UNDERGRADUATE NURSES' EXPERIENCE OF THE FAMILY HEALTH ASSESSMENT AS A LEARNING OPPORTUNITY

JULIANA JOAN WILLEMSE (Ne é SOLOMONS)

STUDENT NUMBER: 9434329

A mini-thesis submitted in partial fulfillment of the requirements for the degree of Master in Nursing (Education) at the Department of Nursing, Faculty of Community and Health Sciences, University of the Western Cape

SUPERVISOR: PROFESSOR W. KORTENBOUT

NOVEMBER 2008

ABSTRACT

This phenomenological study explored the lived experiences of undergraduate community health nursing students at the University of the Western Cape who conducted a family health assessment learning task in communities during their clinical fieldwork placement.

The population included the 2008 semester two, third year undergraduate baccalaureus nursing students. These students completed their community health nursing modules at the end of the first semester. A total of nine (9) out of the eighty- nine (89) semester two students participated in this qualitative research study. The purposive and convenient sample consisted of those students who agreed to voluntarily participate in the research study.

In-depth interviews were conducted with seven (7) female and two (2) male students to collect data. Field notes were taken and utilized to capture non-verbal communication of the participants. The focus of the researcher was to explore the lived experiences of students and not that of the family whom they interviewed. All interviews were audio recorded and validated by participants after transcription, before any of the data was used for the data analysis process. The data collected was categorized into themes as guided by the systematic data analyses process according to Tesch's (1990) method, as cited in Creswell (2003). Saturation was tested after nine interviews and the researcher found that no new data emerged. The importance of the research study was to reflect on the exploration of the self-reported lived experiences of the third year community health nursing students while conducting the family health assessment learning task.

Key words: Phenomenology, in-depth interviews, family health assessment, clinical experiences, student nurses, community setting, clinical placement coordinator.

DECLARATION

I declare that *the undergraduate nurses' experience of the family health assessment as a learning opportunity* is my own work, that has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Juliana Joan Willemse (Neé Solomons)

Date: November 2008

Signed: ……

ACKNOWLEDGEMENTS

Firstly I would love to express my gratitude towards my Heavenly Father for the wisdom and strength for the completion of this academic paper. I can justifiably say "*I can do all things through Christ who strengthen me*" Ephesians 4 verse 13.

I wish to dedicate this thesis to my late father, George Joan Solomons, who believed in my potential to achieve at all times and who supported my life long, dream to become a registered nurse.

I wish to extend a special thank you to:

- Professor W. Kortenbout, my supervisor, for your persistence and expert guidance toward the completion of this thesis.
- Professor Thembisile Khanyile, my post-graduate educator and academic mentor, your constant motivation made this achievement possible.
- Karen Cook and the inter-library team, for all your assistance.
- The participants who volunteered to be a part of this study.
- My colleagues: Wendy, Faith, Mogasweri, Elton, Unathi, Ryan and the entire SON staff for your continued support and encouragement.
- My Masters Study Group (MSG): Douglas, Jeffrey, Franco and Patricia, for all the late night sessions that helped to make our studies manageable.

To my beloved mother and best friend, Magdalene Solomons, my brothers and sisters with their families', thank you for trying your best to understand when I could not be present at all the family commitments.

My loving husband, Jeremiah, and my three amazing children, Amy-Lee, Jessica and Emileo: a very special thank you to the four of you for constantly believing in me and for supporting me during the most difficult times experienced during my studies. A great sense of appreciation is expressed towards the Petra Life Centre Family for all your loving support and prayers.

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CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND TO THIS STUDY

In the apartheid era, there was an evident disproportion in health and accessibility to health care in South Africa. With South Africa's transition to democracy, the post-apartheid government has developed a more equitable national health care system to address the health care needs of the entire population. Through extensive new legislation regarding national health, there has been an increase in the accessibility to health care facilities within a district based system of primary health care. The focus on primary health care is believed to have an impact on addressing the equitable improvements in health care delivery (Benatar, 2004).

Primary health care includes the following: "education about health problems and methods to control and prevent these problems, promotion of proper nutrition, provision of water and basic sanitation, care of high risk groups such as mothers and children, immunization against infectious diseases, prevention and control of such as epidemics and available treatment and drugs for the common illnesses and injuries" (Naude and Setswe, 2000:2). The authors further state that through conducting a family health assessment the health professional would be able to identify the essential and overall basic care that a person, family or community may need to remain healthy, through the provision of affordable and accessible health care.

The emphasis on primary health care guided the Department of Nursing in 2007 at the University of the Western Cape to embark on a project in which third year community health nursing students conducted a family health assessment. The

health assessment was completed in various communities during the period of their clinical placement. The community health nursing module guide required the following from the student:

- To assess the physical, social, psychological, economic and environmental factors that could pose a threat to or enhance the health of the family.
- To identify the existence of communicable and non-communicable diseases in the family and
- To identify how the family's environment and current lifestyle predisposed them to certain health related conditions.

On completion of the family health assessment, the student should have, in conjunction with the family, designed a health promotion plan to aid the family in the improvement of their health status where required. The focus of the module was to ensure that on completion of the assignment, the student ought to enter any community health facility as a competent community health practitioner with a clear understanding of the importance of the family's participation in identifying and managing their health needs (Hattingh, Dreyer and Roos, 2006; Community Health Nursing 311 Module Guide, 2008).

1.2 RATIONALE FOR A FAMILY HEALTH ASSESSMENT

The family health assessment was devised as a self-directed and experiential learning process. The aim of the learning task was to provide students through clinical practice with an opportunity to prepare successfully for future practice as a community health professional. Experiential learning is described as learning by doing. This is an approach to assist adult learners to become firmly established in its application in the clinical field of community health nursing. The student is an active and informed participant, who is involved in and responsible for his or her own journey of learning (Quinn, 2000). The study

focused on the students' experiences and not on that of the family, while conducting the family health assessment.

A community health nurse has the ability to implement various interventions to promote the health of a family. Community health nurses are able to play an important role by assisting a family in the assessment of their health to evaluate and improve their current health practices. High risk behavioral factors can be identified that may affect their health. This may grant families an opportunity to make informed decisions about the improvement of their health and lifestyle choices. The health professional is able to obtain a history of health issues during a family health assessment by means of an interview, observation, home-visits and an environmental assessment. A family health assessment is done for the following reasons: to establish the type of relationships in a family, the coping ability of the family with regard to stressors, the existing cohesion between different family members and to assess any dysfunctional behavior (Hattingh, et al, 2006).

In order to manage a family holistically, it appears to be of importance for a community health professional to go into the home and environment of the family. The involvement of community health nursing students in a family health assessment was intended to provide an opportunity to go into the homes of community members to assess their health needs and to advise them accordingly to promote the improvement of their quality of life.

1.2.1 Community Involvement

Primary Health Care (PHC), as stated in the Declaration of the Alma- Ata indicates that all people have the right to participate as individuals or as a group in the planning and the implementation of their health care. PHC addresses the needs of the community in the quest towards health for all (Hattingh, et al, 2006).

The family health assessment learning task occurs within this context and within a variety of community health settings.

1.3 PROBLEM STATEMENT

The community health nursing students may be exposed to situations unfamiliar to them, such as negotiating an invitation into the home of a family. Students may be exposed to communities different to their own, having had to manage cross-cultural communication and to maintain their own and the family's safety. It is not known how students experienced this complex learning task.

1.4 RESEARCH PURPOSE

The purpose of this study is to:

- Explore the lived experiences of community health nursing undergraduate students from the students' perspective, as related by themselves when they interviewed a family while taking a health history, on how they experienced conducting a family health assessment.
- Generate an understanding of the phenomenon that is the lived experience of students, as above, through in-depth interviews.

1.5 RESEARCH AIM

The aim of this study is to explore the lived experiences of undergraduate community health nursing students during their clinical fieldwork while conducting a family health assessment in a community.

1.6 LIST OF OPERATIONAL DEFINITIONS

Clinical experiences – Experiences to enhance practical learning while in clinics and community health centres

Clinical placement coordinator – The individual that is employed by the university and who is responsible for ensuring that the student achieves the requirements of the clinical placement

Community setting – This is a place or social group which includes communities, neighbourhoods, the homes of community members.

DOTs Supporter – Directly Observed Treatment Supporter – A person from the community that is trained to give tuberculosis treatment to those infected, at any time when the person is able to be present at his/her home in the community

Facility Manager – The person in-charge of the clinical placement facility

Facility Staff – The personnel attached to or working at the clinical placement facility

Family health assessment – An assessment of the physical, social, psychological, economic and environmental factors that could pose a threat to or enhance the health of a family

In-depth interviews – These are interviews conducted on a one to one basis to gain an understanding of the experiences of an individual on certain phenomena

Literature Control – References from literature incorporated to support and enhance findings in a study

Phenomenology – The exploration of the real meaning of the lived experiences of an individual of a certain phenomena

Student nurses – Those individuals who have enrolled in a program to gain the experience and recognition as a professional nurse at the end of that program

Tuberculosis Sister – The Professional or Registered Nurse responsible for the management of the Tuberculosis programme in the clinical placement facility

1.7 OVERVIEW OF THIS STUDY

Chapter Two - Research Design and Method

This chapter will present an outline of the research design and method and will include a discussion on the research purpose, qualitative research methodology, phenomenology, the research method, data collection, data analysis and ethical issues.

Chapter Three – Data Analysis and Literature Control

This chapter will give an account of the research findings as narrated by the participants of the study. The researcher will explore the experiences of the participants from the in – depth interviews conducted and attempt to support these experiences with a literature control.

Chapter Four – Conclusion

This final chapter will present a summary of the research findings and recommendations for future research will be presented.

CHAPTER TWO: RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The research study was conducted within a qualitative research framework that Burns and Grove (1997) describe as a systematic, interactive and subjective approach. This approach explores lived experiences and gives significance or meaning to the experience. The phenomenological approach offered an appropriate framework for the exploration of the lived experiences of community health students regarding the family health assessment.

The previous chapter provided an introduction to this study. This chapter will provide a broad overview on the research design and method. Recommendations will be provided after the data analysis to inform lecturers and students of possible future adaptations to the family health assessment that was devised as a self-directed and experiential learning task, with the aim of equipping students to practice successfully in the clinical field.

2.1.1 Literature Control

The themes identified from the data analysis process were discussed in the light of related literature and the information obtained from similar studies to enhance the findings (Pope, Nel and Poggenpoel, 1996).

2.2 RESEARCH DESIGN: PHENOMENOLOGY

2.2.1 Introduction

A qualitative approach and phenomenological design was used to explore the meaning of the lived experiences of third year undergraduate community health nursing students as described by the individual (Creswell, 2003). Qualitative research is concerned with the everyday human experiences within their natural environment (Wilson, 1985). According to Smith (1989), as cited in Rose, Beeby and Parker (1995), phenomenological research findings are descriptive with the purpose of enhancing knowledge. Omery (1983) as cited in Rose, et al (1995) states that phenomenology has been described as a philosophy and an approach. The diversity in qualitative research is explored until a position of saturation is reached during the data collection process. When no new data emerges during the data collection process, it is assumed that the researcher has reached a point of saturation (Kumar, 2005).

This qualitative research approach explored the depth, richness and difficulty of the situations faced by the participants during the execution of their assigned project (Burns and Grove, 2003). There was an exploration of the real meaning of the lived experiences of the participants according to the phenomenological view of Husserl (1970), as cited in Rose, et al (1995), while searching for the similarity in meaning that identifies the core experiences of participants. There was a further attempt to explore the consciousness and knowledge of the participants regarding their experiences and knowledge gained from their involvement in carrying out a health assessment in communities. Thus the phenomenological approach provided a deeper perspective of the lived experiences of participants.

Phenomenological research has been significantly influenced by the two phenomenological philosophers Edmund Husserl and Martin Heidegger (Morse, 1994).

2.2.2 The Eidetic Phenomenology of Edmund Husserl

Husserl (1970), as cited in Rose et al, (1995), states that the purpose of phenomenology is to explain the real meaning of the lived experiences of the phenomena while searching for the harmonious meaning that identifies the core experiences of that phenomenon. Bassette (2004), states that Edmund Husserl, the German philosopher who lived from 1859 to 1938, developed a systematic process of studying human beings' perceptions and experiences. His idea of phenomenology went through various stages of development. He first explored the objective and the subjective fundamentals of learning. The Husserlian tradition argues that the association between perception and the object is not passive. This tradition emphasizes a return to reflective descriptions and the clarification of an experience as it was lived and perceived in the consciousness. Husserl further asserts that the individual reality of the researcher may possibly be set aside when analyzing data through bracketing, to ensure validity of the research project by excluding the researcher's own personal viewpoint. Without bracketing, the data may contain the preconceived ideas or perceptions of the researcher (Bassette, 2004).

2.2.3 The Ontological Phenomenology of Martin Heidegger

Heidegger (1962) derived the word phenomenology from the Greek word *phenomenon* that means "to show itself or to shed light on something" (Morse, 1994:118). Martin Heidegger, continued his association with Husserl's phenomenological movement of exploring consciousness and knowledge (Bassette, 2004). Heidegger viewed phenomenology as a new way of finding

solutions or answers in exploring consciousness and knowledge. The focus of Heidegger's research was with "being" and "time" through analysis of the being of human beings (Morse, 1994:142), but he later shifted in his philosophy by focusing on what is to be.

2.2.4 Relevance of the phenomenological view of Husserl and Heidegger for this study

The focus of this study was a phenomenological approach in an attempt to try to understand the lived experiences of undergraduate community health nursing students during their clinical fieldwork while conducting a family health assessment. The researcher made an attempt to explore the real meaning of the lived experiences of the participants according to the phenomenological view of Husserl (1970), as cited in Rose et al, (1995), while searching for the harmonious meaning that identifies the core experiences of the participants. The researcher made a further effort to explore the consciousness and knowledge of the participants regarding their experiences and knowledge gained from their involvement in carrying out a family health assessment in communities. Thus the phenomenological approach provided a deeper perspective of the lived experiences of the participants. A literature control was conducted after the data analysis process in accordance with Husserl's approach to bracketing.

2.3 THE SETTING

As indicated in the Western Cape Socio-Economic Review (2003) trends in the economic growth of the economy in the Western Cape increased on average by 3.3% between 1995 and 2001. There has been major restructuring within the economy of the province. The proper functioning within the labour market should be a key component of any policy to ensure poverty alleviation. Within the Western Cape, tertiary unemployment has decreased while there has been an

increase in unemployment at lower educational levels. Due to a loss of income, families affected by unemployment may experience health challenges (www.capegateway.gov.za/Text/2003/socio-economic_review.pdf).

Thus it is important for affordable and accessible health care for all, as stipulated in South Africa's Millennium Development Goals Country Report (2005), to address goal one which includes eradicating extreme poverty and hunger and goals four, five and six which include the reduction of child mortality; improvement in maternal health and the combating of HIV and AIDS and other diseases (www.undp.org.za/docs/mdg_midterm.pdf).

In the South African National Burden of Disease Study, Western Province (2000), it is estimated that 78.4% of all households live in formal dwellings with 16.2% and 2.2% respectively living in informal and traditional structures. It was found that on average 3.6 persons share a dwelling. Piped water is available to 98.3% of households, either inside the dwelling, on site or from a communal tap. It was found that 7.7% of households did not have access to a toilet facility. Electricity was available to 78.8% of households, 2.9% used wood and 10.9% use paraffin.

Five of the single leading causes of death identified in the Western Cape in 2000 were HIV/AIDS (14.1%), Homicide and violence (12.9%), Tuberculosis (7.9%), Road traffic accidents (6.9%) and Ischaemic heart disease 5.9% (www.mrc.ac.za/bod/westerncape.pdf).

The following table will give an indication of the crime statistics in the areas of the clinical placement facilities where community health nursing students are placed within the Cape Metropole in the Western Cape Province.

2.3.1 Table with examples of Crime Statistics of three (3) areas within the Cape Metropole from April to March (2001-2006):

Crime Category: Brackenfell	**2001/2002**	**2005/2006**
Murder	5	17
Rape	15	16
Attempted Murder	16	12
Common assault	204	212
Robbery with aggravating circumstances	80	58
Common robbery	49	43
Car jacking	3	3
Crime Category: Delft		
Murder	62	87
Rape	181	187
Attempted Murder	109	74
Common assault	1,419	762
Robbery with aggravating circumstances	357	356
Common robbery	390	351
Car jacking	24	41
Crime Category: Langa		
Murder	76	65
Rape	90	81
Attempted Murder	77	22
Common assault	312	320
Robbery with aggravating circumstances	248	249
Common robbery	304	211
Car jacking	15	37

(www.issafrica.org/cjm/stats0906/western_cape.htm).

The clinical placement settings for community health nursing students are within the Cape Metropole in the Western Cape Province. Within the Cape Metropole there are rural farming communities, for example areas outside Macassar, where health care is provided to farm workers by means of mobile clinics. In the urban areas there are well- equipped and accessible health care facilities for members

of the community, for example Brackenfell Clinic. Community health nursing students are placed at community health facilities that have been accredited as training or educational facilities by the South African Nursing Council. Students are placed within settings where they are able to reach their specific learning outcomes as set out in their community health nursing module guide.

2.4 THE PILOT STUDY

Due to the experience of the researcher in having had the opportunity to regularly conduct interviews within community health settings, practice in interviewing was not needed and a pilot study was not relevant for the selected method.

2.5 POPULATION AND SAMPLING

Purposive sampling methods were employed by the researcher for this research project by only including third year community health nursing students from the University of the Western Cape of which eighty nine (89) had been exposed to conducting a family health assessment. Burns and Grove (2003), state that a researcher may make use of purposive sampling or selective sampling where the participants are known to have the necessary experience that is sought after by the researcher. This means that the researcher had a conscious selection criterion of a certain subject, elements, events or incidents that were included in the study.

2.5.1 Sampling Criteria

The voluntary participants in this study consisted of a purposive sample of which the inclusion criteria were as follows:

- Voluntary participation in the research project

- Students willing to share lived experiences of conducting the family health assessment in a community
- Students who completed their third year community health nursing module in semester one of 2008 at the University of the Western Cape
- Verbal fluency in English was a requirement as it was the language medium in which the interviews were conducted.
- In total the purposive sample consisted of fourteen (14) students who agreed to participate in the study of which nine (9) were interviewed. Two (2) of the participants withdrew from the study and the remaining three (3) were not interviewed, as no new data emerged indicating that saturation had been reached.

2.6 DATA COLLECTION

Data collection was done through in-depth interviews to gain deeper insight into the experiences of these participants within the community health setting. The interview sessions were audio recorded and transcribed. Additional field notes were taken to capture non-verbal communication. The participants did validation for the true reflection of the interviews. Data collection continued until theoretical saturation was identified.

2.6.1 In-depth Interviews

Interviews are the most frequently used method for the collection of data in qualitative research (Green and Thorogood, 2005). In-depth interviews were conducted by the researcher to collect data for the interpretation of the experiences of the participants. In addition, field notes were taken to capture non-verbal communication of the participants and to enhance data collected. The interviewee was granted enough time to develop his or her own accounts of lived experiences in relation to the family health assessment. For this particular study,

in-depth interviews were conducted to obtain information and understanding of the relevant issues pertaining to the general aims of this research project.

2.6.2 Data Collection Procedure

On 18 July 2008, an information session was held at the University of the Western Cape in Room GH3.15 that served as an introduction to the research project to explain clearly the procedures of data collection methods to the possible participants. At this meeting, the researcher informed the possible participants of all the ethical issues concerning this research project **(Annexure E)** and written consent was obtained **(Annexure D)** from four (4) students who volunteered to participate in this project. At this meeting, appointments were scheduled with the voluntary participants for the in-depth interviews on the next Tuesday that they attended the University of the Western Cape's Skills Laboratory at Groote Schuur Hospital for Midwifery self-directed learning sessions. Due to an insufficient number of participants, a second introduction session to the research project was held on 22 July 2008 at the University of the Western Cape's Skills Laboratory at Groote Schuur Hospital to explain clearly the procedures of data collection methods to students. Ethical issues concerning this research project were addressed and the researcher obtained written consent from seven (7) students who volunteered to participate in the research project.

Due to participants not attending booked sessions for the interviews, a third introduction session to the research project was held on 29 July 2008 at the University of the Western Cape's Skills Laboratory at Groote Schuur Hospital to explain clearly the procedures of data collection methods to them. At this meeting the researcher informed possible participants present of all the ethical issues concerning this research project and obtained written consent from three (3) students who volunteered to participate in this project. In total, fourteen (14)

students agreed to participate in the study of which nine were interviewed, two (2) withdrew and the remaining three (3) were not interviewed as no new data emerged, indicating that saturation had been reached.

Green and Thorogood (2005), state that qualitative research is an interactive process. Data collection in this research project was pursued to a position where the researcher identified that the theme had been saturated and no new data had emerged after conducting nine in-depth interviews. The collected data was categorised according to meaning, themes and the general description of the experiences identified.

2.6.3 Interviews Conducted

The researcher conducted the in-depth interviews in a vacant laboratory at the University of the Western Cape's Skills Laboratory at Groote Schuur Hospital that was familiar to the participants in the study. Appointments were made for the in-depth interviews with students to collect the data for the completion of the study. All interviewees were provided with a participant information letter **(Annexure E)** to present them with a detailed explanation of the research study. An interview schedule **(Annexure C)** was provided at the start of the in-depth interview in which the participants were asked to narrate their lived experiences in a manner that they deemed comfortable. There were three probing questions on the interview schedule **(Annexure C)** to assist the researcher should the participants deviate from narrating their lived experiences.

2.7 ETHICAL CONSIDERATIONS

2.7.1 Ethical Approval

Ethical approval or clearance to conduct the study was obtained from Senate Higher Degrees, the Senate Research Ethics Committee, and the Registrar of the University and the Director of the School of Nursing of the University of the Western Cape. Written consent **(Annexure D)** was obtained prior to commencing the in-depth interviews and from the initial contact; participants were informed that they could withdraw from the study at any stage **(Annexure E)**. As the researcher taught the participants in the first semester, all efforts were made to secure the confidentiality of all the information throughout the research process. Participants were provided with codes when commencing the audio recording and with the transcription of their interviews. Their names only appeared on the consent form that meant that the researcher only knew their identity. Participants were informed that their responses would have no negative influence on their current studies as one of the requirements for participation in this study was that they should have completed their Community Health Nursing Modules in semester one of 2008.

2.7.2 Informed Consent

Written consent **(Annexure D)** was obtained from those who volunteered to participate in this research project. As participation was voluntary, participants were informed that they had the right to withdraw at any stage from the research process. This was explained verbally and in written form **(Annexure E)** to all participants prior to their participation in the research project. Participants were informed that meetings might occur more than once, to collect information and to validate if the transcript of the in-depth interview was a true reflection of the information that they had verbalised during the interview. With every interview

the participants were informed of the research intention. Students participating in this study received no reimbursement for their time and they were informed of this beforehand. Participants were reassured that the data collected would be applicable for this research project only and that the interviews would be audio-taped for transcription for their verification before any of the data would be used in this research project.

2.7.3 Confidentiality

The participants were informed that all the responses in the interviews would be kept confidential in order to protect and respect their rights. As mentioned in the section on ethical approval, only the researcher knew the identity of the respondents and all efforts were made to secure the confidentiality of all the information that the participants were comfortable to share with the researcher by providing them with numerical codes with the audio recording and the transcription of the interviews. The names of the participants only appeared on the consent form.

2.7.4 Ethical Consideration

A summary of the data analysis using Kvale's (1996) reference to the ethical issues concerning the seven research stages is given to present an overview on how ethical issues were complied with in this research project.

Thematizing: The purpose of the interview was not only focused on the scientific value of the knowledge gained, but also on to the improvement of the human situation being researched. The aim of this study was to explore the lived experiences of undergraduate community health nursing students during their clinical fieldwork while conducting a family health assessment in a community.

The research objective was to give a description of the experiences of students, as related by themselves, when interviewing a family, taking a health history and conducting a family health assessment. The phenomenological approach offered an appropriate framework for the description of the lived experiences of community health students regarding the family health assessment.

Designing: The ethical issues of design involved obtaining informed consent from participants who participated in this study to ensure confidentiality with the consideration of the possible consequences for participants that participated in the research study.

To motivate voluntary participation various information sessions were held where the research study was clearly explained to participants including the procedures of the data collection method. At these meetings the researcher informed the possible participants of all the ethical issues concerning this research project. At these meetings appointments were scheduled for the interview session. In total fourteen (14) students agreed to participate in the study of which nine were interviewed, two (2) withdrew and the remaining three (3) were not interviewed as saturation was reached as no new data emerged from the interviews.

Interview Situation: At this stage the confidentiality issues were clarified with the participants before the start of the in-depth interview. The consequences of participation have to be taken into consideration, e.g. stress experienced during the conduction of the interview.

The researcher made appointments for the in-depth interviews with the participants to collate the data for the completion of the study. Every interviewee was provided with a participant information letter which gave a detailed explanation of the research study that included a section to inform participants on

measures to secure confidentiality of all the information that they were comfortable with to share with the researcher. There were three probing questions on the interview schedule to assist the participant and the researcher should the participant deviate from narrating their lived experiences.

The following were the questions on the interview schedule:

- Participants were asked to narrate their lived experiences while conducting the family health assessment in a manner that they deemed comfortable.
- Tell me more about your experience.
- Name your worst and your best experience while conducting the family health assessment.
- Is there anything else that you would like to add?

Transcription: This section includes the concerns regarding ensuring of confidentiality and the question of the trustworthiness of the transcription of the interviewee's narrated statements. The researcher audio recorded all the in-depth interviews. In addition, some field notes were taken to capture the non-verbal communication during the interview to enhance the data collected. The audio recordings was transcribed and labeled using codes rather than participant's names in order to remove information that may identify the participants. The information was validated with the participants before the data was analyzed. Data collected was categorized into themes that emerged from the in-dept interviews. Data that emerged was coded according to the themes that were identified.

Analysis: An ethical issue in the analysis involved the question of how intensely and significantly the interviews were analyzed and how much the participants should have been involved with the interpretation of their statements.

2.8 TRUSTWORTHINESS

The participants were granted an opportunity to review the researcher's understanding of the collated data to contribute towards the trustworthiness of the data at hand. Creswell and Miller (2000) as cited in Creswell (2003), state that the researcher may present the analysed data to the participants in the research project. By doing so the researcher ensured that the data presented was a sound representation of the lived experiences of the participants in the research project.

2.8.1 Credibility of Phenomenological Research

Heidegger (1972), as cited in Morse (1994), states that the credibility and affirmation of phenomenological research can be described as the confidence in the concept truth of the data. Thompson (1981), as cited in Morse (1994) builds on Ricoeur's (1981) idea that the truth will unfold as the study progresses. The researcher made an explicit attempt to capture the experiences through the process by which themes were identified. A second person, the supervisor, also identified themes in order to establish consensus in the thematic analyses of the research findings. Guba and Lincoln (1981, 1989), as cited in Cutcliffe and McKenna (1999: 377), state that to ensure credibility for qualitative findings the researcher should leave an 'audit trail' if it was decided that data analysis should be checked. Themes that were identified as a result of data analysis have been supported by direct quotes from participants in this report.

2.8.2 Reflexivity

The participants in this study have been exposed to the researcher to some extent during the period in her capacity as a community health lecturer during the first semester of 2008. Being part of their formative understanding of the assignment,

the researcher has been conscious that it may have impacted the level of disclosure of certain experiences of the participants while in the community.

The researcher accommodated the scheduling of appointments to ensure that clinical and academic learning time of the participant was not being compromised.

The assumption of the researcher was that the assignment gave students an opportunity to gain a holistic view of what community health nursing is about via the family health assessment task.

2.9 DATA ANALYSIS

The researcher audio recorded all the in-depth interviews and some field notes were taken in addition. The audio recordings were manually transcribed and a numerical code was assigned to each participant to ensure confidentiality. The information was validated with the participants before the data was analysed. Data that emerged was analysed and coded according to the themes that had been identified to explore the meaning of the lived experiences of the participants.

The data analysis was completed as guided by the systematic process of data analysis according to Tesch's method (1990), as cited in Creswell (2003), which includes eight (8) steps for data analysis:

1. Read through all the transcribed interviews to search out a sense of the whole with attentiveness to reflect on the overall meaning and general impression of all the participants.
2. Decide on one interview, the most appealing one, keeping in mind its fundamental meaning. Attempt to comprehend the data by asking yourself what

it is all about. The substance is not what is important, but the underlying meaning. Write summarizing thoughts in the margin.

3. After completing the abovementioned with all the transcripts, compile a list with all the topics identified. Group similar topics together into columns that may be arranged as major topics, unique topics and left over topics.
4. This compiled list of topics should now be rechecked with the data collected by the researcher. The topics should be abbreviated as codes. These codes should be written in the margin next to the appropriate sections in the text. This provides an opportunity to see if new categories or themes emerge.
5. Descriptive words for topics must be identified. Topics that relate to each other are clustered together to reduce the total list of categories.
6. Use abbreviations for each category; place the codes in an alphabetical order.
7. The related data in each category should be assembled in one area to perform a preliminary analysis.
8. If indicated the existing data should be recoded.

The researcher followed seven (7) of the eight steps to analyse the data collected. Step six of Tesch's (1990), as cited in Creswell (2003), data analysis method was excluded as the researcher did not use abbreviations for any category identified or place the codes in alphabetical order. A literature control was done after the data analysis in an attempt to support or substantiate the results of the research findings.

CHAPTER THREE: DATA ANALYSIS AND LITERATURE CONTROL

3.1 INTRODUCTION

The previous chapter provided a discussion on the research design and method. This chapter identifies the themes that were clustered together into similar topics (Tesch, 1990), as cited in Creswell (2003), that were derived from the data collection through in-depth interviews. Themes were categorised into major topics, unique topics and left over topics. All interviews were audio recorded and manually transcribed. With the data analysis, six (6) themes were identified of which five (5) were major themes with sub-themes and one (1) left over theme was identified.

3.2 DISCUSSION OF RESULTS

3.2.1 Population and Sample Realisation

The population included the 2008, semester two, third year undergraduate baccalaureus nursing students (89 students) who participated in a family health assessment in communities during their clinical fieldwork placements in the first semester of 2008. The participants in this study completed their community health nursing modules at the end of the first semester of 2008.

The sample population consisted of two (2) male and seven (7) female students. From the field notes taken it was observed that the ages of the participants ranged between twenty one (21) years and twenty six (26) years of age.

3.2.2 Data Analysis and Transcription

After every interview the data was transcribed and analysed. Data analysis was guided by the systematic process of data analysis according to Tesch's (1990) method, as cited in Creswell (2003). The researcher followed seven (7) of the eight steps to analyse the data collected. Step number six (6) was excluded as it did not pertain to the data analysis process of this research project. The themes identified will be presented in the format of a table (Table 3.2.5).

3.2.3 Empirical referents

Empirical referents are given for each theme in this study. These take the form of quotes from the data that succinctly capture the essence of each theme. Empirical referents can be described as specific actual phenomena that illustrate a concept (Walker and Avant, 1995).

3.2.4 Findings

Five major themes with a total of fifteen sub-themes emerged from the data analysis with one residual theme as listed below (Table 3.2.5).

3.2.5 Table of themes identified

THEMES	SUB – THEMES
1. Safety challenges experienced by students Empirical referent…*she was scared and she is very nervous…*	1.1 Support from facility staff in ensuring safety while in the community 1.2 Safety implications while in the homes of the community
2. Challenges of family selection Empirical referent… *So we had to go from house to house and house to find a perfect family and it was quite difficult.*	2.1 Family identified with help from facility staff 2.2 Selection of a family from own community 2.3 Selection of a family while in the community 2.4 Disagreement in the selection of the family
3. Emotive experiences Empirical referent….*I wish I could do more for this family…relleviate their poverty…*	3.1 Family well-being 3.2 Family appreciation 3.3 Student role definition 3.4 Strengthening personal bonds

4 Issues in family contributions Empirical referent…*only the mother was communicating with me the others were just going in and out.*	4.1 Socio-cultural factors 4.2 Language 4.3 Protection of family secrets
5 Academic challenges experienced Empirical referent …*40% wow 40%...after this effort.*	5.1 Interpretation of assignment guidelines 5.2 Workload versus academic progress
RESIDUAL THEME	
6 Relationships within communities Empirical referent … *We gave her a gift afterwards to thank her…*	

3.3 FINDINGS AND DISCUSSION

The themes, sub-themes and residual theme are discussed and elaborated on based on the narration of the individual experiences of the participants. The purpose of the discussion will be to shed light on the meaning of the phenomenon as experienced by the participants.

The themes identified were enhanced and supported by references from pertinent literature in the form of a literature control. Ebscho Host, Scopus, Pro-Quest and Scholar Google data bases, from the University of the Western Cape Library system, were used and librarians with expertise consulted in literature searches; however published literature was not available in every instance and where that is the case, it will be indicated.

3.3.1 THEME ONE: Safety challenges experienced by students

Students were placed in various communities that included rural, semi-rural and urban areas within the Cape Metropole Area in the Western Cape Province. Some of the participants related some safety challenges that they were faced with while conducting the family health assessment in communities. Students received some or no accompaniment from facility staff members or their clinical placement coordinator while in the various communities. From their responses, it was noted that at some facilities the staff were concerned about ensuring the safety of the students while within the community setting. Transport was provided and students received mentorship from the facility manager and staff while they were busy with their project. The following quotations illustrate the safety challenges experienced by participants while in the community where robbery may occur.

Participant 4: "*We were two students, the one stayed in Community A, but she, she don't even know the place because umm I rely on her, because I, I'm from*

Community B, I only work there and I rely on her, but she was as lost as I were so we asked around in the streets we umm, but we were very particular for who we ask. We only ask women and maybe small children. And there are gang activity in Community A especially in, in umm that area I can't remember the name of the area, but especially there because (name of second student placed at the same facility who resided in Community) the other student she didn't, she don't know that area and it was like she umm she didn't want she want us to umm, umm to go back to the clinic so I say no we almost there because it was like there were a lot of umm gangs standing there and they smoke and they making umm like when uh when we cross them they was like teasing us, but we just ignored them. Yes, ***she was scared and she is very nervous,*** *umm she is very nervous and she can get umm scared very easily, because she umm she's used to, to, to umm driving with a car to the facility or one of her family members they took her there, but she don't walk from the house, from the house to the clinic like alone."*

Participant 9*: "…as we went into the community you will find umm, we found that on every second corner of the street there was like groups of young men umm some of them were old, some of them young, but you know … the gangster looking guys. They look like gangsters, we found them on the streets and umm giving comments to, to people who's passing by so umm yes we were accompanied but I think umm not with adequate safety methods."*

3.3.1.1 Sub-Theme 1.1: Support from facility staff in ensuring safety while in the community

A remarkable experience shared by one of the participants was the occurrence where their facility manager not only assisted students to identify an appropriate family for their study, but she personally transported and introduced the students to the family. This form of support and dedication towards student nurses in training may have a significant influence on their future practice. Students go into

community facilities with certain clinical criteria that must be met or adhered to, to ensure growth as community health professionals. The student and their clinical placement coordinator have to relay their clinical requirements to the facility manager to ensure that the student receives adequate exposure in the fields indicated. Pope, et al (1996) states the importance of nurses communicating their requests and concerns to the management of the facility to which they are allocated. The authors further indicate that management (in the South African context the facility and educational management) has a responsibility to provide guidance and support to nurses, especially student community health nurses who lack experience, when they are allocated to facilities.

Participant 7: *"My best, my best experience was when our, our…..what's her name again, the, the facilitator, the sister in charge of the family study she told us that ok she will take us there. We didn't know that who to go for and what to do next and then she was very helpful because she just offered to take us there with her car and then she waited for us to finish with our interviews and then she took us back. She even offered to introduce us, to introduce us to the family so that they may not feel that we're there to intimidate them (participant clapping hands) or anything. She just explained everything for us to them and then she ehh helped us along just to go, how to go about this study and then she offered a lot of help. I think that was the best experience."*

Participant 1: *"The clinic didn't want us to walk to my family's address and they gave us a brief explanation why not. They said that gangsterism, robbery is very prominent in that area and they would feel safer if they will drop us and come fetch us."*

Participant 1 clearly indicated that a member of staff "dropped" them at the dwelling of the family and arranged with them what time they would be collected

as the facility staff did not want the participant to walk around in the community that the staff regarded as unsafe.

Participant 4: "*…my worst experience was the fact that we as students was going alone there and the clinic sister or the manager there wasn't even prepared to help us maybe because there is a lot of transport because there are a lot of transport they didn't even want to take us there, so they just leave us on our own that was the worst experience that they were not, they are not into students.*"

Not all the participants received support and guidance at the facilities during their clinical placement period. At certain facilities students ventured into the communities unescorted. Their safety requirements did not appear to be the main concern of the facility personnel.

3.3.1.2 Sub-Theme 1.2: Safety implications while in the homes of the community

From the nine (9) participants in this study, seven (7) participants verbalized some form of threat to their physical safety while in the community. One (1) of the participants named the safety measures she took before going into the community that was known to her to ensure her safety. Participant 1 indicated that she experienced some form of anxiety due to exposure to gang-related violence in the vicinity of the home that was visited. Participant 9 shared how he and some female students comfortably managed a situation when they found themselves alone with a family member of the visited family who had recently completed a period of incarceration due to rape and murder.

Participant 9: "*There were also a, a few safety issues with this family because it was myself and two other ladies umm that accompanied me to the family and then one of our family members which is a male would talk to me about his social*

problems and issues and how he deals with it. So he obviously mentioned a few gangster related type of umm things like in gambling and he's been in jail for killing and raping and things like that. So umm we had to sort of find better coping mechanism and sort of try and cut our visits short with the family so that we can just get done so we can try to prevent umm situations where we will only find him at home."

It was observed that the participant and his fellow students ensured their own safety by shortening their visits to the home of the family. They also avoided being alone with the family member that had been incarcerated for murder and rape. The assumption is that this person may have been successfully rehabilitated as he made comments, but never made physical advances towards the participant and his fellow female students. There may potentially have been a real safety threat or safety implication if a female student were to visit this home without being accompanied. Fortunately these students always visited this particular home in a group with the male participant of this study with them.

The experience of participant 2 showed the importance of knowing which safety challenges may be specific to the community where the health assessment was completed, and taking the necessary preventative measures to ensure safety before going out into that community.

Participant 2: *"I'm familiar with the place nnh, I'm familiar with the place, because I live nearby that we know that in that side is normally, is dangerous most of the times so I didn't take my phone with me, I left the phone, the phone at home, I only have the exam pad and a pen to write…"*

This participant indicated that she took safety precautions as she walked to the home of the family as she was familiar with the environment. She was aware of

which measures to take to ensure her safety, for example, not taking a valuable possession such as her mobile phone with her. Having a visible article of value with her might have led to mugging or even bodily harm should she have refused to hand over the mobile phone.

A study by Drury, Francis and Dulhunty (2005) was based on the lived experiences of rural mental health nurses working in community settings in the southwest region of Western Australia. These nurses listed their geographical isolation as part of their every day life visiting remote farmhouses, seeing clients alone in areas where mobile phones don't work with limited immediate support. All these participants in the above study raised personal safety as a concern (Drury, et al, 2005).

Working in remote areas as in the southwest region of Western Australia where mobile phones don't work, cannot be compared to the South African context where reception is not the issue, but rather how the safety of the health professional will be compromised if found with a visible mobile phone or any other valuable article in certain communities.

Participant 1: "*We were in the house and umm Anne (fictitious name), my family participant, she was very worried about her child who wanted just to play outside by the front door, she didn't want him to play there and I asked her why not, she said to me its very unsafe there's robbery, the car's even drives fast because they also feel unsafe in the area. She also said that umm, umm gangsterism is very, very popular and fierce fighting, fierce fighting amongst the gangsters occurs anytime of the day. While we were in the house we felt unsafe but Anne (fictitious name), assured us that nothing will happen to us.*"

Participant 3: *"I felt in the community that I was in from Mitchell's Plain I didn't find any problems in the sense and it was holiday and all the children was playing outside because they were at home so it was a better time so I could see the children, I could see they are well. Sometime the children would come out of the room and we could get the look from them or she would give them a look but I could see that they are well. The children was playing outside it was evident if I went during the day. If you choose a community to do it in I would suggest someone from your own community."*

Participant 6*: "…I chose my family in Community F because its easier for me uh and they luckily for me I got a family with uh communicable and non-communicable problems that was close to where I live so it was in walking distance so I could walk there and it was a safe environment so I didn't have any safety issues when I went to the family and it helped that umm they aren't direct friends of mine but my family, my parents knows them."*

Participant 7*: "We both were not from the same community, she's from Community C and I'm from Community D we, we, we differ in a lot of things. Finally I agreed because we had no other choice. The, the, the area is very, it's dangerous, it's not safe. I did not feel safe, because most of all I, I, I'm, I'm from Community D, from a small town in Community D, where everything is just quiet, now all of a sudden you have to be exposed to this kind of, (big sigh let out by the participant), to this kind of, it's a, it's a horrible place to be in. You don't feel safe to even go into a shop and even coming standing outside, waiting for the clinic to open, you just don't feel safe."*

Participant 8: *"…the community as we were working there in, in, … in Community E, neh, there is places where there is the, the sisters in the clinic to this, okay this side is dangerous and this side is better you see 'cause there we, we*

working it was not that, they said its no its fine this side and the family was not far from that side and its not so far from that side."

From the various experiences of the participants, it appears that the majority of the participants experienced some form of anxiety regarding their safety while conducting the health assessment in a community that was unknown to them. From the response in the interviews it was found that two participants did not experience any threat towards their safety while they conducted the family health assessment in the area where they resided. Six of the participants experienced feelings of anxiety regarding their safety in the community where they conducted their family health assessment as they conducted the health assessment in an area that was unknown to the participants. Some of these participants had to rely on facility staff and fellow students who resided in the area for directions to the homes of participating families while others were forced to find their own way in an unknown community.

Doutrich and Storey (2004) reflect on the experience of a public health nurse with the preparation of students for what they might encounter while conducting home visits. These students were involved in a partnership that was formed between Washington State University Vancouver College of Nurses with Southwest Washington Health District known as Clark County Health Department. The public health nurse identified substance abuse, family violence and child welfare challenges as issues that occasionally had to be dealt with. Possible threats to physical safety had to be prepared for when entering the community. It was noted that when in the community the nurses were on the known environment of the client and there was little control over what might happen in this setting that might affect personal boundaries of the nurse or the student.

In a survey by Fry, O' Riordan, Turner and Mills (2002) of aggressive incidents experienced by community mental health staff, the participants working in a mental health institution were at increased risk of experiencing aggression because of the nature of the clients. The participants in the study referred to, experienced numerous challenges to their safety in the various communities where they were placed. There were many risks that could threaten the safety of the participants in this particular research study, but the authors indicated that there was not a considerable amount of material available on the risk to the safety of community health workers while working in the community (Fry, et al, 2002).

Working within a community setting predisposes the community health nurse to the safety threat that may dominate in that particular area, for example robbery, and rape. There are no security guards, policeman or colleagues within the South African communities and health facilities to provide any form of protection.

The findings of this section demonstrate that not all the facility managers or clinical placement coordinators made an effort to ensure that students' safety was not being compromised while they were conducting interviews in the community. The participants who completed the family health assessment in the community that was known to them perceived fewer threats to safety than students who were not familiar with their environment. The participants who completed this assignment in an unfamiliar community were more alert to the safety threats as indicated by participant 2. She clearly narrated the measures that she took to ensure her safety, as she was aware of the safety threats while completing the assignment in the particular community that was known to her.

3.3.2 THEME TWO: Challenges of family selection

Finding the appropriate family to do the health assessment on proved to be a very intricate exercise for some of the participants. They went to great lengths to ensure that they located a suitable family to meet the guidelines necessary for the completion of their assignment.

Participant 9: "***So we had to go from house to house and house to find a perfect family and it was quite difficult."***

Participant 2: "*Mmm, first, mmm I was, I first think, I thought how am I going to approach the family. I took, I took I think about three weeks, although I know it was the time was going by. So in my mind I just, I just picked that family I don't know why, but I thought this family can make my family study like good, but I didn't have the guts to go inside. So I keep on greeting them everyday when I passed them. I keep on greeting, greeting and then the other day I wanted just to, to, to go in and ask for their permission but I didn't go, I go again. Then I went home and then I told my father you know I want to do a family study on the other family there in Community G, but I'm afraid of that mother and then my father said what are you going to do, you can just do us, like here and then I said no it's not allowed, I cannot do my own family I must go to, like to the strangers, people who don't know me."*

Establishing a relationship with the family, gaining entry into their home to be able to complete the health assessment proved to be a major challenge for some of the participants. Even though it was challenging for students to identify the appropriate family to participate in their family health assessment, Drevdahl, Dorcy and Grevstad (2001) refer to the exposure into the complexity of what the community is about as an essential part of the development of a community health

nurse. The individual and the family as a group are located in a community context. Gaining entry to the family unit is an important skill for a community health nurse. Thus the lecturers performed a role play **(Annexure B)** to the community health nursing students with the introduction of the assignment. This was performed to give them a practical demonstration on how to gain entry into the home of a community member.

3.3.2.1 Sub-Theme 2.1: Family identified with help from facility staff

Three of the nine participants had no involvement from facility staff members with their family health assessment as they did not complete the assignment in their clinical placement area, but in a community that was known to them. The other participants had some form of involvement from the facility staff members whether negative or positive. Participant 1 and participant 7 received a considerable amount of support as they were taken by the facility transport, or private transport of staff members, to the homes of families in that community to conduct their interviews to gather the necessary data so as to adhere to the requirements of the assignment. Some of the participants were assisted with the selection of a family by facility staff members, but they were not escorted into the community that was unfamiliar to them and subsequently they received no transport from the facility to the homes of families that had to be interviewed.

Participant 1: "*I was introduced to my family by a staff member. I consulted some of the staff members to find out, to find a family that I could work with. There was a bit of, not difficulty but a disagreement in which family I should choose because there was two families that they identified. I interviewed the first family member who's a male he's surname is Mr. A and he is very well known at the clinic and I spoke to him on two occasions and I decided not to take him. The family that I took was a young female 30 years old she came to the clinic with her second born*

or the second child, a boy who was ill at that moment that was how I met my family."

Participant 3: *"I found, I found my family, I found at the clinic through the TB sister at Clinic X."*

From the nine participants, three (3) selected their families on their own and six (6) were assisted by a member of the facility staff, either the sister responsible for managing clients with tuberculosis or the facility manager, in the identification of a suitable family. A great concern was to find that students went into communities to find a suitable family for their study with very little or no assistance from the facility staff members or their clinical placement coordinator. McNamara (2007) identifies that the role of the clinical placement coordinator is to act in a supportive capacity toward the nursing student. This involves the responsibility of ensuring that the students meet their clinical learning outcomes and the monitoring of their clinical learning to ensure safe practice. In facilities where the staff is not able to accompany students into the community, the clinical placement coordinator should then try hard to ensure the safety of the student while in the community setting.

3.3.2.2 Sub-Theme 2.2: Selecting a family from own community

It was interesting to note that three of the nine participants interviewed families that were known to them in the community where the students resided. Some of the participants stated that they expected this to make it easier to complete the family study, but each of them had their own challenges to face.

Participant 2: *"I was passing to this, to this house its in Area A in Community G; I also stay in Community G. So as I passed I saw this big family…. So in my mind I*

just, I just picked that family I don't know why, but I thought this family can make my family study like good…"

Participant 5: *"Ok, well I actually did wait, I did procrastinate with this family study a lot, but umm with regards to meeting a family, going out and conducting my interviews, like I said I personally I knew my family."*

Participant 8: *"…my colleague she is the one who knows the family and then the family didn't accept that umm to do our, our, our … assessment. She, she knows the family personally and, and we thought at the time maybe its going to be easy for us because she knows the family. And then it didn't work like that."*

Three of the participants knew the family personally that they selected to complete the health assessment on. Two of the participants had good contributions from the families while one participant found that the selected family was not that prepared to divulge personal information to someone known to them. They found that it was not that easy to get participation from a family just because you knew the people personally.

Clinical learning is an integral part of nursing education. Students are granted learning opportunities, including the acquiring of new skills and knowledge on professionalism (Chesser-Smyth, 2005). Macleod Clark, Maben and Jones (1997), as cited in Chesser-Smyth (2005), reflects on clinical placement as being one of the most important aspects of teaching and learning. Kleehammer, Hart and Keck (1990), as cited in Chesser-Smyth (2005), indicate that the clinical learning environment may be challenging, unpredictable and stressful during the period of the clinical placement. Meisenhelder (1987), as cited in Chesser-Smyth (2005), perceives increased anxiety immobilises the individual, their perceptions may be narrowed and their learning may be impaired.

Participants had different experiences with the selection of a family from their own community. The perception drawn from their responses seems to be that learning took place in their environment even though there may have been stressful events or feelings of anxiety.

Some participants who selected a family that was personally known to them experienced a setback in their assignment due to certain personal information being withheld by the family due to familiarity.

Participant 6: ***"****Umm, no I don't think they gave all the information, umm I think maybe like the financial circumstances they weren't happy to disclose that so I can place them in middle class or low class, because they are familiar with me so maybe I did, I did inform them that it's completely confidential, their names will not be used umm but maybe they was a small part of them that was afraid I might disclose their personal information to others.*

This participant who personally knew the family had the feeling that she did not receive all the relevant information from the family as she perceived that the family guarded against her being able to categorize them into a certain social class because of their income.

After an extensive literature search, no supporting data or journal articles could be located to support the impact of knowing the family personally that may have influenced withholding of information due to familiarity. The search engines used by the researcher included a search of the electronic data bases from the University of the Western Cape Library system mainly using Ebscho host, Scopus and Scholar Google. Key words that were used during the literature control study included: family, health assessment, familiarity, student, nurse, community health, health information, social status impact.

3.3.2.3 Sub-Theme 2.3: Selection of a family while in the community

The staff in the tuberculosis clinic and the directly observed treatment supporters mostly assisted participants who were assisted in finding a family for their health assessment. Participant 9 indicated that he met his family while in the community with the directly observed therapy supporters ("DOTs supporters"). Directly observed therapy is described as a short course of treatment under supervision. This refers to clients being given their treatment and seeing that the treatment is swallowed. In the South African context, the National Tuberculosis Control Programme (2004) describes directly observed treatment as that of an accepted person watching, in a sensitive and supportive manner, while the client is swallowing the treatment. This is to ensure that the client takes the correct treatment at the correct intervals to enable the client to complete the treatment. "DOTs supporters" are thus involved with many families.

Participant 9: *"Ok… Umm at first finding the family, finding the family in the community umm just the thought of it was, brought some difficulties into my planning. Umm, because at your, at the clinic we weren't exposed at first to, to sort of get to know the families well, umm we were bombard with, with a lot of work and I thought that we won't have enough time to go into the community. So we got an excellent opportunity umm with the dots supporters to go and umm assess the community first."*

Reflecting on education programs, Drevdahl, et al (2001) state that community health is often related to a place or setting rather than a way of thinking about influencing the health of groups and communities. Clinical placements primarily consist of students experiencing home health and family case loads. Tanner and Lethbridge (1998), as cited in Drevdahl, et al (2001), gives a description of the community health practical experience of students while working with older clients. Their observation was that through the limitation of the student's exposure

to only local health services or interventions and by not exposing them to the environmental, cultural, and spiritual factors that affect and strengthen this specific population group, a void in learning is created where addressing the causes for public health problems is denied.

Even though some of the participants experienced difficulty in locating an appropriate family, completing the family health assessment in the community is very relevant in community and public health nursing. This opportunity exposed the students to an awareness of environmental, social, cultural and other factors that play an important role in the provision of a holistic approach to ensure the health of a family.

3.3.2.4 Sub-Theme 2.4: Disagreement in the selection of a family

The assignment instruction to students was to complete an individual assignment, but they were permitted to interview the same family within the community. One of the participants clearly indicated that she did experience some form of group dynamics in the selection of an appropriate family to do the health assessment on. Working together in partnerships could provide community health nursing students with an opportunity to develop their verbal and written communication and negotiation skills. Group work is an essential skill as students may learn the concepts of working, trusting and being with others to ensure the success of a community health clinical experience (Drevdahl and Dorcy, 2002). Drevdahl, et al (2001), state that the success of a community project depends on how effectively students are able to work and communicate with each other.

Participant 7: "*But the worst was the disagreement because at the end I was right the family was not the right one for the marks, but then just I don't know for what it was a good thing.*"

Participants had different experiences in the selection of an appropriate family to do the family health assessment. Some of the participants received help and guidance from facility staff members, especially the sister in the tuberculosis clinic, in the selection of a family, while some had to go into the community to find a family, and others selected a family that was known to them to complete the health assessment.

3.3.3 THEME THREE: Emotive experiences

Some of the participants indicated some emotional and interpersonal connections made with the families or individuals in the family.

3.3.3.1 Sub-Theme 3.1: Family Well-being

The economic circumstances, the environmental and safety challenges experienced by the families, who were interviewed, resulted in some emotional consequences for the participants in this study.

Participant 1: *"My worst experience during this family study was when I was at Louise's house. It was umm, the school is just situated behind their house and her son came to the backdoor and asked for a piece of bread or something to eat. There was really nothing that Louise could give to the child. She felt embarrassed and she said to us that her mother wasn't even at home so that her mother could give the child a 50 cent to buy him chips…**I just feel that I wish I could do much more for this family to relleviate them from the poverty**, help them financially if I could, but I am unable to do that and I feel very sad about it."*

This particular participant was to a great extent affected by the poor economic circumstances of the family. She expressed feelings of hopelessness as she felt powerless to bring about change to improve the standard of living of this family. During the interview her facial expression showed compassion. Participant 1

subsequently made contact with the family while completing her midwifery practical in the community. She assisted them with the application for a child care grant and a follow-up visit for the mother of the house at the community health centre with the assistance of the social worker based at the community health centre in the community.

In real life projects, such as through the completion of a family health assessment, students are granted the opportunity to connect the theory of the discipline studied to what they are exposed to while working in the community. Their participation in theory- informed practice will assist them to become familiar with the families and the community's lived experiences, Drevdahl, et al (2001).

Participant 2: "*… Okay, the other thing I didn't mention this family neh, there's a lot of people inside, inside for overcrowding. There's no… inside the house. There's no toilets. They use the bucket toilets. So when they go to toilet they need to go there and I notice that those toilets they don't have the lockets, the doors they are always banging. So that means anyone can come in and do his things, her thing and then go. So the hygiene of the toilet is not, it is just unsafe. It is not good and it is contributing to their health thing.*"

This participant expressed her concerns about the environmental and safety threats to the health of the family that participated in the health assessment. The concerns identified by the student may be an indication that she may be exposed to good sanitation facilities at her home and in her social circles. The experience of being exposed to such a situation may have an effect on the student to create an awareness that even though they are supposed to be in an urban area, there are still communities with very basic or no sanitation facilities within the Western Cape.

3.3.3.2 Sub-Theme 3.2: Family Appreciation

Different experiences were indicated, but a few of the participants mentioned in their interview how grateful the family was that a representative from the health care facility showed an interest in their families' health condition. Family members were surprised that a health worker actually came to their home to enquire about the health of the family.

Participant 9: "*Umm … Another experience also to go out in the community and I found that there is a lot of things that we, that we as health care givers overlook when we see our patient or our client at the facility and we don't know the challenges that the patient faces when the person is at home. And I think umm going into the communities and working with the community is the best method how we going to prevent umm diseases from spreading umm because then we can have more control over, over the wellbeing of our community.*"

Participants identified challenges that they perceived should a health professional not be able to do home visitations. They noted that the community health nurse would not be able to manage the presenting condition of an individual effectively, if they had not been to their homes to observe the conditions that the person was living in.

Participant 4: "*… and umm I could see that our, our the fact that we choose them they were very grateful for us that's why they come and every time to us and tell about what they doing now and because I, I, I, … really would like to go back there and talk to them again.*"

Kolb (1984), Middlemiss and Kenny (1994), as cited in Callister and Hobbins-Garbett (2000), state that students have tangible experiences on which they reflect and they integrate these experiences with conceptual knowledge. The appreciation

for the interest shown in their health through the home visit expressed by families may positively impact on the future practice of the student. As a qualified professional nurse, he or she may promote the need for home visitation to ensure the holistic management of the family.

3.3.3.3 Sub-Theme 3.3: Student's role definition

Due to inadequate role definition, some of the participants experienced some challenges where the family had the expectation that once their health challenges has been identified; the student would be able to present an answer to the problem. Participant 6: "*…but it is difficult for a student to go to a family only as a student because most families will expect you to give advice regarding their health problems that you see in that family, because they allow you into that family, they give you all the information you need and if there is some health problems that might be very sensitive to them they will ask you haven't you got advice for this or uh can't you tell us a alternative methods to alleviate this problem in our family.*"

Regular intervention sessions between the lecturer and the student with feedback from students on their experiences could provide relevant information to the student on how they may be able to assist the family on the completion of the health assessment. Being aware of the resources within the community will give the student an opportunity to make the necessary referrals where indicated.

3.3.3.4 Sub-Theme 3.4: Strengthening personal bonds

Participants, who personally knew the family, indicated that they either experienced a strengthening of the friendship bond or they rekindled a previous relationship.

Participant 5: "*My best experience was,… it's not actually a best experience it's just they I don't know the feeling of me being part of the family I think that was*

the best experience. There was a time that I was there the whole family was there I'm not sure which day that was, the whole family was there and then we were like, like in, in our house everyone moved out I also moved out so that only happens once a month that all of us are together, all the children and all the grandchildren, everyone. They not much of a big family but what happened this particular day is I was there interviewing and whatever, I think that was also in the beginning stages and what happened was we were just like all there and sitting and like a normal family it doesn't happen often where and we were just like talking and it wasn't about me, me and the family it was like just, you know we had, we spend the evening together, mommy made food or whatever not that I ate but it was nice and we were just there we had a nice evening a nice time. They just kinda like accepted me they said no, no, no sit here and do what you need, it was nice."

This particular participant knew this family personally and this was an opportunity for her to experience in this family what she personally did not experience at home.

3.3.4 THEME FOUR: Issues in family contributions

There were some socio-cultural issues identified by participants where families were not comfortable to inform the participant of the personal challenges faced in their homes. Participants in this research study were able to identify different socio-cultural or family practices in communities and from the information received through the interviews it was noted that they respected the socio-cultural or family practices that were in place.

Participant 2: *"Then I didn't wanted to just sit there and watch them, but the mother was;* ***only the mother was communicating with me the others were just going in and out."***

3.3.4.1 Sub-Theme 4.1: Socio-Cultural influences

International or trans-cultural learning experiences provided an opportunity for nursing students to practice their acquired skills in a socio-cultural system different from their own. This may assist the student to gain an increased global perspective that will enhance their socio-cultural competency. The study on the experiences of graduates in Nicaragua reported how their knowledge, personal growth, and interpersonal connections were influenced by their experiences in being exposed to a trans-cultural community (Kollar and Ailinger, 2002). Being exposed trans-culturally as a student may assist in the development of skills to manage emotional experiences regarding social challenges of families the student may be exposed to. Moving beyond their "personal borders" may assist the participant to develop personal bonds with families that may be known or unknown to them.

Participant 8: "*And then umm … the, the, the, the, the father's umm … they still believe that they are the heads of the, of the families and then they, they don't allow anything 'cause we went there firstly and there was only the, the mother in the house and the father ehh… is selling ehh… drinks and beers then he was there, he was umm in the, in the shop to buy some ehh things to sell. And then the mother didn't give us the information, yah.*

Doutrich and Storey (2004) documented the following experience of a nurse who had a long term client with whom she built a trusting relationship and because of this relationship she was able to receive an articulate description of the cultural beliefs, traditions and values of this family on an invitation into their home. She further observed that a woman never crosses in front of a male, as that is perceived as disrespectful in that culture. Similarly cultural competence is important to the local context.

Participant 3: **"***A lot of times in the colored community they don't want people to know what's really happening in their homes. It's more of a cultural thing and they don't want people to know, even though you nurse they keep things from you unless they really grow to trust you."*

Participant 1: "*They are very involved in the church; they get a lot of sponsorship from the church as well and they are very active in the community as well. I've also asked her about her relationship with the neighbors which she said they have a very good relationship. They are still from those people you borrows a cup of sugar from each other and they will share like if Louise and her mother doesn't have food for the evening then the auntie next door will just see that the children have something to eat.*

South Africans are diverse in social and cultural aspects. During the health assessment, some of the participants were able to experience a culture different to their own. This paved the way to understanding and showing respect for diversity. Language is another aspect of diversity in South Africa.

3.3.4.2 Sub-Theme 4.2: Language

There were participants who experienced some language barriers while conducting interviews with families.

Participant 9: "*Umm going into the community to find my family umm I didn't know what to expect from, from my client so one thing that I said, goal that I set for myself umm pertaining this, this study is not to be umm judgmental to any person. Umm most of the families or the houses that we umm visited were "black" people and it was quite difficult for us to get a family because it's all the family don't understand, the families don't understand the umm, my language or I don't understand their language. It was quite difficult umm for the families to*

understand what the dots umm support system was about umm and then I also find it difficult to, to bring my part in where I have to search for a family to do the family study on."

Participant 9: *"Umm and most of them couldn't answer because they don't understand English or umm or Afrikaans. So we had to go from, from house to house and house to find a perfect family and it was quite difficult. Unfortunately, umm the covers, the area that we covered umm in, in that specific community umm were because it, it was newly developed and it was umm a dominant black area. After a few attempts umm which took us about an hour to two hours umm we came across a family which were umm good we … they were quite good candidates according to our judgment to participate in the family study."*

Drevdahl, et al (2001) states that using real life projects serves the purpose of allowing students to apply what they have learned in theory to what happens around them while being exposed to the community setting. The students are able to identify and understand community, community health, health care access, racism, sexism and other issues when they come into contact with people from different ethnic and economic backgrounds and when they become familiar with people's lived experiences.

3.3.4.3 Sub-Theme 4.3: Protection of family secrets

Participant 3 had had a previous family that withdrew from the study as they were not prepared to divulge any personal information about their family. Doutrich and Storey (2004) state that the first goal of a public health nurse is to build trust and establish a relationship in this context, establishing relationships with families or members of the communities. The continued relationship may depend on the established relationship between the client and the nurse or the nurse and the family. As observed, in the responses of participants, trust or ensuring of

confidentiality of information was an important prerequisite of families for continued participation from the family. Doutrich and Storey (2004) identified the importance for participants to realize that a trusting relationship must be developed with an individual to be entrusted with their confidential family information.

Participant 3: "*They had family issues and she spoke openly about it but we could see she was keeping things from behind, out of it. So that also affected our family study in a sense because we couldn't get the real true issues out of them.*"

3.3.5 THEME FIVE: Academic challenges experienced

Some of the participants indicated that they experienced some challenges in understanding what they were expected to do in the assignment. Participant two was very disappointed with the mark that she was awarded for the assignment after all her efforts.

3.3.5.1 Sub-Theme 5.1: Interpretation of assignment guidelines

There was one participant that indicated her disappointment in the mark that she was awarded as she had worked hard to complete the assignment. She indicated that she was honest in finding a family within the community and not taking a short cut by using her own family to complete the health assessment. However, the participant received a low mark, below the pass rate, as there was a section of the assignment that she did not complete due to either not following the guideline or not fully being able to interpret the expectations of the guidelines provided. It is important to note that even though this participant did not receive the anticipated mark, she personally acknowledged that experience was gained through this learning task.

Knowledge and skill can not develop unless the individual has developed perceptual abilities and is interested in new ways of learning (Dawson, Zeitz and Wright, 1989; Shanteau, 1988; Young, 1987) as cited in McMurray (1992). Being able to read and interpret an assignment is an important indication of academic growth that was supported by the enquiring mind of the student.

Participant 2: *"Then to me, I had this confidence that uhm... I'm going to get at least sixty and above in this assignment. Now, as I finish now, like okay, I've checked the assignment, I thought okay everything is fine. Um … I don't know if I'm going to pass 'cause I'm going to the end of the thing. Then you gave me the assignment back. Then I was looking …* ***forty percent. WOW … forty percent? … After this effort?*** *I've, I thought I've putted in a lot of effort …"*

Having marked the assignment and having had the experience of listening to the experience of the participant, the researcher, being both an academic and a student experienced a sense of empathy towards the lengths that the participant had gone through to complete an "honest" assignment. However, the participant's comments illustrate the disparity in the understanding of the assignment instructions and the marking guide in use.

Participants identified that they experienced some confusion initially on what they were expected to do for this assignment. After some intervention by the lecturer to provide transparency on the expectations of the guidelines provided, participants were comfortable that they knew what they were expected to do.

Participant 3: *"The family study, umm from the beginning was very confusing when we first received the information and the guidelines to do what we were suppose to do. It was very confusing, but the lecturer's helped out a lot by explaining any questions we had."*

Participant 9: *"Umm … the guidelines umm to sort of when we do the study umm maybe give clearer guidelines to, to the students because I'm sure that umm most, half of the students didn't know what it was about…"*

Drevdahl, et al (2001) indicates that during clinical exposure into the community setting, students are provided with an opportunity to:

- Reflect on their own personal values and beliefs regarding race, class and gender,
- Make use of empowerment approaches to gain an understanding into the health of communities,
- Be able to identify the influence of the socio-environmental and cultural factors that have an effect on the health of communities,
- Apply principles and skills regarding research, communication, critical thinking and cultural diversity towards the practice of community health,
- Move from an individual-focused way of thinking towards a community centered way of thinking,
- Focus on inter-sectoral collaboration to ensure the most appropriate intervention for the community and
- Ensure that the community grows to a position where they acknowledge taking responsibility for their own health.

3.3.5.2 Sub-Theme 5.2: Workload versus academic progress

Mannix, Faga, Beale and Jackson (2006) state that during clinical placement students are moved from a sheltered and supportive environment with the focus on learning into a workplace where they experience continued pressure.

Participant 9: "*…at the clinic we weren't exposed at first to, to sort of get to know the families well, umm we were bombard with, with a lot of work…"*

Participant 9 identified that the workload in the facility initially led to insufficient exposure to families.

Participant 9: *"…I thought that we won't have enough time to go into the community."*

Participant 9 indicated that it took some time before they were able to leave the facility to locate a family for their study in the community as they were expected to work in the facility. From the study it appears that some facilities are under the impression that they have an increased number of staff when students are in the facility, thus making the student part of the workforce; that may lead to the student not meeting the expected outcome for their clinical placement.

Dean in Muff (1982), as cited in Pope, et al (1996), state that nurses should support and facilitate continuous learning opportunities, ethical and professional conduct. Nel (1993), as cited in Pope, et al (1996), states that nurses need to communicate their needs and define their rights and responsibilities in their allocated work area. Drevdahl, et al (2001) state that there is a need for baccalaureate community health nursing students to understand the community assessment, planning, intervention and evaluation and not only the focus on an individual. They further state that the distinctive perception of Community Health Nursing (CHN) as reflected in education programs within the CHN curricula, is frequently understood as somewhat associated to place or setting, rather than a way of thinking about influencing the health of groups or communities. Clinical placements in CHN first and foremost consisted of student experiences within home health and family case loads. In community based clinical placements, clinical work does little to help the student grasp the concepts and processes of community centered practice if students are not exposed to health promotion or the community health setting.

Drevdahl, et al (2001), state that it is important for nurses to understand the concept of community health. This concept is further supported by the increasing emphasis on health promotion and disease prevention. A need has been identified for baccalaureate nursing students to have a sound understanding of community health nursing and the legal requirement of the South African Nursing Council as stipulated in Regulation 425, The Nursing Act 33 of 2005 and The Health Act 61 of 2003.

3.3.6 RESIDUAL THEME SIX: Relationships within communities

One participant related how the community supported each other financially due to poor socio-economic conditions. A study on the barriers to accessing anti-retroviral therapy in Kisesa, Tanzania by Mshana, Wamoyi, Busza, Zaba, Changalucha, Kaluvya and Urassa (2006) gives a description of the death of a female participant in this study through food deprivation and neglect from her family after disclosure of her status. The family of participant 1 was fortunate to have the support of neighbours and the church in their time of need as it appears that they were not regarded as a burden or shame for the community due to poverty.

A community member encouraged one of the participants, a young female, to complete her studies to be able to enjoy a brighter future. One participant felt motivated to reward the mother of a family with a gift to thank her for her participation in the family health assessment.

Participant 3: *"**We gave her a gift afterwards to thank her** because we felt that we needed to do something just to say thank you to her. That was because we as students, it was our own initiative, knowing that we would not get something out of it but just to say thank you for helping us out of it. She helped us a lot with our*

assignment in a sense but I feel we could have had better a better family study and more in depth and more better a family would have been better”.

3.4 CONCLUDING STATEMENTS

The family health assessment learning task gave the researcher an opportunity to explore the experiences of the participants while conducting the family health assessment. The following chapter gives the main conclusions derived from the findings and makes pertinent recommendations.

CHAPTER FOUR: CONCLUSION

4.1 INTRODUCTION

The study aimed to explore the lived experiences of undergraduate community health nursing students while completing a family health assessment learning task. In chapters one and two, the background to this study and its rationale and the research purpose and design are discussed.

In chapter three the data was analysed into five main themes, fifteen sub-themes and one residual theme. These themes were related to documented references during a literature control study to enhance and support the narration of the lived experiences of these students. This chapter will conclude this study with recommendations of issues needing to be addressed to improve the experiences of undergraduate community health students.

4.2 CONTRIBUTIONS OF THE STUDY

The qualitative methodology contributed towards the in-depth discovery of the lived experiences of undergraduate community health students to provide a deeper understanding into the lived phenomena experienced.

The study was conducted with participants who were in the third year of their undergraduate program in which community health nursing modules were conducted during the first semester of 2008. This study contributes towards community health nursing specifically to inform future students, lecturers and facility staff of some of the challenges experienced by the participants.

4.3 LIMITATIONS OF THE STUDY

The following limitations were identified by the researcher:

Although the participants in this study provided a valuable input into the lived experiences that were explored, it is important to note that these are the experiences of the students who are affiliated to this specific academic institution. In addition, it should be noted that the input from facility personnel and lecturers may also prove to be of importance or relevance but was beyond the scope of this mini-thesis.

It proved to be challenging to ensure that participants kept to appointments arranged to conduct the interviews. A number of the participants did not turn up for the scheduled interview and did not forward any apology. Students' not turning up for scheduled appointments meant that time was expended on making new arrangements. It will be necessary and useful to identify the reasons for this non-attendance at interviews to inform any future research with students and meant that other students had to be interviewed for the purpose of this assignment.

Two of the participants withdrew from the study as they verbally informed the researcher that they did not go into the community to complete the interviews for the completion of their health assessment and they felt that they could not give a full account of their lived experiences as they did not follow the guidelines of the study. A "paper trail" or family visit register should be incorporated into the learning task for the lecturer to identify the student who did not go into the community to complete the family health assessment. There should be a penalty in the marking guide should this be identified as the student may not present a holistic view on the health status of the family as there may be no relation to the environment of the family. The ethical aspects of non-compliance with learning tasks are a serious matter needing investigation.

Only one venue was used to conduct the interviews and on one day participant and the researcher had to move to another venue in the same building due to the noise level during building alterations. We had to change the venue in the middle of the interview as the venue became too noisy and it took some time to settle into the new venue and to re-commence the interview. The change in venue during the interview should be prevented as it "disturbs" the person narrating an experience and this could lead to a loss of valuable information.

Published literature was not always available and this created a void in the exploration of the experiences. However, the themes identified were enhanced and supported with references from literature as pertinent in the form of a literature control study. Ebscho Host, Scopus, Pro-Quest and Scholar Google data bases, from the University of the Western Cape Library system, were used and consulted. The lack of published literature also supports the need for a study such as this one.

4.4 CONCLUSIONS AND RECOMMENDATIONS

4.4.1 Practice

4.4.1.1 Safety challenges experienced by students

Conclusion: This study found that most students expressed concerns about their safety. In the South African context students may be placed in areas where community violence may prevail.

Recommendations: With reference to the article of McNamara (2007), it appears that ensuring the safety of students while in clinical practice is the shared responsibility of the clinical placement coordinator and the facility manager. The facility manager has a responsibility to provide the student with feedback,

guidance and support while he or she is allocated to that facility (Pope, et al, 1996).

It is recommended for the improved quality of the safety support that the following be addressed:

Information about the clinical placement setting should be made available to students prior to their placement. This will grant them the opportunity to prepare for any safety challenges that may exist, for example to refrain from taking valuables with them to the facility.

Physical Accompaniments – There should be a policy or guideline available to give clear direction to facility managers, facility staff and clinical placement coordinators on who is responsible for ensuring the safety of students whilst they are in the community.

Resources should be made available to the students. For example, transport should be made available to students to the homes of community members should they conduct the health assessment learning task in an area that may be dangerous. Feedback on the students' progress or an incident should be given to students, facility managers and staff, clinical placement coordinators and others who are involved in the clinical training of the students.

Guidelines should be developed and be made available to students on when it is safe to enter the house of a person and when it is unsafe. Where the situation has been identified as unsafe, there should be an instruction that students are to return to the facility, for example if he or she suspects that the family may be intoxicated, etc. These guidelines should include how to assess the general safety of a community.

During visits into the community, there should be a communication system in place where the students will report when they leave the facility to go into the community and to announce their return to the facility.

There have been participants that opted to complete the assignment in a community that was known to them. The recommendation is that students, who complete an assignment in their own communities, should complete a second assignment in a community unknown to them, for them to learn the skill of conducting a health assessment in an unknown environment.

4.4.1.2 Ethical Practice

Conclusion: Through learning by doing in this assignment, students learned to become capable in the management of issues regarding ensuring the confidentiality of client information.

Recommendations: The students' professional development is associated with ensuring that confidentiality of clients' personal information is maintained at all times. In practice, it is important to strengthen the preparation of the students to deal with ethical dilemmas that they may be faced with whilst in the community.

4.4.2 Education

4.4.2.1 Interpretation of assignment guidelines

Conclusion: The study found that students experienced challenges in understanding the task that they were expected to complete. They experienced difficulties with interpretation of the learning task at hand during the orientation to the assignment.

Recommendations: These difficulties and misunderstandings experienced are acknowledged and a review of the current assignment guidelines is strongly advised **(ANNEXURE A)**. The recommendation is that the guidelines be simplified and be made available to students on the electronic university system, once simplified, for quick reference whenever needed. In addition, a hard copy should be provided.

Another recommendation is that the detailed assignment guidelines be presented and discussed with the facility manager and relevant staff where the student is placed to ensure clarity on the expectations of the task at hand. This is a process that should be facilitated by the clinical placement coordinator. This will encourage the provision of guidance and support to the student while allocated to the facility.

The students will have to acknowledge some responsibility regarding the scheduled due date and correct completion of the assignment. They will have to inform their lecturer, clinical placement coordinator and facility manager in a professional manner of where they need guidance and support throughout. It is recommended that students sign a learning contract when receiving the assignment which will bind them to keeping to the stipulated time frames for the submission of drafts to their lecturer to be checked for guidance and corrections.

4.4.2.2 Preparation for emotional aspects

There were two aspects identified with regard to the emotional aspects.

Conclusion One: The study found that some students struggled to negotiate entry into the homes of a family.

Recommendation One: With the diversity within the South African communities that students are exposed to, they should be granted an opportunity to practice negotiation strategies in class before they go into the community in order to strengthen the management of diversity amongst families in various communities.

Strategies recommended to manage emotional experiences that may occur may include extensive debriefing group sessions to be held for students which are to be facilitated by the community health lecturers. At these sessions, students will be able to share emotional experiences and guidance can be provided on how to manage certain aspects that may occur. Where indicated, students may have to be removed from "threatening" communities and be reallocated to "safer" communities for their clinical placement period to ensure exposure for the completion of their assignment. Students should be invited to extended consultations hours with their lecturers to have debriefing sessions on emotional experiences where needed.

Conclusion Two: Further more some students also described emotional discomfort in the context of the family health assessment.

Recommendation Two: Based on the data analysis, it is acknowledged that students still experienced challenges in negotiating entry into the homes of families. It is not clear on how many problems were averted by doing this exercise, as only some issues were raised by participants. A strategy that is recommended is that it is suggested to the facility manager that a DOTs supporter that is known in the community escorts the student during home visits initially to grant the student the opportunity to build a relationship with the family.

4.4.3 Further Research

Conclusion: This study focused on the lived experiences of the community health student. An area for further research may be to explore the lived experiences from the family's perspective while being interviewed by students in their home and community.

Recommendations: Essential elements that need to be revisited by lecturers and clinical placement coordinators are the responsibilities of the clinical placement coordinator towards the student while in clinical placements.

The responsibility of the clinical placement coordinator during the supervision of the participants or students while completing a family health assessment learning task, as identified in the limitations, needs to be addressed during further research.

4.5 IN CONCLUSION

This study was conducted with third year undergraduate community health nursing students at the University of the Western Cape. The focus of the study was to explore their experiences during their clinical fieldwork placement, while conducting a family health assessment in communities. The expectation of the researcher was to create an increased awareness and understanding of the experiences and challenges faced by these students while within communities.

The background to with the rationale to carry out this study, as outlined in chapter one, created a platform for the discussion of the phenomenon being explored by the researcher.

The qualitative research methodology, as outlined in chapter two, contributed to the exploration of the lived experiences of undergraduate community health

nursing students during their clinical fieldwork period, while conducting a family health assessment in communities. The in-depth interviews conducted provided a deeper perception of the phenomenon being researched and provided the basis for the conclusions and recommendations made

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APPENDICES

ANNEXURE A

Family Study Guidelines
BCUR 111 Community Health Nursing 2008

Please note that although you will visit the family in groups, you MUST each submit your own **INDIVIDUAL** assignment – we will check to make sure you have not copied from each other

Component	Description	Pages
Cover sheet	Includes your name, student number + plagiarism declaration (please include the names of the students you worked with)	
Consent form	Copy of the completed consent form	
Biographical data	Complete a detailed genogram on your family study family (see Hattingh et. al., 2006, section 5.3.1). Please include significant family members not living in the household e.g. grandparents, aunts and uncles etc. Please mark on the diagram those living in the household. Please include key.	1
Environmental assessment	Do an assessment of the following aspects of the family's	2

	environment: - Physical environment e.g. size of house, cleanliness, services e.g. electricity and water, resources in community, crime, health hazards in the environment etc. **Name and describe the factors that could be a threat to the family's health** - Social e.g. family relationships, social network, social activities, support system **Name and describe the factors that could be a threat to the family's health** - Psychological e.g. psychological stressors, coping mechanisms **Name and describe the factors that could be a threat to the family's health** - Economic (what source does the family's income come from and are they coping on their income – do not ask questions that are too personal) **Name and describe the factors that could be a threat to the family's health**	
Communicable	Does the family have any	1

diseases	communicable diseases at present? Name each disease and give the mode of spread. Describe the factors in the family's environment (physical, social, psychological, economic) or lifestyles that put them **at risk** of contracting communicable diseases e.g. poor nutrition due to lack of money (economic environment) puts them at risk of contracting communicable diseases such as TB)	
Non-communicable diseases	Does the family have any non-communicable diseases at present? Describe factors in the family's environment (physical, social, psychological, economic) or lifestyles that put them **at risk** of contracting non-communicable diseases	1
Health promotion	From your assessment of your family's health status, **together with the family:** 1. Select the **most important health problem/s** that the family is either experiencing or at risk of experiencing (e.g. at risk of	1

	heart disease due to life style) then **together with the family** 2. Design a health promotion plan that will help improve the family's health status in relation to the health problem you have selected. (E.g. a plan to help family members give up smoking using the behaviour modification cycle). Please research your information carefully and make sure it is accurate. **Give appropriate referrals where necessary**	
Diagrams	Include relevant diagrams to help your family carry out the health promotion plan (e.g. meal plan, exercise routine etc.)	Extra pgs
References	At least two references – correctly referenced in the body of your assignment and reference list at the end (Harvard method)	Extra pg

ANNEXURE B

Family Study Guidelines: Interview example role-play

BCUR 111 Community Health Nursing 2008

Student Nurse:	Knock Knock
Mrs. Adams:	Who's there?
Student Nurse	It is Student Nurse Brown from the clinic. May I come in?
Mrs. Adams:	I suppose so - come in (Sounds reluctant)
Student Nurse	How are you Mrs. Adams?
Mrs. Adams:	I am fine… But, what is this all about? I don't remember anything you said at the clinic yesterday and I don't know why I agreed to let you come. Maybe I have changed my mind…
Student Nurse	That's okay. Can I explain it to you again? It will only take 10 minutes of your time and then you and your family can decide whether you want to take part in our family study or not. There is no pressure on you at all – it is totally up to you.
Mrs. Adams	Okay, if you put it that way. Explain it to me again.
Student Nurse:	Thank you. As I explained yesterday, I am a third year nursing student from UWC and this year I am learning about families and community. Part of my course is to

	do a family study in which I visit a family in their home.
Mrs. Adams	So you want to visit my family?
Student Nurse	Yes – if you agree to take part in the study
Mrs. Adams	But why? What do you want to know?
Student Nurse	The purpose of the study is to learn more about the environment in which families live and how it affects their health. If you agree to take part, I will make three visits to your family at a time convenient to you and ask you some questions about your health and your environment. But don't worry I won't pry into your private affairs and if there are any questions you don't feel comfortable with you do not have to answer.
Mrs. Adams	That's good. But what's in it for me – do I get paid?
Student Nurse	No unfortunately, there's no money for that but there are some benefits to being involved.
Mrs. Adams:	Like what?
Student Nurse	Well, **firstly**, you will be helping me to learn to be a better nurse, so that in the future, I will be able to help others more. And **secondly**, if there are health problems in your family, I will try to help you solve them; either by giving you some information and helping you to problem solve or by referring you to someone else if I

	cannot help. I am not a qualified nurse yet so there will be things I do not know, but I will ask and find out for you.
Mrs. Adams:	Well... that does sound nice and I do have some questions about my high blood. It is just that I had a bad experience with a student.
Student Nurse	Oh no… what happened?
Mrs. Adams:	I forgot to take my high blood tablet and so my pressure was very high when I went to the clinic and this student shouted at me in front of everyone. I was so upset to have that happen in front of all those people
Student Nurse:	You felt embarrassed and hurt?
Mrs. Adams	Yes, I cried all the way home
Student Nurse:	I am so sorry to hear that – that was a horrible thing to happen. So what you are saying is that that experience made you afraid to trust a student again And that is part of our contract with you. If you agree to take part,
Mrs. Adams	Yes – after that I never wanted to see another student again
Student Nurse	I am very sorry that happened to you. That student had no right to do that and I am sorry for the hurt it has caused you. I am also sorry? that has given us students a bad name. I hope I can convince you that we are not all bad!

	If you agree to take part in our study, I will be signing a contract with you to say that I will treat you with respect at all times and I will not reveal any of your private information to anyone without your permission. Even when I write up my report for my teacher, I will not put your name into it.
Mrs. Adams	That makes me feel a lot better! But I still want to think about it some more and talk to my family. Is that okay?
Student Nurse	Yes, of course. There is no pressure to take part and even if we start the study and then you change your mind, you are free to stop at any time. I will give you our information letter which you can read over in your own time and make a decision. Should I phone you or would you prefer to phone me?
Mrs. Adams	Phone me on Friday and I will give you the answer
Student Nurse	I will do that. Thank you so much for your time Mrs. Adams. It has been good to talk to you. Before I go would you like me to summarise the main points about the family study for you again?
Mrs. Adams	Yes please – my memory is so bad
Student Nurse	Certainly. The main purpose of the family study is for us students to learn about families and the communities. If you take part, I will come and visit you three times at a time convenient to you. I will ask you questions about your health and your family, but if there are any

	questions that make you feel uncomfortable you do not have to answer. The benefits of the study are that you will help me learn to be a better nurse and that I will try to help you find some solutions to any health problems you have or refer you if I cannot help. I will not give your private information to anyone without your permission and I will treat you with respect at all times. The names and numbers of our lecturers on the letter I have given you and you welcome to contact them with any questions or concerns.
Mrs. Adams	Thanks very much, Nurse Brown. Goodbye
Student Nurse	Goodbye Mrs. Adams. I will call you on Friday.

ANNEXURE C
UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa

Interview Schedule

Question to initiate interview

Participants will be asked the following question and they will be allowed to narrate their lived experiences in a manner that they deem comfortable.

How did you experience the family health assessment?

Possible probing questions to obtain clarity on information provided

- Tell me more about your experience.

- Name your worst and your best experience while conducting the family health assessment.

- Is there anything else that you would like to add?

ANNEXURE D

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Consent Form

Title of the Research Project: The undergraduate nurses' experience of the family health assessment as a learning opportunity

I **……** hereby agree to participate in the in-depth interview conducted by Juliana Joan Willemse (Neé Solomons), a post-graduate student at the University of the Western Cape. The study has been described to me in detail and in a language that I understand. I hereby freely and voluntarily agree to participate. My questions regarding this study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name…….

Participant's contact no: ……. ….

Participant's signature……... Date …….

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher or the study coordinator:

Researcher: Juliana Joan Willemse (Neé Solomons) **Telephone:** (021) 959-2258

Cell: 0846192968 **Fax:** (021) 959-2679 **Email:** jjwillemse@uwc.ac.za

Coordinator's Name: Professor Wilhelmina Kortenbout

University of the Western Cape, Private Bag X17, Belville 7535

Telephone: (021) 959-2274 **Email:** Wilhelmina Kortenbout @uwc.ac.za

ANNEXURE E

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Participant Information Letter

Project Title:

The undergraduate nurses' experience of the family health assessment as a learning opportunity

What is this study about?

This is a research project being conducted by Juliana Joan Willemse (Neé Solomons) at the University of the Western Cape. You are invited to participate in this research project because you are currently a third year community health student at the University of the Western Cape who is presently conducting a family health assessment. The aim of this study is to explore the lived experiences of you, the community health nursing student, during your clinical fieldwork while conducting a family health assessment in your assigned community. During this research project you will be requested to give you view or responses on questions asked during an in-depth interview.

Would my participation in this study be kept confidential?

Written consent will be obtained from you, the participant, who will participate in this research project. As the researcher will know your identity, all efforts will be made to secure confidentiality of all the information that you are comfortable to

share with the researcher. All your responses in the interviews will be kept confidential in order to protect and respect your rights. The data collected will be applicable for this research project only and the interviews will be audio-taped for transcription for your verification before any of the data will be used in this research project.

What are the risks of this research?

Please be assured that your answers will have no negative implication on your present studies. There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the lived experiences of the third year community health students with regard to the family health assessment to contribute to future teaching and support methods for students.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized.

Remuneration

Participation in this study is voluntary. The researcher is in no position to offer any form of remuneration to any of the participants in this study.

What if I have questions?

This research is being conducted by Juliana Joan Willemse (Neé Solomons) at the Faculty of Community Health Sciences at the University of the Western Cape.

If you have any questions about the research study itself, please contact:

Researcher: Juliana Joan Willemse (Neé Solomons)

Telephone: (021) 959-2258

C**ell:** 0846192968 **Fax:** (021) 959-2679 **Email:** jjwillemse@uwc.ac.za

Study Coordinator's Name: Professor Wilhelmina Kortenbout

Telephone: (021) 959-2274 **Email:** Wilhelmina Kortenbout @uwc.ac.za