

**THE UNIVERSITY OF HULL**

**AN EVALUATION OF COMMUNITY BASED  
UNIVERSITY NURSING EDUCATION PROGRAMME  
AND STAKEHOLDERS' EXPERIENCES**

**By**

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A Thesis Submitted to

The University of Hull

in partial fulfilment of the requirements for the degree of

**Doctor of Philosophy [PhD]**

Nursing Studies  
Department of Nursing  
Faculty of Health and Social Care  
The University of Hull  
December 2014

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## **Conference Presentations**

Nambozi, G. (2010). An evaluation of 'Community Based University Nursing Education Programme and Stakeholders Experiences'. Oral presentation at the International Conference on Qualitative Research in Nursing and Health. Scientific Research Methods Chiang Rai, Thailand. 1<sup>st</sup> to 3<sup>rd</sup> December 2010.

Nambozi, G. (2012). An evaluation of 'Community Based University Nursing Education Programme and Stakeholders Experiences'. Seminar presentation to the Department of Nursing Faculty of Health and Social care. 25<sup>th</sup> January. University of Hull.

## **ACKNOWLEDGEMENTS**

There were many challenges during the journey to completion of this thesis. I lost six beloved relatives including my only surviving uncle, but the love of God, family and friends gave me strength and kept me focused to the end. The research process has been very demanding and challenging, but it has enriched my understanding of community nursing education programmes and research methodology. My gratitude goes to my supervisors Dr Jeremy Jolley for his professional support, guidance, patience and good - humour which kept me going and Dr Pat Pearcey, for her timely professional advice, which all proved to be so much resourceful to this thesis. This work would not have been possible without their vast experience and expertise and guidance in understanding the complexity of doing qualitative research.

My gratitude to my employer Mbarara University of Science and Technology for granting me permission for study leave.

Nothing would have been possible without the financial support from the University of Hull, Faculty of Health and Social Care for the scholarship and Mbarara University I am very appreciative.

I would like to thank Fulbright Alumni Initiative Award for their initial funding towards this Community-Based University Nursing Education Programme. Special thanks to professor Locsin Rozzano and professor Marilyn Parker for spearheading the process that enable the department of nursing at MUST to

realise its vision of educating student nurses using this innovative pedagogical approach.

Special acknowledgement to the Faculty of nursing MUST-DON who continued to work during this study leave despite the gap left behind.

I thank all the faculty department of nursing the University of Hull for their support and always asking how I was getting on.

Thanks in a unique way to, Dr Joan Kemp, Dr Gloria Likupe, Mary Hall, David Muir, Khetam, Webster, Joy, Esther and Ola for offering me support, and constructive criticisms, which shaped this thesis.

Special gratitude to Professor Locsin, Professor Barry Charlotte, Dr Florence, and Dr Bonie for their inspiration and support towards this thesis.

In a special way I would like to thank the following; the family of Dr Jeremy, David Muir, Dr Joan Kemp, Dr Gloria Likupe and Mary Hall, who ensured that I was at home away from home. Dr Joan a big thank you for your monthly visits and encouragement.

Special thanks to the research assistant Esther Beebwa. I thank all the study participants for answering all the questions posed to them especially young children who endeavoured to draw and illustrate their experiences.

My friends who have been so supportive, some names, are worth mentioning here. Nick, Khetam, Beatrice, Brandi, David, Felix, Isaac, Jannat, Maria, Richard,

Ritah, and Webster. All the PhD students of the University of Hull, surely graduate school was our real home in this race.

Special thanks to my boy Danny for his patience and enduring all the challenges during my absence. My sincere appreciation to mum, brothers and sisters for their prayers, encouragement, support and love that gave me the strength to overcome challenges encountered during the journey of this thesis.

Lastly gratitude goes to Hull University and the community for making me feel welcomed and study in an enabling environment that enabled me realise my dream of accomplishing this thesis.

## **DEDICATIONS**

This thesis is dedicated to God the loving father who enabled me reach this far in my academic endeavours. To my late dad who always told me 'the sky is the limit', my Mum and my boy Danny.

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## LIST OF ACRONYMS

CBE:	Community-Based Education
CBNE:	Community-Based Nursing Education
CBUNE:	Community-Based University Nursing Education
DoN:	Department of Nursing
F t F:	Face to Face
FAU:	Florida Atlantic University
FGD:	Focus Group Discussion
FAO:	Food and Agriculture Organisation of the United Nations.
FAIA:	Fulbright Alumni Initiative Award
MoES:	Ministry of Education and Sports
MoH:	Ministry of Health.
MUST:	Mbarara University of Science and Technology.
MUST-DON:	Mbarara University of Science and Technology Department of Nursing.
SBNC:	School Based Nursing Centre.
UBOS:	Uganda Bureau of Statistics.
UMMPS:	Uganda Ministry of Public Service.
UNMC:	Uganda Nurses and Midwives Council.
UNICEF:	United Nations Children Funds
UNESCO:	United Nations Educational, Scientific and Cultural Organisation.
UNFPA:	United Nations Population Funds.
WHO:	World Health Organization.

## DEFINITIONS OF TERMS

**A client** is a person who engages the services of another who is qualified to provide this service.

**A patient** is a person who is waiting for or undergoing medical treatment and care.

**A primary school** is an institution in which children receive the first stage of compulsory education, known as primary or elementary education. In the study area it is known as “Universal Primary Education (UPE)” (Ministry of Education and Sports 2004).

**A programme evaluation** is *“the systematic collection of information about the activities, characteristics, and outcomes of programs, for use by people to reduce uncertainties, improve effectiveness, and make decisions”* (Patton 2008 p. 39).

**Community** is most often used to mean a geographical community in which people live with a common interest or perspective. It can also be based on human relationships (Bramston, Bruggerman et al. 2002).

**Community Based Nursing Education:** Those educational experiences associated with community nursing which encompass a variety of services that emerge from the needs of the community and are characterised by interdisciplinary effort (Zungolo 2000; Mtshali 2009).

**Community empowerment:** Involves enabling individuals, group and the community to take as much control of the process of change as possible and in the absence of persuasion reward, coercion or manipulation (Tengland 2008; Laverack 2009; Tengland 2012).

**Evaluation:** Evaluation is a process that places judgment on a given situation (Stavropoulou and Kalesi 2012), it can either be formative or summative (Menix 2007).

**Experience:** Experience is a person’s knowledge or skills, based on his or her personal observations, actions and contacts throughout his or her life (Van der Wal 2002).

**Faculty nursing:** refers to the teaching staff with academic rank in a nursing school. In this study faculty nursing will be used interchangeably with lecturers with academic rank in a university.

**Formative Evaluation:** is a technique used for assessing the project, when it is in the running stage (Hubball, Gold et al. 2007).

**Health:** a resource for social, economic and personal development and an important dimension of the quality of life (World Health Organisation 1986); it is socially and culturally constructed (Scott-Samuel and Springett 2007).

**Health Education:** “comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health” (World Health Organisation 1998 p. 4).

**Health Promotion:** the World Health Organisation (1986 p. 1) defines health promotion as *“the process of enabling people to increase control over and to improve their health”*. According to Laverack (2007) health promotion is a multifaceted approach in inspiring positive health-related lifestyle changes in individuals, families and communities.

**Humanness:** is a feeling of compassion for fellow human beings and about spontaneous caring in a loving way (Nussbaum 2003).

**Learning:** Learning is an active process in which learners construct new ideas or concepts based upon their current or past knowledge, either incidentally or through institutional learning in order to create a change (Brandon and All 2010).

**Nursing:** An autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Including the promotion of health, prevention of illness, and the care of ill, disabled and dying people as well as advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (International Council of Nurses 2009).

**Participant Observation:** Is a research strategy that allows the researcher to operate within the field, observe and influence what is being observed by his/her participation in events.

**Programme:** The term "programme" includes any organised action such as, service provision, educational services, media campaigns, public policies, research projects, etc. (Centre for Disease Control 1999).

**Pupil:** a school-age child attending school.

**Reciprocal relationship:** A relationship characterised by the sharing of expertise, experience, attitudes, beliefs, and skills.

**Rural sites:** are practical community sites for students located outside the urban environments. These areas are often resource-limited (Kasirye, Ssewanyana et al. 2004).

**Service learning:** Service learning is an educational activity distinct from the traditional clinical rotation and which focuses on learning through the application

of nursing skills in a supervised setting. Students collaborate with community partners and work to meet their learning needs (Seifer and Vaughn 2002; Mueller and Norton 2005).

**Stakeholders:** Any person or organisation that is actively involved in a project, or whose interests may be positively or negatively affected by execution or completion of the project. A stakeholder for the purposes of this study means service providers, users and other members of the community.

**Student:** A student is a person studying post primary education and in this research study is a person studying to enter nursing profession.

**Student nurse:** A nurse in training. In this document 'student nurse' is a person studying to enter nursing profession and they will be referred to as "student nurse" or "nursing student".

**Summative Evaluation:** examines the overall impact of the programme (Hubball, Gold et al. 2007).

**Wellness:** An approach to health that focuses on balancing the many aspects, or dimensions, of a person's life through increasing the adoption of health enhancing conditions and behaviours rather than attempting to minimize conditions of illness (Joint committee on Health Promotion Terminology 2001).

**Ubuntu:** '*Ubuntu is an ancient African worldview based on the primary values of intense humanness, caring, sharing, respect, [and] compassion ...*' (Khoza 2005 p. 269).



## **ABSTRACT**

This study is concerned with an evaluation of a nursing education programme designed to provide practical experience of child health education in two primary schools local to a university in Western Uganda. The purpose of the programme evaluated in this study, was both to provide health promotion and education experience to students in a real-life situation while being supervised by a member of the academic staff and to offer 'real' health care in relation to preventable diseases. This programme represents a paradigm-shift where students can practice health care within a project developed and run by their university for the local people.

The programme focused on health promotion, illness prevention, and early intervention with the aim that, pupils would pass on their learning to children and through them to the wider family and community. This is suggested to take place through a 'Reciprocal Ripple Effect Model' and role modelling guided by 'Ubuntu' philosophy with its focus on community members helping each other.

This qualitative study aimed to evaluate the project through an exploration of participants' experiences. Data were collected using participant observation, document analysis, focus group discussions, semi-structured and email interviews from a total of 71 participants. Participants included children, parents, academic staff, nursing students and local administrators. The data were analysed using content analysis.

The study provides new insights into community-based nursing education programmes. It found key themes that reflected a positive experience of the programme from all participants. Through collectiveness, participants valued 'being involved and participating', 'sharing information', and the wider communication that the initiative enable for all actors. Students valued 'acting as role models' and the project was associated in the participants' experience with 'developing and growing confidence'. The one key theme which most clearly reflects the child and parents' experience was 'transforming one's life', indicating the way in which the project helped make members of the university's local community feel valued. The university had ceased to be an institution of privileged outsiders and had become integrated and valued with their community.

This study provides support for the use of the 'Reciprocal Ripple Effect Model' guided by 'Ubuntu' philosophy in resource-limited environments in empowering the community to make decisions and embrace informed responsibility for their health. Also in enhancing the learning and intervention performed by student nurses and in a manner that was culturally acceptable and sustainable in a resource-limited environment.

# **CHAPTER 1. INTRODUCTION**

This chapter discusses traditional nursing education in Uganda, the background to the Community-Based University Nursing programme, the study site and the researcher's role in the programme.

This thesis is based on an evaluation of the Community-Based University Nursing Education Programme in Uganda. The programme was designed to provide health promotion and education to school-age pupils and to provide community practice experience for Bachelor of Nursing Science (BNSc) students. The essential feature of the project was that student nurses, guided by faculty staff, provided health promotion and education to the pupils in primary schools. The project was founded on the assumption that pupils would pass on their new-found knowledge to their families and to the wider community, with the aim of achieving a healthier community. This project required a working relationship between the university, local primary schools, community and local politicians and did so in a manner characteristic of the Ubuntu philosophy, which emphasise human care for others.

## **Background to traditional nursing education in Uganda**

Traditional nursing education in Uganda followed the pattern developed by Florence Nightingale (Baly 1986) in the mid-nineteenth century. The turning point of modern nursing education started when, the first British medical doctor, Sir Albert Cook, also referred to as the 'father of modern medicine' came to Uganda in 1897 with a group of 12 nurses (Walusimbi and Okonsky 2004; Mbalinda,

Nabirye et al. 2013). In 1900, Albert Cook married Katherine, one of the 12 nurses (Walusimbi and Okonsky 2004; Basudde 2012). Katherine became matron of Mengo hospital, near Kampala from 1897 to 1911. Katherine also became the general superintendent of midwives and inspector of country health centres (Basudde 2012).

By 1919, there was concern regarding the level of maternal mortality and the lack of trained midwives to care for mothers. Midwifery training was introduced to combat the increasing maternal mortality rate at Mengo hospital. The training was for one year, and the first group graduated in 1920. This marked the beginning of the formal education of nurses (Midwives) in Uganda.

Nurse training at enrolled level (EN)<sup>1</sup> followed in 1930 with the first group of ENs qualifying in 1933. EN training was based in mission hospitals and few government hospitals. In 1947 changes were made to the recruitment criteria, and recruitment was limited to young women who had attained nine years of formal education and who could speak English. The first group qualified in 1950 as both nurses and midwives (Walusimbi and Okonsky 2004; Mbalinda, Nabirye et al. 2013).

The training of nurses at registered level did not start until 1961. This led to an adjustment of entry requirements, and only those who had the Cambridge School Certificate of 'Ordinary Level' of education with credit in English and a science subject were admitted to the course. In 1967, training of registered midwives

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<sup>1</sup> Enrolled Nurse – a second level nurse whose main role was to provide support for registered nurses (though training for first level registered nurses had not yet commenced in Uganda).

commenced. Mental health training started at Butabika in 1960. The clinical rotation was under the supervision of a registered nurse or midwife as students rotated through specific areas within the hospital. The trainees were provided with uniforms and offered accommodation in hostels. In return, these vocational students were expected to provide for the service needs of the hospital and were offered a minimal wage. Apart from working under the guidance of registered nurses, students were given additional responsibility to take charge of wards in their final year before graduating. It can be argued that this type of training provided an inexpensive and disciplined workforce for the hospital. It is the case that students' learning needs in this vocational training system took second place to the service needs of the hospital; a situation that reflected that present at the time in the United Kingdom. Teaching input was minimal, with most lectures delivered by medical doctors after ward 'rounds' when there would have been a low rate of concentration on the part of the students after a day's hard work. The theory component of the course was seen as less important than the clinical component; the 'doing', and 'learning by doing' dominated the educational system.

The Uganda Nurses and Midwives Council (UNMC) was formed in 1956 as a regulatory body. The UNMC laid down requirements for nursing education, examination, registration / licencing and practice. In 1967, the Uganda National Association of Nurses and Midwives was formed to deal with professional interests and the welfare of nurses and midwives.

During the post-independence era (1962-1971), Uganda enjoyed good health outcomes and a vibrant health care system (Ministry of Health (Uganda) 2009).

Two decades of civil unrest followed and the health care system collapsed. After the war and in response to these challenges, the government of Uganda started a reconstruction and rehabilitation programme which prioritised improvements in health care delivery.

In the 1970's and early 1980's, a number of further development courses were introduced, including courses in nurse education, administration, public health nursing, anaesthesia and ophthalmic nursing. In 1992 further changes were made in the admission requirements and standardisation of entry requirements was initiated. Applicant now had to have attained a minimum of five passes in English, Mathematics, Biology, Chemistry, Physics or Geography, or Agriculture for enrolled certificate and with credits for registration level. A minimum standard for both theory and clinical components of nurse training was introduced. In addition, accrediting of all training institutions and a state final examination at the end the programme were introduced.

Traditionally, nursing in Uganda was predominantly a female profession, as caring was considered a woman's role. Also at that time the culture favoured boys' education to that of girls; the education of girls was seen as a poor use of resources, since they would get married and move away. Therefore, since the entry requirement for nursing was relatively low, this opened an avenue for girls who could not go further with their education. Midwifery training was not seen as appropriate for males. Today, however, this trend is changing and more men are joining the profession and specialising in midwifery. Psychiatric nursing was introduced in the 1960s and attracted male applicants.

In 1993, a number of reforms to nurse education took place. Health sector reforms required a cost-effective, multipurpose cadre of nurse, capable of delivering the required level of nursing and midwifery care. The introduction of Government policy to establish health centres at village, parish, sub-county and county levels throughout the Uganda reinforced the need to have multi-skilled health workers to provide the range of services in the community. This initiative led to the introduction of 'Comprehensive Nursing'<sup>2</sup> courses which would provide basic promotive, preventive, curative and rehabilitative health care at lower level health centres (Ministry of Education and Sport (Uganda) 2004a; Ministry of Health (Uganda) 2010; Ministry of Public Service (Uganda) 2012).

Thus, two programmes were introduced in government training schools. The comprehensive nursing programme at Registered and Enrolled level in 1993 and 2003 respectively and the Bachelor of Nursing Science degree programme in 1993. In 2001, master's degrees in nursing became available. There was a need for nursing programmes that focused both on student nurses' learning needs and the health needs of the community to be served. However, at this time, community involvement was mainly geared towards health education.

In the last 20 years', pre-registration nurse education in Uganda has undergone radical changes with an increasing focus on community-based education. There has been an emphasis on health promotion, illness prevention and early referral.

Today, nursing education in Uganda involves three programmes. The bachelor degree has two types of entry, the direct entry from high school (4 years) and

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<sup>2</sup> Meaning general nursing combined with midwifery.

practising nurses with diploma, who enter through a 'completion programme' (2½ years), bachelor of medical education (3 years). In addition, diploma level courses are also available in Registered nurse comprehensive nursing (3 years) and Enrolled nursing certificate (2½ years). There is also a diploma in related disciplines; public health and tutorship (2 years), midwifery, nursing, mental health, paediatric public health nursing and community health (see Uganda nurses and midwives Council, Uganda<sup>3</sup>). Currently, there are two government and six private universities that offer BNSc degree and 62 tertiary institutions which offer diploma and certificate education for nursing.

University-based courses in nursing are regulated by each university. Non-university courses are regulated by the Ministry of Education. All nursing courses follow regulations approved by the Uganda Nurses and Midwives Council. Many nursing programmes, especially those at postgraduate level, are coordinated in collaboration with international universities. Today, the nursing curriculum in Uganda is influenced by British, American and Canadian models of nursing. For example international concepts of community-based education, caring, the nursing process, health promotion, etc. have become integrated into the Ugandan nursing curriculum.

Such has been the development of nurse education in Uganda over the last 95 years from the vernacular-trained nurses and midwives to registered nurses and midwives. Training in English and graduating with certificates, diplomas and more recently, with degrees. The PhD in nursing remains unavailable within Uganda.

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<sup>3</sup> [http://www.unmc.ug/approved\\_sch.html](http://www.unmc.ug/approved_sch.html)



## **The Study Site**

This study took place in Mbarara, Uganda. Mbarara is situated in the western region of Uganda, 295 Kilometres south-west of Kampala. Uganda is located within the East African region, just north of Lake Victoria, and lies astride the equator (Uganda Bureau of Statistics 2002) (see appendix 2). The country has a total area of 241,038 square kilometres, which is made up of swamps and lakes (43,942 square kilometres) and forests (197,096 square kilometres) (Uganda Bureau of Statistics 2002).

Mbarara is one of Uganda's fastest growing districts (Uganda Bureau of Statistics 2002; AMMICAALL Uganda Programme 2009). Mbarara Municipal Council is one of the 15 Municipalities in Uganda and the third largest town after Jinja and Kampala.

## **Disease Burden**

Today, the public health care system in Uganda works on a referral basis, with the top level being the national referral hospitals (Kavuma 2009). Because of limited resources, a minimum package of health service provision for all the citizens of Uganda was developed (Ministry of Health (Uganda) 2008), this comprises:

- Health promotion
- Disease prevention and community health initiatives including epidemic and disaster preparedness and response
- Maternal and child Health
- Nutrition
- Prevention, management and control of communicable diseases
- Prevention, management and control of non-communicable diseases.

Ministry of Health (Uganda) (2010)

72% of households in Uganda live within 5km of a health facility (Ministry of Health (Uganda) 2008). However, utilisation of health care services is often limited by poor infrastructure such as lack of transport, medicines and other health supplies (Ministry of Health (Uganda) 2010). All these challenges compromise both the health of the community and government efforts to promote the health of citizens.

Approximately 60% of Uganda's population seek care from traditional and complementary practitioners. For example; herbalists, traditional bone setters, traditional birth attendants, hydro-therapists, spiritualists and traditional dentists (Ministry of Health (Uganda) 2010). Most traditional and complementary practitioners have no functional relationship with public and private health providers. Unfortunately, this lack of cohesion often results in late referrals and high morbidity and mortality rates (Ministry of Health (Uganda) 2010a).<sup>4</sup>

Employing preventive measures is considered the cheapest way to achieve disease prevention. Ministry of Health (Uganda) (2009) acknowledged that 75% of the disease burden in Uganda was preventable through improved hygiene and sanitation, vaccination against the childhood diseases, proper nutrition and other preventive measures.

Communicable diseases account for 54% of the total burden of disease in Uganda, with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndromes (AIDs), Tuberculosis (TB) and Malaria being the

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<sup>4</sup> However, it is generally acknowledged that traditional practitioners can practice safely where they are provided with guidance on what they can safely manage and when to refer.

leading causes of ill health (Ministry of Health (Uganda) 2008). Malaria remains one of the most important diseases in Uganda in terms of morbidity, mortality and economic loss. Malaria has been recognised as a disease of poverty (Gallup and Sachs 2001; Sachs and Malaney 2002.; World Health Organisation and Fund 2003) often claiming the lives of young and economically productive Ugandans.

The fact that the poor tend to utilise health facilities less was demonstrated in Kasirye, Ssewanyana et al. (2004) study. This situation was found to be exacerbated by a preference among all social classes for traditional healers, even though they were more expensive than the western health care. Furthermore, according to Uganda Bureau of Statistics (2002), some members of the community combine both modern pharmaceutical and traditional medicine (op.cit.).

### Education system

Prior to Ugandan independence, the education system was modelled on the British educational system. This heritage is still evident in the school system today. Uganda follows seven years of primary school education, four years secondary (O level), two years higher school (A level); at the end of each stage there is a national examination.

Arguably, the school system was not equal for all because it was not universally free. While primary school education is free, secondary education is selective with fewer pupils continuing at each subsequent level of education (Kasirye, Ssewanyana et al. 2004). As a result, many Ugandans remained Illiterate. Since the introduction of Universal Primary Education (UPE), enrolment in primary schools increased to 7.6 million in 2005/06 from 3 million in 1997 (Ministry of

Education and Sport (Uganda) 2004b; World Bank and United Nations Children's Fund 2009b; World Bank and United Nations Children's Fund 2009a). Today the literacy rates of Uganda stands at 73%.<sup>5</sup>

The prevalence of diarrhoea, respiratory infections and fever among under-five year old children have been positively associated with the educational level of the child's mother (Uganda Bureau of Statistics 2006). Therefore, increasing access to education through Universal Primary Education could improve health outcomes (Kasirye, Ssewanyana et al. 2004).

It is against this background that the Universal Primary Education programme was launched in October 1996 to address some of the shortcomings of the educational reforms and also to ensure that all children of school-going age had access to education. Although primary education was free, it has been noted that some schools still charged for some costs (Kasirye, Ssewanyana et al. 2004) even though this was contrary to government's policy. Such practices adversely affect children in rural areas forcing them to drop out of school if their parents cannot afford to pay.

The major challenge of the current educational system is ensuring that children remain in school. Currently, the school dropout rate is high; only 49% reach Grade 5 (Kasirye, Ssewanyana et al. 2004). Regrettably, Uganda's completion rate is only in the region of 33% (Tamusuza 2011). According to the United Nation

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<sup>5</sup> 2006, 2012 estimates UBOS as cited in Ministry of planning and development and United Nation Population Funds (UNFPA) 2012).

Millennium Project (2005), multi-factorial issues have been linked to school dropout; these include:

- poor socioeconomic status;
- being an orphan;
- engaging in child labour;
- girls who have reached the Menarche;
- lack of food provision at school.

### **The community-based education project: background**

The community-based education project is essentially an opportunity for nursing students to gain experience in a primary school which has a health education annex (school-based nursing centre). Student nurses teach the children good health care practices alongside a nurse-teacher from their university (in this case, Mbarara University of Science and Technology). This not only teaches children good health care practices but aims to encourage the children to pass the information onto their family, thus propagating the educational intervention to the wider community. It is the evaluation of this project that is the basis of the research upon which this thesis is based.

The following stakeholders were involved in the design and implementation of the project:

- Fulbright Alumni Initiative Award (FAIA) USA;
- Mbarara University of Science and Technology (MUST);
- Florida Atlantic University (FAU) USA;
- The District Education department of Mbarara Municipality.

MUST and FAU provided faculty members who contributed to the design and implementation of the programme. The FAIA provided the initial funding, which made it possible to implement the programme. The FAIA funds facilitated the

creation of the School-Based Nursing Centre at St. Mary's Primary School, Katete. Katete is a village in the Mbarara Municipality. The Katete area predominantly accommodates low-income families and has poor access to health facilities.

The funding enabled the centre to take student nurses three times a week for three hours a day. The funding from FAIA was conditional upon sustainability and the development of a cooperative relationship with MUST and consultative activities with Florida Atlantic University. The host institution and the primary schools shared the cost for the sustainability of the running the programme at the expiry of the Fulbright Alumni Initiative Award.

The classroom and security staff were provided through the district education office of Mbarara municipality. A bit of space for data and health care equipment was created at the site. The support of the Municipal Mayor enabled the provision of community nurse practitioners. This partnership was affirmed during the official launching of the programme in June 2004.

One aim of the project was that students and their lecturers would be better able to practice nursing in the community. The community nursing centre was also intended to serve as an avenue for nursing research (for example, the current study) as well as increasing the availability of health services to the community.

The health promotion activities provided by the nursing students in the community centre included:

- hand washing;
- care of common skin diseases;
- providing counselling and advice;
- assessment of growth and development of children;
- physical assessment;
- administration of medication;
- treatment of minor ailments.

In addition, more complex problems that presented from time to time, were referred to the regional referral hospital by the faculty member present.

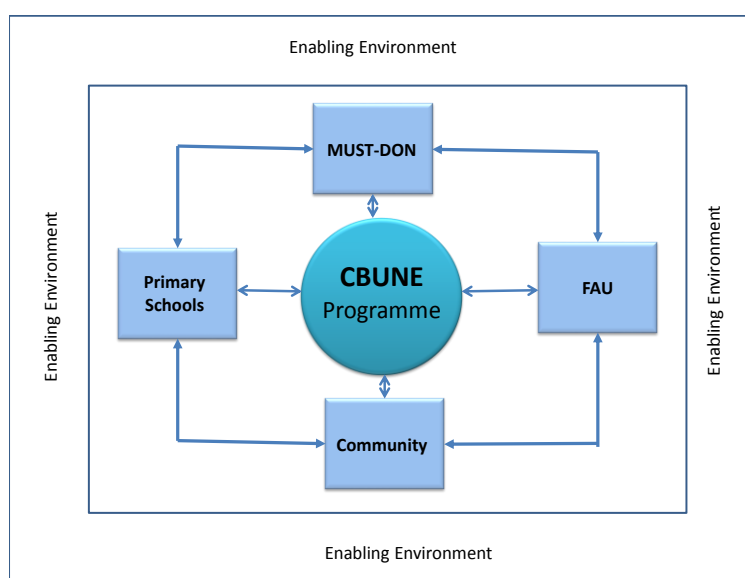
The activities for students were instituted from a model that emphasised the critical practice role. This role included participatory activities that enhanced multiple ways of living healthy lives through educating the pupils, their parents and eventually the community about healthy lifestyle practices. This model of health care was exemplified by the 'ripple-effect' of practice (Locsin 2004). According to (Newman 2003), 'Ripple Effect' refers to the spreading effect or series of consequences caused by a single action or event; in this case, health information from nursing students to pupils, parents and the wider community.

Prior to their community placement, student nurses were provided with information and equipped with skills to successfully practice in the School-Based Nursing Centre setting. They were introduced to the concepts of community-based care, cultural issues and competence, principles of collaborative interdisciplinary care delivery and health promotion and disease prevention services.

The faculty staff continued to teach and work beside students within the community placement to ensure that students were working within their objectives and could access appropriate supervision. In addition, the faculty regularly held meetings with students to share, learn from and educate each other.

Students rotated in groups of twos or threes throughout the period of their community placement. During this period, the uncompleted community tasks by each group of students at the end of their rotation was passed on as a building block for the next group of students. The significance of this was to inform new students about their responsibilities in promoting the continuity of the programme. This concept of handing over was a dual strategy for preparing student nurses to undergo a 'role transition', for entry into professional practice after graduation, as well as a matter of policy for nursing practice.

Figure 1. Relationship between the stakeholders and the programme



Source: Author (2012).



The above model of practice (Fig.1) summarises the relationship between the stakeholders, their involvement in the programme as well as its impact on them.

The collaborative approach of stakeholders was made possible by the enabling environment in which the programme operated. In addition, the reciprocal relationship facilitated the participation.

### **How the community-based education programme differs from traditional nursing education**

The mission statement of Mbarara University of Science and Technology (MUST) is that of 'focussed community-oriented practice' (Mbarara University of Science and Technology 1999; Mbarara University of Science and Technology 2004). The undergraduate programme has two entry routes; a programme with direct entry from high school is a four-year baccalaureate degree leading to 'registered nurse'. The second route is a two-year course designed for registered nurses with a diploma and wanting to 'top-up' to a degree qualification. Both groups undertake a one-year internship before they can register with the Uganda Nurses and Midwives Council. The undergraduate curriculum is comprehensive, encompassing all nursing disciplines except learning disabilities.

Community-based education differs from traditional nursing education in that it is a new Ubuntu pedagogy, designed to prepare nursing students to work with the community to achieve and maintain health and wellbeing. According to World Health Organisation (1946 p. 1) 'health' is a state of maximum potential for "physical, mental and social wellbeing and not merely the absence of the infirmity". The community-based education programme embraces this understanding of 'health' by enabling students to go out into the community and

attempt to deal with health issues that are relevant to that community. The students work directly with people in their communities while focussing on the promotion of health and the prevention of locally prevalent diseases. This contemporary approach places the learning of nursing students in the context of the social, political and cultural world of the client (Mtshali 2009). Furthermore, according to Bellack and O'Neil (2000 p. 18), this approach helps 'students develop empathy, social awareness and social and cultural competence' of cultural context of the client. Thus, this model of education is designed to enhance students' understanding of community needs and is congruent with nursing's commitment to the healing and caring interaction guided by 'Ubuntu' or 'being there for others'. In addition, nursing students working together with the community contribute to the mutual benefit leading to the realisation of Ubuntu philosophy in promoting community health and wellbeing. Furthermore, the programme is designed to prepare student nurses to act as change agents in the community. This is compliant with the WHO's position that in Sub-Saharan Africa:

*"There is a desperate need to prepare nurses to act as agents of community change who can help people work on clean water and sanitation projects while also helping to combat malnutrition, maternal and child mortality and communicable diseases"* (World Health Organisation 1997 p. 33).

The implementation of the programme was developed through nursing education constructing its own models and philosophies of community practice which were seen as culturally appropriate in relation to promoting community health and wellbeing within the communities local to the university. The programme also involved sharing of information, specifically in the way that the children share what they have heard from the nurses, with their parents and wider family. This last is designed to take place, despite the cultural norm of elders teaching their

children. In fact, children's role in teaching their parents has received little attention (Lwanga 2004) and is not regarded as 'normal' in the local culture. In addition, cultural practice directs that males frequently make decisions as to what is best for their family. Decisions about family planning, for example, are very likely to depend on the husband's views. Despite these apparent cultural norms, this programme is concerned with empowering individuals with knowledge and skills to make an informed decision regarding their lifestyle behaviours.

As has already been noted, the emphasis of the programme is on health promotion, illness prevention and early intervention. This project was designed to both increase student nurses' knowledge and their knowledge of the health issues which impacted on the local community. The programme focused on community health nursing in a practice setting that was accessible to the then 'under-served' community. The project was managed by the Department of Nursing at Mbarara University of Science and Technology, Uganda. There were two project sites (two schools), both of which were in the Katete area, within Mbarara municipality, close to the University.

### **Researcher's role in the programme**

The researcher's role in this programme resulted from her position as a lecturer at the Department of Nursing, MUST<sup>6</sup>. Within this role, the researcher was involved in teaching, clinical supervision and conducting research as well as acting as head of department for the nursing programme at MUST. The nursing education programme at MUST is comprehensive, meaning students study both

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<sup>6</sup> Mbarara University of Science and Technology, Uganda.

nursing and midwifery. In 2001, the researcher, as head of the department for nursing education at MUST participated in a curriculum review of BNSc programme with a visiting Fulbright scholar. The review showed that the then approach of running a 'community nursing' module without exposing students into the community practice was not effective in preparing students who are expected to practice in the community. A recommendation was made that we should find a practicum site to practice community nursing and provide learning opportunities for students. This was not readily available given the financial constraints of the nursing department. Therefore, a proposal to the Fulbright Alumni Initiative to seek funding towards this programme was made. The researcher's role in this programme was that of a project coordinator, overseeing the design, implementation and coordination of the programme between the university, primary schools and the community members (see appendix 1). The researcher also engaged in teaching students community nursing and later accompanying them in the community, to guide, supervise, support and work together with the community. This role was undertaken for the six year prior to the start of the research project. As a programme coordinator, the researcher was able to visit Florida Atlantic University to experience the community-based nursing education programme there, in order to learn and share ideas.

The researcher envisaged that understanding stakeholders' experiences would provide useful information about the community project at MUST; this eventually led to this present research study. In this way, the researcher played a dual role (insider researcher), acting as programme coordinator and researcher (Dwyer and Buckle 2009). Such a position could be regarded as encouraging subjectivity. However, this thesis is based in a qualitative evaluation of the programme, the

evaluation being chiefly subjective in nature. The subjectivity of the resulting research is fully embraced and welcomed. A project such as this means nothing at all unless the views and experiences of stakeholders are understood and mapped. The researcher was intimately involved in the very subjectivity of this process allowing her to be of the same mind and in the same mind as the participants, with all parties working towards a common understanding of the project.

## **Summary**

Nurse educators are being challenged to be innovative in educating nursing students in partnership with communities. Thus, contemporary programmes such as the community-based university nursing education project described in this chapter are appropriate in addressing these challenges. Such programmes as this, are interesting, not least because of the way in which they engender an Ubuntu<sup>7</sup> relationship between university and community and in the way that information is designed to spread from nurse to child and from child to adult and to the wider community. This present study seeks to provide an evaluation of a community-based education programme at MUST. This study provides an account of stakeholders' experiences of this programme and a critique of the current programme. Evaluation research has a significant role to play in identifying what is working and what needs to be changed, as well as drawing on interventions that have demonstrated merit.

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<sup>7</sup> Meaning 'human kindness' or helping others.

Lastly, this is a study that looks at an innovative educational project in a resource-challenged area of Africa. However, this is also a project that may have potential in other parts of the world, including the developed world. The underlying philosophy of Ubuntu, in this case epitomising the relationship between the university and its local community, is one from which the wider and developed world can surely learn.

## **CHAPTER 2. LITERATURE REVIEW**

### **Introduction**

This chapter provides a literature review on Community-Based Nursing Education programmes and stakeholders' experiences. This chapter will critique the literature; identify key findings and areas for future research.

Community – Based Nursing Education programmes have emerged in the 21<sup>st</sup> century, shifting clinical education from institutions to communities, with the aim of both enhancing students' learning and universities' contribution to their local community. This pedagogical approach enables students to meet course objectives as they provide services to the community.

This pedagogical approach links community service, promotes and enhances students' learning; and does this through multiple meaningful connections between theory and practice in the real-life context of the community's own cultural values (World Health Organisation 1987). The application of theoretical knowledge in assessing, planning and participating, provides a guide to the solving of community health problems (Salmon and Keneni 2004). The interaction between different stakeholders empowers students' learning. It has been suggested that this use of real-life situations in communities makes such educational approaches powerful (Callister and Hobbins-Garbett 2000; Hmelo-Silver and Barrows 2006).

In order for students to meet the expected skills and competency to work in the community, nurse educators need to provide students with diverse learning

experiences (Mtshali 2009; Marshall and Shelton 2012). Arguably, there has been an increased focus on better preparation of nursing students who will ultimately work in community settings. The approach needs nurse educators to be knowledgeable, imaginative and innovative while they support students through this pedagogical approach in the community (Oermann and Heinrich 2003). Furthermore, they must adapt the curriculum in a manner that fosters collaboration and partnership with communities, as well as other organisations. These partnerships can create more efficient and effective educational learning environments for students, as well as building links between community and nursing education in order to bring about a holistic approach to care (Aiken, Clarke et al. 2003).

Community-based education programmes have been acknowledged as an innovative pedagogical approach to nursing education, yet little attention seems to have been given to understanding stakeholders' experiences. Consequently, there is a need to explore stakeholders' experiences of such programmes.

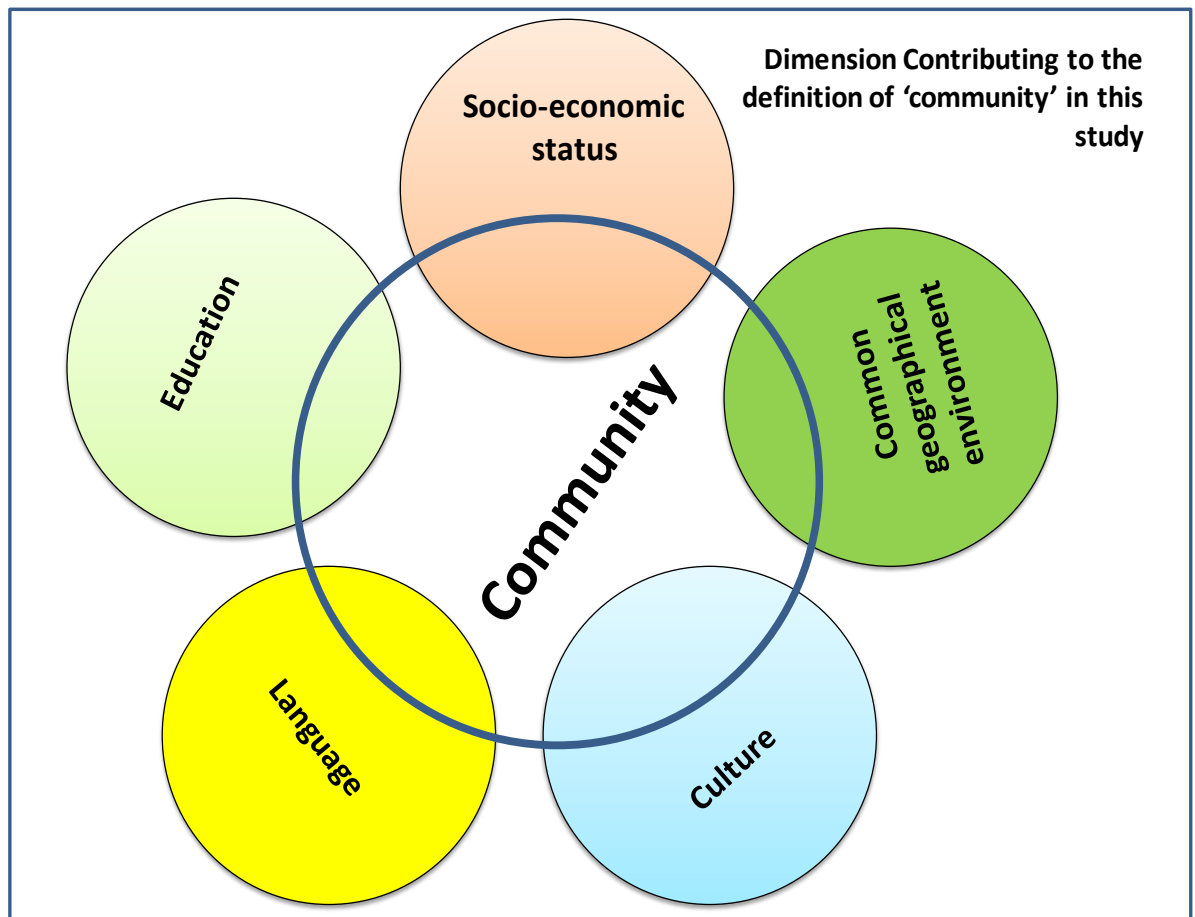
### Defining community

What constitutes a community is understood differently by scholars in different geographical areas. Allender and Spradely (2001) describe community as a group of people who share some essential features of their lives and use common institutions. Smith and Maurer (1995) considered it as a safe place for its members. A community has shared membership and is characterised by shared values and geographical boundaries. Parker and Barry (1999) emphasise that community is an environment that offers a sense of personal security. In most of these definitions, there is a focus on security and the values attached to the



community. It is suggested here, however, that 'community' is also about shared culture, language, education and socio-economic factors (see Figure 2). These elements make each community unique and must be accounted for in the planning of community-based nursing education programmes.

Figure 2. Dimensions contributing to the definition of the community in this study



Source: Adapted by the researcher from (Smith and Maurer 1995; Parker and Barry 1999).

### The Review Method

The literature search involved scoping and then systematically searching the literature in relation to community-based nursing programmes. According to (Davis, Drey et al. 2009 p. 1386) '*Scoping involves the synthesis and analysis of a wide range of research and non-research material to provide greater conceptual*

*clarity about a specific topic or field of evidence*'. The scoping exercise sought to answer the following questions:

- What is known about community-based nursing education programmes in Uganda;
- What research methodologies and research designs are currently employed in these programmes;
- Have studies evaluated all stakeholders' experiences;
- How were participants selected;
- What data collection techniques have been used in relation to children aged six years;
- Have any studies presented a model of nursing guided by community philosophical values such as Ubuntu;
- What are the reported stakeholders' experiences;
- What recommendations exist for implementing and evaluating these programmes in resource poor settings?

The search strategy was iterative with the review of the literature being conducted throughout the life of the study. There was found to be a paucity of research material on community training programme in resource-limited countries. As a result, both the research and anecdotal literature were searched. Anecdotal literature provides a valuable source of 'ideas' and philosophical debate without which the research literature would contribute to less effectively to the progress of nursing education.

The literature search was not limited to date or country of publication. Research on a range of educational disciplines (medicine, dental, and physiotherapy), philosophy, sociology, and psychology were considered where this was constructive. This process continued throughout the life of the research project to ensure that new material was not missed or omitted.

The following keywords were employed:

- Clinical placement
- Community placement
- Community-based nursing education

- Learning environment
- Service learning
- Work-based learning

The above were searched using Boolean operators with:

- Children
- Community
- Curriculum
- Education
- Evaluation
- Faculty role
- Health education
- Health promotion
- Model
- Nursing
- Nursing students
- Programme
- Project
- Pupils
- Qualitative research
- Resource-limited
- Ripple effect
- Stakeholder experience
- Ubuntu.

A list of synonyms, abbreviations and alternative spellings and word-conjunctions (nursing student / student nurse) were used. Keywords were used in singular and plural forms. Both British and American spelling were used. Truncation (with ‘\*’) was used to identify some word variations.

The following databases were searched:

- Applied Social Science Index and Abstract (ASSIA)
- Books on community nursing education were searched
- British Library catalogue
- British Nursing Index
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Elsevier,
- Google Scholar
- Medical Literature Analysis and Retrieved System Online (MEDLINE)
- Ovid SV
- ProQuest for PhD theses
- PUBMED
- Science Direct.

The educational databases such as Educational Resources Information Centre (ERIC) and JSTOR academic journals were searched. The grey literature was also searched. Such material mainly took the form of unpublished reports from conference proceedings and nursing curricula. The World Health Organisation database and government websites were searched for reports.

A manual search in the reference lists using a snowballing approach was also carried out. Researchers working in a similar area were contacted for advice. Studies were selected according to pre-specified criteria and the methodological quality was appraised using a quality checklist. The review involved three steps; planning, conducting and reporting. The following Population, Exposure (issue) and Outcome table was used (see Bettany-Saltikov (2012)).

Table 1. The Qualitative research question involving 'PEO'

Population (P)	Exposure (E)	Outcome (O)
All stakeholders  [nursing students, faculty, pupils, teachers, parents, community]	Community-based nurse education programmes	Experiences  Impact  Challenges

Therefore, the research questions to be addressed by the systematic review were defined as;

1. What are stakeholders' experiences of the community-based nurse education programmes?
2. What is the impact of community-based nurse education programmes on stakeholders

### Criteria for Inclusion and Exclusion

The literature review was based on a predefined protocol (Aveyard 2010; Bettany-Saltikov 2012) for the selection of appropriate studies ensuring that all the available information were incorporated (see table 2 below). The inclusion and exclusion criteria were developed based on the aims of the study.

Table 2. Criteria for the selection of articles

Inclusion criteria in reviewing literature	Exclusion criteria in reviewing the literature
<ul style="list-style-type: none"><li>• Witten in English language</li><li>• Accessible full article</li><li>• Community based education in the title</li><li>• Literature on stakeholders experiences- student nurses, faculty, community, pupils</li><li>• Literature on impact of community based nursing education on students nurses, faculty, community , pupils</li><li>• Purpose and objectives of the study clearly stated, addressing directly or indirectly the experiences of stakeholders</li><li>• Credibility and dependability of the study included</li><li>• Research design and method described clearly</li><li>• Findings presented unambiguously</li><li>• Discussion of findings oriented towards stakeholders experiences</li><li>• Recommendations outlined according to the purpose and objectives of the study.</li></ul>	<ul style="list-style-type: none"><li>• Not written in English</li><li>• Unobtainable articles from inter library loan, search on line, purchasing it or contacting authors</li><li>• The studies that did not involve stakeholders' experiences, and CBNEP anywhere either in the title, abstract to full article</li><li>• Summary reports containing insufficient information.</li></ul>

Source: Author 2013 adapted from Bettany-Saltikov (2012)

### Identification of Articles

Initially, 1,530 articles were identified. After duplicates were removed, 800 citations were screened using titles and abstracts. Further reductions were made and 680 studies were excluded because they were not directly relevant, thus leaving 120 articles for consideration. This included those that were relevant and those that it was not easy to make a definite decision. Further reduction left 50 articles for inclusion. Later searches (iterative) revealed five additional studies bringing the total to 55. The review of 55 papers followed the protocol that can be found in Appendix 14.

The selected articles led to the emergence of sixteen core themes; these were:

- Academic-community partnership,
- Challenges of CBE,
- Children as conduit of health promotion.
- Community experience,
- Community model
- Community-based programmes,
- Education schools in partnership
- Empowerment
- Models of programme evaluations
- Nurse teachers / facilitators' role in community education programmes
- Nursing students' experiences
- Relevance of community-based nursing education
- Relevance of health promotion
- Role of placement learning environment
- Suggestions for improvement
- Sustainability.

### Data Synthesis

In order to aid the review of the literature, the critical appraisal skills programme (CASP UK 2014) was employed to assist the review of the qualitative studies. The use of CASP helped the review to focus on the rigour, methods, credibility and relevance and the papers being reviewed (see appendix 15).

## **Detailed Findings of the Review**

### The nature and purpose of community-based education programmes

Any nursing education programme is a planned educational curriculum which involves both theory and practical experiences in clinical and community learning environments and is aimed at preparing nurses to be fit to work in those environments.

Historically, student placements have been in acute care hospital settings (Hutchinson 2003) with experiences centred on sick individuals. The current trend in healthcare focusing on community well-being, has seen nursing education programmes respond to the community-based approach of education and health care, integrating community components in the curriculum (Reimer Kirkham, Hoe Harwood et al. 2007; Mtshali 2009). The literature indicates that nursing education programmes typically incorporate community placements in, for example, health centres, schools and prisons (Parker and Barry 1999; Frank, Adams et al. 2005a).

Spradley (1991 p. 83) defines community health nursing as an approach that *“combines the knowledge and skills of nursing to maintain, protect and promote the health of specific populations ...”* The phrase ‘community health’ is characterised by meeting the needs of the community by identifying problems and managing interactions within the community (Allender and Spradely 2001; Stanhope and Lancaster 2001; Stanhope and Lancaster 2012). Nurses must be well equipped with up-to-date community health nursing knowledge and skills. These skills must include those relating to developing partnerships with

representatives of the people, members of various professions, organisations and groups in the community who are community health stakeholders. Improving the health of individuals and the family could be an important milestone in the reduction and control of disease. In order for community care to be effective, nursing education has to be responsive to these challenges through innovative approaches in the education of future nurses with community health care knowledge.

Whilst community nursing forms an essential component in the nursing education curriculum, the issue exists as to how nurses should best be educated to face the new paradigm of healthcare. There are challenges to nursing educators, especially in developing countries, where the emergent acute and chronic diseases are at an alarming stage, a situation compounded by meagre resources. Innovative education programmes are needed to help prepare tomorrow's nurses to meet such challenges.

'Community-based education' is a model of educating health care professionals in resource-limited communities (Kristina, Majoor et al. 2004). The concept is similar to programmes that emerged from 'Community-Oriented Primary Care' which originated from South Africa (Mullan and Epstein 2002). The model was first introduced in 1940 by two physicians (Sidney and Emily Kark) in Pholela community in Bulwer (Mullan and Epstein 2002). The model was later adopted by other countries and by the WHO (World Health Organisation 1978) in its definition of primary health care (Mullan and Epstein 2002). According to Mullan and Epstein (2002 p. 1750) Community-orientated primary care is;



*“a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services”*

Arguably, this definition has become embedded in community-based education programmes (Kristina, Majoor et al. 2004). These programmes are typically multidisciplinary in nature, with the primary focus being based on the need for students to gain the competencies needed for future professional practice in the community.

Arguably, there is enough evidence to suggest that community-based programmes provide the most influential learning experience in a student's journey to become a competent health professional (Koontz, Mallory et al. 2010) as they bridge academic and workplace learning (Chan 2002; Newton, Jolly et al. 2010; Rodger, Fitzgerald et al. 2011). However, there is a need for students to be supported as they learn to become good future professionals, otherwise demoralisation and alienation from the community may result (Silén-Lipponen, Tossavainen et al. 2004; Bradbury-Jones, Irvine et al. 2007).

According to Carter, Fournier et al. (2005) community-based nursing education programmes are a pedagogical model that enables students to learn to provide nursing care for people no matter where they encounter them. Mtshali (2009) noted that community-based programmes are mainly employed where universities are in partnership with the community. Rosenkranz (2012); Murray (2013) refers to these programmes as 'community service-learning' being a reciprocal relationship between students and the community, whereby both parties participate in service and learning (see also Seifer, Mutha et al. (1996);

Buff, Jenkins et al. (2014)). This approach goes beyond a simple practice allocation and is based instead on a partnership between the university and the community, requiring that the needs of both parties are addressed in such a way that the dignity and humanity of both parties are affirmed. For example, students' needs for learning are met through planning and providing services while community needs for services are met through student learning activities, such as health promotion and education and growth monitoring.

Poirrier (2001) viewed community-based programmes as a strategy that guided nurse educators to preparing nurses for the 21<sup>st</sup> century. This school of thought is important because health care is moving away from curative to more preventive measures (Hunt 2005). Zotti, Brown et al. (1996) suggests that community-based programmes all rest on a philosophy that guides care in all specialities and all settings in the community, consisting of more than observational experiences, as students engage in both service and learning. The essential element of this approach to education is the collaboration between academic and community partners to define mutually the meaning of learning for the student. Peterson and Schaffer (2001 p. 208) argue that there is a *“reciprocal relationship in which both parties engage in both services and learning”*. Callister and Hobbins-Garbett (2000) acknowledged that the vital elements of this form of learning are a reflection of the experience and reciprocity in the relationship in which students, their education institutions and the community benefit. Stullenbarger, Kiehl et al. (2001) state that community-based nursing education programmes enable the educational institutions to engage with other formal and informal health care providers within the community. Zungolo (2000 p. 17) defines community-based programmes as:

*“Educational exercises generally associated with community nursing which encompass a variety of services that emerge from the needs of the community and are characterised by interdisciplinary effort”. She adds, “Community- based nursing education requires partnership between education and the community”*

Zungolo’s definition placed emphasis on choosing appropriate learning experiences for nursing students while at the same time focusing on the needs of the community through partnership. The collaborative efforts of all stakeholders dispel the traditional idea that academic institutions are the ‘ivory tower’ of knowledge (Carter, Fournier et al. 2005). Hence, the faculty and community are regarded as teachers and learners simultaneously. This process further empowers the community to have control over their lives (Carter, Fournier et al. 2005). However, this is only likely to happen if collaborating partners in the projects are willing to explore their own social location, cultural values, their relative privileges and how these influence the knowledge and experience that is generated in the project.

A number of studies (Papp, Markkanen et al. 2003; Chesser-Smyth 2005; Bradbury-Jones, Irvine et al. 2007; Tremayne 2007; Papastavrou, Lambrinou et al. 2010) demonstrate the centrality of students’ placement learning environment. Placement experience shapes students’ experience of the nursing programme as a whole (Edwards, Smith et al. 2004; Gerzina, McLean et al. 2005; Pearcey and Draper 2008) and provides socialisation to professional roles (Chan 2002; Papp, Markkanen et al. 2003; Edwards, Smith et al. 2004) and the development of students’ professional identity (Dornan and Bundy 2004; Edwards, Smith et al. 2004; Clouder, Davis et al. 2012). Within their practice placements, students acquire nursing judgement, skills and knowledge (Hall 2006; Hartigan-Rogers,

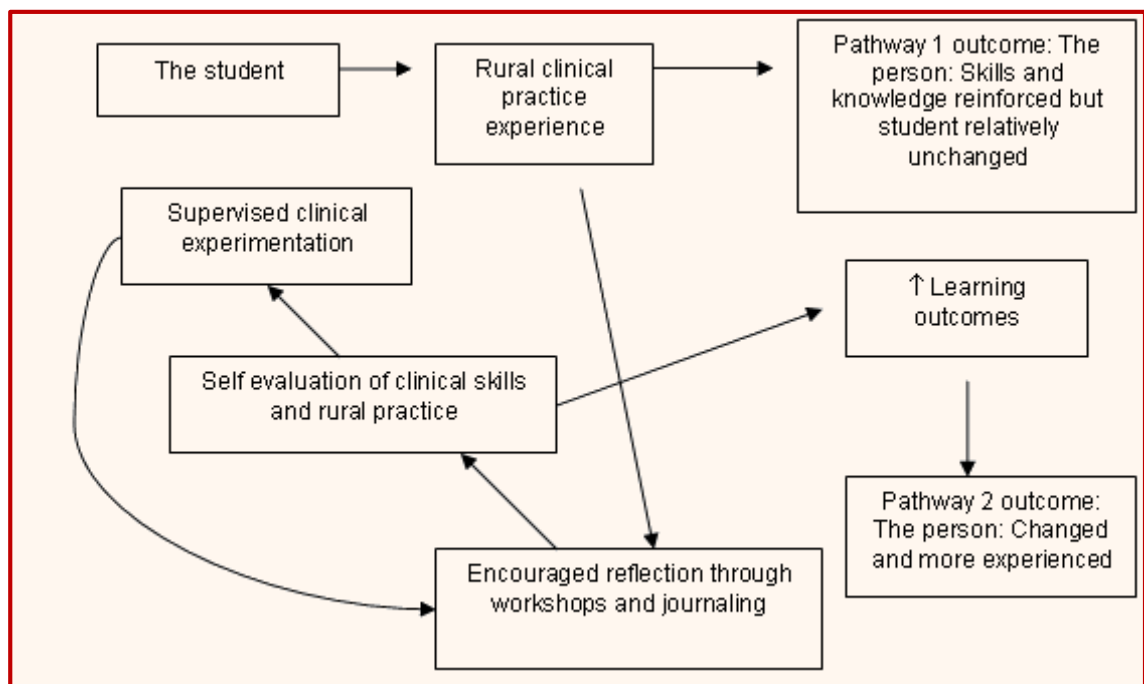
Corbbett et al. 2007) as well as nursing professional values (Ritchie and Spencer 1994).

Numerous studies (Baillie 1993; Hallett, Williams et al. 1996; Mtshali 2009; Baglin and Rugg 2010; Marshall and Shelton 2012; Naidu, Zweigenthal et al. 2012) found that placement learning environments provide valuable experiences for both students and the community. Chan (2004) found that the placement environment had a direct impact on students' learning outcomes as well as provision of opportunities to combine cognitive, psychomotor, affective skills, and problem-solving abilities. She concluded that students' interpersonal relationships with health care professionals and autonomous learning within established student roles were crucial to positive learning environments. Gerzina, McLean et al. (2005) in their study echoed the same and highlighted that placement experience promoted teamwork, collaboration and acceptance of differences.

Community-based education placements are clearly relevant to the education of nursing students (Hallett, Williams et al. 1996; Chan 2002; Timmins and Kaliszer 2002; Dornan and Bundy 2004; Stockhausen 2005; Baglin and Rugg 2010). It enhances student experiential learning (Quinn 2000; Carr 2001; Jarvis 2001; Smith, Emmett et al. 2008; Morris 2010). Learning and practicing simultaneously is widely regarded as a valuable tool for facilitating nursing students to gain the competence needed for community practice (Hallett, Williams et al. 1996; Chan 2002; Edwards, Smith et al. 2004; Baglin and Rugg 2010; Naidu, Zweigenthal et al. 2012). Students are able to link theory to practice (Smith, Emmett et al. 2008; Baglin and Rugg 2010; Kaphagawani and Useh 2013) and through active

participation (Morris 2010; Schuessler, Wilder et al. 2012) students acquire cultural competence (Mtshali 2009; Amerson 2010). Community placements also provide benefits to both the community and educational institutions (Naidu, Zweigenthal et al. 2012) thus improving relationships. Most importantly this pedagogical approach to education is a low-cost approach to achieving community well-being (Beauchesne and Meservey 1999). Smith, Emmett et al. (2008) found that experiential learning involves students putting theory into practice, with resultant new knowledge that captures social reality (Jarvis 2001).

Figure 3. Experiential Learning Map



Source: Adapted with permission from Smith, Emmett et al. (2008)

Morris (2010 p. 48) argues that learners should be guided to understand that they are learning '*how to do the job*' by '*doing the job*'. Edwards, Smith et al. (2004) and Courtney, Edwards et al. (2002) note that it is in rural community settings that students capture some of the most critical competencies as they discover the

ability to provide care to diverse populations. Edwards, Smith et al. (2004) found that rural students reported greater competence, confidence and organisational skills than did metropolitan students.

### **Uganda-based studies**

This review of the literature has sought to identify what is already known about community-based education programmes and their impact on stakeholders' experiences. Only six studies of such programmes have been documented in Uganda (Chang, Kaye et al. 2011; Kaye, Mwanika et al. 2011; Mbalinda, Plover et al. 2011; Mwanika, Okullo et al. 2011; Talib, Baingana et al. 2013). These programmes were adapted to enhance students learning in the community with the aim that students would work in rural areas of Uganda after graduation. The source of funding was mainly from the universities concerned and was often inadequate. Some programmes were partly funded by the Medical Education Partnership, United States President's Emergency Plan for AIDS Relief and the US National Institutes of Health (Talib, Baingana et al. 2013).

Kaye, Mwanika et al. (2011) study<sup>8</sup> was focussed on community education programmes for medical students. The study found that training institutions had community-based education attached to either primary health care practicum sites or schools where trainees were linked to the community where they could have hands-on experience. Kaye et al found that some programme sites offered multidisciplinary education, while others offered specific courses (for laboratory technicians). However, the evaluation in Kaye et al's study failed to capture all

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<sup>8</sup> 'The organization and implementation of community-based education programs for health worker training institutions in Uganda'

the participant's voices and some of these studies were not specifically about nursing. Despite these shortfalls, the studies do inform us about the implementation and organisation of community education programmes. Chief difficulties relate to funding and the provision of appropriate mentors for the students.

Kaye et al. (2011) identified multifactorial challenges similar to those identified in table 3 below. In addition, they found that there was no training of tutors for the programme. The study concluded that the programme needed further work and greater involvement of stakeholders, including the Ugandan government.

Mbalinda, Plover et al. (2011) study looked at the community-based education and service model at Makerere University, Uganda. The study found positive community outcomes, including decreased morbidity rates, increased health seeking behaviour and sustainable healthcare programmes. However, sustainability and the lack of funding remained an issue, with community leaders declaring poor motivation due to a lack of compensation and fatigue.

Mwanika, Okullo et al. (2011) studied the evaluations of Makerere alumni of the community-based education programme to which they had been exposed as students. A mixed method approach found that the programme had had a positive impact on the alumni. The alumni reported that the programme had contributed to their confidence as health workers, communication skills and that as a result, they were willing to work in rural areas. However, it should be recognised that the sample size (7) of nursing students was small.

Chang, Kaye et al. (2011) study on a community-based education programme in Uganda assessed student and educator perceptions. The study found that all participants perceived the programme positively and valued their experiences. They highlighted the need to address the lack of human and financial resources. It should be noted, however, that the response rate (90 out of 300 alumni) was low.

In summary, the few studies conducted in Uganda identify broadly positive experiences of stakeholders and that many students indicated the possibility of taking their career into the community after graduating. It should be understood, however, that being willing to work in rural communities and to achieve this goal are two different things. In Uganda, the infrastructure and funding for rural community work still need to be developed.

### **The impact of community-based education programmes**

Studies by Lynch, Ash et al. (2010) and Smith, Lennon et al. (2006) found there to be a positive impact on students involved in community-based education programmes in the UK, particularly in relation to preparing them for rural practice. The findings indicated that community exposure successfully prepared the students for their subsequent clinical career. Naidu, Zweigenthal et al. (2012) evaluated the University of Cape Town medical students' community placements. It was found that well-designed community placements benefitted both the community and academic institution. The students' contribution to community medical needs was seen as useful. There is a definite potential for community-academic partnership. Community involvement and participation is an active involvement of people from communities in analysing, decision-making, planning,



evaluating and programme implementation (Rifkin 2009), including activities that promote the achievement of sustainable development. Involving the community in shared goals and responsibilities, has been shown to have a transformative effect on the involved communities (Ndiaye, Quick et al. 2003; Anderson and McFarlane 2006). Gehrke (2008) and Hunt and Swiggum (2007) found that community members felt responsible for their health and wellbeing, while students and faculty gained knowledge and skills (see also Shea (1995); Oneha, Magnussen et al. (1998) and Bellack (1998)).

It is clear that students gain from providing care in the community and the faculty benefit as traditional nursing boundaries are expanded. The faculty and the community become regarded as teachers and learners simultaneously. The academic faculty are no longer the only source of knowledge. This collaborative approach sees the emergence of a new partnership between educational institutions and the community (Matteson 2000; Nehls, Owen et al. 2001).

Through community-partnership, students gain cultural competency (Mtshali 2009; Amerson 2010; Schuessler, Wilder et al. 2012). Amerson (2010) emphasised that acquisition of cultural competence needs a constant, evolving level of knowledge and skills in order to work with diverse populations. Campinha-Bacote (2002 p. 181) describes cultural competence as consisting of five constructs: *“awareness, knowledge, skill, encounters, and desire”*. Amerson (2010) suggests that students’ exposure to culture and community enhances their understanding of the role culture plays in both education and practice. Schuessler, Wilder et al. (2012) suggests that the cultural competence is acquired by students as a continuous process. Schuessler, Wilder et al. (2012) found that

'cultural humility' is first seen in the "*first semester as students practice thinking and self-reflection in their journals*" (p.99) and start to recognise the importance of culture. It was found that the process was life-long and was still developing at the end of the course of study. The study found that the students appreciated the similarities and dissimilarities among individual human beings and how this impacted on their care. Students came to understand that the best care was offered through respectful partnership with patients. Schuessler, Wilder et al. (2012) concluded that cultural humility requires reflection on experiences over time and that it cannot be learnt in the classroom using traditional approaches.

An important outcome is the development of an enhanced faculty-student relationship which was highlighted in studies by Poirrier (2001) and Nehls, Owen et al. (2001). These studies found that community placements often resulted in students working closely with faculty staff in practice situations and that this led to an enhanced relationship between student and faculty-member. Similarly Tagliareni and Coleman (1999); Hurst and Osban (2000); Matteson (2000) note the benefit of students and academic staff working together to meet the needs of individuals and families in the local community. Speakman (2000) suggests that students who experience being co-learners with their lecturers consider it as an important process; helping them to mature and feel adequate in practice. As they explore the unknown, their self-confidence begins to deepen (Poirrier 2001). Students' relationship with the community is enhanced as they begin to perceive themselves as competent providers of care.

## **Challenges facing community programmes**

Edwards, Smith et al. (2004) found that rural placements required support structures to be in place. Edwards et al suggest that students should have prior preparation and the timing of their placement in the community needed to be planned carefully. Such preparation could help students, especially those without experience of rural life, to make the most of their placement opportunity. The evaluation of community programmes (Foss, Bonaiuto et al. 2003; Fear 2004; Hamner, Wilder et al. 2007; Mtshali 2009; Naidu, Zweigenthal et al. 2012; Mabuza, Diab et al. 2013) revealed a number of challenges (see table 3 below) which had similarities regardless of geographical location, setting, participants, and political, socio-cultural and economic status.

Table 3. Challenges facing community-based programmes

External factors	Internal factors
Time limitation	Curriculum design
Logistic issues	Implementation process
Transport	Communication issues
Inadequate staffing	Student guidance issues
Financial constraints	Poor relationships with stakeholders
Long distance	Teamwork challenges
Accommodation	Site facilitators challenges
Technology	Lack of qualified mentors
Language barriers	Lack of sufficient information about the programme by the community
Cultural myths	Un met needs
Availability of electricity	Lack of pre-planning
Security/ safety	Follow up
Untidiness of community placement	Supervisors of higher level of competency
Non- involvement of nursing professional body	Space
	Schedules
	Students resistance
	Lack of practice

Source: Author (2014)

Significant challenges were associated with the lack of resources, funding, infrastructure, and the lack of time. Community-based programmes come with additional costs of travel and the need for educational materials (Runciman, Watson et al. 2006; Beaudet, Richard et al. 2011). Funding issues exist in both developed and developing countries (see (Whitehead 2009; Medicare Payment Advisory Commission 2010)).

Naidu, Zweigenthal et al. (2012) found there was a need for supervisors with higher levels of competency to provide adequate support for students' learning needs in the community. The importance of this was realised in the study by Lynch, Ash et al. (2010) in which students attached their positive outcome of the programme to the availability of suitably trained supervisors.

Lack of planning was noted in a number of studies (Peterson and Schaffer 1999; Bittle, Duggleby et al. 2002; Quinn 2006; Hamner, Wilder et al. 2007) leading to dissatisfaction among stakeholders. Quinn (2006) found that limited pre-planning had a deleterious effect on the collaboration between stakeholders. Hamner, Wilder et al. (2007) argues that there is a need for adequate planning in fostering community alliances. Prior planning can contribute to a deeper understanding of the efforts needed to sustain effective relationships with the community (Bittle, Duggleby et al. 2002).

Accommodation and staff retention were raised as issues in Lehmann's study (Lehmann, Dieleman et al. 2008). The findings here indicated that providing excellent accommodation results in the better retention of health workers in middle and low- income countries. A safe working and living environment in rural

areas is what Lehmann, Dieleman et al. (2008) referred to as a “*bundle of comprehensive interventions*”.

The challenge of cognitive ‘untidiness’ was highlighted in Carr’s study (Carr 2001). This concept relates to the conceptual ‘untidiness’ of the community practice setting. Carr (2001) found that in the community, much of the power rests with clients because they are in their home. Carr found that lifestyles varied and clients’ problems failed to fit into neat categories. Carr observed that:

*“part of the community nurses’ skills appeared to be being able to function within these apparently blurred boundaries and redefine the role as situations arose”* (p. 334).

It can be argued that the community clients’ needs are not defined by medical diagnoses and as such the nurses’ roles are correspondingly broad. In Carr’s study (Carr 2001) some students reported difficulty identifying clients’ care needs. Students saw community practice as less standardised, less pre-determined, more negotiable and more open than hospital-based care. Although this presented students with conceptual difficulties, the students were at the same time able to see that individualised care was easier to achieve. Community-based practice exposed the students to a great deal of information that is usually filtered out in the hospital environment. The result was that students identified and negotiated varied roles, managed different types of nurse-patient relationships, undertook new types of assessment and participated in unfamiliar decision-making processes.

Baglin and Rugg (2010) noted that the lack of community practises experience created challenges to students learning in community settings. Students should be offered opportunity to practice skills in the community and to receive regular

and honest feedback from experienced nursing faculty. Most importantly, these opportunities should include exposure to real models of community action for health (McKnight and Van Doner 1994). While there are challenges in providing students with community experience, it is clear that such experience is valuable. Nolan (1998) further added that learning by doing was an essential element of a community placement. It allows challenges to be addressed and critical thinking to advance (Hallett, Williams et al. 1996; Stockhausen 2005).

### **Sustainability of the programmes**

Sustainability is the continuity of the programme's activities beyond the life of the initial funding (Claquin 1989). Wolff and Maurana (2001) argued that for sustainability and ownership of the programmes to take place, its consideration should start at the very beginning of the project and be achieved through attaining reciprocal relationships with the community. Community members need to be involved and 'invested' in, in order to assume community ownership. Failure to sustain some community health programmes can lead to serious problems. Holland, Foster et al. (1993) illustrate the consequences of discontinuing cancer screening in the community. Furthermore, Wolff and Maurana (2001) found that the discontinuation of programmes may negatively affect new programme as they may meet unexpectedly-reduced community support and trust.

The literature identified that funders and policy makers are becoming increasingly concerned regarding sustainability of programmes as they allocate scarce resources to community health programmes (Shediac-Rizkallah and Bone 1998). The long-term viability of health intervention programmes in the community needs to be transparent to all stakeholders.

## Stakeholders' Experiences

Stakeholders' experiences of community-based nursing education programmes are considered the hub of this study. Key stakeholders are considered to be nursing students, faculty staff, the local community and pupils. Consideration was given to the question posed by Carr (2001) "*What is it about nursing in the community as opposed to the hospital setting that it is important for students to experience?*" (p. 331).

### **Nurse teacher / facilitators' role**

Baillie (1993); Andrews and Roberts (2003); Lambert and Glacken (2005); Tang and Choi (2005); Wilkes (2006) noted the importance of nurse educator/facilitator's role in teaching and guiding learners in the placement learning environment and identified concerns that university lecturers were not actively involved in guiding students in placement environments (see also Allan, Smith et al. (2008); Mabuza, Diab et al. (2013)). Educator's presence may not only colour the learning experiences of the students but also avert challenges students commonly face in this new learning environment. In addition, continuous feedback from academics 'on the ground' enables the desired outcomes to be achieved.

Leipert (1996) argued that the community-based education calls for nurse educators to give up their old habits, philosophies and rationale for what nursing is and does. While Leipert's work is some years old, surprisingly similar findings were echoed in an empirical study by Saarikoski, Warne et al. (2009) on the role of nurse teacher in clinical practice. The quality of teachers' relationship with students was found to promote active learning in the practice area.



According to Field (2004), the curriculum should place emphasis on the shared responsibility between lecturers and mentors. Finnerty and Pope (2005 p. 315) found that the transfer of practical knowledge in professional practice “*occurs through a range of subtle, often hidden, methods*” and experience plays an important role. This view is supported by Turner (2001) and Davies (2007) who remind us that the more experience and knowledge a nurse has, the better he or she is at delivering care as well as teaching. Consequently, the student nurses develop both individual and professional maturity and become aware of the effect of their behaviour on themselves, their colleagues and their clients.

Pearcey and Draper (2008) found that first-year nursing students highlighted the need for mentors and educationist to work together to promote positive learning for students. The same was echoed by Papp, Markkanen et al. (2003) in their study of 16 Finish student nurses, which identified the importance of collaboration between mentors and nurse educators.

Nurse educators are called upon to shift their focus towards the type of education that nursing students need in order to become successful learners in today's practice settings (Speziale and Jacobson 2005). However, Shea (1995) argued that preparation, guidance and support should also be offered to lecturers who are interested in learning community health concepts and developing collaborative skills with the community. By so doing the faculty, can be energised to embrace and move into this contemporary educational settings and enhance students learning

### **Nursing students' experiences**

A number of studies explored student nurses' community experience (Baillie 1993; Baglin and Rugg 2010; Marshall and Shelton 2012) and clinical experiences (Bradbury-Jones, Sambrook et al. 2011). Positive experiences were attached to meeting students' learning needs (Löfmark and Wikblad 2001; Levett-Jones., Lathlean et al. 2009; Bradbury-Jones, Sambrook et al. 2011) and an emphasis on belongingness (Levett-Jones and Lathlean 2008; Levett-Jones, Lathlean et al. 2008). Being part of the team enhanced students' learning, as they faced the realities of clinical / community environments and the culture of nursing (Dalton 2005). Being valued (Silén-Lipponen, Tossavainen et al. 2004; Bradbury-Jones, Irvine et al. 2007) was crucial for students' sense of empowerment and being understood, supported and accepted into the group. In addition, the feeling of being appreciated in their placement practice, promoted learning (Papp, Markkanen et al. 2003). Papp, Markkanen et al. (2003) found that being valued as a person was seen simply as being treated with respect.

The studies on positive nursing experiences all had similar findings, showing that the curriculum should explicitly state students' needs and should be well-planned. In addition, placement periods should be understood as learning (not work) time, and the time available should be maximised to good use, rather than as purely service provision.

Silén-Lipponen, Tossavainen et al. (2004) pointed out that teamwork is “a *complex multi-level phenomena*” (p.91). They alluded that for its success to be realised, three aspects had to be considered; working conditions, prevention of

errors and the learning atmosphere. Although positive staff-student relationships are crucial for student learning (Levett-Jones and Lathlean 2008), Silén-Lipponen, Tossavainen et al. (2004) stressed that in order for the qualified and novice nurses to work together, there has to be a motivation to work together to promote positive students learning experiences.

Very few studies are available which consider nursing students' experience of community-based education programmes. However, evidence from the nursing literature generally (discussed here) is at least relevant to community-based programmes.

Chesser-Smyth (2005) argued that any form of placement environment could be challenging, unpredictable or stressful and any negative experience may impede learning. Common negative experiences are:

- Failure to link theory to practice (Sharif and Masoumi 2005; Mabuda, Potgieter et al. 2008; Kaphagawani and Useh 2013);
- Not recognising students learning needs (Bradbury-Jones, Sambrook et al. 2011);
- Students observing instead of participating (Baillie 1993; Baglin and Rugg 2010);
- Lack of support and encouragement specifically, lack of interest in learners (Lindop 1999);
- Marginalisation and isolation of students (Bradbury-Jones, Sambrook et al. 2011).

Levett-Jones and Lathlean (2008) study found that absence of 'belongingness' affected students' learning negatively especially their confidence to get involved in experiential learning and that such experiences can affect students'

competence and confidence. Levett-Jones, Fhay et al. (2006) notes that it is difficult to manage, given the involvement of different key players.

Other negative experiences were related to mentors who seemed to disregard students' feelings or make no attempt to hide their impatience and frustration (Levett-Jones., Lathlean et al. 2009; Bradbury-Jones, Sambrook et al. 2011). This was highlighted in the study by Levett-Jones., Lathlean et al. (2009) where students did not feel valued on placement, were not accepted as legitimate team members and were ignored or excluded (see also Cope, Cuthbertson et al. (2000); Silén-Lipponen, Tossavainen et al. (2004); Hoel, Giga et al. (2007)). Students being devalued and disrespected has been widely reported (McKenna, Smith et al. 2003; Evans and Kelly 2004; Curtis, Bowen et al. 2007). A number of students reported that they were belittled in front of staff and patients (Löfmark and Wikblad 2001; Gopee 2004). These issues tend to occur where relationships with members of the team are problematic (see also (Timmins and Kaliszer 2002; Evans and Kelly 2004; Mabuda, Potgieter et al. 2008)). How students and their educators viewed the relationship is paramount, given that a welcoming learning environment is associated with good learning outcomes (Fenton 2005; Hartigan-Rogers, Corbbett et al. 2007; Morris 2007; Rodger, Fitzgerald et al. 2011).

Apparently, students are the future healthcare providers; current nurse educators and practitioners should respect students for a career choice they have made and for their potential to make real differences to the health of the community.

Gaines, Jenkins et al. (2005) study found that empowering both the faculty and the students in community activities resulted in benefits for the community. They suggested that nursing education needed to re-examine students' experiences in

order to increase their abilities to function in a changing society (Liimatainen, Poskiparta et al. 2001).

A study by Rojo, Bueno et al. (2008) found that students were familiar with the medical model of disease but found this difficult to relate to concepts of health promotion and wellness and that this created a gap between theory and practice. It was also the case that working in the community meant talking to, and listening to people, skills that hospital work had ill prepared them for. It is only by talking with community members that the factors underlying their health situation can be properly understood. In the same way, nurse educators need to ensure that students are exposed to culturally relevant concepts of health and illness.

Liimatainen, Poskiparta et al. (1999) study on student nurses and reflective health promotion found that students had difficulty in transferring knowledge taught at university into practice. They were not able to recall aspects of the theory which they had found relevant to practice. Liimatainen et al concluded that nursing students should be motivated to critically think and reflect in their education and practice. Perhaps, a reflective approach to the curriculum would enable students to promote and act as new role models of empowerment in health promotion.

It is clear that an early exposure to the medical model of disease causation and treatment can inhibit student nurses' understanding of health and wellness in the community. This makes it all the more necessary to expose student nurses to community, and particularly rural settings, so that they can learn to communicate with community members and appreciate the real and day-to-day issues which prevent the community from achieving its potential for health.

### **Child (community) experience**

Very little evidence is available of pupil's experiences of their involvement in community-based education programmes. However, evaluations were mostly positive in the studies by Linda, Mtshali et al. (2013).

Linda, Mtshali et al. (2013) study raises some questions about the difficulty of achieving robustness of the design in eliciting responses of children. Although the study sought permission from parents and children themselves by show of hands, being asked by their teacher to participate raises some questions. Fear of the teacher might have caused them to put up their hands, or perhaps social pressure as other children consented. Wendler (2006) emphasised taking into account children's age, maturity, and psychological state when seeking to elicit consent.

Children can be easily distracted and become difficult to control in an interview (Gill, Stewart et al. 2008). While others pupils may be lonely, playful or shy (Mayall 2000). For this reason, Mayall recommended the presence of a friendly supportive person to support the child. Mayall (2000); Instone (2002); Gill, Stewart et al. (2008) suggest that focus group discussion with children can yield trustworthy accounts. Appropriate planning should be done before, during and after involving children. Aldgate and Bradley (2004) suggest that the researcher should establish familiarity, trust and rapport in order to enhance the effectiveness of interviews with children.

According to Green and Hogan (2013), data gathering techniques should match children's cognitive abilities. In their study exploring children's views through focus groups, it was found that age and level of shyness could affect children's ability to communicate their ideas.

In summary, there is very little information on the views of children concerning community nursing and the impact on them of student nurses working in the community. There is more material on the inclusion of children in research studies.

### **Community members (adult) experiences**

Wolff and Maurana (2001) study found that the partnership strengthened the community's capacity to gain skills and become involved in solving their problem. Partnership encouraged the community to work towards sustainability of programmes.

Similarly Luque and Castañeda (2013) in their study of a review of a practice model for community-academic partnership found the model significant to the health of immigrants. They reaffirmed that for the partnership to be active and engaged there was a need for such coalition to be continually re-energised.

However, the literature also highlighted barriers to successful community–academic partnership experiences (see table 3 above). Wolff and Maurana (2001) suggest that academic institutions are sometimes ignorant of community knowledge and experience. They suggest that mutual trust and respect are crucial elements of partnership and that academics should tap into community knowledge and experience rather than taking it for granted. Furthermore, the implementation of partnership goals should be tailored towards community-defined needs rather than those needs perceived by academic institutions. White and Connelly (1992) noted that such approach would facilitate acceptance of the university services to under-served communities.

Wolff and Maurana (2001) recommended that if community-academic partnership is to flourish, the institutions should avoid a repeat of previously failed partnership by creating a trusting relationship which should be nurtured. Arguably, communities that have had a negative experience and experienced a lack of trust are unlikely to accept any other programme. Thus, the academic institutions should use the strength of building trust as the hub of their partnership attempts. Failure to consider the community's needs and their unique knowledge, however good the intention, is likely to result in failure. Furthermore, Wolff and Maurana (2001) caution that the process may not always be smooth and that it requires a lot of patience, sincerity, openness and a willingness to work together.

### **The primary school as a setting for Health promotion**

Community placements occur in a variety of settings such as homes, prison, health centres, primary schools (Parker and Barry 1999; Frank, Adams et al. 2005b). Parker and Barry found that the creation of a school-based community centres allowed nursing students and the community to come together in a dynamic way. Schools can provide an efficient platform for promoting the health and well-being of pupils, school staff, families and community members (World Health Organisation 1996). School-based health centres are practicum sites based in the schools within the communities and may, therefore, be used as entry points to the community (Parker and Barry 1999).

Schools can be useful settings to improve the health of young people (St Leger 1999) and often exist in areas where health education needs to be focused. The schools involved in health promotion in collaboration with nurses have many benefits, for instance: producing better health outcomes for pupils now and into



the future (Adams 2009). For this reason health and education cannot be fully separated because children learn better when they are healthy (Arya and Devi 1991; Lavin, Shapiro et al. 1992; Igoe 1993; World Bank 1993; Levinger 1994; World Health Organization 1995; National Health and Medical Research Council 1997). The common themes running through this literature is that learning is faster, more comprehensive and more enjoyable if pupils are healthy. The health promoting school approach appears to enrich classroom-based learning outcomes such as knowledge acquisition and decision making. One can argue that if the physical environment is appropriate for children, then conditions for health are, therefore, established, which will in turn reduce the risk of injury and disease.

#### The role of the school environment

The school environment is difficult to assess, but there appears to be enough substantive research to suggest it is a vital place for health promotion to take place (Rowling 2007; Rowling 2009). Teachers are considered important stakeholders in promoting school health. Levin (1997) and Lee, Tsang et al. (2003) support this notion by emphasizing the role the classroom teacher has in creating learning opportunities for children within and beyond the classroom, to grow, be productive and accept lifelong responsibility for their health and social behaviour. Lee, Tsang et al. (2003), in their study of a comprehensive 'healthy schools programme' (Hong Kong) found that such programmes can only be successful if partners beyond the health sector, such as education and social services, are actively involved. They suggest that since school communities are microcosms of the wider community, they could act as a catalyst in uniting all stakeholders to have an impact on the wider community. Schools can be used to

provide opportunities for pupils to practice and attain the skills necessary for a healthy lifestyle.

Kwan, Petersen et al. (2005) suggest that health promotion enables children to acquire health-related knowledge and to embrace good health practices which will serve them well when they grow up. Also through health promotion and education children can become change agents at school, at home and in their community (Parker and Barry 1999). Hawkins and Catalano (1990) and Nutbeam, Smith et al. (1993) also suggest that the experiences children have at school are factors in determining their health behaviours during adolescence and beyond. However, one of the conclusions reached from nearly two decades of work in health promoting school initiatives across the globe is that progress is slow and sustainability difficult to achieve (Deschenes, Martin et al. 2003; Dusenbury, Brannigan et al. 2003; West 2006). The most cited reason being that, achieving health outcomes is not the core business of schools (Rowling 2009). This indicates the importance of involving school teachers and convincing them of the importance of good health generally and of the benefit it has on children's contentment and academic performance.

#### Pupils as conduits for health promotion

There is considerable evidence which supports the notion that children communicate with their parents in a manner that can lead to parents learning from their children (McKee, Karasz et al. 2004; Fox and Inazu 2008; Mwanga, Jensen et al. 2008; Mosavel 2012; Sedighi, Nouri et al. 2012; Jukes, Zuilkowski et al. 2013). Researchers have begun to incorporate children in various health programmes in advancing creative approaches to health intervention. Children's

involvement is beginning to attract recognition, as noted in a study by Mwanga, Jensen et al. (2008) in Tanzania. It is noted that children, especially girls, initiate communication with their parents (Fox and Inazu 2008). Furthermore, there is a growing body of knowledge indicating that parents and other community stakeholders are receptive to the idea of children sharing knowledge with parents and potentially influencing their health behaviours (Jukes, Zuilkowski et al. 2013). The study by Mwanga, Jensen et al. (2008) supports the notion that pupils can be engaged to enhance their health and promote their family health situation, thus acting as health change agents in the community. This can be attained through their own effort. The study further found that children preferred strategies where they played an active role as health change agents in both school and community health programmes; rather than taking the role of passive recipients of information. Others; (Onyango-Ouma, Aagaard-Hansen et al. 2004) in Kenya, Simovska (2004) and Simovska and Jensen (2003) in Denmark; all agreed that children may act as change agents, leading to positive outcomes in hygiene and tropical diseases as well as in reproductive health and substance abuse. They all concur with the notion that pupils and schools are now viewed as social agents for change. A study in Egypt (Al Khateeb 1996) supports this idea, evaluation of the parent's knowledge after being 'taught' by their children for six months found an increase in their knowledge regarding disease prevention.

Similarly, studies on knowledge transfer using children have been employed in research. Sedighi, Nouri et al. (2012) in Iran found knowledge transfer from children to their parents was possible through encouraging the children to sing poems designed to promote health and prevent diseases. Seven infectious disease topics were modified into children's poems. The study randomly selected

five kindergarten children and taught them the poetry. At the same time, utilising it for the teaching of a wider population may require modification. Arguably, the key factors that influenced the success of this knowledge transfer were the simplicity of the poems and expression of the topics. Evans, Clark et al. (2001) found that knowledge transfer to parents could be delivered through homework assignments given to children on asthma management, thus the parents were indirectly taught. Through collaboration with children, knowledge transfer regarding the disease leprosy was passed on to parents (Bhore, Bhore et al. 1992; Jacob, Amar et al. 1994). However, although the post-test results indicated that the households had reasonable improvement in knowledge regarding leprosy infection, regrettably their attitudes toward the disease remained unchanged. Also, Rimal and Flora (1998) articulated that children and adults influence each other in changing and maintaining health behaviours. This study supports the idea of health campaigns employing both children and adults as potential sources of influence as may be beneficial to both groups.

Participation is fundamental and it acts as the primary prerequisite of any health promotion and education programme. Therefore, devoid of ownership, health promotion and education will not have influence on pupils' practice and actions. Two forms of pupils' participation were identified in the literature (Hart 1997; Simovska 2000), 'genuine' and 'token' participation. Genuine participation was present when pupils' critical reflections were at the centre of focus. While token participation was linked to health behaviour changes strategies where pupils were not active participants.

Pupils are encouraged to be active, although they are obliged to adopt predetermined practices and behaviours. Therefore, it can be argued that pupils assume the role of change agents while the aim is to ensure their genuine participation, ownership of educational process and action competence. In addition, the facilitation of processes leading to concrete change in an action-oriented and participatory teaching and learning approach. Hence, this is a crucial move from projects that utilise children as peer leaders.

#### Hindrance to pupils' communication

Although the literature clearly indicates that children can share health promotion messages with parents, this is not without challenges. Studies (Lwanga 2004; Mwanga, Jensen et al. 2008; Nyemah and VanderPlatt 2009; Ryan, D'Angelo et al. 2010) found that pupils' ability to communicate with parents was limited due to a number of factors. They are after all, children and parents are not used to obtaining advice from their children. It is, therefore, not surprising that there is some evidence of resistance from parents (Mosavel 2012). Mwanga, Jensen et al. (2008) found that children were expected to be a passive recipient of the information passed on to them. Parenting style is often authoritarian in Uganda. In Uganda, as in many African countries, there is a deeply held belief that children should respect their elders, both parents, grandparents and other older people in the community.

It may be challenging to get Ugandan children to break such barriers, where parents and children are separated by a solid line of power; for instance, children have strict obligations to respect parents, while the parents reserve the right to physically or verbally discipline children if they misbehave (Nyemah and

VanderPlatt 2009). The key point of transformation surrounds the term 'respect'. In the cultural context of Africa, respecting parents' means not challenging their views or relating to them as equals and not talking about 'mature' subject matter such as sex (Mann and Tarantola 1996; Nyemah and VanderPlatt 2009; Ryan, D'Angelo et al. 2010).

It is clear that there is documented reasonable scepticism about the feasibility of an upward flow (child to parent) of health information (Mosavel 2012). This is mainly associated with the fact that the implicit paradigm of parents being knowledgeable continues to be unchallenged (Gustafson and Rhodes 2006). Consequently the focus of most health programmes tend to be to encourage the downward flow of health information (Riesch, Jackson et al. 2003; Hynie, Lalonde et al. 2006; Swain, Ackerman et al. 2006). In addition, there is an assumption that conflicts and challenges exist between adolescents and parents (Graber, Brooks-Gunn et al. 1996; Laursen, Coy et al. 1998; Steinberg 2001) especially daughters and their mothers, and that this complicates communication.

However, even in these areas, contemporary society is arguable beginning to allow for the notion that adults should sometimes listen to children. Education is considered very highly in Uganda and where children are accessing education, their knowledge and ideas are often seen to be worth listening to. There are clearly challenges here. However, it remains the case, that young children are receptive to the information given to them at school and that if we can get them to transfer this information to their parents, there will be a great deal to be gained.

## **Evaluating community programmes**

Evaluation is a process that places judgement or value on a given situation (Stavropoulou and Kalesi 2012). A programme evaluation is *“the systematic collection of information about the activities, characteristics, and outcomes of programs, for use by people to reduce uncertainties, improve effectiveness, and make decisions”* (Patton 2008 p. 39). These evaluation models (Abruzzese 1978; Koch 2000; Walker and Dewar 2000; Rankin and Stallings 2001) range from simple (process evaluation) to complex (impact evaluation).

Formative evaluation targets improve the effectiveness and efficiency of the programme (Hubball, Gold et al. 2007) and are undertaken while the programme activities are ongoing (Bhola 1990; Rossi and Freeman 1993). Process evaluation determines whether the programme is meeting its intended goals (Rossi, Lipsey et al. 2004). Content evaluation takes place immediately after the learning experience to answer questions such as ‘to what degree did learners achieve specified objectives?’ This is to determine whether the learners have acquired the knowledge or skill taught during the learning experience. In this present study, the scope of content evaluation would be limited to specific learning experiences of nursing students, pupils and communities according to the programme objectives.

Summative evaluation serves to demonstrate the impact of the programme (Hubball, Gold et al. 2007) and whether the goals and objectives were met. Summative relates to being accountable (HeyWood 2000) for instance, demonstrating that the programme provides ‘value for money’ (Scott 2005). It indicates how effective the overall programme is; resulting in further decisions

about whether to continue or not to continue a programme. While it does not serve to modify the existing program, it may influence future programmes (Downie, Tannahill et al. 1996).

Outcome evaluation involves assessing an activity in terms of specific aims or objectives (Downie, Tannahill et al. 1996) and providing a basis for decision-making that may justify maintaining certain components of the programme or suggest modification. It focuses on the observable conditions of a particular population, organisational attribute, or social condition that the programme is expected to have changed. For example behaviours that the programme was expected to affect most directly and immediately (Rossi, Lipsey et al. 2004).

Impact evaluation is the assessment of the short-term, immediate and long-term impact of programme processes and outcomes, and the possibility of transferability to other settings (Rossi, Lipsey et al. 2004). It involves assessment of both positive and negative outcomes.

The evaluation phase of an educational programme is critical in identifying both successful and unsuccessful aspects of the project. Engaging stakeholders in a programme evaluation can improve the quality and sustainability of the programme.

Within the existing literature on evaluation of community programmes found both positive and negative outcomes in both developed and resource poor setting. The positive outcomes were based on several factors, such as collaborative partnership, access to funding and developing a relationship between the university and community as indicated in studies in U.S.A. and South Africa (Wolff



and Maurana 2001; Foss, Bonaiuto et al. 2003; Hamner, Wilder et al. 2007; Mtshali 2009; Naidu, Zweigenthal et al. 2012; Linda, Mtshali et al. 2013; Luque and Castañeda 2013).

Linda, Mtshali et al. (2013) study used an interpretive existentialist-phenomenological approach to evaluate a community-based education programme. The study found benefits to the community, including; developing partnership, increased awareness of services and sharing of resources. However, the study concluded that there was a need to improve communication between partners to enhance sustainability through a closer interactive relationship. Furthermore, a number of methodological challenges and ethical issue regarding child participants were raised.

It is apparent that any programme involving student nurses gaining experience in the community needs to be evaluated. The need for such an evaluation is more acute where the situation is resource-limited and where the core idea is to place students into an environment in interaction with the university, where sustainability is a central goal and where the community's perception of health and wellness matters to all parties. It has been shown here that project evaluation can take many forms. Importantly perhaps, some form of evaluation needs to be carried out and this needs to be done in full collaboration and partnership with the community, so that in truth, it is an evaluation fully 'owned' by all the stakeholders.

## **Summary**

The literature search identified studies published between 1993- 2014. Many authors described efforts by nursing schools to improve community-based experiences that were part of an undergraduate curriculum (Foss, Bonaiuto et al. 2003; Narsavage, Batchelor et al. 2003; Hamner, Wilder et al. 2007). Reports of student outcomes were based on researchers' overview of course evaluations, field evaluations, observations, or journal entries.

There were found to be relatively few studies undertaken in Uganda. The primary studies included 31 qualitative, 17 quantitative and 7 mixed methods studies. The methods employed mainly cross-sectional surveys or qualitative interviews or focus group methods with student and community stakeholders, as well as journal reflective diaries. There were consistent results across study methods.

The main themes emerging from the studies related to enhancing students' learning with the aim of motivating graduates taking on work in rural areas while improving community well-being. Participants were mainly students, community individuals, educators, children, and primary school teachers.

Although the literature revealed a preponderance of narratives on the process of designing and implementing service learning programmes, there was a lack of clarity concerning the variables that constituted an authentic partnership between an educational institution and the community. There was lack of thorough or systematic process of evaluating clients' responses to service learning activities.

Evaluation of programmes were carried out by internal rather than external evaluators. Most of the studies were conducted by researchers who were

educators or practitioners; this could have influenced the objectivity of the studies. In many cases, the faculty staff who created the programmes were the authors and they seemed to be nested professionally and emotionally in programme outcomes. In view of the above, a methodological observations approach could have reduced observer bias and led to strengthening the validity of conclusions about the programmes' value to student learning and community problem-solving behaviours.

The review of studies identified methodological weakness. Most studies were small scale, methodologically challenged studies carried out by educators or practitioners. Methodological weaknesses appeared in studies that failed to describe either the measurement instrument, such as survey or group discussion (Fahringer, Assell et al. 2000; Scott, Harrison et al. 2005) or the methods for analysing the data (such as detecting attitudes expressed in reflective journals (Narsavage, Batchelor et al. 2003)).

Low response rates for minority disciplines' in interdisciplinary studies indicated how generalisability was limited, thus hindering a thorough exploration of stakeholders' experiences. In some cases it was difficult to justify the authors' claims that both quantitative and qualitative methods were used in the studies reported. Thus, the problems of methodological rigour, mainly the results obtained by different research methods, and sources were not triangulated in the majority of the papers.

Most authors did not allude to theoretical frameworks for the design of the study or interpretation of findings. Only a few studies employed theoretical frameworks in their studies of nursing students' experiences in the community placements.

For instance, while Reising, Shea et al. (2008 p. 1) recognised John's philosophy in education and referred to him as the "*father of service learning*", they failed to associate their findings with John's philosophy of community-engaged learning. Similarly, Kolb's theory of experiential learning was not included in the discussion of findings (Baker, Bingle et al. 2004). Some studies only named the model in their study without further elaboration (Cashman, Hale et al. 2004), while in other studies, theoretical concepts were intertwined throughout as in the study by (Cohen and Milone-Nuzzo 2001). Arguably, this indicates a lack of 'maturity' in these studies. Indeed this is a relatively new area of study, looking as it does on a relatively new way of ensuring that nursing students learn how to work in rural communities. While some studies did make use of a theoretical framework, none employed an African philosophy in guiding either the project being studied or the study itself. Arguably, there is a place for a wholly African concept, such as Ubuntu in such studies.

Sampling employed either purposive or convenience methods. The purposive sampling may have excluded sites where experiences were considerably different. Furthermore, recruitment of research participants was not apparent in some studies especially when only one participant from each site represented the community, in case of key informants.

The process of obtaining informed consent was questionable especially with regards to children. Studies tended not to identify the process for gaining consent from students to analyse journal entries or publish quotes. Nursing scholars should pay attention to the ethics of research and clearly state the action taken to protect the participants.

Data collection varied from single to multiple techniques. Qualitative approaches mainly employed observations, interviews and open-ended survey questions. Quantitative survey methods were employed in assessing students' learning and community benefits. In studies that used multiple data sources, only a few triangulated between methods and sources (Kaye, Mwanika et al. 2011).

The choice of closed questioning (as in 'yes' or 'no') could have left many unanswered questions. There appeared to be some weakness in probing during the in-depth interviews, where researchers failed to find out what participants meant by what they were saying. There were often poor response rates especially from children. Lack of translation of research instruments was noted in some studies (Reimer Kirkham, Hoe Harwood et al. 2007); this was sometimes due to a lack of funds.

#### Main outcomes of this review

In summary, there is a need for a robust methodological study into the impact of community-based programmes for nursing students and which carefully considers such impact on the whole community, the students themselves and the university:

- i. The articles reviewed provided insight into what is already known regarding stakeholder experiences, gaps in knowledge were identified;
- ii. Research questions guided the choice of methodological approaches and in this case, experiences were best mapped by qualitative approaches;
- iii. Research grounded in cultural values was more capable of mapping participant experiences;

- iv. Conducting research among communities requires the researcher to be aware of prevailing cultural values and to be willing to be guided by such values during the data collection process;
- v. Partnership and collaboration as well as teamwork was the key to programme successful;
- vi. Ensuring that all stakeholders' voices are heard through their experiences could benefit nursing education, practice and research.

#### The current knowledge deficit and the need for further research

This literature review has found only limited information on community-based educational programmes, especially those taking place in Uganda and sub-Saharan Africa. The existing evidence does not reveal all stakeholders' experiences, especially those of children. There is especially a paucity of data on community-based education programmes for nursing students in Uganda.

It is clear that community education programmes for nurses have potential benefits both for resource-limited communities and for student nurses who may one day seek to work in rural areas. It is also clear that such projects require collaboration and a deep sense of 'working together', the process of which can help integrate the university with its local community in a manner that may deeply enhance its position in society.

Existing studies of Ugandan programmes show that there is a need for a study that looks at all the experience of all the stakeholders, including children and local administrators. There are voices that have never been heard before. By giving equal opportunity to all stakeholders to share in the study, the researcher will be able to capture a comprehensive picture of stakeholder experience. The

researchers' illumination of the stakeholders' experiences would expand nursing's body of knowledge about the impact of the programme as viewed from the perspective of stakeholders. The knowledge about their experiences would potentially inform understanding and planning of similar programmes involving community partnership in preparation of nurses' responsiveness to the health of the community.

### Research question

Three research questions emerged that the study seeks to address as outlined in Chapter five. There is currently a need to identify:

- 1) What are stakeholders' experiences of community-based education programmes for nurses?
- 2) What is the impact of these programme on stakeholders?
- 3) What are the challenges associated with these programmes and how can they be overcome?

### Conclusion

In conclusion, this chapter has reviewed studies that addressed evaluation of community-based nursing education programmes and stakeholders experiences, within Uganda and internationally. This search was conducted entirely by the researcher; therefore, the critique of the articles cannot be purely bias free. However, being supervised at every stage of the systematic search and review process has enabled this chapter to provide a robust account of the available literature.

Although most literature lacked depth, substantial anecdotal evidence were found. Most literature originated from countries outside Uganda. Despite the scarcity of information in the study area, the number and range of studies were found sufficient to provide evidence of the significant role community-based education programmes could play in nursing education in Uganda.

Therefore, the literature review provides a strong rationale for this thesis to explore the gap in the evaluation of such programmes.



## **CHAPTER 3: THEORETICAL BACKGROUND**

### **Introduction**

This chapter describes the theoretical concepts and models used to underpin the study and which were derived from the literature and research. Discussed here specifically, are the theories or models relating to the community-based education programme, the use of Ubuntu and the Ripple Effect Model. The same theoretical underpinning was used for both the community-based nursing programme (evaluated in this study) and the study itself, demonstrating the integration of underlying principles.

### **Background**

It was considered appropriate to find a culturally appropriate philosophy to guide both the programme and its evaluation. In order to be effective in promoting health in the community, the programme needed to develop innovative approaches. It was considered that employing the ripple effect model and Bandura's approach to social learning in conjunction with the guiding principles of Ubuntu, could overcome some of the challenges. It was considered that such an approach would impact positively on the project and thus enhance students' learning in a culturally appropriate environment guided by positive community values.

## **Relevance of the theoretical approaches**

According to Bacharach (1989 p. 485), a theory, “*is a set of interrelated concepts, definitions, and propositions that explains and predicts events and situations by specifying relations among variables*”. Theory should provide a purposeful and systematic view of phenomena (Karnick 2013). Therefore, given that good theories are essential in clarifying issues and making them open to comprehension (Alligood 2011), they should form the basis of nursing practice (Colley 2003; Karnick 2013).

In recent years, the development of nursing theory has been related to the justification of nursing as an academic discipline and the need to develop and describe nursing knowledge (Alligood and Tomey 2010; Alligood 2011; Chinn and Kramer 2011; Im and Chang 2012). It can be argued that most nursing theories have focused on the person, the environment, health and nursing (Alligood 2011). However, since there are so many practice situations, a single nursing theory may not be sufficient and Colley (2003) argues that a plurality of theories is needed to inform nursing research and practice.

It is recognised that there is a tendency to dismiss empirical evidence of health challenges (Lizewski and Maguire 2010). It should be noted that people do tend to be aware that health risks can be reduced or prevented. However, people often either disregard the preventive measures or adopt programmes without adequate understanding (Ibid). Most theoretical approaches to nursing are not designed for resource-limited settings. This raises questions about the degree to which existing health models, designed for a Western and resource-rich nursing environment can be capable of guiding health promotion in communities such as

those in sub-Saharan Africa. It was considered that addressing this question would contribute to the success of a community-based education programme, mainly because socio-cultural and political factors play a significant role in shaping people's behaviours.

It should be understood that community members may be inclined to insist that their ideas are the correct ones, ignoring any arguments that could be in conflict with their beliefs. In Uganda, it is common for people to use traditional medicine instead of seeking western medical care. As such, members of the community may not benefit from health promotion intervention. However, progress can be made by understanding the community well. Communities are not all the same and for this reason, models should be carefully designed with a particular community background in mind.

Understanding individuals' viewpoints on what they consider important and how they situate themselves in that context, determines their success or failure in achieving a goal (Hochbaum 1958). Furthermore, Bandura (1977) theory of self-efficacy reaffirms the above notion, that for an individual to change behaviour, he or she should be willing and feel able to do so. It is *this "personal efficacy that determine whether coping behaviour will be initiated"* (ibid, p.191). Drawing from Bandura's theory, individuals are surrounded by internal and external factors, such as personal strengths, culture, religious beliefs, peers, poverty - the list is endless. It is argued here that although personal efficacy is paramount, there is a need for reciprocal support towards enhancing their intention through an enabling environment and the use of culturally acceptable approaches. Thus, the use of a reciprocal model employing Ubuntu philosophy is appropriate for the

resource-poor context of the community-based programme and the research which evaluates it.

### **The use of the Ripple effect model, Bandura's theory of role modelling and Ubuntu**

The Ripple effect model with Bandura's theory and Ubuntu values formed the basis of this study. The 'ripple effect' has been described as an event that produces effects that spread and produce further effects like a "*series of waves*" (Soanes and Stevenson 2004 p. 1241). For example, in the community, the nursing students offered health promotion and illness prevention to the pupils. Through this health education, the pupils taught their parents the same information and the parents in turn educated their neighbours. The ripple can be just described as a 'cascade of information'.

Other studies identified in the literature which employed the Ripple effect model, include the ripple effect in community nursing (Forbat 2011; Smith 2012), caring for cancer patients (Illingworth, Forbat et al. 2010), rehabilitation nursing (Miller 2014) and in nursing management (Burke 2002). The use of the ripple effect model in enhancing health messages blends well with Bandura's theory. Observational learning acts as a vehicle for active learning. Further, it can be argued that learning through direct and vicarious reinforcement is a powerful vehicle for behaviour change (Bandura 1977).

Thus, Bandura's Social learning theory, claims that people learn from one another through observation, imitation, and modelling. For this reason, the theory has been referred to as a bridge between behaviourist and cognitive learning theories since it encompasses attention, memory, and motivation. It also explains learning

as the constant reciprocal interaction of environmental events, personal factors, and behaviour. Therefore, the use of role modelling in the programme can influence the Ripple effect positively where it is guided by community values. It should be noted that the community environment has a powerful influence on shaping the health beliefs held by individuals and that modelling plays an important role in the development of individuals' sense of efficacy (Bandura 1997b).

Bandura further asserted that individuals do not merely react to their environment, but rather use past experience to perform a behaviour that is purposeful and thoughtful. Forethought motivates individuals to perform actions. Bandura's theory states that individuals do not learn by trial and error, but rather by observing others. Modelling according to Burton, Ray et al. (2003 p. 238) is *"imitating of one person's behaviour to another person's behaviour as consequences of direct or symbolic observation"*. Additionally, modelling hastens the acquisition of new behaviour by an individual. As such, modelling of behaviour has been highlighted as a fundamental feature of learning, particularly when the behaviour is blended with other learning elements (Bandura 1986).

The ability of individuals to reflect on their behaviour on the one hand and their thought process on the other is referred to as 'self-reflective capability'. This further enables individuals to acquire an increased understanding of their actions and thoughts (Bandura 1986). Bandura proposes that modelling leads to quicker establishment of behaviours than other means of establishing new behaviours.

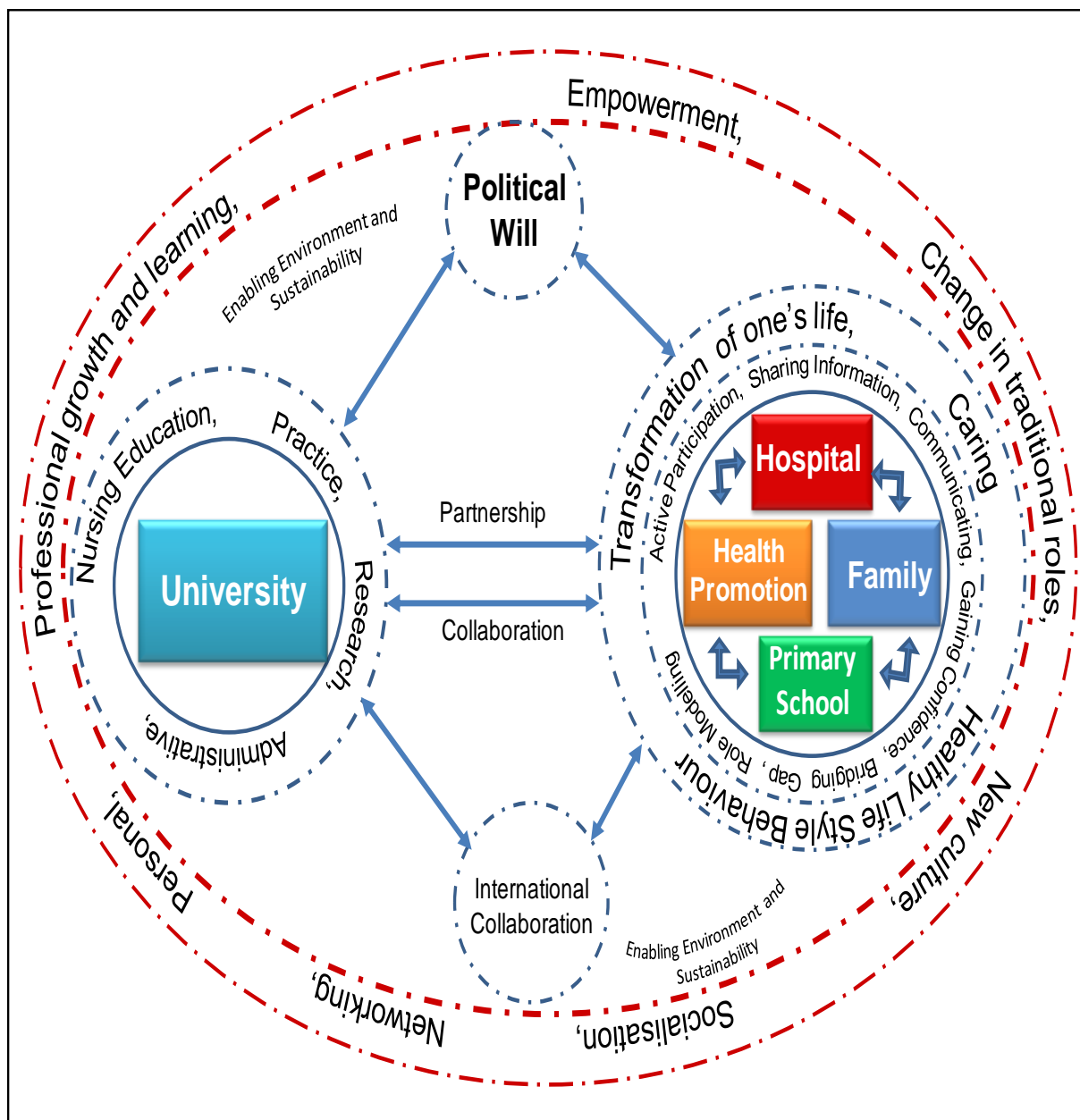
Ubuntu is an African philosophical approach. It is imperative for African nurse educators to start exploring and conceptualising theoretical approaches to

nursing that include African values. Ubuntu promotes collaboration and working together and focusses on active participation and involvement of community members in community programmes. As noted by Mbiti (1989) the worldview of the individual within the community is implicit within Ubuntu:

*“Only in terms of other people does the individual become conscious of his own being, his own duties, his privileges and responsibilities towards himself and towards other people... Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: “I am, because we are; and since we are, therefore I am”. This is a cardinal point in the understanding of the African view of man” (p. 106)*

Ubuntu has been used recently to develop the sense of community in nursing (Mulaudzi, Libster et al. 2009), to reinforce humanism and caring in nursing (Maelane 2001), to frame respect for human life (Jali 2010), to develop a support system for nurses (Dolamo 2008) and importantly here, to embrace a wholly African culture of nursing (Haegert 2000). Ubuntu is a fundamental predisposition by which people express and extend humanness within a community (Nussbaum 2003). The Ubuntu philosophy is fully compliant with both Bandura’s theory of social learning and the Ripple Effect Model (Parker and Barry 1999). Ubuntu adds to Bandura and the Ripple Effect Model the notion of the community knowingly working together for the common good. In Ubuntu, learning from others (Bandura) and spreading that learning (Ripple Effect Model) is undertaken deliberately and for the good of the community as a goal.

Figure 4. Reciprocal Ripple Effect Model



Source: The author, (2013)

*Note: the dotted lines between the levels (rings) of the model denote interaction and connectedness between and among the various levels and groups of stakeholders in the Community-based Programme.*

### **Development of a new theoretical approach**

Most models employed in community-based nursing education programmes in resource-poor settings were designed to be compliant with western cultures (Culley 2006) and as such, they pose challenges for nurse educators in Uganda. For the community-based project at the centre of this study, it was felt that a culturally sensitive model was necessary. As such this warranted a model of practice that promoted listening, remembering of the issues discussed, and clarifying myths that could lead to trust and openness.

*“Ubuntu”* (Le Roux 2000; Venter 2004) was adopted as a philosophical underpinning for the community-based programme. This philosophy embraces cultural aspects, values and behaviours as an essential way of caring for the community as a whole rather than an individual. The community aspect of welfare was echoed by Le Roux (2000 p. 43), who emphasised that the *“interdependence, communalism, sensitivity towards others and caring for others are all aspects of Ubuntu as a philosophy of life”*.

Within the community-based programme, nursing students acted as role models for the community members through their knowledge of health promotion, health education and illness prevention. In this way, students sought to empower community members with knowledge and practical skills who in turn shared with their neighbours and empowered them. The principles of Ubuntu are collaboration, partnership, active participation, communicating, sharing



information, and role modelling. It was anticipated that these theoretical principles would impact on the students and the community, enabling them to gain confidence and lead to the community moving away from working in isolation by promoting collaboration and partnership.

The central focus of this approach is both nursing and education. Nursing education is seen as empowering the individual and community through partnership and in collaborating through a holistic approach. Thus the approach has the potential to influence people in the community to change their lifestyle behaviour as well as transform the curriculum of nurse education by emphasising ways of knowing through their culture guided by Ubuntu. This is also possible through an enabling environment, partnership and political will, with the hope of achieving sustainability of the programme.

A community nursing model was designed that focused on partnership and collaboration between academic institutions and communities. The ripple effect model of Parker and Barry (1999) which guided this study was modified in this study and is now known as the '*Reciprocal Ripple Effect Model*'( see figure 4 above). Parker and Barry's model was important as it related to the use of children as change agents for their communities; although the present study was carried out in a different geographical environment than Parker and Barry's study area, the ideology was similar. The *reciprocal ripple effect model* was guided by Ubuntu philosophy (Swanson 2007).

#### Ubuntu: an African Philosophy

Although Africa is sparsely populated, accounting for 20 percent of the world's total land surface and only 10% of the total population, surprisingly it exhibits a

greater degree of linguistic complexity than all other continents (Ki-Zerbo 1989). Bantu were first identified as a group in 1862 by Wilhelm Bleek. Ubuntu is derived from the Bantu word for 'people' (Ki-Zerbo 1989). There are two types of Bantu languages according to Lwango-Lunyiigo and Vansina (1992 p. 75) the "*Western block*", located in the equatorial forest region and the "*Eastern block*", extending from Uganda to the Cape. The languages belonging to the eastern group are more closely related to each other than those of the western group. This suggests that the expansion of the eastern group began at a later stage and occurred more rapidly than of the western group.

Most people occupying the southern third of African continent from "*the Cameroon-Nigeria seaboard in the west to Somalia-Kenya coastlines in the East and southwards as far as Port Elizabeth in South Africa*" speak Bantu languages and are closely related (Ki-Zerbo 1989 p. 114; Gade 2011). The Bantu family of languages consists of over four hundred languages all derived from the same ancestral tongue known as "*Proto-Bantu*" which contains proven lexical and grammatical connections with the modern word 'bantu' (people) (Lwango-Lunyiigo and Vansina 1992 p. 75). For example see table 4 below.

Table 4. Example of humanness (Ubuntu) present in some languages of Africa

Country / Tribe	How people are called
Cameroon- Duala	bato
Democratic Republic of Congo - Tio	baanu
Democratic Republic of Congo - Mongo	banto
Democratic Republic of Congo - Luba	bantu
Rwanda	a bantu
Zimbabwe- Shona	Hunhu
Herero	Abandu
Uganda- Runyankore	Abantu
Uganda- Luganda	Buntubulamu
South Africa - zulu	Ubuntu
South Africa- Xhosa	Umntu
South Africa- Zulu	Ubuntu
Kenya- Shwahili	Utu
Tanzania- Kiswahili	Ujamaa
Sesotho	Botho
Shangaan	Numunhu
Venda	Vhuthu
Tsonga	Bunhu
Ghana- Akan	Biakoye
Yoruba	Ajobi
Cape Afrikaans	Menslikgeit

*Source from (Lwango-Lunyiigo and Vansina 1992; Broodryk 2006; Muwanga-Zake 2009; Muzvidziwa and Muzvidziwa 2012)*

Different Bantu languages have different terms for Ubuntu as indicated above such as “*Buntubulamu*” in Luganda language in Uganda (Muwanga-Zake 2010

p. 73). This study employed the term of Ubuntu as used by the Xhosa and Zulu in South Africa.

All the above words according to (Lwango-Lunyiigo and Vansina 1992) are derived from the root “\*-ntu”, which is a suffix referring to ancestors (Foster 2006) and the prefix \*ba-, denoting the plural (Bantu). The corresponding singular prefix is \*mu- which, combined with the root, forms the word “muntu” meaning “individual person” (in Luganda Muntu, or Umuntu in isiZulu). There are about 400 Bantu languages which have a strong ancestral resemblance in relation to the roots of vocabulary or grammatical structure as well as to the sound and meaning or words (Ki-Zerbo 1989).

Ubuntu is pronounced in English as, ‘U-b-ntu’, phonetically as (‘oo-BUUN-too’). (Broodryk 2006 p. 132) explains:

*“Ubuntu is a Bantu characteristic of relationships and ... deems that society must be run for the sake of all, requiring cooperation as well as sharing and charity... Ubuntu consequently, is the quality of being human ... involving caring, sharing, respect, compassion... ensuring a happy and qualitative human community life in the spirit of family”*

Ubuntu is based on an individual as ‘Muntu’, who *is* because of *others* and his or her success is intertwined with the progress of a community (Muwanga-Zake 2009). It requires co-operation and charity (Broodryk 2006) and quality of being human (Murithi 2006). Additionally, Ubuntu involves “*caring, sharing, respect, compassion and ensures a happy and qualitative human community life in the spirit of family*” (Broodryk 2006 p. 13).

In order to comprehend the meaning of Ubuntu, the prefix ubu- can be extracted from the root - ntu. ‘Ubu’ refers to being closed and ‘ntu’ is the ancestor who

created human beings and the path of life (Broodryk 2002). 'Closed' in this context simply means inclusion in the community and not 'trapped in' and captures "the art of being human; the indigenous pattern of thought and the achievement of humanness. It "recognises the oneness of humanity through interconnectedness, and interdependence of all creation" (Goduka and Swandener 1999 p. 37). Thus emphasising how African communities are inclusively oriented.

There are different ways of comprehending the notion Ubuntu. According to Hailey (2008, p.2) Desmond Tutu, suggested that it can be translated as "*my humanity is caught up, is inextricably bound up, in what is yours*". Elsewhere, Tutu (2004) describes it as "*I am human because I belong. It speaks about wholeness. It speaks about compassion*". Furthermore, Tutu sees a person with Ubuntu as someone who is welcoming, hospitable, warm and generous, and willing to share. Therefore, Ubuntu is a traditional African philosophy that offers an understanding of 'humanity' in relation to the world view (Ramose-Mogobe 2003). Its first recognition in South Africa as a philosophy was during the second half of 1900s (Gade 2011).

The use of Ubuntu in nursing and medicine is already well documented (Haegert 2000; Mulaudzi, Libster et al. 2009; Jali 2010; Mullan, Chen et al. 2010; Kwizera and Iputo 2011) and has been used within the NHS (UK) in relation to conflict resolution (Wilkinson 2012). The curriculum of nursing education should be informed by culture in which the nursing students practice (Jali 2010). Employing this philosophy in community nursing education will contribute to a better understanding, analysis and response to communities' needs. Through the

model, promoting health is seen as an activity that can only take place in genuine partnership with the community.

Ubuntu philosophy can contribute to the achievement of constructive outcomes of as well as learning for nursing students as they collaboratively work with the community in achieving healthy lifestyle behaviours. However, as noted by Abdi (2013 p. 715), Ubuntu is not only concerned with ways of thinking, but also contains “*pragmatic aspects of life that can fulfil the real need of the learner and others through expression of the humanness that binds us all to the human family*”. Abdi (2013) suggests that Ubuntu has both global significance as an epistemology of life.

#### Ubuntu values and the Community-based programme

The concept of Ubuntu is based on five social values; survival, solidarity, compassion, respect and dignity (Mbigi 1997). Because these central values of Ubuntu track down to the grassroots level, Ubuntu promoted collaboration, partnership and the working together of stakeholders within the programme. The survival of the programme in the community was achieved through communal care and in respect of the needs and interests of all (Broodryk 2006). Survival is the ability of people to overcome challenges collectively rather than individually (Broodryk 2006). It was imperative that any conflict between stakeholders, such as cultural values, economic status, knowledge difference, the language barrier, dressing code, to mention just a few, were addressed. As illuminated by Mbigi (1997), conflict is the greatest threat to the survival. Holding meetings prior to the implementation phase enabled the community to appreciate being treated as equal partners in the programme. This promoted acceptance and sustainability

of the programme, resulting in collaboration, partnership and teamwork. This led to inter-reliance and each stakeholder was contributing to the programme's success. Additionally there was a sense of mutual accountability towards achieving the aim of the programme. Since the programme was in a community that lived according to Ubuntu values, stakeholders' developed a shared will for the programme's 'survival' to continue even after funding ended. Survival entailed collectively finding the 'other' in the community, "*to benefit the community, as well as the larger communities of which it is a part*" (Lutz 2009 p. 318).

The spirit of solidarity in African communities pertains to the combined efforts of individuals in serving their communities (Engelbrecht and Kasiram 2012). Similarly when the personhood of the African community member is embedded in the identity of the community, a person is defined in terms of the community in which he or she is living (Poovan, DU Toit et al. 2006). The value of the spirit of solidarity increased the cohesion among members. Arguably, Ubuntu created a bond between stakeholders. This was possible because each member took on the identity of a stakeholder and this increased the level of cohesion among them. By fostering solidarity with the programme in the spirit of Ubuntu, stakeholders achieved high cohesion that resulted in achieving the programme goals of educating students while providing services to the community and promoting health. Consequently, solidarity empowered the stakeholders in this study; to acquire knowledge, skills and good practice.

Compassion, as a value of *Ubuntu*, is the ability to reach out in friendship to others, practising "*humanism in a delicate and artful way*" (Poovan, DU Toit et al. 2006). Through caring, one's friendship gets wider and spreads. The community

took joint responsibility in promoting health and preventing disease in the community. As stated by Senge (1990), a vision emanates from team members' deep care for the issue in question. This deep caring can be equated to the social value of compassion. Similarly, the shared vision by stakeholders created a climate of collegiality based on sharing and caring. This was seen from the perspective of their understanding that all humans are interconnected. Therefore, through understanding and caring for each other, stakeholders could see themselves as belonging to the Community-based programme and willing to support each other. Valuing others with respect and dignity is not solely an African value, however, the centrality in Ubuntu and the Ripple effect model was a cardinal feature of the Community-based programme.

The underlying philosophy of the Community-based programme rested on the premise that everyone belongs to the whole, and while that remains the case, health promotion and education should focus on improving the health of the entire community and the nation at large. This can be realised through employing models that take into consideration socio-political, cultural and environmental aspects. It follows that adopting Ubuntu philosophy for change and transformation in the community-based nursing education programme has the potential to change the way people behave and interact with each other significantly.

### **Significance of academic institution in promoting health**

The University as an educational organisation has a mission to make changes at community level. Arguably, the university is a natural point of entry for making change in communities. Educational strategies are needed which more



adequately meet the practice requirements of the learner. The Community-based nursing education programme rises to two key challenges: to enhance community health through increased active participation in the project, and to strengthen nurse education with more innovative academic strategies to enhance and support the community. With the primary schools as partners, the pupils become a beginning audience for health promotion. The initiative also means that nursing students serve as first level agents of change with their actions eventually cascading to parents and to the wider community. The Uganda primary school education curriculum (Nsubuga and Kateba 2010) emphasises health education. The Community-based programme builds on this, making pupils change agents for their community.

Providing education on healthy living and prevention of diseases in schools by nursing students is designed to assist pupils to develop personal skills, provided knowledge about health and promoted positive attitudes and healthy behaviours (Kwan, Petersen et al. 2005). The approach takes into consideration the cultural and social determinants of general health. Thus, integrated approaches to active participation promote sustainable changes in behaviour (World Health Organisation 1996; Kwan, Petersen et al. 2005). At the same time, a well-designed programme should enable teaching staff members in the schools to acquire skills and sustain healthy lifestyles, and to integrate their knowledge and skills into their teaching. Furthermore, such programmes promote collaboration between the school and the community, whereby the same health messages are taken to families, encouraging them to be part of the school community. Through the pupils, other members of the community can benefit from health promotion

and health education given to pupils at schools by nurses. Thus, interaction between the university, schools, home and the community is achieved.

### **Summary**

This chapter has addressed the theoretical approach underpinning both the Community-based programme and the research study described in this thesis. It has considered role modelling and the ripple effect model with the context of Ubuntu in enhancing the learning of students as well as that of the community. The use of theories and models were considered in guiding effective health promotion and education. It was suggested that there is a need for a theoretical approach that is culturally appropriate for the target audience in order to enhance acceptability.

Most nursing theories were designed for western communities; identifying theories based on an African context is paramount in guiding health promotion activities in African communities. Thus, the 'Reciprocal Ripple Effect Model' of practice and Ubuntu Philosophy should be considered suitable for community-based nursing education programmes in African, resource-poor settings.

# CHAPTER 4: METHODOLOGY AND METHODS

## Introduction

The chapter discusses the methodological approaches used to conduct the study. The justification for the exploratory case study approach and the rationale for the chosen methodological approach and the use of Ubuntu philosophy are discussed in relation to this new and under-researched area.

This chapter will discuss the methodological underpinning of the thesis, Ubuntu philosophy, the qualitative method employed, the epistemological stance, design, sampling, access and consideration of ethical issues. Also discussed, are the pilot study, participant interviews, participant observation, document analysis, use of triangulation, establishment of credibility, data analysis and the researcher's role as 'insider'.

This study used both Ubuntu and Western paradigms. Paradigms are defined by Sandelowski (2000 p. 247) as being:

“world-views that signal distinctive ontological (view of reality), epistemological (view of knowing and relationship between knower and to-be known), methodological (view of mode of inquiry), and axiological (view of what is valuable) positions”.

Guba and Lincoln (1998 p. 2000) suggested that a paradigm represents a worldview that defines, for its holders:

“the nature of the 'world,' the individual's place in it, and the range of possible relationships to that world and its parts, as for examples, cosmologies and theologies do”.

Ubuntu, the guiding principle of the collective orientation, guided this iterative research process through mutuality between the participants, and respect for others, their language and cultural views. Thus, a meaningful stakeholders' experience required involvement of a research relationship that engaged the participants and the cultural values to be embedded in the research design (Prior 2006). Ubuntu philosophical approaches and Western evaluation paradigms were combined in this study of participants' experiences of the community-based nursing education programme. Arguably, the use of Ubuntu also complemented the qualitative research method employed, since both approaches accept that people employ interpretative schemes which have to be understood in the character articulated within the local context (Mkabela 2005).

The use of 'Ubuntu' in the planning of this study strengthened the centrality of indigenous African ideals and values as a legitimate frame of reference for collecting and interpreting data (see Mkabela 2005). Such discourses assume the social, political, intellectual, and cultural legitimacy of indigenous African people (Mkabela 2005). In this way, African indigenous culture, knowledge, language and values were accepted in their own right.

### **Methodological Underpinnings**

Qualitative research is a process of coming to understand and making sense of the meanings people bring to the settings (Patton 1990; Denzin and Lincoln 2005). This definition illuminates the epistemology involved in qualitative research, and that knowledge is narrative (linguistic) rather than statistical in nature. Polit and Hungler (1999) suggest that qualitative research is a systematic collection and analysis of narrative materials; using procedures, in which there

tend to be a minimum of “*researcher – imposed controls*” (p.15). Morse and Field (1996) describe qualitative research as an “*inductive, holistic, subjective and process-oriented approach to understand, interpret, describe and develop theory pertaining to (a human) phenomenon*” (p.199). Qualitative research is an approach designed to help the researcher to understand the unique interactions in a particular situation as well as meanings brought by participants to their surroundings. Hence, according to Holloway and Wheeler (1996 p. 8), it is a “*person-centred*” and a holistic approach to generating an in-depth account that mirrors respondents’ reality. The Ubuntu philosophical approach offers a new understanding of approaches to qualitative research by challenging the constructed meaning of our knowledge, identities, and ways of seeing; by attempting to ‘resource’ these through co-construction and ‘humble togetherness’ (Swanson 2006). In this study, this philosophical underpinning shaped the research design and method as well as supported the credibility of the research study described in this chapter (see Jackson 2013).

### Choosing the Approach and Methods

A qualitative approach was chosen because the rationale for the study aimed at exploring, describing and interpreting the experiences of participants (Burns and Groves 2011). In addition, Coyle (2007) acknowledged that the phenomena being studied cannot be removed from its cultural context but rather that the task is to understand the practices, traditions, and ways of thinking and knowing that surround the phenomena in question. This approach was considered appropriate because the study aimed at achieving a critical understanding of knowledge-creation (Stones 2005; Pandit and Hamilton 2013) by people grounded in the context of a particular phenomenon. Furthermore, qualitative methodology was

employed based on the premise that Western positivism is not the only form of knowledge (Coyle 2007).

There has been some criticism of qualitative approaches (Krueger and Casey 2000; Smith 2003) that 'qualitative investigators' are too close to their participants, and for this reason, the question of prejudices and personal interpretation of research findings may be queried. Perhaps because the characteristics of qualitative research have sometimes been poorly understood, the approach has been criticised and regarded with suspicion and hostility. This criticism relates to the idea that qualitative research lacks scientific rigour and exists as merely a collection of anecdotal and personal impressions, replete with researcher bias. In qualitative research, the research is more personal to the researcher and there is no assurance that another researcher would not come to radically different conclusions. For instance, Yin (1994) argues that because of its dependence on a small sample size, the findings cannot be generalised. Arguably, however, the trustworthiness of qualitative research depends on the methodological quality of the study and the rigours upon which the study is constructed. Thus, attention to rigour serves to offset some of the criticisms of qualitative research as being a 'soft' approach.

#### The researchers' epistemological position

According to Creswell (1994) and Creswell (2014), epistemology is a theory of knowledge and within research, determines how social phenomena are studied. In this present study, the purpose of the investigation was to understand and communicate the meaning stakeholders had regarding their experience of the community education programme. This was achieved by employing an

interpretive paradigm (Holloway and Wheeler 2002). Therefore, knowledge was produced between the viewpoints of two parties, the investigator and the interviewee. Through interpretation of participants' narratives, the investigator was a joint constructor of social knowledge. This required the researcher to achieve rapport as a means of linking the investigator and the investigated in a manner that was both mutual and active. Through this philosophical genre of interpretation (Hickey and Zuicker 2002), an Ubuntu communal consensus embraced the position of the researcher's 'insiderness'. According to Smith and Eatough (2007 p. 35) "[The] *aim of the interpretivist perspective is to explore in detail, individual personal and lived experience to understand how individuals make sense of their personal and social world*". In this way, the participants in this study created their interpretation of their experiences, based on the context of their worldview.

The primary purpose of carrying out interviews was to enable the researcher to be acquainted with participants' experiences. This procedure according to Kvale (1999 p. 29) is "*a situation of knowledge production*", whereby knowledge is generated between the investigator and the participant during each dialogue. The researcher conducted the study in her familiar environment, thus, making her an 'insider'. For instance, she worked as coordinator of the programme under evaluation, supervised the students in the community, shared the nationality, speaking a common language and organising educational demonstrations in the community.

Dunbar, Rodriguez et al. (2002) suggest that in most research interview situations, emphasis is disproportionately placed on obtaining information from

respondents. This is problematic as it can include little if any mutual exchange or disclosure. However, Lewis (2003) asserts that a common cultural background between researcher and participants may enrich the researcher's understanding of participants' accounts and the language they use. Douglas (1985) refers to this type of interviewing as creative interviewing and states that to achieve the likelihood of discovering the truth and depth of data; the interviewer must establish a climate of mutual disclosure. The position outlined above formed the basis for using the methods employed in this study of data collection. The study employed Ubuntu framed qualitative interpretivist case study approach within which, participant observation, focus group discussion, drawing methods, semi-structured interviews, email interviews, and document analysis were used.

### **Study Design**

Research design is described as a *"blueprint or detailed plan of how a research study is to be conducted"* (De Vos and Fouche 1998 p. 77). The purpose is to provide coherence between the research question and methods proposed in the study so that data can be generated that is valid and reliable (Ritchie and Lewis 2003), whilst ensuring that the research design is realistic in relation to the research context and setting.

Therefore, the research design provided the framework for the collection, analysis of data and subsequently indicated which research methods were appropriate. After examining the research purpose for this study and realising the lack of previous study and published literature on community nurse education programmes in Uganda, an explorative research design was chosen. Yin (2003) and LoBiondo-Wood and Haber (2010) suggests that where a great deal is



known, the research should be explanatory in nature and where less is known the design should be descriptive or exploratory.

Miles and Huberman (1994) define a case as, "*a phenomenon of some sort occurring in a bounded context*". The case is, "*in effect, your unit of analysis*" (p. 25). It was important that appropriate steps were taken to maintain "the methodological integrity of the case study" (Rosenberg and Yates 2007 p. 448). Commonly used methods used in case studies include observations, documentary analysis, interviews and focus groups (Morse, Swanson et al. 2001).

The research design was adapted due to the nature of the study. This approach was deemed pragmatic and capable of enhancing the credibility of the study and was in line with Creswell (1998) eight criteria for conducting qualitative research:

(a) "the research question often starts with *how* or *what*"; (b) "*the topic needs to be explored*"; (c) there is a "*need to present a detailed view of the topic*"; (d) the study occurs in a "*natural setting*"; (e) the researcher is interested "*in writing in a literary style*"; (f) enough time and resources are available for extensive study; (g) audiences are receptive to qualitative research; and (h) the researcher is emphasized as an "*active learner*" whose purpose is to "*tell the story from the participants' view*" (pp. 17- 18).

### Research Questions

This study sought to answer three research questions. The research questions that guided the study were developed as outlined below and probes were used to stimulate participants' narratives of their experiences. These research questions were designed to give voice to participants.

1. How do stakeholders who participated in this programme describe their experiences of the community-based university nurse education programme?

2. What has been the impact of the community-based university nurse education programme on stakeholders?
3. What are the challenges associated with the programme and how can they be overcome?

#### Aims of study

- i. Explore stakeholders' experience and views of the community-based university nurse education programme;
- ii. Explore the impact of community-based university nurse education programme on stakeholders;
- iii. Explore stakeholders' view on challenges and how the programme can be improved;
- iv. Explore stakeholders' views on sustainability and possibility of rolling out the programme.

#### **Study Participants**

The study participants involved members from all the identifiable stakeholders of the programme. Each category of stakeholder; that is; the pupils, pupil-parent couples, teachers, education administrators, nursing students, faculty staff, university administrators, and Florida Atlantic University faculty staff all gave narratives of their experiences of the community-based university nurse education programme. The involvement of the stakeholders injected Ubuntu into the research process which advocates for mutual collaboration. This gave the research process a human face and this participatory approach prompted a working relationship (Mkabela 2005). This enriched the stakeholders' experiences of the programme through inclusion of community values (Denzin and Lincoln 2005).

#### Inclusion and Exclusion Criteria

No exclusion criteria were applied to school and community members of the project. However, members of staff, with less than 2 years in the nursing

department as well as those with less than 2 years in the primary school and the community were excluded because their experience would not capture the initial stages of the programme implementation.

### **Ethical Considerations**

Ethical issues are rightly, a central focus of the research process (Burns and Groves 2011). The research was guided by the principles of justice, beneficence, and autonomy (Orb, Eisenhauer et al. 2001). These principles are in line with the core value of Ubuntu philosophy. Therefore, the aphorism “*do no harm*” guided the formal ethical requirement process in conducting this research (Morrell, Epstein et al. 2012 p. 616). Ethical clearance and permission were obtained from the University of Hull Faculty Ethics Committee and the Institutional Review Board (IRB) Research Ethics Committee MUST<sup>9</sup> (See appendix 3 a, and 3b respectively). Also, permission was obtained from the Municipal Education Ministry, the Local Council III (LC II) the political representative of the community and the parents for their children’s participation (See appendix 4 a, 4b, 4c and 4d respectively).

Participants were told that they had the right to withdraw from the study at any point. If a participant chose to withdraw after the interviews, then all their data was destroyed (see appendix 5a, b, c and d).<sup>10</sup> Participants were told that all information would be kept confidential. The interviews were transcribed and every transcript anonymised and all identifiable material removed. Participants were

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<sup>9</sup> Mbarara University of Science and Technology, Uganda.

<sup>10</sup> This occurred only during the pupil focus group where one of the participants became ill and withdrew from the study.

made aware that it was likely that the final report would include quotations from interviews but that these would also be anonymised. Participants signed a consent form (see appendix 6a, b, c, d and e). The researcher acknowledged the participants' contributions to the study. Participants were made aware of how the results would be published as the informed consent sought the approval to use any quotations for publication. The names of participants and demographic information were secured in a locked cabinet and were only accessed by the researcher and thesis supervisor. Five years following the research study, the data will be destroyed.

The interview guide was written in English and translated in Runyankore, the local language. This was then back-translated into English to ensure validity. This translation was done by persons approved by the Institutional Review Board – Mbarara University of Science and Technology, for the purpose of confidentiality. (See copies in appendix 7a, b, c, d, e, f, g, h, I, j and K). Data was stored in a secure personal computer. The researcher ensured that there was a backup drive kept together with tapes which were secured in a filing cabinet which was only accessible by the investigator.

### **Pilot Study**

Conducting a pilot study is a crucial element of a good study design. The term 'pilot' refers to a 'mini' version of the full-scale study, as well as to the specific pre-testing of a particular research instrument such as a questionnaire or interview schedule (Teijlingen van and Hundley 2002).

A pilot study was carried out chiefly to ensure the robustness of the interview guide. Baker (1994 p. 182-183) suggests that a pilot study is the "*trying out*" of

the study tools and Polit, Beck et al. (2001 p. 467) states that a pilot study is a *“small scale version [s], or trial run[s], done in preparation for the major study”*. Importantly, performing the pilot study can provide an early warning regarding the challenges that the main study might face, potentially identifying techniques that could be unsuitable (Teijlingen van, Rennie et al. 2001).

The initial stage of the pilot study entailed employing in-depth focus group interviews, phrasing of the interview guide and noting the scope of responses to the procedures (Teijlingen van, Rennie et al. 2001). The pilot study enabled the researcher to recognise practical problems. For instance, problems such as poor recording and response pace were identified and dealt with accordingly. Because the study was conducted in a rural community, the researcher took no risks with losing data due to a faulty tape recorder. As a safety measure, two tape recorders were used in case one had a problem. The pilot study involved two groups of stakeholders, nursing students and the pupils. Those who participated in the pilot study were not recruited in the main study. It was carried in a manner similar to the main study. Some questions were improved, for instance, the pupils' interview guide was re-phrased (see appendix 7f, g, h, i for pupils' interview guide). In addition, piloting enabled the researcher to discover whether the enquiry provided a sufficient depth of discussion. The pilot study also enabled the researcher to gain experience in interviewing this particular group of participants.

### **Recruitment Process**

The recruitment of participants was achieved by sending out letters to teachers, parents, administrators and emails to potential participants (FAU faculty) and by word of mouth among faculty staff, nursing students and pupils. Purposive

sampling (Kyngäs, Elo et al. 2011; Creswell 2013) was used to recruit the administrators. This approach was suitable for administrators as the researcher was interested in informants who had the best knowledge concerning the research topic.

Random sampling was used to select pupils, nursing students, and parents. This technique ensured that each individual had the same chance of being invited to participate in the study. For example; the total numbers of pupils in three classes were 156 (primary five: 50 pupils; primary six: 50 and primary seven: 56). To be able to select the total number required to participate in the study, the researcher, after receiving consent, listed all the numbers from 1 to 156 and attached their names to the numbers. The researcher then used an excel® random number generator. The selection of nursing students and parents followed a similar approach.

Streubert and Carpenter (2007) argue against the use of random selection in qualitative studies. However, random sampling was used because the participants were more than the number needed for each focus group.

Table 5. Participants' Sample

<b>Participant</b>	<b>Method (s) used and Sample size</b>
Upper class pupils (age 10-15 and above):	1 focus group 10
Lower class pupils (age 6-9):	1 focus group 9 (use of drawing)
Teachers:	1 focus group 10
Parents:	2 focus groups 10 + 7= 17
Nursing students:	1 focus group 10
Faculty nursing:	1 focus group 8
Faculty FAU:	E-mail interview 4
Administrators:	Face to Face interviews 3
<b>Total Sample Size</b>	<b>71 participants</b>

In addition to the above, documents which met the criteria for inclusion (see appendix 9) were obtained from the Department of Nursing, School Based Centre and the two elementary schools giving a total of seven documents. Furthermore, two participant observations were conducted while nursing students gave health education talks to pupils and when they conducted home visits (see appendix 8 for the guidance structure).

Arguably, good informants can put into words the meaning or description of their experiences and are willing to reflect and share them with the researcher. Thus, Morse (1991) argued, *“an appropriate sample is guided by informant characteristics and by the type of information needed by the researcher”* (p. 135).

Stakeholders of different ages, gender and language, and professional backgrounds participated. The rationale for selecting participants in this study was based on their unique experiences with the community-based university nurse education programme. For this reason, a large sample size was not important as the researcher ensured that only those with experience of the programme were recruited to the study. This approach provided appropriateness and adequacy of the sample.

### **The researcher's role**

Being aware of the cultural context, local challenges and political dynamics, the researcher was in control of how she participated in the entire research process. Ubuntu enhanced the research dialogue and brought the researcher to the level of the participants. The researcher became part of the collective approach to the programme and shared the participants' view of the world. This influenced how she approached problems, resolved issues, gathered information and managed the research. When Ubuntu is used as a research paradigm, the study becomes participative and involves respect between the researcher and participants as they are bound together with each other in a shared experience (Tutu 2004) with an emphasis on "*togetherness*". This resulted in consensus in decision-making and the processes that led to decisions and to the empowering of participants. As highlighted by Muwanga-Zake (2009 p. 420) "*Ubuntu as a research philosophy gives the research process a human face*". It promoted collaboration with the participants and community, humanely, with respect to their values, norms, and customs. Arguably Ubuntu eliminates any differences in research dialogue and places the researcher at the level of the participants. The researcher being a 'Muntu' facilitated the research process, otherwise as highlighted by



Mkabela (2005 p. 179) a “non- Muntu” researcher would have to convert to “Muntu” in order to achieve full cooperation of “Bantu” (Muwanga-Zake 2009 p. 420). Becoming a Muntu is to submit oneself to Ubuntu. Mkabela (2005 p. 19) argued that the notion of “the Ubuntu-becoming process requires “cultural and social immersion as opposed to scientific distance . . . to understand African phenomena”.

## **Reflexivity**

The extent to which a researcher participates in his / her own research varies between studies, but it is inevitable that the researcher’s experiences are reflected in any research project. This is in line with Ubuntu; unavoidably, one’s own views and ways of seeing the world trickle intrinsically into the writing attempts. Brewer (1994) advocates the need for researchers to be reflexive and *“to give attention to the social processes that impinge upon and influence”* them (p.223). There are different ways of either acknowledging or dealing with reflexivity; this study adopted one advocated by Abbey (1995) who claims that we *“should all begin a study knowing who we are and why we chose to study a certain problem”* (p.65). The researcher’s interest derived from acknowledging her own particular viewpoint as well as the nature of her reflection on her experiences of the project.

Reflexivity has been described by Mays and Pope (2000 p. 52) as *“sensitivity to the ways the researcher and the research process have shaped the collection of data, including the role of prior assumptions and experience”*. While Northway (2000) suggests that reflexivity contributes to rigour of study by promoting honesty and transparency in the research process, through the provision of an

audit trail. Therefore as researchers, reflexivity requires us to remain knowledgeable of our perspectives as we endeavour to interpret the perspectives and voices of others (see Patton 2002). In addition, Caelli, Downie et al. (2003) emphasize that qualitative researchers should endeavour to illustrate their theoretical position, with explicit reference to their “*disciplinary affiliation, what brought them to the question and the assumptions they make about the topic of interest*” (p.23).

Flood (1999 p. 35) suggested that “*without some degree of reflexivity, any research is blind and without purpose*”. The researcher was reflexive at every stage of the study (see appendix 11, an example reflexive account). However, the researcher was cautious about the danger of over-concentration on self as this can impede the understanding of participants’ experience. The researcher was guided by Ubuntu in relation to respectful engagement in the study through “*humble togetherness*” (Swanson 2007 p. 54). Consequently, this allowed reflexivity, reciprocity, community connectedness and cross-cultural understanding. Ubuntu was drawn into this study to shape the research experience from ‘indigenous knowing’.

Electing to employ content analysis provided the flexibility to look not only at the specific content of actors’ experiences, but also to investigate deeper into the meaning of those experiences. This required the researcher to find a balance between the actor’s voice and the voice of the researcher. This in turn was designed that the data should embody both perspectives and be an integration of all our voices into rich data.

## **Subjectivity**

The researcher's motivation has in part, been her personal journey towards understanding how and in what ways stakeholders describe their experiences of the community-based university nurse education programme. Working in the programme and accompanying students in the community for community nursing practice, in addition to being a stakeholder of the programme right from the time of its inception and implementation, motivated the researcher to explore stakeholders' experiences. The researcher needed to know how the evaluation might illuminate and deepen her understanding.

The researcher was motivated to gain insight and a greater understanding of the programme and how it might be used to prepare nurses who are better able to provide care in the 21<sup>st</sup> century. Furthermore, as stated by Kiger (2004), nurses who evaluate their programmes demonstrate their willingness to show accountability for their success or failure. It is on this basis that the researcher developed interest in evaluating this programme to find out whether the programme had delivered what was intended. The dearth of knowledge regarding evaluation of the programme and stakeholders' experiences in a resource-limited environment motivated the researcher to carry out the present study.

This study was a profound experience for me as a novice researcher. The stakeholders' experiences gave me much insight into their understanding and the whole programme. Therefore, my problem was in designing a study that would present this information to others not only with the *"insider's voice of intimacy"* as former stakeholder and lecturer, but with the *"excited voice of discovery"* of the researcher (Patton 2002 p. 65). Palmer (1993) reminds the researcher that much

overlap exists and reality is never “out there” apart from us, but “in here” between us and the rest of the world (p. 107). Palmer also states humility as a virtue is central to creating space for voices other than our own.

### Partiality

One of the advantages for the researcher in this study was that she was acquainted with the programme. Furthermore, this allowed her a better understanding of the situations expressed by stakeholders. The researcher had significant interactions with the programme stakeholders.

While legitimacy and trustworthiness are critical values in qualitative research neutrality was seen a difficult goal to achieve (Diebel 2008). Therefore, understanding the drawbacks and benefit associated with a dual role enabled the researcher to minimise the biases related to insider membership. This was achieved through a detailed reflection on the subjective research process with a close awareness of my personal biases and perspectives of the programme. The researcher was open, authentic, honest, profoundly interested in the stakeholders’ experience and committed to representing their experiences accurately and adequately guided by Ubuntu philosophy.

As noted by Maykut and Morehouse (1994) one’s own biases and preconceptions can influence what one is trying to understand being too close to the project and the participants can impede the research process. Familiarity with the participants could have led them to fail to explain their individual experiences fully. Furthermore, the position of the researcher as a PhD student in the UK could have created a barrier and caused me to be seen as someone who was just interested in extracting data from stakeholders without having their interest at

heart. However, these problems were outweighed by the shared attributes of culture and common experiences. This was achievable because the researcher entered the field in another capacity as a researcher using a low key approach (Fetterman 2010), as an 'insider', a listener, a learner and a participant.

### **Data Collection**

Throughout the data collection, building a trusting relationship with the participants was paramount. This led to the development of interpersonal relationships that contributed to trust and cooperation with participants. According to Hammersley and Atkinson (1995), relationships are vital to knowledge creation. This is clearly elaborated in Ubuntu philosophy. Thus, Ubuntu promoted the practical research relationship with participants and this was nurtured throughout the data collection process.

### Access

The research involved three settings; the university, the primary schools and Katete community. Achieving access to the study settings was a crucial part of the procedure (see Devers and Frankel 2000). Prior dialogue was carried out with all levels of 'gate-keepers' who authorised the advancement of the study. The researcher made use of individual acquaintances, with those who were able to write a correspondence of support (see Devers and Frankel 2000).

### Data Collection Methods

Selection of the most appropriate method of data collection was essential for ensuring the credibility of the data and the resulting analysis (Graneheim and Lundman 2004).

A number of methods were used to elicit data from the study participants:

- Participant observation
- Interviews
  - focus group
  - semi-structured interviews
  - email interviews
- Document analysis

A combination of different methods was used to ensure trustworthiness. In addition, the above methods were best suited to dealing with the research questions. All data collection activities were scheduled at a time convenient to participants. For example, pupil interviews were conducted after classes.

#### Participant Observation

Observational methods are a naturalistic approach which allows enquiry of a phenomenon in a natural setting. The researcher worked with participants using this method, to document performance, conduct, communications and proceedings that were played out during the health education sessions with the pupils. The researcher became involved in the activities carried out during health education, without forgetting the primary priority of attentive observation.

This method was chosen because participant observation offered an opportunity to collect information that was salient to the study and symbolised individual actions in the natural environment (Glaser 1996). It was important not to allow pupils to get distracted by the presence of the investigator as an outsider but rather as a participant observer through involvement. In this way, what was observed and recorded were explicit descriptions of natural occurrences rather

than an interviewee's account of their performance. Hammersley (1990) suggests that:

*“ ... to rely on what people say about what they believe and do, without also observing what they do, is to neglect the complex relationship between attitudes and behaviour” ( p. 597).*

This technique increased the validity of the data as the researcher had a better understanding of the context and the phenomenon under study. The researcher was able to check non-verbal expression of feelings, how participants interacted during health promotion and education. Two participant observation sessions were carried out over two weeks. This enabled enough time to gather in-depth data. Furthermore, the time allocated facilitated observation and interpretation of participant behaviours. The method allowed the behaviour of participants to be translated into words. Participant observation elicited the first data collected during the field study. The technique was less structured; spontaneous participant observation happened during health education talks at school and home visits in the community. Field notes were taken throughout the time participant observation was taking place.

### Interviews

Interviews are techniques of investigation that depend on the individual's ability to discuss, thus potentially yielding rich data through verbal and non-verbal communication (Seidman 1991; Onwuegbuzie, Dickinson et al. 2009).

Semi-structured interviews were employed because of their use in enabling an examination of experiences (Silverman 2004). Furthermore, interviews offered

the researcher and participants an opportunity to investigate exhaustively all that was relevant. In addition, the interviews allowed the researcher the freedom to adapt vigorously to the flow of the dialogue and offer responses as they occurred (ibid). For example, the researcher investigated topics that were not part of the initial intended dialogue. Some participants introduced subjects such as 'school dropout; and 'use of lay helpers' in the community. Therefore, semi-structured interviews facilitated the interviewee with the necessary liberty to share their experiences, opinions and at the same time remain within the framework of the study enquiry (Smith 1995).

A face-to-face discussion was employed for the administrators. Prior to the data collection, consent was sought to tape-record the dialogues. Interestingly, none of the participants refused the use of tape recorders; probably because this was not an overly sensitive study and they had no reason to object to being recorded. The interviews lasted 1-1½ hours. The participants were informed of the expected length of the interview. This made them comfortable and also enabled them to adjust their schedules as the interviews were conducted at their workplaces. Apparently, each dialogue differed in duration depending on how much each participant had to say. Blaxter, Hughes et al. (2010) argued that less than ½ hour was not likely to be useful. On the other hand, a period of greater than an hour may create pressure on the interviewees who have busy schedules and this could hinder the number of participants wishing to be involved in the study. The format of the session was similar to the interviews and the broad purpose was the same, to enable participants to provide an in-depth account of their experiences.



### Focus Group Discussion (FGD)

Focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (Krueger 2000) and is socially oriented. It narrows the gap between the interviewer and the interviewee; at the same time it allows group members to safely express their perspectives with others who share their experiences (Morgan and Krueger 1993; Vaughn, Sahumm et al. 1996) through group dialogue. The technique can also increase actors' sense of belonging and cohesiveness (Peters 1993).

The focus group technique attempts to understand the participants' "*worlds in their own terms*" (Rubin and Rubin 1995 p. 2). Interaction was useful in eliciting responses (see Carey 1995) and stimulated individuals' recollections of experience thus inspiring participants to find meanings based on their own experiences (Roberts 1997). The participants endeavoured to work together except on one occasion when nursing students disagreed with each other about the benefits of the project. In this particular case it was the discussion and the interaction that was of interest to the researcher (see Campbell 2007). In an Ubuntu sense, everyone brings something the team needs and the team defines a common goal.

Conducting a focus group discussion is an art that requires substantial knowledge and preparation. Each focus group was arranged and moderated by the researcher. Prior to data collection, the researcher underwent a training session in the use of focus groups and discussed with researchers experienced in focus group methodology. Furthermore, participated in three focus group interviews for the purpose of critical analysis and piloted the technique. A research assistant

also underwent preparation for focus group discussion prior to data collection. The researcher was the moderator and worked with a research assistant moderator who was fluent in both English and the local language. After formal introductions, the moderator sought participants' consent to use the tape recorders and informed them of the expected length of the focus group discussion. Ground rules and use of an icebreaker (see appendix 10) were employed. Focus group discussion was tape-recorded and each discussion lasted one to two hours. Vaughn, Sahumm et al. (1996); Morgan (1997) suggested that a well-designed focus group should last from 1 to 2 hours. The time enabled meaningful dialogue during the discussion.

A common background of experience among members was ideal as it stimulated sharing among the groups and they appeared to feel comfortable with each other (see Stewart and Shamdasani 1990; Krueger and Casey 2000). They were in the same profession (teachers, faculty, nursing students), age group (pupils) or family (parents). The rationale for this was based on the researcher's awareness of how differences could manipulate participants' responses. Pre-existing hierarchical structures within groups could have affected the dialogue (Kitzinger 1994). People who perceive themselves to be socially inferior may keep quiet, due to factors such as a 'culture of silence', power balance among participants etc. It was imperative that participants were comfortable with one another.

Each group of stakeholders had one group interview except for parents who had two focus groups. It appeared in the first group discussion that females tended to conform to male opinions (Crawford and Acorn 1997) leading to 'group think' as noted by Nyamathi and Shuler (1990). The males dominated the discussion and

the females tended to talk very little. However, dominant talkative males were tactfully requested to allow others opportunity to share their experiences. The moderator was also sensitive to equal gender participation. All participants were encouraged to speak throughout and discussion continued until no new information was forthcoming (see Sandelowski 2008; Saumure and Given 2008). The researcher introduced the topics systematically, guiding the participants throughout; this ensured that the focal point of attention was not derailed (see Krueger and Casey 2000).

At the end of each focus group discussion, the moderator re-introduced the major issues raised during the discussion in order to allow the group to either concur with the summary provided or provide clarification. In total, seven focus group meetings were held. (See details of the procedure of FGD: Appendix 7).

#### Focus Group Drawing Technique (lower primary 6-9 years)

The drawing technique was employed in order to understand the pupils' experience of the programme. Drawing is a standard approach to expression for younger children. "*During the elementary school years, boys and girls can often express their thoughts and feelings better in visual images than in words*" (Koppitz 1984 p. 2). Younger children illustrated and drew shapes and painted their experiences and views about the programme.

Allan (1978); Koppitz (1984); Rubin (1984) have identified techniques to help interpret children's drawings. The sketching session employed a qualitative data collection method in order to understand the pupil's experiences and views. Prior to each drawing session, the pupils were taken through an explanation of what was expected of them. Pupils chose five colours to signify their experiences about

the programme. Pupils reached a consensus as to what each colour meant to them: yellow meant sunshine or enlightenment gained through this programme. Blue meant that they were loved and were happy through this programme, because the nurses treated them when they were sick and were friendly to them. Green meant that they had been taught to keep their surrounding clean and to look after the flowers. Purple meant that they were appreciative of what was being done for them. Black meant unhappiness. Interestingly no child used the colour black.

The process of shading experiences was done step by step:

- a. The research moderator and assistant explained to the pupils what “feeling” meant in the context of this study. The pupils were asked what their feeling (experience) was regarding the programme (in local language see appendix 7h and i) and each one worked around what his or her feelings were about the programme;
- b. Pupils, with the help of a research assistant, noted down their feelings (experiences);
- c. The research assistant, together with the moderator, helped pupils to ‘bring out’ what they meant by the feelings (experiences) they had mentioned. All the meanings were written on a blackboard to enable all the pupils to see them;
- d. With the crayons, the pupils as a group agreed as to which colour most suited each of the feeling (experiences) noted. They sketched shapes of their individual experiences about the programme and shaded their experiences with a Crayon;

- e. The research assistants then invited each pupil to share with the group and explain what they meant, using their drawings to illustrate their experiences;
- f. As they explained their sketch, a research assistant and the moderator took note of each participant's remarks and later attached it to each participant's sketching for reviewing afterwards;
- g. Later the research assistant removed all the sketches and noted each participant's number, dates and experience for the dialogue and reconsideration with the researcher then.

The drawings were analysed using the following measures:

- 1. The experience
- 2. The sketching substance
- 3. The child's remarks concerning his or her sketch

Inter-rater reliability measures were not achieved in this present study.

However, the children's drawings were analysed using the patterns and colours used in the drawing and the pupil's own remarks concerning his or her sketch.

### Email Interviews

Email interviews were used to gather the experiences of Florida Atlantic University faculty participants. This was considered a less costly option for reaching this group of participants (who were at this time in the USA) than the use of other means such as video conference, telephone. Skype could have been used, but some participants were not used to Skype and preferred the email interview method.

The technique of interviewing by e-mail appears to becoming more accepted (Meho 2006). Denscombe (2003 p. 51) notes that “*the quality of responses gained through online research is much the same as responses produced by more traditional methods*”. This has also been shown elsewhere Curasi (2001); Meho and Tibbo (2003); Murray (2004); Murray and Harrison (2004). These authors argue that the interviewees in e-mail interviews sometimes provided deeper description than when face to face interviews were used. This last may be because interviewees can think through their responses prior to emailing them to the researcher (Karchmer 2001).

The e-mails interviews involved multiple e-mail exchanges between the researcher and the interviewee over an extended period of time. However, like any other method it was not without problems. There were some delays encountered from some participants; these were overcome through polite reminders. This worked well, as it was clear that most of them were busy during semester / term time.

Each stakeholder was contacted individually, this technique according to Dillman (2000) showed potential participants that they were important, thereby encouraging them to participate. One participant withdrew from the study due to the ill health of the spouse.

### Document Analysis

Document analysis is similar to other data collection methods in qualitative study. The technique involves data analysis and interpretation in order to arrive at a constructive, comprehensive meaning of the phenomenon Rapley (2007); Corbin and Strauss (2008). In all, seven separate documents were accessed.

These documents assisted the investigator to unearth the 'gist', become knowledgeable and find perspectives pertinent to study questions (Merriam 1998). Furthermore, the written records permitted access to events which may have been forgotten by participants. Documents may also concern negative events and problems which some participants may have been reluctant to discuss in an interview.

The document analysis involved reading the documents while focusing on the primary questions of the research. Relevant passages of information in line with the purpose and design of the research were identified and distinguished from the less relevant ones (see Corbin and Strauss 2008). Reviewed documents included the annual reports from 2006 to 2009 from the nursing department and the two elementary schools. The total number of document reviewed were seven: (1) Report from Katete primary school (11<sup>th</sup> November 2006); (2) Report from Katete primary school the (8<sup>th</sup> December 2007); (3) Annual Report from St. Mary's primary school (14<sup>th</sup> December 2009); (4) One year Report of the community programme - nursing department 2004- 2005 (10<sup>th</sup> December 2005); (5) Nursing Department report of the community programme for the year 2009 (15<sup>th</sup> December 2009) . The investigator also looked at students' reports of their community placement (two documents). These were: (6) Year III Student community nursing experiences (20<sup>th</sup> April 2006) and (7) Students reports on community visits (16<sup>th</sup> June 2009).

The documents were critically reviewed and not automatically accepted as factual recordings of events. In addition, the 'reliability' of the documents was taken into account for their use as a source of information for this study. The chosen

information was analysed using content analysis. The data from the documents offered additional confirmation of the result from other sources (triangulation) (Yin 1994).

### **Trustworthiness of results**

Trustworthiness and integrity of this qualitative research project was embodied in each phase of the research, including the preparation, organisation and reporting of results. Together, these stages provided a clear indication of the overall trustworthiness of the study. This was achieved by employing the four concepts suggested by Graneheim and Lundman (2004), which is credibility, dependability, confirmability and transferability.

#### **Credibility**

Credibility refers to the confidence in how well the data address the intended focus (Polit and Beck 2012). In order to portray the participants' experiences of the community programme correctly, credibility was achieved through different approaches indicated below:

(a) Prolonged engagement in the research setting; enough time was allowed to become acquainted and to establish a trusting relationship with the participants before, during and after the interview. Gathering the information over a longer period of time led to a broader scope of knowledge of experiences and views of participants about the programme evaluation;

(b) Persistent observation; involved observing participants from the beginning to the end of the health education talks. This enabled the participants to gain confidence and trust in the researcher and discuss without hindrances or fear;



(c) Note taking; Prior to the interviews participants were informed that note taking will be done during the interviews. Note taking was done discreetly to avoid distracting the participants' attentions;

(d) Triangulation of evidence from data sources and methods was used to understand the experiences from different vantage points (see below);

(e) Purposeful sampling of administrators increased in-depth understanding by selecting information-rich experiences from participants who had experience of the programme (Patton 2002);

(f) Reflective journals were kept throughout the fieldwork, and the analysis process helped to keep track of research content and process;

(g) The interview guide was translated from English to local language Runyankore which was understood by parents and younger pupils and back translated into English;

(H) Interview guide was piloted.

Credibility was further enhanced by applying the following procedures:

- peer review and debriefing;
- clarification of researcher bias;
- member checking;
- rich comprehensive description;
- external audit.

The researcher enquired if participants wanted to read through and alter the transcripts to ensure that those texts communicated the accurate views of participants' narrative during the interviews. Eight participants accepted to be contacted and this approach enhanced the authenticity of the information and

constituted what Lincoln and Guba (1985) expressed as member checking. This process provided participant validation of the data. In addition, cross-checking helped the researcher maintain reflexivity by encouraging self-awareness and self-correction.

The researcher employed assistants who were not part of the data collection to listen to the tape recordings and to assess the information and edit transcriptions to make sure that the records communicated accurately what was said during the discussion.

### Confirmability

Confirmability refers to objectivity and implies that the data accurately represent the information that the participants provided (Polit and Beck 2012). The researcher ensured that an audit trail was maintained. Verbatim translations of the interviews were kept. Field notes that included the researcher's reflexivity were maintained. The use of peer and supervisor consultation also helped to ensure confirmability.

### Dependability

Dependability is similar to the concept of reliability in quantitative research. It is the degree to which results are consistent over time for information gathered across researchers (Lincoln and Guba 1985; Miles and Huberman 1994). Dependability was achieved by elaborative description of the methods of data gathering, data analysis and interpretation. It was envisioned that these descriptions would enable other researchers readily to follow the decision trail (Magilvy and Thomas 2009).

Dependability was established with the audit trail which involved maintaining and preserving all transcripts, notes, audiotapes. The provision of the full description of information gathering and analysis methods was provided in order that other researchers could trace (audit) the methods used.

### Transferability

Transferability refers to the possibility of how other researchers in similar circumstances may find meaning in the research findings and be able to apply them in their settings (LoBiondo-Wood and Haber 2010). Transferability was not controllable within this study. However, the community-based nurse education programme has definite potential for use in the wider African health care education field and it presents an interesting model for other, more developed parts of the world.

### Triangulation

Triangulation in its wider context has been defined as the use of multiple methods to investigate the same phenomenon (Jick 1979; Hussein 2009) in order to increase the study's credibility. Creswell and Miller (2000) describe triangulation as, *"a validity procedure where researchers look for convergence among multiple and different sources of information to form themes or categories in a study"* (p.126).

Denzin (2009) further highlighted the four types of triangulation (see table 6 below).

Table 6. Denzin's (2009) description of four types of triangulation

Type of triangulation	Meaning
Data	Multiple sources of data used to obtain different views about a situation in order to validate findings.
Investigator	Two or more skilled researchers are involved in the study
Theoretical	Use of different theoretical interpretations as the framework for study, competing hypotheses are included.
Methodological	Use of two or more research methods.  Across-method: different data collection approaches used in the same study.  Within-method: two or more data collection approaches in the same study.

Based on Denzin's four types of triangulation, this study employed data collection from various sources and methods. Using these multiple methods enabled the researcher to understand the phenomenon of stakeholders' experiences and allowed a degree of triangulation robustness. The method of triangulation employed here is described as 'within method' meaning that two different data collection approaches were used within the qualitative paradigm.

### **Data Analysis**

An inductive content analysis approach (Elo and Kyngäs 2008) was used to generate the categories. According to Elo and Kyngäs (2008) content analysis is a method of analysing written, verbal or visual communication messages. The analysis process of this study was iterative. Yin (2003) four guiding principles for successful high-quality analysis guided this study:

*“(1) attend to all of the evidence, including considering all alternative interpretations and rival hypotheses, thus leaving no loose ends, (2) address all major rival interpretations, (3) focus on the most important issue in the study, and (4) the researcher should use his/her own prior, expert knowledge in the analysis (pp. 111- 115)”.*

### The Analysis Process

Analysis took place in three phases – preparation, organisation and reporting (Elo and Kyngäs 2008). The analysis process started with data preparation. The researcher selected the unit of analysis, considered both manifest and latent content (Burns and Grove 2005; Onwuegbuzie, Dickinson et al. 2009). For instance in latent content, consideration was given to meaning behind; silence, sighs, laughter’s and postures (Burns and Grove 2005).

The audio taped recorded interviews were transcribed verbatim and data were encrypted and stored on a device that was password protected. The researchers’ observational notes and transcribed recordings were interwoven within the transcripts, and different fonts were used so that the researcher’s voice could be clearly distinguished from the participant’s voice in the data. The field notes were used as reference to fill in gaps where the recording was inaudible. Some participants’ voices were faint which could have been obliterated by sound of the pupils playing outside. Such was the challenge of conducting research in participants’ own environment as opposed to conducting research in a laboratory.

The researcher became immersed in the data as she read through several times (see Burnard 1991; Polit and Beck 2004). In addition to reviewing the transcripts from the audio recordings, the researcher re-read the observation notes and the

reflective journal kept during data collection (see appendix 11). This enabled her to make sense of the data as a whole.

This process of transcribing allowed the researcher to become acquainted with the data (Riessman 2008) as well as obtained an overall impression and to capture the ideas and the assumptions of the meanings of the data. The researcher used 'meaning' as the unit of analysis. This meant that the data were not coded sentence by sentence or paragraph by paragraph, but coded for meaning where themes were seen as expressions of the latent content. That is, what the data 'was talking about' (Graneheim and Lundman 2004). This approach allowed identification of convergent and divergent themes. Each unit (idea, sentences, and paragraph) was grouped together with similar thoughts and ideas. The group of ideas were then classified according to main categories.

In the organisation phase the researcher used two approaches to data analysis; computer assisted analysis, using Nvivo 9, combined with manual analysis. The transcripts of the interviews were imported into the Nvivo 9 qualitative software programme. However, the use of the software proved challenging. The time taken slowed down the progress of data analysis. Therefore, the researcher resorted to Webb (1999) suggestion that it was imperative for the researcher to use the method she felt comfortable with in order to gain deeper understanding and the meaning of data. Furthermore, although the utilisation of a particular form of data analysis is entirely dependent on the researcher's comfort with the method, educational and research background; her ability and knowledge is equally important (Webb 1999). The researcher's in-depth understanding of the analytical process before its application was imperative. In the end, manual

analysis was used and which arguably resulted in a better intimacy with the data.

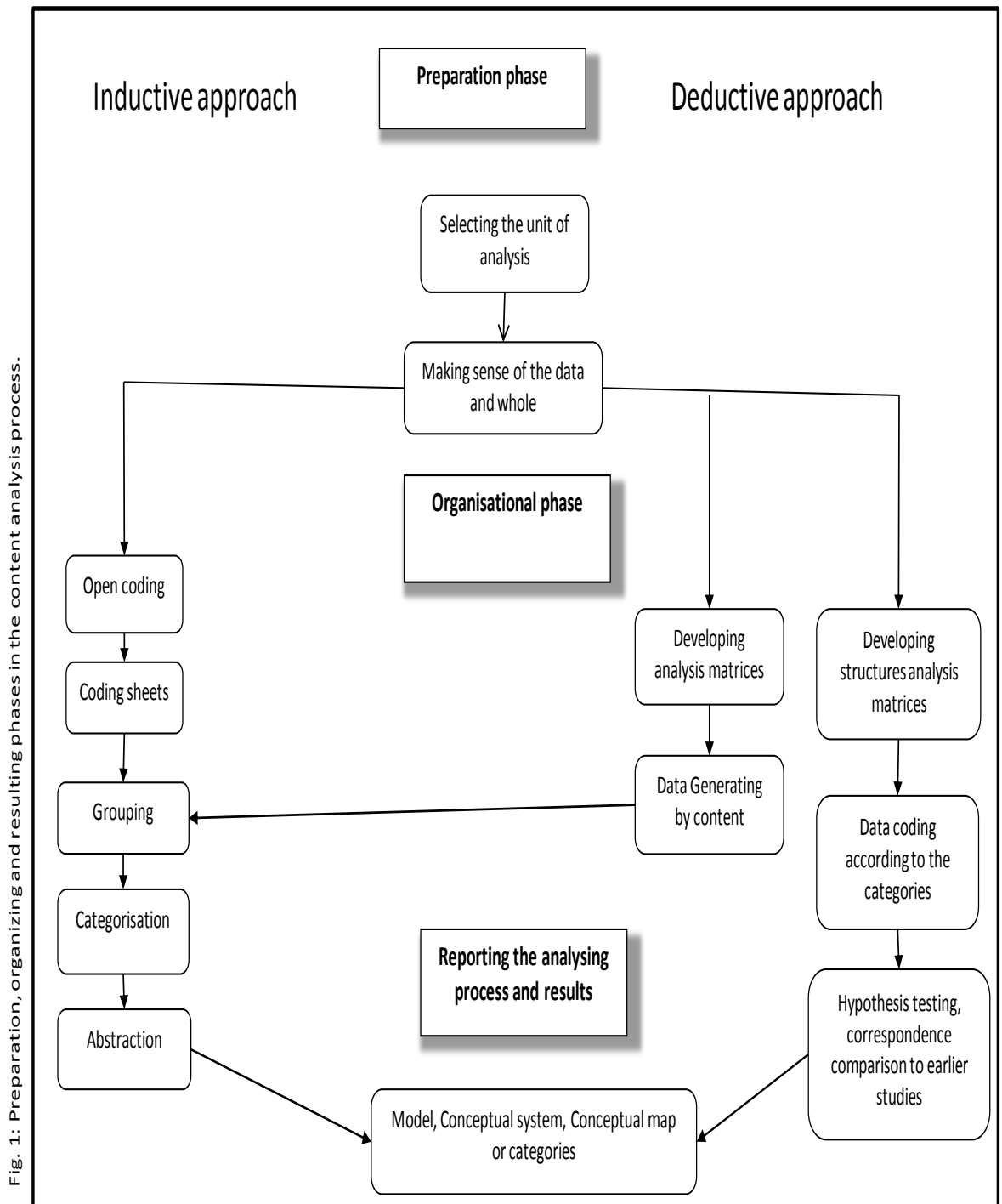
Webb (1999 p. 329) suggests:

*“the best way to come to grips with the joys and pains of analysing qualitative data is to do it oneself the first time as well as document the data analysis process” ( ibid p.329).*

Although manual analysis was time consuming it was nevertheless satisfying, because it kept the researcher focussed, engaged and provided the opportunity to connect, imagine, contextualise and reconstruct the experiences of stakeholders. The exercise facilitated the researcher to mentally dwell and live the worlds of each of the participating stakeholders. The connection with the stakeholders as they narrated their experiences was so strong to the researcher.

The manual analysis process involved creating open coding, categories and abstraction that led to the discovery of meanings expressed by the participants. A process that mirrored that described by Elo and Kyngäs (2008) (See figure 5 below) was used. A code, as described by Schreier (2012) and Graneheim and Lundman (2004) is a label for a meaningful unit which is understood in relation to the context. A category is defined as *“a group of words with similar meaning or connotations”* (Weber 1990 p. 37) and which should be mutually exclusive. Moretti, VanVliet et al. (2011) make it clear that the advantage of qualitative research is the richness of the data gathered, but that this also means that the data requires to be interpreted and coded in a valid as well as in a reliable manner.

Figure 5. Preparation, organising, and result phases in the content analysis process. Adapted from Elo and Kyngäs (2008 p. 110) with permission (see appendix 16-a).





Open coding involved writing notes and headings in the text as the researcher read through them. The scripts were read over and over and numerous headings were noted in the margins describing aspects of the contents Burnard (1991); Hsieh and Shannon (2005). Transcripts were subjected to close scrutiny. At this point, some categories were developed around topics that appeared consistently in interviews; for example, no selfishness, openness, respect, confidence, closeness, removal of fear (Main category: Collectiveness). These were later transferred to a coding sheet and the categories emerged from this phase. The researcher arranged the codes into categories using axial coding, a process of sorting out information to build and recount categories (Strauss and Corbin 1998). The researcher grouped the codes that described the experiences and views of the participants into categories.

Categories were arranged into higher order headings, thus allowing further development of categories into either similar or dissimilar higher order categories (Downe-Wamboldt 1992; Dey 1993). It should be noted that the development of categories did not only involve putting similar observations together but rather classifying similar descriptors as belonging to each other (Dey 1993). In this way, the development of categories provided a better understanding of the phenomena and generated knowledge (Cavanagh 1997). The researcher achieved this through interpretation and being able to arrange categories under headings that were meaningful to the wider data. The meaning of categories and the content of a category were illustrated through subcategories.

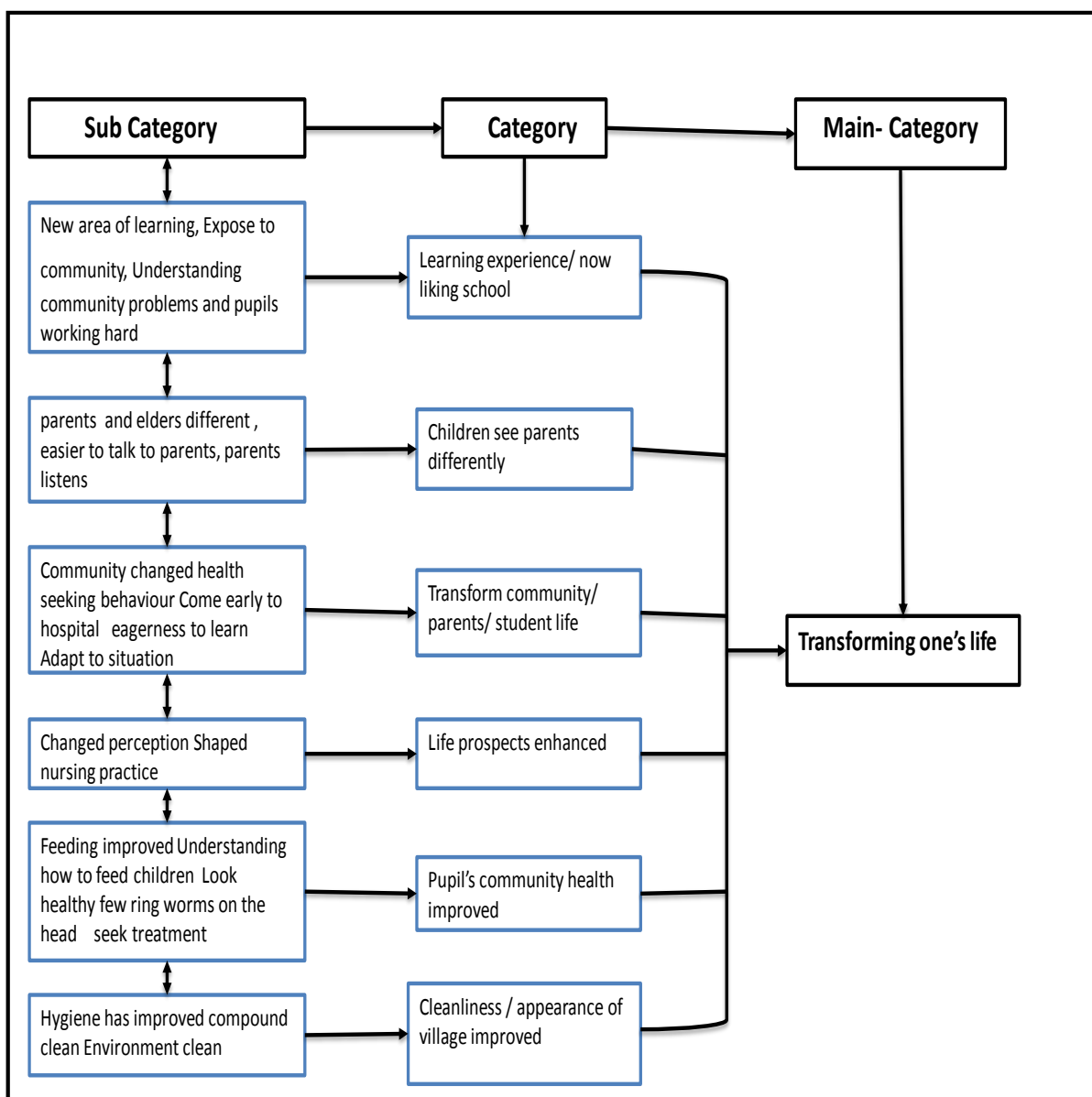
Care was taken not to over-collapse the information as it was noted that over-collapsing qualitative data during analysis could result in losing the aim of

upholding the integrity of narrative information. At the same time just giving synopses with less supporting quotes could lead to the original wealth of the information to become hidden.

Participants who had agreed to be contacted by research assistants were sent copies of their transcript to check whether the categories were an accurate summary of their experiences. In addition to PhD supervisory oversight, a peer debriefer as defined by (Rossman and Rallis 2003) as “intellectual watchdog” and a colleague in the department heading community practice were involved in the validation of the emerging findings. Further, the supervisors read the transcripts and met regularly with the researcher to validate that saturation of the data had been reached.

Main categories were arrived at through abstraction in order to provide a broader picture of participants’ experiences generated through categories (Robson 1993; Burnard 1996; Polit and Beck 2004). For example, a group of content-characteristic sub-categories were grouped together and given a category name. At the same time, sub-categories with similar events and incidents were put together into categories and these were grouped as main categories (Dey 1993; Robson 1993). Below is an example of the process of abstraction and how ‘transforming one’s life was arrived at.

Figure 6. An example of an abstraction process of transforming one's life



Source: current study

Interpretation and assigning meaning to the category was guided by how it related to the contextual issue of participants' experience of the project. The analysis aimed at making sense of the findings in a meaningful and useful manner (Holdford 2008; Elo, Kääriäinen et al. 2014). Specific quotations were used to justify the categories (Schilling 2006) and so that both the data and voices behind

them could be heard (Polit and Beck 2012). It was important to capture the participants' voice validly through an interpretive approach. This was facilitated through self-reflection directed at avoiding a situation where ideas could be forced into the narrative (see Auerbach and Silverstein 2003). LeCompte, Preissle et al. (1993 p. 315) suggest that "*kinds and degrees of truth are held differentially for different audiences and constituencies*". Nevertheless, it was important to ensure that others could at least be able to 'see' where the researcher's interpretation lay in the data.

#### **Summary of chapter four**

In summary, this chapter has discussed the qualitative methodologies employed in unveiling the stakeholders' experiences. A qualitative case study design based on an exploratory, interpretive paradigm was employed to give an account of stakeholders' experiences and views regarding the Community-based nursing education programme in Katete community, Uganda. Ethical issues were described. A pilot study was useful as it helped to enhance the pupils' interview guide.

The study involved the use, both of multiple sources and data collection methods. A range of data collection techniques was employed to enable the study to achieve trustworthiness. These included face-to-face and email interviews, focus group discussions interviews and drawing methods, as well as participants observations and document analysis. Transcripts and other data were analysed to establish an initial coding scheme, and cross-case analysis was conducted to discover patterns and categories that were related to the experiences.

The underlying principles of this study, together with the design and methods, were carefully planned to enable an exhaustive evaluation of the Community-based nursing education programme. A key strength of this study is the range of people from whom data were collected and which included student nurses, administrators and school children. Much effort was made to ensure the study findings were based on an iterative and explorative research process while also ensuring that the study was both trustworthy and robust.

# CHAPTER 5: PRESENTATION OF RESULTS

## Introduction

This chapter discusses the data analysis which was conducted using the content analysis model of Elo and Kyngäs (2008). The chapter is divided into three sections; the demographic characteristics of the participants, discussion of the data categories (key themes) and summary.

The study sample consisted of 71 participants. Data collection was over a period of three months. The result of this study yielded a rich description of stakeholders' positive and negative experiences of the programme. The analysis is presented in the form of main categories, categories and subcategories containing empirical evidence (data units).

## Demographic Characteristic of the Participants

Table 7. A summary of demographic characteristics of participants

- Age, sex and occupation of adult participants

Age of adult participants						
	Teachers	Parents	Nursing students	Faculty staff	FAU staff	Administrators
18-25	1	-	9	-	-	-
26-35	4	3	1	3	-	-
36-45	1	4	-	1	-	1
46-55	4	6	-	4	1	1
56-65	-	2	-	-	2	-
66+	-	2	-	-	1	1
Totals	10	17	10	8	4	3

Sex of adult participants						
	Teachers	Parents	Nursing students	Faculty staff	FAU staff	Administrators
Male	6	7	3	2	1	3
Female	4	10	7	6	3	-
Totals	10	17	10	8	4	3

Occupation of adult (Parents) participants	
Occupation	No.
Business	6
Politics	1
Housewife	4
Catering	1
Retired	5
Total	17

- Age and sex of pupils participants

Age and sex of Pupils			
	No.	Male	Female
Children 6-9 years of age	9	5	4
Children 10-17 years of age	10	4	6
Totals	19	9	10

- Faculty staff and teachers positions

Faculty staff positions		
	MUST Nursing Faculty	FAU
Professor	-	3
Instructor	-	1
Lecturer	4	-
Teaching assistant	4	-
Totals	8	4

Teachers: position	
Teacher	8
Head Teacher	1
Deputy Headmaster	1
Totals	10

A total of 73 participants enrolled in the study. However, two were lost due to unavoidable circumstances and their data was not included. The following data collection methods were employed as shown in table 8 below:



Table 8. Participant category and data collection methods

<b>Data collection methods</b>	
<b>Participant category</b>	<b>Data collection method</b>
University administrators	Face to face interviews
School administrators	Face to face interviews
FAU (US academic staff)	Email interview
Nursing students	Focus group
MUST faculty staff	Focus group
Older pupils	Focus group
Younger pupils	Focus group using drawings
School teachers	Focus group
Parents	Focus group (x2)
Health education sessions	Participant observation (x 2)
Community-based nurse education programme	Document analysis (x 7)

Credibility of findings in this study was achieved as discussed in chapter 4 and triangulation of data sources and methods of data collection as discussed in table 9 below. This allowed the discovery of convergent and divergent categories between methods and sources.

Table 9. Triangulation between data source and collection method

Data Source	Data collection methods	Main Categories						
		Collectiveness	Involvement/ Participating	Communicating	Roll modelling	Gaining Confidence	Bridging the gap	Transforming one's life.
Pupils in the upper class	FGD	x	x	x	x	x	x	x
Pupils in the lower class	FGD (Drawing method)	x	x	x	x	x	x	x
Teachers	FGD	x	x	x	x	x	x	x
parents I	FGD	x	x	x	x	x	x	x
parents II	FGD	x	x	x	x	x	x	x
School administrator	Interview F- 2- F	x	x	x	-----	-----	-----	-----
Nursing Students	FGD	x	x	x	x	x	x	x
Faculty, Nursing (MUST)	FGD	x	x	x	x	x	x	x
FAU ( Faculty, nursing)	Internet interview	x	x	x	----	----	----	x
University administrators	Interview F- 2- F	x	x	x	-----	-----	x	-----
Participant Observation		x	x	x	x	x	-----	-----
Document Analysis		x	x	x	----	x	x	-----

In the above table, three main categories; collectivism, involvement / participating and communicating cut across all data sources and methods.

Table 10. The number of participants and each one's experiences of each main category

Experiences	Number of Participants in each group, their code and number and their experiences of each main categories									
Main categories	NS (1-10) (n=10)	FN (1-8) n=8	UA (1,3) (n= 2)	FAU ( 1-4) (n=4)	UP (1-10) (n=10)	LP (1-9) (n= 9)	PPI (1-10) (n=10)	PP II (1-7) ( n=7)	PT (1-10) (n=10)	SA (2) (n=1)
Collectiveness	1,2,3,4 ,5,7,8, 9, 10	1,2,3,4, 5,6,8	1,3	1,2,3,4	1,2,3,4,5, 6,7,8,9, 10	7,8	1,2,3,4, 7,8,9, 10	1,2,4,6,7	1,2,3,4, 5,6,7,8, 10,	2
Involving/ participating	1,2,3,4 ,6,7,9, 10,	1,2,3,4, 5,6,7,8,	1,3,	1,2,4	2,3,5,6,8, 9,10	1,2,3,6,7, 9	2,3,4,5, 6,10	6, 7	2,3,5, 8,9, 10	2
Communicating	1,2,3,4 ,5,6,7, 8,9,10	1,3,5,6, 7	1		3,5	2,8	1,2,8	2,3	3,5,6, 10	2
Acting as role model	1,5,6, 10	2,3,5,6, 7,			3,5,6,7, 10	7,9	8,6	2	8,10	
Gaining confidence	1,2,3,4 ,7,8,9, 10	1,2,4,5, 6,8			3,5,7	8	4	2	2,7,9	
Bridging the gap	1,3,6	2,3,4,6, 7,8	1,3		1,8	8,9		1,4	2,3,4, 10	
Transforming one's life.	1,2,3,4 ,5,6,7, 8,9,10	1,2,3,4, 5,6,7,8		3,4	1,2,3,4,5, 7,9	2,3,5	1,2,3,4, 5,6,7,9, 10	3,4	1,2,3,7, 8,10	

**Key: Participants' code and the number in each group.**

Nursing students (NS= 1 - 10)

Faculty Nursing MUST (FN= 1 - 8)

University Administrator (UA= 1, 3)

Florida Atlantic University participants (FAU= 1 – 4)

Upper pupils (UP= 1-10)

Lower Pupils (LP= 1-9)

Parent Participants I (PPI = 10)

Parent Participant II (PPII-7)

Participant Teachers (PT= 10)

School Administrator (SA= 2)

## Responses from the participants

After reading participants' transcripts, they were subjected to 'content analysis' whereby each unit (idea, concept etc.) was grouped together with similar thoughts and ideas. This process resulted in the development of seven main categories, each with a number of sub-categories (see table 11 below).

Table 11. Main category and categories

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Learning/Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

The main categories were derived from the data as described in table 12 and 13 below.

Table 12 and 13 below both show examples of how ‘gaining confidence’ by nursing students was arrived at by the researcher. Every word in the text was synthesised carefully considering its meaning and relevance to the stakeholders’ programme experiences.

Table 12. An example of category flow chart

Participant	Main category	Sub category	Subcategory	Researchers notes
	Gaining Confidence	Community exposure experience	Utilisation of prior knowledge experience	
FGD NS 10	Overcoming fear/ shyness talking in public and practicing with confident	“Yeah, for me in this programme I have gained confidence to give health promotion and education talk. I use to fear talking in public, but through this programme I have acquired experience, ah, I can approach any home and educate them”	“Aah, I have become confident with the care of patient, I respond to their concerns with confidence which was not the case before I was introduced to this programme”	Gained confidence through community exposure and started teaching parents. Community after overcoming fears. As well as building on their prior knowledge to practice with confidence.

Table 13. Second example of category flow chart

Participant	Main category	Sub category	Subcategory	Researchers notes
	Gaining Confidence	Community exposure experience	Utilisation of prior knowledge experience	
FGD FN 2	Prior knowledge, practice without fear and teaching medical students	“I have noticed that because of their prior knowledge, ah, they had in the community, they come with confidence and they practice without fear. Discuss the patient nursing care and come up with clear nursing concerns and develop the plan of care...”	“Ah, our students when they are with medical students, mmm they are the one on the lead, ah, guiding the medical students because of their prior knowledge, talk with confidence as they teach them. Mmm this makes me feel proud of our nursing students and profession at large. I am happy seeing that we are the one in the lead guiding other professionals, ah we have a cause to be proud of ourselves as nurses”	Gained confidence due to prior knowledge, practising without fear, teaching and leading medical students.

The tables 12 and 13 above illustrate how categories were derived from all interviews conducted. Data analysis was not linear, but iterative, the process continued until stakeholders experiences were captured, while retaining their voices in their language. The abstraction led to the creation of the community nursing education model as illustrated in chapter 3.

Data collection was both in English and the local language ‘Runyakore’. Since English was the second language of the participants, some quotations were not

grammatically correct and have not been amended. Furthermore, American English was not edited.

Table 14. Participants codes used in this chapter.

Participant	Code
Pupils in the upper class	UP
Pupils in the lower class	LP
Teachers	PT
parents	PP(I)
parents	PP(II)
School administrator	SA
Nursing Students	NS
Faculty, Nursing (MUST)	FN
FAU ( Faculty, nursing)	FA
University administrators	UA

## MAIN CATEGORY 1: COLLECTIVISM

Table 15. Collectivism

The main category 'collectivism' emerged from 4 categories. This category of collectivism integrated with other main categories.

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

Participants' experience of collectivism emerged from the Ubuntu values of connectedness, respect, sharing and compassion. Participants felt that respect resulted from mutual trust that led to teamwork and that there was caring in the programme. Participants felt that sharing of information and knowledge contributed to the learning of students and the wider community as well as leading



to a circle of friendship as they started networking together. Further, the experience of collectivism resulted in compassion towards others. The participants' nature of collectivistic culture was clearly integrated into their experience and was seen in the meaning of the underlying value system of Ubuntu. Through this collective mind-set, equality among stakeholders developed because there was a sense of belonging to a bigger whole, the Community-Based Nurse Education Programme.

### Connectedness

The experience of connectedness in the programme led to cohesion that contributed to collaboration and partnership. It enhanced a spirit of solidarity amongst the stakeholders towards the achievement of the programme goals as claimed by FA participants, that the programme had been successful.

*My experience with the Community-based nurse education programme has been one of awe. The participation of the University and the teachers towards the success of the Nursing Center has been magnanimous. Program established continue to provide the needed experience of the studentry, at the same time provide the needed health care for the pupils, their parents and the community in general (FA, 1).*

Connectedness was experienced by teachers, parents nursing students, faculty nursing, FA faculty, and administrators. Participants claimed that it arose from appropriate planning, consultative meetings, sensitisation, transparency and involvement of the politicians as well as being regarded as equal partners' pupils inclusive.

Proper planning of this programme was considered essential from its inception. Success could not have been possible without gaining trust of the stakeholders. Therefore, participants claimed that the step by step approach of implementation was important as it allowed clarification of queries at every stage of planning, thus facilitating mutual understanding contributing to the involvement of stakeholders and acceptance of the programme.

*The process of implementation was very good as all stakeholders were involved from the very beginning and the programme was accepted by the community (FGD FN, 7).*

*.....ah they understood the nature of the programme.... (SA, 2).*

*The pupils and community actively got involved in the activities of the programme like maintaining cleanliness of the environment and personal hygiene (FGD NS, 10).*

Through planning, each stakeholder became committed towards contributing to the success of the programme as noted by the FA faculty in the statement below.

*It was implemented using funds provided by Fulbright Alumni Initiative Awards. The contribution of the primary school was allocating one classroom as the physical set-up of the center (FA, 1).*

*.... commitment of MUST to sustain the project.... (FA, 1, 2).*

Consultative meetings enabled participants to understand the programme and its objectives. Sensitising the community and consulting them contributed to their appreciation of how much their views were valued.

*Sensitisation through participatory meetings clarifying issues and they became partners in this wonderful programme... (FGD, FN, 8)*

The university administrators felt that, because this programme was beneficial to the learning of the nursing students in the community they had to participate actively. They got involved in sensitising relevant stakeholders of its benefits in order to gain their trust.

*Accepted the programme as it was very beneficial to the teaching of the students and within the University philosophy of community based. It would facilitate learning of our nursing students in the community. It will also help the community to be able to take care of themselves living and remaining healthy (UA, 3, 1).*

*[A smile! and putting both hands together!]. As an administrator I have been involved in promoting Katete programme (UA, 3).*

Through sensitisation, parents welcomed the programme and appreciated the importance of having a practicum site for the nursing students as noted in these excerpts below. The community of Katete realised that if students were to become good practitioners in the future, they needed to practice and this could only be possible where there was a practicum site.

*They approached the management of this school, requested if they could come and exercise their talents, experiment and even participate in the nursing of our children, mm, because they lacked experience we thought it right. Um.., you see to have good nurses in future; they must have a practice place to their practical (FGD PPI, 7).*

*Uh.., i have been in this programme since inception in the year 2004, ah, that time I was the chairman management committee of this school (FGD PPI, 1).*

Transparency contributed to teamwork through partnership and collaboration. Transparency from the beginning of this programme led to trust and promoted participants' involvement. Furthermore, it culminated in the development of cooperation and the signing of a Memorandum of Understanding (MoU) between the university and the Municipal Primary Education Officer.

*The programme was launched officially in the presence of all the stakeholders. This was a big occasion here in our school (FGD PT, 8).*

*...signed memorandum of understanding putting things right (FGD FN, 8).*

*...I signed the MoU (SA, 2).*

Importantly, the school administrator highlighted that the programme was not forced on people; they freely accepted and welcomed it after understanding its purpose.

*...the programme..... was not forced on people, ah, people willingly accepted it because they understood the programme objectives very well right from the very beginning (SA, 2).*

Participant (teachers) felt that being respected and consulted as equal partners promoted their cooperation. They claimed that this was unlike other community programmes, where people were not usually consulted. This was in compliance with Ubuntu, involving the community in all aspects of the programme. Also, students claimed that the community and pupils felt happy and accepted the programme:

*We feel we are partners, respected. University came here to seek our ideas, this is important even our pupils were asked in regards to this programme. We are happy and we have trust in this programme because some programmes they just bring it and they do not consult people (FGD PT, 3).*

In addition, the University, and the two primary schools ensured that their planned curricula were not interrupted as a result of the presence of the programme. Both primary schools had equal opportunity to participate actively. Understanding the programme objectives made them appreciate their importance as well as being beneficiaries of the programme. Thus, avoiding any form of expectation outside the programme objectives.

*...the programme was understood right from the very beginning ... to avoid a lot of expectation and demands from community (FA, 3, 4).*

However, the expectations of some participants were misplaced, probably due to the challenges of translating some of the English words into the vernacular. Therefore, programme objectives may have been misinterpreted by some community members. Consequently, some of the community members expected a well-equipped and functioning hospital in the school.

*At the beginning of this programme raised many expectations, simply because it was not well understood by some community members. There*

*was a problem in translating the wellness centre in local vernacular. They would say, the University is bringing us a hospital (FGD FN, 6).*

Confusion about the purpose of the project was perhaps most acute in homes where there were grandparents, orphans and child-headed families. They claimed that they were anticipating material support, such as food, drugs, monetary assistance, and mosquito nets. This was further supported by students who felt that better sensitisation of the community regarding the programme objectives could have overcome such expectations.

*Some homes are expectant, have multiple problems. Aah... , some do not have food, where orphans are the head of the family or very old grandparents staying with siblings, no clothing (FGD FN, 5).*

*I think the community should be sensitized about our objectives so that they know what our purpose is; so that they don't have high expectation of material gains (FGD NS, 10).*

Participants felt that the involvement of political leaders in this programme acted as '*enabling agents*'. Their presence paved the way for sharing information even on issues not related to disease prevention. The community took advantage of the programme and their involvement to put their challenges before politicians for consideration. Therefore, unless 'political will' was present it was highly unlikely that programme activities such as community-based nurse education programme could be sustained. Political support was crucial in enabling the continuity and ensuring the programme achieved its intended goals. The community valued the presence of politicians amongst them as claimed:

*Aah..., involving the politician made the community known and voiced out their problems, and they promised to address their concern" (FGD FN, 1).*

*"Hmm, inviting the politicians so that they can learn and know the benefits of this programme, and also what is happening in the community. Hm..., that way the municipality council can include programme activities in their annual budget (UA, 3).*

Furthermore, participants felt that the presence of politicians among the community at the launching of the programme was appreciated and promoted community participation as claimed;

*“There was also involvement of political leaders on that day right from the local council one (LC 1)” (FGD PT, 2).*

Nursing students felt that engaging and having partnership with the community leaders enhanced programme success as noted in their excerpts:

*Ooh, good working relationship with the community leaders is a key success of this programme (FGD NS, 10).*

However, some participants were cautious of the support offered by politicians:

*Aah, the mayor and the area Member of Parliament (MP) had promised, but the promises are in words not action. As soon as the MoU was signed, It was hoped that municipality would be kind enough to provide some funding for the project activities, so that this programme which is a pilot could be spread to other primary school and community in municipality but the politician were willing in spirit, but when they praise a good programme like this: they do not budget for such programme activities in practice and this is very sad (UA 1, 3)*

### Respect

Respect was another experience felt by the participants; it arose from the fact that everyone was consulted including the Ministry of Education prior to the implementation of the programme in the school and community. Consultation with elders offered a sense of respect, caring and contributed to partnership. In addition, a sense of mutual trust created a friendly working environment that promoted teamwork.

Involving the views of everyone was in line with Ubuntu values and a sign of respect as noted in the excerpts below;

*From the time of inception we consulted the Ministry of Education in municipality for advice on the rightful school. They participated in planning*

*which was in phases and this was understandable by the stakeholders and they accepted and own it (FGD FN, 8).*

*Oh, the programme was implemented in such a way that all the stakeholders were consulted before it was implemented and they all agreed and welcomed the idea (FGD PT, 8).*

*I think all the stakeholders' opinion was consulted to ensure that the programme was understood right from the very beginning to ensure that they own... (FA, 3).*

Respect contributed to the community's commitment to participate in the programme signifying a desire to lead a healthy life style and learn disease prevention. Therefore the support of the elders, the university and the schools was influential in the programme's implementation, and which led to the achievement of trust:

*The program was implemented with community support and reflects the community's desire to have a wellness centre at the primary school. Community support included local elder input, the university administration support, primary school administration support and the school of nursing support for innovative education community in nursing (FA, 2).*

In addition, parents felt that nurses treated them with respect and were thus convinced that a good level of cooperation existed.

*Um, the nurse has been very cooperative and very good to us. The nurse treats us with respect and motherly love, mm..., she attends to us here and visits us in our home (FGD PPII, 4).*

Teachers' development of mutual trust in the programme led them to welcome it in their schools and actively participate. Consequently, teachers and the community took further responsibility for providing security for the programme materials housed in one of the classroom blocks. They also ensured that the area surrounding the block was kept clean. This was an indication that they co-owned

the programme with the university as reflected in their narratives, “*this programme is part of us*” (FGD PT, 6). In addition, Faculty of Nursing agreed with the teachers that the programme was valued and it had been owned. Hence, there was trust.

*The project was welcomed, we expect the project to continue and expand. This programme is good and it is teaching us a lot* (FGD PT, 5).

*Aah, we clean around the area (wellness centre)* (FGD PT, 6).

*The community values the project no doubt about that, aah, when we get to the community we are very much welcomed and the sharing of information is very easy. Hmm, there is trust by the community about the project and they have owned it, ah, evidenced by providing a security guard for wellness centre. Hm..., taking care of materials housed there. Mm..., even when we invite them the turn up is very good* (FGD FN, 3).

Furthermore, collaborative experience promoted a caring and friendly environment which enhanced students learning and community entrance. Faculty staff claimed that they had created a partnership with the community and the stakeholders. As such, it was easier to penetrate the community. The development of partnership was echoed by the university administrators, teachers, the community and FA faculty. This partnership led to a favourable learning environment that helped the students acquire good practical skills. Furthermore, the proximity of the practicum site to MUST offered a good learning environment, as well as enabling frequent visits.

*We have developed partnership with the community and our colleagues in other universities and the communities* (FGD FN, 6).

*Hmm..., when visitors come to visit the programme it creates international collaborations* (FGD FN, 2).

*We work in closely with the department of nursing in various activities of this programme* (Annual report Katete primary school 11<sup>th</sup> November 2006).



Students noted that it was much easier to work as a team in the community because the discussion and the care were based on situations at hand. This made it easier to focus the health promotion and education talks and advice on the community. Consequently, the community participated in the discussions and decisions on the best possible approach. In contrast, students felt that in hospital-based care, advising clients or patients without knowing their financial means was not only frustrating to the students but also to the clients or patients.

*Ah, it was different in the community, ah, because you discussed with the members and they came up with solution to their problems. This was a nice experience for me. Hmm.., it is much easier in the community than in hospital to work together (FGD NS, 7).*

Furthermore, students felt that their weekly activities during their community placements motivated the community members to participate in the programme and to put into practice what they had learnt during health promotion and education talks. They considered the nursing students as good educators who were in the community for a good cause: to care, to educate and to ensure that they lived healthy life styles thus promoting the shared value of Ubuntu.

*People in the community, see this students going there every week, they feel motivated. They are encouraged to practice disease prevention and know the students are there to care and educate and help them. This encourages them to follow the teaching they have received and put into practice (FGD NS, 4).*

*Um, the nursing students are very cooperative and very good to us (FGD PPI, 4).*

This collective mind-set and interconnectedness among participants facilitated the development of solidarity and they saw stakeholders accepting the programme. Parents felt that the programme was beneficial. Parents supported the idea of one classroom block being utilised for programme activities. Gaining the trust of the parents and the community was an important factor in increasing their involvement at the very beginning.

*Hmm..., we accepted the project and also we agreed that one of the classroom to be used. Aah.., this is because we love our children (FGD PPII, 1, 7; PPI: 3, 4).*

It may be worth noting that although parents were excited and accepted the programme, they had some doubts regarding the extent of the programme. However, some parents stated that they were surprised that the programme turned out to be very useful in teaching them and their children. This uncertainty could have indicated an initial lack of clarity about the programme objectives, especially as this was a new initiative; it appeared some community members were sceptical of the entire programme.

*Um, when they started we thought it would be a simple practical, ah, but it turned out to be a very useful programme to our children, besides being a practical exercise. It is very useful to these schools and the children learn how to protect themselves, ah, they learn measures to take to avoid contracting diseases, and gain other experiences offered by nursing students (FGD PPI, 4).*

#### Sharing of information and knowledge.

Participants felt that gaining access to the community was the cornerstone for the dissemination of information. The sharing was from University to communities, and between stakeholders.

Participants claimed that the teaching they got from the University students resulted in them gaining knowledge; it was also seen to raise their awareness of the programme, promote collaboration and lead to global networking. The process facilitated the university's fulfilment of its community-based philosophy of educating and meeting the community's health need through education and empowering the community and primary school children. Through practical experience and learning in the community, the university's philosophy was implemented.

*Ok, the implementation of this programme followed the University philosophy of the community based education (UA, 1).*

*The programme has done a lot in educating and creating awareness among teachers, pupils, parents and the entire community about disease prevention and living healthy lifestyle (Annual Report from St. Mary's primary school 14th December 2009).*

University sharing with the community resulted in a close collaboration and partnership as noted by parents, pupils and nursing students. Engaging collaboration were critical factors to the success of any programme in changing behaviour. This motivated and empowered the community to live a healthy lifestyle and addressed health related issues within the community (Bruce and MacKane 2000).

*Aah..., we have developed partners with the University the students come and teach us and our children to remain healthy (FGD PP11, 6).*

*Eeh, I also realised that this programme created a good working relationship between the students, lecturer and community (FGD NS, 9).*

Parents claimed that they were able to acquire knowledge from the University educating them because the university; “*come down to our level to teach us*” (FGD PP1). They appreciated and realised that apart from educating, the university is also a place where friendly people promoted community health through sharing knowledge.

*The University is not only academic place. Mm..., but also people who are friendly, (FGD PPI, 1).*

*Ah, this programme has helped us, is educative, not only we here at the school but also the community at large (FGD PPI, 1, 2, 4).*

The programme helped nursing students to learn essential skills in a systematic manner through the guidance and supervisory role of their lecturers. Nursing students were learning and were able to identify real problems and advise the community on problem solving; as they worked together with the faculty.

*We students get the knowledge from our lecturers and we get better and better in our skills. Mmm..., our practice was good for example the way I would do health assessment was very systematic (FGD NS, 1).*

*Yes, the nursing lecturers also participate in supervising the nursing students and of course passing on information and skills to the primary teachers as well (UA, 1).*

Nursing students met pupils who came from a variety of family backgrounds, and were able to provide health promotion and educate them. As a result, health information reached a wider community in the shortest possible time. Nursing students, FA, pupils, teachers, parents, and school administrator participants also highlighted the same. One participant from FAU further noted that, this was the “*best possible implementation of the community-based theoretical nursing perspective*” (FA, 1) in which the pupils were the initial beneficiaries of the programme, who in turn provided education to their parents who often could not attend and participate in community projects because they had to be out in the fields. This was supporting the “we” rather than “I” in Ubuntu values through sharing.

*The students educate the children, the children come and tell us and educate us. Mm..., we also share with our others in the community us (FGD PP II, 6).*

*...parents have not been to school ... ask their children what they learned in school and become the opportunity for the children to teach their parents the various health care programs (FA, 1).*

The students claimed that through working with community members, they understood the community’s concerns, educated them about problem prioritisation and disease prevention. Students learned and understood the challenges that faced parents, the communities and patients in the hospitals through shared experience.

*We benefited a lot, as we shared information with the communities when we talked to them (FGD NS, 9, 4).*

*... nursing students benefit other than staying in the university or in the hospital mm, by going out to see environment in the community and how people live and behave (FGD PPII, 2).*

In addition, students felt that the sharing of information could include “*annual feedback*” on the progress of the programme objectives as it could enrich the stakeholders’ knowledge regarding the development of the programme.

*It would be greater motivation to the users by equipping them with more knowledge and information, regarding how the programme is progressing through annual feedback on the activities and the objectives of the programme, ah..., whether the programme is achieving its goals (FGD NS, 7).*

Younger pupils felt that not only did nursing students provide education on personal hygiene but that they also cared for them. The child participants drew pictures of flowers for the student nurses. These drawings, according to the participants, signified happiness and appreciation of what the nursing students taught and shared with them. Caring and offering a gift relates to the Ubuntu value for compassion. The significance of yellow flowers symbolised the enlightenment the programme had brought to the participants. In addition, flowers symbolised their friendship with nurses (see figure 7 below).

Figure 7. Pupils experience of sharing (Crayons on Paper- 8 Years old)



Source: Authors' Photograph of the of Pupils' Drawings in FGD LP 7 (2010)

*The nurses have taught us to look after ourselves. Ah..., so I am giving the nursing students flowers for teaching us and giving us treatment when we are sick (FGD LP, 7).*

Older pupils stated that nursing students taught them to prevent diseases, keep personal hygiene, eat a well-balanced diet, to use mosquito nets and keep the environment sanitised (as discussed in the main category being involved and participating in the subcategory learning and achievement; also in the main category transformation of one's life under subcategory pupils and community healthy). Pupils mentioned the names of green vegetables in the local language. Their scientific agricultural names according to Food and Agriculture Organisation of the United Nations (FAO) were added for the purpose of understanding. Literature indicates that there are over 600 species of local vegetables in Uganda (Goode 1989; Ssekabembe, Bukenya et al. 2003; Musinguzi, Kikafunda et al. 2006).

*When the University students come here and teach us, ah, i also get the knowledge from them by attending the health education talks, I learnt personal hygiene (FGD UP, 1, 4, 10).*

*Learnt about prevention of diseases like malaria, AIDS, mmm, I learnt how to prevent malaria, ah, to sleep under mosquito nets, slashing bushes around the home, mm, removing broken bottles around the homes and draining stagnant water around the home and to close our windows / doors early ( FGD UP, 7, 5,10).*

*Hmmm, they helped us promote sanitation (FGD UP, 9).*

*I have learnt the importance of feeding on balanced diet, ah, like eating beans, meat, milk, potatoes, peas,, banana plantain, fruits and green vegetables, mmm, “ like Dodo”, (the agricultural name : “Amaranthus dubious”) “Nakati” (“Solanum aethiopicum”) “Entula” or egg plants (“Solanum gilo”) and “Katunkuma” ( “Solanum indicum subsp. Disticum”) ( FGD UP, 8).*

Despite the learning and sharing that was taking place among students and the pupils, the pupils felt that the contact time given was insufficient. They further highlighted that sometimes; student nurses came late and rushed through their talks. This could have left pupils without clear understanding of substantive issues under discussion. Teachers also felt that weekends could be utilised so that valuable time was spent together.

*Giving nursing students more time like 3 hours to teach us, mm, this will be enough time. Hah, at times they rush through some topics, um, they come late also (FGD UP, 3).*

*Time for being with pupils is limited they too need more time than expected, even weekends can be utilized so that we could have longer hours together. Like when we had a nutritional day we had the all day and that had a big impact on the community (FGD PT, 1).*

Through sharing, teachers claimed they learnt to socialise with health professionals; as a result this promoted their learning and enabled them to improve their teaching. They felt the sharing experience made their teaching easier and that the knowledge they gained assisted them in providing better education. This was in subject areas where they perceived themselves as having a knowledge deficit (as discussed in the main category being involved and participating under achievements).

*... we talk freely and exchange ideas. ... we learnt a lot and when it comes to teaching we find our work much easier as we can explain as well as giving examples (FGD PT, 4).*

*In my profession, it has helped me in teaching; and the pupils learn things which I would not have explained any better (FGD PT, 5).*

Furthermore, teachers reinforced their beliefs that better learning occurred when pupils acquired knowledge from different sources [nursing students]. They further claimed that the pupils had learnt to socialise with others who came into their schools

Hmm, pupils understand it better when they have different teachers, mm, it helps them to understand, to apply the science, ah, and to know what to do with their health (FGD PT, 6, 1).

*This programme has helped our pupils to interact with people, in class they are only used to the teachers, mm, but when other people come they interact so well (FGD PT, 5).*

Teachers' claimed that the value of accurate information or knowledge was better than "*being given medicine*" as they stated. Without knowledge, problems could reoccur.

I feel "*obwengye nibukira omubasi*" ("knowledge is better than medicine") " mm..., medicine may not be enough, but when somebody gives you the brain (knowledge)" it is better (FGD PT, 6, 1).



Parents affirmed that the nursing students educated them about the causes and prevention of diseases and this resulted in enhancing their understanding, as well as on how to care for their children. The knowledge gained made it easier for them to care for their sick children appropriately and followed the advice. Parents also felt that nursing students “*loved their children and taught them.*” This promoted partnership in caring and sharing of health related information.

*... A parent would be invited here by nurse and told about the child's sickness. Hm, she even teach the parents about that condition so that she understand the disease and how to take care of the child at home, ah, like giving plenty of fluids, mm, to sponge the child with luke warm water if the fever is high. She not only teaches the pupils, but the parent as well (FGD PPI, 9 Translated).*

Therefore, promoting partnerships in caring was the cornerstone that strengthened the health outcomes of the community and patients (Jonsdottir, Litchfield et al. 2003). The partnership process is regarded as the central point of the discipline of nursing, which, according to Newman, Sime et al. (1991), is further considered as ‘caring in the human health experience’. Partnership promoted openness and sharing among stakeholders. Furthermore, parents stated that nurses visited and educated them in their homes. This enabled them to become more responsible. They also advocated for more “*health education talks*” (FGD PPI, 10).

*Ah, the nursing students have been visiting our homes and educate us and as parents we are happy and we feel we have become responsible for our own health (FGD PPI, 10).*

Although parents were happy regarding nursing students visiting their homes, it seemed that initially, some community members were surprised by this. Parents stated that they thought nurses were only stationed in hospitals. Parents felt humbled by the student nurses’ visits. Parents ‘opened up’ and were able to share freely and ask questions. This further promoted partnership value and mutual learning.

*Aah..., in those homes where we visited, the community were surprised to see nurses come down to their homes, at first I remember one saying “I thought nurses only work in hospitals, but we are very happy that you have come into our homes (FGD NS, 9).*

*Everyone in the community seems happy. Eh..., who knew a nurse could come and sit in your home irrespective of the type of house, educate you happily and you ask as many questions as you can? Aah..., to me this is a big change I have seen (FGD PP II, 4).*

The University faculty administrator felt that students going to people's homes would cause problems because of the variation in social class. There was concern that the students' visits would be greeted with suspicion. However, Ubuntu crosses class borders and welcomes everyone, whatever their social status, no-one is a stranger.

*Hm..., they are not as educated as them or never went to school completely. So this makes them have the inferiority complex. They will always suspect you to want to see how poor they are, ah..., basically they feel uncomfortable having people intrude their environment (UA, 1).*

In practice, parents expressed happiness at the length of time nursing students spent with them in their homes. There was a discourse [sharing] and trust. The privacy of the familiar home environment, facilitated families to 'open up' and share ideas. In addition, sharing allowed myths and fears to be dispelled.

*Eh..., this programme is good as we would discuss with mothers and allay their fears and myths about some services like family planning. We spend enough time with each family unlike in the hospital. Hm..., you do not have enough time to sit and discuss everything with the patient (FGD NS, 5).*

Furthermore, parents claimed that the knowledge gained enabled them to go to hospital immediately in the case of sickness, and they used health services, such as counselling.

*Um...., we use not go to hospital immediately we are sick, ah, but now, we don't wait until we are not well, we go early for treatment straight away ( FGD PPI, 2).*

*Oh, we have been coming here to share with the nurse problems we are facing like when we get problems with family planning methods. Ah, we don't only come when we are sick (FGD PPI, 9 Translated).*

Pupils claimed that the programme enabled them to gain from the sharing with parents and grandparents, pupils and other siblings as well as interacting with the wider community (as discussed in main category of developing/ gaining confidence under pupils talking to parents). Other participants supported the practice of sharing, and parents firmly acknowledged the interaction between them and their children. In addition, there was evidence in the document analysis reports from the schools.

*Using the pupils as change agents of their community is a magnificent way to go (FA, 2).*

*I am teaching my parents how to keep our compound clean (FGD LP, 8).*

*I have been taking information to my parents, aah.., I have been telling them to go for treatment when sick (FGD UP, 2, 6).*

*Inform our people in the village to improve on sanitation in order to control certain diseases, ah, like cholera and some other diseases are dangerous to us, to drink boiled water and to cook food (FGD UP, 1, 3).*

*When I am taught about sanitation... teach the same to my parents, mm, also ... personal hygiene (FGD UP, 10).*

Pupils' teaching of their parents was an achievement for this programme. In African traditional culture, children only listen to their parents (Ryan et al. 2010; Lwanga, 2004). Parents also confirmed that they were implementing what they learnt from their children. Such as hand washing, disease prevention, and maintenance of good personal hygiene. These were crucial disease prevention

strategies for the individual and the community. For instance, when one had good health this would better defend them from infections:

*The children teach us and I have learnt a lot from this young girl of mine especially disease prevention, mm, sleeping under mosquito nets and so on (FGD PPI, 4, 9).*

The pupils further claimed to have been educating the community members regarding breastfeeding the babies; this is not only important to the baby, but also to the mother. Lactation Amenorrhoea (LAM) is a form of natural family planning (Vekemans 1997) which rests on the idea that as long as women breastfeed, they are less likely to have another pregnancy. Breast-feeding inhibits ovulation and therefore, the woman are less likely to conceive. Its effectiveness is approximately 98% (Vekemans 1997), comparing favourably with other contraceptive methods.

*Huh..., for me there are people in the community I have told to breast feed their babies, um, when the baby breast feed, ah..., the baby breast feed on balanced diet, and also breastfeeding helps the mother to prevent unwanted pregnancy and acts as family planning (FGD UP, 8).*

Another area of importance was the pupils' work to educate the community on the importance of childhood immunisations. As stated by one participant:

*This programme has helped me to teach our community to take the children for immunization (FGD UP, 3).*

Children also taught and advised their siblings and other pupils who did not have this programme in their schools; for example on the importance of personal hygiene, daily bathing, keeping their body clean, daily oral hygiene (brushing teeth), and disease prevention:

*I also teach the young ones at home, how to use the toilets. Other pupils who do not have this programme in their school, ah..., I teach them what I have learnt like personal hygiene, ah, to bath daily. I also teach them to be*

*responsible and prevent diseases, and brush their teeth every day... (FGD UP, 5).*

*Oh, I have learnt to advice my friends on healthy habits, ah, like hand washing, hmm, not to drink water which is not boiled, ah, taking alcohol or smoking. Hmm, not to walk alone in the night, mm, they can get raped and get infected with HIV (FGD UP, 4).*

Pupils also felt the need to have a joint health education talk with their parents so that the parents would appreciate what they had tried to teach them. This could also act as a way to reinforcing health information in case of forgetfulness.

*Putting us together with our parents during these talks so that we learn together would be good. I think they will appreciate the messages we tell them when we are at home (FGD UP, 2, 1).*

Parents claimed that through sharing experience, they were teaching fellow parents and community members without incurring difficulties.

*I can teach my neighbour without problem (FGD PPI, 7).*

Parents felt that having visitors and kindness shown towards the children in various forms including material support, was a result of wider friendship. Participants (Faculty of Nursing, nursing students, teachers, the pupils, and parents) claimed that they had made friendships as a result of this programme. This was also highlighted in the documents analysed from the two elementary schools. The Faculty emphasised that nursing students made friendships with fellow students, community and the pupils. This was very evident during participant observation. The pupils and the nursing students were very friendly and pupils were excited about seeing the nursing students. The children who were playing abandoned the games and ran towards nursing students held their hands and were full of excitement. Further, nursing students attested that because the community searches for knowledge this made them become friends because they want them to be healthy. Parents stated that the programme resulted in friendship with the “outsiders” to their community.

*This programme has helped us create friendship with U.S.A people... (FGD UP, 2).*

*Oh, you get to know what type of people they are and what you consider them to be. Mm, but they are very friendly and lovely eagerly waiting to be given information as to keep healthy (FGD NS, 10).*

*We have got friends for example these people from America, student nurses and staff from Mbarara University are now our friends because of this programme (FGD PT, 2, 8).*

*Students made friendship with the pupils, international students, and communities (FGD FN, 8).*

Parents claimed that they were “*excited to have visitors in their community*” because visitors loved their children. Accepting a person in one’s territory was regarded as a sign of love; parents mentioned that their “*children are happy to see them*” as well as their “*environment was favourable to visitors*”.

*We are very happy to see foreign visitors; the children love to see them. It is a good environment here (FGD PPII, 1).*

In addition, the kindness of the nursing students towards the pupils resulted in the pupils wanting to be friends with them. Pupils claimed they wanted to be in their company all the time and as such, it motivated them to come to school every day. Pupils and teachers further felt that developing friendship with nurses who came from other districts was an achievement and they hoped to meet with them in the future.

*Eh, when they come here at the school I want to be with them all the time, because they are kind to us and they are our friends (FGD LP, 8).*

*Oh..., the achievement I have is that I have created friendship outside my district; I talk to nurses who come from different districts (FGD UP, 4).*

Furthermore, pupils and their teachers claimed that they received scholastic materials for learning, medicine, balls for netball and some pupils received tuition

fees from stakeholders from FAU, visiting international students and faculty from MUST-DON. Teachers felt that this was a gesture of love for the needy pupils.

*Pupils received balls for football and netball. Ah, so our pupils are keeping physically fit by playing every day (FGD PT, 10).*

*... they give us knowledge and help, ah, such as books, pens, pencils, files to improve on our academics, ah, we also get treatment when we are sick ( FGD UP, 2).*

*Also there are some needy pupils who have received tuition fee through this programme. Aah, I feel if this programme didn't come, mm, they wouldn't be studying now as they are from poor background (FGD PT, 10, 3).*

Furthermore, participants experienced global networking that resulted from sharing between the community, the university and international partners from Florida Atlantic University (FAU) as experienced by the Faculty of Nursing. This further raised the profile of Katete community and the Department of Nursing at MUST. The joint approach by all stakeholders led to improved health of the community through collaborative approaches and friendship.

*It has also created the awareness of existence of Katete community, nursing department and the community activities done, ah, for example when the visitors come to visit the programme it creates international collaborations and leads to sharing of information about community nursing (FGD FN, 2).*

*Oh,oh,oh, this programme has helped me as individual to know and meet the people from the University; lecturers even people from abroad...made friendship with outsiders ( FGD PT, 10).*

*...the global networking to improve the lives of the disadvantaged communities. (FA, 2).*

### Rolling out the programme towards others

Participants' experience of rolling out the programme emerged from avoiding selfishness. The experience of avoiding selfishness was congruent with Ubuntu values. Parents attested that "*not to share is selfish*" (FGD PP11, 1, 7). Most importantly, they claimed that this programme was good and should be shared with other communities so that everybody benefits from it. They felt that good things must be shared; failure to do so was seen as being "*selfish*".

However, the University administrators' felt that individualism was being practiced instead of collectivism in some departments. 'I' was contrary to Ubuntu where 'we' was regarded as the golden rule (Broodryk, 2006; Tutu, 2004). They felt that although the university was sharing information in the community, participants claimed that there was no "*sharing across the university faculties*" (UA, 3) as noted in the excerpts below

*One of our biggest problems is that we do very good things but it's not shared across faculties. Hmm, it's only known in the departments and faculties without others knowing of it. And this is not for this programme alone, but also other programmes in the university and the university have this weakness (UA, 3).*

Furthermore, participants felt that a programme such as this could promote the university's image as being community oriented as claimed below.

*When we are being rated on our website, it is one way to show that we are committed to community and one way to advertise the University (UA, 3).*

In addition, the university administrators felt that putting the programme on the website could serve two purposes; demonstrating the community programmes they have and their achievements as well as providing evidence of their commitment to achieving community health.

Consequently, they suggested that the programme should be rolled out to other communities and districts, indicating reasons why they felt it was necessary as indicated below.



*Hmm.., if we don't take this programme to other schools and communities it would appear we are selfish – Not to share is selfish (FGD PPII, 1, 7).*

*I want this programme to continue even to spread to other parts of the community in our district, so that we continue helping one another to be responsible for our health (FGD PPI, 4).*

*People will not know what this programme is doing if it is not taken to other schools and community. Hmm.., this will also make us proud when they will be consulting us in our community (FGD PP II, 7).*

*Aah, lets share our experience with other communities so that they too can benefit as we have so that one day the whole country (FGD PPI, 8).*

*Sharing experiences will lead to a big change (FGD PPII, 2).*

*mm, this will make the programme expand, and many people will be healthy and change their life style in the whole of Uganda (FGD PP II, 4).*

*Um, actually this programme being confined in only these two schools is not good, mm, parents need to sensitize other communities (FGD PPI, 3).*

Rolling out the programme was a reflection of how they were oriented towards others through Ubuntu. Group benefit was considered more important than individuality. For instance, parents claimed the programme left “a *hallmark on their lives*” (FGD PP I, 2) citing the nutrition fair. This was further emphasised by nursing students who claimed that attendance at such activities was good and they felt it should be carried out more often as noted in their excerpts below.

*Nutritional day activity or any other activity should be organised yearly as the community members actively participated in the event (FGD NS, 8).*

Other participants also felt that the programme should be rolled out to other communities and institutions as indicated in their excerpts' below.

*Other universities should also use similar programmes, so that the nursing graduates acquire the skills and knowledge of health promotion and disease prevention (FGD NS, 4).*

*OK, all communities should be visited more frequently, and the programme should be expanded to cover a wide area (FGD NS, 8, 2).*

*I believe that the 'ripple-effect' framework works well in communities in Uganda and in most African countries (FA, 1).*

The pupils had various reasons why they felt that the programme should be rolled out to other schools. Their ideas rotated around assisting their fellow children whom they felt were missing out and should be given an equal opportunity to learn how to promote health and prevent diseases. Pupils noted that when they fell sick they were treated quickly and they got back to class or referred to hospital. They felt that in schools where such programmes do not exist, children walked far distances when they fell ill in search of treatment. Therefore, taking similar services near to them would be helpful. They claimed that some parents gave their children inadequate doses of medicine because it was expensive and that this prolonged the children's illness. Pupils felt that parents of those children needed to be given health education so that they understood the importance of the right treatment for curing diseases. The pupils suggested that their teachers needed to be educated as well. They stated that health promotion and education would benefit those teachers the same way their teachers benefited. In addition, pupils felt that through this programme, they interacted with the university students without fear and children from other schools should equally benefit from such socialisation.

*It is very good, and very helpful in making children grow knowing about disease preventions, taking care of themselves to prevent diseases (FGD UP, 5).*

*Children in other schools should enjoy the way we are enjoying interacting with University students freely without fear and learning about prevention of diseases so that they remain healthy (FGD UP, 3).*

*At times some parents buy half doses of drugs. You take long to get better and miss classes for many days. Hm., I remember missing school for two weeks because I was being given herbs, for my sickness. But when I was taken to hospital I got better after three days (FGD UP, 6).*

Teachers felt that rolling out the programme would make the community responsible for their health and become more productive. They also highlighted that since it involved disease prevention, it was a good programme.

*Aah, this programme can be rolled to other community as we have seen, mm, it is mainly concerned with preventive measures. Ah, so many people will be healthy and hence all communities will be responsible for their own health and be healthy (FGD PT, 8).*

While, the University administrators supported the rolling out of the programme to other communities, they were of the view that a different approach be implemented. They suggested that fewer nursing students in each school could lead to more schools visited. Thus, leading to a wider coverage as well as having greater impact on the communities. However, on the one hand, they were sceptical of the financial challenges facing the programme. On the other, they were optimistic that the support of the politicians would facilitate the rolling out of the programme to other parts of the community.

*This was a pilot study ah..., we have been visiting frequently but once establish in other schools may be we would change the way of approach, may be two – four students per school. Change from having many students going to one school and the community. Starting in a small way then later cover bigger area that would be helpful (UA, 1, 3).*

Despite collectiveness, sharing and suggesting rolling out the programme, participants claimed there were some drawbacks. For instance male dominance in some homes, language barriers and limited resources. Participants' felt these drawbacks could affect the sustainability of the programme, hence their experience pointed towards having a collective solution towards these potential issues. Some participants [male nursing students] felt that some homes were not welcoming. The male family members did not feel happy seeing another man talking to their woman or women. The male nursing students felt uncomfortable. Culturally, a man is the head of the family, therefore makes decisions. Arguably, the male family members had fears that their wives would contradict their authority in decision making. One example was the use of family planning

especially when the man was not in agreement with the practice as noted in participant's excerpts:

*Uh.., for me I noted that some families were not welcoming, may be because I am a man I noted in some home men were not happy seeing me a man talking to their women; (laughter's). Yeah, indeed they didn't feel comfortable. Ah.., I think, they could have been suspicious that may be their women may get astray, seeing the women so free discussing and very attentive. Mm, I think it's important that we move in pairs, but on this day, my colleague remained behind talking to another lady who had stopped her, so I continued. Ah, you see the issue is mainly about women delivering many children (FGD NS, 3).*

*So if you get a man who does not want the wife to use family planning methods, it is difficult, mm..., this lady told me she was hiding her pills, because she did not want the husband to know, otherwise she would be punished (FGD NS, 4).*

Nursing students felt that a deficit in understanding and speaking the different languages of Uganda affected their sharing of information. Uganda has about 65 languages recognised and documented in the Uganda Constitution (National Legislative Bodies 2005 Chapter Two). Students coming from other parts of the country had language problems when it came to community placements such as this one. Some community members did not speak English. These situations affected the students' interaction with communities. Both the students and community members experienced frustration. The language barrier affected nursing students negatively especially in their self-confidence. Not being able to express themselves during education talks could have minimised their ability to express important points with clarity. They also claimed that the situation was worse if they had no colleague who spoke the language.

This left them in a state of "*helplessness*" where they acknowledged feeling "*demoralised*", "*demotivated*", "*lost and robbed*" of the ability to interact and communicate effectively as narrated:

*Hm, mine was unique challenge, I realised that some people in the community were not happy when you did not speak the language, so language barrier was another challenge (FGD NS, 3).*

*... the issue of language barrier was really challenging and demoralising. Hmm, especially when you want to discuss and you find that you cannot say it in the language the client can understand, mm, you get demotivated and get into a state of helplessness. Hm, it is terrible, as you feel lost and robbed of expressing your views to the client. Oh, it is sad (FGD NS, 4).*

On the other hand, students felt that it was their responsibility to try and learn some local language prior to the community placement as stated by one participant;

*The students should try to learn some words in the local language before going into the community. It makes the community happy and appreciative... (FGD NS, 5).*

Participants' experience of limited resources was diverse. They felt each constraint became a cascade of another problem as noted in their excerpts below. They stated financial constraints, lack of readily available transport to take students on time-affected dissemination of the health information messages and consequently, it led to poor time management. In addition, the gap left behind by nursing students when on holidays contributed to a break in the dissemination of information. Furthermore, participants felt that the sustainability continued to be a material struggle due to lack of financial resource. Dedicating a building solely to the centre for wellness and nursing was considered critical. Having a building, well designed to suit different activities of the programme was required - currently a classroom block was used. Lack of sufficient drugs for first aid, teaching materials and equipment to use were also highlighted in the participants' statements as indicated in statements below. Participants concern of programme survival was central to Ubuntu. Their suggestions towards solutions as well as willingness to contribute to resources was based on mutual concern for existence as noted in their excerpts.

*Time management was another challenge brought about by lack of transport on time. Hmm., on top of delaying at the primary school at times when we would come late we would interrupt their break time for playing games, or we would rush the talks, in order to try and be within the time schedule. Mm., this is not good as some pupils learn slowly (FGD NS, 1, 10).*

*“Umm., in adequate resources to facilitate the nursing students and lecturers to the training site in the community regularly” (UA, 1, 3).*

*Aah, definitely there is need for transport to take them to the site, the biggest challenge is to maintain the nurse financially. And to buy necessary requirements to be use at the centre and of course to have a building which is well designed to suit different activities of the programme. Currently a classroom block is used (FA, 2).*

*There is need to increase on the space because currently this space is too small. Aah, I don't think it can accommodate all the nursing students and the pupils (FGD PT, 2).*

*The places where this programme is operating now, is congested, it needs a wider space. As the school of nursing is expanding we will need a wider space to accommodate all of them (nodding in agreement) to put 20 students in this room will not be convenient (FGD PPI, 7).*

*The child after getting some medicine cannot rest properly because of noise being made by other pupils outside when they are playing (FGD PT, 7).*

*Aah, you see when examining or taking history, there should be enough space, in this room, mm, the privacy is not adequate we need an infrastructure” (FGD PPI, 4).*

*“To me the problem I have found with this programme is that it lacks drugs, mm, I went to see the nurse one day when I was not feeling well, ah, she only examined me and said I should go to the hospital, ah, because she*

*was lacking some drugs for malaria. Hm, yeah, I was sad (FGD UP, 1, 4, 6, 7, 8, &10).*

*We also had few learning materials to use in the school or community for illustrations (FGD NS, 6).*

*Indeed a laboratory should be here if the funds are available. Oh..., there is need to have laboratory here so that they can do blood testing for malaria (FGD PT, 7).*

*Hmm, we need to know exactly what we are suffering from (FGD PT, 1).*

Participants' experience of a collective solution focused on how the programme could be improved and sustained as mentioned in their excerpts below.

*If the department can get its own transport will improve on time management (FGD FN, 4).*

*I think this programme can be made better if the government come in and support the programme activities (FGD UP, 3).*

*If we can get donors I think this programme will improve (FGD PPI, 8).*

*Political will is very important the programme activities should be include in their budget. This can lead to sustainability (FGD FN, 5).*

*Katete community are the main beneficiaries; they should contribute in the sustainability of this the programme (FGD PT, 3).*

*Hmm..., we will continue supporting the programme activities until such a time when there would be big money (UA, 1, 3).*

*The University to increase more funding to the programme (FGD NS, 1, 4).*

*Help them start some small income generating projects like poultry, bakery or piggery. This way the money generated can be used to facilitate some programme activities (FGD PT, 7).*

*Hah..., I think the programme should also device means of helping the community members get some income generating activities to help them be able to support themselves financially (FGD NS, 7).*

*Publishing will allow people to understand what we are doing and to document the model we are using and publish the findings and will be locally and internationally known (FGD NS, 9).*

*I believe after this evaluation we can improve where we are not doing well. It can also be spread to the whole division Nyamitanga and at a later stage cover the all municipality, and then the all district (UA, 1).*

*Yeah, more frequent supply of demonstration materials to enhance the learning of pupils and the community members (FGD NS, 4, 2).*

*Seeing those microorganisms make us learn and not forget, uh, thus improving our academic performance (FGD UP, 1).*



## MAIN CATEGORY 2: BEING INVOLVED AND PARTICIPATING

Table 16. Being involved and participating.

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Learning /Empowerment Achievements / raised self-esteem, pride, success, widening of horizon.
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

Participants described their experience of being involved in terms of learning / empowerment, which led to achievement, raised self-esteem, pride and widened their horizons.

### Learning / empowerment

Participants' experience of learning in the community resulted in the empowerment. Empowerment stemmed from a quest for knowledge about

health. For example, nursing students found they were motivated to update their knowledge so that they were ready to lead the health education classes.

*Community they expect a lot of information from us. Uh, it demands that we have to learn more in order to be able to contribute and answer communities' questions (FGD NS, 10).*

Teachers claimed that the knowledge and advice they got from the University staff empowered them to go for further studies. For instance, some of them commenced masters' programmes.

*Hm..., they give us advice about many things not only health related but even in academics. Actually, they have encouraged us to go back to school, for me I am doing my masters now (FGD PT, 10).*

Nursing students learnt and were empowered to overcome shyness while, pupils and parents felt empowered to prevent disease. Parents further claimed that their children (the pupils in this study) were no longer shy talking to their parents.

*Yeah, with regards to the pupils, they have learnt how to behave especially with regards to health. Hm..., I have a small girl in this school who knows exactly what to do when she comes home, with regards to health. Ah, she can tell you "I can't drink un-boiled water", "I can't sleep in a bed without a mosquito net" because I do not want to suffer from malaria. I can't do this and can't do that, hah..., this is because I have learnt that this is bad (FGD PPI, 4).*

Older pupils claimed that knowledge had empowered them to prevent sexually transmitted diseases such as HIV/ AIDS by abstaining from premarital sex. HIV /AIDS is one of the killer diseases and there is cultural sensitivity about discussing it with children (Lwanga, 2004). Of course, children should not be kept ignorant as this may endanger their lives when they become sexually active.

*Hm, this programme has enabled me know how HIV/AIDS is spread. I have avoided all practices, which lead me to catch AIDS, practices like playing sex, ah, we were taught that until you are ready to get married and*

*you must go to test for HIV first. Um, I am very careful, also how to control malaria, mm, by sleeping under mosquito nets (FGD UP, 8, 9).*

The younger pupils illustrated their experience of empowerment through drawings of dancing as symbol for happiness of the programme and Ubuntu way of expressing self. They claimed that, they had learnt how to prevent diseases from being clean as demonstrated in drawing Figure (8) below:

Figure 8. Pupil's experience of involvement through dance (FGD LP 1: 7 years)



Source: Author's Photograph of one of the of Pupils' Drawings in FGD LP 1 (2010).

*"Hah, for me what has excited me is that they teach us about cleanliness. I have drawn my picture dancing "ekitaguro" (traditional dance) because I am very happy with the programme" (FGD LP, 1).*

One participant [administrator] also claimed that he had gained knowledge through personal learning. He experienced that not only money can make a difference in people's lives; but also commitment of the stakeholders.

*Personally as an administrator I have learnt that not only big monies can make a change in community activities like this one. This programme is very good for the University, ah.., because MUST prides itself in doing community based activities .This programme has had a positive impact on the university and its programmes (UA, 1).*

Empowerment enabled the community and pupils to change their behaviour as they claimed to practice what they learnt such as personal hygiene and keeping their compounds clean. Similarly, this was also discussed in the main category: transformation of one's life under the subcategory; pupils and community health improved. They looked healthier, their health seeking behaviour changed. Pupils further claimed that; they no longer took herbal medication.

*The communities are practising health-seeking behaviours, are being accountable for their health, and have changed their life style. Mm.., getting responsible for their health they want to learn (FGD FN, 1, 4, 5).*

*Eh, community members are empowered and have become responsible for their health, as they come for treatment whenever not feeling well (FGD, NS 3).*

Pupils claimed that they washed fruit before eating it to prevent infections such as cholera. Interestingly, they were able to mention what could happen if they did not eat fruit, such as bleeding from the gum (scurvy). Understanding the rationale was an indication that something more than rote learning had taken place.

*I eat fruits after washing it as the nurses have taught us. Hah, because I want to stop germs from getting into my stomach, hmm, like cholera (FGD LP, 9).*

*Yes, diseases like scurvy where you bleed from the gums if you do not eat fruits (FGD UP, 6, 8).*

Teachers said, *"The pupils are lucky"*, when unwell in class they requested to see the nurse. They neither waited to be told nor needed taking to see the nurse by

the teacher. Such was the empowerment of behaviour change and it appeared it did not create any difficulties for either the teachers or nursing staff.

*Mm, when I am sick I go to the wellness centre for medicine. I ask the nurse for other advice if I am not sure of what to do especially my periods (FGD UP, 10).*

*When I am sick I come here and see the nurse, she treats me and I go back when I am cured. Hmm, she gives me tablets, I swallow and I get better (FGD LP, 2, 6).*

Furthermore, FA participants claimed parents were delighted with the programme recounting the improvement in their children's health. It was also observed that the school administration had a sense of security knowing the pupils' health was addressed at school.

*If they do not feel well, they come to school to seek the nurse's assessment (FA, 2).*

Another perceived benefit, was that nursing students felt that empowering early the community prevented disease progression and its spread. In addition, pupils continued attending classes:

*I have I learnt that empowering the community to be responsible for their health and to seek medical treatment early was important, diseases would be managed before they are advanced or spread in the family or community. The pupils continue attending classes (FGD NS, 6).*

Availability and accessibility of services nearer people from their community facilitated an empowerment to live healthy lifestyles. The Faculty claimed the community was "lucky" since as soon as they felt unwell; they sought for assistance.

*I think this community is lucky, ah; having such a programme in their community is a blessing, mm, because they have access to information and wellness centre amidst them. Aah, availability of services is very*

*important for the health of people, because you do not need to move far (FGD FN, 3).*

*Yeah, more community members have started seeking health care following health education talks. Uh, I think taking services near people helped to improve the life of most people in the community, as they would access treatment anytime they are sick. Hah, this has further improved their health seeking behaviour unlike in the past before this programme, ah, as most members shared with us during the home visits (FGD NS, 2).*

Participants gained health and environmental knowledge through programme empowerment. Awareness experiences enabled the young pupils to be empowered and become environmentally conscious and choose to preserve and beautify the nature as a way to prevent diseases by maintaining cleanliness. One participant demonstrated how learning about the environment empowered him to plant flowers (see figure 9 below) and keep the compound clean.

*Figure 9. Pupil's experience of environment (FGD LP 3: 6 years old)*



Source: Authors' Photograph of the Pupil's Drawings in FGD LP 3 (2010)

*I have drawn myself planting flowers; because this programme has taught me to keep our compound clean, by planting flowers you make it look beautiful. My parents are very happy with my flowers I plant at home (FGD LP, 3).*

Nursing students claimed that being involved enabled them to gain increased awareness of health related problem affecting the community and the causes. They highlighted diseases such as, HIV/AIDS, jiggers, worm infestation and diarrhoea as some examples (Jiggers are small insects that burrow under skin of the victim; see appendix 12).

*...my experience through this programme; I have gained Increased awareness of health related problems, ah, especially disease prevention such as HIV/AIDS, sexually transmitted infection, malaria, diarrhoea, malnutrition, jiggers, alcohol intake and worm infestation as we gave health education talks ( FGD NS, 1).*

Assessing and understanding each disease process and the community's perceptions and practices about them were probably one of the greatest achievements. Consequently, students learned to place a high value on preventive measures, as well as acknowledging them as cheaper for the community. They noted that the curative treatment is expensive and time consuming, which has negative implications for resource-poor communities.

Similarly, pupils' awareness of disease infection focused on those that lead to disfigurement such as the jiggers.<sup>11</sup> They claimed they kept their homes and school environment clean. Hence, pupils took the necessary precautions to prevent it as observed in their narratives below.

*We keep classroom clean by sweeping it every day and moping it to prevent dust which can be the cause of diseases like jiggers. Hmm, we*

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<sup>11</sup> The jigger flea infestation is a disease among the poor communities. This disease is endemic in the warm, sandy, and dirty environments of tropical and subtropical countries. The scientific name for the jiggers is Tunga Penetrans flea – see Veraldi, S. and M. Valsecchi (2007). "Imported tungiasis: a report of 19 cases and review of the literature." International Journal of Dermatology **46**(10): 1061-1066.

*keep the compound clean. Aah..., throwing the rubbish into rubbish pit and slashing the bushes around the school and at home (FGD UP, 6; LP, 7).*

### Achievement

Participants' experience of achievement emerged from the subcategories of securing funds for the programme, improved practical skills, problem-solving, improved academic performance, improved health seeking behaviour, questioning skills. In addition guidance and counselling, benefits to teachers as well as to parents.

Various successes were due to contributions from each stakeholder, for instance, one of the FA stakeholders participated in sourcing the initial funding from the Fulbright Alumni Initiative Awards. Their presence reinforced the programme, strengthened and supported the programme's success. Although their visits were inconsistent and often irregular, they provided excellent opportunities for the department of nursing when they came; both the undergraduate and the masters' students benefited as noted in their narratives:

*My participation has been in establishing the initial funding and the continuing recruitment of prospective faculty members from US schools, basically from Florida Atlantic University. Funding was received form Fulbright Alumni Initiative Award as a mutually organized project, that of MUST and FAU (FA, 1).*

The creation of a stable practicum site for the department of nursing facilitated students to practice in the community and improved their practical skills. In addition, it was only a short distance from the university. The training of undergraduate, postgraduate and both local and international students was located in the Faculty of Nursing. Furthermore, the university administrator felt that the presence of the practicum site was an indication that the programme was successful in bringing services nearer people and training of nursing students.

*We have a practicum site as a department for community nursing as part of our ongoing curriculum, students use the centre as a learning site and*



*research studies are conducted. It is also great learning site for our international students as well (FGD FN, 2, 6).*

Students were able to achieve good practical skills because they were involved in real life experiences in the community. This contributed to them gaining confidence in practice as discussed in the main category; developing / gaining confidence under sub category; community exposure. The faculty felt that the use of real life experience in teaching nursing students enhanced their teaching as well as made their work easier.

In addition, improved clinical skills were also attributed to collaboration among the students themselves and the stakeholders. The continuous support and guidance from their lecturers was a contributory factor as well as a friendly and welcoming community members. FA participants and parents further supported the idea that moving away from the University environment into the community, enabled the students to learn better, and thus improved their understanding of the community. Educators embrace the idea that learners of all ages learn better when immersed in a culturally and socially rich environment (Bruner 1990).

*This is a wonderful collaborative relationship with the community (FA, 2).*

*To me I also think the nursing students benefit other than staying in the university or in the hospital mm, by going out to see environment in the community and how people live and behave (FGD PPI, 2).*

The University administrators noted that this programme enabled students to move away from a classroom orientation to a real life perspective, helping them to understand the community and to learn and appreciate the differences that existed between them.

*It is really a good experience for nursing students to see how someone can live so close town and yet lead rural life (UA, 3).*

The faculty staff stated that in terms of institutional innovation, the community practicum site led to better learning of students; they “*think critically*” and “*make quick decisions*”. In addition, the use of different sites for training enabled the

department and the university to produce better graduates. They felt this would not have been possible if only hospitals were used for practical skills. Therefore, the faculty staff took pride in preparing the students to become practitioners serving the community.

*In the community, they work together with families to find suitable solutions to the problems. Institutional innovation has enabled students to learn better makes the students to think critically, very sharp in making decision. Mm..., if the training was to relay on hospital setting our students would be of low quality (FGD FN, 4, 6).*

The University administrators agreed that this programme improved practical skills for the nursing students, by showing them how best to implement preventive measures. In turn, the institution received credit for adhering to its philosophy of community-based nursing and for training the workforce that is better prepared to understand the community's needs.

The accessibility and availability of these services made the University well-known in the community. They also claimed their graduates were being praised for good work as noted in their excerpts below

*This programme has led to better graduates who are able to answer people's needs in the community. Aah..., they have are being praised wherever they go practising making Mbarara University exceptional in preparation of graduate nurses who are ready to work in today's situations (UA, 1, 3).*

The students were happy in utilising the locally available resources in the community for instance 'smoking the pit latrines' to keep it free from bad smell and flies. This demonstrated community partnership was appreciated especially what the community can offer and afford. Thus, their experience was in line with Ubuntu values of survival. Students echoed another innovation they collaboratively put in place; the use of tippy tap to wash hands after toilet use.

*I learnt affordable alternate ways community use such as; instead of washing toilets with soap and water they smoke it to remove the smell and*

*flies, mm..., this is good. The programme has enabled us to appreciate the use of locally available resources within reach (FGD NS, 4).*

Nursing students reported that understanding the uniqueness of the community, their values, needs, problems and the diseases which affect them was an achievement. They emphasised the importance of understanding the community well, before implementing any activity. Listening to community views, conveying simple messages and not imposing ideas on them, was seen as a useful approach to fostering community participation. Students observed that community opinions were complementary to the success of the programme as well as to promote a combined effort of teamwork in finding solutions to problems, thus enhancing learning.

*The programme has taught me how to approach the community by being simple; they know best what their problems are (FGD NS 7, 10).*

*Mm..., coming up with solutions together; to me this was great learning and we all worked as a team in order to solve the problems (FGD NS, 9).*

A by-product of the programme was improved academic performance for both nursing students and pupils. Students asserted that their academic performance improved due to this programme, evidenced by good marks in their examinations. Lecturers concurred with this, as indicated in their excerpts below.

*Ooh, the performance of nursing students improved, ah, because we get good marks (FGD NS, 1).*

*This programme has led to our students' performance to improve drastically in class and in the practical area (FGD FN, 2, 8).*

Pupils demonstrated improved achievement by passing exams and being promoted to higher classes, as expressed by the pupils themselves. The school administrator associated good performance with 'reduced illnesses', 'daily attendance' and 'reduced absenteeism'. FA faculty and the university administrators highlighted 'lower absenteeism'. Teachers attributed reduced absenteeism to 'parents learning about disease prevention'. Absenteeism has

been associated with poor academic performance and eventual dropping out of school (Kasente, Nakanyike et al. 2003). While the parents attached daily attendance of their children due to the presence of this programme in the school, pupils getting treatment at school contributed to better performance as they continue with their classes.

*Hmm, programme has helped me improve in my performance in class; I pass my tests (FGD UP, 10).*

*This programme has led to pupils' good performance in their state examinations; many were able to join secondary school. The pupils tell us that they are doing well in their science subjects (FGD NS, 2, 1, 7).*

*According to the reports got from the headmaster as we interact with him, ah, he always says that there is a great improvement in the performance of the pupils in class and their cleanliness (FGD FN, 7).*

*School pupils now no longer absent themselves as they get treated in time (Document analysis: Headmaster's report from Katete School 11<sup>th</sup> November 2006).*

*The daily attendance of pupils has improved because they are healthy. The enrolment of the school in 2008 was 360 but now we are talking of 562 pupils. Another point of interest is that the number of girl children in school is more than that of boys (Document Analysis: Headmaster's report from St Mary's School 14<sup>th</sup> December 2008).*

*Attend five times a week (SA, 2).*

Daily attendance and health educational messages further enabled the pupils to improve in science subjects. Pupils claimed they had previously experienced more difficulty understanding the science subjects and were missing classes due to illnesses. As a result, they developed a dislike for the subject as narrated.

*It has helped me to pass the examinations. Long ago I was very weak in science subjects but now I improved greatly because of this programme,*

*mm, we come to school every day. My attendance in coming to school has improved (FGD UP, 3).*

*Oh, some of the most difficult words are now very simple to understand. Mm, we were not interested in science subject before as we found the words very difficult (FGD UP, 5).*

Improved performance was also attributed to the donation of writing and reading materials that enabled them to develop their reading and writing skills. Donations were seen as acts of friendship as discussed in category sharing information under subcategory wider circle of friendship.

*This programme has helped us create friendship with USA people, (FGD UP, 2).*

*Um, the programme provided reading materials, yeah, they can read well and their writing is good and clearer (FGD PT, 8).*

The school administrator claimed that the reading culture in school was born through this programme especially with donated children's storybooks, which the pupils enjoyed reading. He associated the understanding and being able to interpret questions set in examinations to this new learning as discussed in the main category of transformation of one's life.

*Ohh, before this programme the pupils had poor reading culture (SA, 2).*

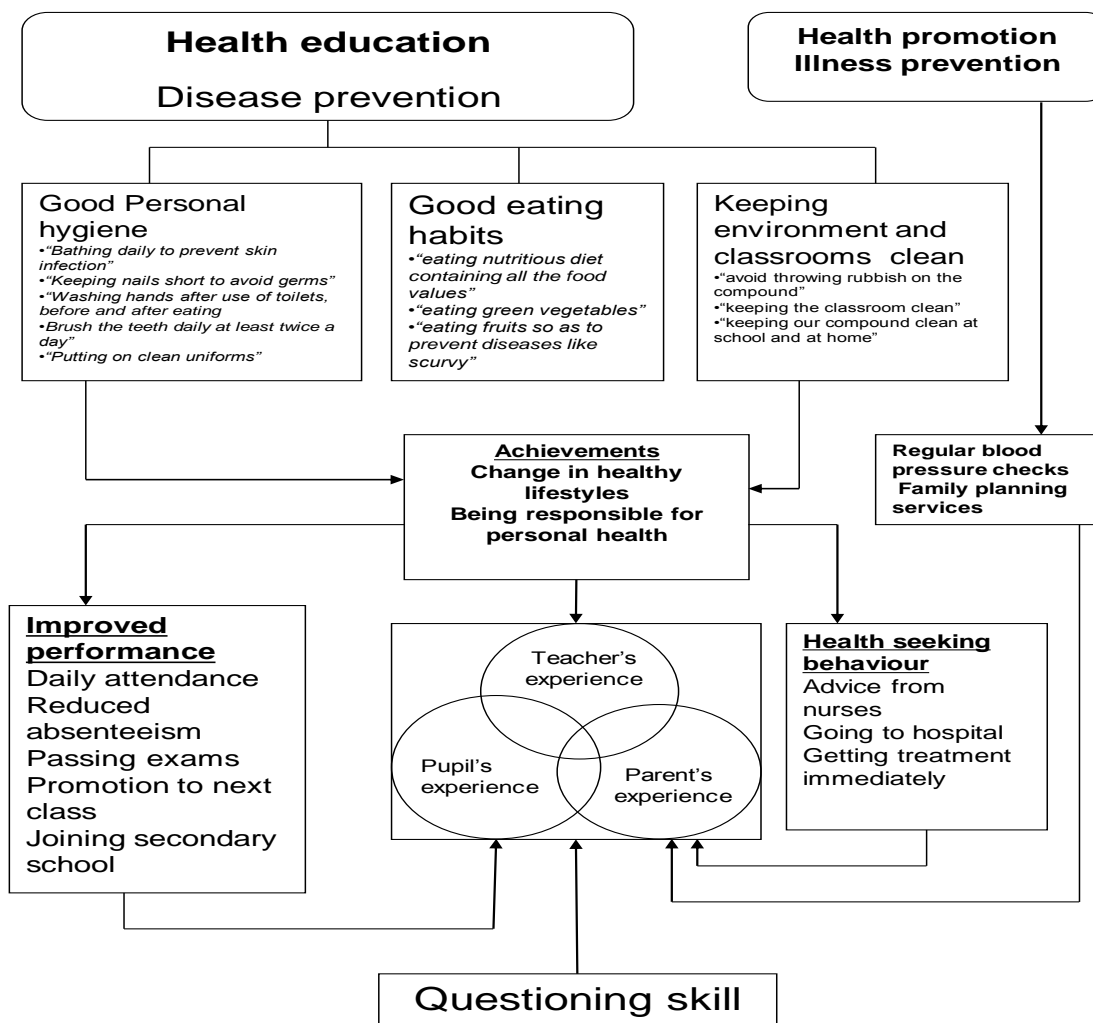
Teachers felt that there was a need for a bigger library with more books for the pupils. They suggested that it could create a significant learning centre for the community as well.

*If we can have a library here, would be good to improve on our reading. Hmm, I request that if possible set up a bigger library (FGD UP, 9).*

*I think it can be improved by having a facility which is in place as a learning centre with learning materials like charts (FGD PT, 10).*

## Summary of similarities of achievement of pupils, parents and their teachers.

Figure 10. Summary of achievement similarities for pupils, parents and teacher experience of involvement



Source: Author (2012)

The above figure illustrates similarities in what the participants (pupils, teachers and parents/ community) claimed the programme enabled them to achieve. They were able to prevent the diseases due to knowledge gained from health promotion and education talks. They maintained personal hygiene, kept their environment, homes, and classrooms clean as well as developed good feeding

habits. This was also discussed under subcategory learning / empowerment and main category transforming one's life under subcategory pupils and community health improved as well as cleanliness of the community/ pupils. They underwent lifestyle changes and developed health-seeking behaviour. Furthermore, through health promotion the community claimed, they were having regular check of blood pressure and utilising family planning services. Parents and teachers felt that pupils had developed questioning skills both at home and in the school. Nursing students also experienced questioning from the community.

Pupils and teachers noted that the female pupils were being given advice and counselling regarding menstrual hygiene, sex maturation and the essential facilities used while at school. Counselling guided both girls and boys into a safe and healthy adulthood.

*Um.., if I start my periods while at school....she gives me sanitary pads to use and teach me about personal hygiene (FGD UP, 8).*

Apart from achievements indicated in figure 10 above, teachers expressed that their schools became more prominent evidenced by pupils' increased enrolment. In addition, parents appreciated the importance of this programme in imparting knowledge, as well as the treatment, received at school. However, parents felt the need for more space as the numbers increases.

*This programme has improved the enrolment of the school (FGD PT, 8).*

*Umm.., as the enrolment of the pupils is increasing we shall need the classroom (FGD PT, 2).*

The female teachers received family planning services. Hence, they felt that the programme had been helpful because they were better able to continue with their work. For instance, they did not need to take time offsite to attend hospital appointments since they received advice from the centre: they further attested that this made their neighbouring schools envy them. Treatment received was experienced as friendly, respectful and avoiding queuing that they would encounter in hospitals.

*Oh, oh, (smiling and happy face expression) because of this our neighbouring schools envy us. Ah, because of the programme and its services we get (FGD PT, 9).*

*Yeah, the treatment I get is friendlier than when you go to the hospital, umm, there is no waiting or queuing you don't have to wait. Ah, you are immediately attended to and you go back to work you don't waste time (FGD PT, 5).*

Importantly, teachers and pupils found teaching and learning science subjects easier due to similarities in the topics taught in health education. Teachers claimed that, they were not labouring as much in explaining medical related terminologies, since pupils came to classes with some knowledge acquired through health education. Equally, teachers felt that, due to their prior knowledge from health education talks they found it easier and enjoyable to teach. Furthermore, teachers and school administrators stated that, the science syllabus was being covered in a shorter period.

*... as an individual, one thing I have achieved from this programme, the nursing students have helped me, I am a teacher but they have taught some topics like sanitation, hygiene, immunization, all those are in the curriculum. After the nursing students have taught it during health education, it is easier to go through it with pupils later. Aah.., so they have helped me a lot (FGD PT, 1).*

*Umm, again this pupils we teach them science and some topics are similar with some health education talks, ah, so what they see is compared to what they learn in classes and they understand better (FGD PT, 3).*

*Um, the teaching has become easier for the teachers especially the science subjects, ah, for example topics like STIs, communicable diseases, mmm.... Hm.., when we are teaching we find certain things already known ah, making our teaching easier. Aah.., the pupils go to class when they are familiar with the topics (FGD PT, 8).*



The school administrator's work was made easier as school activities were running according to planned schedules. There were fewer interruptions for sickness of pupils and as such the schools registered the achievement of pupils' performance and the classroom teachers were happy.

*I find my responsibility easier, because the children are always in school no absenteeism, ah, this makes my work easier, the school activities are moving on well with no interruption (SA, 2).*

*Teachers are happy as their lessons are not missed (SA, 2).*

In addition to achievements in figure (10) above, parents claimed they learnt food preparation of nutritious meals; especially cooking the right food for their families through attending the 'nutritional demonstration fair'. Parents and the rest of the participants further claimed that, the learning "*cannot be forgotten*" except those who were not around (FA faculty). They requested that such demonstrations be regularly held as it enhanced their learning, and nursing students felt that it should be organised on a yearly basis.

*Being invited to attend the demonstration fair held at school taught the pupils and the parents on how to prepare a good diet from the foods we have at home, that day, eh.., cannot be forgotten this was a very good learning day (FGD PPII, 6,7; PPI, 5).*

*I hope we shall get such kind of teaching and shown how to prepare food more frequently (FGD PPI; 3).*

*Umm, we would eat food which is not well balanced, may be only Matooke ( green plantain) and Ntula ("Solanum gilo"), fry with much oil, or just boil matooke, but we got good education of preparing food using the foods we have and make a good diet. Ah...this is great, learnt how to include different types of green vegetables such as "Egobe" (Vigna unguiculata), "Bbugga" (Amaranthus lividus), "Egyobyoy", (Gynandropsis gynandra) and "Ensugga/ Eshwiga" (Solanum nigrum) (FGD PPI, 10).*

Also, parents felt that the presence of the programme in the community enabled the pupils to receive immediate attention in case of sickness. This reduced other risks, such as being run over by a vehicle as the child walked home.

*The programme is nearer and it is helping the pupils even the teachers. In the past the children would fall sick, the children would be sent home and even they would lie on the road side (FGD PPI, 4, 6).*

Furthermore, active participation widened participants' horizons. Nursing students claimed that the programme had expanded their horizons from theory to practise based knowledge, and in understanding community culture. Giving health promotion and education in the schools and local communities broadened their knowledge and increased their understanding of community nursing. Practising while interacting with the clients enabled nursing students to appreciate the relevance of giving ample time to clients, listening to them and being able to understand their problems better.

*The programme broadened our knowledge from theory base to a wider practical knowledge. It has exposed me to the community. You work as a team in achieving apposite solution (FGD NS, 9, 10).*

FA participants reported that the supervisory role in the community activities enabled students to receive teaching from other educators. As a result widened their horizons with greater recognition of the value that of health promotion, illness prevention, and early intervention, thus increasing their knowledge. This also facilitated further research and knowledge development in the view of nursing as a science, a discipline and professional practice as indicated by one FA participant. The university administrators associated the positive feedback they received regarding their graduates, to supervision that students got in the community placement. This was also highlighted in the nursing department documents.

*Participating in teaching nursing students while in the community and supervising them during community activities like community diagnosis, physical assessment and health education talks (FA, 4).*

*Yes, it teaches our nursing students rightful skills to be able to understand the communities and I believe the practice too is good because we hear reports that our graduates have good skills in their practice (UA, 1).*

*The graduates who have undergone this community programme are knowledgeable in their practice according to reports we get (Document analysis report; Department of Nursing 2009).*

### MAIN CATEGORY 3: Improving communication / Receptiveness

Table 17. Improving communication/ receptiveness

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

#### Interaction with pupils, communities parents and nursing students

The faculty teaching staff claimed that their communication skills improved due to the opportunity for learning offered by the programme.

*I have learnt communication skills, ah this is a good learning opportunity, and how we approach the community ... ah, I think I can be good programme officer or coordinator of some project in future. (FGD FN, 1, 7).*

The faculty staff further asserted that through interacting with the community, the nursing students' communication skills improved. FA faculty agreed, and this was also noticed during participant observation. Good communication skills of nursing students also enabled the pupils to gain a better understanding during health promotion and education talks. Good communication was not only in the community but was also observed during students' placement in a hospital setting. Their communication was more directed and they were able to consider their findings and subsequently counsel their patients more efficiently. This improvement in communication was attributed to the experience of on-going health promotion and education talks given to pupils as well as the community:

*Students know how to handle the community members very well, when they come to hospital, the way they communicate is more focused easily interpret their findings after observations, ah, good at counselling the client (FGD FN, 6, 5 , 3).*

Parents claimed that the communication between community's members had improved as claimed "*Our communication among community members is good*" (FGD PPI, 1).

Nursing students agreed with the nursing faculty that continuous health promotion and education talks improved their communication skills. They felt that through interaction with the pupils, they understood that most diseases attended to in the hospital setting could be prevented through health promotion and education of the community.

*Our communication skills were enhanced by participation in the programme and um.., I am very confident now, communicate well during health education talks and this has further motivated me. We have become very confident FGD NS, 7).*

*It was a nice experience, eh, because it gave me the opportunity to learn to carry out health promotion and education in the community (FGD NS, 4, 2).*

*Mm, because we interact with the pupils, ah, you realise that most illness we treat in the hospital could be prevented by health education than the curative means we offer in the hospital (FGD NS, 5, 4).*

Good quality, jargon-free communication from the nursing students appeared to boost pupils' confidence and understanding. However, nursing students highlighted the importance of appropriate language for the target group. Appropriate language with no jargon usage enhanced their communication skills and enabled the pupils to understand the messages. During participant observation, it was evident how pupils were motivated and interested in learning during a nutritional health talk (see figure 11 below).

*My experience has been that when addressing people of different age, educational background and community members or when giving the messages, ah, the language should be clear and use of familiar words is very important, ah, this facilitates learning and the participants gets interested in what they are learning. Hmm, they become attentive and keen to learn (FGD NS, 6).*

*Proper communication channel is important, and message simplified according to the target group. Hm, so no use of jargon language as this makes the messages difficult to understand (FGD NS, 10).*

The pupils were able to observe the demonstrations and were attentive as well as the environment was conducive. At the same time, the nursing students noted the interest of the pupils.

*The content we use is appropriate to the level of pupils, mm, which actually follows their curriculum outline of health educations, and appropriate to the level of pupils (FGD NS, 9).*

*When giving a health education talk the sitting arrangement is very important, so that everybody is able to see what you are demonstrating. Mm, the environment should be conducive free of distracters as pupils attention will be diverted (FGD NS, 1).*

Furthermore, the use of teaching and learning aids enhanced communication skills and facilitated the explanations given to pupils. The importance of teaching aids in enhancing communication was very evident during health education talks and was viewed during participants' observation. In addition, participants praised the use of charts as very educative.

*Ah, the use of teaching Aids enhances their learning better. Ah, the wellness centre has good charts on nutrition, family planning and immunization and many other types; mm, it became easier to explain to the pupils and the community at large (FGD NS, 4).*

Figure 11. Health education class; Topic Nutrition



It should be noted that health education classes were conducted under the trees, due to non-availability of a large enough classroom to accommodate 80-100 pupils from two schools. Activities for pupils were based on the Uganda School Health Report as mandated by the Ministry of Health (Ministry of Health (Uganda) 2010). This was to ensure that pupils were educated at the level congruent with their Primary School Curriculum (Nsubuga and Kateba 2010).

Good communication skills of students increased pupils' and communities confidence and they were able to 'open up' and discuss health related issues.

*Yes, the pupil's interaction with us the nursing students raised their confidence. Yeah, they open up, ask questions regarding their health. (FGD NS, 2).*

The school administrator claimed that the pupils learned to communicate as well as develop a good grasp of terminologies. These, facilitated them, to appreciate and understand the science subjects, as noted in the statements below.

Um, the pupils have developed vocabulary (SA, 2).

*Umm, the pupils are able to express themselves because of the new words they learn during health education talks. Um, also health education talks have helped them in science subjects (SA, 2).*

Pupils in the younger classes acknowledged that their improved communication assisted them and they were able to interact with parents. They claimed they communicated to their parents what happened to them at school. They narrated the personal touch they got from nurses as well as a keen interest the student nurses showed when looking at their exercise books.

*One of them was looking in my book and she said good and touched my shoulder. Hmm..., I was happy and went and told my mother as well. Hah, this programme should stay here (FGD LP, 2, 8).*

Communicating with different community members enabled nursing students to appreciate the various concerns of each individual, group, and family. They were able to understand practices which threatened their health. A vivid example was that some families shared their house with domestic animals, (goats) for the fear of them being stolen.

*In the community you interact with women, men children young and old and the community leaders, this is the beauty of community, ah; through interaction you understand their pressing health needs (FGD NS, 9, 7).*



*Hm, visiting the homes and interaction you get to know what problems they face and what they think is a major pressing issue and what they need to know. Mm, for example in one home we found they were staying with animals (goats) in the same house as my colleagues found. Mm, we advised them that it is not healthy to live with animals in the same house. Aah, the family had fear of their animals being stolen, mm, we discussed the dangers to their health, and for example they can get serious illness from those animals which may be fatal (FGD NS, 3, 4).*

Furthermore, nursing students felt that once in a while a combined activity with all stakeholders would reinforce the community's understanding of programme activities.

*It would be better once in a while to have a joint interaction with pupils, parents and teachers like one day activity, mm, so that there is better understanding of the activities like home cleaning, preparing of food. When they go home they can keep reminding one another, and they practice the right things taught, mm, in case one has forget (FGD NS, 9, 4).*

Participants also felt that listening and remembering improved throughout interaction within the programme. The university administrators, teachers and pupils themselves highlighted this finding. Interestingly nursing students did not raise it as their experience of the interaction. Arguably, in listening skills, individuals might take time to recognise they have gained the skill, and yet it may be visible to the people listening, interacting and observing them. In this case, the observations by the Faculty of Nursing and the university administrators noted that nursing students developed listening skills, and improved their communication skills. During participant observation both the pupils and the students listened attentively to one another and asked questions vice versa.

*Mm, I think their communication and practical skills have improved greatly. They listen and practice what they have learnt (UA, 1).*

Since teachers spend time with pupils in and out of class, they noted that pupils' interaction and listening improved. This success was as a result of pupils' interaction with nursing students. In addition, the school administrator claimed

that this helped the pupils to learn and to appreciate the importance of education. Through interaction, pupils received advice and were encouraged to work harder to achieve their goals as claimed by teachers.

*Hm, they talk and listen to nurses so through this interaction it helps the pupils to know that education is good. Hah, this makes them know that those who are up in higher institution passed through the same system of education that is primary school, secondary now university. This also makes them to be serious with studies (FGD PT, 5).*

Pupils also claimed that their parents listened to them during discussions. Being listened to, indicated that someone was interested and signified respect; thus parents were respecting their children. This shaped their children's behaviours in relationship to adult viewpoints. Pupils were motivated and prepared for better interactions with others in the school and the community.

*Parents nowadays they are good, ah, they listen (FGD UP, 5, 3).*

Parents claimed that when the pupils came back from the school, they ensured that what they were taught or discussed was still remembered, as noted in the parents' excerpts below.

*When my children come back from school they ask me Mum, do you remember what we taught you yesterday? Mm..., to make sure that I have not forgotten (FGD PP II, 2, 3).*

#### Interaction without collision

Collision in this study is referred to as conflict. Nursing students felt that their communication with the community, teachers, and politicians was non-judgemental and without collision. They claimed they were not biased, but understood and appreciated different opinions with respect to their own culture. In addition, teachers highlighted interaction without conflict allowing pupils to interact freely with nursing students and other visitors who came to their schools. Such interaction was considered beneficial to the pupils.

*This programme has enabled me to improve my communication skills I am able to interact with teachers, pupils, politicians, freely and community members. Oh, I have learnt to talk to people without being judgemental, understands their situations without putting in my own views (FGD NS, 8).*

*Hm, get to understand them, Um, interact with the community without colliding into their culture. Appreciate them the way they are (FGD NS, 1).*

*We have been allowing the university students and other visitors to talk to our pupils and to tell them all they want without hindering anyone. We give them permission (FGD PT, 6).*

### Being an advocate

The nursing students, teachers and parents claimed that they were advocating for the community. For instance, one student broadly stated that she learnt the health challenges of the community through her interactions. Therefore, if given the opportunity to “speak out” for the “community’s unmet needs” with policy makers, she would shed light on their health problems and advocate for them. They further noted that any advocacy required an active collaboration and the involvement of community leaders was significant when advocating for the community’s health in ensuring the voices of the helpless were heard. While the teachers claimed they were acting as “ambassadors” in the community.

*Ooh, personally by going to the community and the homes, ah, I identified major health challenges, and if a policy maker from ministry of health asked me the major health challenges affecting communities in Katete, mm, I will be able to speak out and mention, mm, for I have now known what health related problems they face. Yeah, challenges like poor hygiene, knowledge deficit about prevention of diseases like those sleeping with animals in the same house and so forth (FGD NS, 10).*

Teachers claimed that their interaction within the programme and community also involved advocacy. They advocated to the parents and the community about the programme’s usefulness. The teachers ensured that pupils and parents understood the messages by continually reinforcing the health information.

Furthermore, they stated that each time a parent was needed at school in case of the child sickness; they reinforced the communication messages sent to parents.

*Aah, the message we get from here we disseminate to the community, mm, we are ambassador as some people would not know the purpose of the project, mm, we would explain that to them, that this programme is to help the children, their parents, and the rest of the community as how to live a healthy life (FGD PT, 10).*

One parent indicated that because of his political status he was not only advocating but also mobilised and explained the programme to the community members. A case in point was the successful nutritional day exhibition. Advocacy in this programme contributed to the involvement of diverse groups of people (including politicians).

*Aah, for me I have been in this programme as parent as well as a political leader (L.C 1.) I have been in this programme since the beginning. Hm.., i remember when we mobilized the community, mm, when we had a very big function of nutrition day, ah, this was a great day, and the day was very successful. Hmm, the nutrition day for educating us how to prepare good nutritious food (FGD PPI, 2).*

Teachers felt that although there was communication between the teachers, pupils, nursing students, and parents; some parents were not responding to communication when invited to the school regarding their children's health. They claimed that there was a need for sensitising them in relation to the care of their children.

*There is need to sensitize parent involvement in the care of their children when they are sick. Hah, at times parents are requested to come and be given explanation of the condition of their children ...hmm, but some parents could not come" (FGD PT, 3).*

## MAIN CATEGORY 4: Acting as a role model

Table 18. Acting as a role model

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

Faculty staff, nursing students, pupils, teachers and parents, highlighted observing other stakeholders as role models. Acting as a role model emerged from four categories as shown above. Role modelling is a significant factor of Ubuntu in changing people's behaviour either positively or negatively.

### Lecturers as role models to nursing students

Both faculty and students portrayed positive role models in the community. The community learnt from them as they gave health promotion and education talks together. Students felt that their lecturers were role models for knowledge and practice. Observing lecturers helped them to learn appropriate nursing skills which facilitated them to gain confidence.

*Hm, we students got the knowledge from our lecturers and we gotten better and better in our skills. Ah, our practice was good for example the way I would do health assessment was very systematic (FGD NS, 1).*

*Going with the lecturers they introduced us to some good techniques of giving health education talks and also understanding this, mm, opened our minds to learning different people in different communities. Observing simple techniques of making teaching aids to make our health talks interesting, as pupils learn better by seeing. Ooh, I am happy, as it has made me learn more and I enjoy giving health talks (FGD NS, 5).*

*We attend to the problems in their order of priority and listen to everyone in the home. Hmmm.., the nursing students learnt from us to treat patients with respect and in holistic manner (FGD FN, 5).*

The nursing students observed their lecturers and emulated their behaviour and practice and this made the students become responsible for their own learning in order to be like their lecturers. At the same time, offering constructive feedback facilitated the students' interest in their own learning. The manner in which the faculty communicated to the students led to their improved communication and this was reflected in their practice as claimed by the faculty staff.

*Exposing the nursing students to the community they observe us how we behave towards the community member, is a very good idea as students learn (FGD FN, 3).*

*Each one of us has a role to play in this programme, teaching them, guiding them how to behave in the community, answering their concerns mmm... many roles which assisted them to learn (FGD FN, 2).*

*Yeah, what I mean is that students have become responsible for their own learning (FGD FN, 6).*

The faculty staff felt that the students' attitudes towards the profession changed in the community. This, the faculty staff attributed to students being closer and observed how they practised.

*Working closely with lecturers and the community, ah.., changed the perception of nursing students and their attitude towards nursing profession has changed (FGD FN, 6).*

*Our graduates are praised wherever they go, ah, that they are good in knowledge, skills and their attitude towards caring is marvellous **(all nodding their heads in affirmation)**, ah, this is attributed to practice they go through while in this community programme guided by us (FGD FN, 5,6,7).*

#### Student as role models for Pupils and the community

Nursing students' cleanliness was emulated by the pupils and the parents and community members. Seeing nurses clean in their uniforms made the pupils keep their uniforms clean. Teachers felt that the pupils' admiration of the nurse's smartness in their uniforms raised their hopes of joining the nursing profession.

*They are very clean and I am also keeping my uniform clean (FGD LP, 7, 9).*

*The nursing students come here and they are smart, and our pupils admire them and say actually I must be like them in future (FGD PT, 10).*

In addition, the faculty claimed that the pupils' role modelling of nursing students arose from both observations of the cleanliness and through the health education discussions which emphasised cleanliness.

*Nursing student give health education to the pupils, mm, also being role models, we are clean ourselves. Yeah, the pupils are becoming responsible by keeping their uniforms clean. Even the community is clean (FGD FN, 3).*

Pupils began to see nursing as a possible career choice. Even if nursing wasn't for them, the pupils recognised the nursing students' professional style and, their confidence and authority. One pupil noted that the nurses were *"being able to stand before the congregation and ask questions"*.

*Aah.., we are motivated to become nurses, and for me I would like to become like you stand in front of others and ask them questions (FGD UP, 5).*

*I would like to study and become a doctor in the future or like these nurses. Umm.., they help children to improve with their studies. Um.., also they give medicine when you are sick (FGD UP, 7).*

*I am reading hard and I want to be like the nursing students'. Ah.., I have enough books to read (FGD UP, 10).*

Pupils understood that in order to become nurses or other professionals, they needed to take their education seriously. This inspired them to endeavour to become university students themselves.

*"I am motivated to go up to university" (FGD UP, 6).*

Teachers further attested that the presence of nursing students in the community acted as role modelling to the community members. The nursing students supported the teacher's ideas, and in addition noted that the community was practising what they had learnt, such as disease prevention measures, keeping their homes and the environment clean.

*Ah.., this can be attributed to university students visiting the community and being role models in the community (FGD PT, 8).*



*Giving health education in local communities and this helped the community implementing different health practices in the homes. Aah..., like keeping environment clean etc... (FGD NS, 10, 6).*

#### Pupils as role models for other pupils.

Pupils felt that having this programme in their school equipped them with knowledge as discussed in the category sharing information better than their peers who had none. For that reason, they claimed they were acting as role models for them. As one pupil stated; “*we have better information*” about preventive health measures as well as “*good at expressing themselves in health related matters*”. Pupils indicated that they could judge that their peers lacked knowledge through communication and they were teaching them as well as being role models as expressed in their excerpts below.

*Hah..., we feel we have better information than those children without this programme in their school, mm..., when we are conversing with our friends, for example if you express how to prevent diseases, you can see your friend do not know, and you do (FGD UP, 3).*

#### Katete community as a role model for other districts

Parents claimed Katete community was acting as a role model for the district. That the programme was useful and that it could benefit other members in the community, region as well as the country at large. They also noted that this could lead to a healthy nation.

*Ah..., I prefer that this programme be expanded, ah, so that it is exemplary to all district and to Uganda as a whole (FGD PPI, 8, 6).*

*We want all the communities in the municipality to be a role model of healthy living in the whole of Uganda (FGD PP II, 2).*

## MAIN CATEGORY 5: Developing / growing confidence and self esteem

Table 19. Developing / growing confidence/ self esteem

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

Developing or growing confidence and self-esteem emerged from four categories as shown in table 19 above. The categories of nursing students teaching medical students and pupils teaching parents appeared in more than one main category see (collectivism under sharing information and knowledge and Improving communication / reception).

Participants noted that both the pupils and the nursing students gained confidence and this was evident from participant observation. This was due to overcoming fear and shyness as illustrated below. Nursing students had confidence while giving health education talks stressing important points to the pupils. In addition, confidence was highlighted in all the documents analysed that the students had developed confidence in their practice and the pupils were confident talking to teachers and parents. The university administrators and the faculty from FAU did not claim development of confidence as part of their programme experience. This was to be expected, as the nature of their involvement in the programme was mainly administrative, support and guidance.

#### Community exposure / overcoming fear

For student nurses, the community exposure was an exciting opportunity and a new learning approach away from the classroom. For some nursing students, this experience was their first time of going into a rural area. Faculty staff claimed these students felt excited about going into the community. This type of learning experience coupled with practice and guidance from lecturers enabled students to gain confidence. Being able to ask lecturers questions at any time promoted their understanding of students. Community exposure helped the students to understand the community better, learn how to approach and enter the community, as well as be able to interact with people in the community. Nursing students became more focussed and knowledgeable in their community practice. Their practical skills improved. They were able to assess clients from head to toe systematically and arrive at the correct diagnosis. This process facilitated the linkage of theory to practice. Furthermore, not only did students learn but also helped the community to become healthy. As stated by the nursing faculty, “a *healthy community is a healthy nation*”.

*The skills of clinical practice improved. Nursing students gained skills to equip them in their practice, um.., we have acquired the skills which will enable us practice better (FGD NS, 1, 8).*

In addition, supportive faculty and an enabling environment influenced student learning and they achieved competency in practical skills; especially history taking, physical examinations and observational skills. The students claimed that

they had the ability to differentiate abnormal conditions such as difficulties in breathing (pneumonia) through counting respiratory rate and observing for flaring of nostrils. Participants also attested to the improvement in health education skills in personal hygiene, environmental sanitation and proper nutrition to mention a few.

*I was able to do very well, assessment of most conditions ah..., I mean like respiratory problems, I am able to tell normal respiration and a person suffering from pneumonia, abnormal respiratory rates, ah by listening to the chest, counting the breath rate, mm, also looking at some signs, ah, like flaring nostrils especially in children. I am very confident; i do my nursing care systematically, also when giving health education talks (FGD NS, 3, 7).*

Students claimed they had gained confidence and were able to speak in public, or give health education talks to the community without fear. Overcoming fear and gained confidence through community exposure facilitated students' self-esteem.

*Yeah, for me in this programme I have gained confidence to give a talk in the homes. Mm, at first I used to fear talking in public but through this programme I have acquired experience, ah, I can approach any home and educate (FGD NS, 10).*

Students' proximity to their lecturers enabled them to overcome the fear of their lecturers and they saw them as friends. The confidence gained allowed them to ask lots of questions without fear. Consequently, the fear of the practicum site and making mistakes was overcome. This friendship and collegial atmosphere empowered them to take the lead in their own learning. Although the lecturers had noted that some students were shy they reaffirmed and stressed how students had overcome shyness and gained confidence through their involvement in this programme. Developing confidence and competence has been associated with overcoming this fear and anxiety in the practice area (Sharif and Masoumi 2005; Baglin and Rugg 2010).

*...they come with confidence as they practice without fear... (FGD FN, 2).*

*I would ask a lot of question, and the lecturers would direct me on what to do. I was closer to the lecturers and not very shy as I was before going into the community. Ah, I realised that the lecturers are very friendly and ready to help us learn. Mm, that is how I gained my confidence (FGD NS, 3).*

*However, some are 'shy to talk' even cannot have a conversation with lecturer (FGD FN, 8).*

Nursing students claimed that community exposure enabled them to make decisions, practise autonomously and to be non-judgemental, handling each patient in a unique manner with respect. Students stated that this exposure to learning was motivating and was interesting; furthermore practising autonomously was a satisfying experience and rewarding. This was supported by the faculty that students were empowered and made decisions.

*Oh, I have learnt to talk to people without being judgemental (FGD NS, 1).*

*Aah, I have learnt to involve patients in the decision making about their management, because it's very important to get their involvement, so I appreciate this programme for having exposed me to this kind of care with respect (FGD NS, 7).*

*Aah, the nursing students are empowered in their decision making and they practice autonomously. Yeah, their judgment of care is not biased, appreciating what community goes through and how to handle the patients in a unique manner (FGD FN, 6).*

Students felt the community had beliefs attached to treatment. Therefore, any communication in relation to treatment had to be done with great caution.

*Oh, in the community I have learnt that people have different beliefs even when it comes to treatment of illness they believe differently. Mm, so we have to be very careful when giving information to them (FGD NS, 10).*

Nursing students improved in their care, treating the clients in totality including other family members and assessing the environment. They claimed the programme opened their minds to go beyond the presenting ailment treating the community with respect in their homes and employing a holistic approach. This was supported by the faculty of nursing and parents. Students felt that the approach was different than that of the hospital, where they focused on the presenting complaints only. Students became confident and their response to the clients' concerns was different from their previous practice before this programme.

*It opened my mind to think broader than the actual person to go beyond and look at him or her with respect and in a holistic approach (FGD NS, 9).*

*Wow, my experience is that my care has also improved as I look at a person in totality. Mm, unlike in hospital where the person is looked at only addressing the disease problem which has brought him or her (FGD NS, 10).*

*Um..., here we even go to homes and looked at the whole family, the environment, other family members (FGD NS, 4).*

*Hmmm..., the nursing students have learnt to treat patients with respect and in holistic manner and they have gained confidence (FGD FN, 4).*

*Aah..., the nurses offer the care with respect, this is very important. I feel cared for when I am sick, the pupil and the whole family (FGD PT, 9).*

#### Utilisation of prior knowledge

Nursing faculty claimed that this exposure and utilisation of their prior knowledge had led to strengthening nursing students' confidence not only in the community practice but also in the clinical area. They were able to determine the correct nursing concerns and were able to come up with an appropriate care plan.

*Aah, I have become confident with the care of patient, Mm, for example I respond to their concerns with confidence which was not the case before I was introduced to this programme (FGD NS, 10).*

*They are more focused and knowledgeable through practising in the community and are able to assess the patient from head to toe systematically, arrive at the right diagnosis and differentiate the normal and abnormal (FGD FN,1,5).*

*I have noticed that because of their prior knowledge, ah, they had in the community.... discuss the patient nursing care and come up with clear nursing concerns and develop the plan of care. (FGD FN, 2).*

#### Students teaching medical students

Acquiring knowledge through this programme made the students change some traditional roles. Participants claimed that nursing students gained confidence and developed self- esteem and were teaching the medical students. Students claimed that their prior knowledge in the community empowered them with confidence and enabled them to teach and guide medical students. Nursing students attributed their lead to medical students in community diagnosis to their prior knowledge of community nursing experience.

*Yeah, in the community we have been doing community diagnosis, ah, I have also realised that we are better than medical students in community aspects are, mm, because of this programme. We also gained confidence in what we were doing, mm, knowing that we can make good nurses (FGD NS, 10).*

*I gained confidence in community diagnosis; ah, even when we are in the community with medical students, I teach them because they do not know how to enter into the community. Aah, they only wait for the patient when sick in hospital but for us nurses, uh, our approach is preventive and we tackle the problem right from the community, this is a great achievement for me (FGD NS, 1).*

*When we were put together in our last placement medical students did not know how to approach a community, we were the ones leading our various groups and guiding the rest, ooh..., I am so happy of my community nursing experience through this programme (FGD NS, 2).*

The lecturers expressed excitement seeing nursing students teach medical students. They further felt that the traditional way of practise is changing as noted in their excerpts.

*Ah, our students, when they are with medical students mm, they are the ones on the lead, ah guiding the medical students because of their prior knowledge, talk with confident as they teach them. Mmm, this makes me feel proud of our nursing student and profession at large. I am happy seeing that we are the one in the lead guiding other professionals, ah, we have a cause to be proud of ourselves as nurses (FGD FN, 2, 6).*

*The traditional way of practising that the doctor knows it all is no longer the case. The programme empowered them to know and make a decision and work as a team (FGD FN, 8).*

#### Pupils talking to parents, teachers, and nursing students

Through this programme, pupils gained confidence and were talking to their parents, teachers, nurses and even the community. Similarly, this was discussed in subcategory of sharing information and knowledge and main category of improving communication / receptiveness. Pupils talked about good nutrition with their parents. Most importantly, the parents listened. Pupils had acquired knowledge of a balanced diet from health education talks, and had confidence talking about it to their parents. The pupils understood what made up a good balanced diet. This was demonstrated during participant observations as well. They actively participated and mentioned the types of food they needed to eat to remain healthy, as well as identifying diseases they could get by eating the wrong foods. For example malnutrition, scurvy, interestingly they even mentioned the lack of blood (anaemia) if they did not eat food containing iron such as liver, millet, milk, green vegetables to mention a few.



*We communicate easily with our parents now. Uh, in the past, we did not talk with them about nutrition, but now we talk with our parents about it (FGD UP, 3, 5).*

Parents reaffirmed the new role of the pupils. Now their children spoke and gave advice to them without fear. They claimed children told them openly if they were not satisfied with any practices at home. It was easier now to communicate with them than it had been in the past. The confidence they had acquired gave them courage to sit and talk with their parents and share as a family. Parents regarded this as an achievement, and one parent admitted being proud of his daughter as noted:

*I am actually very proud of her. Hm, it is even easier now to communicate with my girl because in the past it was difficult, she only did what we told her, but now she gives us advises without fear and she is very firm on her points ( FGD PPI, 4).*

*Eh, they are no longer fearful; we sit and talk as a family. Aah they can say that is not good, we need to do it this way. So this is a big achievement (FGD PP II, 2).*

In addition, pupils claimed that they were communicating with teachers as well. These enabled them to develop more self-esteem and were able to express and engage themselves in discussions during class time. They actively participated in science lessons as stated in their excerpts.

*Hm, we are able to stand and express ourselves and ask questions about science topics (FGD UP, 7).*

*mmm...also we can communicate with our teachers ( FGD UP, 3).*

Pupils in the lower (younger) class, developed confidence and it enabled them to speak some English. They communicated with nursing students and teachers in the classroom. English language is the language of instruction as well as the local language. Children that come from communities where only the local language is the medium of communication were more at a disadvantage; they

found it very difficult to speak to teachers at school. In urban areas, English may be the primary language of the town and the family. Therefore, having nursing students from different parts of the country likely meant some communication problems would exist. In this programme, English was used alongside the local language. This approach enabled the pupils to understand and improve their spoken English. In addition it contributed to overcoming shyness as noted in their excerpts:

*We have learnt to speak some English with the nursing students even in class with our teachers. Hmm it is good (FGD LP, 8).*

Teachers claimed that pupils gained confidence and were talking and asking questions freely without fear to nursing students. During participant observation, pupils' interaction with nursing students was engaging as they actively asked questions and responded to queries asked without being shy.

*Oh, when these pupils come for this health education talks, ah, when they are teaching them on health related topics they feel free to ask questions and interact with the nursing students easily (FGD PT, 7, 2).*

## MAIN CATEGORY 6. Crossing / bridging the gap

Table 20. Crossing/ bridging the gap

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents' / nurses' lives Life prospect enhanced Pupils / community health improved

### Breaking down the barriers/ penetrating

The faculty staff claimed that the barrier that existed between institutions and the community were removed and they were able to enter the community uninhibited. They claimed this programme was 'a link' between the University and the community.

*It is easier to penetrate the community without questioning, ah..., the barrier wall between the primary schools, the community and higher education is no longer there (FGD FN, 2, 8).*

*...the programme is a link... (FGD FN, 4).*

Easy accessibility to the community through primary schools was reaffirmed by nursing students. They also noted that communicating with the pupils and their teachers, as well as the community members, was simple because of this programme

*It is easier to penetrate the community through the primary schools within the community (FGD NS, 6).*

The university administrators claimed that the barrier between the community and the university was bridged by the nursing students' humility; going into the community to teach health promotion and illness prevention up to their homes as discussed in category of sharing information

*Hmm..., the community to have seen the university coming down to them and give the health education talks and to narrow the gap between the University and the communities where the University is situated (UA, 1, 3).*

Administrators claimed that the community mixed freely with the university staff; there was no fear unlike before. Consequently, this heightened the university's reputation among the community members. They discussed this one to one, as evidenced whenever there were functions, or when they came to the 'University for consultation' they had no fear.

**Smiles!!** *Oh, you know, institution of higher learning are feared by community as they take it to be a place of highly knowledgeable and learnt people. Hmm, the community being in the rural area do not see how they can mix with them. But my experience of this programme is that the community mixes freely and they are very happy. Um, seeing nursing students visit their homes is great. Aah, whenever there is a function we all sit together and chat freely so this is great and has made MUST a well-*

*known University in answering communities' needs. Ah, the community feel free to come to university for consultation without fear. Um, this was not before this programme. I am really very happy for this programme (UA, 3).*

On the negative side, administrators claimed that some community members felt inferior and considered the University staff highly qualified. Participants felt that, such attitudes of “*inferiority complex*” could prevent some members from interaction, considering themselves inferior thus making it difficult to penetrate the community. In addition, it could negatively affect the achievement of programme objectives.

*Uh..., they see institutions of higher learning as highly academic and community feels inferior to mix with. Of course the obvious reason is that, they are not as educated as them or never went to school completely. So this makes them have the inferiority complex (UA, 1).*

The administrators felt that some members of the community could have been suspicious of the university involvement with their community. Seeing them in their community and their own home could have raised some concerns in some members

*Huh..., difficulties to penetrate the community if they suspect you to want to see how poor they are, ah..., they feel uncomfortable having people intrude their environment (UA, 1, 3).*

#### Getting down to children's level and the community

The nursing faculty noted that nursing students getting down to the level of the pupils and the community humbled them. In carrying out the community activities as well as communicating to pupils the students appreciated the uniqueness of community and pupils' problems. For instance challenges such as, adolescents' risk behaviour; “*the danger of drinking and smoking habits, as well as peer pressure into early sex*”... (FGD NS 1). Nursing students claimed that this was possible because they were able to befriend the pupils and get to their level of understanding. These acts enhanced nursing students' communication with the

pupils, bridging the gap and promoting trust between them. They discussed the risk behaviours affecting the pupils. Students were happy with this approach and each time they employed it they found a satisfying experience.

*The community activities humbled the students and they appreciate that different people have unique problems and how they should be handled is never the same (FGD FN, 3).*

*Putting ourselves very low to their level and being friendly and free with them was satisfying experience (FGD NS, 3).*

Nursing students experience of bridging the gap, led to cooperation between stakeholders. They claimed they were working together for the common goals of the programme as noted in their statement below.

*I have noted that throughout this programme, there was cooperation between the nursing students, teachers, pupils and the community members (FGD NS, 6).*

#### Better relationships between teachers, parents and pupils

Teachers felt that since the inception of this programme, it was easier to communicate with other groups. Parents visited the school regularly, thus bridging the gap between the school and the community. They came either to check on their pupils' performance, or when children were sick for advice and treatment at the wellness centre.

*Communication is much easier than before with the parents. As they come they also keep on getting feedback about their children performance or they can look into their books (FGD PT, 4).*

*Regular visit of parents to our school they always come to get knowledge or bring their children to school (FGD PT, 2).*

Communication between teachers and parents appeared to be improved. For instance, they claimed that whenever messages were sent to parents through their children they took it seriously and acted accordingly, as evidenced on the nutrition fair demonstration day. Large numbers of parents attended. Teachers

noted that the communication was much easier. Parents responded immediately, whereas prior to the programme their response would be delayed or not occur at all. Parents agreed and reaffirmed their improved relationship with the schools and the teachers since the implementation of this programme.

*When the teachers at school send messages with our children we respond positively. Mm, in the past it would not be easy to get parents response (FGD PPII, 1).*

#### Better reception in the hospital

Teachers claimed that nursing students offered services with respect not only in the community but also when they met them in the hospital. They stated that they received good care in the community as well as in the hospital. Some parents were in support of teacher's narrative regarding nursing students' "care with respect".

*.... they treat us with respect and assist us when we need guidance and direction may be to see a doctor I am really happy about this programme (FGD PT, 10).*

*The way services is delivered here at the wellness centre is the best way, hm..., because when you give pupils medicines and counselling, it helps as they get knowledge as well ( FGD PT, 3).*

Importantly, on the negative side, some parents expressed their disappointment over the services they received in the hospital. Hence, they expressed fear to go to the hospital; rather they preferred services in the community, highlighting difficulties they faced in the hospital. They claimed they were happy at home where they could talk freely with the nursing students, who were good to them. Such negative perception of hospitals could have an impact on communities' health seeking behaviour.

*Hmm..., everyone in the community seems happy. I am learning every day. Unlike in hospital, ah..., you are frightened you can't speak out your mind. Many patients and few nurses they are usually overwhelmed by the number of patients (FGD PP II, 4).*

Nursing students further claimed that some community members wondered about the differences between the nurses they see in the community and the ones in the hospital. In addition, the students felt that such feedback from the community could be used to improve services.

*Mm..., a woman was saying that “we go to them in the communities and we are good, but when they go to the hospital they get different nurses”, she wondered...their behaviours were the opposite of ours...Yeah, each patient / client should be treated the way they are not to generalise because each one is unique. Therefore such feedback we get from the community members should be the basis upon which we should use to improve our nursing care we give to patients (FGD NS, 6).*

Although the pupils claimed that they received better reception from the student nurses in their school, they also felt disappointed whenever no first aid was given, or they were referred to hospital for simple cases.

*When are sick they treat us by giving us tablets; they are good because they don’t give us injections (FGD LP, 8, 9).*

*I went to see the nurse one day when I was not feeling well, ah..., she only examined me and said I should go to the hospital, because she was lacking some drugs for malaria. I was sad yet if she had drugs I would not have missed my class (FGD UP, 1).*

*Aah..., when a pupil comes to see the nurse, he or she knows that he must get the drug. Hmm..., when he doesn’t get it is disappointing (FGD UP, 8).*

#### Getting to know traditional healers

The faculty staff claimed that they understood the traditional healers better than before. In addition, traditional healers gained trust. They were not suspicious and shared freely without any fear of betrayal of that trust. The nursing faculty stated that they entered their premises without difficulties claiming they had become



friends. This trust was also highlighted in the documents analysed from department of nursing.

*Traditional healers do not easily share their information or knowledge with strange people they have gained trust and are very confident with us. They share their practice and they know we are not going to share their ideas with other traditional healers or lay people to get their knowledge. Mm..., we are using it for teaching the nursing students (FGD FN, 8).*

*Actually we have become friends with them. Hah, the barrier wall between traditional practices which used to be very secretive is not the case (FGD FN, 7).*

## MAIN CATEGORY 7: Transforming one's life

Table 21. Transforming one's life

Main Category	Sub-Category
Collectivism	Connectedness Respect Sharing information Compassion
Being involved – participating	Empowerment Achievements / raised self-esteem, pride, success Widening horizons
Improved communication / Reception	Interaction with pupils, communities, nursing students Interaction without collision Being an advocate Listening / remembering
Acting as a role model	Lecturers as role model to nursing students Students as role model to pupils and community Pupils as role model to other pupils Katate community as role model to other communities
Developing / gaining confidence / self esteem	Community exposure – overcoming fear Utilisation of prior knowledge Students teaching medical students Pupils talking to parents, teachers and nursing students
Crossing / bridging the gap	Breaking down barriers / penetrating Getting down to children's level and community Better between teachers, parents / pupils Better reception in the hospital Getting to know traditional healers
Transforming one's life	New learning experience and liking school Children seeing parents differently Transformation of community / parents / nurses life Life prospect enhanced Pupils / community health improved

### New learning experience and liking school

Community placements were a new learning experience for the student nurses. Exposure to the community provided students with an appreciation of the rural settings in which most Ugandans live. The nursing faculty staff felt that this approach enhanced their learning and practice. The community awareness created by the programme gave students an understanding of the communities and the associated health challenges. Students were enthusiastic, willing to learn

and were interested in the programme. Interested students learn better, than uninterested and it was easier for the teachers to engage with the students.

*Students have become enthusiastic willing to learn on their own and are interested. As such this has made our work as faculty easier (FGD FN, 3, 4, 5).*

More new learning came from the discovery of new diseases that they had not seen in their hospital practice. For example, during health assessment of the pupils, students identified cataracts. Previously, the community had associated cataracts with witchcraft and cultural beliefs. Consequently the pupils were not taken to hospital to seek appropriate medical attention. The students did refer the pupils to the hospital. Being able to diagnose and refer conditions to the hospital for specialised care was considered an achievement and was rewarding for the students.

*Oh..., we learnt many type of diseases which were not seen commonly in hospital. Hmm, especially those the community thought was not treatable like ring worms on the head of the pupils, cataract in children's eyes some parents thought it was witchcraft (FGD NS, 10, 5).*

*Parents would not send pupils for treatment, but when we diagnosed these conditions, cataract, we refer them to hospital, mm, indeed they are attended to and I believe those pupils would have lost their sight (FGD NS, 7).*

*I came across two cases which needed referral to hospital, they had severe pneumonia, with in drawing chest and fast respirations and one pupil had flaring nostril as well. I referred them to hospital, oh; this was a good learning for me (FGD NS, 9).*

Through participation, they were able to learn to differentiate normal conditions from abnormal findings and this learning could later be applied to their hospital work.

*We were able to learn the normal, mm; this made our work easier in identifying abnormal condition like high blood pressure, rapid pulse and so forth. I learnt to differentiate the normal range between different ages of children when taking temperature, pulse, respiration and blood pressure (FGD NS, 3, 1).*

*Community diagnosis skills was a good learning experience especially the use of all senses such as see, smell, listen, touch and feel as we moved in the community , ah, using this approach, Ooh ..., we learnt a lot and we were able to come up with rightful diagnosis in the community (FGD NS, 8, 9).*

Nursing students felt that these new skills enabled them to approach communities differently. They took pleasure in giving health promotion and education talks, and they found that observing pupils' keen interest to learn was a satisfying experience. This was also noted during participant observation when the nursing students were giving health education. They used a lot of innovation to capture pupils' attention during the nutritional health talk. Pupils were very interested and participated actively.

*I learnt some of the techniques I did not know, but by going with the lecturers they introduced us to some good techniques of giving health education talks and also understanding this, opened our minds to learning different people in different communities (FGD NS, 5).*

*Seeing the pupils very actively listening and smiling throughout the talk is very interesting and satisfying (FGD NS, 9).*

Practicing anywhere, outside the hospital environment transformed nursing students and they started to enjoy nursing.

*I realised that nursing can be practiced anywhere not only in the hospital and this has made me to like nursing more (FGD NS, 4).*

The programme helped to prepare them for their future work. Through this exposure, students knew what to expect in their practice and they understood the

community better. This knowledge assisted them in planning health education talks.

*Introducing the nursing students to this approach of care is the best. They understand different group of patients in the villages and treat them appropriately (FGD FN, 7).*

In addition, understanding the uniqueness of people in the community transformed their lives, allowing them to appreciate their own roots and changed their way of thinking. This led to the appreciation of the usefulness of the community placement.

*I come from the homes that are quite different and I have grown thinking that most homes are like where I come from in urban setting. Ah..., but by going into the community, I have appreciated because the people are not like you (FGD NS, 7, 4).*

Further, nursing faculty claimed students going into the community for the first time were willing and had an intense desire to learn, to understand the community, and be part of the community.

*Nursing students have changed some of them come when they have never been in the community; their eagerness to learn and adapt to the situations on the ground is a big change in their life as well (FGD FN, 2).*

Equally pupils claimed they liked schooling because the programme was 'educative' and nurses were 'good' to them. As a result, they never missed schooling as discussed in the main category being involved and participating.

*Aah..., I love my studies because the programme is educative, is teaching me how to look after and take care of myself (FGD LP, 3, 2).*

*I love coming to school every day because I learn from the nurses and they are good to us (FGD LP, 7, 9).*

Teachers and faculty nursing also claimed that, the career guidance pupils received from nursing students made them strive to join the university education with the hope of helping their parents in the future.

*The pupils read hard and work towards joining the University, hm.., in future they can help their parents and the community (FGD FN, 2, 1).*

*For career guidance this pupils have seen nursing students from the University ah, are reading very hard to joining the university in the future (FGD PT, 7).*

Through transformational experience, pupils did not only like schooling but were able to see their parents differently. Pupils highlighted that in the past, it had not always been easy to talk to their parents. Since this programme was introduced parents and elders were different and easy to talk too as discussed in subcategory of sharing information and main category improving communication and receptiveness.

*It was difficult talking to my parents in the past (FGD UP, 3, 2, 5).*

#### Transformation of community / parents/ pupils/ nurses lives

The new knowledge acquired by the community enabled them to prevent diseases as well as care for their children. This was further supported by faculty's narratives that on the nutritional health fair day, women were seen "*breastfeeding their babies*", their "*fingernails were short and clean*". These were examples of knowledge translation into practice. The students further attested that those community members who in the past would share their homes with animals had constructed separate animal shelters.

*Mm.., the community have improved in their lives, mm, those who use to sleep with animals in their houses, we educated them and they have built shelters. Yeah, we told them it's important to stay in well ventilated houses, to prevented diseases and reduce the spread of infection (FGD NS, 5, 1).*

The pupils claimed parents who previously shared toilets with neighbours constructed their separate pit latrines as well as kept their environment clean.

Parents through this programme were listening to their children, and were able to be implementing what the children suggested.

*My family keep our compound clean. This programme has helped my family to have proper sanitation even our neighbour, ah; we have pit latrines at home. Hmm, in the past we would go to neighbours (FGD UP, 5).*

#### Life prospects enhanced

Both nursing students' and pupils' worldview was enhanced through this transformational experience. The Nursing faculty noted that through this programme nursing students changed their perception of the nursing profession. The faculty staff stated that some had decided to pursue community nursing upon graduation. Nursing students highlighted this and claimed that the programme increased their nursing competency. These students desired to "promote *health and prevent illness rather than working in the clinical area waiting to receive sick patients*".

*Going in the community has shaped her nursing practice. She was undecided at the beginning of her course whether she really wanted to join nursing. Going into the community has changed her perception she wants to work more in the area of preventive and contribute towards disease prevention. Isn't this great? (FGD FN, 8, 6).*

*After we had started going to community, that I realised my interest to work is more in the community than in the hospital (FGD NS, 5, 6).*

Students claimed that the exposure to this programme changed their approach to patient care. They noted that not all complaints were physical. Some were psychological. Understanding where the patients come from in the community, changed students' perception of care, having ample time with the community facilitated their interaction with communities or patients or clients. This enabled the students to understand them better in their environment. Understanding the impact of psychological illness on people's lives required time and a holistic

approach to health care. In addition, FA faculty felt that community experience offered students transformational learning.

*Some problems are not physical but could be psychological. Yeah, I have learnt holistic approach including the home and the people in it (FGD NS, 2).*

*It is very important asking them few questions so that they give a picture of where they come from. I spend more time without being in a hurry talking, ah, interacting with them dealing with their problems (FGD NS, 4, 8).*

*I felt that the program offered transformational learning experiences for the students. – See the people in their home environment is always important (FA, 4).*

#### Pupils / Community health improved

All participants claimed the pupils' and the community health improved. This was attributed to health seeking behaviour, getting treatment immediately, disease prevention, improved hygiene, better eating habits, and a clean school environment. This was also discussed in the main category involved and participating in the category learning and empowerment as well as achievements. The community members sought advice from nursing students and referred themselves earlier. Furthermore, parents utilised family planning services as noted by nursing students.

*Better health of pupils and the school environment is clean (FA, 3).*

*A mother came and told us that "family planning has helped her", ah, she is able to care for her children without being heavy with pregnancy gain (FGD NS, 5).*

*I feel good because this programme has helped me to know my life and improve on my personal hygiene like bathing daily, cleaning my teeth after meals (FGD UP, 1).*

*This programme has made me to know my body (FGD UP, 4).*



*The community health behaviour has changed they come to hospital immediately and they do not stay long on the ward (FGD FN, 6, 4).*

*Children used to come when they are hungry they used not to eat lunch, they would come hungry fall sick or go home (FGD PT, 3).*

*This programme has helped us a lot on feeding habits especially the pupils how to feed on a balanced diet (FGD PT, 2).*

In addition, parents valued the programme because of its benefit to them and their children. Parents and the Faculty of Nursing primarily observed behaviour change and knowledge on disease prevention as discussed in the main category being involved and participating in the subcategory learning and being empowered. Teachers further emphasised and supported the claim that pupils were no longer disturbed by sickness as they got treatment immediately and learnt to prevent disease.

*This programme is good, our pupils are benefitting and they are settled not many problems unlike in the past where children would fall sick now and then. Ah, children are in good health (FGD PPI, 3, 5, 6).*

*... It's a good project (FGD PT, 10).*

*The children, parents, and the community have all benefited from this project (FGD PT, 8).*

*The behaviour of the pupils have changed they seek treatment straight away whenever not feeling well (FGD FN, 2).*

*We no longer get many pupils falling sick. Most children had malnutrition before, and now the children are looking healthy. They learned the purpose of eating well (FGD PT, 8).*

*...even the schools around us have benefited from this programme since they send their pupils here for treatment when sick (FGD PPI 1, 2, 4).*

*The programme has helped the school and the community at a large in educating the children how live healthy lives (Annual report from Katete primary school 11<sup>th</sup> November 2011).*

The nursing faculty and nursing students felt that strong cultural beliefs were deeply rooted in some communities. One example was a cultural attachment to malnutrition in children. This idea revolved around cultural myths, shifting blame for pregnancies and feeding practices. For example, children who had kwashiorkor and their mothers were pregnant with another baby; the causes of kwashiorkor in these children were attributed to the new pregnancy rather than poor feeding. In addition, children with disabilities were associated with a “*bad omen in the family*” and therefore, not given the same treatment as other healthy children. The cultural beliefs, attached to such cases, were that the parents did not appease the ancestors or the gods. Consequently, as a punishment, they delivered an abnormal child or one who suffered uncommon diseases such as epilepsy.

*Strong cultural beliefs and practices which at times made it hard to convince the community about some good practices for example, malnutrition not associated to poor feeding but due to the pregnancy the mother was carrying. Hm, this was hard to change, but with time they are beginning to understand, mm, through continuous health talks (FGD NS, 8).*

*Ah., still have poor attitudes, when you discover a disabled or mentally handicap child, some families will not take such children to the hospital like other children due to cultural beliefs (FGD FN, 1).*

#### Cleanliness of the community/ pupils

Cleanliness in the community and the schools was an indication that the community and the schools were practicing what they had learnt, keeping their environment clean. This was equally noted during participant observation that the school was clean. Environmental cleanliness was highlighted by the Faculty of Nursing, students, teachers, pupils and parents.

*When you go to their homes the hygiene has improved, there is general improvement in the community and at schools the classrooms are clean, compound clean and the grass cut low, the community has learnt to keep their environment clean ( FGD FN, 7, 8).*

*Clean environment. The disposal of waste has been improved in the community (FGD PT, 8).*

*School cleanliness has improved. Um..., the smartness, cleanliness of this school has improved greatly because of this programme (FGD PPI, 7, 10, 9).*

*Ah, for me the change I see in our community, ah, there is improvement in the sanitation (FGD UP, 3).*

Parents emphasised how they were keeping themselves and their environments clean to prevent diseases. This was very evident in the excerpt below.

*Hah, I am happy the way I look after myself very well, by following the teachings. I am clean yeah, I am proud of myself, ah, I ensure that my home is clean, because I do not want any sickness attacking me. Eh..., germs can be in dirty environment (FGD PP II, 4, 3).*

Furthermore, they highlighted and suggested that competition and rewards could be used as an incentive for the community members whose homes are clean. This they stated could motivate the community practice what they have learnt.

*We should start competing among ourselves, so that the community or homes which do well should be given a reward, as a way of encouragement (FGD PP II, 3).*

The pupils, their parents, teachers, FAU faculty, nursing students and nursing faculty were aware of the pupils' cleanliness (body and uniform).

*Pupils are very clean in their uniforms (FGD NS, 9).*

*I have seen is the hygiene and cleanliness among pupils, teachers and community at large (FGD PT, 1).*

Although the participants experience transformation and were putting into practice what they learnt, they felt that poverty was hindering most members in the community as they noted that some could not afford to sleep under mosquito nets. Such inability made them vulnerable to malaria infection. Thus, although the participants were willing to change, precarious conditions, beyond their means, were hindering them as felt by nursing students:

*Some community member cannot afford like use of treated bed nets to prevent malaria (FGD NS, 10).*

## **Summary**

This chapter detailed the approach employed in analysing the data collected. A detailed description of the data analysis is presented. The seven main categories emerged from stakeholders' experiences and views of the Community-based nurse education programme. Participants' experience of collectivism was woven into the backbone of Ubuntu values and contributed to the cohesion, respect, mutual trust, sharing knowledge and compassion. Being involved and participating, communicating, together with role modelling enabled the participants further to experience confidence, self-esteem and overcome shyness. Participants were able to bridge the gap and transform their own lives. However, a few negative experiences emerged such as a lack of resources and the need to propagate the programme for other village communities. These negative experiences were reflected in participants' compassion for and solidarity with others.

# CHAPTER 6: DISCUSSION

## Introduction

This Chapter is divided into five sections: (1) Positive experiences, (2) Negative experiences, (3) Suggestion for sustainability and improvement, (4) Future direction, (5) Summary. The research study is discussed in relation to the literature discussed in Chapter 2.

The study is concerned with participants' experience of the Community-based nursing education programme. This study demonstrated the unique influence of the African cultural concept of Ubuntu in explaining stakeholders' experience of community-based nursing education in the Ugandan context. The results indicated that the Community-based education programme was accepted as well as 'owned' by the community; this shared 'ownership' of the programme contributed to the positive stakeholders' experiences. This study offered valuable insight into stakeholders' experiences of the Community-based nursing education programme and the students' community placements.

## SECTION (1): POSITIVE EXPERIENCES

This research recognised seven positive experiences which are labelled here as:

1. Collectivism;
2. Involvement and participation;
3. Improved communication;
4. Role modelling;
5. Developing and growing confidence;
6. Crossing and bridging the gap;
7. Transformation of one's life.

## **Collectivism**

The study revealed that collectivism fostered a sense of partnership with the Community-based nurse education programme and the various people involved in it. From participants' narrative, it was clear that the process employed in establishing this programme, created a cohesive partnership between the academic institution and the community. Most importantly, this was based on trust, respect, connectedness and compassion. It can be argued that the partnership was a strategic alliance that fulfilled the mutual interests and shared goals of the university and the community. The collective experiences of the participants towards the programme served as a common goal. Ubuntu had both "affective" and practical aspects emphasising the sense of belonging that contributed to the overall success and commitment of stakeholders to programme achievements. These aspects of Ubuntu were augmented by the use of the ripple effect model which involved sharing information from an individual to participant's family and to the whole community.

The study found that participants' inclusivity and their being part of the collective contributed to collaboration, teamwork, openness, transparency, honesty, communication and trustworthiness among the stakeholders. The study revealed that this was associated with acceptance and respect, with each stakeholder being seen as 'valuable knowers' with a unique experience. The diversity in knowledge among different stakeholders was seen to contribute to the sustainability of the programme.

This "collective-mind-set" and interconnectedness among participants facilitated the development of a spirit of solidarity among the stakeholders with each feeling

that they were part of the programme and that the programme was part of them. It can be argued that the 'we' state of mind contributed to a cohesion among stakeholders' as they felt belonging to the 'collective' and dependent on each other.

The participants' experiences of compassion were demonstrated through their sympathies to other community members not involved in the programme. This ability reflected participant's understanding of other members situations. Thus through caring and loving in a collective manner, kindness was shown and the need to help and care for each other was understood. Furthermore, compassion was exhibited through caring and understanding of each other and contributed to shared vision, respect as well as dignity towards one another. Respect in African culture is being humane towards others, a significant value in Ubuntu (Poovan, DU Toit et al. 2006). Dignity is related to respect created through individuals' behaviour towards others. It was found that participants' experience of respect was displayed through their daily interaction with each other. For instance, student nurses offered care with respect and valued individual's opinion and were non-judgemental. According another person respect and dignity led to the acceptance of that person and the programme they represented. Acceptance, respect and dignity, contributed to mutual trust among stakeholders in ensuring collaboration. Honesty, respect and dignity for each other promoted sharing and active participation in the programme while embracing the key principles of Ubuntu (Poovan, DU Toit et al. 2006; Muwanga-Zake 2009).

The study found that nursing students were sharing information with the community. Humility and being respectful to communities' indigenous knowledge

and culture supported this sharing and allowed students to be accepted by the community. As Schuessler, Wilder et al. (2012) points out, cultural humility cannot be learnt in classroom, but must be learned in interaction with real people. Through community exposure and sharing; students' knowledge, practice and attitudes promoted their cultural competence and understanding of communities' culture, and indigenous knowledge as they endeavoured to provide culturally congruent services to the community. This finding is reflected in the work of Amerson (2010) and Jeffreys (2006) who argue for the importance of cultural competence and its association with the development of confident practice in nursing students.

The community naturally had 'respect' for their 'Indigenous Knowledge'. Indigenous knowledge is that knowledge which the community accumulates over the generations (Flavier 1995). Through listening, the students grew and understood the indigenous knowledge and practices. This respect for indigenous knowledge enabled them to discouraged deleterious health care practices in a manner that was acceptable to the community. The study found that students' understanding and respect of indigenous knowledge led to trust to the extent that traditional healers accepted and shared with the students, inviting them into their premises.

Students learned much from their involvement in the community. Students learned to respect the knowledge possessed by the community. Through reflection, the students came to understand the significance of community knowledge and practices. This learning requires sensitivity and respect for culture (see Jarvis 2005; Swanwick 2005) and enabled the students to contribute to the



community usefully (see Mtshali 2009). Detaching culture from health and illness may neither be possible or desirable. Yasuda (2002) makes it clear that understanding the cultural importance of traditions can improve communication. It is likely that students being present in the community for a 'long' time helped to dispel any mistrust and led to openness.

Sharing of information with pupils may have acted as a foundation for building pupils' knowledge and enhancing classroom-based learning. It probably developed their ability to educate their parents, as well as 'speak some English.' As a result, the ability to share information enhanced their decision-making both at school and home. Furthermore, the data indicates that sharing of information resulted in improved pupils' health. Improved health could have been attributed to health promotion and education.

Younger people are likely to be involved in risky behaviours (Mosavel 2012). The study indicates that peer pressure probably influenced teenagers into being sexually active. However, by reinforcement of positive health messages during their school years, pupils appear to have developed positive attitudes to their health. This finding is supported by Mwanga, Jensen et al. (2008) who suggests that health education given at a younger age appears to improve healthy lifestyles. The community programme was probably effective at several levels; through the sharing of information and through observing nursing students acting as role models. These findings concurred with Social Cognitive theory which suggests that people learn from one another through observation, imitation, and modelling (Bandura 1997a). In this way, the right knowledge and information at

an early age can transform the pupils' lifestyle behaviour as well as making them agents of change within their community.

There appeared to be little if any incongruity between the content of students' and school-teachers' health promotion teaching. However, there is some evidence that the teachers learned from the discussions and were able to integrate the material into their teaching. Interestingly, Oluka and Oplot-Okurut (2008) found that Ugandan teachers' pre-service and in-service training in health promotion and education was less than optimal. There is also some evidence that health promotion and education talks increased pupils understanding and motivation toward learning science. It could be argued that the health education input was 'science' applied directly to the pupils' world and was, therefore immediately meaningful to them.

The study revealed that knowledge was transferred from pupils to their parents, siblings and the community through sharing. The pupils taught their parents, and this influenced their health behaviour. The results were in agreement with recent research findings supporting the premise that children can influence the health behaviour of adults (Mwanga, Jensen et al. 2008; Mosavel 2012; Sedighi, Nouri et al. 2012). Although pupils were able to educate their parents, this was not without some challenge at first; especially in dealing with some traditional norms. For instance, it was easy telling their parents / grandparents to 'drink boiled water' sourced from a nearby river, in order to prevent diseases such as diarrhoea. The parents / grandparents had drunk un-boiled water from the same source for many generations. However, such friction between Western and traditional knowledge

is to be expected and indicates the usefulness of this approach of Ubuntu and the reciprocal ripple effect to health promotion and education.

This study showed that health promotion and education by pupils had the potential to address even strongly-held beliefs of parents and others. Pupils in this study, like other young people, had a zeal and vigour to be more open to new information, and the drive to harness new practices. These pupils were in an excellent position within the family to examine health beliefs and practices. Their access to education is often highly valued by their parents and the community. As a result this, together with the known trait of most young people to question and search for 'new' knowledge, made them ideal conduits to help promote preventive behaviours and discourage wrong ideas. The emotional bond between pupils and their parents and the pride associated with newly acquired knowledge, motivated parents and the community to explore and examine their health beliefs, practices, and cultural prescriptions.

Historically any communication between parent and child was the opposite direction (parent to child). In this regard, the value of Ubuntu, ripple effect and role modelling could have played a significant role in clarifying why some parents felt motivated to listen to their children.

The parent-child relationship is an important cornerstone on which these values can be built for health promotion purposes. This approach is compliant with social integration theory (Umberson, Liu et al. 2008), which emphasises the importance of parent-child relationships in changing the parent's social environment. It further acknowledges that these relationships give the parents a sense of purpose and meaning, which influences lifestyle choices. Therefore, the sense of responsibility

originating from such relationship could have helped the parents to improve their health behaviour.

The finding that pupils can educate their parents is an important milestone in altering the African-prescribed cultural norms. Pupils' success could have emanated from being empowered with knowledge through health promotion and education. The pupils gained confidence and were able to share with their parents. Also, the pupils appeared not to have approached their parents claiming to 'know it all', but rather employed the same approach they had observed being employed by the student nurses and which used an approach based on 'respect and humility'.

The study found that parents were sharing with neighbours, an indication that the ripple effect model and Ubuntu were successful in this programme. It also confirmed the achievement of transfer of knowledge through the ripple effect model (Parker and Barry 1999). Knowledge was further reinforced by the presence of nursing faculty and students in the community. The Community-based nursing education programme is an illustration of nurses and the parents as change agents in the community. Mkabela (2005) argued that when natural and social life is integrated into a single whole, relationships between individuals become intimate. In the present study, participants interconnected through multiple bonds which promoted understanding, confidence and closeness which in turn discouraged selfishness and dishonesty.

Political leaders' involvement in the sharing of information meant that they were 'enabling agents' in the programme, and their presence paved the way to sharing. Interestingly, sharing was not only in health related issues, but also in such

matters as the lack of clean water and electricity. This finding supported the importance of political participation in community programmes in promoting the sustainability of the programme. However, the challenge with the political leaders' involvement over time is that they were sometimes found to offer only 'lip-service'. Such practices could affect the smooth flow of the programme. As their support toward resources was not always forthcoming.

### **Being involved, participating**

Active participation is one of the Ubuntu values and is an essential component of the reciprocal ripple effect. Stakeholders were empowered at individual, professional, institutional and community levels by developing relevant skills. For instance, at the individual level participants overcame shyness by communicating, teaching and socialising. At the professional level they developed a holistic approach to care and teaching, broadening their range of skills by being involved in collaboration and networking. At the institutional level, there was the development of partnership and collaboration and at the community level they developed teamwork, "practised" illness prevention and were networking. These competencies led to benefits that impacted positively on the stakeholders.

Nursing being a practical profession; active participation was the cornerstone to students' learning of nursing skills in the placement environment (Baglin and Rugg 2010). The study found that student nurses' learning was both individualised and group guided by a quest of knowledge. The experience of participation enabled the students to work in close collaboration and support of one another in pursuit of a common goal. Thus, through this approach the

students learned to support each other. Students overcame shyness and achieved self-esteem as their performance improved. Furthermore, these findings are consistent with Lave and Wenger (2003) who found that learners' active participation in community settings enriched their learning experience.

It is clear, that participation in the programme by all stakeholders, was an active process. Voluntariness was exhibited and an enthusiasm for the programme borne out of an appreciation not only for personal benefits but benefits for the community too.

### **Being involved: health promotion and education activity**

Nursing students' active involvement centred on the activities of health promotion and education. The study revealed that the students learnt, were empowered and gained confidence not only in their knowledge but also their practice for instance in home visitation, offering quality time and answering questions. Similarly health promotion and education promoted greater independence and empowerment among individuals and the community. The community, pupils, and teachers became empowered, achieved knowledge, and demonstrated changed behaviour.

Stakeholders' responses to health promotion and education information promoted personal and social skills, as well as self-efficacy. It contributed to individual and community social benefits and improved the community's knowledge and understanding of disease prevention, raising awareness of social, economic and environmental determinants of health. This study found that pupils accepted the benefits in avoiding premarital sex, not only to prevent unwanted

pregnancy, but also to prevent HIV/AIDS. There is evidence here that the pupils developed negotiation skills, assertiveness and questioning.

### **Being involved: using a nursing model to aid involvement**

While most student nurse teaching in hospital settings tended to follow a medical model (Kaye, Muhwezi et al. 2011), in this programme, a nursing model was used. Students found that it was necessary to change from the medical model to one which focused on nursing and employed culturally appropriate values. As a result of using a nursing model, students were able to place a high value on preventive measures. It can be argued that the nursing model of practice combined with Ubuntu offered a new and effective method of practice. However, Rojo, Bueno et al. (2008) found that students often found it difficult to give up using the medical model that they had learned to use in hospital. Research indicates that the medical model of practice appears to be used across health professional training in Uganda (Kaye, Muhwezi et al. 2011). It is interesting therefore, that the Community-based programme studied here, did find that students nurses willingly adopted a nursing model when they could see that the medical model did not help them to 'frame' the issues they saw in the community.

### **Being involved: empowerment of nursing students**

There was general agreement among stakeholders that involvement in the community programme empowered nursing students and increased their awareness of the community's needs. Experiential learning was not new as learning in an authentic environment has been reported in earlier studies (Chang et al., 2011; Smith et al., 2008). Empowerment led to student engagement, creativity in decision-making, critical thinking, and professional relationships with

the community. In addition, their practical nursing skills developed primarily in the area of history taking, health assessment, health promotion and education. Students' academic performance of both theoretical and practical knowledge improved. The students were practising semi-autonomously. The success of the programme in relation to student involvement and learning was evident, however, the programme would not have been possible without the lecturers' proximity and regular feedback.

### **Being involved: lecturers**

The university lecturers were present in the field with the students. This approach enabled them to support the students; it allowed lecturers to act as a role model and to offer guidance and feedback. The lecturer's presence also helped the students to see the link between 'theory' and practice as it allowed the lecturers to put theory into practice in a real-world situation. The involvement of the lecturers also brought the students and lecturers 'closer together' and helped develop not only a shared understanding of each other's needs but also a common respect for each other. This was arguably a perfect situation to deal with the sometime 'shyness' (perhaps, lack of confidence) in students (see transcript FGD, FN8).

The study found that learners were able to assimilate what they learnt, and they attached meaning to their new learning. Through discovery-learning, experiences shaped their reasoning. The proximity of the lecturers also enabled them to better assess the students' performance in the field. These findings agree with the work on the relevancy of nurse teachers in placement environment (Lambert and Glacken 2005; Wilkes 2006) and in promoting active learning (Saarikoski, Warne



et al. 2009). These findings in this study challenge previous studies (see for example Mabuza, Diab et al. 2013) which advocate the non-involvement of university lecturers. Arguably the question of mentor / lecturers preparation should be considered, given the need for them to work as independent practitioners in the community programme. Students are also expected to practice semi-autonomously given that learning is an active process. It follows that both lecturers and students must be able and willing to practice at least semi-independently in the community. Mthembu and Mtshali (2013) suggest that this can only be possible through active involvement and sharing where students' and lecturers become both learners and teachers. This is so because in any practice situation, the lecturer is also learning. Perhaps there is real professional strength in such a situation, where student and teacher learn together in the real-life situation of the community in which the university is part.

In the event, the real-life situations in which the students and lecturers worked, enabled students to translate theory into practice and perhaps even practice into theory. The process did not only enhance their learning but also promoted professionalisation as students began to appreciate nursing as a discipline. The making of this journey, hand-in-hand with their lecturers, gives the experience an almost Hippocratic quality; it is certainly one that embraces Ubuntu.

The study demonstrated that the interaction between the faculty and the students in the community was beneficial to both parties. The faculty benefited because the nursing boundaries were expanded while, for the nursing student, the teaching based on a student-centred approach benefited the students' learning. In addition, the proximity of their lecturers allowed the students to learn by taking

their lead. This approach facilitated the students to learn the basic skills required for their training through having real-life experiences in the community. Arguably, the presence of their lecturers helped students to develop confidence and self-esteem. The lecturers' responsibilities continued to be essential in the milieu, offering learners assistance and guidance to achieve competency in professional practice.

### **Being involved: community members**

The community placement made students appreciate where the rural population lived and the health challenges they faced. It also provided a place where students appreciated their culture and roots. The community placement was more significant for students who did not have any prior experience of village life in Uganda. The study found that students were able to adapt and utilise locally available resources, even where these were sub-optimal in nature. For instance, one of the innovative skills used was the use of tippy tap and smoking pit latrines.<sup>12</sup> In an attempt to address poor feeding, a nutrition demonstration fair was organised involving the whole community and all stakeholders, including the local politicians.

Community was involved and actively participated in the Community-based nursing education programme. Linda, Mtshali et al. (2013) and Calleson, Seifer et al. (2002) argue that community involvement is vital for the achievements of a programme such as this. Through the project, community members were empowered to find solutions to the problems that affected them. Furthermore,

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<sup>12</sup> "Tippy Taps" are simple and economical hand-washing stations, made with commonly available materials and not dependent on a piped water. 'Smoking pit latrines' are a simple measure of eliminating bad odour and prevent attraction of flies to the pit latrine.

empowerment of participants in this study was associated with outcomes, such as: increased knowledge, overcoming fear, personal learning and social participation at individual, and at institutional levels.

Through reciprocal trust and respect, community members' viewpoints influenced students, faculty and other stakeholders' learning. Sharing of ideas, knowledge and resources further contributed to the enhancement of cooperation and collaboration of the stakeholders. It was evident that apart from benefiting the university's presence in the community, the community also benefited. Community members considered the students as their children; contributing and being part of their learning motivated the community.

Community members provided a safe learning environment for the students. Arguably, community members' interest in partnership was always better thought-out than academics tended to imagine. The community tapped into academic knowledge to enhance their understanding, and that of their children to achieve healthy lifestyle behaviours and wellbeing. These results agree with the work of previous scholars (Jacoby 2003; Pasque, Smerek et al. 2005; Mbalinda, Plover et al. 2011; Linda, Mtshali et al. 2013) who indicated that the community benefits through partnership, learning and being empowered.

Community partnership with the university led to the removal of barriers that had previously existed. Community members were able to express their views as well as gaining access to decision-making. However, community involvement should not be taken for granted but should be exposed to proper planning, trust, honesty and openness at every step (see Wallerstein 1992; Wolff and Maurana 2001).

The community's participation also extended to the two selected primary schools used in the programme. This experience encouraged parents to be part of the school community as noted by the teachers in this study. As a result, barriers between community and school were removed.

### **Being involved: Pupils**

Pupils worked to prevent diseases as well as develop health seeking behaviour, as demonstrated through the pupils' drawings. These pictures depicted how pupils attached their awareness of disease prevention through 'action-oriented' pictorial representations of the knowledge gained. Younger pupils in the lower class were able to highlight one infection, the 'Tunga penetrants' (jigger infection) that neither their parents nor teachers had reported. It is clear that the children enjoyed their participation in the community programme, enjoyed meeting with the students and benefitted from their interaction with them. There is evidence here that the children's involvement in the community programme contributed to better performance academically as well as to better quality teacher-pupil interactions. Teachers employed a child-centred approach which motivated the pupils to learn. In addition, daily attendance improved as did retention and the increased exposure of children to schooling.

Through counselling, the myths surrounding health-related conditions were addressed. While pupils in general benefited, girls in particular may have benefited more in the area of personal hygiene such as in the management of their monthly periods through the provision of sanitary pads. Furthermore, female teachers in this study indicated the magnitude of the challenges that female pupils faced. These challenges are reflected in the literature (Kasente, Nakanyike et al.

2003; Fund 2005; Matovu 2011). Menstruation of primary girls is known to absenteeism and poor academic performance. For families that can barely afford basic needs such as food, sanitary pads are simply too expensive. The intervention provided by the community programme appears to have been instrumental in increasing the attendance of girls. There is clear evidence here that the children's liking for school increased.

### **Improved communication / receptiveness**

Community placements offered nursing students an opportunity to improve their communication skills. Interaction with the pupils, parents and the communities acted as an enabler in enhancing good communication. This finding was in line with a previous study in Uganda (Mwanika, Okullo et al. 2011) in which it was found that students developed their communication skills during a community-based education programme.

Effective communication skills are related to achieving good patient outcomes. Communication is an essential determinant of client / patient satisfaction and the nurse-patient relationship (Thorsteinsson 2002; Rogan and Timmins 2004; Hall 2005; Mahon and Nicotera 2011). Also as an indication of best practice (McCabe and Timmins 2006). However, gaining communication skills is challenging especially where there are language differences.

Through improved communication, both the faculty and nursing students were able to develop interpersonal and Inter-professional communication skills. The study revealed that students worked together with the pupils and the community. The approach enabled them to understand the importance of future practice as well as increasing their awareness of individual needs. Gaining competence in

communication skills was frequently highlighted. For instance, one faculty member stated; “I am competent, I think I can be a good programme officer or coordinator of some project in future” (FGD FN, 10). These findings are interesting in relation to the work by McCabe (2004) which found that nurses’ communication skills could be ineffective.

Through improved communication skills, nursing students were able to understand the pressing needs of the community, to the extent of identifying unhealthy practices among some members such as ‘sharing houses with their animals’. Such findings further confirmed the reciprocal friendship and trust to the point of revealing secrets or sensitive issues.

### **Advocacy**

The study revealed that the experience of improved communication through this programme enabled nursing students to attain advocacy skills. According to Labonte (1994) advocacy is the act of ‘taking a position on the issue and initiating action in a deliberate attempt to influence private and public policy choices’ (p.263). Other scholars regard it as pleading, defending, or supporting a cause or interest of another (Tomajan 2012). Advocacy is a process of seeing a need and finding a way to address it (Amidei 2010).

The student participants were able to advocate for the community needs. It is not surprising that students felt obliged to act on the unmet needs of the community. It is likely that the vulnerability of the community and the existence of so many unmet health needs triggered the students to take action. Arguably, various skills such as problem-solving, communication, collaboration enhanced the students’ ability to advocate.

It should be understood that the student nurses had 'status' in the community because they were university students, and this status probably helped them act as advocates. The friendship they developed with the community also probably motivated them to advocate. This is interesting in the light of other studies which are critical of nurses' inclination to advocate; for example, the study by Negarandeh, Oskouie et al. (2006) which found that the advocacy role was difficult for nurses. Negarandeh, Oskouie et al. (2006) concluded that advocacy was intrinsically controversial and a 'risky' component of nursing practice. Arguably, the positive finding on advocacy in this present study is related to Ubuntu and the atmosphere of mutual respect that was core to the community programme. It is possible that this allowed both the students to understand community issues and to act on them in an environment that was characterised by mutual respect and community action (Ubuntu).

The students were able to communicate effectively with communities other than their own (the students often came from other parts of Uganda). The students were conscious of being non-judgemental and of respecting other people's opinions. In this way, cultural awareness was the foundation upon which students based their working experience in the community. It was also enhanced through their prior educational preparation of cultural diversity. At the same time, the notion of being vulnerable to personal change when interacting with people from other cultures was as much about personal growth as it was about enhancing the care of others.

Despite student's positive experience of communication skills, the realisation of their full potential after graduation is yet to be realised. A number of challenges

in both clinical and community settings are well documented (Mbalinda, Plover et al. 2011; Mabuza, Diab et al. 2013). Over-worked staff and the historical patient-nurse hierarchy are key challenges in most work settings and which are likely to hinder nurses from practicing what they have learnt. While the lecturers clearly indicated how students related their knowledge and practice from community to hospital practice, this may not stand the test of time. How best students are prepared to overcoming these challenges was beyond the scope of this study. After graduation, these students will be working in community health centres and hospitals in environments with a different culture to that of the community programme which this study evaluates. Certainly, these challenges need to be overcome.

Workplace policies and practices may be a distracter, especially since the traditional focus of nursing is ritualistic, making individualised patient-centred care a virtual impossibility. Nursing shortages in Uganda make the matter even more problematic. With large numbers of patients to look after, it is not surprising to find that communicating with patients in the hospital may not be as effective as it is in the community. However, if the workplace workload improves, and the number of nurses per patient increases according to the World Health Organisation's (WHO) recommendation of 1:5; then this could lead to increased levels of therapeutic listening and improved patient satisfaction. However, meeting the WHO recommendation is unlikely to happen in the near future.

The dominant medical paradigms and the medical model of care (Clare and Jackson 2008; Speedy 2010) could affect the ability of the students to practice what they have learned from the community programme. Although they had been



communicating with, and taught medical students, this is a new generation of professionals who do not have the authority of more senior staff. Cohen (1996) study on class and age and Nettleton (1995) study on gender, suggest that younger students may be vulnerable to the prevailing nursing culture (Hall 2005), with its emphasis on hierarchical obedience and the priority of task, over person-based care (Batch, Barnard et al. 2006; Huston 2010; Walker 2010).

In view of this group of stakeholders' experiences, it is appropriate to suggest that nurse education should provide a safe and supportive experience of both independent working and indirect supervision in the community. This would increase students' level of confidence and competence and perhaps make them better able to meet the challenges likely to be faced in the clinical workplace.

New contemporary learning approaches should prepare students to remain assertive and guard the new knowledge and skills acquired. This study has revealed that the students were optimistic regarding their empowerment and the confidence gained from their communication experience. We must hope that they remain able to meet the challenges posed by a resource-limited and medically dominated health care environment. At the same time, the profession surely has a responsibility to change its prevailing culture; to provide a 'nursing' focus to nurses work and to replace notions of hierarchy with the culture of Ubuntu, which in any case, is African in origin and present, if only under the surface in every sub-Saharan nurse, doctor and administrator.

### **Pupil's experience of communicating**

Interestingly, the study found that the use of non-verbal communication, such as touch, was a powerful tool that increased the interaction between the younger

pupils and nursing students. The pupils related such interaction, to friendship. Expression through touch was seen by pupils as a valued aspect of communication that further enhanced the nurse-pupil relationship in this programme. The power of touch should not be underestimated. Touch is a source of support and can create an 'affective' bond. Touch as an action, can be worth more than words. Cultural interpretation of non-verbal communication should not be underestimated. For example, different cultures interpret distances maintained in an interaction differently. Nurses should use touch within the appropriate cultural context in order not to impede communication. Rebouças, Pagliuca et al. (2007) for example, pointed out that among the Latino 'very close' is regarded as an invasion of one's personal space and 'too far' as a lack of interest. Thus, cultural competence is pivotal for both verbal and non-verbal communication. Touch is a process that promotes not only comfort but also a sense of wellbeing, as well as maintaining psychological, spiritual, and mind-body connection (Sunk 2001). Although nurses commonly employ intimate touch in clinical practice (Harding, North et al. 2008; O'Lynn and Krautscheid 2011), understanding how patients prefer to be touched is important. O'Lynn and Krautscheid (2011), in their qualitative study of intimate touch in nursing, found that patients had a preference as to the type of touch they preferred. The researchers caution nurses to pay attention to clues from the patients and exercise their clinical judgement.

Although touch has been widely used in caring for patients, its use in health promotion and the education of young people has not been well documented. In this present study, touch appeared to transform pupils from a position of fear to being friends with the nursing students, and they 'opened-up' to the students.

Touch in this context was fully compliant with the local culture which saw it as appropriate to show love to children. This was very evident from the data from the pupils; they became closer to the nurses, walking hand in hand, sitting on their lap and touching them in return.

While communicating with their parents, pupils used phrases such as ‘the nurse touched me’, ‘looked into my book’ (FGD, LP 8). It can be seen that touching played a significant role in motivating the children to respond, as well as promoting feelings of comfort and calm. In addition, nursing students’ compliments to pupils acted as a motivational tool that encouraged them to work hard towards achieving a good ‘lifestyle’ as well as towards achieving excellence in their academic endeavours. Older pupils’ confidence in communication enabled them to be assertive, and there was a quest to share health-related information with their parents as they were no longer shy. One pupil felt he would like ‘to stand and talk in front of others’ (FGD, UP 5).

### **Community experience of communication**

The study found that the community members were happy and satisfied with the communication skills of nurses. Notably, the stakeholders in the community who communicated with the student nurses agreed that students had improved their communication skills. This was further highlighted by evidence that the student nurses’ communication to patients in hospital had also improved. However, community stakeholders revealed long-standing difficulties communicating with medical personnel. It follows that this project could teach nurses, and perhaps medical staff, better ways of communicating with the public so that eventually communication in the hospital setting would be improved. It is known that

community members tend to resort to traditional and complementary practitioners for their health care (Kasirye, Ssewanyana et al. 2004; Ministry of Health (Uganda) 2010), even where this is not always the cheapest option. The data even provides evidence of one patient who admitted himself to the hospital for treatment of his fractured tibia, only to elect to leave the hospital to seek help from a traditional bone-setter.<sup>13</sup> It seems apparent that better nursing and medical communication skills might prevent this happening and encourage community members to consider using 'Western' medicine as a first option.

### **Acting as a role model**

The lecturers acted as a role model to students, students to pupils and community, pupils to parents and siblings and Katete community to other communities. Lecturers' role-behaviour impacted on the students' learning and practice, broadened their knowledge, and caused them to appreciate teamwork and supervision. The impact of role modelling was in line with the literature (Cruess, Cruess et al. 2008; Perry 2009; Curry, Cortland et al. 2011; Baldwin, Mills et al. 2014). It can therefore be concluded that it is a practical and powerful teaching approach. Although the findings seem to suggest positive role models from the lecturers, it should be noted that even negative role models can contribute to student learning through avoidance (Grealish and Ranse 2009).

Role modelling is an Ubuntu value and the nurse educators and student nurses in the study probably accepted this position as 'normal'. In Uganda culture, a teacher is seen as a 'parent' to students and in this sense, has a responsibility

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<sup>13</sup> See appendix 13.

which goes beyond educating students. In this study, the role of 'parent' may have helped to create a friendly and respectable relationship. It is clear that the relationship between teacher and student developed as part of the experience of the community programme; some students being 'shy to talk' before the programme. The relationship between student and teacher also influenced the learning experience. It was clearly demonstrated in students' reports that they saw their lecturers as 'friends'. Most importantly, the study found that positive role modelling resulted from the keen interest by the lecturers in their willingness to listen to the students' responses and to answer their questions in an appropriate and caring manner. The nature of this relationship fostered trust and respect and further enhanced the teaching and learning transaction of students in the community placement. Fostering an environment of trust, enabled the students to ask questions freely and without fear. Thus, the experience of role modelling contributed to the development of a professional relationship, professional identity and new learning for nursing students. This finding of culture where nurse educators acted as parents to nursing students is congruent with Klunklin, Sawasdisingha et al. (2011) study in Thailand and Nouri, Ebadi et al. (2013) in Iran. Both studies found that culture and role modelling combined to enhance students' learning and that nurse educators served as 'parents' to the students. It is not argued here that this is 'normal' throughout nurse education (see Myall, Levette-Jones et al. 2008; Halcomb 2010) but only that it is a situation that is possible to achieve.

Students' observation of the lecturers' good practice in the community promoted a professional relationship between the nursing students and the lecturers. Lecturers' behaviour had a direct effect on students learning. The lecturers were

able to demonstrate the skills the students needed to learn, with emphasis on immediate and regular feedback. The importance of regular feedback to students learning (Boud and Feletti 2003) is well documented. The students associated the lecturers' way of interacting with a positive role model that further enhanced their learning. Such an approach could prepare students for lifelong, self-directed learning through continuous feedback and could lead to longer retention of knowledge. The role model provided by the lecturers, coupled with a healthy learning environment appears to have been the foundation for the students' positive experience of the programme. Wong and Lee (2000) showed that a conducive clinical learning environment contributed to healthy relationships and positive role models (see also Donaldson and Carter 2005; Perry 2009). In practice, the learning environment was one in which both teacher and student nurse had a 'common cause' and were working together on a joint project.

The role model process leads to professional socialisation. Role modelling, according to Bandura (1977) guides students to learn new behaviours without the trial and error of doing things for themselves. Murray and Main (2005) suggested that it is a form of learning from experience that uses humanist and social learning theories. Importantly, a key feature is the experience that learners brought to the situation; in this present study, the students were willing to learn, and thus their lecturer fulfilled a dual role of educators and learning facilitator. In so doing, lecturers assisted the students to identify the best direction to take and facilitated the best environment for this to occur.

Lecturers interacted with students and structured the environment to ensure learning occurred; they led by example; they appeared to enjoy teaching clinical

skills and had a caring attitude to the community and the students. Therefore, this process of observing their lecturers enabled students to internalise their lecturers' behaviour through a process of reflection, building on previous knowledge and experience.

The benefits of role modelling were the opportunity of students working with experienced and knowledgeable lecturers and practitioners. The approach helped the students to develop an enthusiasm for their own development. Lecturers were experience people (aged between 35-66 years old). Arguably, experienced teachers care about their profession and make the strongest role models in an academic setting. Role modelling is an expression of professionalism.

The visibility of nursing students in the community provided role models for the pupils, judging from their appearance in their clean uniforms, communication and their acceptance of the student nurses. Pupils wanted to become nurses so that they could help their community. Arguably the pupils appreciated the importance of giving back to the community and also caring for their parents.

The pupils were impressed by the students' uniforms although the students did not want to wear their uniform. The uniform present a contentious issue (Spragley and Francis 2006). Although uniforms have been regarded as a sign of power and control they have also been used as a way of communicating their trustworthiness and professionalism to the public. This study revealed that students were not comfortable wearing a uniform in the community, however, the pupils were happy to see the students in their uniforms which perhaps communicated to them a sense of caring and of trust.

The pupils also acted as role models to their siblings, other pupils and their parents through what they had learnt. In turn, parents executed their experiences of role modelling to other communities through cleanliness, disease prevention, and health seeking behaviour.

### **Developing / growing confidence/ self esteem**

The study demonstrated how community exposure contributed to the nursing students' confidence. The community practicum experience engaged the students, and they became active learners at an early stage. This approach enabled them to acquire knowledge and skills that were relevant, organised, accessible and functional in their day-to-day work. In addition, the students were able to construct their knowledge in the context of its future application. The quality and nature of the students' placement experience directly affected their ability to perform adequately. Through exposure, they linked theory to practice as well as situational experiences that assisted them to incorporate and find meaning in the principles and theory learned in the classroom. Gaining confidence enabled the students to overcome fear of the unknown in practice and public speech. This further increased their professional skill. For instance, in giving health education talks, history taking and physical examinations, treatment of minor ailments, and being able to identify cases for referral. The finding of professional competency is consistent with the literature from Uganda (Mwanika, Okullo et al. 2011) and from other countries (Papp, Markkanen et al. 2003; Edwards, Smith et al. 2004; Hunt and Swiggum 2007; Ranse and Grealish 2007; Baglin and Rugg 2010; Koontz, Mallory et al. 2010; Papastavrou, Lambrinou et al. 2010). These researchers found that the quality of the learning environment influences student learning.



Although students were satisfied with their community experience; confidence needs to be nurtured. Stockhausen, (2005) pointed out that nurturing students' confidence should be a central feature of the learning environment if students are to acquire competency.

### **Friendly and supportive lecturers**

Gaining confidence could not have been possible without the support of their teachers in the community. It has already been argued that the presence of faculty staff was paramount in guiding the students in their learning. Overwhelmingly, the study found that the students enjoyed the presence of their lecturers. They had the opportunity of developing relationships that resulted in them feeling part of a professional team.

The sound relationship between the students, their lecturers and other stakeholders promoted a sense of belonging that enabled participants to adapt and operate efficiently in the community setting. Therefore, the presence of friendly supportive faculty staff and an enabling environment were enhancers of student learning and competency. Levett-Jones and Lathlean (2008) argued that belongingness is a motivational factor to learning and its impediment could affect students learning negatively. The presence of friendly lecturers was timely in this new community practicum setting in allowing the students to traverse the challenges that a new experience brings. Positive staff-student relationships are crucial for student learning (Koh 2002; Levett-Jones and Lathlean 2008). Thus, it appeared that both lecturers and students achieved what Silén-Lipponen, Tossavainen et al. (2004) suggest is necessary, that both sides have to be motivated if they are to work together.

### **Overcoming fear**

It is evident that students having a faculty member with them removed their shyness and enabled them to become confident. They were able to ask questions, and this led to openness, which facilitated students in overcoming fear. They saw the faculty as colleagues engaged in a common purpose. Other studies have found that fear adversely affected the student ability to learn. Finnerty and Pope (2005) found that student midwives placement fear, resulted in reduced practice performance. Similarly, Sharif and Masoumi (2005) found that fear of failure and the theory-practice divide caused students anxiety and reduced their competence. Mabuda, Potgieter et al. (2008) found that poor interpersonal relationship with tutors and ward sisters impacted negatively on students' clinical experience. Negative experience is likely to affect student ability. Clearly, this present study demonstrates the advantage of having academic staff practising in the field alongside students.

The study revealed how students gained competency by being in the community with their lecturers. The role of the lecturer in the practice situation should be valued. Lecturers were not only skilled in practice, but they knew their students and knew best what their learning needs were and how to support them. As a result, a gap was bridged, a gap that too often exists between lecturers and students and students and patients.

### **Regular feedback**

The presence of the lecturers meant that the students received constant feedback regarding their practice, something that the students viewed positively. This feedback was seen to improve the students' feelings of confidence and sense of self-direction and motivation. Appreciation was evident through arriving at a

correct diagnosis. For example, when students referred children to hospital, with a tentative diagnosis such as a cataract. This is not surprising because the value of feedback is well understood (Löfmark and Wikblad 2001). This study indicated that the manner in which the lecturers interacted with the students was respectful, and that this promoted shared learning. Allowing students to take control, motivated them to learn, and they used the motivation as a vehicle to achieve their learning objectives.

### **Prior knowledge**

Arguably, prior knowledge learned in the classroom played a role in enabling the students to feel confident. In addition, the support and guidance which they received while in the placement area, promoted the students' self-esteem. Baglin and Rugg (2010) and Timmins and Kaliszer (2002) found that students' expectations prior to their placement, coloured their understanding of what the placement would be like and helped them to accommodate to it. There is a clear implication here that the preparation of students is an important pre-cursor to a good community experience. It necessarily follows that a lack of planning could impact negatively, not only on the student learning experience but also the entire community programme.

### **Change of traditional roles**

Gaining confidence did not only prepare the students to take on the new roles in practice, but also to challenge and overcome historical, traditional roles. Nursing students demonstrated that gaining confidence allowed them to 'teach and lead' medical students in community placements. Historically doctors have taught nurses. Overcoming medical dominance in community Inter-professional practice

and teaching was an important discovery for many of the students. This change in traditional roles was described with passion and excitement in the focus group discussion. In appreciation of their efforts in breaking this barrier that has always existed, particularly in the study area, participants smiled, nodded their heads and clapping their hands. Indeed, this was a significant achievement, especially in a society based on a patriarchal culture and a dominant medical profession. Perhaps this is the beginning of 'new culture' in the education and practice of nursing and medicine in Uganda.

The lecturers reaffirmed students' confidence and regarded it as a step toward personal and professional development. The change in trend could have been attributed to the same science subjects taken in high school, similar entry points into medical related professions and studying preclinical basic science courses together in year one and two. Arguably, this type of educational approach prepared the students to face the journey through these long-standing historical differences and the dominance of medicine. Inter-professional learning enables different disciplines to work and appreciate their respective roles. It is not surprising that the students experience in the community prepared them to take the lead role in aspects of community care.

The findings in this present study indicate that where students are free to learn in a practice setting in partnership with the academic staff, that their confidence grows to the point where they are actually excited about teaching doctors to be doctors. Perhaps this could lead to a better nurse /physician relationship; perhaps this is already beginning to take shape.

### **Providing holistic care**

Holistic practice is a philosophical approach to care which involves taking account of the 'whole person' and not just their presenting need. A focus on holistic practice can have the effect of helping patients maintain a lifestyle that contributes to their satisfaction and health within their community. Such an approach is guided by patients' thoughts, feelings and beliefs, and carries the notion that these qualities are intimately associated with the individual's body, mind and spirit. Through holistic nursing, the students helped the community and patients to develop self-responsibility and assume appropriate self-care by attaining a balance of the body, mind, and spirit.

Interestingly, the study revealed that the students were able to appreciate that not all illnesses are physical in nature; they realised that most clients' complaints had a psychological element that required appropriate listening and understanding. In the community, students were able to sit down and talk with individuals, this led to improvement in communities' well-being as well as enhancing nursing students' knowledge of care. Having someone to listen to is a healing experience in its own right.

It may have been the students' orientation to holistic practice which made them so popular with community members. However, Heller, Oros et al. (2000) argue that it is the community setting itself which facilitates a more holistic approach to care. Van-Manen (2002) suggests that human care involves someone who believes that you are important, loved and a special person. Importantly, the students in this present study learned that health per se is more than the absence of disease.

### **Pupils talking to parents**

Confidence enables pupils to overcome fear of their parents, teachers and strangers. The study found that the pupils were talking to their parents regarding the importance of good nutrition, personal hygiene and health promotion and disease prevention. Pupils' knowledge and rationale of why it was important to promote health and prevent diseases facilitated better understanding and boosted their confidence. For example, pupils associated anaemia with lack of iron in the diet, and they were able to mention the type of food to be eaten. The pupils' knowledge hastened their determination to change their family's lifestyle through good eating habits etc. The appropriate education and support which pupils had in this programme acted as a catalyst in creating change and overcoming challenges.

Parents agreed that their children had gained confidence and were talking to them. Importantly, pupils' ability to speak to their parents without fear could have created a new culture. As exemplified by these words "we sit down as a family, talk, listen and respect each other's opinion" (FGD PP, 2). One parent could not hide his joy, "I am proud of my little girl" (FGD PP, 4). This finding supports the idea that children indeed can be change agents to their parents and their community.

In addition to confidence, a door was opened to communication between the pupils and their teachers. Before the programme, the pupils were not talking to their teachers. The situation could have been made complex due to a combination of educational, cultural, and personal factors. The educational environment probably promoted a culture of silence with pupils listening dutifully

but not contributing to the discussion. Teachers are considered as 'elders' culturally. Ubuntu prescribes obedience and respect of elders. Such cultural practices of not talking when the elder was talking could have made it difficult for the pupils to appreciate the importance of communicating with the teachers. Through active communication, the pupils were learning more ably, seeking clarification of any misconceptions, enabling them further to express themselves and preparing them to speak in public and at home. In addition, through interaction teachers are likely to identify and understand the weakness of each child.

Pupils emphasised how their confidence in talking with their teachers enabled them to improve in the science subjects. Teachers were aware that pupils engaged more in discussions during class time, especially during science lessons as the topics were linked to the health promotion and education talks. The Teachers agreed that the pupils had gained confidence in talking with the nursing students. The pupils were able to talk to the nurses and were neither afraid nor shy. They asked questions and interacted.

### **Crossing / bridging the gap**

Prior to the community-based programme, a 'gap' had existed between the school and the community and between the university and the community. People in the community saw the school and university as being on a hierarchical plane above them. It is found that the community programme enabled this 'gap' to be breached, enabling community members to communicate with the school and the university and vice versa. Bridging the gap was an important finding that promoted coalition with the community. It enabled all stakeholders to work

together collaboratively in achieving the programme aims. Bridging the gap allowed the academic institution to partner with the community rather than operating in isolation. This was a necessary precursor to the university being able to act as a change agent in the community and for nursing students to function as health educators. Therefore, the programme acted as a link between the institutions of higher learning, the community and the primary schools. The community-based programme broke the barrier that existed between education and community, facilitating easy entry into the community. The need to bridge such 'gaps' is well understood, both in Uganda (see Kaye, Mwanika et al. 2011; Mbalinda, Plover et al. 2011) and elsewhere (Ward and Wolf-Wendel 2000; Williamson, Callaghan et al. 2011) but the community-based programme is perhaps unique in bringing the community and university together by implementing a common initiative designed to the benefit of all parties. So it was that nursing students benefitted, as did pupils and their families, as did the local reputation of the university.

It is found that bridging the gap was possible because of the humility of the university staff and students. Humility contributed to the trust gained by the community in relation to this programme. Through this partnership, the community had the confidence to mix freely with the university staff and the students. Although the community overcame their fear and feelings of inferiority, they were suspicious at the beginning, questioning why the university was so interested in their community to the extent of having students visit them in their homes. This was not an irrational fear. It is not uncommon for large institutions to use and abuse communities to their advantage (Wolff and Maurana 2001; Luque and Castañeda 2013). This present study shows the positive effect of using



Ubuntu and the ripple effect model; that it fostered trust, friendliness and honesty, with the result that the community overcame their fear and partnership was enabled.

Bridging the gap promoted relations between the schools and the parents as indicated in this study. Parents' communication with teachers and their participation in school matters improved, including visiting the school to discuss their children's performance. The study found that the visits occurred on a regular basis, due to improved cooperation between the parents, school, and other stakeholders. Through the programme, the pupils and the students mixed freely. Teachers allowed other visitors into the school to mix with pupils. Receiving visitors was very beneficial to the pupils as they learnt to socialise and overcame their shyness.

This experience enabled the students and the lecturers to know the traditional healers better. Mbalinda, Plover et al. (2011) found much the same effect with students in community-based education. It should be noted that obtaining knowledge from the traditional healers is not easy, for many reasons. However, trust gained by the community regarding this programme removed the barrier that existed between the health professionals and the traditional healers. Students and teachers mentioned that the traditional healers allowed students into their premises freely. The achievement resulted in overcoming the long-standing barrier between the two groups of informal and formal health providers. This finding has further implications for health promotion, practice and policy; notwithstanding, individuals in the community have their reason for preferences, seeking treatment wherever they prefer. What a qualified health professional

health care would consider high risk and needing special attention, the individual and some informal health care providers may see differently (see appendix 13).

It could be argued that the lack of knowledge and information could be one of the many reasons why some of the high-risk clients opt for treatment in the informal sector instead of going to the hospital. Alternatively, could this be due to inadequate hospital services or the unfriendliness of hospital staff. Kiwanuka, Ekirapa et al. (2008) found that health workers attitudes were one of the hindrances to the community's utilisation of health services. There is a need to find out why patients prefer informal or traditional care, even with high-risk cases such as fractures. The study argues that the informal sector may often be the only accessible, friendly, provider around. However, evidence suggests that most community patients live within about 5km of health facilities (Ministry of Health (Uganda) 2010). Arguably, a traditionally paternal and domineering attitude on the part of health professionals is what drives community patients to an informal care provider.

The experience of bridging the gap, resulted into participants making wider circles of friendship. The study found that students, the pupils, and the community at large were friendly to each other. This friendliness helped children to enjoy school, and they would come daily because they wanted to be near nurses as well as to learn from them. While in the community, this friendship enabled them to allow visitors into their communities and even at schools. This friendship enabled the community to be closer to the university. These findings support the values of Ubuntu to live in friendship in the community.

Bridging the gap promoted friendship among stakeholders. Through this friendship, the students got down to the level of the pupils and the community. This further enhanced the trust of the children and the community toward the students. The community and pupils realised that the students took them the way they were, and because of this they were able to discuss freely with the students. Friendship and being at the level of the other is an imperative approach in discussing sensitive issues. Arguably, this could have been the reason pupils were active. They saw students who understood them and treated them not as children from a poor environment, but as individuals who should be accepted the way they were.

Importantly, community individuals who met the same students in the hospital setting praised the reception and the care they received. The community and the pupils emphasised that the care nursing students offered them in the community was one characterised by love and respect. On the other hand, the experience of some community members regarding their reception and care in the hospital was not positive. This contributed to fear among them about going to the hospital as they felt they could not even discuss their concerns with the hospital staff. This led to the community wondering whether there were two types of nurses. The ones in the community and the others in the hospital as indicated by how the community responded to the students. For instance; “we go to them in the communities, and we are good, but when they go to the hospital they get different nurses” (FGD NS, 6). However, participants were keen to highlight the overwhelming workload nurses have in the hospital. Although the practice of qualified nurses in the hospital is beyond the scope of this study, it is argued here that the heavy workload should not make the nurses work unprofessionally.

### **Transformation of one's life**

The stakeholder's new learning, knowledge and change of their world-view was an epiphany of transformation. The community placement gave students a new form of learning and an understanding of communities and the problems there. The discovery of cultural and health practices in the community changed students' perception of the nursing profession, and they started to like nursing and were able to understand the causes of illness in the community.

New learning enabled the students to strategise their approach on how best to work with the community without interfering with their culture, and to adjust to the profession. Working alongside the community resulted in respect for their culture. New learning was seen as pivotal in the students' future practices with the community. Consequently, the students' willingness and intense desire to learn and to understand the community prepared them for their future work and they wanted to be part of the community.

The students acknowledged that the clinical experience in the hospital was crucial to learning practical skills needed in nursing practice. However, it was not until they were introduced to another environment, outside the structured environment of the hospital, the community, that another facet of learning took place for some students. This, was the beginning of their metamorphosis in the profession. Consequently, most nursing students changed their perception of nursing as a profession to the point of being motivated to pursue a career in community nursing.

A great deal has been documented regarding entering the nursing profession in relation to its public image (Kiwanuka 2010). It is noted that most high school

students who apply for nursing only do so after failing to be selected by their preferred profession (Kiwanuka 2010; Safadi, Saleh et al. 2011). Nursing may thus be seen as fit only for people who have failed to meet their academic objectives. However, community experience is associated with students selecting community practice for their future career (Talbot and Ward 2000; Courtney, Edwards et al. 2002; Lea, Cruickshank et al. 2008; Mwanika, Okullo et al. 2011; Talib, Baingana et al. 2013). Importantly, this present study reveals that appropriate clinical and community experience is capable of transforming students' thoughts about the profession. Clearly, it is not simply being in the open air that has this effect. Rather, community placements can allow students more freedom to develop their skills by working more independently. It has been shown here that this can work well where students are supervised by academic staff in an atmosphere of partnership and mutual respect.

Equally the pupils' lives were transformed through the community-based programme, and they started to think about school more positively. This seemed to be influenced by many factors, such as the programme based in their school, the respectful treatment they received at school when sick.

Pupils' hopes of furthering their education to a higher institution of learning increased. The ideas emanated from interacting and observing nursing students. Pupils became hard working and were looking for a better future. This was enhanced by the career guidance they received from the nursing students as well as the students being role models to them.

Importantly, the study found that the experience of transformation allowed the pupils to start seeing their parents differently. Parents started listening to their

children. Some parents who were sharing pit latrines with neighbours listened to their children's advice and constructed their own.

In addition, through transformation the pupils' and the community's life prospects were improved, and they started practising health-seeking behaviours and preventing disease. The health of the community improved as well as the cleanliness and the appearance of the village. The study found that there was improvement in the health of the pupils as there were fewer noticeable 'ring-worm' infections on their heads. Also, it seemed that the pupils understood the importance of disease prevention and why they needed to eat fruits. They were able to mention that lack of "vitamin C" could result in "scurvy (FGD UP, 6). This was also witnessed during participant observation sessions. This was a clear indication that their learning was not rote learning, or theoretical knowledge, but rather practical knowledge. Pupils did not take for granted the knowledge they gained, but developed higher level skills of critical thinking and reflection.

Pupils' behaviours changed; they were practising universal precautions of infection prevention, washing their hands, keeping their environment at school and home clean. Their health seeking behaviour improved, and they were clean both in body and uniform; as one pupil put it; "this programme has made me know my body" (FGD UP, 4). It appeared that they were practising a healthy lifestyle. As a result of this transformation fewer pupils were falling sick, and the pupils were settled enjoying their education. Pupils were able to maintain environmental sanitation, by keeping their compound clean both at school and home by planting flowers on the compound and maintaining a beautiful environment.

For the parents, health seeking promoted personal and community well-being. As one parent indicated “I am looking after myself” (FGD PPII, 3). It was clear to all that parents were developing health seeking behaviour and sought advice from nurses. They also maintained their compound and kept their environment clean.

Although parents’ and communities members identified that their health behaviours had changed, some expressed difficulties practising what they had learnt. For example, some families were unable to afford mosquito bed-nets to prevent mosquito bites, running tap water to wash hands, or cleaning materials for the pit latrines due to their level of poverty. But this did not hinder them from trying locally available resources such as smoking toilets to prevent the bad smell. Such findings are important in confirming that, first of all, the community listened and remembered what they were taught.

The transformation experience enabled community members and pupils to take over responsibility and make decisions for their lives. The new way of knowing and understanding enabled them to decide to change their practices such as attending to personal hygiene, diet and keeping the environment clean. The process of becoming aware of illness prevention and being responsible for one’s life was transformative for the community members, parents and pupils.

## **SECTION (2): NEGATIVE EXPERIENCES**

Only a few negative experiences were found in this study. Namely: limited resources, lack of sharing, language barrier, misinterpretation, cultural beliefs, unreceptive husbands and suspicions. However, understanding participants’ negative experiences contributes to further insights. The negative experiences

were associated with challenges affecting the smooth running of the programme activities.

### **Limited resources**

Limited resources were some of the bottlenecks challenging the programme's success, especially when the funding ended. The most mentioned resources were human; financial; time, transport, and materials. Studies by Kaye, Mwanika et al. (2011) and Chang, Kaye et al. (2011) in Uganda highlighted the challenges of limited resources in community-based programmes. Participants had a clear vision of how they felt these deficiencies could be addressed in order to promote the programme's sustainability. Principally, they felt that since the programme was benefiting all of them, it was imperative that they too contributed to the programme resources.

### **Lack of sharing**

Although the university was sharing with the community, it was also evident in this study that it had a weak culture of sharing information across its faculties. This could be a reflection of the weakness in the university system, where programmes are confined to mother faculties. The culture of confining knowledge in one department can affect the overall university performance and knowledge contribution. The tendency for universities to fail to share information with their own local community is documented in the literature. For instance, Linda, Mtshali et al. (2013) found insufficient knowledge hindered the community from understanding a community nursing programme's aim. Mabuza, Diab et al. (2013) found that the community felt undermined by the university trying to operate in the community without their proper consultation. Wolff and Maurana



(2001) argued that a failure to liaise with the community can cause the community to reject the programme. It is clear, that sharing is one of the Ubuntu values that can make the difference in terms of the success or otherwise of a community-based nursing programme.

### **Language barrier**

The finding of a language barrier was expected and is consistent with the literature (Mbalinda, Plover et al. 2011; Mabuza, Diab et al. 2013). Some students could not speak the local language and it was evident that some community members could not speak, write, or read in English. Such a finding could be referred to as a 'double-tragedy' for the programme's aims of sharing information. For instance, failure to comprehend the information passed on during health education or to read the materials used to complement health messages could have posed significant barriers to the success of the programme. The challenge of illiteracy cannot be under-estimated, especially in relation to children and grandparents. This is an advantage of conducting the health education in schools; where literacy and health education can be addressed at the same time.

The language barrier frustrated the students, the pupils and community members. The frustration was captured in their discourses as "feeling robbed" and "state of helplessness" (FGD NS, 4). Such findings are of concern and clearly indicating how students felt impotent in such situations. Interestingly, Ryan, D'Angelo et al. (2010) argued that language is not an insurmountable obstacle in most cases and can be overcome relatively quickly. However, it is likely that the development of a higher order of fluency and advanced level of understanding may take some time and it does constitute a challenge. Including language

learning in the nursing curriculum could enable a lasting solution. It is surely the case that students should be offered support while they face this challenge in community settings so that they are able to find their community experience a less frustrating one. Without this last, the challenges attributed to language barriers are among the many that can negatively affect their experiential learning as well as the programme outcomes.

### **Misinterpretation**

Community members sometimes misunderstood aspects of the community programme. For example, the word 'wellness centre' was translated into "*university is bringing us a hospital in the community*" (FGD FN, 6), thus contributing to a high expectation from the programme. This posed challenges as community members expected to find a fully functioning hospital. Expectation, according to Louw and Edwards (1998), has been known to play an important role in "*how people respond to situations*" (p.578). Clearly, communicating the correct, understandable message is important and the use of technical terms should be accompanied by a clear explanation of their meaning. Better still, the community programme needed to have been advertised using the language of the local community.

### **Cultural beliefs**

The study found that the community held a firm belief that disease is caused by witchcraft, and disability by evil omens. Witchcraft is an act of sorcery. The most vivid examples were those children who had cataracts and those with a disability who were all referred to as 'bad omen' and were thus denied medical treatment. This cultural belief could have been a source of conflict between the students'

values and those of the community who often had strong views on the existence of witchcraft. Cultural beliefs about mental illness made the community neglect such individuals and their families. It was not surprising that most members in the rural community who had such cultural beliefs sought treatment from traditional healers. The evidence of finding children with cataracts, but whose parents had never sought help from formal care further confirmed the treatment delay caused by such beliefs. Other studies conducted in the region confirm these findings (Uganda Bureau of Statistics 2006; Ministry of Health (Uganda) 2010). It is not appropriate to criticise local cultural practices but rather to respect them as cherished and cultural knowledge. However, it is still possible to encourage the seeking of medical help where appropriate and to encourage local healers to cooperate with medical services within an atmosphere of mutual respect. The sharing of information that this process encourages, is surely to everyone's benefit. This study did find evidence that cooperation between cultural and western medical practices was sometimes lacking. Students had to deal with the resulting conflict and contradictions and they had to deal with ethical issues surrounding the non-treatment of some children. However, such are the skills needed in this area.

Identifying witchcraft and cultural medicine, even in the 21<sup>st</sup> Century was expected. Nevertheless, nurses need to help communities' value equality for all children, irrespective of any form of disability. Indeed while some members of the community still held these beliefs, education did seem to be reducing its impact. It is important not only to be sensitive to cultural beliefs but also to understand how culture influences a community's view of health care.

### **Unreceptive husbands**

The study noted one incident where some male nursing participants found it challenging to communicating with females when no chaperone was available. Husbands were sometimes afraid that their wives would be empowered to use family planning services, a practice over which most men felt they should exert control. The challenges for women wishing to use family planning services are well documented in the literature (Wolff, Blanc et al. 2000; Gebreselassie and Mishra 2007; Khan, Bradley et al. 2008; Do and Kurimoto 2012). This finding calls for a change in the programme's approach, enabling students to operate in mixed gender groups.

### **Suspicious**

Some community members were suspicious of the programme, something that could have hindered their participation. It is not unreasonable for community members to strive to protect their personal and environmental space from strangers. There is no doubt that university staff and students' presence in the community and even in individual homes raised concerns. In this situation, the community was indeed vulnerable. It is important that such suspicion is acknowledged, and dealt with respectfully.

## **SECTION (3): SUGGESTIONS FOR SUSTAINABILITY AND IMPROVEMENT**

Participants' made suggestions on how the programme could be improved from the perspective of 'ownership', "*the programme is part of us*" (FGD PT, 6). This was further realised in the pupils, parents and the teachers' discourse, "*we pray that the programme should stay*" (FGD, LP 8) and that the programme "*should never stop*" (FGD, UP 10; PI 3, and PT 7).

However, the challenges raised by this study were enormous. Although participants did not appear to indicate how sustainability could be achieved and monitored, they did suggest raising funds towards programme activities and regular feedback on the programme's activities to the stakeholders. Regular feedback could be one way of monitoring the programme activities for sustainability. Previous studies indicated how feedback was valued by community members (Naidu, Zweigenthal et al. 2012) and that they requested regular feedback (Chang, Kaye et al. 2011).

This present study suggests that it is important to plan a programme's sustainability right from the outset. If it is not planned well, it may face early termination, thus affecting all the beneficiaries. Although Shediak-Rizkallah and Bone (1998) study suggested that not all programmes can be sustained, in the longer term early discontinuation can lead to serious harm. This is arguably the reason participants felt that becoming self-reliant would enable them to support the programme and sustain it.

Additionally, recruiting more nursing staff to work in the community could be another way of sustaining the programme. It was very evident that when students were on holiday a gap in provision existed. Such gaps could have an adverse effect on the programme.

#### Motivation / incentives

Participants did consider some form of incentives to the community members who volunteered their free time in guiding students in the community. Interestingly the suggestion came mainly from nursing students and teachers. Such are the

challenges, as they were not in the initial programme objectives. Incentives are likely to have positive and negative outcomes, especially if people's participation was attached to a reward. In any case, financial resources are already hard to come by as shown in the study and are even harder to sustain.

It is suggested here, that programmes such as this are always likely to depend on voluntary involvement of community members for there is almost no source of consistent funding. Incentives can still be offered in the form of praise, awarding inexpensive prizes etc. Such incentives are sustainable but need to be considered carefully in the planning of any community-based nursing education programme. The issue calls for a wide consultation given that the success of such education approaches in the community requires facilitation for both student learning and lectures movements for supervision.

Participants offered a variety of suggestions as measures to improve and sustain the programme. Their recommendations focused on the gaps identified in the programme.

#### Income generating activities

The participants in this study recognised that the programme was benefitting them and wanted to have a way of raising some money to sustain it. However, this is not easy for a resource-limited community to do. Arguably, in the area of capacity building and sustainability, the programme would need more income-generating opportunities.

### Acquiring transport

Participants felt that obtaining transport for students would facilitate their movement, reduce time wastage, and motivate the students. Having to wait long periods for transport demoralised the students and their late arrival was criticised by community members. Transport delays were responsible for pupils and community members noting that 'health education talks were given in a rush'.

### Joint teaching sessions

The study found that teachers were missing out on health promotion and education, especially when they were in class teaching; this was demotivating for the teachers. Joint teaching sessions would appear to be a better option as it would include the teachers and the children. Such a plan could empower the teachers in the school to take an active role in promoting health and education in their schools. This approach could contribute to the sustainability of the programme. Teachers' involvement was an indication that their schools are involved. Hence, the results are congruent with the work of Carter, Bannon et al. (1994); Denman (1998); St Leger (1998) who found the role of teachers in health promotion acted as school-parent link. The gains thus experienced appear to be associated with the level of teacher's commitment, and parental and community participation.

## **SECTION (4): FUTURE DIRECTION**

Despite the monetary and non-monetary constraints raised in this study, participants overwhelmingly supported the roll-out of the programme to other schools, communities and districts. The programme benefited nursing education, primary education and the health of the communities. Understanding experiences

of stakeholders was a key to the success of future delivery. Each group of stakeholders had their reasons why they suggested programme rollout. Although, the benefits could have been the driving force of their ideas; it was also a true reflection of the communities' sense of togetherness. In addition belonging to one another as advocated in the Ubuntu philosophy (Swanson 2006; Swanson 2007). The interconnectedness, mutual support and sharing was apparent among participants. This was captured in the tone of their discourse. For example, the parents argued that, "not to share is selfish" (FGD, PPII 1). The pupils suggested that, "they are human beings like us (FGD, UP 4)". While the students suggested that other nursing institutions could benefit from the programme. The faculty staff were optimistic that, since this programme had been successful in Katete, it could work in comparable settings in Uganda and perhaps elsewhere.

The university administrators, like other participants, felt that the programme should be rolled out to other areas. However, they cautioned that a different approach of attaching fewer students to each school would enable more schools to be visited. Their suggestion raised significant questions. For example, in the current pilot programme students were in one community and two schools, and the community was able to feel the presence of students all over their community or school.

## **SECTION (5): SUMMARY OF THE DISCUSSION.**

This chapter has discussed the positive and negative experiences of the stakeholders in this programme, the challenges, how to improve and sustain the programme and possible future directions. An important conclusion from this programme is that it has been successful in enhancing nursing students' learning



as well as forging an academic-community partnership in promoting community's health. Thus, the programme was beneficial to all. Participants' experiences of the programme highlighted how the reciprocal ripple effect, role modelling and Ubuntu provided and strengthened their actions and beliefs and practices. Sharing the same philosophy, Ubuntu motivated and strengthened the participants, influenced them through inspiration to meet programme goals. Furthermore, through caring and kindness, Ubuntu offered connectedness and orientation towards others. Interestingly, all stakeholders indicated the positive and engaging experience that met their needs, which resulted in an overwhelming sense of achievement.

The community-based nursing education programme was a contemporary approach to education and practice; it revealed how rich learning could occur in a non-clinical placement in the community. Through employment of a socio-cultural model, cooperation and teamwork with community partnership was enhanced. Without partnership, all this would have been impossible. Students' involvement did not only contribute to learning nursing skills but also to community, culture, political and socio-economic health of the community. Importantly, the programme prepared them for what to expect in their future practice and how to deal with many of the key challenges which will undoubtedly confront them.

Through partnership and collaboration, nursing students learned to develop, implement and evaluate interventions that reflected the needs of the clients. They developed a wider scope of practice in a culturally sensitive manner. Through role modelling and friendly lecturers, student were sharing information, gaining

communicative skills, and developing advocacy for their clients. Their competency and confidence increased through supervision, guidance and regular feedback. Through experience of the programme, students were empowered to be change agents and to be creative in their care, regardless of the setting in which they worked.

Likewise, the pupils, teachers, parents and others learned much about their own health. Their health-seeking behaviour improved through health promotion and education. They were empowered to be the change agents of the community. The programme led to a transformation in pupil's life skills and positive perception toward parents, friends and community. In addition, pupils' grades improved due to improved school attendance; their attitude towards school changed, and they liked school.

The experience of participants was a clear indication that the community-based nursed education programme enhanced nursing education and improved nursing practice. The programme created a partnership with the community. The bridging of the barriers that had existed between the academic institution and the community occurred concomitantly with a change in traditional roles that had existed between different professions, between parents and their children and between community and health care institutions.

## **CHAPTER 7: EVALUATION, IMPLICATIONS AND RECOMMENDATIONS**

This chapter discusses this study's contribution to knowledge and in doing so looks at the strengths and weaknesses of the research. Implications for practice and further research are considered.

### **Contribution to knowledge**

The findings of this study provide new insights into the Community-based nursing education programme and student nurses gaining practice experience in community settings. There has been a paucity of research in this area, perhaps because of the way in which programmes such as this are both new, and largely confined to resource limited and under-researched areas of the world.

The study used a range of data collection methods including some (e.g. the use of children's drawings) which were aimed at identifying young children's experiences. It is too easy for the views of children to be ignored. However, children were inexorably part of this study, for they were to be the change agents who, through the reciprocal ripple effect model would spread the health education message to their community.

Both the programme being evaluated and the study itself were tied up in the values central to Ubuntu, a core African philosophy which has characterised the African peoples for centuries. So it is that central to the programme's identity was the notion that the community would work together toward a common interest and that the research embraced the 'insider-ness' of the researcher who at once was both researcher and an intimate player in the programme.

The community learning environment is a complex entity and is difficult to manage and to research. Central to both the programme and this study were values that were educational, cultural, social and political in nature. This was also a venture which combined the values of African and Western paradigms for health but in a manner that focussed on a small community in Western Uganda and its particular needs.

The study has identified the benefits of a university collaborating meaningfully with its local population. Enabling students to practice in the community whilst being accompanied by academic staff was useful in that it enabled students to grow the confidence needed to deliver health care themselves, using their knowledge and their initiative. The study has shown that this can be effective if undertaken in an atmosphere of Ubuntu, where the community members are part of the initiative. The Ripple effect of passing health information from student nurse, to school children, to their families and to the wider community and indeed, back to the student nurses, is shown to be effective here.

The study has shown that the ripple effect model guided by Ubuntu philosophy worked in enhancing the intervention performed by student nurses and in a manner that was culturally acceptable and sustainable in a resource-limited environment.

Participants' experiences indicated that community programme had the effect of empowering individuals, professionals, the institutions and the whole community. It did this by creating settings in which stakeholders could participate, develop critical awareness, and act together to gain increased control over their lives.

The enthusiasm and interest of students contributed to learning while providing services to the community. Their scope of practice and knowledge broadened and the students were able to provide holistic and respectful care to a community that was ready to receive it. The students became empowered with knowledge and overcame shyness; this enabled the students to go beyond their traditional role, and they were seen at the forefront of practice, promoting inter-professional collaboration.

Because they were supported by academic staff, the students were able to provide health promotion and education to the community with confidence, teaching and leading medical students. The students interacted with traditional healers and shared information, acting as agents of change. This led to a new culture of practice among professionals in the local area. Nursing students had learned to be both respectful of other professions and to respect their own profession and what it could achieve. The students became more interested in the profession of nursing and in developing their own careers; they became proud of nursing because they had learned at first-hand what it could do.

The study confirmed that health promotion and education given to young people could transform and lead to improvement in their lifestyle and a new sense of responsibility for their own health and that of their family and community. The programme had further consequences on the school children. The children learned about their own health but their academic performance also improved and they came to enjoy science at school. Communication between parent and child was improved and parents listened to their children and came to value their

ideas. Disease prevention measures were undertaken by community members themselves and health behaviour changed.

Teachers' knowledge on health promotion and education improved. The pupils' enrolment increased. Interaction between the teachers and the parents improved as the barrier between the school, parents and the community collapsed. Teachers networked with health professionals and began to welcome parents into the school.

Parents and the community learned health seeking behaviour and their knowledge regarding disease prevention improved. As a result, they were able to teach the neighbouring communities. In addition, they fostered a partnership with the university, and there was collaboration. Bridging this gap led to the removal of the 'barrier' which had long-existed between the university and the community

This study has some value because it is one of only a small number of studies of community nursing education in Uganda. However, it also has value because of what the West can learn from it. In this small, Ugandan community, local people came together with 'their' university department of nursing to collaborate on a project that was in their mutual interest. In so doing, a project delivering health education was implemented with only minimal financial resources but with a human resource which demonstrated what people can do with nothing but their own effort. This is a project that teaches the West what can be achieved when African Ubuntu values are embraced.

### **Study strengths**

The main strength of this study is its originality and utilisation of a wide range of data collection techniques in order to understand the stakeholders' experiences. This was an area in which there existed limited research and poor understanding of stakeholders' experiences of the very few community-based nurse education programmes offered in Uganda. Importantly, this research offers substantial insight into how the stakeholders' experience the community-based programme.

#### Advantage of being an insider

The role of insider-researcher worked well. It allowed the researcher to be accepted by the stakeholders of the programme. The resulting atmosphere of trust and openness contributed to the depth of the data. Such a position would have been difficult to achieve as an outsider or as an impartial witness. Participants willingly shared their experiences; this could have been on the assumption that the researcher was one of them, it was very evident that everyone wanted to participate in the study. This was particularly evident on the faces of the pupils who were not chosen to participate. This does appear to confirm the views of Dwyer and Buckle (2009) that researcher membership in the group of participants being studied is a useful approach in qualitative research.

The researcher's experience of being part of the community-based nursing education programme continued to inform the study. This dual role placed the researcher as researcher and researched, putting her in what Dwyer and Buckle (2009 p. 61) described as the "space between". Being in the space between two perspectives enabled the researcher to gain a deeper understanding of participants' experiences of the programme and enabled participants' acceptance

of the researcher. Being part of the study and of the participants' narratives was useful. It would, in any case, have been difficult to take an impartial stance. Indeed, just as Dwyer and Buckle (2009) argue, the intimacy of qualitative research no longer allows us to remain true outsiders to the experience under study.

### Ubuntu

The study's adherence to Ubuntu philosophy not only made it 'compatible' with the programme being studied, it linked the purpose of research to the discourses that emerged, and facilitated their interpretation. Taking such a position was vital to prevent misinterpretations and judgement on participants' experiences, cultural practices and the myths that were extant in the community and among the participants.

### **Study weakness**

There was a limited period of time in which the study could be conducted. The study was time-limited because it was undertaken as part of a PhD programme and the study was not funded.

The study provided evidence of a community nursing model that may be applicable in similar resource-limited environments. However, given that this is a qualitative study of a unique community programme, care should be taken before assuming its transferability.

### Use of Western literature

On the whole, the literature used in this study has been published outside Uganda and Africa. Most of the studies reviewed here were undertaken in UK, USA,



Canada, Australia, Denmark, and Sweden. Some of the studies were undertaken in South Africa, Tanzania and Kenya but with only a few were undertaken in Uganda. This was unavoidable and due to the small number of studies undertaken in Uganda. Nevertheless, it will be clear that at times the discussion seemed to be comparing 'apples with pears'. It has, however, been worthwhile to compare studies in Uganda with those undertaken in the West, not least this had led to the argument that there may be things that the West can learn from this small community-based nursing education programme in Western Uganda.

Nursing educators working within resource-poor settings, especially in Africa, are challenged to generate knowledge that could guide community-based nursing education programmes in their communities. This present study will contribute knowledge both locally and perhaps internationally. It is also the case that nurse educators in these communities are challenged by the high burden of disease and poverty and their efforts are rarely seen by the West. Perhaps this study will help in some small way to making their efforts known more widely.

#### Cultural differences

Culture provided other limitations, for example, the members in the study area would not readily criticise the programme. However, insider-ness was an important quality of this study and both provided insight into this issue and limited its effect. In practice, care was taken to encourage participants to communicate both their negative and positive experiences.

#### **Implications of the study**

It is suggested here that nursing education should promote new approaches in community nursing education using culturally appropriate models. There is a

need for flexibility and adaptability in relation to programme development so that it is fit for purpose and compliant with social and cultural needs. Critical thinking and lifelong learning skills need to be embedded throughout nursing education programmes. Specifically, student nurses need the kind of learning opportunities which the programme evaluated here provides, namely the ability to plan and provide care while being supervised by an academic member of staff. While the West may have the luxury of placing students with practicing community nurses and has taken this route, there is a clear advantage in academic staff practicing and supporting students. The theory-practice divide which has so long plagued nursing is finally breached. Academic and student work together on matters that tax them both; the result is a truly hippocratean, professional relationship between academic and student, where theory meets practice and drives health care home to where it is needed.

Nursing educators should address the challenges of language barriers before the students get into the community. Language modules should be designed which should take into account the local language. Language should be emphasised and taken as part of a service course in the first year. This would enable students to overcome some of the challenges of language barriers before they start their placements into the community.

Nurse educators should also be prepared and trained in community mentorship. Given that the approach is quite different from mentorship in the acute care settings of the hospital. They should also receive all the necessary support in this new role.

Health promotion and education based on reciprocal friendship can be successful when there is community-academic partnership. The approach enhances respect, trust, openness and listening. The use of Ubuntu, role modelling and the ripple effect model has proved to be effective in promoting knowledge, sharing and transferring knowledge.

#### Areas for future research

The research reported in this study was exploratory in nature. While this was appropriate, there is now a need to subject the community-based nursing education programme to a quantitative study to measure the effect on the health of the community and on student learning.

Further investigation should consider a longitudinal design to evaluate the long-term impact of the programme on the stakeholders.

Incidental findings in this study have raised questions, for example:

- How do parents view the fact that their children are sometimes teaching them about health care?
- Why is it that community members often prefer traditional to western medicine?

The sample chosen for this research included only stakeholders of the programme; future research might draw from a larger sample of the community. There is a need for follow-up the nursing graduates in their workplaces to explore the extent to which they utilised the knowledge gained during this programme. Also, whether this has generated interest in future research for themselves. It would be interesting to see how many students become community practitioners as a result of their experience of this programme.

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AN EVALUATION OF COMMUNITY BASED UNIVERSITY NURSING  
EDUCATION PROGRAMME AND STAKEHOLDERS' EXPERIENCES

## **Appendices**

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## **Appendix 1: Community programme - implementation overview**

### **Phase I: Designing the Project**

This phase involved planning a wider consultation with various stakeholders at different levels. The university administration was very supportive from the inception of the idea of a community-based university nursing education programme. It was recognised that gaining the trust of the school/ teachers / pupils and the community as a whole was paramount. It was also important to establish mutual objectives between the school and the community that would promote sustainability and self-reliance after the project funding from Fulbright Alumni Initiative Award has ceased.

### **Phase II: Meeting with Municipal Principal Education Officer**

The purpose of the meeting was to seek approval and support relative to the need for a Nursing Centre that is focused on health promotion, illness prevention, and early intervention. The purpose of community-based university nursing education programme and its aim as well as the objectives were clearly explained and described. The municipal education officer was very excited about the idea and he identified two suitable elementary schools for the project. That is Katete Primary School, a government school, and St Mary's Primary School, a sectarian school. Permission was granted and authorisation was received to organise and implement the programme. The initial step was to meet the headmasters of the two identified schools and the respective school management committees. The project was met with enthusiasm. They appeared excited to have their schools

nominated for the project. This kind of the project was the first in the district. It also had the proactive and reactive goals involving pupils and their parents within the community.

However, one of the headmasters was sceptical about the reaction of the community towards the project. The Project coordinator met with the community through the leaders and made clarifications emphasising that, community involvement in the early sensitisation / implementation stage will rule out distrust while furthering commitments and creating ownership of the project. Once the project was received, it was envisaged that the community would have feelings of ownership, that this project was their project and that its success or failure will be truly of their making. Their wholesome support was a critical factor in the implementation of the project. Arguably, once the community's roles are appreciated they will have a sense of belonging, acceptance of the project and use its services. In addition, protecting and taking care of the infrastructure would be assured. This explanation made the headmaster convinced that the community will embrace the project and that success was not an imagined goal

### **Phase: III Meeting with community leaders**

The third phase focused on establishing the ownership of the project. Meetings with community leaders were done. Most of the leaders were parents of pupils in the two primary schools proposed as settings/site of the programme/project. Through this meeting initial rapport was established with the community leaders, the project director, and other stakeholders of the programme such as the teachers of MUST Department of Nursing, and of the primary schools. It was critical to demonstrate an attitude of sincerity, of genuine interest in the pupils'

welfare, of their community, and willingness to commit until the end of the project. Ubuntu values of sharing information were emphasised. The community leaders were convinced that through the pupils, the life of the community could indeed change for the better; leading healthy lives and taking responsibility for their own health care.

#### **Phase: IV Joint meeting with stakeholders**

The final meeting with the lecturers in the department of nursing, the municipal principal education officer, and the two headmasters was carried out to make sure that all parties had the same vision of the project. A close look at the Bachelor of Nursing Science curriculum was undertaken to ensure that the timetable did not conflict with other courses offered in other departments that students of nursing also attend.

#### **Phase V Signing of the memorandum of understanding**

A memorandum of understanding was signed by the university administrator and the municipal principal education officer.

#### **Phase VI Official opening of the project**

The official opening of the project was done by His Worship the Mayor of Mbarara Municipality. The function was well attended by dignitaries from the university, education office, town clerk, politicians, parents, community members, nursing students and faculty. At the same function, we were very privileged to have the senior expatriates from Florida Atlantic University (FAU) USA. It was on this occasion that the project became actively functioning.

In the same year, the representatives from the American Embassy visited the project as part of an exercise to evaluate the projects and programmes being supported by the United States Government and other agencies from the United States.

### **Phase VII Visitation of similar projects in USA**

Finally, the project coordinator visited the various community nursing centres in Florida USA. This was aimed at gaining more insight into how the community nursing models there were implemented, how they functioned, for the purpose of providing an impetus for research and practice. Also, ensuring that the dissemination of knowledge can be assured regarding the design, establishment, and evaluation of a community-based university nursing education programme.

[illegible]

### Appendix 3: Ethical clearance and permission letters

## Appendix 3 (a): The University of Hull Faculty of Health and Social Care Ethics Committee



Ms Grace Nambozi  
Faculty of Health and Social Care  
University of Hull

**FACULTY OF HEALTH  
AND SOCIAL CARE**  
T: 01482 464524  
E: [p.a.pearcey@hull.ac.uk](mailto:p.a.pearcey@hull.ac.uk)

06 May 2010

OUR REF 030

Meeting date 29 March 2010

Dear Grace

**Re: Your proposal**

Thank you for submitting your amended application for approval of your study to the Faculty Ethics Committee. I am pleased to inform you that, after consideration I am delighted to give Chair's action to approve your study and you may begin data collection with immediate effect.

Yours sincerely

Cat Clavery

Dr Pat Pearcey  
Chair, Research Ethics Committee

cc. file/JJ/PD

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**MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY  
INSTITUTIONAL ETHICAL REVIEW COMMITTEE**

P.O. BOX 1410, MBARARA,  
TEL: 256 4854 21387,  
Email: [irc@must.ac.ug](mailto:irc@must.ac.ug)



UGANDA

Fax: 256 4854 20782

Your Ref: .....

Date: 15 July 2010

Our Ref: MUIRC 1/7

Ms Grace Nambozi  
University of Hull

Re: SUBMITTED RESEARCH PROTOCOL ON "AN EVALUATION OF  
COMMUNITY BASED UNIVERSITY NURSING EDUCATION  
PROGRAMME AND STAKEHOLDERS' EXPERIENCE AND VIEWS."  
NO. 28/06-09

Reference is made to the above study proposal which was submitted to the  
Institutional Ethical Review Committee for consideration and approval.

I am glad to inform you that the committee at its sitting of 9<sup>th</sup> July, 2010 did  
consider your study protocol and agreed to approve it for a period of one year  
up to June 2011.

You can now proceed with the rest of the research activities as per your work  
plan.

I wish you all the best.

  
Emmanuel Kyagaba  
CHAIRMAN MUST-IRC

Cc Secretary –IRC



## Appendix 4: Permission letters to conduct the study

### Appendix 4 (a): Permission Letter from headmasters

St. Mary's Primary School  
Mbarara Municipality  
P.O BOX 150  
Mbarara

15<sup>th</sup> August, 2010

Dear Miss Nambozi,

**RE: PERMISSION GRANTED TO CONDUCT RESEARCH AT OUR SCHOOL**

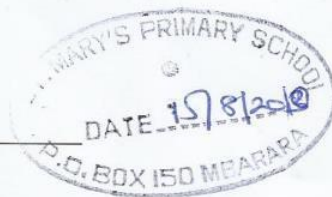
Thank you for your interest in conducting research at our primary school St Mary's with teachers and the pupils regarding their experiences and views of being involved in the health promotion and education programme. I am pleased to inform you that after receipt of your request letter, along with your ethical approval from the Faculty of Health and Social Care Ethical Review Committee at the University of Hull and IRB MUST approval letters, we discussed and permission has been granted. We wish you the best in this exercise you are about to undertake. Please bring this letter with you when you come to collect data.

Kind regards



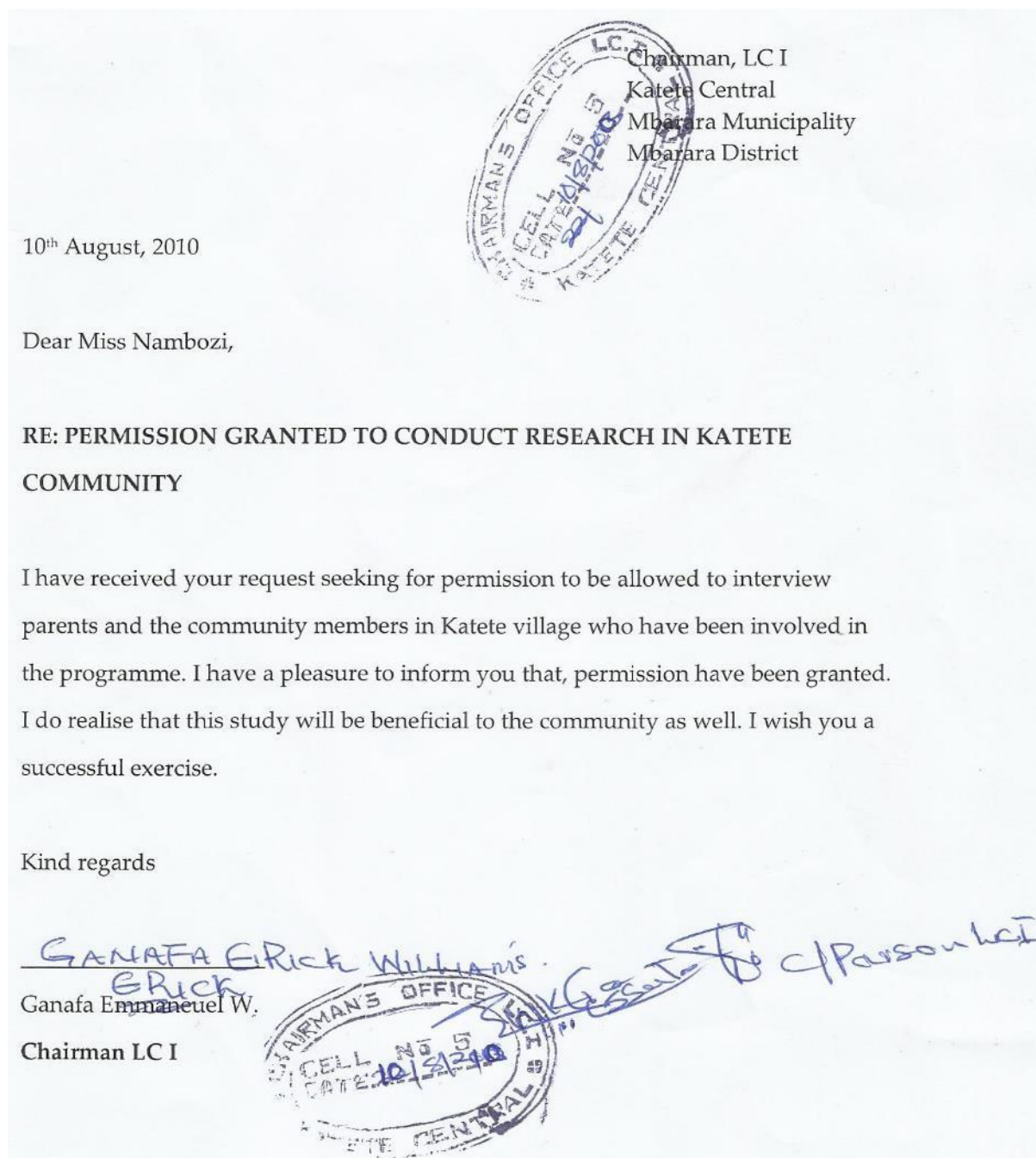
Betunga Deus

Headmaster





Appendix 4 (b): Permission Letter from the Local Council



**Mbarara University of Science and Technology**

**Department of Nursing**

5<sup>th</sup> August, 2009

**RE: Parents Request Form for Permission to Interview their Children**

I am **GRACE NAMBOZI** I am writing to seek your permission if I can invite your children at St Mary's and Katete primary school to participate in the study I am undertaking titled: "**An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences**"

The purpose of this study is to explore their experiences of the programme. By participating in this study, they will help to increase our understanding of how their experience in the programme impacted on their learning of healthy lifestyles; and what we can learn from it, in order to improve on health promotion and education of children.

I am going to ask your child for information about his or her experience with the programme as well as background characteristics. Should you agree for your son or daughter to take part in the study, there is a chance that I might contact him or her again to re-interview him or her? The information that he or she will provide for the study will be kept confidential. Only the Researcher will have access to them.

Your child participation in this study is voluntary and he, or she has the right to refuse to participate or answer any question that he or she feels uncomfortable with. If he or she changes his or her mind about participating during the course of the study, he or she has the right to withdraw at any time. The decision to withdraw will not affect any future education of your child at the school or health care at the centre or hospital.

If there is anything that is unclear or you need further information, I shall be delighted to provide it.

### **Declaration of the Parent**

I have read the above information, or it has been read to me. I have understood the purpose of the study. I have had the opportunity to ask questions about the study and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a subject in this study and understand that he or she has the right to withdraw from the study at any time without it in any way affecting his or her future education to the school or health care at the centre or hospital; and that my child might be contacted again if need be.

.....

.....

Name/Signature of Parent/ Guardian

Name/Signature of Investigator

Date: .....

Date:.....

**Mbarara University of Science and Technology**  
**Department of Nursing**  
5<sup>th</sup> August, 2009

**EKIHANDIKO KYA BAZAIRE KWIKIRIZA ABAANA BABO KWEZUMBA**  
**OMUKUCONDOZA KWAPUROGURAMUYA CBUNEP.**

Ninye **GRACE NAMBOZI**, nimpandika ndikubashaba mwikwirize abaana banyu aba St Mary's na Katete primary school ekwezumba omumushomo ogukwetwa **“OKUNCONDOZA KWAPUROGURAMUYA CBUNEP NEBITEKATEKO BYABARI KUGIKOZESA”**

Ekigendererwa kyokucondoza oku, nokumanya ebitekateko byabaana aha puroguramu egi. Omukwezumba omumushomo ugu, nikiza kutuyamba okukyenga gye puroguramu egi, nakweyambire nanokwejesa aha bikwatine nokutura namagara marungi, omubikorwa nokumanya emiringo yebyokurya ebirungi. Ekindi, nitwenda obuhabuzi butubasize okwongyeramu amani omukushomesa abaana emiringo mirungi yokurinda hamwe nokugira amagara amarungi.

Ninyiza / Nimbasa kubuza omwana wawe ahabikwatinine nokumanyakwe aha puroguramu egi. Kworikirize mutabani nginga muhara wawe okwezumba omukucondoza oku, ni mbasa kugaruka kumubuza kyayetengyesa. Okuganira kwona nikuza kubikwa nka ekihama. Ebituracondoze niwe arabase kubimanya wenka.

Omwana wawe takugyemwa kwenzumba omukucondoza oku, kiri ahakukundakwe, kuyakuhindura entakateka aine obugabe kurugamu eshaha

yona. Tikirateganise ebyokushomakwe ninga okuragurirwa aha irwariro. Haba hariho ekyotayetegyereza ninza kushemererwa wambuza nkakushoborera.

**Okwikiriza kwomuzaire**

Nashoma ninga banshomera abyagambwaho ahiguru. Nayetegyereza ekigyendererwa kyokucondoza oku. Naherwa omugisha gwokubuuza kandi burikibuzo kyinabuza kyangarukwamugye. Ninyikiriza omwana wangye kwezumba omukucondoza oku. Kandi kuyakuhindura entakateka aine obugabe kurugamu eshaha yona. Tikirateganise ebyokushomakwe ninga okuragurirwa aha irwariro. Kandi nibabasa kugarukamukamu kuganira nawe kyayetengyesa.

.....

.....

Ayacondoza ahandike ahansi Eizina

Omuzaire handika ahansi Eizina

Omukono\_\_\_\_\_

Omukono\_\_\_\_\_

Ebiro byokwezi ..... Ebirobyokwezi: .....

## **Appendix 5: Information sheets**

### Appendix 5 (a): English Information Sheet Part I

**Title:** An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences.

#### **Participant information sheet Part I**

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take the time to read the following information carefully. Talk to others about the study if you wish.

I am a PhD student in the Department of Nursing Faculty of Health and Social care The University of Hull United Kingdom. This study is being done as part of my doctoral thesis. The aim of this study is to evaluate the programme and elicit the views and experiences of users of the programme (CBUNEP).

You are one of the users of this programme, so you meet the inclusion criteria for my study, and you have expressed interest in this to participate by responding to my letters.

I hope the information gathered in the interviews will generate accurate account of experiences of the programme. This information will help in improving the service delivery and to create similar programmes in other schools and communities.

You are under no obligation to participate and if you choose to do so, you will be free to withdraw at any time.

If you do decide to take part, you will be interviewed for approximately one to one and half hour in a mutually convenient place.

All interviews will be audio taped. The interviews will then be transcribed. The transcript will be anonymised and the tape destroyed. This study will be completed in October 2012. If you would like to receive a summary of the findings, detail of any publications or any other information related to this study you can email me at [G.Nambozi@2008.hull.ac.uk](mailto:G.Nambozi@2008.hull.ac.uk) or write to me at this address 19 Melbourne street, HULL HU5 2ET. OR Mbarara University of science and technology department of nursing, P.O BOX 1410, Mbarara – Uganda (East Africa)

Should you have any concern while participating in this study please do not hesitate to contact Mr. Emmanuel Kyagaba, the Chairperson Institution Review Board- Mbarara University of Science and Technology, P.O BOX 1410 Mbarara

.....

**Name of participant**

**Date**

**Signature**

.....

**Researcher**

**Date**

**Signature**

**Title:** An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences and Views.

**Participant information sheet Part 2**

**Right to withdraw**

You have the right to with draw from this study at any point. If you choose to pull out after the interviews then all data collected from you will be destroyed and will not make up part of the study.

**Confidentiality**

All information will be kept confidential. Each interview will be recorded on audio-tape. The content of the interview will then be transcribed from the tape by the researcher and the tape destroyed. At this point, all identifiable information's will be anonymised for examples name of the institution.

In the final write up quotes from interviews may be used to enhance the experience of the reader but care will be taken so that participants will not be recognisable from their quotes.



### **The results**

The findings of this study will be written up in my doctoral thesis as part of my doctorate in nursing, also as a result of this study, research papers will be submitted for publication.

### **Sponsors**

This research is being sponsored by two universities. The University of Hull Faculty of Health and Social Care, Department of Nursing in terms of financial resources and Mbarara University of Science and Technology for granting me permission and time to study.

### **Ethical consideration**

The study has been given ethical approval by the Faculty of Health Science and Social Care University of Hull and Institutional Review Board Mbarara University of Science and Technology.

Thank you for taking the time to read this information sheet. If you still wish to take part in this study please read and sign both copies of the consent form provided.

**EKIHANDIKO KYOKUBURIRIZA EKICWEKA KYOKUBANZA**

**OMUTWE GWOMUSHOMO: OKUNCONDOZA KWAPUROGURAMUYA  
'CBUNEP' NEBITEKATEKO BYABARI KUGIKOZESA. EKICWEKA  
KYOKUBANZA.**

Ninkweta kwenzumba omukucondaza aha puroguramu yeitu ya 'CBUNEP'. Otakasaziremu nikirungi, obanze wetegereze ebikwatine nokucondoza oku. Ninkushaba otware obwire wetegereze ebiri ahansi aha. Nobasa kuganiraho nabandi waba noyenda.

Ndi omwegi omu Univasite yaheru. Okucondoza oku nikuza kunyamba kuhandika ekitabo ekikwetengwa okumara omushomo. Ekgygindererwa kyo kucondoza oku, nokwenda kumanya ebitekateko byabakozise obuheraza obu.

Niwe ori omwe ahabakozise obuhereza obu kandi okaba wanyorekire okwikiriza kwawe okwetaba omukucondoza kwangye oku orikugarukamu amabaruha gangye.

Ninyesiga ebiraruge omukucondoza oku, nibiza kutuha ekishushani kyobuhereza yapuroguramu egi. Ebirarugyemu nibibasa kuyamba amashomero agandi hamwe nebyaro ebindi kutunga obuhereza nk'obu

Tokugyemwa kwenzumba omukucondoza oku, kiri ahakukunda kwawe, kuwakuhindura entakateka oine obugabe kurugamu eshaha yona.

Washaraho kwezumba omukucondaza oku, nobasa kubuzibwa okumara obwire bwa shaha emwe ninga emwe necicweka omwanya gweherire.

Okuganira kwona nikuza kuza ahari rutambi. Bwanyima bwokucondozebwa nibiza kuhandikibwa aha rupapura, orutambi rushenyerwe. Okucondaza oku nikuza kuhwa omu October 2012. Kworabe noyenda kumanya byona ebirugiremu, nosindika obutumwa aha [G.Nambozi@2008.hull.ac.uk](mailto:G.Nambozi@2008.hull.ac.uk) ninga handika aha 19Melbourne street, HULL HU5 2ET. Ninga Mbarara University of Science and Technology Department of Nursing, P.O Box 1410 Mbarara

.....

.....

.....

Eizina ryawe

ebiro byokwezi

sayini

.....

.....

.....

Eizina owacondoza

ebiro byokwezi

sayini

**OMUTWE: OKUNCONDOZA KWAPUROGURAMU YA CBUNEP  
NEBITEKATEKO BYABARIKUGIKOZESA**

**ORUPAPURA RWOKUMANYISA OMUCONDOZEBWA. EKICWEKA  
KYAKABIRI.**

**Obugabe bwokurugamu**

Ayiine obugabe kurugamu obwire bwona yakikunda. Washaraho kurugamu bwanyima yokuganira niwe, ebitekateko bwawe tibikuza omubyacondozebwa kuza omukitabo.

**Okubiika ebihama**

Buri kimwe ekyagambwaho nekihama. Buri kucondozwa nikuza kukwatibwa aha rutambi rwa rediyo (odio- tepu). Omucondoza naza kuhandika ebiri aha tepu bwanyima egishenye.

Okuhandika okurahererukeyo ebigambo ebimwe nibiza kuhandikwa nka kwebyagambwa okuhamisiriza okucondoza. Konka okwegyendesereza nikuza kuba okwamanyi, obutahandika amaziina gabacondozebwa aho kubasa kurinda ebihama.

### **Ebirarugyemu**

Ebiraruge omukucondoza\_nibiza kunyamba okumarira okuhandika ekitabo kyangye ekyokumarira okushoma obwa dokita omubunansi. Ekindi a ripota araruge omukucondoza neza kwanzarwa emanywe.

### **Abanyambire**

Obuyambi bwokukora okucondoza oku mbwihire omu univasiti ibiri: Univasiti ya Hull Faculty of Health and Social Care, ekitongore kyo bunansi na univasiti ya Mbarara Science and Technology ahabokunyikiriza kuza kushoma.

### **Amateka**

Okucondoza oku, kwikirizibwe kukuraba omumateka gaza univasiti zombi, aya Hull neya Mbarara.

Webare munonga kumpa obwire bwawe kubasa kushoma ebikwatirine nokucondoza oku. Waba noyenda kugumizamu nokucondozebwa, handika amazina gawe okuhamisiriza okwikiriza kwawe aha mpapura zombi.

## Appendix 6: Consent Forms

Appendix 6 (a): English consent form for those who can read and write

**Participant identification number:** \_\_\_\_\_

**Title of study:** An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences and Views

**Researcher:** Grace Nambozi

Please tick in the box provided

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my rights being affected ☐

I agree to take part in the above study ☐

.....

**Name of participant**

.....

**Date**

.....

**Signature**

.....

.....

.....

**Researcher**

**Date**

**Signature**

When completed, 1 copy for the participant and 1 copy for the researcher.

**Participant identification number:** \_\_\_\_\_

**Title of study:** An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences and Views

**Researcher:** Grace Nambozi

Please put your thumb print in the box provided.

I confirm that information on the content sheet for the study above have been read and explained to me in details and I therefore understand, I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my rights being affected

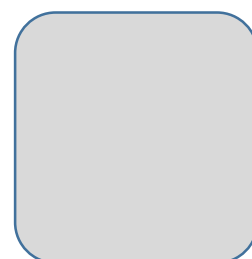
I agree to take part in the above study

.....

**Name of participant**

.....

**Date**



**Finger print**

.....

**Researcher**

.....

**Date**

.....

**Signature**

When completed, 1 copy for the participant and 1 copy for the researcher.

**ENAMBA YO MUCONDOZWA:** \_\_\_\_\_

**EKICWEKA: OKUNCONDOZA KWAPUROGURAMU YA CBUNEP  
NEBITEKATEKO YABAKUGIKOZESA**

**Omucondozi:** Grace Nambozi

Ninkushaba ote ekinkumu ahanamba ahansi:

Nimpamisiza ngu ebihandikirwe aha rupapura babinshomera kandi babinshoborera nabikyenga. Nahebwa omugisha okukyenga nanokubuza ekintayetegyereza / ebintayetegyereza.

Ninkimanya ngu okwezumba omukucondoza oku nekundire, nimbasa kurugamu naba ntashemeirirwe, kandi tikuza kuteganisa obugabe bwangye.

Nikiriza kwezumba omukucondoza oku.

.....

.....



Eizina

Ebiiro byokwezi

Ekinkumu

.....

.....

.....

**Omucondoza**

**Ebiiro byokwezi**

Sayini



Study Title: An Evaluation of Community Based University Nursing Education Programme and Stakeholders' Experiences and Views

**Child or if unable, research assistant on their behalf to circle all they agree with**

- Have you read (or had read to you) the information sheet about the project? **YES / NO**
- Has somebody else explained this project to you? **YES / NO**
- Do you understand what this project is about? **YES / NO**
- Have you had the chance to ask questions and talk about the project?  
**YES / NO**
- Do you feel happy with the answers you have been given? **YES / NO**
- Do you understand that it is your choice to help with the study? **YES/ NO**
- Do you understand that your response will be tape recorded during the conversation? **YES / NO**
- Do you understand it's OK to stop taking part anytime? **YES / NO**
- You do not have to say why you want to stop. It will not affect your learning? **YES / NO**
- Are you happy to take part in the study? **YES / NO**

If any answers are 'no' or you don't want to take part don't sign your name  
If you do want to take part, you can write your name below:

Your name \_\_\_\_\_

Date \_\_\_\_\_

The researcher who explained this study research to you needs to sign too:

Print name \_\_\_\_\_

Sign \_\_\_\_\_

Date \_\_\_\_\_

**EKIHANDIKO KYOKWIKIRIZA OMUKUCONDOZA OYEKUNDIRE (ABAANA)**

**OMUTWE GWOMUSHOMO: OKUNCONDOZA KWAPUROGURAMU YA  
CBUNEP NEBITEKATEKO YABAKUGIKOZESA**

Abaana bakyebera kimwe ahari ebyahansi nginga okubabuza abakyeberere

Oratungireho okumanyisibwa ebikwatirine na puroguramu egi? EGO/NGAHA

Noyetegereza ebiri omupurguramu egi? EGO/NGAHA

Oratungireho omugisha ogwo kubuza nginga kugamba aha puroguramu egi?  
EGO/NGAHA

Oshemereirwe nebibagarukiremu? EGO/NGAHA

Nokimanya ngu nobugabe bwawe kuyamba puroguramu egi? EGO/NGAHA

Nokimanya ngu obyo kugamba nibabikwata ah rutambi? EGO/NGAHA

Nokimanya ngu nobasa kureka kuganire nanye obwire bona? EGO/NGAHA

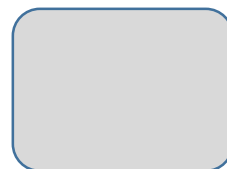
Nokimanya ngu wareka kuganira nanye tikikuteganisa kushoma kwawe?  
EGO/NGAHA

Noshemererwa kuganira nanye omu puroguramu egi? EGO/NGAHA

Ebigarukwamu byawe byona byaba NGAHA Otahandika eizina ryawe  
aharupapura oru

Wabanoyenda kwenyigira omukucondaza oku handika eizina ryawe ahansi

Eizina\_\_\_\_\_ Ebiro byokwezi\_\_\_\_\_ Omukono



Ayacondoza ahandike ahansi

Eizina\_\_\_\_\_ Ebirobyokwezi\_\_\_\_\_ Omukono\_\_\_\_\_

\_\_\_\_\_

## **Appendix 7: Interview Guides for Stakeholders**

### Appendix 7 (a): Demographic Characteristics of Participants

**Tick or write the space provided.**

#### **Age range**

10-19

20-29

30-39

40-49

50-59

>\_ 60

Others\_\_\_\_\_

#### **Sex**

Male \_\_\_\_\_

Female\_\_\_\_\_

**Professional** \_\_\_\_\_ **Others** \_\_\_\_\_

**How long have you been in the programme?** \_\_\_\_\_

Please tell me your experience of CBUNEP

Please tell me your experience of CBUNEP programme?

How appropriate was CBUNEP project at Katete primary school in terms of institutional learning for nursing students/ pupils?

How best do you think CBUNEP can be improved?

Probing question on (How did you participate, how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme, any impact, to you and to the community, what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study

Please tell me your experience of CBUNEP activities

How have you participated in CBUNEP programme?

How best do you think CBUNEP can be improved?

Probing question on ( how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme to you and to the community, any impact, what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study

Please tell me your experience of CBUNEP

How have you participated in CBNEP programme?

How useful was CBNEP/SBNC to your family or school?

How do you think CBNEP/SBNC can be improved to meet your needs?

Probing question on ( how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme, to you and to the community, any impact, what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study

Ekicweka kyobubanza: Ebiri kukukwataho

Kyebera kimwe ahari ebyahansi

Emyaka yawe

10-19

20-29

30-39

40-49

50-59

>60

**Obuhangwa**

Omushaija \_\_\_\_\_

Omukazi \_\_\_\_\_

Omurimo gwawe \_\_\_\_\_ Ebindi \_\_\_\_\_

Omazire bwireki omupuroguram egi? \_\_\_\_\_

**EKICWEKA KYAKABIRI: ENGYENDERWAHO Y'OKUBUZA ABAZIRE  
OMUBICWEKACWEKA**

Ninkushaba ongambire ekyoyihire omupuroguramu egi (CBUNEP)

Obiire nokora nka ki omupuroguramu egi?

Puroguramu egi ekuyambire eta omuka yawe ninga aha ishomero ryanyu?

Notekateka ngu puroguramu egi tukagitwaza tuta kureba ngu kuhisyaho/ktungisa ebyetago byawe?

Okucondooza kwomutaano:

Puroguramu egi ekatandika etya?

nikintu ki ekihang'o ekiotungire omupuroguramu egi?

Nimpindukaki ebireho ahabwa puroguramu ahabwawe naha bantu bona omukicweka kyawe?

Oshangiremu buremeziki omupuroguramu egi?

Puroguramu egi nebase kugumizamu etya?

Notekateka puroguramu nebase kukora omubantu abandi nomumashomero gaabo?

Webare munonga kumpa obwire bwawe.



The moderator will use the focus group to promote interaction, probe for details when warranted, and ensure that discussion remains directed towards the topic of interest.

**Pupils in upper classes primary 5-7**

Please tell me your experience of the project?

How have you participated in this project?

How useful were health promotion messages, how was the content?

How do you think the project can be improved to meet your needs?

Probing questions ( how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme, to you and to the community, what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study

**ABAANA OBOMUBIINA BYAHIGURU (5-7)**

**ENGYENDERWAHO Y'OKUBUZA**

Ninkushaba ongambire eki orikutekateka aha puroguramu egi (Projecti CBUNEP)

**Ebibuzo**

Okakoraki omu puroguramu egi?

Okushomesha aha byamagara kukahwerakutya?

Nimaaniki agakubasa kongyerwa omu puroguramu egi ekahikana nebyetago byawe?

Nikihangoki eki mutungire omu puroguramu egi?

Nimpindukaki ebireho ahabwawe naborikutura nabo omukayaro ekyo?

Niburemeziki obwosangire omu puroguramu egi?

Puroguramu egi nebase etya kugumizamu?

Notekateka ngu puroguamu egi nabaasa kukoresibwa omubaryo ebindi nam shomero egandi?

Webare munonga kumpa obwire bwawe.

**Pupils in lower classes -primary four and below.**

1. What is your experience of the programme?
2. Please use the drawing to describe your experiences?
3. Thank you for your time to participate in this study

**ABAANA OBOMUBIINA BYAHANSI**

**ENGYENDERWAHO Y'OKUBUZA**

1. Ninkushaba ongambire eki orikutekateka aha puroguramu egi (projecti CBUNEP)
2. Kozesa ekishushani orikworeka ebyokumanya aha puroguramu egi
3. Webare munonga kumpa obwire bwawe.

Please tell me your experience of CBUNEP

1. How have you participated in CBUNEP programme?
2. How appropriate was CBUNEP project at Katete primary school in terms of institutional provision of learning for nursing students/ pupils?
3. How do you think CBUNEP can be improved?

Probing question on ( how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme, to you and to the community, impact, what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study

Please tell me your experience of CBUNEP

1. How have you participated in CBUNEP programme?
2. How appropriate was CBUNEP project at Katete primary school in terms of institutional provision of learning for nursing students/ pupils?
3. How do you think CBUNEP can be improved

Probing question on ( how was the CBUNEP implemented, What has been the biggest achievement of the programme, what changes have resulted due to the programme, to you and to the community, impact what challenges did you realise with the programme? How can this programme be sustained? Do you think this idea can be used in other communities and schools?)

Thank you for your time to participate in this study.

## Appendix 8: Observational Guide for Participant Observation

Unstructured participant observation was carried out by the researcher and research assistants to observe nursing students skill performances and content of health promotional messages. In addition, pupil's classroom action for instance, involvement, enthusiastic, interested etc and parents' interactions during health messages talks. The observation was guided by the check list of items to observe in relation to the programme activity outcomes (see the check list attached, table 22). During the process confidentiality / anonymity was maintained at all time. As a result there was no identification of individuals.

**Table 22. Observation guide**

<b>Category</b>	<b>Will Include</b>	<b>Researcher/ research assistant will note down</b>
<b>Pupils</b>		
	Classroom action	Pupils behaviours in relation to Involvement Enthusiasm Interested Lack of interest Use of body languages etc...
<b>Nursing students</b>	Health promotion messages	Description of sessions and use of body language Content of messages Methods used for delivery of messages
<b>Parents in the community</b>	Interactions during health promotional messages	Their interaction Use of body language

## **Appendix 9: Guide to Selection of Document Analysis**

Documents in the department of nursing ( annual reports, and curriculum), documentation at the School Based Nursing Centre (SBNC) , and the annual reports from two elementary schools were analysed for any information linked to CBUNEP from 2006-2009. During the process confidentiality / anonymity was maintained at all time. Furthermore, only authentic documents were analysed. Documents were considered authentic if they met the following criteria: Reports from 2004-2009 which included the programme activities and duly signed by the headmasters and had the school stamp; reports in the department of nursing followed a similar format instead of the stamp it had to have a university logo. The reports at the wellness centre were considered, based on the completeness and being signed.

## **Appendix 10: Fundamental Rules Employed in Focus Group Discussion.**

The participants were assured that there were no correct or incorrect responses instead the study was looking at their experiences of the programme. Interviewees were free to seek for clarification whenever it seemed convenient. After their consent were sought; were informed that their viewpoints would be respected and promised them anonymity, and were encouraged to talk without fear and frankly regarding the issue of the enquiry. All members were to contribute. The interviewees were notified that the data generated would be handled with the greatest privacy. No name would be used in the final thesis or any report or allusion to any particular data which can make someone recognised.

An icebreaker was used to get the interviewee started. The initial enquiry was rather general, for example, participants were asked 'what is your experience of the programme?' This approach set the participant to discussion. While for the pupils, it started off as; 'was the programme fun or enjoyable?' Thereafter the enquiry shifted to detail of the programme experiences and views.



## **Appendix 11: An example of a reflective account during interview process.**

### **An example of reflective Journal Entries**

<b>Example of challenges faced during focus group discussion with parents</b>
Putting men and women in a focus group discussion may make women ideas missed out. Even though they were being encouraged to talk still they tended to agree with what men said. In this interview, I learned today that culture played a significant role. This could affect the research findings. Although this study was not focusing on any particular gender, if women shy away to voice their experience this could influence the result of research. Another focus group will need to be conducted with more women than men.
<b>Example of challenges faced with some pupils left out of study</b>
Today I learnt that pupils are more emotionally affected when not selected to take part in the study. It was very visible on their faces. Although they were offered an activity to keep them occupied during the time their colleagues were being interviewed, it appeared they seemed happy for a while. Occasionally some pupils continued strolling quietly near the building where their colleagues were. This movement could have distracted the attention of the pupils who were study participants. The good thing is that the pupils sat in a way that their back was towards the window. In addition, those pupils were quiet and stood at some distance. Although the teachers kept watching on the pupils in the playground, they still found their way towards the classroom although not entering but standing and looking at a distance, with a questioning look.

## Appendix 12: Tunga Penetrant (Jigger Flea) and the effects



- Jigger flea is the smallest flea in the world about **1mm** and can be easily missed by the naked eyes
- Its scientific name is *Tunga penetrans*
- Found in endemic tropical and sub-tropical warm dusty, sandy areas-coast and beaches
- Due to globalisation the disease has been transported to non tropical countries
- It is estimated that about 88 countries are infested with the Jigger fleas
- It releases the eggs through the opening in the victim's body
- They fall on the ground
- In the favourite climate, it takes 3-4 days for the eggs to hatch
- It takes about 3-4 weeks to mature and the person gets re-infection.



### In the Hosts' body

- Male and female fleas Feed on their warm blooded hosts
- The female burrows under skin of the host
- The process is painless
- It's abdomen enlarges and a tiny black dot at the point of penetration – quickly develop into a white- pea sized nodule



- Continuous re-infection results in cluster nodules giving a honey comb appearance.
- Leading to devastating effects



- **Physical pain**
  - Difficulty walking
  - Deformity ( amputation of toes)
- **Psychological pain**
  - Social stigma ( low self esteem)
  - Social isolation
  - School drop out

Source: generated from literature search at the following websites:

Ahadi Kenya Trust ( 2008) The jigger menace in Kenya. Anti-Jigger magazine Final. Indd. Available [online] at <http://jigger.ahadi.org/Anti%20Jigger%20magazine%20Final.pdf> retrieved 15th April 2012.

Jigger flea burrows in the body available [online] at [http://www.healthinplainenglish.com/health/infectious\\_diseases/tungiasis](http://www.healthinplainenglish.com/health/infectious_diseases/tungiasis) (retrieved 15th April 2012).

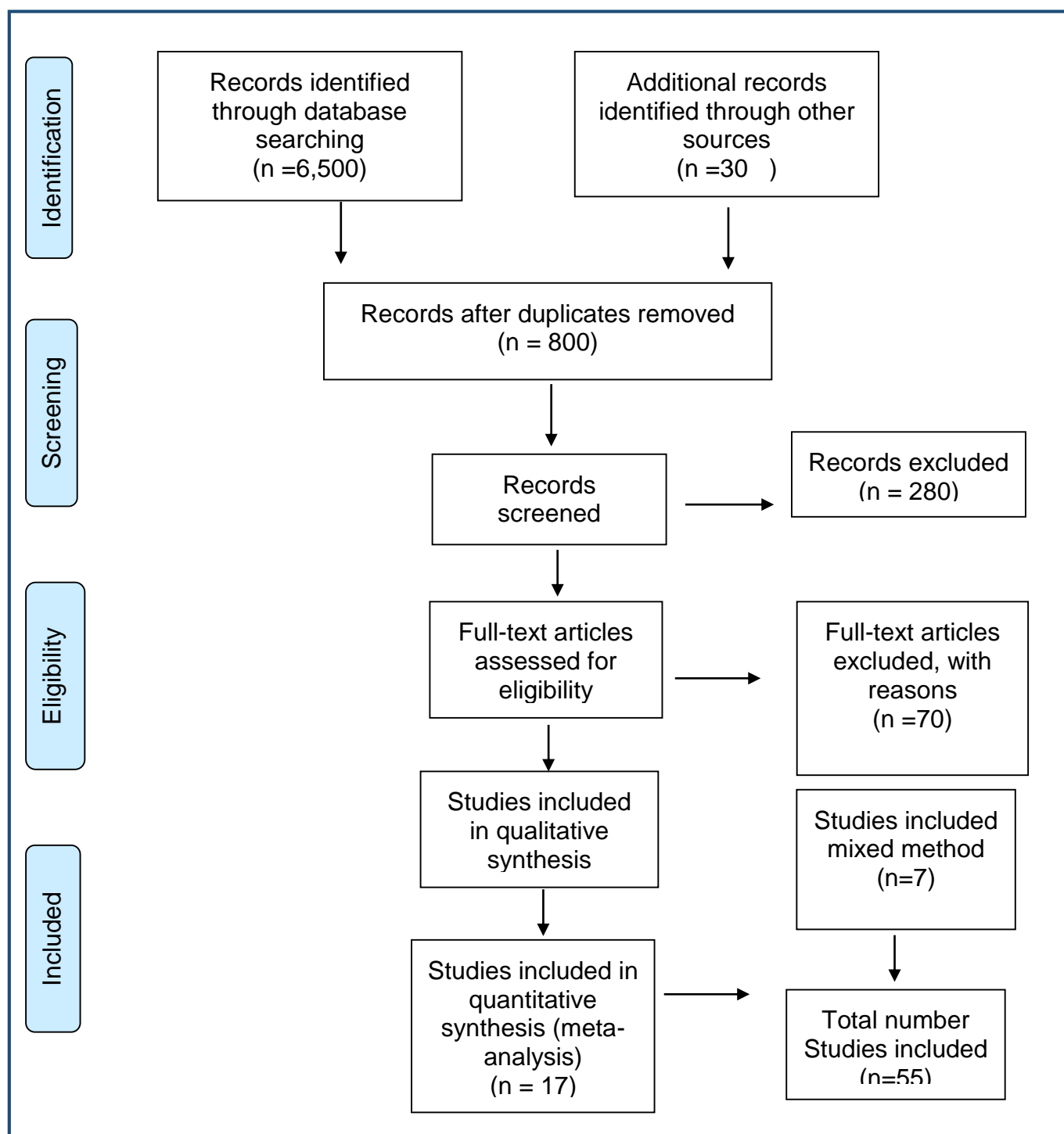
**Appendix 13: An example of Treatment of fracture at a bone setter's premises**



Source: adapted from: Omololu et al., (2008) Available [on line] at [http://www.springerimages.com/Images/RSS/1-10.1007\\_s11999-008-0371-8-5](http://www.springerimages.com/Images/RSS/1-10.1007_s11999-008-0371-8-5). Retrieved on 2nd May 2012.

## Appendix 14: Details of Included and Excluded Studies

### PRISMA 2009 Flow Diagram



Adapted from Moher, D., Liberati, A., Tetzlaff, J and Altman, D.G., The ORISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.

## Appendix 15: Studies that met the Inclusion criteria.

Studies that met the systematic literature search inclusion criteria

COMMUNITY BASED EDUCATION PROGRAMMES								
Date	Reference	Title	Country	Design	Sample	Setting	Focus of Study	Limitation of Study
2014	Buff, Jenkins, Kern, Worrall, Howell, Martin, Brown, White, and Blue.	Interprofessional service-learning in a community setting: findings from a pilot study	U.S.A	Questionnaire - 13-item survey included a 5-point Likert scale	230 ( 65 percent response)	University	An evaluation was developed to assess the effect of the activity in three areas: student appreciation and knowledge of their own and other professions, interaction with other professional students, and student teamwork skills	A pre-test was not conducted to provide comparative analysis for student learning significance over the course of the project. The profession of the student completing the survey was not recorded to allow comparisons of results between professions
2013	Mabuza, Diab, Reid, Ntuli, Flack, Mpofu, Daniels, Adonis, Cakwe,	Communities' views, attitudes and recommendations on community-based education	South Africa	An exploratory qualitative study- was conducted at three South	Purposive sampling of participants was used	Both urban and rural sites both urban and rural sites took place	To explore communities' views, attitudes and recommendations regarding	The researchers were all healthcare professionals, which may have influenced the subjectivity of the

	Karuguti,.and Molefe	of undergraduate Health Sciences students in South Africa: A qualitative study		African universities			CBE undertaken by undergraduate Health Sciences students at three South African universities	findings. The findings focused on medical students thus limiting generalizability among study samples However offered opportunities of 'transferability
2013	Linda, Mtshali, and Engelbrecht,	Lived experiences of a community regarding its involvement in a university community-based education programme	South Africa	An interpretive existentialist-phenomenologic al design-employed individual interviews and focus groups	Purposive sampling	rural community	Investigated the experiences of a community regarding its involvement in a community-based education programme offered by a university nursing school in Durban, South Africa.	Questionable approach of sample selection of children and only women in the community. Ethical issues regarding minors as participants, The choice of data collection for the children age 6-11,experiences fragmented potential for bias findings Language used for data collection for minors age 6-11.
2013	Mthembu, Mtshali,	Conceptualisation of knowledge construction in community service-learning programmes in nursing education	South Africa	Qualitative-grounded theory – semi structured interviews	Purposive sampling – 16 participants	Two nursing education institutions	To conceptualise the phenomenon of knowledge construction and thereby	Qualitative sample size limit generalizability beyond the sample

							provide educators with a shared meaning and common understanding, and to analyse the interaction strategies utilised by nurse educators in the process of knowledge construction in community service-learning programmes in basic nursing education.	
2012	Schuessler, Wilder, Byrd,	Reflective Journaling and Development of Cultural Humility in students.	U.S.A	Qualitative - reflective journaling	50 students were reviewed	Auburn University School of Nursing (SON) in Auburn,	To describes the use of reflective journaling as students progressed through four semesters of a community clinical experience	Qualitative sample size limit generalizability beyond the sample
2012	Naidu, Zweigenthal, Irlam, London, Keikelame	An evaluation of University of Cape Town medical students' community	South Africa	Quantitative- Survey email questionnaire Qualitative- in-depth interview	Random sampling of 32 projects	Communities were the projects were based	This study evaluated the placements as a learning experience	Self-reported findings there could be a potential of recall bias, this was

		placements in South Africa					from the perspectives of past students and community stakeholders.	supported by most students declining participation. Hence this low response limits generalisation between broader students' populations.
2012	Courtney-Pratt, FitzGerald, Ford, Marsden & Marlow	Quality clinical placements for undergraduate nursing students: a cross-sectional survey of undergraduates and supervising nurses	Australia	Quantitative-survey Qualitative	Cross-sectional study	The study hospital is a tertiary referral centre	To describe the quality of clinical placements provided to second year undergraduate students in an acute care hospital.	It was not clear how sample size was arrived at
2012	Marshall, Shelton	Preparing nursing students to be community health practitioners	United Kingdom	Quantitative-questionnaire Qualitative-focus group and semi structured interviews.	self-selected	a large community health care organisation with a broad spectrum of ethnic and socioeconomic diversity contained within a mix of urban, inner city and semi-rural locations.	to explore the experiences of pre-registration student nurses who undertook community-based placements	The study provides a snapshot based on the perceptions of a small sample of students. Thus limiting generalizability. No control group was used to evaluate students' perceptions
2011	Bradbury-Jones,	Empowerment and being valued:	United Kingdom	Data were generated	Thirteen, first-year nursing	A university in the UK.	The aim was to explore	Empowerment and 'being valued' are



	Sambrook and Irvine	A phenomenological study of nursing students' experiences of clinical practice		through the means of in-depth, semi-structured interviews. Hermeneutic phenomenology	students were recruited using purposive sampling and the students must have experienced at least one clinical placement		nursing students' experiences of empowerment in clinical practice and to capture how this changed as students progressed through their programme	amorphous concepts and difficult to guarantee equivalence of understanding between researchers and the student participants. The study was confined to UK which limits transfer claims.
2011	Kaye, Mwanika, Burnham, Chang, Mbalinda, Okullo, Nabirye, Muhwezi, Oria, Kijjambu, Atuyambe, and Aryeija.	The organization and implementation of community-based education programs for health worker training institutions in Uganda	Uganda	This was a cross-sectional study and used both Quantitative-questionnaire Qualitative- in-depth interview, review of documents. y	Purposively used a stratified approach was used to select 22 community-based programmes. five degree, eight diploma and nine certificate awarding programs, and have rural and urban location	Community sites and the institutions offering CBE	To gain a comprehensive picture of how CBE is provided in various programs in Uganda a survey was carried out of community rotations for 22 community based programme.	The purposive sampling may have excluded sites where experiences were considerably different. Also local factors could have been varied among training sites. Detailed on in depth interview not discussed.
2011	Chang, Kaye, Muhwezi, Nabirye,	Perceptions and evaluation of a community-based	Uganda	Quantitative-The	internet-based survey of 255 respondents	Makerere University, the largest	This study assessed student and	Low response rate could have resulted into

	Mbalinda, Okullo, Groves, Kennedy, Bollinger, Sisson, Burnham, and Mwanika,	education and service (COBES) program in Uganda		surveys contained Likert scale questions 1-5		university in Uganda	educator perceptions and evaluation of a Ugandan COBES program	biased sample hence limiting generalizability within the participants for instance only 6 radiography, 7 dentistry, 11 nursing, and 20 pharmacy students participated compared to 143 medical students. Availability or accessibility of internet could have hindered good response rate, lack of electricity.
2011	Kaye, Muhwezi, Kasozi, Kijjambu, Mbalinda, Okullo, Nabirye, Oria, Atuyambe, Groves, Burnham, and Mwanika,	Lessons learnt from comprehensive evaluation of community-based education in Uganda: a proposal for an ideal model community-based education for health professional training institutions	Uganda	Qualitative - documentary review -in-depth and key-informant interviews were conducted with key people involved in running CBE	curricula and other documents in 22 health professional training institutions in Uganda,	University, Makerere University CBE	To answer the following questions: What is the nature of CBE conducted? Does CBE promote learning? What challenges do institutions face in implementing	Purposive sampled in may not achieve representativeness of rural versus urban institutions, private versus public. No guarantee that the institutions that were not sampled may have similar challenges. The four teams piloted the instruments,

							CBE and what are potential solutions?	there may have been slight variations in the way interviews were conducted, checklists performed or documents reviewed. No direct observation was conduct of CBE was performed, yet this should have been done in an ideal CBE assessment. Detailed number of participants on in- depth interview not discussed. This study does not indicate whether it's part of the previous study
2011	Mwanika, Okullo, Kaye, Muhwezi, Atuyambe, Nabirye, Groves, Mbalinda, Burnham, Chang, Oria, and Sewankambo. Sciences	Perception and evaluations of community-based education and service by alumni at Makerere University College of Health	Uganda	mixed methods Qualitative- focus group discussions (FGD) Quantitative telephone administered questionnaire	purposefully selected twenty four Alumni (13 females and 11 males) for the focus group discussion and a total of 150 COBES alumni for	Makerere University College of Health Sciences (MakCHS)	To assess the efficiency of the management and administration of COBES and obtain the views of the impact of COBES on its alumni.	The inclusion criteria is questionable- the perceptions of those whose telephone contacts were not available could have affected the findings. Sample size

					telephone questionnaire			
2011	Mbalinda, Plover, Burnham, Kaye, Mwanika, Oria, Okullo, Muhwezi, and Groves.	Assessing community perspectives of the community based education and service model at Makerere University, Uganda: a qualitative evaluation	Uganda	Qualitative - Interviews	A stratified random sample of 11 site tutors and 33 community	Community COBES sites	This study evaluated the perspective of the communities and the COBES model	The findings may not be representation of the community, only elite appeared to be selected.
2011	Rodger, Fitzgerald, Davila, Millar, Allison	What makes a quality occupational therapy practice placement? Students' and practice educators' perspectives	Australia	Qualitative design- focus group discussion	78 participants	hospital and community services, in both urban and rural/ regional settings	to explore the perspectives of practice educators, students and university practice education staff in answering the question	Not clear how participants were selected Study limit the generalizability of the findings to the sample of study
2010	Lynch, Ash, Chadwick, Hannigan	Evaluation of a U.K. Community-Based Clinical Teaching/Outreach Program by Former Dental Students Two and Five Years After Graduation	United Kingdom	Quantitative-postal questionnaires	Postal questionnaire was distributed to dentists who graduated from the	School of Dentistry at Cardiff	The aim of this study was to investigate the views of graduated dental students who had trained in our unit after two and five years' experience	Time frame could be a potential of recall bias. Low response limits generalisation between broader students' populations. Another geographical rea,

							working as independent dental practitioners.	challenge of generalizability
2010	Baglin & Rugg	Student nurses' experiences of community based practice placement learning: A qualitative exploration	United Kingdom	Qualitative-Reflective diaries	6 second year students	Practice placements	Students experiences of community based practice	Small study sample. Only 6 students.
2010	Papastavrou, Lambrinou, Tsangari, Saarikoski, and Leino-Kilpi,	Student nurses experience of learning in the clinical environment	Cyprus	Quantitative-questionnaire	sample of 645 students of all the undergraduate students	Public School of Nursing in Cyprus (Ministry of Health - clinical placements	The aim of this study was to explore the students' experiences of the clinical environment and supervision of the hospital-based system of education in Cyprus, and forms the basis for future replication when nursing has totally moved to the "university system".	Student data collection was organised from the only nursing school on Cyprus, so the results cannot be generalized
2010	Amerson,	The Impact of Service-Learning on Cultural Competence	USA	Quantitative - The Transcultural Self-Efficacy	A convenience sample of 69 baccalaureate	University/ community Health nursing course	To evaluate self-perceived cultural competence	The findings limit generalizability No control group was used to evaluate

				Tool (TSET) consists of 83 items that measure confidence on a 10-point rating scale	nursing students enrolled in a community health nursing course		following the completion of service-learning projects with local and international communities.	self-efficacy perceptions for students not involved in service-learning projects
2010	Playford, Wheatland, Larson	Does teaching an entire nursing degree rurally have more workforce impact than rural placements?	Australia	Quantitative telephone interview	-	Rural school	The aim of this longitudinal cohort study was to determine the undergraduate education most related to rural recruitment for nursing graduates in Western Australia	The findings limit generalizability to the sample.
2009	Mtshali	Implementing community-based education in basic nursing education programmes in South Africa	South Africa	Qualitative-grounded theory-interviews, observation, document analysis	Open theoretical sampling first, then variational sampling then lastly discriminate sampling	4 university nursing schools, 2 nursing colleges and 1 campus in a rural area a total of 7 settings. A total of 44 participants interviews conducted in offices	Analyse the process of implementing community-based education in basic education in basic nursing programme in South Africa. Describe CBE antecedents,	The study involved only implementers, facilitators and policy makers and did not include nursing students and the community who are the beneficiary of such community programmes

							context, action/ interaction strategies under which the phenomenon CBE occurs in basic nursing education in South Africa.	
2009	Saarikoski, Warne, Kaila, and Leino-Kilpi	The role of the nurse teacher in clinical practice: An empirical study of Finnish student nurse experiences	Finland	Quantitative methodology - Questionnaire were used	Purposeful sample involved student nurses (n = 549)	Four different sized nursing schools located in the Western, Central and Eastern parts of Finland	Exploration of how Finnish student nurses in hospital clinical placements perceived the role of the nurse teachers.	The validation of research instrument used in this (CLES+T) scale. The validation process and the psychometric properties of the CLES+T scale have not been reported in resource poor setting- thus posing challenges of new approach to new settings.
2008	Pearcey, and Draper,	Exploring clinical nursing experiences: Listening to student nurses.	UK	A qualitative phenomenology - used Semi- structured interviews	Purposive sampling of first year nursing students – exposed to clinical setting	University	To explore the clinical nursing environment through the perceptions of first year student nurses.	The volunteer aspect of sampling limits the findings in terms of potential bias The interviews were conducted

							To identify the reality of nursing and whether nursing theory matches experience	solely by a lecturer of the students and this may have influenced their answers
2008	Reising, Shea, Allen, Laux, Hensel, and Watts	Using service-learning to develop health promotion and research skills in nursing students	U.S.A	Quantitative-survey using Likert scale Qualitative - interviews	173 students	The University	to provide nursing education scholars with a research plan on designing, Implementing, and evaluating service-learning programs.	The sampling of students is questionable, the findings limits generalisability beyond the sample.
2008	Mwanga, Jensen, Magnussen, Agaard-Hansen,.	School children as health change agents in Magu, Tanzania: a feasibility study.	Tanzania	Across sectional Qualitative-focus group discussion	Purposive sampling of 306 participants	Rural part of Magu district, Tanzania.	The feasibility of an action-oriented and participatory educational approach, where school children function as health change agents, in a rural community of (Magu district) Tanzania was explored.	The purposive sampling technique limits the generalizability of the findings
2008	Lea, Cruickshank, Paliadelis,	The lure of the bush: Do rural placements	Australia	Quantitative-Survey and qualitative,	75 final year Bachelor	A rural university campus	To investigate whether rural clinical	Convenience sampling is limited by the possibility



	Parmenter, Sanderson, Thornberry.	influence student nurses to seek employment in rural settings?		individual semi-structured individual interviews	of Nursing students at a rural university of New South Wales who were enrolled in clinical units of study in 2005		placements for student nurses at a rural university in New South Wales influence their decision to join the rural and remote Registered Nurse workforce	of partial representation in its sample.
2008	Levett-Jones, Lathlean	Belongingness: a prerequisite for student nurses clinical learning	Australia and UK	Quantitative-questionnaire Qualitative- in-depth semi-structured interviews	A total of 362 online survey and 18 volunteered for interviews	Schools of nursing within two Australian universities (in New South Wales and Queensland), and one in the United Kingdom.	to explore and define belongingness through a detailed interpretation of nursing students' clinical placement experiences	Only in-depth interview results reported, not clear whether it involved both students' experiences from two countries, no triangulation. Qualitative sample size limit generalisability
2008	Rojo	Conceptions of nursing students on health promotion related to psychoactive substances	Argentina	Qualitative-study. Focus group interviews and non-participant observation	Nine students	Community placements	To investigate the perception of undergraduate nursing students on health promotion in view of the use of psychoactive substances.	Qualitative sample size limit generalisability

2008	Kenyon, Peckover,	'A Juggling Act': An analysis of the impact of providing clinical placements for pre-registration students on the  organisation of community nursing and Health Visiting work	UK	Qualitative- semi-structured interviews	Voluntarism- 28 participants	Community placements	To explore the issues facing community nurses and health visitors in providing clinical placements for pre- registration nurses.	The volunteer aspect of sampling limits the findings in terms of potential bias
2008	Mabuda, Potgieter, Alberts,	Student nurses' experiences during clinical practice in the Limpopo Province.	South Africa	Qualitative- phenomological interviews	Purposive sampling- 11 students	campuses of Limpopo College of Nursing and its clinical Facilities included: general, community- and psychiatric nursing, and midwifery.	To explore student nurses' experiences during clinical practice at a nursing college in the Limpopo Province.	The findings limits generalisability beyond the sample.  Also recall could have affected past experiences
2007	Hunt, Swiggum,	Being in another world: Transcultural student experiences using service learning with families who are homeless	U.S.A	Qualitative- interviews	-	Community setting	Describes transcultural experiences from service learning clinical rotations at a family homeless shelter, described by	It was not clear how participants were selected, type of interviews, Small sample size limits generalizability

							students as being in another world	
2007	Reimer Kirkham, Hoe Harwood, Terblanche, Van Hofwegen, and Sawatzky	The use of innovative clinical placements: A national survey. Final Report	Canada	Quantitative: on line email Survey design - questionnaire  Qualitative: focus group discussion	90 Canadian generic undergraduate nursing programs participated in the study. A total of 147 respondents participated and 10 convenient sample for focus group discussion	Canadian nursing education	This study was designed with the purpose of describing the utilization of innovative clinical placements within Canadian nursing education from the perspectives of clinical placement coordinators and nurse educators.	Convenience sample, was limited by the possibility of partial representation in its sample. Potential bias lies in the possibility that those with strong opinions are those who respond. Responses were received from only 4 of the identified 11 predominantly French language programs within Canada. Agency stakeholders who would add an invaluable dimension regarding the use of ICPs were not involved
2007	Florence, Goodrow, Wachs, Grover, Olive,	Rural Health Professions Education at East Tennessee State University: Survey of Graduates from the First Decade	U.S.A	Quantitative- Survey questionnaires, Likert scale	-	All graduates from 1992-2002	Community Partnership Programme East Tennessee state	Students elected to participate in the rural program; they were not randomly assigned. Lack of data to compare

		of the community Partnership Program.						this with similar students who participated in a traditional program. Data were based on self-report- there may be some inaccuracies in data reporting due to inaccurate recall
2007	Hartigan-Rogers, Cobbett, Amirault, and Muise-Davis	Nursing Graduates' Perceptions of Their Undergraduate Clinical Placement	Canada	Qualitative semi-structured telephone interviews	Random selection to achieve a quota of 25 students per cohort all 1999-2002 graduates from school of nursing	Clinical placement	The purpose was to describe newly-graduated nurses' perceptions of their student clinical intersession placements and how these placements impacted their functioning as graduate nurses	Study limit the generalizability of the findings. The study involved only one School of Nursing, located at one rural and one urban site. Telephone interviewing can restrict probing and in-depth explorations, and decrease response rates. Also, recall of information about the clinical placement may have been easier for the more recent graduates
2005	Mtshali,	'Conceptualisation of community-based basic	South Africa.	Qualitative-grounded theory-	Purposive sampling and later	The South African Nursing Council's	The purpose of the study was to analyse	The purposive sampling

		nursing education in South Africa: a grounded theory analysis		interviews, observation and document analysis	theoretical sampling was used for selecting a total of 45 interviewees	(SANC) education committee, the National Department of Health, human resources division representatives as well as seven nursing education institutions with well-established CBE programmes.	the concept 'community-based education' with the aim of discovering shared understanding of this phenomenon in basic nursing education within the South African context.	technique limits the generalizability of the findings
2005	Chesser-Smyth	Phenomenological study explores and describes the 'lived' experiences of general student nurses on their first clinical placement in an Irish School of Nursing	Ireland	In-depth interviews were conducted	nine female student nurses and one male student nurse	Clinical placement in an Irish School of Nursing	Interpret descriptions of students' textual experiences	Views were from one nurse education institution. Therefore, their capacity for representation is limited.
2005	Finnerty and Pope	An exploration of student midwives' language to describe non-formal learning in professional practice	UK	multi-method case study design-using interviews, non-participant observation and diaries	A purposive sub-sample of student midwives from the five case study sites from the larger national	The students studying on a range of midwifery programmes (for example, three year diplomas, three and four year	The aim is to investigate the nature and extent of non-formal learning acquired by midwifery students during their	The selected extracts are individual student midwives to describe their learning in a range of circumstances therefore cannot be generalisable.

					study was selected Nineteen mentor/student pairs were recruited across five case study sites (four pairs at most sites)	degrees and also 18 month shortened degrees) across England	clinical placements.	Data collected focused on diaries. No mentioning of other methods indicated and whether students' language was consistent in all methods used.
2005	Frank, Adams, Edelstein, Speakman, and Shelton	USA	Community-based nursing education of prelicensure students: settings and supervision	Quantitative- A web –based survey questionnaires . 324 completed the survey	-	827 accredited AD and BSN programs with usable email addresses were contacted,	The study had a fourfold purpose: to describe the community-based settings that are being used by faculties in associate degree (AD) and baccalaureate degree (BSN) nursing programs to provide community-based nursing care experiences whether or not settings used in AD and BSN programs differ.	Not clear how the sample was selected

							How faculties in AD and BSN programs provide for supervision of their prelicensure students in community based settings.	
2005	Sharif and Masoumi	A qualitative study of nursing student experiences of clinical practice	Iran	Qualitative-focus group discussion	Randomly selected 90 baccalaureate nursing students	Shiraz University of Medical Sciences (Faculty of Nursing and Midwifery)	To investigate student nurses' experience about their clinical practice.	geographical area limits the generalizability of findings
2005	Donaldson, and Carter	The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students	UK	Qualitative-Grounded theory	Theoretical sampling-	Nursing and midwifery school-university of Glasgow	To explore the views of undergraduate and Diploma nursing students on the value of role modelling on teaching and learning within clinical learning environment to facilitate learning for student nurses	Small sample size and geographical area used makes the generalizability of findings necessarily cautious

2004	Dornan and Bundy	What can experience add to early medical education? Consensus survey	UK	Qualitative- Small group discussions to obtain stakeholders' views. Grounded theory analysis with respondent, internal, and external validation.	purposive sample of 64 students, staff, and curriculum leaders from three university medical schools	Problem based, undergraduate medical curriculum that is not vertically integrated.	To provide a rationale for integrating experience into early medical education ("early experience").	This qualitative study cannot claim generalisability beyond the study conditions. Also it did not involve the clients (patient or community's) view where the students were practicing.
2004	Salmon and Keneni	Student Nurses' Learning on Community-Based Education in Ethiopia	Ethiopia	A Quantitative - descriptive, survey design five point Likert type scales	Convenience sample of 95 students	University	The aims of the study were to identify factors that students considered had helped or hindered their learning on CBE and to ascertain if the stated learning objectives were met.	The quantitative method for exploring experiences could limit in-depth discussion. Also convenient sampling could biased the findings as majority of the participants could be from one group
2004	Sarena, Seifer, and Calleson	Health professional faculty perspectives on community-based research: implications for policy and practice	U.S.A	Quantitative - survey	Purposive- a two-stage sampling design to select the universities and the key respondents 27	eight universities and academic health centres two private and six public institutions and research and non-research	to determine the perspectives of health professional faculty on the factors affecting their involvement in CBR and the	The purposive sampling technique used to select the universities limits the generalizability of the findings



					health professional schools 8 medical, 6 nursing, 5 pharmacy, 3 public health, 4 dental, and 1 allied health	intensive institutions	extent of community participation in that research	
2004	Edwards, Smith, Courtney, Finlayson and Chapman,	The impact of clinical placement location on nursing students' competence and preparedness for practice	Australia	Quantitative- using a pre-test post-test survey was used	A quasi-experimental design of all final year Bachelor of Nursing students who undertook their clinical placement in either a rural or metropolitan location (no 212).	at Queensland University of Technology	To determine the relationship between the location of clinical placements and competence and preparedness for practice from the perspective of the nursing students	Not clear how participants were selected
2004	Chan	The relationship between student learning outcomes from their clinical placement and their perceptions of the social climate of the clinical learning environment	Australia	Quantitative- survey questionnaires	108 second-year nursing students undertaking clinical.	Clinical Learning Environment Inventory placement in 14 metropolitan hospitals in South Australia	To investigate the relationship between student learning outcomes from their clinical placement and their perceptions of the social	Sample selection not clear

							climate of the clinical learning environment	
2004	Nehls and Vandermause	Community-driven nursing transforming nursing curricula and instruction	U.S.A	Qualitative - A hermeneutic research individual interviews	undergraduate nursing students, faculty, and community preceptors	University and community	The aim of this study was to evaluate an innovative approach to teaching and learning community-based nursing.	It was not clear how participants were selected, This qualitative study cannot claim generalisability beyond the sample
2003	Mofidi, Strauss, Pitner and Sandler.	Dental Students' Reflections on Their Community-Based Experiences: The Use of Critical Incidents	U.S.A	Qualitative-reflection essays	160 senior student	University of North Carolina (UNC) School of Dentistry	To fill the void. Analyzed students' reflection/critical incident essays to seek insight into their community-based experiences and explore what learning outcomes and benefits students reported	This qualitative study cannot claim generalisability beyond the sample. Time elapsed between essay and incident occurrence could have introduced recall bias.
2003	Papp, Markkanen and von Bonsdorff,	Learning environment: Student nurses' perceptions concerning	Finland	A qualitative-Phenomenology	16 students un-structured interviews	Clinical setting	To describe student nurses' perceptions of clinical learning	The relatively small sample from one polytechnic as well as the qualitative nature of

		clinical learning experiences					experiences in the context of the clinical learning environment.	the study limit the generalizability of the
2002	Koh	Practice-based teaching and nurse education	UK	A qualitative approach was adopted, with the use of focus groups	A mix of opportunistic and convenience sampling was used to recruit participant-three groups between 4-14 participants	Thames Valley University, University	This study aims to provide insights into the students' perceptions of practice-based teaching facilitated by link lecturers in pre-registration education	This qualitative study cannot claim generalisability beyond the sample.
2002	Courtney, Edwards, Smith and Finlayson	The impact of rural clinical placement on student nurses' employment intentions	Australia	Quantitative - A pre-post-test survey design	- final year Bachelor of Nursing students	Queensland University of Technology	to evaluate the effectiveness of a Clinical Placement Support Scheme for nursing students as a recruitment strategy for rural and remote health care services, and to develop an increased awareness of the employment opportunities	Not clear how participants were selected

							available in these areas	
2001	Carr	Nursing in the community - impact of context on the practice agenda	United Kingdom	Hermeneutic phenomenology - Focus groups	A total of 45 participants experiencing their community placement with a Community Health Nurse during the last semester of a 3 year RN/Dip HE programme	Two community trusts	The impact of the community, and specifically the patient's home, as a location for practising and learning to practise nursing, is an issue which has received limited exploration	This qualitative study cannot claim generalisability beyond the study done in another country
2001	Wolff and Maurana	Building Effective Community–Academic Partnership to Improve Health	U.S.A	Qualitative-structured interviews	25 community partners representing eight community–academic partnerships	Community at five AHCs.	To identify, through a qualitative study, community perspectives on the critical factors that facilitate the development, effectiveness, and sustainability of community–academic partnerships	This qualitative study cannot claim generalisability beyond the study done in another country

2000	Talbot and Ward.	Alternative curricular options in rural networks (ACORNS): impact of early rural clinical exposure in the University of West Australia medical course	Australia	Quantitative-pre- and post-questionnaires	103 Medical students	The Department of General Practice	to assess the impact of a 4-day rural placement in Western Australia on the interest of fourth year medical students in a career in rural general practice.	Not clear how sample were selected
2000	Peach and Bath.	Comparison of rural and non-rural students undertaking a voluntary rural placements in the early years of a medical course	Australia	Quantitative post-placement questionnaire	-	Melbourne University Australia	The experiences of rural and non-rural students undertaking a voluntary rural placement in the early years of a medical course were compared	Not clear how students were selected
1993	Baillie	Factors affecting student nurses' learning in the community placements: a phenomenological study	UK	Qualitative-phenomenological study-interviews	Random selection- 8	A college of nursing and midwifery in South – East England	To explore the question, what factors affect student nurse learning in a community setting?	This qualitative study cannot claim generalisability beyond the sample.

## **Appendix 16: Permission letters to use figures.**

### 16 (a) Use of content analysis Figure by Elo and Kyngas (2007)

Dear Grace Nambozi,

It is nice to hear that you have used the inductive content analysis method. You can use that picture, just refer to us in the picture title.

All the best for your researcher career!

Yours,

Satu Elo

Lähetetty iPhonesta

16 (b) Permission to use the figure of practice of traditional bone setting from Dr Omolo

Bade Omololu [bade57@gmail.com]

**Sent:** 15 October 2013 14:51

**To:** Grace Nambozi

**Subject:** Re: Kind Request for permission

Thank you very much Grace. Please feel free to use the figure you requested for.

Regards,

Bade Omololu.

Michelle Woods

To Me, Lindsay Smith Heather.Emmett@utas.edu.au

18 Aug 2014

Hi Grace,

This is good with me. Wishing you well with your research.

Below is an additional article that may aid with your research

<http://www.ncbi.nlm.nih.gov/pubmed/20597856> [Int J Nurs Educ Scholarsh.](#)  
2010;7: Article 17. doi: 10.2202/1548-923X.1957. Epub 2010 May 27.

Kind regards,

Michelle

Michelle Woods RN MSN-NP DNSc.

Nurse Practitioner/Senior Lecturer

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