Interprofessional service-learning: cutting teeth and learning to crawl

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Interprofessional service-learning: cutting teeth and learning to crawl

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ABSTRACT
An interprofessional community-based service-learning initiative, supporting early childhood development in an impoverished community, was launched on a South African university’s rural training platform. The study aimed to determine how this learning experience influenced students’ interprofessional person-centered practice. An interpretative qualitative approach was followed. In-depth focus group discussions with dietetic (n = 15), medical (n = 24) and occupational therapy (n = 6) students were conducted before they left for a rural training site, directly afterward and again six months later. The findings indicated that most students had a limited experience of interprofessional collaborative practice (IPCP) beforehand. Afterward, those demonstrating developmental learning reported increased knowledge about their own roles, a deeper understanding of the roles of other professions and a realization of the importance of IPCP. Different reactions were related to students’ profession, attitude and insight, and other interprofessional experiences during the placement. Contact with service users in the community, additional interprofessional clinical activities and shared living spaces are likely to further enhance students’ competencies in IPCP. A lack of interprofessional role modeling in the academic hospital, where most students returned to, hindered them to continue following an interprofessional, person-centered approach. Longer, synchronized rotations on a decentralized platform may be beneficial to inculcate competencies related to IPCP.

KEYWORDS
Service-learning; rural health; interprofessional education; community-based education

Introduction
The World Health Organization (WHO) identified interprofessional education (IPE) in 1984 as one of the activities that should be prioritized to ensure “Health for All” (Areskog, 1995). Boelen (1993) stated that medical doctors should be able to work effectively in interprofessional teams to address the needs of communities. While a curative approach is important, curricula should also focus on critical dimensions, like preventing disease, promoting health and interprofessional collaboration (World Psychiatric Association & World Federation for Medical Education, 1999). These calls were reiterated by Frenk et al. (2010), as well as WHO (2010), recommending radical changes to health professions education if we are to address the health needs of populations in this century. They advocated for interprofessional, competency-based and community-based education, and for social accountability of health workforce training institutions.

Community-based settings offer more opportunities for IPE compared to acute hospital settings (Anderson & Lennox, 2009). However, a literature review found that community-based projects were the least reported setting (16.9%) of IPE experiences (Abu-Rish et al., 2012). Community-based education endeavours to: (1) facilitate learning in, with, for and from the community with a focus on reciprocity and sustainability; (2) render relevant, meaningful and mutually agreed upon service with the community, addressing community needs and the learning outcomes of students; (3) foster personal growth; and (4) promote active citizenship and social responsiveness (De Villiers, Conradie, Snyman, Van Heerden, & Van Schalkwyk, 2014).

This understanding of community-based education is closely aligned with Smith-Tolken’s definition of service-learning as “a form of community-based experiential learning and a curriculum-based, credit-bearing and carefully structured educational experience in which students participate in an organized community interaction activity that meets identified and agreed upon community goals; reflect on the service activity in order to gain a deeper understanding of module and programme content; acquire a broader appreciation of the discipline; and develop an enhanced sense of social responsibility towards society as a whole.” (Smith-Tolken, 2010, p. 6)

A service-learning pedagogy has been described as contributing to the development of competencies for interprofessional collaborative practice (IPCP), such as teamwork, role clarification, collaborative leadership, critical reflection, communication, conflict management and patient- and community-centredness. The value of service-learning as a catalyst for identity formation, transformative learning and civic engagement should not be ignored in efforts to reform health professions education (Buff et al., 2015; Clark, Spence, & Sheehan, 1987; De Los Santos, McFarlin, & Martin, 2014; Eyler, Giles, Stenson, & Gray, 2001; Kloppers, Koornhof, Bester, & Bardien, 2015; Oandasan & Reeves, 2005a; Smith-Tolken & Du Plessis, 2015; Thomas & Landau, 2002).
Darlow et al. (2016) highlight the importance of obtaining insight into student perspectives to understand why and how certain programmes are perceived to be effective or not. Curran, Sharpe, Flynn, and Button (2010, p. 43) also advocate that “student attitudes are an important evaluative measure of the perceived reception of a new IPE curriculum and have implications for the design of IPE to ensure it is achieving beneficial and intended outcomes.” There is a need to develop ways to assess students’ knowledge, attitudes and behavior as ultimately, IPE strives “to develop health professionals who leave their training programs as competent collaborative patient-centred practitioners” (Oandasan & Reeves, 2005b, p. 46).

Context and overall approach

The IPE strategy at Stellenbosch University (South Africa) was revised by faculty members representing all undergraduate programmes (human nutrition, medicine, occupational therapy, physiotherapy and speech-language, and hearing therapy), as well as postgraduate nursing. (Snyman, Von Pressentin, & Clarke, 2015). It was agreed that the IPE strategy should be integrated in all undergraduate curricula and not presented as loose standing modules to already overloaded programmes. There was a consensus that the University should move away from primarily a biomedical model of health professions education towards embracing a bio-psycho-social-spiritual person-centered model to health and social care. It was also agreed that this IPE strategy should be piloted on the University’s distributive rural training platform, where professional silos were perceived to be less entrenched. Learning activities were also being experienced as more flexible than in the tertiary hospital environment and therefore open to creative innovation (Van Schalkwyk et al., 2012; Snyman et al., 2015).

In planning the interprofessional learning opportunities for this pilot, Bender’s service-learning curriculum design model was followed (Higher Education Quality Committee, 2006). (See Figure 1).

A process of consultation with service managers of community-based organizations (CBOs) in an impoverished neighborhood, resulted in the university being invited to partner with one organization to develop and conduct a parenting programme focusing on early childhood development. The mutually agreed partnership with the service provider was welcomed by other CBOs, the local municipality, the elected ward councilor, and his political committee. The scope of the project allowed for numerous learning outcomes of the three professions involved to be aligned, creating the opportunity for community-based interprofessional service-learning. The first pilot project was launched in a coastal town 100 km from the main campus, where medical, dietetic and occupational therapy students were placed. Table 1 provides an overview of these placements.

The aim of this study was to determine how an interprofessional service-learning experience changed students’ interprofessional person-centered practice.

The implementation of the project followed four phases. During the first few months, interprofessional student groups performed a community diagnosis culminating in a needs assessment related to early childhood development and parenting. The second phase entailed the planning and development of an intervention with the service provider and community members. They developed forms, learning, and teaching resources, drawing on interdisciplinary expertise in the university (e.g.}

![Figure 1](https://example.com/figure1.png)
from health professionals, sociologists, social workers, educators, psychologists, theologians, sport scientists), while considering the indigenous knowledge and belief systems of the community. The next phase was the implementation phase, which included interprofessional parenting workshops, weekly home visits, the assessment of children’s development, referral (where needed), and deemed suitable for (phase 4) the agile, iterative improvement of the material and approach. As students came and went, handover meetings were conducted to ensure continuity. Students were supported by the university’s local IPE facilitator, profession-specific preceptors and members of the local CBO.

Medical students, in addition to this IPE learning opportunity, also had to complete an in-depth case study on two of “their” patients. Here students served as interprofessional “case managers” for these patients. In this process, they drew on the expertise of the occupational therapy and dietetic students and engaged with other health professions based at the local hospital. Medical students discussed their patient-centered management plans with an interprofessional team of examiners at the end of their rotation (Snyman et al., 2015).

The placements varied in duration with no synchronization regarding the start of rotations between the various professions. These issues are often reported as stumbling blocks to IPE (Freeth, Hammick, Reeves, Koppel, & Barr, 2005; Oandasan & Reeves, 2005a; Reeves, 2000). During their placement, the students stayed in a house provided by the university.

Reeves (2000) argued that typical before-and-after research designs provide insufficient insight into the complex process of how changes occur as a result of IPCP. This is why we not only conducted interviews directly after the learning activity, but also six months later, exploring the qualitative aspects of why and how these changes occurred (or didn’t occur) (Abu-Rish et al., 2012; Furze, Lohman, & Mu, 2008; Mellor, Cottrell, & Moran, 2013).

Interview questions were open-ended, neutral, coherent and singular. During these semi-structured discussions, uncertainties were clarified by the interviewer. Interviews were recorded and transcribed. A complete audit trail strengthens the dependability of the data and its analysis (Babbie & Mouton, 2001).

Methods

Research design

The study followed an interpretative qualitative approach allowing researchers to explore and understand students’ experiences (Nieuwenhuis, 2010; Patton, 2001; Thistlethwaite & Ewart, 2003). This offered insight into the factors contributing to the success of the interprofessional programme.

Data collection

Data were generated thorough in-depth focus group discussions (FGDs) with students placed at the above-mentioned site and who consented to voluntary participation in the study. The first FGDs were conducted in uniprofessional groups before students left the main campus for the rural platform. Immediately upon their return from the rural platform, a second FGD was conducted with the interprofessional group. A final FGD was completed six months later, again in an uniprofessional group for practical reasons.

Table 1. Summary of students participating in the interprofessional service-learning pilot project.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Duration: Degree programme (years)</th>
<th>Year of study exposed to IPE pilot</th>
<th>Duration: Module (weeks)</th>
<th>Name of module</th>
<th>Students per rotation</th>
<th>Rotations per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>MB, ChB</td>
<td>6</td>
<td>Middle phase (year 4 or first half of year 5)</td>
<td>2</td>
<td>Clinical rotation: Health and Disease in Communities (Family Medicine, Rehabilitation and Community Health)</td>
<td>2–4</td>
<td>10</td>
</tr>
<tr>
<td>B in Occupational Therapy</td>
<td>4</td>
<td>Late phase (latter half of year 5 or year 6)</td>
<td>5</td>
<td>Medical, Rehabilitation and Community Health</td>
<td>2–4</td>
<td>5</td>
</tr>
<tr>
<td>BSc Dietetics</td>
<td>4</td>
<td>4th year</td>
<td>6</td>
<td>Community Interaction</td>
<td>2–3</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 2. Number of students interviewed per profession.

<table>
<thead>
<tr>
<th></th>
<th>Pre-exposure</th>
<th>Directly after exposure</th>
<th>6 months later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Dietetics</td>
<td>15</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Medicine</td>
<td>24</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>41</td>
<td>34</td>
<td>25</td>
</tr>
</tbody>
</table>
The number of human nutrition students participating in the FGDs over the course of the study remained consistent. The occupational therapy students tripled from the initial to the final FGDs, while medical students dwindled over the course of the study. A third of the group had graduated and left campus before they could be interviewed again.

Prior to their rotation at the rural clinical training platform, students could offer definitions of interprofessional holistic care. Some students recalled examples where they had observed interprofessional holistic patient care (e.g. on the distributive training platform, a psychiatric hospital and certain departments in the academic hospital, such as the burns and oncology units). However, none of the medical or dietetic students had actually applied or practiced interprofessional holistic care before. Occupational therapy students were the exception, as they considered holistic patient care integral to their profession and claimed that they had practiced it from the onset of their clinical training.

Following the rural rotation, students’ responses regarding their experience of interprofessional holistic patient care varied. Some students reported having had a rich learning experience, while others were unaffected. Those who showed evidence of developmental learning highlighted as key themes (a) an increased knowledge about their own profession’s role, (b) a deeper knowledge about the role of other professions and (c) the importance and value of IPCP.

Factors identified as reasons for the different reactions to this interprofessional experience, were the students’ (a) profession, (b) attitude and insight and (c) different experiences during the rural rotation. These will each be explored below.

**Profession**

Students’ degree programme (future profession) influenced their previous exposure to the holistic management of patients and their perception of the purpose of the rural placement. Students from the different professions were exposed to different learning opportunities and the duration of their stay on the rural distributive teaching platform varied (See Table 1).

For students who had never practically participated in providing holistic interprofessional care, the rural rotation was effective in introducing them to this approach and convincing them of the benefits thereof.

> I think I’ve experienced a different approach to the holistic management of a patient and thinking about the patient in the context much differently, as opposed to my friends who went to [other training sites]. [P10: 115/4M14]

On the other hand, students who previously had practical experience in applying holistic care perceived no apparent change in their approach. Some students expressed a desire to learn more about other health professions.

> … I still don’t know as much as I should about the different roles of the other members of the team, but I am interested in learning about it. So my personal attitude is that I would like to learn more about the other members of the team. [P5: X/M18]

Students’ duration on the rural platform had an impact on the exposure to interprofessional collaboration and influenced to what extent they could experience its value. Irrespective of whether students spent one or two weeks at the rural training platform, there was agreement among students that the limited time was a barrier to effective learning.

> I think in such a programme where we all came together … we could have stayed longer, that we could have had more exposure to the other disciplines … [P7: X/D14].

**Attitude and insight**

Students’ attitude toward interprofessional collaboration and towards other health professions had an influence on their experience and their perceived value of the experience. Some students considered the experience as valuable to their development as health professionals. However, other students were dissatisfied by viewing the service-learning activity as a sacrifice of time which detracted them from perceived learning time within the hospital setting. They favored profession-specific input rather than interprofessional experiences.

They expressed the desire to first be more secure in their own professional identity or “perfect [their] own profession” before pursuing interprofessional holistic care.

> … it’s not that I don’t want to use [allied health team members] … maybe I need to pay attention to some other things before I can start looking at them … [P6: 111/M4]

Many students expressed a positive attitude toward other health professions prior to the placement. They offered this as a reason for the lack of change in attitude toward others following the rotation.

> I never really had a negative feeling towards any other health profession. I mean two weeks [on the rural platform] was a very good experience, but it didn’t really change how I view them, because I’ve always seen them as just as important as any other healthcare worker. [P6: X/M32]

Students suggested that being in relationship with people from other health professions outside of professional context – be it family members, friendships, romantic relationships or shared living spaces – had a valuable influence on their increased knowledge and positive perception of other health professionals. As one of the students noted:

> … having a personal relationship with somebody, a friendship with somebody from another discipline did help, because if you’re sharing a room with somebody and then you come home at the end of the day, they tell you about everything that happened in their day. So, it does broaden your horizons in terms of just wanting to take their opinion into account sooner. [P8: X/D26]

Students also commented on the value of getting to know health professionals personally and how that enhanced their interprofessional holistic care.

> … I will now refer more easily because I got involved with the people and personally got to know them. [translated] [P7: X/M25]

**Different experiences**

Students had different experiences depending on (a) the phase of the project they were involved in, (b) the presence of other health professions at the site and (c) other interprofessional learning opportunities apart from the service-learning project.
Students were involved in different phases of the community-based parent support project and their perceived value of the project was largely influenced by the phase of the project and the activities they participated in. Students considered the administrative tasks (Phase 2) of developing assessment forms ineffective in providing an adequate understanding of the roles of other health professions.

It was nice to work with them. I feel that also, we only got about an hour to set up the forms, not really see the occupations in action. So, I still don’t really know that much. I mean, I know you need the multidisciplinary approach. I know that everyone’s important, but I didn’t actually get to see anyone working in their specific field. [P5: X/D2]

However, students who had the opportunity to do home visits (Phase 3) as part of an interprofessional team generally considered it valuable.

I liked the fact that before we went for our home visits, we all sat around the table and we discussed what our roles are going to be that day. So, we divided into groups and there were the different disciplines in each group. So, for example a dietetics student with a medical student, and when we went to the home visit, the dietetic student would then do the nutritional assessment. So, I actually got to see a little bit of what their role would be. [P5: X/MX]

The presence of other health professionals influenced the holistic interprofessional experience of students. Students on longer rotations had the opportunity of working with groups of other health professions who were on shorter rotations. On the contrary, students spending shorter periods at the site had less opportunities for collaborative, informal learning, e.g. through sharing a living space. A student on a two-week rotation commented:

I know when we were in the house and we had free time, we sat with the occupational therapy students and we actually discussed what their roles are, which was quite a learning experience. I learned a lot of different things, like for example that they have a role when it comes to patients with mental disabilities as well, which I didn’t know before. [P5: X/MX]

The planned community-based parent support programme was the key intended mechanism for the interprofessional service-learning experience. However, most medical students cited the in-depth case study, which included a home visit, as more significant in shaping their understanding of interprofessional holistic care.

I would say that our patient case study actually forced us to approach a patient differently and see all areas of their life and incorporate that into the management, because the different aspects will affect the long-term outcome of the patient… it sorts of forced [us] … how we should approach the patient and [that] we should look at all the areas. [P5: 51/M18]

Students returning from their rural clinical rotation to the tertiary hospital setting reported experiencing many barriers to implement an interprofessional holistic approach. The final FGDs highlighted differences between the majority of students who continued their clinical training in the tertiary hospital compared to a small number of students who selected to continue training at other rural training sites. The former students expressed no difference in their practice:

My approach to patients hasn’t changed since our rural rotation. It is difficult at the tertiary hospital, because you don’t look at the patient as a whole, which you are not supposed to do. [translated] [P 4: 20/M44]

Another student commented:

I think in that way my mindset has changed, and I would actually really like to treat patients in that way. I just don’t think right now [in the tertiary hospital], as a student, that it isn’t always possible to do so. [P10: 44/M15].

However, students who continued their training at a rural clinical site experienced that holistic patient management is more often observed:

… on the rural training platform when you are attending to a clinic, an interprofessional holistic approach to a patient is at the order of the day, quite the opposite than in the tertiary hospital. [translated] [P: X/M39].

There was agreement among students that their experience of the tertiary hospital setting is one of hostility toward interprofessional holistic care. Allied health professions are underminded or neglected to the detriment of patient well-being. Effective communication between different health professionals is lacking and holistic care is generally not well modeled by qualified health professionals. One of the students acknowledged that they were ignorant of the value of interprofessional holistic care until seeing it in action.

I think it’s actually very necessary, because I’ve only been in [the tertiary hospital] before, you don’t know how necessary it is until you’ve worked in other places and you see how well it works. [P16:105/M5]

Discussion

This interprofessional rural service-learning experience had a mixed influence on students’ perception and practice of interprofessional patient care. Some students had positive attitudes prior to the rural placement, some students’ perceptions were positively influenced by the rotation and other students seemed to have come and left with a neutral or even negative attitude toward IPCP. These findings are not unique and have also been reported by Furze et al. (2008).

Various factors influenced students prior to this rural placement and their experiences during the rotation were not consistent. However, even if all the students could be offered a very similar experience, the depth or extent of learning would have varied. Complexity theory proposes that learning is unpredictable and due to factors beyond our control, students may not always learn what we have planned or intended (Furze et al., 2008). Sargeant (2009, p. 179) notes that “health professionals attending the same educational event can see it through very different eyes, both individually and professionally.” She comments, “If and how individuals learn from that experience is influenced by their own worldview, values, and beliefs. Experience may trigger learning for some and not for others” (Sargeant, 2009, p. 182).

The findings suggest that students’ attitudes toward IPCP were influenced by their profession, with some professions showing less enthusiasm for IPCP than others. In a qualitative exploration of the processes that occur during
IPE, Reeves found that although students valued IPE experiences, their initial stereotypical ideas and sense of interprofessional hierarchy remained unchanged (Reeves, 2000). Professional identity and previous educational experiences affect the way in which students approach interprofessional collaboration (Curran et al., 2010; D’Amour & Oandasan, 2005; Oandasan & Reeves, 2005a).

Forte and Fowler (2009, p. 65) suggested that the perception of students – that discipline-specific learning should take precedence over interprofessional learning – can be due to either not having fully developed professional identity or being so deeply rooted in theirs that they “are unwilling to consider the perspectives of other professional groups”.

Clark (2006) emphasized that the powerful forces of socialization into individual professions, with their emphasis on autonomous practice and individual responsibility, take time and effort to be countered with the message of cooperation and collaboration. His suggested response is to expose students to a graded series of interprofessional experiences. Even though multiple IPCP experiences seem to be the reasonable solution, a study by Curran et al. (2010, p. 49) found that “student cohorts exposed to a greater number of interprofessional modules did not exhibit any significant attitudinal changes in comparison to student cohorts exposed to lesser levels of interprofessional learning.”

Sargeant (2009) quotes Allport, a social psychologist, who argues that contact is not enough to build collaboration among members from different disciplines. Therefore, students don’t only require more IPCP exposures, but they need help to recognize and explore the powerful impact of their own professional identity on their ability to learn and practice collaboratively (Sargeant, 2009). To help them “to see the world through the eyes of other professions, to be able to frame the patient’s problem and the potential solutions to it in the terms of understanding of other kinds of health care providers” (Clark, 2006, p. 578).

Factors that seemed to enhance effective interprofessional collaboration include an understanding of the necessity thereof for optimal patient care and constructive relationships with members of other professions (linked to an understanding of others’ roles and a breakdown of stereotypical ideas).

Students highlighted the value of experiences where there was a real person (patient/client) involved (e.g. home visit or case study), compared to tasks with no service users’ interaction (e.g. compiling assessment forms). This could be attributed to the experiential learning that occurs when students work with a real person. By placing the service user at the center of the team and focussing on providing person-centered care, the focus on one’s own profession and collaboration are enhanced. (Anderson & Lennox, 2009; Anderson & Thorpe, 2014; D’Amour & Oandasan, 2005; Sargeant, 2009)

Shared living space was raised by students as a factor that enhanced the discovery of other professions’ roles. This was also found in a study by McKinlay et al. (2016, p. 5), who noted the value of shared accommodation during interprofessional placements in addressing professional stereotypes and hierarchies. They stated that “when able to be arranged, living together in shared accommodation as an informal learning experience appears to enhance formal programmes through students participating in and socialising in everyday life activity.”

Clark (2006) described how the social aspects of learning follow real-world contexts in which knowledge is acquired in more informal ways that rely heavily on the everyday settings of work and family. In accordance with the social learning theory, Reeves’ study reiterates that students consider informal social meetings as “a central feature to building and maintaining constructive interprofessional relationships” (Reeves, 2000, p. 272).

In keeping with the emphasis on the social aspects of learning, our findings suggest that the students’ context had an influence on their ability to implement, develop and continue their interprofessional collaborative care. While attitude influences behavior and practice (Ruebling et al., 2014), a change in attitude is not enough to bring about lasting change, especially when students return to an environment that is largely hostile to the practice of IPECP. As Sargeant (2009, p. 179) contends, “individual workplace factors influence the ability to integrate new learning into practice”.

Curran et al. (2010) highlighted the social cognitivist theory that proposes how considerable human learning takes place in a social environment where knowledge, skills and attitudes are obtained through the observations of others. Given the lack of adequate role modeling in many of the settings where students return to for the continuation of their studies following the rural placement, it is no surprise that they were unable to further develop their much-needed skills in collaborative practice (D’Amour & Oandasan, 2005). However, it is encouraging to see how IPCP can flourish among students in an environment where this way of working is the norm, e.g. at a rural clinical school.

**Limitations**

The different disciplines were not represented equally which could have influenced the findings. The number of participants from each discipline was also not consistent throughout the different FGDs. For occupational therapy students, we have limited data of their attitudes and perceptions prior to their rural rotation. In contrast, medical students were well represented regarding pre-exposure perceptions, but we obtained limited data six months later regarding the change in attitude following the rural rotation. The findings represent the opinions of students who chose to participate in the FGDs, with students who may have felt negative about IPCP or the rotation itself possibly avoiding the post-exposure discussions. Initial and final FGDs were conducted with students from the same health profession while the FGDs directly after a rotation, were conducted in an interprofessional group. The data gathered during FGDs immediately afterward may have been influenced by the interprofessional group dynamics. Even though the composition of FGDs was logistically sensible, results may have been more comparable had all the FGDs been unprofessional or interprofessional instead of a combination of both (Darlow et al., 2016).
Conclusion
The effect of this interprofessional service-learning experience on students’ interprofessional person-centered practice was negatively influenced by the difference in the duration of their exposure and the unsynchronised nature of the placements. Longer, synchronized rotations on a decentralized platform will go a far way for health workforce training institutions to practically demonstrate social accountability and to enhance interprofessional community-based education.

A service-learning initiative based on various phases, where different rotations perform different parts of the project (e.g. situational analysis, planning, implementation, evaluation), seems a good idea. However, to optimally facilitate interprofessional learning students need to be part of the interaction with service users. Home visits and building trust relationships with service users in interprofessional groups are essential in planning a service-learning programme. If possible, a community programme could be complemented with interprofessional activities in other contexts, e.g. clinical exposure in a hospital. Taking “ownership” of a project or patient seems to motivate students, perhaps even more so than assessment. A common goal or sharing the same patients in a more holistic care mode has the potential to avert attention from each discipline’s own individual manner of approaching care.

The lack of interprofessional role-modeling in the students’ main learning environment (i.e. the academic hospital) appears to be a major contributor as to why the effect of this service-learning exposure was not sustained. However, students who opted to do their final year of study on a decentralized platform had the opportunity to continue applying what they had gained from the service-learning experience.

Attending to social learning theory by arranging shared accommodation for students on a distributive training platform and modeling interprofessional collaborative care could also have a positive effect on the outcomes of an interprofessional service-learning initiative.

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Declaration of interest
The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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