

On being a rural origin Health Care Professional:

Lives, learnings and practice

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ABSTRACT

Rural origin health care professionals (HCPs) have been identified as those who are most likely to work in rural areas after graduation. However, there are significant challenges of access, selection and throughput for South African rural students wanting to train as HCPs. Many studies have focused on strategies for staffing rural healthcare facilities. However a life history approach has not previously been used to study the educational experiences of rural origin HCPs in South Africa, and there is a paucity of data about the lived personal and professional educational experiences of rural origin HCPs and their experiences of returning to work in rural areas after graduation. A deeper understanding of these issues using a life history approach may help in supporting rural origin students and contribute to improved staffing levels at rural healthcare institutions.

Social identity theory and a generative understanding of rurality provided the theoretical framing for this study. A life history approach complemented by arts-based methods generated stories through which to gain an understanding of the complex, multidimensional, multi-layered lives of HCPs who grew up in rural areas, their personal lives in relation to others, and the context in which they grew up (time, person and place).

Their developing identity is seen in their performances through the choices they make in response to everyday situations. Their learning experiences are complex and reveal that as active and critical thinkers they adopted a range of strategies to succeed at institutions of higher learning, and found platforms and communities to develop as those with knowledge and agency to change/challenge dominant and stereotypical ways of being. They demonstrate their willingness and ability to work in rural contexts, leading transformation in the healthcare setting.

The findings of this study point to a new understanding of rurality – that of home and a sense of belonging where the possibility for better healthcare services exists. A junctional hub is presented as a theoretical ‘model’ to frame lived experiences and to understand rural origin HCPs’ personal and professional identity and work in a complex, interconnected, negotiated space where different forces are negotiated. This provides a platform to open up the opportunity for other ways of being, knowing and practising. (362 words)

DECLARATION

I, Andrew John Ross, declare that

The research reported in this dissertation, except where otherwise indicated, is my original research.

This research dissertation has not been submitted for any degree or examination at any other university.

This research dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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May 30, 2016

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My father died in January 2015 and this research dissertation is dedicated to his memory and all that I am because of his influence in my life.

I am grateful to those rural origin healthcare professionals who have returned to work in rural areas, who have been willing to share their stories with me. I believe that these stories must be told. They are stories of hope, of possibility, of changing the script, of daring to dream and then having the courage to work towards the fulfilment of those dreams. I salute you all.

PUBLICATIONS AND PRESENTATIONS

Publications

1. **Ross A**, MacGregor G, Campbell L. Review of the Umthombo Youth Development Foundation scholarship scheme, 1999–2013. *African Journal of Primary Health Care and Family Medicine*. 2015; 7(1), Art. #739, 6 pages. [http:// dx.doi.org/10.4102/phcfm. v7i1.739](http://dx.doi.org/10.4102/phcfm.v7i1.739)
2. **Ross A**, Pillay G. Portrait of a rural health graduate: exploring alternative learning spaces. *Medical Education* 2015; 49: 499- 508. DOI: 10.1111/medu.12676
3. **Ross A.J.** Building on Tinto’s model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme. *African Journal of Health Professions Education*. 2014; 6(2): 119-123
4. **Ross AJ** Working in rural area – the experiences of Umthombo Youth Development Foundation graduates. *African Journal of Primary Health Care and Family Medicine*. 2014; 6(1): 1-7. doi: 10.4102/phcfm.v6i1.673
5. **Ross AJ**, MacGregor RG. Scholarship success: Umthombo Youth Development Foundation. *South African Medical Journal*. 2012; 102(5): 288
6. **Ross, A.** From rural scholar to health care professional. *South African Family Practice*. 2015, 1(1), 1-6. doi:10.1080/20786190.2015.1071537

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Presentations based on research findings

1. Educational journey of rural origin health care professionals working in rural areas. **16th National Family Physicians conference** May 2013
2. Educational journeys of rural origin health care professionals working in rural areas. **17th National Family Physicians conference** June 2014
3. Doing research – workshop on how to do a literature review. **PrimaFamed conference** June 2014
4. Learning spaces of rural origin health care professionals at institutions of higher learning. **SAERA conference**, Durban 13 August 2014
5. Learning spaces of rural origin health care professionals at institutions of higher learning. **College of Health Sciences research day**, 11 September 2014
6. Learning spaces of rural origin health care professionals at institutions of higher learning. **WONCA Africa conference**, Ghana, 7 May 2015

7. Troubling selection: Towards a broader selection policy. **Family Practice conference**, Durban, 31 July – 2 August 2015
8. Troubling selection: Towards a broader selection policy. **Story telling conference**, Oxford, England 3- 5 September 2015
9. Troubling selection: Towards a broader selection policy. **Teaching and learning conference**, University of KwaZulu Natal, 22 September 2015

ACRONYMS AND ABBREVIATIONS

FOM	Friends of Mosvold
FOMA	Friends of Mosvold Alumni
HCP	Healthcare professional
HCW	Healthcare worker
HPCSA	Health Professions Council of South Africa
KZN	KwaZulu-Natal
NGO	Non-governmental organisation
SA	South Africa
UKZN	University of KwaZulu-Natal
UYDF	Umthombo Youth Development Foundation
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

“Education is the great engine of personal development.

**It is through education that the daughter of a peasant can become a doctor,
that the son of a mineworker can become the head of the mine,
that a child of farm workers can become the president of a great nation ...”**

Nelson Mandela – *Long walk to Freedom*, 1995, p. 172

**“There are those who look at things the way they are, and ask why ... I
dream of things that never were, and ask why not?” – Robert Kennedy**

1. Rationale for the study

Lived experiences in rural areas

I am the son of medical missionaries and grew up in rural Nigeria, Ethiopia and South Africa (SA). My parents were committed Christians and their life choices and deep Christian faith has had a profound influence on who I am and the work that I have chosen to do. My interest in rural health care stems from both personal and professional experiences.

An early memory is of me accompanying my mother to a homestead in rural Ethiopia and grinding teff with an Ethiopian woman in the traditional manner (see Figure 1). This experience provided a momentary glimpse of the everyday life of rural women living in Ethiopia. As I reflect as a researcher on this memory of rural life and the people who inhabit it, I am prompted to think about rural discourses¹ and the influence that these have on the

¹ Discourse has been used to describe a *way of knowing*, a way of **conceptualising** the world. A discourse is articulated from an authoritative, powerful position which makes it perceived to be true. Lawler (2008) contends that, although discourses are not fixed, they are not easily ignored or opted out of, and it is difficult to speak or think *outside this truth*.

lives people live, the choices they make, and how these are entangled relationally with the socio- political context in which they grow up.

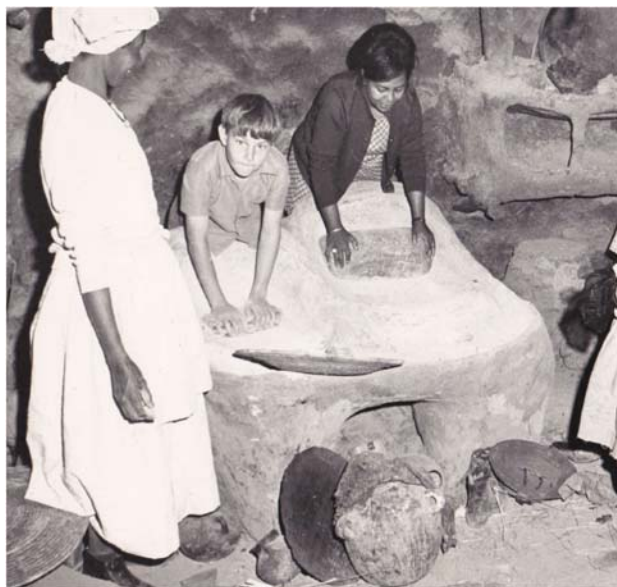


Figure 1: Grinding teff in a rural village in Ethiopia while my ‘instructor’ looks on, taken when I went with my mother to a rural village in Ethiopia. My mother was providing family planning training to the local midwives while we learnt how to prepare *injura* (local Ethiopian dish).

For those growing up in a rural context there are many, often conflicting concepts of rural² and rurality, and although often perceived of in the singular and as a uniform, homogeneous, deficient entity, are in reality a complex, multiple, interactive, dynamic and poorly understood space (Weinhold & Gurtner, 2014; Chisholm, Morrow, waKivulu & Engel, 2005; Eagar, Versteeg-Mojanaga & Cooke, 2014; Balfour, Mitchell & Moletsane, 2008; Ray, 2006; Letseka & Cosser, 2010). There are a range of contradictory discourses which constitute what rural means and how individuals are constituted through such complex and contradictory discourses in making sense of who they are and what it means to live in the world. These discourses are multiple, often hidden and subtle, and form an interconnected web which works synergistically in complex ways to perpetuate poverty in rural areas (Ray, 2006). Most are drawn from a deficiency perspective – no money, poor infrastructure, poorly

² In this research dissertation I am understanding rural as a geographical space and rurality as the learned and lived subjective experiences and relationships associated with living in a rural space (Balfour, R. M., Mitchell, C. & Moletsane, R. 2008. Troubling contexts: towards a Generative Theory of Rurality as education research. *Journal of Rural and Community Development*, 3, 95-107.)

trained teachers, poor health services, poor infrastructure, high unemployment, migrant labour, mine workers, etc. (Chisholm et al., 2005; Organisation for Economic Cooperation and Development, 2013; Spaul, 2013; Letseka & Maile, 2008; Letseka & Cosser, 2010; Nkambule, Balfour, Pillay & Moletsane, 2011; Versteeg, 2015). These discourses are (often) oppressive and restrictive and block rural (young) people from escaping poverty and reaching their potential, and are the discourses that shape the identity of these healthcare professionals (HCPs) of rural origin (Ray, 2006; Lawler, 2008; Nkambule et al., 2011).

Remembering this momentary experience in the context of this PhD research project, I want to problematise these and other everyday rural practices and to ask “How does everyday life experience in rural settings shape and continue to shape rural origin HCPs who chose to live and work in rural settings?”.

Healthcare practice in rural areas

I trained as a medical doctor to work in areas of need and became the Medical Superintendent at Mosvold Hospital in Ingwavuma, Northern KwaZulu-Natal (KZN) in 1992, at a time when medical staffing at the hospital fell upon only two doctors. Dr. Heese and I were stretched to the limit as we continued to provide (limited) services to the inpatients and outpatients which the hospital was responsible for. This experience reinforced for me personally what the World Health Organization (WHO) says about the importance of a sufficient number of well-trained staff, as there can be no health without a workforce to provide that service (WHO, 2013).

Although numbers are not the whole story, without adequate numbers of well-trained healthcare providers it is not possible to provide a quality health service. The service that we were able to provide at Mosvold Hospital (a 252-bed district hospital in Ingwavuma) when we were only two doctors was very different in quality and scope from what we were able to provide when we were 10 doctors.

The need for adequate health care for all, including those working in rural areas, was further reinforced when I developed an L4 disc prolapse resulting in severe pain radiating down my right leg and inability to sit or drive. Having access to financial and human resources, I was able to have an MRI (magnetic resonance imaging) scan done the next day at a cost of R6 500.00, and was able to see the neurosurgeon at lunchtime the same day. I had a discectomy the following week, and was able to have four weeks of bed rest before returning to work. Eight weeks following the prolapse I had minimum symptoms: some numbness in the right leg and slight weakness of the big toes.

Reflecting on my own experience and comparing it to those of the majority of South Africans, I am blessed indeed. I had easy access to skilled medical personnel, I had resources to pay for the MRI scan, and I was able to take 4 weeks' sick leave and still pay my bills. The majority of South Africans, and specifically those African South Africans living in rural KZN (George, Quinlan & Reardon, 2009; George, Quinlan, Reardon & Aguilera,

2011), have to use the public health sector and are dependent upon whoever is working at their base clinic or hospital – if anyone – and the skill and dedication of that HCP. Most indigent patients would have to wait at least six weeks for an MRI scan and even longer to see a specialist neurosurgeon. The operation might only be scheduled months after the initial prolapse, causing prolonged immobility, difficulty in working and all that this implies in terms of earning ability and perhaps prolonged morbidity.

Drawing upon my memory of having a disc prolapse and being able to access appropriate medical care timeously, as a researcher I wish to problematise the issue of appropriate health care made available by well-trained HCPs for the majority of South Africans. With only 12% of doctors and 18% of nurses serving 46% of the population who live in rural areas (Hamilton & Yau, 2004), I wish to ask what it would take to broaden healthcare provisioning so that everyone – even poor, marginalised and rural people living in contexts where resources (human and material) are limited – have appropriate health care, made available by skilled and competent HCPs?

Understanding HCPs working in rural spaces

Many studies have been published about strategies for staffing rural healthcare facilities to ensure adequate provision of healthcare services. However, a life history approach has not previously been used to study the educational experiences of rural origin HCPs in SA. In this study I wanted to understand, from the perspective of a rural origin HCP, his/her lived educational experiences as he/she transitioned from a rural student to an HCP willing and able to work in a rural context. I want to problematise the understanding of rurality as more than a geographical space which is fixed and deficit, and to move to an understanding of rurality as a dynamic negotiation between the individual and the rural context which is generative and dynamic, as suggested by Balfour et al. (2008) and Mangaliso (2001).

Currently there is no agreement of what is considered to be rural; whilst some definitions use population density or population size, others use economic activity or distance from metropolitan areas. Other authors suggest that the definition of rural is anything that is not urban, or that in fact the definition depends upon the purpose for which the definition was required (staffing norms for hospitals, resource allocation for education, etc.) (Chisholm et al., 2005; Colaldarci, 2007; Eagar et al., 2014; Weinhold & Gurtner, 2014). There is, however, broad consensus that rural areas are usually geographically remote, transport infrastructure is poor, access to services such as water, sanitation and electricity is often challenging, healthcare and educational facilities are generally under-resourced, and these areas struggle to attract and retain HCPs (Couper, 2003; Farmer, Baird & Iversen, 2001; Eagar et al., 2014).

This deficit model of rurality has been challenged by Balfour et al. (2008) who, while accepting the many challenges associated with rural areas, argue that relationships and knowledge arising from rural experiences

provide skills which help rural communities find their own solutions to the challenges that they face. It is this perspective that I am taking as I explore the learning experiences of six paradigmatic individuals who have used their rural experiences and the lessons learnt from these experiences as a platform for overcoming challenges at institutions of higher learning (IHL) and contributing to healthcare delivery in rural areas (Flyvbjerg, 2006).

I considered a life history approach to be the most appropriate for me to gain an understanding of their lived experiences, as their stories made their lived experience visible to me (Clandinin, 2006). A life history approach enabled me to focus on critical events in their educational journey, and to understand deeply their lived experiences and meaning making (ideas, beliefs, values, perspectives, world views) (Taylor & Milton, 2013). Their stories also reflected the social, cultural and historical conditions in which they were told, heard and understood, and provided the substance for me to use to explore the social, cultural and historical contexts in which these rural origin HCPs had grown up and where they practice as HCPs (Jeong-Hee, 2011; Caine, Estefan & Clandinin, 2013).

Social identity theory and a life history approach opened up my understanding of lived experiences, relationality and dynamic negotiation between individuals and their rural context (Wenger, 1998; Lawler, 2008).

2. *Understanding HCPs differently*

This research dissertation is set within the South African context and seeks to understand differently the lived personal and professional educational experiences of rural origin HCPs who are currently working in rural contexts. The previous section has foregrounded the personal, professional and theoretical motivation for this study, which seeks to understand rural life and rurality as experienced by rural origin HCPs and rural healthcare practice as provided by rural origin HCPs living in a geographical space. I want to understand this space as a dynamic, relational, transactional, fluid space beyond just the geographical location of a rural site (Balfour et al., 2008; Lawler, 2008).

This research dissertation consists of an introductory chapter, six original articles and a Letter to the Editor of the *South African Medical Journal* that were published by the author, that contribute to an understanding of the experiences of rural origin HCPs as they transitioned from rural scholar to HCP. Five of the articles have been reviewed by peers and published in Department of Higher Education and Training-approved local or international journals. Article three “Troubling selection: towards a broader understanding of selection” has been accepted for publication in the *South African Journal of Higher Education*.

The purpose of the research dissertation is not to present the merits of each article but to present an understanding of the becoming and being an HCP working in a rural context. It is not a comprehensive exposition of all their lived educational experiences from the perspective of rural origin HCPs working in rural

contexts, but rather my contribution to a deeper understanding of rural as home, the care of self and how this can lead to endless possibilities in healthcare provisioning. It is about the imagined possibilities of well-staffed rural hospitals providing quality care by local HCPs who are passionate, transformational leaders.

There are still gaps in my understanding of the lived educational experiences of rural origin HCPs and many additional issues that need to be explored in greater detail. These include issues such as exploring alternative selection criteria, validating a selection tool which would help to broaden selection of Health Science students, and additional support required for rural origin students at IHL. These areas provide further research opportunities.

I am grateful to those rural origin HCPs who have returned to work in rural areas and been willing to share their stories with me. I believe that these stories must be told. They are stories of challenge and triumph, of despair and hope, of possibility, of changing the script, of daring to dream and then having the courage to work towards the fulfilment of those dreams. I salute all who participated in this study.

3. *Professional and political context*

In SA 43% of the population live in rural areas and are served by 12% of doctors and 19% of nurses (National Department of Health, 2011). Despite the transition to democracy in 1994, decades of colonialism and apartheid have left rural areas in SA more associated as being reservoirs of cheap labour and the dumping ground of the elderly and the sick, with poor schooling and high levels of unemployment instead of being places of sustainable livelihoods (Madlala-Routledge, 2013).

It is widely acknowledged that despite the high levels of unemployment in SA there is a massive skills gap, and universities and other training institutions have a poor throughput of students; this is due in no small measure to the legacy of poor schooling (Scott et al., 2013; Letseka & Cosser, 2010). These factors have contributed to understaffing of government health institutions, particularly rural institutions, with resultant poor quality of healthcare delivery. Rural origin students have been identified as those most likely to provide services in rural healthcare facilities (Wilson et al., 2009), stimulating my interest in understanding who they are, their lived educational experiences and their experiences of working in a rural context.

Health outcomes are generally poor in SA and compare unfavourably with those other countries at a similar stage of development (National Department of Health, 2011), with healthcare indices in rural areas generally worse than those in urban areas. The 10 districts with the highest deprivation index³ in the country in 2008 were

³ The deprivation index is based on income and material deprivation, employment deprivation, education deprivation and living environment deprivation measured at either the individual or household level according to the indicator. The overall deprivation index combines each of these individual domains of deprivation using equal weights (Day, Barron, Massyn, Padarath & English, 2012).

all rural (Health Systems Trust, 2009). According to the SA index of multiple deprivation, 10 out of the 20 most deprived municipalities are in KZN (Wright & Noble, 2009). Most rural areas suffer from a high burden of infectious disease, high under-five mortality and reduced life-expectancy rates (Health Systems Trust, 2009).

The major inequalities between staffing levels at hospitals in rural and urban areas contribute to the poor health outcomes (Health Systems Trust, 2009; Langa & Strydom, 2011), and these disparities remain despite the commitment of the National Department of Health to “Health for all” (Declaration of Alma-Ata, 1978) and the prioritisation of recruitment of HCPs for rural areas (National Department of Health, 2011). Such a disconnect between policy and practice highlights the need for training institutions to be more socially accountable in their training. Training institutions need to recognise the “social obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve” (Boelen, 1995).

In their selection and training of HCPs, IHL need to ensure that they train adequate numbers of HCPs willing and able to meet the healthcare needs of the country. In 2009 the WHO highlighted the fact that increasing the number of healthcare workers (HCWs) in underserved areas improves health outcomes in general, and that maternal, child and infant mortality rates increase as the number of HCWs decrease (WHO, 2009). In 2013 the WHO reiterated the critical role that HCWs play in improving health care and urged governments to prioritise the training, recruitment and retention of HCWs, as there can be “no health without a workforce” (WHO, 2013).

4. *Description of the core research problem and its significance*

Taking seriously the need for adequate numbers of staff willing and able to work in rural areas, I started the Friends of Mosvold (FOM) scholarship scheme in 1998. The scheme was based on research conducted in Australia and Canada which showed that rural origin students were more likely to return to work in rural areas after graduation (Versteeg & Couper, 2011; Wilson et al., 2009), and the belief that rural students had potential and deserved to have opportunities to study Health Science courses. Through a partnership between Mosvold Hospital and a non-governmental organisation (NGO) the FOM scholarship scheme (now Umthombo Youth Development Foundation (UYDF) scholarship scheme), rural students with potential⁴ to become HCPs were identified and supported at university on condition that they return and work for a specified time in the area from which they were recruited.

Despite being told that “The schooling in Ingwavuma is so bad no one will make it into medicine”, and “Even if, by some miracle students from Ingwavuma get into Medicine, they will not pass” and “Scholarship schemes don’t work – no one comes back”, I persisted with the project. To date 218 rural origin HCPs who have been

⁴ Potential was defined as gaining access to an IHL to study a Health Science course.

supported by the scheme have graduated, and more than 90% of the students supported by the scheme have progressed each year (MacGregor, 2015). This is a remarkable achievement when compared to the average throughput at universities across SA (Scott et al., 2013). All UYDF-supported graduates have returned to the hospital near where they lived to fulfil their work-back obligation. Less than 10% have bought themselves out of a portion of their work-back obligation, and more than 68% have remained in rural areas after completing their work-back obligation (MacGregor, 2013; Ross, MacGregor & Campbell, 2015).

In this PhD I was interested in exploring some of the issues raised by the UYDF scholarship scheme and wanted to explore questions such as ‘When rural black students, usually associated with failure, succeed – what is going on?’ and ‘What is working for them? And why? What motivates them to go back home and work in a rural context?’. I wanted to open up my understanding of their lived personal and professional educational experiences. Although I had the ‘facts’ and was aware of the data, which we intuitively knew – since 1999 the UYDF had been able to find and support rural students who had gone to university, graduated as HCPs and returned to work in rural areas – what I did not have was a complex understanding of their lived experiences of growing up in rural Ingwavuma in the 1980s and 1990s, and how they disrupted the dominant rural discourse.

5. *A brief overview of the relevant literature*

The literature in the articles contained in the body of this research dissertation focused on the shortages of HCPs, the pipeline concept in raising awareness at schools, preferential selection of rural origin students at IHL and curriculum content and context as a strategy to increase the number of HCPs at rural sites.

With shortages of staff at rural healthcare facilities being a challenge throughout the world (Crisp & Chen, 2014), a number of different strategies have been adopted to address these staffing issues (WHO, 2009; Wilson et al., 2009; Versteeg & Couper, 2011; Henry, Edwards & Crotty, 2009; Laven & Wilkinson, 2003; Dolea, Stormont & Braichet, 2010). Four main strategies for recruitment of HCWs for rural areas are described in the literature, with a fifth strategy being the recruitment of foreign-trained HCPs. These are:

- a) Recruitment of foreign-trained HCPs;
- b) Coercion;
- c) Incentives;
- d) Creating enabling environments; and
- e) Educational initiatives.

Many initiatives aimed at staffing rural healthcare facilities have been discrete, stand-alone projects aimed at responding to the challenges associated with staffing of rural facilities. Most have not been rigorously evaluated,

and where evaluation has been carried out this has mainly been observational in nature, and mainly focused on educational initiatives (Dolea et al., 2010; Huicho et al., 2010).

Educational strategies for training rural origin HCPs

Evidence from local and international observational studies suggests that the best strategy for the long-term staffing of rural facilities is recruitment and training of rural origin students and other educational initiatives such as early exposure to rural settings (Versteeg & Couper, 2011; Wilson et al., 2009; Ray, Woolley & Sen Gupta, 2015; Shires, Allen, Cheek & Wilson, 2015; Couper, 2011). In thinking about provision of staff for rural and remote areas, the pipeline concept has been used to help identify critical points at which educational interventions could be made (Hart, Salsberg, Phillips & Lishner, 2002).

The pipeline concept – becoming an HCP

Educational interventions include exposure of local high school students to careers in Health Sciences, preferential recruitment of rural origin students, early rural clinical rotations, establishment of rural campuses, and postgraduate training programmes in rural sites (WHO, 2009; Wilson et al., 2009; Versteeg & Couper, 2011; Henry et al., 2009; Laven & Wilkinson, 2003; Ray et al., 2015).

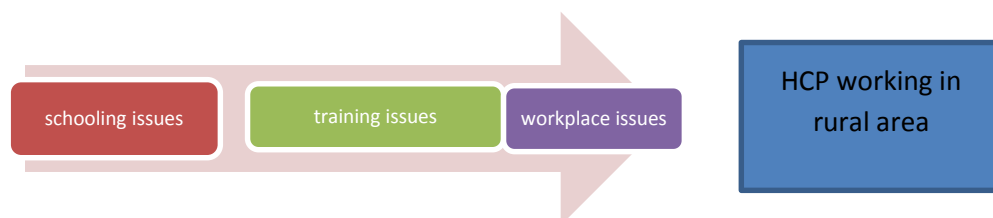


Figure 2: The pipeline concept for staffing of rural facilities

The pipeline concept (see figure 2) was originally taken from agriculture and conceptualised a need for input at one end (school – with programmes that promote an interest in a career in Health Sciences), a pumping system to get water where it was needed (selection and training, curriculum, etc., at university), rurally based work-based training programmes, addressing push and pull factors at rural health institutions, and support to keep HCPs working in rural areas (output) (Norris, 2000).

This pipeline concept has been found to be useful in that it integrates the various steps and conceptualises the processes involved in recruiting, selecting, training and deployment of staff to rural areas and highlights areas of possible intervention (Norris, 2014; Tesson, Strasser, Pong & Curran, 2005). Success has been shown in North America, Canada and Australia, indicating that by increasing the recruitment of rural origin students, preferential selection of rural origin students, decentralising the training platform to include rural areas, and including rural

healthcare issues in the curriculum, as well as measures to address issues of retention of rural HCPs (financial incentives, training opportunities, etc.), a greater number of HCPs have chosen to work in rural areas (Rabinowitz, Diamond, Markham & Wortman, 2008; Rabinowitz, Diamond, Markham & Santana, 2011; Shires et al., 2015).

Although useful to identify strategies for possible intervention for identifying and recruiting possible HCPs, the pipeline concept does suggest a linear process, with discrete, separate components as the person moves from school to university to the workplace. Little consideration is given to understanding the lived experiences of those undergoing the training and how their contexts influence their educational experiences as illustrated in figure 3.

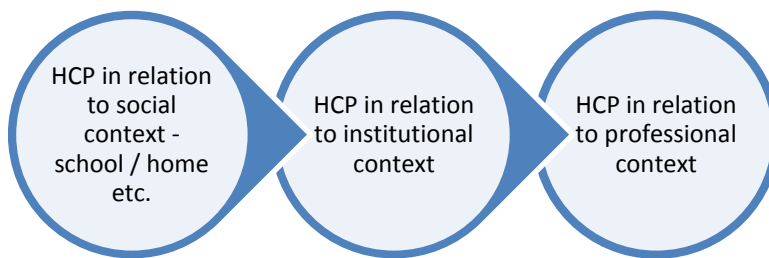


Figure 3: The pipeline concept

With evidence from international observational studies, and some local evidence, showing that the recruitment and training of rural origin student is a key strategy for the long-term staffing of rural facilities (Versteeg & Couper, 2011; Wilson et al., 2009; De Vries & Reid, 2003), the pipeline concept for the identification and training of the rural HCP has gained traction in many parts of the world (Norris, 2000, 2014). Studies from Australia have shown that rural origin students are twice as likely to work in rural areas than graduates from urban areas (Laven & Wilkinson, 2003). Studies from Canada suggest that rural doctors are five times more likely to have originated from rural areas than from urban areas (Rourke & the Task Force of the Society of Rural Physicians of Canada, 2005).

Evidence is also growing about the impact of other educational initiatives, such as longitudinal rural placement, and a recent study has shown that students who spend a year at a rural site during their medical training are five times more likely to choose to work in rural areas than those who did not have this exposure (Shires et al., 2015).

After reviewing the current literature on educational strategies to recruit staff to work at rural and remote facilities, it is pertinent to ask: Does the pipeline concept hold true for SA? Is it a viable strategy for the staffing of rural healthcare facilities in SA? How do South African rural origin HCPs experience work in rural areas after graduation? What is the local evidence to support this, or is education seen as a way out of rurality? Are educational initiatives training for export out of rural areas and out of poverty, as has been reported by some authors, rather than training to meet the health needs of the rural population (Chisholm et al., 2005)?

These questions are particularly relevant if one is to propose that rural origin students be part of the solution to the staffing of rural healthcare facilities, and are key questions to be considered in this research dissertation.

Evidence for rural origin HCPs returning to work in rural areas in SA

There is good international evidence supporting the selection and training of rural origin students. However, there is relatively little evidence from countries other than America, Canada and Australia (Dolea et al., 2010) that rural origin graduates will return to work in rural areas. Many rural origin graduates see education as their ticket out of rural areas (also seen in the global migration of HCPs from rural to urban areas and from developing to developed countries) (Chisholm et al., 2005; Crisp & Chen, 2014; Zimbudzi, 2013).

While the pipeline concept might be appropriate for some countries, it does assume that rural schools (in SA) can produce quality matriculants,⁵ that rural students will be accepted to study Health Science courses at university, that rural students will persist, progress and graduate, and that graduates will return to work in rural areas. These assumptions can by no means be taken for granted, particularly in SA.

On the other hand, if the concept of a pipeline is useful, then it is important for those concerned about the staffing of rural healthcare facilities to consider what the points of leverage are and how these could be used to improve staffing levels at rural facilities in SA. Key to this discussion would be an understanding of the experiences of rural origin HCPs, who have experienced the educational system, managed to gain entry into healthcare training institutions, graduated from these facilities and returned to work in rural hospitals.

Up until very recently the evidence from SA has been based on a single study done by De Vries and Reid (2003), which reported on addresses registered with the Health Professions Council of South Africa (HPCSA). In this study addresses were used as a proxy for origin: if the address given was in a rural area, then it was assumed that this HCP was working in a rural area. The data showed that 14% (138 graduates) of the 1991 medical class gave a rural address, and that by 2001 38% (49/138) of those who had originally given a rural address still gave an address in a rural area. Only 12% (102/829) of those who had originally given an urban address now gave a rural

⁵ Matric is the school-leaving examination in SA and is used by universities as the main basis for selecting university students.

address. It was on this basis that it was concluded that rural origin HCPs were three times more likely to work in rural areas than urban origin HCPs.

In this paper by De Vries and Reid (2003) the analysis of postal addresses was followed up with a questionnaire, which was sent to those working in rural and urban areas. Of the 138 medical graduates who had given addresses in rural areas, only 37 (26%) responded, and only 17 of these were actually working in rural practice. Although the proportion of rural graduates was higher for those of rural origin (and statistically significant), the response rate was poor, the total number of graduates working in rural areas was small, and one must question whether the conclusions drawn can really be justified from the data and whether one could build a coherent strategy for the staffing of rural facilities based on these data.

Although the finding and conclusions from this study are consistent with data from other countries (Wilson et al., 2009), the numbers are small and there is a need for more robust South African studies before the findings could be considered ‘clinically’ significant. The lack of high-quality studies in this area highlights the need for more studies (both quantitative and qualitative) to interrogate the issues of poor staffing of rural facilities and the role that educational and other initiatives could play in contributing to finding solutions to staffing challenges in rural healthcare facilities.

The South African evidence for rural origin healthcare graduates returning to work in rural areas has been strengthened by the publishing of **Paper 1: Review of the Umthombo Youth Development Foundation (UYDF) scholarship scheme 1999 – 2013** (Ross, MacGregor & Campbell, 2015), which provides an overview of the UYDF programme over the last 14 years.

South African (rural) education – will they be prepared?

To train as an HCP able to work at rural health facilities, students need to access training opportunities at an IHL. Healthcare training institutions generally have high academic entrance requirements, which are a challenge for rural students to attain, particularly when, according to Prof. Jonathan Jansen, “South African education is rubbish” (Erasmus, 2015). This sentiment is not new, as in 2009 Bloch stated that 60-80% of South African schools were dysfunctional and produced barely literate and numerate learners. He highlighted the toxic mix of poor teaching, poor learning, dysfunctional schools, poorly prepared teachers, poverty, lack of resources, poor school management, problematic education policies, militant teacher unions, a lack of commitment to quality teaching by many teachers and a lack of political will, all of which were contributing to the crisis in education in SA (Bloch, 2009; Letseka & Cosser, 2010; Lubben, Davidowitz, Buffler, Allie & Scott., 2010; Sennett, Finchilescu, Gibson & Strauss, 2003; Organisation for Economic Cooperation and Development, 2013; McCarthy & Oliphant, 2013; Simkins, 2013).

In 2013 Mathematics teaching in SA was reported as being the worst in the world due to poor teacher competencies, resulting in South African learners having the lowest Mathematics performance amongst 21 middle-income countries, and worse than Lesotho and Zambia (McCarthy & Oliphant, 2013; Spaull, 2013). Rural schools in SA are reported to be the worst off of all schools in SA, with fewer teachers, frequent absenteeism, larger classes, generally less qualified teachers, incomplete curriculum coverage, poor teacher capacity and subject knowledge, fewer resources, less chance of matriculating, less chance of going to university and less chance of graduating (Organisation for Economic Cooperation and Development, 2013; Spaull, 2013; Jama, Mapesela & Beyliefeld, 2008; Letseka & Cosser, 2010; Letseka & Maile, 2008; Scott, Yeld & Hendry, 2007).

Thus, despite Balfour et al.'s (2008) views that rural areas are generative, and with the pipeline perspective for recruiting rural students to train as HCPs, rural scholars in SA who aspire to train as HCPs face significant obstacles. It would appear that those students who (according to the pipeline concept) are most likely to contribute to rural health care are those least likely to access IHL. This is one of the reasons that this PhD study is important, as it seeks to understand those generative factors alluded to by Balfour et al. (2008) that have helped these rural origin HCPs to engage and persist at IHL and return to work in rural healthcare facilities.

The challenges in rural education have been highlighted in **Paper 2: From rural scholar to health care professional**, **Paper 3: Troubling selection: towards a broader selection policy**, and **Paper 5: Portrait of a rural health graduate: Exploring alternate learning spaces**, and a greater understanding of how rural students respond to these challenges has emerged from this research.

Access to and selection at IHL – will they be accepted?

Access to IHL

In SA there are no national data on the number of rural origin African students accessing IHL. However, national data show that the number of black African students accessing IHL has risen over the last 20 years, with 66% of the students at IHL in 2010 being black compared to just over 30% in 1990 (Manuel et al., 2013). These numbers have not been disaggregated between rural and urban black students, but there is some evidence to suggest that instead of being preferentially selected, rural Health Science students are in fact underrepresented at IHL in SA. Tumbo, Couper and Hugo (2009), using addresses given when registering for university in 2003, showed that only 27% of those studying Medicine, Physiotherapy, Occupational Therapy or Dentistry at nine South African Health Science institutions were from rural areas. This was even though at the time 43% of the population of SA lived in rural areas (Statistics South Africa, 2001), and confirms the underrepresentation of those from rural areas at IHL (Tumbo et al., 2009).

Selection of rural origin students

International debate has focused around the selection of rural origin students as a strategy for the staffing of rural healthcare facilities. Quotas and specific criteria to ensure selection of rural origin students have been introduced at a number of universities around the world (Stagg, 2013; Ray, Woolley & Sen Gupta, 2015). In Australia, for example, the National Government has mandated that 25% of places at Commonwealth-supported medical schools must be assigned to rural origin students (Stagg, 2013). This process of selecting rural origin students has been refined by the University of British Columbia, which uses 50% cognitive and 50% non-cognitive criteria for student selection. At this university, to ensure a match between student selection and the need for graduates to work in rural areas they use a rural remote suitability score, in which rural upbringing counts 50% and the balance is made up from information provided on rural links, rural activities and self-reliance (Bates, Frinton & Voaklander, 2005).

At James Cook University in Australia preferential selection of rural origin students ensures that over 60% of students selected into their healthcare training programme are from rural or very rural locations (Ray et al., 2015). However, in SA in 2010 no facility admission criteria favoured rural students, and some policies (e.g. writing the national benchmark examination) disadvantaged rural students (Reid & Cakwe, 2011). This highlights the disjunction between policy as articulated in *Human Resources for Health 2030* (prioritising the training of rural origin students) (National Department of Health, 2011, p. 97) and selection practices, and the need for robust research evidence to support a change in selection criteria at IHL.

There is good evidence that rural origin influences where graduates choose to work, and that selecting rural origin students is an important strategy in the staffing of rural healthcare facilities (Stagg, 2013; Wilson et al., 2009). However in SA, given the challenges associated with rural schooling along with the issues of access and selection, it is important to ask whether students from rural schools will be able to cope with the demands of tertiary education. Engstrom and Tinto (2008) have cautioned against increasing access without appropriate support, as this leads to high failure rates rather than increased opportunity (Engstrom & Tinto, 2008). So what is the situation in SA, and how have IHL responded to the challenges associated with teaching and training when a large percentage of those accessing the university come from dysfunctional schools?

Persistence at IHL – will they pass?

Increased access and an increasing number of black African students admitted to IHL should lead to a corresponding increase in the number of graduates (Jama, Mapesela & Beyliefeld, 2008). However, only 30% of South African students at IHL graduate within five years, and just under 50% graduate at all (Dhunpath & Vithal, 2012; Department of Education, 2010; Department of Higher Education and Training, 2010; Letseka & Cosser, 2010; Tewari, 2014). Cohort studies show that the completion rates of black African students at contact

universities in the Life Sciences, Mathematics and Physical Sciences is about 33%, which is about half the completion rate of white students, with no data on the percentages of rural students completing (Lubben et al., 2010; Jama et al., 2008; Letseka & Cosser, 2010; Letseka & Maile, 2008; Scott et al., 2007). Although throughput is better in the Health Sciences (Sheppard, 2014), possibly due to the higher entry requirements, the data are not disaggregated between rural and urban or between school quintiles. However, one might predict that rural students in general to do worse than their urban counterparts, given the current education challenges.

Perceptions of university lecturers

The perception of those teaching at IHL is that many (black African) students accessing IHL are inadequately prepared for the challenges associated with studying at university, due to the dysfunctional nature of schooling in SA (Letseka & Cosser, 2010; Department of Education, 2010; Adam, Backhouse, Baloyi & Barnes, 2010; Chisholm et al., 2005; Gilmour & Soudien, 2009; Soudien, 2008). Many of these students have poor studying techniques, are unable to deal with the large volume of work at IHL, and struggle to study independently (Lubben et al., 2010). For many English is a second (or third) language, leading to poor comprehension and literacy, which has been identified as an important factor in student failure at IHL (Dhunpath & Vithal, 2012; Leibowitz, 2013; Adam et al., 2010; Agar, 1991; Fisher, 2011; Sennett et al., 2003).

In addition, rural (disadvantaged) students arriving at an IHL find the university environment intimidating (Letseka & Cosser, 2010; Agar, 1991; Leibowitz, 2013; Tinto, 1975), and feel isolated and inadequate (Davidowitz & Schreiber, 2008; Fraser, Kennedy, Reid & McKinney, 2007; Letseka & Cosser, 2010). These feelings may be compounded by academic failure (Sennett et al., 2003), creating a vicious cycle of feelings of inadequacy – failure – feelings of inadequacy, leading to further failure and exclusion from the IHL.

Five of the six participants in this study (Dumisani, Themba, Siphamandla, Nelisiwe and France) identified poor English, poor study skills and poor preparation as major challenges that they faced at IHL. **Paper 4 (Building on Tinto's model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme)** looks at the need for engagement to persist at IHL, and recognises that students bring learning experiences with them when they come to university. These experiences can be transposed into their university context and used to develop communities of learning and build relationships. These issues are explored further in **Paper 5 (Portrait of a rural health graduate: Exploring alternate learning spaces)**.

Universities in SA have recognised the need for massive improvements in teaching and training at schools across the country. However, pointing the finger at others does not absolve IHL of the need to provide appropriate

support so that all students accepted have the necessary resources to succeed and to graduate. IHL have responded to the challenges of underprepared students in a number of ways, outlined below.

Institutional support

Academic support programmes

IHL have responded to the challenges in basic education by developing academic support programmes to address deficiencies in the schooling system, designed bridging programmes to respond to the gap between the competence of the students when they arrive at IHL and the expectations of the institutions, and established foundation courses which have extended the curriculum by an additional year (Lubben et al., 2010; Davidowitz & Schreiber, 2008; Dhunpath & Vithal, 2012; Letseka & Cosser, 2010). Many of these programmes have seen good success rates, with students who participate often doing better than those who access the traditional university programmes (Lubben et al., 2010). These support programmes are supplemented at many IHL by additional add-on mentoring programmes designed to address some of the social and emotional factors which may impact on student engagement at IHL.

The criticism of these initiatives lies in the fact that they cater only for a minority of the student body and are not integrated into the curriculum. In the 2012 academic year only 13 000 students participated in extended programmes, representing only 14% of the students enrolled at IHL, whereas enrolment of black students, who may benefit from such programmes, accounts for two-thirds of the intake at IHL (Dhunpath & Vithal, 2012; Department of Higher Education and Training, 2012; Scott, 2013; Letseka & Cosser, 2010). A further criticism of these programmes is that they work from a deficiency model, are often reactionary in nature (only responding once problems are identified), and do not fundamentally change the approach to teaching and learning at university (Davidowitz & Schreiber, 2008; Dhunpath & Vithal, 2012).

‘Extended programmes’, ‘bridging programmes’, ‘mentoring’ and ‘additional support’ may also inadvertently perpetuate a perception of inferiority among students, as it is mainly black disadvantaged students who participate in them (Scott, 2013). Hidden messages are sent to these students that they are weak, disadvantaged and likely to fail, which leads to resentment and non-participation in programmes designed to help students, many of whom are on the brink of educational failure at university (Davidowitz & Schreiber, 2008).

Paper 4: Building on Tinto’s model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme, and Paper 5: Portrait of a rural health graduate: Exploring alternate learning spaces are important as they explore the relationships students develop and the learning spaces that they use, as well as how they access these learning spaces. Insights from the experiences of these students can be used to critically review and strengthen support programmes for students at IHL.

Facilitating the formation of communities of learning

Succeeding at IHL requires major social, emotional and academic adjustment, and underprepared students from disadvantaged backgrounds often experience anxiety and feelings of alienation at IHL (Letseka & Cosser, 2010; Agar, 1991; Leibowitz, 2013; Tinto, 1975; Sennett et al., 2003). Wenger (1998) suggests that learning is relational and occurs better within a community of learning where students feel that they belong, are able to make meaning for themselves as part of their learning experience, and where members are mutually engaged in a common enterprise (Wenger, 1998).

A number of authors have shown that academic success at IHL is linked to academic and social engagement (Case, 2007; Mann, 2001; Tinto, 1997, 2003, 2005, 2006; Tinto & Pusser, 2006). Participating in such communities of learning increases student productivity and the quality of effort that students put into learning activities, and ultimately to success (Lave & Wenger, 2013; Van Rheede Van Oudtshoorn & Hay, 2004; Tinto & Pusser, 2006). Tinto (2006) also reported that students who participate in communities of learning show greater engagement in social and academic activities, greater motivation, greater support and encouragement, access more university academic resources, get more support and show a greater willingness to participate in activities because they feel valued and appreciated (Tinto & Pusser, 2006). In addition, participation in communities of learning encourages reflection and an honest assessment of self, willingness to risk acknowledging deficiencies and looking for solutions, which is a prerequisite for seeking out help (Morales & Trotman, 2004). Facilitating and encouraging the formation of communities of learning is an important task of IHL.

Paper 4: Building on Tinto's model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme, and Paper 5: Portrait of a rural health graduate: Exploring alternate learning spaces, explore students' experiences with engaging in multiple communities of learning and provide insight into how and why they were able to access support in the various communities of learning at IHL. The insights provided through the articles presented may help to strengthen institutional support programmes provided to rural origin students.

Conclusion to the literature review

This brief literature review has focused on educational strategies to address the shortages of staff in rural and remote healthcare facilities. Much of the literature is based on quantitative studies and there is a need to understand, from the perspective of those who have experienced rural education and training at IHL and who have worked at rural healthcare institutions, what the challenges are, what contributed to their success, and what we can learn from their experiences.

In this research dissertation I wanted to extend the literature by using a life history approach to gain a more nuanced, textured, deeper and more complex understanding of the lived personal and professional educational experiences of rural origin HCPs who have chosen to return to work in rural areas. This methodology allowed me to explore relationships between the person and their various contexts (rural, university and work place), which is lacking in the articles reviewed as most studies have been quantitative in nature.

6. *Problem statement and knowledge gaps*

Most research into the challenges of staffing rural healthcare institutions has been quantitative in nature (WHO, 2009; Wilson et al., 2009; Versteeg & Couper, 2011; Henry et al., 2009; Laven & Wilkinson, 2003) and has looked at numbers of HCPs, shortages and strategies to improve the number and retention of HCPs working in rural areas. The vast majority of the studies are based in Australia, Canada and the United States of America, with very little evidence emerging from Africa or other developing countries. These studies have not explored the lives or educational experiences of rural origin HCPs and what it means for them to return to work in rural areas.

Documentation from UYDF and a life history approach to understanding the educational experiences of rural origin HCPs addresses some of these gaps identified in the literature. **Article 1 (A review of Umthombo Youth Development Foundation scholarship scheme 1999 – 2013)** provides evidence from Africa that rural origin students do have potential to succeed at IHL and will return to work in rural areas after graduation. Using a life history approach provided an opportunity to get a nuanced, complex understanding of who these HCPs are, their life and educational experiences and critical events which have shaped them into the HCP that they are and the services they provide. **Papers 2, 3, 4, 5 and 6 use a life history approach which complements and extends the other quantitative approaches and fills some of the gaps in understanding** what it takes for rural origin HCPs to train and return to work in rural areas.

7. *Research questions*

As I started to think about doing a PhD and deepening my understanding of the kind of students who had been supported by UYDF, I realised that I knew little about their personal and professional lives and how they had negotiated ‘Who am I?’, and ‘Who am I as an HCP who had grown up in different rural contexts in the province of KZN and was now working in a rural context?’. I was curious about the role of significant others in their educational journey. As a trustee of UYDF I was interested in understanding their experiences better and being able to ‘institutionalise’ important learning that will open up opportunities for all students.

The focus of this study is to understand the educational experiences of rural origin HCPs as they move from rural student to HCP, as lived and experienced within a particular space, time and place (Caine et al., 2013). All

of the participants grew up and attended schools in rural areas and had to negotiate the poor quality of education made available in these areas in the 1980s and 1990s (Chisholm et al., 2005). All participants obtained a professional qualification at a South African university and were able to register with the HPCSA as HCPs. All were working in a rural context at the time of the study.

The following critical questions seemed to capture the essence of what I wanted to learn more about.

Question 1

- **Who are these rural origin HCPs currently working in rural areas?**

The objective of this question was to better understand the individual and professional identity of these rural origin HCPs working within a rural context.

Question 2

- **What are the personal and professional learning experiences of rural origin students in becoming HCPs?**

The objective of this question was to understand the critical moments, significant encounters and people who contributed to their educational experiences as they moved from rural scholar to HCP.

Question 3

- **How do their personal and professional educational experiences inform their practice as rural HCPs practicing in rural contexts? (What informs their decisions to work in rural areas? Being an HCP in a rural context)**

The objective of this final question was to understand how their educational experiences influenced their choices of where they practice, how they practice and what it means to practice as an HCP in a rural context.

Although guided by these research questions, the papers presented do not focus specifically on one question at a time. Responses to these questions are integrated in the life stories of the participants as they share their experiences of growing up, going to school, accessing tertiary education, graduating and then returning to work at a rural hospital. Issues of identity are seen as they live their lives. On a superficial level one can be identified by sex, race and class. However, one's identity is much more complex than this and can be seen in their relationships and their responses to everyday dilemmas (Honig, 1996).

This study opened up the opportunity for me to understand something of the complex, challenging lives of those rural origin HCPs who, despite the context from which they had come, were able to negotiate the transition from rural scholar to HCP. This has deepened my understanding of the challenges and complexities of training and

working as an HCP, and changed the way I think about the rural context and what it means to work in such a context.

The significance of the study lies in the fact that rural origin HCPs have been identified as those most likely to return to work at rural healthcare facilities. However, those rural scholars most likely to return to and work in rural areas are the least likely to be selected to study at IHL, and the least likely to succeed due to the major challenges associated with rural education (see literature review). Any improved insight into and understanding of the educational journey of rural origin HCPs who returned to work in rural areas may help other rural origin travellers to complete this journey, and may contribute to improved healthcare services in rural areas.

A theoretical framework using social identity theory and the generative potential of rurality was used to frame my understanding of the lived experiences of rural origin HCPs.

8. *Conceptual framework*

The focus of this study was to understand in depth the experiences and meaning making (ideas, beliefs, values, perspectives, worldviews) of rural origin HCPs, made accessible through the stories they tell (Taylor & Milton, 2013). An interpretive paradigm using a life history approach was considered the most appropriate to explore and understand these experiences (Taylor, 2013, 2014; Taylor & Milton, 2013). An interpretative paradigm allowed for an understanding of lived experiences within a sociocultural historical context. The epistemology of this paradigm acknowledges that people's subjective experiences are real and can only be understood by interacting with, listening to and building a relationship with the person whose experiences one wants to understand (Terre Blanche, Durrheim & Painter, 2004).

In the analysis a critical paradigm was added as I reflected on the personal agency shown by these rural origin HCPs in responding to the situations they found themselves in, the dynamic relationship between the individual and society, and the potential for change within the individual and the context.

The conceptual framework was made up of concepts around the (rural) context and understanding identity within a social context at a particular place and time using social identity theory. Each focuses mainly on one aspect (contextual factors or the generative potential of rurality) and they are limited in their understanding of the complex multiple identities of the HCP and his/her educational experiences within the rural context where he/she was located. It was therefore helpful to combine different concepts to get a deeper, fuller, more complex understanding of the issues faced by rural origin HCPs as they journeyed from rural scholar to HCP.

Rurality – deficient or generative

Balfour et al. (2008) are helpful in understanding the rural context as dynamic and generative rather than fixed and deficient. Although often deficient in material resources but not in human resources, the rural context could be considered to be generative ‘in spite of’ the deficiencies. Recognising this generative potential of rural experiences helped me to understand some of the strategies which enabled these rural scholars to transition to HCPs, and helped me to explore issues of rurality from a perspective of resources and dynamic relationships (Farmer et al., 2001). This is developed further in **Paper 4: Building on Tinto’s model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme** (Ross, 2014).

Identity – social identity theory, making of identity

Social identity theory (SIT) (Wenger, 1998) provided an overall framework for understanding the individual within his/her rural context. SIT recognises that peoples’ lives are lived in relation to the context (social, political, cultural) and their identity is formed as people interact with one another and with their environment (Lawler, 2008). One’s identity could therefore be considered to be social and collective, as identity is formed by the social world and “one ... understands the person in terms of their relations with others and hence understands identity as formed *between* rather than *within* persons” (Lawler, 2008, p. 7). Using SIT “places us within a complex web of relationships” (Lawler, 2008, p. 13) and facilitated a deeper understanding of important relationships and how they contributed to and influenced individual and professional identity formation and contributed to educational experiences.

The power of rural discourses can also be understood in terms of SIT where members of an homogenous in-group are expected to act according to the group norms (Stets & Burke, 2000; Hogg, Hardie & Reynolds, 1995). Without obvious alternatives it becomes easy for ‘rural students’ to become stuck in these social categories as they are known and safe and what is expected is clearly understood (Stets & Burke, 2000; Hogg et al., 1995). SIT allowed me to explore the lived educational experiences of these rural origin HCPs and their choices as expressed in stories told in space, place and time as they described relationships with the context and with others. A social identity perspective helped me to understand these experiences in all their complexity.

All of these aspects are connected in complex ways as these HCPs negotiate their relationships with the context, training programmes and professional practices. SIT allowed me to look at the individual in relation to the social, institutional and professional context. This ongoing negotiation of self and identity in these multiple contexts is generative and relational, and full of possibilities and potential. Using a social identity lens opened up an understanding of these relations with others and with the context in which they are developing as HCPs. This conceptual framework also aligns with the methodology, as narrative enquiry using a life history approach

provides the tools, through stories, to understand the complex, multidimensional, multi-layered lives of HCPs who grew up in rural areas, their personal lives in relation to others and the context in which they grew up (time, person and place) (Chisholm et al., 2005).

9. *Methodology*

Data for **paper 1 (Review of the Umthombo Youth Development Foundation (UYDF) scholarship scheme 1999 – 2013)** were collected from the UYDF records. Detailed records kept by the organisation include: students selected, mentoring provided, holiday work completed, date of graduation, and working experience (to ensure that work-back obligations are fulfilled). The Friends of Mosvold Alumni (FOMA) has been established to provide ongoing support to graduates. All graduates were contacted to determine where they were working once their work-back contract was completed.

A life history approach

Life history research rests on the epistemological assumption that people make sense of their experiences by the stories that they tell. Through stories people select experiences; they organise them to give meaning to and create new meanings from those experiences. (Duff & Bell, 2002).

Although new to me (having come from a Health Science background), through my reading in preparation for this PhD I came to realise that all our lives are shaped by the stories we tell of ‘who I am’ and ‘how I came to be who I am’ (Lawler, 2008) and that, in the words of Clandinin and Connelly (2000, p. 17): “... if we understand the world narratively ... then it makes sense to study the world narratively”.

In light of this I considered a life history approach to be the most appropriate methodology for me to use to study the educational experiences of rural origin HCPs, as it seemed to be the most authentic way to experience their experiences (as far as possible) (Alvesson & Skoldberg, 2000; Hatch & Wisniewski, 1995). A life history approach provided the research tools I needed to explore the meanings that these HCPs attached to their lived experiences and how they made sense of these experiences (Pope & Mays, 2006; Clandinin & Connelly, 2000; Hatch & Wisniewski, 1995).

This approach provided the platform for these HCPs to share something of their lives, their stories and how they made sense of their experiences of growing up in a rural context in SA in the 1980s and 1990s, the effects of an unjust system (apartheid and the migrant labour system), the impact that these had on their schooling and family life, and their training to be an HCP. This methodology allowed me to get a multidimensional understanding of these HCPs and the factors which shaped them and enabled them to transition from a rural, disadvantaged background to becoming an HCP involved in transforming healthcare delivery. It made visible these lived experiences from the perspective of the other (Clandinin, 2006).

Shared meaning

Listening to their stories created shared meanings (Dillow, 2009) and provided a window through which to look into their world (Hatch & Wisniewski, 1995), providing meaning, context and perspective and an understanding which could not be arrived at by any other means (Greenhalgh & Hurwitz, 1999). The stories are multidimensional (time, person, place) and allowed me to explore the multiple identities (son, student, friend, HCP) (Clandinin & Connelly, 2000; Clandinin & Huber, 2010) of these rural origin HCPs – ‘Who am I?’ ‘Who am I in relationship to others?’ (their rural context) as well as ‘Who am I as a professional in the context in which I am working?’ (their professional identity). The stories provide a deep, insightful and complex understanding of the personal and professional lived lives of these particular HCPs, who have grown up in a rural context, and journeyed from rural scholar to HCP, and what it means for them to work in rural areas. I was a co-participant in the creation of these stories as they told their educational story as it was – with all its details: richness, contradictions, uncertainties and complexities. Their stories told of real-life experiences and how they responded - stories of pain and triumph, of challenge and disappointment, of success and failure, of resilience and persistence - and reflect how their identities changed in the process.

The stories reflect the social, cultural and historical conditions in which they were told, heard and understood and provide the substance to explore the social, cultural and historical contexts in which these rural origin HCPs had grown up (Jeong-Hee, 2011; Hatch & Wisniewski, 1995). The stories that they told reflected their identity as the teller in relation to the context and the relationships within that context, and the telling and retelling of stories produced certain identities. Through the research process I came to understand that their life history narratives were in fact social acts, as in speaking they were performing their identity, in the selecting and organising of the resources of language to tell their stories in particular ways to fit the occasion (telling me their stories), appropriate for me an outsider, with no real understanding of what it was like to grow up in rural SA in the 1980s and 1990s (Mishler, 1986).

Through the ‘lives as told’, this methodology has given me insight into how these HCPs experience their reality, and enabled me to explore emotions, thoughts and interpretations arising from these experiences and how they made meaning and sense of events and actions (Denzel & Lincoln, 2005; Polkinghorne, 1995; Smith & Sparkes, 2008). It allowed me to explore the inner and outer (relational - with myself and with others), time (past, present and future) and contextual issues where these events were occurring. (Clandinin & Connelly, 2000).

Choosing participants

Guided by the intention of selecting those who could best understand the issues around the educational experience of rural origin HCPs, provide richness of information and be willing to participate in the research process by sharing their stories, (Terre Blanche, Durrheim & Painter, 2004; Northcutt & McCoy, 2004;

Polkinghorne, 1995; Terre Blanche, Durrheim & Painter, 2006), six rural origin HCPs previously supported by UYDF were purposefully chosen (Creswell, 2008; Seidman, 2006; Malterud, 2001) by me as the researcher. In addition to the above considerations, to ensure broad representation issues of gender (four males and two females), diversity of qualifications and training institution and currently working in rural areas were also taken into consideration when selecting participants.

By January 2013, 39 graduates supported by UYDF had completed or were completing their work-back obligation to UYDF. Only 22 met the inclusion criteria (one graduate had died, one had changed occupation, three were specialising, six were working in private practices, five were working in urban hospitals and one was unable to get his registration with the HPCSA and was teaching). France and Dumisani were chosen as they were the first students supported by UYDF, Nelly was the first pharmacy graduate, Lungi was the first medical graduate, Themba was the first therapy graduate from the University of the Witwatersrand and Siphamandla was the first clinical psychologist. All were articulate, able to express themselves and willing to participate in the research process. Details of their university of training is presented in Paper 2 (Ross, 2015).

The six participants were all HCPs from Umkhanyakude district in northern KZN, 450 km north of Durban. The deprivation index for the district was 4.5 in 2012, which was the second lowest deprivation index in the country (Day et al., 2012). All participants completed their primary schooling in local schools in the district. Lungi Hobe attended Inanda Seminary, an independent girl's high school in Durban, for one year of her high school and Nelisiwe Mthembu attended a government boarding school in Nongoma for her high school. All of the others attended high schools in Umkhanyakude district. Although there are multiple definitions of rural, by any definition (geographical remoteness, population density, deprivation index) those who participated in this study would have been considered to have come from rural areas (Eaga et al., 2014; Farmeret al., 2001).

I have a personal and professional relationship with all those who participated in this study. I have known all of them for many years and was responsible for raising funds to support their training and for mentoring and supporting them at university. Since their graduation I have continued to have a professional relationship with them and am interested in their professional development. I have regular contact with Dumisani as mentor coordinator for UYDF and with Lungi as she is currently a registrar in Family Medicine at Bethesda. I hear intermittently from France, Siphamandla, Nelly and Themba.

Data generation

Interviews

Interviews were the primary method of data generation (Terre Blanche et al., 2006; Clandinin, 2006, 2007; Clandinin & Connelly, 2000; Denzel & Lincoln, 2005) and participants were asked to “Tell me about your life as a practicing HCP having grown up in Umkhanyakude district, and your education and what it means to work as a healthcare professional in a rural area”. There was some sense of chronology in how I elicited memories and experiences of their memories, as I used a journey metaphor of starting somewhere (at home), going somewhere (school, university and then working in a rural context), and having experiences along the way, as a means of introducing the topic. Interviews took place in a variety of settings and at the convenience of the HCPs and researcher. Some interviews occurred at their places of work and two interviews occurred at my home after I had had back surgery.

Use of photographs

Interviews can tend to be linear and limited by words. My data collection strategies were deepened by including some arts-based techniques, allowing participants to move away from linear thought and opening up new ways of thinking and remembering. At a meeting following the interviews all participants were asked to select four photographs of significance, representing different aspects of their educational journey, and an artefact representing a critical incident in their educational experience (Pillay, 2003). These arts-based methods were key to eliciting memories of particular incidents across time, place and space, which allowed participants to move between past and present and helped provide insight into new connections between experiences and a new understanding of the phenomena being studied (Butler-Kisber & Poldma, 2010; Samaras, 2009).

Each participant described the photographs, what they remembered about the incident in the photograph and how it contributed to their educational experiences. The visual reality seen in the photographs helped them to drill down into those experiences captured, as they reinserted themselves into the situation, which triggered memories about school, family, community, and university life seen in the photographs. Without these methods the telling based on language would not have elicited such rich information about their lives.

Reflecting on the photographs and the reasons for choosing these pictures enabled them to move beyond the linear, spoken remembering, and contributed to a deeper, more complex, nuanced understanding of the multiple identities of each of the participants and deepened our understanding of some of the events in their educational journey. Unfortunately Nelisiwe (Nelly) was unable to find any pictures from when she was growing up, as they did not have sufficient money at home to capture images of family events or school activities, clearly highlighting the economic hardships faced by her family. Dumisani, France, Siphamandla, Themba and Lungi

were unable to find an artefact of something significant from school or university. However, Nelly brought the trophies which she had won from the Olympiad, which had been instrumental in her educational journey and resulted in her being able to attend a boarding school in Nongoma.

Collage inquiry

Collage is defined as “the process of cutting and sticking found images and image fragments from popular print/magazines onto cardboard” (Butler-Kisber & Poldma, 2010, p. 265), and when interpreted, it tells a story. They elaborate that collages “help to mediate understanding in various ways” (2008, p. 264). At the final interview during the data generation process, participants were given an A1 sheet of paper and a collection of local papers and magazines, and asked to make a collage – a visual representation – of a “day in their life” to make visible their various identities (Pillay, 2003). Of all the arts-based activities, I found this to be the most difficult, as none of the participants were familiar with doing collages. Initially all participants struggled to represent themselves using collage; however, with encouragement and with me also developing my own collage, all participants were able to make a collage. As photographs, artefacts and collages are unable to speak for themselves (Samuel, 2009), participants were given the opportunity to explain why they brought what they did and the significance of the photographs, artefact and images selected for the collage.

Who they are and their educational experiences are inseparable. Thus, as they told their story of their educational journey they were telling about who they are and the reasons they made certain decisions at certain times. The telling of their stories, the reviewing of pictures, and the development of a collage enabled them to connect events and give significance to things that happened along their journey.

Field notes

After each interview brief notes were made of when and where interviews took place as well as personal observations, emotions and insights gained during the process of data collection. These notes supplemented the data obtained directly from the participants, and helped provide a thick description of the research process (Corbin & Strauss, 2008). They were also used to refresh my memory about events and to reduce the narrative relativism (Clandinin & Connelly, 2000).

Data analysis

First-level analysis was the writing of one coherent story from all of the field text, for each participant, with a beginning, middle and end (Caine et al., 2013; Clandinin, 2006; Polkinghorne, 1995; Hatch & Wisniewski, 1995; Pillow, 2003). The stories were constructed chronologically with a plot that revolved around the educational experiences of these HCPs and how they negotiated the challenges of growing up in a rural area with limited resources and opportunities. In the retelling of the stories, first-level analysis involved decisions about what to

include and what to leave out, and how to connect a range of data in a coherent manner (Mishler, 1986; Seidman, 2006; Smith & Sparkes, 2008). The reconstructed stories were the basis for the papers presented in this research dissertation.

Transcription

All interviews and discussions were recorded electronically and transcribed verbatim (McCormack, 2000; Terre Blanche et al., 2006). The spoken word was therefore transformed into a written text for analysis and study (Dillow, 2009). Emotions and observations were more difficult to capture and analyse, but field notes were used to try and capture these aspects of the interviews.

My role as a narrative inquirer

The stories are reconstructions of fragments of life as remembered and reconstructed by the participants to give meaning to and share those experiences with me the researcher. In an attempt to ensure ‘truthfulness’ and ‘accuracy’ or fidelity (Polkinghorne, 1995) of the stories, the ‘finalised’ version was sent to each of the participants to validate their stories – to check the accuracy of the details captured in their stories and to indicate whether they believed that the stories accurately reflected their experiences – their personal truth – and captured the essence of what they were trying to say (Denzel & Lincoln, 2005; Pope & Mays, 2006; Kitto, Chesters & Grbich, 2008; Sparkes, 2001; Pillow, 2003). When asked to authenticate their ‘life story’, participants were asked to consider the following questions: Was the story a true representation of their educational experiences? Was there material that they felt should be added or removed? Was there sensitive material that they wanted removed? Minor modifications were made and a small amount of additional information was added to each of the stories. Permission was given by each of the participants for the ‘final’ version of their reconstructed story to be used in this research dissertation.

I believe that this study offers a unique view of the rural origin HCP because of the rural context and the methodology used to understand these particular individuals. A life history approach allowed me to enter into their world, albeit briefly and only in a fleeting manner, to catch a glimpse, to see the world from their perspective and make discoveries that will contribute to empirical knowledge. (Corbin & Strauss, 2008).

Writing the papers

Paper 1 (Review of the Umthombo Youth Development Foundation (UYDF) scholarship scheme 1999 – 2013) provides background and context to this study. This paper was written with Dr Gavin MacGregor (the director of UYDF) to give local substance to the fact that South African rural students could train to become HCPs and would be willing to return to work in rural areas. We intuitively knew the facts, as student progress and graduate work-back is presented to the UYDF board on a regular basis. However, no formal programme

evaluation had been done prior to the writing of this article. It is an important article as it provides evidence of success both in students passing at university and graduating, and in graduates coming back and working at rural hospitals, which strengthens the work of UYDF and helps with fund-raising efforts.

Papers 2 (From rural scholar to health care professional) and 6 (Working in rural area – the experiences of Umthombo Youth Development Foundation graduates) were written after the initial analysis of the reconstructed stories. Using a grounded approach (Glaser & Strauss, 1967; Strauss & Corbin, 1994), codes, categories and themes were identified around their experiences at home, school, university and working in a rural context based on the pipeline concept of a linear progression from school to university and then graduating and working. This was a rather simplistic understanding of the educational experiences of rural origin HCPs, with the stories providing a deeper, more complex understanding of their experiences at school, the challenges of getting a place at university, adjusting to and learning to cope at IHL, graduating and then returning to work in rural areas.

Papers 3 (Troubling selection: towards a broader selection policy), 4 (Building on Tinto's model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme) and 5 (Portrait of a rural health graduate: Exploring alternate learning spaces) were written to address a specific issue in relation to their educational experiences – engagement and persistence and what rural students bring to that process (Paper 4), learning spaces (Paper 5) and issues around selection of rural students and how to broaden our thinking about who to select for rural practice (Paper 3).

Papers 3 and 5 focus specifically on stories related by TM, FN and SM. While all participants related powerful stories, we felt that these stories were particularly interesting and troubling in relation to what they convey of learning experiences on a university campus setting as well as in the broadening of selection criteria for IHL. Van Manen (1990, p. 120) explains that stories can also “[tell us] something particular while really addressing the general or the universal.” Using the data from these participants offered a way to represent the commonality without compromising the specifics of their narrative. Drawing on extracts from their storied narrative we illuminate their experiences at a particular moment of their life, and the social relations in and through which particular practices were enacted to affirm, support and propel the desire to learn and succeed.

Paper 5 was also written in response to the challenge by Prof. Samuels to present something from our research at the South African Education and Research Association conference which was being held in Durban in August 2014. Prof. Samuels suggested looking at the data and the students' learning experiences at university from the perspective of learning spaces as described by Fraser et al. (Fraser et al., 2007). Using this analytical framework to look at the data provided fascinating insights into where learning occurred and relationships which facilitated and encouraged learning.

Paper 3 (Troubling selection: towards a broader selection policy) was the last paper to be written, and it was the paper we struggled with the most. Daisy (my supervisor) and I wanted to capture something more about their identity and also wanted to signal the need to broaden selection criteria if IHL are to train the kind of HCPs willing and able to bring about transformation in the healthcare system. The paper argues for broader selection criteria based on internal values demonstrated through responses to everyday dilemmas (Honig, 1996).

Together these papers deepen my understanding of the experiences of rural origin students as they journeyed from rural student to HCP, and add to existing body of knowledge of the experiences of rural origin HCPs as they return to and work in rural areas.

10. *Layout of the research dissertation*

This research dissertation is written up in a publication format with five publications, a Letter to the Editor and a manuscript which has been submitted for peer review. The way it is organised is outlined below.

Chapter 1 provides a background to the study and sets the scene. The chapter provides insights into my own experiences as a doctor working in a rural hospital in SA and the rationale for doing the study. This is followed by a critique of the literature on educational initiatives to address the shortages of HCPs in rural areas, an overview of the methodology used and an outline of the critical questions which guided the study and which the study seeks to answer.

Chapter 2 contains five published papers, an article which has been accepted for publication by the *South African Journal of Higher Education* and a Letter to the *South African Medical Journal* which answer the critical questions.

Chapter 3 is the final chapter, and it provides a synthesis and critique of the articles presented. A theoretical model for a more complex understanding of the issues around selection and support of rural origin students is presented.

11. *Conclusion*

This study was inspired by my desire to understand the lived educational experience of rural origin HCPs currently working in rural areas. In this chapter I have highlighted the need for adequate numbers of HCPs willing and able to work in rural areas in order to address healthcare challenges.

A life history approach was used to generate data from six paradigmatic (Flyvbjerg, 2006) rural origin HCPs who work in a range of healthcare institutions in rural parts of KZN.. From the reconstructed stories five articles have been written, which are presented in the following chapter.

CHAPTER 2: PUBLICATIONS

1. *Introduction*

This is a research dissertation by publication and this chapter contains five papers published in accredited journals, an article accepted for publication by the *South African Journal of Higher Education* and a letter written to the *South African Medical Journal*. These articles should not be considered to be a comprehensive account of all of the educational experiences of rural origin HCPs, but rather a start in a journey of exploration into factors which contribute to rural origin students training and working as HCPs.

Rural origin HCPs are seen as part of the solution to the challenge of staffing rural healthcare facilities. The focus of this research dissertation is to understand the educational experiences of rural origin HCPs as they moved from rural student to HCP working in a rural context, and in some way contribute to the discussion on staffing of rural healthcare facilities in SA.

2. *Umtombo Youth Development Foundation scholarship scheme*

Paper 1

Paper 1 (Ross et al., 2015) provides an overview of the UYDF scholarship scheme, the success of the scheme over the last 14 years and what can be achieved with passion, a vision and a plan. The paper provides the context and background to this PhD study.

Title: Review of the Umtombo Youth Development Foundation (UYDF) scholarship scheme 1999 – 2013. Afr J of PHC

Authors: **Ross AJ**, MacGregor R and Campbell L

Journal: African Journal of Primary Health Care and Family Medicine

Declaration regarding a Doctoral student contribution to the journal articles to be included in a doctoral
'research dissertation through publications'

Student name: A.J. Ross

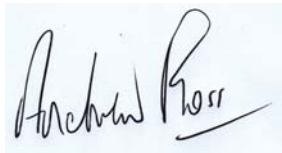
Student number: 212557836

The students' contribution to the article was as follows:

1. Formulation of hypothesis: I formulated the concept for this review of the Umthombo Youth Development Foundation data.
2. Study design: I was responsible for the study design
3. Ethical permission: Dr L. Campbell was responsible for obtaining ethical permission for the study
4. Work involved in the study: Dr MacGregor was responsible for generating the data and for the initial analysis.
5. Writing the article: I was responsible for writing the article, reviewing and rewriting the article based on the feedback from the journal reviewers.

I declare this to be a true reflection of my contribution to this journal article

Signature:

A handwritten signature in black ink, appearing to read 'Andrew Ross', is written on a light blue rectangular background.

Date: 15/12/2015

Review of the Umthombo Youth Development Foundation scholarship scheme, 1999–2013

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Introduction: Staffing of rural and remote facilities is a challenge throughout the world. Umthombo Youth Development Foundation (UYDF) has been running a rurally based scholarship scheme since 1999. The aim of this review is to present data on the number of students selected, their progress, graduation and work placement from inception of the scheme until 2013.

Methods: Data were extracted from the UYDF data base using a data collection template to ensure all important information was captured.

Results: Since 1999, 430 rural students across 15 health disciplines have been supported by UYDF. The annual pass rate has been greater than 89%, and less than 10% of students have been excluded from university. All graduates have spent time working in rural areas (excluding the 32 currently doing internships) and 72% (52/73) of those with no work-back obligation continue to work in rural areas.

Discussion and conclusion: The UYDF model is built around local selection, compulsory academic and peer mentoring and social support, comprehensive financial support and experiential holiday work. The results are encouraging and highlight the fact that rural students can succeed at university and will come back and work in rural areas. With 46% of the South African population situated rurally, greater thought and effort must be put into the recruitment and training of rural scholars as a possible solution to the staffing of rural healthcare facilities. The UYDF provides a model which could be replicated in other parts of South Africa.

Examen du Programme de Bourses de la Fondation Umthombo pour le Développement de la Jeunesse, 1999–2013.

Introduction: La dotation en personnel des institutions en zones rurales et lointaines est un défi dans le monde entier. La Fondation Umthombo pour le Développement de la Jeunesse (UYDF) a organisé un programme de bourses en milieu rural depuis 1999. Le but de cet examen est de fournir des données sur le nombre d'étudiants sélectionnés, leurs progrès, l'obtention de leur diplôme et leur placement professionnel depuis le début du programme jusqu'à 2013.

Méthodes: Les données proviennent de la base de données de l'UYDF en se servant d'un modèle de collecte de données afin que toutes les informations importantes soient saisies.

Résultats: Depuis 1999, 430 étudiants ruraux dans 15 disciplines de la santé ont été aidés par l'UYDF. Le taux de réussite annuel était de plus de 89%, et moins de 10% des étudiants ont été exclus de l'université. Tous les diplômés ont travaillé en zone rurale (à l'exception des 32 qui sont en train de faire leur stage) et 72% (52/73) de ceux qui n'ont pas à rembourser leur bourse par le travail continuent à travailler dans les zones rurales.

Discussion et conclusion: Le modèle de l'UYDF s'articule autour de la sélection locale, du mentorat académique et par les pairs, et du soutien social, un soutien financier complet et du travail expérientiel de vacances. Les résultats sont encourageants et montrent que les étudiants ruraux peuvent réussir à l'université et reviendront travailler dans les zones rurales. Avec 46% de la population sud-africaine vivant à la campagne, il faut s'efforcer de recruter et de former d'avantage d'étudiants ruraux comme solution possible pour pourvoir en personnel les services de santé ruraux. L'UYDF fournit un modèle qui pourrait être reproduit dans d'autres parties de l'Afrique du Sud.

Background

Staffing of rural and remote health facilities is a challenge throughout the world. The World Health Organization (WHO) estimates that there is a global shortage of 4.3 million doctors and nurses, with up to 1 billion people without access to healthcare workers.¹ The Department of

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Health in its *Human Resources for Health for South Africa 2030* estimated that there is a shortage of 14 932 professional nurses, 4145 doctors, 778 pharmacists, 1777 social workers and 345 physiotherapist in South Africa (SA), with rural areas impacted by staff shortages more than urban areas.²

In Australia, Canada and the United States of America, recruiting rural origin scholars who return to work in rural areas after training has been shown to be an effective strategy for increasing staffing levels at rural and remote facilities.^{3,4} Using the pipeline metaphor, various strategies have been employed to increase the number of rural origin students in these countries. These include the promotion of careers in medicine at high schools, reservation of a certain percentage of places for rural origin students at medical schools, increasing the rural content and exposure to rural medicine at university, and recently the development of rurally located medical schools.⁵

Although there is substantial evidence from First World countries, there is relatively little evidence from developing countries that rural recruitment impacts on staffing levels at rural facilities. In 2003 a South African study reviewed where 138 rural origin and 140 urban origin students where working as health care professionals (HCPs). This study concluded that rural students were more likely to work in rural areas than urban origin students (38% vs. 12% respectively).⁶ In 2003 Ross and Reid reviewed a number of HCPs who remained at a rural district hospital (DH) post-community service and found that the numbers who remained were small (22/278; 8%). The authors concluded that rural origin HCPs and those with provincial work-back obligations were more like to stay at a rural DH than those who grew up in an urban area or those without any contractual obligations.⁷

Currently there appear to be no systematic efforts to promote health science careers in rural areas of SA, and dysfunctional schools make entry into and success at medical school a challenge.⁸ Most South African healthcare training institutions currently have a race-based admission policy to address the imbalances of the apartheid past. The University of KwaZulu-Natal has recently introduced a policy of admitting 28% quintile 1 and 2 students to the medical school to increase representation from these schools. Although many rural schools may be represented by quintile 1 and 2 schools this is an incidental consideration and not a policy to ensure adequate selection of rural origin students. Tumbo's 2009 study, which looked at rural representation at the nine health education facilities in SA, showed that rural origin students accounted for 27.4%, 22.4%, 26.7%, and 24.8% in medicine, physiotherapy, occupational therapy and dentistry respectively – significantly lower than the national rural population ratio.⁹ As such, the recruitment of rural origin students could be considered to be an issue of social justice, important for the provision of health services in rural areas.

With 46% of the South African population situated rurally,¹⁰ it would appear that geographical origin must become

an important selection consideration at health training institutions. Greater effort should be put into the recruitment of rural scholars, the prioritisation of places for them to study at medical school and other health training institutions, provision of adequate support to enable them to succeed, as well as creation of posts, and other postgraduate career opportunities in rural areas.

Umthombo Youth Development Foundation (UYDF) has been running a rurally based scholarship scheme since 1999. The scholarships scheme was initially established to address staff shortages at a rural DH. The conceptualisation of the scheme was based on evidence from studies in Australia and Canada which showed that rural origin students are more likely to work in rural areas than urban origin students.^{11,12} UYDF students are selected by the local hospital selection committee and sign a year-for-year work-back contract with UYDF. UYDF provides comprehensive financial support at university and a compulsory structured peer, academic and social mentoring programme. The hospital provides opportunities for experiential holiday work experience and employment opportunities on completion of their degree. By any definition (geography, work opportunities, distance, population density, etc.) the students supported by UYDF would be considered to be rural.¹³

Aim and objective

The aim of this review is to present data on the number of students selected, their progress, graduation and work placement from inception of the UYDF scheme in 1999 until 2013. It is hoped that this review will stimulate debate on admission policies and indicate possible solutions to the staffing challenges at rural healthcare facilities.

Methods

Data were extracted from the UYDF data base using a data collection template to ensure that all important information was captured. All students supported by UYDF have been included (even those partially funded by UYDF and who received a provincial bursary or other funding during the course of their studies). Graduates were contacted by UYDF staff to verify the information available at the office and to obtain any outstanding information.

Ethical considerations

Ethical permission for this study was given by the Human and Social Science Ethics Committee of the University of KwaZulu-Natal (HSS/0228/014)

Results

Some health science courses are three years in duration (dental therapy, environmental health, radiography, biomedical technology), some four years (physiotherapy, pharmacy, nursing) and others six years (medicine). This means that intake rates do not necessarily correspond with graduation rates; see Table 1 for details. In 2007

TABLE 1: Student numbers supported by UYDF since 1999.

Year	New students	Cumulative total*	No. passed**	Number repeating	Number excluded	Number graduated	Pass rate (%)
1999	4	4	4	0	0	0	100
2000	5	9	8	1	0	0	89
2001	6	15	13	1	1	0	87
2002	22	36	29	1	6	2	81
2003	17	45	40	4	1	7	88
2004	12	49	47	2	0	5	96
2005	12	56	50	3	3	10	89
2006	11	54	47	4	3	12	87
2007	17	56	52	0	4	13	93
2008	26	65	53	10	2	7	82
2009	37	83	71	10	2	19	86
2010	36	108	97	9	2	15	90
2011	61	152	132	16	2	25	87
2012	56	181	166	15	8 + 2 (poor attitudes)	22	92
2013	42	191	179	8	4 + 1 (ill health)	48	94
2014	66	205	-	-	-	-	-
Total	-	430	-	-	41 (9.5%)	185	-

*. Cumulative total = new students + existing students – number graduated – number excluded.

**, Number passed = number of students who were able to progress (they may have been carrying some subjects).

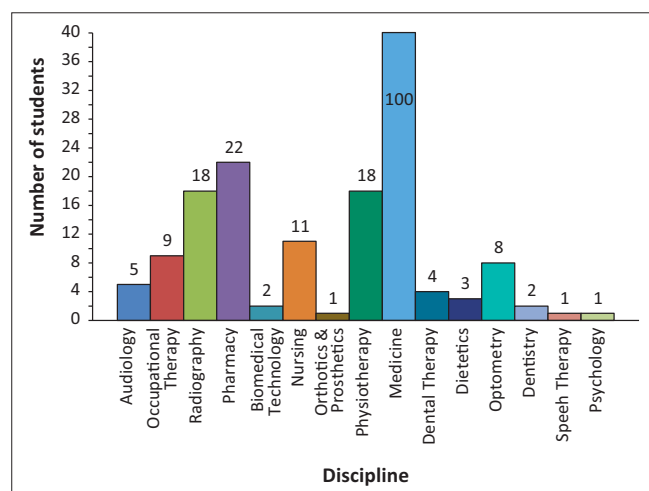


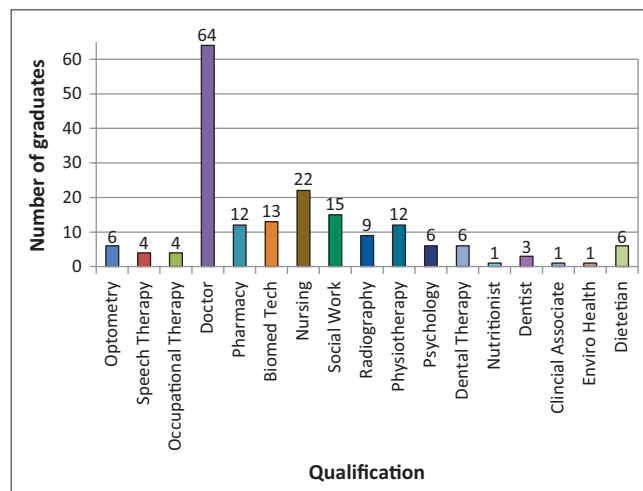
FIGURE 1: Current students by discipline ($n = 205$); there are 100 medical students (off the scale).

UYDF moved from a voluntary run organisation to having full-time staff members (Director, full-time student mentor and administrative support), and the dramatic increase in the total number of students supported since 2008 can be attributed to this. Currently UYDF is supporting 205 students across 15 health disciplines, 65% of whom are women. A breakdown of students by discipline is presented in Figure 1.

As of May 2014 there are 185 UYDF graduates. A breakdown of graduates by discipline is presented in Figure 2.

Figure 3 shows the breakdown of graduates by current place of work

Some public sector hospitals are in urban areas, but most of the non-governmental organisations (NGOs) and some private practices where graduates work are in rural areas. Not all students are supported by UYDF for the duration of their training, as some students obtain a provincial



$N = 183$ (excludes the two who graduated in May 2014).

FIGURE 2: Breakdown of graduates by qualification.

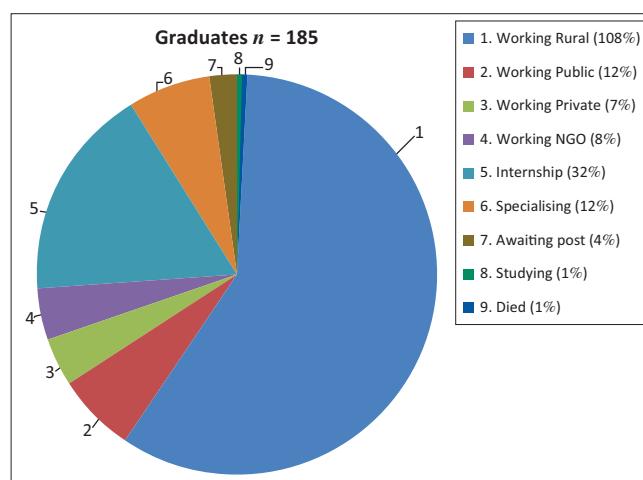


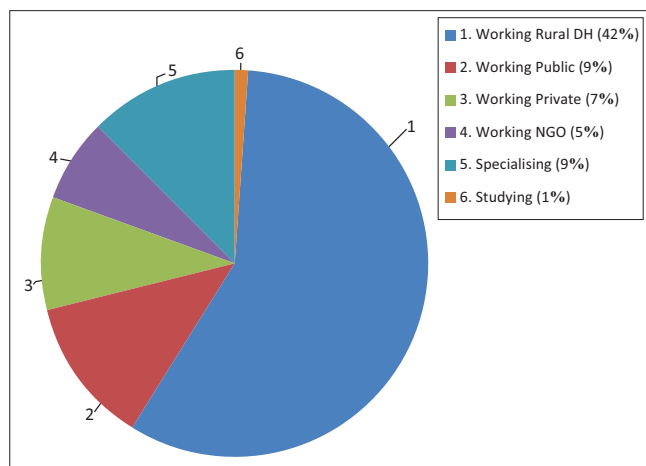
FIGURE 3: Current graduates by current place of work.

bursary during the course of their studies. The provincial bursary programme has different work-back obligations;

their graduates may work in any KwaZulu-Natal provincial hospital (including urban hospitals), and may engage in postgraduate training during their work-back obligation.

All graduates who received any support from UYDF have spent at least a year working at a rural DH (this excludes the 32 currently doing their internship, as it is not possible to do ones internship at a rural DH in SA). Nine graduates have bought themselves out of a portion of their UYDF contract, and only one has defaulted on their contractual obligations. Of the 73 graduates who have completed their contractual obligations to UYDF, 52 (71%) continue to practice in a rural area, 42 in rural DHs, and the balance are working for rural NGOs or in rural private practice. A breakdown of these graduates by location is presented in Figure 4.

Currently 57% (106/185) of the graduates are women, and qualification by gender is presented in Figure 5. Slightly more women than men have qualified as doctors and pharmacists, whilst numbers are equal for nursing and



UYDF, Youth Development Foundation.

FIGURE 4: Work placement of graduates with no work-back obligation to UYDF ($n = 73$).

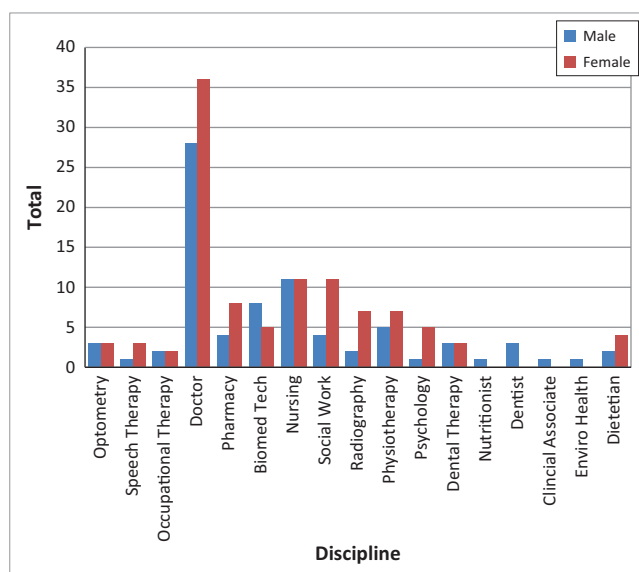


FIGURE 5: Breakdown of graduates by gender.

occupational therapy. More men than women have trained as biomedical technologists, nutritionists, dentists and clinical associates.

Discussion

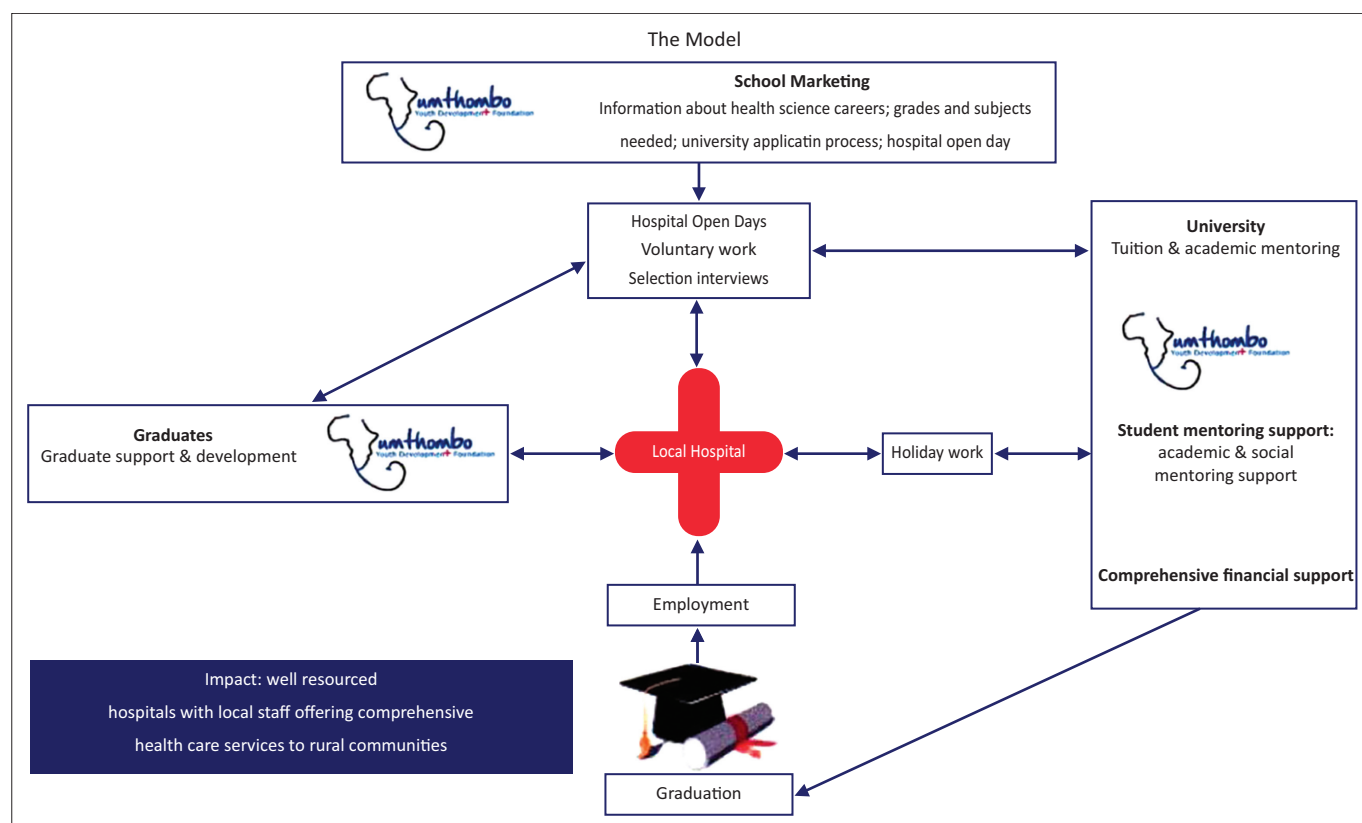
The UYDF results are significant, particularly within the current SA context, and more so because of the rural origin of these students. With a pass rate of greater than 89% over a 15-year period and less than 10% of students being excluded from training institutions, these figures highlight the latent potential of rural scholars. These figures are also in sharp contrast to the national experience where, despite the number of black students at institutes of higher learning (IHL) rising from 30% in 1999 to 66% in 2010, this has not translated into an increased number of black graduates.

Cohort studies have shown that the completion rates of black African students at contact universities in the life sciences, mathematics and physical sciences is only about 33%, which is about half the completion rate of white students.¹⁴ Other scholarship programmes have had varied student success, with the Rural Education Access Program (REAP) reporting 57% – 66% student completion rates of the 131 students supported in 2002.¹⁵

The success of the UYDF model may be related to several factors, including the following: (a) local hospital participation; (b) academic and peer mentoring; (c) social support; and (d) the reintegration and support of graduates into the hospitals once they have completed their training. These aspects are depicted in Figure 6.

The local DH is at the heart of the UYDF model, as the scholarship scheme started as a response to the need for staff at a rural DH. To ensure that the scheme is responsive to the needs of the hospital, the hospital selection committee is responsible for the promotion of a career in health through open days, and selection of health science students according to hospital priorities. UYDF students are also expected to do four weeks of experiential holiday work at the local hospital each year. This enables students to consolidate their theoretical knowledge in a practical way, and to apply their knowledge at a DH level, work alongside local HCPs and strengthen relationships with one another, with management at the hospital and with community members. This holiday work also prepares them for working at a DH as they understand the local conditions, challenges and resource constraints at such hospitals as well as what is expected of them as HCPs. Career-specific work experience is recognised as an important motivating influence for students at IHL and can contribute to students persisting and achieving academic success at IHL.¹⁴ Experiential holiday work is an integral aspect of the UYDF model.

UYDF is responsible for facilitating the academic and peer mentoring and the social support at university. Rural students often feel alienated when they first attend IHL,



UYDF, Youth Development Foundation.

FIGURE 6: The UYDF model for student selection and support.

and this contributes to their social isolation and inability to access social and academic support.¹⁶ The UYDF provides a 'family' of other rural origin students who help each other to adapt to the challenges of university and city life. TM, a UYDF graduate, put it this way: 'I would mentor new students. Not teaching them maths and physics, but I would mentor them in terms of social life, and how to handle the situation, knowing their background. So it was easier for the new guys to adapt in that environment, because I was there.'

Social and academic engagement has been identified by Tinto as critical to student success at IHL.¹⁷ Academic mentoring and support is provided by UYDF mentors who meet regularly with UYDF students to review their progress and ensure that academic and social issues are being addressed. This accountability encourages and supports students to find solutions to any challenges they might face at university. The academic mentoring also communicates a belief that students have the potential to succeed and that they belong at an IHL.

Other studies have shown that when students believe that they have the ability to succeed and that they belong or deserve to be at an IHL this contributes to their success.¹⁸ Laude at the University of Texas found that the introduction of small classes, mentorship and support which communicated to students that they had the ability to succeed and that they belong at university, influenced success of students who traditionally failed.¹⁹ The academic

and peer mentoring as well as social support facilitated by UYDF is considered key to students' success, as it enables them to identify and overcome academic and social challenges in order to succeed at IHL.

Comprehensive financial support is also an important component of the support provided by UYDF, which may assist in the success of the scheme by allowing students to focus more on the academic challenges at university. Inadequate finances have been identified as an important reason why students in SA fail at IHL.^{16,20} A criticism of the current NSFAS (National Student Financial Aid Scheme) funding model is that students only receive partial financial support, which covers fees and residence with only a small food and book allowance. This NSFAS model is based on the assumption that parents should make a family contribution towards these costs. However, for many rural students the family contribution is not forthcoming, and hunger and their limited access to the necessary resources distract from academic work and may contribute to their high failure rate. The Rural Education Access Programme, which supports many disadvantaged students, has recommended a review of the current funding model for NSFAS to ensure comprehensive funding for financially needy students at IHL.¹⁶

Recommendation

The UYDF provides a model which could be replicated in other parts of SA. However, further studies are needed to

identify and understand the key aspects of the UYDF model and whether or not this model can be taken to scale.

Conclusion

Results from the last 15 years of the UYDF are significant and highlight that rural students can succeed at university with appropriate support. Whilst numbers are still small, all graduates have spent time working at rural hospitals, thus helping to ensure services are provided at these facilities. With 71% of those who have completed their work-back obligation having remained in rural sites, these numbers are encouraging and support data from other countries that rural origin students will return to work in rural areas.

As most of the current literature around the recruitment and training of rural origin students to provide services in rural areas is based on Australian and Canadian studies, this study adds to the body of literature by showing that even in developing countries, strategies to identify and support rural origin students to train as healthcare providers can contribute to the staffing of rural healthcare facilities.

Acknowledgements

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Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

Authors' contributions

A.R. (University of KwaZulu-Natal) was responsible for conceptualising the research project, analysing the data and writing the article. G.M. (Umthombo Youth Development Foundation) was responsible for collecting and collating the data and contributed to the analysis and writing of the article. L.C. (University of KwaZulu-Natal) contributed to the writing and reviewing of the article.

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3. School to university

Papers 2 and 3 look at the experiences of these rural origin HCPs at school and at university and how they responded to the challenges that they faced. Paper 2 explores issues such as determination, support, funding and pressure that they felt to complete. Question 3 looks at the challenges that they faced at school, university and at work and how they responded, and asks whether response to challenges should be taken into consideration when selecting students to study Health Science courses. The Letter to the Editor was written in response to the announcement of 40 additional places at medical schools in SA, which we saw as an opportunity to increase the number of rural origin students admitted into training programmes.

Paper 2

Responds to

Critical question 1 - **Who are these HCPs?**

Critical question 2 - **What were their educational experiences?**

Paper 2

Paper 2 looks at their experiences from school into university. It responds to critical questions 1 '**Who are these HCPs?**' and 2 '**What were their educational experiences?**', from a grounded perspective in which codes, categories and themes were identified and used to describe their experiences from school to completing university. The paper highlights how difficult the journey was, the support that they received from family and other community members, how they funded the various aspects of their educational journey, companions on their journey, their determination and the pressure that they felt to complete the journey. These themes give an understanding of what it takes to graduate as an HCP when coming from a rural context.

Title: From rural scholar to health care professional

Author: Ross, A.

Journal: From rural scholar to health care professional. *South African Family Practice*, 1(1), 1-6. doi:10.1080/20786190.2015.1071537

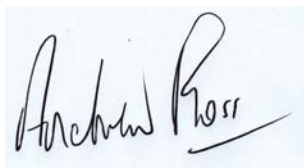
Declaration regarding a Doctoral student's contribution to the journal articles to be included in a doctoral 'research dissertation through publications'

Student name: A.J. Ross

Student number: 212557836

I declare that the entire article, including formulation, design, analysis and write up was completed by the author alone.

Signature:

A handwritten signature in black ink on a light blue background. The signature is written in a cursive style and appears to read "Andrew Ross".

Date: 15/12/2015

From rural scholar to health care professional

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Background: International studies have shown that the best strategy for the long-term staffing of rural facilities is the recruitment and training of students of rural origin. However, the crisis in education in South Africa means that these rural students are the least likely to access institutions of higher learning to train as healthcare professionals (HCPs). The aim of this study was to explore the educational experiences of six HCPs of rural origin working in rural areas.

Methods: This was a qualitative study using unstructured interviews supplemented by photomemory and collage development. All interviews were transcribed verbatim and themes were developed. Appropriate ethical permission was obtained prior to the study.

Results: HCPs of rural origin found the journey from rural scholar to HCP to be tough. Personality characteristics such as tenacity, determination, problem-solving skills, self-belief and hard work were essential for success — but not sufficient on their own. In addition these HCPs needed social support, academic and social mentoring as well as comprehensive financial support.

Conclusions: HCPs of rural origin have the potential to provide long-term staffing for rural hospitals. However, if rural healthcare institutions are serious about finding long-term solutions to their staffing challenges, attention needs to be given to finding and appropriately supporting local scholars.

Keywords: academic and social support, health care professional training, rural origin

Introduction and background

In November 2013 the World Health Organization (WHO) released a report highlighting the central role that well-trained, culturally sensitive, competent staff have in attaining and sustaining universal health coverage.¹ It is widely acknowledged that despite the high levels of unemployment in South Africa (SA) there is a shortage of highly skilled professionals, and institutions of higher education (IHE) have a poor throughput of students — due in no small measure to the apartheid legacy of poor schooling.² These factors contribute to understaffing of government health institutions, particularly rural institutions, and poor quality of healthcare delivery.^{1,3,4} International observational studies have shown that the best strategy for the long-term staffing of rural facilities is the recruitment and training of students of rural origin.^{3–8} However, the crisis in education in SA means that these rural students are the least likely to access IHE to train as healthcare professionals (HCPs).⁹ There is no South African research which has used a life-history approach to explore factors that hinder or facilitate the training of rural origin HCPs as they progress from rural student to HCP.

The aim of this study was to understand the educational experiences of rural-origin HCPs currently working in rural healthcare settings. It is hoped that a better understanding of their educational experiences in their journey from rural scholar to HCP will inform and deepen discussions around selection and support of rural origin students, and contribute towards addressing SA's healthcare skills shortage.

Methods

This was a qualitative study using a life-history methodology to explore the educational experiences of six rural-origin HCPs. A life-history methodology was chosen to explore life experiences as stories ('lives as told') and to understand how these HCPs made meaning and sense of their experiences of growing up in a rural context in SA in the 1980s and 1990s and of training to be a HCP.¹⁰

Six rural-origin HCPs were purposefully selected from Umthombo Youth Development Foundation (UYDF) graduates.¹ Selection criteria were richness of information, willingness to participate, being articulate and currently working in a rural context.¹¹ To ensure that the voices of all members of the healthcare team were heard, a variety of HCPs were included in the study (see Table 1).

Data were collected by the author in two unstructured interviews and two discussion sessions, which involved photograph and artefact memory and collage development. The author is the founder of UYDF and currently a trustee, but no longer actively involved in operational aspects of the scheme. None of the participants have any current contractual obligations to UYDF. Each interview and discussion lasted 60–90 minutes; in the first interview participants were invited to tell stories of their life growing up in a rural setting and to relate memories of their primary and high school experiences, as well as their post-school experiences up to the present moment as practising HCPs. The second long interview was used to clarify issues raised in the first interview, and to allow participants to share other meaningful experiences.

Interviews, however, tend to be linear and focus on the 'telling' of stories of a 'life lived'. Visual images allow one to move away from linear thought and open up new ways of thinking.^{12,13} To broaden and deepen the understanding of their experiences each participant was asked to bring four photographs and an artefact to the third meeting, at which participants spoke about each photograph and artefact and the memories that they elicited (see Figure 1 and Figure 2 [all photographs are used with permission]). The fourth meeting was a collage inquiry activity where participants were asked to construct and describe a collage that focused specifically on the topic 'A day in your life as healthcare practitioner'.

All of the data generated from the interviews and arts-based strategies were tape-recorded and transcribed verbatim. The data

Table 1: Healthcare professionals who participated in the study

Name	Current position	Professional qualification and graduation date	Professional experience	Gender
DG	Umthombo Student mentor coordinator	BSc Physiotherapy 2003	2004–2008 Physiotherapist 2008–present mentor coordinator for Umthombo	M
FN	Sub-Saharan coordinator Brian Holden Eye Institute	BSc Optometry 2003	2004–2009 Optometrist — Mosvold Hospital, Pelopele Eye Train 2010–present Brain Holden Eye Institute	M
SM	Psychologist at Hlabisa District Hospital	MSc Clinical Psychology 2009	Clinical psychologist Hlabisa Hospital 2010–present	M
TM	Physiotherapist at Emmaus District Hospital	BSc Physiotherapy 2006	Physiotherapist 2007–present	M
NM	Pharmacist military research post in Mtubatuba	BSc Pharmacy 2004	Pharmacist 2005–present	F
LH	Medical officer Mseleni District Hospital	MBChB 2006	Intern 2007–2008 Medical officer 2009–present	F

Note: F = female; M = male.



Note: A discussion of this photograph of TM outside his house in Ingwavuma (Figure 1) led to a deeper understanding of what it was like for him growing up in a rural area, and the challenges that he now feels as a qualified HCP to be a role model for other young people in his community.

Figure 1: TM outside his house in Ingwavuma.



Note: A discussion around Figure 2 highlighted the importance of friends and a support group at university, which contributed to TM's success.

Figure 2: TM's university friends.

were then reconstructed into six stories. The reconstructed stories included written and visual data, and the 'finalised' version was sent to each of the participants to correct, amend or extend.¹⁴ Reconstructing the story as a narrative was an iterative process of reading and re-reading, selecting and filtering to create a story in such a way that the teller was not diminished or written out of his/her telling.

From these reconstructed stories codes and categories were identified, patterns and relationships between categories were reviewed and themes were developed as described in the literature.^{11,15,16}

Ethical approval was obtained from the Social Science Ethics Committee of the University of KwaZulu-Natal in Durban, SA (HSS/1205/012D). Written informed consent was obtained from all of the participants prior to the start of the study. Consent was given to use the photographs presented.

Results

The journey metaphor provided a structure around which these HCPs could select and organise the details of their reality so that their educational experiences could be seen with some sense of cohesion. The metaphor of climbing a challenging mountain or going on a difficult journey came from the data analysis. The journey from rural student to HCP was tough, with many challenges that needed to be overcome if these rural scholars were to succeed. Material poverty, poor school infrastructure, unmotivated teachers, and being pushed to take subjects at a standard grade (as opposed to higher grade) level all conspired to make this journey difficult.

These HCPs of rural origin found adjusting to the academic and social pressures at IHE to be challenging. Orientation was often inadequate and many missed lectures at the beginning of the academic year because they could not understand the timetable or could not find the lecture venues. Some fell behind almost immediately because of missing lectures, compounded by their inability to understand the lecturers and to take adequate notes. These were top students from rural schools, who felt intimidated by the academic environment and unable to participate and engage with the lectures to understand difficult concepts. This feeling of not belonging was often compounded by lecturers who told them that they would fail and that they should deregister. This sense of not belonging, of not being able

to cope — particularly when they failed tests and assignments — threatened to undermine their self-belief and confidence in their ability to succeed:

'English was a challenge. ... I had never had a white lecturer standing in front of me and teaching in English, only English ... telling us something that we really needed to understand. They spoke so quickly that I couldn't understand what they were saying. It was the speed, they'd say this and this and this and then finish and then they'd be gone! And I couldn't even take notes because everything was so quick!' (TM)

'On three occasions I got a note on my assignment "go and see the lecturer". That was tough because at high school I was always a top student. I started to question myself — "Is there something wrong with me? Is this really for me?" and I felt so discouraged.' (SM)

To succeed at university these rural origin students needed to ignore those rural voices on the roadside which told them that going to university and succeeding was not possible. They needed to close their ears to the lecturers who told them that they would fail and be excluded. When the going got tough they needed to resist the urge to follow their peers who had left school to work in the mines, and they needed to rescript their socialisation, which told them 'that working in the mines was going to be a great experience.' (SM)

From the data the following four themes were identified:

- (1) determination to complete the journey;
- (2) support for the journey;
- (3) funding the journey; and
- (4) pressure on the journey.

Determination to complete the journey

No major undertaking can be successfully accomplished without determination, self-belief and a realistic assessment of the difficulties, as well as hard work. Travellers often face challenges that can seem overwhelming, and it is the determination to succeed and find solutions no matter what the difficulties are which may be the difference between success and failure. These graduates were solution finders, both at school and at university. Despite the difficulties and challenges these students faced, they learnt to take responsibility for their own learning because they saw education as a way out of poverty. They were determined to succeed and they looked for solutions to address deficiencies in their school education, even if it meant walking 10 km for extra maths lessons, and forming study groups:

'... we formed a study group — there were five of us — we used to share information with each other to ease the pressure.' (DG)

These graduates were able to take the life lessons from their rural schooling experience to university, where they continued to find solutions to the challenges they faced. They attended extra English classes and made friends with other students who only spoke English, so that they were forced to communicate in English. In addition, they were able to apply what they had learnt at school about cooperative learning and they formed study groups to help them master the work at university:

'Study groups were a way of cementing my knowledge. I studied by myself first, then when we were in a group, I shared what I've learned. Right up to my final year I worked in study groups.' (DG)

A realistic assessment of their deficiencies and a willingness to access available support to address these deficiencies was an essential component of their success at IHL:

'You can't fix a problem unless you are prepared to say "I failed. I have a problem. I must do something." You need a kind of a hunger to succeed, a determination to succeed, a kind of whatever it takes to succeed attitude.' (DG)

A determination to succeed, a can-do attitude and a willingness to work hard were key personality characteristics that contributed to their success. In addition, academic success encouraged them and built a belief that they could succeed and that hard work paid off:

'We worked, worked, worked. In June, I moved from the 17% I got in the previous year to 62%. It was the same for Biology. After passing Physics it gave me the confidence that I can do this.' (DG)

These students were highly motivated and determined to succeed. For these rural scholars the opportunity to go to an IHL was the chance of a lifetime. Success virtually guaranteed permanent full-time employment; failure was unthinkable:

'Failing would mean going home to ... what? If you don't pass you will come back and stay in the rural area and you'll be the same or worse person there like you were before.' (TM)

Support for the journey

In spite of their self-belief, determination, hard work and problem-solving abilities, this educational journey might not have succeeded without the support and funding they received. Their families prioritised education and communicated the importance of education and persisting at school. Critical others such as teacher and friends saw potential in them and played an important role in encouraging them to continue their studies:

'My mum believed in education as the key to everything. Although she had got no education at all — she thought that if her kids can get education, they'll be better people. She was the person motivating me.' (SM)

'When I was doing Standard 3, my class teacher said "you can be a good teacher" and the Principal promised to employ me when I passed matric. This motivated me to work hard at school.' (DG)

Most universities have academic support programmes available for students. However, students need to utilise these services if they are to benefit from them. These HCPs asked for tutors and mentors and took advantage of the institutional support available, which was provided by Medical Education for South African Blacks, tutors and university academic staff.

Over and above the institutional support, UYDF provided academic and social mentoring and demanded academic accountability. Students were expected to find solutions to the challenges that they faced at the IHE and to pass. The compulsory UYDF mentoring programme provided social support and ensured that students were accountable to one another as well as to the scheme. As part of this accountability students were asked to give regular feedback to one another and to the funder about solutions to problems they encountered:

'We had monthly meetings, and we'd discuss how everyone was doing. Sometimes when you haven't done well in a test, say you

got 45%, you get depressed, or are embarrassed to tell others that you didn't pass. It was tempting if you had done badly to hide your result or even lie about your results and say "I have passed", when in fact you haven't passed. But you know when you're in these groups, you will hear someone say "No, I haven't done well, I got 35%". And you would say "Yoh, I got 45%, I'm much better than this guy!" And someone else would come and say "No, they got 70% or 75%", then you would think if he got 75%, why don't I just try to get 50%, or 55%. Then you work even harder'. (TM)

Funding the journey

Funding for university for black rural students in SA is a major issue, and without it students with potential cannot even begin this leg of their educational journey. All of the participants alluded to this, but none so powerfully as NM who, after her father died, resigned herself to the fact that 'there's no way I can go to university now ... that varsity thing, forget about it. I think I lost hope in 1997'. These were students with incredible potential, wanting to improve their lives and their family circumstances, wanting to have a chance in life but trapped by insufficient resources, the unavailability of State resources or the lack of information about resources. NM and TM capture something of the impact that funding had for them:

'In January 2002 I went to the University of the Witwatersrand to do Pharmacy. That's when my life changed. Things changed because I got a chance.' (NM)

'Umthombo came to my rescue. That scholarship, ah, I don't have a proper name, but it was where everything started to change. That's where I got my life that I'm living now.' (TM)

Accessible funding gave them a chance, which these HCPs seized with both hands.

Pressure on the journey

In any undertaking, particularly a major undertaking, there is pressure to succeed and finish the journey. For these rural students this was a high-stakes winner-takes-all endeavour. There was the pressure that they put on themselves:

'I had no option, I had to make it. And if I don't make it, I'd lose the scholarship and it would just be the end of the world.' (SM)

There was also external pressure to complete from the community and the funder who had to raise money from corporate South African companies who did not want to see their donations wasted on students who were failing:

'We did not want to fail ... because it was an embarrassment, not only to yourself but to the whole community, because in the rural area, once you go to university, everybody in a hundred kilometre radius knows. To come back now, having not finished, is always a very big disappointment to many people.' (FN)

Discussion

The educational journeys of these HCPs illustrate that rural-origin students have the potential to succeed at IHE, and if properly identified and supported can be part of the long-term solution to staffing of rural hospitals.

This study suggests that the journey from rural scholar to HCP is tough. Lack of resources impacts upon educational opportunities and aspirational poverty stifles dreams, as one's belief in the possible is often limited by the experiences of other individuals in

the community.¹⁷ Many rural schools in SA are unable to provide the tools necessary for scholars to take advantage of educational opportunities. Many of these schools are poorly resourced and staffed by teachers who themselves were under- or poorly trained.^{18–24} As highlighted in other studies, poor proficiency in English and poor studying skills were identified as particularly challenging by these HCPs, skills which should have been provided at school in preparation for attending IHE.^{18–25} However, this study suggests that despite the challenges, rural families and communities are resilient and resourceful and have the potential to encourage and support rural-origin students.

Significantly, rural-origin students in this study showed that they had the potential to succeed manifest in their personal characteristics, such as their determination, problem-solving, self-belief and hard work. These rural-origin students were determined to succeed, and willing to work hard, study together and ask for help. A realistic self-assessment of one's deficiencies and a willingness to access institutional and other support available to address these deficiencies has been identified as key in the development of academic resilience and success at IHL.²⁶ Although a rural upbringing is often associated with deficiency, Balfour (2008) has suggested that rural experience may in fact be an advantage.²⁷ Finding solutions to many of the challenges encountered in their community provided these rural students with life skills which they were able to apply in other environments. These rural students were problem solvers who had learnt the value of cooperative study. At university they were able to draw on previous learning and personal strengths, adopt problem-solving behaviour, seek out social support from like-minded peers and learn how to access resources at university.²⁰ They believed in themselves and their potential and were determined to succeed. These personality factors are important to draw upon to help rural origin students succeed at IHL.

If one believes that rural graduates are the solution to staffing rural hospitals, innovative strategies need to be found to identify and support rural students with potential who are interested in careers in the health sciences. This study suggests that the process of recruiting and selecting students from rural contexts needs to consider variables beyond academic performance in high school. Rather, personal characteristics such as determination, problem-solving ability, self-belief and hard work must form part of the skills and attitude package that rural-origin students must have to be selected for study at university.

These traits may or may not be obvious and immediately recognised by significant others (parents, teachers and university selectors) and even the student themselves. Currently the selection of UYDF students is based on an interview with hospital and community members after the completion of pre-selection work experience. Academic ability is assumed if students meet the university entry requirements. However, in a systematic review of selection practices that predict rural practice, Henry, Edwards and Crotty (2009) reported that the predictive power of interviews was modest, while prior rural residence was the strongest predictor of rural placement.⁶ Further research is needed in this area as it may be other aspects of the programme, such as the rural origin of these students, the community involvement in their selection or the financial and mentoring support provided, which encouraged these graduates to return to work in rural areas.

However, even great potential, determination and problem-solving ability may not be enough to ensure success in the journey from rural scholar to HCP. In keeping with other studies, these students also needed social support, academic and social

mentoring as well as comprehensive financial support.²⁵ This study has highlighted the role of support from family and peers, all of which was important for these rural scholars as they trained to become HCPs. Benard (2004) has highlighted the importance of even one supportive relationship which promotes high academic goals and encourages scholars to aim high. This relationship can make a major difference in the academic life of students, even in the face of dysfunctional families and poorly functioning schools.²⁸

The UYDF funding communicated a belief in the potential of these students, and was linked to accountability and participation in mentoring programmes and in communities of learning, all of which were identified as important in their success. Student participation in communities of learning with peers and academic staff has been shown to lead to greater social and academic engagement, greater support and encouragement, willingness to risk acknowledging deficiencies and looking for solutions, greater access to faculty support services and improved academic achievement.^{29–31} Universities and other funding organisations need to review how funding can be used more effectively to promote academic and social engagement at IHL, as these have been shown to be important factors influencing student success.²⁰

The compulsory UYDF mentoring programme is proactive, it monitors students' progress, provides peer support and encourages engagement with the academic community, all important aspects of Tinto's proposed interventions to support student engagement and success at IHL.³² UYDF also holds students accountable and encourages them to reframe current challenges and find solutions in the light of previous successes. The mentoring is provided with the expectation that they would succeed because they had potential. Morales and Trotman (2004: 45) state that 'high expectations based on the strengths, interests, hope and dreams [of students] helps [them] tap into their intrinsic motivation and own desire for learning and personal gain'.²⁶ Hospitals and other organisations that are serious about finding rural scholars who can train to become HCPs should take cognisance of this fact and the experience of UYDF in the role of setting high standards and providing ongoing support.

Rural students often come from poor families and as such are unable to finance studies at IHL. In keeping with other studies, families often prioritise funding for schooling but not for tertiary education.³³ Tinto (2012) reported that finances often affect decisions about whether or not one can access IHL, but did not influence student persistence at IHL.³² There is, however, other research which suggests that lack of funding contributes to many students dropping out of IHL.²⁰ The experiences from this cohort suggest that finances influenced their decision about whether or not they could pursue further education, but was not a significant factor at university as they were fully funded. The South African Government has an extensive financial support programme for financially needy students. However, based on the findings of this study, information concerning government financial support does not appear to reach all rural areas. It is essential that relevant, accessible funding of students with potential be made available if these students are to reach their full potential and make a significant contribution to the health services of the country.

Strengths and limitations of study

The strength of this study lies in the fact that it gives a voice to rural-origin HCPs for them to share their experiences. The small number of participants and the qualitative nature of the study mean that the findings cannot be generalised to other settings.

However, it is hoped that those reading this study will be able to identify with the participants and apply learning to their own context.

Conclusions

That these rural-origin HCPs succeeded in overcoming multiple challenges is a tribute to their determination, their belief in their own potential, and their dream for a better future. It attests to their willingness to work hard, smart and with others, to develop realistic insight into their challenges. They had a willingness to find solutions as well as a refusal to listen to those negative voices telling them that it was impossible.

For those involved with the selection, training and support of students of rural origin, greater cognisance needs to be taken of the difficulties that these students face and the pressure that they feel. Appropriate support (such as peer and academic mentoring and encouraging formation of communities of learning) needs to be put in place to ensure that they succeed. In addition, suitable funding models needs to be developed to enable students of rural origin to access the necessary financial support to be able to train at IHL.

Further research is needed around student selection to clarify which personal attributes help to predict success at university and a willingness to return and work in rural areas.

Note

i. UYDF is an innovative rurally based scholarship supporting rural youth to train as HCPs.

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The letter to the editor

Responds to

Critical question 2 - **How do their experiences influence their practice?**

Letter to the editor

The **letter to the editor** responds to critical question 2 and highlights the success of UYDF in supporting rural students, and suggests that additional spaces should be given to rural learners to address the healthcare challenges in SA. The idea of broadening selection criteria is developed further in Paper 3.

Title: Scholarship success: Umthombo Youth Development Foundation

Authors: Ross, A.J. and MacGregor, R.G.

Journal: South African Medical Journal

Ross A, MacGregor RG. Scholarship success: Umthombo Youth Development Foundation. South African Medical Journal. 2012;102(5):288

Declaration regarding a Doctoral student's contribution to the journal articles to be included in a doctoral
'research dissertation through publications'

Student name: A.J. Ross

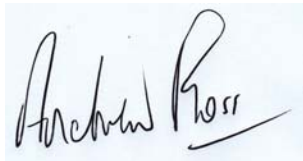
Student number: 212557836

The student's contribution to the article was as follows:

1. I was responsible for generating the data and for the initial analysis.
2. Writing the article: I was responsible for writing the letter to the editor.

I declare this to be a true reflection of my contribution to this letter to the editor.

Signature:



Date: 15/12/2015

EDUCATION

Scholarship success: Umthombo Youth Development Foundation

A J Ross, R G MacGregor

The well-recognised shortage of healthcare workers in South Africa is compounded in rural areas due to the misdistribution of those in favour of urban areas.^{1,2} Numerous local and international studies have documented that students of rural origin are more likely to return to work in rural areas.^{3,4} However, rural health science students are underrepresented at South African universities.⁵ In 2006 Tumbo reported that only 26% of health science students were of rural origin despite 46% of the national population living in rural areas. Despite an increase in health science student admissions to universities between 1999 and 2002, the proportion of rural students did not increase. In fact, in some departments the proportion decreased.⁵ There may be numerous legitimate reasons for this, including poor rural schooling, poor career guidance, challenges with applications and insufficient funding. However, without a more intentional approach or a change in policy on preferential admission of rural origin students, the inequities will remain.

The Umthombo Youth Development Foundation (UYDF) – originally Friends of Mosvold Scholarship Scheme – was started in January 1999 in Ingwavuma, one of the most socially deprived and educationally challenged areas in the country.⁶ The aim of the scheme is to address the shortage of qualified healthcare workers at rural hospitals through the training and support of rural youth to become qualified healthcare professionals (www.umthomboyouth.org.za).⁷ Selection criteria include rural origin, indication of commitment through voluntary work, securing a place to study a health science degree, selection by a local committee and willingness to sign a year for year work-back contract. To date, the scholarship scheme has produced 115 health science graduates across 14 disciplines. The pass rate over the last 13 years has exceeded 84%, with an overall drop-out rate of 13%. All graduates have returned to work in their

area of origin, with the majority (apart from 4 students) honouring their work-back contract. Of the 35 graduates who have completed their contracts, over 75% have continued working in rurally situated hospitals. In 2011, 149 students were supported by the UYDF, of whom 132 progressed and 24 graduated.

We believe that the following factors have contributed to the success of the scheme:

- (i) a strong emphasis on student initiative and responsibility (voluntary work exposure, obtaining university placement, work ethic, holiday work experience and peer support)
- (ii) financial and social support from UYDF (comprehensive financial support, academic and social mentoring support and student accountability)
- (iii) a working partnership with the local community and hospital (open days, student selection and graduate employment).

Student mentoring merits special attention and is fundamental to the success of the scheme. Each student is expected to meet monthly with an assigned mentor to review academic progress and discuss any social issues that may be impacting on the student's abilities. An accountability plan is agreed upon by the student and mentor.

The factors contributing to the success of the UYDF scholarship scheme are replicable. If the rurally based scheme can work in Ingwavuma, it can work anywhere. We believe that the 40 additional places at each medical school, recently announced by the National Minister of Health,⁸ provide an opportunity for focus on the training of rural origin students. The evidence suggests that with appropriate support, more than 85% of rural origin students can succeed at university and will return to work in rural areas. All that remains is the willingness to implement.

Dr Ross is the founder of the Friends of Mosvold Scholarship scheme, and is currently working in the Department of Family Medicine at the University of KwaZulu-Natal. Dr MacGregor is the director of the Umthombo Youth Development Foundation. Both authors believe in the potential of rural scholars to train to become healthcare professionals. Evidence suggests that rural graduates will return to work in rural areas.

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Paper 3

Responds to

Critical question 1 - **Who are these HCPs?**Critical question 3 - **How do their experiences inform their practice?****Paper 3**

Paper 3 responds to critical questions 1 and 3: **‘Who are these HCPs?’** and **‘How do their educational experiences inform their practice as rural HCPs?’** This paper looks at the emerging identity of rural origin HCPs through the dilemmas they faced and how they responded, and suggests that selection criteria should be broadened if IHL are serious about developing transformational leaders who can take health for all into the 21st century. **Paper 3** shows a progression from simply requesting additional spaces for rural origin students, as suggested in the Letter to the Editor, to a general broadening of selection criteria to include both personal and social issues by looking inward (‘How to be’) and outward (‘How to act’) in relation to the temporal (i.e. a dilemmatic event) in terms of its past and its future.

Title: Troubling selection: towards a broader selection policy

Authors: Pillay, G. and Ross, A.J.

Submitted to: South African Journal of Higher Education

Declaration regarding a Doctoral student’s contribution to the journal articles to be included in a doctoral ‘research dissertation through publications’

Student name: A.J. Ross

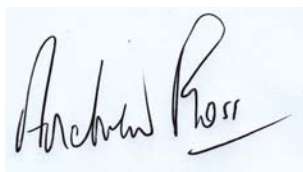
Student number: 212557836

The student’s contribution to the article was as follows:

1. Formulation of hypothesis: I formulated the concept for this paper.
2. Study design: I was responsible for the study design.
3. Ethical permission: I was responsible for obtaining ethical permission for the study.
4. Work involved in the study: I was responsible for generating the data and for the initial analysis.
5. Writing the article: Both authors contributed to the writing of the article.

I declare this to be a true reflection of my contribution to this journal article

Signature:



Date: 15/12/2015

Towards a broader understanding of selection of students to train as healthcare professionals

7257 words, 8903 with abstract and references

Abstract

Introduction

Institutes of Higher Learning (IHL) must train healthcare professionals (HCPs) able to meet priority needs of the population and address health system deficiencies. Concerns about the mismatch between outcome and policy have led many IHL to review their curriculum content and training context. In this article we argue for a broadening of selection criteria when choosing students to train as HCPs.

Methods

A narrative inquiry drawing on life-history interviews and art-based methods was used to generate data on lived lives as told and experienced by six rural-origin HCPs.

Results

Analysis of two narrative vignettes framed as dilemmatic spaces show how personal beliefs and practices inform perspectives that HCPs adopted in their learning and development at IHL, and the transformational practices they enacted.

Discussion

How competing forces were negotiated and positions were taken in committing to become HCPs with the capacity to lead transformation is described. Introducing and using dilemmatic spaces analytically enabled deeper understanding of personal beliefs and priorities that informed the choices made, among the many options available, in everyday situations that are important to consider alongside academic potential in the selection of students to train as HCPs who will lead transformation in health care. (196)

Keywords: Dilemmatic spaces, student selection, rural health care delivery

INTRODUCTION

I do quite a lot of things with the community - when we started at university, no-one was sending their kids to university. But now, people in the community sell their cows to send their kids to university because they are able to see what education can do for their kids.

(interview with France on the 18 January 2013)

Recently I was talking at a rural school just like the school I went to, where children could not communicate in English and where they know nothing about the Central Application Office. When I speak at these schools I start off telling them where I come from ... I start at the beginning, and then go on to tell them about the options.

(interview with Siphamandla on the 20 February 2013)

The National Development Plan 2013 (Manuel et al., 2013) and *Human Resources for Health 2030* (DOH, 2011) tasked Institutions of Higher Learning (IHL) with training increasing numbers of Health Care Professionals (HCPs) as a key component of ensuring a “long and healthy life for all South Africans” (Manuel et al., 2013). These policy documents highlight the need for IHL to develop training plans to address the needs of all South Africans, including those living in rural and underserved communities.

On completion of training South African HCPs need to be skilled and competent, professional and ethical, and able to meet priority needs of the local population, address health system deficiencies and work in cooperation with other HCPs and stakeholders (HPCSA, 2012). In mandating this responsibility to IHL, the National Department of Health has reaffirmed the social obligation of IHL to contribute to social change and direct activities towards addressing priority health needs of communities they are mandated to serve (Frenk et al., 2010).

Although local and international evidence shows that rural origin students are more likely to work as HCPs in rural areas (Versteeg & Couper, 2011; Wilson et al., 2009), no South African health science university admission criteria favours rural students and some policies (e.g. the national bench mark exam) disadvantage rural students (Reid & Cakwe, 2011). Currently South African training institutions use colour as a proxy to enable the university to meet the transformation agenda while failing to meet their social responsibilities to train for the needs of this country. This is evident in the underrepresentation of rural students in training institutions (Tumbo, Couper, & Hugo, 2009). In addition, the high drop-out and low throughput rates at IHL (Letseka & Maile, 2008; Scott et al., 2013; Spaull, 2013), challenges many rural healthcare facilities’ experience in recruiting and

retaining adequate numbers of HCPs (Crisp & Chen, 2014; WHO, 2013; Versteeg & Couper, 2011), the rising number of malpractice claims (Whitehouse, 2013), and doctors' unprofessional behaviour and uncaring attitudes (Naidu, 2010; Stones, 2011) suggest that current models for selecting and training HCPs are not producing the desired outcome and are misaligned to policy intentions envisioned in the Constitution and national planning documents.

In response, South African universities training HCPs are reviewing curriculum content, context and selection criteria, as these have been shown to influence where health care graduates choose to work (Reid, 2011; Tesson, Curran, Pong, & Strasser, 2005). Deepening our understanding of who we select to become HCPs that are autonomous thinking subjects with the desire for acting in community in underserved rural areas, has potential for rethinking university selection criteria – this is the focus of this article.

Background

Rural areas are often considered remote and disadvantaged (Chisholm et al. 2005) with many rural district hospitals struggling to find sufficient HCPs willing and able to work in these hospitals (Versteeg, 2015). Balfour et al (Balfour, Mitchell & Moletsane, 2008) has however suggested that rural areas should rather be understood as dynamic areas with resources and relationships which are potentially transformative and have a profound impact on an individual's ability to succeed in life. Mangaliso (2001) identified the sense of belonging to and connectedness to others in the community as a strength of rural communities, and Marshall and Case (2010) have suggested that coping strategies learnt in rural communities provide tools to succeed at IHL. We use the perspectives of Balfour et al (2008) and Marshall and Case (2010) to respond to the research question that drives our argument for a broadening of selection criteria when choosing students to train as HCPs: "What can we learn from the stories of experiences of practising rural-origin HCPs which can inform and broaden selection criteria?"

In this article we draw on the narratives of France and Siphamandla, two of the six research participants in a larger doctoral project using narrative enquiry, titled 'Educational Journeys of rural origin healthcare professionals practising as healthcare professionals in rural settings', of going to an IHL and graduating as HCPs. We use dilemmatic spaces as the conceptual and analytical frame to understand what perspectives they adopted in response to situations they faced daily.

We believe this offers the potential to deepen our understanding of HCPs' everyday lives and the cultural or symbolic knowledges that is garnered in the rural context that seems to provide the disposition to succeed. We argue that dilemmas are mediated in and through the specific context, and the individuals physical and psychological demeanour negotiated in this dilemmatic space, are as a result of habits and practices developed over a period of time, which help us to understand a person's attitude towards society.

We show how ethical practices and value choices made within these spaces offer both opportunities and constraints (Fransson and Grannas 2013). Making visible the choices and knowledges they prioritise to inform the positions adopted, may broaden our understanding about who to select into our training programmes as potential HCPs. Finally, we show that individuals like France and Siphamandla are able to see themselves as the main source of transformation, rather than waiting for structural or material change (Allan 2013, 27).

Theoretical lens

We draw on Honig's idea of dilemmatic spaces (1996) as the conceptual lens to frame our understanding. Like Fransson and Grannas (2013), we adopt the stance that HCPs and those who wish to become HCPs may sometimes "find themselves in situations in which there is often no right way of acting", and only a way of acting for the best. As Veyne (1997, 231) observes: "the self is the new strategic possibility" (Foucault 1984, 343). Observing how rural-origin students respond to everyday dilemmas gives us critical insight in the process of selecting potential HCPs for training.

Like Honig (1996) we argue that dilemmas are an everyday feature of people's lives; they are socially constructed and the effects of relations of power and structural conditions. When people are faced with dilemmas, how they react is relational to the social spaces which are embedded within relations of power and in response to structural conditions. While a number of options present themselves (dilemmatic space), and only one can be chosen, the choice made depends on the perspective or positioning one adopts. This choice, Fransson and Grannas (2013) claim, depends on the individual's values, priorities and knowledge.

We find congruence in also drawing on Foucault's theory of ethics (1984), in which he proposes a view of agency depicting individuals as capable of working on themselves to achieve new kinds of existence. Foucault's concern moves to the self as the main object of care and its capacity for both resistance and transformation when making choices from several options.

Forms of practice from this perspective are not only ethical but also political, social and philosophical (Foucault 1988) and evoke "the care of what exists and might exist". Foucault foregrounds that the self is the principal object of care, and a means through which care for others can occur (Allan 2013, 29). Using this frame we want to establish an ethical perspective in our response to student selection and healthcare provisioning in underserved areas in South Africa.

While the temptation is to look for individual resilience, we want to understand and be critical of systemic injustices and material conditions in and through which individuals (particularly those who live and work in rural settings) react and respond to the world around them.

Methodology

In his doctoral project, AR the second author, employed a life history-narrative inquiry approach for generating data for the larger study. Drawing on a life-history approach, which is about ‘a life’ lived and experienced historically, culturally and politically, is an attempt to understand their identity and their actions, located in the rural context (Clandinin, 2006). This approach has the potential to focus on selected individuals, and as the storyteller, their personal accounts reflect subjective positionalities (Pillay 2003).

Data from six rural-origin HCPs practising in a rural context were generated from unstructured interviews and a range of visual methods (photo-memory, artefact retrieval inquiry and collage inquiry). Guided by the intention to select those who could best understand the issues around the educational experience of rural origin HCPs, provide richness of information, be willing to participate in the research process by sharing their stories, be articulate and able to express themselves (Northcutt & McCoy, 2004; Polkinghorne, 1995; Terre Blanche, Durrheim, & Painter, 2006), six rural origin HCPs previously supported by an non-government organization supporting the training of rural origin HCPs, were purposefully chosen (Creswell, 2008; Malterud, 2001; Seidman, 2006).

In addition to the above considerations, to ensure broad representation issues of gender (4 males and 2 females), diversity of qualifications, training institutions and currently working in rural areas informed the selection of participants. The six participants were all HCPs from Umkhanyakude district in northern KZN, 450 km north of Durban. The deprivation index for the district was 4.5 in 2012 which was the second lowest deprivation index in the country (Day, Barron, Massyn, Padarath, & English, 2012.). Of the six, France is an optometrist currently working for the National Department of Health and Siphamandla is a clinical psychologist working in Mtubatuba, northern KZN, and their stories form the basis of the narratives we draw on in this manuscript.

Ethical approval was obtained from the Social Science Ethics Committee of the University of KwaZulu-Natal in Durban (HSS/1205/ 012D). Written informed consent was obtained from all of the participants prior to the start of the study.

Interviews lasted an average of two to four hours and were conducted over three to four sessions. Participants responded to the following question: *“Tell me about your experience of growing up in a rural area, training as an HCP and returning to work in a rural area as an HCP”*. They started by telling A.R. of practices they enacted that offered them moments of agency and pleasure, pain and struggle. He listened as they spoke about everyday experiences which ranged from home and family life to the school site, university and working as an HCP. Understanding the relations between private life and personal responsibility highlighted the complexity and ambiguities of lived experiences, instead of a simplistic, linear, fixed story of academic deficit and disadvantage. Audiotaping was used to capture the telling of the life histories.

Each HCP was also requested to select four photographs and an artefact as part of the face-to face conversations, and to describe the memories these represented and how they related to their personal and professional experiences. The self-selected artefact included, for example, a Mathematics Olympiad trophy, representing a critical moment of a participant's educational journey. Photographs captured agentic moments such as a student leader of the Student Representative Council meeting with top-ranking university officials. Construction and discussion of a collage composed by each participant focused on 'A day in my life as an HCP'. These different methods encouraged participants to open up new ways of thinking (Butler-Kisber & Poldma 2010) of a life "told and experienced" (Bruner 1984). Six reconstructed stories were composed from the range of research sources, and the 'finalised' story was sent to each participant for them to correct, amend or extend (Terre Blanche, Durrheim, & Painter, 2006). In this paper we draw on two of the six biographical narratives by rural-origin HCPs working in healthcare facilities in rural settings.

Findings

Vignette One: France Nxumalo

France's personal history intersects with broader cultural changes; dilemmas he faces and choices he makes reflect a radical shift in his views about education and the social positioning of learners in the family, school and society.

France was born in Mtubatuba in northern KZN in 1981. His parents separated when he was four and he, his brothers and sister moved with their father to Skemelele, close to the Mozambican border. There his father started a spaza shop and built a primary school so that his children could attend school.

First dilemmatic space: From discouraged learner to student activist

France struggled to achieve what was required to complete his schooling:

The school environment was not that good when it was raining or windy classes couldn't continue ... There were some teachers who were lazy or never came to school or come to school drunk. Our maths teacher knew nothing about geometry, and according to the teacher most of the guys who were in the higher grade class were not higher grade material. When asking the teacher about one maths problem in the study guide he said, 'No, don't worry about that, this is a university level maths problems, it's not at your level'.

But guess what, when the exam came, the same problem was there! I was really angry and had a big fight with the teachers to push them to offer maths and science on higher grade. On a number of

occasions we engaged the teacher, and if nothing changed we reported to the Principal that these are some of the challenges that we're having.

Teachers' entitlement is seen as perpetuating the hegemonic pattern of authority and expectation of respect (Bhana 2013) and deference from learners. While such situations are ever-present in rural settings (Chisholm et al. 2005, 25), they are rarely challenged and usually accepted as the norm.

However, France and his friends chose to respond to this situation as a dilemmatic space where choices could be made and their unhappiness voiced. We see conflicting forces at work, and in this negotiating and positioning being a young learner carries little weight. In this way learners like France are faced with a dilemma that makes them uncomfortable (Fransson and Grannas 2012, 7). The search for the 'right thing to do' in relation to the different stakeholders (self, teachers, and principal) is the essence of the dilemma. France's "turn to ethics" (Allan 2013) informs his decision. Taking responsibility verses being coerced, as a learner he calls for resistance in his struggle for a new kind of existence:

If talking to the teacher and to the headmaster did not work, we would organise a strike to highlight to the community that we can't have a teacher who is not doing his work.

Rather than waiting for a structural or material change, France and his friends see themselves as the main source of transformation and not accepting inferior educational experiences:

We'd call parents to a meeting, we would not go to classes but sit outside and sing and march. We would call the headmaster and indicate that this teacher is doing this and all that and either there's a change of behaviour or the teacher goes and we get another.

Choosing alternative ways to work and observe the school rules, France and his friends revise their relationship with teachers and parents demonstrating belief of self and ability to act with agency (Foucault, 1988, 328). Because France cared about what was happening and what might happen, he made ethical and political choices which benefitted him and in turn other students. France passed his matriculation examinations well enough to gain access into university.

Becoming a student at a South African university offered him the space for possibilities to perform his success as a rural, African, health science student.

Second dilemmatic space: From silent outsider to authoritative student leader

The university as a dilemmatic space entails the negotiating of power by students over students and by academic authorities over students. Students from diverse origins (and minority groups) continue to struggle at IHL, creating dilemmas for students like France who feel marginalised and alienated:

I had to beg the head of department to let me in, because they had finalised admissions... after a lot of persuasion, they agreed to let me register for a BSc in Optometry. At the beginning ... I remember just sitting and listening in lectures and not uttering any word, not because I could not utter any English, but because the environment was intimidating.

Two values are in tension (Honig 1996), fear as a marginalized and alienated learner and commitment to the self as the principal object of care, inform the choice he makes for himself and the broader student community. From an ethico-political (Foucault 1984, 383) stance, France decides which aspect of the self he needs to work on or change in order to ‘do the right thing’ as a university learner.

Working within the rules of acceptable behaviour as a university student, France draws on cultural resources to negotiate the situation. His agency is exercised in and through social formations where his power is exercised more productively, working and learning with other students. By mentoring other students and getting involved in student leadership he is able to sustain his commitment to continue and learn – and to become visible and vocal:

I was active in the university mentoring programmes ... when new students came we would take them through registration and assisted them with understanding the university processes, helped them to settle and put them in touch with the tutors and showed them the library and how it's used and all those kinds of things. It was both academic and the university life adjustments. I also made friends at university who helped me adjust in terms of the social life and academically

Finding ways to bring about his own learning and transformation in an ethical manner creates possibilities to help others within his circle and within the broader community. Informed by his ethical stance as a black student caring for a different kind of existence for himself and others like him, in a university setting culturally misaligned to the values he and his rural-origin peers bring with them (Stephens et al. 2012, 123), France operates creatively within the university rules:

In 2000 I was elected to the Executive of House Committee which meant speaking to students in English and addressing their issues, so I grew in confidence.

From this position as a student leader he could watch university staff from a more resistant place, and in that way expose the university and staff to a more public gaze (Hope 2013).

France is thus able to resist the dominant traditional hierarchies as an African student operating inside and outside the lectures halls of the university, and to strategise in a controlled and self regulated way the means and methods to develop voice. He did this within the context of caring and close relationships that he formed along the way as a school learner, university mentor, student leader and successful student:

The lecturer asked what had happened, because when I came to the department I was this shy boy but all of a sudden in clinics and in class I was now able to contribute.

Third dilemmatic space: Moving into rural health care

After graduating as an optometrist France returned to his childhood community to work as an HCP. This ethico-political choice is framed by general resistance to the stasis that defines rural healthcare provisioning. Despite being the first to graduate from his community, the hospital was unprepared for him:

When I graduated there were no optometry posts - I eventually started work in an oral hygienist post. The biggest challenge, apart from the money, was working in a system that was dysfunctional.

France did not accept the status quo, nor choose to opt out and leave. In returning he makes a journey towards complete self-mastery – highlighting the moral aspect of his transformation of self (Allan 2013):

Graduation brought a belief that I could do things. I made it my responsibility to ensure that eye services were a priority, not just in my hospital but in the whole district and the province. That led to the creation of two optometry posts per district. It was my job to make sure that we place optometrists and other eye-health professionals in rural areas where people still do not have access to optometry services.

Despite being newly graduated, France provides an alternate version to the dominant discourse that homogenises HCPs' work. As a visionary and architect of change, he recognised and responded to dilemmatic spaces, and was able to motivate for posts and build an optometry service throughout the province.

Frances' ability to redefine himself and his potential to open up and engage in ongoing redefinition is the mark of a transformational leader and activist:

I do quite a lot of things with the community - when we started at university, no-one was sending their kids to university. But now, people in the community sell their cows to send their kids to university because they are able to see what education can do for their kids.

His capacity as a ground-breaker, initiator and activist, as a school learner and a university student, through big and small dilemmas he faced in everyday life, speaks to his potential as a leader in healthcare provisioning within rural communities.

Frenk et al (2010) speaks of the need to train HCPs for the 21st century, HCPs who can strengthen health systems and who can look at a situation and see the potential for (transformational) change. Finding, training and

supporting such individuals should be a core role of universities committed to fulfilling their mandate of improving health care to individuals and underserved communities.

Vignette Two: Siphamandla Mngomezulu

Siphamandla was born in rural Ingwavuma in northern KZN in 1984; his father left to work on the mines in Johannesburg when Siphamandla was four years old. His father never returned home, which left his mother burdened with the responsibility of bringing up Siphamandla and his sister in a fragile family structure particular to African townships and rural contexts (Bhana 2013, 119). These sites were engineered by apartheid to keep African people separate, economically impoverished and powerless (Chisholm et al, 2005; Garran, 1908).

Siphamandla remembered his life as a young child:

My mother bought and sold sugar and bananas to generate an income. After she was mugged she stopped getting sugar from Swaziland. The community then recommended her as a community health worker (CHW) as she now had no way of providing for us. As a CHW she earned R400 a month which she supplemented by selling bananas. My mum made R360/ month from the banana business and used this money to pay school fees and to buy something valuable for the family.

Even though men still hold economic power (Bhana 2013), many rural households are supported financially by women. In the rural community where Siphamandla grew up most young men only attended school until Grade 5 (end of primary school), and then left the community to look for work on the mines (Sender, 2002). From an early age Siphamandla was expected to fill the ‘man’s role’ around the house in the absence of his father (Bhana 2013). While he recognises that he cannot gain much freedom from the limits of his rural life, he sees moments of hope and space for otherness in the limits of being a mineworker – what Foucault regards as a form of non-positive affirmation (1977, 34):

All I knew was that working on the mines was going to be a great experience, because I could buy some clothes and things to relieve my mom.

First dilemmatic space: From poor and inferior learner to top student

Apartheid’s policy of unequal education resulted in serious neglect of rural schools (Chisholm et al. 2005, vii). Being a child of the 1980s Siphamandla received an education designed specifically for poor African people:

In Grade 8, I attended Nqobizazi Secondary which was a new school in walking distance from home. We were the first 16 students and that’s where I experienced the hardship of being a rural student. Initially we didn’t have teachers – so they borrowed two teachers from the primary school to teach us. We didn’t

have books – the teachers came with about seven books. The school only had two classrooms and there were absolutely no resources, no water, no electricity, nothing.

Despite these structural conditions and relational aspects in schooling practices Siphamandla creates dilemmatic spaces and recognises choices that are possible for himself and others.

Encouraged by his mother he shows initiative and agency, driven by the desire to be a different rural learner. He engages in practices with others that go beyond the school and draws on relations where there is a sense of belonging and connectedness (Mangaliso 2001):

The parents paid money towards building a new classroom and on Fridays we went with a truck to fetch sand from the river and helped build the new classroom. We were 16 very committed students determined to take charge of our own destiny. We took the responsibility of learning on ourselves and competed with one another, which was very important for me as I didn't want my friends to get higher marks than me.

Working closely with others they were able to spur one another on as they coached and mentored one another in the absence of professional teaching resources.

[Figure 1 here]

Unable to complete his schooling at Nqobizazi intermediate school Siphamandla moved to Ingwavuma High School for the last two years of his schooling:

From Grade 11 I went to Ingwavuma High School about 25 km from home because Nqobizazi didn't have the infrastructure for us to continue. Initially I struggled to adjust at Ingwavuma High, not with academic stuff, but mostly to the social life. Everybody in my class at Ingwavuma High was talking about YizoYizo, the gangster story on TV. I had nothing to contribute to those discussions. I felt so inferior. The kids teased me and called me 'Nqobizazi', which meant that you were from the underprivileged school where people are just joking or clowning around...I had to do something to compensate for that and to make me superior. That one thing was to work hard and really excel. Initially I didn't even have a friend as I just spent most of my time studying. Eventually I was in the top class, and taught other students maths and biology and agriculture. In Grade 12 there were very few teachers who were motivated to see us passing. We had a fight with the teachers because they said we would fail maths on higher grade and it will lower our overall marks and prevent us from doing anything after school.

Informed by Foucault's theory of ethics, we recognise Siphamandla's fight as an ethico-political fight for quality education. We see conflicting forces at work, and in this negotiating and repositioning see how he resorts to his own methods and techniques "imposed on the self" (Foucault 1985, 29) to respond to the dangers associated with being poor and inferior.

Siphamandla realises that waiting for any substantial material or structural change to disrupt the oppressive, routinised ways of schooling was pointless, and his only way of 'acting for the best' (Honig 1996) was to make the "self the new strategic possibility" (Veyne 1997, 231) through working hard and fighting with teachers who stood in his way. This search for the right thing to do in relation to different stakeholders (self, teachers, other learners) who choose to construct poor learners as weak and those who "would fail maths on higher grade" is the essence of the dilemma.

Unable to leave and access better schooling elsewhere and refusing to accept the situation as 'just the way it is', he engages with his struggle for a new kind of existence as a rural learner in a measured and organised manner:

My friend and I wanted to do horticulture and realised we needed to do well in biology and maths, so we arranged evening classes and organised a teacher from a neighbouring school to teach us, because our matric maths teacher got sick in February and never came back. I chose to do all my subjects on higher grade except Afrikaans.

Siphamandla's response is one of determination, recognising education as key to further opportunity (Chisholm et al. 2005, 103)

From June 2001 we knocked off at Ingwavuma High at 14.00 and we attended a maths lesson at SceloSethu. We'd walk there and sit in the maths class as they had a very good teacher. In August 2001 we got a teacher from Nyamane High School to come and teach us maths, but he didn't have a car. We decided to walk to his place [about 10 km] after school. We just had to push. In September we started going three or four times a week for those extra maths lessons.

His demonstrates his agency and care of self (Foucault, 1988, 328) in refusing to accept an education that produces barely literate and numerate learners (Bloch, 2009) and highlights the tension between motivated learner and unmotivated teachers.

What kept me going was the sacrifice that my mom made. Only two of us [out of a class of 70 students] wrote matric maths on higher grade, and when the results came back I got B and my friend got D. The teachers were all surprised, and even up to today they are still shocked that we really achieved so much.

In this dilemmatic space between his mother, uncommitted teachers and motivated learners, we see how Siphamandla is positioned and positions himself in relation to the forces at work. His choice is informed by inner motivation and determination to move from being a poor outsider with poor educational opportunities to a different mode of being (Foucault 1985, 30), seeking alternative ways to be seen and experienced. (Hope 2013). Determined to throw off familiar ways he “evoke(s) care of what exists and might exist” (Foucault 1988), and seeks out ways to foreground the most important object of care, ‘his determined motivated self’ - and caring for himself opens up possibilities for the care of others – his mother.

Siphamandla obtained a matric exemption in 2002.

Second dilemmatic Space: From demotivated matriculant to top university student

Many schools in rural settings in South Africa produce students with limited chances of obtaining a meaningful education and life after matriculation, due to poverty and poor-quality education (Chisholm et al. 2005, 2). We see here how particular discourses control and normalise life for young men like Siphamandla, and how black people watch themselves to remind themselves what and how they should be. However, Siphamandla negotiates and repositions himself as having initiative, agency and determination:

It was a very difficult time for me between December 2002 and January 2003. I was not getting the sponsorships I was looking for. I remember thinking ‘Am I just going to finish matric with that energy and then just stay home like others who were just sitting around Ingwavuma?’ Those guys would tell me ‘We’ve been there, don’t push it hard, because we know how it feels and we know that it’s not possible.’ I was very anxious and thought ‘Am I going through the same cycle?’ University was only if you were rich and your father was owning a tavern, or a shop and have cows.

Siphamandla decides that he needs to do something, even if it means engaging in voluntary work, to be seen and known as different – someone with initiative. This ethical stance and choice marks him as different to “those guys”:

In December and January I did voluntary work at Ingwavuma Orphan Care where I kept meeting new people and hoped that somebody would be able to help me with the university registration fees.

In February 2003 he received financial support from a non-governmental organisation working in Ingwavuma and was accepted to study Psychology at the University of Zululand on the basis of his matric marks. At university he imposed a strict routine of work, sleep and prayer. Despite this he struggled to adjust to the demands of university, and after failing a number of assignments began to question his ability to cope:

I worked so hard when I got to university. It was going to the library, going to the dining hall, or going to church. In the morning and the afternoon I was going to church to pray and that's what kept me really focused. Nothing else mattered to me. Despite working as hard as possible, things just seemed impossible for me.

Siphamandla struggles with the university teaching and learning and he tries hard 'to be faithful' (Foucault 1985, 26) as a student (going to church, the library and dining hall). Positioning himself as a committed and hardworking student and at the same time being positioned as a struggling first-year university student who needs to "go and see the lecturer" entailed negotiation of power and powerlessness:

In philosophy they would tell you all these Russian stories and you had to give your own critical and creative interpretation of those stories, to think out of your head. With my poor English, it was complicated and on three occasions I got a note on my assignment 'go and see the lecturer'. That was tough because at high school I was always a top student. I started to question myself, 'is there something wrong with me? Is this really for me?'

Siphamandla was determined not only to bring himself into compliance with the university ethos and academic success but to transform in a way that makes him an 'ethical subject' (Foucault, 1985, 26). Determined to succeed, in a moment of hope or what Butler (2004: 2) calls the "improvisation within the scene of constraint", we see how and what he does to resist:

I sat with the Professor and tried to understand what was happening. The Professor told me that my ideas were very good but the way I presented them and the way I constructed sentences was not good. The Professor offered for the Department to pay for me to attend English classes - after two weeks I had an idea about how to write at university. By the end of my second year I was selected as the best performer within the Faculty of Arts out of more than 7000 students.

At university individual studying and independence are privileged, despite studies pointing to the value of group study and interdependence (Stephens, Fryberg, Markus, Johnson, & Covarrubias, 2012). However, for Siphamandla his option is informed by his morality – his deep sense of belonging and connectedness with friends:

I had a group of five friends who competed with each other, which really helped me. It was the most amazing and rewarding time; when you compete, you get good marks, and at the end of the day you stay being the top student - that motivated me a lot.

As a team member Siphamandla recognises expertise which can be shared; he was imaginative and creative in drawing on resources that that were not particularly encouraged at university but known to work for him from

his experiences as a rural learner. We learn about Siphamandla's loyalty in the journey towards complete self-transformation. This measured and honest movement from invisible, struggling rural student to top university student is attainment of the ultimate goal towards being immersed into the world (Blacker 1998).

Third dilemmatic space: Moving into a rural district hospital as an HCP

After graduating as a clinical psychologist Siphamandla was approached by BMW with a lucrative deal. This new dilemma involved whether to stay in Johannesburg or return to work in a rural area:

I had this thing that if I took any of these options I would be leaving my family by staying in Jo'burg. So I left all that, and I put in an application for a community service post and started at Hlabisa Hospital in 2010.

Siphamandla's choice to return to his rural village with an increased understanding of his own context and prevailing conditions positions him differently. As the first clinical psychologist at the rural district hospital close to home he has control over what he can do to change and influence:

I was the first psychologist to work at the hospital and I had to think wider and more strategic than just providing services there. In 2011 I started rotating around the other hospitals in the district and then motivated for each hospital to employ their own clinical psychologist.

Within these spaces are disrupting moments and dilemmatic spaces which account for better and more relevant healthcare practices:

There's so much that needs to be done, and I'm getting a better understanding of culturally relevant psychology. There isn't a direct word for depression in Zulu. Ngipathekekabi is the word that signifies that I am depressed, but few patients actually say that at the hospital. People don't realise that they are depressed. Professionally I have come to understand that what the DSM IV says is not what works. The criteria might be the same, but it is the contextual criteria that count.

In this professional space he becomes known as a ground-breaker, developing a culturally appropriate descriptor for psychological problems in his rural community. Siphamandla's determination to lead transformation goes beyond healthcare provisioning and he continues to play a key role in his community:

Since being back at Hlabisa I have been involved in a lot of organisations that do career guidance. At church they invited me to the youth services to motivate the young people, and to talk about growing up in rural areas, and the fact that you can actually succeed. Recently when I was talking at a school I realised how privileged I was. The school was just like the school I went to where children could not communicate in English and where they know nothing about the Central Application Office. I'm trying

to be a role-model and someone that can encourage them. When I speak at schools I start off telling them where I come from ... I start at the beginning, and then go on to tell them about the options.

Siphamandla's determination "to achieve new kinds of existence" (Allan 2013, 27) and the measured and honest ways in which he works this out with those with whom he shares a deep sense of connectedness arose from his care of the self, and his capacity for both resistance and transformation of traditional hierarchies at work, in schools, at university, in health care and in the broader community.

Discussion

Dilemmatic spaces for understanding 'how to be' and 'how to act' in becoming and being an HCP

'How to be'

The two vignettes analysed allow deeper understanding of the complexity of educational contexts inside and outside rural spaces, and how both France and Siphamandla 'react to' and 'react in relation to' them (Honig 1996). Analysis of dilemmatic spaces makes visible competing 'pull and push' forces and options which are valued and positioned in relation to one another when making a choice. The potential that these competing forces open up is critical for understanding which values and priorities inform the ongoing relational processes of negotiation and positioning that France and Siphamandla take up in constituting themselves as ethical subjects capable of working on themselves to "challenge closed thinking and opening up to the possibility of new forms of thought and action" (Falzon 1998, 91).

Foucault's theory of ethics and ethical practice sharpens our understanding of the particular meanings of self that France and Siphamandla adopt to "seek out difference, and ... unsettle habitual thinking and prevailing categories" (Falzon, 1998, 91), and transform what it means to be, know and live as rural HCPs. Their choices to act on themselves are evoked by care of what exists and might exist in emergence of better ways of knowing and being (Foucault 1988, 328).

Honig (1996, 259) explains that dilemmatic spaces "both constitute and form the terrain of our existence". Our insight into the dynamic nature of dilemmatic spaces represented through selected moments and the choices made on 'how to be' (personal), 'how to act' (social) and 'how to understand' (professional) (Beauchamp and Thomas 2009, 178) emerge in a space between dilemmas. Being African, male and rural means both France and Siphamandla had to resist particular institutionalising practices which normalise deficit and failure, and exercise agency and responsibility – which they knew was the right thing to do.

'How to act' as learner and student

Actively effecting transformation of the self, we learn, may be practised silently in measured and regulated ways, or more explicitly through public forums and networking. Through selected dilemmatic spaces we make sense of France and Siphamandla's desire to be 'a different kind of rural learner' relational to particular structural and material constraints. The decisions they take highlight the moral aspect of their self-transformation – revising their modes of being through methods and techniques (working collectively and collaboratively, extra maths tuition), that were acceptable to others (parents, borrowed teachers, peers/friends).

The vignettes show how the personal is inextricably linked to the professional. Both resist the individualism and independence of university culture, choosing instead connectedness with others. Organically formed, these relations and practices sustain and nourish them (Stephens et al., 2012), and offer them different ways to observe and work with the rules of the educational setting (Allan 2013, 29). The ethical practices which inform their work and life as HCPs are also political, social and philosophical endeavours (Allan 2013, 29).

As transformational leaders in rural health care, France and Siphamandla are able to take responsibility for leading and initiating better healthcare provisioning in the healthcare sector.

How to understand the 'how to be' and 'how to act' in selecting rural-origin students for university study

The vignettes provide evidence that both France and Siphamandla showed leadership ability prior to entering university, and continued to do so at university. Broadening selection criteria to include rural origin has been accepted as an important strategy to increase the number of HCPs choosing to work in rural areas (Wilson et al. 2009; Stagg 2013). We argue that selection criteria that exclude knowledge about the personal (how to be and how to act) is limiting and dangerous. Illuminated in the vignettes and dilemmatic spaces are values and priorities pointing to the potential for becoming transformational leaders in health care, especially in underserved areas.

CONCLUSION

Drawing from the analysis of lived experience using dilemmatic spaces as the framework – we propose that selecting potential (healthcare) students as future transformational HCPs/leaders requires positioning the individual in a selection 'model' or framework that addresses both personal and social issues by looking inward ('How to be') and outward ('How to act') in relation to the temporal (i.e. the educational event) in terms of its past and its future (Mara 2009). Selecting potential health science students according to this two-dimensional spatial understanding (past and future) will include asking questions and eliciting 'stories' of educational events/dilemmas and deriving interpretations of educational dilemmas, choices and decisions.

Considering the individual's internal (values-reactions-ethical dispositions) and external forces (initiatives-ethical practices) relational to particular educational dilemmas/events – past and future – we conclude, is inextricably linked to the choices and decisions they make as transformational HCPs.

In light of policy prerogatives for training transformational leaders and increasing the number of graduates choosing to work in under-resourced areas, selection criteria that include and go beyond academic ability and experience are critical.

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Figure 1

Fig. 1: Siphamandla (left) and his friend at Nqobizazi, at the construction site of the new classroom.

(Picture used with permission)

4. Engagement and persistence: Relationships and learning spaces at university

Papers 4 and 5 look at the experiences of these rural origin HCPs at university based on Tinto's model of engagement and persistence (Paper 4) and how they accessed and utilised the different learning spaces at university (Paper 5). Recognising that a university qualification is mandatory to practice as an HCP in SA, a deeper understanding of the challenges, the learning spaces as well as what students bring with them when they enter IHL was essential to my understanding of their educational journey.

Paper 4

Responds to

Critical question 1 - **Who are these rural origin HCPs?**

Critical question 2 - **What were their educational experiences?**

Paper 4

This paper builds on Tinto's theoretical model of persistence and engagement at IHL. It added to the pre-university component of Tinto's model by suggesting that rural African students come to university with life experiences – generative potential – which need to be recognised and strengthened so that they can use their problem solving skills to engage socially and academically at university.

Title: Building on Tinto's model of engagement and persistence – experiences from
Umthombo Youth Development Foundation scholarship scheme

Authors **Ross, A.J.**

Journal: African Journal of Health Professions Education. 2014;6(2):119- 123

Declaration regarding a Doctoral student contribution to the journal articles to be included in a doctoral 'research dissertation through publications'

Student name: A.J. Ross

Student number: 212557836


The student's contribution to the article was as follows:

1. Formulation of hypothesis: I formulated the concept for extending Tinto's model of engagement and persistence – experiences from Umthombo Youth Development Foundation.
2. Study design: I was responsible for the study design.
3. Ethical permission: I was responsible for obtaining ethical permission for the study.
4. Work involved in the study: I was responsible for generating the data and for the initial analysis.

5. Writing the article: I was responsible for writing the article and reviewing and rewriting the article based on the feedback from the journal reviewers.

I declare this to be a true reflection of my contribution to this journal article.

Signature:

A handwritten signature in black ink on a light blue background. The signature appears to read "Andrew Ross" in a cursive, flowing script.

Date: 15/12/2015

Building on Tinto's model of engagement and persistence: Experiences from the Umthombo Youth Development Foundation Scholarship Scheme

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Background. Major inequalities in staffing levels at rural and urban hospitals contribute to poorer health outcomes in rural areas. Local and international studies have shown that healthcare professionals (HCPs) of rural origin are more likely than those of urban origin to work in and contribute to improved health outcomes in rural areas. However, absent role models, dysfunctional families, schools that perform poorly and inadequate funding make it almost impossible for rural-origin students to gain access to institutions of higher learning (IHLs) to train as HCPs.

Objective. To present the experiences of graduates from the Umthombo Youth Development Foundation Scholarship Scheme, build on Tinto's model of persistence and engagement, and contribute towards the success rates of rural-origin HCPs.

Methods. This qualitative study used a life-history methodology. Unstructured interviews, photomemory, artefacts and collage development were used to explore the educational experiences of six rural-origin HCPs. Data were coded and categorised and themes identified.

Results. Compulsory academic and peer mentoring promoted academic and social engagement, helped students to recognise their pre-university experiences as generative, and contributed to their success. The generative potential of pre-university experiences and compulsory work-based experiential learning were identified as initiatives that could strengthen Tinto's model of persistence and engagement.

Conclusion. A number of targeted interventions, if introduced at South African IHLs, could contribute to improved success rates of rural-origin health science students.

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Despite the promise of a better life for all made after the first democratic elections in South Africa (SA) in 1994, excellent legislation and policy documents, health outcomes in SA are poor and compare unfavourably with other countries at a similar stage of development.^[1] In 2009, the *District*

Health Barometer reported that healthcare indices are generally worse in rural than in urban areas, with a higher burden of infectious diseases, higher under-5 mortality and reduced life expectancy at birth.^[2] There are major inequalities between staffing levels at rural and urban hospitals, which contribute to poor health outcomes.^[2] These disparities remain, despite the commitment of the National Department of Health of 'Health for all' and the prioritisation of recruitment of healthcare professionals (HCPs) for rural areas.^[1] Failure of the health service to deliver on the promises of a better life for all has been attributed to the shortage of well-qualified HCPs.^[3] Increasing the number of healthcare workers in underserved rural areas improves health outcomes in general, and maternal, child and infant mortality indicators specifically.^[4]

Rural-origin HCPs are more likely than those from urban origin to work in rural areas and contribute to improved health outcomes in these areas.^[5] However, only a small number of rural-origin SA scholars are trained each year as HCPs,^[6] and staffing of rural hospitals remains an ongoing challenge. Absent role models, dysfunctional families, poorly performing schools and inadequate funding make it almost impossible for rural-origin students to gain access to tertiary institutions to train as HCPs.^[7,8] In view of this, new

strategies are necessary if SA rural scholars are to provide a solution to the shortage of HCPs in rural areas.

Since 1999, the Umthombo Youth Development Foundation Scholarship Scheme (UYDF SS) has run an innovative scheme in rural KwaZulu-Natal. The UYDF SS model includes the selection by rural hospitals of rural students with the potential to train as HCPs, comprehensive funding for students, a compulsory mentoring programme and hospital-based experiential vacation work. The annual pass rate of students supported by UYDF SS is >85%, and by December 2013, 184 rural-origin HCPs supported by UYDF SS had graduated from tertiary institutions in SA.^[9] All these graduates have returned to rural areas to work there, <10% have bought themselves out of a portion of their work-back contract, and >60% continue to work in rural areas after completing their work-back obligation.

The objective of this article is to present the experiences of UYDF SS graduates, build on Tinto's model of persistence and engagement, and contribute towards building a theory of success for rural-origin HCPs.

Methods

This qualitative study used a life-history methodology to explore the educational experiences of rural-origin HCPs. This methodology enabled participants to tell their life story within a social, historical and cultural context. The meanings that they attached to their experiences and how they made sense of their world as they journeyed from rural scholar to HCP became clear. Six rural-origin HCPs were purposefully selected from UYDF SS graduates. Selection criteria included

that they were (i) willing to participate; (ii) articulate; and (iii) working in a rural environment.^[10] To provide a service of excellence at a district hospital, a team of HCPs is required. Therefore, HCPs in a variety of healthcare disciplines were included in the study (Table 1).

The author collected data using two unstructured interviews, which were supplemented by photomemory, artefacts and construction of a collage. Participants were asked, 'Tell me about your educational experiences from rural scholar to healthcare professional'. The first interview provided an overview of their home environment and educational experiences, while the second interview clarified and elaborated on issues previously raised. At a subsequent meeting, participants were asked to bring four photographs and an artefact from different stages of their educational journey and to construct a collage of a day in their lives. They had to explain how the photographs/artefacts/pictures selected for the collage related to their educational experiences. All interviews and discussions were recorded and transcribed verbatim.

From the transcripts, a reconstructed story was written and sent to the participants for validation of content.^[10] The stories were read and re-read, codes and categories identified, patterns and relationships between categories reviewed and themes developed.^[10]

Ethical approval for the study was obtained from the Social Science Ethics Committee of the University of KwaZulu-Natal, Durban, SA (HSS/1205/012D). Written informed consent, including possible identification, was obtained from all participants after explaining the objective of the study.

Theoretical model

Although there are many theoretical models to study the reasons why students succeed or fail at institutions of higher learning (IHLs), Tinto's theory of engagement and persistence has been the major theoretical/explanatory model about student success at IHLs since the 1980s.^[11,12] Tinto's initial writing

focused only on academic and social integration as key factors in determining engagement and persistence at IHLs and, finally, success at university. As the model developed, Tinto added pre-university factors that may influence students' ability to engage, persist and ultimately succeed at IHLs (Fig. 1).

Tinto's theoretical model is useful because it recognises factors beyond the control of academic institutions. These may influence retention and success at IHLs, including students' academic abilities, and study and language skills. The acquisition of all these factors is usually the responsibility of the family and school.^[13,14] In addition, attitudes towards higher education, such as commitment, motivation, aspirational goals and expectations, influence retention and success at IHLs.^[13] External commitments such as family

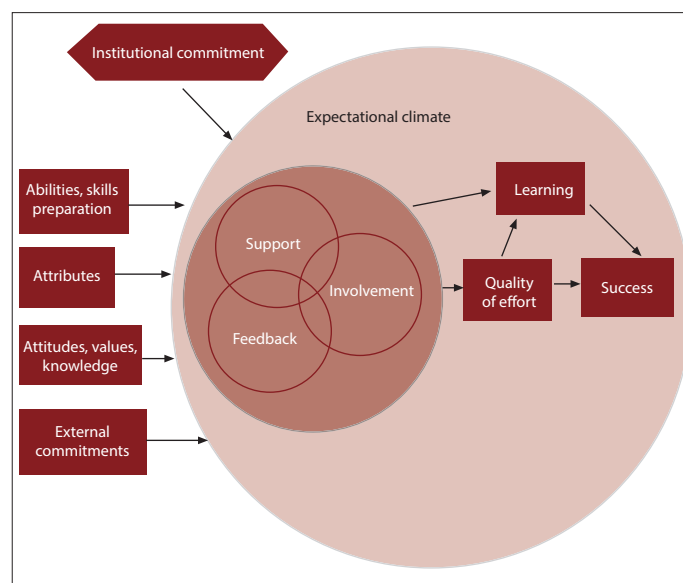


Fig. 1. Structure of a preliminary model of institutional action.^[12]

Table 1. List of healthcare professionals who participated in the study

Initials	Current position	Qualification	Professional experience	Professional experience, yrs	Age	Gender	Originally from	Schooling
DG	Student mentor co-ordinator, Mtubatuba	BSc Physiotherapy (UKZN, 2003)	Physiotherapist (2004 - 2008) Mentor co-ordinator (2008 -)	11	37	Male	Ingwavuma	Ingwavuma
FN	Sub-Saharan co-ordinator, Brian Holden Eye Institute	BSc Optometry (UKZN, 2003)	Optometrist, Mosvold, Phelophepa train (2004 - 2009) Brian Holden Eye Institute (2010 -)	11	34	Male	Ingwavuma	Ingwavuma
SM	Psychologist, Hlabisa Hospital	MSc Clinical Psychology (UJ, 2009)	Clinical Psychologist, Hlabisa Hospital (2010 -)	4	29	Male	Ingwavuma	Ingwavuma
TM	Physiotherapist, Emmaus Hospital	BSc Physiotherapy (Wits, 2004)	Physiotherapist (2005 -)	10	33	Male	Ingwavuma	Ingwavuma
NM	Pharmacist, Mtubatuba	BSc Pharmacy (Wits, 2004)	Pharmacist (2005 -)	10	35	Female	Ingwavuma	Nongoma
LH	Medical Officer, Mseleni Hospital	MB ChB (UKZN, 2006)	Intern/Community Service 9 Officer/Medical Officer (2007 -)		30	Female	Ubombo	Ubombo

UKZN = University of KwaZulu-Natal; UJ = University of Johannesburg; Wits = University of the Witwatersrand.

responsibilities and adequate financial support also play a role in whether students complete their degrees.

However, while recognising that experiences before entering university may influence student success, Tinto's model focuses on the contribution of institutions to ensure that students complete their courses and graduate. At the core of the model is a need for student engagement with peers and faculty members in a supportive university environment, with high expectations of student success.^[15] Tinto suggests that student engagement be facilitated by lecturers, primarily in the classroom, to promote academic and social interaction that in turn lead to the development of communities of learning. The latter would ensure student involvement, provide opportunities to develop relationships with peers and faculty members, and provide academic and social support and opportunities for feedback on whether learning has been adequate. Student involvement with these communities has been shown to increase the quality of effort put into learning, which in turn contributes to success and graduation.^[11,12,16,17]

Results

From the data collected from rural-origin HCPs supported by UYDF SS, one can add to Tinto's model of persistence and engagement at IHLs in three important ways:

- Introducing compulsory academic and peer mentoring for all students to promote academic and social engagement.
- Assisting students to recognise pre-university experiences as generative.
- Strengthening learning at university by introducing compulsory work-based experiential learning.

Compulsory mentoring, promoting engagement and persistence at university

The UYDF SS model has a compulsory mentoring programme for all students. It involves regular meetings with a university mentor and the establishment of peer mentorship groups. These proactive meetings with a local mentor ensure that academic problems are identified early. 'I would get a call from the mentor to find out how I was doing.' (FN) The mentoring ensured that students recognised academic challenges so that solutions could be identified. 'You can't fix a problem unless you are prepared to say, "I failed. I have a problem. I must do something."' (DG) These early interventions were initiated by the student and monitored by the mentor and their peers to ensure resolution of the problem. Evidence from this study suggests that the early identification of deficiencies and active interventions were key to student retention and success. This problem-focused behaviour to achieve success encouraged students to access academic resources. 'I approach the physics lecturer to help me pass the course, and to find a tutor for physics and maths.' (DG) Students also worked with like-minded peers and formed study groups, 'which was a way of cementing my knowledge. I studied by myself first, then when we were in a group, I shared what I had learned.' (DG)

The mentoring process focused on accountability to the funder and to one another. 'We would be asked, "Why didn't you pass the test?", and then I needed to know exactly why I didn't pass the test.' (TM) Mentoring was based on the belief that students had the potential to succeed, and tapped into their hopes, dreams and determination to succeed. 'I had no option, I had to make it. And if I don't make it, I'd lose the scholarship and it would just be the end of the world.' (SM)

The UYDF SS mentoring was not only academic, as social integration is also important for success at IHLs. 'When other students came to Johannesburg for the first time I would tell them, "This place is like this and that and that." I would tell them, whatever your circumstances, you need to pass, because that's the only thing that you are at university for. So I would mentor them. Not teaching them maths and physics, but I would mentor them in terms of social life, and how to handle the situation, knowing their background.' (TM) For these students peer mentoring helped with social integration and accountability. It facilitated the development of friendships and helped them to make the most of the academic support available at IHLs. 'The group of friends that I had, we had the same vision, we did not want to fail, we wanted to graduate.' (FN)

The rural community as a generative context

In the rural context, these graduates and their families recognised that education was a priority and were prepared to make sacrifices for a good education, because 'We really wanted to learn. Even though our matric maths teacher got sick in February and never came back to school we walked 1 km after school for extra maths lessons.' (SM) They learnt to work hard and work together to compensate for deficiencies at school by 'forming study groups where we shared information with each other to ease the pressure.' (DG) 'Our experiences built some personalities within us so as to be able to push even when it was difficult.' (FN) Through the mentoring process, UYDF SS students were encouraged to reflect on their rural experiences, learn from these experiences, and apply the learning to new challenges at university. The mentoring encouraged students to draw on previous learning and personal strength, and sought to reframe challenges at university in the light of previous successes in overcoming challenges. This was based on the understanding that if students had overcome challenges in the past, there was no reason why they could not overcome challenges at university. 'I knew this world where I could do things, and where I was going to do things.' (SM) In response to challenges that they faced at university, UYDF SS students sought lecturers who could help them, asked for tutors and mentors, and formed study groups to help one another. 'We were willing to learn to study in different ways to ensure that we passed.' (TM)

Work-based experiential vacation work

Rural-origin students supported by UYDF SS worked at the hospital closest to their home for at least four weeks per year, alongside qualified colleagues. Students recognised the value that this added to their learning, because 'Our vacation work at the hospital made things better for us ... we got to know about the drugs ... the pharmacist would tell me, every day "I want you to choose three drugs and read about them, know what they are for and why are you using them"' (NM)

In the physiotherapy department, for example, 'The therapist wanted to see what we had learnt, and that we could apply it, which was also very good and very helpful.' (TM) This work-based experiential learning allowed them to gain experience in a real-life environment and witness role models who were providing a service in rural areas.

Discussion

Tinto's model of institutional action recognises pre-university experiences outside the control of IHLs, a sentiment echoed in the recommendations for undergraduate curricula reform recently submitted to the Council on

Higher Education.^[18] Tinto emphasises the need for social and academic integration if students are to persist at IHLs.^[19] The UYDF SS supports the importance of engagement at IHLs as many academic resources are available to help students to succeed, but they can only derive benefit from these resources if they are willing and able to access them. Tinto suggests that this engagement should happen primarily in the classroom and be facilitated by academic staff. However, in an SA context of large, diverse classes this may not be effective. A compulsory academic mentoring programme for all students would ensure that they are helped in a proactive manner so that problems are identified early and solutions found. This academic mentoring should tap into the students' intrinsic motivation, desire for learning and personal gain, and should be provided in a supportive framework.

Peer mentoring ensures social engagement, which Tinto has recognised as contributing to student persistence and success at university. Peer support and learning have been shown to increase productivity, the quality of effort put into learning activities, and ultimately success.^[12,20] The experiences of UYDF SS graduates and the success of the scheme point to the critical role that academic and peer mentoring plays in the success of students at IHLs and could be incorporated into such programmes in SA.

The UYDF SS model recognises the many challenges faced by rural-origin students, e.g. finance, being first-generation students, and poor preparation owing to dysfunctional schools, and adds to Tinto's model by suggesting that these experiences can be generative, dynamic and transformative.^[21] The UYDF SS encourages students to embrace, not to ignore, these experiences so that these can become the substance on which future solutions are built. Many students entering a university in SA, particularly rural, black students, are underprepared both academically and in terms of the skills needed (studying skills and practical laboratory-based skills) to succeed. However, many of them have life experiences that have given them tools to problem solve and find solutions that could be applied to the challenges at IHLs. Encouraging students to reflect on their experiences and to view these as important life lessons that give them tools and resources to succeed at IHLs, are important additions to Tinto's model.

Career-specific work experience has been recognised as a motivating influence for students

at IHLs and can contribute to academic success.^[22] Alignment between training programmes and career aspirations is a powerful motivator for students to persist and succeed at IHLs.^[22] Vacation work provided opportunities for students to study in a supportive environment, practise their skills and view their studies in relation to the working world. The vacation work also exposed them to HCPs working in a rural environment and helped them to gain insight into their chosen career. This relevant and focused learning experience contributed to their knowledge and skills, influenced their attitudes and values about working in rural areas, and contributed to their motivation, engagement and success at university. Other studies have shown that such exposure contributes towards motivating students to put in the effort required to succeed at IHLs.^[22] A similar programme could be added to most university programmes in SA (Fig. 2).

Limitations of this study

Although students supported by the UYDF SS have been very successful at IHLs over the past 14 years, the number of students in the current study was very small. In similar upscaled projects, similar outcomes cannot be guaranteed.

Conclusion

This study aimed to present the experiences of rural-origin graduates at IHLs in SA in order to build on Tinto's model of persistence and

engagement. The study analysed participants' experiences in the UYDF SS, which supported them financially, academically and socially in their journey from rural scholar to HCP. Tinto's model promotes student engagement at classroom level, which may not always be possible in an SA context. The model also suggests some limitations to the contribution by universities to facilitate student success by identifying pre-university experiences beyond their control.

The findings of this study have implications for universities that are looking to successfully educate students from rural regions. While Tinto's notion of academic and social integration is essential in the success of students at IHLs, the current study suggests that for students of rural origin to succeed at university, a number of targeted interventions are essential: (i) a compulsory structured academic and peer-mentoring programme, emphasising student potential; (ii) reframing of academic challenges, thus helping students to recognise the generative nature of pre-university experiences; and (iii) introducing compulsory vacation work. Drawing on the success and learning of UYDF SS graduates, these additions have the potential to improve persistence and success at IHLs in SA. With institutional commitment, the mentoring model and work experience are practical and implementable, and if offered to all students could lead to immediate improved success rates at IHLs throughout SA.

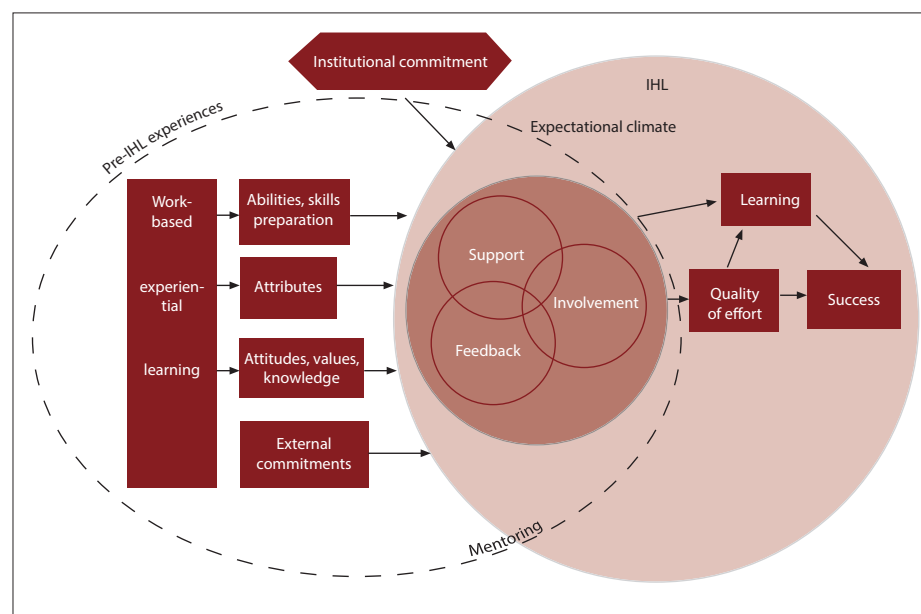


Fig. 2. Mentoring and work-based experiential work added to Tinto's model of institutional action. (IHL = institution of higher learning.)

Conflict of interest. The author was the founder of the Friends of Mosvold Scholarship Scheme (currently UYDF SS). He was intimately involved in running the scheme until 2007 and knows all the participants, as they were supported by the scheme. However, since 2007 he is no longer actively involved in student selection or financial support of the students and serves only as a trustee of the scheme and a mentor at the local university. None of those who participated in the research has any financial or other obligation to or any personal relationship with the author. This research project was supported by a grant from Discovery Health and conducted during a sabbatical period at the University of KwaZulu-Natal.

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Paper 5

Responds to

Critical question 1- **Who are these rural origin HCPs?**

Critical question 2 - **What were their educational experiences?**

Paper 5

Paper 5 responded to critical question 2 ‘**What was their learning experience?**’ and approached the learning experiences of rural origin HCP’s using Reid et al.’s four quadrant framework (Fraser et al., 2007) as an analytical tool to identify and understand learning spaces at university. Planned / formal, planned / informal, incidental / formal and incidental / informal learning spaces were identified and the importance of social integration in the incidental / informal learning space was identified as important in enabling students to integrate socially, access institutional support in the planned / informal learning space and succeed in the planned formal learning space.

Title: Portrait of a rural health graduate: Exploring alternate learning spaces

Authors: Ross, A.J. and Pillay, G.

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Declaration regarding a Doctoral student’s contribution to the journal articles to be included in a doctoral ‘research dissertation through publications’

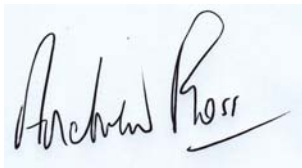
Student name: A.J. Ross

Student number: 212557836

The student’s contribution to the article was as follows:

1. Formulation of hypothesis: I formulated the concept for this review of the Umthombo Youth Development Foundation data.
2. Study design: I was responsible for the study design.
3. Ethical permission: I was responsible for obtaining ethical permission for the study.
4. Work involved in the study: I was responsible for generating the data and for the initial analysis.
5. Writing the article: The first author was responsible for writing the article. The second author gave inputs and commented on the drafts.

I declare this to be a true reflection of my contribution to this journal article.

Signature: 

Date: 15/12/2015

Portrait of a rural health graduate: exploring alternative learning spaces

Andrew Ross¹ & Daisy Pillay²

CONTEXT Given that the staffing of rural facilities represents an international challenge, the support, training and development of students of rural origin at institutions of higher learning (IHLs) should be an integral dimension of health care provisioning. International studies have shown these students to be more likely than students of urban origin to return to work in rural areas. However, the crisis in formal school education in some countries, such as South Africa, means that rural students with the capacity to pursue careers in health care are least likely to access the necessary training at an IHL. In addition to challenges of access, throughput is relatively low at IHLs and is determined by a range of learning experiences. Insight into the storied educational experiences of health care professionals (HCPs) of rural origin has the potential to inform the training and development of rural-origin students.

METHODS Six HCPs of rural origin were purposively selected. Using a narrative inquiry approach, data were generated from long interviews and a range of arts-based methods

to create and reconstruct the storied narratives of the six participants. Codes, categories and themes were developed from the reconstructed stories. Reid's four-quadrant model of learning theory was used to focus on the learning experiences of one participant.

RESULTS Alternative learning spaces were identified, which were made available through particular social spaces outwith formal lecture rooms. These offered opportunities for collaboration and for the reconfiguring of the participants' agency to be, think and act differently. Through the practices enacted in particular learning spaces, relationships of caring, sharing, motivating and mentoring were formed, which contributed to personal, social, academic and professional development and success.

CONCLUSIONS Learning spaces outwith the formal lecture theatre are critical to the acquisition of good clinical skills and knowledge in the development of socially accountable HCPs of rural origin.

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INTRODUCTION

There has been a global shift in the emphasis of health professional education from the training of medical experts to the training of socially accountable, transformational leaders with good clinical skills and knowledge. The intention is to equip graduates with professional attitudes and leadership skills that will enable them to address health system deficiencies and provide high-quality services to the whole population, in cooperation with other health care professionals (HCPs) and stakeholders.^{1,2} For this to happen, personal, social, academic and professional attributes and competencies need to be taught in appropriate learning spaces.

Appropriate numbers of HCPs are necessary to achieve key health outcomes.³ However, the staffing of health care facilities, particularly rural health care facilities, is an international challenge.⁴ As rural areas are more severely impacted by staff shortages than urban areas,⁵ the support, training and development of students of rural origin at institutions of higher learning (IHLs) should be an integral dimension of health care provisioning. International studies have identified HCPs of rural origin as those most likely to work in rural areas and to contribute to improved health outcomes.⁶

Context

South Africa (SA), like many other countries, has an overall shortage and a misdistribution of HCPs.⁴ Only 12% of doctors and 19% of nurses work in the rural areas that are home to 44% of SA's population.⁷

Qualitative data from SA have shown that despite a rise in the number of Black African students at IHLs from 30% in 1999 to 66% in 2010, failure rates of Black students at South African IHLs are high.⁸ Only 30% of the student intake at South African universities graduate within 5 years, and just under 50% complete their studies.^{9–12} Despite extensive student support, extended learning and academic mentoring programmes at most South African universities, cohort studies have shown that the completion rate of Black African university students in the life sciences, mathematics and physical sciences is approximately 33%, half that of White students.^{8,12,13} Although the completion rates of Black African students studying health sciences is better than those in other faculties, only a small number of rural-origin students graduate as HCPs each year.¹⁴ Poorly performing schools, dysfunctional

families and lack of role models result in many rural-origin students being unable to access IHLs; those who do are often inadequately prepared for the challenges of studying.^{12,15–19}

There are no published South African data on the learning experiences of rural-origin HCPs working in rural settings in SA. This article addresses this gap and is framed by the research question: what are the learning experiences of HCPs of rural origin within the context of training at IHLs in SA? Insight into these learning experiences and the spaces in which they happen has the potential to elucidate aspects of how we can train and develop competent, professional and socially responsible HCPs.

METHODS

Within the broader qualitative study that forms the basis of this article, a life history approach was used to explore the learning experiences of six HCPs of rural origin currently working in rural settings in SA, to elicit and understand the meanings they attach to these experiences.²⁰ In narrative modes of inquiry, participants' stories are elicited to bring the texture, depth and complexity of their lived experiences into view, in order to discern significant narrative tensions and patterns that occur, as Clandinin and Connelly write, 'along temporal dimensions, personal-social dimensions, and within place'.²¹ Considering these stories through a narrative inquiry lens required us to pay close attention to their narrative features – the storylines, characters and settings that both influence and are influenced by the students' lived experiences.²¹

In the telling of their stories, these HCPs were able to connect seemingly disparate incidents and to give meaning to these experiences within a particular time and context. Purposive selection in qualitative research serves to ensure participation and richness of data.²² Participants were chosen on the basis of their willingness to participate, fluency in English and representation of a range of HCPs who had studied at a variety of training institutions. They were also required to be working in a rural setting and to have been supported by the Umthombo Youth Development Foundation (UYDF). The UYDF is an innovative, rurally based scholarship scheme supporting students of rural origin to study health science courses on the understanding that they will return to work at the local hospital upon graduation. AR is the founder of the UYDF and is currently a trustee, but is no longer actively involved in

the operational aspects of the scheme. Although all of the research participants are known to the authors, none of them have any contractual obligation to the authors or to UYDF.²³

What emerged through our research with these graduate HCPs were stories of personal, social and academic isolation, marginalisation and exclusion, albeit with some glimpses of more positive encounters²⁴ enabled through particular social formations and spaces. The participants chosen represented a range of HCPs (Table 1).

Data were collected in four contact sessions over a 6-month period by one of the authors (AR), using two unstructured long interviews. These were complemented by data generated through a range of alternative methods such as photomemory, artefact retrieval and collage inquiry, which broadened the ways in which participants thought about and remembered their experiences.^{25,26}

The main research method involved an unstructured interview, which was intended to draw forth the participants' 'lived stories as data sources'.²⁷ In the interviews, each participant was asked to: 'Tell me the story of your educational experiences from your earliest memories of growing up and schooling in a rural setting to becoming a health care professional.' Each interview lasted about 2 hours. In the first interview, the participant told stories of life growing up in a home in a rural setting and related memories of primary and high school experiences, as well as post-school experiences up to the present moment as a practising HCP. The second long interview was used to clarify issues raised in the first, and to allow participants to share other meaningful experiences.

Whereas the interviews focused on the 'telling' of the stories of a 'life lived', the use of photographs,

artefact retrieval and collage elicited stories of a 'life as experienced'.²⁸ Each participant was asked to bring four photographs and an artefact to a third meeting at which he or she was asked to talk about the artefact and each photograph and the memories they elicited, and to use the artefact as a symbol to help the participant remember a critical moment of his or her lived educational journey. Whereas photomemory and artefact inquiry generated data of 'a life' told and experienced, the collage inquiry activity at the fourth meeting focused specifically on the topic 'a day in your life as a health care practitioner'.

All of the data generated from the interviews and arts-based strategies were tape-recorded and transcribed verbatim. Six stories were reconstructed from the written and visual data. Reconstructing the story as a narrative was an iterative process of reading and rereading, selecting and filtering to create a story in such a way that the teller was not diminished or written out of his or her telling. The 'finalised' version was sent to the respective participant to correct, amend or extend.^{29,30} From the six reconstructed stories, codes and categories were identified, and shared patterns of common themes and positions were elicited and developed.²²

In this study trustworthiness was addressed by consideration of the four criteria of credibility, transferability, dependability and confirmability.³⁰ To address credibility, data were collected from a number of different participants by a range of different means, which allowed for the triangulation of data. In addition, codes, categories and themes were independently identified and, where differences existed, these were discussed until consensus was reached. To allow for transferability, 'thick descriptions' are provided to allow the reader to decide whether the finding could justifiably be applied in another setting. Meeting the dependability criteria is difficult in

Table 1 Details of study participants

Pseudonym	Current position	Professional qualification and graduation date	Gender
DG	Umthombo student mentor coordinator	BSc Physiotherapy 2003	Male
FN	Sub-Saharan coordinator, Brian Holden Eye Institute	BSc Optometry 2003	Male
SM	Psychologist, Hlabisa District Hospital	MSc Clinical Psychology 2009	Male
TM	Physiotherapist, Emmaus District Hospital	BSc Physiotherapy 2006	Male
NM	Pharmacist, military research post in Mtubatuba	BSc Pharmacy 2004	Female
LH	Medical officer, Mseleni District Hospital	MBChB 2006	Female

qualitative work, although enough information is provided to enable others to repeat the study. Finally, to achieve confirmability, direct quotations are used to allow the reader to follow the logic behind the present interpretation of the data.

Ethical approval for the study was obtained from the Social Science Ethics Committee of the University of KwaZulu–Natal. Written informed consent was obtained from participants prior to starting the study.

RESULTS AND DISCUSSION

In this article we have chosen to focus specifically on stories related by TM, one of the six participants. Although all of the participants related powerful stories, we felt that TM's were particularly interesting and troubling in relation to what they convey of learning experiences in a university campus setting. Van Manen explains that stories such as TM's can also tell us 'something particular while really addressing the general or the universal'.³¹ Using data from only one participant offered a way to represent the commonality without compromising the specifics of TM's narrative. Drawing on extracts from TM's storied narrative, we illuminate his learning experiences at a particular point in his life at a university, and the social relations in and through which particular practices were enacted to affirm, support and propel the desire to learn and succeed.

Other studies have found the analytical framework reported by Fraser *et al.*³² to be useful in the analysis of learning spaces.³³ Reid's four-quadrant

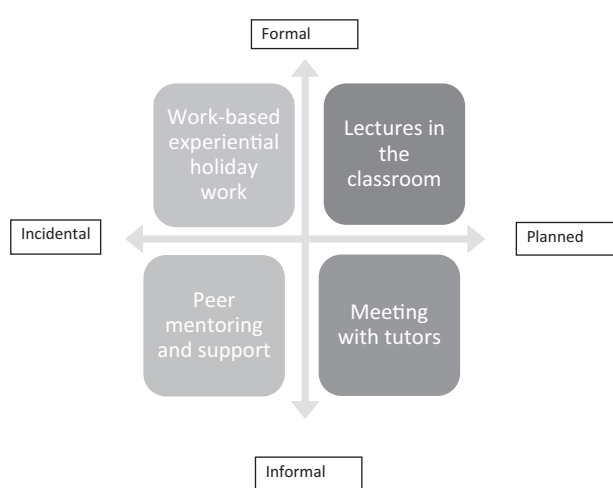


Figure 1 Reid's analytical framework.³² (Reproduced by kind permission of Taylor & Francis Ltd [<http://www.informaworld.com>])

framework of planned and incidental, formal and informal learning spaces³² (Fig. 1) helped us conceptualise and arrange the data around TM's learning experiences at university, from which emerged issues identified as common themes across all of the storied narratives.

Moving from struggling undergraduate university student to student mentor

Born in 1981, in Ingwavuma, a rural village 400 km north of Durban in SA, TM attended local schools and passed his school-leaving examinations in November 2000. Rural schools, staffed by under-qualified and unqualified teachers did little to disrupt and challenge the stereotypical meanings of rural schooling:

I'm the firstborn and have one brother and two sisters. Our family was poor and we lived in a very disadvantaged area. My mother only went up as far as Standard 4 [Grade 6] and my father went up as far as Standard 6 [Grade 8]. My parents knew that it was important for me to continue to study. But to study for what? That was not clear. I went to the school that was closest to home. Those schools didn't open up your mind to encourage you to think that whatever you are doing now might impact on your future, or that subject choice was important, or about life in general. We had teachers at school, but not the best teachers. In biology we were helped by a student who was in our study group. He ended up teaching our class because students understood him much better than they understood our class teacher!

The contextual realities of rurality combined with the institutional culture of rural schooling experienced as a boy, a learner and a son are narrated by TM in particular ways. Support from individuals out-with the school offered hope to learners like TM. Once a year, the local hospital held an open day to expose local students to career options in health. Those attending rotated through all of the hospital's departments, where staff outlined what the job entailed, entrance requirements and possible funding options:

That open day is where I got my career, and in September 2001 I received a UYDF scholarship and was accepted to study physiotherapy.

Through particular relationships TM's power as a rural student is extended, not in a forbidding and

denying force, but in a productive way involving new possibilities for him to be known and understood.³⁴ Interestingly, we recognise the turning point in TM's story and in his life when he chooses to become a physiotherapist.

Learning struggles in the formal lecture space at university

When TM arrived at university, he, like all the other participants, initially struggled with feelings of exclusion and alienation created by the language, pace of work and assessments. Because English is his second language, he found that his school experience had inadequately prepared him for studying at university, where students are expected to understand English, take notes and meet course requirements:

English was a challenge in first year. I was good at English, but I'd never had a White lecturer standing in front of me and teaching in English, only English. I never had a teacher whose first language was English, telling us something that we really needed to understand. They spoke so quickly that I couldn't understand what they were saying. It was the speed, they'd say this and this and this and then finish and then they'd be gone! And I couldn't even take notes because everything was so quick! [...] My first assignment, I got 35%, and I cried. I knew I had to pass, and if I didn't pass I would have to go back home and experience the very same life that I had been through. So it was that kind of pressure.

Formal training traditionally occurs in planned, formal spaces at university, often seen as essential learning spaces for acquiring information and qualifying as an HCP. This is a challenging learning space for many rural South African students like TM who are coming to an IHL for the first time. Evidence of this is seen in TM's struggle with the language and pace of the lecturer. Comprehension of English as a second language has consistently been identified as an important factor in student failure at IHLs,^{9,35} where the resulting deficiency in comprehension and literacy represent major handicaps for many rural students.^{12,36–38}

In addition, rural (disadvantaged) students arriving at an IHL find the university environment intimidating,^{16,35,36,39} and are required to make major social, emotional and academic adjustments in order to succeed. These students are often under-prepared and many feel isolated and inadequate.^{16,40} As TM's experience shows, these feelings may be

compounded by academic failure, which further undermines the student's confidence in his or her ability to succeed.³⁸ In addition, poor study techniques and inability to deal with the large volume of work and to study independently are all challenges that these students must overcome if they are to succeed.⁸

Going back to the life that TM had left behind was not an option. Pressure to reinvent himself cultivated in him a desire to exercise agency and to seek out alternative spaces where possibilities to think and act differently were made possible. For TM this meant actively participating in a group of supportive, like-minded students and accessing academic support provided in informal-incidental and informal-planned learning spaces:

By second year I had already adapted to the university setting, the university standards, and I knew what was required of me. I coped because when I encountered problems I knew what to do. I knew where to go, and I knew how to prepare myself for such circumstances.

In this excerpt, TM expresses his capacity as someone with power to act, and the knowledge that his reserve of hope originates outside the formal lecture room.

Learning informally with other rural students

Along with the other UYDF students, TM understood the challenges associated with transitioning from a rural area to living and coping at university. All participants were involved with peer support groups, and meeting together provided a safe space for honest sharing, caring and motivating one another:

As a group of UYDF students at university we supported each other a lot. We had monthly meetings, and we'd discuss how everyone was doing. The meetings were not just there for us to sit and discuss problems – they acted as a support group. Sometimes when you haven't done well in a test, say you got 45%, you get depressed, or are embarrassed to tell others that you didn't pass. It was tempting if you had done badly to hide your result or even lie about your results and say "I have passed", when in fact you haven't passed. But you know when you're in these groups, you will hear someone say "No, I haven't done well, I got 35%". And you would say "Yoh, I got 45%, I'm much better than this guy!" And someone

else would come and say no, they got 70% or 75%; then you would think if he got 75%, why don't I just try to get 50%, or 55%. Then you work even harder.

Social integration at university is important for students, particularly rural students, who often feel isolated and different,^{16,40,41} and has been linked to academic engagement and success at IHLs.⁴² TM had a network of rural colleagues with similar experiences who supported, encouraged and motivated him and held him accountable to the group. This learning community, brought together by similar goals, provided a powerful, supportive space in which shared beliefs, values and expectations contributed to TM's success at university.⁴³ For TM this included an expectation that everyone would participate in the group, sharing their results honestly, working hard, and supporting and helping one another.

Peer learning and participation in such communities of learning encouraged an honest assessment of self, which is a prerequisite for seeking help.⁴⁴ Such social learning has been shown to increase student productivity and the quality of effort that students put into learning activities, and ultimately to lead to success.^{45,46} This learning community created a safe, supportive and caring environment that motivated TM to work hard and encouraged him to access other support services provided by the university in the planned–informal learning space.

In addition, access to funding meant that TM was able to access and move into certain exclusive spaces (like playing golf) and become part of different supportive relationships:

I remember asking for money for the Physio golf day. I was the only African in the class and most of the White students played sports which were different from what I was used to. I wanted to make friends with guys in my class because we spent most of the time together. I thought that if I don't participate in their sports, I would always be on the outside... To be part of the Physio team I learned about rugby and golf, and I even went to a ballet dance!

Building relationships with critical friends and colleagues in a variety of informal–incidental learning spaces led to personal and social development. Moving from outsider to insider through particular social formations enabled TM to think and act in agentic ways as a leader and mentor. He was able to

provide support to other students and help them adjust to living in a large city:

When I was well adapted to the situation in Johannesburg and clear about studying, I became a leader to some of the new guys coming to Wits [University of Witwatersrand]. When they came to Johannesburg for the first time I would tell them: "This place is like this and that and that." I would tell them, whatever your circumstances, you need to pass, because that's the only thing that you are at university for. So I would mentor them. Not teaching them maths and physics, but I would mentor them in terms of social life, and how to handle the situation, knowing their background. So it was easier for the new guys to adapt in that environment, because I was there.

The range of types of knowledge that TM accumulates and negotiates from his student life within and outwith the formal learning spaces endows him with power to inhabit the student position in unique and personally meaningful ways. As a committed physiotherapy student he cultivates new ideas to improve educational opportunities for other young students coming from rural settings.

Informal learning with tutors

TM's sense of purpose, enthusiasm for learning and desire to access the different types of social support needed to develop the necessary knowledge and skills open up other opportunities for him to exercise his vision:

I went to the MESAB offices [Medical Education for South African Blacks, a non-governmental organisation which supports university students and helps them access university resources] and asked for their help. They provided a student tutor who taught me how to take notes, how to compare my notes to the books. The tutor told me to make sure that whatever I'm reading in the book is related to what the lecturer was saying. They also told us about the resources available at the university, such as the counselling service for students to teach us alternate ways of studying, about dealing with pressure and the workload at university. I learned to study in many different ways, because I tried everything to make sure that at the end of the day I got the required result.

Universities across SA provide extensive student support in the form of tutors, mentors, extra

classes and extended curricula. However, for a variety of reasons many students who might benefit from these resources fail to utilise them.^{12,13} Encouraging students to make use of institutional resources in this learning space is critical to those who wish to compensate for any deficiencies in their pre-university academic preparation. Engstrom and Tinto⁴² argue that increased access to IHL must be supported by institutional programmes which ensure (social and) academic engagement and persistence for all students, particularly first-year students. Without this support, increasing the number of students with access to IHLs will result in higher numbers of failures, rather than opportunities for under-prepared students.⁴² Tinto identifies social integration and feeling as if they belong as key factors in helping students integrate academically.⁴¹

For TM, social integration and support from like-minded UYDF students in the informal-incidental learning space motivated and supported him to ask for tutors as part of the extended university support programme. In this planned-informal learning space, TM learned how to take notes, developed alternative ways of studying, and learned how to deal with pressure and workload as key tools for academic integration and success.

Learning incidentally through holiday work

Professional values are more 'caught than taught', and powerful, socially mediated learning occurred as TM worked alongside other HCPs during the holidays. Holiday work experience allowed him to see, learn and develop the knowledge and skills needed to deal with the challenges and constraints of working at a rural district hospital:

During the holidays we would work at the hospital with the therapists, which made a huge difference because we would speak English from the morning until the afternoon. Being there all the time, asking questions – "Why do we do that?" – the therapists would teach and show us. The senior physio was a mentor, a teacher and a guide. I learned a lot from her as a person and in the actual work. There was also support from the senior students who were mentoring us. Sometimes they were hard on us, to see what we had learned, and that we could apply it, which was also very good and very helpful. And as we grew, we also became seniors. We guided the other students who were coming

[up] behind us, mentoring those students, guiding and coaching them.

This formal-incidental learning space accessed during TM's experiential holiday work provided opportunities for TM to practise his clinical skills in a supportive environment, and to see the relevance of his studies to the working world. He was able to consolidate theoretical knowledge he had learned in lectures in a practical way, and to apply it in an authentic clinical setting.

Career-specific experiential work has been shown to be an important motivating influence for students at university.⁸ It makes a major contribution to academic success, as students recognise the value of what they are learning and see the application of knowledge learned in the workplace.⁸ Socialisation, mentorship and comments of significant others, as well as observations of professional behaviour during training,⁴⁷ all represent important ways of learning what it means to be an HCP and the ethos of the medical profession.

Although for TM this learning space was formal-incidental, rural experiential learning can be incorporated into the formal-planned learning programme. The World Organization of Family Doctors' rural medicine education guide describes rural training sites as ideal for integrating knowledge, developing professional and ethical behaviour, learning resource management skills and learning to work in a team.⁴⁸

Active participation in all of these learning spaces, networking with others in the different and alternative learning spaces and utilising available support structures and resources enabled TM to graduate as a physiotherapist. TM currently works at a rural district hospital addressing the health care needs of the local population, and supervises junior therapists. As a role model to many local students, TM represents the hope that other students of rural origin may become socially responsible HCPs in rural settings.

Strengths and limitations

The strength of this approach to understanding the lived learning experiences of a rural HCP lies in the storying of TM's memories of lived experiences of learning; this enabled him to reconstruct his experiences and give meaning to them.^{29,49} However, the storied narrative is offered tentatively in recognition of how much is open to interpretation, and that this

story is retold 'in the midst' of TM's life, which is dynamic and changing.^{20,21,50} In keeping with other qualitative studies, the small number of participants limits generalisability, but the reader is invited to assess whether the findings could be applied in another setting. The personal relationships between AR and the study participants may be seen as representing both a limitation and a strength. Participants expressed a willingness to participate and shared intimate details of their experiences, which may not have been accessible to another researcher. However, the relationship may also have resulted in the participant painting a particularly positive picture of the role of UYDF, although this was not the focus of this article.

CONCLUSIONS

As the extracts from TM's storied narrative show, learning happened in different learning spaces; the use of Reid's analytical framework³² allowed those that are often not acknowledged to be explored. The alternative spaces outside the formal lecture theatre were critical to the support, training and development of TM as an HCP. Caring, sharing, motivating and mentoring relationships facilitated TM's social and academic integration and success in the formal learning space. In addition, personal development occurred as TM recognised his agency to think and act differently when he received support and was able to provide support, was mentored and was able to become a mentor.

Universities need to take cognisance of all of these learning spaces, particularly those neglected alternative spaces that promote personal and social integration, in preparing medical graduates and specifically students coming from dislocated schooling systems. These alternative and critical learning spaces work in complex and complementary ways to contribute to the development of the personal, social, academic and professional attributes and competencies necessary to practise as a socially accountable HCP. Universities need to move from a training paradigm to a development paradigm to ensure that rural-origin HCPs have appropriate knowledge, learn good clinical skills and develop the attributes necessary to practise as responsible transformational HCPs in rural settings.

Contributors: this work is part of a larger PhD study. AR was responsible for conceptualising the study, collecting and analysing the data, and writing up the paper. DP

contributed to the conceptualisation of the work, analysis of data, and the review and editing of the manuscript. Both authors approved the final manuscript for submission.

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Ethical approval: this study was approved by the Social Science Ethics Committee of the University of KwaZulu-Natal (HSS/1205/012D).

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Paper 6

Responds to

Critical question 1 - **Who are these HCPs?**Critical question 3 - **How do their experiences inform their practice?****5. Challenge and potential - working as an HCP****Paper 6**

Paper 6 and to a lesser degree Paper 3 look at their experiences of working at a district hospital as an HCP.

Paper 6 is a response to critical question one but in particular it is a response to critical question 3 **‘How do their educational experiences inform their practice as rural HCPs?’**

This paper looks at the experiences of these HCPs of rural origin when they return to work in rural district hospitals. Using a grounded analysis to identify codes, categories and themes, the paper explores where they worked, the challenges that they faced, how they worked and the influence these HCPs who chose to remain and work in rural settings had on the healthcare service and on the local community.

The themes identified highlight the huge impact that these HCPs have had on service delivery, the challenges of working in rural areas, the satisfaction and status for themselves and their families that they get by working in these rural areas. The transformational role that they play in the lives of their families and their community is also highlighted. The chapter challenges the notion that working in a rural area is unsupportive and unfulfilling.

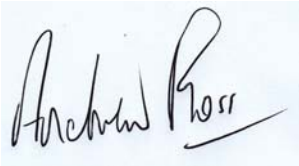
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Student name: A.J. Ross

Student number: 212557836

I declare that the entire article, including formulation, design, analysis and write up was completed by the author alone.

Signature: 

Date: 15/12/2015

Working in rural areas – the experiences of Umthombo Youth Development Foundation graduates

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Background: Recruiting and retaining healthcare professionals (HCPs) for rural areas is challenging throughout the world. Although rural origin HCPs have been identified as being the most likely to work in rural areas, only a small number of rural-origin South African scholars are trained as HCPs each year and many do not return to work in rural areas.

Aim: The aim of this article was to present the experiences of rural-origin HCPs who returned to work in a rural area after graduation.

Setting: Umthombo Youth Development Foundation has been running an innovating rurality-based scholarship scheme since 1999. By December 2013, 184 students supported by the scheme had graduated and all had returned to work in a rural area for a period of time.

Methods: This was a qualitative study using a life history methodology to explore the educational experience of six rural-origin HCPs working in rural areas.

Results: The four themes that emerged from the data were: (1) contribution to service delivery; (2) professional development (3) the challenges and frustrations of working in rural hospitals; and (4) the impact of working as an HCP.

Conclusion: Rural-origin HCPs are willing to return and work in rural areas. However, context and content factors need to be addressed if a work-back scholarship scheme is to be a long-term strategy for the recruitment and retention of HCPs.

Travail dans les zones rurales – les expériences des Diplômés de la Fondation Uthombo pour le Développement de la Jeunesse.

Contexte: Le recrutement et la rétention des Professionnels de la Santé (HCP) pour les zones rurales est un problème mondial. Bien qu'on considère que les HCP d'origine rurale seront probablement ceux qui accepteront de travailler dans les régions rurales, un très petit nombre d'étudiants sud-africains d'origine rurale reçoivent une formation de HCP chaque année et beaucoup d'entre eux ne retournent pas travailler dans les zones rurales.

Objectif: Cette étude a pour objectif de décrire les expériences des HCP d'origine rurale qui sont retournés travailler dans les régions rurales après leurs études.

Cadre: la Fondation Umthombo du Développement de la Jeunesse dirige un système de bourses innovant en région rurale depuis 1999. En décembre 2013, 184 étudiants boursiers avaient reçu leur diplôme et tous étaient retournés travailler un certain temps dans une zone rurale.

Méthode: Cette étude qualitative a utilisé la méthode de l'histoire de vie pour étudier l'expérience éducative de six HCP d'origine rurale travaillant dans les zones rurales.

Résultats: Trois thèmes ont émergé des données: (1) la contribution à la prestation de services; (2) Les défis et frustrations de travailler dans des hôpitaux ruraux; et (3) l'impact de travailler comme HCP.

Conclusion: Les HCP d'origine rurale veulent bien retourner travailler en zone rurale. Cependant, il faudra examiner le contexte et le contenu si l'on veut que le système de bourses à rembourser par le travail devienne une stratégie de recrutement et de rétention à long terme des HCP.

Introduction

Without sufficient numbers of well-trained professional staff, key health outcomes will never be realised.¹ Many rural areas in South Africa have a high burden of infectious diseases, high under-five mortality and reduced life expectancy at birth. The 10 districts with the highest

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deprivation index in South Africa in 2008 were all rural.² There are major inequalities between staffing levels at hospitals in rural and urban areas which contribute to poor health outcomes.^{2,3} These disparities remain, despite the commitment of the National Department of Health to 'Health for All'⁴ and the prioritisation of recruitment of healthcare professionals (HCPs) for rural areas.⁵ Maternal, child and infant mortality rates increase as the number of healthcare workers (HCWs) decreases, whilst increasing the number of HCWs has been shown to improve health outcomes in underserved areas.⁶

Rural-origin healthcare professionals (HCPs) have been identified as being the most likely to work in rural areas after qualification and to contribute to improving health outcomes in these areas.⁷ However, only a small number of rural-origin South African scholars are trained each year as HCPs⁸ and finding staff for rural hospitals is an ongoing challenge. Absent role models, dysfunctional families, poorly-performing schools and limited financial support all make it challenging for rural-origin students to gain access to tertiary institutions in order to train as HCPs.^{9,10,11,12,13,14} Compounding the issue of staffing for rural institutions is the fact that only a small percentage of rural-origin HCPs actually choose to work in rural institutions.¹⁵

The Friends of Mosvold scholarship scheme (now the Umthombo Youth Development Foundation Scholarship Scheme [UYDF SS]), an innovative rural scholarship scheme, was started in 1999. It was based on international research which showed that the training of rural scholars was potentially a long-term solution to the chronic staff shortages in rural and remote areas. Although there are a number of definitions of 'rural' (based on distance from urban areas, resources available, geographic location, economic activity, etc.),¹⁶ by any definition students supported by UYDF SS would be considered to be of rural origin. By November 2013, 184 HCPs supported by the scheme had graduated. All graduates have returned to work at a rural district hospital near where they live to fulfil their work-back obligation. Less than 10% of graduates have bought themselves out of a portion of their work-back obligation and more than 60% have continued to work in a rural area after their work-back obligations were complete.¹⁷

The willingness of these graduates to return and work in rural hospitals stimulated this research project which is part of a PhD dissertation looking at the educational journeys of rural-origin healthcare professionals working in rural areas. The aim of this article was to present the experiences of these rural-origin HCPs who returned to work in rural areas after graduation. It is hoped that this article will contribute to the discussion regarding the selection and support of rural-origin scholars and strategies for the staffing of rural health care institutions.

Research methods and design

Study design

This was a qualitative study using a life history methodology to explore the educational experience of rural-origin HCPs.

Selection of participants

Six rural origin HCPs were selected purposively from UYDF SS graduates. The criteria for selection of graduates were: (1) their willingness to participate; (2) the ability to articulate their thoughts and express themselves clearly; and (3) whether they were working in a rural context.¹⁸ A variety of HCPs from different disciplines were included in this study in order to ensure that the voices of several members of the healthcare team were heard, many of whom play a significant role in service delivery in rural areas.¹⁹ In addition, women's experiences may be substantially different from those of men – particularly the experiences of rural women – and it was important that the voices of women should also be heard.

The six graduates who were selected (details provided in Table 1) are referred to throughout the rest of this article by their initials only.

Data collection

Data were collected by the author using two unstructured interviews where participants were asked the question, 'tell me about your educational experiences from rural scholar to healthcare professional and what it means to work in a rural setting'. Interviews were supplemented by photographs and artifacts from different stages of

TABLE 1: List of those healthcare professionals who participated in the study.

Name	Current position	Professional qualification	Professional experience	Years of professional experience	Age	Gender	Originally from
DG	Student mentor coordinator based in Mtubatuba	BSc Physiotherapy UKZN 2003	2004–2008 Physiotherapist 2008 – current mentor coordinator	11 years	37 years	M	Ingwavuma
FN	Sub-Saharan coordinator Brian Holden Eye Institute	BSc Optometry UKZN 2003	2004–2009 Optometrist – Mosvold, Pelopele train 2010 – current Brian Holden Eye Institute	11 years	34 years	M	Ingwavuma
SM	Psychologist at Hlabisa Hospital	MSc Clinical psychology UJ 2009	Clinical psychologist Hlabisa Hospital 2010 – current	4 years	29 years	M	Ingwavuma
TM	Physiotherapist at Emmaus Hospital	BSc Physiotherapy Wits 2004	Physiotherapist 2005 – current	6 years	33 years	M	Ingwavuma
NM	Pharmacist Military research post in Mtubatuba	BSc Pharmacy Wits 2004	Pharmacist 2005 – current	10 years	35 years	F	Ingwavuma
LH	Medical officer Mseleni Hospital	MBChB UKZN 2006	Intern / community service officer / Medical officer 2007 – current	9 years	30 years	F	Ubombo

F, Female; M, Male; UKZN, University of KwaZulu Natal; UJ, University of Johannesburg; Wits, University of Witwatersrand.

their educational experiences and by the construction of a collage of a day in their lives (see Figure 1). Participants were asked to describe the photographs and/or artifacts and/or pictures chosen for the collage and how they were connected to their educational experiences. All interviews and discussions were recorded on a voice recorder and transcribed verbatim.

Data analysis

A reconstructed story was written from the transcripts²⁰ and was sent to the participants for content validity. The stories were read and re-read, codes and categories identified, patterns and relationships between categories reviewed and themes developed.¹⁸

Ethical consideration

Ethical approval was obtained from the Social Science Ethics Committee of the University of KwaZulu Natal (HSS/1205/012D). Written informed consent, including possible identification, was obtained from all of the

participants after the aims of the study were explained to them.

Results

These UYDF SS graduates were chosen to participate in this study because they have continued to work in rural areas. They all had a year-for-year work-back obligation to UYDF to return to the area they came from. Although this was important, because '... I wanted to fulfill my contract with Friends of Mosvold' [DG], fulfilling a contractual obligation was not the primary reason for returning to the hospitals.

SM had a 'great offer to run an employee wellness programme from one of the mining houses'. He could have bought himself out of the contract and remained in Johannesburg, but because of his personal commitment he chose '... to come back for the community. Not returning would have been cheating. I had this moral obligation to my mum and the community'. There were also community expectations that students, who had been chosen by a committee made up of hospital and community members, would return to work on the area after graduating. Graduates were motivated to return because:

'... [p]eople kept on asking me "when are you coming back?". So that kind of put pressure on me ... they must see me coming back now.' [DG]

Working at the local district hospital enabled some of these graduates to stay at home. Even those who had accommodation at the hospital found it easy to visit and provide support to their families. An additional advantage of living in a rural area was that it was cheaper than staying in an urban area because less money was spent on transport as home was close to work and there were less things to spend money on:

'... [M]oney-wise, you don't really spend as much as you would be spending in the urban areas. If you really want to save, you can, and that this [sic] was an important advantage of working at a rural district hospital.' [NM]

The following themes were identified from the data:

- Contributing to service delivery.
- Professional development.
- The challenges and frustrations of working in rural hospitals.
- Personal, family and community impact of working as a healthcare professional.

Theme one: Contributing to service delivery

These professional graduates were able to contribute toward service delivery:

'... [W]e worked hard seeing patients in the wards and in OPD [the outpatient department] and visiting the clinics.' [DG]

Having grown up in rural areas, they understood what life was like for the majority of the population and this



Source: Photo taken by Andrew Ross

FIGURE 1: Collage development [SM].

BOX 1: Discussion of collage in Figure 1.

In the discussion following the construction of the collage, SM highlighted the importance of his job as a clinical psychologist and the important role that he was playing in the community. He also mentioned the contribution that he was making as a clinical psychologist and as a graduate in the community. He also talked about his changing role within his family, the importance of family and the fact that he was looking forward to having a family of his own. The importance of his religious beliefs, along with how these had impacted upon his choice to return to work at the local district hospital, were also discussed, as well as his love for soccer.

influenced their work ethic and attitude to work. SM recognised that:

'... [i]f I don't go to a certain clinic, there's a person there who is waiting for me, who has only that option, to go to that clinic, and nothing else.'

Graduates were able to extend the services provided:

'I saw the therapy department grow from one therapy assistant visiting 16 out of the 34 clinics on her own ... to four physios, two OTs [*occupational therapists*], two audiologists and two speech therapists.' [DG]

Using contacts established through UYDF, they were also able to raise money for equipment needed to support these services.

They brought new skills to the hospitals:

'... I made it my responsibility to make eye services a priority in the whole district ... because of my rural origin I am passionate about making sure that quality healthcare is delivered to people.' [DG]

These graduates were proactive in motivating for posts to be created, staff to be recruited and equipment to be purchased:

'... [T]hings never happen by chance ... I always had a plan for the eye clinic.' [FN]

Meaningful contributions were made both to patient care and to the training and support of other HCPs:

'... [W]hen I started, the TB [*tuberculosis*] cure rate was below 40%; by the end of the first year, we managed to get it up to 60%, then we got it up again to 75%.' [LH]

'... I orientate [*sic*] them about the HIV and TB programmes.' [LH]

Theme two: Professional development

These HCPs found the work to be interesting, varied and stimulating, with DG commenting that:

'... I remember seeing conditions that you would never see at university – I used to phone the lecturers and say "I'm seeing this, what is it?" Seeing those kind of conditions helped me to say, "[L]et me learn more."'

They were also able to take advantage of opportunities for professional development. LH was involved in 'a research project on multiple drug resistant TB' and is '... currently working on modifying the new antiretroviral guidelines'.

SM has had the opportunity to develop professionally as he learnt more about community psychology and culture-bound psychology.

There were also opportunities for promotion which happened more quickly than would have happened in urban hospitals and at some hospitals they felt valued and appreciated by the management, other staff members,

patients and members of their community. For most, working in a rural district hospital:

'... [h]as been a wonderful journey and I'm loving what I'm doing ... I'm developing caring, supportive relationships and working as a healer and comforter. I see my work as somebody who brings hope to the sick.' [LH]

Theme three: Challenges and frustrations

Graduates, however, found that there were significant challenges and frustrations when working at rural district hospitals. These graduates were chosen by a local selection committee which included community members and management based on a prioritisation of services needed. As students they had returned to the hospital for work-based experience every year and management were aware of their graduation date. Despite this:

'... [t]here were no [*optometry*] posts [*when I graduated in December*] ... I eventually started work on the 5th of April in an oral hygienist post; there was no job description and the necessary equipment was not available to function [*sic*].' [FN]

Keeping graduates and making them feel that they were valued and important members of the hospital staff did not appear to be a priority for hospital management at some hospitals. At these hospitals, management was not perceived to be proactive in the creation and filling of posts or in the provision of basic facilities such as suitable accommodation:

'I was willing to fulfill my five year contract but the hospital could only offer me accommodation in a dorm in the Nurses Home with the student nurses although the hospital offered houses to other professional staff.' [DG]

Although management had high expectations of them, graduates often did not feel supported or appreciated:

'... I was left alone to do the job of three [*pharmacists*] ... [T]hey told us that we could not close at four but needed to work until five pm but there was no money for overtime. They offered us the opportunity to take time back but it wasn't easy to take time off when I was the only pharmacist.' [NM]

All of the graduates experienced many frustrations whilst working at the hospitals. LH remembered the following regarding working as a newly-qualified doctor:

'... [D]uring a particularly difficult and stressful operation ... I called one doctor. He told me "I'm not on call today. You are a doctor, just see how you can handle it."'

She concluded with:

'... [T]hat's how rural medicine is like. Everyone always said rural medicine was horrible and I experienced that first hand.'

She had planned to work at a rural hospital for a number of years, but after that experience she decided:

'... I couldn't stay in rural medicine; the only option was just to quit and go do fashion designing. So I waited for the end of the year and in December when my contract ended I packed everything and said, "I'm leaving medicine" and I stayed at

home without a job until I was approached by Dr F who asked me to work at Mseleni hospital.'

Opting out and leaving rural medicine was an understandable consideration for some of these HCPs when working in an unsupportive environment and faced with overwhelming challenges. However, the HCPs who participated in this study remained and continue to work in rural areas. Some of them (LH, DG, NM, TM) moved to other rural, more supportive institutions whilst others found perspective and were able to continue to work in the same hospital (FN, SM). However even when moving to another hospital, perspective was important as there are challenges in every environment:

'... I realised that there are problems wherever you go ... [I]f you can make a difference here, you can make a difference anywhere. You just need to find a solution to whatever challenges you are facing.' [DG].

Theme four: Personal, family and community impact

For these rural-origin scholars, graduation brought status and respect to them and to their families and has changed their lives forever:

'Graduating changed me and changed the way people relate to me and my family. Graduation brought a belief that I could do things.' [FN]

Working as an HCP meant that they had material resources which they used to build houses for their families, provide water and electricity at home and make sure that other members of their family had opportunities to further their education:

'... Since finishing "varsity", I have helped my eldest sister. After matric she spent two years at home without doing anything as she couldn't continue because of the money. I supported her to go college.' [TM]

These graduates were looked to for health advice as:

'... I can diagnose and give information to improve their condition.' [DG]

They are seen as role models in the community, helping to inspire others to undertake their own educational journey:

'When I speak at schools I start off telling them where I come from and a lot of them get surprised ... [W]hen I tell them, "this is what has happened to me – you can make it", that's when they start relating to the message. I start at the beginning and then go on to tell them about the options.' [SM]

However, perhaps even more profound than being a role model to scholars in the area, was the impact they had on the wider community. Returning to work in the areas and sharing their educational experience with others has changed the communities' perspective regarding the value of higher education:

'... [T]hrough seeing us, through us talking to them they then got encouraged and now maybe 20% of people in that rural

area are taking their kids to places of higher learning. When we started, no-one was sending their kids to university. But now, people in the community sell their cows to send their kids to university because they are able to see what education can do for other kids. That's why quite a lot of kids have gone to university from that side – not only kids from good families, but from poor families as well. Parents are putting in their last pennies for their kids to go to university because they can see it does change the family structure, the economics and all that. It's massive. From what I see now. It's massive.' [FN]

Discussion

Using a life history methodology enabled these rural-origin HCPs to tell their life story within the context in which they worked. The stories provided a window to understand the meanings that they attached to their experiences and how they made sense of their world as they worked as an HCP at a rural hospital. Interviews tend to be linear and limited by words whilst the use of arts-based techniques allowed these HCPs to move away from linear thought. Photographs, artifacts and pictures selected for the collages have meaning and memory associated with the experience that the photograph, artifact or picture represents. Using these techniques broadened and deepened my understanding of their experiences as they recalled experiences and explained the meaning relative to the photo or the artifact or the pictures chosen.²¹ The use of these tools in this research project was innovative and provided insight and a better understanding of their experiences of working as an HCP in a rural context.^{22,23}

A number of recruitment and retention strategies have been proposed with regard to staffing rural hospitals. These include: educational interventions (rural recruitment, early exposure to rural sites, rural campuses); coercion (compulsory service, regulatory requirements); incentives (increased pay, more holidays); and the creation of an enabling environment (increased support, community appreciation). The UYDF SS, as a rurally-based scholarship scheme, could be considered both a recruitment tool in getting graduates to rural areas and a retention tool in the year-for-year work-back obligation imposed on the graduates. The success of the scheme in encouraging graduates to return and fulfil their work-back obligations supports the evidence from international observational studies that the recruitment and training of rural-origin students is an effective strategy for the long-term staffing of rural facilities.^{7,24} Studies from Australia have shown that that rural origin students are twice as likely to work in rural areas than graduates from urban areas.²⁵ Studies from Canada suggest that rural doctors are five times more likely to have originated from rural areas than from urban areas.²⁶

In keeping with other studies, reasons given by these graduates for choosing to return to work in a rural district hospital included being able to make a contribution to their communities and to their families, as well as the opportunity to live close to home.^{27,28} It was interesting to note that it was not predominately their contractual obligation which

motivated them to return but rather a personal commitment to themselves and their community.

A World Health Organization report published in 2013 reiterated the critical role that HCWs play in improving healthcare, stating that governments must prioritise the training, recruitment and retention of HCWs as there can be 'no health without a workforce'.²⁹ Having and retaining these rural origin HCPs at a district hospital meant that health services could be provided and extended and important services such as optometry and psychology could be introduced. The graduates' intimate knowledge of the community fueled their passion to both improve and extend the healthcare service. Having graduates who understand the local conditions and who appreciate the value and the need for their services is an important asset which should contribute toward the provision of a service of excellence. These graduates found their work to be both interesting and challenging. Opportunities were provided for professional development, they had opportunities for promotion and they felt valued and appreciated by the community. These experiences are similar to the reasons given for remaining at a district hospital by community service officers who were already working in rural district hospitals in South Africa. HCPs who feel valued and appreciated by management, their patients and community members and who feel that they are providing a worthwhile service have been shown to be more likely to choose to remain in a rural setting.²⁷ Purohit has identified these as being the content factors and/or intrinsic motivators which contribute to HCW motivation, quality of work, job satisfaction and a willingness to remain in rural areas.³⁰

However, whilst working at rural district hospitals, many of these graduates experienced multiple frustrations and challenges – often with regard to issues such as a lack of posts, lack of policies (no job description), lack of equipment, inadequate accommodation and poor supervision. Purohit has identified these as context or hygiene factors, which are things that should be in place for the smooth running of a healthcare institution. If they are absent, they can lead to high levels of frustration and dissatisfaction. Context and content factors are complementary and not opposites and both need to be addressed if HCPs are to be retained at rural district hospitals.³⁰ For example, dealing with accommodation issues may reduce frustration but does not necessarily increase motivation. Doing interesting and worthwhile work which is valued by the community may be motivating but could be undermined by high levels of frustration and plans to leave if, for example, salaries are not paid on time. In this study, four of the six graduates (DG, LH, NM, DG) moved from one district hospital to another, mainly because of context factors. If management wants motivated and productive HCPs who chose to stay and work in rural areas, attention must be given to addressing context factors, in order to reduce and/or eliminate frustrations, as well as to content factors that both motivate and provide a sense of purpose because of doing something that is worthwhile.

The graduates who participated in this study are contributing to service delivery and, in turn, are having a profound influence on their families and on their communities. However the main long-term impact that these graduates have may not be on the health services that they provide but rather on their ability to inspire others to study and to see the potential in education. Ray (2006) has commented that, in relation to aspirations to achieve a better life for oneself and one's family, 'there is no experience quite as compelling as the experience of your immediate family and more broadly those in your socioeconomic and spatial neighbourhood'.³¹ The experiences of these rural-origin HCPs echo the words of Nelson Mandela:³²

Education is the great engine of personal development. It is through education that the daughter of a peasant can become a doctor, that the son of a mineworker can become the head of the mine, that a child of farm workers can become the president of a great nation ...

Strengths and limitations

The strength of this study lies in the fact that it gives voice to rural-origin HCPs, enabling them to share their experiences. The small number of participants and the qualitative nature of the study mean that the findings cannot be generalised to other settings. However, it is hoped that those reading this study will be able to identify with the participants and apply what has been learnt to their own context.

Conclusion

This study has shown that the recruitment and training of rural scholars is a worthwhile, viable, long-term strategy for the staffing of rural institutions in a developing country such as South Africa and that a scholarship scheme can be a successful strategy for both recruitment and retention. These graduates found their work to be both satisfying and enjoyable and were able to provide and extend healthcare services. They gained status and respect within the community and were role models to scholars in the area. Access to resources improved conditions at home and changed the trajectory of the lives of their family members. However, if such a scheme is to be an effective long-term strategy for the recruitment and retention of HCPs for other rural areas, managers need to invest in the effort of finding and supporting such rural origin scholars. They also need to give attention to addressing context factors (which lead to frustration) and content factors (that promote motivation) in the workplace.

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Competing interests

The author was the founder of the Friends of Mosvold Scholarship scheme (now the UYDF scholarship scheme). He was intimately involved in running the scheme until 2007 and knew all of the participants since they were supported by the scheme. However, since 2007 he has no longer had an active involvement in the selection or financial support of any student and serves only as a trustee of the scheme and a local mentor at the University of KwaZulu Natal. None of those who participated in the research have any financial or other obligation to the author or any personal relationship with the author.

Author's contributions

The author was responsible for the conceptualisation of the research project, the collection and analysis of the data and the writing of this manuscript.

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6. *Conclusions*

The papers presented in this chapter provide a glimpse into the identity of these rural origin HCPs in relation to their rural context, the IHL where they trained and their work context after graduation. The papers have highlighted the challenges that rural origin students face when going to university and the strategies that they adopt to ensure that they are able to succeed.

Paper 3 and the Letter to the Editor call for a broadening of selection criteria to ensure selection of those able and willing to work in rural and underserved areas. The final paper highlights the motivation graduates have to return to work in rural areas, the challenges associated with working in these areas and the unlimited generative potential of local graduates when returning to work in these areas. Together these papers provide insight into the challenges of schooling in rural areas, how these HCPs responded to these challenges and developed strategies which they were able to utilise at IHL, and how these experiences contributed to the kind of HCPs they were and the services they sought to provide to the communities from which they had come.

The three critical questions which guided this research dissertation are responded to below. However, when using a life history approach participants tell stories of their experiences and how they make meaning of these experiences. It is not possible when using a life history approach to isolate the critical questions and to answer them as discrete stand-alone questions, and the stories told were not compartmentalised according to my research agenda.

For this reason the answers are presented as integrated stories of lives lived, from which I extracted learning. While focusing on different aspects of their educational experiences, the papers presented cover a range of experiences as I tried to understand the complex, multidimensional lives of these rural origin HCPs.

Critical question 1: Who are these rural origin HCPs?

This question is answered in a small way in all of the paper, but **Paper 2: From rural scholar to healthcare professional**, **Paper 3: Troubling selection: towards a broader selection policy** and **Paper 6: Working in rural area – the experiences of Umthombo Youth Development Foundation graduates** touch on this question in a bit more detail as we see their identity being lived out.

Critical question 2: What were their educational experiences?

This question is addressed in **Paper 2: From rural scholar to health care professional**, in **Paper 4: Building on Tinto's model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme** and in **Paper 5: Portrait of a rural health graduate: Exploring alternate learning spaces**. The papers presented focus mainly on their experiences at IHL.

Critical question 3: How did these experiences influence their practice?

This question is addressed in **Paper 3: Troubling selection: towards a broader selection policy** and **Paper 6: Working in rural area – the experiences of Umthombo Youth Development Foundation graduates.**

I believe that these papers add to the body of knowledge by providing insight into the life histories of rural origin HCPs and how they made sense of these experiences.

Grant (2011) has suggested that a research dissertation by publication must show connectivity on at least five levels:

- ✓ Clustering of articles around a research question
- ✓ A common literature thread
- ✓ Common theoretical framing
- ✓ Common methodology
- ✓ Insights from synthesis and critique.

The articles presented have used a range of models / frameworks / theories which have contributed to my understanding of the lived educational experiences of rural origin HCPs. I have ended up with an eclectic collection or bricolage (Dictionary.com, 2015), which like a tapestry provides a more ambiguous, open and complex understanding of the lived personal and professional educational experiences of rural origin HCPs.

The articles presented are clearly clustered around the educational experiences of rural origin HCPs, focusing on different aspects of this educational journey. There is a common literature thread, theoretical framing (SIT and generative nature of rurality) and methodology. Synthesis and critique will be offered in the following chapter.

CHAPTER 3: CONCLUSIONS AND RECOMMENDATIONS

1. Personal development: From description to dilemmas

The quotation by Nelson Mandela given at the beginning of this dissertation in Chapter 1 represents the excitement that I felt as I commenced on this new voyage of discovery, of understanding the lived lives of rural origin HCPs who were working to transform healthcare practice in rural settings. My initial purpose in this PhD study was simply to understand something of the experiences of rural origin HCPs. However, through a life history approach my understanding has progressed from a simplistic interpretative perspective to a more nuanced, complex understanding of what it means to be and become an HCP, conceptually, theoretically, methodologically, and contextually.

I have moved from a simplistic, descriptive, linear understanding of the training of rural origin HCPs who work in rural settings, conceptualised by the pipeline, to a much more complex understanding of the need for negotiation at every stage of their educational experiences. In thinking about SIT and how it locates people relationally within communities, it has also given me a more complex, nuanced understanding of my own development and negotiation with multiple contexts and the effects that these have on choices that I make.

This PhD has also contributed to my own academic development as I moved from a purely descriptive, quantitative study showing the success of the UYDF in **Paper 1 (Review of the Umthombo Youth Development Foundation (UYDF) scholarship scheme 1999 – 2013)**, to a more abstract, deeper, multidimensional and nuanced understanding of the complexities of everyday experiences and the negotiations which occurred at multiple levels in training to be and practising as a rural origin HCP in **Paper 3 (Troubling selection: towards a broader selection policy)**.

In addition, although studying the lived experiences of these paradigmatic HCPs (Flyvbjerg, 2006) within the context in which they live, I have a greater appreciation of the fact that without obvious alternatives, it becomes easy for ‘rural students’ to become stuck in certain social categories, as they are known and safe and they clearly understand what is expected of them (Stets & Burke, 2000; Hogg et al., 1995). However, through the stories of the lived experiences of these HCPs I have come to see that even within rural discourses there are spaces for rural origin students to develop, to grow, to excel and to become exceptional HCPs.

Through their stories I have gained a better understanding of the intersections of rurality, learning, and working as a rural origin HCP in rural context. Indeed, education has been the great engine for my personal development.

As part my own personal development I wish to critique a number of aspects of the dissertation, which I outline below.

2. A reflective critique of the research dissertation

A reflective glance at my researcher positioning

I was the founder of UYDF, the mentor of and instrumental in finding funding for the university education of all of the participants. As such I was an ‘insider’ to the UYDF scholarship scheme. However, although I knew all of the participants personally and as university students, I was not aware of their educational experiences as rural origin learners. I knew very little of their university life and ‘training’ to become a doctor. I realised that I knew nothing about how they had negotiated the transition from rural scholars to HCPs, or of the role of significant others in their journeys. A life history approach opened up my understanding of other categories, beyond those that I already know, of who they are (Pillay, 2003).

However, in adopting a life history approach it is important to acknowledge one’s subjectivity and to reflect on one’s role in the telling and hearing of the shared lived experiences, as all stories are a co-construction between the teller and the hearer. As Steedman (1991) has written, “knowledge cannot be separated from the knower”. During this research dissertation I struggled as I moved in and out of knowing and not knowing as both an insider and an outsider. I tried to be aware of the effect that I had on both the process (interviews, sharing of information) as a previous figure of authority and privilege within UYDF, and outcome (how I interpreted and made sense of their shared experiences), in understanding the complex, contradictory lives of practising rural origin HCPs (Olive, 2014).

Life history research is based on a trusting and honest relationship between researcher and co-participants, which is essential if personal stories are to be shared (Kathard, 2009; Hatch & Wisniewski, 1995; Caine et al., 2013). Although I have a long-term relationship with all of the participants, in this research I wanted to honour that relationship and not take their participation for granted. Each participant was therefore formally asked to participate in the study, the purpose of the study was clearly outlined, and each signed informed consent; each also had the opportunity to review ‘their story’ and make amendments. I believe that this process has deepened the trust and extended the relationship that I have with them. Doing life history moved our relationship from a top-down relationship to a reciprocal relationship, which has provided space for their voice as rural origin HCPs.

However, as an older white male it is possible that certain aspects of the interviewees’ lives may have been inaccessible or invisible as a result of the differences in background, social class and culture between myself and those who participated in the research. In addition, because of the role that I had played in UYDF, a sense of

obligation to me could have influenced the construction of data presented and contributed to the participants painting a particularly positive picture of the role of UYDF in their educational journey.

The arts-based methods enabled the participants to 'name' their stories and they chose what to bring to our meeting, which provided space for them to find a different voice in the presentation of their photographs, artefacts and colleges. Their time and personal narratives were gifts to me as I needed their stories, and I needed to accommodate their schedules and activities. They were co-participants actively engaging with me in the telling of their stories, and we now relate more as equals that previously was the case. In many ways our relationship as researcher and participants is now fundamentally different following this research dissertation, as in this research process I needed them.

Employing arts-based strategies complemented the life history process, as participants were asked to select their own photographs and their own artefacts and to construct their own collages. As participants inserted themselves into these visual reminders, they were able to tell their story in a way which was less dependent upon me facilitating the process, which opened up the understanding of their experiences and allowed for productive ambiguity (Butler–Kisber, Allnutt, Furlini, Kronish et al., 2002-2003).

Interpretation of their lived experiences as complex and entangled in the material and structural was deepened as I reflected on the stories told, made field notes while generating data, and involved my supervisor in the reviewing of the field texts and stories to ensure that themes, analysis and conclusions were grounded in the data generated.

While acknowledging the multiple interpretations of a life as lived, in order to do justice to the participants and not to inadvertently impose my own interpretation, several strategies as outlined by Olive (2014) were adopted. These included the provision of thick descriptions (covering selection, interviews and analysis), recognition of the role of participants as co-creators in the (re)construction of their stories, and using participants' own words in the identification of codes, categories and themes and in the papers presented.

Methodological reflections

A life history approach has allowed me a glimpse into others' understanding of rurality and rural contexts, which is influenced by the context and relationships in which they grew up. It is a relational and transactional experience both for the receiver and the teller, and it was a methodology which allowed me to learn from their subjective, complex experiences. This was a methodology that I found useful to explore, explain and understand how people make meaning of their experiences in a certain context, at a particular time in history, which is different from what and how I had come to know them (Smith & Sparkes, 2008; Clandinin, 2007; Greenhalgh &

Wengraf, 2008; Hatch & Wisniewski, 1995; Mishler, 1986; Polkinghorne, 1995; Terre Blanche et al., 2004; Van Manen, 1995).

Using a life history approach was a new methodological approach for me. Listening to the stories of these HCPs affirmed the value of the teller and the value of their experiences and deepened my understanding of who / what they are – beyond the students that I had known and the relationship which I had with them. Through their stories I gained a deeper understanding of their lived educational experiences as rural origin HCPs. Their stories were fascinating and opened up greater insights for me into what it meant growing up in rural KZN in the 1980s and 1990s. Through this methodology I have come to understand that the individual, who they are and what they do, is relational to the historical and cultural context from which they come. I also recognised the importance of finding a way to talk back to the wider context and systemic issues raised, and not just to focus on the individual and his/her subjective experience (Hatch & Wisniewski, 1995).

After engaging in the research experience I have come to understand that life history research is the only method of understanding lived lives and empirical reality, and although it may only be scratching the surface (Alvesson & Skoldberg, 2000; Hatch & Wisniewski, 1995), I have learnt deeply about their lives in relation to the material and structural constraints from the stories they shared with me.

The problem of text

Capturing stories as text allowed for understanding, analyses, reflection and construction of a theoretical framework (St Pierre, 1997; Van Manen, 1995). Consistent with Smith and Sparks' (2006) understanding, I found that language and text were limiting and could not capture 'life as lived' or even 'life as told', as life is always much more complex, varied and colourful than stories could express or words could capture (Smith & Sparkes, 2006). Alvesson and Skoldberg's (2000) understanding resonated with my experiences as they highlighted the ambiguous, unstable, context-dependent character of language, which further compounded the problem of taking the spoken stories and capturing them in literary format for analysis.

Writing the reconstructed story for each participant was an iterative, backwards and forwards process, reading and rereading, arranging, removing and rearranging information to recreate a story which captured, in an authentic manner, something of the lived experiences of these rural origin HCPs in such a way that the teller was not diminished or written out of their telling (Polkinghorne, 1995; Clandinin, 2006; Lincoln & Guba, 1985). I was also aware that because of my relationship with the participants and my involvement with UYDF, there was a danger that in 'texting' the stories I could smooth them out and select only that which resonated with what I already knew about rural life, rurality and practicing HCPs, and reconstruct an inadequate story which misrepresents their experiences, creating either heroes unconnected to the real world or sanitised, simple lives (Clandinin, 2007).

In the reconstructed stories I was able to capture something of the anxiety, struggles and pain as well as the triumphs of their complex lived experiences. The intention was to compose a compelling account of the lived educational experiences of growing up, learning and working in rural areas, which would allow the reader to ‘see’ the rural HCPs with fresh eyes and from a new perspective (Terre Blanche et al., 2006).

The reconstructed stories are selected excerpts from different field text and are offered in a tentative manner – recognising how little I had known, how much is open to interpretation, and the fact that these stories are told ‘in the midst’ of the participants’ lives, which are dynamic, ongoing and changing (Hatch & Wisniewski, 1995; Clandinin & Connelly, 2000; St Pierre, 1997).

Although not presented in this research dissertation (as I have chosen to use a publication format), these reconstructed stories formed the basis for the articles that are offered for critique and reflection in this research dissertation.

Framing the analysis – a reflexive stance

Identifying and describing an analytical framework for the critique proved to be challenging and felt a little forced as I tried to do it in retrospect, after the articles had been written. For some of the articles I had a definite analytical framework (Papers 3, 4 and 5: **Troubling selection: towards a broader selection policy, Building on Tinto’s model of engagement and persistence – experiences from Umthombo Youth Development Foundation scholarship scheme, and Portrait of a rural health graduate: Exploring alternate learning spaces**), while other papers were based on emerging themes (Glaser & Strauss, 1967; Strauss & Corbin, 1994) as I tried to understand the educational experiences of these rural origin HCPs and their experiences of returning to work in rural areas (**From rural scholar to health care professional, Working in rural area – the experiences of Umthombo Youth Development Foundation graduates**).

While each of the articles drew on a specific model, framework or theory, in the critique I wanted an analytical framework which would contribute to an overall, nuanced understanding of the educational experiences of rural origin HCPs. Using different lenses through which to examine different dimensions of the educational experiences of rural origin HCPs had allowed me to shift from a descriptive stance to a deeper, more complex insight than could have been gained from using a singular perspective. All of these aspects – the who, the where, the how, the structural and material – are complex, relational and transactional and are interconnected in complex ways as HCPs negotiate who they are and what they do and why, as socially accountable HCPs.

The papers enabled me to explore the lived educational experiences and highlighted issues of complexity, and of negotiation of identity in multiple contexts (home, school, community, university, work). The synthesis of all the papers therefore points to the negotiation required between the personal and the social, as relational, as shifting

and as multiple. These negotiations of identity seems to be best captured by Samuels' force field model (Samuel, 2008) which recognises the need for multiple negotiations in multiple relationships, a continual negotiation of multiple forces and multiple choices.

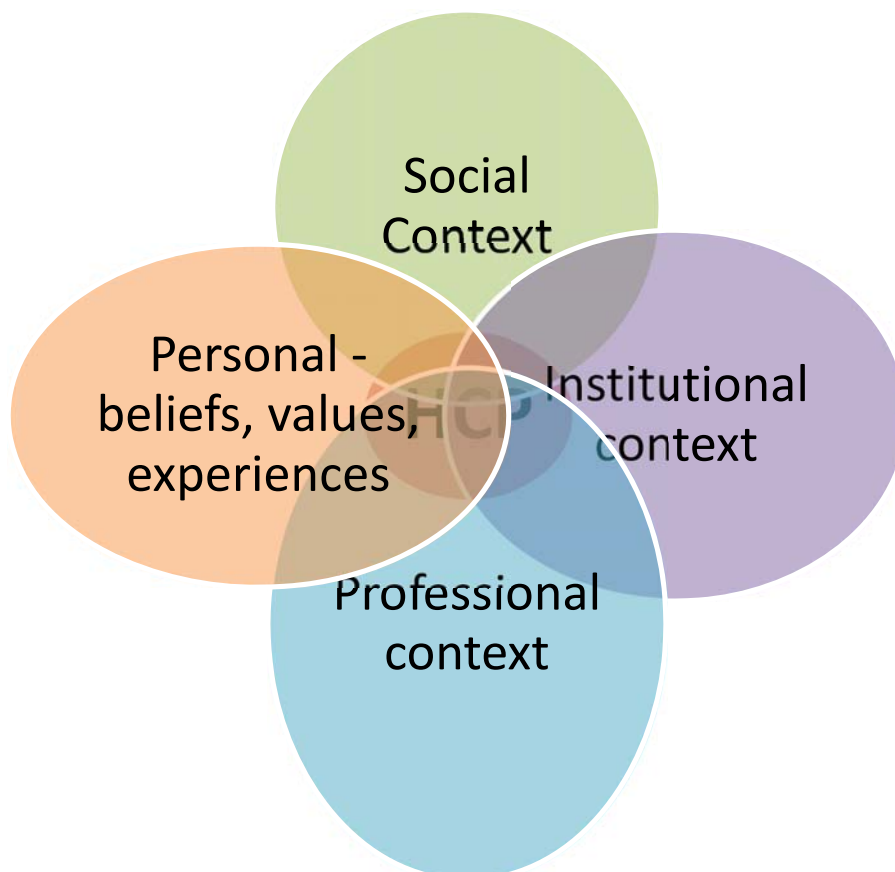


Figure 4: Framing the analysis of the educational experiences of rural origin HCPs using the force field model (Samuel, 2008)

It is important at this point to state that this research dissertation is not a comprehensive exposition of all the educational experiences of these six rural origin students who trained to be HCPs, but rather my contribution, from the perspective of rural origin HCPs working in rural contexts, to an understanding of the lived educational experiences of rural origin HCPs currently working in rural healthcare settings. There are still gaps in my understanding of the educational experiences of rural origin HCPs and many additional issues that need to be explored in greater detail. Echoing the sentiments of Gouch (2010, p. 55), who contends that the conclusions reached probably constitute “some application of theory, guess work and conjecture”, I am able to say with certainty only that “something is happening”.

The challenge of ethics

Much has been written about the ethics of qualitative research and the limitations imposed by the concepts of validity and reliability taken from the positivism paradigm of quantitative research. (Koro-Ljungberg, 2008; Corbin & Strauss, 2008; Guba, 1990).

Talking about validity within life history research is not appropriate, as all stories are authentic in the sense that they are the way that (unique) people see and make sense of their lives. As the stories are personally authentic and reflect “personal truth” (Hatch & Wisniewski, 1995), it is not possible for an outside agent to determine the ‘validity’ or authenticity of these stories (Frank, 2002). However, the issue of validity is important and needs to be struggled with and addressed by the researcher as questions such as ‘It what is being reported representative of the data?’, ‘Are the conclusions justified?’ and ‘Whose truth is that?’ must be answered.

While acknowledging that there is no universal truth against which this study can be deemed to be valid or reliable, there are clear aims for this study, thick descriptions are given for the choices made, the first-level analysis (the narrative analysis) was shared with the participants, who felt that it accurately represented their experiences, and my supervisor and I reviewed the codes, categories and themes identified. There is evidence of reflexivity as I tried to be true to the participants and the stories which they shared by recognising and reflecting on my positioning both as an insider and outsider in this research dissertation.

3. *Synthesis*

Set within the South African context where shortage of HCPs in rural areas impacts on the quality of care delivered and the health indices of the rural population (Versteeg, 2015), the aim of this research dissertation was to understand the lived personal and professional educational experiences of rural origin HCPs. Shortages and misdistribution of HCPs is a global issue (Crisp & Chen, 2014), with local and international literature showing that rural origin students are more likely to return to work in rural areas after graduation than urban origin students (Wilson et al., 2009; De Vries & Reid, 2003).

A life history approach complemented by arts-based methods enabled a nuanced, textured understanding of their multiple selves and the multiple meanings embedded in their experiences, made visible through their stories. These provided a new way to understand the challenges and triumphs, the highs and lows of their complex, entangled educational experiences and helped me gain a complex perspective of a life as told by rural origin HCPs.

In the following section I have stepped back from the individual papers and have extracted important learnings which come from the sum or from the whole rather than from the individual papers. These are, however, offered in a tentative manner, recognising how little I know and how much there is to know.

These will be discussed under the following headings:

- Going home - a broader generative understanding of rurality;
- HCPs and the care of self;
- Rurality and healthcare practice; and
- Broader systemic issues.

Although these issues will be looked at separately, to understand the phenomena all need to be understood together as multidimensional and complex. It is recognised that the individual is entangled with the context (human and non-human) and that it is a negotiation between the individual and the forces (material and structural) in multiple contexts which influences who they are and the choices that they make, which are informed by peculiar beliefs and priorities.

Going home - a broader generative understanding of rurality

Traditionally seen as deficit in material resources, dilapidated and depleted (Chisholm et al., 2005), through exploration of the lives of HCPs working in rural healthcare institutions, I wish to present a different, alternative understanding of rurality. These rural origin HCPs return to their homes with a sense of belonging, familiarity and insiderness (Hooks, 2009). They returned in a physical sense, but also emotionally and morally. This 'sense of belonging' to the rural, of appreciating and valuing the rural as a nurturing space (Hooks, 2009), gave them the impetus and confidence to do what they loved most and to be what they want to be.

In understanding rural as home (Hooks, 2009), rurality takes on a different meaning. It moves from depletion to possibility and opens up the potential of rural spaces for new ways of being and for new practices. Going back home after graduating as an HCP, they have a different vision and a different perspective on who they are and what they can contribute. They were sojourners intellectually who had explored beyond the horizons (Said, 1996). Through their 'eyes' they no longer saw rurality as just a depleted, deficient space, but rather a complex space of negotiation which is generative and dynamic, a space full of possibilities. Their horizon of aspiration were shaped by their rural sense of belonging and their university training. They wished to become something better than the rural promises, to overturn the cycle of neglect. Indeed, in some senses it was the very depletion which makes this possible. The depletion provided the fertile ground, the opportunities for new things to happen in the provision of health care. It is in the depletion that they see hope, and in going back they are able to put things in those depleted spaces. It is in this deeper, secondary sense that the rural is arguably generative. It is because of its very barrenness that is generative - generative in producing bearers of hope, of those who refuse to accept the depletion, refuse to accept place as fate.

We wish to argue that it was from this this place of comfort, familiarity and belonging (Hooks, 2009) that they were able to exercise agency in caring for self and for others.

HCPs and the care of self

Coming 'home' and seeing the rural context as a space with new meaning and new possibilities challenged them to 'an ethics of care' and gave them confidence to make a contribution to healthcare services. They also invoked a moral imperative of the responsibility for self, which includes a moral responsibility to the other (Foucault, 1976). Indeed, the other is the self, mirrored in the self, so in refusing to deny the other, the participants are refusing to deny self.

In their care of self, these rural origin HCPs resisted the oppressive and institutionalised practices that say 'this is what rural life should be'. Through their practices they showed that they believed and cared enough for themselves to say 'I want to do this here', 'I want to be home, in my community, even if there are challenges, I will make a difference because I love what I do and see potential'. In caring for themselves, they care for others as they show determination to resist those structural and material constraints which were limiting.

As ethical subjects, capable of working on themselves (Allan, 2013), and as Foucault (1987) highlights, they foreground the self as the principal object of care and as the means through which care of others can occur (Allan, 2013) in multiple ways. By working as a graduate HCP in a rural community close to home, the multiple positionings that each adopt and the responsibilities each take up in and through these positionings, make available their commitment to self, family, community and healthcare profession. Their determination to throw off familiar oppressive ways and traditional hierarchies and to look at life and work in different ways opens up healthcare services and what it means to live and work there.

Rurality and healthcare practice

Returning to work in a rural context as an HCP challenged the dominant discourses which fix and institutionalise rural learners as drop-outs from school sitting at the roadside doing nothing, or as mine workers with limited education.

In the lived experiences of these HCPs who have chosen to 'come home', we see what Edward Said (1996) suggested, that a sense of home [he sees it as an intellectual space] should not be static and stagnant, but should always be extending the boundaries of the possibilities of home. Through their lived experiences we see the limitless potential made possible through the training of rural origin HCPs as they returned to work in rural areas and initiated new services, making appropriate healthcare services available close to home in rural areas. Their horizon of aspiration when they return was to make the rural home a better home for many more, and not perpetuate the barrenness and depletedness often associated with rural health care.

Within this dynamic rural context we see their generative potential and the generative potential of the rural context where they worked. Drawing on previous experiences at school and university, they made themselves the instrument of change as they recognised choice and agency and their unlimited potential as HCPs with skills to offer and services to provide and develop. Through their stories we see the potential to provide access to professional healthcare services made available to everyone. Their stories of their lived experiences inform us that rural areas need not be debilitating but offer opportunity to think and act differently as HCPs become agents of change. This is the dynamic nature of the rural space that provided opportunities for change and highlights the transformational potential in the individual and the context to contribute to change in families, the community and the healthcare services.

Broader systemic issues

A life history approach can have a bias towards the individual as it looks at individual life histories and the meaning making of an individual in relation to his/her context. There is a danger that in only focusing on the individual more systemic issues may be forgotten, or one can be tempted to shift the emphasis from the need for systemic reform by focusing only on individual action as a way to compensate for and overcome systemic ills. This must be guarded against and was not the intention of this research dissertation.

Life history research, although focused on the individual and their lived experiences, provides commentary on the context in which their lives are lived. Hatch and Wisniewski (1995, p. 128) highlight “the power of life history ... in the dialectic between unique experiences of the individual and the constraints of broad social, political and economic structures”. Using a life history approach provided the platform for these HCPs to share something of their lives, their stories and how they make sense of their experiences of growing up in a rural context in SA in the 1980s and 1990s, the effects of an unjust system (apartheid and the migrant labour system), the impact that these had on their schooling and family life, and their training to be an HCP. We see in their stories a need for greater support for rural families and communities and a need for system change at rural schools and at IHL.

Individual resilience vs need for systems change

Individual resilience and personal agency are strong themes which emerge from the data presented. These were without doubt paradigmatic individuals who succeeded where many others have not (Flyvbjerg, 2006). They demonstrated resilience in their ability to succeed where others from a similar background have not (Morales & Trotman, 2004) and in their ability to withstand stress and difficulties and to ‘bounce back’ after difficulties (Gralinski-Bakker, Hauser, Stott, Billings & Allen, 2004). They showed personal agency in the choices that they made and the opportunities which they created.

While believing passionately in the need to provide opportunities for these kind of individuals to train to become HCPs, on another level these graduates represent millions of young South Africans who desire educational opportunities which have been denied to many due to system failures. As I write this, students at IHL are demonstrating around the country for free tertiary education. These are legitimate student protests for greater access to higher education. The South African National Development Plan (Manuel et al., 2013) and Human Resources for Health 2030 (National Department of Health, 2011) recognise the role that IHL can play in contributing productively to social change and in directing education and service activities towards addressing the priority health needs of the communities which these institutions are mandated to serve (Frenk, Chen, Bhutta, Cohen et al., 2010). These issues need to be grappled with to ensure that system issues are addressed and appropriate opportunities provided to young people, including rural young people, in SA.

Generative potential of individuals vs degenerative impact of previous policies

The legacy of colonialism and apartheid has resulted in rural areas in SA becoming reservoirs of cheap labour, poor schooling, and high levels of unemployment, and the dumping ground of the elderly and the sick instead of being a places of sustainable livelihood (Madlala-Routledge, 2013). Although this research dissertation recognises the generative potential of rurality (Balfour et al., 2008) and the unlimited possibilities for change in the individual and the context, it is important not to overlook or to downplay material and educational lack or to condone the systemic injustices of previous policies. This research dissertation in no way seeks to suggest that these issues are inconsequential, but seeks to recognise the human and relational potential which exists in rural areas. It also highlights the need to actively work towards addressing, in a systemic manner, the long-term consequences of these policies in a way that harnesses the generative potential which exists in these areas.

NGO intervention vs social obligation of training institutions

Responding to the challenges of shortages of staff at rural healthcare facilities by the training of rural origin students has been shown to be possible. Selection and support of these rural origin students was an intervention that happened at a local, limited level. However, there is a need for a much more systematic approach to the problem of staff shortages, where training institutions become more socially accountable in the training of graduates to meet local healthcare needs.

In 1995 the WHO reiterated that training institutions have a “social obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve” (Boelen, 1995). This call for social accountability has led to a shift in the emphasis of health professional education at some medical schools, from training a medical expert to developing a socially accountable, transformational leader with good clinical skills and knowledge, equipped with professional attitudes and leadership skills to be able to address health system deficiencies and provide high-quality services

to the whole population, including those living in rural and other underserved areas, in cooperation with other HCPs and stakeholders (Frenk et al., 2010; HPCSA, 2012).

While acknowledging the high quality of medical graduates produced at South African universities, there is a need for these training institutions to be more socially accountable and to ensure that their graduates are willing and able to contribute to healthcare delivery in rural and underserved areas of the country.

The issues raised in this synthesis, while acknowledging the challenges, expose the deficit model of rurality as limited and highlight the dynamic and generative potential of rural origin students and HCPs to contribute positively to healthcare delivery and development in rural areas. In understanding the complexity of this lived experience we see dynamic potential for change, opening up possibilities and allowing for transformation.

There are gaps in this study and this research dissertation does not try to address all of the issues around the educational experiences of rural origin HCPs. It does, however, wish to contribute in some small way to a deeper, fuller, more complex understanding of what it means for rural origin students to go to IHL, train as an HCP and then return to work in a rural context.

4. Theoretical model - from pipeline to junctional hub

In this research dissertation I have come to understand that the educational experiences of rural origin HCPs and their work are not linear, not a pipeline, not simplistic, but are complex at every point. In considering a theoretical model which captures something of this complexity, multiplicity and disruption we want to offer something more complex than a pipeline. Like the endocrine system or a junctional hub (see Figure 5), the lives and lived personal and professional educational experiences of rural origin HCPs are complex, integrated, and multiple. In presenting a 'model' we need to recognise and value the complexity of their life and experience in the community, at school, university and in the workplace and how beliefs and practices grounded in these experiences influence practice, as graduates live out their lives in rural communities. In addition, we need to recognise the complexity of the selection process, and the support necessary at IHL for rural origin students to create and participate in supportive communities of learning in a variety of learning spaces, to ensure that they are able to succeed, contribute and disrupt the current dominant discourses that continue to reproduce deficit notions of, about and on rurality.

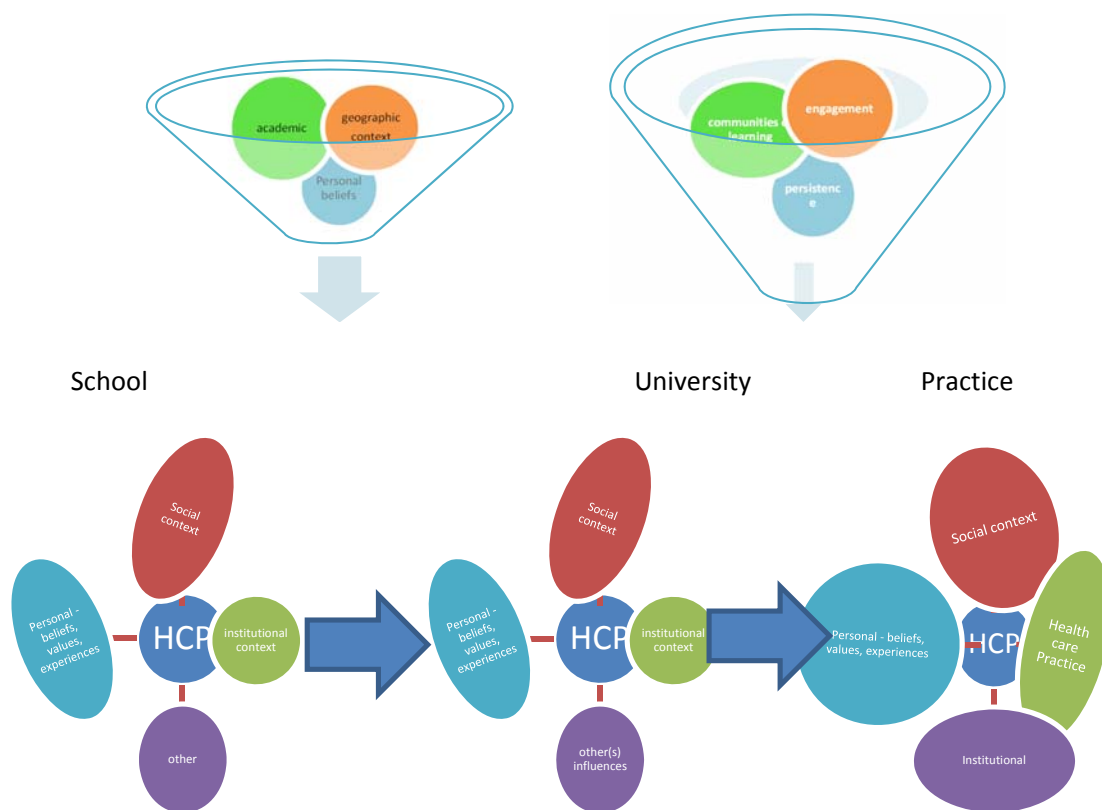


Figure 5: The complexity of training rural origin HCPs

This ‘model’ (as depicted in Figure 5) suggests that there is a need for a complex understanding at every stage – at home and school, university and practice. The pipeline model is too simplistic and too linear, with our stories pointing to the complexity of understanding the who, the how and the what involved with being an HCP in a rural context. The junctional hub is presented as a theoretical ‘model’ to frame lived experiences and to understand rural origin HCPs’ personal and professional identity and work in a complex, interconnected, negotiated space where different forces are negotiated. This provides a platform to open up the opportunity for other ways of being, knowing and practising.

5. Conclusions

This research dissertation is about lives lived in a historical context and how understanding this life in this context yields multiple possibilities. I have been amazed at the challenges that these rural origin HCPs faced, yet they managed to achieve so much. It is about hope and making possibilities possible, and as such it is life affirming. It affirms the value of education and the limitless possibilities that it brings to change one’s self,

family, community and health care. It highlights the dynamic and generative potential of rural origin students and HCPs to contribute positively to healthcare delivery and development in rural areas. In understanding the complexity of this experience I was able to see that these negotiated spaces have dynamic potential for change, opening up possibilities and allowing for transformation. This is the beginning of a new journey for these HCPs.

However, while valuing individual resilience and recognising what the individual can achieve, it also signals the need to strengthen educational and support systems so that more young people have access to educational and work opportunities that follow from obtaining a qualification. It challenges us to ask why the education system is so debilitating. Why did these rural students have to work so hard against the system in order to achieve? What can be done to change the systems?

This research dissertation highlights the importance of learning from these paradigmatic individuals and the need to recognise the complex issues within schooling, selection, university and working that need to be better understood if we are to support rural origin students in their journey from rural scholar to HCP.

There is also a need to rethink selection if one is to train the kind of HCPs that are willing and able to provide transformational leadership within the healthcare service, as well as a greater appreciation of what rural (African) students bring with them when they come to IHL. There is a need to investigate further how these can be tapped into to strengthen, facilitate and support learning, engagement and persistence at IHL. In addition, there is a need to develop a greater understanding of the relationships students develop at IHL and the learning spaces that they utilise in order to facilitate / encourage engagement and persistence at IHL.

This research dissertation is about the imagined possibilities of well-staffed rural hospitals, providing quality care by local HCPs who are passionate, transformational leaders. It is hoped that by providing a glimpse into the lives and educational journeys of these HCPs this will serve as an inspiration to other (rural) students, and that these stories will build belief in the possibilities.

Without dreams there is no need to work

Without work there is no need to dream

6. Limitations

This was a qualitative study based on the lived lives of six paradigmatic individuals. Important learning from their experiences can be drawn from the material presented, but the findings cannot be applied in other contexts

in the same way as data from qualitative studies can be. In this study there was greater focus on educational experiences at IHL rather than on broad educational experiences at school.

7. Further study

There was a focus in this study on the university educational experiences, influenced in part by my involvement in UYDF and my interest in understanding the lived educational experiences. This study opens up opportunities for further study around schooling, selection, working experiences, identity and understanding identity of rural origin HCPs.

There is a need for more work around the issues of how to select and who to select - who would be willing and able to work in rural and underserved areas. I have suggested a broadening of the selection criteria at South African IHL to include personal beliefs as well as geographical location. I have not provided any details on how this could be done with the large number of applicants received by IHL. There is a need to explore selection criteria in detail and to establish some evidence-based selection criteria that could be used in this process.

In addition, there is a need to explore and evaluate how to facilitate and support the creation of meaningful communities of learning at IHL which would allow rural origin students to engage in multiple communities of learning in a variety of learning spaces.

There is also a need to explore how graduates working in rural settings could be meaningfully supported, so that they can contribute in a generative manner to healthcare delivery.

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ADDENDA

Proposal

1) Educational journeys of health care professionals of rural origin working in rural contexts.

The focus of this research is to explore the educational journeys of health care professionals from rural areas who have completed a health science degree and who are now working as health care professionals in a rural context. The metaphor of a journey will be used to explore and give structure to the educational narrative. A life history approach will enable me to explore the complex, lived lives of these health care professionals. Through their stories I will be able to understand and compose their educational experiences as a rural scholar now working as a health care graduate.

2) Background and outline of research problem:

The educational journey of health care professionals of rural origin has not been previously studied in a South African context. The metaphor of an educational journey will be used as a heuristic tool, to understand and explore the complex multidimensional lived lives of rural origin health care professionals. Metaphor has been used in many studies to explore teachers' experiences of teaching and their perceptions and beliefs about teaching (de Leon Carillo, 2007; Goldstein, 2005; Shaw & Mahlios, 2008) and has been used to help health care workers understand informational processing (Suomi, Tähkääpää, & Holm, 2001). According to Mariaya, the (journey) metaphor will provide a structure around which these health care professionals can simplify, select and organize the details of their reality so that their educational experiences can be seen with some sense of cohesion (Mariaye, 2012). The journey metaphor allows for an exploration of both the literal meaning of the journey – the concrete steps taken, the progression from one level to another, as well as an understanding of the subjective, experiential, relational aspects of the educational journey from rural scholar to health care professional (2012).

Despite the promise of a better life for all made after the first demographic elections in 1994, excellent legislation and policy documents (Constitution of the Republic of South Africa No. 108 of 1996, 1996; Mahlathi, 2006), health outcomes in South Africa are poor and compare unfavorably with other countries at a similar stage of development (DOH, 2011), with health care indices in rural areas generally worse than in urban areas with the 10 districts with the highest deprivation index in the country all rural. Since 1990 life expectancy has decreased and under 5 mortality has increased (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009), while in Brazil, commitment to the implementation of the principles of primary health care – particularly in rural areas, has seen a dramatic improvement in health outcomes (Svitone, Garfield, Vasconcelos, & Craveiro, 2000).

Without sufficient numbers of well trained professional staff, key health outcomes will never be realized (WHO, 2010). Rural origin health care professionals have been identified as the most likely to work in rural areas and to contribute to improved health outcomes (Wilson et al., 2009). However only small number of rural origin South African scholars are trained each year as health care professionals (Tumbo, Couper, & Hugo, 2009) and finding staff for rural hospitals is an ongoing challenge. With absent role models, dysfunctional families, poorly performing schools, inadequate funding all making it almost impossible for rural origin students to gain access to tertiary institutions to train as health care professionals (Adam, Backhouse, Baloyi, & Barnes, 2010;

Chisholm, Morrow, wa Kivilu, & Engel, 2005; DOE, 2010; Gilmour & Soudien, 2009; Letseka & Cosser, 2007; Soudien, 2007). Human resource strategies to recruit staff for rural hospitals are essential as shortages of professional staff has been identified as the limiting factors in the provision of health services in the rural areas (WHO, 2010). Much of the literature portrays rural as deficient, however Balfour (2008) has alluded to resources within a rural context which are generative, dynamic and transformative which can be drawn upon – these will be explored and understood through the stories told. This study will open up the opportunity to understand the complex challenging lives of those rural origin health professionals who, despite the context from which they have come from, have negotiated the transition from rural scholar to health care professional. Such an understanding will deepen my understanding of the challenges and complexities of training and working as a rural health care professional and may change the way I think about the rural context and what it means to work in such a context.

A narrative approach, using stories will be used to understand the lived lives of these rural origin health care professional within their socio cultural historical context (Wenger, 1998). Most research into the challenges of staffing rural health care institutions has been quantitative in nature (Henry, Edwards, & Crotty, 2009; Laven & Wilkinson, 2003; Versteeg & Couper, 2011; WHO, 2009; Wilson et al., 2009) and has looked at numbers of health care practitioners, shortages and strategies to improve the number of health care professionals. By using a narrative approach I will gain a more nuanced understanding of who these health care professionals are and the life experiences and critical events which have shaped them. The stories will give me a deep, insightful and complex understanding of the personal and professional lived lives of these particular health care professionals who have grown up in a rural context.

3) Preliminary literature study, and reasons for choosing topic: Personal motivation

I qualified as a medical doctor in South Africa in 1985 and worked at Mosvold Hospital in the Ingwavuma district from 1990 – 2003. Recruiting and retaining professional staff was a major challenge and the hospital was often critically short of professional staff (personal observation).

Learning from research conducted in Australia and Canada in the late 1990's which showed that rural origin students were more likely to return to work in rural areas after graduation (Versteeg & Couper, 2011; Wilson et al., 2009), and based on the belief that rural students had potential and deserved to have opportunities to study health science courses, I started the Friends of Mosvold Scholarship scheme in 1998. Despite being told that “the schooling in Ingwavuma is so bad no one will make it into medicine”, and “even if, by some miracle students from Ingwavuma get into medicine they will not pass” and “scholarship schemes don't work – no one comes back” I persisted with the project. Through a partnership between Mosvold Hospital and the Friends of Mosvold Scholarship scheme (now Umthombo Youth Development Foundation Scholarship scheme), rural students with potential to become health care professionals have been identified and supported at University on condition that they return and work for a specified time in the area from which they were recruited. To date 119 rural origin health care professionals who were supported by the scheme have graduated. All graduates have returned to their hospital of origin to fulfill their work back obligation. Less than 10% have bought themselves out of a portion of their work back obligation and more than 75% have remained in rural areas after completing their work back obligation (MacGregor, 2011).

This study hopes to make available an understanding and interpretation of the lived experiences of these health care professionals. Stories are the way that individuals tell of their experiences and make sense of their lives. This interconnectedness of narrative and human experience means that the personal and professional experiences of these health care professionals will most appropriately be uncovered/unearthed and understood through a narrative inquiry approach. My interest in this study was motivated by a desire to understand the critical events that contributed toward these individuals becoming health care professional and what it mean for them as graduates to work as a health care professional in a rural context.

Professional motivation

Most rural areas suffer from a high burden of infectious disease, high under five mortality and reduced life expectancy rates ("The District Health Barometer 2008/09,") and the 10 district with the highest deprivation index in South Africa in 2008 were all rural ("The District Health Barometer 2008/09,"). There are major inequalities between staffing levels at hospitals in rural and urban areas which contribute to poor health outcomes ("The District Health Barometer 2008/09,"; "The Rural Health Advocacy Project "). These disparities remain despite the commitment of the National Department of Health to "Health for all" (Declaration of Alma-Ata, 1978) and the prioritization of recruitment of health care professionals for rural areas (Human Resources for Health for South Africa 2030, 2011).

There are many who believe that the failure of the health service to deliver on the promises of a better life for all is due to the shortages of well qualified health professionals (Human Resources for Health for South Africa 2030, 2011). Increasing the number of HCWs in underserved areas has been shown to improve health outcomes in general and maternal, child and infant mortality rates increase as the number of HCWs decrease (WHO, 2009). Evidence from international observational studies has shown that the best strategy for the long term staffing of rural facilities is the recruitment and training of rural origin student (Versteeg & Couper, 2011; Wilson et al., 2009).

Most studies into staffing of rural and remote facilities have looked at total numbers needed, explored reasons for staff shortages, and have explored recruitment and retention strategies (Henry et al., 2009; Increasing access to health workers in remote and rural areas through improved retention., 2009; Laven & Wilkinson, 2003; Versteeg & Couper, 2011; Wilson et al., 2009). These studies have not explored the lives of rural origin health care professionals and what it means for them to work in rural areas. This study is not about supply and demand of health care professionals but about understanding the lives of rural origin health care professional in a complex, dynamic manner. It will provide new insight into the individual health care professional working within a rural context. Understanding the person in his / her context is essential if one is to understand who these rural origin health care professionals are, what meanings have shaped their individual and professional identities and what has contributed to their decision to return to work in rural areas. Studying rural origin health care professionals who have returned to work in rural areas will enhance my understanding of their experiences and may help strengthen programs to support rural origin scholars who wish to train as health care professionals.

Contextually

The context of this study is rural and an understanding of this context is essential if one wants to understand the rural origin health care professional. There is however no universally accepted definition of what is rural with some authors using population density or population size while others economic activity or distance from metropolitan areas as a definition of rural (Chisholm et al., 2005; Colaldarci, 2007). Whatever your definition, rural areas are usually geographically remote, health care facilities are generally under resourced and they struggle to attract and retain health care professionals.

Balfour (2008) has challenged the deficiency view of rurality and has suggested that rural must be understood as dynamic with resources and relationships which are potentially transformative and which have a profound impact on an individual's ability to succeed in life (Chisholm et al. (2005). Balfour suggests that lived experiences in rural areas are in fact generative and significantly influence the lives and identities of those who grow up in these environments. Mangaliso (2001) identified a sense of belonging to and connectedness to others in the community as a strength of rural communities and Marshall (2010) has suggested that coping strategies learnt in rural communities provides scholars with tools to succeed at institutions of higher learning.

Despite Balfour's views, and the evidence for recruiting rural scholars to train as health care professionals, there are many challenges which prevent rural scholars training to become health care professionals. Schools in rural areas of South Africa are generally the worst off – with fewer teachers, larger classes, generally less qualified teachers, fewer resources, less chance of matriculating, less chance of going to university and less chance of graduating. School leavers are generally underprepared to cope at institutions of higher learning with an attrition rate of over 50% among all students, with black students doing worse than students from other racial groups (Jama, Mapesela, & Beylefeld, 2008; Letseka & Cosser, 2007; Letseka & Maile, 2008; Scott, Yeld, & Hendry, 2007). In spite of the challenges, some rural origin health care professionals have managed to negotiate and triumph in this environment. They have drawn on personal and community resources and have transitioned from rural scholar to health care professional.

Research into the educational journeys of rural origin black health care professionals will provide valuable insights and an understanding of the lives and practices of the rural graduate. Understanding the hows, what and whys of their everyday lives as a scholar and as a health care professional may enable a better understanding of issues, often for granted, of rural life and its relevance to health care professionals and rural students who wish to become health care professionals. Using narrative inquiry, I will be able to generate stories which will offer a nuanced, complex understanding of the lived educational experiences of particular health care professionals who grew up in rural areas and who have taken up work opportunities in such settings.

Theoretical

Using a journey metaphor and narrative approach this study will look at rural origin health care professional from a sociological perspective to gain an understanding of the individual from his / her socio cultural historical perspective. Social identity theory (Wenger, 1998) sees identity formation as a dual process of identification (who am I) and negotiation of meanings (who do other see me as, how do others talk about me and how do I act) with others. This negotiation of meanings is relational in nature and influenced by the context where one lives (Balfour, 2008) (Stets, 2000). Identity is therefore not fixed or static but is constantly being worked and re worked throughout life as one interacts with others and the social context (Sachs, 2001; Sutherland, Howard, &

Markauskaite, 2010). Reflective practices such as thinking, reflecting and evaluating who I am, what am I doing and why, how I relate to others and how they relate to me is an important part of identity formation (Antonek, McCormick, & Donato, 1997; Beijaard, Verloop, & Vermunt, 2000).

One's identity as a health care professional is a new position acquired when graduating and one of multiple identities for these rural origin health care professionals. Understanding what it means to be a professional is essential as it influences attitude, practice and behavior (Lindquist, Engardt, Garnham, Poland, & Richardson, 2006). Stufflebeam and Sugrue (2002; Sugrue, 1997) have suggested that professional identity is formed by the interaction of societal expectations, personality traits, institutional values, socialization and mentorship at institutions of higher learning as well as professional practice. Understanding the individual and professional identity of these rural origin health care professionals and what it means to practice as a health care professional in this context is therefore important for this study.

Experience happens narratively (Clandinin, 2006) and a narrative methodology allows me access to the lived experiences (temporality, spatiality, contextually) of those health care professionals. This study will offer a unique view of the rural origin health care professional because of the rural context and the methodology used to understand these particular individuals. This study will offer a complex, contextual and interactive view of the health care professional which will give understanding and meaning within their lived experiences. Understanding their stories may highlight issues of motivation (Ryan & Deci, 2000), resilience (Morales & Trotman, 2004), critical encounters which enabled these individuals to seize opportunities which presented within their rural context and journey from being a rural scholar to being a health care professional.

Narrative enquiry, using a life history method gives a window through one can look into the world of another (Hatch & Wisniewski, 1995). This method will allow rural origin health care professionals the space to tell their own stories, which will give insight into how they view themselves as individuals (who am I), their identity in relationship to others (their rural context) and their professional identity (what specialized skills do I have and what are the expectations that others have of me and what does it mean to be a health professional in this context). Stories are multidimensional (time, person, place) in nature (Hatch & Wisniewski, 1995) and ideally suited to this research as they allow one to explore the identity of rural origin health care professionals, what it means for them to be a health care professional and their educational journey from rural scholar to health care professional.

Theorizing the lived lives of health care professionals of rural origin will allow me to challenge the status quo around rurality and rural health care, help develop a new and deeper understanding of the rural health care practitioner and how he / she negotiates the socio cultural context in which he / she lives and practices and may change the way I understand rural health care practice and the support necessary to sustain good health care practice in rural settings.

4) Research problems and objectives: Key questions to be asked

4.1 Who are the health care professionals who grew up and who work in rural areas? (Understanding their individual and professional identity within the rural context)

4.2 What were their learning experiences in becoming a health care professional?

4.3 How do their educational experiences inform their practice as rural health care professionals?

5) Principal theories upon which the research project will be constructed (-> research design): The following theoretical concepts will be helpful in understanding the educational journey of rural origin health care professional and in developing a theoretical framework. The theoretical framework is made up of concepts around the context (rural), programmatic issues, professional practice and the personal and professional identity of the health care professional. Each of the concepts focus mainly on one aspect – the programmatic factors or the contextual factors and are limited in their understanding of the complex, multiply identity of the health care professional and his / her educational experiences within the rural context where he / she was located. My study will add to the body of knowledge by developing and integrating these theories and will contribute to the development of a new theoretical understanding of the complex multidimensional health care professional and his / her educational experiences within a rural context.

Balfour (2008) is helpful in understanding the rural context as dynamic and generative rather than fixed and deficient. These concepts will enable me to understand some of the contextual issues which have enabled these rural scholars to transition to health care professionals and will help me to explore issues of rurality from a perspective of resources and dynamic relationships.

Morales (2004) highlighted programmatic issues which contributed to the educational experiences of educationally disadvantaged scholars and these concepts may be helpful to consider when developing a theoretical framework for the educational experiences of rural origin health care professional. Issues considered by Morales include risk factors such as socioeconomic background, financial stresses, first generation scholars, poor schooling environment, protective factors such as future orientation and career goals, supportive and caring educators, role models, support systems, strong obligation, high self-esteem, strong work ethic, persistence and an internal locus of control as well as compensatory mechanism learnt while growing up in rural areas. These concepts attempt to link the individual to some of the contextual issues which they face. These concepts are limiting however as they see the context as deficient rather than an enabling and dynamic space, and need to be integrated with Balfour's understanding of the context. It is important when considering programmatic issues not to be limited to only these concepts but rather to allow rural origin health care professionals to tell their stories and their experiences. Jama's (2008) concepts of retention, persistence and engagement at university may also be helpful when developing a theoretical framework as it takes into consideration multiple factors such as family background and other contextual factors, as well as social and academic integration at university when trying to understand the educational experiences of students at institutions of higher learning.

Ryan and Deci's (2000) theory of self-determination is helpful as it considers the importance of autonomous motivation, expressed as a willingness to engage in academic activities, intrinsic interest, personal commitment to study, self-belief when considering success. This theory compliments social identity theory as it recognizes that motivation is influenced by the social context within which one lives.

Social identity theory (Wenger, 1998) will provide an overall framework for understanding the individual / professional within his / her rural context. It will facilitate an understanding of important relationships and how they have contributed to and influenced individual and professional identity formation and have contributed to his / her educational experiences. Social identity theory will also be useful to understand what draws an individual back to a community ("Emerging voices. A report on education in South African Rural Communities,"

2005) and how the individual identifies with his / her community of origin and the ongoing relationship between the individual and the community.

The narrative approach will enable the rural origin health care professional to tell their stories about their educational experiences within their social, historical and cultural context. These stories will enable me to understand the individuals who have grown up in rural areas, who have created new meanings in their lives. It will help to see the health care professional in the multiplicity of who they are. Story will give a more figurative, complex understanding of how meaning is created, of how individuals change. Other studies have been done with rural origin health care professionals, but these have often represented them in a linear, numerical manner. In this research, by adopting a narrative enquiry I will offer a more nuanced, complex understanding of the rural origin health care professional. The study will select health care professionals from a rural context who have travelled from rural scholar to health care professional. Stories will allow me to explore the (unique) factors which helped propel them out of their rural context and then brought them back into this context. By choosing narrative enquiry, the journey metaphor will provide a different meaning of the rural origin health care professional.

Applying theoretical frameworks from a variety of perspectives (Balfour – the generative rural context, social identity theory – Wenger - understanding of self in relation to a social context, key concepts around programmatic issues such as resilience and persistence – Jama, Morales, which may also apply to the practice of health care in a rural context) ensures that this study does not focus on the “idiosyncratic” (Hatch & Wisniewski, 1995) issues. Narrative enquiry using life history research would best suit this research as it can cover all these dimensions mentioned as life history research covers the individual in relation to the broader social economic context. In support of this I draw support from Hatch and Wisniewski (1995) pg. 128) who states that “We see the power of life history and narrative accounts in the dialectic between the unique experience of individuals and the constraints of broad social, political and economic structures “. Tentatively these theories may offer insights into the practice of rural health care professionals who have chosen to work in rural areas. Life history research will open up the possibility of developing new insights and deeper theorizing because each story will contribute to the theorizing.

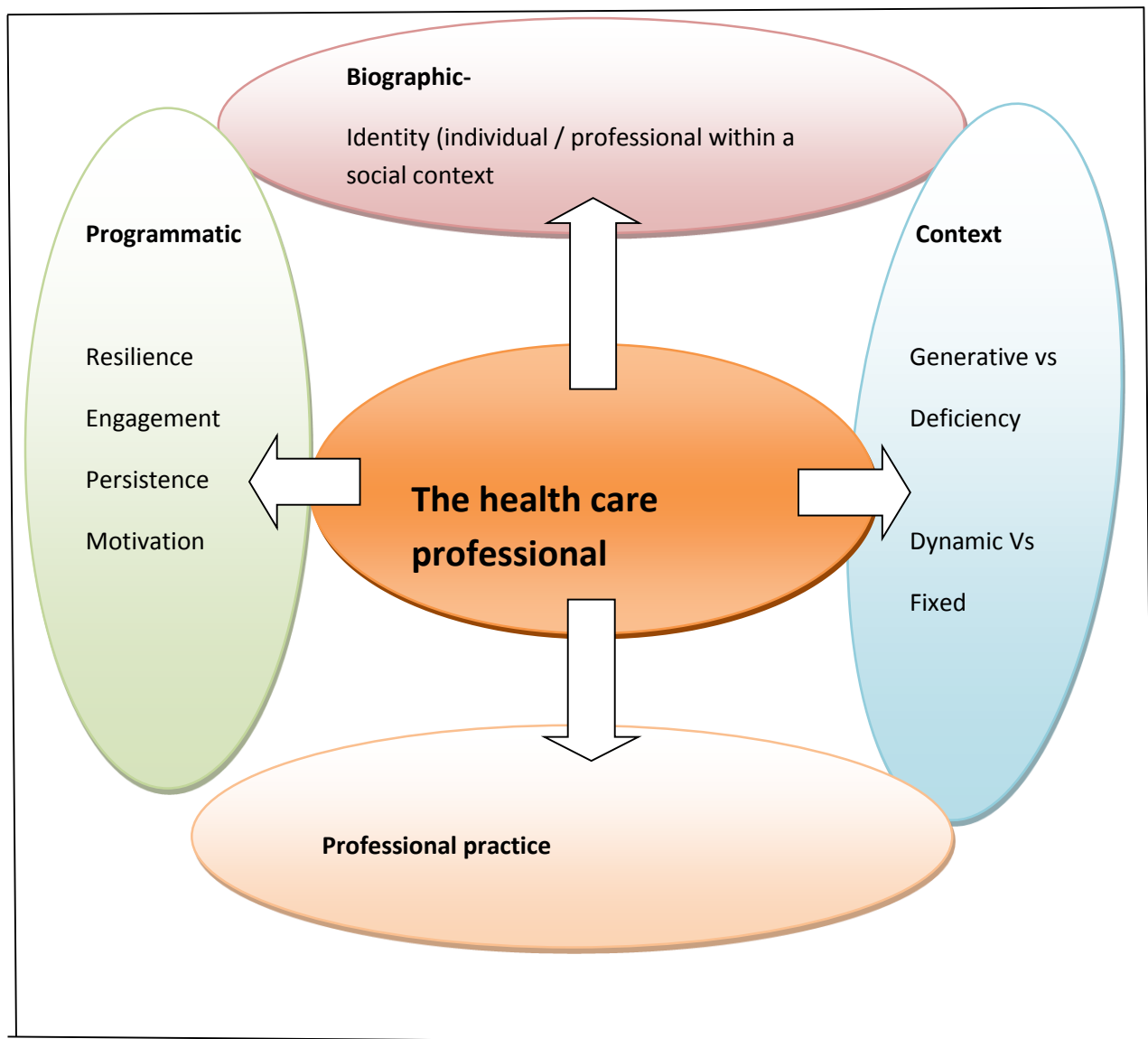


Figure 1. Concepts to understand the educational journey of rural origin health care professional

6) Research methodology and methods:

This is an exploratory research project located in an interpretive research paradigm. An interpretive paradigm recognizes that peoples' subjective experience is real and that it can only be understood by interacting with, listening to and building a relationship with the person whose experiences what one wants to understand (Terre Blanche & Durrheim, 1999). This methodology will provide the research tools for understanding and making visible these lived experiences from the perspective of the other (Clandinin, 2006).

Clandinin (2006) has defined narrative enquiry as the study of experiences as stories and it is the connection of one's life events to social events that distinguishes life history from other forms of narrative enquiry (Hatch & Wisniewski, 1995). A narrative methodology enables one to capture, in an authentic manner, these life experiences as stories told. In life history research, the researcher provides a structure for the telling of the story so as to be able to understand in greater detail the life experiences, memories and the way individuals interpret and gave meaning to those experiences (Hatch & Wisniewski, 1995). A life history method will therefore give me a multidimensional understanding of health care professionals from rural areas and the factors which have significantly influenced their lives and influenced them to return to work in rural areas.

The metaphors of an educational journey will be used as a descriptive tool to represent the progression of the rural scholar to health care professional (Mariaye, 2012) and will link the characteristics of the educational journey to their lived lives. This educational journey will be captured through stories – which will tell of their lived lives from their particular context. The stories they tell will be used to examine the role of social and cultural contexts in shaping them and their understanding of their world and to understand how they represent their individual and professional selves. The use of lived stories will allow one to explore the complexities of the journey within a particular context. The metaphor of a journey may help to simplify the concepts into something everyone can understand (Mariaye, 2012; Milne, Kearins, & Walton, 2006; Thomas & Beauchamp, 2011). It will provide a thinking tool for exploring and making known the world of these rural health care professionals and will provide an opportunity to explore how they see and think about their educational experiences both literally and figuratively (Milne et al., 2006).

The stories they chose to tell will be used to understand the way they experience and make sense of their world and how they give meaning to these experiences (Connelly & Clandinin, 1990; Smith & Sparkes, 2006). Their stories will also provide an opportunity to explore critical encounters as well as the world view (Webster & Mertova, 2007) of these rural origin health care professionals.

A life story can never be the full story, but a life history method using stories provides a glimpse into the world of these rural origin health care professional. A life history method will allow the rural origin health care professional to tell their educational story as it was – with all its details, richness and complexities. Their stories will tell of real life experiences and how they responded – stories of pain and triumph, of challenge and disappointment, of success and failure of resilience and persistence and will reflect how their identities changed in the process. Through these stories, these rural origin health care professionals will construct who they are (their identities), how they want to be understood, how they understand their reality and how they make sense of their lives. Stories will help them arrange significant events into tales of important happenings to which they assign meaning (Smith & Sparkes, 2006; Webster & Mertova, 2007). Events and happenings not appreciated at the time, but when viewed from the perspective of the final outcome, may then take on significance (Hatch & Wisniewski, 1995). In this study, stories of rural origin health care professionals will be used to understand how individuals experienced particular events, how they made sense of these events and why they acted in the ways that they did.

Stories are never told in isolation of who the person is (their identity) and how that person is connected to others (context). Everyone is part of a family and a community and the stories they tell are told within a particular social context, along social and cultural conventions storytelling (Smith & Sparkes, 2006) and must be understood within this context. Using Wengers social identity theory (Wenger, 1998), these stories will help us

understand the context and complexities of relationships in which these stories are constructed and may give insight into factors which support educational journeys of rural origin students.

In this study I will be using a life history method to understand the educational journeys of rural origin health care professionals. How they have made sense of their educational story through their school years, undergraduate training and eventually working as a health care professional. This method will allow one to understand who the participants are within their context, and for them to give their perspective on critical events / encounters which enabled them to transition from a rural, disadvantaged background to becoming a healthcare professional.

Selection of participants: Five South African rural origin health care professionals who were supported during their university career by Umthombo Youth development Foundation (UYDF) will be selected. Although each individual is unique and his or her story is unique, Kelly (Terre Blanche & Durrheim, 1999) has suggested that when conducting in depth interviews in a relatively homogenous sample (in this case all rural, black, trained as health care professionals) a small number of participants is sufficient to contribute theoretically to the phenomenon under investigation. Over and above this, these individuals represent what can be achieved against a background of many who fail to achieve their potential. Much can be learnt from them about their educational experiences and factors which culminated in qualifying as a health care professional. Flyvbjerg (2006) has called these paradigmatic cases – a small number of carefully chosen participants who act as co investigators who can shed light on their success in the face of overwhelming disadvantage. These participants act as co investigators.

Possible participants:

1. A male physiotherapist currently working as the mentor coordination for Umthombo Youth Development foundation
2. A male optometrist currently working as an optometrist for an NGO supporting optometrists throughout KwaZulu Natal.
3. A male clinical psychologist currently working at Hlabisa Hospital
4. A female doctor currently working at Mseleni hospital
5. A female pharmacist is currently working for SA national defense force in Mtubatuba

Participants will be selected on the basis of gender (3 males and 2 females), the diversity of their qualifications and because they are working in rural areas. Pseudonyms will be used during the write up to preserve confidentiality.

Data generating strategies:

Interviews will be conducted to gain insight into who these graduates are, their understanding of their educational experiences, critical encounters /moments (McCormack, 2004), as well as what this means to them, their families and their communities to work as a health care professional, will be explored. Participant will be asked to reflect on the environment in which they grew up and the impact that this context had on their

educational experiences. They will be asked to collect artifacts that help them remember what contributed towards them becoming a health care professional as well as constructing a collage of what it means to practice as a health care professional in a rural context. A time line of critical events will be developed with them as well as an ecomap and genogram giving an idea of supportive relationships with their family of origin. All interviews will be recorded and transcribed verbatim and content validity will be checked by participants. Field notes will also be kept to record observations and insights gained during the process of data collection. A focus group discussion with all participants will be held to discuss the results generated.

Data production

Producing data for the first research question: Who are these rural origin graduates working as health care professionals in a rural context? Will encompass issues such as identity, understanding their context and the meaning that their context gives to them as individuals and as a health care professional and how they negotiate their new identity as a health care professional. To generate data I will conduct life history interviews – focusing on who they are and their educational experiences from preschool, through junior and senior school, university and then as a professional involved in ongoing learning. Interviews will be unstructured but will initially follow an interview guide to ensure that important aspects are not forgotten. Generating data in this manner allows for a deeper, fuller, broader understanding of the person and the context and how these impacted on the educational journey. The primary source of data generation will be personal narratives. This will be supplemented by drawings, artifact collection and the development of a collage. Stories can be told in either English or isiZulu. A translator will be employed to translate all isiZulu interviews. Field notes will also be kept to record observations and insights gained during the process of data collection.

Strategies used for eliciting data will include:

Personal narratives – these are their stories. The lived experiences of growing up in a particular family in a particular rural context and how these influenced their identity and educational experiences. These interviews will be unstructured but an outline of broad areas to be covered will be used to ensure important events are not overlooked. Generating this data from the telling will be used to produce a deeper and nuanced understanding of these health professionals by exploring how their educational experiences in their context and rural environment influenced their personal and professional identity formation. The stories will allow me to understand significant events which influenced their educational experiences. I will draw from their childhood upbringing, the social environment where they grew up, schooling and university education and what it means for them to work as a health care professional in a rural context.

Development of collages. Participants will be encouraged to take photographs of significant places and people which stimulate memories of their educational experiences. Using this material, participants will be asked to develop a collage depicting their educational experiences (at junior school, at high school and at university). Participants will be asked to interpret their collage and why they have chosen to represent it in the way that they have

Drawing of ecomaps and genograms. These are visual representations of their context and will help to understand who the participants are within their context (family and community) and will be used to highlight important relationships which influenced their educational journey.

Focus group discussion. A focus group allows for a sharing of ideas and the possibility of exploring ideas together. Data generated from the interviews

Producing data for the second research question: What were their educational experiences? And what critical factors / incidents occurred along the journey? The data generating strategies mentioned above will be used to understand their educational experiences. Who they are and their educational experiences are inseparable. Thus as they tell their story of their educational journey they will be telling of who they are and the reasons who they made certain decisions at certain times. The telling of their stories, the taking of pictures, and the development of a collage, ecomap and genogram will enable them to connect events and give significance to things that happened along their journey.

Producing data for the third research question: How does their learning experience inform their current practice as health care professionals? Will also be answered through interviews and the focus group discussion.

Research questions	1. Who are these graduates?	2. What were their educational journeys	3. How does their learning experience inform their current practice as health care professionals
Why is the data being collected	To understand the individual within his / her context	To understand the journey from rural to health care professional and working as a health care professional	To understand how their journey has changed and influenced them
What is the research strategy	Life history interviews Collage development Ecomaps and genograms Focus group discussion	Life history interviews Collage development Ecomaps and genograms Focus group discussion	Life history interviews Collage development Ecomaps and genograms Focus group discussion
Who will be the data source	Rural origin graduates	Rural origin graduates	Rural origin graduates

Where will the data be collected	A mutually convenient venue	A mutually convenient venue	A mutually convenient venue
How often will the data be collected	<p>A number of interviews will be conducted with each participant. It is anticipated that each interview would last about 1 hour. Participants will also be asked about their collage and artifact collection as well as their ecomap and genogram</p> <p>A 1 hour focus group discussion would be held after other data has been reviewed</p>	<p>A number of interviews will be conducted with each participant. It is anticipated that each interview would last about 1 hour. Participants will also be asked about their collage and artifact collection as well as their ecomap and genogram</p> <p>A 1 hour focus group discussion would be held after other data has been reviewed</p>	<p>A number of interviews will be conducted with each participant. It is anticipated that each interview would last about 1 hour. Participants will also be asked about their collage and artifact collection as well as their ecomap and genogram</p> <p>A 1 hour focus group discussion would be held after other data has been reviewed</p>
How will the data be collected?	Interviews will be recorded using a voice recorder. Discussions around collages, artifacts and ecomaps / genograms will be recorded	Interviews will be recorded using a voice recorder. Discussions around collages, artifacts and ecomaps / genograms will be recorded	Interviews will be recorded using a voice recorder. Discussions around collages, artifacts and ecomaps / genograms will be recorded
Justify this plan of data collection	Life history enables one to obtain a multidimensional view of who these health care professionals are – individually and professionally. This method of data generation will be supplemented by the visual representation in the development of the collage, artifact	Life history enables one to obtain a multidimensional view of who these health care professionals are – individually and professionally. This method of data generation will be supplemented by the visual representation in the development of the collage, artifact	Life history enables one to obtain a multidimensional view of who these health care professionals are – individually and professionally. This method of data generation will be supplemented by the visual representation in the development of the collage, artifact collection, ecomap and genogram development to

	collection, ecomap and genogram development to ensure that nothing significant is omitted	collection, ecomap and genogram development to ensure that nothing significant is omitted	ensure that nothing significant is omitted
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7) Analysis

The stories will be analyzed, critiqued and interpreted in a systematic fashion and consideration given to when the story starts and stops, what was told, why they told what they told and how they told their story (Hatch & Wisniewski, 1995; Polkinghorne, 1995). Reflecting critically on the stories told will help identify the interests, biases and worldviews of rural origin health care professionals which may not have initially been obvious. Data analysis will be an ongoing process as data is generated as each story will contribute towards the theorizing, and will continue until theoretical saturation occurs.

My supervisor and a critical reader will also be involved in reading the narrative transcripts, in identifying themes and reflecting critically on the material presented. A bottom up approach in which themes are identified from the data (Terre Blanche & Durrheim, 1999) will be used. Once themes are identified they will be coded and arranged in a logical manner. The researcher will explore the themes with the participants to understand more clearly the intended meaning of the data. The data will be interrogated to understand the deeper meaning of the information presented. Based on the understanding of the data a model or theories will be generated which help explain the phenomena observed. (Hatch & Wisniewski, 1995) Understanding these stories may lead to the development of new theoretical insights into the educational journeys of rural origin health care professionals (Dhunpath & Samuel, 2009) and what it takes to progress on this journey and may also be used to make broader contextual meanings (Hatch & Wisniewski, 1995).

A detailed description will be given of the participants, the processes involved in the selection of participants, where the interviews occurred and why, the context in which the participants lived while growing up and their perspective on key factors on their educational journey in becoming a health care professional. This will allow the reader to make their own conclusions about whether or not the work is relevant to his / her situation and whether the information is transferable. Criteria such as believability (Lawrence – Lightfoot & Hoffman – Davis, 1997), credibility (Polkinghorne, 1995), and fidelity – the extent to which the story is coherent in the sense that a complicated world is brought together in a way that makes sense to the teller and reader (Blumfield- Jones, D. 1995). (Hatch & Wisniewski, 1995), may be used to assess the validity of the work.

Trustworthiness of this study will be ensured by keeping field notes of events, recording of the interviews, transcribing the interviews, using a critical reader to review transcripts and allowing participants to validate the content of the interviews. Although qualitative studies are not generalizable, providing a detailed description of decisions taken and reasons for those decisions will help readers determine if the findings are transferable to their setting (Terre Blanche & Durrheim, 1999).

8) Ethics

This protocol will be submitted to the postgraduate ethics committee for approval. All participants will be given an information sheet and asked to sign a consent form prior to participating in the research project. Pseudonyms will be used to prevent the identification of participants.

I have a long standing relationship with all graduates supported by Umthombo Youth Development Foundation. To a greater or lesser degree I was responsible for finding funding for their university studies. It is possible that data might be distorted because these graduates feel beholden to me and want to tell me things that I want to hear. I do not however think that this will be a major issue as the participants that I intend to choose have been working as health care professionals for more than three years, are not accountable to me and have nothing to lose or gain from participating in this research project. (1750 words)

9) Structure of dissertation: (300 words)

Introduction

The introduction will cover issues of rurality, the challenges of finding health care workers willing to work in rural hospitals and the evidence which suggests that rural origin students are more likely to return to work in rural areas. This topic is important as lessons learnt from participants may contribute to improved retention of health care workers in rural areas and an improvement in the quality of care provided at these facilities. Research questions will focus on understanding the identity of these rural health care practitioners, their educational experiences and critical events / encounters and how these experiences have influenced who they are and how they practice as a health care professional

A life history methodology will be used to understand from the perspective of the participants, the issues, challenges and critical encounters which they encountered along their educational journeys. Although a few paradigmatic individuals will be chosen to participate, the study will be limited by the small number of participants and the geographical location of the study.

Literature review

The literature review will give a comprehensive overview of rural deprivation and resources, the human resource challenges facing health care delivery in rural areas, strategies to overcome these challenges, identity formation and the use of narrative methodology as a research methodology for conducting life history research.

Theoretical framework

Social identity theory (Morales & Trotman, 2004) will be used to understand the individual within the social context. Programmatic theories as well as the theory of self-determination theory (Ryan & Deci, 2000) will be used to understand the educational experiences of participants

Description of research methodology

A life history methodology will be used to understand the metaphor of educational journey of these rural health care professionals. Five health care practitioners who originated from a rural area who were supported by the Umthombo Youth Development Foundation (UYDF) and are working in a rural area will be selected. Data will be collected by interviews, a self-reflective journals, development of collages and other visual representations and a focus group discussion.

Research results

Results will be written up as a thesis. Data will be presented to interested parties (universities, Department of Education, Department of Health, and Board of UYDF). It is anticipated that a number of publications will emanate from this research. Potential topics include:

- * Important factors in the educational experiences of rural origin health care professionals
- * Rural resources to draw on – experiences of rural origin health care professionals
- * What it means to be a health care professional – a rural perspective

A conceptual framework will be developed highlighting important aspects in the educational journeys of rural origin health care professionals. The implications for long term staffing of rural health care facilities will be outlined.

Summary and conclusions

A summary chapter will summarize the main finding; outline the contribution made by the results, and give recommendations and suggestions for further research.

(300 words)

10) Research schedule (work plan/ time-frame):

Month / year	Description	Outcomes
October 2012	Defend protocol	Protocol approved
October / November 2012	1 st interviews	5 interviews conducted
November 2012	Transcribe interviews	All interviews transcribed
November / December 2012	2 nd interview done	5 interviews conducted
Jan / Feb 2013	Focus group discussion with participants	Focus group discussion completed
March 2013	Transcribe FGD	FGD transcribed
May 2013	Chapter 1	
June / July	Analysis of results	
August 2013	Write up literature review and theoretical framework	

September 2013	Methodology and results	
October 2013	Discussion and development of conceptual framework	
November 2013	Conclusion	

11) Budget

Books / journal articles stationary		R 15 000
Transcription at R 10 / minute	3 x 3 hour interviews 1 x 2 hour FGD	R 10 000 R 1 200
License for the qualitative software	Available from UKZN	
Travel expenses	4 trips to Ingwavuma at R 3.00 / km x 800km / trip Participants for FGD 4 x 800 km x R 3.00	R 9 600 R 3 600
FGD facilitator	Flight from Cape Town	R 3 000
Accommodation	For facilitator x 1 night Participants 4 x 1 night During visits to Ingwavuma x 6 nights	R 1 000 R 4 000 R 6 000
Presentation of findings	Flights Accommodation x 2 nights	R 3 000 R 2 000
Proof reading		R 10 000
Binding		R 2 000
Cost of publication	R 5 000 x 2	R 10 000

Loss of overtime during sabbatical	R 15 000 x 6	R 90 000
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Each doctoral research proposal should be submitted together with a fully completed

- ***Research Ethics Application Form, as well as a***
- ***Contract between Supervisor and Candidate.***

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Response of Postgraduate Education Committee



HIGHER DEGREES DISSERTATION/THESIS PROPOSAL REPORT FOR RESEARCH MASTERS AND PhD STUDENTS

(This report is to be completed by the appointed scribe or Postgraduate Administrator after the proposal panel has met and thereafter submitted to the Supervisor)

DATE OF ORAL PRESENTATION: 19 October 2012

NAMES OF CHAIRPERSON AND PANEL MEMBERS PRESENT:

Dr S Maistry

Professor L Ramrathan

Administrator: Bongi Bhengu

STUDENT NAME: Andrew Ross

STUDENT NUMBER: 212557836

DEGREE: PhD

DISCIPLINE: Higher Education

SHORT DESCRIPTIVE TITLE: Educational journeys of health care professionals of rural origin working in rural contexts.

SUPERVISOR/S: Dr G Pillay

ETHICAL CLEARANCE CODE: Not Applicable

GREEN: *No human subjects*

ORANGE: *Human subjects but research not of a sensitive nature*

RED: *Human subjects and research of a sensitive nature:*

1. Please document the findings of the panel in respect of the categories below. Where no comment was made indicate so:
 - The general impression of the study :
 - **Good Study**
 - The literacy style and presentation:
 - Acquaintance with the methods of research and their application to their investigations:
 - Acquaintance with the relevant literature:
 - Potentially assessing the significance of their findings:
 - References and Referencing:
 - Research Schedule (work/plan/time-frame):
 - **(PhD ONLY):** Does it show potential as an original contribution to the field:

Yes

Please see comments below.

2. Decision (tick one of four choices below)

The proposal is:

Accepted, without any corrections or revisions.	Accepted, provided corrections and revisions/ extensions are carried out to the satisfaction of the supervisor. The student will complete a schedule of revisions indicating the changes made. The supervisor to confirm the changes made in writing. The revised proposal must be submitted to the School Postgraduate Administrator for noting at School's Research and Higher Degrees Committee.	Should not be accepted, but should be returned to the candidate for substantive revision / extension and then be resubmitted to Academic Leader Research	Should be rejected outright.
	√		

Additional comments:

- Paradigmatic orientation must be clearly articulated as an interpretive study.

- To be critical and reflective in using the methodology and its methods.
- Remove the reference to ‘race’

Congratulations to the supervisor and student on a well-crafted proposal.

Dr S Maistry (Chair)

Response to the ethics committee

Department of Family Medicine

University of KwaZulu Natal

26/10/2012

Dear Dr.G.Pillay

Re: Responses to the queries raised by the reviewers in respect of protocol : Educational journeys of health care professionals of rural origin working in rural contexts.

Thank you for the opportunity to respond to queries raised by the reviewers

Issue raised	Response
1. Remove the reference to ‘race’	Reference to race has been removed from the text
2. Paradigmatic orientation must be clearly articulated as an interpretive study.	Page 8 paragraph 1 makes it clear that this is a study located in the interpretative paradigm. This is an exploratory research project located in an interpretive research paradigm . An interpretative paradigm recognizes that peoples’ subjective experience is real and that it can only be understood by interacting with, listening to and building a relationship with the person whose experiences what one wants to understand (Terre Blanche &Durrheim, 1999).

<p>3. To be critical and reflective in using the methodology and its methods.</p>	<p>Under analysis on page 13 issues of reflecting critically on the stories told, the involvement of my supervisor and the use of a critical reader as well as the keeping of detailed field notes will ensure that the material collected is interrogated in a critical manner.</p> <p>Paragraph 1 Reflecting critically on the stories told will help identify the interests, biases and worldviews of rural origin health care professionals which may not have initially been obvious.</p> <p>Paragraph 2 My supervisor and a critical reader will also be involved in reading the narrative transcripts, in identifying themes and reflecting critically on the material presented.</p> <p>Paragraph 3 Criteria such as believability (Lawrence – Lightfoot & Hoffman – Davis, 1997), credibility (Polkinghorne, 1995), and fidelity – the extent to which the story is coherent in the sense that a complicated world is brought together in a way that makes sense to the teller and reader (Blumfield- Jones, D. 1995). (Hatch & Wisniewski, 1995a), may be used to assess the validity of the work.</p> <p>Paragraph 4 Trustworthiness of this study will be ensured by keeping field notes of events, recording of the interviews, transcribing the interviews, using a critical reader to review transcripts and allowing participants to validate the content of the interviews.</p>
---	---

I trust that these responses meet the requirement of the reviewers.

Thank you once again for your support and encouragement.

Yours sincerely

Andrew Ross

Research project approval from the Social Science Research Ethics Committee



16 November 2012

Dr Andrew Ross 212557836
School of Education
Edgewood Campus

Dear Dr Ross

Protocol reference number: HSS/1205/012D

Project title: Educational journeys of health care professionals of rural origin working in rural contexts.

Expedited Approval

I wish to inform you that your application has been granted Full Approval through an expedited review process.

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 school/department for a period of 5 years.

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

Yours faithfully

Professor Steven Collings (Chair)

/px

cc Supervisor Dr G Pillay
cc Academic Dr D Davids
cc School Admin. Mrs S Naicker

Professor S Collings (Chair)
Humanities & Social Sc Research Ethics Committee
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350 Facsimile: +27 (0)31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za
Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS



Order of Baobab



THE PRESIDENCY
REPUBLIC OF SOUTH AFRICA
Private Bag X1000, Pretoria 0001

Dr Andrew Ross
31 King George V Ave,
Glenwood
Durban
4041

Dear Dr Ross,

AWARD OF THE ORDER OF BAOBAB: SILVER TO DR A. ROSS

I have the pleasure of informing you that President J.G Zuma has accepted your nomination for the Order of Baobab.

The President has therefore decided to honour you with the Order of Baobab: Silver for your outstanding contribution in training young rural medics in the field of health sciences. Your work has provided hope in the rural communities who utilise rural hospitals.

The Awards Ceremony will be held on the 27th April 2015, at the Sefako Makgatho Presidential Guest House. Travelling expenses to Pretoria shall be borne by this office. You may bring along one personal guest. Please contact Ms Futhi Ntshingila on: Tel 012308 1619; Cell: 0810379846; Email: futhin@presidency.gov.za, regarding travel and hotel accommodation.

You are kindly requested to be at the Sefako Makgatho Presidential Guesthouse on Monday 26th April 2015, at 15:00 for a briefing regarding the Awards Ceremony.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R. Cassius Lubisi'.

R.CASSIUS LUBISI, PhD
CHANCELLOR OF ORDERS
DATE: 10/04/2015

Guidelines for the presentation of a thesis by publication

GUIDELINES FOR PRESENTATION OF MASTERS AND PHD DISSERTATIONS/THESES BY RESEARCH

1. Purpose

The purpose of this document is to provide guidance to students and supervisors on how to prepare a dissertation/thesis for Masters by Research and PhD degrees using the manuscript or publication format..

2. Introduction

These guidelines must be read together with the College of Health Sciences (CHS) Handbook as well as the Jacobs documents on examination policies and procedures for PhD degrees. The rules on thesis format are based on modification of point 1 of the definition of terms section in the Jacobs document. In this section a thesis is defined as “*the supervised research component of all PhD degrees, whether by supervised research only, or coursework and research, or by papers that are either published or in manuscript form (the supervised research component of the PhD degree by paper(s) comprises the introduction, literature review, account of the methodology, selection of manuscripts, and conclusion).*” A dissertation is defined as “*the supervised research component of all Masters degrees, whether by supervised research only, or coursework and research, or by papers that are either published or in manuscript form (the supervised research component of the Masters degree by paper(s) comprises the introduction, literature review, account of the methodology, selection of manuscripts, and conclusion).*”

2.1 PhD thesis

In the CHS Handbook the rules for a PhD thesis are not in one place; they are stated in DR8 a i & ii, DR9 c and CHS 16. DR8 a i & ii and direct that a thesis be presented in the **standard format** together with **one published paper** or an **unpublished manuscript** that has been submitted to an **accredited journal**, arising from the doctoral research. CHS16 (thesis by publications states that the thesis may comprise of at **least three published papers** or in **press in accredited journals**; such papers must have the **student as the prime author**. The same CHS16 provides for a thesis by **manuscripts that may have at least 3 papers** with the student as the prime author that have not yet been published but are in the **form of manuscripts**; at least **two of such papers** must constitute original research. In both cases (thesis by publications and manuscripts), there must be introductory and concluding integrative material sections.

The standard type thesis is being **phased out in many African** countries in favour of the other options that originate from the Scandinavian countries. While this format ensures that all details of the work done for the doctoral degree are captured and thoroughly interrogated, they often **remain as grey literature** which is mainly useful to other students, usually within the same university, although with digitization of theses, such work may become more accessible beyond the source university. Apart from the risk of losing good work because of it not being on the public domain, as students **rarely publish such work after graduating**, this approach denies the college additional productivity units (PUs) emanating from publications.

The thesis by publication encourages students to **publish key aspects** of their doctoral research as they will not graduate if the papers are not published or in press. This approach ensures that the work of the student **enters the public domain** before the thesis is examined, providing the examiner with some **assurance of prior peer review**. The thesis must constitute a full study of the magnitude expected of a PhD with the papers providing a **sound thread or storyline**. Furthermore, the college maximizes the students' work as PUs are awarded for the papers as well as for graduating. However, this approach may negatively affect throughput and frustrate students as

they cannot graduate unless all the papers are published or in press, in addition to the synthesis chapter demonstrating the story line of the thesis.

The option of a **thesis by manuscripts** ensures that students make **efforts to start publishing**. The risk of not passing because of failure to publish all papers (as in the thesis by publication) does not exist under this option. However, the PUs emanating from publications from the doctoral work are not guaranteed as the submitted papers may eventually be rejected. Thus there is a possibility of the doctoral work remaining on the university library shelves as is the case for the standard thesis format. The standard thesis does have the advantage that more details of the doctoral work are usually included.

In view of the above, the best option for the college is that of a **thesis by publication**. However, in the interim, the attractive option is that of thesis by manuscripts, as it provides the possibility of publication without putting the student at risk of delayed graduation when some of the manuscripts are not published/accepted, which also disadvantages the college in terms of PU earnings. The standard **thesis option should ultimately be phased** out for the stated reasons and students are not encouraged to present their theses in that format. Consequently this document does **not describe the standard thesis**.

2.2 MSc dissertation

The rules on presentation of MSc dissertations are presented in CR13 (course work), CHS 14 (course work) and **MR9 (research)** in the CHS Handbook. CR13 c and MR9 c direct that a dissertation “may comprise **one or more papers** of which the student is the prime author, published or in press in peer-reviewed journals approved by the relevant college academic affairs board or in manuscripts written in a paper format, accompanied by introductory and concluding integrative material.” Such a dissertation should include a detailed description of the student’s own distinct contribution to the papers. Both CHS14 and CR13 specify that reviews and other types of papers in addition to original research paper/s may be included, provided they are on the same topic.

3 Length of thesis and dissertation by word count

Table 1 provides a guide of the length of a thesis or dissertation by word count excluding preliminary pages and annexes.

Table 1: **Thesis** length by word count

Sections				
	Minimum	Maximum	Minimum	Maximum
Introduction	2700	2700	2000	2000
Chapters	10000	25000	6000	11000
synthesis	2000	2000	1700	1700
bridging	300	300	300	300
Total	15000	30000	10000	15000

4. *Intention to submit*

A written intention to submit a thesis or dissertation should be submitted to the appropriate postgraduate office with endorsement of the supervisor at least three months before the actual date of submission which should be before November if the student intends to graduate in the following year. The actual submission will under normal circumstances require approval of the supervisor.

5. **Format for theses/dissertation**

There is little variation in the actual format of the PhD thesis and Masters dissertation for the various types described above. The box below summarise the outline of a thesis/dissertation for the thesis by manuscripts and thesis by publications.

Box 1: Outline of thesis

Preliminary pages

- i. Title page
- ii. Preface and Declaration
- iii. Dedication
- iv. Acknowledgements
- v. Table of contents
- vi. List of figures, tables and acronyms (separately presented)
- vii. Abstract

Main Text

1. Chapter 1: **Introduction**
Introduction including **literature review**
Research **questions and/or objectives**
Brief overview of general methodology including study design
2. Chapter 2
First manuscript/publication
3. Chapter 3
Second manuscript/publication
4. Chapter n
Final manuscript/publication
5. Chapter n+1: Synthesis
Synthesis
Conclusions
Recommendations
6. References Appendices

NB. Between the manuscripts or publications there must be a 1 page (maximum) bridging text to demonstrate the link between them

6. **Details for thesis/dissertation subheadings**

This section summarizes what is expected under each subheading shown in Boxes 1 and indicates where there might be variations between a Masters Dissertation and PhD Thesis.

6.1 Title Page

The officially approved title that is concise (Fewest words that adequately describe the contents of the thesis/dissertation – usually 15 or fewer words) is presented at the top. This should be followed by the candidate's name in a new line. At the bottom the thesis statement should be presented. The thesis statement may be stated as "*Submitted in fulfillment of the requirements for the degree of _____ in the School of _____, University of KwaZulu-Natal*" for a PhD/Masters by Research thesis. In the case of a Masters Dissertation it should be stated as "Submitted as the dissertation component in partial fulfilment (% stated) for the degree of _____ in the School of _____, University of KwaZulu-Natal". For both Masters and PhD the date of submission must be stated.

6.2 Preface (Optional)

The preface merely states the reason (motivating factors) why the study was conducted without getting into details of what was investigated.

6.3 Declaration

This must be structured as follows:

I, Dr/Mr _____, declare as follows:

1. That the work described in this thesis has not been submitted to UKZN or other tertiary institution for purposes of obtaining an academic qualification, whether by myself or any other party.

Where a colleague has indeed prepared a thesis based on related work essentially derived from the same project, this must be stated here, accompanied by the name, the degree for which submitted, the University, the year submitted (or in preparation) and a concise description of the work covered by that thesis such that the examiner can be assured that a single body of work is not being used to justify more than one degree.

2. That my contribution to the project was as follows:

This is followed by a concise description of the candidate's personal involvement in and contribution to the project, in sufficient detail that the examiner is in no doubt as to the extent of their contribution.

3. That the contributions of others to the project were as follows:

This is followed by a list of all others who contributed intellectually to the project, each accompanied by a concise description of their contribution. This does not include people who ordinarily would be "acknowledged" as opposed to considered for authorship.

4. Signed _____ Date _____

6.4 Dedication

This is an optional section. Should it be included it must be very brief merely indicating to whom the work is dedicated. Avoid anything too flowery

6.5 Acknowledgements

This section acknowledges all individuals, groups of people or institutions that the candidate feels indebted to for the support they rendered. The funding source for the work should also be acknowledged.

6.6 Table of contents

Table of contents must be inserted after the preliminary sections and must capture all major sections of the thesis at the various levels (primary, secondary, tertiary subheadings). It should be electronically generated and should be able to take the reader to specific headings in the thesis.

6.7 Lists of figures, tables and acronyms

These lists must be presented separately. All titles of figures presented in the thesis/dissertation must be listed indicating on what page they appear. Similarly for tables the titles must be presented indicating on what page they appear. In the case of acronyms, the acronym is stated and all the words describing the acronym are presented. Only key acronyms should be stated. In some cases they may not be listed as long as full text is presented whenever the acronym is used for the first time.

6.8 Abstract

The abstract should summarize the thesis mainly stating the purpose of the study, highlights of chapters and the new knowledge contributed by the thesis. The abstract must be approved by the supervisor of the thesis and should not be **more than 350** words in length.

6.9 Introduction

The introductory chapter for both types of thesis is similar. The section should include literature review and have the following information. Headings are used as appropriate and need not correspond exactly to the following.

- i. Background and the context of the study
- ii. Description of the core research problem and its significance
- iii. A **comprehensive, critical, coherent overview of the relevant literature** leading to **clearly defined knowledge gaps**
- iv. A coherent problem statement highlighting the nature and magnitude of the problem, the discrepancy, knowledge gaps therein and possible factors influencing the problem.
- v. Clear and SMART research questions, objectives and hypothesis and/or theoretical framework
- vi. A **conceptual framework (optional)**
- vii. Description of the study area and general methodology (*in a standard thesis this should be a stand-alone section*)
- viii. Layout of the thesis (thesis structure) indicating what chapters are presented in the thesis and how they address the objectives.

6.10 Literature review

This section is subsumed in the introduction within the stipulated word count for a thesis or dissertation.

6.11 Methodology

A standalone section is **not needed** as the methods are adequately described in each manuscript/publication.

6.12 Data chapters/manuscripts/publications

The full published paper or manuscript submitted for publication should be presented as published or submitted to the journal. The **actual published paper should be scanned and inserted**

in the chapter. There should be a separator page between chapters that has text linking the previous chapter to the next and providing details of the next manuscript/publication indicating publication status.

6.13 General discussion/Synthesis chapter

This is a **general discussion that demonstrates** the **logical thread** that runs across the various manuscripts/publications (synthesis). There should be no doubt that the manuscripts/publications complement each other and address the original objectives stated in the general introduction of the thesis. The general discussion/synthesis chapter should end with a conclusion and recommendations where necessary.

6.14 References

Only references cited in the introduction and synthesis chapters should be listed as all other references should be within the manuscripts presented under data chapters.

6.15 Annexes

All information (questionnaires, diagrams, ethics certificates, etc) considered important but not essential for inclusion in the actual thesis is put in this section as reference material. In addition papers that emanated from the work but not directly contributing to the thesis may be included.

7. Thesis formatting

For standardisation of thesis the following formatting specifications should be followed.

7.1 Font

Times New Roman 11pt should be used throughout the thesis. However, major headings may be made bigger (12pt) but using the same font type

7.2 Paper size and margins

A4 (297 x 210 mm) should be used and in the final thesis both sides of the paper should be used. However, the loose bound copy submitted for examination should be printed on only one side. The recommended margins are 30mm for all the left, right, top and bottom margins.

7.3 Line spacing

The copy submitted for examination should **have 1.5 line** spacing but the final copy should have single line spacing. Paragraphs should be separated by a blank line. Published or submitted manuscripts should remain in their original format in all aspects as they are inserted in their published format in appropriate places.

7.4 Headings

A consistent numbering system and captions should be maintained with first level being in CAPS and centred, second level being **normal bold** font and third level being *italics bold*. If there is need for 4th level it should be *normal italics*.

7.7 Pagination

Page numbers should be centred at the **bottom of the page**. All preliminary pages should be numbered in lower case Roman numerals and subsequent pages should be numbered as indicated in the Box The title page should not be numbered.

The body of the thesis (chapter 1 onwards) should be numbered consecutively with Arabic numerals. The numbers should continue consecutively from the introduction through the through the publications or submitted manuscripts and subsequent sections. The published papers will therefore bear two numbers: a set specific to the manuscript (it is recommended to place these in the upper right hand corner) or published paper, as well as the consecutive numbers belonging to the thesis as a whole. Care must be taken to distinguish these in terms of position and font.

7.8 Referencing

Supervisors have the freedom to decide the type of citation of references but there must be **consistency**. This is mainly applicable to the standard type of thesis. In the case of thesis by manuscripts or publications, individual papers will maintain the reference system of the journal but the supervisor can decide on the type of referencing for the introductory and synthesis chapters.

8. Final thesis submission

The thesis should be submitted for examination in a **loose bound** form accompanied by a PDF copy. After the examination process the final version PDF copy of the thesis must be submitted to PG office for onward submission to the library. It is not a requirement to submit a copy fully bound in leather cloth or similar material.

Turnitin report

Turnitin Originality Report

Educational experiences of rural origin students by Andrew Ross

From Protocol submission (Registrars 2015)

- Processed on 02-Dec-2015 10:22 AM CAT
- ID: 608522708
- Word Count: 19268

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Ross, A.. "From rural scholar to health care professional", South African Family Practice, 2015.

3

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<http://ajhpe.org.za/index.php/ajhpe/article/view/404/271>

4

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Ross, Andrew, and Daisy Pillay. "Portrait of a rural health graduate: exploring alternative learning spaces", Medical Education, 2015.

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Ross, Andrew, Gavin MacGregor, and Laura Campbell. "Review of the Umthombo Youth Development Foundation scholarship scheme, 1999–2013", African Journal of Primary Health Care & Family Medicine, 2015.

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[Ronald L. Ettinger. "Rural dentistry - Lessons from other countries", Special Care in Dentistry, 11/2007](#)

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[Corey Drake. "Turning Points: Using Teachers' Mathematics Life Stories to Understand the Implementation of Mathematics Education Reform", Journal of Mathematics Teacher Education, 12/01/2006](#)

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[Michael Noble. "Using Indicators of Multiple Deprivation to Demonstrate the Spatial Legacy of Apartheid in South Africa", Social Indicators Research, 05/01/2012](#)

14

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[Submitted to 76830 on 2014-10-28](#)

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[Submitted to Cranfield University on 2015-11-18](#)

19

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[O'Mahony, Don, Graham Wright, Parimalarani Yogeswaran, and Frederick Govere. "Knowledge and attitudes of nurses in community health centres about electronic medical records", Curationis, 2014.](#)

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[Submitted to Monash University on 2015-08-23](#)

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[Submitted to University of KwaZulu-Natal on 2015-10-05](#)

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http://www.angelfire.com/theforce/shu_cohort_viii/images/Trustworthypaper.pdf

23

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[Mashige, Khathutshelo P., Olalekan A. Oduntan, and Rekha Hansraj. "Opinions of South African optometry students about working in rural areas after graduation", African Journal of Primary Health Care & Family Medicine, 2015.](#)

24

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[Submitted to University of KwaZulu-Natal on 2011-12-19](#)

25

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<http://www.iime.org/documents/hawkins.htm>

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<http://www.wacountry.health.wa.gov.au/uploaddocs/ahtwi%202002%20final%20report.pdf>

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http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2012/sa_child_gauge2012.pdf

30

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http://www.rhap.org.za/wp-content/uploads/2014/02/Building-consensus-on-key-priorities-for-rural-health-care-in-SA_Versteeg-et-al_2013.pdf

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http://african-decade.co.za/wp-content/uploads/2014/03/AU_Shadow_Report_Final_draft01-6-march-2014-Final.pdf

32

< 1% match (Internet from 10-Jul-2009)

<http://asht.awardspace.com/ash/idea.html>

33

< 1% match (publications)

[Zeng Fancai. "Seeking reform paths in medical education from the revelation of Global Commission Report on Lancet", 2011 IEEE International Symposium on IT in Medicine and Education, 12/2011](#)

On becoming a Health Care Professional in a rural context: lives, learnings and practice

Submitted to:

COLLEGE OF EDUCATION

UNIVERSITY OF KWAZULU-NATAL DURBAN

SOUTH AFRICA

This dissertation is presented in the publication format

By Ross Andrew John

SUPERVISOR

Dr.G.Pillay

Accompanied document

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1 Introduction

These are the stories of six rural origin health care professionals (HCPs) who grew up in rural areas and who have returned to work in rural areas after graduating. They are stories of challenge and setbacks, of triumphs and trials. The stories are drawn from interviews, photo memory (photos reproduced with permission from the participants), artefact review and the construction of a collage titled “A day in my life”. The stories presented are a 1st level analysis as I needed to reduce the information available and construct it as a story with a beginning, middle and end around their educational experiences as they moved from rural student to university student to HCP working in a rural context. I have tried not to smooth out their experiences or to present them as hero’s but have tried to remain true to the stories and life experiences shared with me. I trust that your experiences will resonate with the stories of life experiences shared by those who participated in this research project.

Although each individual is as unique as his or her story is unique, Terr Blanche et al (2006) has suggested that a small number of participants is sufficient to contribute theoretically to the phenomenon under investigation (Terre Blanche et al., 2006). In addition Flyvbjerg has suggested that a small number of paradigmatic individuals – those who represent what can be achieved against a background of many who fail to achieve their potential- would be able to provide insight into the educational experiences of rural origin students who have transitioned to HCPs (Flyvbjerg, 2006).

The six participants were all HCPs from Umkhanyakude district in northern KwaZulu-Natal, 450 km north of Durban (see maps below). All six completed their primary schooling in local schools in the district. Lungi Hobe attended Inanda Seminary, an independent girl’s high school in Durban for one year of her high school and Nelisiwe Mthembu attended a government boarding school in Nongoma for her high school. All of the other attended high schools in Umkhanyakude district.



Figure 1: Map of South Africa with KwaZulu-Natal province highlighted



Figure 2: Map of KwaZulu-Natal with Umkhanyakude district highlighted

2 Dumisani's story

Introduction

Dumisani Gumede is a 36-year-old African man, who is married to Zonke and they have two children. Dumisani grew up and went to school in Kwashukela in Ingwavuma. He matriculated in 1998 and trained as a physiotherapist at the University of Durban Westville (now the Westville campus of the University of KwaZulu Natal (UKZN)). He graduated in 2003 and worked as a physiotherapist, initially at Mosvold Hospital and then at Hlabisa Hospital from 2004 to 2008. He is currently working as the mentor coordination for UYDF scholarship scheme, and is responsible for ensuring that all students supported by UYDF receive mentoring at university.

Dumisani's story

I grew up Kwashukela a rural village in Ingwavuma where my father lived with his three wives and 21 children. He passed away in 1983 when I was six years old and my mum, who was uneducated and unemployed, was left to support us. That situation forced my elder brother to quit school and find employment so that we could get some food on a daily basis. Life was tough. I had no school shoes, often I'd go to school without food and some year's school fees were not paid. When it rained at night we were unable to sleep because the thatched roof and mud walls leaked and we had to crowd together on one side of the house.

I grew up with lot of anger towards my dad for leaving us in such a state and ashamed of how we lived. So I said to myself, "do I want to grow up like this, hungry and poor forever?" I was motivated to work hard by looking at the houses other people were living in, the cars they were driving and the food that they were eating and I wanted to achieve those things.

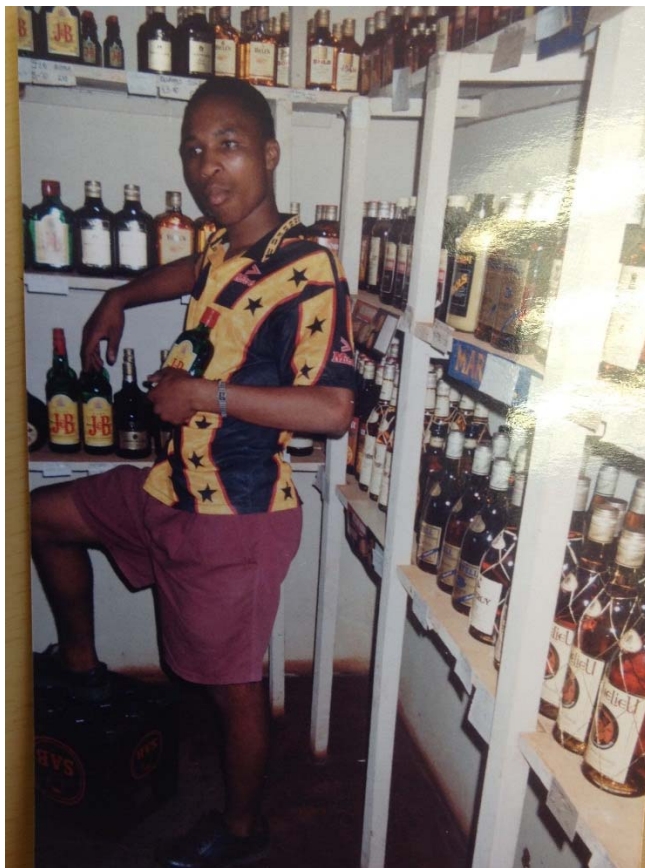


Figure 3 Dumisani working at bottle store during his holidays

In June and December holidays I worked at the local bottle store for about R250 a month to assist my mum with buying school uniforms and books and paying school fees. The owner

taught me to drive a car so that I could fetch the alcohol, and about cashing up, balancing the books and stock-taking.

1993...

In 1993 my older brother Zama completed his matric and got employment as a teacher. The situation improved at home as he provided financially for us. In 1996 my brother Simon passed matric and got a job with Illovo in Mtubatuba, however Zama left his teaching job to further his studies in mechanical engineering at Mangosuthu technicon. My brother used to say to me “our father left us when we were still young, so whatever you will get, you will be sweating for it. So if you do not work hard, you will get nothing”. He was the first person from the area to go to tertiary, but after qualifying in 1998 he could not get employment until 2004.

My mum believed in education as the key to everything although she had no education at all. I think that she saw some people who had education, who were successful, so she thought that if her kids can get education they'll be better people. She was the person motivating me. She would tell us “I only have money for school fees not for shoes or uniforms.... if you mess it up, it's your problem. If I die, you'll be left alone.” Those words kept on ringing in my ears. I had to work hard at school and pass. When we did well at school my mum used to slaughter a chicken just to celebrate and that motivated me to keep working hard because my mum was recognizing the hard work and effort we were putting into our studies.

My mum taught us three vital values which became my foundation: Respect, honesty and walking with God. She used to say “if you work hard and have faith in God, He will do everything for you”. She also taught us not to depend on others – that if you are looking to someone else, you will not go anywhere but if you've got something, do that thing, and do it perfectly on the first attempt because you might not have a chance to re do it and people may lose faith in you”. She passed away on the 28th July 2007- she was a pillar to all of us, and she was a peace-maker. Losing my mum nearly destroyed me as I was close to her and felt that I had not had the opportunity to thank her for raising me and the principles that she installed in me.

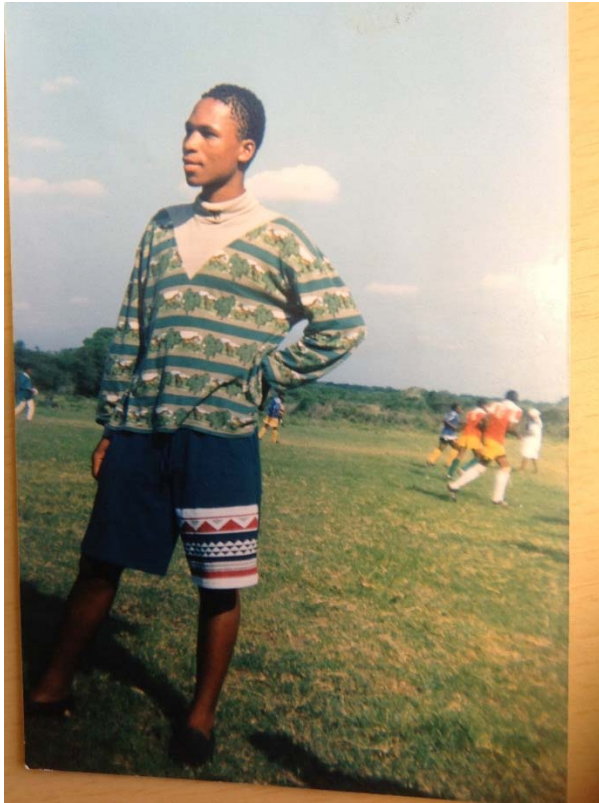


Figure 4: Dumisani playing soccer

There were no role models in my community when I was growing up. Only a few people had completed matric and most others were still at home, doing nothing but playing soccer. I was going to play soccer too. That was the only hope that we had that when I finished matric, I might be employed because of my soccer skills. There are lots of rural boys who are thinking, 'I'm going to play soccer and be a big star' and most of them play and then end up drinking, because there is nothing in front of them. At least now there are a couple of us who have gone to university, who are successful and are working. Now when I see the boys at home I encourage them to work hard and get a good matric, to play football as a part of relaxing, but to find something else to do for the rest of their life.

My standard 3 teacher

I got quick promotion at primary school - missing out two classes and jumping from Standard 1 to Standard 3 and from Standard 3 to Standard 5. This helped my confidence and was a motivation to me. When I was doing Standard 3, my class teacher said "you can be a good teacher" and the Principal promised to employ me when I passed matric. This motivated me to work hard at school as teachers are never unemployed and are earning a salary. In 1993 in Standard 8 I got an award from Illovo sugar mill where my brother was working for being the

best science student. That paid my school fees for standard 9 and boosted my self-confidence.

Let's do the maths - Mavela High school 1993 - 1998

My older brother supported me when I moved to Mavela High School 1993 and in return I helped with the ploughing on weekends. I worked hard at high school. We formed a study group - there were five of us - I remember it was myself, Komplane, Celo Dlamini, Zumu, and Similane. I was better at physical science, and biology but weak in mathematics. Celo and Komplane were better at mathematics and Zumu and Similane were better at languages. We used to share information with each other to ease the pressure. In Matric we used to stay after school and say, 'Let's do maths, let's do physics, let's do biology.'

Career advice from school and home

My principal at high school said to me, 'what do you want to do when you complete matric?' I said 'I want to become a teacher.' He told me 'You have more potential than that.' So he gave us information on engineering, and gave us a lot of information about bursaries. Information was the key, it changed my thinking. I had been thinking that even if I passed matric I was not going to go anywhere, that I would just sit at home like the others, but when he told us that funding was based on merit and that many people had been funded, we said 'oh, I can also get funding' and that motivated me to work hard as I knew my background would not allow me to go to university without help.

I fell in love with electrical engineering and applied for funding from CISA and other companies. I forgot about teaching because I knew that there was funding to study other things. However none of the companies agreed to fund me. As my brother and another guy from our village with electrical engineering training could not get employment after qualification I thought - no I won't go for engineering,

April 1988

In April 1998 my principal announced to us "Dr Ross from Mosvold was here, looking for students who are doing well at school. Go and try to get sponsorship at the hospital- if it doesn't work, then you can fall back on engineering" so I went to Mosvold to try my luck.

After Dr Ross came to our school I applied to do medicine. Unfortunately I was late at the University of Natal so I also applied to MEDUNSA and to Stellenbosch, where I was accepted. My mum said I could not go to Stellenbosch, as it was very far! My principal also discouraged me from going to Stellenbosch because of the Afrikaans and I was not good in Afrikaans. After that there was no option for me to do medicine. I went to Mosvold in June 1998 to do voluntary work and met the physiotherapist who encouraged me to apply for physiotherapy. Unfortunately by then applications had closed and I thought that I'd have to wait for the following year to get into physiotherapy.

Although my heart was in medicine I knew that I could not get into Medical School. So in December 1998 I went to Mosvold to do voluntary work in the therapy department. I learned that a physiotherapy can work in hospitals, the army, in sports, and in all different kinds of things. So I thought, 'Oh, at least sports! I would like to be a physio, as long as I'm going to work in sports.'

Determined to find a place

In January I took my matric results and drove to the University of Durban Westville to try my luck. When I got there they told me 'You didn't apply. Sorry. We're not talking to you.' But I insisted that they had lost my forms. I remember going to the physiotherapy department.... Prof Gounden and Mrs. Simelane, were the lecturers. They asked if I was serious about physio and then interviewed me. I had an advantage because I was in the physio department for a week so I knew what physio was all about. They asked me a question that, if the patient comes with a fracture of the leg. There are physios there, there are doctors 'Who is supposed to see this patient?'

"Both are supposed to see this patient, but the doctor has to see the patient first to fix the broken leg, and thereafter I will come and try to teach him to walk. I was not familiar with the word 'rehabilitation' at that time."

Then Prof Gounden went out, and Mrs. Malan said, 'We are taking you. Go there to apply, now!' I came with a good matric and not enough black students had applied that year with a good matric so I was given a chance. I went straight to Dr. Ross and gave him the acceptance letter as he had promised to fund me if I got a place at university. He gave me a cheque for registration straight away.

Cerebral malaria

The 8th of February 1999 was my first day of university. I was expecting a bell to ring announcing the start of classes as we were used to from school. But there was nothing, you were just there with your timetable. I didn't understand this timetable or what it meant or what venues you were supposed to attend - I was lost on the first day. Fortunately the first three periods of lectures were in the physio department, and I knew how to get these.

In the middle of a lecture I felt dizzy so one of my classmates took me to the campus clinic where they said I had the 'flu as I was feeling hot and cold. The doctor gave me an injection and let me sleep there for a while. That was the last thing I remember. When I woke up six weeks later I was at King Edward Hospital. I really didn't know what had happened. But I had been diagnosed with cerebral malaria. When I woke up I couldn't talk, I couldn't do anything. Even writing was difficult as I couldn't hold a pen, or write a message.

My friends said I would be able to catch up, if I managed to work hard. Everyone who was talking to me about university was hurting me, because I was thinking now, I've lost the opportunity of the scholarship, because I won't be able to cope at university. I've lost my lifetime opportunity to come out of poverty. After the pass-out from hospital I went home and people from the church came and prayed with me. They asked me if I wanted to continue at university. Although I was not talking at that time, I communicated by writing that I was going to continue. They advised me to rather sit out for that year and reapply, and I said 'no, this is my last chance, I'm going to go there, and even if I fail everything, I will fail everything. I'm going there to try, because I have only one chance at the scholarship scheme, there is nothing else. Nobody at home can afford to pay the fees.'

Before returning to university, I met with Andrew Ross to find out about my bursary. He advised me not to go back to university as I had missed a lot of work, and I would be likely to fail. I told him that if fees had been paid I could not drop out. I needed to go back to university and continue where I left off.

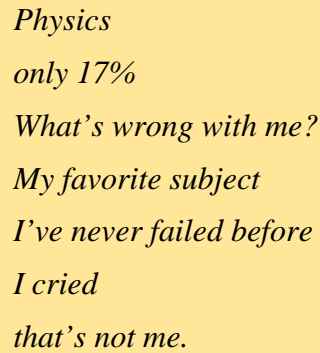


Figure 5: Back at university after his cerebral malaria

Helped by the speech therapist

After Easter I went back to King Edward to see the speech therapist who helped me to talk again. Although, I'm stuttering now, at least you can hear what I'm trying to say. After the speech therapy I was discharged from hospital.

I missed all the first tests. The physio department asked colleagues to teach me what I'd missed and I managed to pass the two tests from the department, although my mind was slow and my concentration poor.



*Physics
only 17%
What's wrong with me?
My favorite subject
I've never failed before
I cried
that's not me.*

Figure 6: Dumisani's thoughts after he failed physics

(poem written after one of the PhD cohort groups meetings where we discussed the value of poems in summarising information)

There were a number of reasons why I struggled in first year. Having malaria, my poor comprehension and lack of fluency in English, being lonely and poor studying techniques all contributed. Initially I studied by myself and only used the prescribed books. If I struggled to get the answer, I just moved on. My stuttering affected my self-esteem because I wasn't sure that people were hearing what I was trying to say. Missing the 1st semester wouldn't have been much of a problem if you are of normal mind because you would be able to study hard and catch up. However because my concentration was low and I got tired easily, I had problems in catching up.

The second semester went well and I passed all my four modules. Although 52% was not a good mark at least I passed those subjects. My confidence to speak English was improving because I had friends who were Indian, Xhosa, and Sotho so I was forced to speak English. I also read a lot of English newspapers to regain my concentration and I attended English class twice a week.

Turning point

In 2000 I had to re do physics and biology which affected my progress. I knew that physics was challenging because a lot of people failed physics, even those who attended full time. There was a lecturer who was very nice so I approached him and said 'look, I failed this course last year, so now I need to pass this course. If I don't pass I am going to lose my sponsor.' He asked what had happened last year I told him, 'I got sick, I missed the whole

first term last year, and when I got back my concentration was too low.’ He said ‘okay, that’s fine. We’ll assist you.’

The physics lecturer gave me the previous papers, and he said, “you go and do these papers, and come back and give it to me and I’ll mark it for you.” He said the questions are more or less the same every year. I did that, I struggled, but I passed.

My confidence developed and when I was struggling it was easy for me to consult the lecturer and ask for clarity and that helped me to be a better student. Thinking of my home situation and my father who died with nothing motivated me to double my effort so that I could graduate and help my mum to get out the poverty situation and sufferings that she had been through.

Study groups

We formed a study group of four and we worked on the question papers - we’d work, work, work. We were given a chance to write in June, and we all passed - I moved from the 17% I got in the previous year to 62%. It was the same for biology. After passing physics it gave me the confidence that I was back to normal now, I can do this.

Study groups were a way of cementing my knowledge. I studied by myself first, then when we were in a group, I shared what I’ve learned. Right up to my final year I worked in study groups.

Isikolokuthwala

In 2000 we did Community Studies in the Valley of a Thousand Hills, just outside Hillcrest. At the end of the course we had to present to the class. That was challenging because I felt that my English was not good and they would not understand what I was trying to say and would laugh at me. Our group spoke about Zulu cultural practices such as isikolokuthwala and we got excellent marks. After the presentation even lecturers were asking questions which gave us built our confidence knowing that we can talk to the group.

Learning from patients

In 2001 when I was doing my third year I failed one course. I got 64%, but failed the sub-minimum. I was given a chance to do a supplementary exam. But supplementary exams are very difficult, and it's emotional. You can say, I know this thing, so how am I going to study because I know it? Before the supplementary exam I went to the lecturer and she said to me, 'if you look at this thing, don't think of the theory part, look at the patient who has this condition and think, what you can see from this patient? Once you are able to paint this picture, then you will be able to pass this.' And I went there and did that just before the sup-exam, and I managed to pass.

Dr.Ross and his questions

When we came back to the hospital in June and December to do holiday work Dr Ross used to call us to his office and ask us one by one 'how was the semester?' It was a small office, I think there were six to eight people, all squashed in, and he used to say, 'why did you fail?' That question sounded like an easy question to which you could just say 'one two three. If he asked us that, 'why did you fail?' some of us were trying to justify it but when he said, 'that's not good enough,' the tears were coming from the guys, it was not good enough. Every year in June he had to remind us: 'guys, you have to pass because I don't know if I will have money for next year'.

At Durban Westville France and I would say 'let's avoid this old man. Let's just make sure that we pass.' We'd rather hear him say 'congratulations.' So whenever we were going to the library or to study groups we'd say 'guys, we need to pass.' Whenever we'd see each other – the group was growing at that time – I think we were about seven or eight in that year – we'd say 'guys, we need to pass. We need to pass, so that he cannot ask us anything!' Dr.Ross was giving us funding and we did not want to disappoint him for all his faith in us, so we were helping each other where possible. We started to have monthly meetings which helped to expose those who were not doing well. Everybody was kind of forced to do well because before you answer to Dr Ross you had to answer to whole group. In a Zulu culture, the uncle usually takes care of his sisters children if they have challenges so we gave Dr Ross a new name, we called him Malume (meaning uncle, due to his support for us and believing in us while nobody else believed in us).

At the beginning of each year we reminded ourselves that we owe Malume, therefore we need to just do one thing, just pass. Malume use to say “the bottom line you have to, have to have to pass”, we just wanted to that. He used say “I do not have money for next year” and those words indirectly saying “make sure that you pass” and I wanted to pass so that if he does not give me money I would be able to attract other sponsors and I did not want to disappoint my mother by losing the funding.

Those questions helped us and motivated us as we knew that there was someone who was going to ask us about university. I think that it worked well, because for the new guys who were coming in, we were able to orientate them. We said ‘guys, there’s one person who is going to ask you, ‘why did you fail?’ That question is not easy, and if he keeps on saying that then he will say, ‘I don’t have funds for next year,’ that means that if you have failed, you are not going to get funds for next year. So it helped the group at Durban Westville to keep on passing and I think that was motivational enough to me.

The second part that was motivating was the community and the staff in the hospital. There was no black physiotherapist before me and community members kept on asking me, ‘How come you are doing this? How is it like? Are you qualified now? So that kind of put pressure on me so that nobody will ask those questions anymore. They must see me coming back now. The fear of humiliation from my village if I went to university and came back empty handed also helped me to keep focus.

For others in the community, it was a motivation to see a black guy doing physio. They used to think that’s impossible! But it was possible, I am doing it, so that was a motivation for them. They didn’t believe a black guy could be a physiotherapist. I wanted to prove to them that a black guy could be a physiotherapist. I managed to do it and pass.

Determination

I also think I worked to please other people, more than pleasing myself. Because when I was at university I was avoiding by all means to fail. If I failed I’d lose the financial support, then I’d be excluded from the university. I would have to go back home and my mum would not be happy about that. She kept on saying that you must do things thoroughly, because if you fail it means that you haven’t done things thoroughly. I remember lots of what she’s taught me while I was growing up. I used to say ‘I am different from others’, and ‘the university

owes me, it owes me my degree, because I must go there, take my degree and go home' and this motivated me to work hard at university.

Whatever it takes

I decided that whatever it takes to get my degree, let me do that. At university I initially behaved like all other students playing soccer, singing choral music, participating in the house committee. But when I failed the test after sitting in the house committee meeting for 3 hours instead of 15 minutes, I resigned as a house committee member. Soccer also had a big impact on me so I decided to only play soccer on Friday afternoons.

After that things were back to normal with my studies. I discovered that I study better at night than during the day so I developed a study plan for myself. My plan was studying the whole week, have free time on Friday afternoon and evening and then wake up in the early hours of Saturday morning to study until midday. Then I would go and watch soccer until late, as I am soccer fan. Saturday after soccer was my time to write the assignments that were due. I'd write the assignment until ten o'clock, then at three o'clock on a Sunday, I had to wake up and study until about seven then I went to church. When I came back at eleven I finished the assignments that were due, and anything that else needed to be done. My studying hours were very set - I studied at night while everything was quiet because that was my best time to study.



Figure 7: Graduating

Graduating was life-changing. When I finally saw my name with people who were graduating, I said, 'It's completely changed, now. Now I've got a certificate in my hand, so I can work anywhere and will have a job for life.' It helped me a lot in terms of seeing things differently because now I had a degree. I stated to be more responsible at home taking initiatives and improving my house.

The day I completed my degree my mother slaughtered two chickens and one full chicken was reserved for me alone. I was so happy and said to myself “my mother is out of poverty

forever now” because I was going to earn money every month and would be able to support her.

Working

In 2004 after graduation I went to Mosvold Hospital to do my community service. Some community members came to check to see if it was really true that I was working at the hospital as a physio and not as a nurse! Working at Mosvold changed my thinking as when people come to me for consultation, I was now on the other side of the fence. I could diagnose problems and give them information to improve their condition.

We worked hard seeing patients in the wards, in OPD and visiting the clinics. I even started a monthly clinic at Bambanana. Initially it was an osteoarthritis group but other patients used to come as well including some cerebral palsy kids and so it grew into a big clinic. I wanted to stay at Mosvold to fulfill my five year contract with Friends of Mosvold but they could only offer me accommodation in a dorm in the Nurses Home.

I moved to Hlabisa Hospital in January 2005 and stayed until September 2008. When I first got to Hlabisa, there was only one therapy assistant who was visiting 16 out of the 34 clinics on her own. In April 2005 I was joined by a community service physio so we increased the number of clinics we visited. In 2006 we were joined by an occupational therapist (OT) from Mosvold and then in 2007 we were joined by a speech therapist. We also got a few new community service therapists. In 2007 I raised money to buy some audiology and physio equipment so that helped to improve the service we were able to provide.

Life was tough at Hlabisa. I felt lonely and isolated and if it rained no-one was able to go to Mtubatuba and the N2 freeway. I had a friend who really helped me to adapt. He used to say “you went to university to study so that you could come back and work and make a difference. If you can make a difference here at Hlabisa, you can make a difference anywhere. You just need to find a solution to whatever challenge you are facing” There were times when I was frustrated and said, ‘I’m going to resign now’. He would say ‘look, even when I first came to Hlabisa, things were a mess-up, everything was difficult, but because I knew that I had a calling to assist the patients, I stayed - you can do the same. If you leave here, you are going to find problems wherever you go.’ I had had problems at Mosvold, I had problems at Hlabisa, and so I realized that he was right. Even if I go, I’ll still find problems wherever I go, so I stayed.

Promotion happened at Hlabisa because I went there as a junior physio, before the end of the year they promoted me to a senior physio, before I completed my three years at Hlabisa I had jumped to assistant manager.

I resigned from Hlabisa in August 2008 to join Umthombo Youth Development Foundation. When I started at Hlabisa we were two in the department and when I left there were four physios, two OTs, two audiologists and two speech therapists.

Being a health care professional

To be a health care professional is very challenging:

One: The community think that you can solve any problems they bring to you. It takes at least two years for community members to understand the role of physios on the hospital staff

Two: When people know you are a health worker they think you can give them a grant. However there are very strict guidelines concerning those who are eligible for grants and it is a serious offence to issue grants to those who are not eligible.

Three: The people respect you, they say ‘Oh, these people can help us, when people come to me for consultation, now I’m on the other side of the fence. I do have the information that I can pass on to people. I can say ‘This is what happened, that’s how you should prevent it in future.’

Four: The kids in the area see me as a role model. In my area, I think I’m the only one who has worked in a hospital apart from two nurses.

Continuing to working rurally

When I started to work in a rural area I used to see conditions that you would never see at university –I used to phone the lecturers and say ‘I’m seeing this, what is it?’ Seeing those kind of conditions, helped me to say ‘let me sit here and, learn more.’

There have been incentives for me to continue working in a rural area. I stay at home and live near where I work thus travel costs very little and I do not waste a lot of time travelling. This has meant that I was able to stay close to my mother before she died.

My background influences so many things when I am encouraging and demanding things from my students.

1. I've mentioned my mum and the church. I believe that in order to talk to the students, I need to pray to God to give me wisdom as well as to encourage them to work hard.
2. I grew up in a background where there was nothing, my brother and mum used to say: "this is your chance, and if you mess up, it's your problem" and "there's nothing you can get if you don't work hard". So I'm using that, it was motivational for me. And I use it as a motivation for students I tell the students "Now the money part has been covered let's see what you can do"
3. The last part it came from Dr Ross himself, by the way he kept saying to us, "Next year I don't have money, next year I don't have money, I only have money for this year." It motivated me, and I'm still using it to students to say 'look, if it was your own money coming from your own pocket, and you take this money and you pay the university and then you fail you're left with nothing. Are you not expecting an investment from the money that you put into the university? What can make this investment grow?' I used to share my story with them.

Motivation

Doing something about your challenges is key. Because to look at a book and keep on moaning about it, it's not going to help you. I didn't want to die like my father. I didn't want to have kids that I would not be able to support. I don't want my kids to have an education like mine. My kids, when they go to school, I want them to have shoes on their feet and food in the morning and lunch bags, and when they come home they should be able to eat. So that kind of shaped me. One wife is enough for me and I think I'm the luckiest person, to have the wife that I have right now.



Figure 8: Dumisani and Zonke getting married

We got married on 25 October 2008 - we were starting life together. I was committing myself to her, and she was committing herself to me. I was investing in this person, investing my life with her, investing everything I had with her. That's the reason why I supported her training from a nursing assistant to a professional nurse. In 2009 God blessed us with this beautiful boy - Wandiswa Pendulu –and my mother's prayers have been answered

Family is important to me. When I got married, that was a big step for me, because now I had someone I could relate to and to talk to. And also it told me that now, you are responsible now. You have to make things happen. If you cannot provide for your wife, then you are not man enough. Then there are many benefits of getting married. If I am stressed my wife will go to the kitchen and cook a nice meal for me. She will say, 'Now stop worrying, let's have a meal together.' That's the kind of the thing that's helped me... even if I'm away, I always think that I'm going to go home and eat nice food at home.

Church is central

I'm spending much of my time at church... When my dad passed away my mum had no education and no money but she said, 'When you got to church, God will provide.' So the

things that we grew up with were church-based. She used to say to us, 'You cannot eat and be full if someone is hungry. Because that means that you didn't provide God with food.' So even though we didn't have anything, we grew up with that advice, if there's something to eat you need to share. Whatever you've got you need to share, because in turn you are feeding God. So I am still teaching my kids around church.

Current role

There is a young lady called Wendy who was excluded this year. If you look at her situation and my situation, it's almost exactly the same. She's struggling with first year and was still doing first year physics in her third year. One of the things I've noted from her, she turns the blame to someone else. You can't fix a problem unless you are prepared to say 'I failed. I have a problem. I must do something.' Obviously if she did not find studying on her own successful the first time or the second or the third time, then she's got to do something different. You need a kind of a hunger to succeed, a determination to succeed, a kind of whatever it takes to succeed attitude. When I was at university I struggled, and then found some people to help me, I went to my physics lecturer, got old papers, - you have to pass if you are to get a degree, and I was able to learn that.

My mum used to say, 'you must be ashamed if something that you did is not right.' So for me, I knew that she was waiting for me to complete my degree, so that I could come back and work, because she was calling me a doctor in my second year of university. So I went to university, and as much as I wanted to please Dr Ross, but back home, I knew what was expected of me. So I said, I must work, and pass. As much as there are other forces opposing me, I must work and pass. That put pressure on me because if I failed I knew that once I got back home they would see me as a failure. What I realized was that if I came back with nothing I wouldn't be able to work, I wouldn't be able to feed my mum.

Other family members

My second brother didn't do well at school but he passed matric and trained as a paramedic. While he was studying I had to sit with him almost three times a week over the phone, and say 'this is this, this is this, and this is this.' And then he qualified. He's a paramedic now.

When my father passed on, he left us with nothing. My older brother Denis was forced to quit school and look for jobs so that he could support the entire family. Although he was not

earning much from ploughing, at least every month there was something coming into our account. After my graduation I said to my brothers ‘Okay, now there’s three of us who can support the entire family. What can we do now to uplift others who are still coming after us?’ My younger brother was still in matric, my other brother from the third mother was still at school, and my eldest brother was uneducated so improving him was going to be difficult.

I remember my father saying that “If you are successful, then support that person behind you. Because if that person is successful, then he will support someone after him as well”. So that was a way of developing ourselves. As three of us were earning a salary every month we decided that each of us would support the brother that comes after him. The elder brother, we found him a job. He’s good using his hands with engines, so they took him at Spoornet as someone to put spanners in the box. When he got there he did well and was promoted to a mechanic so he was out of the picture. So then there were two more brothers. One had completed matric. We asked him if he wanted to go to university but he said he would rather find a job. He didn’t want to participate in anything that we were doing, so we let it go. I said to the younger brother, to him, ‘You are doing matric now, it is your chance to excel. If you excel, you might get a sponsor, like happened to me’. Unfortunately he didn’t do well, but after matric he asked if I can pay for him to do this basic ambulance course as he would be able to drive an ambulance with that qualification. I paid for him, he passed and he got employed at Jozini.

If you look at our situation, we’re coming from a very big family, a polygamous family. But if you look at my father’s kids, we have all developed this one principle that if we have to do things, we do things together. That’s why people mustn’t ask ‘How do you manage to do this?’ Because the answer is that we support one another.

Ongoing studying

Currently I’m doing a Masters in Leadership Studies at the University of KwaZulu-Natal. I chose that course because of my current role with UYDF. I’m working with students who look up to me, with local mentors who look after the students and I’m also supervising staff in the Mtuba office.

Students have lots of social problems as well as academic problems which we try and help them solve. There was this lady... her father drinks and after her sister fell pregnant, the father chased her sister away. After that the father kept calling the student at Wits. She was caught

in the middle because the father was not talking to anyone at home, because at home they were asking him why he chased the young child away. Then he would drink and beat everyone up at home. She is in second year and all these issues at home disturbed her, so I had to visit her home and I said to the father 'Look, I understand there are issues with the family. But this girl, if she qualifies, she will help the whole family. But if these issues are affecting her, she will fail and they are going to kick her out of university. And she will be back here at home, and be your responsibility. But if you let her study, then she will come back and help you.' I think that has helped, because she is improving now. Although she's not high up in her marks but at least now she's getting 60s.

Wanting to be a farmer

In time I want to do stock farming with cows. At the moment I'm busy looking for a farm that I can get. I do have a couple of cows already but I don't think that they are secure enough where they are because I'm not looking after them every day. But if I can have a farm, that's where I'll put all my cattle and I can look after them and make sure they grow up well.

3 Frances's story

Introduction

France Nxumalo is a 33 years old African man, married to Bongekile and they have a son and twin girls. France is from Skemelele and went to local government schools close to home. He matriculated in 1998 and went to the University of Durban Westville (now the Westville campus of UKZN) where he studied optometry. He graduated in 2003 and worked at Mosvold Hospital from 2003 to 2006. In 2007 he joined the Phelophepa train (a Transnet initiative to bring primary health care services (PHC) services to communities without health services) as an optometrist. In 2009 he joined the Brian Holden Eye Institute, an international non-government organisation (NGO), working towards improving eye services around the world. France is currently the Southern Africa regional coordinator and is responsible for working with governments in the region to develop sustainable eye plans (funded posts, infrastructure, equipment, human resources etc.). He also works with universities and training institutions in Southern Africa strengthening their eye training programs so that there are skilled local personnel available to take up posts in the region.

France the activist

My father and my mum were separated in 1985. I was four years at that time. My father took me and all my siblings to Skemelele in Ingwavuma and left my mum in Mtubatuba. I never saw her again until 1992. In my final year at university she had a stroke and passed away. Although my father had his flaws he did not abandon us as many fathers do and he raised us the best way he could.

There was no school near Skemelele so I did not go to school until my father built a school next to his shop. There was no contract but my father was a business man and he built the school next to his shop. That assisted his shop, because when we went to school people would buy things, and the place became bigger and bigger. The school opened in 1987 and I went into Grade 1. One of my father's sisters taught at the school when it opened. The school had only two classrooms and when it was raining or windy classes couldn't continue because grades would need to be combined. Although there were challenges of resources at school I loved school.

In 1988 I had a very bad burn on my leg and because my dad was busy in his shop, I just walked around with that big burn.

There was a doctor who used to come to Skemelele and I remember taking myself to see that doctor who bandaged my burn and put ointment into the wound. He was one of the few people I've ever met willing to see a dirty child, and treat him without asking any questions or getting any money. That humane act ignited something about medicine in me and I wanted to become a doctor.



Figure 9: France and some school friends highlighting their soccer hero's

Like the other children I did not have any role models. I was crazy about soccer and played soccer and made cars from wood and coke cans. From those cars I developed a love for cars and wanted to do either engineering or medicine which were those are the things that I was exposed to.

A love of learning

The drive to learn was always there. I developed a love for studying and reading when working at my dad's tuck-shop during the holidays. There was not much to do at the shop when no one was buying things so I would always have a book handy, especially one for the next year. That's why school was always easy, I was always ahead as I used to take my brothers book for the next grade.

Although my parents never went to school my father loved school and at home he gave us incentives to motivate us. There was always competition between the kids to see who was going to get better grades. He never used to buy me ordinary clothes, but he'd buy me school clothes and anything that was around school. Although I always got better grades than my elder brother, I never got that watch he offered. It always went to my brother, the one who ended up dropping out after failing matric. The only time that I knew my dad was proud of me was when it came to school. I always got position one in class and that was something that he always spoke about.

Nelson Mandela is one of those people that keep inspiring people – his coming out of jail in 1990 changed the direction that the country took and ignited politics in me. My life of politics started then.

I never drank or smoked, I loved sports, and I loved school and was committed to my school work. Even though the environment was not really that good, I always wanted to be at school. I didn't ever tolerate a teacher who was lazy or never came to school or who came to school drunk. If no one did anything about that teacher we went to the staff room and engaged with the teacher. If that did not help we would report to the Principal that these are the challenges that we're having. If talking to the teacher and to the headmaster did not work we would organise a strike to highlight to the community that we can't have a teacher who is not doing his work. We'd call parents to a meeting, we would not go to classes but sit outside and sing and march. We would engage with the parents and indicate that this teacher is doing this and that and either there's a change of behaviour or the teacher goes and we get another teacher.

I remember we had a teacher who came to teach us physics. She couldn't do it, so we moved her to English. She could not do it, she couldn't even put a single English sentence together, so she did Zulu which she could not do either. So we went to the head master and raised the

issue as a grievance. His role was either to accede to these demands or not. If he did not respond that's when we would call the parents, and say to them look, we have a teacher who can't even speak English and is teaching us English. Now we can't speak English and we're doing Standard 7, but we're much better than her! Even with Zulu, she would just come into class, give us a book – especially when it came to poetry – to analyze but she never did anything, not even give her own opinion about anything. It was just 'No, whatever you said!' so we refused to be taught by her, so she moved.

High school

I moved to Ndumo High School in 1997 where I did Grade 11 and 12. When I was doing Grade 12 there was an issue about subjects, because most of the students were not doing physical science or maths on higher grade. I was interested in doing medicine or engineering so for me doing everything in standard grade would not help me. I had a big fight with the teachers to push them to offer the science subjects on higher grade. They ended up allowing me to do mathematics on higher grade but not physical science, because the science teacher was already teaching from Grade 10 to 12 and it would have been difficult to break up the Grade 12 into Standard Grade and Higher Grade with one teacher. That year was the first time the school was offering maths on higher grade, and according to the teacher most of the guys who were in the higher grade class were not higher grade material. The teacher felt that there were just two or three of us who could cope with higher grade subjects but we ended up having a group of eleven students who took mathematics on higher grade. The maths teacher was very good at teaching algebra and trigonometry but knew nothing about geometry. We accepted that when the paper came, we'd not write geometry, we'd write trigonometry, and then algebra and we would have to score high marks on those.

In 1997 four pupils got sick and died and there were suspicions that the Principal was involved in witchcraft. As a result there was a strike at the school in my matric year and the school only started in April 1988 when the deputy took over the school. During the strike I stayed at home and tried to find alternative local schools to go to, unfortunately I was not accepted because I was from Ndumo High and my dad could not afford to send me to a school outside of the area.

Enrichment program

In August 1998 I was selected to go for an enrichment program in Durban and spent a week at Durban High School. It was very hard. I had never been to Durban or to a town even half the size of Durban before, so the environment was very intimidating and just too different and I had never been in a school where there was a white teacher. There was one gentleman I shared a room with who got 98% in physical science and went to complain, and I wasn't even sure if I got 30%. I thought that he was cleverer because of the background that he had and I decided that I just had to just do my best and not even aim to get what he got!

That experience was very valuable and I got a lot of tuition that week. The challenge was when I went back to school my teachers could not help if I had problems when studying. I remember one maths problem in the study guide and I asked the teacher. He said, 'No, don't worry about that, this is a university level maths problems, it's not even at your level.' But guess what, when the exam came, the same problem was there! I was really angry about that.

Career guidance

Growing up in a rural area, medicine, engineering, teaching and law were the fields that we knew about. I always thought that I had the capacity to do any one of them. Being a doctor was about helping people and prestige. Mechanical engineering, well I was fascinated by car engines. Law... maybe law links with my personality because at an early age, I felt that I could engage with any one. And I felt that I could translate engaging randomly, to engaging in a court room. Though I was never in a court room, but hearing people engaging, I always thought that law is about that, and being able to put your argument across.

I passed matric with exemption so I went with my marks to Friends of Mosvold because we were informed that we had received a bursary to study in the medical field. There were some issues because I was told that there was no money at that time and they could only get money around June or July, so if I could get money to go and register, they would then be able to assist later in the year. Unfortunately I was in no position to find that money, so I went back home. However a week or two later some nurses came from the hospital sent by Dr Ross - there's money now, a chance for me to register and all that!

Funding is absolutely critical for rural students

Early funding is critical for those wanting to go to tertiary. Most people in the rural areas are not coming from good financial backgrounds. So once you start working for a year or so, it becomes difficult for you or your family to stop working, as you would no longer have those finances that you were contributing to your family. But if you go straight from school to university you never feel that. The other thing is that once you start working, you start to see certain things that you didn't see before. You start to dress differently, wear brand names and all that. Going to university we were not having resources to get those things because we almost never had support from home.

Once you start to earn money, you start to have that financial independence; you don't go to bed hungry. Dumisani and I struggled with money when we first went to university. If we had been working before we went to university, we would probably have been discouraged and thought, 'No man, this is not what we want... when we were working, we had these resources...' So it's very important, to go to varsity straight away, before your mind gets contaminated with all these other things that are happening around about. I think that is quite critical.

The security guard

Due to poor career ideas, I hadn't applied for anything at the university. After hearing about funding I packed my bags and went straight to the University of Durban Westville. I stood in a queue for the whole day and my turn only came round at about four in the afternoon. When I got to the front of the line the people asked what I wanted to do. I said that I wanted to do medicine. So those people said 'look, we don't offer medicine here' and then they called for the next person! So that was a bit of a shock, when you're in this intimidating environment and that is the response you get. Fortunately the security guard who was standing in the queue looked at my results and said 'these results are very good. You can't just go home with these results.'

The security guard took me to the BSc department where I told them I was the security guard's nephew and they accepted me for a BSc. That was a problem because the bursary I'd received was for a health-related field not for a BSc. After registration I tried to find a place in a health related course and went with the pharmacy department to Prince Mshiyeni Hospital as part of their orientation program. That day I realized that pharmacy was just not for me.

I had never been to an optometrist's room, never been to an eye clinic, I had never seen an ophthalmologist, an optometrist, or even an eye-care worker. Never. While looking for a place in a health science course I met with some students who were doing optometry. After they told me what optometry was I got interested and went to the department to get a brochure and some more information. Then I started discussing and asking if I could join.

Getting into optometry was not easy. I had to beg the head of department to let me in, because it was way late. They had finalized admissions, and had even told people who had applied whether or not they had places. It became a big issue - I went to the Head of Department Dr Naidoo and said 'Look, this is what I think I like. I am from the rural area, I did not have career guidance and I did not apply. But coming to the university and having spent a week or two here, I feel I want to do this course.' I was honest with them. I said 'I know it's closed, but now, if you don't take me, it means I'm going home. Basically that was the decision we had to make, because what I'm registered for, that's not what they gave me money for. I need to do a health-science thing, and optometry is what I think I can do. I've seen pharmacy, and I don't like it.'

I was told that it was not possible, because admissions were closed. I indicated that it's got to be possible. I have been given the money but if I cannot get a place I will have to go home because I would not be able to continue with the BSc. Then there was a meeting and after a lot of persuasion, they agreed. I think I still have the acceptance letter dated 24 February 1999 so it was a very late acceptance! People had already started attending classes, so I missed two weeks of lectures. So that's how my academic life started.

Academic life

At the beginning I missed quite a lot of lectures and a number of practicals for chemistry and physics. When you are coming to university for the first time reading the timetable is a challenge. I'd get lost, the lecture would be in T3 or T4, and you'd not know. Sometimes I'd go and sit in Physics 101 whereas I was doing 171, because some of the people with whom I'd sat in the previous lecture went straight to that venue. Sitting in a big class where people were conversing freely in English with the lecturers was also intimidating. I just used to sit and listen and not utter any word, not because I could not utter any English word, but because the environment was intimidating

What helped me, it was more like a confidence booster, was after we wrote a physics test which I failed with 29%. Then the next test we wrote was a chemistry test. There was this gentleman in our class who was always talking with the teachers. Then I found him at the results board celebrating because he had got 51%! I'd received above 60%, so that kind of changed my perspective about people who were conversing in class.

Support at University

What helped was the mentoring support we received. Dr Ross and MESAB people spoke to us and put us into a structured mentoring program. The program put us in touch with senior students and tutors to assist us with whatever challenges that we were experiencing, not only academically, but also life in general, to adjusting to the university life. It made life easier because we could share those frustrations and hopes that we had. The second thing was the support that we got from the scholarship scheme, where almost every week you'd get a call from Dr Ross, or Matron Nsimbini, to find out how you're doing, how are things and all that. At times it was frustrating, because you know when you're asked how you're doing, and you know things are not going that well, it can be a frustration. But I think that it made a big difference because we knew that there were other people behind us that we could just not disappoint. They always wanted to know, what are the challenges? And if you had challenges, then they could put you through to people who could assist you.

The MESAB and university mentoring programs were good programs, and I became active in them and also did a bit of tutoring as a senior student. I was not just involved in the formal programs but also informally as most of the guys who were coming from Ingwavuma ended up coming through me and I would assist them to adjust at university. When new students came in January, we would take them through registration and even provided them with some accommodation at the beginning, because most of them really did not know Durban which was like me when I first came to Durban. So we assisted them with understanding the university processes and helped them to settle because we knew it was a big adjustment for them. We also put them in touch with the tutors and showed them the library and how it's used and all those kinds of things. It was both academic and the university life adjustments, even in terms of sports where we helped them understand the system and all that.

As a MESAB mentor I was assigned students who I assisted in terms of academic and non-academic activities. Because most of us had come in from those rural settings that those guys

were coming from, and we had that kind of experience, and we were settled we could assist them to adjust to university. For people to do well at a university it's not just about them adjusting to the academic pressures, but also to the pressures that the university brings. For most of them, the freedom that they're getting, it's the first time that they're getting that kind of freedom so if they can't balance their private life with their academic life most of them will not do well. I have seen some people who have not completed their degrees just because of the environment and pressures outside academic life. Most of these guys who are there have the potential to succeed. They've done well in high school under difficult conditions, but it's just for them to be able to adjust to the university and city life.

I would say that academic and non -academic support are equally important. As much as they come from poor schools they've got potential and academically they would be fine. The fact that they've managed to pass their high school with flying colours, means they've got potential but the one experience that they don't have is the city life, or the university experience. We never had career guidance at school, some of us had never been to the cities before that, so adjusting is very important, and being able to say no to some of the things that other kids are doing. Some people were on drugs and some people were dedicating more of their time to doing other things rather than school work. There were issues of girlfriends and all that. When you can't balance your private life with your academic life, it kind of messes with your academic life. I would say, you need to be able to adjust to your academic environment, to the language and the volume of work. Your private life also needs to be well-balanced, because otherwise you will have a problem.

Support from long term friends



Figure 10: France and a group of university friends

At university I had friends from my high school who formed a family and a support structure. We were not all doing the same academic courses but we were all doing health science courses so the work load was similar. They helped me adjust in terms of the social life which is a big challenge at university, particularly for us from the rural areas, probably that is just as big a challenge as adjusting to the academic life.

When we went back home, it was the same guys supporting each other, encouraging each other about the academic work, our commitment to our community and our commitment to the funder. We learnt certain things about being in the city, but we still knew where we came from, and we knew why we were there. Probably that's why we all managed to finish- it really was that support structure. It was the social aspect of things that also then translated into support in academics, that if you did not understand something, they would have ways of telling you how to approach it. Having this support structure was key for me, and it also made a big difference that it was the same structure I had at home during the holidays –these friends played a massive role in my life.

I think that social support is more critical than many things at university. I saw quite a lot of guys who came from good schools, who never made it at university. They were there but they

never finished, because they started to be hooked on drugs, focused on alcohol, and all that, because there's nobody to police you. And now there's all these many things around you that you've never had. So that's why, for me, it was also important to have the kind of group that I had. We always had the same vision. We did not want to fail. We wanted to graduate. And failing was really not an option, because it was an embarrassment, not only to yourself, but to the whole community. Unlike towns where it's almost guaranteed that after high school you go to university, in the rural area, once you go to university, the whole village, and in a hundred kilometer radius, everybody knows. To come back now, having not finished, is always a very big disappointment to many people.

Because of the many experiences that we had from the rural areas, even when we did not have all the necessary books and things we could still try to do with what we had. This kind of built some personalities within us so as to be able to push even when it was difficult.

Giving back at the local schools

We had been victims of poor career guidance, so during the holidays we visited some of the communities, to offer life-skills education, talk about substance abuse, teenage pregnancies, and to offer career guidance. It was never enough, but it made people aware about careers in the health sciences. What grew out of that was that even the teachers started taking career guidance more seriously, taking the kids to the University of Zululand and all those kind of things. It kind of set a tone for people to start saying look, this is important.

Those community talks helped us become more confident and it put pressure on us, because we did not want to go back without anything having spoken to those people. It kind of put pressure that look, having gone to my school, people are looking at me in a different light now, so I owe it to myself and to them to actually do well, because you end up becoming a laughing stock, having gone to school and telling people what to do and all that, when you're not doing well yourself.

Through seeing us, through us talking to them people then got encouraged and now maybe twenty percent of people in that rural area are taking their kids to places of higher learning.

We benefitted directly from the funding, but now other people are benefitting indirectly. Since our group went to university, many people have started to send their kids to university.

When we started, no-one was sending their kids to university. But now, people in the community sell their cows to send their kids to university because they are able to see what education can do for other kids. That's why, quite a lot of kids have gone to university from that side - not kids from good families, but from bad families as well. Parents are putting their last pennies for their kids to go to university because they can see it does change the family structure, the economics, and all that. It's massive, from what I see now it's massive.

Minimal family support

Unfortunately there was not much family support for me at university, but obviously that was because of where we were coming from. My parents never went to school, so it was a little bit of challenge for them to understand, or even to know what support to give me. It became the hospital's role and basically I became more like the hospital's child. So then my parents removed themselves from that responsibility. I don't ever remember getting money from my dad to go anywhere. Fortunately during the holidays, working at the hospital, I was given pocket money and all that, and those things made a big difference, because I never worried about money for going back to school.

I remember I had a fight with my father because I needed transport money to return to university. The bus fare from Ndumo to Durban was R42.00. He gave me exactly R42.00, but not without a fight. Now I said to him, 'you know, Dad, I don't live in the bus-stop. I live at the university. I still have to get from town to the residence.' So the support from the family was not really that much and that was for me a big gap.

Having role models

Tony Yoelles put me in touch with an optometrist who owns a Specsavers in West Street in Durban and he gave me a part time job as a student. As a student doing holiday work at Mosvold and doing practical's at university I was never exposed to any private patients. It was nice to go and practice in a private practice and learn new things and it brought some belief in my ability to practice optometry while I was a student.

In June and December holidays we would spend time at Mosvold hospital, which created a supportive environment for all the students to meet together, read books and share the challenges and solutions from university. Many black students struggled with equipment at university. Fortunately I never had that problem as when I requested equipment from the funder it was provided for me. That made a big difference because when I went to the hospital I could practice and my clinical skills improved quite a lot.

Politics and the house committee



Figure 11: France and senior members of the university staff

In second year, as I grew more confident at university I got involved in the house committee and many political structures. I would be the first one to agree that those things were really a serious distraction. When you are struggling with your academic work and you involve yourself in so many other committees it distracts you from your studies as it takes your time, day and night when you are called to meetings. But one thing that I realized that for me, as much as it contributed to me getting delayed by a year, I think that what I learned was much more valuable. I wasn't getting that experience anywhere else. In 2000 I was elected to the executive of house committee which meant speaking to students in English and addressing their issues, so I grew in confidence. One of my lecturers even remarked about my confidence and asked what had happened, because when I came to the department I was this shy boy but all of a sudden in clinics and in class I was now able to contribute. So as much as

it was a distraction, I still feel that the challenge was to balance it well, because I felt it was a very important part of learning, of growing up, to be involved in some of the structures.

Participation in leadership positions was critical. It improved my communication skills, helped me academically and launched another person in me. Addressing students built character in me that still helps me today

But one thing that I did realise, was that if extracurricular things are not controlled it can lead to all sorts of problems. For me it meant that I took an extra year to get my degree.

Graduation

Graduating changed me and changed the way people relate to me and my family. Graduation brought a belief that I could do things, that if I could get a degree, I could also get other degrees and do other things.

When I graduated there were no optometry posts - not just at Mosvold hospital, but in the province there were no optometry posts. I eventually started work on the 5th of April 2004 at Mosvold hospital in an oral hygienist post. When I started there was no job description, no equipment and no proper space. My first monthly salary was around R4000. After I withdrew money from the ATM on the first pay-day I called a friend 'Have you seen your salary? How are we going to live?' So the system was not great and money was a bit of a challenge.

Working in a dysfunctional system

The biggest challenge, other than the money, was working in a system that was dysfunctional. Management put us in a small room with no equipment and no supervision. However we did not just sit and say this is the situation. I negotiated with the institution to provide a service for the whole district, instead of just one institution. Fortunately the institution was really pro-active as they gave me transport and allowed me to develop the service by visiting the other institutions in the district. In 2005 I managed to raise funds for equipment for the main clinic at Mosvold hospital. When we were doing the outreach to the other hospitals, if there was a difficult case that would require certain equipment, I would refer them to myself at the base institution.

In 2005 my financial situation improved as I was given an optometry post. I also became part of the provincial team evaluating eye services and trying to put in structures for optometrists. That led to the creation of two optometry posts per district. Those optometrists were expected to provide an out-reach service to the whole district similar to what we were doing at Mosvold. In 2005 the Mosvold eye clinic was voted as the best eye clinic in the province.

Things never happened by chance and I also always had a plan for the eye clinic. When the department's budgetary processes started we would start early. We would meet on a Saturday, invite the management, and present the plan so our plan always got critiqued at the very beginning. When it was time to present the budget my program never got cut because it had gone through the correct process.

Phelophela train

I left Mosvold Hospital to join the Phelophela train in January 2007. When I left Mosvold there was a fully-functional eye clinic with two optometrists, an ophthalmic medical officer providing cataract surgery and an outreach services to all other hospitals in the district. I worked on the train as an optometrist for two years and left in 2009 even though I was offered an eye clinic manager position because I got tired of all the travelling.

(* Phelophela Train is a train operated by Transnet which goes to rural parts of the country to provide a health service to needy people, to provide eye services)

Working for Brian Holden eye institute

I joined the Brian Holden Eye Institute as an Education Development Officer in April 2009, was promoted to Project Development Officer in May 2010 and promoted again in May 2011 to Country Manager in charge of programs. In March 2013 I assumed the position of Sub-regional Manager for Southern Africa.

As the sub-regional manager I am in charge of programs in Mozambique, Malawi, Swaziland, Zimbabwe and South Africa. In Mozambique we are partnering with the University of de Lurio to train local optometrists. Five years ago there was no optometry programme in the country and no optometry services. In 2012 we had the first nine graduates from that programme. We assist the government to develop optometry programmes, create posts to ensure that all graduates can be absorbed into posts and provide optometry equipment so that graduates can do their work. In Malawi we are doing the same thing - we

are running an optometry technician programme at the Malawian College of Health Science and at Mzuzu University and helping the Ministry of Health to develop vision centres.

South Africa

In South Africa we work with the government at National, Provincial and District levels. At National level we work around policy formation to ensure that there are appropriate eye care policies e.g. spectacles policy or assisted devices policy. At a provincial level we lobby for the development of eye care plans, because without those plans there won't be any budget allocation and at district level we work with the district office and hospitals to ensure that policies are implemented. We play an advocacy role for eye services.

Until last year there were no optometrists in the Northern Cape. In 2011 we provided optometry equipment, employed an optometrist and then signed an agreement with the government agreeing to fund the optometrist for a year after which the government would take over the funding. In 2013 they took over one position and will be taking over two positions in 2014. We are doing the same thing in the Eastern Cape and in Mpumalanga province. All of our programs have a research component built into them for advocacy and for planning. We demonstrate to government that there is a need for eye services by employing someone for a year then use the statistics to motivate for the creation of posts and an eye service. We're also pushing for the development of eye care plans because we also feel that they are very important.

We also focus on improving the clinical skills of optometrists and have developed partnerships with local universities to ensure that continuous professional developments (CPD) are meaningful for public sector optometrists. We have been organizing and funding CPD workshops to help develop a public health system that offers a similar kind of quality eye health to that which is being delivered in the private sector - if not even better.

To be a health care professional means that I can contribute towards making sure that many people can see better. By raising awareness people start taking eye care seriously. Because I come from a particular area where eye health was not a priority from the government, I made it my responsibility to make it a priority. Not just in my hospital – but in the whole district and also in the whole province. Probably at the moment it has gone beyond the province and even the country. Partly because of my rural origin I am a public health person and am passionate about making sure that quality health care is delivered to people. Whatever I do

now is really to make sure that optometry and eye health becomes a priority in government. Currently I work with the universities in this country, and even in other countries, to make sure that all the optometrists when they graduate have posts and that their work is recognised as important. If you look at the distribution of health professionals, the rural areas still lag behind, so in my job I try to make sure that we place optometrists and other eye-health professionals in rural areas where people still do not have access to optometry services. At one time my contribution was in my district, however I felt that that was not enough. I wanted to contribute at a much bigger level than that, so I went to Phelophela and from there I came to Brian Holden Institute where my contribution is now at a Southern African level.

Being a health care professional means a lot beyond my profession in the sense that I've been the role model. Quite a lot of people are going to university because I've been there. And when I went there, it was not just a case of me going there and then not coming back to impart whatever I'd learnt. It was also about me going back and showing that it's possible for other people as well.

I am also contributing to the community in general. I do quite a lot of things with the community in terms of community work and all that - whether it's in politics or just in community work. We just had a project where we're looking at assisting the very needy, looking at those households that are struggling badly. Our aim is to pull together some resources to build better places for them at their homes.

Long term plans

In the long term I would like to be a Hospital manager or programs manager. Currently I am finishing off my Master in Public health (MPH) at the University of KwaZulu Natal. The MPH is not really an eye care thing but it would give me a qualification that is broader than eye care and I already have lots of experience in project management.

Family



Figure 12: Frances wedding

I got married in 2011. Getting married was a significant milestone in my life. It changed the way I viewed life, the things that I enjoy and my priorities. I think that getting married changed me into a much better human being. My family is now my priority. I don't think there's anything that comes close to my family. My career comes way second, but it is also there. After work I go straight home to spend time with my family and whatever else has to be done has to be fitted into the time, because most of the time is for them. Last year I even resigned from the ANC Youth League. Many people were not happy when I refused to participate in the struggle things but now I am a family man and I have different priorities.

I learnt a lot from my father. In many ways he always had good advice to give but he made a lot of mistakes in life, and that I've learnt a lot from those as well. I take family very seriously. My dad was too busy to spend time with us as kids. We never saw him. He was too busy working hard. I do work hard, I travel a lot, but I spend every minute I have in Durban with my family. Every spare minute I've got I go to them, I play with them and spend time because for me that is what is very important.

4 Siphamandla's story

Introduction

Siphamandla Mngomezulu is a 32-year-old African man who is married to Samkelisiwe and they have one child. Siphamandla grew up in Ntabayengwe, 15 km from the town of Ingwavuma. He attended local schools in Ntabayengwe and completed his matric at Ingwavuma High School in 2003. He studied psychology at the University of Zululand, did his masters in psychology at the University of Johannesburg and his internship as a clinical psychologist in Bloemfontein. In 2010 he started as a clinical psychologist at Hlabisa Hospital. He moved to Mtubatuba in 2015 and he is currently lecturing at the University of Zululand and is registered for a PhD.

Educational journey

There were guys who had completed matric with high energy just sitting around who would tell us 'we've been there, don't push it hard, because we know how it feels and we know that it's not possible.' So that was the kind of environment in Ingwavuma. Things like that I had to ignore.

Family life – early upbringing

I was born at Ntabayengwe in Ingwavuma just south of the Mozambican border. I have one sister and a half-brother and we were raised by a single mother. From an early age I was expected to be the man at home because there was no dad at home. We had a donkey who was part of the family and each Saturday Mum and the donkey went to Big Bend to fetch sugar which she'd repackage and sell. After she was mugged she stopped getting sugar from Swaziland. The community then recommended her as a Community Health worker (CHW) as she now had no way of providing for us. As a CHW she earned R400 a month which she supplemented by selling bananas. My mum made R 360/ month from the banana business and used this money to pay school fees and to buy something valuable for the family.



Figure 13: Siphamandla on couch bought with money from banana sales

Schooling

In July 1990 when I was five years old I went to Ntabayengwe Primary School because there was no one to stay with me at home. For a few weeks I stayed with the soldiers who were looking after the school and then I started going to class with my sister as an informal learner. After a month I could read and write a little bit and at the end of the year I qualified to go to Grade 2. There was a struggle as to whether or not I should go to Grade 2. Age-wise I didn't qualify and I hadn't paid the Grade 1 school fees. They took me back to Grade 1 for January and February 1991 but at the end of February they decided that mom should just pay the school fees for the previous year, and that I should go to Grade 2. That's why I say I went to school accidentally.

Growing up I wanted to be a family man and work for one of the mining companies in Joburg and come back in June and December like my uncle used to do. Most of males around my area would study up to Standard 5 and then exit and look for a job in the mine and come back during the holidays with a bit of money. All I knew was that working on the mines was going to be a great experience, because I could buy some clothes and things to relieve my mom. Going to university was never really considered. University was only if you were rich and your father was owning a tavern, or a shop and had cows. Then when you completed

matric, then you could sell the cows and go to university.

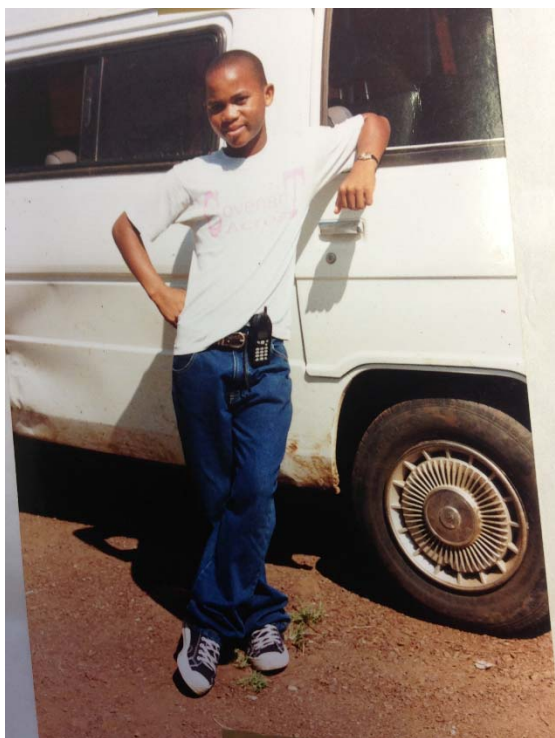


Figure 14: Siphamandla showing off a cell phone next to the taxi

I remember this guy from the community who came home driving this taxi. For me it was a huge achievement that he was a taxi driver, and he was now driving and that he had his own cell phone. He had finished school after Grade 8, went to Joburg to look for work, got his license and was now employed as a taxi driver. I personally saw him as my hero - he had what I thought was life at that time.

I don't know what kept me at school because there was very little reason to stay in school. I think that it was because my mom expected me to and it was important to please my mum. Although she never went to school, studying was not negotiable - I never went to school without shoes or without a proper uniform even if it was an old uniform. I think that she had an idea of me being a clerk, and if I was to be a clerk I needed to complete matric. I think every parent's dream was to see their child working in Home Affairs, there in the offices, typing on the computers so that when they got there they would be able to say "there's my child.....".

Friends of the family

The Mngomezulu family were our neighbours. Mr Mngomezulu keep motivating me, telling me poverty doesn't remain forever. In Zulu we say, *ukhupheka kuyadlula*, poverty will one

day be overcome, that one day you will be surprised that you were there. The Mngomezulus weren't rich but they were very generous, they budgeted for things and were able to take their kids to Scelo Sethu high school in Ingwavuma and to the university. I saw in them a willingness to invest in education. I was very close to their kids. One of them passed so well in matric, he went to Natal Tech, and then went to work at Technicon SA. He motivated me to keep trying to just work, work, work and was the person who carried me through, even though our situation was not the same. I didn't have money, and the only way I could be close to him was to just push and prove myself to him.

Grades 8 - 9

After completing Grade 7 at Ntabayengwe primary school, I went to Nqobizazi secondary school which was a new school in walking distance from home because we could not afford to pay the transports costs to go to other schools. We were the first 16 students in Grade 8 and that's where I experienced the hardship of being a rural student. Initially we didn't have teachers - so they borrowed two teachers from the primary school to teach us. One was very good in Afrikaans, but not good in any other thing. She taught Afrikaans, Maths and English and the other teacher was good in Biology and Zulu. We didn't have books – the teachers come with about seven books. The school only had two classroom – one for learning and the other was initially used as a teacher's room. As the school was not registered with the Department of Education there was no financial support and there were absolutely no resources, no water, no electricity, nothing. That school was almost like an extension of the primary school, which was also struggling.

We were sixteen very committed students, determined to take charge of our own destiny, who studied and were committed to developing our school. When we moved to Grade 9 and a new grade 8 started there was no teacher's room. The parents paid money towards building a new classroom and on Fridays we went with a truck to fetch sand from the river and helped build the new class. During that year the Department of Education came on board and they brought a couple of teachers and then everything started stabilising.



Figure 15: Siphamandla and his friend building the school

Competing in that secondary school was very important for me as I didn't want my friends to get higher marks than me. Looking back now, that competition was very important for all of us because we took the responsibility of learning on ourselves as we really wanted to learn. The whole of that class has gone on to do something great. We were all from humble beginnings and were very very poor and it was the competition that kept us going.

High school

From Grade 11, I went to Ingwavuma High School about 25km from home because Nqobizazi didn't have the infrastructure for us to continue. It cost my Mum R110 a month for me to travel daily to school. The car was not reliable and when it broke down I'd have a problem going to school or coming back. In Grade 12 I had to be at school at half past six

and we would knock off late so my mum found a family close to school that was prepared to adopt me for that year.

Initially I struggled to adjust at Ingwavuma High, not to subjects or academic stuff, but mostly to the social life. Ingwavuma was different from growing up in Ntabayengwa, where we never had electricity, or water, and the school never had electricity and water, and something like TV was unknown. Everybody in my class at Ingwavuma High was talking about Yizo, the gangster story on TV. It was the buzz around the school and people would ask me about Yizo, and it was very difficult to comment when I don't have a TV at home, let alone having electricity. So I struggled to fit in because I had nothing to contribute to those discussions.

I felt so inferior and lacked confidence when I went to Grade 11 at Ingwavuma High. I knew that we hadn't been studying high school material at Nqobizazi as we didn't have anything equivalent to what they had at Ingwavuma High. The kids teased me and called me Nqobizazi and I felt very demoralised, because I knew it meant that you were from the underprivileged school where people are just joking or clowning by going there. Because I felt inferior I had to do something to compensate for that, to find the one thing that would make me superior. That one thing was to work hard and really excel. Initially I didn't even have a friend as I just spent most of my time studying. After three months I realised that most of the teachers were on my side, that they quite liked me because I had a good attitude and I wanted to work. The teachers started to trust me, to give me some extra work, and eventually I was top in the class, and taught other students maths and biology and agriculture.

Starting early and finishing late

In Grade 12 there were very few teachers who were motivated to see us passing. My friend and I wanted to do horticulture and realized we needed to do well in biology and maths, so we arranged evening classes and organised a teacher from a neighbouring school to teach us because our matric maths teacher got sick in February and never came back to school.

I chose to do all my subject on higher grade except Afrikaans which I did on standard grade. We had a fight with the teachers because they said we would fail maths on higher grade and it would lower our overall marks and prevent us from doing anything after school. My friend and I fought and fought, and never listened to them. From June 2001 if we knocked off at

Ingwavuma High at 14.00 and we knew that there was a maths lesson at Scelo Sethu we'd walk there and sit in the maths class as they had a very good teacher.

In August 2001 we got a teacher from Nyamane high school to come and teach us maths but he didn't have a car and he only arrived occasionally. We decided to walk to his place (about 10km) after school and although it was dark when we come back we never saw anything wrong with that. We just had to push. In September we started going three or four times a week for those extra maths lessons. I was very good in geometry but not so good in algebra, so this guy from Nyamane taught us the tricks of doing maths. What kept me going was the sacrifice that my mom made. Every time I just thought, I cannot afford to disappoint my mom.

Only two of us wrote matric maths on higher grade exam and when the results came back I got B and my friend got D. The teachers were all surprised, and even up to today they are still shocked that we really achieved so much.

The other subjects were easy because we had teachers. Whenever the teacher would say, Spha or Thabiso (my friend), can you take the lesson today I used the opportunity to revise the subjects by teaching them. By August, I knew I was up to date with all my other subjects.

Thinking about university

While I was doing Grade 12, the reality sat with me that I don't have money to go to university. Between January and November, I applied for about ten or fifteen bursaries from engineering to health-related fields to horticulture. My first choice was horticulture and my second choice was psychology. Although I'd never seen a psychologist I sort of had an idea as my mum was responsible for running the DOTS (Directly observed treatment support) TB program from home. TB patients would come to our house every afternoon for their medication and I ended up giving out the medication. I noticed their lack of compliance and that most of them came drunk, and would vomit after taking their medication. I started chatting to them, finding out what was going on and why they were drinking. Mostly they didn't see any problem with drinking but a few decided to change, to come and collect their medication in the morning because I thought that would be ideal, then they could drink later during the day. I never thought that was part of psychology. It was just in me, there was that thing that I wanted to do.

Psychology was my second choice, and my third choice was dentistry. I so applied for funding from MESAB and from Eskom and Telkom, and a lot of them responded quite positively, that they were just waiting for my final year exams, and they could sponsor me in January. In July 2002 Sabelo come to Ingwavuma High to talk to us. He had graduated from Ingwavuma High in 2001 was doing dentistry at Wits. The school was very proud of him, so they invited him to come and inspired us. That's how I got to know about Friends of Mosvold (FOM) scholarship scheme. After hearing about FOM SS I went to the hospital where Mrs. Nsimbini told me everything including that psychology was not sponsored. Despite that I just thought, I'm going to pursue it and I kept psychology and dentistry as two careers that I wanted to pursue.

Challenging times – easy to get discouraged

It was a very difficult time for me between December and January. Things were not going my way as I was not getting the sponsorships I was looking for. I was very anxious and though am I going through the same cycle? Am I just going to finish matric with that energy and then just stay home? I did voluntary work at Ingwavuma Orphan care, initially for two weeks but I ended up working there for about two months, because I just didn't want to stay at home. I kept meeting new people and I thought there was always a hope that somebody would come and rescue me and help me with the university registration fee of R 1900 which my mom just couldn't raise.

In January 2002 I went for the interview at the hospital which was my last hope. I was not very optimistic after the interview as there wasn't a student who had been sponsored in psychology. My only option now seemed to go to my uncle, do a short mining courses and get a job on the mine. I told Dr Barnard (at Ingwavuma orphan care) "I'm leaving next week, this is my last day, I'm going to Welkom to my uncle." She said to me, "no ways, no ways, and no ways. If you don't get the scholarship, you can stay here, we will give you R350/month just to buy toiletries and have money for transport to come here. We will see during the course of the year if we can get families from abroad willing to pay your school fees."

Towards the end of February 2002, Mrs. Nsimbini called to see if I still had a space at university and could register. She told me that one of the other students didn't get a space at the university, so they were giving the scholarship to me. I remember that day, just how everything happened. I called UKZN and they said they were full. When I called the University of Zululand (Unizul) they said I can still come although they had finished registering first years.



Figure 16: Siphamandla's first day at university

When the Mngomezulu's heard I had received a bursary they gave me clothes to take with me. They were old clothes but I was so proud that I had something to keep in my box so that if I had go to town I had things to wear. I was so excited that I was going to university, to study and become something.

I was so excited when I got to the university and the whole family was waiting to hear how things were going, because they never thought it could happen, because things like this didn't happen. I had a letter from Dr.Ross saying that Friends of Mosvold had given me a scholarship and would be paying my fees. At Unizul I presented that letter to Mr Grobber at the Financial Aid Bureau. Mr Grobber looked at me and said 'Friends of Mosvold, what is that? I have never seen this scholarship and I cannot register you for this year. It was my last hope. I remember I shut myself in the bathroom and I prayed and prayed for an hour or so. I was afraid to tell my mom because I knew that she was just going to be hopeless, and really really sad, that things were not going well. I went back to see Mr Grobber at one in the afternoon and then the next day and the next day and the next day hoping he could sort

something out. On the fourth day, the Mr. Grobber said, 'you can register.' And that was the beginning.

By that time lectures had started and I had to catch up with everything. There was just one thing that used to keep me going at that time, and that was the thought: if I fail here, I'd lose the scholarship and it would be over with me and the career and everything. I worked so hard when I got to university. It was going to the library, going to the dining hall, or going to church. In the morning and the afternoon I was going to church to pray and that's what kept me really really focused. Because nothing else mattered to me. It was library, church, and the dining hall for food. And for the whole year, the first year, that's how I survived. At the end of first year I scored very high marks simply because I had no option, I had to make it. And if I don't make it, I'd lose the scholarship and it would just be the end of the world.

Despite working as hard as possible there were things that just seemed impossible for me. In Philosophy they would tell you all these Russian stories and you had to give your own critical and creative interpretation of those stories, to think out of your head. With my poor English, it was complicated and on three occasions I got a note on my assignment 'Go and see the lecturer'. That was tough because at high school I was always a top student. I started to question myself 'is there something wrong with me? Is this really for me?' and I felt so discouraged at that time. I decided to go and sit with the Professor to try and understand what was happening because it troubled me and kept me awake at night. The Professor told me that my ideas were very good but the way I presented them and the way I constructed sentences was not good. As I was very motivated I asked the professor what I could do urgently with my English. The Professor offered for the Department to pay for me to attend the English classes offered by the English Department. I attended those English classes for two weeks after which I had an idea about how to write at the university and I excelled. By second year everything was easy - I'd adjusted and at the end of my second year I was selected as the best performer within the Faculty of Arts out of more than seven thousand students. It was such a motivation that I got recognized, something that I never thought would happen.

At university I had a group of five friends who competed with each other which really helped me. It was the most amazing and rewarding time, when you compete, and you get good marks, and at the end of the day you stay being the top student. I think for me that motivated me a lot.

Friends of Mosvold family

The FOM group at Unizul keep us connected and focused, to say, this is what we're here for. It's so easy to get involved in a lot of things at university, and end up forgetting that, I have a scholarship, and I am accountable, and I have to answer questions from Andrew at the end of the term. As a group and we met for braais, and talked about those issues. We supported each other and brought that sense of accountability. Visits from Dr. Ross made a huge contribution. His visits reminded us that we were important and that we needed to pass, and if we don't pass we would have to account at the end of the day.

Computers

In 2002 I registered for Computer Studies because the computer fascinated me and I just had to know what was happening with the computer. I took more technical courses and by the end of my first year, I knew that I was interested in computers. In February 2004 I was asked to work in the computer LAN and so on top of all the other stuff that I was doing I did a night shift from twelve at night to five in the morning in the computer LAN and studied during the day. They paid me a little money which made my life to be easy, I had a bit of cash, I wasn't stuck, and there was nothing really to be worried about. When I went for holidays, I could buy things for my family, that's how I managed to relieve my mom, to say, I'm okay now.

In my third year, they promoted me to the technical service department and in my fourth year they promoted me to the network services. While working there I was still the top student academically. I never got bored at university and never had time to sit or party. Either I was active as a leader in church, or working as a computer technician, or working in technical services department, or doing my studies. My commitments forced me to prioritize, to say my school work comes first. I did my assignments straight away, attended lectures and studied early for the exams. I did so well because everything was up to date.

Can do attitude

During my honours year, when I was doing my practicals at Mosvold I saw an advert for an overseas scholarship in the Mail & Guardian and I decided to apply. I thought -why not, I'm performing well at school and it looks so lucrative. I don't know what convinced them to take my application because I didn't have four years working experience. I was twenty at that time and went there with this attitude that nothing is impossible and feeling that I had the potential

to do anything. The others at the interview were 45 or 50 years old, had worked as directors and wanted to do an MBA abroad to upgrade their qualifications. It was so exciting for me, being on the flight for the first time, my mom knowing that I'm flying and seeing Johannesburg for the first time.

I was so ignorant or innocent. I didn't know about the world generally, that there was a world where things were impossible. I knew this world where I could do things, and where I was going to do things. It was an international scholarship so there was an old professor from New York who asked me a lot of questions. A week later I get a letter saying that I've been accepted, and I need to start looking for a place to study at any university in the world. I thought wow!

I had applied to Unizul and the University of Johannesburg (UJ) for the Masters clinical psychology and after I heard about the scholarship I started looking for a university abroad. I was accepted at the School of Health at the University of London and at Amsterdam University for a three years D Psych program. The scholarship had a pre-departure program where former students came and told us what things were like within your field. I met a lady who told me that she had studied psychology in the US but was unemployed as a psychologist because her master's degree was not recognised by the Health Professional Council of South Africa (HPCSA). That was my turning point, because I just thought no ways am I prepared for that. At the back of my mind I still had this thing that I need to go back home, because my mom, even though she's excited that I'm there, her life hasn't changed. Even though I had managed to put in electricity and water at home with the little money I had from holiday work and working in the computer department there was still that passion that I still need to build my mom a house, I still need to really make sure that she is fine.

Eventually I settled on University of Johannesburg (UJ) for my masters, with the option to do a sandwich program at the University of London. In 2007 I started at UJ as the only black African in the class. It was quite a challenge because UJ is the former Rand Afrikaans University (RAU), so certain departments still have that legacy of RAU and there was a lot of Afrikaans spoken on the campus. At the time I never saw anything wrong but when lecturers came they were forced to lecture in English. Independent consultants who came to give lectures, would come with Afrikaans slides and when they got there they'd ask me 'do you

understand Afrikaans?’ When I said no they would have to try and adjust and translate the slides into English. Some of them really struggled with English.

The course coordinator and Head of Department was very supportive as I came with this prestigious scholarship and was well taken care of. The people from New York would call wanting to know how I was doing so that gave me a bit of respect! During the course I would say to the coordinator ‘I need to go to England’ and they had to accommodate my sandwich program which meant spending three months in London, then coming back to UJ to write the exams. That was quite a challenge, doing the Master’s program at UJ plus doing the sandwich program. I was in the D Psych class at School of Health at the University of London and what I enjoyed the most was when I when I got to London, they were behind and I knew a lot and would be lecturing them!

There were just a lot of things around UJ that marginalized me. The system, the research, many things. I felt that I had to fight to show that I can make things happen, I had to prove myself all the time. After the Master program I just felt I needed to break away from Joburg.

Internship

I did my clinical psychology internship at the Free State Psychiatry Complex in Bloemfontein. Most of the patients there were Afrikaans or Sotho speaking and no one was willing to translate for me. To learn the languages I fellowshipped in an Afrikaans church and had Sotho friends. I learnt Sotho and Afrikaans in a very short space of time and the Free State became my home for that year.

Struggling with the dissertation

A full dissertation counted 50% towards the master’s qualification and by the end of my internship I hadn’t completed it so I went back to UJ to finish my research. I ended up spending the whole year in Joburg, - I did some lecturing on Saturdays at Wits, at UJ, and the College Campus. I was very much into academics then and was amazed to think that I was a student here and the following year, I’m lecturing. But there was still that thing for me, I made a promise that I had to go back and serve my community.

BMW approached me with a lucrative deal to change to Industrial Psychology and to work for them. A mining company also approached me with a great offer to run their employee wellness program. However I had this thing that, if I took any of these options I would be leaving my family by staying in Joburg. So I left all that, I put in an application for a community service post and started at Hlabisa hospital in 2010.

It felt strange to come back to a rural area and have a slow life, taking it easy. That part was very difficult for me. So I tried to really push, push, push at work. I was the first psychologist to work at Hlabisa and had to think wider and more strategic than just providing services at Hlabisa. Mosvold, Bethesda and Mseleni hospitals were all referring patients to me so I fought with the medical manager for beds and it seemed like I was exhausting Hlabisa's budget. So I decided I would try and visit all the hospitals with the Red Cross plane. However it became too complicated for me.

In 2011, I started rotating around the hospitals in the district using a car that belong to Hlabisa hospital. That was much easier for me and it meant that on certain days I would sleep at home, wake up in the morning and drive to the next hospital. I had a hectic schedule so I requested a community service psychologist to work at the other hospitals.

Coming from the rural area I've learnt a lot from the rural community. It gave me that grounding, across all these places I've gone and every activity I've been involved in. It kept me very open-minded, because I know the rural community life. The one thing that was evident with me was I had this attitude that nothing is impossible, and two, I had this humility that was with me. I knew that I came from a very difficult situation and had this moral obligation to my mum and the community and I was very careful about decisions that I made. Even when I had fantastic opportunities, I was aware that I would not make decisions that would backfire on me in the long run. I've always had this dream that I wanted to come back and change my family.

The challenges that I've had to overcome, contributed to knowing that, if I want to do something, I can do it. I went to Bloemfontein, I worked there when I never understood anything, but I wasn't worried because I thought, I'll do it. And nothing would really be in my way. I think that's the strength that I still have even today.

Working as a health care professional

For me, personally my humble beginnings makes me see my work as a health care professional as a calling. I don't know what kept me going but surely God must have had a plan as there must have supernatural intervention to turn things around because not many people have had these opportunities. I see it as a calling, and that keeps me humble and in

touch with the community. As a psychologist I'm expected to be strong, but I get so emotional when I go to communities that are struggling. A week ago I was in a clinic next to Mpembeni, where people still go to the river to fetch water and everything. I saw two little boys going barefoot to school. You could see that they were late, but they had to take the cows and leave them somewhere, and then go to school. And that made me emotional. I thought of these young, helpless guys who I know have potential to make it, but how many of those young people will persevere to stay at school until they finish. So that made me realize how lucky and how privileged I was. I have been able to break through the socio-economics circumstances and generational boundaries of not studying. Working as a health professional within my area, makes me think broader than just my duties and my responsibilities, which is why I decided to implement my services across the district. There's so much that needs to be done, and I'm able to understand better what people mean if they say they can't get to the hospital. Because to say that you're going to the hospital is like saying that you're going to town, because the hospital is located next to Spar. You must actually be going to town to get to the hospital! So I understand when people say that they can't afford to go to the hospital. As a result my services are more community-based than hospital-bound, and I'm more in the community than in the office. Knowing that if I don't go to a certain clinic, there's a person there who is waiting for me, who has only that option, to go to that clinic, and nothing else. That's why I don't have working hours. Today I'll probably come back at seven but that is what gives me peace to go to bed knowing that I've done my responsibility.

Working rurally

I'm able to adjust everywhere and have this motivation that just keeps me in the rural areas. Working in a rural areas meant that I had no guilt, because a lot of companies tried to recruit me when I was in Joburg, and I just had that sense of guilt, I had promised to come back for the community. It didn't feel like was cheating the scholarship, but it felt like would have been cheating the community. And I felt that, even if I could have a lot of money there, I would still have one thing in life unfulfilled, you know, whenever I come back home, there would be that gap. It would feel like I've even cheated not only my community but also my family. Working here in a rural area it brings so much respect and dignity to my mum from the community. She knows that her child is something, is assisting in the community, that her child is actually doing something meaningful in the community. It's unlike working for BMW, coming back with a BMW, come back home and then leaving.

Since I have been back my family has been transformed, people have started recognizing that there's a family there. We live in a new house that I've just finished building, and it's now being counted as one of the families in the community. Last week people from my mom's church came to pray when we moved Mommy to the new house. People were amazed when they got there, and started narrating the old stories about the donkey and how we struggled. It made me to think that people have a tendency of writing other families off when they see that you're struggling. They never see that something good can come. And I think that's what brings this cycle of poverty in the communities, a **belief that nothing will ever come out of that family**.

Previously people never really counted us, we were never really looked at, but people have now started looking at me as a role model, looking at me as a person kids could look up to. Even though my mom is a general orderly in Mosvold, a lot of people respect her because she has a son who is a psychologist and that has brought the dignity to my family.

Culturally appropriate psychology – living in two world professionally

During my training, I went deep into Western psychology. It was frustrating though because I had this sense that this will not work for the people in my community. In Bloemfontein when people are stressed or depressed they go for therapeutic interventions. People in our communities don't even realise they are depressed. There isn't a direct word for depression in Zulu. Ngipatheke kabi is the word that signifies that I am depressed but few patients actually say that at the hospital. It's very common and acceptable for people to complain about somatic pain, which most of the time is not supported by any medical condition and that's how we pick up depression in the rural communities. Professionally I have come to understand that what the DSM IV says it's not what always works in rural mental health. The criteria might be the same, but it is the contextual criteria that counts. So professionally it has taken me a long time to understand these things, but the more I read about community psychology and culture-bound psychology I'm getting to understand it.

Career guidance and sharing information

Since being back at Hlabisa I have been involved in a lot of organisations that do career guidance. At church they invited me to the youth services to motivate the youth, and to talk about growing up in rural areas, and the fact that you can actually succeed. I also talked of the

importance of young people grounding themselves spiritually, which contributed a lot in my life.

Along with others from the church we have been looking for opportunities that exist for young people within this area. Many local companies and most departments have bursaries and we want to know about those opportunities and share it with those that need it. We have also partnered with the municipality and have taken over the municipal strategic plan for youth development.

Recently when I was talking at a school I realized how privileged I was. The school was just like the school I went to where children could not communicate in English and where they know nothing about the Central Application Office. I'm try to be a role model and someone that can encourage them. When I speak at schools I start off telling them where I come from and a lot of them get surprised. Without that it is easy for them to think Ag, he's one of those privileged people and they never really internalise the message. But when I tell them this is what has happened to me – you can make it - that's when they start relating to the message. I start at the beginning, and then go on to tell them about the options.

Current studies

At the moment I am registered for a PhD through Unizul and am finishing off a diploma in public health and I actually intend to start a consulting company in the near future that will be specializing in wellness programs for corporates, local government and then hopefully for the mines.

Head of the House

In my second year at university I appreciated more and more what my mom had done for me. For me, it was a completely new dynamic. I saw myself as a son and also the leader in the family who was expected to change things around because there was no-one else. My older sister got pregnant when we were doing Grade 11 together. So I was the only hope for my mom.

Lessons from my sister

After my sister got pregnant she left school for a year. Mom then took her back to school and she passed matric but with bad results. She didn't want to go back and repeat matric so she

went to work for Zisize. She worked there for a year then she got pregnant again, so she had to leave home and stay with the father of their kid until she had problems, and then she came back home. Since then she's been working for less than R1500 a month with no promise of future development.

When I was at the university I was so angry with her. She didn't look at the situation, all that she did was make my mom depressed – initially when she got pregnant, and in the second instance when she had to move out of the house, and to go and stay with a man whom she was not married to. Ya, and since then she has three kids, she's back home, so with that minimal job for her to survive.

Although we are from the same family I developed a determination to see things change at home but I don't think my sister had that idea. We had no real role models in the community but when I went to Ingwavuma I think I had the grace to find good people who were really inspirational to me.

For my sister, I don't remember any good role models around her. I think we all had friends and most of her friends came from very dysfunctional families. Not only financially unstable, but also in terms of discipline and everything.

Living between two worlds

I have struggled with juggling the different roles in the family. I grew up as a boy who had to be a father at a very early stage. My mom consulted me whenever she had to make family decisions. She trusts me and she trusts my judgment and I still struggle with the role of being a son and the head of the family and an uncle to my sister's children.

Planning a wedding in a culture in transition

One of the biggest challenges this year has been negotiating with my family about our wedding. Family members think that we should be having our wedding at home. Having the wedding at home means not sending out invitations, just putting up a tent and hoping that your guests will arrive as well as any number of community members. For me, with my educated mind, I'm thinking, how are we going to control the numbers? In terms of food and in terms of cost ... but our families are thinking in terms of what is the community going to say. So I guess for me I find very difficult to adjust. And it's not that I don't feel like I'm part of the community, but once you've gone to tertiary, once you've qualified or once

you've lived in an urban area, once you've socialised with certain people, there is a certain level of understanding that I've sort of accumulated. Even though I adjusted well when I came back to the community, I'm different. Not just in terms of the qualification, but also in terms of the level of my thinking. So that's my main struggle these days. We've eventually settled on having two weddings, one English wedding, and one African wedding. I see it as something that's going to be a struggle for the rest of our lives.

Family is important

I'm ambitious about the family. I always just picture myself with my better half and my child. I never thought I would reach the stage where I would have such an interest in seeing my own family. It doesn't matter how poor or how underprivileged you are, when this stage comes, you just... You know, I've stopped being concerned about everything but establishing my family.

And I've always dreamt of growing up with a father figure, someone that I could refer to as a father, and sit on his lap and enjoy being a son. Unconsciously within me there's still that son crying to have a dad.

Spiritually grounded

My deep-seated spiritual grounding is what drives me. During my years at the university I had found meaning and grounding in spiritual things and I ensure that I grow spiritually. This is what has guided me throughout my life and gives me meaning and a sense of self and a sense of purpose.

My dad

I have vivid memories of my dad. He left when I was four and a half years old to work in a mine in Joburg and came back with an old car after six months. After that he left and he never came back. The last time we heard from him was about 1996 or 1997. Part of why I went to Joburg to do my Masters was that I wanted to see him. I wanted to meet him. From Joburg I went to the Free State. I spent a lot of time looking for him in the mines. I've been to Rustenburg, I've been to North-West, and I've been to Vaal Gold. I've been to all of these mines looking for him. Lately I have come to terms with the fact that I cannot spend the rest of my life looking for him. Instead I must invest my resources looking after my mom.

5 Themba's story

Introduction

Themba Mngomezulu is a 32-year-old African man who is married with three children. Themba grew up in Ingwavuma and attended the local junior and high schools. He matriculated in 2000 but was unable to afford the university application fees so spent 2001 doing odd jobs, including construction, to try and raise the money that he needed for university registration. In 2002 he went to the University of the Witwatersrand where he trained as a physiotherapist. Themba graduated in 2006 and worked at Mosvold Hospital from 2007 to 2010. From 2011 Themba worked as the chief physiotherapist at Emmaus hospital near Bergville and in March 2015 he returned to Mosvold Hospital where he currently works as the chief physiotherapist.

Themba's story the man from nowhere

I don't know where to start, because it's a very long journey. I was born on 25 September 1981 at Mosvold Hospital. I'm the first-born and have one brother and two sisters. Our family was poor and we lived in a very disadvantaged area. We are a very religious family and attend the Shembe Church.



Figure 17: Themba participating in a church function at home

Personally, I'm into sport, left and right, to and fro, particularly soccer, which will always come everywhere in my life, even at my funeral.

My mother only went up as far as Standard 4 and my father went up as far as Standard 6 but they were both curious about education. They knew that it was important for me to continue to study. But to study for what? That was not clear. The school that I went to was 14 kilometers from home and we walked there and back for 12 years, seven years to Our Lady and five years to Isicelosethu high school.

We didn't chose schools because they provided a better education than other schools in the area. We went to the school that was closest to home. Those schools didn't open up your mind to encourage you to think that whatever you are doing now might impact your future, or that subject choice was important or about life in general.

I chose mathematics in Standard 8, not because I wanted to be a physio (at that time I didn't even know that to be a physio you had to have maths), but because I liked it and I was very good at mathematics. I enjoyed each and every subject that I was doing at school even English and Afrikaans. I used to debate in English and Afrikaans and really enjoyed that.

Personally I was down to earth and respectful. I respected my teachers and they would enjoy teaching when I was there, because I would always bail the class out if there was no-one to answer their questions. We had teachers at school but not the best teachers. The maths teacher in Grade 11 and 12 was fantastic - one of the best teachers I've ever met. In biology we were helped by Sabelo Mngomezulu who was in our study group. He ended up teaching our class because students understood him much better than they understood our class teacher! Although the teacher was not good, he was open and not jealous, he was not that kind of a person. I got C for biology, which Sabelo Mngomezulu played a huge role in.

Initially I wanted to do engineering because there was a brother in the area who did electrical engineering and he bought a red Honda which I thought was very nice. I decided I want to be an electrical engineer so that I could drive that car! That was the only thing that was in front of me, besides seeing a doctor when you went to hospital, and then you'd only meet a white person. Other than that there was the teacher that's in front of you in class and the nurse when you're sick.

In Standard 11 I was getting excellent marks in the electrical section. However when I was in Grade 12 I saw some people who had done electrical engineering becoming correctional service officers, and teachers, and I thought maybe it's not good work. I don't want to come back and stay at home if I've spent a lot of money studying. And, ya, it changed my mind a little bit.

I did not have money at school and I struggled when we had weekend games or trips to places beyond Jozini. My best friend, Sabelo paid for me when we were visiting Richards Bay with the school. He's got building talent and used to get money by building houses over the weekend which enabled him to pay for me to go on that trip.

Open day

Most of us didn't really have a clue about what to do after matric. During my matric year there was an open day at Mosvold Hospital where we were exposed to different disciplines in the hospital, and the one that interested me was physiotherapy because it was sport-related. That open day is where I got my career. I thought if I work as a physio I will be exposed to my favorite soccer players and might even work for the Sundowns team, because it was too late for me to become a professional soccer player. So that was the motive behind physio. The open day was very important in making people aware of the opportunities in health science, and exposing us to more than just medicine and nursing.

After finishing matric in 2000 I didn't have money for registration so I couldn't continue my studies. I wanted to apply to Mangosuthu technicon, but I didn't even have money for the application fee. I tried to make money by taking photos using a camera that my father bought for me. Then I joined a company called Golden Neo Life Diamite selling soaps and herbs and stuff like that. I used my money from taking the photos to get stock. It was hard work and difficult to find customers because those products were very expensive. I worked for that company for three months and after that I couldn't continue. All the money that I was getting from the camera, I was using to buy those products, and I couldn't cover all the costs. It was a failing thing. So I had to get piece-jobs, one of which was working in a construction company. If you don't have money you can't go to 'varsity - **it is just like a dream that is impossible**. Because you have to pay a lot of money to go to varsity.

From the information we were got at the open day, I realized that if you can get the money to register, you stand a better chance of getting funding than someone who is not in 'varsity at

all. So I tried by all means to get money to register. That was my target, - I thought that if I could get the registration fee, then anything would be possible.

In September 2001 I heard that Friends of Mosvold were doing interviews mid-week. I asked someone to work in my position at the construction site for the day so I could go to the interviews. I went to the interviews and was accepted to be a Friends of Mosvold student and I applied to Wits with the assistance of the scholarship and was accepted in 2002 to study physiotherapy.

*Friends of Mosvold came to my rescue. That scholarship, ah, I don't have a proper name, but it was **where everything started to change**. That's where **I got my life that I'm living now**.*

University

There was a huge gap going from the rural area in Ingwavuma to the University of Witwatersrand one of the best known universities in the country. For me it was the first time I was leaving my family, staying away from home.

Adapting to city life was a challenge. There were lifts in the university and I remember one day I got stuck in the lift. I think that lift was faulty, but you know, you have to be exposed to something before you know what to do when things like that happen. So it was very challenging.

On the other side it was also nice. As first year students, we were taken to Sun City, Gold Reef City, and to Monte Casino which was really lovely. We were exploring whatever was in front of us. We were studying and at the same time, enjoying life.

There were a lot of challenges at Wits. In first year, English was a challenge. Not because I couldn't speak, but because I was not used to speaking English. I was good at English, but I'd never had a white lecturer standing in front of me and teaching in English, only English. I never had a teacher whose first language was English, telling us something that we really needed to understand. In my first lectures I remember thinking 'Oh! What are they saying?' They spoke so quickly that I couldn't understand what they were saying. It was the speed, they'd say this and this and this and then finish and then they'd be gone! And I couldn't even take notes because everything was quick!

I started to think to myself, 'How am I going to make it in this place? The pass mark is 50% and this place is difficult. I can't understand what they're saying. They're quick.' You know, it becomes very difficult. I remember thinking 'I don't know how I'm going to cope. Maybe I will get used to it as time goes on.' But there is no time to adjust as soon you are writing assignments, tests are coming and they all count towards your year mark. There's nothing like, 'Oh, we're not going to count this because people are still new,' and they were not understanding what was happening.

I remember Dr. Ross used to tell us 'talk English to each other as much as you can, read, and if possible make friends with someone who only speaks English. You must also go to MESAB office to find some tips on how to patch up with the 'varsity life.' I went to the MESAB offices and asked for their help. They provided a student assistant who taught me how to take notes, how to compare your notes to the books, and to make sure you know that whatever you're reading in the book is related to what the lecturer was saying. It became better, and at the end of the year, I passed.

Extended program and struggling

I didn't go straight to mainstream. I started at the College of Science, which meant doing first year over two years, as it was an extended program. I think that helped me a lot because there was enough time to deal with the other pressures of being at university besides the actual university work.

My first assignment, I got 35%, and I cried. Ya. Because I knew, as I was there, **I had to pass, and if I didn't pass I would have to go back home and experience the very same life that I had been through, that I wouldn't like.** So it was that pressure. Dr Ross, used to visit us monthly, and if we had problems he would ask, 'What's your problem? How can we help you?' And then he would follow up and make sure your problem is solved. I don't remember a single time when I said, 'I've got a problem,' and I didn't get an answer or a solution for the problem. I'm also the kind of a person who doesn't give up and I was determined to make it.

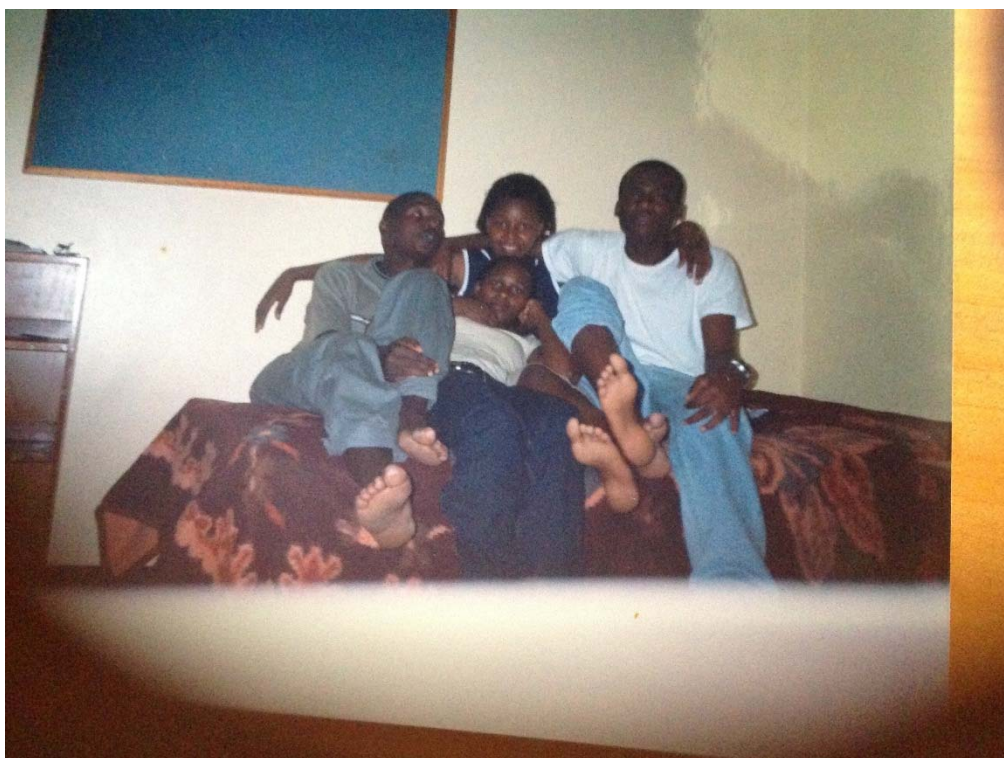


Figure 18: Themba and a group of friends of university

As a group of FOM students we supported each other a lot. We had monthly meetings, and we'd discuss how each and every one of us was doing. We had a representative, someone who was in charge, whom we were reporting to, and that one person would report back to Dr Ross about how we were doing as a group, where we were struggling and where we needed support. As a team we really worked very nicely together. The meetings were very useful. They were not just there for us to sit and discuss problems. They were also acting as a support group. Sometimes when you haven't done well in a test, say you get 45%, you get depressed, or are embarrassed to tell others that you didn't pass. It was tempting if you had done badly to hide your result or even lie about your results and say 'I have passed,' when in fact you haven't passed. But you know when you're in these groups, you will hear someone say 'No, I haven't done well, I got 35%.' And you would say 'Yoh, I got 45%, then I'm much better than this guy!' And someone else would come and say no, they got 70 or 75%. Then you would think if he got 75%, why don't I just try to get 50%, or 55%. Then you work even harder.

Issues and support

There were lots of issues when we got to varsity - like coping with the amount of work that we were exposed to. Failing was another one of them. Failing tests, assignments, preparing

for examinations it was all quite a challenge. Sometimes there were social problems. My step father passed away when I was still at 'varsity, and that took away some of my concentration at the time, but with the support that we had I was able to overcome it.

The support was mentoring. I will call it all the words - it was mentoring, it was coaching, it was guidance, all kinds of support. For instance, if I didn't pass a test, Dr Ross would come and ask, why didn't you pass the test? That was a question. And then I needed to know exactly why I didn't pass the test. Most of the time it would be because I didn't understand the question, or I didn't finish on time, or the paper was tricky in the way that I couldn't understand what was being asked. So when Dr Ross came there, he would tell us about the resources that are available at the university, some of them we were not aware of, such as the counseling service for students which was available to teach us alternate means of studying, about dealing with pressure and the work load at university. I learnt to study in many different ways, **because I tried everything** to make sure that at the end of the day I got the required result. Then, at the end of the year, I managed to pass, because that was the bottom line, you needed to pass.

Attending the golf day

I remember in 2003 asking for money for the physio golf day and Dr.Ross was not very sympathetic about funding a golf day. I was the only African in the class and most of the white students played sports which were different from what I was used to. I wanted to make friends with guys in my class because we spent most of the time together. I thought that if I don't participate in their sports I would always be on the outside... so Dr.Ross gave me the money and I went to the golf day!!!

To be part of the physio team I learnt about rugby and golf and I even went to a ballet dance, something that I'd never seen before coming from Ingwavuma. Going to 'varsity, getting to know all these different activities that people do, prepared me for things like going out to visit, eating out and all that. When I was growing up my family never had money to eat out so it was something we were not taught. But now you know, it's even applicable to my own family. When I've got money I will say to the kids, 'guys, can we go and eat somewhere?' And they will say, 'Let's go and get a pizza' And we'll go there!

Second year

First year was difficult, but second year was very difficult. Second year was difficult but the good thing was that I had already adapted to the city life, I had adapted to the university setting, the university standards, and I knew what was required of me. Even though it was tough, anatomy and physiology in the same year, it was a lot of work and another language, not just English. It was a medical language, so we had to learn it. But I coped, because when I encountered these problems I knew what to do. I knew where to go, and I knew how to prepare myself for such circumstances. Even though it was hectic I continued to play sport and did not just study, study, up until you can't study anymore. I went to second year, third year, and final year. I passed final year.

Having been involved in Friends of Mosvold Scholarship Scheme, I had to come back and work with the therapists in the hospital during the holidays. We would work at the hospital, meet other students who were in the same program and get support from the seniors. Mrs. Ross was the senior physio and she was very good with me. In my entire life, I have never met a manager like her. I learnt a lot from her as a person and in the actual work. She was a mentor, a teacher and a guide. Holiday work made a huge difference because we would speak English from the morning until the afternoon. Being there all the time, asking questions, 'Why do we do that, Glenys?' She would teach and show us. It was interesting. Ya, those times were good.

That mentoring and support contributed quite a lot. At university when we had problems, I'd call Glenys and ask her to help me. One day I called at midnight because I didn't even realise what the time was, because of pressures at 'varsity. There was a lot of support and it helped us a lot.

There was also support from the senior students, Dumisani, he was very helpful. He was mentoring us and he was always there for us when we went back to do our holiday work. Sometimes he was hard on us, but he had to be hard because he had to see what we had learnt, and that we could apply it, which was also very good and very helpful. And as we grew we also became seniors. We also guided the other students who were coming behind us, so we also became Dumisani's after Dumisani had pulled us up. We were also mentoring those students, guiding them, coaching them, especially the physio students.

During the holidays we would go visit the local schools and tell them about Friends of Mosvold, tell them about the possible opportunities that they might have. Doing those talks and seeing us at 'varsity, inspired a number of people in Ingwavuma and we developed relationships with some of them. They would call me; they would ask a lot of things about going forward when you want to study. Because they were in the same situation that I had been in, in terms of needing money and making choices about their future.

Helping others adapt at university

When you have been led and taught, you need to then teach and lead others. When I was well-adapted to the situation in Johannesburg, clear about studying and the complications that arose there, I became a leader to some of the new guys coming to Wits. When they came to Johannesburg for the first time I would tell them, 'This place is like this and that and that. I would tell them, whatever your circumstances, **you need to pass, because that's the only thing that you are at university for.** So I would mentor them. Not teaching them maths and physics, but I would mentor them in terms of social life, and how to handle the situation, knowing their background. So it was easier for the new guys to adapt in that environment, because I was there. Although they got some hiccups here and there, because I couldn't be there all the time. But it was much easier than when I first went there. We spoke about a lot of stuff. Crooks, complications in town. You have to be aware when you go out that there are crooks there. They will take your money, they will take your wallet, and all that. And just about the university in general. Because there are lifts! You mustn't get stuck in the lift. You must know how to open it. That's one other thing I will never forget. I couldn't tell my mom, she would laugh at me every time.

Working

I graduated in 2006, and went to Mosvold Hospital in 2007 for my community service (com service). It was also another new environment... although it was also not that new. Working though was another new experience. During com service there were these courses about planning and managing your finances offered by Friends of Mosvold, and they were very helpful. I'm still using the techniques that I got there especially around finances. I have cascaded that information to my subordinates and fellow students for them to know that to manage your finances properly, you have to manage yourself properly. We also had courses on HIV and AIDS, which was also very important. One thing that I used to remember is when Dr Ross said 'I have sex with my wife only. No-one else. I check, we know our status.'

You know, those were good role-modelling techniques and skills that stayed with me. I realized that it is important to look after yourself, to plan your life, and the other thing is you have to love your family! Dr Ross also said that you mustn't chase money because if you start chasing money, there will be a lot of problems.

I finished my com serve in 2007 and worked as a junior physio for two years then I got a post as a senior physio at Mosvold supervising com-serves and some junior physios. After working for two and a half years I applied for chief posts and was called for interviews at two different hospitals. I took the post at Emmaus hospital in August 2010. The medical manager wanted a white physio from around the area and the HR manager wanted an African supervisor in the therapy department because the therapy department had only white and coloured practitioners. So they wanted that mix. They wanted me to come to Emmaus, so much, so much. So that was the kind of politics that was there. So they called me, 'Please, please, please. Make sure that you come here. We really need you here.'

I went to Emmaus hospital in August 2010. When I got there they said 'Uh-uh. We can't accommodate you with your kids, just take them back home to Ingwavuma (300 km away). I decided that I couldn't stay that far from my wife, it would just be make my life miserable. I found accommodation in a nearby rondavel for my wife and kids with a gogo who was staying by herself. My kids became her grandkids, and I became her son, and my wife became the makhoti of the house!

Learning to supervise

I was the first permanent chief physiotherapist at Emmaus hospital as they had been relying on community service therapists to run the service. At the time I didn't know the four steps of management – the planning, the evaluation, implementing. However we started to write policies in line with the national policies, provincial and district policies, together with the hospital policies. Since then the department has grown to two permanent physios, a physio assistant, and three com-serves therapists. I'm very passionate about physio. I enjoy the clinical work, seeing a stroke patient from when they come in unable to walk, and then seeing them learning to walk again. Initially I did physio to help soccer players but when I got to 'varsity I found that physio is very broad. You see neuro patients, those are the strokes, Gillian Barre syndrome all different kinds of neuro patients, and I just liked that, even the CPs. So from 'varsity that's where I developed another area that was more interesting than what I thought was interesting about physio.

Helping other family members get training

Since finishing 'varsity, I have helped my eldest sister. After matric she spent two years at home without doing anything because she couldn't continue because of the money. I supported her to go college to do computers for a year after which she was taken at Mosvold to do nursing where she currently works as a staff nurse. I took my brother to the FET College in Manguzi to do engineering. Unfortunately he failed and came back home. He needed to find something where he could earn cash so I took him for HIV and AIDS training. When he came back with that certificate he got employed at Spar.

My younger sister finished matric in 2010. I took her to the University of KwaZulu-Natal to do nursing – currently she's doing third year. There were some issues between us. I gave her money to register and to stay inside the 'varsity, and we had rules between us. I'm married, I've got a wife and kids, so I told her that the one thing you need to do is go there to study. Only study nothing else. And in her first year she got pregnant. And our agreement was once we do something else, besides what we agreed on, our relationship will cease. When my sister started at UKZN she got a bursary, which covered accommodation and tuition fees, everything. Even the money that I gave her, she didn't have to use it for school, she just had to use it for something else. After she fell pregnant our relationship kind of became sour. **I told her that you have to have to pass.** If you don't pass you will come back and stay in the rural area of Ingwavuma, and you'll be the same worse person there like you were before.

Helping people and making a difference in my community made me to be very proud of myself and very proud of my parents. In my community I'm a role model. I remember at Mosvold I used to treat my teachers who were teaching me in high school, in primary, when they had to come to therapy, they would find me there and they would be very happy. You know, it was like I had turned a corner, because by the time they become my patients, they have to listen to me! I don't have to listen to them, they have to listen to me, they have to respect what I say, and that was nice.

Soccer-wise I started a soccer team in my area with young players during the 'varsity holidays. After I graduated I was with the team before work and after work. I provided money for transport, soccer balls and was transporting them to the games. I was the coach, the manager and also a player. In 2008 I requested some people to sponsor the team and they

gave us jerseys and soccer boots. When we got that sponsor, we were rich. Ya, because when we went to play, we'd take out the soccer boots. It was all very very very nice.

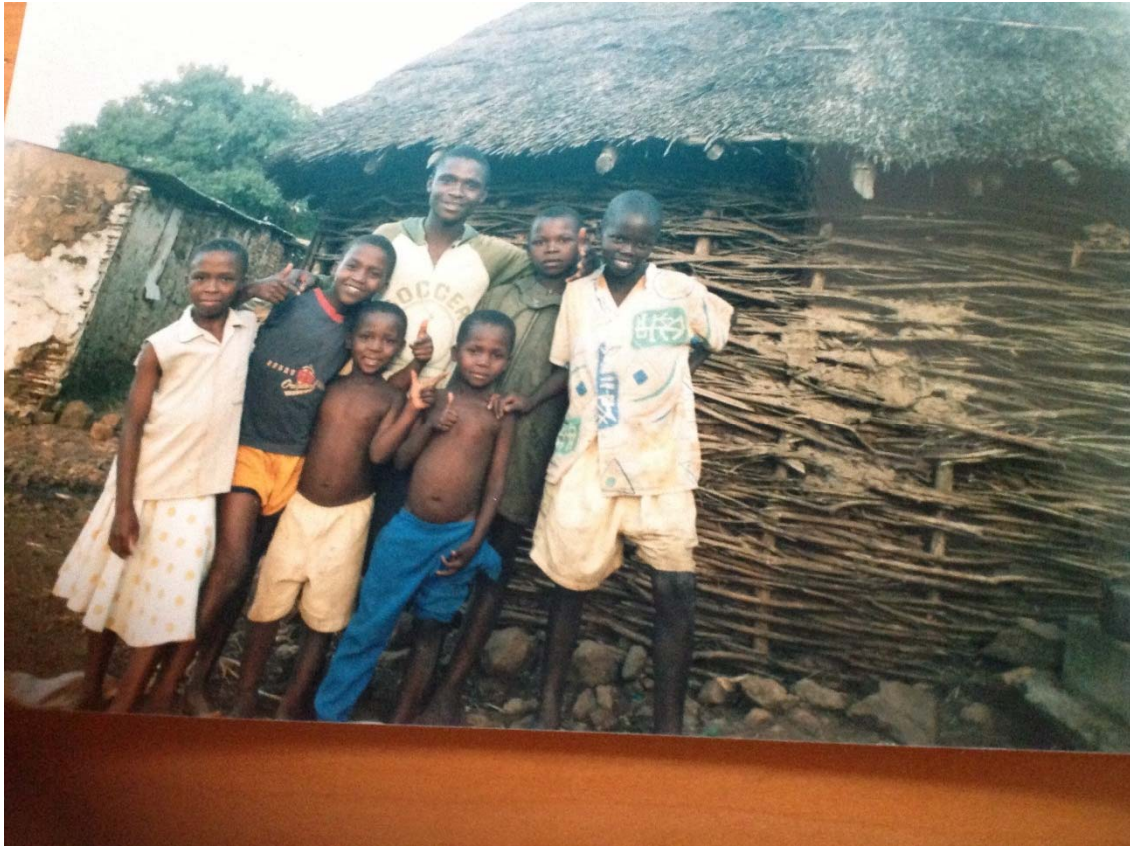


Figure 19: Themba outside his house with some local kids

When local kids came to visit me I used to give them clothes and they would join my soccer team. I used to be just like them, walking with bare feet, not having fantastic clothes and living in houses that were built from mud. I was a role model to them. When I came back from varsity the teachers in high school, would point me out and say 'that guy was here with us. You should go to him and ask how he got there. Because we knew that after he finished matric he was working for a construction company. But now he's working as a physio. How did he do it? So that you also can take note and see someone from a rural area can become a physio and study in an expensive university like Wits University.' So I became popular.

In 2008 I became the Chairperson of Ingwavuma Sports Local Football Association (LFA) in charge of eighteen teams on three different levels. That position was previously occupied by my primary school principal and we had to go head-on in the election which I won. I was the chairman for one year and six months until I left Ingwavuma to go to Emmaus. If there was anything to do with the Ingwavuma LFA, I was the one who was in charge of that. I used to

represent Ingwavuma LFA at meetings in Jozini and at Mkuze. The LFA is for the whole of Ingwavuma, so all those teams were under my supervision, and they really achieved a lot at the time, because the management was better than what they were getting before, from my perspective! This was a way of giving back to my community, making a difference and being a role-model and running the team

In the place I am staying now, I've also recruited young players, the under-15s; I've formed a team that was very very strong. However there's politics everywhere. After I formulated that team people from the area came and said 'these are my boys, these are my boys,' and I don't like politics. I just left and just remained a player rather than a manager. But that was my passion.

In 2008 I had a baby with my finance, so I had to quick-quick pay lobola, for my wife. Family is very important to me. I've got a very good makoti, who loves me, and I love her. She is very supportive and I have great kids. I'm currently building a big nice house for my family.

Ya, I like my sports, I like church, I like my family, and I also like my extended family too, because they are the ones who brought me up. Ya, I always think about them, and always wish good things for them. And on top of that you know if someone kick-starts the car, if someone drives it on top of that, until it reaches all the heights, I will never forget the Friends of Mosvold Scholarship Scheme. Because I wouldn't be where I am if it was not for that scholarship that was run by the Superintendent, Dr Ross. Everyone who is next to me, everyone who knows who I am, will definitely know where I come from.

And I always share that with people, that I'm just a person from nowhere, absolutely nowhere, who knew nothing but Ingwavuma and now I'm somewhere. I'm very very positive I am somewhere. I'm supervising people who are professionals, who are not just people.

Currently I'm a family man, I've got kids whom I think have a bright future. There are others who are in my situation, and those people need to know 'how did he get there?' Yesterday in church I was talking with other men about the importance of education and how expensive it is. I encouraged them to help their kids be clear about what they want to do, and to encourage

their kids to work hard to meet the requirements to study in those fields. I said to them, 'at the present moment, in these communities that we're living in now, there's no-one who can pay even R20 000 per annum. No-one. But those kids have opportunity to study. But if they don't pass well, or they you don't choose their career appropriately or they don't take care of themselves, then they will go nowhere.

When I am out there in the communities working, interacting with many different people, people often see me as their role model. And some people end up forgetting that they're talking to a physio, because of the way that I am, so down to earth, on their level. But it doesn't mean that I am the same as them – I'm really not.

Working in rural areas

I like being in a rural area. That's where I grew up. City life was great, but it was not my life. It was not me at all. My background was not so good but here in the rural areas I can be involved in lifting many people up.

I needed to be in a place where I won't spend a lot of money, but be able to build my future and my family's future. From last year I was building an eight-room house at Ingwavuma.

Personally I'm a down-to-earth person. I don't enjoy staying with the so-called big guns. Outside of work when I see someone who is coming from the very same background that I'm coming from, I motivate them, tell them that it's possible to succeed, that you can make it. In my church the church leaders used to say 'okay guys, if you want to know something about studying or see someone who has been there and has made it, you can ask Themba, he will show you the way.'

In the hospital we had an open day, and in church we have educational talks about the importance of education, and giving hope to rural kids who are still doing lower levels, who are still looking forward to becoming successful in life. So I'm a role model, sometimes I do a little bit of mentoring. I have a passion for other people to succeed like I did. I want people to get the same opportunities that I got. When I am around them I try giving hope and showing them the way. I tell young people what I have been through in life. You giving them hope that it's also possible for them to do more or less the same thing.

Opportunities

The hospital has provided a platform for me to learn and develop. I have learnt to be a good supervisor and have had opportunity to be involved on many committees.

Church involvement is very important to me. There is a place where we can worship at my house. Personally I like to go to church and read the bible as it provides guidance from God. My faith came from my family, and later when I went to 'varsity I realised this was the right path. Before I went to 'varsity I just thought it was one of the activities that you need to do at home. But then I realised that it's very important. You can't just do things alone without God. You have to be with God all the time and he will give you strength and guidance, and you will be prosperous if you have him next to you.

I learned from watching famous soccer players that when you are a role model you need to use that opportunity fruitfully. Sports stars like Teko Modise the Sundowns captain have two lives. I like him as a soccer player but what he's doing getting divorced is not right. It's good to be known all over the world, but you need to make decisions properly because the community at large are watching you and want to follow your example.

Ongoing studying

Currently I'm studying management and have also done Human Resource Management, which will help me to manage better in the future because there is little that you learn about management when you're doing your clinical work as a therapist. I've noticed that my medical manager has no management skills – he only has clinical skills. Maybe this training will help me later, when I've got, say five or six year's supervisory experience, plus a diploma in management.

6 Nelly's story

Introduction

Nelisiwe Mthembu (Nelly) is a 35-year-old single African woman from Ingwavuma and has one child. She attended primary school in Ingwavuma and went to a government boarding school in Nongoma for her high school. She matriculated in 1996 and was unable to find any opportunities to study or work from 1997 to 2001 despite applying for a large number of bursaries and dropping off her CV at numerous places. During this period she sold groceries at the market in Ingwavuma and did domestic work in the village. In 2002 she went to the University of Witwatersrand to study Pharmacy. She graduated as a pharmacist in 2005, did her internship at King Edward Hospital in 2006 and worked as Mosvold Hospital from 2007 to 2009. From 2009 to 2013 she worked as a research pharmacist for the military in Mtubatuba and has recently moved to Mkuze to coordinate pharmacy services for the clinics in Umkhanyakude district.

Nelly's story

I'm a rural girl from Ingwavuma and have three brothers and three sisters. My father was a mineworker and my mom was a house worker so we were not well off... but we did manage. My dad never went to school so I don't know where he learnt to write.

At primary I would wake up around four in the morning and go to the fields to plant or plough or whatever and at half past six I would go home to bath. There was no electricity at home, so if you wanted hot water you needed to pick up wood, make a fire then maybe you'll have tea. There was nothing like breakfast at home so we would eat leftover food and then go to school. We didn't have any lunch boxes and usually got salt porridge for lunch when we got home. After eating we had to fetch water, collect wood and then cook supper.

I started schooling at Lundini Primary School in Ingwavuma. Sometimes we went to school with bare feet, because we were six, so my father couldn't get shoes for all of us (laughs). There were no teaching aides or even a library at the school. I never got books to read at home so I never used to read. Growing up I don't see anything different from normal as I was never exposed to anything else. It was only when I went to tertiary that I realized that I grew up in a very different place.

I was a smart student who had a good memory and I was able to participate in maths and science Olympiads at junior school. In Standard 4 I got a trophy for the best student in the circuit.



Figure 20: Trophy Nelly won in Standard 5

In Standard 5 I went as far as the Provincial in the maths Olympiad and got a trophy for the school, the circuit, and for myself. After that most teachers knew me, so when I went to register for the local high school the teachers said no, you can't come here. You need to go to a boarding school. But then the problem was my dad could not afford it. So the teachers arranged with the circuit inspectors for me to go to a boarding school in Nongoma.

High school 1992 - 1996

Boarding fees at high school were R700 per year which was a lot for my dad considering my brothers were paying R 26.00 a year at the local high school. He asked me, 'do you want me to pay your fees at boarding school and you won't be able to go to tertiary or do you want me to keep the R 700 every year so you to go to tertiary?'" That's the choice I had to make. I thought that I would get a bursary if I went to boarding school, because the local schools were not good. I chose to go to boarding school and my dad agreed to pay for me and so in 1992 I went to Mlokothwa High School in Nongoma.

There were some challenges at boarding school. I could only afford the school fees, luckily enough the uniform and meals were also included in the school fees. I didn't have those nitty-grittys that the others had - things like Cornflakes and biscuits and cakes - all those good things. Things that you don't really really need, so I just lived on the school food. My mom left me there with my trunk, that's all I had - I didn't have many clothes, but it was okay. As long as I had a uniform I could go to school. I remember that I never went on school trips - no-one was going to give me that money. I learnt to stand my ground at boarding school, to fight my own battles there.

At high school there was lots and lots of homework to do and we were forced to study from six to nine each evening. I worked hard at high school. Even the teachers at that school were different... they knew what they were doing. There was proper guidance from the teachers - they would tell you, you don't want to get out of here and just do a plain BSc. So they'd get information for you, they'd call companies for us, so I think that's why we knew exactly what we wanted to do because even when I was at high school I knew I wanted to do chemical engineering.

The school was well run. All of the teachers were involved and there was good interaction between the teachers and students. There were very few students in history and geography, those general subjects, but there were fifty or sixty science students all on higher grade. There was no standard grade in our school. I was a top student at that school, so the teachers knew, this one is a good one! And the teachers expected me to choose maths and science - they don't ask, and they expected you to hard work.

The teachers created competitions within the school which motivated us. I remember in standard six at Easter I got position two and a clever guy from Manguzi got position one. The teacher told us, if we got 90% in June we would be promote you to Standard 7. So I worked hard, but in June he came top and got promoted to Standard 7 and I was left in Standard 6. He went to standard 7 in June and in December he was the top student in the standard. After he was promoted I was the top student in my year.

During matric, companies like Anglo American visited the school to look for students who wanted to do engineering and stuff like that. I was a clever student, top in class so I went there and passed the first interview. The second interview was in September 1996 after the Summer School which they ran in Durban. At the summer school they gave us everything. I was so happy - they did washing for us, they gave us nice food, setting a fork and knife on the table and we don't even know what that is. And then we had to write two long Science and Maths papers. Unfortunately I didn't go through.

Although I failed to go though from the summer school I learnt a lot - that's when I really understood geometry. I went to the summer school because I said I was going to do chemical engineering although that really was my last choice. I was really interested in medicine and pharmacy.

In matric I applied to most universities and applied for bursaries. Someone in my class got a list of names and addresses of companies who gave bursaries - so we all applied to every company that we knew of. Mostly we got no responses and a few companies wrote back saying 'we regret to inform you that you didn't get a bursary,' and stuff like that. I was invited to an interview with Eskom but it was during the week and I didn't know that I could ask the school for permission to go to an interview so I didn't attend the Eskom one. And then after that, I didn't get anything.

Dad retrenched

My dad got retrenched in 1996, while I was doing matric. Money was really short after Dad was retrenched as nobody at home was working. My sister was second year at college and I don't know how she survived. Come 1998 she didn't even have money to register, but she went to school anyway. When I phoned home to ask for application fee money, he would shout at me. 'Why do you ask for this money? Why do you need to apply for 'varsity?' Things like that. 'Where do you think that money will come from?' Because I mean that's how they are, they don't have money, but he did give me the money for applications. So I applied. I remember I was taken at UCT for engineering. I didn't get a bursary but UCT told me I got TEFSA funding but I needed to get to UCT. I think there was something that I didn't understand, because my problem was how am I going to get to Cape Town? Then that was the end of that whole thing!

At the end of the 1996 I got my results, I passed my matric with flying colours! I got A's, I got B's on higher grade, so that was wow!

Dad died

My dad passed on in August 1997 and I thought it will be difficult for me to continue with my life. When somebody you really rely on passes on - all hope just went with that and I thought, 'okay life sucks' there's no way I can go to university now.... that 'varsity thing, forget about it. I think I lost hope in 1997.

Before my dad died I had that hope that when my sister finishes I'll be the one to go to 'varsity. When my dad got retrenched in 1996 he went back home and started a chicken farm. He was raising chicks, growing them up and then he'd sell them. I think that's how he paid

for my sister's fees. When he passed on, this chicken farm thing died. People were just stealing, they broke the fence and took everything.

1997 was a very tough year. You see your class-mates when they come back from Mangosuthu Technicon and they tell you, so-and-so is doing this...' it was really tough, I even lost weight. I think 1997 was my worst year ever. That's when I started doing some washing and doing house work for madams and for people in Ingwavuma. I applied at the hospital but there was nothing, nobody called me. I helped my mom by selling fruits and veggies at the market to try and get some money. Other than that I stayed at home, or visited my aunt in Empangeni, or tried to look for a job. At one stage I went to Richard's Bay, they told me 'drop your CV's here, and there;' I did that but never got a job.

I was at home in 1997, '98, '99... until 2001. I don't know what I was doing. I was just staying at home..., oh and in 1999 I got a child. In the middle of this I had a baby – it really made things more stressful. That's how people are, that's how we are – the poorer you are, the more children you get. The situation didn't allow for a child but I added more expenses - I had a child. I didn't think about the consequences. I don't know what was happening to me. I think I just lost hope that I was going to be something one day, going to 'varsity never crossed my mind.

Serendipitous opportunities

In September 2001 I heard about interviews at the hospital and thought that it was a job interview. When I went to the hospital it was a bursary they were talking about. I thought Oh, okay, if I can get a chance to go to 'varsity again, then I'm going. Dr. Ross asked us, 'who's got an A in matric?' And I was the only one. 'Who's got B's? Who's got Maths and Science?' We went for the interviews and I was selected. I thought, hah! I still have a chance at getting my degree, I'm going, no matter what! But then the application fee – I didn't have the application fee, until Dr Ross gave me the application fees and signed surety.

I didn't even think about where I was going to leave my child while I was at 'varsity. I decided I don't care, I'm going, it's only a matter of four years. My child will suffer for four years, but I'm sure after four years I'll come back and it will be better. I was told, if you pass in four years you'll get a job. You're guaranteed a job. So I decided let me go there, four years is nothing. I'm sure I'll get a job when I come back. I'm going. We'll have everything

that we want to, let me just go. Four years, forget about the child, forget that I have a child and only work toward my degree.

My mother was kind of against it. 'You must look for a job.' 'But I told her "I've been staying here for five years, I never got a job!" My granny agreed to look after my child. She was the one who said 'go for it.' and she told me 'your ancestors are looking out for you, go there.'

So in January 2002 I went to the University of Witwatersrand to do pharmacy. Dr Ross gave me a thousand rand for transport and food and those small things that you buy. And off we went to university. That's when my life changed. Things changed because I got a chance.*

(* Nelly was selected along with 5 other students from Ingwavuma. She was the only one doing pharmacy)

University life

First year at Wits it was difficult. Our first tests were really bad, I remember I got 31% and was told that we were not going to make it and that we should just deregister. I was very sure that I would pass, so when I failed my first test I thought, oh my God! I'm going to fail! But I told myself IF somebody else before me did it, what will stop me from doing it? If someone has done it before, I'm sure I can do it. I worked hard but I was really struggling with biology.

We had a lot of support from MESAB and from Dr. Ross. Dr. Ross came to see us at Wits to see how we were getting on. At Wits we were working as a team with all those people we came with, so we could support each other. So I did pass my first year. It was difficult. One of the difficult things was the accent. There were no black lecturers, so getting used to the accent was very difficult. During lectures I remember thinking 'what are they saying? In class I met a girl from the Eastern Cape who was doing medicine - we just clicked and became friends. I used to ask her, 'what are they talking about?' Then we went to the text, and worked out that they were talking about this and this. She really helped me out - especially with biology. With time I adapted and got used to everything, so I passed.

First year was really tough. I think the support we got from FOM and the university was very good. I remember going to the MESAB offices they really opened their doors for us, even the Dean opened his doors for us. So it was kind of easy to get help from the MESAB offices.

MESAB and the Dean arranged tutors and mentors when we asked for them. I had a tutor for physics and a tutor for maths. The tutors really made time for us, because they'd call you and say 'okay, maybe we'll meet again on Friday.' If students in our class couldn't understand, then we asked the tutor to explain the content. And they also went through past papers with us. University was not like high school where you just answer. At university you have a certain way of answering the questions. So the tutors give us guidance about how to answer exam questions. Especially with the exam papers, it really helped, so you knew exactly what they wanted, and how to answer the questions. The tutors and mentors were really important in first year.

Determined to pass

I was determined to pass - I think the fact that I had a child I needed to support was really pushing me. I need to give my child a better life, after these four years. I was also motivated by the situation at home, I mean my mom needed to stop selling fruit and vegetables - she couldn't live like that forever. I just knew that I had to finish my degree in four years, no matter what it took.

I worked hard when I was at 'varsity. When I look back now I never had a life in Joburg, because even when you go to town, you come back and say 'oh, so-and-so has studied this, now I'm left behind, I need to push.' If you go to town you become 'oh my God, I wasted so much time!' You go back to your room and studied.

I found in pharmacy you couldn't rely on the text books -you had to rely on your notes. So if you miss a lecture, you've missed a lot. In the exams they would ask on your notes, not on the text book so you really had to be sure that you are in class.

Second year wasn't as difficult - it was much better than first year. Second year was difficult but I had adapted. We had lots and lots of subjects to study, and I had to do physiology and anatomy. I got a supp. for physiology. For the first time in my life, I failed a subject. The supp. was on the 5th of January and so I had to leave home on the 26th of December, when everybody was at home and enjoying Christmas, I had to leave home, go back to Joburg to

study for my supp. And I studied, and luckily enough, I passed it. So that's how my second year went.

Third year was getting more clinical. And I think one other thing which made things better for us as Friends of Mosvold students was the fact that we were doing our vacation work at the hospital. That's how we got to know about the drugs. In my first year of pharmacy, during my holiday work the pharmacist would tell me, okay every day I want you to choose three drugs – it's either injections or whatever – read about them, know what they are for and why are you using them. I want you to tell me why are they in an anaphylactic box. The following day the pharmacist would tell me “do the anaphylactic shock boxes for the wards.” So I got used to the names of the drugs and what they are used for. I even got used to processes such as how do they order medicine. So when you get to third year knew how to order stock and the role of the PMSC (Provincial Medicine Stores Control). So I think third year was much easier because of my exposure in the pharmacy at Mosvold. So I passed my third year, right.

Fourth year, was mostly presentations and research. At first I struggled a bit with pharmacology. I think it was because pharmacology was multiple choice questions, so you had to be sure of what you are doing, and there was negative marking, so that's why I struggled with pharmacology. I know I failed my first test. I was the only one who failed it in class. That's why I won't forget it.

Working

After graduating I went to King Edward for my internship in 2006. Then that's when we were putting theory to practice. I really learnt a lot. I was out of school, learning to be myself, learning to be a pharmacist. We were a group of eight interns and we were exposed to eight pharmacists, so we circulated with them. We did ward rounds, were exposed to ARVs and all that stuff and paediatrics. My internship was great.

I went to Mosvold for my community service in 2007. When I got there, there was a pharmacy manager and another pharmacist. We really worked well together and were involved in lots of things including the PTC (Pharmacy and Therapeutics Committee) meetings which I even chaired at time. It was a bit difficult at first, you know with doctors, but I got used to it and it was a learning process.

The pharmacist left in September 2008 and the pharmacy manager left in October 2008 leaving me alone to do the job of three people. Added to this was that in January 2007 only 300 patients were on ARVs but by October 2008 there were more than a 1000 patients on ARVs. I initiated 100 patients per month as only the pharmacist could initiate patients. I had to learn to plan, really really plan things because I still had three pharmacy assistants and I needed to plan who does what.

At the end of 2008 I got the principal pharmacist's post. I was alone until June 2009 when I was joined by a com service pharmacist. The pressure at work was made worse when in 2009 the management told us that we could not close at four but needed to work until five pm but there was no money for overtime. They offered us the opportunity to take time back but it wasn't easy to take time off when I was the only pharmacist. It got too much and I decided to go somewhere else especially when they were not even advertising the posts. I left Mosvold to become a research pharmacist for the military at Mtubatuba in 2010 and I have been here since then. I have been working on a research project with the NRI (National research institute). There are over 1000 people here who are HIV +ve and over 600 who are on ART's and I have been responsible for following up those on treatment, doing pill counts and adherence training and issuing ART medication.

I am moving to Mkhuzi next month to be a pharmacist advisor to provide technical support to all the hospitals and clinics in the district. I am trying to register with the Council for the Registration of Medicine. If you get that certificate, you get to be a regulatory office pharmacist. When drug companies make drugs, they must get a patent. If you are registered with the Counsel then you are the one doing all the paperwork and things like that, and you must see if things are done right, if they can or can't do that certain things.

Being a health care professional

Since working I have been able to do a number of things for my mum at home. Even though we still don't have running water, we now have three water tanks, so we never run short of water. We still don't have electricity at Ingwavuma, we have this solar thing. You can't cook with it but you can watch TV and you can light up and we have gas stoves to cook on.

Life is much better, we have more resources at home and every month end I am able to send a thousand two home for groceries so nobody really starves, unlike before. Having resources

makes it possible to give a better life for a whole lot of people here. My child, my mum and for my brother.

As a pharmacist in rural areas they treat you like this big person. Rural people treat you differently, they show appreciation and you just feel, okay, these people still need me here.

Here in Mtubatuba I'm Nelly the pharmacist. At home I feel that something has changed. Because I think there's more respect now, they see me as somebody they can really rely on. Whenever they have a need they inform me. I think in their minds, I can solve them! (laughs). You know, I think they're more dependent on me, or have more confidence in me. They even refer others to me - maybe there's somebody who's sick they tell them to, 'Please come and see me!' Maybe a neighbour or somebody who says to me, 'Please come and check on my son! See what he has, see what you can do,'

Having more resources I am able to help not only the family, because when you're at home, there's only two or three families with cars. So if there's an emergency at night, they come and wake you up, 'Please take so-and-so to the hospital.'

In rural areas - money-wise you don't really spend as much as you would be spending in the urban areas. If you really want to save you can save.

I have continued to work in rural areas because I still feel there's a need for healthcare professionals in rural area. There's still a huge gap. We still don't have enough healthcare professionals. Although we are here we still need more. Because of the background that I grew up in a rural area. I think I understand rural people more than somebody who grew up somewhere else. Because you put yourself in their shoes, knowing that okay, if somebody says the clinic closes at two, but you know that person has walked a long distance to that clinic, you can't just shut them out, you know the clinic is closed. But if you've never been there, you don't know what exactly what the problems they encounter. You just say 'okay, I'm closed, see you tomorrow.' I think that's one of the things that... those kind of people still need to understand their patients, to understand their clients. Ya, I think that's one of the things, that we need people like that.

Even here in Mtubatuba, there is still a shortage! For two years when I was here they didn't have a pharmacist. So I was helping the army although I was employed in the research project. For the most part I am still interested in staying in rural areas. I would have stayed at

Mosvold if somebody had just said, 'no, stay,' or provided some encouragement. I wanted to stay.... it was just that I really didn't get much support at Mosvold. Health professionals often don't want to go to rural areas, because of the infrastructure problem, people say there's no life. I think there's really not much you can do after work. There are no cinemas close, there are no shops to shop around, but I think that we are really still wanted, we are still needed.

7 Lungi's story

Introduction

Lungi Hobe is a 29-year-old African woman married to Thulani and has two children. Lungi is from Mseleni, near Lake Sibiya. She did her junior schooling at the primary school close to home, and attended Inanda Seminary, an independent girls' secondary school in Durban, for one year. After the year at Inanda Seminary, Lungi returned to the local high school in Mseleni where she matriculated in 2002. She attended the Nelson R Mandela Medical School at the University of KwaZulu- Natal where she graduated in 2006 and did her internship at McCords Hospital, a State-subsidised hospital in Durban from January 2007 until December 2008. After her internship, she completed her community service at Bethesda Hospital in Umkhanyakude district in 2009 and worked as a medical officer at Mseleni hospital in Umkhanyakude district from 2010 until she joined the Family Medicine registrar program at Bethesda Hospital in January 2014.

Lungi Hobe – the jungle girl

I called myself the Jungle Girl, because nobody knows where Mseleni is. Mseleni is in the jungle. Everywhere you go you have to explain that Mseleni is by the border of Mozambique, close to Sodwana Bay, and they still say, 'Oh!' So that's why I decided that I was just going to call myself the Jungle Girl.

I remember the first day at university we were required to make a presentation about ourselves on a power point. And I had never done a power point presentation before, but fortunately the technicians at medical school were very good, so they helped us through the whole process. And when I got up in the Steve Biko auditorium, everyone started making a noise before my presentation. My intention was to say 'Attention please,' but I ended up saying 'Umtention please' and everyone just started laughing at me.

Life at home

I was born in 1984 and have two brothers and a sister. Growing up was not so good. My mom was a very strong and inspiring woman and I drew most of my motivation to grow up and to study and succeed from her. She worked at Mseleni Hospital as a Community health worker facilitator and retired in 2011. My Dad did odd jobs, drank excessively and did not contribute much to the running of the house or play a very significant role in our upbringing. Life was tough at home with an alcoholic father. As children we were afraid of our father and

when he was drunk my mom would then hide in our bedroom, or just hide outside the house, but tell us not to tell our dad where she was. Most of the time that landed us in more hot water because my Dad would end up beating us if we were hiding our mom. When it got really bad we would hear a gunshot in the yard and wouldn't know if he'd actually shot at my mom, or was just scaring her off. There were times when I just wished that me and my mom would just take my other siblings and get out of there, but my mom was like, 'no, I can't leave here. This is the life I have chosen for myself, and I'm going to stick it out.' So it was very hard. Living like that really inspired me to study further and study hard and just dedicate my life to my mom. I thought that if I studied then I could afford a better life for my mom, and I could eventually take my mom out of the situation.

In June 1993 my mum had a massive car accident, and was in hospital for six months. I was still quite young but remember not being allowed to go and see her for at least for a month or two, because she was so swollen. Even the day that we were allowed to see her, I couldn't recognise her. She had a skull fracture and was blind and deaf in one eye and one ear. So it was horrible. And at that time we didn't even think she was going to be able to walk again, or go back to work. I'm glad she survived, because I always say I don't know what I would have become, if she hadn't survived.

Following the accident I had to take responsibility for the house. My dad actually helped quite a bit then. He was still a family man though he didn't have a job at the time. During the time my mother was in hospital my dad started reading the ABC of the Human Mind (to understand my mother's injury). I think he actually stepped up then because he was the only parent we had at home. He had to do a lot of hospital visits to see how my mom was doing. He actually stopped drinking in those days. He was wonderful. He would cook for us. I would do the dishes and he would teach me how to cook. I think we had a beautiful foundation relationship, even though it got destroyed along the way.

After my mum returned home from the hospital my dad started drinking and fighting again. I used to take my mom's side because he was abusive. I remember this huge fight when I was thirteen. I came back from boarding school, and he was on the phone busy chatting to his girlfriends. When my mom arrived home she took a rope and said 'I'm going to hang myself.' I said 'Dad, you're hardly ever here, and when you're here, you're hurting my mom, and now she's going to hang herself. So how are you going to solve this? Are you going to make it right?' And he thought that this was just disrespectful for me to say that to him as the

head of the house, and I was just a little girl. So I think that's where our relationship got destroyed. At that time he didn't speak to me for two months, until he called a family meeting and told everyone that he didn't consider me his daughter anymore, and that I'm going to have bad luck for the rest of my life. His ancestors are not going to look after me. So, he was like, you know, only if I apologize will he ever forgive me. As a symbol for his forgiving me, he was going to slaughter a chicken to sort of appease to the ancestors. And up to this day, he has never done that. So he's, you know, he's always said hurtful things, like I'm going to be a nobody, I'm going to stay at home and do nothing and I'm not going to be successful.



Figure 21: Lungi in her new dress

None the less Lungi she remembers there were a few good times. *I was having a good relationship with my dad growing up. I think I was his favorite girl.* She clearly remembers at five years of age getting a beautiful new dress and going with her dad to the pension point to get her ears pierced. *I just felt wonderful.*

Although things were not easy at home I was aware that for me, even though I had grown up in a rural area, I had always been cushioned. I had my mom there. My dad wasn't there for most of the time, but I knew that my mom would be coming home every night.

Carefree school years

When I talk about school I always talk about Mrs. Dlamini who was my teacher in Grade 2. I told her once that I couldn't do my homework because my mom told me to put out the candle. Mrs. Dlamini just said to me, 'It's fine. I know where your mom works, I'm going to go and see her after school and I'm going to discuss this with her, so that she stops abusing you.' On my way back home I met Mrs. Dlamini by the hospital gate, and she said to me, 'I've spoken to your mom, and we'll meet at school tomorrow.' When I got home my mom was very angry with me and she gave me a hiding. And then she said to me, 'I told Mrs. Dlamini to give you a hiding when you get to school tomorrow as well.' So that's what I got and I always tell people, I hated lies.

I went to Mzila Higher Primary School in Mseleni. I remember that I had shoes but a lot of kids didn't have shoes. Not wanting to be different and wanting to fit in I often left my shoes at home but then I developed cracks in my heels. My class teacher Miss Khumalo - called me and said, 'Where are your shoes?' and I said 'Oh, everyone in the school is walking barefoot so why should I wear shoes to school?' And she said, 'No, but your heels are getting cracked and I know you've got shoes. Do you know why the other kids are not wearing shoes?' And I said 'No, they probably left them at home just like me.' And she said, 'Because they don't have shoes. So they're not wearing them not because they want to, they're not wearing them because they don't have any.' And so since that day I started wearing shoes to school. It was really sad, because I realized that I was in a different class of students, a class that could wear shoes, while others couldn't wear shoes, so that was quite tough.

The one other person I remember was my primary school principal, Mrs. Ntuli She was such a strong person, who ran the school very well. She was a motherly figure at school and if anyone was picking on you, you knew that you could run to her. She was a big woman, and whenever we were making a noise she would come into class and shout, 'WHO'S MAKING NOISE?' and everyone would just hide under the desks. But when you had trouble, you knew that you could run to her and hide under her skirts.

Bullied and unhappy

My cousin Mr Nxumalo sent all his children to Inanda Seminary in Durban. My dad wanted to seem like this high-profile person, sending his daughter to a private school to get the best education that she could even though the fees were R1400 per term and he couldn't help my

mom financially. I applied to Inanda Seminary, went for an interview and was accepted from Standard 6.

I've always been close to my mom and when I got to Inanda Seminary I cried a lot because I just couldn't cope away from my mom. I was bullied because I was this short little thing. I remember one night the other girls cut one side of my hair and in the morning they told me, 'Oh, it's the rats! Ya, so I had no choice but to cut my hair. They also put Colgate toothpaste in my mouth when I was asleep. It was just horrible. The last straw was when the house mother's son stole a whole lot of things from the dormitory. When the house mother was confronted she said 'Oh, next time he will rape you, because you've got big mouths and talk too much'. When you're thirteen, you don't fully understand what's happening so I just said to Mum 'I can't stay in this school anymore.' It was also emotionally draining knowing that my mom was not coping with the whole financial situation as she was also paying my cousin's school fees at EsiKhawini College of Education.

In terms of schooling Inanda seminary was brilliant. I remember Mr Ngomese my accounting teacher. I really enjoyed accounting and got 100% for most of his tests. I remained in the top five for most of the year and ended up getting a sponsor for the final term so I didn't have to pay. Being in the top five I thought was quite acceptable considering all my primary education was done in Mseleni and I had never done accounting before I started at Inanda seminary. There was also Mr Lewis who taught us English and Miss Mfeka who taught us Afrikaans, and we had a beautiful science lab, and I think it was Mr Govender who used to bring us pickled mangoes.

Socially it was tough and I was so unhappy at Inanda seminary that I left after the strikes in September 1997 and went to Zenzeleni High School in Mseleni where I did Standard 7 to Standard 10. The experience at Inanda seminary school provided a very good background for going back to Mseleni.

To improve English speaking at Zenzeleni High School we developed a carry card system and if you heard anyone talking isiZulu you would give them a card. At the end of school a list would come out showing who had a card and they would have a little punishment, maybe to sweep the classes. I was on the committee which was responsible for enforcing the system. We also started a debating team with support and encouragement from our English teacher Mr Mkhabela - most of the members of the debating team came from the committee. Mrs. Gumede our principal was very supportive of these initiatives to promote English in the school.



Figure 22: Lungi (2nd from the right) and her debating team

I was part of a study group in matric which was the naughtiest group in high school but I used to love them because we used to study together. Thinking about them reminds me of how amazing high school was. I had all these friends, unfortunately now we've gone our separate ways, we've grown, different people have chosen different things, but we used to study together, and looking back now I think that we inspired a lot of positive attitudes among us. After school we'd all go home and then meet at four to studying together until half past six. We met in the Children's Home in Mseleni because Mandla Makhoba, lived there and he couldn't attend the evening study group at school, so we just decided we were going to help him study with us and it was a central place for all of us. We just worked through the material and we also got a few study guides. I can't remember where we got them from, but I had a few. I think I may have bought a few. I think I may have asked my mom to buy a few. Because we had a maths and a physics one, and then we had a lot of matric past exam papers, so we used to work through all of those as well.



Figure 23: Lungi and her study group

We all worked hard and all decided to apply to university. None of us knew where we were going to get money from for tertiary but we applied anyway. My mom was a nurse and there were four of us at home and I knew that she was not going to be able to cope with the fees. I don't know how I was going to get through university, but I was determined that I was going to get through university.

My brother struggled at university because he was not computer literate. My mum encouraged me to do some computer training during my matric year so that I wouldn't have the same problem when I went to university. During the holidays and on weekends I would go and do the basics at a computer lab called Chips and Bytes which had opened at Mseleni.

And then I completed Matric. Fortunately I had a very good pass and I was quite excited about that.

Getting into medical school – that was the difficult part

I always knew I always wanted to be a doctor – the motivation really came from my mom. My mom wanted to do medicine, but she couldn't. She did nursing instead. And I think she had plans to go back to university at some point, but then she ended up having babies.

Growing up I just wanted to prove that my mom actually did raise us well, and on top of raising us well, that we could actually create a very good life for ourselves and for our mom as well. So that really inspired me to study further and study hard and just dedicate my life to my mom.

I had applied at the University of KwaZulu-Natal to study as a doctor. They didn't call so I called them in the first week of January, and it seemed that they had not received my results, so they said to me, 'okay, fax us through your Matric statement, and then we'll take it from there.' I called them after I had faxed my results and I was offered a place to do medicine. And then it was a battle of finances now – where was I going to get all the money to get through university? My older brother was also at university then and was studying agriculture at the University of Tswane. My mom was the only one who was working, and my dad was not able to contribute financially. So it was just my mom, supporting us, and I knew that she was just not going to be able to do it. She had an educational policy that she had taken for me when I was younger, but then when she called them they told her that it wasn't actually an educational policy, that it was a life policy, so they couldn't pay for my studies.

I begged my mom to talk to Mr Nthuli, the local Mayor at Mseleni. After looking at my symbols Mr. Nthuli told me 'you can't be staying home, we will fix something for you.' and he took me to see Dr Victor Fredland at Mseleni Hospital. Dr Fredland called the university and told them that I had been offered a place at university but I didn't have any money. On the application form I had indicated that I needed financial aid but when we talked to them they said that they had not made a decision. The following day my mom went to Jozini to get money from Ithala and buy me a few things that I needed.

My mum's accident turned out to be a blessing in disguise because the money the government paid her for the injury she had on duty was in a fixed deposit in Ithala and she was able to take a loan against that. The university needed a family contribution of R6 000 - we had that money, and everything got sorted, so I was registered, and then I started at varsity - I was very excited.

I had applied for a Department of Health bursary, but unfortunately I got rejected and I was very angry and disappointed. However after registration I was able to apply for a NEFAS loan to cover the rest of the fees and residence. At the end of the 1st year, I got 40% fee reduction because I had passed all my modules. In 2003 at the start of my second year I was introduced to Dr Andrew Ross who had a bursary for me. So that's how I got introduced to

the Friends of Mosvold scholarship scheme who funded me for the four years that I was at university from second year to fifth year.

Umtention please – this is the jungle girl

I remember the first day I decided I would call myself the Jungle Girl because no one knew where Mseleni was. When I stood up and said ‘Umtention please’ everyone laughing at me. I had schooled in Zenzeleni high school and had only a year in Inanda Seminary, which is an English-based school, so my English wasn’t really that brilliant. After that presentation I vowed to myself that I was going to read as many books as I could, and I was going to read them out loud so I could actually hear myself reading English and speaking English. So that’s what I did and my English improved quite a lot from then.

The jungle girl finds university easy

I think university was easy! I think it was easy, because although I had a problem with spoken English, reading wasn’t that difficult. I think the other thing that made it easy was because medicine is like a totally new language for everyone, so it wasn’t that if you knew English very well then you would cope very well with medicine. I got in with a positive attitude that I would make it work, and I knew that I just had to make it work.

At medical school I had very good module facilitators. Once I got to know my facilitators, I didn’t have a problem asking when I didn’t understand things. I preferred the small group sessions to lectures because I still had that fear that if I had to ask a question in a lecture, then I will go wrong with my English and then everyone will start laughing again. So even if I had questions, I would prefer approaching the lecturer individually and just asking, which I think helped a lot. I think when something is explained to you individually it is also easier for the person explaining it to understand the level of understanding that you have, and you form an understanding and a relationship based on that.

At university I stayed in a little room in J12, Louis Botha Hall. Looking back it was just bliss and I lived in that room for my five years of university. I didn’t have too many books, just histology, anatomy, and human pathology and also this little book, the ABC of the Human Mind. It’s like a layman’s book in understanding how the brain works. So for me coming into medical school and wanting to understand what really happens in the brain I would go back to this book which put concepts in short, simple terms which was really amazing. For all my years at the university, I mainly used the Internet. We’d be given a topic to go and research,

or we'd be given aims and objectives for a particular topic, and then we had to go and look it up. There were a lot of books in the library, but I hated the library because it was just too cold for me. We got most of our information from was the Merc Manual, and eMedicine - these were the main search engines that we used. In our first year we were supposed to attend computer classes if we hadn't done computers in high school - those helped us quite a lot as well.

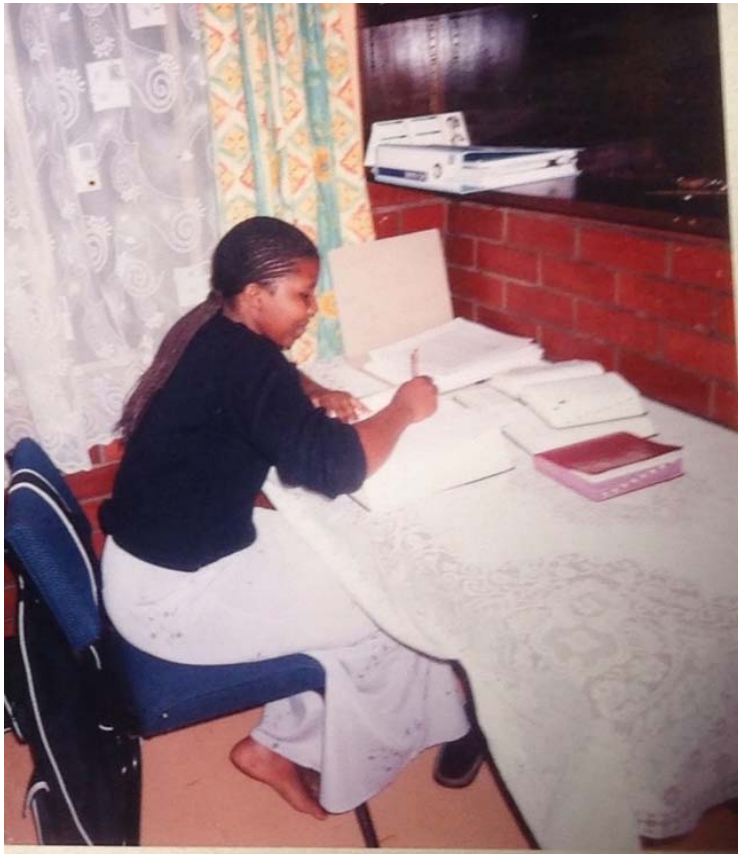


Figure 24: Lungi studying in her room at medical school

I was never shy to ask for help whenever I didn't understand anything. When necessary I would even get out of bed, put a t-shirt on and quickly go into my friend's room and say 'and what is this?' And she would do the same thing. So with explaining things over and over, we exchanged quite a lot of information. Another friend was Londiwe Buthelezi, we also interacted quite a lot with her. She stayed at the same residence, but she was a level below us. So ya, we usually shared the information that we got, and if anyone didn't understand, we would try and explain it to them.

I always tell first and second year students 'Try and understand your anatomy and your physiology really well, because if you understand those two things then it's very easy to

understand the pathology that goes on around that area. So if you're studying the pancreas, and you know how it works, and you know all the anatomy around it, if you come across diabetes, then you know exactly what happens. So ya, I think that was the most important thing to me.

The staff at university were supportive and resources were available. I can remember some key people, like Miss Saras Reddy, who used to be our skills teacher. I think with medicine, you need the theory, but you also need the skills. So she would make sure that we had that. She would always say that the skills lab is open after hours, she would even open on weekends for us to come and practice our skills, putting up drips, putting up CVP lines. She had all these dummies so that you could check yourself that you're doing the right thing. I think that was amazing.

I hated histology though! I hated histology, because most of the time you didn't know what you were looking at. I would sit with the histology book and I would read the same line over and over and over again and still I would just be like, 'What the hell is this?' But there was also a histology lab that we could go to. Me and my friends would go up to the university even on Sunday afternoons, to see if we can look at some slides. Everyone had a locker with their own microscope in it, and you could come in any day and just look at the slides, so I think that helped as well.

Holiday work prepared me quite a lot, because I discovered that I'm not a surgical person, especially working in at one of the district hospitals. People there just beat and bash each other like nobody's business. So this one day we were on call... okay, I'm not supposed to be saying this but we were on call with a GP, who said, 'Don't call me unless there is an emergency' And this guy comes in. I was the most senior student there, I was in fourth year, the others were in third year and second year. And this guy comes in with a huge laceration of the neck. Fortunately vessels weren't touched. But it seemed that he got injured and he fell onto the sand, or somebody had put sand in there, so it was just like this gross, gross wound. And we had to clean it up and suture him, and it was the worst thing ever, and I've hated blood ever since. We called the doctor on call, but his phone was off and that is how rural medicine can be...

Thembilile (another UYDF medical student) and I had partnered up in university to go and do a project in Mosvold for an elective and we were there for two weeks in the first semester and two weeks in the second semester. We were doing a project on how to care for orphans

that were in the community. I remember the one story that really touched me was when we got to this house, a thirteen year old was fathering the household. The little ones had gone to school and he was left behind, preparing meals for them, fetching water, and the orphan care based at Mosvold used to bring them groceries every month. So that was quite touching. Then, ya, the Mosvold stuff was amazing. I think we were just having an evening dinner here, and this was where the pictures were taken.



Figure 25: Lungi (sitting on the floor) at Mosvold during holiday work

I worked hard and I managed to finish my Medicine in the five years. I didn't have to repeat any year, or any modules even though I had a baby in my final year. I had been together with my boyfriend since 2003 and then in 2006 I think he was just not too sure why he was still with me, or whether I still loved him or whatever. So he was like, 'You know what, it's your parent's fault that we're not married yet. By this time I wanted us to have two children, so can you please have me a baby.' I was stupid enough to fall for that. I had a baby in 2006, and this was my final year of university.

I had a lot of support from the university student counseling while I was pregnant. What they would do is, if you fell pregnant while you were at varsity, they would arrange everything with your lecturers, for you to go and deliver and have special classes. So what happened was, I had one week of the winter holidays, and then I came back and did two weeks of what

I was supposed to do after the holidays, during the holidays. So this also meant that I got individual attention with not a lot of students around, so I could do all my procedures and whatever.

I got induced on the 2nd of August, and I delivered on the morning of the 3rd at 6.51am at King Edward Hospital. And then on the 4th, Mario (Samantha's dad) came to fetch me. We spent a night with his family in Newlands East, and then he drove us to Mseleni, where I left Sammy, a week old, with my mom. I came back, did my surgery exams, and then I went on. I had to travel home every two weeks to see her until my mom said, 'No, you can't do this. You are wasting time, and you're wasting money. Concentrate on your studies, and then when you graduate you can spend more time with her.' And I was like, 'No, I can't cope away from her.'

Working life

Internship

I graduated at the end of 2006 I did my internship at McCord Hospital in 2007 and 2008 where I worked under Dr Sunpath, and a lot of other doctors. I learnt a lot there and I think that's where my love for HIV started. It was such a good HIV program at McCords, it catered for all patient's needs. There was a lot of support at McCords and they made it interesting, it wasn't just that oh, it was this disease that was killing people. The paediatric support group was amazing, and they looked at patients as family units, not as individuals. So if the mom presented, they would try and track where the baby is, or where the father is, so it was a very comprehensive program.

Community service a disastrous year

After my internship I did my community service in Bethesda Hospital, and my interest remained in the HIV domain. 2009 wasn't such a good year – in fact it was horrible and I nearly went crazy! The hospital was short-staffed and on top of that the four senior doctors who were supposed to support us were not really supportive. So we ended up having to do a lot of stuff on our own which was very, very frustrating. I worked with two other African doctors who were also quite junior, I think they were somewhere around post-community service, and they also needed a lot of support. At some point that year I tried to transfer to

Hlabisa hospital, but the CEO at Bethesda just wouldn't let me go even though I got a place in Hlabisa.

At Bethesda I worked with some doctors who were unavailable and unsupportive. I remember early one morning calling one doctor when I had a Caesar that had complicated. He told me 'I'm not on call today. So how can you call me to come and help you? You are a doctor, just see how you can handle it.' And I was just like, yew, okay. Fortunately another doctor ended up coming and helping.

At least that's how rural medicine is like. Everyone had always said rural medicine was horrible and I had experienced that first hand. After that year at Bethesda I couldn't stay in rural medicine, the only option was **just to quit and go do fashion designing.** So I waited for the end of the year, and in December when my contract ended I packed everything and said, **'I'm leaving medicine'** and I stayed at home without a job from the 1st of January until the 10th. My mum didn't know what happened with me, as all of a sudden I quit my job. She was concerned about how I was going to pay for my car and how was I going to support them? It was **sad particularly as my aim had been to spend a few years in rural medicine.** My mom even went and saw the social worker.

Medical officer at Mseleni hospital

When visiting my mom at Mseleni at the beginning of 2010, I bumped into Dr. Victor Fredland and he was just like 'Well, I'm waiting for you. The year has started. So what are you up to? What's happening? Have you got another job? Why are you not updating me?' I was like, 'No I don't have job, but I just want to stay at home and do nothing.' So in the next few days he called me and said 'We're waiting for you.' And it turned out that in the time during those weeks, they had been waiting for Dr Hobe to start work, and I only discovered this after I had started. So on the 10th January 2010 I went up to the hospital to sign my contract, and then I started work on the 11th. Eventually I calmed down and I was okay, this is it, we'll see how it goes. And then, ya, I started working in Mseleni Hospital and it was **like the east and the west of medicine**, if you compared Bethesda to Mseleni. It was just totally different. The opposite of what I had experienced in Bethesda.

When I got to Mseleni I received such a warm welcome from the staff most of whom had known me as a kid. Dr. Fredland is very supportive and very good with his junior staff. I think he assesses personality very well, and is able to give you your space to do your thing, but when he sees that there's something going on he can also pull you into order. So I think

that's the difference with Mseleni - it is the support that you get. You know that Dr.Fredland is there, even if you call him at midnight, and he's not on call, he'll still answer his phone and he'd be willing to help, so I think that is the main difference between the two hospitals.

When I arrived Dr.Fredland allocated me to the HIV/TB committee and I've learnt a lot about HIV and TB just by being part of that committee. When I started the TB cure rate was below 40%, by the end of the first year we managed to get it up to 60%, then we got it up again to 75% **so it's been a wonderful journey**. I even managed to do my diploma in HIV in 2012. Currently I am responsible for the HIV adolescent program and when new doctors arrive I orientate them about the HIV and TB programs. I also did a research project on multiple drug resistant TB with Dr.Fredland and we are currently working on modifying the new antiretroviral guidelines.

At the moment I exploring the possibility of specializing in Family Medicine, with the decentralized program. I've also spoken to a doctor in the Africa Centre, and there is a possibility of doing a little bit of research before I specialize in Family Medicine. I think that would help me with my Family Medicine research project and with a PhD one day.

To be a health care professional in Mseleni means that I'm a role model. Being from such a rural community and being a doctor from that community, a lot of girls and boys look up to me. Some have approached me personally, that they want me to be their mentor, which I appreciate very much. But being a role model also means that you need to be very cautious about how you conduct yourself in the community and at work. So being a health-care professional to me is a big deal. In terms of work, it means that you're in contact with a lot of people, and if you're in contact with a lot of people you come across people with different attitudes, different beliefs and cultures and religion. And it just means that even though I have my own beliefs, my own culture and my own religion, I still need to respect how other people feel, and just try not impose my beliefs on other people. I think that's difficult sometimes, because I do find myself, praying with my patients. But I think it's very important.

I also think it's important to continuously develop yourself, because in health there are new policies, new guidelines and there's one thing I've learnt at Mseleni, you need to base your management on evidence.

Being a doctor it is about developing caring, supportive relationship, working as a healer and comforter. I see my work as somebody who brings hope to the sick, and I think that's more important than just being a doctor. I see myself as somebody sent by God to save others,

either physically or spiritually. If you combine being a doctor and a Christian, I think ultimately you are called for something bigger than just the career that you're in. I think as a doctor we make it to be more professional, and we don't realise that it's actually a calling, it's what God wants us to do. And when patients say 'thank you' at the end of a consultation, they don't just say 'thank you for seeing us,' but 'thank you for having a positive impact onto our lives.' And I think I've learnt this in practice that it's not about the medication that you dispense. It's about the hope that you bring. The smile that you greet them with when they enter that door. They get hope.

Working does also mean that I have resources. As a mother and as a daughter I have a responsibility to take care of my family and the community as well. My little sister couldn't get a loan at university, and my mom was still working at that time, but she needed a lot of help. My sister was doing a degree in psychology, so she couldn't do it alone so I had to help her. And then in 2011 when my mom retired, my little brother was still in college doing public relations. He was in his final year, so I took over his fees, and just generally taking care of him. I think that that's naturally our responsibility, to take care of our own. And I must say that along with my mom, we've been able to renovate at home, and financially I am satisfied. They say charity begins at home, but it doesn't end there. So even though you put up food on a plate to feed your family, you still need to look at what happens in your community. And ya, that's how I look at life as well. God helped me - I always believed in God, I'm a worshipper, I'm a Christian, I just love God, and I'm glad to have God in my life every day.

Moving back to Mseleni meant that I have been close to my mom though my dad moved out of the house shortly after I arrived back at Mseleni. I still do not have a good relationship with my dad although I have made a big effort with him.

I have remained at Mseleni because it's comfortable and I just love being close to my mom. I think she suffered a lot when we were younger and she worked so hard to raise us... I just am glad for the years that I've been here, I know she just needed to see me and appreciate being around me and appreciate my success. I have also stayed for the community as well. The welcome they gave me when I came back meant that they appreciated me being there. I've enjoyed the relationships I've built with the youth of my age, older people, younger people, people in the community just makes it so comfortable. **And it makes it just enjoyable.** And

then it's also about their trust. I think that the trust that I have with my patients has gone to an extent that some of them just don't want to be seen by other people.

Being integrated back into the community means I'm part of the community. I don't feel like I'm a doctor, I just feel like I'm one of the youth in the community. I can participate in activities are happening in the community without any discrimination. That means quite a lot to me, because you don't want to be in an area where you're going to be given this status, and end up being this person who's high and above others, and that helps me a lot with staying humble as well.

Because I grew up in the community, I schooled in the community, I kind of know what the challenges are. There are a lot of patients that are really poor, really really destitute. And I think that makes me say that I want to help as much as I can. Like when I see a patient, most of the time it doesn't just end with 'What's wrong with you?' It usually ends with 'So what do you want to do when you've finished school?'

And meeting young girls in the community and letting them know that actually it can be done – I did it. If you think that your parents don't have money, come forward, we will try and help. I always tell them, I don't have money but we can do something to help you. I think it also bridges the gap, because when you're educated, most of the time you're seen as this high and mighty person, but if you come back to the community and you get down to the community level, because you've got a background, you know what's happening, it makes it easier to communicate with your patients as well.

When I moved back to Mseleni I moved back home. Mum still cooks and gardens, so yes, she's my inspiration. She's a very strong woman, she believes in God as well. I have a close relationship with my mum and my daughter Sammy ... she's a beautiful little girl ... but my dad decided he was just going to leave and build a new house just after I returned to Mseleni. His new house is about a kilometer away, and he stays there alone. He said he wanted his goats to live in a secluded area so that they could feed nicely.

After completing medical school I just showered my dad with gifts because I wanted to show him that I didn't have a grudge against him. I bought him cigarettes and wine and when I bought a car in 2009 I brought it home to show my parents. My mom came out, got into the car and started praying inside the car. My dad he went into his bedroom and said, 'How can you think that you're going to do better than me? Do you think that you can just buy a VW and I'm going to envy you? I've driven expensive cars in my life, you know that, I've driven

BMW's and whatever,' It seemed to me that he thought I was trying to compete with him but I wasn't trying to compete with him. I was actually trying to make our lives better, but he wasn't appreciating that. Since he's moved out of the house it's difficult for me to know what he wants. I give him money on his birthdays and when he needs something, but he now lives this secluded isolated life. When his car breaks down and I find him hitch-hiking I stop for him but have to really convince him to get into the car. It's just a taxing kind of love.

I'm currently engaged to Thulani and we hope to get married in the near future. All the traditional arrangements have been made and it is only a matter of setting a date! My mom-in-law recently asked me to make her biscuits for a quarterly church meeting for all the women in our church. Ya the training to be a Makhosi has started! And I'm getting excited over it. So ya, I'm still trying to balance and see what my role is. I am an African woman, even though I'm educated and privileged to be a doctor, but at the end of it all I'm still humble and I embrace my culture.

I see myself as a very warm person, as a loving person, so I'm always loving to my family and my patients. I am a daughter and I'm a mother to Sammy whom I love very much, and I'm blessed to have.

I'm a worshipper, I'm a Christian, I just love God, and I'm glad to have God in my life every day. And then moving here, I'm a daughter to my mom. I think she's the best thing that ever happened to me. She's an inspiration, she's my strength, she's my pillar of strength, she's everything.

8 Conclusion

Six stories have been presented of rural origin HCPs contributing to health care delivery in rural areas. Their stories tell of agency, of possibilities despite challenges, of resilience and belief in the possible. These stories form the basis for the articles written for my PhD thesis.

9 References

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