfilment of the requirements for the Master's degree in
Community Health Nursing in the School of Nursing and Public Health, College of Health
Sciences, University of KwaZulu-Natal, Durban, South Africa

By

Student Name: Agathe UWITONZE

Student Number: 213570302

Supervisor: Ms E.N PAKKIES

Co-Supervisor: Professor G. MCHUNU

FEBRUARY 2017

DECLARATION

I, Agathe Uwitonze, hereby declare this research dissertation titled “an exploration of nursing students’ experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal” is my original work. It has never been submitted for any other purpose or to any other academic institution. Sources of information used in this work have been acknowledged in the reference list.

This research project has been read and approved for submission by supervisors, Ms E.N Pakkies and Professor G. Mchunu.

Student`s name: Agathe Uwitonze

Signature..........Date...16th February 2017.....

Supervisor`s name: Ms E.N Pakkies

Signature.....Date.....

Co-supervisor`s name: Professor G. Mchunu

Signature.....Date.....

ABSTRACT

Background

Health promotion constitutes a priority in the World Health Organization's agenda of health for all (WHO, 2014b). Therefore, nursing students should be introduced to the principles of health, illness prevention and health promotion early in their course of training. They need to develop competencies required for their career as well as to improve the health and wellbeing of the community.

Purpose

The purpose of this study is to explore nursing students' experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

Methodology

A qualitative, exploratory, descriptive research design is used to investigate the experience of seventy second-year nursing students in the Bachelor of Nursing programme at a selected school of nursing who were exposed to a community based health promotion and illness prevention programme. Data was collected through focus group discussions and content deductive analysis was used to analyse data.

Findings

The findings of the study are presented and discussed according to the four main themes that emerged during the data analysis: (1) community accessibility (2) safety in the community environment (3) learner support, and (4) skills development. Each of these themes have sub-themes that are presented and discussed, facilitating a full insight into the experiences of the participants in this programme.

Conclusion

Satisfying personal experience enhanced students' clinical skills, especially in building the confidence and expertise required by health promotion and illness prevention programmes.

Students' participation in this programme developed capabilities such as: creativity; the identification of community health issues; the promotion of a greater sense of community responsibility; the ability to engage in group discussions; the envisaging of professional goals and the encouragement of a sense of connection with the community.

Keywords: Health promotion, illness prevention, community participation, community-based education

ACKNOWLEDGEMENTS

- Above all, I would like to express my gratitude to God Almighty who directed me in His plan.
- My sincere appreciation goes to my research supervisor and lecturer, Ms E.N Pakkies, for all her support, guidance, encouragement and patience throughout the study period.
- My greatest gratitude also goes to my co- supervisor, Professor G. Mchunu, for her input, advice and tolerance. I have been blessed to have her as my Co supervisor.
- My deep appreciation to all my family members, especially my sister Mamie, who has stood by me with support, understanding and love; thank you so much. Deep appreciation to my best friend ever Dr Francine who always supported me spiritually as well financially. May God richly bless you. Also to my brother Martin and brother in law Serge Makaba, my sister Baby, my brother Docta for being there for me.
- Special thanks go to my friend and brother Alexis Harerimana, my sister Toto, Papa Ema, Pastor Andre, Maman Nathalie, my sister Mawuwa, my sister Yemi, my sisters Yemisi and Irene, Sister Nike, Pastor Lanre Wojuola, and all my nieces and nephews for their support and understanding.
- Warm appreciation and heartfelt thank you goes to my friends especially Elodie and Gilbert for prayers, motivation and support.
- To the study participants, this work was a success because of you. I am so thankful.
- To all the University of KwaZulu-Natal, Faculty of Health Sciences, School of Nursing lecturers and administrative staff have all impacted my life in one way or the other. They include Prof. Fikile Mtshali, Dr. Joan Naidoo, Mrs. Makhosi Dube and Mrs. Caroline Dharanj. Thank you all. You have all contributed in one way or another to this success.

TABLE OF CONTENTS

DECLARATION	i
ABSTRACT.....	ii
ACKNOWLEDGEMENTS	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES	ix
LIST OF APPENDICES.....	x
ABBREVIATIONS	xi
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction to the study	1
1.2 Background to the study.....	2
1.3 Problem statement.....	7
1.4 Purpose of the study	8
1.5 Research objective.....	8
1.6 Research questions	8
1.7 Significance of the study.....	9
1.8 Operational definitions of concepts.....	10
1.9 Conclusion.....	10
CHAPTER TWO: LITERATURE REVIEW.....	12

2.1 Introduction	12
2.2 The concept of community-based education.....	12
2.2.1. The case of the selected School of Nursing in KwaZulu-Natal.	15
2.3 Health promotion programmes in the community	16
2.4 Implication of community-based health promotion and illness prevention in nursing education	19
2.5 Nursing students’ participation in community-based health promotion and illness prevention programme	22
2.6 Nursing students’ experiences of community-based health promotion and illness prevention programmes.....	24
2.7 Challenges encountered by the students during community interventions.....	30
2.8. Conclusion.....	32
CHAPTER THREE: RESEARCH METHODOLOGY	33
3.1 Introduction.....	33
3.2 Research paradigm	33
3.3 Research approach.....	34
3.4 Research design.....	34
3.5 Research setting.....	35
3.6 Population.....	35
3.7 Sampling and sample size	35
3.7.1 Inclusion criteria.....	36

3.7.2 Exclusion criteria.....	36
3.8 Research instrument	37
3.9 Process of data collection.....	37
3.10 Data analysis	38
3.11 Academic rigour for qualitative data.....	39
3.12 Ethical considerations	41
3.13 Data management.....	42
3.14 Data dissemination	42
3.15 Conclusion.....	42
CHAPTER FOUR: PRESENTATION OF THE FINDINGS	43
4.1 Introduction	43
4.2. Social demographic data	44
4.3 Overview of emerging themes	46
4.3.1 Theme 1: community accessibility.....	47
4.3.2 Theme 2: safety of environment.....	50
4.3.3 Theme 3: learner support.....	53
4.3.4 Skills development	57
4.4 Conclusion.....	64
CHAPTER FIVE: DISCUSSION, CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS	66

5.1 Introduction	66
5.2. Socio-demographic characteristics of respondents	66
5.3 Student experiences.....	68
5.3.1 Community accessibility	68
5.3.2 Safety of environment	70
5.3.3 Learner support.....	72
5.3.4 Skills development	75
5.4 Conclusions	80
5.5 Research limitations	82
5.6 Recommendations	83
5.6.1 Procedural support.....	83
5.6.2 Team work	84
5.6.3 Community	84
5.6.4 Future research	85
REFERENCES	86
APPENDICES	103

LIST OF TABLES

Table 4-1 Socio-demographic data 45

Table 4-2: Themes emerging from the study 46

LIST OF APPENDICES

Appendix 1: Information Sheet.....	103
Appendix 2: Informed consent form.....	105
Appendix 3: Focus group interview guide with nursing students.....	106
Appendix 4: Focus Discussion One.....	108
Appendix 5: Head of the Discipline authorisation letter	131
Appendix 6: Registrar authorisation letter	132
Appendix 7: Ethical approval	133
Appendix 8: Editing letter.....	134
Appendix 9: Turnitin plagiarism report	135

ABBREVIATIONS

CBE:	Community-Based Education
CBHP:	Community-Based Health Promotion
IPP:	Illness Prevention Programmes
FGD:	Focus Group Discussion
PBL:	Problem-Based Learning
NNCC:	National Nursing Centers Consortium
NCHE:	National Commission of Higher Education
TV:	Television
UKZN:	University of KwaZulu-Natal
UNICEF:	United Nations International Children's Emergency Fund
WHO:	World Health Organisation
Z-Score:	The standard deviation units away from the mean a particular value of data lies.

CHAPTER ONE: INTRODUCTION

1.1 Introduction to the study

Health promotion activities are community-based and, as such, it is the responsibility of health care professionals, especially nurses, to introduce community members to these activities (Whitehead, 2011). The scarcity of human resources in health has permeated the wall of the health care profession, especially with the shortage of nurses, leading to a global crisis (Crisp and Chen, 2014). The shortage has been especially evident in most African countries, including South Africa (Uta, Francoise and David, 2012). In view of this crisis the incorporation of nursing students into community-based health promotion, has become imperative as a means of clinical or practical experiences for nursing students.

In South Africa, the participation of nursing students in health promotion activities is important not only for learning purposes, but because of the national benefit which the country stands to gain from the alleviation of the double burden of communicable and non-communicable diseases threatening the country's health system (Motsoaledi, 2011). To meet this challenge the South African health department has emphasised the urgency of promoting population health through community participation in partnership with health care professionals at every level (National Department of Health, 2013; National Department of Health, 2012).

In order to achieve community participation in health promotion activities, the Department of Nursing, at selected schools of nursing in KwaZulu-Natal has, over the years, developed and implemented a diversity of creative and valuable community experiences for nursing students enrolled in the Bachelor of Nursing undergraduate degree (Mtshali, 2005; Uys, 1998; Gwele, 1997). By dividing the students into three groups which are allocated to three different communities in the surrounding areas, where they are required to undertake health promotion projects, the school is able to engage students in the task of health promotion (Adejumo and Ganga-Limando, 2000; Gwele, 1997). Among other activities, the students under their facilitators' guidance are required to conduct a community assessment and an epidemiological study. Each group is also expected to identify and prioritise health problems in that community, and then plan and implement an appropriate project to address priority problems in consultation with the

stakeholders. At the end of the year, these groups present their projects to an audience consisting of fellow students, staff members and respective community members and stakeholders (Mthembu and Mtshali, 2011). On this platform, students also reflect on the effect their participation has had on their personal and academic growth.

Literature reveals that health promotion interventions, carried out at the local levels by nursing students, provides a service to the community, while allowing students an opportunity to develop their health promotion knowledge and skills (Kushner, Van Horn, Rock, Edwards, Bales, Kohlmeier et al., 2014; Bronstein, Anderson, Terwilliger and Sager, 2012; Kulbok, Thatcher, Park and Meszaros, 2012). Furthermore, nursing students learn to make independent decisions during community-based learning experiences. Several studies of student perception of community participation have been conducted at various settings giving a range of reports which may not be generalised to all curricular contexts (Okoronkwo, Onyia-pat, Agbo, Okpala and Ndu, 2013; Walton and Blossom, 2013; Karp and Bork, 2012; Walthew and Scott, 2012; Mtshali, 2009; Uys and Gwele, 2004). This prompted the researcher of this study to explore nursing students' experiences of the community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

1.2 Background to the study

Health promotion constitutes a priority in the World Health Organization agenda of health for all (WHO, 2014b). As a result of the need for a new universal public health movement, in 1986 the First International Conference on Health Promotion took place (WHO, 1997; WHO, 1986). Health was acknowledged as a resource for social, economic and personal development. Thus, it serves as an indispensable aspect of quality of life because health promotion is a process which enables people to improve their health. Through the varieties of actions involved, health promotion can also develop and change life styles.

The WHO (1997) adopted and acknowledged five crucial health promotion actions: (a) building healthy public policy, (b) creating supportive environments, (c) development of personal skills, (d) strengthening community actions, and (e) changing present health care systems from a curative to a preventive focus. The concerted effort of health promotion implementation through

comprehensive approaches to health development is therefore considered largely efficient when it is implemented in settings such as mega-cities, islands, cities, municipalities and local neighbourhoods (O'Neill, Simard, Sasseville, Mucha, Losier, McCue et al., 2012; WHO, 1997; WHO, 1986).

Health promotion and illness prevention actions can also be facilitated in community settings such as schools, hospitals, workplaces and residential areas; they also need to be built into all health policies which provide guidance to health promotion. Equity-focused health policy provides a realistic approach to attaining better equity in health (Makaula, Bloch, Banda, Mbera, Mangani, de Sousa et al., 2012; O'Neill et al., 2012; WHO, 1997; WHO, 1986).

Furthermore, Bircher and Kuruvilla (2014), note that the central tenet of health promotion is to consider people, not as isolated entities, but as part of a wider environment, with the defining characteristics of an environment as the “setting” in which people live, work, recreate, and engage in health related activities like grooming, cleaning and cooking. Therefore, any approach to health promotion and illness prevention should take into account all the elements of an environment, and seek to change those negative aspects which could undermine health (Bircher and Kuruvilla, 2014). In this regard, since nurses are the most numerous group of health professionals, working in the community, they are viewed as fundamental to achieving this goal (Mendenhall, Harper, Henn, Rudser and Schoeller, 2014; Propp, Apker, Ford, Wallace, Serbenski and Hofmeister, 2010).

Studies conducted in different parts of the world point out that nurses have important roles to play in the operation of health promotion programmes (Mendenhall et al., 2014; Kemppainen, Tossavainen and Turunen, 2013; Labarthe and Dunbar, 2012). It is, therefore, strongly recommended that before performing any role in health promotion, illness prevention or primary health care, nursing students should be introduced to the principles of health, illness prevention and health promotion early in their course of training (Healy and Sharry, 2011). Consequently, the numerous teaching strategies, including community-based education (CBE) and problem-based learning (PBL), should be used to improve nursing students' competence by linking the theory to the practice in the community setting (Koch, 2013).

Nursing education programmes should aim to support all learning that allows nursing students to meet professional entry-to-practice competencies (Valaitis, Schofield, Akhtar-Danesh, Baumann, Martin-Misener, Underwood et al., 2014). Community-based education is the process by which nursing students learn to respond to community needs, through self-involvement and engagement with health care activities or practices in the community (Bassi, 2011; Vogt, Chavez and Schaffner, 2011).

While implementing community-based health promotion and illness prevention programmes, students should develop a deep understanding of the course content as well as a sense of social responsibility (Millican and Bourner, 2011). It is argued that through community-based programmes, students will gain an understanding of the health needs of the community (Vogt et al., 2011).

In order to respond to the health needs of the population, nursing students in their different community settings should carry out a mixture of consistent community learning activities, such as community health promotion and illness prevention projects, as they attain their learning objectives in partnership with community members and other sector representatives operating in the community (Bassi, 2011; Millican and Bourner, 2011; Vogt et al., 2011). Students should also develop significant knowledge related to this experience and learn how several problems have an important influence on an individual, a family and entire community.

By using the community as a learning environment, students can understand the complexity of health issues, and how various factors determine the health status of individuals, families and the community as a whole, and develop multidisciplinary skills to solve health problems and determine which skills are needed in dealing with complex individual and community health problems. According to Mtshali (2009), this approach has been adopted by higher education institutions to replace the traditional way of teaching, that was criticised for not equipping students with sufficient skills to address social problems, and for not being responsive to the population's needs, especially in rural and under-resourced settings. Students were being trained in sophisticated and technological ways, which were not always applicable in the environments in which they were required to work (Mtshali, 2009) Therefore, students should be equipped to solve the multitude of health problems they encounter in the community.

The problem-based learning (PBL) should be recommended as a teaching strategy in community-based education. PBL is a student-centred teaching strategy in which small groups of students work in collaboration on real problems and learn how to solve them (Uys and Gwele, 2005; Uys and Gwele, 2004). Through the process of working in groups, students are called on to identify and solve real problems which consequently permit them to gain knowledge and acquire skills such as problem solving, communication, decision making and effective team work. These are required skills in health professions and enlarge the student's knowledge base. Furthermore, PBL intensifies friendships among students and encourages closer contacts between students and teachers (Schmidt, Rotgans and Yew, 2011). Students also develop the competences required in dealing with the persistent changes and challenges of real-world situations.

A study conducted by En, Koh and Lim (2011) where nursing students conducted a health screening programme during a home visit in an under-served community acknowledged that nursing students developed professional skills such as communication, teamwork and critical thinking. By interacting with the people in their living setting, nursing students gained a better understanding of the community needs and learned how to respond appropriately to those needs. This had a positive effect on nursing students learning experience which was beneficial to both students and the community. A related study conducted by Babenko-Mould, Ferguson and Atthill (2016) of nursing students experiencing a neighbourhood as a community of practices and its impact on their learning process, stated that nursing students involved in such community settings learned how to be more independent and become more self-directed. Students developed a team spirit and become more knowledgeable regarding community needs and thus more creative in responding to them. Students highlighted that through creative collaboration they were able to link theories learned in the community health class with this practical environment, which benefited both them and the community.

A study conducted in America by Walton and Blossom (2013) reveals that nursing students believed that the experience in the community setting is fundamental to their nursing education since it provides opportunities for them to learn about the clinical context, to listen, and to develop a therapeutic relationship through creativity and innovation. Another study conducted by Pfaff, Baxter, Jack and Ploeg (2014), in Canada noted that a community-based health promotion and

illness prevention programme emphasises close collaboration between nursing students and community members and therefore develops new graduate nurses' knowledge and experiences in terms of collaborative practices.

These views are supported by Bentley (2013), who suggests that such knowledge ensures that students are well prepared to work in the fields of preventive and rehabilitative care. Such care continues to be important, as it extends beyond the care setting in the community. Furthermore, students experienced gratification in their role as nursing students as they recognised that working with the community catered for their clients' health needs within the context of their lifestyle and culture (Karp and Bork, 2012; Walthew and Scott, 2012).

The findings of an Australian study conducted by Merritt and Boogaerts (2014), showed that intervention in the community focuses more on helping people make decisions that enable a more comfortable and appropriate lifestyle. Besides, students felt satisfied with themselves in their role as nursing students and recognised that working with the community covers the person and their health needs as well as their lifestyle and their culture (Karp and Bork, 2012; Walthew and Scott, 2012). Similarly, another study by Walthew and Scott (2012) conducted in New Zealand found that while most of the nursing students focused on individuals and used an approach based on a traditional approach to health promotion and providing information, other nursing students embraced empowering and interactive approaches in their health promotion and illness prevention activities.

A study conducted by Kaye, Mwanika, Burnham, Chang, Mbalinda, Okullo et al (2011b) in Uganda concluded that the community setting offers to the nursing students contextual and experiential expertise which leads them to improve their collaborative and clinical skills, teamwork, and learning assessment methods. Students working in the community setting should assess and diagnose the community needs and thereby create a community consciousness of common diseases, and also conduct disease prevention and health promotion activities (Kaye et al., 2011b). Community participation in health programmes therefore improves their sustainability and affordability. Similarly a study conducted by Naidu, Zweigenthal, Irlam, London and Keikelame (2012) in South Africa highlighted the appropriateness of the students' feedback and its significance in providing them with an opportunity to comment on the outcome of the processes

involved and to understand the students' challenges. The same authors revealed that nursing students acknowledge the pivotal role the community setting contributes in enhancing their knowledge and giving them the opportunity to work in teams with others and, therefore, procuring significant advantages such as time for practical experience, and a closer understanding of the community needs and culture. Students emphasised that the community enhances their sense of personal achievement and also provides valuable cultural exposure (Naidu et al., 2012).

Despite the active interaction of the students with the community and the appreciation by the community of the student involvement, it was unfortunately noted that students frequently do not provide feedback to the communities (Kaye et al., 2011b). This has made communities hesitant and unconvinced about any communities-learners partnerships (Kaye, Muhwezi, Kasozi, Kijjambu, Mbalinda, Okullo et al., 2011a). Besides the fact that the community-based programme involves more improvisation and is more unrestrained than in hospitals, nursing students seem to be uncomfortable when they do not have enough knowledge, and are facing a situation in which they lack skills or appropriate resources (Moyer, 2012). Furthermore, students expressed their views on the need for creativity with community engagement and carefulness in choice of words. This in essence implies that the manner in which students are taught in class, with the complexity of lecturer's language and medical terms, may require a student to be creative when attempting to communicate with a community that has no understanding of technical terms (Daniels, Adonis and Karuguti, 2013; Hawala-Druy and Hill, 2012). This scenario can be of significance to South Africa, which is a multi-racial country.

1.3 Problem statement

Although the use of community-based health promotion and illness prevention programmes has been highlighted, several challenges encountered by nursing students, have been reported that hinder the overall expected outcomes of these interventions. These challenges include lack of time, lack of resources, including lack of transportation and lack of accommodation and facilities for research such as the internet (Okoronkwo et al., 2013). Added to this are lack of communication and collaboration between the university and the community, resulting in communities being unaware of the learning objectives of the students. Mabuza, Diab, Reid, Ntuli, Flack, Mpofu et al. (2013), point to the problems encountered when communities do not fully, engage in the

intervention while Choi, Hui, Lee and Chui (2010) emphasise the problems that arise due to cultural and language barriers and the students' lack of knowledge of local context. The longer the time nursing students spend in an appropriate community, the more they acquire a sense of belonging and the belief that they are having a beneficial impact on the community. This results in a deeper the intensity of learning for both students and the community (Betony, 2012; Rosing, Reed, Ferrari and Bothne, 2010).

Despite the great impact of community-based health promotion and illness prevention programmes being implemented in various Bachelor nursing programmes, it is still not clear how the students perceive their participation in such programmes. While community-based health promotion and illness prevention programmes are being carried out by nursing students at selected schools of nursing, the information about the experience of the students in the community-based programme is limited. Therefore, the purpose of this study is to explore the experiences of nursing students in community-based health promotion and illness prevention programmes.

1.4 Purpose of the study

The purpose of this study was to explore nursing students' experiences of the community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

1.5 Research objective

- To explore nursing students' experiences in a community-based health promotion and illness prevention programme.

1.6 Research question

- What are nursing students' experiences of community-based health promotion and illness prevention programmes?

1.7 Significance of the study

Involvement in community-based health promotion and illness prevention programmes represents a comprehensive approach to bringing about social change in order to improve health and wellbeing (Bircher and Kuruvilla, 2014; Raingruber, 2014). The literature reveals that health promotion and illness prevention programmes carried out at the local level, by nursing students, provides a service to the community, while giving students an opportunity to utilize their health promotion knowledge and skills (Kushner et al., 2014; Bronstein et al., 2012; Kulbok et al., 2012). Literature supports the fact that the crucial goal of nursing research is to change the practice and improve the welfare and the health of the people in the community (LoBiondo-Wood and Haber, 2013; Polit and Beck, 2013). The findings from this study would be useful to nursing students, community members, nursing administration, nursing education, nursing programmes and research.

To nursing education programmes: The findings from this study may provide a body of knowledge to the students for a better understanding of community based health promotion and illness prevention programmes and their implementation. They will also help the administration of the selected School of Nursing to transform the teaching and learning of nursing community health skills. Furthermore, it may lead to changing or updating the existing curriculum. The study will highlight the gaps in terms of nursing students' preparedness to deliver health promotion and illness prevention activities.

To the community: Given the importance of the involvement of the community in all community-based health promotion and illness prevention programmes, it is hoped that the findings from this study will reveal how students perceive community-based interventions and what they expect from the community. This study might also reveal the challenges encountered by the students in the community. This will assist community members to better work in collaboration with the nursing students.

To research: The findings from this study will provide important information to the existing body of knowledge of community-based health promotion and illness prevention programmes, and will serve as a basis for further studies.

1.8 Operational definitions of concepts

For the purpose of this study, the following concepts were defined operationally.

Experience: Cohen et al. (2007) describe experience as narratives of an encounter, or a series of encounters, something which has been participated in or lived through. In this study, experience refers to feelings and observations arising from student participation in community-based health promotion and illness prevention programmes.

Nursing Student: In this study, a nursing student refers to a person who is studying at a nursing education institution and is registered as second year nurse student in a programme leading to a Bachelor qualification in nursing.

Community-based nursing programme: Also called community-based education/learning, this is a way of achieving educational relevance to community health needs and a manner of implementing a community-oriented educational programme (WHO, 1987). In this study, it refers to the programme designed for second year nursing students in their practical experiences. Nursing students are located in the community to learn from everyday life, experience the real-life problems of that community and be allowed to practice by solving these problems.

Health promotion: Health promotion is a process of enabling people to increase control over their health and its determinants, and thereby improve their health (WHO, 2005). For the purpose of this study, the definition by the WHO (2005) was adopted.

Disease prevention: In this study, disease prevention refers to any approach which prevents or reduces the risk of disease.

1.9 Conclusion

Community-based education is used in various health disciplines, including nursing education, to ensure adequate and relevant nursing training and education. It aims to produce nurses who develop the ability to solve community health problems, especially in rural, poor and under-served areas, as they achieve their learning objectives. Community-based education was adopted in response to recommendations of the WHO and the South African government in the promotion of

primary health care. The National Commission of Higher Education (NCHE), recommended equipping nursing students with the comprehensive knowledge, competency and attitudes to respond to the health care needs of the population of South Africa (Fitcards & Rand, 2000). The literature showed that community-based education is very important in health promotion and illness prevention, where the students provide different health services in under-resourced and underprivileged areas. Furthermore, community intervention provides an opportunity for the students to apply the knowledge they have acquired during class interactions, which allows them, at the end, to reflect on their experiences and how those experiences have facilitated their personal and academic growth.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

A literature review involves the identification and location of information on a particular topic or topics (Briner and Denyer, 2012; Bryman, 2012; Machi and McEvoy, 2012). Similarly Furseth and Everett (2013) argue that a literature review is a survey of progress in a particular aspect of a subject over a given period, and may range from a bibliographical index or a list of references, to a general critical review of original publications.

In this literature review, the topic that directed the systematic search of information was exploring nursing students' experiences about community-based health promotion and illness prevention programmes. Extensive information was collected on the concept of community-based learning, community health promotion programmes, the implication of community-based health promotion and illness prevention programmes in nursing education, nursing students' participation in community-based health promotion and illness prevention activities in the community, their experiences in the community-based health promotion and illness prevention programmes. Information was also collected on the challenges encountered by nursing students during their participation in community-based health promotion and illness prevention programmes. The literature search included the following computer-assistance and data-based bibliographies, namely; MEDLINE (Medical Literature Online), Academic Search, Premier, Nexus, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and Google Scholar.

2.2 The concept of community-based education

According to Elwell and Bean (2011), community-based-education is also recognized as community learning or community-based service learning, and all these expressions can be used interchangeably . Thus, community-based education (CBE), as an educational approach, is based on experiential learning and students are actively involved in a real situation where they are required to respond to community needs (Vogt et al., 2011). Consequently, students will acquire professional competencies in the community of practices which help them to build a sense of connection with their communities.

Relevant studies have recognised that nursing students' participation in community intervention, through health promotion and illness prevention programmes, is a significant contribution to the health and well-being of the whole community (Bahar, Beşer, Özbıçakçı and Haney, 2014; Blout, Rose, Suessmann, Coleman and Selekman, 2012). Community policy mostly focuses on health promotion, disease prevention, and wellness (National Nursing Centers Consortium [NNCC]. 2011). Therefore, in order to address health issues, a holistic approach will be used by empowering individuals and communities to take action for their health, promoting actions for building healthy public policies in all sectors (Laverack and Mohammadi, 2011).

According to the WHO (1987), community-based education is an approach to education that focuses on the needs of the community in which the students use the community as a learning environment. It is understood that while applying theories they learn about in the classroom to real situations, students also meet explicit community needs (Mtshali, 2005; WHO, 1987). Thus the community learning activities are performed anywhere people reside and work and everyone is involved including students, teachers, community members and other multidisciplinary and multi-sectorial teams.

According to Frenk, Chen, Bhutta, Cohen, Crisp, Evans et al. (2010), and Jones, Higgs, de Angelis and Prideaux (2001), the use of community-based education is recommended and has been recognised as a criterion for the design of health professionals' curricula. Thus, students in a community-based curriculum convert to self-directed learning and become more confident. They are required to provide quality health service at all levels, including community, district and primary health care facilities, and general and tertiary hospitals. Community-based-education, according to Thompson and Bucher (2013), offers an experiential learning approach which focuses on health promotion, illness prevention, treatment of occurred diseases and rehabilitation.

The literature emphasises that community-based education also provides an extensive learning avenue for the students in a number of areas, bridging the gap between learning and practice by bringing together what is taught with an emphasis on health promotion, illness prevention, and treatment and rehabilitation. This approach encompasses all forms of health care delivery, inclusive of the primary health care systems which are the global focus for the attainment of improved universal health by 2000 (Mthembu, Mtshali and Frantz, 2014; Fichardt and Du Rand,

2000; WHO, 1987; WHO and UNICEF, 1978). In addition, students should be well informed about the organisation and the role of the health care systems which will help them to develop those skills and competences recommended for an integrated health service to the population.

According to Mariam, Sagay, Arubaku, Bailey, Baingana, Burani et al. (2014), community-based education as a learning approach is a component of the curriculum of numerous African medical schools. It focuses on preparing students to deliver high-quality primary care to the community in general and especially to under-served rural populations. It is believed that this approach may prepare students to work in this environment after completing their studies. The South African government has suggested that higher education institutions (HEIs) focus on responding to the needs of the community through an intensive use of community-based learning (Department of Health, 1997). Thus, Medical and Health Sciences students in South Africa are required to undertake CBE.

Mtshali (2005), reported that numerous nursing education institutions in South Africa adopted community-based education programmes, including the University of KwaZulu-Natal in which the School of Nursing was the first to implement CBE in 1994, followed by the School of Nursing at the University of the Witwatersrand in 1995, the School of Nursing at the University of the Free State and the University of the Transkei in 1997. The Frere College of Nursing piloted CBE in 1997 and adopted it by changing the curriculum in 1998. CBE is also offered at the University of the Western Cape, and the Transkei College of Nursing and its seven satellite campuses. Other institutions also show signs of adopting CBE (Mtshali, 2005).

Mtshali (2009), advocates that everyone, including communities, health education institutions and government, work jointly and in partnership to implement community-based education programmes. The above author emphasised the fact that stakeholders such as the community members should have a say on the character of the curriculum as well as the required skills for nursing students and the clinical environment. Thus, resolutions for any transformation should be taken conjointly for it to succeed (Mtshali and Gwele, 2016). Furthermore, nursing students have to be allocated to a clinical setting which allows them to practice what they learned in class in real-world situation and facilitate the acquisition of necessary competencies. Thus, after completion of the study programme, graduates should be able to work in any team to meet the needs of the South

African community in general, and specifically in the rural and underprivileged population. Mthembu and Mtshali (2011), observe that students increased their sense of responsibility while resolving community health problems which decrease the disparity of health care and encourage its accessibility to all. Thus, nursing education in particular should aim to produce a sufficient number of highly qualified health professionals who can serve the community and meet the health needs of the nation at community level and produce community-oriented health professionals who are able to serve their communities and deal effectively with their health issues.

2.2.1. The case of the selected School of Nursing in KwaZulu-Natal.

The second year training of bachelors of nursing undergraduates at selected schools of nursing is the beginning of the primary health care component. The students deal with the family and the community and focus on the health promotion and illness prevention component. Nursing students mainly acquire practical knowledge acquisition through community-based nursing education (Uys and Gwele, 2004).

Therefore at the beginning of the second year of the programme, students receive an introduction to epidemiology study and community-based learning which provides them with knowledge and skills such as community needs assessment and critical analysis of collected data. Later on, students are divided into three groups and allocated to three different communities where they are required to undertake health promotion projects (Adejumo and Ganga-Limando, 2000; Gwele, 1997). Thus, students have a chance to observe and get involved in the activities in the clinical community setting (Mtshali, 2009; Mtshali, 2005; Uys, 1998; Gwele, 1997). The placement of the students in the community takes place during the vacations (university holidays).

During the first two weeks of the January vacation, students are exposed to concrete experiences in the community. The students in collaboration with their facilitators and the community members, conduct an assessment of the community and determine the health needs that require nursing interventions (Mthembu and Mtshali, 2011). After the needs have been identified and prioritised, the students design a relevant community intervention project, and address the community health needs in the April vacation. Based on the priorities, preventive and promotional interventions are planned in consultation with the community. Students share their plans with, and

receive feedback from, their peers, facilitators, and the community. After the top priority intervention to be executed has been agreed upon, the project is implemented in collaboration with the community during the winter vacation.

During the September vacation students evaluate and present the report to their fellow students, members of staff and community members (Mthembu and Mtshali, 2011; Gwele, 1999). Students provide honest feedback on the positive and negative aspects of their experiential activities, as well as strategies to modify the process. It is understood that, throughout community-based education, nursing students make an essential contribution to the wellbeing of individuals, families, and communities. Therefore, they may contribute to the quality of life in a specific community.

2.3 Health promotion programmes in the community

Health is one of the main factors that contribute to a nation's development, especially in this age of globalisation, where the health of a population is considered to be the key to better productivity and efficiency in the society as a whole (Lomazzi, Borisch and Laaser, 2014; Wanless, 2004). The WHO (2014a), notes that a healthy individual should be able to achieve an optimal level of functioning in all spheres of life and that the achievement of the health of each individual is pivotal to the global health. Health promotion is described as the process of enabling people to increase control over, and to improve, their health (WHO, 1986). It represents a comprehensive approach to bringing about social change in order to improve health and wellbeing (Bircher and Kuruvilla, 2014; Raingruber, 2014).

The Ottawa Charter remains a source of global guidance and continues to shape the development of health promotion, in conjunction with other important documents such as the Jakarta Declaration (WHO, 1997) and the Bangkok Charter (WHO, 2005). In recent years growing attention has been given to health and the development of health promotion and illness prevention programme within the clinical community setting (Heath, Parra, Sarmiento, Andersen, Owen, Goenka et al., 2012; King, Gill, Allender and Swinburn, 2011). This is in order to confront the climbing medical costs and embrace health improvement in the community (Busza, Walker, Hairston, Gable, Pitter, Lee et al., 2012; Edwards, 2012; Braveman, Egerter, Woolf and Marks, 2011).

In the Ottawa Charter (1986), the WHO (1986) defined five health promotion action areas for achieving better health. These areas include: building healthy public policy; creating supportive environments; strengthening community actions; developing personal skills and reorienting health services. Makaula et al. (2012), reported that health promotion action is facilitated in community setting such as schools, hospitals, workplaces and residential areas and needs to be built into all the policies. Similarly Bircher and Kuruvilla (2014), noted that the central tenet of health promotion is to consider people not as isolated entities, but as part of a wider environment. This environment is the “setting” in which people live and work, and has a profound effect on people’s health. Therefore, any approach to health promotion should take into account all the elements of an environment, and seek to change those negative aspects which could undermine health.

The literature reveals that the primary objective in the community setting is to implement health promotion and illness prevention programmes which will allow and empower all communities to have influence over factors that affect their health (Macfarlane, Wood and Campbell, 2014; Allender, Gleeson, Crammond, Sacks, Lawrence, Peeters et al., 2012; Richard, Gauvin and Raine, 2011). The National Nursing Centers Consortium (2011), also points out that in the community environment, the focus is mostly on health promotion, disease prevention, and the wellness of the population. Furthermore, Bauer, Briss, Goodman and Bowman (2014), note that although disease prevention is difficult to measure and to demonstrate empirically, this approach is less costly than crisis intervention and treating disease and disabilities after they have occurred . Moreover, several studies have revealed that disease prevention is better than cure (Parrott, Peter McGill, Ward and Cooper, 2013; Daunton, Puig, Taniere, Forde, Alderson and Tucker, 2012; Srivastava and Fatima, 2012). Merritt and Boogaerts (2014), assert also that intervention at the community focuses more on helping people make decisions in a way that makes their life more comfortable and more appropriate to them or generally improve their quality of life.

According to Healy and Sharry (2011), nurses play a crucial part in community health promotion. Their practices may therefore have a positive impact when they are counselling patients on issues related to their health. Given their unique relationship with communities, nursing students may be regarded as improving community health (Grealish, Bail and Ranse, 2010). Furthermore, professional bodies and global organisations have recognised the impact of nursing students in

achieving improved health for the community, and recommended that the training of health professionals be targeted towards meeting the health needs of the population in a community-based manner (WHO, 2011; International Council of Nurses, 2009; American Association of Colleges of Nursing, 2005; Department of Health, 1997; WHO and UNICEF, 1978). Other studies have also emphasised the significance of student participation in promoting a country's health through community-based health promotion and illness prevention programmes (Peters, McInnes and Halcomb, 2015; Mabuza et al., 2013; Inman, van Bakergem, LaRosa and Garr, 2011).

According to Luthy, Beckstrand and Callister (2012), nursing students' experiences in the community consist of assessing the community health needs and planning, implementing and evaluating the interventions. Students are likely to conduct family studies, pay home visits and deliver health education as components of health promotion and illness prevention. This helps students to understand that economic, political, psychosocial and cultural factors may affect health status at individual, family and community levels (Schaffer, Cross, Keller, Nelson, Schoon and Henton, 2011). Walthew and Scott (2012), found that most nursing students still focused on individuals and principally used an approach in keeping with traditional attitudes to health promotion, while other students embraced more empowering and interactive approaches. However, whichever approach the student used, Bindels et al. (2014), argue that the successful launching of a health promotion programme is possible only if the participation and motivation of the community remains sustained at a high level. Furthermore, Merritt and Boogaerts (2014), have pointed out that nursing students acknowledged that making concessions to the community can result in good intervention outcomes; therefore, the use of more flexible approaches to traditional practices and collaboration with the community seem to be an effective way of responding to the community's choice for the way they want to live their lives. Moreover, Bindels et al. (2014), also note that the successful launching of a health promotion programme requires the participation and motivation of the community. Therefore, health promotion activities need to be in line with the setting and needs of those who utilise these services (O'Neill et al., 2012).

2.4 Implication of community-based health promotion and illness prevention in nursing education

The acquisition of competences for future nurses is vital for safe, ethical and legal nursing practice. Therefore numerous teaching strategies should be used to improve nursing students' competence by linking theory to practice in the community setting (Koch, 2013). Nursing education programmes need to support all learning that allows nursing students to meet professional entry-to-practice competencies (Valaitis et al., 2014). Thus, while implementing a community-oriented educational programme, students should develop a deep understanding of course content while also developing a sense of social responsibility (Millican and Bourner, 2011). It is argued that through community-based programmes, students will achieve educational relevance to community health needs (Vogt et al., 2011). According to the above authors, nursing students placed in community-based health promotion programme better understand the community and become responsive to community needs.

According to Fillingham, Peters, Chisholm and Hart (2014), training in undergraduate nursing education provides a great opportunity for assisting nursing students to develop their skills and confidence by working positively with the community members. Similarly, Yang, Woomer and Matthews (2012), assert that community clinical experience enables nursing students to be better equipped for future employment within the community setting. The above authors also claim that having more graduate nurses with a wide understanding of the role of the community health nurse is essential to addressing the need for nurses within any community care settings. Although the universities are devoted to exposing students to community-based programmes, other aspects should also be catered for, such as the links between the university and the clinical staff at the community setting (Betony, 2012). Community-based education is established on primary health care and therefore the needs of the community are a component of a health worker's education (Kronfol, 2012).

While in many countries community-based education aims to develop the capacity of individuals and groups of all ages through their actions, the central capacity of communities to improve their quality of life and maintain their health is their ability to participate in democratic processes (Marmot, Allen, Bell, Bloomer and Goldblatt, 2012). Evidence in nursing education supports the

practice of active learning strategies such as community-based learning as a method of promoting nursing student engagement that has positive effects on problem solving, critical thinking, and persistence (Kicinski, 2014; Macklem, 2014). Likewise, in recent years in South Africa, service learning and community engagement have been acknowledged by higher education institutions. Consequently, service learning through community engagement is producing potent transformative effects for all including teachers, schools, universities, communities and policy-makers (Rowe, 2011).

A study conducted by Ramson (2014), states that service learning brings together the knowledge, skills and experiences of learners in a way that allows them to perform and respond to social needs and engage with communities. Thus, community-based learning related activities should be based on the following principles: (1) Empowerment: increasing the ability of individuals and groups to influence issues that affect them and their communities; (2) Participation: supporting people to take part in decision making; (3) Inclusion, equality of opportunity and anti-discrimination: recognising that some people may need additional support to overcome the barriers they face; (4) Self-determination: supporting the right of people to make their own choices; and (5) Partnership: recognising that many agencies can contribute to community-based learning to ensure that resources are used effectively (Klunklin, Subpaiboongid, Keitlertnapha, Viseskul and Turale, 2011).

The WHO (2010), describes community-based education as a learning activity which utilises the community as a learning environment in which the achieving of education is related to community needs and the implementation of a community-oriented programme. It involves active participation of not only the students, but also the teachers, members of the community, and representatives of other sectors throughout the partnership process. In community-based education in nursing programmes, students are expected to provide health services that meet the population's needs, mainly those who are disadvantaged. According to Carr (2012), nursing students participating in community-based learning are mainly involved in basic activities including community diagnosis, family health, epidemiology, research methodology and management skills for health services. As a result, nursing students enhance their communication and teamwork skills, and increase their confidence levels. Conversely, a qualitative study conducted by Zanchetta,

Taher, Fredericks, Waddell, Fine and Sales (2013b), analysing students' performance and self-criticism of their roles in promoting health literacy in order to facilitate health promotion and care revealed that nursing students suggested more socially inclusive and experiential learning initiatives related to health teaching to address education gaps in classrooms and practice. Students reported that this experience helped them to link theories to concrete practice. Steinhubel (2012), states that nurses take an active role in all facets of healthcare and are expected to possess critical thinking and communications skills. Therefore, nursing students need to be taught in a way that emphasises the use of the information that they collect in the classroom so that they can be more engaged with the content in the community site.

A study conducted by Okoronkwo, Onyia-pat et al. (2013), asserts that, as the community-based programme is realised not by imposition on people but with them, nursing students should be thoroughly prepared for the work they will have to practice in different clinical community settings. This means that to become competent nurses they must have an effective community clinical teaching experience founded on community-based learning which allows them to participate actively in the health care team and to see solutions to real-life problems and to learn by doing while intervening in the community. Nursing students attested that this experience equipped them with professional skills, allowing them to develop self-directed behaviour and interpersonal abilities (Okoronkwo et al., 2013). These thoughts are supported by Bentley (2013), who argues that such knowledge prepares nursing students to work competently in the fields of prevention and rehabilitation. Another study by Luthy et al. (2012), pointed out that nursing students participating in community-based programmes were exposed to cultural life and practices, and were thus enabled to comprehend the link between such practices and life style of the community members. This experience promoted cultural responsiveness in nursing students and consequently determined the success of community-based programmes.

A study conducted by Lai, Chan, Wong, Fung, Pang, Fung et al. (2015), examined a project in which nursing students visited disadvantaged underprivileged elderly people consistently over a period of two years. The students gained valued skills from this project. Students improved their teamwork and communication skills. This experience enhanced personal knowledge and professional development. Furthermore, community-based programmes allow nursing students to

acquire knowledge which is applicable in professional practice and useful in practical situations (Crookes, Crookes and Walsh, 2013). Thus, nursing students become well prepared for their future roles and responsibilities at all levels of and in particular in the community environment (Shinnick, Woo and Menten, 2011; Balen, Rhodes and Ward, 2010). Therefore, the above authors emphasised that community-based education programme promotes nursing students learning while concurrently contributing to the community. Thus, schools of nursing are required to provide students with both theoretical and clinical opportunities in the community, thereby expanding the scope of nursing.

2.5 Nursing students' participation in community-based health promotion and illness prevention programme

The WHO "Health for All by the Year 2000" movement emphasised that nurses should be leaders in health promotion (Kickbusch and Nutbeam, 1998; WHO, 1997). The literature reveals that nursing students' learning practices in the community are mostly based on assessing community health needs, planning for interventions, and implementing and evaluating the interventions (Applin, Williams, Day and Buro, 2011; WHO, 1987). Mendenhall et al. (2014), at the University of Minnesota, stated that nurses are at the forefront of community care and continuity of care can only be achieved through their efforts. Their participation in community intervention is gratefully appreciated since this experience may develop responsibility to serve the community. The same authors point out that community-based health promotion and illness prevention programmes may take place in diverse settings including prisons, public health departments, schools, home care, rural hospitals and community health centres. Therefore, nursing students should be involved in various activities oriented towards health promotion, illness prevention and rehabilitation such as immunisation, surveillance and health education. They also promote healthy practices such as smoking cessation programme, evading of substances of abuse, use of safety belts in cars, reducing use of saturated fats and engaging in daily exercise (Prohaska, Trites and Scott, 2014; Tebes, Kaufman, Connell, Crusto and Thai, 2014; Thistlethwaite, 2011).

A study conducted by Walthew and Scott (2012), in New Zealand asserts that while most nursing students focused on individuals and used an approach in keeping with a traditional approach to health promotion such as education meetings, other nursing students did embrace empowering and

interactive approaches such as being involved in outreach activities and participating in smoking cessation programme. Furthermore, non-judgemental discussion with the community is a great way of understanding and empowering them. For example, nursing students in Uganda are assessing and diagnosing community needs and creating a community consciousness of common diseases. They also conduct disease prevention and health promotion actions (Kaye et al., 2011b).

A study conducted by Wang, Chen, Lai, Chen and Chen (2014), showed that nursing students who were involved in different health promotion projects for rural communities focused on different concerns, including how to maintain oral hygiene, choose a healthy diet, prevent falls, engage in physical activity, be responsible for health, self-protect and manage stress.

Several other studies reveal that students are expected to work in partnership with the community members, stakeholders and their academic clinical instructors during their activities in community-based health promotion and illness prevention programmes (Mothoagae, 2013; Carr, 2012; Yang et al., 2012; Tucker, Lanningham-Foster, Murphy, Olsen, Orth, Voss et al., 2011). Nursing students in partnership with all the stakeholders ensure the involvement of the community in identifying priority health issue for each community and to address the nominated health issue. Students are also expected to develop a plan and identify the strategies for the implementation on the health promotion intervention. The last phase of the intervention is the evaluation phases done at the end of the year. Thus, in order to be evaluated, students should expose their intervention project to other students, members of staff, and also to community members (Mothoagae, 2013).

According Car (2012) nursing students during a health promotion intervention are principally involved in basic activities such as community need assessment and diagnosis, family health, applying epidemiology, research methodology and management skills for health services. These activities focus on health issues and the needs of the community such as immunisation programmes, smoking cessation campaigns, hygiene, infant feeding, assessing blood pressure, giving education on healthy eating, physical exercise, and preventive measures related to weather conditions (Walthew and Scott, 2012; Carr, 2012).

2.6 Nursing students' experiences of community-based health promotion and illness prevention programmes

The experiences of students regarding community-based health promotion and illness prevention programmes helps them to link theoretical knowledge to practice, thus developing the academic and professional competences basic to their future careers. A number of researchers acknowledge the diverse benefits of community-based health promotion and illness prevention programmes to the community as well as to the nursing students. However, others concede various negative experiences.

A quantitative study conducted by Naidu et al. (2012), in South Africa examined medical students who had conducted community-based health promotion programmes during their public health training, and it was found that 52 per cent of 64 students acknowledged the benefit of working in the community setting. A third of the students believed that working in the community setting helped them to enhance their understanding of the course content, better than memorizing in the class context and some students testified that the community setting offered them the opportunity to work in teams with others and this enabled significant advantages, such as time for practical experience, and an understanding of the community's needs and culture. Students emphasized the fact that the community learning experience helps them in terms of personal achievement and cultural exposure. However, students had unpleasant experience and pointed out some challenges including time constraint; obstacles in communication; insufficient settings; financial limitations; long travelling distances; location facilitator challenges; challenges in working in teams and poor involvement of stakeholders (Naidu et al., 2012). In a contrary set of conclusions, a mix of qualitative and quantitative study conducted on community rotations for several community-based programmes by (Kaye et al., 2011a), in Uganda assessing several features of community-based education activities reported that students had a pleasant experience. These students confirmed that the community setting offer them a good contextual and experiential learning experience, which led to collaborative and clinical skills, a sense of teamwork, and performing learning assessment methods. However, the findings of a study carried out by Jain and Langwith (2013), revealed that students reported that community intervention involves more hesitation and that, nursing students feel uncomfortable when they do not have enough knowledge and when they are

faced with insufficient or inappropriate resources. Nursing students expressed the need for medical language to be adapted to the community level of understanding and called for the use of creative intervention in the language of instruction. They noted that the way things were taught at the university were not always applicable in the practical setting, since they were sometimes constrained to conform to the environment and to improvise the needed resources (Daniels et al., 2013; Jain and Langwith, 2013; Hawala-Drury and Hill, 2012). These negative experiences possibly influenced how they embraced community intervention and consequently the level of their expectations.

An inclusive evaluation of community-based education by Kaye et al (2011b), in Uganda stated that nursing students involved in community-based programme in numerous settings such as rural hospitals, community health centres, and general practice in the community develop an understanding of community health problems, especially the socio-economic and environmental factors that are determinants of health, health promotion and illness prevention capacities. Therefore, students reported having learned both thinking strategies and domain knowledge and developed flexible knowledge, effective problem-solving skills, self-directed learning, effective collaboration skills and intrinsic motivation.

The literature, both local and international, points out that a community-based programme emphasises close collaboration between nursing students and community members (Yang et al., 2012; Walthew and Scott, 2012; Applin et al., 2011). Therefore, students became conscious of the needs of the community and developed a responsibility to serve the community. Students interacting with the community members practiced in a real situation, which allowed them to link theories learned in class to the practical environment. Thus, students increased their understanding of community needs and developed some professionals' skills such as belonging to the community and responsibility for serving the community. According to Ziglio, Simpson and Tsouros (2011), the fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Consequently, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing, thus the participation of all remains crucial (Majee, Maltsberger, Johnson and Adams, 2014).

A systematic review identifying studies that have assessed educational interventions in undergraduate nurse training concerning obesity and investigating the interventions' efficiency carried out by Fillingham et al. (2014), revealed that 187 out of 207 nursing students had a good experience because they testified having increased their understanding of concerns related to childhood obesity. In addition, nursing students valued community-based education as it allowed them to see and to demonstrate a greater improvement in client health behaviour and student clinical performance. Community participation in health programmes improved their sustainability and affordability. Thus, students recognised that they were well prepared for working in different fields related to the community, such as the fields of prevention and rehabilitation. They also recognised the value of health care being extended outside of the acute care setting (Fillingham, Peters, Chisholm and Hart, 2014).

A quantitative study conducted by Mendenhall et al. (2014), in America strongly supported the use of community intervention in nursing education and pointed out the importance of the community participation in the entire intervention, from the conceptualisation of the problems and the formulation of solutions, to design, implementation and evaluation. Nursing students in opposition to nicotine and tobacco addiction in a community-based programme in partnership with local medical and mental health providers increased the knowledge of the population about the stress attributed to smoking behaviour and other health issues associated with nicotine dependence (Mendenhall et al., 2014). About one third of respondents were nicotine dependent at the beginning. After education on smoking cessation programmes, participants decided to adopt a healthy lifestyle and almost half (48 per cent) planned to stop within one month and 74 per cent intended to stop within six months. Furthermore, nursing students expressed that the view that community intervention becomes a way of achieving crucial knowledge to assist them in the future (Mendenhall et al., 2014; Schwindt, McNelis and Sharp, 2014).

According to Wang et al. (2014), in a quasi-experimental study examining the outcome of a community-based health promotion programme on change of lifestyle, physiological indicators and depression score among older retired agriculturalists in two rural areas showed positive results. They stated that the benefits from the community-based health promotion programme seem to be shared between both students and the older groups. Nursing students who worked with one of the

groups reported they also adopted a healthy life style through participating in the community activities, practising self-promotion and increasing health responsibilities. The study also highlighted the fact that with little resources, the intervention was successfully realized and led to great results for wellbeing at individual, family and community levels (Wang et al., 2014).

In the study conducted by Brewin, Koren, Morgan, Shipley and Hardy (2013), nursing students acknowledged that health education about sexual risk behaviours they provided to adolescents during their community intervention programme had absolutely changed sexual behaviours among those who received the health education. However, students were not comfortable with this intervention because they did not have adequate information on this topic (Brewin et al., 2013). Furthermore, nursing students recognized the fact that the community intervention develops the feeling of belonging in a group and the recognition of being themselves the mediator of change within the community (Vogt et al., 2011).

Students participating actively in a camp for children with chronic diabetes consequently espoused a diabetes daily life by doing certain routines themselves, including monitoring their blood glucose levels, checking on the effects of diet and activity and doing self-injections with a placebo product replacing of insulin. These students expressed that they worked hand in hand with children and it was very hard for them to leave the camp at the end of the intervention (Vogt et al., 2011). Likewise, participating actively in a community health promotion and illness prevention programmes, nursing students acknowledged reframing and readdressing real-life situations, and being given a great opportunity to offer each other appreciation and support. These activities improved their health promotion knowledge, while developing critical thinking as well as the facilitation of their intellectual development (Kazemi, Behan and Boniauto, 2011). Students also had an opportunity to enhance their cross-cultural awareness and to learn about the unique health needs of a particular community especially when they were involved in various community settings including international ones (Loewen, Underwood and Thompson-Isherwood, 2014). Furthermore, service learning through health promotion practice also lead to the development of critical thinking insofar as students identified the risk factors of a unique population and used the nursing interventions that they had learned to influence positive outcomes (Henderson, Cooke, Creedy and Walker, 2012).

In a study conducted by Kazemi et al. (2011), during the community intervention, nursing students attested learning more about the specific health needs of a given community under circumstances in which they learned to influence outcomes, and benefited by increasing their multicultural consciousness. The study also acknowledged that the involvement of students in public health initiatives helps them to achieve broad spectrum and effective intervention through coaching delivered by students. Another study conducted in America noted that nursing students believed that experience in the community setting was fundamental in their nursing education since it provided opportunities for them to learn about the clinical context by listening, by developing a therapeutic relationship, and by employing creativity and innovation (Walton and Blossom, 2013). In addition, students felt contented with themselves in their role as nursing students and recognised that working with the community covers people and their health needs as well as their lifestyle and their culture (Karp and Bork, 2012; Walthew and Scott, 2012).

In a qualitative study conducted by Merritt and Boogaerts (2014), on nursing student learning in community nursing, students acknowledged that intervention in the community focuses more on helping people making decisions. *“Just simple things that make their life more comfortable, more applicable to them. Yeah, that is definitely what I learned”* (Merritt and Boogaerts, 2014, p 229). Further, nursing students admitted that community health promotion intervention allowed greater creativity, enhanced their understanding of community health issues, and developed a sense of community responsibility (Lindsey and Hawk, 2013). Therefore, students felt satisfied with their interactions and their sense of belonging in the community.

Another study conducted by Kaye et al. (2011a), in Uganda stressed that students had positive experiences during community intervention. They expressed the opinion that working in rural or disadvantaged environments through conducting community assessments and implementing programmes which addressed the problems identified helped them to increase their health promotion and research skills. A qualitative study conducted by Walton and Blossom (2013), exploring nursing students experiences during their health promotion activities in rural community settings showed that the nursing students valued community intervention as it allowed them to be sensitive to the individual needs as well as to respond by listening and asking questions. Students believed that learning how to listen should make a change in an individual life. They had positive

perceptions about community service, saying that visiting older adults living in rural communities and working with them was pleasurable and beneficial in helping them to grow as professional practitioners and they would recommend their colleagues to undertake it as the community benefited from the service as well (Walton and Blossom, 2013). The same authors revealed that the students' experiences were summarized by the following student statement: *"I learned a lot about how people age and the things they go through. It helped me understand that aging doesn't have to be a horrible thing and that prevention is key throughout life. It also helped me learn to be comfortable with the older adult and just be able to sit and talk with him. It was a very beneficial experience."* (Walton and Blossom, 2013, p 248).

A study carried out by Thistlethwaite (2011), showed that students perceived community intervention as a very fascinating and beneficial undertaking. Nursing students felt that being part of community expanded their ability to work with others in groups for a shared project and helped them to develop social interaction skills, particularly connection with others. The study also acknowledged that the involvement of students in public health initiatives helps to achieve broad spectrum and effective intervention through coaching delivered by students, through screen time, and through nutritional pattern assessment in a study conducted on child obesity (Tucker et al., 2011). Nursing students reported that community health promotion intervention allows creativity, enhances understanding of community health issues, and encourages a greater sense of community responsibility. Other factors cited were the importance of group discussions, the development of professional goals and an enhanced connection with the community (Lindsey and Hawk, 2013).

However, a study conducted by Steele, Wu, Jensen, Pankey, Davis and Aylward (2011), revealed that nursing students, participating in the prevention of childhood obesity faced difficulties in the implementation phase of a community health promotion interventions such as the finance from the community, and the lack of importance and time that the community gave to the intervention. They expressed the view that resources were insufficient and time for the families to accomplish children's physical activities was restricted. They also noted that the changing of eating practices was a major obstacle to their health promotion practice. In the same study, students also reported that community cultural factors such as habits and perceptions related to health issues constitute a

significant barrier to their health promotion efforts. This was particularly the case when a community has a different culture from their own.

2.7 Challenges encountered by the students during community interventions

Several factors can influence and contribute to the success or failure of a community intervention. According to Hoffman (2011), the most important contributory factors to the achievement of the community-based education through health promotion intervention include institutional support from the concerned school or university, a well-built partnership with the community and students' motivation concerning community health promotion practices. The same author argued that nurses as good role models could also influence the practice of health promotion and illness prevention programmes in the community. However, numerous factors can inhibit the community intervention such as non-supportive preceptors, outdated preceptor knowledge, the task-oriented nature of the setting, lack of opportunity, lack of time, and a lack of resources including accommodation and transport and a lack of communication between the institution/faculty and the community setting (Zanchetta et al., 2013b; Walthew and Scott, 2012; Motlhale, 2012). Furthermore, cultural and language barriers, students' lack of knowledge and confidence, student levels of maturity, perceived staff attitude, non-receptive communities, unavailable clients (geographic isolation), the personal values of the nurses and the unknown outcome of health promotion activities could negatively influence nursing students' community interventions (Motlhale, 2012; Edwards, 2012).

In a study carried out by Mabuza et al. (2013), nursing students highlighted poor communication among the universities and community facilitators and lack of financial support for community interventions as significant issues which restrained their learning experiences and the quality of their practice. Similarly, in another study conducted by Okoronkwo et al. (2013), at the University of Nigeria, students pointed out a deficit in the financial support for accommodation and transport. Other challenges encountered included administrative constraints regarding students' supervision, and a lack of adequate library facilities and internet provision. Evidence available suggests students used their personal money for transport or were limited to community settings which were closer to their families, even though it was important for them to experiment in other locations. Therefore, families of students were burdened to provide financial support for transport and

accommodation, and the situation was embarrassing to some students from families with limited resources (Kaye et al., 2011b).

Another study found that after an awareness session, students were overwhelmed by the fact that some people had difficulty changing unhealthy behaviour and for whom it was even impossible to move forward due to funding problems (Walthew and Scott, 2012). As one student expressed himself, *“I felt that I was banging my head against a brick wall”* (Walthew and Scott, 2012, page 231). Another student explained, *“But there are a lot of cases that you can give them information, nothing is going to happen with it because they don't know what to do next. Yeah sure this is good to eat but where do I get it at the supermarket ...it is expensive?”* (Walthew and Scott, 2012, page 231).

Furthermore, students pointed out the fact that, having supervisors who are not up to date could have a negative impact on the health promotion events (O'Connor, 2012; Walthew and Scott, 2012). Moreover, some students commented on the fact that they did not have enough supervision, so they felt insecure and lacked self-confidence (Manninen, Scheja, Henriksson and Silén, 2013). A study on obstacles encountered by students in a health promotion practice regarding childhood obesity exposed numerous challenges. These challenges included poor facilitation and communication, administrative deficits, insufficient knowledge regarding nutrition, exercise and other prevention approaches. Other challenges included lack of students' participation during the selection and prioritising of the health issue as well as the limited time allocated to the implementation of the intervention (Steele et al., 2011). Furthermore, nursing students in the same study reported that discussing some health issues such as weight management with community members and families was sensitive and problematic as some of them were themselves overweight.

Although the interaction was appreciated by the community, it was unfortunately noted that students frequently did not have enough time for their health promotion practices, hence they did not provide feedback to the communities (Kaye et al., 2011b). Consequently, communities are hesitant and sceptical about any communities-learners relationships (Kaye et al., 2011a). In contrast, a study conducted by Naidu et al. (2012), in South Africa, emphasised the appropriateness of the students' feedback to the community and subsequently provided an opportunity for them to comment on the outcomes of all the processes and to assess challenges. Nursing students in this

study indicated that the preceptors were mostly available for evaluating and were good role models.

In a study conducted by Hoffman (2011), nursing students attested that staff attitudes discouraged their engagement in health promotion activities and negatively affected their confidence due to the limited knowledge and practical skills. A study conducted in Uganda by Kaye, et al. (2010), revealed that some students had experienced challenges during community intervention, regarding the absence of facilities such as the internet and libraries to promote self-directed learning, inadequate support from the faculty and being cut off from friends and colleagues. These negative perceptions might have influenced how they embraced community health promotion and illness prevention programmes and their future careers. However, in a study conducted by Tucker et al. (2011), nursing students attested that during their community intervention placement, the university provided for their needs such as transport, accommodation and they were satisfied with the levels of support.

2.8. Conclusion

This literature review covered the concept of community-based learning, health promotion programmes in the community and the social implications of community-based health promotion and illness prevention programmes in nursing education. Also covered were nursing students' participation in community-based health promotion and illness prevention activities in the community, nursing students' perceptions and their experiences during community-based health promotion and illness prevention programmes. Attention was also paid to challenges encountered and levels of support offered in the course of these programmes.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology is the application of all the steps, strategies and procedures that a researcher uses for gathering and analysing the raw data that emerges from an investigation, in a logical and systematic way (Burns and Grove, 2009). This chapter describes the research paradigm and gives details of: research approach; research design; research setting; population; research sampling strategy; methods of data collection, the process of data collection, data analysis; academic rigour of qualitative data and plans and ethical considerations followed while conducting the study. For each of the above mentioned aspects, explanations of how they are applied to this study were provided.

3.2 Research paradigm

A research paradigm is a set of fundamental assumptions and beliefs as to how the world is perceived (Wahyuni, 2012). It reflects the beliefs the researcher embraces in answering the question of interest in the study and the way the research is designed, how data is collected and analysed, and how the results are presented. This study is underpinned by a constructivist paradigm.

The constructivist or naturalist view is that knowledge is established through the meanings attached to the phenomenon studied; researchers interact with the subjects of study to obtain data; investigation changes both researcher and subject; and knowledge is context and time dependent (Creswell, 2013; Krauss, 2005; Johnson and Onwuegbuzie, 2004). Furthermore, the constructivism paradigm was chosen because the researcher believes that it is an appropriate model to describe the nursing students' experiences which quantified textual data would not convey. The researcher aims to explore the nursing students' experiences of community-based health promotion and illness prevention programmes in a selected school of nursing in KwaZulu-Natal.

3.3 Research approach

In the current study, a qualitative approach was used. The literature revealed that qualitative researchers are interested in understanding complex phenomena, and allows the compilation of narrative information from participants, in a detailed and holistic manner (Polit and Beck, 2013). (Burns and Grove, 2016; Isaacs, 2014; Creswell, 2009). In the current study, qualitative approach allowed the researcher to get close to the experiences and activities of nursing students' experiences of community-based health promotion and illness prevention programmes which would be difficult to quantify because of its subjective nature (Brink, van der Walt and van Rensburg, 2012; Grove, Burns and Gray, 2012; Morgan, 1997; Nyamathi and Shuler, 1990).

3.4 Research design

According to Brink et al. (2012), the research design is the set of logical steps taken by the researcher to answer the research question. It forms the blueprint of the study and determines the methodology used by the researcher to obtain sources of information, such as participants, elements and units of analysis, to collect and analyse the data, and to interpret the results. For qualitative studies, the design detailed how the subjects were selected and assigned to groups, the way the intervention was applied and a plan for data analysis (Polit and Beck, 2010). Suppleness in design, data collection, and analysis of research is necessary to achieve "profound" understanding and suitable illustration of the participants' viewpoints (Creswell, 2013).

This study adopted exploratory descriptive design that makes use of focus groups to generate the feeling of nursing students involving in community-based health promotion and illness prevention programmes. Furthermore, this best fits the purpose of the study and is compatible with the resources available to the researcher, such as limited time, sources of information, ethical considerations and personal preferences (Brink et al., 2012).

The anonymity of the focus group could embolden participants to provide truthful responses (Steinmetz, 2013). By choosing this design, the researcher believes that the data gained could be used to objectively explain the phenomenon, which is the students' experience of community-based health promotion and illness prevention programme at a selected school of nursing in KwaZulu-Natal.

3.5 Research setting

The study was conducted in a School of Nursing and Public Health, at a higher education institution in KwaZulu-Natal. The school falls under the College of Health Sciences. The school offers various undergraduate programmes, such as a Diploma in Nursing that is offered in two semesters for full time students and three semesters for part-time students. A Bachelor of Nursing, advanced practice, that is offered on a three years basis for full time students and not less than ten semesters for part- time students and a Bachelor of Nursing, offered on a four year basis for full time students. The selection of the setting was determined by the availability of the second year cohort of the Bachelor of Nursing undergraduate degree, who were exposed to community-based health promotion and illness prevention programme. They provided the information related to the study.

3.6 Population

A population refers to the entire group of people, events or things of interest, that the researcher wishes to investigate and is sometimes referred to as the target population (Polit and Beck, 2013). According to Brink et al. (2012), descriptive designs are concerned with gathering information from a representative sample of the population. Joubert and Ehrlich (2010), claim that, when conducting a study, it is important to clearly define the group or target population about which the researcher wants to gather information and draw conclusions. The population for this study was composed of the 70 registered nursing students at the second year level of the Bachelor of Nursing programme at a selected school of nursing.

3.7 Sampling and sample size

According to Polit and Beck (2013), sampling is defined as the process of selecting a portion of the population, which is sufficient to represent the entire population, so that inferences about the population can be made. In a qualitative study, the sampling strategy is aimed to enable the researcher to get a deeper understanding of the phenomenon being studied. In this study, a non-probability purposive sampling method was used to recruit the participants.

Burns and Grove (2011), explain purposive sampling as selecting participants that have deep experience of the phenomenon under study. Thus, non-probability purposive sampling was used

to select those participants with knowledge of community-based health promotion and illness prevention programmes, and participants selected had a recent experience of at least 6 months in these programmes. The researcher was supported by the facilitators from the selected school of nursing to recruit the participants.

Researchers advise a sample size of six to ten for a focus group discussion (De Vos, Strydom, Fouché and Delpont, 2011; Den Oudsten, Lucas-Carrasco, Green and Whoqol-Dis Group, 2011; Howard, Hubelbank and Moore, 1989). For this study, three focus groups were conducted and each group had six second-year nursing students. Participants in each focus group were from three different communities of practice (two per each community of practice).

Authors on qualitative studies, in general, recommend from two to five groups per category of participants. With a homogenous groups, it takes more than one focus group on any one topic to produce valid results – usually three or four. The researcher usually knows they have conducted enough groups (with the same set of questions) when they are not hearing anything new anymore, that is, have reached a point of saturation (Carlsen and Glenton, 2011). In the current study, data collection continued until, after three focus group discussion, as no new data was uncovered, as in qualitative research sample size is determined by data saturation, whereby new data does not contribute to the development of new themes or categories as pointed out by different authors (Polit and Beck, 2012; Hancock, Ockleford and Windridge, 2009).

3.7.1 Inclusion criteria

According to Polit and Beck (2010), these are the criteria that specify population characteristics and they are referred to as inclusion criteria. The following criteria were considered by the researcher:

- All second year nursing students registered in an undergraduate nursing program for the 2015 academic year
- Those who had experienced community-based health promotion and illness prevention programmes for at least a period of 6 months
- Those who showed a willingness to participate in this study

3.7.2 Exclusion criteria

- Students not registered in the health promotion and illness prevention module.

3.8 Research instrument

A focus group discussion guide was developed, related to the research objective. The guide was submitted to the supervisor and co-supervisor who are expert in qualitative studies for validation of the instrument (Annexure3).

3.9 Process of data collection

In this study, after getting the permission to conduct the study (Appendix 6) and the ethical approval (Appendix 7), the co-ordinator of the Bachelor of Nursing Programme was contacted to obtain permission to recruit the participants. Then the lecturers were contacted to arrange a suitable timetable to avoid disturbing the class and permission was requested to speak to their students. After obtaining permission, participants met in a neutral, silent, private and relaxing space as recommended for focus group discussions (Gagnon, Jacob and McCabe, 2014; Liamputtong, 2011).

In this study, the nursing discipline boardroom was supposed to be used but because of exam preparation time, participants were met at their living place. Thus, nursing students were approached at their university residence, the Florence Powell Residence where they were accommodated. The Residence Assistant was contacted and the TV room of the residence was requested as the venue for the focus group discussions. Since students were preparing for their examinations this was the most appropriate venue because it was accessible to the students and the researcher. In the interest of the research, the participants suggested the dates and times which were convenient for them.

Then, the researcher explained the purpose of the study and their rights such as anonymity, confidentiality, being able to withdraw from the study without any consequence. The participants were given the opportunity to ask questions related to the study. Thereafter, participants' permission to record the focus groups discussion was requested and they were invited to participate in the study.

Those who accepted were given a written informed consent form to sign (Appendix 2). It was also explained to the participants that each focus group discussion would take about forty five to sixty minutes. A focus group interview guide was used for facilitating the discussion and clarification

was given to participants where there was a need (Appendix 3). The focus group discussions were recorded with the permission of the participants. Thus, participants were committed to participate and share their experiences. During the Focus Group discussions, the researcher facilitated the process and was supported by a note –taker. In this study, the note –taker took precise notes and paid attention to the non-verbal language of the participants, which the researcher has missed out when conducting focus group discussions (Burns and Grove, 2010).

During the focus group session, the following subjects were discussed in regard to students' experiences during community-based health promotion and illness prevention programmes. The first section explored participants' personal experiences and views during these programmes. Secondly the discussion focused on the activities students participated in and thirdly the group discussed the perceived benefits, advantages and challenges encountered during their involvement. Focus group discussion continued until saturation occurred, meaning no new information was forthcoming. At the end of each focus group session, gratitude was expressed to the participants for sharing the information which was very interesting and informative.

During the Focus group discussion sessions, the researcher encouraged participants to tell their story and occasionally used probes according to the interview guide as recommended by (Burns and Grove, 2016). The literature indicates that while using interview guides during data collection, the interviewer is free to probe the interviewee to elaborate on an original response (Hancock et al., 2009). Charles, Moebus, Beechinor, Pearce and Putney (2014) and Ryan, Coughlan and Cronin (2007) say that in qualitative interviews, as a result of probing, participants may discuss personal information that they had not planned to reveal. In the current study, probing allowed the research to collect more information regarding the nursing students' experiences in community based health promotion and illness prevention programmes. Important information related to all the processes of data collection were recorded.

3.10 Data analysis

This study used content deductive analysis by which themes and sub-themes emerged from the data collected (Elo and Kyngäs, 2008). The content analysis procedure started by preparation of the data, followed by a development of the themes and sub-themes and ended up with recording the findings in a report.

Step 1: Preparation of the Data: The audio recorded focus group discussions were transcribed by the researcher using verbatim transcription. . The researcher read and re-read the transcripts line by line to achieve data immersion and deeper understanding of the data collected. An independent co-coder who was familiar with qualitative research, assisted in the data coding and analysis procedures.

Step 2: Developing themes and a Coding Scheme: The topics were condensed, coded and written next to a suitable section of the text. There was also constant checking for new ideas. Codes were assigned to comparable topics, and the keywords for the topic were turned into sub-themes. Linked topics were clustered together and these illustrated inter-relationships. The researcher identified persistent words, phrases and sub-themes and grouped these into themes. Initial analysis focused on each theme by assembling them in one document. Then, themes were grouped together and separated from each focus group discussion. Thus, the researcher rearranged data through comparing and contrasting the pertinent information (Elo and Kyngäs, 2008).

Step 3: Reporting phase: This phase focused on the analysis process and the findings which described the significance of the themes (Elo and Kyngäs, 2008). Once the final report is submitted, the recorded documents are stored by the researcher's supervisor according to the university policy. The data saved on the researcher's computer will be deleted and the recycle bin emptied (Burns and Grove, 2010).

3.11 Academic rigour for qualitative data

Trustworthiness ensures the quality of the findings and enhances the readers' confidence in the results (Elo, Kääriäinen, Kanste, Pölkki, Utriainen and Kyngäs, 2014). Thus, there should be rational links along with a range of steps in the research progression, since analysis and rationalisation is the purpose throughout the study. There are four components of the trustworthiness: credibility, transferability, dependability and conformability.

Credibility relates to an accurate picture of the information and how the research findings harmonise with reality (Shenton, 2004). In this study, during the discussion, the information was tape-recorded and the researcher took notes to ensure that all relevant information was captured

correctly. The researcher constantly checked the data and asked the external moderator to validate the correctness of the data and the data analysis.

Transferability: Transferability in qualitative research relates to the concept of external validity in quantitative research (Finlay, 2006). Thus, it refers to the extent to which the findings of one study can be transferred to another situation or applied in another place or group (De Vos et al., 2011; Shenton, 2004). To determine transferability, the original context of the research must be described sufficiently so that judgements can be made. It is, therefore, the responsibility of the researcher to provide extensive descriptions, enabling the reader to make informed decisions about the transferability of the findings to their specific contexts (De Vos et al., 2011). The researcher provided extensive descriptions on every phase of the research process, from the research question to the data coding and interpretation processes, thereby enabling the readers to assess the transferability of the study.

Dependability: According to Bitsch (2005), dependability connotes the constancy of data over time. Therefore, in order to determine the dependability of the data collected the correctness and reliability of the data is imperative. Thus, the method used for data collection and analysis in this study was validated by the researcher, the external moderator and the supervisors. The audit of the process was also crucial to ensure dependability (Brink et al., 2012). Focus group discussion was conducted based on the focus group discussion guide; recorded information was transcribed and verified by the researcher. All these procedures were constantly checked by the supervisors of the study.

Conformability refers to the degree to which the findings are supported by the data. Thus, the researcher at the end of each focus group gave a summary and then replayed the audio recordings, so that the participants could listen and confirm if the information was well captured, or if there was any clarification required. Furthermore, after the transcription, the researcher requested the participants to verify their words against the written texts (Brink, Van der Walt and Van Rensburg, 2006).

3.12 Ethical considerations

Ethical framework for research in developing countries must provide more than broad principles (Emanuel, Wendler, Killen and Grady, 2004). Additionally, Emanuel et al. (2004), argue that an ethical framework for multinational research should minimise the possibilities of exploitation. Research ethics is referred to as a system of moral values that are concerned with the degree to which research procedures adhere to the professional, legal and sociological obligations of the study participants (Polit and Beck, 2004).

Ethical considerations in relation to the protection of the human rights were adhered to in this study. Brink et al. (2012), state that essential ethical values, such as respect for persons, beneficence and justice should guide the researcher throughout the study research process. Ethical clearance was sought from the University of KwaZulu-Natal Research and Ethics Committee. The researcher also applied for permission from the Registrar to submit the proposal to the Ethics Committee and permission from the Head of the Discipline (Nursing) to conduct this study. These letters of permission are attached to the dissertation. The research study started once it had been approved by the ethical committee and permission provided from a selected research setting. The researcher adhered to all ethical considerations throughout the study.

Informed consent and information sheets which included detailed information about the study were distributed to the participants. The researcher guaranteed that the participants understood the contents of the information sheet and gave them time for questions. Furthermore, students were informed that participation in the study was voluntary and that they had the right to participate or to refuse without fear of any negative consequences. Participants were also told that they had the right to withdraw at any time if they felt uncomfortable, also without fear of negative consequences. The anonymity of the participants was guaranteed as no name or anything that would identify them would be mentioned in this study. In addition, the researcher ensured that no personal information is shared with anyone outside the research project, and during the publication, no personal information connecting the participants with the data collected would be mentioned, thus the principle of confidentiality was respected. Thus, participants have the right to voluntarily decide whether or not to participate in the study and are able to do so without any risk of penalty

or prejudicial treatment. The principle of respect was adhered to. The principle of beneficence ensures that the wellbeing of the respondents is maintained.

The researcher confirmed that no discomfort or inconvenience would occur during the data collection process. Students were informed that they could withdraw at any time from the study if they felt uncomfortable about it. Thereafter, those who agreed to participate were asked to sign and return the informed consent as well as the information sheet. Furthermore, the participants were assured that no sensitive information would be divulged during the publication of the study results. Also, the name of the institution would not be used in any publication that may arise from this research as recommended by Brink et al. (2012).

3.13 Data management

The data are stored by the researcher on a software with a password known only to the researcher and the supervisor to ensure the confidentiality of the stored information. The hard copy is kept in a secure place with a key locker, which is only available to the researcher, and on request accessible to the supervisor. At the end of this study, the final data were communicated to the supervisor as well as to the Head of the selected school of nursing. In adherence to the school policy on the data management of research, primary data will be collected, recorded and stored for a period of 5 years and under certain circumstances be made available for review. The report of the findings was submitted to the selected School of Nursing and Public Health, Faculty of Health Sciences and to the University Library.

3.14 Data dissemination

The researcher will submit one hard copy thesis to the selected school of nursing and send two copies to the library of the same school. A date will be arranged for feedback to the respondents. Findings will be published in an accredited academic journal.

3.15 Conclusion

This chapter covers the methodology. This includes: the research paradigm; the research approach and design; the study population; the sampling and a sample of the study; the research instrument; the process of data collection, the data analysis, the qualitative academic data, the ethical considerations for the study, and the data management and dissemination. The next chapter covers the findings of this study.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

4.1 Introduction

This chapter presents the findings of this study which used a descriptive exploratory qualitative research approach aimed at exploring the nursing students' experiences of community-based health promotion and illness prevention programmes. Thus the researcher, using an exploratory approach, explored nursing students' experience by compilation of narrative information from participants, in an in-depth and holistic manner (Polit and Beck, 2013). The goal of the analysis was to describe qualitative patterns in terms of themes developed from the data.

To reiterate the research objective was :To explore nursing students' experiences in a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

The findings from this study came from three focus group discussions (FGDs) which were held with nursing students who participated in the community-based health promotion and illness prevention programme (CBHP&IPP). Each FGD comprised of six second year nursing students and lasted approximately an hour. The FGDs were guided by the following main questions:

- What were your experiences when you were involved in the community-based health promotion and illness prevention programme?
- What are some of the activities you carried out during the community-based health promotion and illness prevention?
- What have been the challenges you experienced during your exposure to the community-based health promotion and illness prevention programme?

In this study, based on the responses from the participants, a number of probing questions were asked in order to acquire more information about the phenomenon under investigation. This study used conventional qualitative content analysis whereby coding categories were derived directly from raw data; themes emerged from the data collected (Elo and Kyngäs, 2008). The purpose of

the content analysis was to classify, summarise and tabulate data. The aim of the content analysis was to categorise verbal data for classification, summarisation and tabulation. No meaning was directly derived from data analysis. Deductive content analysis was used.

According to Kyngas and Vanhanen (1999) cited in Elo and Kyngäs (2008), deductive content analysis is used when the structure of analysis is operationalised on the basis of previous knowledge. The process starts by analysing the transcripts from the participants, line by line from which a number of codes emerge. Later, those codes are grouped into sub-themes. The sub-themes are then grouped to produce larger categories (Themes). Content was organised and presented in a tabular form, and thereafter the results were interpreted. A total number of 18 nursing students were involved in this study.

4.2. Social demographic data

The socio-demographic data included the gender, age and race of the participants. The second year nursing students who participated in this study were predominantly female. Among the 18 participants, 16 were female, and two were male and their ages ranged between 18 and 23 years old. In terms of ethnic distribution, 14 of the respondents were Black South African, two Indian, one Coloured, and one White.

Table 4-1 Socio-demographic data

Focus group discussion one		
Gender	Females	6
	Males	0
Age group	18 -20	4
	21-23	2
Race	Black South African	6
	Coloured	0
	Indian	0
	White	0
Sub- Total		6
Focus group discussion two		
Gender	Females	5
	Males	1
Age group	18 -20	5
	21-23	1
Race	Black South African	6
	Coloured	0
	Indian	0
	White	0
Sub-Total		6
Focus group discussion three		
Gender	Females	5
	Males	1
Age group	18 -20	4
	21-23	2
Race	Black South African	2
	Coloured	1
	Indian	2
	White	1
Sub-total		6
Overall total		18

4.3 Overview of emerging themes

Four themes emerged from the focus group discussions. These themes are: (1) *Community accessibility*; (2) *support for nursing students*; (3) *safety in the community* (4) *skills development*.

Table 4-2: Themes emerging from the study

Themes	Sub-themes	Codes
Community accessibility	Geographical access of the communities	Walk long distances Fatigue
	Expensive cost of transportation to the community of practice	No transport offered by the school Self-funded transportation
	Access to community resources	Easy access of information Establishment of a relationship of trust with the community
Safety of environment	Safety instructions	Working, and walking in groups Avoidance of the designated dangerous areas Communicating their movement in community
	Safety uncertainties	Fear of crimes Unsafe working environment
Learner support	Support from the community	Hospitality from the community members Willingness to assist
	Support from the discipline	Allocation of the clinical facilitator in the community Facilitator support Guidance and supervision

Themes	Sub-themes	Codes
	Financial challenges for community Intervention programmes	Availability of funds Helplessness
Skills development	Team work	Peer learning Professional growth Group dynamics issues
	Community engagement	Collaboration with community members Detection of community health problems Responsiveness to community problems Integration of theory into practice Participation in community-based activities Community improvement following the intervention
	Enhanced practical facilitation	Effective community accompaniment Variations of the community of practice

The following section provide an in-depth discussion of each theme and sub-theme highlighting the nursing students' experiences and the challenges which they outlined.

4.3.1 Theme 1: community accessibility

Participants described their experiences of the accessibility of the community to nursing students. Points raised included geographical access to the communities, the cost of transportation to the community practice and the accessibility of community resources.

4.3.1.1 Sub-theme: Geographical access to the communities

The findings of this study revealed that geographical access to the communities was limited by the remoteness of the community.

Walking long distances: In this study participants reported that some communities were geographically inaccessible for them as they were far away from their residences. Participants had to make a long and difficult journey on foot to get to the community centres. The following statements represent some of the participants' experiences:

"...We had to walk long distances to reach the community..." (FGD1).

"...my first encounter, the community was very far, we walked, walked... so long distance. It was not funny at all, we really suffered because of that, you cannot imagine..." (FGD2).

"...What we can say, we use to walk long distance. So long; the community setting was very far.... Yeah, not good experience. We were so discouraged about it, so tired..." (FGD3).

4.3.1.2 Sub-theme: Transport cost

Transport to the community of practice was viewed by the participants as a challenge to the effective progress of practical training. It emerged that no transport was offered to the participants by the school and they had to self-sponsor themselves in order to get to the community of practice.

No transport offered by the school: The findings of this study revealed that students faced a transportation problem because transport arrangements were not provided by the school. Participants reported that it was not easy for them to reach the community setting. This is evident in the following statements:

"...It was difficult to get to the community; some people could not make it because there was no transport..." (FGD3).

"...We were not provided with transport and it was hard to get to the community..." (FGD1).

"...Transport was the main issue, we were never provided the transport.... there was no person that has a transport from the university..." (FGD2).

Self-funded transport: The participants experienced a number of logistical problems including lack of transport to the community settings. The participants had to self-fund for transport due to delays in transport arrangements taking them to these communities. As a result, some of the participants did not visit the communities as scheduled because they could not afford the transportation fees. This was evident in the following excerpts:

“...Also for transport it was R50 a day. Two taxis are very expensive in a way. R50 a day for 7 days imagine, and we had to go there for two weeks, sometimes for three weeks and we also had to prepare lunch...in terms of cost it was very costly for us...” (FGD1).

“...we used our own money to go to the community....so some of us we have to skip some days because we couldn't afford to go there every day due to the money issues...” (FGD2).

“...We had to found out our own way to get to the place, yes, so expensive because the duration was long...” (FGD3)

4.3.1.3 Sub-theme: Accessibility of community resources

In the sub-theme of access to community resources, two main experiences emerged: (i) easy access of information; (ii) establishment of a relationship of trust.

Easy access of information: Participants reported that it was easy in some of the communities for members to willingly share information relevant to the programme. The participants shared their experiences of access to information and other community resources while in the community. Some of the participants related their experiences as follows:

“...we went to the police ...they were welcoming and in terms of asking for direction, they were directing us where to go. So they gave us all the information we needed...” (FGD1).

“...First of all the first day we did the community entry where we worked around the community, looking, assessing the environment, housing, and asking questions... all the staff were very kind to us and communicate easily with us...” (FGD2).

“...At the community, in our first day, it was just community entry, we went there, we went to the counsellor and the counsellor welcomed us...he was ready to communicate with us and so were others like the clinics managers, staff members, principal of the school and some teachers ... yes, all of them communicated well...” (FGD3).

Establishment of a relationship of trust in the community: In this study, participants reported that in some communities it took a long of time to establish a relationship of trust that enabled members of the community to share relevant information with the participants. This is evident in the following participants ’comments:

“...It was very difficult to be able to communicate with everyone...they saw us and they felt very intimidated...you could spend more than a week but could not get any relevant information from them, only when they started getting to know us and see us coming every day to the community, they started opening up and talking to us...” (FGD3)

“...People in the community were not the same like before we entered in the community ...after a certain time, they started to communicate with us, trusting us, and they were more opened in terms of communication...” (FGD2).

“...In my community, it was very difficult to communicate with everyone because they look like people from outside who did not understand the situation and the area they live in; 30 per cent of them are not originally from South Africa...” (FGD3).

4.3.2 Theme 2: safety of environment

Participants described their experiences in terms of safety in the community environment. Participants received some safety instructions and described their experiences of safety

uncertainties. These safety instructions and safety uncertainties formed the sub-themes of this theme.

4.3.2.1 Sub-theme: Safety instructions

The findings from this study indicated that safety issues in the community were addressed by providing effective instructions to the participants. Participants were instructed to work, and walk in groups; to respect forbidden dangerous zones and to comply with provided instructions. This is evident in the following participants' remarks:

"...For our safety, the supervisors recommended us to move around in the community in groups of at least two and make sure that our group members always know where we should be and when they may expect us back..." (FGD2).

"...We went to the police station where they told us about the boundaries of the area which are very dangerous....they told us that when we want to go to that place we have to tell them so that they have to accompany us to those areas..." (FGD1).

4.3.2.2 Sub-theme: Safety uncertainties

In this study safety uncertainties was experienced by participants. This was reflected in fear of criminal activity in an unsafe working environment.

Fear of crimes: Participants described how they were afraid for their lives since they had to walk along lonely roads to get to the community centres. They reported that they were informed of some concerns regarding safety in some communities which had a high population of homeless people and substance users. As a result, participants were advised to request that they be escorted by police into the communities. However, the police station did not have an adequate number of staff to cater for that and so they had to do away with the needed escort. Participants resorted to walking in groups so as to feel safe. This is evident in the following statements by some of the participants:

"...In our community they were crimes so I fear a lot to go around...Also the home visits were much tensed, because of risk, we were very scared. We could not know

what to expect when you go alone. So some opted to go to the clinic or they just asked another group to go with them so they know that they were safe...” (FGD1).

“...In the community; the teenagers were using drugs; so we were like afraid. If they have been using drugs what can we expect them to do to us?...” (FGD1).

“...One day I had an experience, when we were working around the community, one young boy sprayed water on me but I have no idea why....hey....and the all his friends laughed about it....It was not that much of the shock because we were told about that community. But I was scared; I couldn't go there again alone...” (FGD2).

Unsafe working environment: Participants indicated that they did not feel safe while working in some communities and were in fear of being robbed. Participants reported that they were limited in their movement within the community since there were some restricted places where it was not safe to go. Further restrictions were experienced due to vandalism, violence and other threatening activities as revealed in the following excerpts:

“...The community that we went in was not safe. Yeah, not safe. There were street kids and homeless people in the street. When we worked there, we had to carry our bags tightly because you never know what can happen. They can even steal your phone...” (FGD 1).

“...Firstly we were scared; the area was unsafe because there was a lot of vandalism, violence, something like that. So when we went there we were scared.... most of the community members told us that it is unsafe here there is vandalism, while we should take care of our cell phones because they may take them. They could even steal our stuff. Not safe at all...” (FGD2).

“...We were restricted, we should go that side, not that side because it was not safe, there were places we couldn't go because it was not safe, and there was a risk of being attacked...” (FGD3).

4.3.3 Theme 3: learner support

This theme relates to the support that the participants received from both the community as well as from the discipline of nursing. Financial challenges are also considered.

4.3.3.1 Sub-theme: Support from the discipline

Participants in this study experienced support from the supervisor insofar as the supervisors were present during the community entry and gave them timely feedback. However, insufficient guidance and supervision were also experienced in one of the community setting. Participants also reported experiencing a lack of financial support from the school for transportation.

Allocation of a clinical facilitator in the community: Emerging data from this study indicated that the school ensured that nursing students were properly supervised through allocating facilitators in each community setting. The participants experienced support from some facilitators, as they were together during the community entry. This was echoed in the following statements:

“... We had also our facilitator to introduce us to the community, we went with them to the authority to ask for the permission to enter in their community, we were happy to go with our facilitator to the police station so they know that we were around. It was so supportive...” (FGD2).

“... We were with our facilitator like the first day when we went to the community ... it was so nice to be with them, they went with us for the first contact with community members, the clinic staff and to the school where we did our intervention...” (FGD3).

“... The supervisors were there, they do introduce us to the community and show us what we need to do, which place we can go to, I thing that was enough for us because we couldn't on our own do it and we just needed some helping hand to show us and how to do everything...” (FGD1).

Facilitator support: The participants also mentioned that at school, the facilitators were always ready to assist them as well as to give feedback regarding their school assessments such as

assignments. Participants reported that they shared the information collected from the community with their facilitators, and collaboratively analysed the collected data as well identifying the main issues. Facilitators also guided them during the implementation and evaluation of interventions. Furthermore, the facilitators assisted the students to write and finalize the report related to community activities. The reassuring presence of the facilitator helped them to continue despite the obstacles they faced. This is evident in the excerpts from the following participants:

“...So it was enough support that we got from the institution because when we come back, like for example we went to our facilitator, showing them what we have got, and the information and how we went about doing and writing it and put it together and they were very helpful throughout the entire year...” (FGD3).

“...The school was very supportive because we went every time to see the supervisors when we need them and they will never send you back without assisting you...” (FGD3).

“...Our facilitators were supportive in the fact that they were giving us the feedback for our assignments and also they were helping us when we needed recommendations letter for the sponsorship for our interventions...” (FGD2).

Guidance and supervision: Participants reported that sometimes they were on their own without a facilitator to supervise and to guide them. This was perceived as problematic because the supervision was not consistent in fostering cooperation among the group members. Participants also reported that there was no consistency in the allocation of facilitators, which also resulted in poor supervision. This is reflected in the following extracts:

“...We faced a really difficult time without a facilitator; we disagreed a lot during our interventions, because one will come with a point and we would not agree with the point, and so we would disagree. We did not have a facilitator; we had to ask other groups; other facilitators and the fourth year students...” (FGD1).

“...limited guidance, the supervisor was not there all the time and it was so hard being there without his help...” (FGD2).

“...In our intervention, we were limited....with limited suggestions or direction we could not do much...” (FGD3).

4.3.3.2 Sub-theme: Support from the community

The participants from this study reported that they received support and hospitality from those community members who showed a willingness to participate in the community programme.

Hospitality from the community members: Participants indicated that the communities were welcoming and supportive. Such support gave them a sense of satisfaction while working within the community. This is highlighted in the following statements:

“...When we got to the community, everyone was so welcoming...very supportive. It was nice to get the feedback and responses ... they participated in everything we did...” (FGD3).

“...People were friendly even if thought there was crime but most of time they were friendly and welcoming... so supportive...” (FGD2).

Willingness to assist: The findings of this study revealed that the community members were willing to assist the participants. Participants reported that the community members participated in the programme either physically or financially. Some community members funded the intervention, while others participated actively in some of the activities such as painting and cleaning toilets. Furthermore, the participant reported that the community members cooperated during family assessment. This is evident in the following participants' statements:

“...They were students in the secondary school who were so supportive, they helped us in cleaning the toilet and the other students went to look for help outside from their family who were helping us to clean the toilet...” (FGD2).

“...We got some people to sponsor, to assist in painting the toilets, we got a sponsorship in printing posters, as well as sound equipment for the day, and even meals for the day were sponsored...” (FGD3).

“...For the family assessment, they allowed us to investigate with their babies when we were doing family assessment...” (FGD2).

4.3.3.3 Sub-theme: Financial challenges for community intervention programmes

In the sub-theme of financial challenges for community intervention programmes, two main dimensions emerged: insufficiency of funds and helplessness.

Insufficient of funds: The findings of this study revealed that the financial cost of community practice was a challenge to those participants who had no funding for the awareness programme and who encountered costs that they had not planned for. Participants felt that this challenge had hampered their interventions in the community setting because they did not complete all the planned interventions. Participants declared:

“...Our intervention was a challenge because the students used their own money in order to do the intervention...” (FGD2).

“...The intervention was hard because we had to take money from our own pockets...” (FGD1).

“...Before the intervention we had problems with money because you cannot do an intervention without money and we tried getting support but there was none so we had to turn on our own pocket which was not deep enough. So we did not do what we wanted, the entire package that we wanted. We just went and did limited things...” (FGD3).

Helplessness: Participants in this study reported feeling helpless because they could not do anything much to change the situation. During the intervention, some of the community members revealed that they had financial problems among other problems. They expected the participants to help them overcome these problems either by doing something or referring them to the authorities for help. In other cases, homeless people requested money to pay for their accommodation at the shelters. Data from the three focus group discussions reveal that participants were frustrated by these community expectations. This is highlighted in the following statements:

“...during the intervention we had to take out money from our pockets to do the intervention and that was a large sum of money paid. Some had to pay R300. Remember we were doing it for the mark, so we cannot just say no we don't have money, so we have to look for that money...” (FGD1).

“...In my community the challenge of money arose because the area has a lot of homeless people. Some of the streets kids were asking for money from us to just go and pay for the shelters they are in...some community members thought we were going to help them with something or we will take their case to somewhere else to get help but we couldn't do nothing...” (FGD2).

“...The people are very much underprivileged in terms of maybe standard of living. The community has a lot of homeless people living in the streetsIt was difficult to perform some interventions with them especially when there was need of money, it was beyond our control...” (FGD3).

4.3.4 Skills development

The findings revealed that the community-based health promotion and illness prevention programme was beneficial in many ways. This section emphasizes how the participants thought the programme was beneficial. By doing so, it highlights how students benefited from community engagement, from working with each other in a team as well as offering an example of how to enhance practical facilitation.

4.3.4.1 Sub-theme: Team work

The findings of this study revealed that team work was experienced through peer learning and professional growth. However, participants reported group dynamic issues during their work in teams.

Peer learning: It emerged from this study that one of the experiences emphasized by the participants was being able to meet, interact and work with their fellow students. This gave them an opportunity to get to know each other since they did not know each other before the programme.

Participants reported that while working in team they were able to consider other opinions and to understand others as well. Furthermore, participants expressed the opinion that working together enhanced research capability and critical thinking. Thus, they accomplished a lot of activities which may not have been possible without team work. For example, some of the participants had the following to say:

“...We learnt to gather alone information and at the end to combine a community profile in team. We benefited on how to make the profile as a group and how to research and to think critically ... I got a chance to interact with my group mates and know a lot about them and to understand each other...” (FGD2).

“...The good thing with group work is that you get ideas from everyone. So if you have a perception of a specific thing in the community, your perception comes at a point that someone else perception can change your mind or can enable you to see it in different way...” (FGD3).

“...Academically, in my community, I was the group leader, so I learned a few skills in terms of working in team and equipping myself for the future and also how to go in terms of planning, getting the people to work together...” (FGD1).

Professional growth: The participants in this study reported that experiencing a team work environment enabled them to develop leadership, management, academic and fundraising skills. Furthermore, findings revealed that the participants learned certain skills such as team work, doing research, critical thinking, planning, organising and profiling. For instance, a participant indicated as one of the positive experiences that they learned how to work as a team with fellow students. This is highlighted in the following narratives:

“...Working with colleagues makes us grow as well because we had to be assertive and able to control what was happening...as a group leader I gain some skills such as leadership, management skills and academic writing because I had to edit a lot, we have to edit and read over and over again, referencing and all of that...” (FGD3).

“...During our intervention to stress the issue of hygiene, we just collected money within our group members and we bought teeth brush, combs and other things for more than 200 students in the school. Yes, we did like a fundraising between us...” (FGD2).

“...They are several skills that we learned by working with others and taking in account everybody attitude, opinions. So we do learn from each other in team and we learned how to plan, to organize together...” (FGD3).

Group dynamic issues: Findings from this study revealed that some of the participants were not enthusiastic about working with others, which disturbed team work and communication, especially when some individuals were obliged to accomplish all the work, while others were less involved. Bringing everyone to work together was not easy, even for the group leaders. These difficulties are evident in the following narratives:

“...In terms of working in groups, some members were not willing to work, some were willing. We also have a problem of communicating with each other. So we were not all willing to work...” (FGD1).

“...Sometimes working with others was hard; .there was unbalance in terms of the work that has to be done as a group. People sometimes want others to do everything for them...” (FGD2).

“...I was the group leader and it was difficult to work with everyone, trying to put all things together, even if we all knew that we had to reach a common goal but my colleagues could flip their attention to something else and forget about what we are doing at the end, so it was very difficult...” (FGD3).

4.3.4.2 Sub-theme: Community engagement

It emerged from this study that through community engagement, students acquired the following competences in terms of collaboration with community members: detection/ identification of community health problems; responsiveness to community problems; the integration of theory into

practice; participation in community-based activities and community improvement following the intervention.

Collaboration with community members: The finding from this study demonstrated that community practices promoted collaboration with community members. This is achieved through students' exposure to the community environment and collaborative learning with members of the community. It emerged from this study that students acquired competences in terms of communication, particularly with new people, and with various health needs. This is evident in the following statements:

“...I got a chance to meet new people in the community, learn about their problems and try to help them. I learned to speak to people on HIV and AIDS and I did it very well...” (FGD2).

“...The community was welcoming....one day there was a subscription for people who do not have food. So we helped, we were happy to help people...” (FGD1).

“...It taught us how to speak to people.... What I liked is that I learned not to judge, that you have actually to understand the place before placing judgment on that place because what I thought did not actually become the reality...” (FGD1).

Detection /Identification of community health problems: It emerged from this study that nursing students, identified a number of community problems. This was achieved through a joint collaborative effort with the community members. Participants demonstrated skills in problem identification and prioritization through community engagement. This helped the students to prioritize the problems identified by the communities themselves rather than impose their own perceived problems as outsiders. Further, participants emphasized that they gained insight into the underlying causes of community problems and learned that nursing practice should not focus only on providing care at the workplace, but that the nurse should expand his/her imagination to the extent of identifying the probable cause of an occurrence of any disease. This will enable timely interventions and prevent the consequences. The following extracts act as evidence of this:

“...having proper facilities, for example toilets, is a necessity, because you may find that those facilities were destroyed, people were doing their business where ever outside of the toilet something like that. So, it is very important to look at the need of the community, discuss and decide with them what is the most important for them...” (FGD3).

“...We have to go to the community in order to prevent, or decrease the number of people coming to the clinic or hospital. We have to start with the community like identifying together the main issue and doing the intervention...” (FGD1).

“...I learned that even though there was high rate of teenage pregnancy, it is not like all of them were looking for sex or for pleasure. They were from poor family so they needed sugar daddies to get money and boom! They became pregnant...” (FGD1).

Responsiveness to community problems: The findings from this study indicated that, participants took a number of approaches as a solution to the identified problems. Furthermore, the findings demonstrated that participants realized how some of the community members lived in poverty. It was also noted that participants developed a conceptual intuition in their field of study, resulting in empathy for, and changed attitudes towards, the community. This had a beneficial impact on their attitudes towards the underprivileged. This is highlighted in the following narratives:

“...We went to the crèche and the person in charge promise to take care of plantations. We went there, we did some planting, vegetable planting, we bought the seeds for them and then we did the planting...” (FGD3)

“...in the intervention, we talked about hygiene... hand washing and pollution because the area was polluted ...” (FGD2)

“...for teenage pregnancy, we, we did an intervention on condom use. We talked to them to control the problem by informing them on how to use condom and contraceptives; and about the consequences of teenage pregnancy...” (FGD1).

“...It was very shocking to see the way some people live. So it has just opened up a new light for us and made us appreciate the difficulties other people are going through...” (FGD3).

Integration of theory into practice: It emerged from this study that participants incorporated the acquired knowledge, attitudes, and skills into their practice while they were in the community. It was clear that the integration of theory into practice promoted clinical judgement and professional development. This is expressed in the following extracts:

“...We were very happy because we had to apply all our knowledge that we learned in class or all our theory into practice. And we were very happy that we could do that like health educate people, not just learning in class about teenage pregnancy or all that...” (FGD2)

“...It was good to put in practice the community assessment, it helped a lot and opened our mind in terms of reflection which is important even for the future. Yeah, we gained some knowledge in communication, planning...some skills...” (FGD1).

Participation in community-based activities: It emerged from this study that participants were involved in a number of community activities. Participants reported that they participated in the immunization programme. It was reported that participation in this programme helped the participants to gain knowledge and skills in the administration of vaccines and the immunization programme in general. This facilitated their understanding of the link between theory and practice in a real clinical setting. In addition, participants revealed that while conducting home visits and community assessment, they entered into discussions with community members and got opportunities to hear numerous voices from the community which allowed them to acquire knowledge and skills in analysing and planning health issues. The following comments reflect this community involvement:

“...Together with the community we discussed the main issue like teenage pregnancy, drug abuse and we felt that we learned a lot. We were able to reflect and to plan for the interventions...” (FGD2).

“...Being in clinic is totally different setting than in the hospital. We learned how to do child vaccination and after the practice we did it very well and we were able to connect what we learned at school in practice..... So we learned quite a lot...” (FGD3).

“...Yes, we discussed with people in the community to decide what issue to address and while we were discussing with others, we discovered that we were able to determine what to do and this was because of that, otherwise myself maybe I couldn't...” (FGD1).

Community improvement following the intervention: The findings of this study revealed that a positive experience of participating in the awareness programme was evident after working with the community. Participants observed a number of improvements and changes in the community since the first intervention. These changes included better hygiene, new gardens and better municipal services. Further, some of the participants highlighted improvements in healthcare access. For instance, teenagers were asking for contraceptives and condoms from the clinic while children who had missed immunisation had gone for their immunisation. This is revealed in the following narratives:

“...Also there was an improvement, like the municipality does provide the black big plastics for hygiene...” (FGD1).

“...We went back to the school for the evaluation and some of the kids, a lot of them remembered the points we talked about to them which was encouraging. We assumed that they have taken home some of the information that we presented to them...” (FGD3).

“...In September we went to the community, the sisters told us that there is a very big change, the teenagers came to the clinic asking for condoms, and others even wanted the contraceptives, like pills... in terms of the garden, we could see that it was growing because we brought seeds initially and now they were already planted...it was very good...” (FGD1).

4.3.4.3 Sub-theme: Enhanced practical facilitation

Participants in this study suggested that effective community accompaniment, and variations of the community of practice, were indispensable to the improvement of community clinical work.

Effective community accompaniment: It emerged from this study that some of the participants experienced insufficient clinical facilitation and recommended that this aspect of their work receive more attention. This was highlighted in the following statement:

“...For the supervision I think the school should improve the facilitation system..., yeah, this will help us a lot and their guidance will make our work more effective...”
(FGD2).

Variations of the community of practice: Participants in this study pointed out that the School of Nursing uses the same communities for the interventions year after year. This, according to the participants, is problematic as the same questions are asked year after year and the communities give the same responses. As a result, participants recommended that the School secures other communities to conduct the awareness programme. The following narrative reflects this criticism:

“...The community is used to having nursing students visiting there for years, asking the same questions and we end up bringing the same information to the school...it becomes the same community profile, you can even copy the last years’ community profile and make it your own because it is the same community. I will recommend that they find other communities where we would be doing this like for the first semester. Maybe changing the community can be a solution...” (FCD2).

4.4 Conclusion

This chapter dealt with the experiences of nursing students who participated in community-based health promotion and illness prevention programmes. The students’ general experiences were highlighted, providing context for their experiences of community accessibility and the safety of the environment as well as learner support and skills development. Chapter 5 will discuss the

findings using the existing literature. It will also provide the conclusion, an assessment of the study limitations and recommendations.

CHAPTER FIVE: DISCUSSION, CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a discussion of the study results presented in chapter four of this dissertation. The discussion will form the foundation for a discussion of the conclusions and their contextualisation with the relevant literature. The purpose of this study was to explore nursing students' experiences of community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal. This study was guided by the following research question: What are nursing students' experiences of community-based health promotion and illness prevention programmes?

This chapter discusses the implications of the themes that emerged from nursing students' experiences of these programmes. Lastly, conclusions are drawn, limitations to this study are stated, and relevant recommendations are made, based on the research findings. The students' experiences were explored during focus group discussions. The data from these focus groups were analysed using content analysis by which themes and sub-themes emerged from the data collected (Elo and Kyngäs, 2008).

The four main themes that arose from the data analysis were: (1) community accessibility; (2); safety of environment (3) learner support; (4) skills development. Each theme was elaborated through specific sub-themes disclosed by the data set. This facilitated a thorough insight into the experiences of the participants in the programme. Further extensive discussion on the experiences of the participants is presented in the next sections.

5.2. Socio-demographic characteristics of respondents

The findings of this study showed that the participants were mainly females, that is, 16 of the 18 participants, while there were two male participants. These demographics were representative of nursing demographics in South Africa. According to the South African Nursing Council (2007) cited in Hollup (2014), females remain the majority of all categories of student nurses. Nightingale (1969) cited in Loughrey (2008), asserts that nurses, through caring, were only doing what came

naturally to them as women and mothers. Nursing is considered as an expansion of women's household roles and nursing itself as a predominantly female profession from which men are largely excluded.

The findings are congruent with findings of a study conducted in United Kingdom by McLaughlin, Muldoon and Moutray (2010), where the majority of nursing students who were studying a four year nursing programme were females. According to the above authors, men tend to avoid careers such as nursing due to their stereotypical association with women. Similarly, the (US Department of Health and Human Services), notes that even though the number of male nurses has doubled over the last thirty years ago, not more than five to seven per cent of the total nursing population is male. Contrary to Nightingale's assumption, Codier and MacNaughton (2012), assert that both male and female nurses should have the same opportunities in the nursing profession. However, they should be aware of its caring nature which should be an instinctive talent to both genders.

The current study revealed that the minimum age of respondents was eighteen, and the maximum twenty-three. Similarly a study conducted by Codier and Odell (2014), showed that most of the nursing students in their second year of a Bachelor degree were between eighteen and twenty five years old. This may be based on the fact that nursing students generally joined the bachelor programme as soon as they completed the secondary programme and this reflects the conventional age of students attending university to obtain a bachelor's degree. Thus, it is clear that many participants are still teenagers and may feel insecure when they are left alone or when they are asked to take care of themselves and to be responsible for their own transport. Furthermore, requesting them to solve community issues may be too overwhelming an experience.

Although South Africa is a multi-ethnic society, 79.5 per cent of its population consists of black South Africans. The majority of the students who participated in this study were black South Africans, which is in line with the demographics of the South African population and the population of nursing students in general. Similarly a study conducted by de Villiers, Mayers and Khalil (2014), on nursing students' perceptions and experiences of violence at school at the University of Cape Town in South Africa, revealed that the majority of the participants were black South Africans (52.41 per cent) while mixed race comprised 46.9 per cent, Indian 0.17 per cent and White 0.51 per cent.

5.3 Student experiences

The discussion of the student nurses' experiences is guided by the four main themes that emerged from the community-based health promotion and illness prevention programme: (1) community accessibility; (2) safety of environment; (3) learner support; (4) skills development.

5.3.1 Community accessibility

In this study access to the community emerged as a theme describing the nursing students' experiences in relation to their geographical access to the community, the expensive cost of transportation to the community practice and the geographical remoteness of the communities. The main finding in this theme was that students experienced difficulty walking long distances to communities far from the universities. This finding is in line with the findings of a study by Naidu et al. (2012), which aimed to evaluate community placements as a learning experience from the perspectives of the students and community stakeholders. It was found that participants did not appreciate walking long distances during the community health promotion interventions period. They argued that walking long distances impacted negatively on their performance and often resulted in extreme fatigue and absence of students during the planned period. Similarly, in a study conducted by Ndateba (2013), it was found that the students also faced transportation challenges. This finding was, however surprising, since most communities are in the range of ten kilometres or less from the university. It must be assumed that there was a lack of transport at that time which led to students using their own money. These findings are consistent with Kaye et al. (2011a), who noted that transport within and to the community settings was a problem. Students were not provided with any transportation by the school, thus they were using their money or money from their family members. Consequently, students' activities were limited as they were going into communities near their home locations which might have enriched their experiences. Similarly, Kaye et al. (2011a), state that nursing students were constrained to reduce their community placement duration because the school did not organise transport to the community of practice, and students were supposed to deal with the problem in their own way. Mariam et al. (2014), argued that lack of transport and finance distract students from contributing effectively to the practice of health promotion and illness prevention in the community. Thus, for instance, students could not cover the outreach planned in all sites because of limited funds for transportation. Codier

and MacNaughton (2012), also noted that insufficient or even complete lack of transport has been reported as a major limitation on student access to the community setting. However, in contrast to these findings Visovsky, McGhee, Jordan, Dominic and Morrison-Beedy (2016), assert that students self-sponsored their transport, food, and accommodation during their community practice period and that the university ensured the safety of the students. .

It was interesting that the current study found that some community members willingly shared information relevant to the programme. This was a very positive finding in that it showed the willingness of community members to participate in the health community programme. According to Linda, Mtshali and Engelbrecht (2013), the success of a community-based education programme depends on the involvement of the community. This involvement includes the willingness of community members to inform and guide the nursing students during the community practice. Furthermore, a study conducted by Olajide and Otunla (2015), noted that during their clinical practice in the community students got easy access to information, especially from the libraries in the community setting. This is further supported by the findings of Marcus, et al. (2011), who reported the active contribution of the community members in providing relevant information to nursing students.

The findings from this study indicated that the establishment of a relationship of trust in the community remained a challenge. Participants reported that in some communities it took a long time to establish a relationship of trust that enabled communities' members to share relevant information with the participants. According to Wenger (1998) cited in Jørgensen and Hadders (2015), one of the main conditions of learning success in the community is that, at the beginning of the process, people should interact on the basis of a commitment to established relationships and rules for communication. Christopher, Watts, McCormick and Young (2008), have also argued that partnership is important and can mutually benefit and foster relationships t. In addition, relations of trust should be established during the initial periods of any community project, and then maintained in the ongoing process.

Linda et al. (2013), state that communication is imperative because it provides guidance and assistance to learning monitors about students, and this contributes to the success of their activities. Furthermore, when there is not good communication, the learning process of the nursing students

may be jeopardised as they are unable to obtain sufficient information for them to make informed decisions (Linda et al., 2013; Marcus et al., 2011). According to the US Department of Health and Human Services (2007), communicating effectively with people from varied backgrounds, cultures, education levels and ages, and decision making in partnership with community members, is crucial to developing meaningful community engagement and the expansion of nursing knowledge and skills. It is therefore understandable that while participants are communicating with community members they might identify strengths and areas for improvement within the community. This provides an opportunity for deep understanding of community issues related to health promotion and illness prevention and consequently the success of their interventions.

5.3.2 Safety of environment

Safety of environment emerged as a theme which described participants' experiences in the community environment. The findings indicated that while participants received some safety instructions during their orientation, they still experienced safety concerns such as fear of crime. It emerged from this study that while learners were instructed to work and walk in groups, to respect forbidden dangerous zones and to comply with provided instructions, they still felt very unsafe due to the violent incidents that take place in these communities. These findings resonated with the finding by Codier and Odell (2014), that the university should provide students with a list of safety recommendations which included getting directions, moving in groups, avoiding isolated spaces, carrying a cell phone and calling for help should problems arise. It is therefore clear that formal safety sensitisation programmes and guidelines for students and risk reduction approaches are required for the success of the community programmes.

In this study participants reported fear of crimes and described how they were afraid for their lives since they had to walk along lonely roads to get to the community centres. They reported that they were informed of some concerns regarding safety in some communities which had a high population of homeless people and substance users. As a result, participants were advised to request that they be escorted by police into the communities. However, the police station did not have an adequate number of staff to cater for that and so they had to do without the needed escort. Participants resorted to walking in groups so as to feel safe. These findings are supported by Ross, Mahal, Chinnapen, Kolar and Woodman (2014), who noted that students were not comfortable in

the community setting. Students explained that they were scared because the site of the community practices was very unsafe and known as a place connected to drug abuse and frequent crime. These findings are also supported by Chavez, Bender, Hardie and Gastaldo (2010), whose participants reported that safety issues distressed nursing students during their community experiences. Gillis and MacLellan (2010), also reported that students felt discomfort in a community setting notorious for its high incidence of crime.

Participants from the current study reported a fear of being robbed while working in some communities. They attested that outreach was limited since there were some prohibited places which were not safe to enter. Thus, safety issues hampered their community activities as well as their learning. It is also clear that when students feel unsafe their participation suffers because as they are more concerned about their own protection measures than the community programme. These findings are supported by Chavez et al. (2010), whose participants reported that safety issues related to the working environment which was known to be unsafe led to feelings of distress during their community experiences. The results of the current study are also congruent with the findings of Reid and Cakwe (2011), who reported that a number of universities in South Africa had stopped allocating nursing students in rural community settings because of fears for students' security. However, the majority of South Africa's population live in cities and towns where vulnerability to violence is even more extremely experienced due to consistent risk factors such as unemployment, substance and alcohol abuse, the availability of arms, disjointed family structures and high levels of inequality as well as social exclusion (Wakefield and Tait, 2015).

Despite significant improvements over the last two decades, high levels of violence and crime continue to be one of the major growth challenges in South Africa (Wakefield and Tait, 2015; Hadland, 2008). Furthermore, in South Africa, everyone is affected by crime, and the sense of insecurity that comes with living in fear. Some encounter it directly, others through the experiences of friends and family or through news media (Silber and Geffen, 2016). It is understandable that all efforts should be mobilised to improve safety and security for all, in order to enhance the outcomes of community practice.

5.3.3 Learner support

Participants' experiences on support from the school as well as from the community were explored in this study. The allocation of a clinical facilitator in the community of practice was perceived as useful by the participants. They received guidance during the community entry, and familiarised themselves with those who were going to be involved in their community practices. These community members included the clinic and hospital managers, clinics' staff, principals and teachers, counsellors, as well as community agents. Furthermore, the facilitators from the school were always ready to assist them with questions from the community activities as well as to give timely feedback on assignments submitted. Thus, facilitators guided the students during the whole year of the programme. These findings are supported by (Naidu et al., 2012), who stated that participants experienced good supervision by receiving prompt responses from their facilitators. This created a good learning environment and increased knowledge in health promotion and disease prevention. Likewise, Vogt et al. (2011), reported that nursing students in the diabetic children's camp were supervised not only by school supervisors but also by a whole team of specialists including qualified health care professionals and licensed medical practitioners. Students expressed their enjoyment and they attested increasing their knowledge on the disease and its management. This may be due to the fact that students and the team of supervisors slept in the same camp during the whole period. Thus, the supervisor had enough time to concentrate on the students. Similarly, Thompson and Bucher (2013), note the advantages of nursing students being well supervised in different community settings by facilitators from the community as well as from the institution.

It emerged from this study that insufficient guidance and supervision were also experienced in one of the community settings. This was very often perceived as problematic because the supervision was not consistent, and fostering cooperation among the group members was challenging. The insufficient guidance was viewed as a hindrance to the use of the collected information, and the ability to solve adequately the community problems. This is supported by the findings of Manninen et al. (2013), who stated that participants reported that being without sufficient supervision and guidance affected their learning. Thus, they felt apprehensive and did not have the self-confidence to fully engage themselves in health promotion practices. Furthermore, Chavez et al. (2010), noted

that, despite the presence of supervisors, nursing students sometimes experienced negative relationships with their supervisors and their presence impeded their progress. It is understandable that students may experience anxiety and stress in an unfamiliar surroundings and that these negative factors may also be present in the supervisor relationship.

Participants from the current study reported that the communities were welcoming and supportive and facilitated their easy integration with community members and facilitated each step in the whole programme. This gave them a sense of satisfaction while working with them. These findings are supported by the study conducted by Ross et al. (2014), which revealed that students felt welcomed in the community setting. Students attested that the community setting had been a great experience since they felt wanted and well received and everyone was friendly and supportive. This made them more willing participants in the community practice and increased their sympathy for people. Thus, they developed a deep awareness of people's life in general and especially the life of the underprivileged. These findings are also supported by Baglin and Rugg (2010), who documented that the community setting was a favourable environment for the enrichment of nursing students' learning experiences. In a study conducted by Brynildsen, Bjørk, Berntsen and Hestetun (2014), it was found that nursing students valued the fact that the community site welcomed them and incorporated them into their environment. This facilitated the integration of students into the community and their effective participation in community practices.

It emerged from this study that members of the community were willing to assist the students and participated in the programme either physically or financially. Some community members funded the intervention, while others participated actively in activities such as painting as well as cleaning the toilets. It is also reported that community members cooperated during family assessment. According to a study conducted by Marcus et al. (2011), community members participated actively in the whole learning process. Thus community members, together with nursing students, identified substance abuse and obesity as the main health issues in the community. Therefore, preventive measures including physical exercise, avoidance of substance abuse and healthy eating were introduced. Community members were also actively involved, together with nursing students, in educating other members of the community.

In this study, financial cost of community practice appeared to be a challenge, as some of the participants had no funding for the awareness programme and costs they had not planned for. Participants felt that this challenge had hampered their involvement in the community setting because they did not complete all the planned interventions. These findings are echoed by Kaye et al. (2011b), who stated that participants in their study could not implement all the interventions planned since they did not get any financial support either from the community or from the college. Thus, the resources needed for effective community interventions were insufficient. This is further supported by another study conducted by Mariam et al. (2014), who indicated that nursing students' participation in the community was not effective because of logistical issues such as a lack of funding for the intervention, poor internet connections and insufficient or inadequate accommodation.

It emerged from the current study that participants felt helpless because they could do little to change the situation. During the intervention, some community members revealed that they had financial problems and expected the participants to help them overcome these problems either by doing something or by referring them to the authorities for help. In other cases, homeless people were requesting money to pay for their accommodation at the shelters. Data from the three focus group discussions reveal that participants were frustrated by these community expectations. Similar sentiments were expressed in a study conducted by Zanchetta, Schwind, Aksenchuk, Gorospe and Santiago (2013a), when students expressed annoyance over their inability to respond to imperative community needs such as food and safe havens. The findings are also consistent with the findings of Walthew and Scott (2012), where participants reported that some communities have difficulty changing unhealthy behaviour not because they do not want to move forward but because of lack of financial capacity. The participants felt particularly helpless because they could not do anything about the situation. This is further supported by the finding by Steele et al. (2011), that nursing students faced difficulties in their implementation phase of the intervention, such as the finance from the community. They complained that there were insufficient resources for the families to encourage children's physical activities and the shifting of their eating practices.

5.3.4 Skills development

It emerged from this study that skills development was related to the participants experiences of working in teams and to their involvement with community engagement. Team work allowed participants to develop leadership, management, academic and fundraising skills. Furthermore, findings revealed that the participants learned further skills such as doing research, critical thinking, planning, organizing and profiling. This resonates with findings from preceding research by Fillingham et al. (2014), which notes that nursing students valued the learning opportunities they were exposed to in the community setting. These findings are also confirmed by Yang et al. (2012), who argued that undergraduate nursing students, while engaging in group work, polished their teamwork skills, developed critical thinking skills, and became creative in funding projects in the community. Thus, students became more effective through collaboration. The above authors also noted that student collaboration with other colleagues prepares them for future tasks.

Similarly, a systematic review by Stone, Cooper and Cant (2013), showed that by participating actively in peer learning, nursing students learned from each other and become more innovative. Students took responsibility for their own learning, expanded self-confidence and considered themselves part of a working team. This collaboration enabled them to acquire knowledge which may not have been possible if they were learning individually. Mennenga and Smyer (2010), stressed the importance of implementing team-based learning among nursing students. Team work generally engenders communication and critical thinking, planning and organising skills and encourages professional and inter-professional teamwork. Lapkin, Levett-Jones and Gilligan (2013), argue that university-based health professional education programmes should produce graduates with valuable teamwork and communication skills, to improve the results of the activities they are involved in.

Fundraising is an important skill that not only provides students with opportunities for creativity, but also helps them develop communication skills. This fosters professional development through the acquisition of specific knowledge, skills and experiences. Therefore, teamwork is fundamental to the nursing curriculum (Cranford and Bates, 2015; Ehnfors and Grobe, 2004). Furthermore, Brynildsen et al. (2014), point out that in community setting, nursing education is characterized by the fact that nursing students learn with others in teamwork, especially in peer learning where

they learn with and from one another, and collaborate and share thoughts, experiences and knowledge. This experience enhances their self-confidence in the community setting, improves their knowledge and further develops their attitudes and skills (Stables, 2012).

It emerged from this study that some participants experienced group dynamic issues. It was reported that some group members were not enthusiastic to work with others, which disturbed team work and communication. This was especially the case when some individuals were supposed to accomplish all the work, while others were less involved. Bringing everyone to work together was not easy even for the group leaders. These findings are confirmed by the findings of Yang et al. (2012), where nursing students reported some group dynamics issues while working in teams with their peers such as difficulties in communication and the coordination of times of meetings. Some of the students also reported being penalised by those with poor participation records. According to Griebler, Rojatz, Simovska and Forster (2014), the effective participation of all is considered indispensable to health promotion and contributes substantially to its success. Thus, each participant should have an impact on judgements and activities related to the health promotion programme. Students should therefore be encouraged to participate actively in teamwork and to resolve problems which may negate the expected outcome of the programme.

The finding from the present study shows that community practices promote collaboration with community members. This is achieved through students' exposure to the community environment and collaborative learning with the members of the community. It emerged from this study that students acquired competences in terms of communication, particularly with new people, and by being exposed to various health needs. These findings are supported by a study conducted by Nielsen, Noone, Voss and Mathews (2013), which revealed that nursing students working in collaboration with the community developed their communication skills, especially when the community was understanding and non-judgemental. Montgomery and Johnson (2015), also explored the experience of nursing students engaged in health promotion programmes and noted that nursing students 'participation in community-based health promotion activities enhanced their health promotion and communication skills. As a result, nursing students become more confident when giving health promotion information in diverse communities.

Similarly, Kaye et al. (2011b), evaluating community-based education for health training colleges claimed that nursing students engaged in community interventions, developed skills for team work and improved their communication skills. In agreement with these findings, many researchers, such as Lindsey and Hawk (2013), Walton and Blossom (2013), and Naidu et al. (2012), state that through participating in community work, nursing students become more motivated, connected to the community and better able to respond to community health needs.

Findings from the present study revealed that nursing students identified a number of community problems. Identifying these problems was achieved through joint collaborative efforts with community members. Students demonstrated skills in problem identification and prioritisation through community engagement. This helped the students to prioritise the problems identified by the communities themselves, rather than as outsiders impose their own perceived problems. Furthermore, participants reported that they gained insight into the underlying causes of community problems and learned that nursing practice should focus not only on providing care in the workplace, but extend to identifying the probable cause of disease occurrence, thus enabling timely interventions. These findings are supported by Ladhani, Scherpbier and Stevens (2012), who are of the opinion that community assessment affords participants an opportunity to reflect upon the processes and priorities of health needs. Thus participants, in partnership with the communities, were able to prioritise community health needs, then to plan and implement health promotion intervention to address the identified needs. This approach is further supported by Baglin and Rugg (2010), who noted that participation in community assessment expanded the critical thinking abilities of students.

It emerged from the current study that participants took a number of approaches towards the solution of identified problems. While they were in the community, participants incorporated the acquired knowledge, attitudes and skills into their practice. Community engagement provided them with significant opportunities to deliver health promotion and illness prevention programmes and to apply knowledge gained in the classroom to real-world settings. Thus, by working with the community, students developed the ability to apply theories learned in class to real situations. This is consistent with Mtshali (2005), and the WHO (1987), who note that community health awareness programmes are aimed at exposing students to the real-world practice of nursing, where

theories are translated into practice. This therefore shows that the learning process of participants was enhanced through their participation in the awareness programme. Karp and Bork (2012), and Walthew and Scott (2012), also found that nursing students in community health practices acquired new and relevant understanding and improved technical skills, as they gained confidence in applying class learning outcomes to real-world situations. These findings are further supported by Montgomery and Johnson (2015), who claimed that nursing students experienced a positive reception from people in different places during their community-based engagement. This enhanced their opportunities to apply theories learned in the classroom to real situations in the community settings. In agreement with these findings, Marmot et al. (2012), stated that in community settings, students practice in an authentic situation which leads to improving positive health practices and prevention of disease.

Participants in this study revealed that while conducting home visits and community assessment, they got opportunities to hear numerous voices from the community which allowed them to acquire knowledge and skills in analysing and planning health issues. Students developed their professionalism, acquired a deeper understanding of nursing practice and realized the importance of the role they played in the community. This was rewarding, and a satisfying personal experience, because it enhanced students' clinical skills. It especially enabled them to build the confidence and skills necessary to the implementation of health promotion and illness prevention programmes and consequently helped them to measure their interest for the nursing profession. These findings concur with Lindsey and Hawk (2013), who pointed out that nursing students felt satisfied after their participation in community-based health promotion interventions. The students reported that the intervention promoted creativity, an understanding of community health issues, the development of professional goals and the encouragement of a sense of connection with the community. This is further supported by the finding by Montgomery and Johnson (2015), that nursing students involving in community engagement interacted with people of diverse lifestyles and backgrounds. Through this interaction, students were able to recognise the factors that influenced health from a community view, and identify and address community needs. Thus, this experience gave them an opportunity to use their knowledge, which increased their community responsiveness and their communication skills.

Participants in this study were satisfied to observe some positive changes in the community during the evaluation period. These changes included better hygiene, new gardens and better municipal services. Further, some of the participants highlighted improvements in healthcare access. For instance, teenagers were asking for contraceptives and condoms from the clinic while children who had missed immunization had gone for their treatment. The empowerment of community members lead to improved health outcomes. These finding corroborated a study by (Merritt and Boogaerts, 2014), who are of the view that collaboration with the community can result in good intervention outcomes. Therefore, the use of more flexible approaches to traditional practices and collaboration with the community seems to be an effective way of valuing the community's choice for their lifestyle and health practices. This is further supported by the finding by Zanchetta et al. (2013b), that nursing students interacting with the community discerned simple ways to encourage the local community's responsiveness to their conditions and promote change in the community. Also in agreement with these findings were Wright, Giger, Norris and Suro (2013), who noted that nursing students' involvement in educating and advocating for changes in obesity prevention programmes in school districts promoted a healthy lifestyle for all and lead to successful results including decreased Body Mass Index z-scores, decreased TV use and improved daily physical activity.

In the current study, enhancing practical facilitation was viewed as essential for future community placements. Effective community accompaniment and variations in the community of practice were suggested by participants from this study for the improvement of community clinical practices. According to Mabuda, Potgieter and Alberts (2008), an encouraging and supportive learning environment for nursing students is determined by support systems such as supervision, interactions between the faculty and nursing students and student nurses and clinical setting staff. Thus, learning in a practice location necessitates an environment which is beneficial to learning, and offers suitable support from skilled practitioners and educators. Furthermore, the lack of a supportive environment discourages the learners from pursuing experience and impacts the learning process and professional growth.

According to van Iersel, Latour, de Vos, Kirschner and op Reimer (2016), nursing students practising in various community settings offers an important experience which allows them to be

effectively oriented to their future profession. Furthermore, the community practices offer further motivation to be connected to a professional team (Murphy, Rosser, Bevan, Warner and Jordan, 2012). Likewise, community practice experience, which enables nursing students to meet their expectations, may influence their future profession choices. Thus, high-quality community practice is progressively acknowledged as an imperative recruitment approach to source potential workforces (Lamont, Brunero and Woods, 2015). According to Philibin, Griffiths, Byrne, Horan, Brady and Begley (2010), nursing students in community settings connect with diverse people and develop a wider expertise than in the hospital, as they are dealing with different community issues. Furthermore, varied community settings permit students to respond to the needs of the vulnerable population (Thompson and Bucher, 2013).

5.4 Conclusions

Community-based health promotion and illness prevention programmes experienced by nursing students in different community sites in KwaZulu-Natal were predominantly positive despite the various challenges they faced.

In this study, four main themes emerged as central to students' experiences in the community-based health promotion and illness prevention programme: (1) community accessibility; (2) safety of environment; (3) learner support; (4) skills development.

It emerged from this study that access to the community was related to the geographical access of the communities, the cost of transportation to the community practice and the accessibility of community resources. Lack of transport to the community settings was viewed as a hindrance to effective community practice.

The findings demonstrated that easy access to information and the establishment of a relationship of trust with community members was a cornerstone to the community-based programme. It emerged that guidance and assistance provide information which allow students to identify areas for improvement within the community and help them to make informed choices for their intellectual development and community benefit, thus an effective clinical facilitation was viewed as a necessity.

It emerged from this study that safety instructions were essential to community practice. This is because students experienced safety uncertainties due related fear of crime and working in unsafe working environments Students may feel discomfort regarding the community settings which are not safe and may be limited in space of practice.

In this study, it was found that practical training in the community promoted skills development. The finding revealed that through community-based health promotion and illness prevention programme, students benefited from working with each other in a team and from the engaging with the community. Through community engagement, students acquired competences in terms of collaboration with community members and identification of community health problems. These included: responsiveness to the community problems; integration of the theory into practice; participation in community-based activities and community improvement following the intervention. In addition, the study demonstrated that many of the essential tasks of the programme were undertaken by the nursing students and that they expressed satisfaction with their ability to meet their leaning objectives.

The programme proved to be an effective teaching strategy since it resulted in a positive experience for both the nursing students and the community. However, transport, as well as financial challenges experienced by the students, had an impact on the implementation of the interventions, and this was related to an insufficiency of funds to perform all planned activities which led to feelings of helpless by the students. Furthermore, it emerged that insufficient guidance and supervision may affect students learning and that as a result student participation may not be effective.

In this study, enhancing practical facilitation was viewed as essential for future community placements. Effective community accompaniment and variations of the community of practice were also suggested by participants from this study for the improvement of community clinical practices. An encouraging and supportive learning environment for nursing students is determined by a network of support systems, such as supervision, interactions between the faculty and nursing students and collaboration with members of the community.

5.5 Research limitations

The study encountered some limitations, the identification of which may help researchers in the future. For example, the current study used a qualitative study with a limited number of 18 students, hence the findings of this study cannot be generalised to other settings. The participants in this study came from one selected school of nursing in KwaZulu-Natal that is located in urban area. Thus, the findings do not represent the experiences of nursing students in all KwaZulu-Natal nursing institutions.

Despite these limitations, the researcher believes that the study achieved its purpose. The researcher selected to study this topic in a qualitative way because a qualitative approach could embrace a wider understanding of students' experiences in such programmes. This research has broadened understanding of nursing students' experiences and the importance of community programmes for nursing education and for the wellbeing of the community, especially those in underprivileged areas.

A number of recommendations were made, drawing upon the data from this study and are discussed next.

5.6 Recommendations

This section provides recommendations based on the findings of this study. The recommendations presented here are intended to improve the experience of nursing students participating in community programmes.

5.6.1 Procedural support

Three main recommendations related to procedural support are proposed as outlined below:

5.6.1.1 Expansion of community settings

It was found that students were allocated in urban and suburban community settings. Therefore, a limited target community benefited from the health promotion and illness prevention programme. In concurrence with the South Africa Health Department policy which emphasises the necessity to promote population health through community partnership with care professionals at every level, it is recommended that the area of training should be expanded to disadvantaged communities in the rural areas. Thus, students would have a wider experience of community-based problems, and increase their knowledge and skills in problem solving. Many more communities as well will benefit from the programme.

5.6.1.2 Developing funding system

It was reported that financial limitations negatively affected both transport and interventions in the community settings. Establishing a sustainable funding system may be required to meet any ambitions of intensifying community-based health promotion and illness prevention programme. Therefore, it is recommended that the school of nursing provide assistance to the students in accessing the community learning sites by providing transport and some financial support that assists the implementation of identified interventions.

5.6.1.3 Provision of proper supervision

Students who experienced insufficient supervision felt uncomfortable. This study therefore recommends more clinical facilitation. In addition, students in the communities should be regularly

visited by supervisors to assist them in guiding families and individuals to actively participate in interventions identified to have positive health outcomes.

Although participants from all focus groups provided positive comments on the support received from the supervisors, comments that reflect on the absence of supervisors and requirements from participants for further supervision time, indicate that the supportive function of supervisors requires improvement.

5.6.2 Team work

The findings of the study revealed that some students did not display appropriate interactive skills when working with colleagues, thus leading to overwhelming workloads and some unpleasant experiences with fellow students. As a recommendation, therefore, good teamwork skills should be emphasized to the nursing students before and during their community practices.

It emerged from the present study that most nursing students faced serious funding limitations during the community-based health promotion programme and students felt it was challenging because they could not complete the package of planned interventions. However, other students were able to raise funds on their own initiative, which eased their financial burdens during the community programme. It is therefore recommended that an understanding of the fundraising and the financial structures of the university should be emphasized. This will equip students with fundraising skills as part of their preparation for the community learning placement.

5.6.3 Community

Findings from this study indicated that some of the communities' members were reluctant to communicate with the students. It is therefore recommended that community members should be encouraged to actively participate in the community practice programme and increase the opportunity to improve their health. It is recommended to create an awareness for few weeks about the program to the community members few weeks to prepare their minds and carry them along in the planning of the programmes.

5.6.4 Future research

Following the students' experiences in the community, it can be said that participating in the Community-Based Health Promotion and Illness Prevention Programme was beneficial to the community as well as the students. However, more work needs to be done with regard to the impact of these programmes on both students' learning and community health outcomes. This will further strengthen the use of community-based education/service learning in nursing as a pedagogical approach which necessitates more accurate evaluation of research to advance knowledge and to inform developments in nursing programmes (Newton, Bettger, Buchholz, Kulak and Racey, 2015; Magnussen, Niederhauser, Ono, Johnson, Vogler and Ceria-Ulep, 2013). Furthermore, future studies could meticulously measure the impact of Community-Based Health Promotion and Illness Prevention Programmes in the development of specified competences and influence the choosing of careers in under-served areas such as rural areas.

Also recommended is a quantitative study which could be undertaken to determine what learning strategies students use during community practice. Additional information can be collected on future groups to determine certain quantitative traits of the participants such as age, gender, marital status, family background and all other demographic factors which might influence the community experience. Because the research was conducted at only one school of nursing, it therefore recommends that future studies be conducted at other geographically dispersed private and public schools of nursing in urban and rural settings. The use of h more nursing student populations will enable the generalization of the results. Separately, in the current study participants reported fear of crimes; thus they were afraid for their lives since they had to walk along isolated roads to get to the community settings. It is recommended that future studies explore incidents of crime directed at students while in the community.

REFERENCES

- ADEJUMO, O. & GANGA-LIMANDO, M. 2000. Facilitating positive attitudes towards an innovative programme for baccalaureate nursing education. *Curationis*, 23(1), 3-9.
- ALLENDER, S., GLEESON, E., CRAMMOND, B., SACKS, G., LAWRENCE, M., PEETERS, A., LOFF, B. & SWINBURN, B. 2012. Policy change to create supportive environments for physical activity and healthy eating: which options are the most realistic for local government? *Health Promotion International*, 27(2), 261-274.
- AMERICAN ASSOCIATION OF COLLEGES OF NURSING. 2005. *Accelerated programs: The fast-track to careers in nursing* [Online]. [Accessed 20 September 2015].
- APPLIN, H., WILLIAMS, B., DAY, R. & BURO, K. 2011. A comparison of competencies between problem-based learning and non-problem-based graduate nurses. *Nurse Education Today*, 31(2), 129-134.
- BABENKO-MOULD, Y., FERGUSON, K. & ATTHILL, S. 2016. Neighbourhood as community: A qualitative descriptive study of nursing students' experiences of community health nursing. *Nurse Education in Practice*, 17, 223-228.
- BAHAR, Z., BEŞER, A., ÖZBİÇAKÇI, Ş. & HANEY, M. Ö. 2014. Health promotion behaviors of Turkish women. *Dokuz Eylül Üniversitesi Hemşirelik Fakültesi Elektronik Dergisi*, 6(1), 9-16.
- BALEN, R., RHODES, C. & WARD, L. 2010. The power of stories: Using narrative for interdisciplinary learning in health and social care. *Social Work Education*, 29(4), 416-426.
- BASSI, S. 2011. Undergraduate nursing students' perceptions of service-learning through a school-based community project. *Nursing Education Perspectives*, 32(3), 162-167.
- BAUER, U. E., BRISS, P. A., GOODMAN, R. A. & BOWMAN, B. A. 2014. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA. *The Lancet*, 384(9937), 45-52.
- BENTLEY, L. 2013. Developing a faculty fitness training program for community college nurse educators: "A pilot project". *Teaching and Learning in Nursing*, 8(1), 26-32.
- BETONY, K. 2012. Clinical practice placements in the community: A survey to determine if they reflect the shift in healthcare delivery from secondary to primary care settings. *Nurse Education Today*, 32(1), 21-26.
- BINDELS, J., COX, K., WIDDERSHOVEN, G., VAN SCHAYCK, C. & ABMA, T. 2014. Stimulating program implementation via a Community of Practice: A responsive evaluation of care programs for frail older people in the Netherlands. *Evaluation and Program Planning*, 46, 115-121.

- BIRCHER, J. & KURUVILLA, S. 2014. Defining health by addressing individual, social, and environmental determinants: New opportunities for health care and public health. *Journal of Public Health Policy*, 35(3), 363-386.
- BITSCH, V. 2005. Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75-91.
- BLOUT, J. D., ROSE, K. C., SUESSMANN, M., COLEMAN, K. & SELEKMAN, J. 2012. School Violence, Role of the School Nurse in Prevention. Issue Brief. *National Association of School Nurses (NJ1)*, 1-6.
- BRAVEMAN, P. A., EGERTER, S. A., WOOLF, S. H. & MARKS, J. S. 2011. When do we know enough to recommend action on the social determinants of health? *American Journal of Preventive Medicine*, 40(1), S58-S66.
- BREWIN, D., KOREN, A., MORGAN, B., SHIPLEY, S. & HARDY, R. L. 2013. Behind Closed Doors School Nurses and Sexual Education. *The Journal of School Nursing*, 30(1), 31-40.
- BRINER, R. B. & DENYER, D. 2012. Systematic review and evidence synthesis as a practice and scholarship tool. *Handbook of Evidence-based Management: Companies, Classrooms and Research*, 112-129.
- BRINK, H., VAN DER WALT, C. & VAN RENSBURG, G. 2006. *Fundamentals of research methodology for health care professionals*, Cape Town, Juta.
- BRINK, H., VAN DER WALT, C. & VAN RENSBURG, G. 2012. *Fundamentals of research methodology for health care professionals*, Cape Town, Juta.
- BRONSTEIN, L. R., ANDERSON, E., TERWILLIGER, S. H. & SAGER, K. 2012. Evaluating a Model of School-Based Health and Social Services: An Interdisciplinary Community–University Collaboration. *Children & Schools*, cds004.
- BRYMAN, A. 2012. *Social research methods*, Oxford, OUP.
- BRYNILDSEN, G., BJØRK, I. T., BERNTSEN, K. & HESTETUN, M. 2014. Improving the quality of nursing students' clinical placements in nursing homes: An evaluation study. *Nurse Education in Practice*, 14(6), 722-728.
- BURNS, N. & GROVE, S. K. 2010. *Understanding Nursing Research: Building an Evidence-Based Practice*, Saunders.
- BURNS, N. & GROVE, S. K. 2016. *The Practice of Nursing Research - Appraisal, Synthesis, and Generation of Evidence* St. Louis, Saunders Elsevier.
- BUSZA, J., WALKER, D., HAIRSTON, A., GABLE, A., PITTER, C., LEE, S., KATIRAYI, L., SIMIYU, R. & MPOFU, D. 2012. Community-based approaches for prevention of mother to child transmission in resource-poor settings: a social ecological review. *Journal of the International AIDS Society*, 15(4), 1-11.

- CARLSEN, B. & GLENTON, C. 2011. What about N? A methodological study of sample-size reporting in focus group studies. *BMC medical research methodology*, 11, 1-10.
- CARR, C. H. 2012. Nurse/Nurse Practitioner. *Encyclopedia of Immigrant Health*. New York: Springer.
- CHARLES, L. L., MOEBUS, P., BEECHINOR, L., PEARCE, T. & PUTNEY, H. 2014. Getting comfortable as “fish out of water”: Using qualitative research methods training to enhance the technical capacity of family therapy trainees. *Journal of Marital and Family Therapy*, 40(2), 233-245.
- CHAVEZ, F., BENDER, A., HARDIE, K. & GASTALDO, D. 2010. Becoming a global citizen through nursing education: lessons learned in developing evaluation tools. *International Journal of Nursing Education Scholarship*, 7(1), 1-24.
- CHOI, W. H., HUI, G. K., LEE, A. C. & CHUI, M. M. 2010. Student nurses’ experiences and challenges in providing health education in Hong Kong. *Nurse Education Today*, 30(4), 355-359.
- CHRISTOPHER, S., WATTS, V., MCCORMICK, A. K. H. G. & YOUNG, S. 2008. Building and maintaining trust in a community-based participatory research partnership. *American Journal of Public Health*, 98(8), 1398-1406.
- CODIER, E. & MACNAUGHTON, N. S. 2012. Are male nurses emotionally intelligent? *Nursing Management*, 43(4), 1-4.
- COHEN, L., MANION, L. & MORRISON, K. 2007. Research methods in education. (6th Ed.). London: Routledge Falmer.
- CRANFORD, J. S. & BATES, T. 2015. Infusing interprofessional education into the nursing curriculum. *Nurse Educator*, 40(1), 16-20.
- CRESWELL, J. W. 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Carlifornia, Sage Publications, Incorporated.
- CRESWELL, J. W. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches*, London, Sage Publications.
- CRISP, N. & CHEN, L. 2014. Global supply of health professionals. *New England Journal of Medicine*, 370(10), 950-957.
- CROOKES, K., CROOKES, P. A. & WALSH, K. 2013. Meaningful and engaging teaching techniques for student nurses: a literature review. *Nurse Education in Practice*, 13(4), 239-243.
- DANIELS, P., ADONIS, T.-A. & KARUGUTI, W. 2013. Impact of an interprofessional education program on developing skilled graduates well-equipped to practise in rural and underserved areas. *Rural and Remote Health*, 14(3), 2671-2671.

- DAUNTON, A., PUIG, S., TANIÈRE, P., FORDE, C., ALDERSON, D. & TUCKER, O. 2012. Prevention is better than cure. *Journal of Surgical Case Reports*, 2012(6), 10-14.
- DE VILLIERS, T., MAYERS, P. M. & KHALIL, D. 2014. Pre-registration nursing students' perceptions and experiences of violence in a nursing education institution in South Africa. *Nurse Education in Practice*, 14(6), 666-673.
- DE VOS, A., STRYDOM, H., FOUCHÉ, C. & DELPORT, C. 2011. Research at grass roots for the social sciences and human service professions, Pretoria: Van Schaik. EISA. 2014. *Electoral Institute for Sustainable Democracy in Africa. Programmes. Our Work*. Available: <http://content.eisa.org.za/old-page/our-work-2> [2014, April 28].
- DEN OUDSTEN, B. L., LUCAS-CARRASCO, R., GREEN, A. M. & WHOQOL-DIS GROUP, T. 2011. Perceptions of persons with Parkinson's disease, family and professionals on quality of life: An international focus group study. *Disability and Rehabilitation*, 33(25-26), 2490-2508.
- DEPARTMENT OF HEALTH 1997. White Paper for the Transformation of the Health System in South Africa. *Government Gazette*, 382(17910).
- EDWARDS, J. 2012. *Understanding the predictors of participation and the barriers to employee involvement in workplace health promotion programmes*. Doctor of Philosophy in Management Thesis, Massey University.
- EHNFORSS, M. & GROBE, S. J. 2004. Nursing curriculum and continuing education: future directions. *International Journal of Medical Informatics*, 73(7), 591-598.
- ELO, S., KÄÄRIÄINEN, M., KANSTE, O., PÖLKKI, T., UTRIAINEN, K. & KYNGÄS, H. 2014. Qualitative Content Analysis. *SAGE Open*, 4(1), 1-10.
- ELO, S. & KYNGÄS, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115.
- ELWELL, M. D. & BEAN, M. S. 2011. Efficacy of service-learning for community college ESL students. *Community College Review*, (28), 47-61.
- EMANUEL, E. J., WENDLER, D., KILLEN, J. & GRADY, C. 2004. What makes clinical research in developing countries ethical? The benchmarks of ethical research. *Journal of Infectious Diseases*, 189(5), 930-937.
- EN, W. L., KOH, G. C.-H. & LIM, V. K. G. 2011. Caring for underserved patients through neighborhood health screening: outcomes of a longitudinal, interprofessional, student-run home visit program in Singapore. *Academic Medicine*, 86(7), 829-839.
- FICHRD, A. E. & DU RAND, P. P. 2000. Facilitators' perceptions of problem-based learning and community-based education: research. *Health SA Gesondheid*, 5(2), 3-10.

- FILLINGHAM, A., PETERS, S., CHISHOLM, A. & HART, J. 2014. Early training in tackling patient obesity: A systematic review of nurse education. *Nurse Education Today*, 34(3), 396-404.
- FINLAY, L. 2006. 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *The British Journal of Occupational Therapy*, 69(7), 319-326.
- FRENK, J., CHEN, L., BHUTTA, Z. A., COHEN, J., CRISP, N., EVANS, T., FINEBERG, H., GARCIA, P., KE, Y. & KELLEY, P. 2010. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*, 376(9756), 1923-1958.
- FURSETH, I. & EVERETT, E. L. 2013. *Doing your Master's Dissertation: From Start to Finish*, London, Sage.
- GAGNON, M., JACOB, J. D. & MCCABE, J. 2014. Locating the qualitative interview: reflecting on space and place in nursing research. *Journal of Research in Nursing*, 20(3), 203-216.
- GILLIS, A. & MAC LELLAN, M. 2010. Service learning with vulnerable populations: review of the literature. *International Journal of Nursing Education Scholarship*, 7(1), 1-8.
- GREALISH, L., BAIL, K. & RANSE, K. 2010. Investing in the future': residential aged care staff experiences of working with nursing students in a 'community of practice. *Journal of Clinical Nursing*, 19(15-16), 2291-2299.
- GRIEBLER, U., ROJATZ, D., SIMOVSKA, V. & FORSTER, R. 2014. Effects of student participation in school health promotion: a systematic review. *Health Promotion International*, 1-12.
- GROVE, S. K., BURNS, N. & GRAY, J. 2012. *The practice of nursing research: appraisal, synthesis, and generation of evidence*, Amsterdam, Elsevier Health Sciences.
- GWELE, N. 1997. The development of staff concerns during implementation of problem-based learning in a nursing programme [1]. *Medical Teacher*, 19(4), 275-284.
- GWELE, N. 1999. Experiential learning in action: A programme for preparing educators for health professionals. *Studies in Continuing Education*, 20(2), 175-186.
- HADLAND, A. 2008. *Violence and xenophobia in South Africa: developing consensus, moving to action* [Online]. Available: <http://www.hsrc.ac.za/en/research-data/view/4048> [2016].
- HANCOCK, B., OCKLEFORD, E. & WINDRIDGE, K. 2009. *An introduction to qualitative research* [Online]. Nottingham, UK: The National Institute for Health Research and Research Design Services for the East Midlands / Yorkshire. Available: www.rds-eastmidlands.nihr.ac.uk [Accessed 11 November 2014].

- HAWALA-DRUY, S. & HILL, M. H. 2012. Interdisciplinary: Cultural competency and culturally congruent education for millennials in health professions. *Nurse Education Today*, 32(7), 772-778.
- HEALY, D. & SHARRY, P. M. 2011. Promoting self awareness in undergraduate nursing students in relation to their health status and personal behaviours. *Nurse Education in Practice*, 11(4), 228-233.
- HEATH, G. W., PARRA, D. C., SARMIENTO, O. L., ANDERSEN, L. B., OWEN, N., GOENKA, S., MONTES, F. & BROWNSON, R. C. 2012. Evidence-based intervention in physical activity: lessons from around the world. *The Lancet*, 380(9838), 272-281.
- HENDERSON, A., COOKE, M., CREEDY, D. K. & WALKER, R. 2012. Nursing students' perceptions of learning in practice environments: A review. *Nurse Education Today*, 32(3), 299-302.
- HOFFMAN, A. R. 2011. *College students' perceived confidence and importance in helping friends involved in disordered eating*. University of Cincinnati.
- HOLLUP, O. 2014. The impact of gender, culture, and sexuality on Mauritian nursing: Nursing as a non-gendered occupational identity or masculine field? Qualitative study. *International Journal of Nursing Studies*, 51(5), 752-760.
- HOWARD, E., HUBELBANK, J. H. & MOORE, P. S. 1989. Employer evaluation of graduates: Use of the focus group. *Nurse Educator*, 14(5), 38-41.
- INMAN, D. D., VAN BAKERGEM, K. M., LAROSA, A. C. & GARR, D. R. 2011. Evidence-based health promotion programs for schools and communities. *American Journal of Preventive Medicine*, 40(2), 207-219.
- INTERNATIONAL COUNCIL OF NURSES. 2009. *Reducing the gap and improving the interface between education and service: a framework for analysis and solution generation*. Geneva, Switzerland: International Council of Nurses [Online]. Geneva, Switzerland. Available: <http://fnm.tums.ac.ir/userfiles/news/08.pdf> [Accessed 15 August 2015].
- ISAACS, A. N. 2014. An overview of qualitative research methodology for public health researchers. *International Journal of Medicine and Public Health*, 4(4), 318-323.
- JAIN, A. & LANGWITH, C. 2013. Collaborative school-based obesity interventions: Lessons learned from 6 southern districts. *Journal of School Health*, 83(3), 213-222.
- JOHNSON, R. B. & ONWUEGBUZIE, A. J. 2004. Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.
- JONES, R., HIGGS, R., DE ANGELIS, C. & PRIDEAUX, D. 2001. Changing face of medical curricula. *The Lancet*, 357(9257), 699-703.

- JØRGENSEN, W. & HADDERS, H. 2015. The significance of communities of practice: Norwegian nursing students' experience of clinical placement in Bangladesh. *Nursing Open*, 2(1), 36-46.
- JOUBERT, G. & EHRLICH, R. 2010. *Epidemiology: A research manual for South Africa* (2nd ed). South Africa: Oxford University Press Southern Africa.
- KARP, M. J. M. & BORK, R. J. H. 2012. " *They Never Told Me What to Expect, So I Didn't Know What to Do*": *Defining and Clarifying the Role of a Community College Student*, New York, Columbia University, Teachers College.
- KAYE, D., MUHWEZI, W. W., KASOZI, A. N., KIJJAMBU, S., MBALINDA, S. N., OKULLO, I., NABIRYE, R. C., ORIA, H., ATUYAMBE, L. & GROVES, S. 2011a. Lessons learnt from comprehensive evaluation of community-based education in Uganda: a proposal for an ideal model community-based education for health professional training institutions. *BMC Medical Education*, 11(1), 1-9.
- KAYE, D., MWANIKI, A., BURNHAM, G., CHANG, L. W., MBALINDA, S. N., OKULLO, I., NABIRYE, R. C., MUHWEZI, W., ORIA, H. & KIJJAMBU, S. 2011b. The organization and implementation of community-based education programs for health worker training institutions in Uganda. *BMC international health and human rights*, 11(S4), 1-10.
- KAZEMI, D., BEHAN, J. & BONIAUTO, M. 2011. Improving teaching strategies in an undergraduate community health nursing (CHN) program: Implementation of a service-learning preceptor program. *Nurse Education Today*, 31(6), 547-552.
- KEMPPAINEN, V., TOSSAVAINEN, K. & TURUNEN, H. 2013. Nurses' roles in health promotion practice: An integrative review. *Health Promotion International*, 28(4), 490-501.
- KICINSKI, L. R. 2014. *Student Success and Service-Learning: Exploring the Relationship at a Two-Year Public Institution*. Master's dissertation, Grand Valley State University.
- KICKBUSCH, I. & NUTBEAM, D. 1998. Health promotion glossary. *World Health Organization, Geneva*.
- KING, L., GILL, T., ALLENDER, S. & SWINBURN, B. 2011. Best practice principles for community-based obesity prevention: development, content and application. *Obesity Reviews*, 12(5), 329-338.
- KLUNKLIN, A., SUBPAIBOONGID, P., KEITLERTNAPHA, P., VISESKUL, N. & TURALE, S. 2011. Thai nursing students' adaption to problem-based learning: A qualitative study. *Nurse Education in Practice*, 11(6), 370-374.
- KOCH, D. J. 2013. *Experiences of nursing students undertaking clinical placement in a bachelor degree: a perspective of diversity*. Doctoral thesis University of Western Sydney.

- KRAUSS, S. E. 2005. Research paradigms and meaning making: A primer. *The qualitative report*, 10(4), 758-770.
- KRONFOL, N. 2012. Historical development of health professions' education in the Arab world. *EMHJ*, 18(11), 1157-65.
- KULBOK, P. A., THATCHER, E., PARK, E. & MESZAROS, P. S. 2012. Evolving public health nursing roles: focus on community participatory health promotion and prevention. *OJIN: The Online Journal of Issues in Nursing*, 17(2), 1-10.
- KUSHNER, R. F., VAN HORN, L., ROCK, C. L., EDWARDS, M. S., BALES, C. W., KOHLMEIER, M. & AKABAS, S. R. 2014. Nutrition education in medical school: a time of opportunity. *American Journal of Clinical Nutrition*, 99(5), 1167S-1173S.
- LABARTHE, D. R. & DUNBAR, S. B. 2012. Global cardiovascular health promotion and disease prevention 2011 and beyond. *Circulation*, 125(21), 2667-2676.
- LADHANI, Z., SCHERPBIER, A. J. & STEVENS, F. C. 2012. Competencies for undergraduate community-based education for the health professions—A systematic review. *Medical Teacher*, 34(9), 733-743.
- LAI, C. K., CHAN, J. H., WONG, I. Y., FUNG, J. T., PANG, P. C., FUNG, K. H. & KWOK, C. P. 2015. Gains and Development of Undergraduate Nursing Students During a 2-Year Community Service Program. *Journal of Nursing Education*, 54(3), S21-S25.
- LAMONT, S., BRUNERO, S. & WOODS, K. P. 2015. Satisfaction with clinical placement—The perspective of nursing students from multiple universities. *Collegian*, 22(1), 125-133.
- LAPKIN, S., LEVETT-JONES, T. & GILLIGAN, C. 2013. A systematic review of the effectiveness of interprofessional education in health professional programs. *Nurse Education Today*, 33(2), 90-102.
- LAVERACK, G. & MOHAMMADI, N. K. 2011. What remains for the future: strengthening community actions to become an integral part of health promotion practice. *Health Promotion International*, 26(suppl 2), ii258-ii262.
- LIAMPUTTONG, P. 2011. *Focus group methodology: Principle and practice*, Sage Publications.
- LINDA, N. S., MTSHALI, N. G. & ENGELBRECHT, C. 2013. Lived experiences of a community regarding its involvement in a university community-based education programme. *Curationis*, 36(1), 1-13.
- LINDSEY, B. J. & HAWK, C. W. 2013. Training community health students to develop community-requested social marketing campaigns: an innovative partnership. *Progress in Community Health Partnerships: Research, Education, and Action*, 7(2), 219-229.

- LOBIONDO-WOOD, G. & HABER, J. 2013. *Nursing research: Methods and critical appraisal for evidence-based practice*, Elsevier Health Sciences.
- LOEWEN, S., UNDERWOOD, M. & THOMPSON-ISHERWOOD, R. 2014. "Slapped In the Face with It": Internalizing Community Health Concepts from an International Practice Setting. *International Journal of Applied*, 4(2), 29-36.
- LOMAZZI, M., BORISCH, B. & LAASER, U. 2014. The Millennium Development Goals: experiences, achievements and what's next. *Global Health Action*, 7, 1-9.
- LOUGHREY, M. 2008. Just how male are male nurses..? *Journal of Clinical Nursing*, 17(10), 1327-1334.
- LUTHY, K. E., BECKSTRAND, R. L. & CALLISTER, L. C. 2012. Improving the community nursing experiences of nursing students. *Journal of Nursing Education and Practice*, 3(4), 12-20.
- MABUDA, B. T., POTGIETER, E. & ALBERTS, U. 2008. Student nurses' experiences during clinical practice in the Limpopo Province. *Curationis*, 31(1), 19-27.
- MABUZA, L. H., DIAB, P., REID, S. J., NTULI, B. E., FLACK, P. S., MPOFU, R., DANIELS, P. S., ADONIS, T.-A., CAKWE, M. & KARUGUTI, M. W. 2013. Communities' views, attitudes and recommendations on community-based education of undergraduate Health Sciences students in South Africa: a qualitative study: original research. *African Primary Health Care and Family Medicine*, 5(1), 1-9.
- MACFARLANE, R. G., WOOD, L. P. & CAMPBELL, M. E. 2014. Healthy Toronto by Design: Promoting a healthier built environment. *Can J Public Health*, 106(1), eS5-eS8.
- MACHI, L. A. & MCEVOY, B. T. 2012. *The literature review: Six steps to success*, Thousand Oaks, Calif., Corwin Press.
- MACKLEM, G. L. 2014. Student engagement, motivation, and active learning. In: MACKLIN, G. L. (ed.) *Preventive mental health at school*. New York: Springer.
- MAGNUSSEN, L., NIEDERHAUSER, V., ONO, C. K., JOHNSON, N. K., VOGLER, J. & CERIA-ULEP, C. D. 2013. Developing a statewide nursing consortium, island style. *Journal of Nursing Education*, 52(2), 77.
- MAJEE, W., MALTSBERGER, B. A., JOHNSON, L. K. & ADAMS, J. R. 2014. Collaboration: finding the place for Cooperative Extension in the intersection of community development and health promotion. *Community Development*, 45(1), 90-102.
- MAKAULA, P., BLOCH, P., BANDA, H. T., MBERA, G. B., MANGANI, C., DE SOUSA, A., NKHONO, E., JEMU, S. & MUULA, A. S. 2012. Primary health care in rural Malawi-a qualitative assessment exploring the relevance of the community-directed interventions approach. *BMC Health Services Research*, 12(1), 328.

- MANNINEN, K., SCHEJA, M., HENRIKSSON, E. W. & SILÉN, C. 2013. Self-centeredness or patient-centeredness—final year nursing students' experiences of learning at a clinical education ward. *Journal of Nursing Education and Practice*, 3(12), 187-198.
- MARCUS, M. T., TAYLOR, W. C., HORMANN, M. D., WALKER, T. & CARROLL, D. 2011. Linking service-learning with community-based participatory research: An interprofessional course for health professional students. *Nursing Outlook*, 59(1), 47-54.
- MARIAM, D. H., SAGAY, A. S., ARUBAKU, W., BAILEY, R. J., BAINGANA, R. K., BURANI, A., COUPER, I. D., DEERY, C. B., DE VILLIERS, M. & MATSIKA, A. 2014. Community-based education programs in Africa: faculty experience within the Medical Education Partnership Initiative (MEPI) network. *Academic Medicine*, 89(8), S50-S54.
- MARMOT, M., ALLEN, J., BELL, R., BLOOMER, E. & GOLDBLATT, P. 2012. WHO European review of social determinants of health and the health divide. *The Lancet*, 380(9846), 1011-1029.
- MCLAUGHLIN, K., MULDOON, O. T. & MOUTRAY, M. 2010. Gender, gender roles and completion of nursing education: A longitudinal study. *Nurse Education Today*, 30(4), 303-307.
- MENDENHALL, T. J., HARPER, P. G., HENN, L., RUDSER, K. D. & SCHOELLER, B. P. 2014. Community-based participatory research to decrease smoking prevalence in a high-risk young adult population: An evaluation of the Students Against Nicotine and Tobacco Addiction (SANTA) project. *Families, Systems, & Health*, 32(1), 78.
- MENNENGA, H. A. & SMYER, T. 2010. A model for easily incorporating team-based learning into nursing education. *International Journal of Nursing Education Scholarship*, 7(1), 1-16.
- MERRITT, A. & BOOGAERTS, M. 2014. Creativity and power: A qualitative, exploratory study of student learning acquired in a community nursing setting that is applied in future settings. *Contemporary Nurse*, 46(2), 225-233.
- MILLICAN, J. & BOURNER, T. 2011. Student-community engagement and the changing role and context of higher education. *Education + Training*, 53(2/3), 89-99.
- MORGAN, D. L. 1997. *Focus groups as qualitative research*, London, Sage Publications.
- MOTHOAGAE, G. 2013. *A review of University of the Witwatersrand medical students community based health promotion service learning projects in South Africa*. Master's thesis, University of Cape Town.
- MOTLHALE, L. M. 2012. *Guidelines for effective student accompaniment during community health nursing science clinical practice*. Doctoral thesis, University of Johannesburg.

- MOTSOALEDI, A. 2011. *How we're re-engineering the health system*: [Online]. Cape Town: Motsoaledi: Health Budget Vote Policy Speech presented at the National Assembly. Available: <http://www.politicsweb.co.za/documents/how-were-reengineering-the-health-system--motsoale> [Accessed April 2015].
- MOYER, V. A. 2012. Behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention in adults: US Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*, 157(5), 367-372.
- MTHEMBU, N. & MTSHALI, N. 2011. *Knowledge construction in community-based Service Learning Nursing Programmes: A grounded theory approach*. Thesis, University of KwaZulu-Natal.
- MTHEMBU, S., MTSHALI, N. & FRANTZ, J. 2014. Contextual determinants for community-based learning programmes in nursing education in South Africa: part 1: contemporary issues in nursing. *South African Journal of Higher Education*, 28(6), 1795-1813.
- MTSHALI, G. 2005. Conceptualisation of community-based basic nursing education in South Africa: a grounded theory analysis. *Curationis*, 28(2), 5-12.
- MTSHALI, N. 2009. Implementing community-based education in basic nursing education programs in South Africa. *Curationis*, 32(1), 25-31.
- MTSHALI, N. G. & GWELE, N. S. 2016. Community-based nursing education in South Africa: A grounded-middle range theory. *Journal of Nursing Education and Practice*, 6(2), 55.
- MURPHY, F., ROSSER, M., BEVAN, R., WARNER, G. & JORDAN, S. 2012. Nursing students' experiences and preferences regarding hospital and community placements. *Nurse Education in Practice*, 12(3), 170-175.
- NAIDU, C. S., ZWEIGENTHAL, V., IRLAM, J., LONDON, L. & KEIKELAME, J. 2012. An evaluation of University of Cape Town medical students' community placements in South Africa. *African Journal of Primary Health Care & Family Medicine*, 4(1), 1-7.
- NATIONAL DEPARTMENT OF HEALTH. 2012. *Annual performance plan 2012/2013-2014/2015* [Online]. Available: <https://www.health-e.org.za/wp-content/uploads/2014/11/National-Department-of-Health-Annual-Report-2013-14> [Accessed 5 June 2015].
- NATIONAL DEPARTMENT OF HEALTH. 2013. *Annual performance plan 2013- 2014/2015* [Online]. Available: <https://www.health-e.org.za/wp-content/uploads/2014/11/National-Department-of-Health-Annual-Report-2013-14>. [Accessed 5 June 2015].
- NATIONAL NURSING CENTERS CONSORTIUM [NNCC]. 2011. *Nurse-managed centers are changing the face of health care*. [Online]. Available: <http://www.nncc.us/about/nmhc.html>.

- NDATEBA, I. 2013. *Exploring promotion of primary health care philosophy in a community-based nursing education programme at a selected higher education institution in kwazulu-natal: the students' Perspective*. In partial fulfilment of the requirements for the course work Master's degree in Nursing (Nursing Education), University of KwaZulu-Natal.
- NEWTON, G., BETTGER, W., BUCHHOLZ, A., KULAK, V. & RACEY, M. 2015. Evidence-informed strategies for undergraduate nutrition education: a review. *Applied Physiology, Nutrition, and Metabolism*, 40(999), 1-10.
- NYAMATHI, A. & SHULER, P. 1990. Focus group interview: a research technique for informed nursing practice. *Journal of Advanced Nursing*, 15(11), 1281-1288.
- O'CONNOR, S. 2012. *The experience of practice nurses who had obtained a postgraduate nursing qualification and how the knowledge was utilised in the general practice setting*. University of Otago.
- O'NEILL, M., SIMARD, P., SASSEVILLE, N., MUCHA, J., LOSIER, B., MCCUE, L., MCCALL, D., DESCHESNES, M., LAITSCH, D. & LAGARDE, F. 2012. Promoting Health through the Settings Approach. *Health Promotion in Canada: Critical Perspectives on Practice*, 171-192.
- OKORONKWO, I. L., ONYIA-PAT, J.-L., AGBO, M.-A. E., OKPALA, P. U. & NDU, A. C. 2013. Students' perception of effective clinical teaching and teacher behaviour. *Open Journal of Nursing*, 3.01(2013), 63-70.
- OLAJIDE, A. A. & OTUNLA, A. O. 2015. Use of Information Resources by Student Nurses. *Library Philosophy and Practice*, 1-16.
- PARROTT, R., PETER MCGILL, G., WARD, C. & COOPER, V. 2013. Prevention is better than cure.... *Tizard Learning Disability Review*, 18(4), 208-211.
- PETERS, K., MCINNES, S. & HALCOMB, E. 2015. Nursing students' experiences of clinical placement in community settings: A qualitative study. *Collegian*, (2015), 175-181.
- PFAFF, K. A., BAXTER, P. E., JACK, S. M. & PLOEG, J. 2014. Exploring new graduate nurse confidence in interprofessional collaboration: A mixed methods study. *International Journal of Nursing Studies*, 51(8), 1142-1152.
- PHILIBIN, C. A. N., GRIFFITHS, C., BYRNE, G., HORAN, P., BRADY, A. M. & BEGLEY, C. 2010. The role of the public health nurse in a changing society. *Journal of advanced nursing*, 66(4), 743-752.
- POLIT, D. F. & BECK, C. T. 2004. *Nursing research: Principles and methods*, Philadelphia, Lippincott Williams & Wilkins.
- POLIT, D. F. & BECK, C. T. 2010. Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47(11), 1451-1458.

- POLIT, D. F. & BECK, C. T. 2012. *Nursing Research Generating and Assessing Evidence for Nursing Practice*, Philadelphia, Wolters Kluwer Health.
- POLIT, D. F. & BECK, C. T. 2013. *Essentials of nursing research*, Philadelphia, Lippincott Williams & Wilkins.
- PROHASKA, T. R., TRITES, H. K. & SCOTT, K. L. 2014. Health policy development: health promotion and illness prevention among older adults in Illinois. *Sociological Practice*, 11(1), 9.
- PROPP, K. M., APKER, J., FORD, W. S. Z., WALLACE, N., SERBENSKI, M. & HOFMEISTER, N. 2010. Meeting the complex needs of the health care team: identification of nurse—team communication practices perceived to enhance patient outcomes. *Qualitative Health Research*, 20(1), 15-28.
- RAINGRUBER, B. 2014. *Contemporary Health Promotion in Nursing Practice*, Burlington, Mass, Jones & Bartlett.
- RAMSON, A. J. 2014. Service-learning: A tool to develop employment competencies for college students. *Journal on Excellence in College Teaching*, 25(1), 159-187.
- REID, S. & CAKWE, M. 2011. The contribution of South African curricula to prepare health professionals for working in rural or under-served areas in South Africa: A peer review evaluation. *SAMJ: South African Medical Journal*, 101(1), 34-38.
- RICHARD, L., GAUVIN, L. & RAINE, K. 2011. Ecological models revisited: their uses and evolution in health promotion over two decades. *Annual Review of Public Health*, 32, 307-326.
- ROISING, H., REED, S., FERRARI, J. R. & BOTHNE, N. J. 2010. Understanding student complaints in the service learning pedagogy. *American Journal of Community Psychology*, 46(3-4), 472-481.
- ROSS, C., MAHAL, K., CHINNAPEN, Y., KOLAR, M. & WOODMAN, K. 2014. Evaluation of nursing students' work experience through the use of reflective journals: Positive learning outcomes can be achieved by combining clinical community placements with critical self-reflection, say Charlotte Ross and colleagues. *Mental Health Practice*, 17(6), 21-27.
- ROWE, C. D. 2011. *The sustainability of service learning and community engagement in the post 'community higher education service partnership' era*. Master of Education Dissertation, University of the Witwatersrand.
- RYAN, F., COUGHLAN, M. & CRONIN, P. 2007. Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal Of Nursing*, 16(12), 738-744.

- SCHAFFER, M. A., CROSS, S., KELLER, L. O., NELSON, P., SCHOON, P. M. & HENTON, P. 2011. The Henry Street Consortium: Population-based competencies for educating public health nursing students. *Public Health Nursing*, 28(1), 78-90.
- SCHMIDT, H. G., ROTGANS, J. I. & YEW, E. H. 2011. The process of problem-based learning: what works and why. *Medical education*, 45(8), 792-806.
- SCHWINDT, R. G., MCNELIS, A. M. & SHARP, D. 2014. Evaluation of a theory-based education program to motivate nursing students to intervene with their seriously mentally ill clients who use tobacco. *Archives of Psychiatric Nursing*, 28(4), 277-283.
- SHENTON, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22(2), 63-75.
- SHINNICK, M. A., WOO, M. A. & MENTES, J. C. 2011. Human patient simulation: state of the science in prelicensure nursing education. *The Journal of nursing education*, 50(2), 65-72.
- SILBER, G. & GEFFEN, N. 2016. Race, class and violent crime in South Africa: Dispelling the 'Huntley thesis'. *South African Crime Quarterly*, (30), 35-43.
- SRIVASTAVA, S. & FATIMA, A. 2012. Prevention is better than cure. *Asian Journal of Home Science*, 7(2), 592-596.
- STABLES, I. 2012. Development of clinical skills: The contribution of peer learning: Ian Stables describes a pilot project in which third-year learning disability nursing students taught vital skills to their first-year colleagues. *Learning Disability Practice*, 15(8), 12-17.
- STEELE, R. G., WU, Y. P., JENSEN, C. D., PANKEY, S., DAVIS, A. M. & AYLWARD, B. S. 2011. School nurses' perceived barriers to discussing weight with children and their families: a qualitative approach. *Journal of School Health*, 81(3), 128-137.
- STEINHUBEL, J. 2012. *Evaluating the use of simulation with beginning nursing students*. Master of Science Thesis, Ball State University.
- STEINMETZ, J. M. 2013. *Cyberbullying and the digital divide: Student and teacher perceptions and reactions*. Doctoral thesis, Ohio State University.
- STONE, R., COOPER, S. & CANT, R. 2013. The value of peer learning in undergraduate nursing education: a systematic review. *ISRN Nursing*, 2013, 1-10.
- TEBES, J. K., KAUFMAN, J. S., CONNELL, C. M., CRUSTO, C. A. & THAI, N. D. 2014. Evaluation in primary prevention and health promotion. *Encyclopedia of primary prevention and health promotion*, 69-101.
- THISTLETHWAITE, J. E. 2011. *Non-traditional nursing students' perceived ability to form caring relationships*. Doctoral thesis, Indiana University of Pennsylvania.

- THOMPSON, C. W. & BUCHER, J. A. 2013. Meeting Baccalaureate public/community health nursing education competencies in nurse-managed wellness centers. *Journal of Professional Nursing*, 29(3), 155-162. doi:<http://dx.doi.org/10.1016/j.profnurs.2012.04.017>
- TUCKER, S., LANNINGHAM-FOSTER, L., MURPHY, J., OLSEN, G., ORTH, K., VOSS, J., ALEMAN, M. & LOHSE, C. 2011. A school based community partnership for promoting healthy habits for life. *Journal of community health*, 36(3), 414-422.
- US DEPARTMENT OF HEALTH AND HUMAN SERVICES 2007. Health resources and services administration. The registered nurse population: Findings from the 2004 National Sample Survey of Registered Nurses.
- UTA, L., FRANCOISE, B. & DAVID, S. 2012. Task shifting: the answer to the human resources crisis in Africa? *Human Resources for Health*, 7(1), 49-55.
- UYS, L. 1998. University of Natal, School of Nursing. *Network of Community-Oriented Educational Institutions for Health Sciences Newsletter*, 28, 19.
- UYS, L. & GWELE, N. 2004. *Curriculum development in nursing: Process and innovation*, Routledge.
- UYS, L. & GWELE, N. 2005. *Curriculum development in nursing: Process and innovation*, Routledge.
- VALAITIS, R. K., SCHOFIELD, R., AKHTAR-DANESH, N., BAUMANN, A., MARTIN-MISENER, R., UNDERWOOD, J. & ISAACS, S. 2014. Community health nurses' learning needs in relation to the Canadian community health nursing standards of practice: results from a Canadian survey. *BMC Nursing*, 13(1), 1-10.
- VAN IERSEL, M., LATOUR, C. H., DE VOS, R., KIRSCHNER, P. A. & OP REIMER, W. J. S. 2016. Nursing students' perceptions of community care and other areas of nursing practice—A review of the literature. *International Journal of Nursing Studies*, 61, 1-19.
- VISOVSKY, C., MCGHEE, S., JORDAN, E., DOMINIC, S. & MORRISON-BEEDY, D. 2016. Planning and executing a global health experience for undergraduate nursing students: A comprehensive guide to creating global citizens. *Nurse Education Today*, 40, 29-32.
- VOGT, M. A., CHAVEZ, R. & SCHAFFNER, B. 2011. Baccalaureate nursing student experiences at a camp for children with diabetes: The impact of a service-learning model. *Pediatric Nursing*, 37(2), 69.
- WAHYUNI, D. 2012. The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research*, 10(1), 1-4.

- WAKEFIELD, L. & TAIT, S. 2015. Crime and violence in formal and informal urban spaces in South Africa: Citizen security dialogues dispatches from South Africa: Foreword. *Stability: International Journal of Security and Development*, 4(1), 1-4.
- WALTHER, P. & SCOTT, H. 2012. Conceptions of health promotion held by pre-registration student nurses in four schools of nursing in New Zealand. *Nurse Education Today*, 32(3), 229-234.
- WALTON, J. & BLOSSOM, H. 2013. The experience of nursing students visiting older adults living in rural communities. *Journal of Professional Nursing*, 29(4), 240-251.
- WANG, J., CHEN, C.-Y., LAI, L.-J., CHEN, M.-L. & CHEN, M.-Y. 2014. The effectiveness of a community-based health promotion program for rural elders: A quasi-experimental design. *Applied Nursing Research*, 27(3), 181-185. doi:<http://dx.doi.org/10.1016/j.apnr.2013.11.014>
- WANLESS, D. 2004. Securing good health for the whole population. *London: HM Treasury*, 4, 2003-2004.
- WHITEHEAD, D. 2011. Health promotion in nursing: a Derridean discourse analysis. *Health Promotion International*, 26(1), 117-127.
- WHO. Ottawa charter for health promotion. Ottawa Charter for Health Promotion: First International Conference on Health Promotion, Ottawa, Canada, 17-12 November, 17-12 November 1986 Ottawa, Canada.
- WHO 1987. Community-based education of health personnel . Report of a WHO Study Group. *World Health Organisation Technical report series. No.746*. Geneva: World Health Organization.
- WHO 1997. The Jakarta Declaration: on leading health promotion into the 21st century. Geneva: World Health Organization.
- WHO 2005. The Bangkok Charter for health promotion in a globalized world. *Health Promotion Journal of Australia: official journal of Australian Association of Health Promotion Professionals*, 16(3), 168.
- WHO 2010. *Community-based Rehabilitation: With CD-Rom*, Geneva, World Health Organization.
- WHO. 2011. *Transformative scale up of health professional education: An effort to increase the numbers of health professionals and to strengthen their impact on population health* [Online]. Available: http://www.who.int/hrh/resources/transformative_education/en/index.html [Accessed 12 July 2015].
- WHO 2014a. WHO Definition of palliative care.

- WHO 2014b. The World Health Report 2008: Primary health care (now more than ever). Geneva.
- WHO & UNICEF 1978. Primary health care: report of the International Conference on Primary Health Care. Alma Ata, USSR: Geneva: World Health OrganizationHO.
- WRIGHT, K., GIGER, J. N., NORRIS, K. & SURO, Z. 2013. Impact of a nurse-directed, coordinated school health program to enhance physical activity behaviors and reduce body mass index among minority children: A parallel-group, randomized control trial. *International Journal of Nursing Studies*, 50(6), 727-737.
- YANG, K., WOOMER, G. R. & MATTHEWS, J. T. 2012. Collaborative learning among undergraduate students in community health nursing. *Nurse Education in Practice*, 12(2), 72-76.
- ZANCHETTA, M., SCHWIND, J., AKSECHUK, K., GOROSPE, F. F. & SANTIAGO, L. 2013a. An international internship on social development led by Canadian nursing students: Empowering learning. *Nurse Education Today*, 33(7), 757-764.
- ZANCHETTA, M., TAHER, Y., FREDERICKS, S., WADDELL, J., FINE, C. & SALES, R. 2013b. Undergraduate nursing students integrating health literacy in clinical settings. *Nurse Education Today*, 33(9), 1026-1033.
- ZIGLIO, E., SIMPSON, S. & TSOUROS, A. 2011. Health promotion and health systems: some unfinished business. *Health Promotion International*, 26(suppl 2), ii216-ii225.

APPENDICES

Appendix 1: Information Sheet

Date: 20 September 2015

Name of research student: Agathe Uwitonze (Telephone: 0719016967)

E-mail: 213570302@ukzn.ac.za

Name of supervisor: Ms E.N. Pakkies (Telephone: 0312601783)

Name of co supervisor: Professor G. Mchunu (Telephone: 0312601421)

Name of department: School of Nursing & Public Health

Name of institution: University of KwaZulu-Natal

Dear Participant,

I am completing a research project as part of the requirements for the Masters Degree through the College of Health Sciences, School of Nursing & Public Health.

Title of the research: an exploration of nursing students' experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal

Purpose of the research: the study is aimed to explore nursing students' experiences of the community based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

Day, time and venue will be convenient to avoid disturbing the classes. Three focus groups discussion will be conducted, two on the first day and the third on the second day. Each focus

group will require 1 hour; your involvement will be highly appreciated and respect for each person's opinion is recommended in order to avoid any group threat.

Ethical aspects

Please note that confidentiality and anonymity will be assured. Your identity is not requested; signature alone will be required for the consent form.

The sessions will be taped recorded, but all recordings and transcriptions will remain with the researcher and stored in the confidential custody of the research supervisor's office for duration of the study. After scanning, written copies of transcripts will be destroyed by fire and tapes will be stored in the researcher supervisor's office for a period of five years according to UKZN policy.

Please feel free to ask any questions you may have so that you are clear about what is expected of you. Please note that:

- you are free to not participate
- you are free to withdraw at any stage without repercussions
- your name will not be used nor will you be identified with any comment made when the data is published
- there will be no risks attached to your participation

Advantage to you as a respondent:

The findings of the study will be made available on completion.

Thank you.

Appendix 2: Informed consent form

Researcher: Agathe Uwitonze

Student Number: 213570302

Cell Number: 0719016967

E-mail: 213570302@ukzn.ac.za

Title: Students' experiences perceptions of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal.

Declaration

In regards to the information I have received, I hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of Participant: _____

Date and Time: _____

Appendix 3: Focus group interview guide with nursing students

Date:

Venue: conference room of school of nursing

Time:

Welcome

Thanks for agreeing to be part of the focus group. We appreciate your readiness to participate.

Introductions

Student researcher; personal assistant.

Purpose of focus groups

We have been asked to conduct the focus groups.

The reason we are having these focus groups is to find out your feeling and experiences on community based health promotion and illnesses programme

We need your input and want you to share your honest and open thoughts with us.

Ground rules

1. We want you to do the talking.

We would like everyone to participate.

I may call on you if I haven't heard from you in a while.

2. There are no rights or wrong answers

Every person's experiences and opinions are important.

Speak up whether you agree or disagree.

We want to hear a wide range of opinions.

3. What is said in this room stays here.

We want individuals to feel comfortable sharing when sensitive issues come up.

4. We will be recording the group

We want to capture everything you have to say.

We don't identify anyone by name in our report. You will remain anonymous.

General experience of nursing students:

1. Tell us about your experience in the community setting (real situation)
2. What have been your experiences when you were involving in the community based health promotion and illness prevention.
3. What are some of the activities you carried out during the community based health promotion and illness prevention.
4. Can you tell us some of the challenges you experienced during the community based health promotion and illness prevention.

Thank you for participating in this research.

Appendix 4: Focus Discussion One

Focus group One, 07 November 2015

Date: 7 October

Venue: TV room 2, Florence Power Residence.

Time: 10:00 – 11:00 Am

INTRODUCTION

My name is Agathe Uwitonze, **Welcome** and thank you for agreeing to be part of the discussion. I appreciate your readiness to participate in this discussion. I am a master degree student in Community Health Nursing at UKZN.

Reason for conducting the focus group discussion

The reason why we are having this discussion is to find out your feelings and experiences on community based health promotion and illness prevention programme in your school. I need your input and I will be very grateful if you can share your honest, open thoughts and opinion with me.

Participants were given the information sheet and the researcher explained the title, purpose and the significance of the study to them.

Written Inform consent forms were signed and given back to the researcher.

Participants are acquainted with rule of the discussion

These are the grounded rules

1. Participants were encouraged to be involved in the discussions, hence everyone should participate actively. (I would like to hear from everyone)

- You may be called to contribute if found not participating.

2. There are no right or wrong answers

- Everyone's experiences and opinions count and are very important in this study.
- Speak up whether you agree or disagree.
- In respect for each other, only one person will speak at a time in the group.
- Hope you would be accept it even when your responses are not be in agreement with the rest of the group.

3. Confidentiality (What is said in this room stays here).

- Everyone should feel comfortable and be free in sharing when sensitive issues come up and all Responses given by participants must be kept confidential.

4. Documentation (I will be recording proceedings).

- Everything you say will be captured and nobody will be identified by name in the report. You will remain anonymous. Each participant was then given a code.

They were six participants in number so the following codes were given to them: A1/P1-F1/P6 (A1, B1, C1, D1, E1 and F1). Before we start our discussion do you have a question for the researcher?

Participants responded: No question.

R: Thank you. So I think now we can enjoy our discussion. Isn't it?

R::Okay, so I would like you to tell us about your experiences in the community setting. Yes, your experience during your community based health promotion and illness prevention programme.

Silence....

R: Yeah, I would like you to tell us about your experiences, yeah....., tell us about your community intervention starting from the beginning of the year up to September

Silence.....

R: Yes

FGDs1-P5 (E1). My experiences during the community.at the beginning we were not provided with transport and it was hard to get to the community. (Speaking softly)

R: Can you please speak loudly so that we can hear you clearly?

FGDs1-P5 At the beginning, there was no transport. We had to walk long distances to reach the community.

Finally we went; we had to wait for long time, we went toooo, community....., what is that?

Interrupted by C1: Community entry

FGDs1-P5 E1:.Yes, community entry. And for the community entry we have to meet with the counsellor. The counsellor was not there. We have to wait.., we have to wait...for long time and they even delayed us.

R: Okay

FGDs1-P5 E1: Yeah.....Do we have even to mention the good things?

R: please - Feel free to express yourself

FGDs1-P5 E1:.Okay no problem. My community has a higher crime rate

R: Okay

FGDs1-P5 E1:.Yeah....., students in the community were smoking, and we were scared to work around, they had to appoint someone to go with us round the community. Hee!! We had the problem of transportation, we had to walk to the community on foot and that was so challenging.

R: Humhum

FGDs1-P5 E1:.Some people in the community were welcoming, some not welcoming.

R: Okay

FGDs1-P5 E1: Yeah. ..it was a good thing, good experience, I learned how people live and how people try to overcome the problems they have, I also learned to know about different cultures.

R: Can you help me to understand what you meant by understanding other cultures?

FGDs1-P5 E1: For me, I am a Swazi, and working here in KwaZulu-Natal, people here are Zulu. In our culture.... Like in our culture, the spirit of ubuntu, like rules within the community.

R: Humhum Yes

FGDs1-P5 E1: When we were doing the interview, some people said they are not even ever speaking to their neighbours

R: Okay...

FGDs1-P5 E1: Yeah....of which this does not happen in my community we have Christian and traditional, Swazi traditional. Here they have got Christianity; they have Muslim, and Nazareth. Yeah, of which I do not know. It was my first experience. Yeah...

R: Okay, thank you. What do other people think? Silence. Yes, your experience?

FGDs1-P2 B1, Yes, my experiences... (Softly)

R: Can you speak loudly please?

FGDs1-P2 B1, Yes, my community, in our community they were crimes so I fear a lot to go around

R: Okay

FGDs1-P2 B1, When you go around in our community, they were some part where we were not allowed to go through, and they were small part where we were allowed to go through. And with the small part, they are some information we also wanted but we did not get them all. And we did not know what to do; there was no one to guide us.

FGDs1-P5 E1: To add, in our intervention, the information were limited because we could not go everywhere and... without any helpful suggestions or direction we could not do much, and for the transport we have to take two taxis.

R: Humhum

Yeah. We did not have money, we are all students. Yeah the good experience is that... well, the community is very helpful, yeah, and that is it. Yes, I think hee, how people lives limited our information. Yeah, it should be much easier if we were able to go and get the information everywhere, because we could not just get there and say we need the information.

FGDs1-P3 C1: And they were so scared to let us go to the flat. Yeah.....Haaaaa, the problem that we encountered, haaa, they was sanitation, they were a very poor level of sanitation, high level of crime, teenage pregnancy, heeee, some people were welcoming in the community, some people were not. But, we.....(C1 trailed off)

R: Come again

FGDs1-P3 C1But we managed.

R: Okay

FGDs1-P4 D1: Heuuu, before my experience, I have different perception of the place.

My perception was mostly coloured based, knowing about the coloured, I thought it was very, like crime related. Very rude in norms in the community, so I was very scared to even enter in the community. We all the same had the problem in terms of transport, so, we really felt to locate the place and we did not even know about it. So that was my first encounter.

R: Okay

FGDs1-P4 D1: Then we went to the police obviously and then the people were very welcoming. I was even surprised. So that was the first good thing about that community. They welcomed us. And in terms of religions, it was very religious community.

R: Yes.

FGDs1-P4D1: They valued religion. And in terms of poor..... There was very poor sanitation because of industry area surrounding. So the industry area is the first cause of poor sanitation.

R: Okay.

FGDs1-P4D1: And heee, yeah..that the first think about... the good thing about,.. they were welcoming and in terms in asking direction, they were directing us where to go. And yeah, they are also the social problems; we identified the teenage pregnancy, HIV, diabetes yeah. And also drug abuse even between students. Yeah a good thing is the community has many NGO, yeah, in term of support.

R: Okay. Any comment?

FGD1-P6F1: Yeah, as she said the community were welcoming but there was very higher rate of violence, we were scared.

But the think that make me happy, the series in the community. Because we went there one day there was a subscription for people who do not have food. So we helped and like give us like we were happy to help people. During the community as we were going to the community it help me a lot, like how to work as a group, yeah.

R: Okay any other comment?

FGD1-P5 E1: I would like to add to what they said, also in the community they were no good area, and it was very dangerous. The other thing, there is..., during our intervention, we, we, we...wanted to do the intervention with to students from grade 7 to grade 9. But, we were limited. which grade were we given ?

FGD1 P3C1. Grade 7 and 8

FGD1-P5 E1: Grade 7 and 8. Of course, Yeah, the information we had we were not sure if it was like over help to them because our target group was grade 7 to 9. Because we were doing teenage pregnancy, hygiene, condom uses.. We have to start by the lower grade. Yeah

FGDs1-P4D1: I also like to add in terms of our community, heee, our facilitators were not really available, and were not there for us so we encounter another problem of auto understanding of the work that seems to be done.

R: yes

FGDs1-P4D1: So we had to go and ask other facilitators or other groups in term of ideas or what to do because our facilitator was not there, was not available. So that was also the encounter we had. In terms of our facilitators they need to work with us.

FGD1-P5 E1: Another challenge, I think we had the same challenge in groups, when, heee, during our intervention we had to take out money from our pockets to do the intervention and that was a large sum of money paid. Some had to pay R300. Remember we were doing it for the mark, so we cannot just say no we don't have money, so we have to look for that money, and doing this for a while you cannot. And I think the school of nurse should have, like, should find the funds.

FGD1 P3C1 and FGD1-P5 E1: Responded at the same time: like contribution

FGD1-P5 E1: And they (school) told us that we have to go to the company to ask for donation. That is so difficult for us, the people they do not trust you at all. And even if you want the letter from them (school), it takes time for them to give you the letter. The letter that you are supposed to take to these companies to ask for donation. Yeah...

R: Okay.

FGDs1-P4D1: In terms of working in group members, some members were not willing to work, some were willing. We also have a problem of communicating with each other. Let say you want to further go to the community but some doesn't have time. So we were not all willing to work.

R: Humhum

FGDs1-P4D1: So also participation among the group was different. Some also they do not catch up.

R: Humhum

FGDs1-P4D1: Some came.

R: Okay.

FGDs1-P4D1: So they were unbalance in terms of the work that has to be done as a group.

R: Okay.

FGDs1-P5E1and FGDs1-P4D1: at the same time: Yeah, when at the end the day we had the same mark.

R: Okay, I can understand. So I hear you talking about teenage pregnancy, and you had mentioned some issues in the community including drugs abuse, alcohol and diabetes. So I would like to know if there is an intervention you did related to these health problems. Yes? I want to know the activities you did exactly during your community intervention.

FGDs1-P5E1: Hummmm, like for teenage pregnancy, we, we did an intervention on condom use. We talked to them about....Because you cannot in our days to tell kids to abstain because they want too, like they want to experiment. So we found that better for us too, like to control the problem by equipping them on how to use condom, equipping them on contraceptives use and telling them about the consequences of teenage pregnancy.

R: Okay.

FGDs1E1: Yeah.

R: Okay, any other activity?

FGDs1-P4D1: In terms of social environmental problem,

R: Yes.

In terms of prevention, there is an NGO, heuuu, an active NGO, in the community, an environmental NGO that is working and is always doing much and talking to the nearby the area

industries to try and change or find programs that will be let arm to the environment and also to the people . So what we did, we tried to participate with them in talking and heinnnn, in the work.

R: Okay. Yes D?

FGD1-P6F1: Heuuu, from Teenage pregnancy in our intervention we were doing with grade 8. So we really encourage abstinence, as they are young people. But we also encourage the contraceptive but the abstinence was our real point because they need to abstain. Yes, in order to prevent HIV, pregnancy, STI and all other things.

R: Humhum.

FGDs1-P4D1: Yes, at the young age it is still not actually aware of what is going on. So we tried to inform them at their young age to abstain, so that they were more aware of what it is going to happen if they do not abstain. So they tried and prevent so that in terms of primary prevention. But we could not believe to tell them about contraceptive methods because they were from primary school. So we just told them the effect of teenage pregnancy, having to care for a baby. So we used an example of eggs. In term of when they come in, they cannot do anything. They have to carry the egg forever. That was part of our intervention. The egg symbolise the baby. So we tried to use that analogy to try to explain them teenage pregnancy and effects of it. That what we did in terms of prevention.

R: Okay.

FGDs1-P1A1. Yeah, because we were given the students from grade 7 and 8, which was not our target group but we were.....some were forced to accommodate them. Heuuu, what we did, hee, we had to teach HIV, like the mode of transmission, heee, hygiene, bullying. And what limited us; there was no high school nearby so we did not do anything about teenage pregnancy. I fill like we had to do it, but, there was no school, yeah

R: Okay, can you explain us more on what you did relate to the hygiene you have mentioned? What did you do exactly?

FGDs1-P1 A1: Heuuu, just the basic things like before eating you have to wash your hands, after eating washing hand, going to the toilet, heuuu brushing teeth correctly, the importance of brushing teeth correctly and also after playing to wash hands, things like that, yeah

R: Okay. Yes? Addressing to B

FGDs1-P2 B1: Yeah, and also their toilets were not clean we told them how to wash them. And we gave them teeth brush.

R: Okay. So you did a fundraising to provide the teeth brush

FGDs1-P2B: Yeah

R: Others activities?.Silence..... Yes?..... You were there from January to September, any other activity?

FGDs1-P4D1: The, heuu, in our own we also went to crèche, we did a garden for them, we started planting carottes, cabbage, onions and other vegetables, so that was part of our intervention.

R: What social problem pushed you to do that garden? I would like to know the reason of the garden.

FGDs1-P4D1: Because we went there for, just toward to see the crèche, heuu, when we were working around the community, we decided to go to the crèche and we saw the crèche needed equipment and also like, no garden and we decided us a group to intervene. We talk to the person in charge, heuuu, about garden ideas and she was also aware in terms of garden, to do the garden because she has experience in the past in term of garden and because of working in a place like that she was happy too and willing.

FGDs1-P1A1: In our intervention, in the high school, we cleaned the toilet and we provided money and we painted the toilet because it was very dirty and the hall was written.

R: Wow!!!!. Okay. That is really wonderful.

FGDs1-P5 E1: Yeah, that was like encouraging hygiene even if the students were rude. We painted the toilet today and the next day the wall was written.

R: Ooh

FGDs1-P5 E1: Yeah that was sort of against to us because we tried to help and they even told us in the face that they are going to write. I think the mentality of the community they have that they have. And also in terms of hygiene we also printed posters on hand washing, sleeping plenty because since they were students yeah, sleeping plenty, and like also the food they were supposed to eat in order to be healthy and being more productive in their studies

R: Can you explain us more about that? Like the food they were supposed to eat.

FGDs1-P5 E1: Heuuu, we talked to them about the food they can eat when they are studying, like we told them to avoid fatty food, when you are talking about food they were supposed to eat? Like fruits, fish. During our intervention, we found the community has a poor background, we talk to them and gave condoms and education we gave them also pamphlet on HIV and also we invited a guest speaker who talked to them about HIV, Teenage pregnancy, like concluding all the activities that we were doing during our intervention.

R: Okay. Thank you. So related to what you said I can see that so many activities were based on illness prevention. I would like to know what you did on health promotion. Okay of course you did a part of health promotion, like telling them eating healthy food, like to avoid fatty food, eating fruits, sleeping enough. But, I would like to know if you did like home visit and what activities during home visit.

FGDs1-P2B1: I did home visit. It was also part of our assignment.

R: Yes

FGDs1-P2: And in that home visit we did family history, in term of helping and from there we had to do also health assessment and we did some kind of health promotion because we had to tell them to change a few things in doing it correctly.

R: Like what for example?

FGDs1-P2: Heuuu. Maybe in term of eating any meat meal with any other like vegetable .Also Like to prepare the food in term of boiling to avoid oil and to do some exercises at home.

FGDs1-P5 E1: In term of nutrition, they could not afford like to buy like vegetable and all the staff. So we encouraged them to have a healthy nutrition and we taught them how to do the garden and plant vegetable and fruits because they have space.

R: Okay. Did they do that?

FGDs1-P5 E1: Some did. Some did not.

R: Yes? Health promotion activities (no answer). Okay, others? (No answer)You did not do home visit?

All: We did

R: The home visit was it individual task or you went per group?

All: Individual.

R: Okay, so what did you do during the home visit? I think everyone has to say something.

No answer

R: Our College told us that she use to explain how to cook nice food, to eat healthy food like vegetable, to do some exercises, another explained that she helped them to understand the importance of healthy food and helped the family to do a garden. So I think you did also something else. What did you do? Can you explain to us?

R: Yes?

FGDs1-P1 A1: In addition on what she has done, I also checked the health line of the baby if it was update. Checked if the child got all the immunisation, if not, I advised to....., to go to the clinic. Okay. (Road to health guide)

R: That what you did? Okay. Thank you

FGDs1-P3 C1. In our community we were not allowed to go to the flat so we end up interviewing people in the clinic.

R: Okay. So since you didn't do home visit, what did you do in the clinic? Can you explain to us?

FGDs1-P3 C1: We asked family about family history and we were targeting the mother on health of their child. We checked for the baby, if the baby is getting all the vaccination

R: Yes?

FGDs1-P3 C1. And we found out that some (immunisation) they were missing and some not.

Silence

R: Okay . And what did you do? Others?

FGDs1-P3 C1. Yes, I encouraged the mother to go to the clinic to get those vaccinations for the baby. Yeah

R: Okay

FGDs-P2 B1: For the family assessment likely I went to one flat. Heuuuuuu. What I did it is almost the same like others. Yeah. I just told them about. Heuu about the good way for preparing food for under five years.

R: Yes

FGDs-P2 B1: Sometime the baby does not want to eat. I encouraged them to give to the baby in small proportions at different time maybe an apple, and heuuuu, for the community where I was, there was no space for garden so I encouraged them to go to the market to buy. Where they can buy food and get a discount.

Yeah, what I can say is that flat is not a good environment to raise a child. Yeah. There is no place for a child to play. That is it. Yeah.

FGDs-P6F1 In the family I did the home visit, people were able to get food for their children. So what I did, I encouraged them for the under-five, I encouraged them to give water, and on the hygiene. Like they have to bath the child maybe twice a day, and for preparing the food they need to wash their hands. Yeah.

R: Okay. Is there any activity you did?

FGDs-P6F1: Heuuu. The family that I went to, they were no waste disposal, they were just throwing things around the place.

R: Humhum.

FGDs-P6F1: Yeah, and I encouraged them like to buy these black plastics and to put inside everything because they have this travel collector trucks twice a week. Yeah, I encouraged them to put the waste in the plastic.

R: Yeah. Remember you said that you did health assessment, family assessment and some interventions. So I would like to know if you went back in the community after a certain time. If so, can you explain what you did and how was it?

FGDs1-P1 A1.....Yeah we went in September to do the evaluation. Okay.

R: Okay.

FGDs1-P5E1. Some people have changed.

R: Humhum

FGDs1-P1A1. Yeah, they were not the same like before we entered in the community. Some they used the knowledge to their own benefit.

R: Humhum

FGDs1-P5 E1Yeah. Like the part of the garden, some have done the garden. And for the children who had missed the immunisation, some were updated

For their hygiene, there was improvement.

R: Okay.

FGDs1-P6 F1. Yeah, during September we went in to the community, the sisters told us that there is a very a big change, the teenagers came to the clinic asking for condoms, and others even want the contraceptives like pills. We were very happy.

In terms of the garden, we could see that it was grown up because we brought seed which was already seated. Yeah, it was very good.

R: Okay Yes? What about others? You didn't do the evaluation? Smiling and ask to A1: Was it positive or negative?

FGDs1-P1 A1: Positive.

R: Can you explain more when you say positive? Laughter (all moderator and participants. Yes?

FGDs1-P1 A1: Well, heuu, our intervention was positive, because heuuuuu, we saw that things have changed. Also they was an improvement, like the municipally does provide, you know those black big plastics?

R: Yes

Yeah for some people in some areas. Some people just put things everywhere. Yeah.

FGDs1-P2 B1. Yeah, at first teachers were complaining that the toilets were not clean. But now learners have changed and even spend more time in the toilet because it was clean. More laughter.

R: Yeah. Thank you very much. You have mentioned some challenges like the problem of transport, the facilitator who was not there. So I would like to know if there are any other challenges you experienced during the community based health promotion and illness prevention programme

FGDs1-P4D1. Lack of safety.

R: Lack of safety.

FGDs1-P1A1: Heuu. The community that we went in was not safe, not safe. Yeah, not safe. They are street kids or people in the street. When we worked there, we had to carry our bag tightly because you never know what can happen. They can even steal your phone. Yeah, that what I can say.

FGDs1-P6 F1: In our community, we face a really difficult time without a facilitator; we *disagreed* a lot during our interventions. Because one will come with a point and we will not agree with the point so we would disagree and I blame the facilitator because we got a low mark. We did not have a facilitator; we had to ask other groups, other facilitators and the fourth years. Yes

FGDs1-P4D1: There was no guidance. Even when we were appointed a new facilitator and then the new facilitator had no idea on what happen, it was also like we all do not know. It was very hard for us. It was very very hard.

R: Okay

FGDs1-P4D1: So, it was very hard in terms of understanding all the procedures. We had the information but we did not know how to apply the information. So we have to ask assistance elsewhere. In terms of the facilitator, when it was time for intervention, the facilitator appointed for us was not there, she went back. I do not know, for some personal problems. So she went back.

And also in terms of crime, let say they told us to go to the police because of the security, we should also always be accompanied by the security. We went to the police station on the first day. But during the whole period they were no police so we went there on our own risk. So we travelled on our own risk. So we had to go in groups so we know that we were safe. Otherwise we were not protected.

So also the home visits were much tensed, because of risk, we were very scared. We could not know what to expect when you go alone. So some opted to go to the clinic or they just ask another group to go with them so they know that they were safe.

So safety and our facilitator in terms of assistance was our huge, huge problem that we faced in our community.

R: Okay

FGD1-P5 F1: And the **substance abuse, in the community; the teenagers were using drugs; so we were like afraid. If they have been using drugs what can we expect them to do to us?**

R: Okay. Others? Any challenges?

FGDs1 A1, Safety and transport. Yeah

FGDs1-P4D1. And also for transport it was R50 a day.

R: 50Rands?

Yes, it was R50 a day, because our community setting was very far from (school). So we had to take 2 taxis.

R: Humhum

FGDs1-P4: So those 2 taxis are very expensive in a way. So they were not around so we had to connect and connect. So it was R50 a day so for 7 days imagine, and we had to go there for 2 weeks, sometime for 3 weeks and we also had to prepare lunch. So had also to go back to town to have something and come back, so in terms of cost it was very costly for us. Others did not want to participate, because they did not have the money. Some were willing to go back but they were issue with money. So transport did cause pain like that. So in the future they should try to organise transport for the students. Our other alternative we did, we went with the medical school bus.

R: Humhum

FGDs1-P4D1: So we know that they do pass around the community. So we ask them to give us lift.

R: Okay.

FGDs1-P4D1: So there was another alternative but in terms of time you become late because of the bus.

R: Okay

FGDs1-P4D1: Yeahhhhh.

R: Another challenge? No? Silence...So what were the benefits now? Yeah, one of our college said that she gain a lot because she was happy to work in group. So what are others benefits did you gain during your community based health promotion and illness prevention programme?

FGDs1-P4D1: In terms of the community, I learned to work with the different style. There was a mix, in terms of group. So when one is not willing to work you got another person to work. So I leaned that. And in term of my work, I learned to be more active, and also I became more aware of the fact that, I should not judge. And I'm actually experienced because, heuuu, previously before I experienced, I had a different perception of what the community was like. So when I did get back, I got a different perception. So yeah, that was the good experience I gain. For me that what I liked, I learned for me not to judge, you have actually to understand the place before I could actually put on judgement of that place because what I thought did not actually become the outcome.

R: Okay. Others

FGDs1-P2 B1.

In the point of judgement, I learned that even though they were like heee, higher rate of teenage pregnancy, it is not like all of them they were looking for sex or for their pleasure. Some of them they got the sugar daddies so that they get money. They were from poor family background. So they needs sugar daddies to get money and boom they became pregnant.

R: Humhum

So that what I leaned there, the things that let them get pregnant and other things that they are doing. Okay (drugs, prostitution, and alcoholism)

FGDs1-P4D1.

Another thing, hee, is not always the person that doing a certain thing. It is the circumstance that caused them to do certain things like prostitution because there was also a higher rate of prostitution. Also alcoholism caused by pear pressure. So sometimes it was the situation that caused them to do certain things.

R: Humhum.

So what we did, we tried to keep them out, showed them other ways to get things done, the way things must be done.

R: Humhum. Okay. Other benefits? Yes? You didn't gain anything? What about you?
Moderator addressing to C1.

FGDs1-P3 C1: Laughing. I learned.

R: Yes

FGDs1-P3 C1: I gained how to approach people

R: Yes,

FGDs1-P3 C1: I learned how to talk to them

R: Okay, that is positive. Others? Academically for instance?

FGDs1-P4D1: Academically, in my community, I was the group leader of the group, so I learned a few skills in terms of equipping myself for the future and also how to go in terms of planning, getting the people to work together, and also, yeah, I think that what I learned.

R: She said that she gained some skills in term of planning, leadership skills because she was the group leader. So anyone else?

No response.....

FGDs1-P4D1: Also working with the group members. Not only beneficial from the top but benefiting all of us benefiting from each other.

R: Okay. Yes, other one? You wanted to say something?

FGDs1-P3 C1: No, I just wanted to add we learned the importance of working in a team

R: Humhum. So, what is the importance of working in a team?

FGDs1-P4D1: To respect to each other?

FGDs1-P3 C1: It helped you to understand other people's views, like haaa, this one the approach like you know is like useless; we learned to respect each other.

R: Others? Any other comments?

FGDs1-P4D1: But we also learned the bad effect of working in group.

All participants, laughing

FGDs1-P4D1: That is the negative effect of working in the group. In terms of...,it also made me not to want to work in the group. I just prefer individual. Because group members, 80% of them, they are just not willing to work. This like, they just want to get the benefit but they do not want to work. So I also learned that in life some people are not just willing to work for things, some they want things being given to them some want to work. So it is up to you to integrate that and be a better person.

R: Humhum. Wonderful! That was really a good experience. This will help you even in the future. So another one? **B**, you were saying something?

Me? (B1.)

FGDs1-P2 B1: Yes

About the team work, I learned that we have to respect one another's opinion.

R: Hum hum

FGDs1-P2 B1: Yes.

FGDs-P6 F1: And I learn to work hard. Yeah, we really worked hard in the group and we even raised money, even though if it was not easy but we did. Okay

FGDs-P5 E: I also gained because before I did not know, I thought nursing is just seeing a patient at the..., carry to the clinic with different illnesses while nursing is not only all about that, it is like there is something outside of the health problem like the social, economic status of the people. So I learned that nursing is not a one way working of concentrating on nursing, we also have to go to the community in order to prevent, or to decrease the number of people who are coming to the clinic or to the hospital, We have to start to the community like doing intervention, to do talks.
Yeah

R: So you learned, so in short I can say you learned that health promotion and illness prevention is very important.

FGDs-P5 E1: Yes, it is very vital.

R: Okay, okay. Yes A?

FGDs-P1 A1: And I also learned that people in the community are very cultural. In our community they are Sangomas, they also do things like this, they do hee, illegal abortion.

FGDs1-P4 D1: Because heuuu, in terms of the illegal abortion, also they are not prepared, not registered they are also practicing midwifery, they are not registered because they even do not live in to the hospital so they are illegal midwifery, so there is a lot of crime there.

FGDs-P6 F1: They (illegal midwifery & Sangomas) even try to give treatment, the sisters at the clinic said that the people with TB do not take treatment at all. So yeah.

Moderator: And what did you do with this information?

FGDs-P6 F1:.....Sigh

FGDs1-P4D1: We tried to talk to them (Patients who likes to consult Sangomas or illegal health professional) to people at the clinic to receiving treatment. And what treatment actually does to you in the body and if you stop taking it this is what happen. So we just tell them about the effects of not taking treatment, so we tried to prevent the not taking treatment by telling them why they should take the medication.

FGDs1-P6 F1: And we encouraged them (illegal health professional & health workers at the clinic) to wear the mask at the clinic health because we never know if you seat with people, person with TB.

R: Did they do it?

F FGDs1-P6 F1:1: I'm not sure because we did not ask about. They were ignorant.

R: What did you feel when you saw that they were ignorant? Or maybe you did you be able to do something?

FGDs1-P6 F1: Maybe weeeee.....did not tell them the required information or maybe sometimes you cannot change the perspectives and culture mentality. But there is something the people grew up with and still had; that the "young person, what do you know?" Even if you are health care profession, they still have it that this young person (nurse) does not know anything. So we may try but this ignorant perception would work. But we did try to change their perception.

FGDs1-P5 E1: Yeah, and also in my community, having my Swazi culture background; it is only a culture that when somebody like loose a relative, or something that they will mourn, people will contribute money to help or will use anything that will help.

In case of my group, the counsellor that we were given to go with around the community lost her dad during our community, yeah, like counsellor with low economic status, and I was so happy with my group members because we come to a decision that we have toooo, like contribute money and do something. So we bought vegetables and a lot of staff. Each of us gave like 10 to 15?... 10 to 20Rands. That is maintaining so much to meeee. Yeah.

R: Any comment?

Silence.....

R: Thank you so so much. I really appreciate your participation which was very fruitful, good luck for your exam. Yeah thank you so much for your input and you will get the information in our report. If you have any question we are still around. Thank you.

Participants: Thank you

Appendix 5: Head of the Discipline authorisation letter



13 October, 2015

Student No: 213570302

Ms. Agathe Uwitonze

Re: Discipline of Nursing support for Research Study

Dear Committee Member,

This serves to confirm that Ms. Agathe Uwitonze (Student No: 213570302) is a postgraduate student doing a Masters in Nursing (coursework) at the Discipline of Nursing. She has submitted her research proposal which will involve students from the Undergraduate Programme (Bachelor of Nursing) in the discipline. Her research study has been reviewed and supported in the discipline and permission is granted for her to engage with the selected undergraduate students. The Discipline of Nursing requires Ms Uwitonze to negotiate with the undergraduate coordinator to meet at a time that is convenient for the lecturers and student.

This study is provisionally supported by the Discipline of Nursing. Should you have any queries please feel free to contact me.

Yours sincerely,

Dr. Joanne R. Naidoo

Lecturer & Postgraduate Coordinator

School of Nursing and Public Health

Postal Address: University of KwaZulu-Natal, School of Nursing and Public Health, Howard Campus, Private Bag X 54001, Durban, 4000

Telephone: +27 (0) 31 2602499 Facsimile: +27 (0) 31 2601543 Website: www.ukzn.ac.za

 1918 - 2018
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

Appendix 6: Registrar authorisation letter



2 October 2015

Ms Agathe Uwitonze (SN 213570302)
School of Nursing and Public Health
College of Humanities
Howard College Campus
UKZN
Email: agathe.uwitonze@gmail.com

Dear Ms Uwitonze

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN) towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"An exploration of nursing students' experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal".

It is noted that you will be constituting your sample by performing interviews and/or focus group discussions with students from the School of Nursing and Public Health on the Howard College Campus.


Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely


PROFESSOR D JAGANYI
REGISTRAR (ACTING)






Office of the Registrar

Postal Address: Private Bag X54001, Durban, South Africa

Telephone: +27 (0) 31 260 8005/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: registrar@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

Appendix 7: Ethical approval



2 November 2015

Ms Agathe Uwitonze 213570302
School of Nursing and Public Health
Howard College Campus

Dear Ms Uwitonze

Protocol reference number: HSS/1553/015M

Project title: An exploration of nursing students' experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal

Full Approval – Expedited Application

In response to your application received on 21 October 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Prof G Mchunu & Ms EN Pakkies
cc. Academic Leader: Prof M Mars
cc. School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee

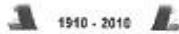
Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3967/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: simbasp@ukzn.ac.za / stnmanm@ukzn.ac.za / mohunop@ukzn.ac.za

Website: www.ukzn.ac.za



100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

Appendix 8: Editing letter



7 November 2016

This is to certify that the thesis by Agathe Uwitonze entitled "An Exploration of Nursing Students' Experiences of a Community-Based Health Promotion and Illness Prevention Programme in a Selected School of Nursing in KwaZulu-Natal has been edited for English grammar, idiom, orthography, punctuation and sentence structure.

Further information can be provided in request.

A handwritten signature in blue ink, appearing to read "D. Newmarch".

David Newmarch BA (Hons)(Natal), M Phil (York)



197 Queen Elizabeth Ave, Durban 4001, South Africa
082 554 9090 (c) • 031 261 2197 (h) • grammarline@gmail.com

Appendix 9: Turnitin plagiarism report

Turnitin Originality Report

Final submission by Agathe Uwitonze

From Research submission (Research 2016)

• Processed on 08-Nov-2016 1:52 PM CAT
• ID: 733865875
• Word Count: 35366

Similarity Index
1%

Similarity by Source

Internet Sources:
1%

Publications:
1%

Student Papers:
0%

sources:

You are currently viewing matches for the following source only:

1% match (Internet from 23-Oct-2015)
http://146.230.128.141/jspui/bitstream/10413/893/1/Benoite_U_2010.pdf

paper text:

UNIVERSITY OF KWA-ZULU NATAL AN EXPLORATION OF NURSING STUDENTS' EXPERIENCES OF A COMMUNITY-BASED HEALTH PROMOTION AND ILLNESS PREVENTION PROGRAMME IN A SELECTED SCHOOL OF NURSING IN KWAZULU-NATAL By Agathe UWITONZE 2016 AN EXPLORATION OF NURSING STUDENTS' EXPERIENCES OF A COMMUNITY-BASED HEALTH PROMOTION AND ILLNESS PREVENTION PROGRAMME IN A SELECTED SCHOOL OF NURSING IN KWAZULU-NATAL Dissertation submitted in the

partial fulfillment of the requirements for the Master's degree in Community Health Nursing

in the School of Nursing and Public Health,

College of Health Sciences, University of KwaZulu-Natal, Durban,

South Africa By Student Name: Agathe UWITONZE Student Number: 213570302 Supervisor: XXXXXX Co-Supervisor: YYYYYY November 2016 DECLARATION I, Agathe Uwitonze, hereby declare this research dissertation titled "an exploration of nursing students' experiences of a community-based health promotion and illness prevention programme in a selected school of nursing in KwaZulu-Natal"

to be my original work. It has never been submitted for any other purpose or to