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MAKING A RURAL WORKFORCE: EXPLORING THE HABITUS OF HEALTH SCIENCES STUDENTS FROM RURAL SOUTH AFRICA

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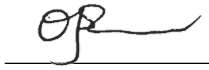
A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy in Public Health

Johannesburg, June 2022

Supervisors: Professor Lenore Manderson
Professor Steve Reid

DECLARATION

I, Nontsikelelo Olga Mapukata, declare that this thesis is my own, unaided work. It is being submitted for the degree of Doctor of Philosophy in Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.



(Signature of candidate) This 8th day of June, 2022 in Cape Town.

DEDICATION

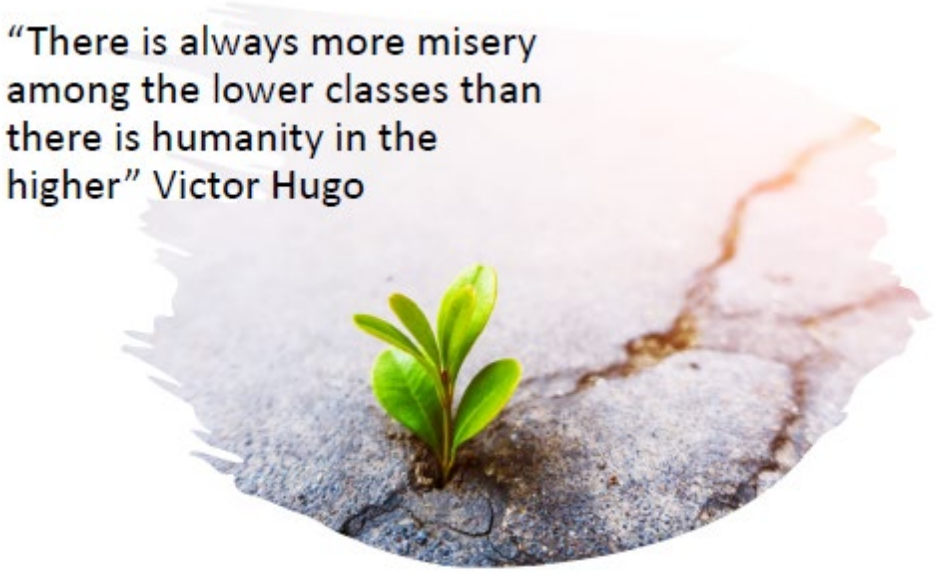
To my family, extended family, my daughter and all my children – thank you for your love, patience, sacrifice, and silent prayers - *nindithwele*, *ndiswele imilomo eliwaka*.

To friends and PhD warriors – I'm grateful for your support and fellowship.

To all my teachers and to all the teachers: lifelong learning is a journey of a thousand steps.

Kubo bonke abasaqamela ngengqiniba, imfundo yintsengwanekazi.

Never give up on your dreams.



PUBLICATIONS ARISING FROM THIS RESEARCH PROJECT

Mapukata, N., 2020. Embodiment of particular ways of being: Habitus as an autobiographical narrative. *Ubuntu: Journal of Conflict and Social Transformation 9* (1) 9-24

ABSTRACT

In South Africa, finding solutions to ensure sufficient, well-trained professionals to meet health challenges is a national imperative. The apartheid system had marked impact on schools and rural communities, influencing the abilities of students to thrive during their training and to continue to work as health professionals. Globally, a growing body of evidence attests to the benefits of recruiting students of rural origin to respond positively to human resource challenges to meet rural health needs. With a concerted effort to change the demographics of the student body in higher education institutions (HEI) in a post-apartheid era, following the Department of Education's 1997 mandate for HEI to transform, the number of Black students who enrol to study for higher degrees has increased to reflect the demographics of South Africa's population. Consequently, there has been an ongoing interest in exploring the habitus of students of rural origin.

Drawing on a social constructionist paradigm, using Bourdieu's framework, I sought to understand the relationship between habitus, capital, and the field, in order to explore the factors that influence the professionalisation of health sciences students. I employed purposive sampling to recruit participants who were registered at the University of Cape Town (UCT) as students in audiology, medicine, occupational therapy, physiotherapy, and speech-language pathology. Drawing on audio-recorded in-depth interviews and journal reflections, I examined the lived experiences of final year health sciences students (n=21) from rural South Africa.

Two-thirds of my participants were female, mostly from KwaZulu-Natal Province and the majority speaking isiZulu as their first language. Only four participants lived with both parents during their schooling years. Participants revealed diverse understandings of rurality of their own communities, as heterogenous, complex, dynamic and ambiguous. They offered new descriptors that provided evidence such as "no ATM" (Automated Teller Machine); "no CBD" (Central Business District); "no computers, no library, no internet, no YouTube, no Instagram, no internet café." The subjective and objective representations of rural spaces reflected the tensions of "living in two worlds at the same time," as they studied and lived in the metropolitan city in Cape Town. Participants contrasted the anonymity of the city with the closeness of rural settings; in Cape Town, they explained, people do not greet and acknowledge their presence.

Through this study, I present theory of practice as a relational multiprofessional framework. Participants had access to social capital generated from multidimensional sources

that included family, community, ancestors and church. The efforts of their families and teachers generated enough cultural capital to secure participants' place at UCT through a phenomenon of school hopping for 80% of the participants. Despite acquiring an educated habitus, as high achievers in matric, in their first year participants experienced a disrupted habitus. Muted by their rural English, they were misrecognized. Some started to isolate and disengaged and as they experienced failure for the first time, they were prone to mental health challenges.

As they progressed in their studies, at times supported by classmates and clinical partners, participants employed social and cultural capital to moderate institutional hierarchies and incidents of racism. Through a generative habitus, supported by academic clinicians and supervisors they experienced transformation in clinical spaces at five levels. Scrubs translated into "professional armour" and became a marker of their professional identity. Participants reported a shift from theory to practice; from standard patient encounters to an appreciation of a holistic and biopsychosocial approach necessary for patient management; a shift from being students to becoming health professionals managing patients under supervision. Lastly, participants experienced a shift in their approach to work, as primary health centres became spaces for multidisciplinary teamwork and facilitated reciprocal learning experiences as participants transformed social attributes into professional attributes. The challenges of being different provided opportunities for their habitus to constrict and expand to different aspects of the field as they generated academic capital.

By using a Bourdieusian lens and employing habitus as a theory and a methodological tool, I have generated insights about how students of rural origin negotiate difficult university spaces. Their rural upbringing, resilience and intrinsic motivation allowed participants to generate the kinds of capital that are desirable in health care professionals and accrued benefits for patients. Through this study, it has been possible to challenge the prevailing perception of deprivation that is often associated with rural areas. I highlight the inherent values and strengths of rural communities that have often been overlooked in previous studies.

Keywords: Bourdieu, habitus, health care professionals, health sciences students, relational multiprofessional framework, professional armour, rural origin.

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This work would not have been possible without the guidance and support of my supervisors – Professor Lenore Manderson and Professor Steve Reid. I am grateful for their wisdom and expertise. They held my hand as I navigated a series of stormy seasons and moments of disquiet. I am grateful for the hours spent in preparation for our weekly meetings, the constructive feedback, the lessons, and all the effort that brought me to the end stage.

I extend gratitude to my immediate line manager and the Head of Division of Public Health Medicine - Professor London, the Head of School - Professor Myer; my BP/BHP colleagues; my surrogate family in the Department of Family Medicine; and Ms. Marja Wren-Sargent (FHS librarian).

I will be forever grateful for the grant that was extended by UCT Faculty of Health Sciences as it affirmed me as an Emerging Researcher.

Thanks to Professor Ian Couper for sharing his vision for rural health and his facilitation of our commitment to the rural health project and to colleagues in the Centre for Rural Health. Gratitude is extended to WIRHE students and now practicing health care professionals in different parts of South Africa who were based at the University of the Witwatersrand, Sefako Makgatho Health Sciences University, and the University of Pretoria - they sowed the seeds for this study.

Finally, I owe much to the 2020 final year health sciences students of rural origin at the University of Cape Town. I am grateful for their insightful reflections and for trusting me with their personal life stories.

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Nangamso

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NOMENCLATURE

AUD	Audiology Therapy Student
CHWs	Community Health Workers
CS	Community Service
DoE	Department of Education
DoH	Department of Health
EC	Eastern Cape Province
FS	Free State Province
GP	Gauteng Province
HCPs	Health Care Professionals
HCWs	Health Care Workers
HEI	Higher Education Institution
HPCSA	Health Professions Council of South Africa
HRH	Human Resources for Health
HSS	Health Sciences Students
KZN	KwaZulu-Natal Province
LP	Limpopo Province
MED	Medical Student
NW	North West Province
OT	Occupational Therapy Student
PT	Physiotherapy Student
SA	South Africa
SLP	Speech-Language Pathology Therapy Student
STATS SA	Statistics South Africa
UCT	University of Cape Town
WC	Western Cape Province
WHO	World Health Organization
Wits	University of the Witwatersrand

CHAPTER 1: OVERVIEW OF THE STUDY

1. Introduction

The novel coronavirus (COVID-2019), which emerged in 2019 and spread to become a global pandemic, exacerbated entrenched health inequalities, and placed enormous burdens on frontline health care workers (Scheeners et al., 2020). In South Africa (SA), as argued by the Academy of Science of South Africa (ASSAf) Standing Committee on Health, COVID has compounded existing health inequalities and is likely to disrupt gains in the management of chronic conditions such as the Human Immmunodeficiency Virus (HIV) and Tuberculosis (TB) (Ataguba et al., 2020a). Despite the swift implementation of a preventative strategy by the government to contain transmission and to mitigate the effects of these measures, national lockdowns as a government-initiated response and subsequent delays in securing a vaccine disrupted economic activity and imposed untold burdens on the health system (Mbunge, 2020).

With South Africa operating as a two-tiered health care system, the private health care system is only available to about 17% of the population (Stats SA, 2017). A major challenge in providing health care is filling gaps in human resources, and health needs far exceed available capacity (R. Rensburg, personal communication, July 6, 2021). COVID-19 infections and mortality rates impacted health care workers in their role as frontline service providers along with other people nationwide, threatening what was already a fragile health care system with a shortage of health care workers (Wilson et al., 2009; Couper and Hugo, 2014; van Rensburg 2014; Scheffler and Tulenko, 2016; Ntuli and Maboya, 2017; Shisana et al., 2019) amid a global health crisis (Scheeners et al., 2020). Below, I expound on initiatives to develop a health workforce in the justification of this study. I begin with reflections on how I became interested in these initiatives, and then consider reflexivity in relation to this study.

1.2 Background

The stimulus for this research was a series of personal events and experiences. In a small rural town eDutywa in the Eastern Cape Province where I was born and raised, for the first eight years of my life, clinical officers undertook home visits. A few years later, in the 1980s, health care was presented as a facility-based model. In what was a mutually beneficial partnership, the school and

the clinic were an integral part of the community. The school was the voice of the clinic as health messages were announced during school assembly. Similarly, social events in the community provided opportunities for health promotion initiatives. These informed my earliest perceptions of health care in my community.

During my 18-month internship in the cytology laboratory in a tertiary facility in Cape Town, I came to value the role of language in the provision of health care. Besides fulfilling the requirements of my training programme, from time to time, in specialised clinics (breast, lung and thyroid cancer), I was asked to interpret for patients whose home language was IsiXhosa. I recall struggling to find words to describe the radiation treatment that was prescribed for one patient. A nurse, speaking to another patient who was in the clinic for her review, referred to radiation treatment as 'ironing'. Her explanation implied that the crinkled tissue would be ironed until it was as smooth as the top layer of the skin. Her tone made clear to the patient the discomfort they would experience when undergoing the treatment, and her explanation was accepted. In that context, I made two observations. First, one can never substitute the value of lived experience in understanding a patient's expectations and experiences of therapeutic encounters. Secondly, patient education in the patient's mother tongue mitigates language discordance between health care provider and the patient and is as critical as the treatment itself.

I was appointed as a health care provider in Umtata, Eastern Cape after I completed my training. Here, I realised that the resources of the small cytology laboratory could not match the capabilities of a cytology laboratory in Cape Town and the opportunity it would provide me to work as part of a multi-disciplinary team. For many of the patients who accessed primary and secondary health care at the Umtata General Hospital, the closest facility with oncology services was in East London – a 3-hour drive away. Several patients who needed to access oncology services were lost to follow up, as this required a second referral from their rural hometowns. Two patients I spoke to in the outpatient's department perceived the referral as abandonment, since the treatment facility was far from home and denied them access to family support. Even after they were counselled, they refused further treatment and chose to return home.

In 2005, I moved to the Division of Rural Health at the University of the Witwatersrand (Wits). Here I had space to explore some of these factors that influence access to care, particularly for citizens who resided in rural areas of South Africa. Health inequalities were partly due to the maldistribution of health care workers, with many graduates opting for urban rather than rural

placements. I worked closely with the Chair of Rural Health, Professor Ian Couper. His main responsibility was to find solutions to human resource challenges in Northwest and Mpumalanga Provinces, the two rural provinces selected by the Faculty of Health Sciences as training sites for Wits students. Among the proposals he tabled for discussion were initiatives that he referred to as "growing your own timber" or "adopting a pipeline approach." Wits accepted an initiative to adopt a pipeline approach, which informed many of the strategic plans developed to respond to the shortage of health care workers in rural and underserved areas.

This initiative included recruiting students of rural origin to study initially at Wits and later at the University of Pretoria and Sefako Makgatho University (SMU) (formerly Medunsa). In addition, all medical students in their 3rd and 4th years were exposed to a range of activities that included, as four-day visits over two years, an introduction to research at community level and participation in health promotion initiatives in rural high schools. In their final year as part of the integrated primary care block, medical students were based in primary health care facilities in Gauteng, Mpumalanga and North West Provinces in six-week rotations. As part of postgraduate training, registrars rotated in the same facilities as final year medical students. Staff training was introduced as a complementary programme for health care workers who were based in the facilities identified as Wits training sites. In an advocacy role, students who were part of the scholarship programme and others in the faculty participated in a rural careers day where they interacted with high school students and, in a peer facilitated approach, briefed the pupils about entry requirements for their own programmes.

I participated in many initiatives aimed at responding to human resource challenges in health. These included a scholarship initiative (Mapukata et al., 2017a), a curriculum mediated intervention (Mapukata et al., 2017b), and a social responsibility collaboration between Wits Centre for Rural Health, the Department of Health, and the Department of Basic Education in Northwest Province (Mapukata et al., 2017c). Collectively, these initiatives fed into the pipeline approach that was presented as a solution to prevailing human resources challenges. Yet, despite the implementation of a range of initiatives at Wits and other higher education institutions (HEI), as just described, inequitable access to health care and the maldistribution of the workforce in the rural areas, even in post-apartheid SA, remains a protracted struggle.

In the initiative aimed to recruit students of rural origin, I assumed responsibility for a programme whose main thrust was to facilitate the socialisation of these students into higher

education at Wits and the two other higher education institutions. For 12 years, in the course of my employment, I observed how students of rural origin engaged with institutional processes. Students faced exceptional difficulties acclimatising to the higher education environment at Wits and the University of Pretoria, where Black student enrolment had been prohibited or highly restricted under apartheid. Levels of discomfort were not as pronounced for the students based at SMU, a university that was reserved for Black students. This was reflected in their throughput rates, positive feedback about their university experience, and their firm commitment to return to their own communities to provide health care. In the first few years, I experienced levels of discomfort similar to those reported by students of rural origin at Wits and the University of Pretoria. My deliberations on the various experiences of these students during our quarterly meetings were the beginnings of this academic enquiry. The groups had a shared identity (rural origin). However, their clinical training took place in a range of contexts that were classified as urban, underserved, and rural as each university had its own training facilities.

As I was keen to explore the role of habitus and the contribution of context to identity making – fitting in, adaptation to new ways of doing and performing, and a sense of belonging – two broad questions came to mind. First, what aspects of habitus contributed to the discomfort reported by students of rural origin based in the historically white institutions? Secondly, what aspects of habitus informed the positive experiences of students of rural origin in the historically black institutions? Although the two questions above did not constitute the final research question, they informed the conceptual thinking about the aims and objectives of this study.

1.3 Reflexivity

In my essay "Embodiment of particular ways of being: Habitus as an autobiographical narrative" (Appendix B), I explored the forms of capital I had access to as I grew up in a rural village. Rural areas are difficult to define, given their fluidity during the apartheid era. Variable definitions tend to reflect population density or are policy derived, as was the case with the homeland system (Geldenhuys, 1981, p.22). Rural areas are conceptualised as having dense social networks through church, family and community gatherings; rural life is linked to living off the land, a pleasant climate, personal safety, hope for a better future, and perhaps social support from philanthropic organisations. In a case study about the Ndumo community in KwaZulu-Natal, Nell et al. (2015)

reported that these factors enhanced psycho-social well-being, generated contentment, and strengthened the ties of social capital for individuals and families in particular communities.

In my essay, I drew on personal memory, and using a narrative approach (see Smorti 2011), I described personal experiences that shaped my journey from the rural village of Idutywa in the former homeland of Transkei (Eastern Cape Province) to a higher education institution. In the social structures of which I was a part, I referred to my personal identity as fixed and continuously affirmed (2020, pp. 10-11). The description offered by Bourdieu of habitus as "society written into the body, into the biological individual" (1990a, p.63) reflects the intersectionality of social identities as performed and established practices of culture, and this applied to me as anyone else.

My shared identity with my study participants is as of rural origin. This is premised on the description offered by Bourdieu of habitus, as a set of social and cultural practices, values, and dispositions that are characterised by the ways social groups interact with their members (1986, p241). I described my grandmother, who introduced me to storytelling and was the matriarch in communicating and sustaining family values. I observed that child-rearing in our context was a duty that extended beyond the primary care giver to include the community with a shared value-based approach. Even an everyday greeting was more than ritual. It affirmed an understanding that the self is not separate from the world but is part of a network – hence a greeting acknowledges the other and extends respect.

In this essay, I refer to patriarchy as a form of social capital that is acquired through the learned dominance of men over women, perpetuated by attitudes, values and the culture of established institutions. I critiqued Bourdieu's three principles of the labour market as its orientation extended favour to men. Within my family context, daily activities were not aligned to gender roles. As this conflicted with standard community practice, it heightened my awareness of societal gender norms and how they are constructed in my community and more widely in South Africa (2020, pp 14-15).

In considering the acquisition of cultural capital described by Bourdieu as knowledge, skills, and behaviours transmitted to an individual within their sociocultural context through teaching (1986, p.241), I examined the role of the school as an integral part of the community. In my essay, I referred to the school as a "space to support community development, it was also a place for behaviour modification and thus a focal point for community activities" (2020, p.15). The school provided objective and structured learning. I referred to work published by Dumais

(2002) of the school as a place where we acquire linguistic and cultural competencies. This was possible in a continuum where social learning, as described by Lave and Wenger (1991), is first constructed at a community level through the games that we played and the social activities in which we participated.

Both my parents were educators. Even though we were based in a rural setting, there was an appreciation that our participation in school would extend beyond the local primary school. My parents invested in my sisters and me, accruing real knowledge and new ways of doing and performing as kinds of knowledge that could not be offered by our primary school. In the last section of my essay, I wrote specifically of the role of teachers in facilitating a transforming habitus and the benefits I had access to once I completed my studies. Bourdieu and Passeron argue that what is imposed on students through education "contributes towards reproducing the power relations" (1977, p. 31). Agbeyenga (2014) subsequently argued that the capital of the educator is relevant to the extent to which it generates incremental value for the student.

What I presented as a reflexive piece defined the role of context and a generative habitus where stones (as play tool sets and mathematical instruments) and books as disposable objects transformed into assets that were instrumental in facilitating the construction of a social, cultural, and symbolic capital and ultimately the attainment of economic capital. By embarking on this doctoral study entitled, *"*Making a rural workforce: Exploring the habitus of health sciences students from rural South Africa*",* I wanted to understand habitus and how it is constituted in students of rural origin. I also wanted to understand its role, if any, in the making of a rural workforce. In the research on which this thesis is based, I explored this with health sciences students at the University of Cape Town (UCT).

1.4. Defining Habitus

As already mentioned, this research is framed around habitus as norms, values, attitudes, and behaviours. Habitus is considered a social property of individuals, which guides their thinking and actions, and orients human behaviour (Lingard et al., 2015). The term habitus was initially conceptualised by Aristotle to provide an ethical framework for a moral behaviour and a virtuous character (Sachs, 2002). To that end, the Aristotelian habitus is informed by Greek moral values, and is not something one acquires as a temporary skill. Instead, according to Mozumder (2020),

habitus is the quality that is embedded deep into one's core self and cannot be altered easily. This argument is relevant only insofar as primary habitus is concerned, deriving from acts and behaviours bestowed by family. For example, the act of curtsying and bowing before a figure of authority such as the chief, schoolteacher, hospital matron or a priest is a tradition that should be observed by all. It is therefore the responsibility of parents (families) and teachers (coaches and others) to ensure that anyone who presents before these figures of authority extends that respect. Similar observances are expected across different structures within families, in schools and in churches. Stephens (2013) argues that the level of embeddedness of such habits requires that you must act against it consciously if you wish to lose it. Within families, this is often perceived as an act of defiance, although it may also be as a result of coming into your own when you opt for a different set of values. Of concern, is the militancy with which this type of habitus is enforced, especially to those lower in hierarchies, such as the expectation that children should not look adults in the eye. This reinforces a hierarchy in which adults have authority over children.

French sociologist Pierre Bourdieu linked habitus to social context, defining it as "the product of history, capable of producing individual and collective practices." Further to the stated historical context, it is presented in multiple forms:

> It is deposited in each organism (individual) in the form of schemes of perception, thought, and action, tend to guarantee the 'correctness' of practices and their constancy over time, more reliably than all formal rules and explicit norms. (Bourdieu, 1990a, p. 54).

Adams (2006) described these phenomena as unconscious formations where one is programmed to act without thinking, but also reveal shared cultural commonalities. Simply put, habitus is by Bourdieu as "that which we do as second nature, the way we are" (1990a, 56). Bourdieu also defined habitus as "a structuring structure, which organises practices and the perception of practices" (1984, p.170), and functional, as "integrating past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions" (1977, p.95). Considering the tensions that arise with reference to a habitus as a structuring structure, Bourdieu justifies the subjectivity and objectivity as a "dialectical relation" (1988, p. 782), culminating in an understanding that habitus is fluid in structure and in function unless it is contextualised.

Bourdieu acknowledged that habitus is not only a principle but also a theory of practice and action. These contradictory approaches offered by Bourdieu in his description of habitus are

described by Nash (1990) as 'interesting', as he also observed that there were limitations (1990, p. 434). In that regard, Nash argues that Bourdieu's presentation of habitus as a concept should be presented as a theory of socialisation. Wacquant on the other hand offers a more structured description of habitus "as the way in which society becomes deposited in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them" (2005, p.316). Wacquant observes that earlier forms of identification are framed by a family/parental perspective. In that regard, Abrams and Hogg define one's personal identity as "people's concepts of who they are, of what sort of people they are, and how they relate to others" (1999, p.4). The identity is thus drawn from one's parents, siblings, grandparents, and extended family. As described by Power, habitus is not only the product but also the reproducer of structures, i.e., it generates practices that correspond to the social conditions that produced it (1999, p.49). Demonstrating the interplay between habitus and identity practices, Webb et al. (2002) argue that the embodied dispositions of an ethnic group are not creations of their own doing and may vary between durable or transposable forms across different times and places in their lives. I reported on this durability of transposable dispositions as I referred to an observed culture of reading that was inculcated subconsciously as one of my family values (Mapukata, 2020, p.19).

Navarro (2006) in his description of habitus assumes a community perspective, as he refers to socialised norms and forms of thinking. These are not derived from individual processes, and while they are enduring and transferable from one context to another, they are also capable of shifting in relation to specific contexts over a period (Navarro, 2006, p.16). This description of one's social identity is reported by Jenkins as "ways in which individuals and collectivities are distinguished in their social relations with other individuals and collectivities" (1992, p.4). In that regard, habitus, in Navarro's description, produces community capital for individuals.

Habitus is capable of altering one's value system and influencing everyday choices and ways of being, unless these are grounded in sound cultural practice (Bourdieu, 1990a). Bourdieu refers to cultural capital as informational capital; Jenkins (1992) refers to cultural capital as legitimate knowledge of one kind or another. Bourdieu (1986) identified three potential sources of cultural capital as the embodied state (language, taste, style, disposition, social grace); objective state (books, cultural goods and works of art); and institutionalised state (credentials, education, qualifications) (pp. 82-84). Social capital is described by Bourdieu and Wacquant (1992) as the

"sum of resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (p.19).

According to Bhandari and Yasunobu (2009), social capital is considered a multidimensional phenomenon that contributes to economic and social development and can be sourced through institutions that foster cooperation and collective actions for mutual benefit. It can be accessed as structural and cognitive bonds that link to people vertically or horizontally, based on a sense of common identity ("people like us") – such as family, close friends and people who share our culture or ethnicity. Secondly, they are bridges that stretch beyond a shared sense of identity and can be used to enable collaborations with colleagues and associates. Thirdly, they are linkages to people or groups through which one can establish networks further up or lower down the social ladder (Edgerton and Roberts, 2014). Economic capital is immediately convertible into money and is institutionalised as property rights and other resources such as home-reared animals and housing structures.

The field is described by Bourdieu as a social space and may be autonomous or semi-autonomous. It is a place that enables formal and informal interactions and events. The field can exist as a department within a school, a faculty or as a place where cultural capital is generated and is governed by a set of rules. These determine boundaries or a form of power that Bourdieu (1984) referred to as *doxa* – a combination of both orthodox and heterodox norms and beliefs – the unstated, taken-for-granted assumptions or 'common sense' behind the distinctions we make with regards to a specific environment (1984, p.417). Fields are organised around specific forms of capital or combinations of capital, which according to Thompson 'are both the process within, and product, of a field' (2008, p.69). Similarly, Navarro (2006) describes the field as a network, structure or set of relationships which may be social, cultural, religious, intellectual, and educational (2006, p.18).

In this study, the field is the Faculty of Health Sciences at UCT, made up of a structured system of social relations between the Department of Higher Education and the Department of Health. Actors include lecturers; clinical educators, registrars and consultants; curriculum designers; demonstrators, patients; students; and administrators as agents (see Hunter, 2004). The practice is an outcome of the relationship between an individual's habitus and different forms of capital. 'The practice' is thus considered to be 'the product of a habitus that is itself the product

of the embodiment of the immanent regularities and tendencies of the world' (Bourdieu & Wacquant, 1992, p. 138). Both the actors and agents in the field perform to produce actions that generate cultural capital for registered students. In that regard, UCT provides for both academic capital and scientific capital.

Cultural capital can also be a source of inequality. As parents (families) are the first teachers, they determine the forms of capital that their children have access to, and their efforts in turn determine if the child accumulates more or less social capital. The school as a mediator and a generator of social capital can also contribute to inequality as presented in the framework on cycle of reproduction (Harker, 1984). Harker, who critiqued some of Bourdieu's work and examined the role of habitus in the production of education, similarly defines habitus as the way a culture is embodied in an individual (1984, p.118).

Rurality is derived from an individual's primary habitus that is engrained by acts, rituals and performances observed during childhood. This social context affords an individual access to social, cultural, economic and symbolic forms of capital (Bourdieu, 1986, p. 242). According to Power, this primary habitus tends to be more durable than secondary habitus that may be learned later - as one assumes a professional role (1999, p.49). As habitus is not fixed and is not considered a permanent concept (according to Navarro, 2006), examining an individual's life history is critical in understanding habitus.

1.5 Developing a Rural Health Workforce

In response to the problems which I referred in the introduction about rural health services and the rural health workforces globally, the World Health Organization (WHO) developed guidelines for the transformative scaling up of health professionals' education, to ensure sustainable expansion, and to include reforms in the training so that outcomes are goal-oriented (WHO, 2013). In enforcing the transformative scaling of health profession education, the World Health Organization issued the directive below to universities:

> Educational institutions must implement reforms that allow them to recruit from the communities they serve, teach to the local disease burden, and educate students to practice within the care delivery models that are likely to best serve the local population health needs (2013, p. 13).

This directive was relevant in South Africa. Prior to the implementation of a democratic state in 1994, South Africa had a two-tiered education system such that access to higher education institutions was stratified along racial lines, consistent with the policies of the apartheid regime (de Wet and Wolhuter, 2009). From 1994 the strategic framework of the governing party, the African National Congress (ANC), focused on identifying interventions and levers necessary for higher education to be transformed (DoE, 1997). The mandate to higher education institutions (HEI) was "to redress past inequality and transform the higher education system to serve a new social order to meet pressing national needs and to respond to new realities and opportunities" (DoE, 1997, p.1).

The goals of the policy framework included value creation and all stakeholders were required to contribute to the development of knowledge and capacity, cultural enrichment, and the development of a global citizenry (DoE, 1997, p.23). Educational approaches to be followed had to advance the interests and rights of individuals, irrespective of race, religion or creed. With this shift in the policy framework, there was a concerted effort to change the demographics of the student body in HEI, with a recommendation that 50 per cent of all admissions be Black and Coloured students (DoE, 1997). Subsequently, flowing from the DoE policy, during a Department of Health (DoH) National Health Summit, a directive was issued for all medical schools to accept a diverse group of students (Lehmann et al. 2001). This was intended to facilitate learning outcomes congruent with the place and to operate in an environment that enabled democratic citizenship (Moore, 2005), in line with earlier recommendations issued by WHO in 2000 in a report on challenges and opportunities for partnership in health development. The DoE subsequently advised HEI to adopt curricula that focused on reforms to benefit communities (Couper et al., 2007; Kent and de Villiers, 2007). This was in response to the call by the WHO for a shift from health service orientation that was overly biomedical, disease focused, technology driven, and doctor dominated, to promote people-centred health care (WHO, 2007).

In 1995, Boelen and Heck, public health specialists at the World Health Organization, argued that medical schools would be judged by their commitment to graduate socially accountable health care professionals able to respond to evolving health challenges. The WHO described social accountability as stated below:

> The obligation of medical schools to direct education, research and service activities towards addressing the priority health concerns of the community, region or nation that

> they are mandated to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public (1995, p.3).

In line with the aspirations of the global community, a Global Consensus on Social Accountability (GCSA) initiative was established to identify the desirable scope of work required for medical schools to have a greater impact on health system performance and on peoples' health status. Subsequently, in October 2010, in a meeting held in East London (South Africa), a team of international experts joined delegates from medical educational and accrediting bodies around the world and agreed on a 10-item consensus document that would provide strategic direction for the implementation of social accountability in medical schools (Boelen and Woollard, 2011). Priority areas out of the ten articulated by the GCSA community, of interest to this study, were identified as an understanding of social context, an identification of health challenges and needs, and the creation of relationships between the university and its communities, in order to act efficiently (Boelen and Woollard, 2011).

In 2011, Kwizwera and Iputo in their capacity as Professors at Walter Sisulu University, the only medical school considered to have successfully implemented social accountability in South Africa, reported that only a few universities across Africa had kept up with the pedagogical global shift in medical education. Following the establishment of the GCSA forum, in a paper published from a PhD study on the same topic, Green-Thompson and colleagues (2017) conceded to an understanding of social accountability as grounded in academia and central agencies, although they also defined a role for communities.

Having considered all global health challenges, Frenk and colleagues (2010) predicted that in an interdependent world, medical education would continue to face major challenges in making a health workforce. In South Africa, push factors such as infrastructure challenges, resources, and skills shortages are described by Mlambo and Adetiba (2017) and Rispel and colleagues (2018) as some of the causes of brain drain of the country's health professionals, including health sciences educators. Health professionals have migrated in significant numbers to countries with better working conditions, feeding into the pull factors that are associated with globalization. Other factors associated with workplace push factors, particularly of specialist physicians, have been cited by Labonte et al. (2015) as corruption, a high burden of HIV and drug resistant TB, government economic policies, government health sector policies, and concerns about personal and family safety or the children's future.

Earlier, Phillip Tobias (1983) had argued that no matter what scale of policy redress was employed, the rules of engagement had ramifications for people who were Black or Coloured at primary, secondary, and tertiary educational levels, and the ills of the past would have a lasting impact. He maintained that medical education in Southern Africa would have a 30-year training deficit as an outcome of apartheid policies. Despite Tobias's prediction, the number of Black students admitted in HEI has increased to reflect the demographics of South Africa's population following the 2001 policy directive that required HEI to prioritise the representation of previously marginalized groups of Black people and women (CHE, 2013).

Lehmann (2001), on the other hand, advanced that in a university, students of rural origin are often marginalized by historical discourse and personal circumstances, and sometimes by the context in HEI (see also Janse van Rensburg, 2011; Czerniewicz and Brown, 2014; Pather and Chetty, 2015). In their high schools, mathematics and physics may have been taught by teachers who could compensate for limitations imposed by a rural context such as lacking access to laboratories and libraries. Although these students gain access to a university if they meet the entry requirements, this does not guarantee immediate access to academic capital if their experience of the university context is disorientating. These defining characteristics described by Lehmann (2001) i.e., personal circumstances, historical discourse, and context, are central to understanding the making of a rural workforce.

1.6 Problem Statement

In a university setting, Bourdieu saw habitus as a formative influence on how students from different social classes might engage with the education system (1990, p.116). This in turn would predict their subsequent levels of educational and ultimately occupational and socioeconomic attainment. In that regard, a university provides for both academic capital and scientific capital as it is defined as an institutionalised form of cultural capital based on entry requirements that must be met to gain access to a university (Bourdieu, 1988). These include prior educational achievement (in South Africa, matric certificate with exemptions) as well as specially designated competencies that justify access to particular programmes (e.g., a good pass in mathematics and physics as prerequisites to register for degrees offered by faculties of health sciences).

In view of the prevailing challenges flagged by Tobias (1983) and Lehmann et al. (2001), even with directed efforts to increase the number of rural students registering for programmes offered by faculties of health sciences and medical schools in South Africa, either through a quota system or through adjusted entry requirements (Tumbo et al., 2009; van Schalkwyk et al., 2014; Ross et al., 2015; Mapukata et al., 2017a), rural students remain under-represented in health sciences (van der Merwe et al., 2016; Mapukata et al., 2017b). This is based on a range of barriers and challenges I alluded to earlier, beyond the control of students, that are reported to contribute to low throughput rates for these students (Wilson et al., 2009; Janse van Rensburg, 2011; Essop 2020).

Despite improved access to HEI, as universities continue to mirror societal norms (Mnguni, 2016) as reported by students during the #FeesMustFall student unrest (Langa, 2017), white students are more likely than their African counterparts to succeed and complete (Essop, 2020), as the culture in HEI is considered alienating for Black students (Heleta, 2016). This hampers efforts to increase the number of health care professionals, particularly those willing to work in rural areas (Rose and Janse van Rensburg-Bonthuyzen, 2015; Econex, 2015). Consequently, among researchers, there has been a corresponding interest in exploring the habitus of previously disadvantaged students as one approach to respond to existing human resources challenges in South Africa. In this study, my intention is to explore the habitus of health sciences students of rural origin, with the aim of generating data to inform strategies and approaches to be considered in the making of a rural workforce.

1.7 Justifying and Contextualising the Study

Internationally, several interventions have been proposed and implemented to develop a rural workforce by targeting high school students from under-represented, underprivileged, and remote communities (e.g., Lawson et al., 2007; Rabinowitz et al., 2005; Pong and Heng, 2005; Kumar et al., 2015). These include a three-pronged strategy as a framework that was adopted by five countries – Sweden, Norway, Canada, Iceland, and Scotland – to ensure a stable rural and remote workforce. The collaborators agreed on a plan to ensure that the population's needs were periodically assessed to ensure that the right service model was in place, and that the right recruits were targeted and retained. Activities were conducted to support team cohesion, train current and

future professionals for rural and remote health careers and assure the attractiveness of these careers (Abelsen et al., 2020). In Australia, three universities - the University of Newcastle, the University of Western Australia and James Cook University - were tasked with the responsibility of training Indigenous doctors to respond to the needs of Aboriginal people. The Indigenous students were required to host road shows, visit schools and participate in Career Expo, in similar fashion to the initiatives implemented at Wits (Lawson et al., 2007).

Locally, interventions to develop a rural workforce have ranged from a broad policy framework instituted by the South African Government (DoE, 1997) to an implementation process, directed by universities (Lehmann et al., 2001) and guided by the Health Professions Council of South Africa (HPCSA Criteria and Guidelines for Accreditors, 2010). As a recommendation towards building a rural workforce, Ross and Couper (2004) suggested a pipeline approach, as I have noted above (see also Tumbo et al., 2009). De Vries and Reid (2003) confirmed that students of rural origin were more likely to return to their communities to practice compared to their urban colleagues. They advanced two sets of recommendations to universities when selecting applicants: prioritising applicants of rural origin and assessing career aspirations particularly for those who indicate that they are likely to choose general practice. The second recommendation is rather tricky to manage, however, as prospective applicants are likely to prioritise general practice if this guarantees their admission to a highly contested medical programme.

Transformation, as an institutional process I alluded to as a policy initiative, is central to rural health workforce development (Lehmann et al., 2001; Couper, 2003; Couper et al., 2007; Tumbo et al., 2009). For example, the Wits Initiative for Rural Health Education (WIRHE) at Wits was established in 2003 as a faculty-initiated policy response (Mapukata et al., 2017a), well before debates on the decolonisation of higher education. In response to the shortage of health care workers in rural areas, WIRHE was premised on an understanding that health sciences students of rural origin are most likely to return to and practice in their own communities (De Vreis and Reid, 2003; Wilson et al., 2009). At Wits, WIRHE students registered for professional degrees offered by the Faculty of Health Sciences, with the intention of joining the public sector as health care professionals (HCPs) or health care workers (HCWs).

In this study conducted at UCT, health sciences students are enrolled in audiology, medicine, occupational therapy, physiotherapy and the speech-language pathology programmes. Elsewhere, health sciences might include nursing, medical technologists, orthotics and prosthetics,

dentistry and other programmes offered by faculties of health sciences at particular institutions. Students of rural origin are defined as having been born and who grew up in rural areas of South Africa, where 32.6% of the population is based (World Bank, 2020). These areas rarely have the same resources as urban areas. At a community level, running water and electricity may be available only intermittently or not at all. Libraries, laboratories, and computers are rare even in contemporary schools.

Established as an international learning exchange model, in 1997, the Nelson Mandela/Fidel Castro Medical Collaboration Programme was established with the view to address the shortage of health care workers in rural areas, improve workforce capacity and strengthen the health care system. This partnership is between South Africa's ruling party – the African National Congress – and the Government of Cuba. To date more than 800 students from rural South Africa have trained in medical universities in Cuba (Donda et al., 2016), returned to South Africa, and following an 18-month placement in a South African medical school, are ready to practice. Two years later, the Umthombo Youth Development Foundation (UYDF) scholarship programme was established in KwaZulu-Natal to benefit students who wished to register for professional degrees in health sciences offered by universities and universities of technology (Ross et al., 2015). WIRHE was modelled on the UYDF, and both WIRHE and UYDF were presented as transformative models for training health sciences students of rural origin. However, despite the successful implementation of these initiatives, the aggregate number of health care professionals has not been sufficient to address the ongoing shortage of health care workers (Econex, 2015; Ross et al., 2015).

1.8 Conceptual Framework

In this study, I draw on the social constructivist theory of Pierre Bourdieu (1984) in relation to reproduction in education. The application of Bourdieu's framework is relevant as it provides an approach to examining the complexities of difference. This framework has been used by others to report on changes in education practice, in policy, and in relation to a changing demographic profile of students in higher education institutions, such as with students of rural origin or working-class students (Reay, 2004; Bathmaker, 2015; Czerniewicz and Brown, 2014; Pather and Chetty, 2015; Gennrich, 2015). The framework allows for a range of factors to be explored to explain how

students become (or not) health professionals (Figure 1). These factors include examining habitus, the field (the university) and different stakeholders in the field, and the inter-relationship between power and knowledge in the construction of institutional habitus (1Bourdieu, 1984, p.19). In this study, I examined the relationship between rural origin and rural education in relation to its impact on performance in the field and in practice.

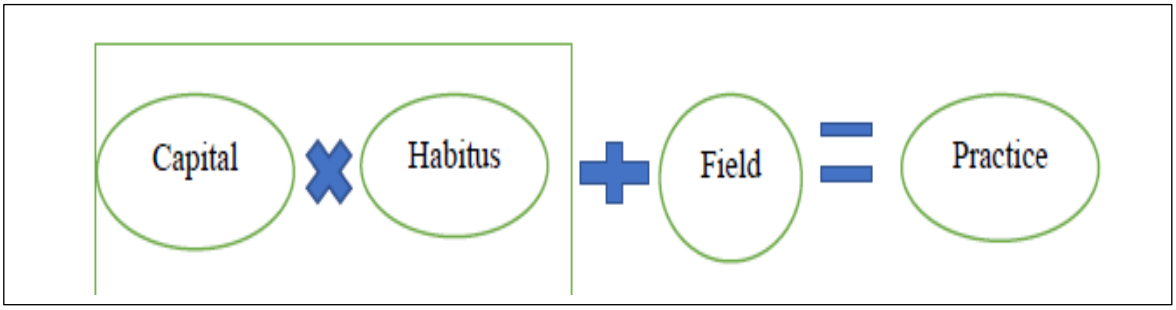


Figure 1: Conceptual framework (Bourdieu, 1984)

The core elements in Bourdieu's framework are habitus, the different forms of capital, and the field, described earlier (see 1.4) as an institution or workplace and practice. As the goal of this study is to understand the role of habitus in the professionalisation of students of rural origin, I examine different forms of habitus in context (Adom et al., 2018). In an individual, primary habitus is informed by gender, social class, culture, ethnicity, and family (Meisenhelder, 2000). In South Africa, it is not possible to overlook the historical dimension, including a two-tiered education system. Thus race (and racism) and schooling constitute experiences in the formative years (Larey, 2018) and beyond. Through habitus, individuals accrue social, cultural, symbolic, and economic capital (Bourdieu, 1994, p.179).

Habitus provides for the interplay of socialisation, experience, and professional practice (Light and Evans, 2011). In that regard, Bourdieu is of the view that through the mechanics of habitus, in the long-term, the practice of the profession is linked to cultural and economic capital, both of which derive from the activities of a university and from professional and inter-professional networks. Consequently, becoming and being an audiology therapist, medical doctor, occupational therapist, physiotherapist, or speech-language pathology therapist, are derived from the knowledge, skills, attitudes, and behaviours that, as cultural capital, accrue during a person's time as a student as well as subsequently during their professional practice.

In his book, *Logic for Practice* (1990a), Bourdieu argues that all habitus produces action. In measuring an individual's commitment to succeed, one must consider that secondary habitus becomes active in relation to a field. For students in a faculty of health sciences, the degree that one is registered for provides the qualities and attributes that faculty and associated professionals wish to reproduce in their students as practitioners (Warde, 2004). It informs their day-to-day interactions with patients, colleagues (including interprofessional partnerships such as doctors vs nurses or doctors vs rehabilitation therapists, where hierarchies are reproduced) and members of the public. On the other hand, the university, although it is essential and is considered a component of the conceptual framework, does not play a substantive role in the same way that the construction of the habits and lasting dispositions are informed by family influences (Harker, 1984, p.118).

The cultural capital that is accrued is derived and determined by the context (Warde, 2004). For example, an understanding that stealing is an inappropriate behaviour is an internalised value (and so a habit) that is (ideally) instilled early in life. The university, as it limits itself to teaching on content specific knowledge and skills as related to a particular profession or area of learning, may approach the same topic as plagiarism as a punishable offence or as cheating from a licensing perspective as standards that must be met by health sciences students and registered practitioners. The field on the other hand is most likely to generate symbolic capital in the form of certificates and awards.

If one considers habitus as a fluid concept, the same habitus within a group can lead to very different practices and attitudes depending on implicit and explicit influences in the field (Bourdieu, 1990b, p.116). In a university, the culture of an institution greatly influences the type of practitioner one becomes – UCT, for example, has an established track record for producing scholars in the practice of medicine, some of whom are recognised as global leaders. That is not necessarily true for all UCT graduates, and not all graduates practice in ways congruent with the values of the institution. In HEI, power and privilege are inherent to the historical discourse and despite a changed framework that focuses on transformation and equity, institutional culture and epistemological traditions have remained Eurocentric according to Heleta (2016); these are reproduced in existing structures. Costa et al. (2019) consider that one of the drawcards of exploring the lived experiences of health science students is the opportunity this provides to examine everyday relational modes of being. These provide a space to explore the interplay between power and privilege (2019, p.20).

Bourdieu's framework is criticised for downplaying the role of agency which is best explained through critical realism - a philosophical framework that is the brainchild of Roy Bhaskar. In his seminal work, *A Realist Theory of Science*, Bhaskar (1975) argued that the Western World is real, complex, and structured. Bhaskar's framework focused on three domains of sociological ontology – ontological realism, epistemological relativism, and judgemental rationality (see also Reid, 2019). His work gained traction in Archer's writings (1982) as she argued that critical realism as a framework extends value to agency as the driver of reproduction and transformation of social structures. Whilst Archer is concerned with morphogenesis of social structures and reflexivity that is derived from a participant's capacity and capability, Bourdieu is concerned about reproduction in education and a transforming habitus in the field. As critical realism is a manifestation of the interplay between structure, culture, and agency (Archer, 1982), in this study, I employed Bourdieu's framework so I can examine the interplay between socialisation, experience, and professional practice for a defined group of students.

1.8.1 Study Aims and Objectives

Against this background, I considered the question in this study to be:

How does habitus influence the professionalisation of health sciences students of rural origin?

Habitus allows for the construction of biographies, and hence I considered a qualitative research design as an appropriate methodology. The research was conducted in the natural environment, with attention to the socio-cultural context of students across a range of programmes in the Faculty of Health Sciences at UCT. The empirical enquiry employed a collective case study design as several phenomena could be studied sequentially to generate a broader appreciation of how habitus influences professionalisation (Crowe et al., 2011) similar to an approach adopted in a doctoral thesis by Hashimoto (2020). Through in-depth interviews and journal reflections, I expected to gain insight into how participants acted in situated contexts (Thomson et al., 2002), the details of which I describe in Chapter 3 of this thesis. The broad aims of the study were to:

- Describe the lived experiences of students of rural origin, and
- Determine the influences of the learning environment as rural origin students adapt to become health care professionals.

I considered the profile of students from rural South Africa, the transition from rural school to university, and explored students' experiences of training to become health care professionals. Thus, the objectives for this study were:

1. To describe and analyse student experiences of their transition from home to school to university.
2. To determine the role of a university in student continuation and explore the coping strategies of health sciences students while at university.
3. To describe and analyse the experience and professionalisation of the students as they become health care professionals.
4. To describe and analyse different forms of capital and how they produce habitus for students of rural origin.

1.8.2 Assumptions

Beyond the interpretation and analysis of qualitative data generated from interviews and journal reflections, in this study, I examine social and cultural attributes of a habitus of students of rural background and the effect of their interactions in everyday experiences on the process of becoming and being health professionals. While developing a testable hypothesis is considered a central construct in quantitative research, in qualitative research (Chigbu, 2019), with a focus on answering the research question using inductive reasoning, a hypothesis generating approach is preferred. Chigbu (2019) describes this as presenting a process that is much more than a tool to restate and clarify the problem under investigation. It is also attributive, that is, meant to describe a scenario, situation, or event; is associative, that is, meant to predict an outcome; and causal, that is, meant to create an understanding of relationships (2019; p.10). Accordingly, assumptions should be made explicit (Nkwake, 2013) and the number of assumptions presented should be sufficient to describe the lived experiences of study participants.

I have noted that the chronic shortage of health care workers in the rural areas in South Africa (SA) has resulted in poor health outcomes for citizens in rural communities (Wilson et al., 2009, Veld & Van De Voorde, 2014; Mulaudzi et al., 2016.; Shisana et al., 2019). Health sciences students of rural origin, although they are under-represented and are marginalised by context, are more likely to practice as rural practitioners. However, the defining characteristics of their habitus

and its influence on their professionalisation is yet to be established. Accordingly, I offer the following as proposition statements:

1. Social capital creates cumulative value for health sciences students of rural origin.
2. Cultural capital facilitates adaptive capacity in health sciences students of rural origin.
3. Health sciences students are likely to experience a disrupted habitus as they generate power in the field.
4. Habitus of health sciences students of rural origin has generative capacity to facilitate transformation from non-professional to professional spaces.

1.9 Structure of the Thesis

In the first two chapters of this thesis, I present my conceptual approach to the study, and provide a review of available literature. In chapter three, I focus on the methodology of the study. Chapters four, five and six are the central results chapters, presenting the findings from in-depth interviews and journal reflections as empirical material interpreted in light of the objective structures of habitus and their generative capabilities. In chapter seven, I discuss these findings and summarise the thesis. Below is the outline of each chapter.

As an orientation to this thesis, in chapter one, I discuss the stimulus for this research. I reflect on the historical context and its influence on several national policies in higher education and examine initiatives in HEI that respond to the human resources challenges. As I draw on a Bourdieusian framework, the aims, objectives, and the research design are all intended to facilitate an examination of a habitus of health sciences students of rural origin at the University of Cape Town.

In chapter two, I present the literature relevant to this study. I prioritise rural origin of study participants and explore the ambiguity that is associated with the terms rural and rurality, focusing on rural areas as places and spaces that generate habitus for students of rural origin. I discuss Bourdieu's concept of habitus and consider how others have studied habitus and its influence on access to health. I consider the historical context to health services and note the challenges to building and maintaining a rural workforce. I examine a range of policies and programmes on redress in South Africa and those adopted in countries such as Australia and Canada on initiatives they implemented that focus on rural education, recruitment, and retention of health care workers

for rural areas and access to higher education institutions. In analysing this literature, I paid attention to the interplay between socialisation, experience, and professional practice.

Using a qualitative methodology to operationalise habitus, in chapter three, I employ a collective case design to generate deep conversations with final year students of rural origin. The study included two phases. In relation to the first objective, informed by in-depth interviews in phase one of the study, in chapter four, I present the findings from a qualitative exploration of rural and rurality by health sciences students as I examine their transition from school to university. In relation to the second objective in chapter five, I describe the role of the university in the continuation of students and students' coping strategies. In the second phase, participants submitted journal reflections about their experiences in the clinical environment. I examine journal reflections in context in relation to the third objective, and in chapter six, I describe and analyse the participants' experiences of professionalisation. I provide a detailed description of the approaches I applied in sampling techniques, population identification, data collection methods, data analysis, trustworthiness of data, ethical considerations, and limitations of the study.

In analysing the findings, in chapter seven, the study outcomes in chapters four, five and six are linked to the work of others. In chapter eight, I describe and analyse different forms of capital by repopulating the conceptual framework with study-specific variables as these inform future research. For this study, opportunities for future research, and ways to continue to address the challenges to rural health, are also discussed.

1.10 Summary

In this chapter, I have described the stimulus for this study as I reflected on the prevailing challenges in providing equitable health care in the rural areas of South African in a context of a global pandemic. I have noted efforts by higher education institutions to provide solutions to prevailing human resources challenges and elaborate on this in the following chapter. I outlined the value in approaching this study as a reflective practitioner and considered reflexivity. I presented a problem statement, aims and objectives of the study and justification for undertaking this research using a Bourdieusian framework. I shared limitations and my assumptions about possible outcomes. In the next chapter, I review the related literature.

CHAPTER 2: LITERATURE REVIEW

In response to the research question of how habitus influences the professionalisation of health sciences students, I have divided this chapter into three sections. I first explore rural and rurality and assess its impact on health outcomes. I then examine the habitus of students of rural origin and lastly, I review existing policies on recruitment and retention of a health workforce.

2.1 Rural, Rurality and Access to Health

In an earlier discussion in Chapter 1, I referred to the stimulus for this study as guided by events and personal experiences and social learning, situated in context as an outcome of extended interactions with others both within and outside of my family structure. Within that social structure, my clan name is a tracer of my genealogy as it relates family history to my place in the ancestry registry (Mapukata, 2020). This is the tracer of the durability of habitus that is embedded in memory as an embodied form of knowledge. Conferring this allegiance defines the relationship of homology as an ingrained link to family and family structures. However, when viewed from a population registry, rural origin as a space I share with my participants is ill-defined. Consensus among policy makers, researchers, and communities is that there is no single definition for rural despite this being a fundamental necessity (Murray et al., 2004; Reid, 2019; Rasheed, 2020; Nelson et al., 2021). Green and Colbert (2013) argued that ruralities is only the plural form of rural. These authors favour the adoption of the plural form as it facilitates a shift from reductionist views about all things rural. I consider this variability below.

2.1.1 Rurality: A Place and a Space

The concept of rurality as a place and a space is central to Bourdieu's work and locating the place of origin of the participants is a critical undertaking in this study. Bourdieu (2000) describes physical space as the place based on the mutual externality of parts as amenities that exist in one's environment, such as the role one assumes as an individual who is part of a community. In the absence of a uniform definition of rural (Gaede and Vesteeg, 2011), policy makers in South Africa have conceded to discipline-specific working descriptions that apply to all contexts (Reid, 2019;

Mngomezulu and Mngomezulu, 2020). Such definitions have tended to reflect population density or are policy derived, often from a service perspective. For example, the Department of Rural Development and Land Reform (DRDLR) in SA limits rural areas to "sparsely populated areas in which people farm or depend on natural resources, including the villages and small towns that are dispersed through these areas. In addition, they include the large settlements in former homelands, created by the apartheid removals, which depend for their survival on migratory labour and remittances" (DRDLR, 2007:1). In a 2012 report, the Human Sciences Research Council (HSRC) described rural areas in the Eastern Cape Province from a deficit perspective as places that did not have ready access to ordinary public services such as water and sanitation. Rural areas were also seen to lack a formalised local authority to direct the provision of such services.

A range of indices to describe rural, remote and urban areas including postal codes apply in developed countries such as Canada (Olatunde et al., 2007), United States (Hart et al., 2005), England and Wales (Cloke, 1977), and Australia (Murray et al., 2004). In South Africa, postal codes do not carry much value except for the purpose of mail sorting. Prior to 1994, postal codes were aligned to the geographical classification of provinces where the country was divided into four regions, namely: Northern, Eastern, Central and Southern. This has since been reclassified into nine provinces. In a study that dates back four decades, Beaton and Bourne (1980) used postal codes in monitoring the distribution of doctors across South Africa by tracking their physical addresses. What was significant then and is still relevant, was the maldistribution of doctors as allocation favoured urban metropolitan areas (76,5%) in what the authors described as urban hierarchies. These hierarchies are still in place; for example, Ntuli and Mabuya (2017) established an inter-provincial maldistribution of the workforce in two of the five districts that had features of urban districts in Mpumalanga Province.

2.1.2 Rurality: As Social Space

Bourdieu (2000) defines rurality as a social space (or field) based on the mutual exclusion (or distinction) of positions which constitute it, that is, as a structure of juxtaposition of social positions. Rurality is sometimes presented as a range of externalities of parts comprising of demographic, geographic and cultural features, thus requiring a multi-focal lens (Roberts and Greene, 2013; Chigbu, 2013; Hlalele, 2012). In Australia, Veitch (2009) refers to rural, rurality

and remoteness as terms that are used interchangeably to include additional elements such as sparse population distribution, isolation, primary industry economic base, and physically constructed or built environments that are most likely to expose residents to unique hazards. This view is shared by Balfour et al. (2008), who also frame rurality from a deficit model and extend Veitch's (2009) description to include a range of held views about rurality that apply to the South African context: "community, poverty, disease, neglect, backwardness, marginalisation, depopulation, conservatism, racism, resettlement, corruption, entropy, and exclusion" (p.101).

In such social spaces, students exist as human beings and social agents, have agency, and may have a role based on privileges to which they have access, or which they lack. According to Haimes (2003), the multitude of places that are occupied by students define their status, class, social position and determine their place within society as individuals and as a community. For example, even a student who has limited cultural and social capital may be promoted to a place of privilege in a university once they assume a new position, for example as the chairperson of the Health Sciences Students Council or when they become a class representative. In instances where they participate in health promotion activities at community level, some members of the community may see them as experts depending on how they communicate a health message or how they respond to the community's concerns. In that regard, the social space is an invisible set of relationships derived from various social groupings, including class groupings. According to Halfacree (1993), the space is constituted by a set of shared experiences, meanings and symbols but also contains diverse and contradictory elements (p.38) and thus confers a sense of community. To that end, Bourdieu (1996) argues that physical and social space have a lot of things in common, which implies that all the distinct aspects of the physical space are reproduced in the social space (p.96). In the next few paragraphs, I explore the social representation of rurality.

This interface between the place and the space is highly valued with regards to rurality as the socio-spatial characteristics, attitudes, and behaviours are best framed by one's identity as derived from a social construct. In such contexts, several researchers have acknowledged the plurality of views and ambiguity that is associated with rurality as a place where diversity, tradition and cultural practice exist side by side (Hlalele, 2014), and a place that brings together people who have a common ancestry and heritage (Hlalele, 2012; Chigbu, 2013). In addition to this description, Rasheed (2020) referred to observable qualities and complexities about rural places that include evolving cultural, demographic, environmental, geographic, and social variances

(p.64). In a first world country like Switzerland, where the focus is on modernity, Lindley et al. (2015) described rurality as a place with poor connectivity, less innovation in subsistence activities such as farming, and a place that has zero public exercise and a poor savings culture. This is in sharp contrast with the experiences of people in rural South Africa where walking is the order of the day due to lack of affordable and reliable transport. Although arguably financial literacy levels are low (Tshabalala, 2019), a savings culture in rural South Africa is structured around stokvels, burial societies and village banks. Stokvels and burial societies are also spaces for social interaction - the meetings are much more than a discussion about bank balances, profit, or loss. This view is supported by Ndofirepi and Masineri who present rurality as constituted by a range of dynamic, complex and heterogenous communities (2020, p.245). Others have extended this understanding to rurality that is derived from socially constructed phenomena (Halfacree, 1993; Woods, 2009).

Considered from Creswell's view of place as a means of "seeing, knowing, and understanding of the world" (2004, p. 11), the place becomes a marker of one's social class, gender, religious identity and capability. Within a particular community, Budge (2005) identified six habits that confer a sense of place and a sense of belonging to an individual, thus confirming the conception of one's identity from a social construct. These are "connectedness, development of identity culture, interdependence with the land, spirituality, ideology and politics, and activism and engagement" (Budge, 2005, p.5). In a study by Nell et al. (2015), similar habits contributed to enhanced psychosocial well-being and contentment for the people of Ndumo community in KwaZulu-Natal.

The challenges in defining rurality extend also to limitations in research and scholarship. Reflecting on "the two-ness of a rural life and ends of rural scholarship," Bell (2007) speaks of a disconnect between sociologists, economists, geographers, and anthropologists such that, even in the United States of America, defining rurality is layered (p.403). On the other hand, Edwards and Matarrita-Cascante (2011) acknowledge that there are challenges in operationalising the concept of rurality in empirical research. In a paper published in 2011, Nkambule and colleagues addressed this challenge prompted by the paucity of research that explored discourses underpinning rurality and rural education. The authors presented three frameworks of postgraduate research that were undertaken at Higher Education Institutions in South Africa. These comprised of dissertations and theses that explored rurality as a lived experience focusing on rurality and rural education issues

(42%), rurality as context (35%); and social issues related to rurality and rural education (22%). A significant finding was that most of the research was conducted by Black African students. This suggested that postgraduate students were pursuing research in areas related to their own backgrounds and lived experiences. This observation complements my goals as a researcher.

In this section, there were no differences in what is reported about descriptive ambiguity and the heterogeneity of rurality, whether communities were based in developed or developing countries. As I have demonstrated that rurality is a fluid concept, a gap in this literature is that views of health sciences students were not solicited in any of the studies. Bennett et al. (2019) are of the view that it is a responsibility of the researcher to clearly define how rurality is operationalised in their work. I cover this in the next section as I review the literature on rurality and its impact on accessing health care.

2.1.3 Rurality and Access to Health Care

Following my earlier assertions about rurality as both place and space, the social context becomes a critical variable in understanding and formulating interventions for improved health outcomes of citizens who reside in rural communities and in addressing disparities between urban and rural communities (Harvey, 2010). This is largely attributed to the migration patterns that tend to favour urban areas (George et al. 2019; Jose et al., 2020). As such, rurality has become a proxy for health inequities due to a heterogenous profile of rural communities such that Couper (2003) cautioned against reducing rural communities to just "non-urban" areas (see also Mngomezulu and Mngomezulu 2020). Likewise, Dunbabin and Levitt (2007) observed that diverse demographic profiles were most likely to impact health outcomes. In a series of cases, I examine this interplay between context and health outcomes. In a study that compared health outcomes in urban and rural[1] places of residence in Canada and Australia (Lagace et al., 2007), heterogeneity in the geographical classification of rural areas between the two countries resulted in methodological challenges and notable differences in the risk profile and health outcomes. The challenges and

[1] In Australia and in Canada places that are classified as rural areas are inclusive of several categories that include and extend beyond rural, remote and very remote areas. Any reference to rural people in this study extends priority to Indigenous people who present with similar profiles to people from rural South Africa (see Veitch, 2009).

variations were attributable to differences in the utilization of the WHO recommended medical classification instrument – the International Classification of Diseases and Related Health Problems code, 10th version (ICD -10). Whereas health outcomes were found to be poorer across disease profiles whether citizens were based in rural Australia or rural Canada, cancer mortality risk was lower in rural Canada compared to Australia. Whilst rural men in Australia had a higher risk of incurring diabetes, there were no notable differences between urban and rural citizens in Canada for the same condition. The risk of having motor vehicle accidents (MVAs) was reportedly higher in Australia due to poor roads and long distances, whilst in Canada MVAs were attributable to weather conditions. In addition to the MVAs, Australia had a high incidence of suicides, a point I will come back to later.

In contrast, in South Africa, besides weather conditions and poor roads in some areas, MVAs are attributable to attitudes and behaviours (drunk driving, ignoring road signage, unlicensed drivers). With a high trauma incident rate and a corresponding burden of care, there is evidence of South Africans as high consumers of alcohol and binge drinkers according to the 2018 WHO global status report on alcohol and health (WHO, 2019). The global and political mandate to restrict alcohol sales during the first few weeks following the announcement of COVID-19 as a global pandemic reportedly had positive outcomes for a rural district hospital in George in the Western Cape Province (Reuter et al., 2020). Based on a review of hospital records in the Emergency Department, Reuter et al. (2020) reported a significant reduction in trauma cases and related contact crimes (rapes and assaults).

This undoubtedly brought relief throughout South Africa's health system. Based on a reported 5% increase in sexual offences between October–December 2020 (Themba, 2021), particularly in some districts in two rural provinces in KwaZulu-Natal and the Eastern Cape, this relief was short-lived. Along with high alcohol consumption, owing to a high incidence of rape cases, as confirmed in a national study by Machisa et al. (2017) where 46% of sexual offence complainants were children, a rape culture was reported to be thriving in South Africa's schools (Paterson, 2017). According to a survey conducted by Stats SA (2019), contact crimes are higher amongst less educated compared to people with secondary education. In addition, there is inherent vulnerability to sexual assaults among women and children (Abrahams et al., 2020) who reside in poverty-stricken communities with poor infrastructure and lower levels of education. This supports the reported 5% increase in sexual offences in the latter part of 2020 (Themba, 2021).

Consequently, in South Africa, Gender Based Violence (Dlamini, 2021) is considered a twin pandemic to COVID-19 but also a health outcome as a result of other social determinants.

With an understanding of the impact of health care access inequity (Gaede and Versteeg, 2011) as an imbalance between need, demand and supply, in a descriptive study in the USA, Butler et al. (2013) developed a social deprivation index (SDI) that was associated with health care access and four health outcomes within a rational area of primary care service. In their study, they employed a range of variables that included poverty, being Black, less than 12 years of schooling, single parent households, and single occupant households, complemented by the Townsend Deprivation Index (1988). They extracted information from the American Census to identify the additional four variables that include households without a car, unemployment in the 18–64 age group, overcrowded households and living in rented households. They reported a positive relationship between SDI, poor access and poor health outcomes, providing a multidimensional measure of deprivation including geographical location. Based on their findings, they observed that health care outcome measures were influenced by changes in SDI variables.

The location and the Townsend Deprivation Index were the two common denominators for poor health outcomes. Based on their formula, even with variable definitions of rurality, one would expect a similar outcome for South Africa's rural areas. In South Africa, Scott et al. (2017) conducted a study in the Western Cape. They employed a social-determinant approach whereby social determinants of health (SDH) were defined as the conditions in the environments where people are born, live, learn, work, play, worship, and age, as broad strokes that apply to any community irrespective of its profile. Tackling the issue of obesity as a public health concern, the authors reported on a range of factors that influence consumption patterns. These included the substitution of breast milk with fortified formula that was reported to have a high sugar content. Carbonated drinks were reported to be the third most consumed food/drink item among very young urban South African children (aged 12–24 months). The authors concluded that a social determinants approach should be adopted at national level and used as an analytical lens to understand population- and community-level factors.

With the Western Cape identified as the least rural province in South Africa (Atkinson, 2014), a rather different picture might emerge if the same study were rolled out nationally. Concerned about the early consumption of sugar-sweetened beverages, Audain et al. (2019) observed that the consumption patterns of sugary drinks in rural South Africa among children and

adolescents had extended to sub-Saharan Africa. As a result, a high incidence of childhood obesity and prevalence of Type-2 diabetes in this age group (Audain et al., 2019) is attributed to lack of nutritional knowledge, poor policy regulation, rapid urbanization and shifting traditional diets in favour of globalised foods, due to a range of marketing techniques that target young people. As presented by Myers et al. (2017), food-consumption patterns are not singularly enacted events but are rather a combination of local material, economic (local and global) and sociocultural factors (Lagace et al. 2007), if we consider rurality and its variability in context.

In view of the above, in a 2018 study assessing changes in SDH inequalities in SA, Omotoso and Koch identified the socio-economic inequalities among those living in the Eastern Cape and KwaZulu-Natal Provinces as one of the greatest challenges to public health in South Africa. These are two of the most populous rural provinces in South Africa (Stats SA, 2021). Omotoso and Koch (2018) considered socio-economic inequalities to corresponding ill-health inequalities over the studied periods (see also May, 1998).

Evaluating poor uptake of Human Papillomavirus (HPV) vaccine, in a rural community in Georgia in the USA, Thomas et al. (2014) concluded that people's perception of risk to develop cancer was influenced by religion and spirituality, confirming the links between culture and spirituality intimated by Budge (2005). Additionally, their level of trust in the health care system was largely shaped by the cultural construct and people's health belief model, as shown by Mburu and George (2017) in a study that evaluated challenges faced by HCWs in a rural facility in KwaZulu-Natal. Similarly, economic standing of the family and geographic distribution of health services were factors that had to be considered in evaluating access to health care. Thomas and colleagues (2014) concluded that a triad of rural health disparities, namely local culture, lack of economic opportunity, and geographic location, are unique to each community and likely perpetuate health disparities.

Locally, using data from the National Income Dynamics Study, racial disparities in accessing health care and geographic distances were reported to hinder access to health care in a study by McLaren et al. (2014), based on geographical distance to nearest health facility. In their findings, 14% of Black African adults who reside more than five kilometres from the nearest health facility, consult less frequently, and are least likely to access health care from private providers compared to only 4% of whites. Respondents from the poorest income communities lived furthest from the nearest health facility and were most likely to present with patterns similar to those found

in Australia, with regards to risk factors for cancers and chronic conditions (Lagarde et al., 2013) due to late presentation and limited access to health care. In addition, empirically, Kabudula et al. (2017) established a correlation between socioeconomic status of an individual and an increased burden of mortality from communicable diseases such as tuberculosis and HIV/AIDS. This was reported in a longitudinal study that analysed data collected over a 10-year period in the Agincourt area, Mpumalanga Province (Kabudula et al., 2017)

Interlinkages between environment, attitudes and behaviour, and health and well-being, were reported in Australia by Veitch (2009). He presented a physical environment that is derived from natural elements such as the weather patterns that range from hot and dry, through tropical, temperate, to cold and wet sub-polar. In such settings, the sun is appreciated for its properties in the production of vitamin D but is problematic because of its potential to contribute to storms and damage to property, heat strokes and increased risk of skin cancers. The inverse relationship between the physical and the built environment is, according to Veitch (2009), responsible for secondary harms and poor health outcomes linked to one's socio-economic status, attitudes, behaviours, and a rural culture that is risk tolerant. Failure to produce crops due to damages following a tropical storm or bush fire may lead to depression, alcohol abuse and ultimately an increase in suicide rates (Lagarde et al. 2007). Similarly, the pressure to generate produce forced farmers to use chemicals and other fortified products that may be harmful to the physical environment. Consequently, Veitch (2009) presented three elements that shape health (environmental determinants of health) and well-being in rural areas: access to and availability of health services; behaviour that includes beliefs and attitudes to health; and context in which rural people live and work (p.18).

In South Africa, the use of Dichlorodiphenyltrichloroethane (DDT) in Limpopo Province as a pesticide to control malaria presents similar dilemmas to the benefits and harms associated with sun exposure in Australia in determining the three elements that shape health and well-being in a rural area. In a cross-sectional study with eligible males residing in malaria endemic areas where DDT is used annually, de Jager et al. (2012) analysed semen of 209 males. Sperm analysis showed no evidence of a compromised quality due to exposure to DDT although they reported a weak association between DDT and DDE (degradation product) and the incidence of sperm with chromatin defects. However, in an earlier study, a physical examination of 330 newborns reported an increased risk of urogenital birth defects in males born to stay-at-home mothers who resided in

highly endemic areas (Bornman et al., 2010). Consequently, in a follow up study that assessed knowledge, perceptions, and practice attitudes by vector-control personnel (Hlongwana et al., 2013), staff concerns about harmful effects of DDT and its impact on the reproductive system were more pronounced despite the fact that the incidence of malaria was much reduced - effectively confirming a reduction in severe morbidity and mortality. Earlier findings about the increased incidence of urogenital birth defects became ingrained as cultural knowledge, justifying Veitch's (2009) recommendation that ideas of health must consider context in which rural people live and work along with their attitudes and behaviours.

Recognising the variable health outcomes in rural communities, Muula (2007) suggested that in profiling rural communities, one could draw on a range of indicators, but also placed emphasis on a curriculum that focuses on introducing medical students to rural and community medicine. This is supported by Corbett (2007) who defined a role for rural communities as a place to introduce students to interdisciplinary and multidisciplinary teaching. On the other hand, Humphrey (2008) not only confirmed that there was no natural classification for rural areas in Australia, he also conceded that there was no need for a theoretical framework. This he based on the mosaic complexity that is associated with geographic, socio-demographic, and environmental characteristics of rural areas as elements that often impede health planning and resource allocation.

However, within a rural health care context, the uniqueness of rural communities should extend beyond individual factors to include demographic, educational and social factors (Rabinowitz,1997). Two decades later, in a paper that explores a framework to guide an approach to teaching, research and the practice of rural health, Reid (2019) proposed an approach using critical realism that focuses on the rural determinants of health as a theoretical framework to balance the empirical evidence of lived experiences of residents in rural communities. It may be prudent in South Africa to consider Reid's recommendation along with Veitch (2009) such that the rural determinants of health include the environment. Although rural culture is diverse, it can generate knowledge for and about community which can inform the provision of health care. It is a place to learn about measures of rurality, disease profile, and diverse populations (Corbett 2007, Balfour et al., 2008) and is thus an academic setting (Mapukata, 2020). Based on findings from the studies I have reviewed, rurality, however defined, and the socioeconomic status of individuals, contributed to increased burdens and perpetuated harms and thus, poor health outcomes. Although the literature review provided an understanding of rural and rurality based on the views of

researchers, scholars and policy makers, the many perspectives of rurality only address the origin of rural students in its variable forms. It was not possible to explore their cultural identity. In the next section, I examine the habitus of students of rural origin.

2.2 Habitus of Rural Students

In Chapter 1, I presented a habitus that is central to Bourdieu's theoretical framework and is a meaning-making structure that generates from one's social environment. I described the different forms of capital and the field as it relates to this study. The purpose of this literature review is to examine the habitus of students of rural origin as one approach to respond to existing human resources challenges in South Africa. I approach the chapter in three ways. I refer to social reproduction theory and employ two cases to explore the interplay between socialisation and experience in the construction of cultural capital. I examine the process of formulating a transforming habitus.

2.2.1 Rural Origin in South Africa: A Familial Habitus

The cycle of reproduction (Harker, 1984) predicts that children of rural origin, born into difficult social circumstances, will continue to have a difficult life compared with children from less disadvantaged backgrounds; their habitus will not generate the kind of capital that guarantees their success. In that regard, I make two inferences based on Harker's work. The first one is that parents, including extended families[2] as the first teachers, determine the forms of capital that their children have access to, and their efforts in turn determine if the child accumulates more or less social capital. This is informed by the forms of access to social, economic, and symbolic capital that their parents have. For example, the child of a Tribal Chief or Traditional Healer may have access to a lot more cultural capital than the child of the local schoolteacher. This also depends on how the

[2] In South Africa, family is constituted in variable forms – previously an outcome of the migrant labour system –more recently though – before the roll out of HIV/AIDS treatments – with the loss of breadwinners, the government had to extend the understanding of family to include child-headed households.

family is constructed. The children of a Tribal Chief are more likely to attend private schools for security reasons and in preparing them to take over the leadership role from their parents. Taking into account the correlation between reproductive structure of social class and the objective relations among social classes, Farid et al. (2021) considered that from the three sources of cultural capital, it is the parents who determine the language that will be spoken by their children. They determine whether their children will be monolingual, bilingual, or multilingual[3], their taste and style of books to access and read, whether they will be exposed to art or not, the qualifications they will have access to and their standard of education (Figure 2).

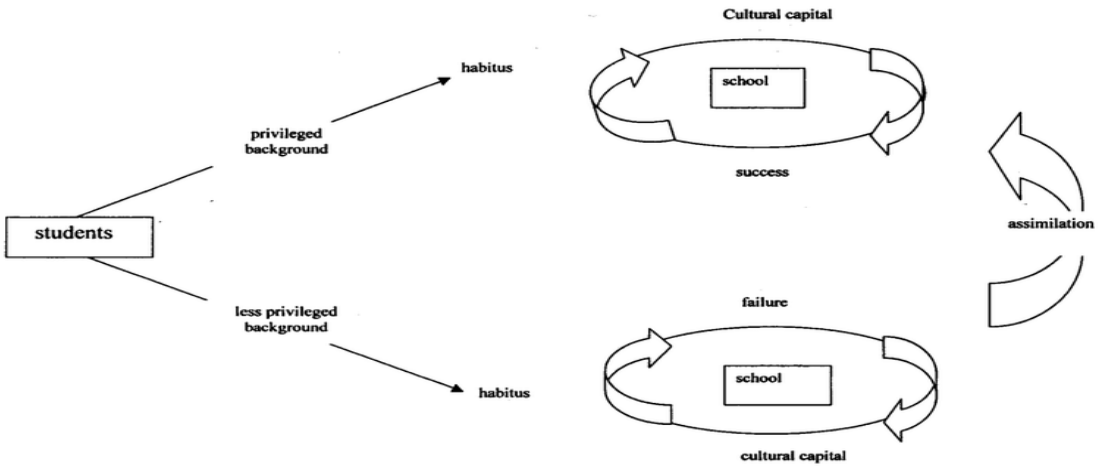


Figure 2: Harker's cycle of reproduction

Equally, as my second point, the school as a mediator and a generator of social capital is described by Bourdieu (2004) as "objective structures, independent of consciousness and the will of these agents, which are capable of guiding or coercing their practices and representations" (p.249). It also contributes to inequality as presented in the framework on cycle of reproduction (Harker, 1984) and Bourdieu's Social Theory of Reproduction (Bourdieu and Passeron, 1979). I elaborate on this in the discussion that follows.

[3] In a country with 11 official languages, a multilinguist is not always proficient in English.

2.2.2 The School: An Educated Habitus

Social reproduction is the way in which society reproduces itself and its systems in education, in demographics, and other forms of entitlements. According to Bourdieu, it is a social process through which culture is reproduced across generations, especially through the socialising influence of major institutions (Bourdieu and Passeron, 1979). This has informed Social Reproduction Theory (SRT), as Bourdieu asserts that schools are not institutions of equal opportunity but mechanisms for perpetuating social inequalities. In education, schools are associated with capitalism's tendencies and thus inequities, with Bourdieu referring to schools as a conservative force in the perpetuation of scholastics and cultural inequalities (Bourdieu and Passeron, 1979). In the literature, there is evidence of an interplay between social class, cultural capital and academic achievement as reported by DiMaggio and Mohr (1985); Crook (1997); Dumais (2002) and Cheadle (2008), whilst others have rejected habitus as abstract and unquantifiable (Sullivan, 2002; Van der Werfhorst, 2010; Edgerton and Roberts, 2014). In the next few paragraphs, I offer insights about the application of SRT in rural schools in South Africa.

Based on historical contexts and resultant disparities between races, inequality has persisted in South Africa such that the education system is reportedly in crisis (van der Bergh 2007; Fleisch, 2008), widening the gap in the academic achievement of learners between those of lower socioeconomic status and those of higher status (Ogbonnaya and Awuah, 2019). With only 21.3% of South Africa's public schools having a school library and average teaching time documented at 16 hours compared to the standard 41 hours (Letseka, 2014), it is not surprising that South Africa has been underperforming since 2006 (Howie et al., 2017) and recording low readings in comprehension in three cycles of the Progress in International Reading Literacy Study (PIRLS). Even in the local Annual National Assessment (ANA), the average performance of grade three and grade six pupils in literacy and numeracy skills was consistently below the desired standard (Howie et al, 2012). Responding to documented disparities as an outcome of the racialised and segregated system during apartheid and thus a separate education system, the Department of Basic Education (DBE) in South Africa sought to level the playing field by introducing the National Education Policy Act No.27 of 1996. With no improvement in the quality of education outcomes in rural schools, in January 2018, the DBE gazetted the Rural Education Policy with the

aim to improve access to education and improve quality of education in rural schools (No. 41399, p.14).

Subsequently, the DBE published a set of three indicators or filters to determine a category of public schools that would meet the criteria to be classified as rural schools. These include location of the school, socio and economic deprivation, and access to resources. It also includes multi-deprivation indices such as living environment, health, education, crime, and social order domains as they apply to rural provinces such as the Eastern Cape, Limpopo, North West and KwaZulu-Natal. Such schools are classified as lower Quintile 1-3 non-fee-paying schools as determined by the National Norms and Standards for School Funding (DoE, 1998). Most of the Quintile 1 schools (Table 2.3) are based in the Eastern Cape and Limpopo Provinces.

Table 2.1: National Quintile Ranking 2018

	National quintiles					
	1 (poorest)	2	3	4	5 (least poor)	Total
Eastern Cape	34.8%	21.6%	21.0%	11.6%	10.9%	100%
Free State	30.8%	14.9%	20.1%	18.8%	15.4%	100%
Gauteng	10.5%	11.4%	27.4%	27.2%	23.6%	100%
KwaZulu-Natal	24.2%	18.8%	25.6%	17.3%	14.1%	100%
Limpopo	34.0%	22.3%	24.9%	11.6%	7.2%	100%
Mpumalanga	16.7%	20.2%	29.8%	19.9%	13.5%	100%
Northern Cape	26.3%	17.7%	21.6%	14.8%	19.6%	100%
North West	22.7%	15.2%	30.5%	20.5%	11.0%	100%
Western Cape	6.5%	8.0%	23.1%	27.7%	34.6%	100%
South Africa	20.0%	20.0%	20.0%	20.0%	20.0%	100%

On the other hand, the economically active provinces, namely: the Western Cape and Gauteng, have the greatest number of Quintile 5 schools and the fewest Quintile 1 schools.

Case 1

Although access to education is guaranteed and was established to be a priority according to the National Education Policy Act No.27 of 1996 4(a), implementation is not always paired with outcomes. Even when most barriers to entry are removed, inequities have persisted such that in 2014, in Limpopo Province, a 5-year-old grade zero pupil fell to his death in a pit latrine toilet. Four years later in 2018, following the introduction of the Rural Education policy, a similar incident with another child of the same age was reported in the Eastern Cape Province (Veriava, 2018). Considering that these are two of South Africa's most rural and populous provinces, Veriava et al. (2017) refer to these experiences as part of an ongoing struggle as "access to safe schools that offer quality education continues to elude most learners (2017, p.3) perpetuating this dichotomy of the "have and the have nots" (Hlalele, 2014; Finn and Kobayash, 2020).

A commitment by the Department of Basic Education in section 4 (b) of Act No.27 of 1996, to "enable the education system to contribute to the full personal development of each student, and to the moral, social, cultural, political and economic development of the nation at large, including the advancement of democracy, human rights and the peaceful resolution of disputes," was not adequate to cover the needs of these two learners: their lived reality tells a different story. Their families were unemployed or poorly employed, had lower levels of education, and relied on the school to facilitate the acquisition of cultural capital. At their tender age (five years), it would not have been possible for the two pupils to negotiate access to a safe environment. Even if they were uncomfortable about relieving themselves in the pit latrines, the scope of their language was limited (Harker, 1984). This experience warrants the call by Veitch (2009) to extend the definition of rural areas to include physical and built environments.

Lareau and Weininger (2003) argue that habitus and cultural capital are central mechanisms to the general theory of social reproduction. In this case, two issues present a challenge. Typically, working-class families do not have the capacity to support their children either because of their low levels of education or work commitments. Lareau and Weininger (2003) refer to this phenomenon as the laissez-faire approach – a parenting style of working-class families that assumes working-class parents take no interest in the education of their children. This ignores the economic deprivation that is associated with working-class families. For example, within the South African context, a mother may leave her children with extended family members whilst she takes on full time employment as a domestic worker for a suburban family. In such instances the income she

provides to the family is highly valued as it sustains the family's livelihood. Secondly, in her book *Unequal Childhoods*, Lareau (2002) observed that in the absence of social capital, working class families tend to hand over decision making to schools. This affirms Bourdieu's (1984; 1986) and Harker's (1984) arguments that families and the school system both perpetuate the reproduction of social and cultural inequalities. Whilst this is true for the reasons I cited above, the actions of the parents should not be perceived as child abandonment as they may have delegated responsibility to others (see also Hall and Sambu, 2018).

Case 2

In the second case, in 2012, in Eastern Cape Province, the Department of Basic Education (DBE) failed to deliver on the Triple T's of learning - textbooks, teachers, and time - such that the DBE was in breach of the basic right to education, prompting a response from Section 27[4] to respond to an emerging teacher crisis (Veriava, 2014). If not for the intervention by Section 27, the cycle of reproduction predestined the learners to an uneducated habitus and lack of social capital (Bourdieu and Passerson, 1977). On its own, the intervention by Section 27 does not guarantee success if the teachers are not effective and if the textbooks are not delivered on time or instances where a learner is dyslexic and there are no diagnostic tools at school level. The intervention by Section 27 was not directed to an individual but to multitudes of learners in several rural schools.

In illustrating the impact of the school on learner's propensity to accumulate social capital, quantitatively, using Bloom's taxonomy as the conceptual framework, Ogbonnaya and Awuah (2019) assessed learners in Quintile 1–4 schools in one district and evaluated achievement in probability. As expected, learners in Quintile 4 schools achieved at all cognitive levels. Whilst Quintile 1 learners performed better than learners in Quintiles 2 and 3, they struggled with synthesis. The authors have attributed this discrepancy to the English language competency of learners in Quintile 1 schools where their parents may not have the capacity to support them linguistically and may not have ready access to reading materials.

In justifying Ogbonnaya and Awuah's findings, according to Van Dyk and White (2019), it is prudent to consider the impact of reported inaccuracies in quintile rankings as this may

[4] Section 27 is a high-profile non-profit organisation and a public interest law centre that advocates for access to basic education and health care services.

compromise subsidies that schools have access to and teaching and learning support available to learners. It is also possible that the variable performance recorded by learners in Quintile 2 and 3 schools may be attributable to the Triple T crisis if one considers the ripple effect of a disrupted school year as we have seen with performance of learners in PIRLS assessment (Howie et al., 2017). This could also be an outcome of a misclassification of the school (Van Dyk and White, 2019).

The school in such instances is culturally challenging, and as such, is likely to produce disruptive behaviours, perpetuate crime, promote teenage pregnancy, and ultimately facilitate early termination and lead to school dropouts. Such inequalities are often reproduced in certain schools and in certain families and may be extended from one generation to the next (Halsey et al., 1997; Farid et al., 2021). Although the study by Ogbonnaya and Awuah (2019) was limited to a district that did not have a Quintile 5 school, it is possible to generalize findings to other schools with similar profiles. At risk are learners from lower Quintiles (Leketsa, 2016; Howie et al., 2017) as they often assume that their lack of talent and inabilities are personal shortcomings and not attributable to failure by the school system (Bourdieu and Passeron, 1977).

A family habitus determines if the child attains basic competencies linguistically. Given this, the low reading performances based on outcomes in PIRLS and in ANA confirm the role of the school in perpetuating legitimized inequalities in learners who attend Quintile 1-3 schools. Concerned about the crisis in South Africa's public schools, Letseka has called for the Department of Basic Education to redesign and reengineer itself in order to deliver and realise 'education for all' (2014, p.4869) as a policy initiative, in a similar fashion to the provision of Health for All (WHO, 1978). It is not clear how the disruptive school practices will be mediated so as to improve contact time in the classroom.

In a PhD thesis, Larey (2018) addressed this very issue. Employing in-depth interviews, Larey examined the role of school practices in mediating and integrating life-world-knowledge of disadvantaged learners in rural Coloured communities in the Western Cape Province. Through her study, it was possible to identify and define roles for a range of stakeholders in the community, in the family and in the school as well as mentors and role models that would facilitate a transforming habitus. Larey reported that learners who participated in her study had an opportunity to take control of their lives and make their own decisions. Webb et al. (2002) confirmed that there is an opportunity for learners to have their own agency when objective structures are in place.

2.2.3 Construction of a Cultural Capital

Not all learners in Quintile 1–3 schools perform poorly even when they are based in the most deprived schools. Whilst Bourdieu (1990) has argued that habitus is class specific, family structures are not homogenous. Gender differentiation and the role of habitus were explored by Dumais (2002), as she examined the effects of cultural capital that exists in embodied, objective and institutionalised forms, on the educational success of eighth grade boys and girls. In her study, female students were most likely to participate in cultural activities and their participation made them more visible to teachers. As they gained the requisite confidence, they became more assertive in the classroom, and this translated into academic success. The author observed that boys used similar approaches in the sports field and weremore likely to achieve cultural capital in that space, hence they are often successful in securing sports bursaries.

Jo (2013) studied the transformative power of habitus of immigrant mothers in South Korea, including the interface between cultural practice and aspirational education outcomes. She described how immigrant parents were forced to alter their habitus so their children could succeed in a competitive education system. They achieved this by observing and participating in social practices of native Korean parents such as investing in assessments that evaluate the child's skills early in their childhood and being present in the child's life by assuming an active role in their education. In Jo's study, one parent, motivated by a friend in their church, reported on the value of learning language and nuances of a Korean culture and could later integrate educational cultural practices in her children's education to the extent that 'she almost became a Korean mother'. The experiences of the Korean parent mirror those of a South African mother, although perhaps with not as much effort. On the occasion of the 2018 AJ Orenstein Memorial Lecture[5] (5 September 2018), Prof Tshilidzi Marwala - the Vice Chancellor at the University of Johannesburg, an engineer and a global expert in artificial intelligence - reflected on his cultural experiences as a student of rural origin from Limpopo Province. Drawn to the intricate designs on the walls of his home as a form of art and science, he acknowledged his mother's role in facilitating embodied and objective forms of learning about science. He also acknowledged his school in facilitating

[5] The AJ Orenstein Memorial Lecture is an annual lecture that is hosted by the Adler Museum of Medicine at the University of the Witwatersrand in memory of Dr Orenstein who had an interest in the eradication of tropical diseases.

institutionalised capital as he was a top achiever in matric in his province and in the National Youth Science Olympiad. His achievements and the impact of his scholarly work transcends many spaces beyond Bourdieu's assertion about a cultural capital (Claussen and Osborne, 2013) that is only a discriminator of academic competencies in children of different socio-economic backgrounds.

In addition to the above, in an article on rural success of academic children, Li (2019) acknowledged that some rural Chinese students break the cycle of production and achieve academic success as university students. Li observed that although the participants in the study were of a low socio-economic status, they had high economic capital, supportive parents and, in their school days, they were the teacher's pet and thus managed to achieve scholarly distinction.

In his book, *Distinction,* Bourdieu (1984) argues that for working class students, success is determined by level of engagement in schoolwork and cooperation with teachers. In rural South African schools, it is not uncommon to hear of teachers who extend additional teaching to their learners in the form of early morning classes or winter schools, thus reinforcing a view that academic discipline requires commitment. This also discourages valueless dispositions to extinction (Bourdieu, 1984) as it instils a discipline to a culture of learning. In such instances, Wacquant (2005) asserts that one should accept that habitus is a product of structure, a producer of practice and the reproducer of structure, that is, habitus mediates between structure and practice. Good teachers in primary school often leave a lasting impression and tend to be credited with the investment they provided by affirming the value of the education system (Agbenyega, 2014). However, there may also be learners among the class with exceptional natural gifts.

Contrasting the experiences of learners from Quintile 1-3 schools to those coming from privileged backgrounds (Quintile 4–5), by the time they start school, Quintile 4–5 learners are most likely to have classroom support, access to decent ablution facilities and facilities for extra-curricular learning, and are least likely to suffer harm (Harker, 1984). If there are learning difficulties, these learners will have access to remedial therapy by the time they start school or may have access to a school-based therapist. Consequently, Bourdieu and Passeron (1977) link habitus to capital and to power and, in the case of the privileged learner in a Quintile 4 or 5 school, they have enough opportunities to accumulate more capital. Lareau (2002) ascribes the success of middle-class learners to parenting styles. Such parents invest in strategic mapping of their children's careers by cultivating a learning culture through extramural activities. They do this by paying for extra tuition in subjects they are not competent in and encouraging their children to take

on additional languages. In that regard, Lareau and Weininger (2003) argue that habitus embodies both cognitive and non-cognitive skills.

In the *Aristocracy of Culture*, Bourdieu (1994, 2008) makes a couple of assertions. He suggests a correlation between the class of school system, the schools' track record and the quality of exit qualifications which in turn guarantees cultural capital. Bourdieu is of the view that the role of the school in social reproduction deviates from the collective approach as educational success is equated to individual merit class privilege. An individual with high-class determines what is considered tasteful or fashionable as they often have a high level of cultural capital. For example, in South Africa, there is much fanfare at the beginning of the year as high achievers in matric are celebrated for their distinction.

Demonstrating the value of cultural capital, referencing the *Aristocracy of Culture*, Bourdieu (1994) referred to class and product consumption as determinants of a social value of products from social use. He argued that products derive value based on how they are consumed and by whom (p.20). In that regard, the ways of cooking, for example, confer class since time, money and electricity must be factored in. So, acts of boiling are quick and cheap and thus associated with working-class, whilst cooking utensils such as casserole dishes confer class as baking is slow and thus considered to be nutritious. Similarly, drinking whisky is considered a class act as it is aged in special wooden casks and should be consumed in a particular way with just the right amount in the right glass, compared to beer, which may be consumed directly from a bottle. A few researchers (Wacquant, 1989; Laurette and Weininger, 2013; Edgerton and Roberts, 2014) have criticised Bourdieu for reducing the concept of research on education and limiting culture to a resource of consumption and taste.

In the literature, besides inherent class status, there is also evidence of parental influence in career decisions of children from high- and middle-income families (see Reay 1998a, 1998b; Symeou 2007) with geographical identity and locality also considered valuable entities in the decision-making about going to university (Donnelly and Evans, 2016). In a paper that tracks the role and influence of parents of Indigenous and Immigrant students in Cyprus, Kleanthons (2014) reported that culturally rich families choose fields that strengthened the families' cultural advantage whilst working class students choose fields in mathematics and engineering to compensate for lack of cultural resources. On the other hand, Liu et al. (2018) argue that decisions about choice of degree are informed by position in the stratification system in society as well as

being shaped or constrained by family characteristics and their identity. Likewise, these decisions are based on socio-cultural identity and economic rationale. For example, children of high- and middle-income families are not named for their own sake but are often associated with their parents – such as the CEO's daughter or son.

The interplay between social and cultural determinants of school effort and success was explored by Kaufman (2004) with Chinese immigrant and second-generation Chinese students. Citing a history of determination and high achievement amongst ethnic groups, particularly of Asian descent, Coleman and Hoffer (1987) assert that the values held in those communities convey success as they extend clear, positive academic goals to their students. However, this is not true for all Asian students. In their study, Chinese immigrants associated success with hard work and expected to be pushed and contend with a difficult curriculum, whilst their US based counterparts did not believe in working as hard although they appreciated having knowledgeable teachers. It seems to me that the second-generation Chinese students, already residents in the USA, were not concerned about accumulating cultural capital, whilst Chinese immigrants used their social capital to accrue cultural capital. If we assume that habitus is multi-layered (Wacquant, 2016), at school level, rural students exit with familial and primary habitus that resembles a baby onion and can be harvested or differentiated to mature into different forms. Acquired in early childhood, through a range of differentiation processes, it becomes secondary habitus in practice and thus capable of transforming in response to situated contexts (Steinmetz, 2013). In the next section, I consider the identity of rural learners and how they are presented in the research literature as they adapt and transition to higher education institutions.

2.2.4 Adapting and Transforming in Higher Education Institutions

In this section, whilst I focus on habitus in higher education, I draw on my earlier discussion on a habitus that is a product of the school, the family and, to a limited degree, the community. With the focus on practice, the discussion focuses on the field (university) and its agents, with a shift from a primary habitus to a secondary habitus. Theorising how rural students might experience university life, Bourdieu (1998) argues that to be a good and competent player in the field you must have a feel for the game.

> Having the feel for the game is…to master in a practical way the future of the game, is to have a sense of the history of the game. While the bad player is off tempo, always too early or too late, the good player is the one who anticipates, who is ahead of the game (p. 80).

Considering the role of habitus in generating cultural capital through education, an educated habitus is associated with a desire to be educated and to identify and be identified as such (Nash, 2000). Both the individual and family have a positive outlook about academia (Nash 2002), and subsequently favourable perceptions of the university and its academics. On gaining acceptance to a HEI, students are considered cultured individuals whilst the university is considered a cultured organisation (Reay et al., 2001). According to Bourdieu (1988), higher education institutions (HEI) are responsible for the production of knowledge, in ways different to schools: the focus in schools is on the transmission of education and thus "a set of historical relations deposited in institutions" constitutes its habitus (Bourdieu & Wacquant, 1992, p. 16). McDonough (1991, 1997) is accredited with the earlier descriptions of an institutional habitus as the effect of a social class or cultural group on individual behaviour as facilitated by an organisation. In that regard, habitus is not static nor is it fixed.

In their book, *Symbolic Domination*, Bourdieu & Passeron (1977) represent the university as an autonomous institution, where engagement with students takes on a Kantian (duty-based) approach as the structural design of the lecture theatres creates a pedagogical distance between lecturer and students. Also, the choice of language makes rural students the passive consumers of their education. Knapper (2001) concurs and refers to a didactic approach to teaching and learning as perpetuating symbolic domination of HEI in the absence of personal contact between lecturers and students. Whilst this is true in some contexts, especially in the first two years of a four-year degree or the first three years of a six-year degree, in their senior years, students tend to be organised into smaller groups.

Confirming this as lived experience, a rural student in the WIRHE programme only managed to find her voice in the fourth year of a six-year degree (Mapukata et al., 2017a). In the first four years, she was able to participate in small group sessions, but she did not trust her English to carry her in lecture theatre with peers who had 'proper' English accents. However, in their senior years, a different challenge prevails. In such spaces, the gap between the consultant (specialist) and the student may be extended based on a novice-expert gradient and hierarchal structures within the profession, thus affirming earlier assertions by Bourdieu and Passeron (1977) and Knapper

(2001). The meritocratic order in HEI ignores the lived reality of rural students and does not consider institutional bias that tends to favour traditional students (Steinmetz, 2013). Considering that culture is shared and a learned experience, the acculturation process for rural students must consider that even the process of belonging to a social class is fluid, time bound, dynamic and context dependent experience (Li, 2013).

Consequently, Steinmetz (2013) refers to a curriculum content that is structured around social class and constitutes narratives and rules that continue to epitomise the life of upper- and middle-class students. For example, most pathology is associated with people from working class communities as their habitus to disease is the most researched. Yet, access to the most advanced and effectivemedications is reserved for middle- and upper-class citizens (Steinmetz, 2013, p.29). Bourdieu considers universities to be industrialised societies and spaces that legitimise class and social inequalities (Sullivan, 2002). Students from working class families are considered cultural outsiders who should sometimes denounce their heritage if they want to belong (Lehmann, 2014). In legitimatising forms of academic discrimination, universities do not attribute this inherent privilege to teaching, rather to individual gifts. This compels working class students to also want to claim a stake so they can be part of the dominant high culture.

In tracking the role of culture in decision making, Swidler (1986) acknowledged cultural capital to be a set of skills and habits, a "tool kit" that confers both traditional academic skills and non-cognitive habits (p.273). In an article titled "Culture in Action: Symbols and Strategies", Swidler presented two models of cultural influence as periods of settled lives where one is confident about their actions. These are instances when students refer to their soft skills in justifying career choices: "I love people, I want to be a doctor." Exploring this concept of settled and unsettled lives with Danish students, Holmegaard et al. (2014) examined processes by which high school students from diverse cultural backgrounds become university students in elite sciences, mathematics, and technology streams. The authors argue that the concept of choosing a programme and thus a career is not a cut-and-dry process as marks do not always confirm what they should pursue, and at times their networks (families and career guidance counsellors) may not be knowledgeable about all career options. Some students must consider if their choices are aligned to family values and for others access to university is only the beginning of a process where they begin to evaluate their choices. In that regard, Holmegaard et al. (2014) motivate for due consideration of the needs of students from diverse cultural backgrounds by creating spaces where

they can be granted opportunities to acclimatise to the field before they are forced to lock in their career. This in their view would facilitate an emancipatory process and a transforming habitus.

In advancing institutional responsibility and accountability in creating spaces for Aboriginal students to draw on their indigenous knowledge, Pidgeon (2008) conducted interviews across three institutions in British Columbia, Canada. Pidgeon argues that a holistic representation of Indigenous students' participation in HEI should aim to reduce cultural distance by maintaining a balance of the four realms of the cultural wheel (intellectual, physical, spiritual, and emotional). In her article, institutional responsibilities were presented as three R's, namely: relationships such as acknowledging Aboriginal students and their community; reciprocity and relevance such as providing resources that facilitate academic achievement, and finally, respect for Indigenous knowledges. Furthermore, Pidgeon (2008) described motivation for pursuing university degrees among Aboriginal people as a social marker of success as it generates economic capital and derives self-determination and self-governance for the individual. This study instilled a sense of agency among the Aboriginal students. Larey (2018) reported similar findings in her study of the cultural capital of learners in disadvantaged communities.

Just as Swidler (1986) describes unsettled lives as periods of social transformation where one is forced to formulate strategies for action such as learning new ways of doing whilst also adjusting to an unfamiliar habitus. Bourdieu (2007) reflects on his own experiences of unsettledness as he traces his journey from a working-class family to becoming a global scholar. In the first few pages in *Sketch for Self-Analysis*, Bourdieu (2007) communicates how his discomfort in acquiring a transforming cultural capital in HEI as a gifted student from a working-class family took precedence over his personal life. He perceived academia as a space where his life took form and shape,

> To understand is first to understand the field with which and against which one has been formed. That is why, at the risk of surprising a reader who perhaps expects to see me begin at the beginning, that is to say, with the evocation of my earliest years and the social world of my childhood, I must, as a point of method, first examine the state of the field at the moment I entered it, in the 1950s. (Bourdieu, 2007, p.4)

Bourdieu (2007) only spoke of his family towards the end. It appeared that his father, although a clerk amongst peasants, was at one with the community. Bourdieu reflected on the difficulties associated with a rural life and lack of basic amenities: "for a long time, water had to be fetched

from the public fountain**."** This seems to contrast with his mother's life; she came from a "great family of peasants" (2007, pp 85-86). In such settings, Steinmetz (2013) refers to a habitus of three orientations – the integrated, disjuncture and split forms (p.120), supporting Bourdieu's (1999) presentation of the effects of a cleft habitus.

> A habitus divided against itself, in constant negotiation with itself and its ambivalences, and therefore doomed to a kind of duplication, to a double perception of the self, to successive allegiance and multiple identities (Bourdieu, 1999, p.511).

Considering that habitus becomes active in relation to a field, Bourdieu (1990a) argues that agents are driven by an urge to accrue symbolic capital and symbolic power. Although on the surface, the vision of agents and the students may seem to be aligned, that is not always the case as agents seek to impose cultural domination on socially deprived rural students. So pervasive and invasive are these acts, that Bourdieu (2001) described symbolic violence as enabling a continuum of the power of the dominators as a "gentle violence, imperceptible and invisible even to its victims" (p.2), resulting in an unconscious habitus of deep-seated emotional pain for the dominated.

In a paper on the value of science, Claussen and Osborne (2013) cite omissions and purposeful acts where students are not informed about opportunities in acquiring cultural capital in the future. At times the employment of scientific language is far too advanced to be processed by students from non-traditional (rural origin) backgrounds that they are automatically excluded from pursuing scientific degrees. Reay et al. (2001) extend Bourdieu's earlier point about an adaptive habitus "but because it confines possibilities to those feasible for the social groups the individual belongs to, much of the time those actions tend to be reproductive rather than transformative" (p.1). Additionally, Reay et al. (2001) describe the habitus that is possessed by universities to be a significant variable that interacts with class, gender and race to impact on secondary school pupils' lives and their university choices. For that reason, institutional habitus should be understood as more than the culture of the educational institution; it refers to relational issues and priorities, which are deeply embedded, subconsciously, informing practice.

The metaphoric presentation of the role of HEI is one of dualism - where institutional class, cultural capital of a higher class, is bestowed based on privilege as it is informed by historical discourse. In that context, a perpetuating agenda of deficit is confirmed for the working class despite a growing number of students attaining access to higher education institutions. Byrd (2019)

reported on this dual representation of HEI as intentional to communicate institutional attributes and institutional effects on students from low socio-economic backgrounds, non-traditional or diverse students, and students from disadvantaged background (see studies by Reay and colleagues 1995, 2001, 2005, 2010).

After joining a HEI, a rural student, who has accumulated a primary habitus with elements that are common amongst family members and similar to the other learners with whom they attended school, is most likely to encounter an institutional habitus as a disorientating experience. Bourdieu and Passeron acknowledge the concept of being a misfit (1977) when they speak of the power and dominance of agents in the field who continuously overlook the talents of working-class students and purposely assign value to students who are socially deserving. Although their research documented the experiences of working-class students in a French university some 30 years ago, who despite their gifts, suffered the effects of misrecognition, their findings have relevance in the South African context.

The internalised class dilemmas are also reported by Barroso (2015) whilst examining Black students' identities in a historically white institution. Barroso observed hierarchies between Black students of different classes whereby a lighter skin, a good command of English and private schooling was associated with whiteness and thus privilege, class and cultural capital. In in his book, *Race for Education* (2019), Hunter refers to schooling in post-apartheid South Africa as racialized markets where social networks and symbolic power are the new gold. Several researchers have considered the dilemmas of rural students as they adapt to universities in South Africa and examined student's perceptions of a university culture (Bizumic et al., 2009); rural students' anxiety about mathematics (Hlalele, 2012); investigated habitus and social capital of first-year students (Pather and Chetty, 2015); and habitus and technological practices of rural students (Czerniewicz and Brown, 2014).The interventions common to these studieswere instituted by individual actors (lecturers), and yielded results which moderated an institutional habitus. This was isolating and subjected rural students to moments of discomfort.

In post-apartheid South Africa, higher education institutions (HEI), particularly those previously reserved for specific race groups, have attempted to close the gap between traditional and non-traditional students by adapting their slogans to reflect an embracing culture (Mafofo and Banda, 2014). For example, the UCT slogan is *Spes Bona*, a Latin phrase meaning 'Good Hope', effectively instils hope in the student body and the broader UCT community. Thus, the logo with

three embedded official languages (English, isiXhosa and Afrikaans) creates an impression that the university is a multicultural institution where curriculum offerings are in all three languages (Mfofo and Banda, 2014, p.424). At Wits with the slogan *Wits gives you the edge*; the qualification affords a claim to a certain class of distinguished scholars. With these symbols, the two universities confer distinct capital that students strive to share.

At UCT and in other HEIs, it could be argued that the rebranding exercise was effective as slogans and the adoption of local languages in addition to English or Afrikaans instilled trust to members of the public (Mafofo and Banda, 2014) and conferred transformed institutional attributes. Yet, class domination prevailed. Structural racism as forms of symbolic domination that were embedded in institutional systems could not be erased without effecting real change (Heleta, 2016). Of concern is that despite substantial increases in head enrolment of Black students, attrition rates among Black students have remained high (Otu and Mkhize, 2018) as universities continue to embark on Eurocentric colonial curricula (Heleta, 2016).

In South Africa, the dominance of the middle class was disrupted by a collective during the #FeesMustFall student movement (Langa, 2017). Students used the power of their voices to denounce acts of symbolic violence and to demand transformation in HEI through the Decolonizing Project (Fataar, 2018). In advancing a resolution, similar to initiatives instituted by Pidgeon (2008) where HEI had to create spaces for Aboriginal students, Fataar (2018) argues that a decolonising curriculum should place students at the centre of pedagogical effort. This can be achieved by shifting the constituents of cultural capital from (mis) recognition of Black students to facilitate their cognitive capabilities. The adaptative process acknowledges that even though habitus is a product of social conditions (Bourdieu, 1994), considered from their experiences, the habitus of rural students can transform.

2.2.5 Transformation and Professional Socialisation

In considering the role of habitus and how it influences the professionalisation of health sciences students, Bourdieu's social reproductive theory (1979) does not cover the concept of professionalisation as this is considered to fall within the ambit of symbolic capital. This is partly due to Bourdieu's view about the profession which does not hold as much value as his own (Noordegraaf and Schinkela, 2011). He reduces the profession to a fleeting concept that for

convenience has been seemingly inserted into the world of science (Bourdieu and Wacquant, 1992) as stated below.

> "Profession" is a folk concept which has been uncritically smuggled into scientific language and which imports into it a whole social unconscious. It is the social product of a historical work of construction of a group and of a representation of groups that has surreptitiously slipped into the science of this group (1992, pp.242–243).

Whilst Bourdieu did not include health sciences professions as an elite profession, several studies have explored the habitus of emerging professionals and qualified professionals and addressed questions around transformation and professional socialization for law students and teachers, junior doctors, and female doctors. For example, Manderson and Turner (2006) explored the interplay between socialisation, experience and aspiration in the habitus and performance of Canadian law students. They reported on an identity that is complex and fluid, and includes unconscious transformation influenced by space and repeated performance. On the other hand, Gennrich (2015) examined shifts and changes in the literacy habitus of a particular group of teachers and students over a four-year period. Gennrich explored the literacy habitus of teachers who were schooled and trained in Limpopo Province, growing up in historically challenged environments with limited access to reading materials. Many tried to bridge the gap during their post graduate teacher training at Wits, by trying to access materials to improve their literacy levels and sometimes opted for storytelling to improve each other's literacy habits. Gennrich (2015) illustrated the importance of social capital as motivated students identified 'literacy brokers' among themselves to facilitate the process of writing and learning.

In a PhD thesis on the professional and cultural development of young doctors, Luke (2001) studied the habitus of medical interns and junior registrars. He described the transition of medical graduates as they negotiated the medical hierarchy to house staff (interns and junior registrars) at the bottom of the professional ladder. Fathi (2018) speaks of the health sciences profession as a gendered activity. Examining the formation of classed and gendered selves, Fathi (2018) interviewed 14 UK based first-generation female Iranian doctors and dentists and evaluated their aspiration for their younger selves back in Iran. Fathi asserted a few realities about the role of mothers as carriers of cultural capital (see also Reay 1998; Lareau and Weininger 2003), the concept of doctorhood, and how it confers class and is revered by families because it confers marriageability and the future of the new family. The elite profession was associated with financial

stability. In Iran, doctorhood conferred class status whereas in the UK, migrant doctors were constantly challenged even when they have earned the respect of their colleagues.

With this understanding, I focus my attention on reviewing existing policies that are supposed to guide recruitment and retention of rural students.

2.3 Policy Review

The urban-rural dichotomy in the distribution of the health workforce is considered a global challenge by the World Health Organization (WHO, 2018). To that end, the WHO predicted a global shortfall in human resources for health (HRH) of 18 million health care workers (Scheffler et al, 2016) to achieve universal health coverage by 2030. In Africa, this shortage is even more pronounced, as only 17 countries in 2015 had submitted a full strategy policy document that responds to human resources for health challenges (Afriye et al. 2019). In contrast to findings by Afriye and colleagues (2019), the National Department of Health (NDoH) in South Africa has been active in publishing a 5-year strategy document on HRH. Yet, particular circumstances (in all categories of health care workers) have resulted in ongoing shortages and the maldistribution of the workforce in the rural areas (Rose and Janse van Rensburg-Bonthuyzen, 2015; Econex, 2015). This chapter provides an overview of the extant literature as it applies to this study, with a view to understanding the relationship between policy and practice and the contribution and responsibility of universities in meeting the needs of the country.

2.3.1 Document Review

Three guiding documents informed the literature review. These were the 2010 *Lancet* Commission report, "Education of health professionals for the 21st Century; A Global Independent Commission" (Frenk et al., 2010), The National Department of Health report, "2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage" (NDoH, 2020), the World Health Organization report, "Global Strategy on Human Resources for Health: Workforce 2030" (WHO, 2020). The three documents highlight the shortage of HCWs particularly in rural and remote areas and acknowledge that skills imbalances and the

maldistribution of the workforce have an impact on health outcomes. The analysis is informed by the main points within each of the three policy recommendations, as presented in Table 2.2.

Table 2.2: Education and Training of a Future Workforce

Framework	Goals and Objectives
The Lancet	Goal: Adopt a competency-based approach.
	Objective: Training must be locally relevant but also consider a global perspective such that health sciences graduates can respond to global pandemics.
The National Department of Health (NDoH)	Goal: Produce a competent and caring multi-disciplinary health workforce through an equity-oriented, socially accountable education and training system.
	Objective: Transforming and aligning health workforce education and training with health and health system needs, using a combination of legislation, and incentives.
World Health Organization (WHO)	Goal: Transform education In low- and middle-income countries, the foreseen expansion of the health resource envelope should lead to cost-effective resource allocation, and specifically to a workforce geared to a primary health care delivery model.
	Objective: The foundations for a strong and effective health workforce able to respond to the priority needs of the 21st century require matching today's supply of professionals with the demands of tomorrow's populations.

All three frameworks categorised interventions into four broad areas, in response to the challenges I referred to in the previous chapter: inadequate production, inadequate recruitment, poor retention, and staff mismanagement (Rabinowitz et al., 2008; Wilson et al., 2009, Veld & Van De Voorde, 2014; Shisana et al., 2019; Malema and Muthelo, 2018; Afriyie et al., 2019). Three interventions are relevant to this study – inadequate production, inadequate recruitment, and poor retention – as

drivers of efforts in scaling up education and training of health care workers. Findings are presented thematically, with an integrated discussion.

The *Lancet* Commission recommended the adoption of a competency-based approach (Frenk et al., 2010). Epstein and Hundert (2002) describe competency as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served. This recommendation supports the "fit for purpose" approach (van Staden, 2021) where students of rural origin are capacitated so they can provide health care in rural areas. The other expectation is that graduates' knowledge must be locally relevant, and they must be familiar with disease processes and the health seeking behaviour of their patients. Their training must also consider a global perspective such that health sciences graduates can respond to global pandemics, as was the case with health promotion strategies implemented by medical students in Guinea and Sierra Leone as a community-oriented response to the outbreak of Ebola virus (Chapman et al, 2016). With the outbreak of COVID-19, teaching and training in HEI in South Africa was adjusted to facilitate a process whereby health sciences students gained knowledge about the virus and were sufficiently skilled to assist during the roll-out phase of the vaccine and participate in contact tracing. This was the case with UCT students (Bernardo, 2020).

The National Department of Health (2020) committed to produce competent and caring multi-disciplinary health care workers, and called for teaching and training that is transformative, equitable and socially accountable. I elaborated on the policy framework and social accountability in Chapter 1. The NDoH thus promoted the implementation of a policy framework and incentives to attract and retain health care workers where they are most needed. The proposed interventions are structured in a similar way to the principles of primary health care. The department recommended that each be assessed for its potential to meet the following targets – availability, acceptability, and effectiveness.

The WHO (2020) presented recommendations for low- and middle-income countries (LMICs) and focused on initiatives that would improve access to primary health care and promote universal access to health care. In that regard, although somewhat outdated, the advice from Travis and colleagues (2004) is relevant. They advanced that LMICs should take stock of the experiences of high-income countries and avoid falling into a trap of skills bias towards high-end technology,

as this may lead to cost escalation and ultimately perpetuate health inequities as only a few will be able to afford health care. The two-tier health system is a prevailing challenge in South Africa, as referred to in the introduction, as the private health care system is well resourced with access to the latest technologies but is available to less than 20% of the population (Stats SA, 2017). A prevailing perception is that in the private sector, there is overservicing due to an oversupply of the health care workforce, while in the public sector there is perceived underservicing due to demand and a shortage of HCWs. An expectation is that participating countries who are co-signatories to the attainment of Sustainable Development Goals (Sub-target 3c) should commit to a substantial increase in training, recruitment, development, and retention of the health workforce (de Francisco Shapovalova et al., 2015) – that is, they must work towards bridging the 18 million shortfall of health care workers. I address these in the discussion that follows.

2.3.2 Financial Incentives

In the 2006 health report, the World Health Organization (2010) recommended financial incentives as a strategy to attract health care professionals to rural, remote and underserved areas. As such, several researchers have considered the benefits of introducing financial incentives as a recruitment and retention strategy focusing on a health workforce in Australia, Africa, Asia, in both low- and middle-income countries (Lehmann et al., 2008; Willis-Shatuk et al., 2008; Wilson et al., 2009; Buykx et al., 2010; Mbemba et al., 2016; Gywnne and Lincolm, 2016; Behera et la., 2017; Humphreys et al., 2009; Tshering et al., 2018; Zhu et al., 2019; Hines et al., 2020; Esu et al., 2021). Others focused on specific categories of the workforce such as efforts to retain general practitioners (Rourke, 2008), dentists or nurses in the Australia, Canada and in the UK (Mbemba et al., 2013; Godwin et al, 2014; Verma et al., 2016; Marchand and Peckham, 2017. In this section, I consider some of the policy initiatives introduced by the South African government since 1996, a comprehensive list of which is published by Ditlopo et al. (2011). In meeting the goals of the study, I limited the discussion to rural allowances, occupation-specific dispensation, and community service. I outline successes and challenges encountered in three selected case studies intended to attract HCWs and address maldistribution of HCWs in rural South Africa (Table 2.3).

Table 2.3 Policy initiatives to address maldistribution of health workforce in South Africa						
Policy	**Authors**	**Location**	**Participants**	**Methodology**	**Successes**	**Challenges**
Case 1: Rural Allowances	Reid (2004)	Rural hospitals nationally	Hospital based Health Care Professionals	Longitudinal Cross section survey	First study to evaluate impact of allowance 30% committed to return	Methodological Long term impact Rural allowance (15%) Scarce skills (10%)
	Mburu and George (2017)	Hlabisa district, KwaZulu-Natal	Doctors	Interviews	Value of rural allowance	Increased workload
					Staff accommodation	Inadequate support and supervision
					Community Service doctors	Health seeking behaviour of patients
	Ditlopo et al. (2011)	North West	Policymakers; hospital managers; doctors and nurses	Interviews	Partial success in attracting staff	Definition of rurality Miscommunication about beneficiaries Benefit short-lived
Case 2: Occupation-Specific Dispensation (OSD)	Ntuli and Maboya (2017)	Limpopo	Doctors	Interviews	Retention of staff levels higher in facilities with academic affiliations.	Inter-provincial maldistribution of the workforce
	Ditlopo et al. (2013)	Gauteng	Nurses	Interviews	OSD extended to a category of nursing staff	Inequitable allocation of the allowance
						Allocation a facility level
						SANC database not updated
Case 3: Community Service	Reid et al. (2018)	National	Doctors	Longitudinal cross-section survey	Equitable access to health care since 1998	Maldistribution of workforce
						Lack of equipment, limited opportunities to study
						Retention of doctors beyond CSD at 16%
	van Stormbroek and Buchanan (2016)	National	OT	Cross-section survey (one year)	High level of satisfaction in their therapeutic relationship with clients	Poor supervision, lack of support Implementation of medical model of disability Lack of equipment

2.3.2.1 Rural Allowance

Rural allowances in South Africa were introduced in 2003 as financial incentives to attract and retain health care workers in the rural areas in response to the maldistribution of the workforce (DoH, 2004). The following year, in 2004, Reid sampled 20 per cent of 159 rural hospitals nationally and evaluated the effect of the newly introduced rural allowance on the short-term career choices of health care professionals in rural areas. The short-term goal was achieved as 33 per cent of HCPs who participated in the study were persuaded to remain in their posts for another year. Younger professionals with less than five years' experience were not persuaded to stay as they were keen to explore opportunities to specialise; however senior personnel with more than five years' experience valued the rural allowance as more important than career development opportunities.

Other factors that were presented as influencing their decision to stay or to leave, besides professional development, were job satisfaction and relationships with colleagues, security, and consideration for family. From this study, it appears that senior HCPs who were settled in their careers were most likely to commit for longer periods (Reid, 2004), compared to younger HCPs who prioritised professional development and opportunities to specialise over short term financial gains. Additionally, Reid (2004) reported that a lot more professional nurses could be persuaded to remain in their posts if there was an option to receive an additional R100 000 per annum, whilst the other professionals were looking at a figure that was five times more.

In another facility-based study, Mburu and George (2017) interviewed health personnel in the Hlabisa district in KwaZulu-Natal to understand their work challenges, whilst in the North West Province, Ditlopo et al. (2011) interviewed nurses, doctors, policy makers and hospital managers to evaluate the effectiveness of the rural allowance policy. Although staff acknowledged the value of the rural allowance as a short-term strategy to address maldistribution of staff, this was not sufficient as staff complained of health system challenges, lack of supervision, and limited opportunities to participate in professional development activities (cf. Reid 2004). An additional challenge related to patients' health seeking behaviour and cultural beliefs as these were considered to hinder efforts for effective health care delivery (Mburu and George, 2017). The variable definition of rural at the discretion of provincial managers compromised implementation, as only doctors and professional nurses qualified to receive the allowance (Ditlopo et al., 2011).

2.3.2.2 Occupation-Specific Dispensation

Ntuli and Maboya (2017) evaluated the occupation-specific dispensation (OSD) policy, implemented by the South African government in 2007, as a financial incentive strategy aimed at attracting and retaining HCPs in the public health sector. The OSD was not sufficient to address staffing challenges. This was due to the geographical maldistribution of the workforce where many medical officers were based in the more affluent districts in Capricorn and Waterberg districts, creating an excess burden of care in the other three rural districts. A concern among staff was that not all rural facilities experienced the same levels of deprivation, as those closest to Gauteng were better equipped with regards to staffing levels, equipment, and access to other desirable facilities such as good schools. Concerns expressed about the shortcomings in the implementation of the two allowances were not only reported by Ntuli and Maboya (2017) but also by Ditlopo et al. (2011).

Similarly, the OSD policy did not meet its intended purpose as nurses in Gauteng Province reported inequitable allocation of the allowance (Ditlopo et al., 2013). The South African Nursing Council is the custodian of the database that registers nurses who have completed their specialist training as paediatric nurses and oncology nurses. Ditlopo et al. (2013) reported the database as inaccurate because payment was delayed for some staff while others were overpaid. For this cadre of HCWs, the roll out was managed at facility level as opposed to being a national mandate. The implementation created unnecessary tensions between the different categories of staff because the allowance only extended to those with specialist training and not to all nurses. This was different for doctors, who all received an allowance based on their geographical location. Ntuli and Maboya (2017) observed that retention of staff levels was higher in facilities affiliated to an academic institution, as evidenced by the retention levels in the Capricorn and Waterberg districts. The affiliation to academic institutions was reported as valued in other studies (Rao et al., 2013; Li et al., 2014).

2.3.2.3 Community Service

A third policy initiative by the South African government, introduced to ensure equitable access to health care for all, was a 12-month compulsory community service (CS) programme. In the case of doctors, this was implemented in 1998 and followed a two-year internship (Reid et al., 2018). For other categories, such as rehabilitation therapists, placement was five years later in 2003, with their CS placement implementable immediately after they completed their studies (van Stormbroek and Buchanan, 2016). On the surface, the policy goals were achieved as equitable access to health care was realised, meeting the social justice need. However, for rural areas in South Africa, although there was reported improvement in the uptake of placements, with a retention rate of doctors in rural hospitals beyond the 12-month compulsory community service period sustained at 16% over the study period, this was not enough to meet the needs of citizens.

A threat to the sustainability of the CS initiative was reported by George et al. (2019) in a study that tracked the retention of Wits graduates and their distribution in post-apartheid South Africa; she noted that 12% of doctors opt out of medical practice. Of those 3.8% left the profession immediately after graduation and 7.1% migrated to developed countries before completing their community service. With a pool of 497 study participants, only 33 (6.6%) confirmed they were working in a rural area. As 20 of the 33 were Black, the authors confirmed the value of selecting students from rural backgrounds as a future workforce. In a country where 32.6% of the citizens reside in rural communities (World Bank, 2020), the low retention rate is attributable to their urban upbringing and schooling (Price and Weiner, 2005), supporting the value associated with socialisation in context (Vreis and Reid, 2003; Couper et al. 2007; Jones et al., 2009; Ross et al., 2015, Mapukata et al., 2017a). Push factors that pose a threat to retention of the health workforce besides migration issues were identified as personal and professional development intentions of community service doctors, and so confirm the findings of the study by Mburu and George (2017) and Ntuli and Maboya (2017).

Similarly, van Stormbroek and Buchanan (2016) employed a cross-sectional descriptive study for one year only (2013) to evaluate experiences of occupational therapists (OTs) about their community service deployment. Of the OTs who participated in the study, 75% reported high levels of satisfaction in their therapeutic relationship with clients. The community service was so fraught with difficult experiences during their rural placement that their only concern was simply

how to survive the year. Likewise, Naidoo et al., (2017) reported on OT graduates who struggled to implement primary health care (PHC) approaches in resource-restricted rural settings in addition to linguistic challenges. This was attributable to lack of supervision (see also Humphreys et al., 2009; George et al., 2019). In a study by Koetzee and Couper (2006), lack of facility support, implementation of the medical model of care that prioritises doctors over rehabilitation therapists and limited opportunities to perform some procedures due to lack of equipment were listed as some of the challenges. These negative experiences threaten sustaining this cohort in rural areas, particularly if concerns of surviving are overwhelming.

2.3.3 Planning for a Rehabilitation Workforce

Concerned about the lack of planning for a rehabilitation workforce globally (WHO, 2020), Tiwari et al. (2020) reported a national shortage of rehabilitation therapists and perceived this to be a threat to retaining rehabilitation therapists in rural South Africa. Compounded by the maldistribution of the current workforce as many of the therapists are based in three provinces (Gauteng, Western Cape, and KwaZulu-Natal), Ned et al. (2020) also expressed concerns about the feminisation of the workforce (95% female), racial inequality (66% white), and inequitable allocation as almost 75% of OTs are based in the private sector servicing 17% of South Africa's population (Stats SA, 2017). Considered from outcomes of the study by van Stormbroek and Buchanan (2016), who reported on a range of challenges faced by rehabilitation therapists during their community service, a sustained effort is required to retain this cadre in rural areas.

The maldistribution of the allied health workforce across rural areas is a concern shared by local and international researchers as well as policy makers. O'Sullivan and Worley (2020) attributed the maldistribution to short term placements and barriers faced by rural youth in accessing placement in universities. A low uptake of rural placements amongst nurses and the allied health workforce 15–17 years post-graduation was also reported by Playford et al (2020). Whilst they identified a positive association between initial placement in a rural area and current practice, this was not adequate to cover the shortage of nurses and the allied health workforce. Similarly, Longman et al. (2020) reported concerns about the 4–10 weeks service-learning placements as these were not adequate to guarantee retention of allied health workforce in rural areas. Longman et al. (2020) reported that although they had succeeded in implementing an

interdisciplinary approach, sustaining the programme was a logistical challenge, and therefore not sustainable as a long-term solution.

For a different cadre of the workforce, owing to limited efforts in attracting pharmacists to consider rural placements, Obamiro et al. (2020) observed that despite oversupply, the workforce was inadequate to reach rural and remote areas. Obamiro and colleagues (2020) note that factors contributing to the shortage of pharmacists in rural areas include limited research such as undertaking discreet choice surveys, insufficient deployment of pharmacists and pharmacy students, and a curriculum oriented towards metropolitan areas. As these studies indicate, retaining allied health care professionals in rural areas remains a global challenge. This shortage and maldistribution of rehabilitation therapists in South Africa presents a challenge to the NDoH strategy to produce a competent and caring multi-disciplinary health workforce.

Reviewing the effectiveness of the rural pipeline approach in five European countries that included doctors, allied health professionals, nurses and midwives, Carson et al. (2015) identified a range of variables favouring women's retention over men. While doctors and nurses of rural origin who trained in rural setting were more likely to choose rural placements, there was no evidence of a long-term plan to attract and retain allied health professionals. A common finding in the study by Carson et al. (2015), and the two studies by Tiwari et al. (2020) and Ned et al. (2020), is that allied health professionals were reportedly younger and more often women than men. As Tiwari et al. (2020) had proposed a long-term strategy that included context specific training and increased recruitment of rehabilitation therapists and considering the findings presented by Carson et al. (2015) and Jose et al. (2020), it is the universities that should assume responsibility to attract males to this cadre of the health workforce. As shown in the findings I presented above, the feminisation of the allied health workforce is not a policy issue but rather a recruitment and a selection priority.

Concerned about the shortage of Allied Health Care Professionals (AHPs) in rural Australia, Durey et al. (2015) have argued for shifts in the recruitment and retention of a future workforce beyond the "one-size-fits-all approach" (p.8). Durey and colleagues (2015) recommended an extended pipeline that adopts a flexible framework and considers social and professional factors as part of the recruitment strategy.

The goal of the NDoH for universities to produce a caring multidisciplinary workforce might address this gap if there were an effort to shift training from a medical model to an integrated

model of disability (McKinney, 2020). To that end, within the South African context, Golozana (2020) considered the shortage of pharmacists in rural South Africa. Golozana made a personal appeal to the fraternity to consider competency standards that must be met if pharmacists are to make shifts from their grade "A" training to a grade "C" placement so they can be effective during their community service year (p.2). Golozana (2020) calls for sensitivity to the kinds of clients one is attending to, a consideration for their socio-economic status, and an appreciation that pharmacists are part of a transforming health care system. This supports the call by the *Lancet* Commission for a competency-based approach so that graduates are reflective as practitioners and considerate in the communities in which they are based (Frenk et al., 2010).

2.3.4 A Discrete Choice Experiment

The World Bank supports the use of a discrete choice experiment (DCE) - a technique that is used to elicit individual preferences as a means to inform health workforce policy regarding recruitment and retention initiatives in remote and rural areas (Ryan et al., 2012). In this section, I examine the value of DCE in communicating the preferred job attributes for a future rural workforce.

In a recent study among final year medical students at UCT, where most participants were female, Jose et al. (2020) reported that rural allowance and a housing allowance were not guaranteed retainers for them to consider placement in rural facilities. Rather, participants advanced practical experience such as access to a consultant, safety, and provisions for protection against occupational hazards as priority needs. In a country with high levels of gender-based violence and high levels of corruption, concerns about safety and exposure to occupational hazards may pose a threat to gender equity of the workforce beyond community service. Other researchers have reported that employing DCE was not enough to persuade students from affluent backgrounds to consider rural placement, in South Africa (George et al, 2019); in China (Liu et al., 2018) and in Norway (Holte et al., 2015). For nursing students in China (Liu et al., 2018), location was the least important attribute, as participants prioritised a reasonable workload and an excellent working environment.

Having considered the current distribution and forecasting of the future demand for medical doctors in South Africa to 2030, Tiwari et al. (2021) conducted a retrospective review

using the HPCSA database and established that the profession is still dominated by men. Of concern was the geographic maldistribution of female doctors per 10 000 population in five of South Africa's nine provinces (Limpopo, North West, Northern Cape, Eastern Cape and Mpumalanga), and the domination of the workforce by older white males and younger white females. Considered from the SDG Goal 5, an effort should be made to achieve gender equality, address the racial inequities amongst doctors and feminisation among allied health care professionals.

DCE is useful in providing insights about health worker preferences. It has been valuable in confirming preferences for rural areas if students are of rural origin (Liu et al, 2018; George et al; 2019) or if they are rural based (Rockers et al., 2012) in creating a platform to negotiate reasonable working hours (Holte et al., 2015). DCE has been useful in communicating a preference for good supervision, working with a full staff complement, or establishing opportunities for specialist training and stating a preference for well-equipped facilities (Miranda et al., 2012; Rockers et al., 2012; Largarde et al., 2013; Rao et al., 2013; Li et al., 2014; Efendi et al., 2016; Mburu and George (2017); Ntuli and Maboya (2017); George et al., 2019; Jose et al., 2020). The value placed on specialist training seems to supersede attributes such as ubuntu, altruism and selflessness as reported by Green-Thompson et al. (2018) and Woolley et al. (2021). These values, associated with a social justice agenda, were recommended to be included in a competency-based approach by the *Lancet* Commission and are desired by the NDoH.

2.3.5 Making a future workforce

In 2010 the WHO recommended a complete overhaul of the admissions policies in universities to address the imbalances in the health workforce. The recommendations required national governments to prioritise recruitment of future generations of the health workforce from communities where there is a need. In Chapter 1, I discussed the policy redress in higher education institutions as a mandate of the ruling party in South Africa. Having considered earlier discussions, pursuant to scholarly evidence locally and in international studies, equitable access to healthcare is possible if the future workforce is drawn from rural communities (Ross and Couper, 2004, Wilson, Couper, De Vries et al, 2009; Strasser and Neusy, 2010). This is premised on growing evidence that students of rural origin have a higher propensity to return to their communities to

practise as health care professionals (De Vries and Reid, 2003; Wilson, Couper, De Vries et al, 2009; Strasser and Neusy, 2010). I discuss this and other initiatives likely to draw students to rural practice as an institutional initiative.

2.3.6 Rural Pipeline

The global health workforce policy has considered the rural pipeline strategy as a preferred approach in the recruitment and retention of the future workforce (WHO, 2010). With a highly agile workforce (Carson et al., 2015), threats of brain drain and a global pandemic (Ataguba et al., 2020a; Scheeners et al., 2020), a preference for city living (Holte et al., 2015; George et al, 2019; Jose et al., 2020), and a demand for financial and non-financial incentives to sustain a rural workforce (Lagarde et al., 2013; Mburu and George, 2017; Ntuli and Maboya, 2017), I considered the initiatives in place in South Africa. Presented as a two-pronged approach (Carson et al., 2015), targeted recruitments involve creating opportunities for students of rural origin to register for health sciences programmes (Worley, 2002; Ross and Couper, 2004; Fisher et al., 2010) and providing rural exposure during undergraduate training through community site visits (Wilson et al., 2009; Couper and Worley, 2010; Woolley et al., 2016), rural electives (Couper, 2015), and exposure to primary health care settings (Nyangairi et al., 2010; Tumbo et al., 2009; Mapukata et al., 2017b).

2.3.7 Targeted Recruitment

Presented as part of the pipeline approach (Ross and Couper, 2004; Ross, 2016; Strasser, 2016), bonded scholarships or year-on-year service scholarships and student loans have been used with great success in Australia, Canada, North America and South Africa (Ross and Couper, 2004; Mapukata et al., 2017a; Zihindulai et al., 2019; Gumede et al., 2020). This is possible, if students as a potential future workforce are socialised in the context in which they will practise and are supported financially and mentored during the training period (Strasser and Neusy, 2010; Ross et al., 2015; Woolley et al., 2016; Mapukata et al., 2017a). Two scholarship programmes, namely Umthombo Youth Development Foundation (UYDF) and the Wits Initiative for Rural Health Education (WIRHE), on which I elaborated in Chapter 1, have already demonstrated the value of

targeted recruitment, and many graduates have returned to their provinces and hometowns to provide health care.

Mentoring

Based on principles of social accountability as a desirable output of the *Lancet* Commission (Frenk et al., 2010), the success of these two programmes was informed by a structured mentorship programme where students had access to a consultant and a mentor to guide them as they navigated the university system. Students had to undertake a compulsory holiday work placement to learn critical skills and familiarise themselves with context and were supported in acquiring educational skills such as note taking, preparing for lectures and time management skills. The students were also required to mentor their peers in critical courses such as mathematics, physics, chemistry, and anatomy (Ross et al., 2015; Mapukata et al., 2017a; MacGregor et al., 2018). Opsahl and Townsend (2020) reported a high retention rate and improved academic performance within a diverse workforce of nurses who were mentored for three years during their training (see also Dubois et al., 2002).

Career Counselling

Students in both programmes (UYDF & WIRHE) were required to contribute to the scholarship's marketing initiatives by visiting schools and participating in career guidance initiatives (Ross et al., 2015; Mapukata et al., 2017c; MacGregor et al., 2018). Durey et al. (2015) considered employing career advisors to assist with marketing and direct recruitment in rural schools. The concept of inviting high school students from rural areas was successfully implemented in and around the US-Mexico border region (Kadavakollu et al., 2020) and in Australia at James Cook University (Ray et al., 2015). By inviting them to engage with university structures as an entry to the pipeline approach of recruiting the next cadre of health workforce, rural students had insight to learning approaches and career projections and were informed about the workforce needs and options to access bonded scholarship or financial loans. Reeve et al. (2020) argue that medical schools should plan to extend targeted mentoring of students of rural origin and others from minority populations. Additionally, medical schools should aim to introduce students of rural origin to place-based education as this is valuable in introducing students to situational learning about context so they could adapt to that environment.

Giving Back

This concept of giving back strengthens partnership between community and the health facility was modelled as a symbiotic model of medical education by Worley (2002) and confers a reciprocal relationship between the university and the community (Mapukata et al., 2017b). In a multicounty study that traced initiatives by eleven medical schools in LMICs (Talib et al., 2017), this symbiotic partnership was assessed and evaluated the contribution of medical students to health care provision when they are based in decentralized training platforms (Nyangairi et al., 2010). Although a few students had variable learning experiences, most students contributed to improved provision of health care, reported positive patient interactions, a corresponding impact in the health facilities and in the community through health promotion initiatives (Talib et al., 2017)**.** These findings confirm a role for medical schools in transforming health facilities into learning environments, and in part fulfils the competency-based approach recommended by the *Lancet* Commission and the social accountability desired by the NDoH.

Servicing Contracts

Following a four-year review of the UYDF programme, Ross et al. (2015) reported a 72% retention of the UYDF alumni in rural hospitals beyond their contractual service obligations, confirming a strong affiliation between intent to practice in a rural area amongst students who self-identify as being of rural origin (Moodley et al., 2020). A similar percentage of WIRHE graduates had returned to the North West and Mpumalanga Provinces to work and service their contracts. However, following a political fallout in 2015, the WIRHE programme was disbanded by the North West Department of Health (Dabula, 2015). WIRHE alumni were released from their contractual obligations as posts were frozen, and funds meant to cover their salaries were redirected to political interests. In planning for rural services, the role of politics in influencing policy cannot be overlooked (Muula, 2007). A policy failure was also reported by Baba (2020) following challenges in securing a health workforce for rural and fragile settings in Ituri Province in the Democratic Republic of Congo.

2.3.8 Intentional Clinical Exposure

The benefits that accrue to health sciences students following intentional clinical exposure to rural communities are well documented (Muula, 2007; Rabinowitz, 2008; Wilson et al., 2009; Strasser and Neusy, 2010). A positive correlation exists between rural origin and intention to practise in a rural area as reported by Naidu et al. (2013); de Vries and Reid (2003); Tumbo et al. (2009) and Diab et al. (2014). In a cross-sectional survey, Sen Gupta et al. (2014) demonstrated a positive correlation between the remoteness of the area of internship and subsequent rural practice or an affinity to practise in rural locations. Similarly, Francophone physicians in Canada who participated in a questionnaire-based survey by Landry et al. (2011) associated the degree of exposure during undergraduate training to relative likelihood to practise in rural settings. Additionally, in a retrospective survey at the University of Manitoba, Tate and Aoki (2012) demonstrated that rural placement of medical students during undergraduate training influenced graduates positively to consider rural areas for their post graduate training. Also, extended placement and complete immersion during undergraduate training is likely to increase an affinity for rural practice similar to the experiences of those born into rural environments. Furthermore, intent to pursue rural practice in addition to background and exposure was associated with higher rural practice self-efficacy in a cohort of 3328 medical students from 17 medical schools (Raftery et al., 2021). However, for the US population, Shipman et al. (2019) observed a decline in the number of students from under-represented, racial and ethnic minority groups, threatening the success associated with the rural pipeline. Introducing rural content to the curriculum and exposing students to supervised clinical placements was a challenge in a study by Durey et al. (2015) for all the other AHPs except pharmacy students.

2.3.9 Longitudinal Integrated Clerkship

Parallel longitudinal placement clerkship (LIC) is defined as a model of integrated clerkship of 12 months or longer (Norris et al., 2009), that runs parallel to the traditional model of training medical students. In a parallel LIC, students are invited to volunteer for this extended placement. This clerkship is structured with a view to facilitate continuity of care and students are placed in facilities where the focus is on student and patient-centredness (Norris et al, 2009). Based on

feedback on the experiences of students from Flinders University and Northern Territory Clinical School in Australia, Worley et al. (2008) described LIC as an opportunity to increase affinity for rural placement (see also Couper et al., 2011). Likewise, at Deakin University School of Medicine (also Australia), Fuller et al. (2021) showed that students who completed a rural longitudinal integrated clerkship followed by a regional rural clinical school year-long placement, and those of rural origin, were seven times more likely to opt for rural appointments. A unique finding was that this applied to international students in addition to those who had bonded scholarships. Similar findings were reported in the South African context by de Villiers et al. (2018), based on the experiences of selected medical students from Stellenbosch University who opted for the longitudinal integrated clinical training at Worcester campus. This approach had benefits for students based in the same setting for extended periods with personalised supervision from facility-based family physicians. Another finding was the model's contribution to the realisation of a distributed platform or the decentralised training platform. It is, however, threatened by disruptions in the health workforce such as staff resignations and other forms of work disruptions.

In an adjusted structured model (Sen Gupta et al., 2008), medical students from James Cook University (JCU) in Australia took up rural placements every second year and spent a month in their second year, two months in the fourth year and a term in the final year. The programme was reported to have benefits for students who enjoyed working with limited supervision and were found to be better prepared for internship. According to Sen Gupta et al. (2008), this plan simulated a consultant-registrar-resident model where final year medical students and junior doctors worked together to manage patients and had ready access to a resident family physician in distributed clinical platforms in select areas (Mackay, Townsville, Cairns and Darwin, Australia). Concerns expressed by students arose from a preference for a traditional approach to learning and an objection to shared accommodation.

Similar objections were raised by final year medical students at Wits, albeit on a shorter placement compared to JCU, with four days in in their third and fourth year, a month in fifth year, and six weeks in the final year. Medical students had an option to take up a placement either in a rural or urban facility or choose an international elective in their fifth year (Mapukata et al, 2017b). Students who prioritised rural placement as their first choice had previous positive experiences in their fifth year or in prior placements, or were of rural origin, and were keen on opportunities to manage patients holistically in a place that would facilitate social and cultural competencies.

Establishing the value of the place, the people and the context among potential graduates was reported by Cuesta-Briand et al. (2020) as a possible recruitment strategy in understanding decision making and interest among junior doctors in undertaking rural practice in Australia. However, O'Sullivan and McGrail (2020) confirmed that rural context was not favoured for female placements, although the authors also confirmed that a multipronged approach should be adopted. This confirms views about the heterogeneity and ambiguity of the context, and that for programmes, 'one size does not fit all' (Couper 2003; Veitch , 2009; Durey et al., 2015). Likewise, in an earlier study on the benefits of exposing final year medical students to primary health care settings (Nyangairi et al. 2010), students opted for rural placement if they had received feedback about good supervision in a particular rural facility from their friends or clinical partners, or if they were born in those communities. Contextual factors such as the opportunity to work during the placement were factors that prompted students to opt out of rural placements, challenging what was reported in previous studies where contextual factors were cited as reasons for opting for rural placements (De Vries and Reid 2003; Couper et al., 2007; Tumbo et al., 2009). Durey et al. (2015) recommended graduated entry to rural practice to accommodate a diverse pool of AHPs.

Given the predicted positive uptake of rural internship and generalist post graduate training by JCU graduates (Woolley et al., 2021), but only two successful LIC models in SA (Nazareth and Mfenyana, 1999; Villiers et al., 2018) based on self-reported commitment to socially accountable practice, there is a need to review what is relevant for SA. Financial incentives offer only a short-term solution. A stated preference for urban placements during a final year integrated primary care block (Mapukata et al., 2017b) and with almost 80 per cent of the final year class at UCT being of urban origin (George et al., 2019; Jose et al., 2020), there is an apathy for rural placements by doctors and rehabilitation therapists (see George et al., 2019; Tiwari et al., 2020; Ned et al., 2020). Presumably, this negative role modelling has an influence on students' attitudes and preferences regarding rural placements. Furthermore, with a retention rate of doctors at only 16% beyond community service (Reid et al., 2018), in a PhD study by Green-Thompson et al. (2017) participants struggled to define their role as socially accountability graduates. Given these factors, there is a training gap between the global HRH strategy of the WHO, the directive of the NDoH to invest in a workforce to realize universal health coverage, and the aspirations of the *Lancet* Commission to graduate socially accountable health professionals in the 21st century.

2.3.10 Concluding comments

This literature review was guided by an analysis of existing policies. Although prevailing evidence confirms a correlation between rural origin and rural intent, the number of practitioners who are willing to take up rural practice for extended periods is not adequate to cover the HRH shortage in South Africa. Rural exposure alone is not adequate in retaining graduates in rural South Africa. Contextual factors must be considered in planning for health care provision as only senior health care professionals were most likely to commit to a rural area. The pipeline approach only presented a linear view to the prevailing challenge. Although Durey et al. (2015) have considered the limitations associated with a one-size-fits-all approach, considering that context matters, some of their recruitment and retention strategies are comparable to the policy failures I presented in this analysis.

2.3.11 Summary

In this chapter, I explored the concept of rural and rurality in its variable forms and assessed its impact on health outcomes. Although this review provided insight about the origins of rural students and facilitated an understanding of undifferentiated contexts, the cultural capital of health sciences students could not be established. In the follow up section, I traced rural origin in South Africa and its impact on the generation of cultural capital. Through Bourdieu's Social Theory of Reproduction, it was possible to examine the interplay between socialisation and experience in schools and to understand the process of adaptation from school to university. Having undertaken the literature review as a policy analysis of educational strategies in addressing human resources for health challenges, the review only offered a linear approach to addressing the prevailing challenges regarding the chronic shortage of a health workforce. In this study, my intention is to explore the role of habitus of health sciences students of rural origin and examine its capacity to facilitate transformation from non-professional to professional spaces. The aim is to generate data to inform strategies and approaches to be considered in the making of a rural workforce. In Chapter 3, I discuss the research design for this study and examine habitus as a methodological tool.

CHAPTER 3: METHODOLOGY

3.1 Introduction

In this chapter, I describe my methodological approach to studying the experiences of students of rural origin, and my approach to examining the influence of the learning environment as they become health professionals. I explain my choice of adopting a qualitative research design as a meaning-making methodology, and I contextualise the research design and sampling techniques to identify a study population. I discuss data collection methods, shaped as the research was conducted in the first year of the COVID-19 pandemic. I then describe methods of data collection and analysis, address ethical considerations, and reflect on the trustworthiness of the data.

3.2. Research Methodology

As this study aimed to examine experience, habitus, and processes of social reproduction, including its relation to transformation, I employed a qualitative research design. As my intention was to understand habitus and how it is socially constructed by exploring the experiences of students of rural origin from South Africa (Figure 3.1), I followed a qualitative method approach as arguably the most appropriate (e.g., Merriam 2001).



Figure 3.1 Map of South Africa

Habitus encompasses both individual and collective identities, and given this, the context was critical as a frame of reference for participants (Austin and Sutton, 2014). It was also relevant as the settings across South Africa are reported as variable (Balfour et al., 2008), heterogenous, complex and dynamic (Ndofirepi and Masineri, 2020). Reay (2004) asserted that habitus can be used to measure the ways in which previously disadvantaged students (of rural origin) and those who are socially advantaged play out attitudes of cultural superiority and inferiority that are embedded in their habitus in daily interactions. Examining their habitus is expected to reveal issues around class, gender, and race (Reay 2004, p 436).

Bourdieu and Chartier (2015) present habitus as much more than a theory; they see it also as a methodological approach and an essential instrument for tracing social practice. Wacquant (2011) presents habitus as a tool to unpack the dispositions that are acquired as a series of character-building qualities; these components contribute to the social production and assembly of the academic habitus, which is the focus of this study. However, this is not without its challenges. Harker (1984) asserted that studying the habitus of an individual and a collective, whilst it offers theoretical potential, may also yield conceptual difficulties due to an unpredictable approach (p.119). This is because Bourdieu (1993) offers conflicting messages about habitus of an individual and the collective and, according to Reay (2004), he oscillates between the two.

Bourdieu refers to individual traces of a habitus within the collective; at times, he also refers to a degree of uniformity between the two, but then also acknowledges diversity and differences among members of the same group (2004, p. 356). Adding to the confusion, Bourdieu also states that "a collective understanding of habitus is necessary, in order to recognise that individuals contain within themselves their past and present position in the social structure" (Bourdieu, 1993, p. 86). To avoid falling into a trap where habitus is merely referenced in passing, Reay (2010) offers a range of options such as an establishment of habitus as a concept before the introduction of data or employing the mixed methods approach (p.445). However, where it is imperative to study the individual and the collective — citing the work of two researchers (Charlesworth, 2000; Nash, 2002) who implemented the dual approach successfully — Reay (2010) suggests focusing analysis on individual habitus, moving organically to the collective and back again (p.440).

In the *Logic of Practice*, Bourdieu (1990a) argued that even within the same community, one cannot expect individuals to display the same habitus as no two families and no two individuals

are the same. Despite the role of families in enforcing acts, behaviours, and attitudes, "(j)ust as no two individual histories are identical, so no two individual habituses are identical" (1990a, p.46). Reay et al. (2009) consider that individual histories are vital to understanding the concept of habitus. In a paper on capturing habitus, method and reflexivity, Costa et al. (2019) conceded that measuring habitus is a complex task and should be considered through a multifocal lens, and hence, a range of methods might be employed by researchers to study different aspects of habitus. For example, Zeng (2021) used a survey and in-depth interviews to examine the primary and secondary habitus of journalists who worked as foreign correspondents. Stahl (2016) reported on the use of an ethnographic approach to grapple with white working-class habitus, whilst Bodovski et al. (2014) used secondary survey data to examine the relationship between family socio-economic status, cultural capital and reading achievement among students in five post-socialist Eastern European countries.

A case study approach was employed by Jawitz (2009) to understand learning in the academic workplace as the harmonisation of collective and individual habitus. Similarly, Pather and Chetty (2015) employed a case study approach to understand habitus and social capital of first year students, whilst Moore (2008) conducted ethnographic fieldwork to examine class formations and their construction as competing forms of Black middle-class identity. Mohyuddin et al. (2021) employed semi-structured interviews to explore the experiences of expatriate professionals from India, Pakistan, Sri Lanka and Bangladesh, and to examine their occupational progress in Australia. In a case study of habitus and technological practices of rural students, Czerniewicz and Brown (2014) employed digital ethnography. Similarly, Galvaan (2015), in her study exploring the contextually situated nature of occupational choice among marginalised young adolescents in South Africa, employed critical ethnography including semi-structured interviews.

In the research that informs this thesis, I considered the socio-cultural context of students across a range of programmes in the Faculty of Health Sciences, and so the empirical enquiry employed a collective case study design (Crowe et al., 2011). This enabled several phenomena to be studied sequentially to generate a broader appreciation of how habitus influences professionalisation. Based on the uniqueness of a habitus and its influence on everyday experiences, this led me to ask the research question**:** How does habitus influence professionalisation of health sciences students of rural origin? As introduced in Chapter 1, the study objectives were to:

1. Describe and analyse student experiences of their transition from home to university.
2. Explore the coping strategies of health sciences students during their university years and determine the role of a university in student continuation.
3. Describe and analyse the continued experience and professionalisation of students in their final year.
4. Describe and analyse different forms of capital and how they produce habitus for particular students of rural origin.

3.3 Research Design

A series of structuring events constitute an individual's lived experiences. Individuals are interpellated subjects, i.e., their culture is embedded into their beings, which according to Bourdieu (1977) "are not imprinted with a fixed set of rules and procedures as much as they are endowed with a social sense or cultivated disposition, inscribed in the body schema and the schemas of thought" (p.15). Effectively an individual sense of belonging is prescribed by families, but it does not follow a fixed set of rules beyond the family. These participants have collective habitus as students of rural origin and a shared identity as health sciences students. They also occupy a range of spaces in a university such as lecture theatres, skills laboratories and simulation rooms, clinical training platforms, social spaces such as their residences, and other places within the Western Cape. I refer to these later when I discuss the sites in which students were placed, including rural, underserved, and urban contexts.

Bourdieu (1977) acknowledges that habitus is a subjective concept; however, he also emphasises that individuals experience life in the groups to which they belong, and for that reason, people with similar backgrounds may share a similar habitus - in this case rural origin health sciences students. According to Ingram (2011), the outcome of any research process should be sufficient to justify the misalignment of habits and practices that are acquired through early life experiences for those growing up in rural settings with habits and practices that are generated through new life experiences, i.e., attendance through school and university.

I was keen to understand the constructions and interpretations of a habitus that is fluid, as young people become health professionals; and to learn about the changes they experienced during their training. For example, the first day of an academic year is not the same as the end of a block,

when students are required to present for evaluation of their knowledge, skills, and attitudes. Graduates of the faculty of health sciences are expected to be competent in managing common health problems in South Africa's primary health care settings and are trained for this purpose in the facilities in which they will practice upon qualification. The aim of the research was to elucidate aspects of their lived experiences as trainee health professionals in relation to their own habitus, and to examine influences of the university and clinical environment in establishing their practice approach.

If we assume a habitus (ingrained habits, skills, and practices) to be Bourdieu's "memory pad" (1990a, p.68), for these students my intention was to explore their ability to remember and recall the impact of perceived experiences. I also planned to examine their belief system as it was informed by their own upbringing and, as my study participants were health care professionals in training, to evaluate the relationship between consciousness, agency, and experience (Pritchard, 2010, p.145). In this study, health sciences students are expected to collaborate with others: doctors, physiotherapists, occupational therapists, audiology therapists, or the speech-language and pathology therapists, all provide health care.

Qualitative research is an interpretive and natural approach. Denzin and Lincoln argue that the approach requires researchers to "study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (2000, p.3). In this study the process of acquiring a professional identity is a personal journey that must be understood within the construct of UCT and its historical context as well as the different professions in health sciences. The research process must facilitate examination of the different components of habitus, as defined by Wacquant as a principle of individuation and sociation (2016). Individuation represents the primary habitus or family habitus as entrenched habits, skills and practices acquired in the early stages of life. Sociation refers to the conditioning, perceptions, and actions in a group of people that tend to reproduce patterns and behaviours influenced by their environment. In a university, this is linked to secondary habitus (Bourdieu & Passeron, 1990).

Creswell (1998) captures the complexity of qualitative research "as an intricate fabric composed of minute threads, many colors, different textures, and various blends of material. The fabric is not explained easily or simply" (p.13). I chose a collective case study design to gather in-depth data in the participants' natural environment at UCT (see Adams et al., 2014). The case design approach has already been used successfully to understand the habitus of students of rural

origin in other studies (Dumais 2002; Reay 2004; Czerniewicz and Brown 2014; Gennrich 2015; Pather and Chetty 2015), as described in the previous chapter. I use the term case study, following Merriam (2001), to refer to an intensive description and analysis of a phenomenon or social unit. I focus on the habitus of students of rural origin, who are registered for traditional degrees in the faculty of health sciences, in their final year. The study group is distinct, therefore, based on the range of professional degrees they are registered for, the period in their training, and their home background.

I opted for a case study approach through interviews to describe the perspectives of participants registered for five independent programmes within the faculty of health sciences. Stake (1995) argues that a case study is a "palette of methods" which draws from a range of qualitative methodologies and thus extracts aspects of "naturalistic, holistic, ethnographic, phenomenological, and biographical approaches" (pages xi-xii). Undertaking case study research, whether it is a single or collective case, should, according to Stake (2005), be viewed as an investigation and an analysis that captures the complexity of the phenomenon. It is "not a methodological choice but a choice of what is to be studied. By whatever methods we choose to study the case. We could study it analytically or holistically, entirely by repeated measures or hermeneutically, organically or culturally, and by mixed methods—but we concentrate, at least for the time being, on the case" (2005, p.443).

In this study, examining the habitus of health sciences students of rural origin required an approach that would generate capacity for collective views to be registered and analysed. Obeng (2015) had similar intentions in opting for a case study approach whilst exploring beneficiary parents' perspectives on the influence of the capitation grant policy on primary education levels 1– 6 in a school district in Ghana (p.9). Yin (2003) argues against case studies because of the difficulty of generalising. I dispute Yin's argument for two reasons.

Firstly, this study is nested in public health and outcomes are likely to influence policy. A case in point is that of a reported rat infestation in the Alexandra township a few years ago, resulting in babies and toddlers being brought to local health facilities with complications from rat bites that included loss of limbs. With no proper consultation with local structures, officials from the City of Johannesburg launched a project where they introduced owls to the community as a control measure (Samuels, 2014). The government representatives had not considered cultural perceptions about owls as instruments for practicing witchcraft. As a result, the owls were

mutilated, causing untold harm to the birds. The rat infestation remained unresolved until further consultations with community stakeholders had taken place.

This study was conceptualised as previous attempts to address the shortage of health care workers (HCW) have focused on process and outcomes-based initiatives and have not considered the habitus of students of rural origin within a broader community of traditional university students. Considered from the scenario about rat infestation and the government's response, a community-oriented approach as a public health response does not assume that solutions to public health challenges will be acceptable in all communities. Rather generalisation at community level is plausible within a defined community.

Secondly, it was possible to triangulate information about the experiences of the participants, as data from in-depth interviews supported the evidence provided in the participants' journal reflections. This was the required validation for pursuing a collective case study approach (cf. Crowe et al. 2011). In this study, the coding approach described by Saldana (2013) was helpful in navigating through events and experiences that occurred over time. The first-year experience was analysed in terms of participants' perceptions rather than focusing on a particular programme. For example, participants in medicine, a six-year degree, were ahead of other students by a good two years: the duration of the other programmes is four years. Describing change as a sequential process and understanding health sciences education as a series of structured events where the complexity of the knowledge is matched by the year of study, then final year in any programme is the end stage of a specified and council (HPCSA) approved training period whether one is studying towards physiotherapy or medicine. In that regard, Becker (1998) offers a tree diagram approach to the analysis phase.

> Assume that whatever you want to study has, not causes, but a history, a story, a narrative, a "first this happened, then that happened, and then the other happened, and it ended up like this." (1998, pp. 51-54).

On this view we understand the occurrence of events by learning the steps in the process by which they came to happen, rather than by learning the conditions that made their existence necessary. There were many of these Becker moments reported in the interviews. My enquiry was guided by research questions, but the methodology also allowed for emerging issues to be explored (Creswell, 2003:181).

3.4 Study Site

As noted in Chapter 1, I began my PhD at Wits, and relocated the study to UCT when I accepted an academic appointment in the Division of Public Health Medicine, Faculty of Health Sciences. At UCT, the Groote Schuur Hospital (GSH) is the main teaching hospital for the Faculty of Health Sciences. GSH is known internationally for undertaking the first human-to-human heart transplant in 1967 and is the teaching platform for undergraduate and postgraduate training. It is one of three provincial hospitals and is described as a tertiary or Level three hospital in the Western Cape Province. Health sciences students at UCT are exposed to the health care system in their first year of training (Mapukata and Toto, 2021). They continue to engage in a range of health care facilities during clinical training (Beckett and Delport, 2019) at GSH and designated satellite training facilities throughout the Western Cape (Figure 3.2).



Figure 3.2 Map of the health districts and subdistricts in the Western Cape Province, SA.

Many of these facilities are located in the Cape Town Metro district: urban and underserved health facilities; mainstream schools and special schools; non-government organisations; specialised hospitals such as Mowbray Maternity hospital; and other facilities including Old Age Homes. The rural health facilities are based in the Eden district (George and Knysna hospitals) and in the West Coast district (Vredenburg Hospital). Green-Thompson et al. (2017) support placement of students in facilities where they will be based as health care providers.

3.5 Population and Sampling Procedures

This study was conducted with a population of final year students who identified themselves as originating from a rural origin. They were registered for traditional, well-established professional degrees offered by the Faculty of Health Sciences at UCT, and in nine other faculties of health sciences in South Africa. In the 2020 class of 369 students at UCT, the majority of whom were studying medicine, only 13 per cent were classified as coming from rural schools.5F[6] My plan was to interview at least six participants from each programme and I aimed to recruit 30 students. I adopted a purposive sampling approach so that profile of participants reflected diversity of experiences by gender, language and province (cf. L.Manderson et al., 2006) with the aim to ensure representation across programmes.

Negotiating Access

Negotiating access is an integral part of the research process, a critical step in ensuring that the prescribed ethical guidelines are followed (Vuban and Eta, 2019). I joined UCT mid-term, and although I was familiar with negotiating entry in higher education institutions, no two institutions are the same. I had my foot in the door as a staff member and had already secured ethics approval from the Human Research Ethics Committee at Wits, but I was still orienting myself to the UCT context. I came across as a stranger looking to recruit health sciences students (HSS) of rural origin. In addressing this challenge, I considered a four-point plan that would facilitate access into this community of HSS.

[6] This is according to repository information supplied by the Institutional Planning Division, a division that collects data on student enrolments and qualifications at UCT

Denscombe (2003) recommends as a guideline that researchers consider who their participants will be, the level and type of data required, the time it will take to collect data, and whether the project is reasonable, feasible and capable of generating mutual benefit. Clark (2002), on the other hand, presents this as a two-stage process that includes securing access to the field as the first step, and persuading participants to provide data through interviews as the second step. As an outcome of his PhD study where he examined the precarious working conditions of mini-taxi drivers, Fobosi (2019) presented an approach to negotiating access to the field as a process that extends beyond initial access to persuading participants to become co-producers of knowledge. These include introducing the study to participants; negotiating with gatekeepers; finding one's way in the field; presenting the information sheet; obtaining consent from participants for interviewing; for audio-recording the interviews and for interacting with participants (2019 p.507).

Reporting on challenges in negotiating access to the field in Ghana, Azungah (2019) commented on his experiences of a two-staged process, similar to those identified by Clark (2002). Azungah observed the following: "one may gain official permission to conduct research in an organization but yet, be unable to get cooperation and collaboration of lower employees or management" (p. 4). As I reflected on potential challenges that I might face in accessing final year HSS, I consulted with my internal supervisor. Besides the oversight role, he provided the names of the chairpersons of the Health Sciences Student Council and the Rural Support Network and shared other useful information relevant to my study. Consequently, I was spared from experiencing many of the factors that hinder access to research sites and participants, as reported by Vuban and Eta (2019). They refer to particularly challenging circumstances in negotiating access in many settings, including administrative formality and red tape within government departments, lack of a research culture, and politics (2019). I was fortunate that UCT is a research-intensive institution and has processes in place that facilitate rather than hinder research.

Recruitment

I embarked on a recruitment drive and designed a flyer that encouraged potential participants to share their life history as students of rural origin by telling their story about their journey to UCT (Appendix C). I arranged for the flyer to be posted in the university residences, where several senior HSS were staying during the term, and on Vula--a dedicated teaching and learning platform.

Prior to in-class recruitment, I shared my intention to undertake this study with the chairperson of the Health Sciences Student Council (HSSC). The HSSC is the parent body of programme-specific councils. I also approached the Rural Support Network (RSN), a UCT student society for health sciences students who have declared their interest in practicing as rural practitioners. These students need not be of rural origin. The president of the RSN club was approached, as a gatekeeper, to initiate a chain referral sampling technique (snowballing) to help identify students willing to participate in the study. Bernard (2011, p.147) advocates this technique in sourcing populations who are difficult to find because they contain few members; I hoped that the gatekeeper would be able to identify students of rural origin who were not members of the RSN, and that these students would in turn nominate others (Vogt, 1999). In this respect, snowballing supplemented purposive sampling.

In the last phase of the recruitment drive, I approached the respective programme course convenors and requested an opportunity to address each class of final year students during their programme specific orientation at the start of the 2020 academic year. As attendance in this session was compulsory, I considered this a critical undertaking to establish rapport with potential participants. Merriam (2001) argued that besides conducting research in a natural environment, the researcher is the primary instrument in data collection and data analysis. Beyond this, based on their understanding of the research agenda, Merriam maintains that this familiarity with context allows the researcher to expand their interpretation of the data by incorporating verbal and non-verbal cues, checking for accuracy of interpretation, and exploring unusual and unanticipated responses (2001, p.5).

Inclusion and Exclusion Criteria

Those who were invited to participate in the study were health sciences students in their final year who met three conditions. They must have grown up and been educated in South Africa, and self-identified as being of rural origin. Crowe et al. (2011) consider this to be the preferred method to select cases where the researcher is looking to explore individual and shared social meanings about a phenomenon – in this case, being of rural origin. Participants must be informed and should have the capacity to provide answers to the research question. In this study, in addition to rural origin, participants needed to be registered as health sciences students in a professional degree in the Faculty of Health Sciences at UCT. These include a four-year degree that would qualify them to

practice as an audiologist, an occupational therapist, a physiotherapist, or a speech-language pathology therapist; or a six-year degree that would qualify them to practice as a doctor. Health sciences students of rural origin were excluded if they were not born in South Africa or were in earlier years of study, as they would not have had a complete experience. Others excluded from the study were students registered for the Higher Certificate in Disability Practice or the Advanced Diploma in Cosmetic Formulation Science. These two programmes did not meet the criteria as professional degrees, as the students are not required to register with the Health Professions Council of South Africa (HPCSA). The HPCSA is a statutory body that regulates health care provision in South Africa.

3.6 Data Collection

Having considered what would be an appropriate sample of the 30 potential participants identified as qualifying for inclusion, 22 agreed to participate. Two potential participants accepted the invitation but failed to confirm their availability despite email and text reminders; the third one could not commit after she returned to her home. A further five declined to participate as they did not regard their schools as rural and thus did not identify as students of rural origin.

The aims and objectives of the study were communicated at the point of invitation and reiterated at the time of the interview (Appendix D). Data were collected in two phases: an in-depth interview guided by a set of questions that served as prompts (Appendix G1) to establish participants' experiences of their transition from home to school and through university; and a self-administered guided journal reflection (Appendix G2). The interviews were estimated to take between 60–90 minutes. The first five interviews were conducted face-to-face prior to 11 March 2020 when COVID-19 was declared a global pandemic (WHO, 2020). One interview was conducted telephonically during Lockdown Level three in South Africa, but the declaration of COVID-19 as a pandemic interrupted recruitment. Except for COVID-19 related research, all direct research was halted, as were contact classes. All learning was migrated to the digital space, and lockdown also necessitated a shift in research practice.

As it was not possible to recruit students through normal channels, I approached the Institutional Planning Division at UCT. Permission to access the database of students who matriculated from rural schools was supported by a letter issued by the Executive Director of

Student Affairs (Appendix J). A couple of weeks after teaching and learning had fully migrated to a digital platform, it was possible to pursue the research online. Potential participants were recruited via email, supported by a short text message (SMS). Most interviews (16) were conducted online, mostly in the afternoons during a participant's preferred time slot; interviews were conducted on Microsoft Teams and audio recorded. In a paper published in April 2020, Saberi reported on the benefits of continuing with research activity amid a pandemic, if participants are safe and research integrity is maintained. Most interviews were conducted in the latter part of 2020. By then, the participants were in the final quarter of their academic year.

The participants interviewed in the last period were least anxious as many had already written their final exams at the time of the interviews. Whilst interviewing a participant who was working at the reception area of her residence, the interview was interrupted a couple of times in the first few minutes. The interview was paused and continued with no further interruptions once the participant was back in her room at the end of her shift. As participants had volunteered to be part of the study, I had an obligation to observe their standing commitments. Crowe et al. (2011) call for sensitivity and respect for boundaries when conducting research with participants using a case study approach.

Only one interview was terminated prematurely, after about 20 minutes, as it became obvious that the participant did not meet the criteria. The participant was keen to access the R100.00 meal voucher that was issued as cash payment at the end of the interview in lieu of the meal they would have missed had they stayed in a catered residence. During the lockdown period, meal vouchers were transferred to participants' cell phones as instant money vouchers.

Interviews were conducted onsite at the University of Cape Town (UCT) and migrated online in accordance with COVID-19 regulations. All interviews were recorded with multiple devices with consent from the participants. To preserve the quality of the interviews, both the participant and I switched on our videos at the beginning of the interview, continued with voice recording, and switched both video and audio off again at the end of the interview. In the second phase of data collection, each participant completed a guided journal of reflections at the end of a clinical rotation, in which they documented their experiences of becoming health care professionals, informed by their experiences at sites where the students were based for their clinical rotations. Through the reflective journals, participants had an opportunity to explore how their

subjective perceptions influenced the interpretation of their clinical experiences (de Vos et al., 2011, p. 310).

3.7 Ethical Issues

The study observed the ethical principles as presented below.

Obtaining permission and safeguarding the interests of students

Permission to undertake this study was initially obtained from the Human Research Ethics Committee (HREC – M180308) at the University of the Witwatersrand (Wits) where this research was conceptualised (Appendix H2). As required by Wits, I had to obtain permission from the University Registrar before I invited students to participate in my study (Appendix H3). At the time of planning this study, I was employed as a lecturer at Wits; I subsequently accepted a position as the Manager in the Office of Student Support. To safeguard the interests of students, prior to applying to the HREC at Wits, I had to obtain permission from the Dean of the Faculty of Health Sciences (Appendix H1).

Despite these provisions, the position and the office that I held posed an ethical dilemma. The students who presented to the office, although they met my criteria for recruitment, were consulting me with personal needs. Inviting these students to join the study would have conflicted with Guideline 1 of the 2016 Council for International Organizations of Medical Science (CIOMS) guidelines as they relate to public health research, that "(s)cientific and social value and respect for rights" is all about safeguarding the interests of students. The guideline states that "all research is [to be] carried out in ways that uphold human rights, and respect, protect and are fair to study participants and the communities in which the research is conducted" (pp. 1-2). In that regard, I had a responsibility to uphold the dignity of students and ensure that I was not prioritising my research interests as the mandate of the office required that I extend a duty of care to the community of students who presented in that office (Hurst, 2008).

In 2019, I accepted a teaching position at the University of Cape Town (UCT). As I no longer had access to students at Wits, I had to submit a new application for ethics approval. I obtained permission from the HREC (Ref 613/2019) to undertake the research with students at the University of Cape Town (Appendix I). As required by UCT to safeguard the interests of students,

I sought additional approval from the Executive Director of Student Affairs (Appendix J). Students are considered a vulnerable group and because of their position they are at increased risk of coercion (Millum et al., 2013). However, for these students, the risk of coercion was limited as I had no previous interaction with any of them at UCT: my teaching responsibilities were limited to first-year students; my potential participants were in their final year of study. I therefore had no means to influence the outcome of any of their assessments.

James and Platter (1999) reported on the moral, political, and ethical dilemmas that should be observed in ensuring a just and fair approach to the research process and draw attention to the values that should reflect a non-judgemental attitude by researchers. I had a heightened awareness of their vulnerability based on extended engagement with students of rural origin in the WIRHE programme at Wits. My research interests with a previous group of students had sensitised me to my obligations and competing interests that must be managed when conducting research with students in their final year. I also understood the historical context and some of the concerns raised by students during the #FeesMustFall movement in 2015 and in 2016. I had no intention of enrolling students as subjects. Rather, my interests were in the students volunteering as participants.

Voluntary Participation

Potential participants were provided with an information sheet detailing the intention of the study, an overview, and the approaches to be followed. They had an opportunity to consult me, study supervisors and the research office at UCT and had access to their full contact details should they have queries and concerns about the research process. Following suspension of face-to-face teaching, learning and research in March 2020, with the subsequent migration to an online platform, I resumed the recruitment process and included the flyer as well as critical aspects of the research process in the email invitation that was sent to potential participants. I was aware of screen fatigue associated with online learning and the demands of the academic programme on potential participants. As a researcher, I had to be mindful, once again, of the burdens that were imposed by a disrupted academic year and accordingly, I created a space for participants to commit to a slot that aligned with their other responsibilities (see also Saberi, 2020).

Informed Consent

All participants signed written consent forms confirming their willingness to participate and for the interviews to be recorded. Prior to that, the flyer that was shared on the student teaching and learning platform –Vula – was structured to appeal to the target group. The information was also explicit enough for participants as autonomous individuals to make an informed decision about their willingness to participate in the study (Appendix D & E). I shared my research journey with potential participants, including the fact that I had to reapply for permission to undertake this study at UCT and not rely on approvals that were granted by Wits. The other protective factor, extended to students, was the additional permission granted by the Executive Director of Student Affairs.

Whilst written consent was obtained from all participants, I revisited the discussion before the interview, ensuring that participants were clear on what they were committing to regarding the research process and the purpose of the study (Miller and Bell, 2012). As participants were in their final year, they were familiar with the research process and had participated in a research programme as part of their degree. This brought about an additional layer of trust to the process as there was congruence between what they were taught, their experiences as researchers for their research projects, and what they experienced in practice as study participants. These participants were keen to share aspects of their journey as students of rural origin. The diversity of participants was structured to ensure fair representation of participants about their place of origin and the degrees for which they were registered.

Confidentiality

In ensuring confidentiality of information, all participants were assigned unique identifiers that were specific to this study so that only my supervisors and I could link interview recordings and journal entries. All potential participants were informed of my intentions to include direct quotes where necessary and valuable in strengthening arguments and views of participants. For reporting purposes only, unique identifiers represent the degree, gender, and province of origin within South Africa (e.g., AudM1/LP). This was intended to illustrate the diversity of students, reflecting also different rural contexts in South Africa (Moletsane, 2012). Austin and Sutton (2014) are of the view that it is not entirely possible to achieve true anonymisation as participants can sometimes be recognised from their life stories. However, they caution researchers to be mindful of their ethical obligations.

Pilot Phase

A pre-test or pilot interviews (de Vos et al., 2011) are considered a "dress rehearsal" (p.105), allowing any researcher to plan realistically for the practical aspects of their research. These include testing for feasibility of the study; acceptability; comprehensibility of the research questions; measuring the time it takes to conduct the interview; and providing space for researchers to test instruments for their recording capacity (p.211). For this study, a pilot interview was conducted with a final year student volunteer at Wits. He met similar criteria but did not qualify to be included in the study as he had a previous degree. The exercise was repeated when the study was relocated to UCT. The final year student volunteer had taken a break in her studies and left UCT to register for another degree. She therefore did not meet the profile to be included in the study. The outcome of the pre-test was that both volunteers felt that these would be difficult conversations. Only one question was reorganised – the understanding of rural origin was prioritised over the question about the participants' families. During the interview, the order became irrelevant as the participants' understanding of rurality was heterogenous and complex, as described in the literature (Balfour et al., 2008; Ndofirepi and Masineri, 2020).

Right to Decline

Details about the research process included the right to withdraw at any point during the research journey without consequences. Participants were reassured that it was unlikely that they would be subjected to physical harm during the study period. I confirmed that there were no benefits that would accrue to them, but their participation may inform future practice. Having considered feedback from the pretest, my expectation was that some of the participants were likely to exhibit varying degrees of emotional distress. Drawing from personal experiences and insight from interacting with health sciences students about difficult experiences immediately after #FeesMustFall student protest, I decided to include a debriefing session at the end of each interview.

In-depth Interviews

The qualitative approach was a method of choice as I sought to find meaning in each of the stories narrated by the students to also consider cultural and social artefacts as determined by the context (Dey, 1993, pp11-13). In anticipation of what would be difficult moments, for the face-to-face

interviews, a bottle of water and a box of tissues were available in the office where the interviews were conducted. For the interviews that were conducted online, I planned to acknowledge, pause the recording until the participant was ready to continue, or defer to a later date and in the extreme, according to a student's wishes, terminate the interview. The interviews ranged from just over 60 minutes to the longest interview with a male participant of two hours and twenty minutes.

Debriefing Participants

Although the study was ranked low on a sensitivity scale during the application process to the Human Research Ethics Committee, during the interview some participants shared personal and sensitive information such as the recent loss of a parent or painful experiences about their adaptation. Some of the distress was presented as difficulties in securing university accommodation, feelings of being isolated, and struggles in adjusting to living in Cape Town. This vulnerability, described as transient by Crowther and Lloyd-Williams (2012), mandated a debrief for participants who reflected on a sensitive topic. This took place immediately after the formal interview was concluded. To maintain confidentiality, this session was not recorded.

Debriefing research participants is considered by Tesch (1977) as fulfilling three functions. The first one is an ethical responsibility for the researcher to engage in containment of the participant such that they do not leave with negative experiences, as this may lead participants to divulge sensitive information about the study to their friends or families. An opportunity to suspend the interview was extended to one participant who was extremely emotional when she discussed a particular topic, but she decided to continue with the interview without coercion. The participant was offered a period of time to recover, a critical undertaking and an ethical obligation for a highly stressed participant (see James and Platzer, 1999). Debriefing with the participant was particularly valuable to us both. Debriefing the volunteers as the second function is considered a critical step in the pre-test phase as it allows for scrutiny of the methodology and to eliminate surprises. The feedback from the two volunteers was useful in preparing for what would be difficult conversations. The third function, an educational one, grants the researcher an opportunity to evaluate the participants' impressions about the process, the value of the study and for them to assess if the purpose of the study was explained to their benefit. In this study, the two functions were met – the ethical and the methodological function. The third function was not tested to its

capacity except in the early stages of the interview, with a quick check-in at the end of the interview.

3.8 Data Management and Analysis

Making sense of qualitative data is resource intensive and requires structure. Merriam (2001) presents data collection and analysis as processes that should happen simultaneously as this allows the researcher to test emerging concepts, categories, and themes; this should be a process guided by literature (Crowe et al., 2011). This is supported by Hashimoto (2020) who refers to the iterative process as the analysis begins during the interviews (p.106). Waiting until the very end, according to Merriam, risks courting disaster as the process can be overwhelming (p.14). In the case of collective case designs, Crowe et al. (2011) are of the view that the analysis should focus on individual sets before making comparisons across cases. Similarly, one should take note of similarities and differences across groups. For each interview, I took copious notes and captured aspects of the initial conversation when we engaged in small talk prior to commencing the interview. This was particularly critical in the online interviews as it was not possible to keep track of non-verbal communication such as eye contact, facial expressions, gestures, posture, or body language. I relied especially on the tone of the participant's voice to gage the pace of the interview. At times, topics created distance between us, particularly when the discussion focused on sensitive topics such as family issues and participants' earlier experiences at UCT.

All interviews were transcribed by an independent person. Transcripts were stored in secure folders in my computer, together with my field notes which I converted into a soft copy. Austin and Sutton (2014) support this approach as they recommend that data be stored in a retrievable format. In analysing data, I opted for the conceptual four-phase approach described by Saldana (2013) as a staged process that uses a unit of raw data (phrase, a meaningful word or narrative) to link codes to identified concepts that merged into patterns and themes. Merriam (2001) refers to this as an inductive approach to justify the participants' presentation of the thick descriptions of their lived experiences. This approach is recommended for collective case studies as it allows for each case study to be analysed before comparing across different variables (Crowe et al., 2011). In their study, the authors included in their framework a fifth stage, familiarity (2011, p.7), complementing Saldana's four-phased approach.

This process is not without its challenges. Coupled with the difficult task of studying the individual and the collective, Reay argues that habitus can itself be subjective if it is "whatever the data reveal" (2004, p. 438). This was evident in one participant's expressions about rurality. In his earlier years, he was schooled in what he considered an urban environment. Although he lived in a rural town, he presented rurality from a position of privilege. According to Reay, habitus can be used to unveil the embodiment of issues such as class, race and gender that are played out not only in individual's actions and attitudes, but also in a whole range of bodily gestures (1995). Later, as he moved schools and relocated to a school in the township, class and race issues were expressed in different forms as a habitus that caused divisions between himself and his classmates, friends, and relatives. He had, at that point, acquired the mannerisms of the elite and, as he could not speak his home language fluently, his tone and bodily gestures set him apart from his group. He was at this point distressed about his limitations.

In overcoming the challenges presented during interviews, Crowe et al. (2011) advance that I should be honest about the extent to which I influenced the data collection and interpretation. For this participant, I took a moment to brief him about the criteria used to justify classification of rural provinces in South Africa from a health perspective. In that regard, unknowingly, I tapped into education as the third criteria that must be met in debriefing research participants (Tesch 1977). Crowe et al. (2011) recommend that researchers 'allow for unexpected issues to emerge and not force fit, test out preliminary explanations and be clear about epistemological positions in advance' (2011, pp 8-9). It follows that ongoing engagement in reflexivity is encouraged (Bourdieu, 2003).

3.9 Trustworthiness of Data

In qualitative research, Merriam (2001) argues that words, not numbers, ensure trustworthiness of data. The process of establishing consensus on criteria that constitutes quality in qualitative research is described as a "quality muddle" by Rolfe (2006, p.304), as the intention is to make sense of the participants' narratives (Austin and Sutton, 2014). Although Lincoln and Guba (1985) acknowledged methodological challenges associated with a naturalistic enquiry, they identified four criteria that must be considered to ensure trustworthiness of data. In this study, credibility and objectivity were achieved as presented below.

Credibility

In determining the truth value, a researcher must engage with the data and confirm if standard procedures commonly used in a qualitative design approach were employed and, if alternative approaches were adopted, these must be justified (Connelly, 2016). In this study, the plan was to follow the standard approach and conduct face-to-face interviews in a natural setting. Because research activities were suspended in the first few months of the outbreak of COVID-19, many of the interviews took place on an online platform. Despite this shift, it was possible to confirm identity of participants at the start of the interview and at the end as this was video recorded (Elo et al, 2014). Data from the interviewee allowed for a range of lived experiences to be captured. It was not possible to sustain a fabricated story for 60 minutes or longer. For example, the participant whose interview was terminated after about 20 minutes could not sustain their misrepresentation beyond this time.

Participants reported a range of emotions before, during and after the interview. These included nervousness about the process following the briefing, at the start of the interview, as illustrated in the excerpt below (P = participant); R = Researcher):

P: It's much deeper (laughs)

R: Oh, what were you expecting?

P: No, I didn't think about the questions, I didn't expect, I didn't think about the questions. I just accepted the offer.

R: Hmm, so are you worried?

P: No, a bit nervous.

The interview period allowed for extended engagement despite disruptions in a couple of the interviews. There was also excitement, with one participant expressing concerns that she was speaking a lot, and a willingness from a participant who said she was eager to tell me about a delicate family situation (Masinire and Ndofirepi, 2020, p.33). At the end of the interview, one participant referred to the interview as 90 minutes of free therapy, confirming the feedback from the pre-test interviews.

Reflective journaling was possible, and intersecting identities allowed for validation of some of the experiences. Although I had only been a staff member at UCT for around ten months and despite the disruptions I referred to earlier, I engaged extensively with colleagues to try to understand the context. Recognising my shortcomings, I employed member checking with

participants (see Hashimoto, 2020), not word choice, to validate meaning, by asking clarifying question and confirming that my interpretation of the narrative aligned with their stated position. At times, I used the participants' home language (isiXhosa/IsiZulu) especially in making sense of cultural expressions and other nuanced speech. Carlson (2010) recommends this approach in ensuring that one does not leave gaps in understanding a phenomenon. I used this approach to establish a connection to earlier statements.

Transferability

Transferability refers to the potential for findings to be generalised so that they are useful to persons in other settings and facilitate a process whereby a different researcher can determine applicability of findings to their own setting (Lincoln and Guba, 1985). In this study, as the plan was to gather context specific information, purposive sampling was employed to maximise sampling variation. I was intentional in drawing participants from rural South Africa and used a snowballing technique to ensure a fit between participants and objectives. Context specific information provided thick descriptions.

Dependability

Dependability refers to maintaining data stability over time and under different conditions (Polit & Beck, 2014). In ensuring data stability, a stepwise approach was employed to ensure validity of the process. The sequence that I followed was that the journal reflection followed the in-depth interview. This was intended to grant participants an opportunity to contextualize their clinical experiences having engaged with Phase 1 of the research process. The audio recordings and journal reflections provided an audit trail of participants' reflections and their subjective experiences. In my field notes, I recorded the date and time of each interview in addition to scheduling the interviews as calendar appointments that were accessible to the participant and myself.

Confirmability

Confirmability is concerned with consistency and objectivity, and confirms if data accuracy, relevance, or meaning can be achieved irrespective of whether data are analysed by one or two people (Polit & Beck, 2014). As this study used an interpretivist approach, Guba (1981) supports an approach where the researcher practices reflexivity by intentionally revealing to the participants

their underlying epistemological assumptions about the study and its intentions. The ambiguity of rurality as a context called for a frank discussion in communicating the intention of the study, particularly during the briefing sessions. Content analysis comprised two sets of data – the interviews and the journal reflections. Ongoing reflexivity during this period allowed for ongoing examination of my biases and subjectivities.

3.10 Summary

In this chapter, I have explained the research design as guided by the aims and objectives of the study and discussed habitus as a methodological tool. I reflected on the measures I had to put in place in negotiating access as the study was conceptualised in a different context to the one where the study was finally situated. I also discussed the adaptations I had to make to my research plan so that I was compliant with COVID-19 protocols. In the next chapter, I present the findings as the study participants' understanding of rurality in relation to their habitus.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter is presented in two sections. In section 1, in response to the first objective of the study, I present findings from a qualitative exploration of rural and rurality by health sciences students. In section 2, I explore the transition from school to university and students' adaptation to the university context. Verbatim quotes from interviews are included throughout to provide evidence about the lived experiences of participants. In section 2, I mostly employed verbatim quotes to enable the voices of students of rural origin and to enhance readability of their complex experiences.

4.2 Exploring Rural and Rurality

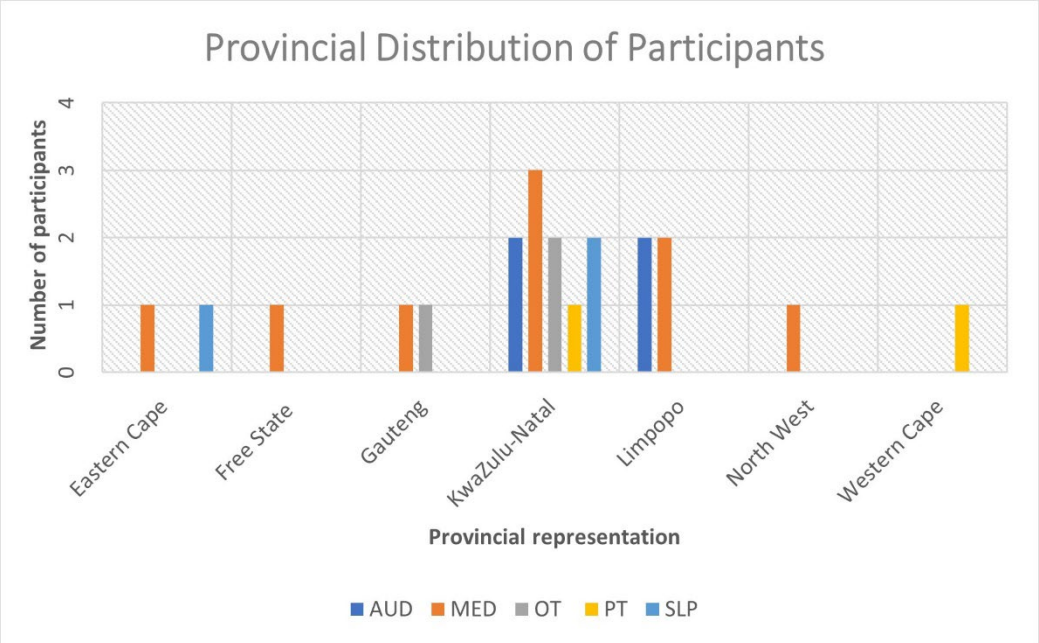
In exploring participants' understanding of rural and rurality, I asked each of the 21 participants: "You identify as a "student of rural origin" – could you tell me about that identity? What does this mean to you?" The participants' responses were distilled into 42 indicators that were consolidated into three themes, namely demographic factors, social factors, and educational factors. All verbatim quotes are reported according to the participant's degree, gender, and province of origin in South Africa (e.g., AudM1/LP – the degree is audiology, the participant is the male no.1 from Limpopo province). This was intended to confirm the extent of diversity of rural contexts in South Africa (Moletsane, 2012).

4.2.1 Theme 1: Demographic Factors

The demographic profiles of participants reflected complex family structures and roots in seven of the nine provinces, with only Northern Cape and Mpumalanga provinces not represented among participants (Figure 4.1). All participants (n=21) offered a descriptive indicator of rurality either from a geographic or infrastructural perspective. One participant contextualized the period in which the research was conducted – "I am currently in quarantine with my mom, aunt and grandmother, my brother and two cousins" – and explained rurality as a home base, as a "township

with some places that are like villages" (AudM1/LP). Some participants linked rurality to locality and to a provincial perspective, as in this description: "So I come from the rural area, I am from the North West, the rural side of the North West" (MedF1/NW). Other participants defined rurality based on population density, referring to a very small town with limited population or a town in a rural province. Participants also compared rural and urban settings:

> Well, for me, a student of rural origin is a student who didn't grow up in a populated, well-developed city area and didn't have, I would say, similar opportunities as those kids living in the cities basically (MedM3/EC).



Key: AUD= Audiology MED = Medicine OT = Occupational Therapy
PT = Physiotherapy SLP = Speech-Language Pathology

Figure 4.1: Provincial allocation of participants per degree

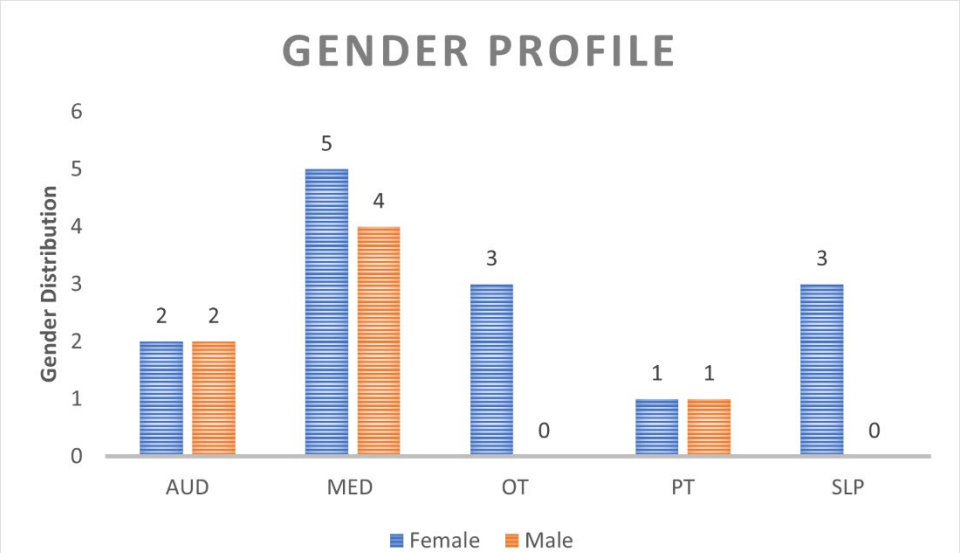
A few participants also mentioned historical context: "I come from a previously disadvantaged area which has limited resources in terms of the community and the schools that we have" (AudM2/KZN). At times reference to quality of infrastructure was linked to the apartheid era, with variable development resulting in dilapidated facilities: "everything was constructed a long time ago…in the 1950 something" (MedF1/ NW). Most participants registered their home language as

IsiZulu (8), whilst one participant also highlighted her lineage: “I am actually Sotho, my father is Sotho but my mum is Zulu so they were never married ... so I grew up in KZN” (MedF2, KZN).

Others stated their home languages: Afrikaans (2), English (2), IsiXhosa (2), Sepedi (2), Sesotho (2), Setswana (2) and Xitsonga (1); some of the participants were multilingual. Participants were conscientized to levels of rurality:

> So I definitely come from a more privileged rural background than a lot of the people I grew up with. Yes, it is a predominantly white farming area (SLPF3/KZN).

Two thirds of the participants were female (n=14), but in two of the programmes – OT and SLP – all participants were female (Figure 4.2).



Key: AUD= Audiology MED = Medicine OT = Occupational Therapy
PT = Physiotherapy SLP = Speech-Language Pathology

Figure 4. 2: Gender profile of study participants

Back in their rural homes, only four participants lived with both parents. Many had either lost one of their parents (6), came from a single parent household as their parents had never married, and some had never met one parent (8). A few participants grew up in an extended family setting (3). The complexity of the family profile was well captured in descriptions provided by a few participants:

> My dad passed away and I have been living with my uncle and his wife, like, I call them my parents…they have two children and those people are my cousins but I call them my brother and sister…My biological mom lives in KZN and I have two siblings that side...that is like my biological family (MedM1/FS).

The family profile also reflected the realities of families in South Africa:

> Mom and Dad, they are about to hit 60. So they're quite old in that regard. So they had my three older siblings ... and then there's me and outside of the marriage, unfortunately, my dad has two other sons, one of which passed away last year (PTM1, WC).

Infrastructure and resources reflected the tensions between the have and the have nots in terms of wealth status.

> What makes it rural? I think we can speak in terms of infrastructure, I can speak in terms of services ... that we don't have, and other places have, when we compare it to Mafikeng, Mafikeng is the capital of North West and then where I am from, you will see that the infrastructure there, there is only, there was only one main town (MedF1/NW).

Rurality was defined based on lack of basic services:

> My definition of rural is very different to a lot of other South Africans' definition of rural. The reason I say I am from a rural area is because it is so far away from those basic services so it is more geographic (SLPF3/KZN).

The urban-rural dichotomy was mentioned as variable and was presented with a multifocal lens that included distance from town, schools, healthcare, restaurants and good entertainment.

> Basically, to me, being of rural origin means growing up in, like rural South Africa where we don't essentially have opportunities that you find in urban South Africa. You have to travel quite a distance to the nearest city. The nearest good schools are really far and that means obviously limited opportunities and limited access to a lot of things. More than education it means limited access to good healthcare, limited access to good entertainment (MedF5/GP).

Other participants gave similar definitions that ranged from limited service to zero basic services such as the fact that there was no automated teller machine "No ATM." This participant also observed that there were no shopping malls except for one supermarket, a "USave store" (MedM1/FS). One participant attributed the closure of a branch of one of the local banks as the outcome of high levels of unemployment: "there isn't a lot of job opportunities…a lot of my people

had to go to other places to look for work" (MedF1/NW). Many of the interviewees referred to lack of resources. Besides being small, some rural towns were profiled as "everything was on the main road" or a town that lacked infrastructure and had no plumbing.

According to some participants, a rural town was not able to be self-sustaining as it had no public transport, it was a place where there were "no roads, nor tar" but had a "proper gravel road." This view was shared by one participant as follows:

> So I mean, firstly, the infrastructure ... you will find that the roads are still, there is no tar road, there is still the old houses, huts and even going to school, I had to walk a long distance going there. And then regarding resources, there is not a lot of basic resources that I needed in grade twelve, like a library, like an internet café. (MedF2/KZN)

Rural areas were referred to as places where you walk long distances and road surfaces consisted of a mixed terrain: "Yes, it is very dusty, there are lots of mountains surrounding the houses, the houses they are not secluded, they are connected together and then in between the houses there's mountains, there are trees, there is a forest. So when you walk from one place to another you have to pass through forests and stuff" (AudF2/LP).

Notably, for some there was no water and no electricity, and so there was an added element as rural areas were also places where you had to use firewood. One other participant referred to this as a place with limited business transactions: "It is bare…it is tough … population there is less than a thousand population and there is not really a CBD (central business district) and animals roam the street" (SLPF1/EC).

One participant expressed shock and disappointment upon realising that her hometown was very small compared to others.

> I didn't realize that it's such a small town, like, I'm such a small-town girl, because I was having a nice experience there. But the moment I stepped out, then I realized that no, like, there's actually nothing going on. It's just in a way, if I could say, a dead place (OTF2/KZN).

This had implications for participants when they were trying to process their application forms as prospective university students, including applications for funding. One participant mentioned having to take two taxis to the main town to sort out paperwork and get copies of bank statements and stamps that were required to support the application forms.

Access to health care was referenced as an indicator of rurality that was presented as either limited, unavailable or far from the community by just over a third of the participants (n=8): “Ja, it (Mobile clinic) comes, they post signs in advance and then they will be there. I don’t think a lot of people actually rely on the mobile clinic” (MedF4/KZN). At times, this reference was used to highlight the fact there was no access to emergency care and security services, including linked to incidents of crime, alcohol misuse, and gender-based violence: “So we had a very poor response when it came to police and emergency services like ambulances” (SLPF3/KZN).

For one participant who resided in a rural town and considered himself somewhat privileged, rurality was defined by the time it would take to travel to a healthcare facility and access health care.

> Access to, well since I am a health science student, access to immediately available tertiary healthcare maybe, and stuff to similar avail, because from where I am it is about two, three-hours’ drive to get to a proper tertiary facility or good healthcare (MedM3/EC).

4.2.2 Theme 2: Social Factors

Participants largely regarded rural communities positively (n=16), although a few participants (n=5) considered aspects of community living intrusive. Participants profiled rural communities as places where everyone was connected to one another, where everyone looked like you and spoke your language. "Dude, we greet each other from where I come from in the North West" (Med F1/NW). A greeting was also presented as a form of affirming established community norms:

> It’s not a simple greeting, it’s acknowledgement of somebody’s presence that I see you and you are worth me saying, hi, how are you. Where I come from we greet not just as a formality but we greet as a form of recognition of a person’s being and I just realize here that people just, not even that they don’t greet, they don’t see you. You’re not seen and I think I’ve also just learnt to adapt to that life. (PTF1/KZN)

One participant was greatly distressed by what she observed when she arrived in Cape Town as she tried to greet everybody and was met with silence:

> I also want to say that within my community everybody knows everybody, and everybody knows what you are doing, and so it was very different to come here to Cape Town where

nobody knows you, nobody knows what's going on and your mom doesn't know where the shops are and now all of a sudden you have to try and figure that out (SLPF2/KZN).

Arriving in Cape Town awakened participants to what it means to be of rural origin, that you are not the same as others and that you come from a disadvantaged background.

So, you know, I only realized this, or I only realized that I had that identity, when I was put amongst other people that I think I would identify as not from that identity. For example, when I was at home, I didn't see anything rural about being home, and I didn't see it, like, as a label or an identity until I was within like, other people that I could see that they clearly do not fall under these criteria or like identity that I'm in as well. So I would say that it was like, I don't know, like, not a wakeup call, but like an awakening to my own identity. And then I did realize that there are differences between me and other people. And I kind of realized that I actually come from a disadvantaged background when compared to other people (OTF2/KZN).

One participant referred to the challenges of maintaining a dual profile:

So something that was really challenging for me was when I came to Cape Town, nobody actually greets, like everyone you just pass by without greeting and that's not something that happens at home and I notice that when I go home sometimes I bring that with me and I am seen as rude or impolite but it's almost like a culture shock whenever I come here or whenever I go back home, it's like having to switch between those two frames of mind, those two identities of being a child of a community and just being an individual which is what I experience when I'm here, I'm just an individual, I'm one of many whereas back home it's like I am one of, I'm not even one of, I am part of whereas here I am one of. If that makes sense? (OTF3/KZN).

Participants reflected on their experience of the community as the place where they were cared for deeply:

I also feel like the achievements that I made in high school when I did well it was a celebrated thing and my parents would tell the neighbours who got super excited and so I

> feel like there wasn't an expectation that I should do well and there were no consequences of not doing well if that makes sense. (SLPF2/KZN).

This in turn fostered a habit to emulate that which they observed in their everyday lives: "you develop an innate need to help those around you and, you also become sensitive to the needs of others" (SLPF2/KZN) and you learn to advocate for the needs of others "you become socially aware and teachable" (MedF5/GAU).

The social connectedness was such that individuals' achievements were celebrated at community level. One participant referred to an appreciation that extends beyond an event:

> But coming from a rural area it is quite different from the township and the suburb as well. In terms of it is much more connected, in a village you are much more connected like a little family where everyone knows each other and is in each other's business and everyone is concerned about each other, whether it is a good thing you just find that as they say that it takes a village to raise a child. The village is really concerned in raising a person…I come from Limpopo by the way in a rural village deep in Giyane. So the culture there is very much people are very humble, soft spoken and all of that. They are not selfish people. They are very considerate people (AudF1/LP).

Similarly, one participant spoke of her appreciation of her village upbringing that made her people-centred.

> So as much as I was growing up in a village setting at home, I wasn't living the same experiences as the other people in the village. I was just there because my grandmother had businesses there. But overall I think I enjoyed the experience and it has taught me to be a grounded person and now I am able to relate to people from all backgrounds even where I am, where after moving those qualities, those characteristics have been instilled in me such that I can relate to anyone and that I am able to make anyone comfortable regardless of where they come from because of the experiences that I have gained and understanding the type of people from villages and just understanding humanity on its own (MedF3/LP).

Church was an anchor for quite a few participants and impacted values: "the values I have is that I am patient and I believe in the thing I am doing, so it is all of that values that I took out from church" (MedM2/KZN). Church was defined as a place where there was a sense of belonging

where you could be one with the community: "Even though I was very young myself, I was actually teaching the young children. So, I was like their Sunday school teacher" (MedF2/KZN). It was also a place where one could make a meaningful contribution as a lay preacher:

> When I went to live with my grandparents you had to know scriptures by words, you had to stand up and speak what, like from what do you think about your Lord, about your Jesus and…people would be saved… there would be scriptures and then there would be interpretation of the scriptures. So we will need to cram the whole thing, like maybe two pages or four pages. So you need to cram it and so you will be speaking as if it was written by you (AudM2/KZN).

Another aspect that was considered as a positive aspect of rurality was the opportunity to build cultural capital and confirm one's cultural identity. For one participant, it was the opportunity to participate in the traditional coming-of-age dance: "I participated in umemulo" (PTF1/KZN). This ceremony is hosted by girls' families or by the community to celebrate their coming of age and their purity (Turner, 2018). It presents an opportunity for the family to declare to potential suitors that the girls are ready for marriage. Another participant revered the opportunity to have ready access to her forefathers: "Basically, this is the ancestral home of everyone. So, a lot of the time so if you like move to the city and are tired of living there then you come back to our house – the ancestral home" (MedF4/KZN). Another participant described rurality as a place that afforded him protection: "Yes, I do wear isiphandla,[7] the sheep, goat skin. When at home we slaughter a goat or (some)thing like that. I think it is about protection mostly" (MedM2/KZN).

The social connectedness that characterised rural settings was at times reported as intrusive, as nothing was personal and private: "Everyone is interested in your business and everyone knows your business" (MedF3/LP). This posed a challenge to participants in negotiating relations within families, with teachers and within the community. One other aspect mentioned by two participants as serving two goals was household chores. One participant presented chores as either promoting social connectedness if others could join you. On the other hand, it was considered a nuisance if this hindered you from playing games with your peers.

[7] Isiphandla is a piece of the goat's skin that is fashioned into a bracelet. It affords divine protection.

These dichotomous views about rural life were evident in quite a few of the interviews. One participant was at pains to describe the contrasts, and summed up her views as follows:

> So I feel like being a rural student for me meant that our opportunities were, there wasn't as much of a drive to do so much and there also wasn't as many opportunities to do so much. But I don't want to speak of it negatively because I also think that with - that it gave you space to not feel so much like…almost I want to say no pressure (SLPF2/KZN).

Another participant who was born in an urban area (Gauteng) but moved to a rural area, lived with her grandmother and attended a local school, referred to the positive aspects of rurality as pursued by those who were looking for a tranquil environment and embraced the beauty of rural living.

> Technically I'm not a rural child but then everything around me is called a village or it's called intimate or quaint so it's got that, it's almost like a more relaxed lifestyle, so it's just being aware of what's good for you like resting, not even that fast paced lifestyle, just slowing down and connecting with people so that's my experience with being a rural child or a rural person I guess (OTF3/KZN).

Participants also mentioned constraints often associated with people who reside in less populated communities. One participant described poverty as an everyday experience for previously disadvantaged Black people who must constantly negotiate as he referred to "difficult socio-economic circumstances" (MedM4/KZN). This was supported by another participant who reported on the effects of poverty as a vicious cycle that influenced people's behaviours and lifestyle choices.

> We can go on forever, poverty is a huge factor in the surrounding communities, poverty is inextricably linked. Two things like alcohol abuse in my person opinion because we saw a lot of people suffering naturally and not knowing how to escape their circumstances. So they turn to things such as alcohol and unfortunately such that I saw the alcohol had a negative effect. Obviously creating this negative cycle because it is affecting finances but also just emotionally on the people in that community. Alcohol resulting in violence and not getting the services they need. It was quite a thing to see (SLPF3/KZN).

4.2.3 Theme 3: Educational Factors

School was highly valued by the parents of many participants, irrespective of their marital status, and by their grandparents who at times were the custodians of their education. In some instances, members of the extended family motivated them to stay in school. Education as an indicator of rurality was represented in a range of mostly negative descriptors. One participant spoke of the size of his primary school and the distance of his high school from home.

> I went to school in Ashton. It's a Model C school. So, it's very mixed. We were, it was a very small school. The entire school had a population of about 130 kids. In high school, I didn't go to high school at home. High school was about 100 kilometres from home, so I was in boarding school (PTM1/WC).

A few others mentioned the lack of school transport and having to negotiate very harsh environmental conditions:

> I remember the other day it was raining and I had to cross a river 'siwel'umfula' because it was so long, I slipped and I could not go to school because my clothes were dirty and obviously, I didn't have a raincoat or umbrella so I had to go back. So it is all those dynamics and we were eating the food they provide in school (Med M2, KZN).

In the rural areas where most participants lived, there was a limited pool of schools from which to choose. Many reported poor infrastructure as limiting their access to good education -- there was "no computer, no library, no internet" (MedF2, KZN). The long distance to school meant that some participants could not participate in extramural activities: "I had to travel a distance of 3 kilometres every day such that I was too exhausted to participate in extramural activities" (AudF1, LP). One participant explained the lack of extramural activities meant that he became bored staying in the school hostel. Subsequently he was caught up with the wrong group and started using drugs even during school hours. There was not even a sportsground at his school for an aspirant professional soccer player: "I loved to play soccer … I wanted to play professional soccer, because there, there were many opportunities to go to play like those big teams – Pirates, Super Sport" (AudM2/KZN). This view highlighted the differences in the schooling system:

> I think I can only speak to my rural context in terms of how I have learnt now what people from other high schools in a non-rural context experience their high schools if that makes sense. The only way for me to explain this is by contrasting (SLPF2/KZN).

Internet access was a challenge. For one participant, this meant climbing a tree at home to find a spot that would provide coverage or finding a spot on the veranda:

> Okay, for example they don't have many schools and at the schools they do have they don't have things, they don't have computers, we don't have resources… you have to walk probably an hour or so to go to school. We don't even have public transport that comes to where you stay to take you to town to take you anywhere…where I come from, we don't even think about things like YouTube or Instagram or things like that. We know there is social media but we are not that established or something and so when I came here, I was like, oh okay, so there are these things (AudF1/LP).

Another participant complained about the lack of resources as hindering academic progress: "And then regarding resources, there is not a lot of basic resources that I needed in grade twelve, like a library, like an internet café" (MedF2/KZN).

Many parents and extended family members were teachers or nurses. Only one participant had a sibling who had completed a medical degree. The range in available resources in schools led to the continued migration from one school to the next in pursuit of a better school, and participants reported changing schools frequently to pursue what one participant described as a "better education" (MedM2/KZN). One participant who stayed in a rural school felt that she was ill prepared for what was required of her at university. Another participant felt that his school trained him simply to pass matric.

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School hopping (Figure 4.3) is an indicator of transferring frequently to different schools. This was reported by many participants (n=17). This was either self-initiated or influenced by a parent (s), grandparent (s) or an extended family member as an intervention against the negatives associated with a rural school. This pursuit of a 'good school' was intended to support participants' plans to study at institutions of higher education beyond their matric year.

Aspects considered positive in rural schools included the support roles of individual teachers, and highly committed teachers who offered additional classes after hours.

> I had a good relationship with my teachers except for a few but I have always had a good relationship but the ones that impacted my life are those in Mafikeng when I was in grade 11 and 12 and in the school that I went to, it is a very good school, the teachers are so dedicated so their dedication inspires us to be dedication also, to our studies and everything and they pour out everything, they gave everything, they would come to school on Saturdays, in our matric year they would make us come to school at half past 6 we are already in class, so they were a working force and they would always tell us the truth and they would put reality here (MedF1/NW).

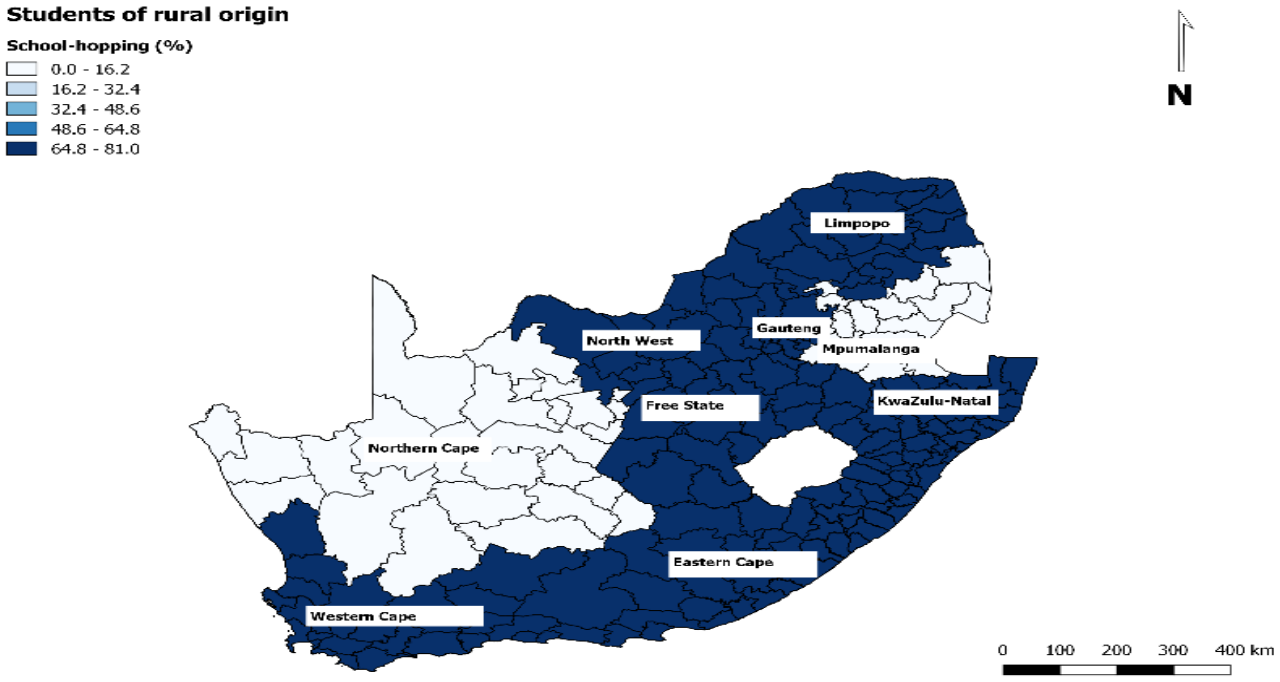

Figure 4.3: School hopping among health sciences students

A few participants considered themselves to be the teacher's favourites:

> I was the favourite; people called me teacher's pet or something. So, I was one of those where you be going in and out of the office, asking questions, getting them coffee, them

> giving you their lunch boxes, all that very close relationship with teachers. I had that one. All primary school years and my high school years were best. They were even volunteering to buy me study guides and things and contacting my mum. We had that; it was…I had a very nice schooling career with lots of support AudF1/LP).

Sometimes it was the principal who ensured continuation in school by paying for transport and school fees.

> My principal helped me a lot. He was almost a father figure to me because he pushed me a lot and he always come with articles … Sometimes he would call someone to call me from class and he would tell … I am preparing you to go to university when you pass matric. I want you to pass with flying colours (MedF3/LP).

In this section, I have presented participants' views about how they have experienced growing up in rural South Africa. They described their experiences in the community as both supportive but also, at times, intrusive. For many, family and teachers played an important role in their education. In the next section, I explore their journey in becoming a health sciences student at the University of Cape Town.

4.3 Becoming a Health Sciences Student

In the following section, I describe participants' personal journeys in becoming university students. I examine their experiences of adapting to a higher education institution. What emerged were three themes: an aspirational habitus, disorientation, and adaptation. Participants had to respond to the following statement: "I would like to know more about your decision to come to university, your expectations of this, and your experiences in the past [n] years you have been studying at UCT."

4.3.1 An Aspirational Habitus

For many participants, becoming a health sciences student was not a straightforward process, although it was the next logical step in realising a career they had always wished for. Many participants described themselves as high achievers throughout their schooling years. Most of the

participants had applied to other universities before settling for UCT. Some of the participants have become aware of UCT's profile and wished to be associated with a high-ranking institution. Many participants were keen to pursue a degree in medicine. A few expected being able to transfer into medicine in their second year, or they registered for their preferred degree:

> So I initially wanted to study occupational therapy, I study speech therapy now…at Clifton it was such an incredible school. I was watching a swimming gala one day and this boy came over and gave me a massive hug and threw me to the ground. He gave me such a big hug I fell over to the ground. That's really how close knit a community Clifton was, I didn't think it was weird that this boy was giving me a hug …and it turns out that he had down syndrome… I asked my mom what down syndrome was. And I said to my mom what can I do to work with people like this every day and she said occupational therapy because that was her understanding of the profession. I tried and I tried, and I worked my butt off, but I couldn't get into OT but I got into speech. (SLPF3/KZN)

Lack of information and unmet expectations were a challenge for some participants, as they were first generation university students and had to break new ground.

> When I was in grade nine there was a school trip and they were going to Cape Town but then I couldn't go and I was like, in my heart, one day I will go and I will stay for a long time until I get tired… I think I can say one of the things I regret is not asking questions, like when I was in grade twelve because that actually made me not to have any expectations really. I didn't know what to expect I was just going to a place, I didn't know anyone, I didn't even know anything. So I think one of the things that shocked me it was registration day and I really enjoyed maths at school. So when I was looking at my courses, I found that maths was not even one of the modules that I was going to do. I was really shocked but I thought to myself there is no other degree that I want to do, I really wanted to do medicine but at least someone should have told me that there is no math. It was hard to expect anything really because I hadn't been to university. No one in my family has been so it was just a new experience (MedF2/KZN).

A few participants relied on their teachers for guidance and were unaware of the administrative processes at various institutions and their primary role in confirming their placement. As a result, they registered for degrees that they knew little about:

> My teachers were influencing me to go to Wits, so I applied to go to Wits and Sefako Makgatho, I applied to University of Limpopo. Yes, I think all this and also UCT, and then they were the same options ... I was going to be taken with medicine… for me things were just very weird it was something because at Sefako Makgatho they were like, you are late with your statement and your results are so beautiful we would have loved to have you in medicine. Then I go to Limpopo and they are like, oh we have already selected for medicine and we didn't have your results. How was I supposed to know that you don't access the results? Because UCT told me they access the results themselves. I thought that every university does that. That's the disadvantage of being in an environment where you don't have information…and so everything just fell apart and I was left with one option -- come to UCT and study audiology (AudF1/LP).

Based on their academic performance in high school, a few participants, and their teachers and family members, had high expectations that they would become doctors. For this participant, the family were already referring to him as 'doctor' and encouraged him to apply to UCT.

> My dream was always to study medicine. Because, you know, I had an interest in it. And because back home, my mom and dad, my siblings always encouraged me and they were calling me like, you know, doctor and stuff like that kind of living in my dream, you know, kind of realizing it. And so that motivated me to study medicine. …The actual reason I applied was because of my brother-in-law…he studied a BTech in Paramedicine. So he, you know, he gave me his laptop, because at the time I didn't have access to a laptop, he gave me his Wi-Fi. And he told me, I could apply from his laptop to UCT And I was like, UCT? He's like, yeah, it's a university there in Cape Town, very big, because I wasn't aware that UCT was even University of Cape Town was even a thing. I only knew about Martie (University of Stellenbosch) and Tukkies (University of Pretoria), and you know, as a high school kid, that was very, you know, go to this university because you know, the rugby player who plays for the Blue Bulls or the guy who studied medicine who is now Dr. Groote Schuur went to this university. Marty's. you know, the big names and stuff" (PTM1/WC)

The support extended by family was enough to inspire one participant to pursue her dream to come to UCT, as a first-generation university student.

> So my dad and my grandmother have really always, just like, given me so much freedom to go after my dreams… And so that's like, kind of freedom really, like, I would say, influenced me or inspired me to feel like I can do whatever I want… So, even though they weren't really like, they weren't graduates, or they didn't have money…them giving that freedom and making me feel like I can really achieve whatever I put my mind to... I think that really like motivated me to get like to UCT and to even look at my end, to see myself as someone that can go to UCT because I actually could have just accepted the other because I was accepted to a lot of varsities, I could have just went to the local ones. But I knew at the time that UCT is ranked as one of the best ones (OTF2/KZN).

Not all participants could afford to pursue their studies directly after matric. Finances were a challenge. Despite limited resources, the determination of one participant paid off as she learnt more about her preferred programme while seeking financial support.

> I had to spend two years, two gap years after matriculating before I entered university… In the two years I worked, I was helping my grandfather, he ran a recycling company. So I was sort of like his PA… I did have plans. I wanted to study psychology and be a psychologist and then get a job, get a house (laughs)…I didn't want speech I wanted more audio, I wanted to do something in the health sciences but I also wanted to do something technological as well so audio combined both those things. Before I applied, I searched audio. So I gathered some information on it then proceeded to apply. I ended up at UCT because one, they responded first, and two, the also offered me financial aid as well in that response. So it was more of a set thing. So if I came, I wouldn't have to worry about finances because that was already sorted." (AudiF2/KZN)

One participant, whose sibling was also doing medicine and whose father was an optometrist, had an opportunity to spend time with a local General Practitioner. He found the transition from high school to UCT much smoother.

> When I was in younger years in high school, I really didn't know what I was going to study. I didn't really have any career guidance… I thought maybe I would do engineering or accounting or something like that. I didn't even regard medicine as an option. I don't know why actually. So in grade eleven I started getting serious about learning about career opportunities. I shadowed a medical doctor, a GP practice to see what that was like. Then

that is when the interest for medicine really started for me. I was in about grade eleven, I thought let me apply to all the universities for medicine. So I applied to all of them and then I heard a lot of good things about UCT. UCT was always this reputed university for being one of the best universities in the country. So I was very interested… And also my sister went to UCT as well, I forgot to mention that. She was already in the city so my parents said you both can be there (MedM3/EC).

On the other hand, one participant came from a family of graduates, was exposed to various career options, and could attend university open days, but she was misinformed about course requirements for the degree that interested her. In the end, she opted for medicine.

Like I said I have always wanted to be a doctor and I remember in high school in grade eleven and twelve I was so into physical science it was crazy… I remember thinking I am going to do materials and metallurgy, I am going to do some engineering of some sort, that's what I want to do and then, but I always knew that I want to live in Cape Town, that has always been a thing for me. I always known that I wanted to go Cape Town and my sisters took me to open days. I went to the University of Pretoria open day and the Wits open day and then I saw the pharmacology department had a little pop up and I was like, oh my gosh, this is so interesting, and they said yes, but you have to do medicine to do it. I was like what? They are like you have to do medicine to do it. And there and then I decided okay cool, this is what I am applying for (MedF5/Gau).

A talk on TV about the shortage of health care workers encouraged another participant to consider pursuing medicine. However, by the time she got to matric, medicine was not considered a priority among her peers, casting doubts about her aspirations.

I had many options because, we went to a science school and our science teachers were very good and it was very easy for us so we were like chemistry is the way to go and you get to varsity and see that it isn't the same as in high school you know but I think because of that and a lot of them were not talking about medicine. We were in an era as a country where they were saying, scarce skills and maths, science were put forth and they were not talking about medicine, it was engineering, engineering was a thing, everyone wanted to do engineering, "they were saying engineering you will never struggle looking for a job and it has a lot of money so engineering nje". My other friends from high school one of

> them did civil engineering and the other did geology and stuff like that, so in my high school those were the careers, no one wanted to do medicine (MedF1/NW)

A few participants opted for UCT as it offered the distance that would allow them to mature at their own pace and in their own time: "I know I was good in accounting, but I don't know something pushed me to do medicine and then…I didn't want to go to Joburg because I didn't like Gauteng and UKZN was close to home. I wanted a bit of distance from home which I did get" (MedM2/KZN).

4.3.2 Disorientation

Level of disorientation was directly related to lack of information about Cape Town and the Western Cape and participants' own assumptions about the place. Limited access to information about the degree they wished to pursue was another contributor. Participants struggled to adjust to the institutional culture and a few experienced failures for the first time. Although he still had to adjust to moving from a small town, the participant whose sibling was also a medical student was better prepared than others, as he was briefed about what to expect.

> My sister obviously had good things to say about UCT and the teaching there, even though she did say it was really difficult… At UCT the first six months of your degree is physics and chemistry. And so it is kind of like an intensive course, you do a lot of, most of physics and chemistry about six months. And it was quite intensive and quite labourful and that was the part that she mostly spoke of… I was excited to become a doctor. I am experiencing UCT, being the big city from a small town, experienced the change of the difference therein. My expectation was it was going to be very difficult, and I had to buckle down and get to work from the beginning… (MedM3/EC).

For other participants, the first few weeks were disorientating as their expectations were not matched by their experiences.

> UCT, the school is within the city. There is fun everywhere, it was all about fun. I didn't think it was serious. I didn't think about the serious stuff; it was just fun … we would be at the beach. And then when I got here things were not what I thought… during O-week when we were going to our classes when they were explaining things, you would see they

are focusing on studying not all these fun things. I think that's when I realised we are not here to play… And I realised here we are here to study, nothing more. The other things are just a bonus (AudM2/KZN),

A few participants struggled as their expectations were that all Black people had similar accents. This forced them to reconsider their position and reflect on their own prejudices.

So much diverse people, it was the major thing…I am used to speaking isiZulu all the time with everyone and here you can speak to a Black person and they don't even know what is isiZulu and you are thinking this person is better because they went to a Model C and you would come with your own preconceptions about Black people why are they behaving like this, they think they are better (AudM2/KZN).

As the orientation goes on...you get put into groups…you know, even though when I got there at UCT, it was very, very intimidating to me, I'm sorry to say that. It was just very weird to me, because, you know, back home, the Black friends that I had spoke Afrikaans, and they spoke it fluently, like, fluently with an accent and everything. When I went to Cape Town, I'm like ... you know, my Coloured friends start speaking English, my Black friends are speaking English, and they speak it perfectly with an English accent and everything. And I was just like, like, how do I fit into this, like, yho my English is so broken and everything. Like, it was just like, a huge, huge, you know, mind shift, you know, to like, say like, Listen, be humble, know, where you're coming from …but you know, won't be as good for you as you think they would (PTM1/WC).

These shifts were framed around living in a big city like Cape Town, but also related to challenges experienced by participants in transitioning from a rural to an urban life.

I always knew I wanted to come to Cape Town. There was (sic) barriers to me getting here …and when I got here it was a very big shock to the system. I came here when we didn't even have a KFC. We didn't have a McDonalds we didn't have any fast food. And now I was living a 100 meters down the road from a KFC and a McDonalds and everything. I found it very difficult once again though to make friends who were like minded and who, I like to think of myself as not a superficial person and… I found a lot of people more concerned about the superficial side of things…I found it very hard to make friends but the

> friends that I did make were very good ones. My mental health took a big hit living in the city. I think I wasn't quite prepared for it (SLPF3/KZN).
>
> To be honest my expectations were -- I am so far from home, I am going to live my best life. I am going to make friends, during the week I am going to study. and in the weekend I am going to go to the beach and just be a nice girl, have fun making friends. And the first thing when I got to UCT was I got a culture shock and then I was in the library every day. The shock made me crawl back into myself; I didn't want to socialise and stuff. I would rather, I kept to myself (MedF5/GP).

A few participants came to UCT with no expectations. They assumed that their academic profile would be adequate and make up for their upbringing in a rural area.

> I think it happened to a lot of people coming to university, you come from where you are coming from, straight A student, you arrive at UCT and you are the cream of the crop you are going to do so well. You come fall on your face for that first year. So I did think it would be a lot easier than it was because I lived away from home for so long I assumed that I would just breeze through everything. The first big hit was being put in digital literacy because I see the computer before; I knew how to type and then I arrive here, and they like, you don't know how to use a computer. Other children are going to go through all these things and I know have to sit in the lab for three hours at a time learning how to use the computer. So that was the first wakeup call in a whole other place now and I don't have the capability like what I did (MedF4/KZN).

For this participant, the transition from being a 'big fish' to a 'small fish' was hard as her presence was not acknowledged and she struggled to maintain the academic pace.

> I came to UCT and when I got here…so I didn't really have expectations. I was here to study and become a doctor and excel... I got very high marks for physics and life sciences I didn't have any expectations. I just assumed that I would do very well, I would be fine. And then that changed… So when I got here remember I said when I was in high school. I had a lot of people cheering me up and I was a big fish in a small pond and then now everything is reversed. Now I am a small fish in a big pond. No one knows me and sometimes you do find that some of our lecturers know some of our classmates or I was the only one in my class I had no social support nothing. No one I knew in Cape Town or

at UCT from my school or town, nothing and some people there has been a history of them coming to the university…So for me that took a toll on my confidence. So now no one knows me, my lecturers don't know me, they don't even care if I am there or not. No one is pushing me and now I am adjusting to this place (MedF3/LP).

Several participants struggled to adjust to being taught in English and this limited their participation in class activities:

And then your accent, your English accent; you can also tell this English of yours, you criticise yourself you don't fit it (laughs)…and then you start to become antisocial; you are like, let me just focus on my books (laughs) that was the most conscious thing to me. I was always conscious of that even raising my hand, I will never raise a hand in class (AudM2/KZN).

I am adjusting to somebody teaching me full blown English it is no longer in Tsonga… it was just very intimidating, but I am still trying to hear what the lecturer is saying and they are very fast. I am still trying to hear what they are saying, and they are still typing, and they are asking questions and I am struggling here, I can't hear what they saying. And sometimes they will make a joke and laugh but I will laugh at the end but not understanding what they said because everyone laughs. I will just laugh as well. And so I think I just lost interest in studying and because I couldn't understand what they are saying, and I tried all methods. Trying to study I remember failing all my tests the first time and that just, I just didn't know anymore. I would come to school for coming to school but when I come back home, I wanted nothing to do with school because I have always been able to do this but now I can't (MedF3/LP).

The range of disorientating experiences was a continuum that extended from social activities to impact academic performance of the participants as presented below.

In orientation week, the introductory lectures, I could not believe I had the registration paper on my table to say that (participant), you are getting into this programme, that is the only time it clicked that I am getting into that space, and that was at the end, the last day of orientation. Looking at all that content and English that was spoken, I felt so dumb, I felt like people here are very smart and everyone is for themselves… we are very individualistic, very small environment, how, I don't know but it is happening… There are

> groups of people you can relate to, your Blacks, Tswana and Xhosa speaking, whoever you contact first makes that relatedness become part of that group, so I think everyone is for themselves and they do not show their struggles. We cry indoors alone, and we come out because we want to appear tough and we all are struggling and I think in 1st year it was that. In UCT people are smart and you shouldn't show your weakness, you have to appear tough because you're in the best university in Africa, one of top 100 around the world, being here is a status (OTF1/GP).

Participants spoke of feeling isolated, including in activities that were intended to socialize them into the university system. They felt excluded from participating in academic activities if they did not have access to basic resources.

> Yeah, I think over time, I think I've had enough time to adjust to it, and even become part of it. But at first, it was just really shocking. There was just so many things happening, I would even say like, it felt like I wasn't even in South Africa anymore. And when you come from a place like where I come from, it was just a shock. Like, what's actually going on, you know, it's going a little too fast paced for me…And I think for my very first years here, I felt like I just didn't belong. Like, the way things were happening that made me feel like I just don't belong you know. It's like an experience for privileged people. Like you must have a card fully loaded for you to Uber everywhere you need to go, you know, you need, you must have like money for lunch to fancy food to the lecturers… you realize that I can actually only be involved in this, if it's free, you know, I can't do all of these things. For societies you had to pay for. Even just even something as free as a study group was actually not free because everyone has laptops, or they have tablets. So you can't really, it's just going to be weird if you join them for that study group, you as a person without that stuff, just go be alone at the computer lab in the library. As I said, I just isolated myself a lot… (OTF2/KZN).

A few participants observed that the anticipated multicultural and multilingual society was not the lived reality, as students were stratified along perceived social class particularly in the preclinical years.

> When it comes to UCT, it was the nicest place I have ever seen, my dream varsity I have always wanted to be in… I felt like the first time I got there, people were divided and a lot

of people were fake in Cape Town. People were trying to be people that they are not, like you find in a class there is like Indians there chilling alone, Coloureds chilling alone, whites are there, Blacks are that side. You know there is like rural Blacks, not in a bad way but there were different classes of Black students like those who speak better English than rural areas, there was a division, and you would get some who were like we are better than you guys, you guys are low and just stay there. There was a lot of fake people, people acting like they are rich while they are not rich, people not being true to who they are, hiding their real identity (MedM1/FS).

It was very…it was very hard to blend in (laughs) you are one of the people here or something. Like every time I would just be searching for somebody to relate to, searching for somebody to speak my language and then I will like oh yes we can be friends we can hang out, looking for people like me I don't know Sepedi or Sotho close. I was just that lost child out there. I was very shy and I was just sitting there (AudF1/LP).

A thread in many conversations was the sense of not belonging as a student of rural origin. This was a threat to their mental health, as depicted in the extract below.:

I think for the first semester I had one friend and I that was just it. That's how I felt safe, this one person that I could trust and also part of the cultural background was like in medicine a lot of people parents are doctors, so I found that very intimidating, like oh my dad's a doctor oh my, you know, and you just get like oh no my mum is just a teacher. …I kept to myself, it is also very important to say that I struggle with generalised anxiety disorder and when it became, it started piling up at that point, so all those factors and my anxiety together were just making to keep to myself and also see all these social differences as threats more than an opportunity to grow and find community in these people. I saw it as a threat, and I didn't feel safe and always thought people will judge me and stuff.

So what made you feel unsafe?

No, it wasn't a thing of safety, physical safety but as in a safe social space where I could just be myself. So, I felt like I thought I would be rejected because I am from a rural area (MedF5/GP).

A few participants failed subjects for the first time in their lives as they struggled to meet the demands of the academic programme.

> I was, you know, an achiever and stuff like that. And so I was like this, this is a possible thing I can do, I can actually study my first year at UCT in physio, get through it. And, you know, apply for medicine, because that's what I always wanted to do. And then it didn't work out that way. I started to like physio. And then I stayed in it until my fourth year. And yeah, and then last year happened. I will not get to last year, what happened last year, especially because that was very hard to me. But now I'm done. So yeah, that was my journey to UCT was, you know, it was unexpected. I didn't plan for this to happen (PTM1/WC).

> In my first year, I wrote my exams. I was really stressed out like overwhelmingly stressed out. So now I know that it was depression at the time…sometimes I just wouldn't attend, I'll just sleep all day, because I was so stressed… I wrote my first exams in June, and I went home, I remember. And then I think, some random day I decided to go to the local library. Because obviously at home, I didn't have internet connection. I think I didn't even have a laptop in my first year. So, I decided to go to the local library, I log into all my CC things. And there I find an email saying that I have a sup the next day, or on the same day for I think Hub. I freaked out. I was so shocked. And I was so like, okay, at first, I thought I'd failed the exam in the first place, but I had a sup. But that was the next day. I didn't know how to handle the situation. I just went home, and I cried, obviously, because I didn't make it to the sup, then I failed. I failed that exam. So, then I got into IP (Intervention Programme). So, all those events of just like, like falling behind. Like UCT it's such an amazing thing, especially being the very first learner for my high school to ever go to UCT is an amazing thing. But yeah, I'm just like, exposed to so much failure, like I'm failing so much because of things that I wasn't exposed to in my high school or in my growing up experience. They are just now like holding me back. So those are all the things that made me realize that I just didn't have an affluent growing up experience or learning experience. And I have to now start from the bottom. And yes, so yeah, I think those are the ones that I can reflect on for now (OTF2/KZN).

> I think someone told them (dining room staff) that there is IP that prolongs your degree by one year. So, I don't know if they were trying to motivate us that you don't want that happening to you and ja, and just how everyone stigmatised IP and how you look at other students that went to IP, like oh that one is IP as if they have a virus on them that's contagious (MedF3/KZN).

4.3.3 Adaptation

Adapting to university culture took many forms. At times, it was difficult to adjust one's expectations based on the experiences of separate living in a racialised society. There was also the culture shock of having to interact with everybody, as presented below:

> You see, where I come from you don't really see a lot of white people, you don't ever. In the community there is a road, a main road. On the other side of the road that is where the white people stay next to the ocean. That is the only way. That division for me and then coming here and everyone is mixed up and it was really hard at first. I think it took me a while to just view them as they are just my classmates. In a way we were raised up to look at white people like they are better or that. So, I think it took me a while to get used to everyone's culture and there was just a lot of people from different places. So, I just had to adapt to that and then there was also coming from a culture where you respect or you take whatever the parents say and here you coming to a place where they question everything like why must we do that. So, it was also, I think, a different way of looking at things as well. Just also the way some people dress, it was just a lot of things that were happening (MedF2/KZN).

For participants who were active in various sports and other recreational activities, it was easier to make friends and adjust to the UCT context.

> Since I am a dope chess player, I went to a local club where people play chess there so they enrolled me in their chess clubs. I made friends there, and then we eventually became friends. Other people like my colleagues, I would go to their places, chill, relax and just speak about things that are not even related to medicine (MedM1/FS).

For one participant, identifying friends who spoke her home language brought relief. The budding friendship extended to academic support and peer mentoring. Residences and dining halls became critical areas in facilitating socio-academic partnerships.

> Yes, the dining hall was a saviour, so where we eat. When I got there, I found one speaking Tswana, so my wish came true, I found a Tswana speaking, a Sepedi speaking and a Sotho speaking person… we became friends and for me in order to connect with me you have to have like some humour, something about you... So, I got my people and we got together, and we were even studying the same courses… I was like okay you guys will be my friends in class you will be my friend in (Name of Residence) and then you will just be my friends for life (AudF1/LP).

> Making new friends, everything like that was quite, it was quite difficult in the beginning… I wasn't really exposed to a variety of different people with different cultural backgrounds. But I quickly found ways to relate to other people… I stayed in res; I have been staying in res my whole university career. It made it easier for me to make friends and socialise with my peers…(MedM3/EC).

For other participants, fellowship through church was a source of comfort as participants adjusted to a demanding academic calendar.

> I think the first three years I was very into the church thing. So, I went to the 7th day Adventist student movement and that is how I socialised a lot…And also, in fourth year I started going out to clubs and stuff and that's how from fourth year I started socialising and then I found a new community and then we started doing other things like just going out for breakfast and things like that (MedF5/GP).

> There I was like I am going to find my ZCC (Zion Christian Church) people, because that was my first thing. Church was going to help me adapt even if it was going to be difficult because we are always being told that university there will be no one following you around and you have to be disciplined, study and eat book. So, I was like I will be able to adapt to that environment (OTF1/GP).

Students engaged in group work in places that facilitated adaptation from academic to social spaces:

> I had friends… the one I met on registration day…He was right behind me on the line and then the other one I met in PBL (Problem Based Learning) and then the other one I met in QL (Quantitative Literacy). And then it just happened that we all met each other in different places but we formed that friendship… we would study together, we would go to church. The only time we really went out was when one of us were having a birthday then we would just go out and celebrate… Maybe if we, when we finished exams end of June just go and celebrate and then go home (MedF2/KZN).

However, the same academic spaces were sources of great discomfort as certain topics such as poverty were associated with rural origin. Being Black was also associated with alternating experiences of being visible and invisible.

> For me I have never been ashamed of telling people where I come from and who I am. But I saw the door that I opened up myself and telling people I come from this place, and this is what is happening. People will think you are stupid, immediately they start undermining you and if there's a topic that speaks about poverty or suffering or anything like some facilitators would point at you, can you tell us since you are coming from a lower SES (Socio economic status). Can you tell us about these experiences, can you tell us, and then even outside of that people would treat you like you are from a lower level than they are, and that sort of knocked off my confidence as well. And it also lowered my self-esteem as well; I think that affected me in a way (MedF3/LP).

One participant had to adjust her expectations of community engagement to match an urban environment.

> In my first year I lived in (Name of Residence) and I would get into the elevator and smile at someone and say hello and they would just ignore me (laughs). They didn't have ear-phones or anything; they would just look straight ahead and it was just a shock for me. Even if I don't necessarily know someone but I have seen them before or something and I will greet them. We have one little Spar in our town and always running into someone and everybody is smiling, and we have big fat chats with the cashiers. The cashiers at the Pick n Pay (supermarket), now I think I have gotten better at the way I approach them, the different cultures, but at first you sit there and ask the cashier how they were, and they would just be like I am fine. In my hometown they would be like, I am good baby, how are

you? And chat about everything and it was just a completely different setting (SLPF3/KZN).

Being strong academically was used by one participant to lever additional social capital:

I had one friend; he's a Coloured friend of mine. He went to Bishops... so financially, he was very well off… but we came to the same place and that like journey, you know, different journeys, you went to Bishop, I went to another school. And I just tried to reflect on it because he invited me over to his place for the first time to help him with his physics. Because I was, you know, like I said, I was an over-achiever. I was very good in Mathematics and Physics and stuff. And he was struggling a bit… You know, still uneasy a bit because, I mean, I came from a very small place and now boom, Cape Town, I have to fit in everywhere. I felt quite a bit intimidated the first six months (PTM1/WC).

A range of emotions reflected the impact of those experiences on their mental health and well-being, the adjustments and the efforts required of participants to find their place in the broader institution. In the next chapter, I describe the role of the university in the continuation of health sciences students of rural origin and their coping strategies as they become health care professionals.

CHAPTER 5: RESULTS

5.1 Introduction

In the previous chapter, I explored participants' understandings of rural life and rurality, and the challenges they faced of adaptation as they transitioned from high school to university. In this chapter, I examine the role of a university in student continuation and explore the coping strategies of health sciences students of rural origin. Again, I draw on interviews with the 21 participants, and their reflections on their experiences as health sciences students at UCT. I conclude by exploring their experiences as health sciences students with dual identities.

5.2 Description of Themes

In determining participants' understanding of their professional identity as health sciences students, I explore the role of lecturers and classmates in supporting their continuation as health sciences students and their professional socialization. I describe and evaluate their experiences of faculty support and their coping strategies.

5.2.1 Professional Identity

Students saw stark differences between themselves and other students in the university, particularly those not studying in health sciences, who they referred to as on the upper campus: "In upper campus, they are more of students. They can have tattoos and colour their hair the whole year, whereas in health sciences you have to behave like a professional" (SLPF2/KZN). Participants perceived upper campus students as having an easy life and not having to work as hard. Some were almost envious, and their perception of the reality of upper campus students was somewhat exaggerated.

> I felt like they had a lot of free time compared to students in the health sciences faculty, especially when you start clinical years because you sort of have a set time for everything that you have to do. Whereas for them they get an assignment to do over weeks, whereas you go to clinics, and you write reports and you do, you write up session plans for your sessions as well. So, I think for them, things are more flexible compared to us who have

> fixed things for fixed times. I know they would have mini concerts on Thursdays, and we didn't have that here in our faculty except once in a blue moon, and also you wouldn't be able to attend it because you would either be in class or in a clinic (AudF2/LP).

Participants reflected on their experiences of academic culture shock as they realized that their academic calendar and that of upper campus students was different beyond first year. They reported on a workload that was overwhelming with each year of study. They also expressed concerns about an accelerated pace as reflected by frequency of assessments.

> The students on upper campus are the upper kids and the other in congress, the businessmen, architectures, the artists, the classists, the psychologists. …So it was kind of like a hierarchy kind of thing.... Like on the med school side, we would have a programme for exams that extend over a three-week period, and the upper kids, whatever exam programme that extend over a period of two months (PTM1/WC).

> I think the fact that, I think we are always serious, we are always studying. There is never a day or a weekend where there is no work to do. We just always have a lot of work (MedF2/KZN).

Participants explained that being a health sciences student implied that you cared and were compassionate, and that you had to strive towards presenting your better self each time.

> A health science student is someone who cares, they don't put themselves first, you care about other people more than yourself. You focus on saving and making other people's lives better. That is one thing health science students should do to improve the lives of other people (MedM1/FS).

> I think a health science student is someone who genuinely wants to help people, you can say you love people and want to help but you must say it in your soul that you want to help people… I think being a health sciences student is not just thinking of yourself as a doctor, but it is thinking of yourself as a doctor, a speech therapist or whatever, it is more about what can I improve in their lives to help them to help themselves (SLPF1/EC).

Being a health sciences student was perceived as a huge responsibility and a burden, as everyday interactions with patients may have serious implications for the patients' health.

Participants also feared breaking equipment with which they were working as their hands were not steady:

> I am sure the thing that the student at upper is worried about is maybe turning an assignment late. While you are worried that today if you miss somebody's hearing loss or bleeding eardrum or something a perforation and then that progresses or what, you feel so much pressure that you can make a mistake any time and that mistake could land you in a lot of trouble…So when you are handling the equipment you are like for me I am very always scared of breaking something when I am handing the equipment, because everything is so expensive you feel a lot of responsibility on your shoulders in terms of the handling of the equipment and the handling of the people (AudF1/LP**).**

Participants noted varying forms of institutional hierarchies that set health sciences students apart from upper campus students.

> In society at large, historically in society, a doctor is always seen as a respectable figure. Moving into the university space, someone who is studying medicine is seen as super intelligent or is seen as an academic elite and is described as smart - normally described as 1% of the 1%. I think you have very intelligent people in other disciplines too (MedM4/LP).

> Yeah, health sciences or med school creates this kind of image that we are better than others in the rest of the varsity, it creates this kind of like, you should feel very important as a health sciences student. And even that kind of importance has its own hierarchy, as you know. So from audiology, speech therapy, OT physiotherapy and then medics.... Like, I would say, I'm at med school, I'm in the health sciences faculty, and without even saying what I'm even studying, like, there's already so much like, respect being given or like praises, or whatever (OTF2/KZN).

One participant considered that even members of the public, such as investors, perpetuate this divide between medical students and health and rehabilitation students.[8] This was reinforced in the experience of some of the participants, following initial closure of the campus in line with

[8] Health and rehabilitation students in this study includes all the other students except medical students.

COVID-19 regulations, because medical students were prioritised in their return to the health sciences campus:

> When it was time for us to return to campus, we were given I don't know how many days' notice, and then when we asked for assistance with transport, there was no money. But medics got the assistance, and it was during tougher restrictions of the lockdown, okay, that's fine. Then when the next group of medics come, then there's fund raising for them to return to campus, so then there were funds raised for them to come back to campus. But when it was us, there is no money, there is nothing we can do…How, how is that fair and things like, for example, now with our oath taking, physio's are finished with their work, we just have the thesis presentation next week, but we have to wait… We have to wait for the medics to finish their degree and do their oath taking before we can do ours. How is that okay? (PTF1/KZN)

Participants spoke at length about inter-faculty hierarchies as well as inter-programme hierarchies that privileged medical students and positioned audiology students at the bottom. These hierarchies were perpetuated by entrenched faculty practices:

> Medical students tend to get preferential treatment. Venues are reserved for medical students. You can be kicked out of a venue, or your lecture can be cut short or cancelled so medical students can use that venue (SLPF2/KZN).

> So, what happens is that the hierarchy thing is built on like ideas about how the type of work that you do, first of all. So, in a way, it's not like a hierarchy that we built ourselves. It's something that we found here, and we grew to see that it actually like it's how we're treated. Like you're treated according to what you actually do, you know, how many hours you even spend at like block, you know...So the less it is, the less important it is, and also how much money are you actually going to end up being paid, you know. So, it's those type of things that end up building that type of hierarchy. And also, like, how well known is your course. Most people don't know what OT is. So, it's just like, ah, like what is OT in the first place, all we know is that you guys play with dolls, or you guys paint or whatever, is that, you know, type of thing. So those are kind of, like build the hierarchy.

> Or even like, within ourselves, we end up grouping each other as important or unimportant (OTF2/KZN).

Participants perceived the act of donning scrubs and a stethoscope as bestowing honour, respect, class and pride. However, this novelty would soon wear off as they began to appreciate the corresponding responsibility.

> I think when I first got my scrubs you would have to pay me to take them off. I love Greys Anatomy (TV programme) and I was walking around in these scrubs, I am not even joking, I wore them to the airport so that I would get off the plane and everyone would have to see me wearing the scrubs. But they all just thought I was a doctor. They didn't know I was a student therapist. People find value in medical professionals; they respect you more and they ask you questions and for your opinion because they assume they assume that you have this wealth of information. So definitely, this put me on a bit of a pedestal, and it made me feel very, very valued as an individual. I would walk home from university in my scrubs and a man would stop me on the side of the road and ask me if I could help his child and that's where I realised the responsibility of wearing scrubs. I had to kind of turn around and say, I am not a medical professional, I am a student speech therapist - sorry but I cannot help you. It is a huge responsibility as much as it is an honour (SLPF3/KZN).

Participants appreciated the responsibility of performing when wearing professional gear, and some referred to scrubs and stethoscopes as 'working tools':

> So, if you are wearing your stethoscope people already think a doctor, medical student and if you are wearing your white coat. And people used to look at us different like who are these people (MedF5/GP).

> So, when I put on my scrubs, I'm a physio, when I'm out of my scrubs, I am me. Yes, you know, like kind of stepping into the role, you know (PTM1/WC).

> I think even though everyone wears scrubs, for me it is just an identification or what I actually do, I am not just a student I am the speech therapist. I don't know, for one it places me in the reality of what I am actually going to be doing, helping people through their lives and what they go through (SLPF1/EC).

One participant reflected that with many incidents of gender-based violence, she felt safer when she was wearing her scrubs. Scrubs confirmed that she was in a professional role even though she was still a trainee:

> I felt safer wearing my scrubs just because of gender and how that can play a role when interacting with service users. I would feel a lot better because those scrubs are very baggy, they are not tightened to your body at all. They are just supposed to be loose, comfortable clothing. I felt very comfortable like I was wearing a battle suit. And nothing could touch that battle suit, I could be a professional (OTF3/KZN).

A few participants cautioned against exerting authority over patients; they felt that the professional armour was likely to influence health sciences students to overstate or be overconfident in their qualifications and capabilities.

> I have always been the student that would put my things in the bag. And only put it on if I am in hospital. I would always try to be normal and look like other people if I am walking out at res and then only putting it when I am in hospital. Because I think once one doctor made us scared saying what if you are at Waterfront and someone drops and you are wearing your scrubs, you are only a student you can't even resuscitate them what are you going to do? And it's also inviting attention (MedF2/KZN).

Participants also believed that the same working tools that afforded them class, respect and status could be sources of symbolic violence. One participant reflected:

> So, at the beginning it was, yay, I finally get this, and also, because we didn't get it in first year, we got it in second year. I am becoming a doctor, the dream is becoming true and then after that you realise oh no white coats are only worn by students and once you have a white coat, doctors are going to discriminate against you and you know nothing. As the years went by, fifth year I would wear it only if they said specifically you need to wear your white coat, and final year, I never wore my white coat (MedF2/KZN).

5.2.2 Role of Lecturers

In this study, the role of lecturers was reflected as generating theoretical knowledge and skills during the participants' pre-clinical years. Clinical lecturers were facilitators of knowledge and skills as participants trained to perform in their professional roles. There was great appreciation for the many forms of accrued theoretical knowledge and an appreciation of the support extended by course convenors during their pre-clinical years.

> I think honestly coming into this space I was a full-on prep. I knew nothing and now I am able to sit with a patient, and ask a few questions, and get an idea of what's wrong, what is going on, where do we go from here, that is literally everything, and that is something that I owe to all my lecturers (MedF4/KZN).

Participants openly appreciated good lecturers, particularly if they were women and in leadership roles. Women clinicians were also revered as role models and mentors. These experiences allowed participants to reflect on what was an acceptable standard for their teachers in their role as health care professionals.

> There are amazing lecturers, Black women mostly they are amazing so that for me if I see a Black woman heading a department of giving me a lecture I am already so encouraged and inspired. To see them do it with excellence just fills me with so much joy. I didn't like surgery but because my mentor is a surgeon and now she is Associate Prof like I look up to her and I am in awe, and I see all the things that she does and I see her compassion and I see she is like fierce, when she is speaking surgery, she is fierce, and compassionate when speaking by the bedside. That is what I want to embody and that motivates me a lot and on the other hand you have doctors and consultants who speak down at patients and say inappropriate jokes who are just mean and just don't regard patients. And I will not embody that. You as someone who is a senior to me, I will not enact what you are doing. I don't take this as an example of what being a doctor should be. So there have been great examples in the field and there has just been some terrible examples of what I don't want to be (MedF5/GP).

> We had lecturers in pre-clinical and then we had doctors in clinical. So, I think some of them that were nice and they were so kind. They would teach you and you could see the

passion in what they were doing, and you could see they had the heart of helping people. That would motivate us and the overall teaching and just how they would interact with patients as we were observing and learning… Others…you start thinking the way some of them are they are burnt out or rude or tired, you just look at it and you like it is hard being a doctor. I can't survive this environment, I don't want to become this angry, or I don't want to become this bitter because of a job. If it makes people like this, then I don't want it. I need to find and escape (MedF2/KZN).

I've had inspiring-like lecturers. And I've also had lecturers that just didn't even care. And there are lecturers I also feel strongly about, but I'll just speak about the ones that actually inspired me. I think for me, finally seeing Black lecturers and not only just, but it's also not just a Black lecturer, this lecturer has a master's degree, this lecturer has a PhD, and things like that. So, like seeing Black lecturers, really inspired me. So yeah, I had three, top three lecturers that were Black and female. And that inspired me to say, and then I had a few, I would say, maybe two or three other lecturers who were not Black, one was Indian, actually, that one helped me get into residence. And then I have still my very favourite lecturer of all time, who is white, but so like, reflective on what being white actually means and what it means for Black people. So those are the type of people that made me want to stay on and find out more (OTF2/KZN).

Although lecturers were openly admired for their pedagogical skills, participants also reflected on their conflicting roles. They observed that some lectures were nice whilst others could tear you apart in what one participant presented as two types of doctors. These doctors were either caring and willing to teach, or they objectified patients and only cared about their own 'tribe' (other students who are of the same race as the doctors).

There is just a lot of lecturers I think I have enjoyed being under. There are some lecturers that have pioneered a whole intervention based on experiences of students and there are others who have also influenced a younger generation to also pursue OT and that's always been something that made me want to be better and just look up to them. Prof R, she has written so many things about OT that I want to have that one day. I want to also pursue my degree one day to also have a doctorate just because she has done it; it has made me believe that I can do it too (OTF3/KZN).

> There are two types of doctors, one that is not connected, one that is off, one does not care, does not see a patient as a human being but just like, oh it is just a patient, and I think this social awareness has made me more compassionate and caring for my patients (MedF4/KZN).

Whether these were once off encounters with a lasting impact or multiple encounters with no impact was derived from three variables –as person-specific, methodology-specific and topic-specific sources of pedagogical effect:

> On paper we have quite elite and highly esteemed lecturers, educators and supervisors who have done well in their careers. In lecturing and mentoring and in being our supervisors, some were great, some were okay, some were in-between, and some were bad. Some were vital and quite important, some were not. Some were very crucial and pivotal in my support and were crucial in my continuation and hands-on… (MedM4/LP).

Participants appreciated lecturers who went the extra mile and extended support as participants were negotiating personal challenges:

> My lecturers contributed a lot; they always reminded me that it was tough, but it will all make sense in the end. There were a couple of lecturers who were a little bit demoralising and definitely had a superiority complex. But there were other lecturers who were just incredible, so helpful after hours, so helpful and understanding when it came to personal matters, having to miss certain lectures or exams or tests based on personal circumstances they were really understanding and helpful. I have come to appreciate them a lot more now (SLPF3/KZN).

Many participants disclosed that they disengaged as students particularly in their first year as their language skills impeded them from participating. This would improve greatly as they progressed in their degrees either because they managed to find their rhythm or did not feel as threatened by the system, or were clinically oriented and could make sense of their theoretical knowledge:

> Well, I would say maybe first, second year I was just, I wasn't even understanding lectures most of the time. I usually actually skipped classes, because I prefer learning on my own, I just like being independent when it comes to school. So I was the type that instead of going for lectures for five hours, I would take the time and skip and put the five hours on studying… Third and fourth year, maybe I have grown up and started realising I really need to relax…I even started attending lectures. Especially because now, you find that you spend a lot of time with your lecturers because now they are also your supervisors at clinics and you find that sometimes you are alone with the supervisor and you are going to have conversation, you are going to get to know them and realise they are not a bad person and you don't have to be scared of asking all those things… So now it is like we are basically colleagues. You don't see that power gap to say…now there is no longer that fear. We are not at the same level but there is communication (AudF1//LP).

> There was a language thing where you weren't really accustomed to English. English isn't really your first language but lacked a way in which to understand the work, how to relate to the lecturers and how I could ask questions because almost, I kind of found it difficult to ask questions of the lecturers because I often found that I couldn't find the words to ask my questions in a clear way. I didn't feel like I could ask my questions in a succinctly in a nice way, so I was kind of more fearful to ask questions. That is more of an intrinsic thing, I guess… Yes, and then clinical years we broke off into smaller groups and then we would rotate to the different rotations and then I felt in these smaller groups I was able to be more inquisitive, ask the questions that I had and found my voice that way (MedM3/EC).

5.2.3 Role of Classmates

The role of classmates was described in similar ways to that of the participants' lecturers. Classmates were considered supportive if they facilitated the co-construction of knowledge. Some were perceived as indifferent whilst others were described as disruptive. Several participants struggled to engage in their first year and thus had limited interactions with their classmates. A few had befriended students in upper campus. A few confirmed that they had no friends at all, as they lacked basic resources that would facilitate engagement such as finances, laptops and

language skills. One participant described the variable engagement with classmates along a spectrum:

> (Laughs)…my classmates – some were classmates, some were friends, some were colleagues. They played different roles. Some were classmates I spent a lot of time with socially and academically. Some were just people in my class I did a degree with. Some played a vital and important role; some had no contribution at all (MedM4/LP).

In supportive roles, classmates were considered a positive influence and were perceived to be extending a collegial hand in what were shared spaces.

> I think because they themselves were doing very well in their studies that was a motivation to want to continue doing well. So, I can say they had a positive influence to my studies and the way they would ask questions and be active and all that… I can say that actually helps you to appreciate the knowledge that someone has (MedF2/KZN).

The clinical space was positively associated with development of professional relationships as participants were allocated to smaller groups and functioned as clinical partners within their allocated clinical teams:

> My classmates are very supportive or have become very supportive, especially this year. But before it was almost like every man for himself type of thing and the very few that were like, we belong to the same type of group, let's work together. (We) would try to push that just realizing that we are having the same degree. We all want to pass and that's just something that I have been very appreciative of during this pandemic, because it's made me want to continue. (OTF3/KZN).

Participants acknowledged that people had different strengths and could benefit from sharing their knowledge and skills. As they matured into professional practice, this was considered a positive attribute as they will continue to learn from each other.

> I feel that medicine is multi-dimensional, I could be clinically smart, another person could be book smart, you need all these elements, and pick that up, how this person interacted with the patient or how this person did this procedure or how this person did their case presentation on the ward round. So it is a lot to take from and knowing that I can go, oh I liked how this person presented let me go to them for some tips. I like how this person

answers this question let me ask them how to do this and of course hearing all these things and also, being together when we are grilled on ward rounds also just the camaraderie is just like has been very comforting (MedF5/GP).

A few participants associated their progress to individual efforts, their communication skills and personality types. This was also attributed to a commitment and an ability to prioritize the needs of patients over their own needs.

> Although I would like to think that everyone is just as amazing in their own right, I definitely think or like to think that my compassion sets me aside from some of my peers. While I do try and avoid the emotional fall out as a result compassion fatigue, emotional fatigue, emotional transference, I also really try to listen to my patients' stories even if it is a bit difficult to hear and help them to the best of my abilities … I have seen a lot of my peers and also some of my facilitators, my clinical educators be quite emotionally detached, and I would like to try to find the balance between maintaining my own emotional well-being but also not just brushing aside whatever my patients have to say (SLPF3/KZN).

Some participants' relationships with classmates had matured into friendships. In such instances, as friends, they looked out for each other and supported one another in locating and securing clinical cases and nurturing each other as debriefing partners.

> So, I have a friend that we started being friends first year, we are still friends now. He is also finishing, it is mostly him that I was talking to and also him giving me support and all those things… Classmates, we are just colleagues. We greet each other and there is nothing after that (MedM2/KZN).

However, this was not always the case. Some classmates were considered welcoming, whilst others refused to acknowledge their peers in intimate spaces where there were only 10-12 students in a group. Collaborative learning was not possible where power dynamics played out, at times, facilitated by staff members.

> Some were nicer in terms of teaching me things that I didn't understand and teaching me concepts and also sharing the trauma and things that we are facing and helping me understand that I am not alone in this. And then there were others that would just make you feel like you know nothing or you (were) not doing enough. Because you were failing to

understand something that they understand because probably they had someone who was teaching them better or they understood much faster than you did. Now they will make you feel inadequate. But in most cases I think the classmates were nicer and carried you along, (they) motivated and supported me in continuing (MedF2/KZN).

There have been times actually in my class where, phew, that actually one of the reasons why I don't want to come back to UCT where I find that white males are taken so much more seriously. The thing is with physio, our degree is very subjective in terms of its marking. I remember in class a simple example was, a lecturer says for five marks, this patient is in ICU. As a physio why is it important for them to be up and sitting in bed in ICU. So we start saying okay, to improve lung capacity, and she (the lecturer) says one point. Then another student says, okay to improve ventilation, she says one point. And then this white student says so that he can interact with the environment, and she says yes, four points. I'm like, how is that four points? Everything is one point, I'm just like, that's just an example where you can definitely feel that you are at the bottom of the food chain as a Black woman here at UCT (PTF1/KZN).

A few participants expressed feelings of discomfort when colleagues refused to acknowledge their presence and attributed their admission at UCT to meeting affirmative action targets.

I remember in my first year, before I had my terrible first experience, it was one of the first few days was O-week and this girl, she was like, how did you get in here because my cousin worked - she is white. She's like, how did you get in here because my cousin like, has been trying for so long. And she's struggling to get in. I just don't understand how you got in here. You know? So, things like that. At the time, I didn't realize the bigger meaning of what she said. I was just like, well, I got distinctions, you know… I actually see what she meant. I understand she in a way she was saying, as a Black person, why are you here? (OTF2/KZN).

A shared view was that a few students who had accumulated historical privilege were still looking for exclusive access to UCT resources despite democratic dispensation.

> Well, I wouldn't say there were no issues. There were in terms of having access to certain resources as well because usually the white students would have access to certain resources that sometimes we didn't really have, then we would have to rely on them to get the resources. Past papers they would get from some tutor that they know personally and then the resources would only arrive to the Black students just a few days before the exam, where they had theirs for weeks. That was an issue (MedM2/KZN).

The two years 2015 and 2016, during the #FeesMustFall student protest,[9] heightened the divide between classmates with fragile relationships. This was because many Black students joined demonstrations against tuition increases as some of their peers have had to abandon their studies due to economic exclusion: "I think, you know it sounds super controversial, my class has been a mess honestly, we were very divided since the beginning of fees must fall my class has been in pieces. I think things only started to get better in fourth year when they started separating us" (MedF4/KZN).

5.2.4 Professional Socialisation

There was a correlation between level of engagement of participants in their first year and their ability to participate in programme or faculty-based social activities. One participant suggested that these were in the list of activities they did not deserve to participate in, if they were constantly struggling to catch up: "My social life was poor in first year. What was I doing socialising…I don't even remember what I was doing?" (AudM2/KZN).

Several participants joined SHAWCO,[10] a community outreach programme where emerging health professionals volunteered their skills by providing care in underserved

[9]#Fees must fall – refer to detailed explanation in chapter 1

[10]SHAWCO, the Students' Health and Welfare Centres Organisation, has developed a reputation for delivering quality primary healthcare in under-resourced communities in Cape Town, South Africa. SHAWCO is a University of Cape Town student-run, non-profit community outreach organisation. It relies on over 100 volunteer doctors and 800 medical and allied health science students in all years of study to ensure that these student-run free clinics continue to be delivered.

communities after hours, under the supervision of a Community Service doctor. Participants felt that this was a space to learn clinical skills and build friendships:

> I joined SHAWCO, it was my practice place, it helped with sharpening my skills. They advised you and then yes, I joined RSN (Rural Support Network) at some point but then I wasn't participating in it. I wasn't really sure about what they did and what they meant by rural placement (AudF1/LP).

Besides SHAWCO, a few participants engaged in leadership roles and participated in academic seminars. These also fulfilled a dual role in imparting a defined set of skills and in providing a platform for networking and in creating spaces for social engagement.

> It was mostly the leadership things. When I got here, house committee and I would do all those things kitchen reps, sub committees, DC, hearing committee. Last year I applied to be a sub- warden in Observatory Square, again to be the head sub warden. Most of the times I doubt myself and once I put myself out there and convinced people vote for me to be house committee and people voted for me and (I thought), oh wow, I can do this (MedF3/LP).

> Yes, they have seminars, there is a lot of very interesting seminars that they have and quiz competitions and stuff I used to go to. And the different societies like surgery society and the internal medicine society; all those societies are very interesting. I wasn't part of any but every time I did go to seminars and talks that was very nice…And that's where you get to speak to senior people and stuff. It bridges the gap outside of the hospital between student and senior doctors (MedF5/GP).

One participant pursued academic writing whilst another was involved in public health initiatives. A concern was that although there were all these clubs and societies, the academic calendar did not grant participants the time and space to participate in extracurricular activities:

> I have been involved with infectious disease and HIV medicine since second year…I was one of the authors in the paper that was published, and I think, yes, it is mostly that (MedM2/KZN).

> I learnt about factors that made me understand social factors that could determine somebody's health (MedM4/LP).

> I think in the health sciences faculty there is no…I hate to be the one to say this but, there is no time to be in other groups because of how heavily demanding the degree is, so you will notice surgical society is there, cardiac society is there, SHAWCO is there… I think there is no time…your degree is demanding so much…you actually don't have the time to engage and socialize in that way (OTF3/KZN).

One participant felt that his degree equipped him with valuable communication skills such that he was able to engage with patients from different sociocultural backgrounds.

> I think it taught me a lot of respect, you know, just general respect and general you know, empathy and not sympathy and non-judgmentalism as we were taught in first year, so you can treat the patient to the best of your ability. Because all patients, different backgrounds, different stories, different cultures, so you have to fit in with them. So you need to like you know, strip yourself of your, you know, personas, essentially, but still maintain that professionalism, in order for them to tell you their story (PTM1/WC).

5.2.5 Faculty Support

Participants reflected on support that was extended to them at four levels during orientation week and beyond, namely: academic, emotional, financial, and social support. These services were extended through faculty appointed academic mentors; psychologists and social workers; the financial aid office; and clubs and societies. For a few participants, these were considered a great resource for facilitating adaptation from high school to university.

> In first year, they gave us academic mentors. So yes, they were very helpful. they also gave me what I will always cherish, a computer. I came here not even seeing a laptop. But I am not going to tell people that. I don't know if this is not normal for not seeing a laptop for seventeen years but…so when I came here, I didn't know how to type. So, I am always going to be thankful for that. Faculty of health sciences for integrating digital literacy into my career… They contributed everywhere, like academically you had so much support and you know okay you can come to this person and then politically they have they have nice societies also HSSC…you just feel like you covered on all fronts - emotional, mental, educational (AudF1/LP).

A few participants missed out on these opportunities for the same reason that they faced limitations in participating in class activities. Although, they knew about availability of these services, not every participant had the courage to seek support.

> I have had a couple of challenges in my journey in becoming a doctor. Firstly, I was scared to ask lecturers. I was never the type to stop a lecturer, is this what you mean? Even afterwards I still felt like I need to go home, maybe the problem is me, I need to go home and study what I need to study and before you know it you are writing an exam you didn't have time. But towards the end I saw that I am struggling. I then started approaching lecturers, sending them emails. Can I come see you in the office? And surprisingly they were all nice and that helped me bounce back and start getting better marks in my exams. So, I felt like the faculty staff were helpful in terms of that (MedF3/LP).

Other participants felt that their efforts to access some of these resources were not successful as their requests were not addressed in time. One participant had to take apply for a part-time job in the local supermarket back home as she was owing a substantial amount in unpaid tuition.

> … my course conveners did help me when I was in trouble, especially now, this year they did help me a lot. But the faculty itself, I did have financial issues in my second year and first year I had a bursary and they ran out of money on the bursary. So, I was left without funding in my second year… I did apply for the Impilo bursary, I did write to (name withheld) but no one could help me because I was owing such a big amount, it was over R100 000, even that bursary they said they only help people with less than ten thousand. So that's why I am saying I don't know if I can say that faculty really supported me in anyway. So I had to appeal and go to NSFAS because I don't know why they rejected my application, but I had to keep going there to main campus to appeal and do all those things and it finally came through around end of March… It was, it was very hard. In December during my second year I had to go and work in Boxer (supermarket) because I needed money (MedF2/KZN).

> Financially I think the university is not very understanding in terms of finances. I have had a couple of friends who couldn't come back to university because they couldn't pay their fees. At one stage I was worried I wouldn't get my results because my parents couldn't pay my fees and I was afraid I wouldn't be able to return the next year…And I think with

> mental health I was struggling with my mental health, and I tried to make an appointment and I don't believe that the counsellors are very competent, nor do they have an interest in helping you. They just kind of there so that the university can tick the box of saying they have counsellors whereas they are not really supportive (SLPF3/KZN).

As with the other themes I presented earlier, satisfaction levels were derived from outcomes of the participants' service encounters. Some were satisfied with their encounters; others complained about poor service. Others were indifferent.

> Oh my God (The Manager) is a lifesaver. I don't think I would have done it without her. She is very supportive, she is very patient, she is just amazing, especially with us students she makes us feel like we heard (OTF3/KZN).

> There were times where they were supportive, there were times they were not. There were times when you felt alone. There were times where they had my best interest at heart…There were times where they were instigators of my downfall. There were times when the university was quite supportive and made things easier and took the burden off me and there were times where they just added an extra burden (MedM4/LP).

> I feel in the faculty of health sciences you have to fight to be heard, and I don't like that. You have to send an email, then you have to send it again, then you have to send it again then you have to go there personally to get something sorted. I as a Black woman don't feel heard. There are so many cases I have sent emails, people see the emails, but they have not acted, until it's too late and that just is rude and if you ask for, like little things. It's so hard to get support like faculty assistance (MedF5/GP).

A few participants reflected on a range of mental health challenges as they struggled to adjust to the institutional culture and the context. For this cohort, the tragic loss of their Dean[11] triggered a series of mental health episodes that required in-patient care in psychiatric facilities; some needed to take academic leave of absence. One participant reflected on this as period of

[11] Prof Bongani Mayosi, a Dean in the Faculty of Health Sciences at UCT died by suicide on the 27 July 2018. https://www.news.uct.ac.za/article/-2018-08-01-open-letter-to-uct-students-on-the-death-of-prof-mayosi

reckoning and since then, the faculty and the university have introduced measures that moderate known triggers.

> I have had quite a bit of frustration honestly with the faculty. My own personal problems, I don't think I have really needed anything beyond just teaching from the Faculty of Health Sciences. But for people close to me who have needed more I have heard mixed reviews in terms of mental health support. Because I know now there is like, since 2018, is a year that we lost our Dean, Prof Mayosi and I think after that it was sort of a wakeup call. I am not sure of those services existed before. I am sure they did, I don't know if they were strengthened after 2018, I am not the best person to comment honestly (MedF4/KZN).

> I like the idea that on Fridays after 1pm there are not meant to be any academic activities. I think the faculty is taking into consideration that people do go out and this thing of keeping them in until late it's just low-key unrealistic, I think that is the way they provided support. (SLPF1/EC).

Despite these efforts, a prevailing perception was of a system that favours a few:

> So, I have this one friend in class, a girl, white. Her mom was diagnosed with cancer (and) was going through chemotherapy and stuff. She had a younger brother who was also at university. But she did not take leave, she managed to finish 2019. Like, you know, and I looked at it like from my perspective as well. I'm also nursing position. I'm a Coloured, university, same class, same year, same everything, academically, we get the same marks… but I couldn't finish the year and I tried to reflect on that. Like why, like, why could she finish it? But I could not. (PTM1/WC).

5.3 Coping Strategies of Health Sciences Students

The events described above led me to explore coping strategies that have sustained health sciences students of rural origin. I asked participants to reflect on their strengths and weaknesses, and to consider benefits that accrued to them, based on their strengths and the risks imposed by their historical profile as students of rural origin. Participants presented their strengths in three themes, namely: intrinsic motivation; resilience and passion for rural health. The weaknesses emerged as vulnerability and rural background. I elaborate on these in the next section.

As depicted in the diagram below (Figure 5), five themes emerged.

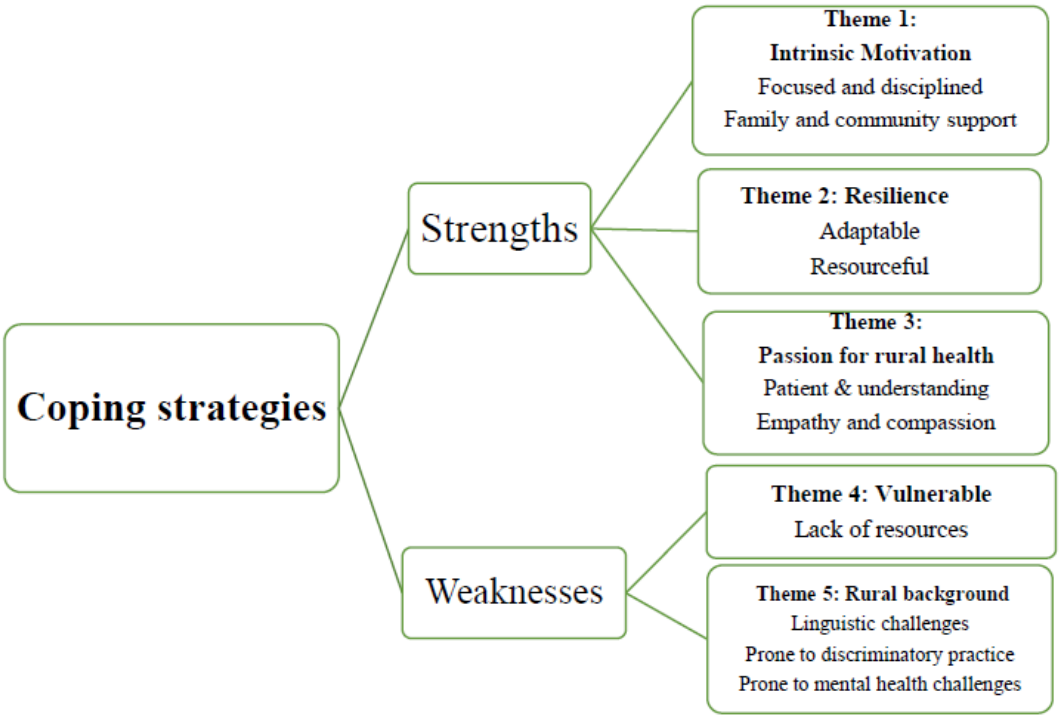

Figure 5: Coping strategies of health science students

5.3.1 Theme 1: Intrinsic Motivation

Participants explained that they had to "dig deep from within" to survive their first year. They cited a number of disorienting experiences that were confusing as they tried to find their place in the institution. One participant recalled a period when she spent a considerable period trying to determine her flaws, as she regarded herself as a displaced high achiever, while she struggled to navigate her way around UCT. An initial concern of several participants was having no family support and being far from the teachers who had always encouraged them and knew them by name. In the end, sheer determination and reestablishing contact with family sustained them:

> I did it on my own…I travelled alone to UCT. It was dark that night… I kind of developed this independence… I always get reminded of what I went through back then compared to what I am going through now and I am doing this because I don't want to go back to that (AudM1/LP).

> I am quite resourceful, and I don't even make excuses. For me I feel like I never complain about food, the amount of work I have to do because I know that it is my responsibility to do that work (MedM1/FS).

The benefit was that the participants became focused and disciplined as they had to come up with a study plan: "My strength is just being focused and being disciplined and knowing how much effort I need to put in and where, so focus and discipline" (AudF1/LP). Related to this, some of the participants opted to focus on their studies. This became a protective factor against external influences: "I think just the mind-set that I have of being grateful for being... I had to appreciate the small things and when it comes to challenges as well. The life I have lived has prepared me to face the challenges" (MedF2/KZN).

5.3.2 Theme 2: Resilience

In the face of adversity, several participants mentioned that they became resilient as they had to navigate through unfamiliar territory, adjust to environments where they could not speak their home language, and survive in spaces where even the food was different. At those times, they could feel that they were grasping at straws:

> I think in all the things that I face, I failed… You are trying to find your feet in academics, but it is not working…I never gave up. I pushed myself and I woke up each day. I remember the first semester I would cry every day because everything was just so hard (MedF3/LP).

Some of the participants cried throughout the adaptation process as they were trying to find themselves. Through their trials, they realised that they were adaptable, and a prevailing sense of community kept them going:

> That is what has been keeping me going, knowing I am not only doing this for myself I am also doing it for the people back home (MedM2/KZN).

> I am resourceful …and I think just thinking out the box, I know that sounds cliché but it's genuinely something I think I am good at that has always set me apart (SLPF1/EC).

The resilience also came from knowing that they had to lay their own foundations and become champions of their own journey. This was also about knowing why they came to UCT:

> I'm from there (rural) but having conquered so much and still standing here today… I didn't have much. I had to build from the beginning, you know, like, I didn't have a layout already laid for me or a foundation. I had to build my own foundation with no resources at all (OTF2/KZN).

> I think, coming from a rural area, first of all, there are no second chances, you know. I can't mess up, you know, because people are counting on me, you know, to do something (PTM1/WC).

5.3.3 Theme 3: Passion for Rural Health

Background and upbringing meant that participants appreciated the attributes that grounded them in culture and in community. The isolating periods at UCT reminded them of their earlier experiences of being cared for and being one with their community. It became easier to extend their expectations of how they should be treated to the patients in their care, as they navigated a range of new environments and constantly experienced discomfort. Being multilingual was beneficial as it extended to patients' compassion and an understanding of different cultures:

> In the entire social economic system, they (patients) are part of family; they are part of the community. They belong somewhere; they exist outside of this hospital setting. And being from a rural area I won't suffer from a lack of imagination because I have seen it, I know what the outside world, outside of this hospital looks like. I don't have to bend over backwards to see that. It's made it easier to relate to patients beyond just what they are sitting in front of me (MedF4/KZN).

> I guess patience…I am more patient, and I am more understanding of other people…So I got that, being patient because you have to wait for taxi to show up so that taught me to be patient. I have to think differently all the time and UCT forces you to think as well as to use those skills (OTF3/KZN).

An overarching theme was that there was a mutual beneficial relationship between multilingualism and multiculturalism, as it allowed participants to extend care and compassion to their patients.

> It made me multilingual…I had exposure to township life through my cousins, I had exposure to village life and to middle class … It allowed me to be fluid with people from different cultures and different backgrounds (MedM4/LP).

> I think understanding where different people come from…so for me I think I have been privileged enough to have come from two different environments and that has given me the purpose to see things from different points of views…my passion for public healthcare …way it translates into rural healthcare (SLPF1/EC).

5.3.4 Theme 4: Vulnerability

Being uprooted from a rural community to study in an institution considered by others as elite had a great impact on many of the participants. As they became isolated, they had no social support, and having to do everything in English silenced some participants for extended periods and threatened their mental well-being.

Lack of access to basic resources or instances where they did not have the desired competencies to perform extended their vulnerability; they were relegated to join academic support programmes due to poor performance. Finances were another major challenge for a few participants.

> I didn't have accommodation. So, I stayed in a very dingy place in Salt River. I would walk back. I was new to even like taking care of myself. So, I wouldn't even make lunch. But most of the times, I would be hungry. I can't sit at the cafeteria with people eating, like wraps and burgers from the cafeteria, or like McDonald's, because I don't have money to buy that, you know, I don't have the nice clothes to even be there at the cafeteria with them. I can't even sit at the front of the class, you know, I can't raise my hand to speak because I don't have the proper English. And the confidence, you know. So, it was just, it was just shocking. And I really felt like I didn't fit in. I felt alone, I felt really alone. And then also remember, I was also like, isolated because I had to join these small groups. So, I didn't

> have free time like the others did, maybe to do social things I had to then go to Digital Literacy and be so focused, because I really don't know what how a computer works. And I had to attend Academic Literacy. And then afterwards, because I didn't have textbooks and I didn't have a laptop, I had to remain in the computer lab trying to understand work that I really don't understand, until very late… it was stressing (OTF2/KZN).

> Yes, it was mostly centred around things I couldn't get. But now I am aware how to channel that and for me there is resources around campus, and I think the biggest challenge is always the financial side…came to the fact that I couldn't enjoy Cape Town (MedM2/KZN).

Participants related these episodes to feeling like imposters as everybody had a place in the university. UCT became a place where they felt like strangers due to lack of resources. There was a prevailing sense of dual identities. Although they were registered as UCT students, they felt like outsiders. These experiences had a lasting impact as lack of resources translated to poor academic performance. In a fast-paced, modern environment, everybody seemed to have a place except for rural students. At times, they felt like foreigners in their own county.

> I think there is a whole lot of sources for the imposters to join and then it is also not being able to fully live in your identity (rural origin). This whole thing of this is the first time that I have spent so much detail describing the place I am from. You need to put on this professional vibe of oh no we all come from the same kind of area, I am from Port Shepstone, it is from the south coast of Durban. People will be like, I have been to Port Shepstone, the beach is so nice, and you will be like, ja the beach is so great…if only…but they don't know how being from a rural area has disadvantaged me (MedF4/KZN).

5.3.5 Theme 5: Rural Background

Coming to UCT, being of rural origin, was an achievement for the participants as they had to overcome many hurdles. As the focus was on their weaknesses, it soon became obvious that this was not enough for them to accumulate the requisite cultural capital. There were internalised fears about who they would be if they could not embrace their personal identity as students of rural origin:

> My weakness would probably be my level of exposure. I was exposed to a very confined set of individuals and individual situations living in a small community (SLPF1/EC).

> I mean, my entire background, as mentioned, that cultural diversity at UCT is huge. And, you know, some of my weaknesses, were my insecurities. A lot of my insecurities, as a person of colour coming from a place, you know, very small place trying to fit into this big world… I was scared that I would forget where I come from, you know, I would act differently and stuff and that always scared me. That also held me back (PTM1/WC).

Their English was inadequate to sustain them in their first year as they struggled to maintain the pace. This, in turn, interfered with their access to curriculum content and to participation.

> Sometimes my English, like the way I speak… I couldn't even grab other people's attention. And sometimes people would overpower you in conversations and you just feel like you are irrelevant or what you are saying doesn't make sense and confidence is not there. I don't understand but I can't go an ask my lecturers because I don't know what I am going to ask them even some of them are intimidating they will ask what is it that do you do not understand (MedF3/LP).

> I was coming from a place where I was taught in my home language, everything, even the English they taught in isiZulu. That changed everything, having to learn in English, being taught in English they would go so fast…I would just go and hear nothing. It was just very challenging. I can say sometimes even in third or fourth year I would still, like sometimes be attending a tutorial and you just say yes because you just want someone to finish, and you didn't really hear and maybe you are scared to ask. Yes, I would say academically those were the challenges of having to adapt to English (MedF2/KZN).

Many participants shared experiences of feeling alone as there were no peers they could relate to from their high school. People around them were partnered or in groups and could trace historical and family affiliation to the institution. For first generation university students, there was no point of reference. Increasingly they were overwhelmed, withdrawn and isolated. They were also susceptible to discriminatory practices. This was a particular concern in the clinical setting.

> Registrars like, I hate anaesthetics, anaesthetics is the worst. They don't want to teach; they don't want you in theatre and they don't want to give you signatures and they don't want to give you procedures and they are registrars. These are registrars. Consultants are nice mostly, but these are registrars are awful. In obstetrics the consultant was horrible, the registrars were horrible, never mind the hours we were expected to be there, understanding it doesn't make sense. It doesn't make sense for my day to end at four and for you to release me at half past five. And when I leave at half past five you ask me where are you going? My day ended at four. So those are the frustrations that during the ward round, you are going to be embarrassed because you couldn't answer just one thing. And also, because you get told over by Matthew and John (white male students) and everyone is going to listen to Matthew and because they express themselves better and because the system favours them, so everyone wants to listen (MedF3/LP).

> So, my insecurities were holding me back to say that I wouldn't fit in, I was afraid that, you know, if I did something a certain way, I wouldn't be seen as you know, as I belong. I was scared actually, I was, you know, addressing something, like, a racial issue, for example, or a bias issue, I was scared of addressing that, because then in the way I address it would seem that I was picking a side and that on the other side, that was my weakness...I didn't have much social interaction, because usually when you raise a point, people like it, people come to you, they ask, you know, where are you from? What do you do, etc.? So, my social interaction declined because of my, you know, fear of interacting, you know, within important discussions in class… I was scared that I would forget where I come from, you know, I would act differently and stuff and that always scared me. That also held me back (PTM1/WC).

Participants did not only have to deal with their linguistic challenges; they also had to contend with computer illiteracy and this hindered their participation in academic activities.

> I think I can say a couple of things from when I started varsity... I was computer illiterate, we never had computers at my school, I wasn't comfortable speaking in English, I wouldn't even have a long conversation with someone in English. I always had confidence but when it comes to English and public speaking, I would say those were my weakness (MedM1/FS).

> I will try and write notes, but I can't write what I can't hear. I tried to type but I am slow. I am not used to laptops and computers, I have never done that. Even though I have had an exposure to a computer and a laptop it was never in me to, I need to learn how to type fast or I am struggling here, I can't even use that, adjustment and also not getting things. Trying to study I remember failing all my tests the first time and that just, I just didn't know anymore (MedF3/LP).

These experiences of not belonging and feeling like outcasts who were silenced were common. Consequently, as they could not engage, they could not participate and could not perform. As they were constantly anxious about how they were perceived, these feelings of being isolated and displaced placed rural students at risk for mental health challenges. This was a recurring theme in all the interviews.

> I am overly emotional, I think any situation that people have been through I feel it in my bones, it brings me, not that it weakens me, but I shatter inside (SLPF1/EC).

> So, I think some of my weaknesses was I guess coming into this space... I have realized how easily it is to fall into mental illness and how it can be disguised into different things...People are like you strong but actually that person might not be strong. They may be acting strong and that also made me realize how vulnerable we actually are…I don't know, I don't enjoy the aspect of not greeting people and I notice that I take that back home with me and then I fit out again, so I don't enjoy that aspect. So, it's what's been happening (OTF3/KZN).

> I think I am just tired. I'm very tired from, I feel like I have to fight a bit more than other students, you know, we have to fight so much harder to even get money to come to campus (PTF1/KZN).

Participants reflected on what they could not achieve in their pre-clinical years and how this set the scene for how they experienced UCT as health sciences students of rural origin. Having acknowledged their weaknesses and the risk this imposed for their continuity, in their final year, they wished they had socialized a lot more and integrated into the clinical setting earlier:

> Coming to university is like a very different culture… I couldn't keep up with what was going on socially… that took a toll on me because I couldn't chill, not that I couldn't chill with anyone but like I don't mind making friends with anyone but I just didn't know how to and coming into university you have to be social if you want to kind of survive (AudM1/LP).

> So, I don't really have the word I will use maybe the confidence to go out and explore what Cape Town really had to offer as when I was younger in my university years. And I think that was a weakness in that I didn't have really have many outlets to de-stress and avoid burnout (MedM3/EC).

> I think for me that a weakness that you don't easily integrate socially with other people. And I mean especially in med school who you socialise with becomes who you study with and who shares resources with you, who will share tips with you (MedF5/GP).

5.4 On Being Black and of Rural Origin

In this study, what has emerged during analysis was a series of lived experiences that were attributed by participants to being Black in Cape Town and at UCT. I explore these in context. Participants reported instances where they had to defend their profile as students of rural origin as they were always assigned to a lower social class.

> I don't know sometimes people just assume that you had the lower role or something. Like for example you would be asked to do the things that nurse should be doing. I don't know if that was my gender or what or maybe it was nothing to do, to be asked to run a line in a busy situation where I could be learning something that contribute to my career (MedF2/KZN).

A triple vulnerability emerged that culminated in participants reporting episodes where they experienced acts of racism as personalised events. These incidents of misrecognition had an impact on the participants' clinical training as they were rendered misfits. For one participant, being Black and female was frustrating during her clinical years as her existence and that of her partner(s) were nullified by a system that favoured white male students:

> Overall, it has been positive, there has just been one or two things. But Doctor M-M[12], why are you only learning that one white guys name when there is like only four of us in this whole group and you could have learnt all the names. And why are you letting him assist, and if I describe it right after him, you ignore me the whole time. I ask questions, I am participating, I am trying to get taught and I get nothing. And most of the time it does not feel intentional which is even more because I think it is just so internal to them that this person reminds me of myself, this person like when I was in fifth year this is what I looked like, this is what I sounded like. So, they want to impart their knowledge into their younger selves and I am just not fitting the description. So, when I just get bodied the whole time it is very frustrating because it is not something you can point out and report and be like, Doctor M-M didn't teach me today, because they will be like did you go for surgery, were you not there present, what do you mean that they didn't teach you? But it is like this extra mile that they went for the person before you that they didn't do for you (MedF4/KZN).

One participant related being Black to an extreme sport:

> I think being a Black woman in medicine - I don't know. It's an extreme sport because firstly being Black means that in ward rounds when you answer you are not just answering for yourself you are representing everyone. You cannot be judged solely; you can see that they are judging your people quote unquote and you can see how you are treated. Personally, I didn't do anything to warrant this treatment. You cannot say you are treating me like this because of me, you are treating me like this because I am Black. People will not want to sign your logbooks; people do not want to help you. People take out their frustrations on you, people leave you with so much responsibility and leave their responsibilities as awful, like, it is very awful (MedF5/GP).

These negative experiences were reproduced across programmes. One participant reflected on the uninterrupted aggregation of students in racialized groups perpetuating episodes of misrecognition. She described her department as "whiter" than the rest of UCT, furthering perceptions of institutionalized forms of racism.

[12] Dr M-M is a pseudonym.

I don't have any gender related complaints, or like experiences when it comes to being a student at UCT. But when it comes to race, on the other hand, my degree that I'm studying towards is very, like I know UCT is white, but the OT is even whiter than UCT. And so, it's just, it's just always so like, Oh, I don't know how to put it. It's just like, you will always be made to be like, you're like, not competent enough. And like, your block partners will make you feel like they know better, or they will make you feel like they can articulate, say you have like an idea. And you tell them, you know, like you just chatting and blah, blah. Next thing, you know, the person is speaking to the supervisor, as if it was their idea. And like, it's almost like you're thinking because like you can articulate it better, then you should say it. But now, it was my idea, you know. So, there's always this thing of wanting to outshine, and it's not even I don't think it's a conscious thing of wanting to outshine other from their side (OTF2/KZN).

Race was an issue I think in terms of an internalized issues, and it would sometimes show up even in our class I would notice the segregation. It would be like all the people of color in one area, and they can inter-mingle but not too much, Coloureds are by themselves, white people are by themselves, Black people are by themselves, and even work groups. Group projects it would also work out the same way, it would be a whole group of white people, a whole group of Black people, a whole group of Indian, Coloured people and maybe a mismatch group because those people are not there for a lecture, so they didn't get an opportunity to choose a group (OTF3/KZN).

Black students of rural origin believed that they must constantly negotiate access to resources and seek affirmation, even as student of distinctions. The following incidents reflect this:

As a Black person in Cape Town, you will have different experiences of race, some good, some bad, but you tend to remember the bad. You experience microracism/ macroracism. You tell yourself you deserve to be studying at UCT. You compete with people from different socioeconomic status. It affects you. Half the time you are trying to represent the child. They think you are here because of some BEE[13], you have to prove yourself…Your

[13] Black economic empowerment (BEE) is a government policy that seeks to advance economic transformation and participation of Black people in the South African economy.

> race definitely, definitely affects you. It's minor things like I remember in first year we wrote a test in physics, and they used to publish marks. Oh, we got our marks, and I was one of the few who got good marks. You see Black people rallying behind you and they say Dude well done, you represent us. You see how much of a shock it is for white people. I remember in second year they published the ranking, and I was number 15. The same thing again and happened Black people rally around you, and you also have white people are wondering how did this guy rank so highly? (MedM4/LP).

Consequently, participants believed that within the institutional hierarchal structures, Blacks are always at the bottom of the barrel, particularly if they are female.

> Okay let me tell you what the hierarchy is. You see there is a bottom, there is a bottom of the bottom, and the bottom of the bottom has a basement and that's where you will find the Black female students. And then at the top of the hierarchy is the white male student and then you will find white female student and then you will find an Indian student, both male and female and then you will find the Coloured student and then you find the Black male, actually the Black male is somewhere with the Indians because the sisters do not like Black females but they like Black males, like it would be so nice for them. And then you have maybe three levels that are empty and then you have Black women. You have to dig for Black women (MedF5/GP).

Black female participants had the added challenge of having to deal with unsolicited and inappropriate advances from patients:

> In terms of gender, I think I experienced it the most last year because that's when the Uyinene Mrwetyana incident happened.[14] Also, the year I came to UCT (as a first year) it was after they reported cases of rape in the university. So, it was the thing of being afraid of exploring things that I could have explored because I am a woman. I can't really access it even if I wanted to because it would be dangerous and that was very much impactful. Also, in sessions with clients, clients would be very inappropriate and having to deal with that. So, they would always ask are you married? Do you have a boyfriend? At some point

[14] This refers to a first year UCT student, who lost her life as a victim of femicide. https://www.news.uct.ac.za/article/-2019-09-10-uyinene-mrwetyana-a-week-of-mourning-and-reflection

> I was wearing a rosary ring because I was feeling a bit lost, so I just liked having it around my finger. I was feeling a bit lost, so I used it as a source of comfort. But whenever I was wearing it, I would always move it to my left hand. And then it would encourage the question of are you married? As soon as I said no, it was almost giving individuals a leeway to be inappropriate. I was in a space where I am a health professional but now, I am no longer a health professional, oh okay she is a woman, and I am like, no guys I am actually a woman who is doing her job, you should have the same respect (OTF3/KZN).

In this chapter, participants reflected on a range of experiences in and out of their classrooms and clinical training spaces. They described their first few years as challenging, but despite the overwhelming experiences their capacity for resilience, derived from their strengths and accrued social capital, sustained them. Although participants could identify academics and classmates who supported them during the acculturation phase, individual and systemic episodes of racism and social exclusion had a lasting impact. These made them vulnerable to mental health challenges. In the next chapter, I analyse their guided reflections as a portfolio of evidence of their experiences of becoming health professionals as they are socialized in a range of clinical facilities.

CHAPTER 6: BECOMING A HEALTH CARE PROFESSIONAL

6.1 Introduction

In this chapter, I present findings from phase 2 of the study. Participants were asked to document their experiences of becoming a health care professional by reflecting on their clinical encounters with patients, consultants (supervisors), and other health care workers for at least one clinical rotation. Only ten participants completed the guided reflection journals. The findings are represented under the following themes: professional development and personal development. A range of experiences are presented to reflect the process of becoming a health care professional from a programme perspective.

6.2 Theme 1: Professional Development

Reflections on professional development are presented as two interactive experiences: organizational factors that include formal and informal aspects of their learning experience, and interpersonal relationships and their interactions with consultants, clinical supervisors, patients and clients, and their families. Context is also a factor in facilitating the learning experience. The reflections are presented as six subthemes: first clinical encounter; becoming a health professional; teaching and supervision; role of patients in facilitating learning; stated preference for training facilities; and successes and challenges of the training programme.

6.2.1 First Clinical Encounter

Participants could recall their first clinical encounter with ease. Many were in their third year when they started to see themselves as health care professionals. Participants had a range of experiences in clinics and in hospital settings and appreciated the role of the patients who were contributing to their training. The encounters were affirming, except for one participant who was shouted at for not wearing a name badge.

> It was the first week of a clinical block. It was very scary, but it made us brave. Also, there were so many kind strangers in the hospital who gave of their time and bodies. It was the first time that we had to build rapport and interact with patients unsupervised, and it was a real learning curve (MedF1/NW).
>
> It was significant because it was the first time that I saw the medical side of being a speech pathologist (SLPF1/EC).

Participants had an opportunity to volunteer in student-run clinics and provide health care in selected underserved communities under supervision. This granted them an opportunity to engage in health promotion activities as first year students:

> The earliest memories of working that I have a medical student is when I was volunteering for SHAWCO health, which is a student driven organization that does primary health outreach to communities around Cape Town. It was in my first year, we went to Brown farm Philippi with SHAWCO health in the afternoon and that day I was allocated to do HIV tests. In my first year, I didn't understand the concept of pre and post HIV test counselling and one of the 3rd-year medical student did it for me. I knew about the epidemiology of HIV and opportunistic infections such as Tuberculosis when I was in high school and how volunteering for SHAWCO health is an example of the health promotion and equal access principles of the Primary Health Care in action (MedM2/KZN).

For one participant, this encounter took place even before she became a UCT student:

> My father was diagnosed with diabetes when I was very young, I think I was in grade 2/3. His biggest fear was getting the diabetic foot and so because of that he would constantly ask us to rub his feet every evening. He used to say that this was to make sure that he still had feelings in his feet and to see if he had no new cuts or bruises...My dad was the first person who made me start using my hands to care for and help people. I learnt through him that hands have the power to heal, whether it's just rubbing his feet with oil after a long day or performing what I now understand to be active assisted ankle mobs to help his stiff ankle. Unknowingly, he planted the seed (PTF1/KZN).

One participant was encouraged as he had unexpectedly earned the trust of the parents.

> In a clinic…That day marked the first time I would come so close to a mother and their children. I was surprised to see how willing mothers were to allow us as students to conduct hearing tests on their children (AudM1/LP).

The encounters in a mental health facility were for some participants beyond their expectations – there was discomfort, reports of new experiences that left lasting impressions, and a shift as they transitioned from being students to become part of an establishment.

> The first two weeks of coming to Lentegeur Psychiatric Hospital was very different to the blocks that I have been on in the past… what caught me off guard the most was the first subjective interview... It was my first time interviewing a person with intellectual disability, and the learning experience is something I shall take with me as I continue to learn more about the block and the patient I will most likely encounter (PTM1/WC).

> I remember the hospital to be very small ward, within a large complex of other health facilities and thinking that it is very isolated and felt like a cage... it was the first setting where I had a shift and was expected to be at site at a certain time every Tuesday to Friday (OTF1/GP).

6.2.2: Becoming Health Care Professionals

A range of factors defined the moment participants perceived themselves as health care professionals. These included experiences of forming relationships at work, being part of a team, advancing their technical knowledge, experiencing a shift from theory to practice, and moments where everything was beginning to make sense.

> By working with other clinicians both at the level of supervisor / clinical educator and fellow classmate has each brought its own experiences. Having a guide during the whole clinical block made the experience more bearable, at times, and more valuable (AudM1/LP).

> I was finally seeing theory come alive. Not only that, I also started feeling like I knew what my profession was about, all the confusion started going away, it was clearer and I realised that it was really something I was looking forward to doing in the near future *(*OTF1/GP).

The experience of being a professional was presented as a process that began with oath-taking and engaging in health care provision, from clerking a patient to the point where they were well enough to return home.

> When we took our first oaths in 2nd year, that is when I began to realise that I am really doing something here. But I really started seeing myself as a healthcare worker in my final year. When I was responsible for patients from admission to discharge (PTF1/KZN).

> Knowing that the work I do actually counts, for example, my treatment was enough to change a clients' life (OTF1/GP).

Participants were beginning to appreciate that patient management required a holistic and a biopsychosocial approach. They defined a role for patients as teachers, acknowledged their role in managing their own patients, and were concerned about whether they were effective in their role as patient educators.

> What I learned is that you have to know about the patient a lot in order to have a holistic approach to treatment and intervention. Also, what I have realised, is that intervention is not only physical, but it involves social and economic angles. You have to think broader than just the physical, you have to think for when you are not seeing the patient anymore, and you have to think will the patient be able to perform all of these things when you are not around to see them perform it (PTM1/WC).

> Learning the art of picking up signs and symptoms from patient. I was doing my neonatal screening clinic in 2018. The experience was amazing, and the level of professionalism was at a high standard *(*MedM1/FS).

Participants appreciated the opportunity to provide care as part of a multidisciplinary team and could define a role for themselves and other members of the health care team.

> Friday clinics were the most interesting as we were working with people with vestibular disorders, and it was a nice way to see a multi-professional team in action which consisted of Audiologists, doctors and nurses. This clinic allowed us to get exposure in working not only with the patient but also with their families and put into perspective each team member's role which was always in theory until then (SLPF1/EC).

> It was affirming, managing a 90-year-old with brain tumour, I was part of palliative team (MedF2/KZN).

Assuming responsibility for patients under supervision was taught and learnt, and a lived experience. Participants were learning to work with patients and their families. There was also an acknowledgement that participants added value to the life of their patients and could see themselves maturing in the practice of their trade.

> Seeing the effect of my work on patients...I previously didn't see the effect of physiotherapy and I didn't believe it was of much benefit. All I thought we did was assess balance and get people up walking. I was wrong. I have helped a cleaner who was on the verge of being retrenched because of ongoing shoulder pain retain her job because we were able to address the underlying instability that led to her dysfunction. I have countless stories of how my patients have taught me to value myself and my profession purely based on how much I was able to help them (PTF1/KZN).

> We held an ASD support group for parents where we were really involved in working with the families and very hands on with strategizing on coping mechanisms. It was significant because it made me feel important and needed by the family/parents (SLPF1/EC).

> Being given responsibility, I felt like I was contributing to the team effort. Feeling competent enough to add value to a patient's life (MedF1/FS).

6.2.3: Teaching and Supervision

Participants appreciated being taught by those who they regarded as "the best," such as the Head of Department (HOD) who was currently undertaking ground-breaking research and had adopted a transformative approach to teaching.

> In first year, our teachers were healthcare workers. They were very knowledgeable people and I learned so much in that short amount of time… in Victoria hospital...Dr G was the one responsible for teaching us final year medical students. Dr G is the consultant that I model (myself on) and he is too good academically and clinically. I also learnt a lot from him, his kindness and being friendly. He was patient-centred and applied the appropriate evidence-based medicine (MedM2/KZN).

Participants also experienced role modelling and had an appreciation of their role as lifelong learners.

> I observed the different ways that seniors teach. Seeing the way they alter questions to suit the levels of education on ward rounds has always been interesting. It was also a reminder that doctors never stop learning, there's an ever-growing bank of information out there for us to vet and integrate into practice (MedM1/FS).

> To see the level of success they embrace, not only that, but the compassion they share for the profession and patients is something I only wish I could experience, and this is partly spearheading my goal of studying further in the field. I want to make a difference in a person's life, I want to promote myself and be the best I can be (PTM1/WC).

Participants appreciated the guidance they received on how to manage patients. They acknowledged constructive feedback from their clinical supervisors and the assurance that they would be future role models.

> During this clinical rotation, the supervisors offered us a lot of emotional support because some experiences with certain patients would be draining. The patients in this clinic would often get emotional because of what they were going through and that posed an emotional burden on us that we were not used to from all the clinical blocks we have done. The gratitude the patients expressed at the end of these assessment was reassuring and helped us to see that we were still on the right track which was to help those we are being trained to help (OTF1/GP).

> Working with supervisors, who are already practising clinicians, has helped me to see myself as a health care professional already, and that I need to start acting like it. (SLPF1/EC).

> Some would always tell us about the opportunities and the impact that we could potentially make in our communities as Black Audiologist (AudM1/LP).

Not all experiences were positive, however, and this motivated one participant to adopt a new approach as he negotiated as sharp learning curve.

> The fourth and second last week of the community block – so many things that happened, personally and on block. This has honestly been one of the worst weeks in a while. I don't know how I got through it. Yet here I am to tell the story. The approach to rehab on this block is much different. Let me not say for this block, rather the approach I am not used to. It has different aspects, and even as a physio you have to get involved in fields that you are not familiar with, or fields in physio that I as a student have not been introduced to yet (PTM1/WC).

Participants witnessed professionalism in action and were gently reminded on what they committed to when they signed up for their respective degrees. They were also realistic about their observations as they sometimes witnessed unprofessional behaviours.

> They have reminded me of the oath I took as I was starting to feel the heat of the clinics – the patient should not know that you have been having a bad day. It's all about the patient, I need to put my own emotions aside (Aud M1/LP).

As they witnessed unprofessional conduct, one participant had to reflect on the type of professional she aspired to be. This encounter created a space for her to reflect about her own prejudices.

> I witnessed a clinician shout at a patient and send him back to the township and she said "*you will be treated by your people, who will hopefully treat you better than I do*", and she walked away. That experience broke my heart because that man was accompanied by his elder mother who had taken off work as a domestic work for that day and was most probably never going to get paid for that day. I was shocked to see a woman with more than 10 years of experience do that to another human being. That experience showed me the type of clinician I never want to be. I was forced to reflect on my own prejudices and how these may actually affect how patient I am towards my patients. I know that I am generally more kinder and understanding and more patient with African patients because I know how much they suffer, I am familiar with their struggle because I too have those struggles. However, what about the Caucasian patients? What are my prejudices towards them and how can these affect how I deal with them. From realizing that my blatant disregard for learning the Afrikaans language to me immediately thinking that they tend to catastrophize so they can get more attention. I had to start dealing with those kinds of feelings and put my own prejudices aside. It took me seeing

my own people being mistreated in my field of work to reflect on how I may also be a perpetuator of racial injustice in this country (SLPF1/EC.

6.2.4: Patients' Contribution to Becoming Health Care Professionals

Participants acknowledged the role of patients in their own professional development. They learnt about the practice of medicine and they learnt from their mistakes.

> At my paediatric aural rehab (block, I saw the same children as patients for six weeks. I've learnt a lot about children, and I have come to enjoy my clinic block with them (AudM1/LP).

> Patients always have a great influence to my career. There were a lot of patients who came in with delirium, they were difficult. So, I learnt how to care and manage confused and violent patients without degrading them. It was a tough time also when patients would just die suddenly, and it would be so painful to deal with the grief, but I am thankful to the counselling I would receive from my senior doctors. (MedF2/KZN)

> When I see a patient progressing, that means I am actually helping them. I am also a great learner from my mistakes and therefore patient feedback helps greatly (SPF1/EC).

Patients had a dual role in facilitating their learning experiences and in providing encouragement. Participants acknowledged that they should maintain an ethical standard when interacting with patients.

> My patients are the ones who gave me the confidence in my work. From explaining to my patient that I will be having an exam and having them smile encouragingly during my exam and sometimes even understate their pain just so that I do not appear to be hurting or inflicting pain on them just in case that will cause me to fail…That encouraged me to go home everyday and read up on their conditions. (PTF1/KZN).

> Each year, the OT department makes us to take a pledge for us to understand that we should be ethical and professional Occupational therapists. This always reminds me that I am working towards working with patients and being responsible for patients. I think it is

because their wellbeing and health is my indicator of my becoming a health professional. (OTF1/GP).

Participants also appreciated the responsibility that was bestowed on them, levels of care, and the role of supervisors in facilitating their learning. Participants had to clerk their own patients, come up with a working diagnosis, and present a management plan to their clinical supervisor.

> I was part of the team, I felt needed and felt like I was contributing to the care of patients. It was the first time I could use the phrase my patient. I no longer had to beg patients to ask for permission to examine them, but it was more like the patients didn't have much choice but to pass through me before they could be seen by a senior doctor. I got to manage patients in an acute setting and performed procedures independently (MedF2/KZN).

The joy and burden of working with patients became evident in one of the reflections. There was a realization of the value of setting boundaries during their patient encounters although the participants were also required to be the best they could be in the moment.

> It really hit me, during the last week, when I told them that I won't be seeing them anymore. The amount of work and stress I endured trying to help them as best I can made me realise that when you invest yourself as an HCP, you can become attached without even realising it; therefore, I need to do my best with the time that I have with my patients (AudM1/LP).

> It is always fascinating to interact with patients because they are all different, they trust student clinicians (SLPF1/EC).

> During my time as a student, I have felt grateful for patients allowing me to learn through them. There is no better way to learn than to do. Initially, I did not have a lot to offer in return and often felt like I was a nuisance but their time helped make me into a doctor (MedicF1/NW).

Some of the participants' encounters with patients brought about a lot of anxiety, as patients had high expectations of them even though they were still trainees working under supervision.

> Their families do not always see us as students, but as health professionals who are here to help them (OTF1/GP).

Power dynamics came with having authority and control during their interactions with patients. However, one participant acknowledged the responsibility of ensuring that they take the time to prepare for each patient.

> It is up to me to make sure I do the necessary research, that I put in the hours, and not just in the testing but in the paperwork as well, the small things when no-one is looking makes a big difference (AudM1/LP).

> The gratitude the patients expressed at the end of these assessments was reassuring and helped us to see that we were still on the right track which was to help those we are being trained to help (SLPF1/EC).

However, not all patient encounters had positive outcomes, as reflected by these participants. Consequently, the gravitation towards patients they could relate to was constructive in meeting their learning needs.

> I noticed that some patients were racist towards us as young students. At times we struggled to find patients because they would just decline and say that they were tired, but if a student of the same race as the patient asked, the patient would readily allow them to examine them. So, I ended up approaching mostly Xhosa patients because they would allow us to interview and examine them (MedF2/KZN).

> I mainly gravitated towards African patients because they were so much more appreciative of me. They were encouraging as my own mother was. Some if not too sick would even have a chat with me about life and impart wisdom. In times when I was tired and even annoyed at a clinician, it is my patients who would sometimes calm me down and encourage me, telling me that it is almost over, I must keep my head down. Knowing that, even though they were in a place of need, in a place of disadvantage, I was more than their physio, I was one of them and so they cared for me as one of them (PTF1/KZN).

6.2.5: Stated Preference for a Training Facility

Many participants preferred to be placed in Level 1 health care facilities as the scope and range of patients was enough to attain most of the core competencies of the curriculum in a less pressured environment. The community health centres allowed for more relatable and common conditions and were mostly likely to involve patients who presented with complaints and symptoms which they would encounter in their own communities.

Participants felt that in these facilities, there was an opportunity to follow up and manage their own patients.

> As opposed to hospitals, which at times one only gets to see the patient once… of actively being in treatment with me as their therapist (OTF1/GP).

> Primary Health Care Facilities (Clinics). because I come across people who live in conditions which are similar to where I come from and that makes it easier to relate to them and their experiences as well as how the added problem, they present with may be affecting their lives (SLPF1/EC).

The district hospital offered participants an opportunity to work with undifferentiated patients.

> There was more to learn there (district hospital) and we get to learn about diseases before they are complicated (MedF1/NW).

> My preferences are informed by the types of patients I see…I do not want to be in an environment that has people who shout at people who are at their weakest. My preference is with my people, whether it is Khayelitsha Hospital or WCRC (Western Cape Rehabilitation Centre) because I generally prefer neuro and the patient population is usually African. I found the clinicians at Khayelitsha were generally kinder to patients, the patients were more receptive to us as students, and I was the most encouraged as a student (AudF1/LP).

A prevailing perception was that in Level 1 settings, teamwork was not simulated but was observed in action and was reported to contribute to positive health outcomes.

> Working with other care workers would be in Vredenburg on my most recent rotation where a multi-disciplinary meeting was held, and all professions had to work together on a case (SLPF1/EC).

A few participants expressed no preference for a particular facility provided they were placed in facilities where they could achieve their learning outcomes.

> No, I do not have a stated preference. There are great teachers everywhere and unkind doctors and nurses everywhere as well (MedM2/KZN).

Others were specific, as they preferred a well-resourced facility. There was also an appreciation that each facility presented unique opportunities to learn and acquire skills.

> I prefer a well-resourced facility. To have access to resources that will allow me to apply my skills (AudM2/KZN).

> I think if I like one specific thing, there will be no room to hone my expertise in another…I want to broaden my skills as best I can by learning my best at each facility I was placed (PTM1/WC).

6.2.6: Successes of the Training Programme

As participants were in their final year and preparing to exit their programmes, as reflection is considered a professional requirement for health sciences students and professionals in practice, participants were asked to evaluate their training experiences. Participants felt that they had attained sound theoretical knowledge practice, coupled with a good skill set. Many had attained confidence as emerging health care professionals and were ready for the workplace such as stated by the participants below.

> I can work independently with the help of a supervisor close by for help (SLPF1/EC).

> The clinics were the biggest success of the programme. The years of theory were solidified, and we learnt new skills we otherwise wouldn't have learnt in class. We developed as healthcare workers to be more people-centered and not mark centered. The programme has succeeded in making me a health professional who cares about their patients (PTF1/KZN).

> The emphasis was on understanding the theory. Also, the focus of the 'softer' topics like professional practice, empathy, health humanities and integration of palliative care principles into daily life (MedF1/NW).

One participant attributed his success to hard work considering that he was a first-generation university student.

> The fact that I have made it up to now is success enough. I have worked extremely hard to get to where I am now. I am basically a first-generation university student so the expectations can't not be met. For myself I have worked hard to be where I am and, I am proud of myself (PTM1/WC).

Participants reflected on stated opportunities to achieve the core competencies of the training programme. As they approached the end of the training, the curriculum was beginning to make sense. There was a renewed appreciation of the hard work, the contribution of supervisors and their defined role in their chosen careers.

> I am starting to understand my role as a health professional and the duty we have to our patients, realising our roles as HCPs really settles in when the practical work starts. Working more closely with patients has renewed my passion for my degree and my future as an Audiologist (AudM1/LP).

> The registrar and MO and the consultants in Internal Medicine were all very helpful and taught us a lot about managing patients. When I started this block, I did not know much about the management of patients, but I learnt a lot by being active and asking questions. Whenever I presented a patient, I would learn from the correction I got from the senior doctors. Comparing this experience to the one I had in fourth year, where I received no teaching at all because the reg did not want to teach us. I came out of this block confident that I would make a great and safe intern (MedF2/KZN).

A shared view was that their training was grounded in a public health approach and participants were confident in their capacity to assume a leadership role. Teaching sites allowed students to get good exposure to a wide spectrum of diseases they were likely to encounter in a community setting:

> Success of this training programme is that you are taught fairly and there is always support in the clinical rotations and in campus (MedM2/KZN).

> As I approach the end of my training programme, I feel I am equipped and will be able to manage patients competently (SLPF1/EC).

> Adequate enough to allow for adequate learning and preparation of employment and best skills practice; the kind of sites that they place us allow for us to engage with conditions that will allow for us to adapt to whichever setting we work in, that is most prevalent in the society and community (OTF1/GP).

The opportunity to tutor other students encouraged growth and professional development and participating in research meant that they could source the best effective and up to date treatment for their patients.

> I feel that I am adequately trained and received enough clinical and academic exposure. I am confident that I can safely apply all that I have acquired at UCT to my internship and career. The investment in theory and academic knowledge is worthwhile because in whatever I do I know exactly why I am doing it and able to apply it to the practical management of patients (MedF2/KZN).

One participant reflected on the value of course evaluations as an opportunity for students to give feedback to their supervisors which in turn could lead to a fulfilling clinical placement:

> There should be ongoing evaluation of supervisors, clinicians and placements and this can result in best placements for students and providing channels of reporting anything unsatisfying/disrupting to the university (OTF1/GP).

For another participant, success was reflected based on progress made by patients in her care:

> My major successes that I hold dear in my heart, from when I started being a clinical student to now as I am about to graduate, is seeing my patients make major progress in their recovery. Patients come in with so much hopelessness, thinking they would never recover again, or they would never be like others but after seven weeks we see such great improvement. That is very rewarding. This is important to me because even I myself never really thought I could make such big changes in other people's lives (PTF1/KZN).

One participant extended gratitude to UCT and looked forward to the year ahead.

> Next year I am going to be thanking myself, obviously I have already thanked UCT for the opportunity. I just want to thank myself now (AudF2/LP).

6.2.7: Challenges in the Training Programme

Participants felt that their programmes did not grant students breathing space, as they always functioned within tight timelines in meeting a demanding schedule. The full calendar denied them an opportunity to participate in social events.

> Having to keep up with a very demanding school schedule and social activities…we don't stop living just because we are (health sciences students) (MedF1/NW).

Finances were flagged as a challenge. The government issued loan scheme NSFAS (National Student Financial Aid Scheme) was not enough to cover the tuition:

> Finances? Why? The tuition is too expensive and NSFAS doesn't cover everything (AudM1/LP).

> Looking at that time my mom's work she was earning very low, in fact her gross income was lower than my first-year tuition at the time. So, I knew that if something happened there was no one that was going to save me (MedF2/KZN).

Poor communication was identified as a challenge that may be an outcome of ongoing staff shortages. However, there was also appreciation that university staff had personal responsibilities beyond the classroom:

> Administration and communication between lecturers and students… I don't know if there is a system of hierarchy in the department, but students who had sent urgent emails only got a response weeks after they needed it. Though I understand that people are only humans and have a life and children and marriages and families to maintain, it is still important to do one's job and to handle responsibilities (PTM1/WC).

Participants expressed concerns about the variable experiences in clinical training sites due to lack of standardisation and equipment, and concerns about the impact of pandemic on missed placements in the community:

> Various supervisors expect different things…in other years it would be the malfunction of equipment in sites we are in or equipment we had to take to the sites. The challenges of my training programme were having limited contact time with patients due to the current virus (SLPF1/EC).

> The placements especially during COVID-19. I missed out on placements like Community which I believe would have been beneficial to me and given me new skills that I needed. (PTF1/KZN).

There were concerns that their training did not prepare them for under-resourced facilities which contrasted with the first world class training at UCT:

> We are well trained to work anywhere in the world and capable of initiating campaigns to fight disease, promote health, decongest tertiary institutions, and educate society about prevention of diseases … There is also an emphasis of doing things the textbook way, not teaching us how to improvise when we do not have the resources. We trained in a resourceful environment but we will practice in places that lack a lot of resources and facilities (MedF1/NW).

Participants were most distressed by the institutional culture and the hierarchy that prevailed both on campus and in the clinical training settings, and the impact of these factors on generations of students.

> I do believe that the Black people of historical disadvantage must be given preference if they are competing with a white person of historical advantage and when they have the same qualification (MedF1).

> The hierarchy. The social impact that it has, to have endured this kind of atmosphere implicitly for so long has a negative impact. It could have contributed to me not being able to see myself as being able to help people in my profession because we are seen as less than. We don't need these additional stressors as students. Who knows how many students may have changed degrees or turned back? (AudM1/LP).

There were also concern about inter-professional hierarchies that denied patients' adequate care*:*

> Most of the time there is a gap between doctors and nurses and nurses are perceived as inferior as they are often compared to doctors but that shouldn't be. Caring for a patient is

an inter- professional kind of a thing, every team member is important and none is inferior if viewed accordingly. If there were no nurses, OT's, speech therapists, physiotherapists, there wouldn't be health care at all (MedF3/LP).

The demands of their programmes did not capacitate participants for sustained mental well-being:

> The lack of bridging the gap between the different years. Each year felt like a steep transition, and we were expected to adapt to it (MedF1/NW).

> The challenges were mostly in blocks that I was very unprepared for emotionally. You see so many things in the clinical platform that make you so sad, that you never expected. Of course, you learn about them before starting clinics, but it is always so shocking when you see real people go through them (OTF1/GP).

Participants expressed concerns about mental health support that was inadequate to meet their needs:

> Limited follow-up on student's mental health needs (SLPF1/EC).

> The challenges of this training programme are that it is very stressful, and you need coping mechanisms to survive (MedM2/KZN)

There were also concerns that there was inadequate support for students whose home language is not English:

> Not giving adequate support to students who did English as second language, or who found it challenging or consider it as a barrier to some students to their learning or understanding (OTF1/GP).

6.3 Theme 2: Personal Development

Individual factors such as gender and race promoted or hindered learning about their professions. Participants acknowledged the contribution of clinical partners and classmates even though they also experienced discrimination in some of the facilities. Two subthemes are presented: gender identity, and role of clinical partners and their classmates.

6.3.1: Gender Identity

The reflections under this theme include both objective and subjective experiences. The gender identity influenced some of the participants' experiences of the clinical environment as they were treated differently to their colleagues.

> I did notice that males are treated with more leniency than us, especially white males. What I saw is when a white male student answers a question, even when he is wrong, he is not told outrightly so that he is wrong. Another student even told us that he knows that they don't have to put in half the effort we do but still get better marks in clinicals (MedF1/NW).

However, one participant used her Christian values to establish rapport with all patients despite the gender differences:

> By embracing my principles from Christian upbringing to show respect to my patients I wear a dress scrub in respect of my Christianity … my church has a certain idea of how women should conduct themselves, and therefore, other people/patients and even other HP's have expectations of how I should conduct myself...I also have to be an ambassador of my church. This is by showing the stated principles to my patients, and colleagues (OTF1/GP).

Being discriminated against compromised the learning experiences for a few participants.

> My gender did not influence my experiences. It was my race that did. As mentioned in question 1 I noticed this in preclinical years that even patients were treating us differently. A throughout my clinical years I feel that I had to work twice as hard to be appreciated and acknowledged. In my first rotation in fourth year, we had a white registrar and in our group we were four Black students and one white. We received no teaching for a duration of eight weeks from the Registrar, but he would have private sessions with the white student whilst we were busy taking bloods, drips etc. I came out knowing how to perform procedures, but my clinical knowledge was so poor that I did not pass my clinical exam and had to have a supplementary exam (MedF2/KZN).

For the gendered male participants, working with a feminized workforce brought about a consciousness of being:

> Over the years, I have realised that physiotherapy is a female dominated profession, as I deducted by observing that 80% of the UCT physiotherapy department heads are female,

> with only 20% being male – this is a margin that I see is still the same because even the years below me, there are significantly less males in the classes compared to females. I think that me being a male in a female dominated profession influenced my experiences, but me being male is not a measure of my intelligence or skills. I love what I do and I love seeing people succeed in something they take on (PTM1/WC).
>
> I only started feeling aware of my gender once at Red Cross: I was with my clinic partner (also male). and we were the only two guys in the office. The staff in the department were all women (AudM1/LP).

In addition, one participant expressed a level of discomfort in managing female patients: "I remember one time in a maternal ward. I would feel awkward to see half naked women. It became a normal after some few days" (AudM2/KZN).

6.3.2: The Role of Clinical Partners and Classmates

Under this theme, I explored the contribution of clinical partner(s) and classmates. The appreciation of the support that was extended by clinical partners/classmates was evident in their reflections to the extent where this was simulated to experiences in a struggle movement where you are sustained by comradeship of the group.

> Having a friend with me in the struggle/heat just makes it better. Knowing that you are not alone in the struggle makes it more real (SLPF1/EC).
>
> Working with the same person in the same year as you with the same teachers and supervisors, on a student level, makes things easier, knowing there is a companion who is in the struggle with you (AudM1/LP).
>
> I cannot imagine going through clinical years without my clinical partner. We went through the most difficult times together and it was so much easier to cope knowing that I was not alone. We were good friends and encouraged each other, supported each other and corrected each other (MedF2/KZN).
>
> Working with the same person in the same year as you with the same teachers and supervisors, on a student level, makes things easier knowing there is a companion who is in the struggle with you (PTM1/WC).

Participants considered groups a resource, and group work brought about a playful side for participants, bringing relief to an otherwise challenging working environment:

> Working in groups, alongside my peers, has also been beneficial in strategizing ways to make therapy more fun and interactive. Putting more minds together helps in many ways (SLPF1/EC).

> …we would form small WhatsApp groups to share information about the clinics we shared, and it kept everyone going. If you didn't understand anything, you could ask in the group (AudM1/LP).

A few had to live with a heightened awareness of their working-class status in an elite university as they relied on their classmates for transport:

> During the rotation, there were occasions where we were expected to go to Maitland cottage hospital and Red Cross children's hospital and the university does not provide transport, yet with the help of our kind classmates we were able to go with their cars to the above-mentioned hospitals (MedF1/NW).

There were unintended benefits for participants who engaged in social partnerships. There was accumulation of social capital and a kinship that motivated them to commit to the requirements of a learning environment:

> My clinical partners were my debriefing partners as it allowed for one to cope with the demands of the setting, and also to exchange ideas on what we can do…My partners also served as healthy competition and for me to track my progress I knowledge and practical skills (OTF1/GP).

> My clinical partner is my best friend. She has challenged me to learn and also has taken care of me as a person. Our partnership has been more than professional, it has been one of the best friendships of my life and med school facilitated that. I now have somebody who understands the work, that I can debrief with after a hard day (MedF2/KZN).

> My block partner was my biggest support structure during the block… We really built our way up, we kept good contact even after hours, communicating, brainstorming ideas. Even just for emotional support outside of the academics we were there for each other, and we became good friends (OTF1/GP).

In this chapter, participants reflected on different aspects of their clinical training. They described various encounters that were meaningful and contributed to learning about their professions, in which they were supported by academic staff and clinical supervisors in a range of facilities. They reflected on interactions with patients that were constructive as they learnt to manage presenting symptoms, and they felt supported by some of the patients they encountered. Their clinical experience facilitated a process whereby they could realistically evaluate their professional journeys.

CHAPTER 7: INTEGRATED DISCUSSION

This integrated discussion is guided by the broad aims of the study to describe the lived experiences of students of rural origin, and to determine the influences of the learning environment as rural origin students adapt to become healthcare professionals. I draw from the findings I presented above. In Chapter 4, I explored participants' understandings and experiences of rural settings and rurality, and the impact of these on health outcomes, and I examined student understandings of becoming a health sciences student. In Chapter 5, I examined the role of the university in student continuation, particular as experienced by the study participants, and in Chapter 6, I focused on professional socialization.

7.1 A Personal Reflection Beyond the Interviews

Up until a few minutes before the scheduled interview, I had only met my participants once in a classroom setting during the 5–10-minute briefing sessions at the beginning of the 2020 academic year. I attended five of those meetings in different venues across the Health Sciences campus - one for each of the professional groups. Beyond that, throughout the COVID-19 pandemic in 2020, I only interacted with participants via email and in short text messages and had telephonic conversations with a few. Although we were strangers, we were bound by a common thread – our intersecting identities.

Many aspects of the interviews were difficult to process. Even as I returned to analyse the data and present my findings, I continued to be weighed down by the heaviness of some of their experiences. In analysing the data, I had to respect the tender moments that I was invited to share – the disclosure of terminal illness of a parent, the loss of a child, experiences of sexual assaults, and episodes of mental health crises. I had to honour the memory of the father who passed away shortly before the interview and respect the aspirations of the participant planning to launch a small business that would empower women in her village. Some of these difficult moments are societal and personal challenges and are not unique to students of rural origin. But the critical issues that came up in our discussions had great impact on some of the participants, threatening their continuing enrolment as health sciences students. Concerns about the vulnerability of participants,

balancing issues of privacy and confidentiality, and an obligation to report authentically, highlight some of the potential conflicts (see Allmark et al. 2009).

In a short practice report (Mapukata, 2019), I reflected on a duty of care that is owed to medical students in instances where patients are abandoned in primary health care settings. I approached this study as a researcher with an interest in student development and student engagement and had reflected on the harms the study might impose on my participants. At the same time, participants affirmed the value of the interviews. One participant referred to the interview as 90 minutes of free therapy. Others expressed relief at the opportunity to share their experiences and to be listened to. One participant was concerned about the emphasis placed on her identity as a student of rural origin and asked if we could just get on with the interview. There was a hint of anger. As this was our first encounter, I attributed this to the pressures of being a final year student, and at the time overlooked the emotional pain central to many of her reflections. I would encounter this a few times with other participants. These were the interviews that left me drained, forcing me to constantly examine my motivation for pursuing this study. As a preface to the discussion, I want to make two points.

Firstly, students of rural origin generally experience difficulties as they are often marginalised by historical discourse and personal circumstances, and sometimes by the context in HEI (Lehmann, 2001; Janse van Rensburg, 2011; Czerniewicz and Brown, 2014; Pather and Chetty, 2015). Secondly, despite these circumstances, they remain highly motivated (Hines et al., 2015). I elaborate on these assertions throughout the discussion chapter.

As I reflect on my personal circumstances, as a Black female of rural origin in South Africa, I can relate to many of the lived experiences of my participants, hence the reference to our intersecting identities. As I had just joined UCT, I lacked the social capital I had at Wits, where this study was conceptualised. Now I realise the value of this, as the distance provided me with the space to manage my subjectivities.

7.2 Examining the Lived Experiences of Health Sciences Students of Rural Origin

According to Wang (2017), the process of telling and retelling a story allows one to engage with their past, the present and the future, and this is what I required of all 21 participants who consented to be part of this study. I invited them to share their lived experiences and "to tell their story as a

health sciences student of rural origin" in a semi-structured interview that focused on five broad areas.

Considering that Bourdieu and Passeron (1977) describe habitus as an interplay between the past and the present, the nature of my research questions asserted an interest in historical events about their upbringing and the role of the family in generating a habitus. The semi-structured approach allowed participants to reflect realistically about their journeys from home to school and the process of being and becoming health sciences students at UCT. Although this did not always follow a logical sequence, as a researcher I guided participants to understand their habitus as it is presented by Bourdieu as a "product of history, capable of producing individual and collective practices" (1990a, p.54). I achieved this through fact checking for accuracy of interpretation and further exploration of unusual responses in a methodological approach that is recommended by Meriam (2001, p.5).

The lived experiences of study participants offered me insight into the diverse backgrounds of students of rural origin, and the verbatim quotations I include above were valuable in confirming authenticity of the findings (Corden and Sainsbury, 2006). Confronted with their reality of limited cultural capital, students were forced to reflect on what they had access to, in contrast to some of their peers, for example, whose parents had long standing affiliation with UCT or were practicing professionals. Participants reflected that their families and teachers had faith in their academic abilities, and already referring to them as doctors as they were using certain skills by proxy. This was the case with a participant whose diabetic father had observed that she had "healing hands." In such instances, participants could claim their identity for motivation: one participant stated that she knew who she was and could not afford to return home empty handed.

In a doctoral thesis, Yenney-Henderson (2019, p. 143) likewise described persistence and motivation as habitus influencing elements of identity among students of rural origin. Similarly, in another doctoral thesis (Wee 2013), participants expressed appreciation that their success would also be the family's success. Profiling my participants as students of rural origin justified an expectation of habitus (Bourdieu, 1977) that becomes functional when past experiences are integrated in current practice. In validating the properties of habitus, in their study, Reay et al. (2009) also reported the benefits of examining individual histories of working-class students, as vital to understanding the concept of habitus (p.1104).

Robb et al. (2007) examined identity construction among 16-year-olds from socio-economically deprived backgrounds. Using a Bourdieusian approach to examine familial habitus, as part of a summer school initiative to expose pupils with academic potential considering a career in medicine, participants were invited to ‘‘tell the story of your life so far’’ (2007, p.744). As the participants were still attending high school, the study extended over a two-year period with progressive modification of the research questionnaire, and a document review of their personal statement. This confirmed maturity is required to reflect on one's educational journey. Recognising the challenges and barriers in attaining a higher degree, exploring educational journeys of Native American students, Arpan (2019) acknowledged that educational attainment extends beyond the participants' capability; family support and access to resources are just as critical.

Bagley's (2019) doctoral thesis is particularly relevant to this study. With intentions to diversify the nursing workforce, Bagley examined the lived experiences of pre-nursing students from ethnically and racially under-represented backgrounds in the United States of America. Bagley employed a descriptive phenomenological approach and critical identity theory to examine the lived experiences of pre-nursing students. Closer to home, Ross (2016) employed life history methodology and auto-photography to examine the experiences of selected rural based health care professionals previously funded by the Umthombo Youth Development Foundation programme. In another study that explored teaching professionalism, Goodson and Choi (2008) examined the collective memory of their participants as well as life history. In this study, participants were able to structure their thoughts chronologically, from reflecting on their understanding of rural origin, their roles as emerging health professionals, and who they had become as they approached their graduation.

7.3 Understanding Rurality and Acquiring Social Capital

A range of reporting formats about rurality were considered, such as those suggested by Halfacree on locality and social representations of rural (1993, 1995) or rural space as a three-fold-architecture (Halfacree, 2006), the Rural Health Advocacy Project's four categories for defining rurality (RHAP, 2015), and Woods and Heley's four pillars (2017). Rabinowitz's (1997) descriptive framework matched the reflections of the participants about their understanding of

rurality as lived experience, not as singular occurrences but as an overlapping array of subjective and objective experiences. In locating place of origin of the study participants, I also reflected on Bourdieu's (2002) representation of rurality as physical place and social space.

The prevailing view of rural life is one of impoverishment and depressed childhood. I disputed this in my reflexive piece (Mapukata, 2020), and similarly, several participants spoke fondly of their upbringing and their families. Reflecting on the demography of South Africa's children, Hall and Sambu (2018) reported that less than 30% of African children were living with their parents. However, parental absence does not necessarily imply abandonment, as the option of being raised by grandparents or extended family members is sometimes in the best interest of the child. For example, the parental home may be some distance away from school or parents may be working in another city.

Muula (2007) offers a range of variables that include political proclamations as professional and social variables to be considered when profiling rural communities. In this study, exploring the participants' understanding of rurality was not a monolayered and sequenced series of life events, but was highly contested, as one participant pronounced: "technically I'm not a rural child but then everything around me is called a village." Bourdieu refers to these assertions as a "dialectic of positions and dispositions," a continuous rearticulation of social structure through the continuous restructuring of the habitus of participants (2000, p.155). A few participants also acknowledged that they had a more privileged upbringing than others: "I definitely come from a more privileged rural background." This was the extent of the diversity amongst the participants.

Contextual descriptors concurred with those reported by scholars of rurality (Balfour et al., 2008; Nkambule, Balfour, Hlalele, 2014; Masinire and Ndofirepi, 2020), as rurality was defined in terms of space based on geographical location and social perceptions of the place. For example, one participant, raised by her grandmother, a successful entrepreneur in Limpopo, lacked for nothing. She had piped water and electricity and a helper, even though her home was in a village. She had internalised class and success but was also appreciative of the values of her immediate community. Another participant reported that they had piped water through the efforts of the village chief. Living in a mountainous area, the chief had identified that the area had the potential to harvest water, and he extended his cultural capital to benefit the community. Considering the value of this initiative in wealth creation and its impact on health outcomes, this dispels the

assumption that all rural children are of a lower class or lack the resources associated with lower class status (cf. Webb et al. 2002).

Notwithstanding the above, rurality was presented in many descriptive forms, such as limited opportunities and poor access to resources. Rural areas were presented as heterogenous, dichotomous, ambiguous, and variable. Home was presented in relation to the community including small towns, small holdings, farming communities, townships, and villages. Schools were mostly distant, poorly resourced, and lacked many of the basic amenities, as reported in other studies (Willits et al., 1982; Halfacre, 1993; Balfour et al., 2008; Couper, 2003; Muula, 2007; Edwards and Mataritta-Cascanda, 2011; Moletsane, 2012; Roberts and Greene, 2013; Rasheed, 2020; Reid, 2019; Nelson et al., 2021).

Framed by rich data from all participants, rurality was presented as dilapidated infrastructure as participants linked economic disparities to under-development, lack of transport, decay and basic services – not even a bank or an automated teller machine – "No ATM." Accordingly, participants established a causal link between poverty, unemployment, and impassable roads; they mentioned lack of shopping malls as there was no central business district – "No CBD" (cf. Ataguba, 2020b). This impacted on education because there were "no computers, no internet, no library." This is similar to observations reported by Mngomezulu and Mngomezulu (2020) and Sayed and colleagues (2020). Given the complexity associated with rurality, the profile of the community and of the school was consistent.

Many participants spoke of strong bonds that "connected everyone." The only discomfort was the intrusive nature of these social bonds. Social networks generated through cultural values, community values, and a close-knit community reflected more of the positivity that is associated with rural communities as a place where identity is affirmed (Halfacree, 1993; Mapukata, 2020). The role of family, however it was constituted, became critical in the embodiment of habitus. Living with members of the extended family was normalised such as the case with the participant who, at the time of interview, was in quarantine (for potential COVID infection) with his extended family (Mngomezulu and Mngomezulu, 2020). This was also evident in the value of the extended family, for a participant who chose to move in with his uncle and his wife following the passing of his father (see McCulloh, 2020). On the other hand, another participant mourned the loss of her polygamous family as she reported on changing relationships in the African culture. Following the passing of her father, her family no longer had access to the shared resources. This had an

immediate impact on their class status within the community and the corresponding social, cultural and economic capital. While her father used to drive her to and from school, she was now forced to rely on public transport. This confirms a habitus that is acquired as a system of generative schemas, and its role in regulating family experiences as contrasting experiences of gaining and losing family (Bourdieu, 1977). Participants drew attention to the complexities inherent in a rural upbringing (Gumede et al., 2021).

Participating in the traditional coming of age dance *umemulo* accrued symbolic capital for selected participants. This practice bestows honour not only to the participant but also to the family. If the girl is married after the *umemulo* ceremony, *lobola* (bride price) as the end stage of this ceremony, is one of the few sources of symbolic capital available to Black women as Shope reports in her paper "Lobola is here to stay" (2006, p.66).

Consequently, *umemulo*, and the cultural bracelet *isiphandla* acquired by one male participant, were converted to objectified forms of cultural capital. According to Bourdieu and Wacquant (1992), families facilitate this acquisition; in this case it was the grandfather who honoured the participant with the protective elements of *isiphandla*. The proceeds from *umemulo* and *isiphandla* can be translated to economic capital either through *lobola* or future employment. Accordingly, a relationship exists between social, cultural and economic capital (Huang, 2019) and while it is transformational, it is non-replaceable (p.45). Hunter (2019) is of the view that family is not a static entity and that irrespective of race, there will always be upheavals, but a critical point is to facilitate social mobility in accessing cultural capital as connections and differences exist within families (p.17).

While home was a place where one has ready access to ancestors and divine protection (Steyn, 2003), language, church and sport were anchors participants employed during the acculturation phase. In a doctoral thesis, Nzayabino (2011) examined the role of religion in understanding the experiences of Congolese migrants who had relocated to Johannesburg. Nzayabino's participants could not be integrated into host religious institutions and had to navigate identity and belonging within diasporic communities as they settled in at the Yahweh Shammah Assembly, a Pentecostal and charismatic church. In this study, church generated bridging forms of social capital where young people had no friends, and this helped them navigate difficult spaces. The bonds formed through church became a resource that generated institutional cultural habitus among students as they became clinical and debriefing partners. For one study participant, church

identity was transferred into the clinical space as she used her values to honour patients and navigate professional hierarchies.

Participation in sport also helped students navigate institutional culture as they had immediate access to social capital if they played sport or specific games such as chess. Light and Evans (2011) contend that habitus is an expression of an individual's social and cultural history. Participants were just as pleased if they met someone who spoke their home language and with whom they could navigate social spaces together. Dining rooms and residences became spaces for scouting for shared identities (rural origin) in addition to being Black (Barroso, 2015) and similarly gendered, and thus were spaces to generate linking social capital. Consistent with the assertions above, Kaufman (2004) confirmed the capacity of a generative habitus among Chinese immigrants who used their social capital to accrue cultural capital.

These lived experiences depicted rurality as a social construct with various socio-cultural mediators such as family, church and ancestors, as reported by Balestrieri (2016) in a paper on rural students in Italy. According to Bourdieu, "the structures of the social space (or fields) shape bodies by inculcating in them, through the conditionings associated with a position in that space, the cognitive structures that these conditionings apply to them" (2000, p. 183). In professional spaces, values acquired in a family setting continue to have higher currency, showing respect to lecturers, to colleagues, and to patients and their families (Power, 1999, Huang, 2019). These values demonstrate the generative capacity of a family habitus.

Reflecting on the experiences of the participant who was conscientized to the extent of rurality of her community and how small her town was only after she was exposed to a big city like Cape Town, one should appreciate the ambiguity and diversity of rural areas. Prior to the urban exposure, this participant probably would never have referred to her town as a "dead place." In that regard, these communities fulfilled the criteria of a heterogenous, dynamic and complex profile as presented by Ndofirepi and Masineri (2020, p.245). Accordingly, rural people and their respective communities do not always share similar profiles (Willits et al., 1982). Qualifying these diverse profiles, Pandey (2003, p.39) defines space as both materialistic and culturally inclined. Effectively, the focus in this study was the "socio-spatial characteristics" of the area (Halfalcree 1993, 23). This assumes that the defining characteristics will determine the socio-cultural definition of the area based on the assumed uniformity of attitudes and behaviours of the residents. Despite the ambiguity and heterogeneity of rural communities, beyond this, I assumed that

participants shared a social identity based on relational components of some of their communities. Bourdieu and Wacquant describe this "as the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (1992, p.119).

A few participants made critical observations about their experiences of rurality and attributes associated with their communities as they were conscientised to values on the interconnectedness of human beings as a collective. They referred to moral development conferred by their participation in church activities and through their faith. In that regard, according to Navarro, in addition to their social capital, they also accrued community capital (2008). In a South African context, this is referred to as *ubuntu* – I am because you are/we are – a humanistic philosophical approach that encapsulated the inter-connectedness of people and is a form of social learning (Lave and Wenger cited in Mapukata 2020, p.13). Social learning has the potential to contribute to an educational habitus and thus generate cultural capital.

Many of my participants expected to be greeted in lifts and in corridors because acknowledging, greeting, and showing respect to one another are established norms in their communities. In their reflections, participants spoke of their distress at the lack of greeting and acknowledgement in the city. The inherent values and dispositions associated with greeting can only be derived from cultural learning as the foundations of a habitus, described by Webb et al. "as a cultural history that stays with us across contexts" (2002, p. 36). In a study by Bergh et al. (2006), medical students at the University of Pretoria could not reach consensus on whether soft skills[15] such as greeting should be taught or not, as some viewed these as "innate skills, as something you were born with," affirming this value as familial habitus. Others did not confer the same value, as they were of the view that practising good soft skills was a matter of personal choice. Students should assume responsibility for their own development of soft skills – "it surely depends on the individual how he is prepared to treat a patient" (p.2).

In a study by Dichaba (2018) on the values of lifelong indigenous knowledge for rural youth development in South Africa, elders confirmed a correlation between a greeting and the respect extended to an individual: "By enquiring after someone's health *le kae*? (how are you?),

[15] In the provision of health care, soft skills are important attributes that are difficult to measure and include interpersonal and social skills, communication skills, professional and ethical attitudes (Bergh et al., 2006)

you show an interest in that person and in their family's wellbeing…you show interest on the other people in his/her life" (2018, p.147). Acknowledging another also affirms willingness to share common spaces.

The lack of acknowledgement in urban settings had far-reaching implications as study participants felt silenced in learning spaces if they could not greet and could not speak their home language. In such instances, students took time to adjust to an unfamiliar context (Reay, 2005), resulting in moments of disquiet, ambivalence, insecurity, and uncertainty as their habitus is disrupted (2005, p.921). Several participants reported varying levels of distress associated with the humiliation and discomfort that resulted from their existence being nullified compared to when they were acknowledged as high achievers in their high schools. Reay (2005) refers to these encounters as everyday humiliations and slights of social class, where lecturers and middle-class students subconsciously colluded to pursue agendas that excluded students of rural origin (p.918). Similarly, Bagley (2019) reported that participants in her study were distressed by their social circumstances as they felt undermined and disregarded.

Just over a third of the participants referred to the conspicuous unavailability of health services in their rural homes. These were either limited or only available at a distance. They associated this poor access with the socio-economic status of individuals who reside in rural areas. Their perception reflects documented inequities and vulnerability of rural and underserved communities (Stats SA Technical Report, 2020). Concerns about having to travel long distances to health facilities and limited or unavailability of services, supports view shared by McLaren et al. (2014) as the distance that must be travelled by people in the rural areas in seeking health care extenuates their suffering. This suggests a relationship exists between policy failures, poverty, health inequities (Ataguba, 2020b) and health outcomes of chronic conditions in rural areas (Kabudula et al., 2017; Omotoso and Koch, 2018). In their final year, I expected participants to engage a lot more on health-related issues. Their limited reflection may be attributable to their youthfulness, their commitment and motivation to pursue their studies despite prevailing challenges. It is also possible that participants' orientation to faculty's teaching hospitals in relation to the landscape in the Western Cape Province (Atkinson, 2014), where rurality is not as pronounced as in their home provinces, contributed to how they prioritised access to health care as an indicator of rurality.

7.4 An Educated Habitus and Acquisition of Cultural Capital

Although several participants were concerned about lack of resources in their schools, only a few mentioned connectivity as a specific challenge. It could be that this was context and programme specific, as all students were required to return to their homes during hard lockdown in South Africa. While on campus, all participants had access to Wi-Fi around the clock. Learning during the pandemic heightened awareness of the benefits of being connected, as all teaching and learning at UCT and other institutions was migrated to the digital space (online learning). Permission to return to the health sciences campus was phased. Final year students were prioritised to return to campus in a hierarchal order that privileged medical students over those enrolled in other degrees.

The pandemic created not only confusion and uncertainty in the health care system; it also posed enormous challenges for health sciences education (Rupley et al. 2020). A few participants regularly spoke of "No computers, no library"; "No YouTube, no Instagram, no internet café", echoing concerns about lack of access to digital technologies and its impact on subsequent adaptation challenges to UCT. With one other participant referring to rurality as a "dead place", this emphasis confirmed levels of deprivation that rural students encounter. Mngomezulu and Mngomezulu (2020) argue that connectivity is much more than a desired resource – it is a necessity for its contribution to social mobility to address challenges encountered by participants in processing application forms and funding applications.

Although 13% of the 2020 class at UCT were categorised as students of rural origin as informed by the DBE Rural Health Policy (2018), which forms part of the National Education Policy Act (Act No. 27 of 1996), 7% of high schools in the UCT list proved to be modern and sometimes elite schools. The location of these schools determined their classification as rural based on DBE's Rural Health Policy (2018). In a paper on locality and social representation, Halfacree (1993) addresses this contentious issue "as spatial determinism that holds an absolute conception of space whereby the space itself possess causal powers" (p.26). For example, a potential participant I recruited confirmed her upbringing as exclusively urban and was disconcerted that her school was classified as rural. It is possible that others were just as offended, as rurality in South Africa is often associated with poverty and deprivation (Mburu and George, 2017).

Reflecting on the polarising attitudes and ambiguity about rurality, Muula (2007) cited the relevance of political proclamations as variables that may influence the definition of rurality. Some

participants described rural areas as places where you either "have and don't have" (Finn and Kobayash 2020); a tranquil environment[16] depicting the "two-ness of a rural life" (ambiguity) (Bell 2007). One participant reflected on the implications of "living in two different worlds at the same time;" another conceded that being of rural origin was a validation of their identity. This perception of living in "two worlds" was observed by Brosnan et al. (2016, p.6) in a study that examined the experiences of medical students who were first-generation university students. Rurality was notable as a place with a dichotomy of perceptions (Halfacree, 1993). While one participant acknowledged that in a rural area people must constantly negotiate difficult socio-economic circumstances (Hlalele, 2014), another asserted that in a village, compared to a township or suburb, social connectedness was at a premium.

A desire to access better education and better resources was facilitated by siblings, parents, grandparents, and extended family. In a paper on lived experiences of American rural first-generation students, Heinisch (2017) acknowledged as critical the supportive role of parents despite lacking academic qualifications. Some of my participants transferred schools in their last two or three years of high school. One participant did not move schools, but rather became a weekly boarder so she could participate in extra-curricular activities and not spend time travelling to and from school. Over 80% of the participants moved schools to pursue a good education and to prepare for university (Baker and Brown, 2008). In a working paper on student transience in North Carolina, a state in the US, student mobility (Xu et al., 2009) was reported as high among minority and disadvantaged students. Authors reported on "strategic" school moves (cross-district) that benefited or had no effect on student performance, but "reactive" moves (within district) hurt all groups of students, especially the mathematics performance of Black and Hispanic students (p.23).

For participants in this study who attended rural schools, what contributed to their positive experiences were the efforts of principals and individual teachers willing to share their personal resources. As they identified students' potential to succeed (Li, 2019), they nurtured the students and encouraged them to develop critical thinking and good communication skills. They supported

[16] St Anne's Diocesan College, for example, is profiled as an independent girls' high school situated in Hilton, KwaZulu Natal, with a long tradition of providing excellent, balanced and globally relevant education. https://www.stannes.co.za

their participation in debate competitions and other activities likely to contribute to their success. The role of teachers is valuable in generating cultural capital for learners and has transformative elements, particularly if the teacher takes time to nurture learners' gifts and talents (Agbenyega, 2014).

According to study participants, one of the qualities reflected in the habitus of rural students, is that as one becomes socially aware, one embraces teaching moments. Hunter (2019) disputes the view that an educated habitus is limited to excellency in English. In his book, *Race for Education*, Hunter speaks of the "white tone" of desirable traits and the perpetuation of cultural hierarchies as Model-C[17] and private schools bequeath linguistic prowess on learners as a privilege not attained by those who attend rural schools (p.10). The privileges referred to above are a legacy of the apartheid state wherein Black and white learners had separate schools. Consequently, resources were allocated and made accessible along the lines of a racialised society – schools for Blacks were poorly resourced compared to schools for whites. White schools became Model-C schools after 1994 in a democratic state. Nkambule and colleagues (2011), who identified under-development and under-achievement in rural schools, confirm this, and several participants characterised their schools as having poor infrastructure and no resources, denying them access to good education.

This was evident in the narrative of one participant whose parents encouraged her to attend an "English school," while another participant's parents moved him to a school in town where the medium of instruction was Afrikaans so he could have a better education. He would later move to a community school in a township and recalled experiences of bullying in both schools because he lacked the "white tone" in one and was ostracised for the "white tone" in the other.

Sayed et al. (2020) have attributed the inequalities in the school system to failures in school governance and a flawed funding policy. They contend that in a post-apartheid South Africa, an "institutionally bifurcated education" system has relegated poor and rural communities to under-resourced schools, while those who can afford to pay, attend Model C schools in the suburbs (2020, p.5). Addressing this, Mpofu-Walsh (2021) in his book, *The New Apartheid* argues that apartheid

[17] Model C schools are well resourced, middle-class, formerly 'white' schools are now open to students of all races provided they can afford to cover the tuition.

did not simply come to an end with the new democratic government in 1994. As systemic racial oppression continues to thrive, "apartheid didn't die, it was privatised" (2021, p.159). According to Hunter (2019), this culminated into the marketisation of the education system, such that in the 2000s, private schools are managed as corporations. The formerly white schools compete to preserve the "white tone" and poor "rural" schools remain marginalised (p13-24). Those who can afford to, as reported in this study, transferred to schools that could provide them with a better education.

Coleman (1988) defines a critical role for social capital and its input in the realisation of educational attainment. Coleman argues that if the human capital possessed by parents is not complemented by an investment in social capital as embodied in family relations, whether the parent has a great deal, or a small amount of human capital is irrelevant to the child's educational growth (1988, p.110). For example, a parent who is adequately educated and a successful employee may block their daughter from pursuing education beyond senior primary school if they believe she should be married by a certain age. In instances when the complementary role between social and human capital are not yoked, students of rural origin are placed at a disadvantage, such as in the absence of technologies to facilitate the learning experience.

Drawing on Bourdieu's theory of reproduction, schools are not institutions of equal opportunity but mechanisms for perpetuating social inequalities (Bourdieu and Passeron, 1977). The expectation is for students of rural origin to exit school with limited cultural capital. In this study, the success of rural students was linked to the efforts of parents and grandparents and extended family members (Archer et al., 2012) – conferring the value of a family habitus as described by Bourdieu:

> The habitus acquired in the family is at the basis of the structuring of school experiences; the habitus transformed by the action of the school, itself diversified, is in turn at the basis of all subsequent experiences ... and so on, from restructuring to restructuring (1992, p. 134).

As one participant argued, the concept "it takes a village to raise a child" defined a role for community. Following this, the acquisition of cultural capital was facilitated by teachers, and by regenerating the social space, they generated an educated habitus (Reid et al., 2010). While Lareau (2002) ascribed the success of middle-class learners to parenting styles, the same effort by family and teachers of rural students ensured their success (for a similar example in Korea, see Jo 2013

and in the US, Heinisch, 2017). Through the efforts of their teachers, families and the community, a positive disruption transformed the destiny of students of rural origin.

7.5 Becoming a Health Sciences Student in an Elite Institution

Many participants in this study were from KwaZulu-Natal (KZN), and IsiZulu was the home language for just over 50% of participants; several were multilingual. Even the two English- and Afrikaans-speaking participants from KwaZulu-Natal could speak IsiZulu, cultivating a sense of belonging among students from this province. Other participants could speak their respective home languages, reflecting and reinforcing personal, ethnic, and cultural identities. Apart from their post matric intentions, the academic performance of participants in school did not require fluency in English. Proficiency in English as determined by the Department of Basic Education was adequate to facilitate an accumulation of an educated habitus and thus cultural capital. Despite this, their rural English would dominate many of the reflections as it presented a threat to their studentship: "I was coming from a place where I was taught in my home language, everything, even the English they taught in isiZulu." This is congruent with findings reported by Ndofirepi and Maringe (2020). Brosnan et al. (2016) had observed a reluctance to seek help among their participants who were the first ones in their family to attend university.

Bourdieu (2002) in his early works acknowledged his own experiences of bullying and isolation as he spoke a different language before he could master the French language. Studying philosophy at the elite Ecole Normale Superieure in the 1950s was not enough. In his unofficial biography *Sketch for a Self-Analysis*, Bourdieu (2007) acknowledged the complexities associated with gaining acceptance in the upper echelons of academia as a member of the working-class. He had to navigate through a series of complex steps and find ways of belonging within the academic elite to be accepted as a philosopher. "One became a 'philosopher' because one had been consecrated and one consecrated oneself by securing the prestigious identity of 'philosopher'. The choice of philosophy was thus a manifestation of status-based assurance which reinforced that status-based assurance (or arrogance)" (p.5).

Goke-Pariola (1993) reviewed Bourdieu's experiences as he reflected on the impact of the legacy of Euro-American colonialism in an African society. As with many African countries, Goke-Pariola (1993) observed that in Nigeria, mastery of English is associated with success and

power. He reported on a normalised practice that included speaking English with an accent: "It will also be spoken employing the perceived bodily gestures of the Englishmen, such as 'twisting' one's neck ('speaking through the nose', as the locals would say) to achieve what is considered the nasal characteristic of English speech" (1993, p.224).

These expectations, as reported by Goke-Pariola (1993), silenced several of my participants in their first year – they were too afraid to speak. Intimidated by the size of the lecture theatres, their dialect, and concerned that they would face rejection from their peers and ignored by their lecturers, a few opted for self-study and, confirming their worst expectations, their absence was not registered. Others managed to find their voices in small group settings, and one reported being ignored beyond these small group sessions. These experiences validated findings I reported in a pre-study publication (Mapukata et al., 2017a) where students of rural origin based at Wits had similar experiences: "For four years I did not ask questions in class – I was afraid people would laugh at me. I was able to talk more in smaller groups". In that study, a group of students who were based in a previously Black university reported that their environment was less stressful as it was not as competitive (p.6).

This resonates with findings by Bangeni and Kapp (2007), whose research participants reflected on the "very English white academic culture" at UCT, although they were more concerned about preserving their home language and their identities (p.7). Concern of losing one's identity was shared among study participants, and this was linked to their cultural identity and values around their rural origin. Prior to joining UCT, one participant in this study assumed that all Coloured people would speak Afrikaans with a particular accent (see also Bangeni and Kapp 2007). Accordingly, the value assigned to language is not limited to just an exchange of information (Norton, 2000); it also facilitates an opportunity to assert oneself in a range of spaces and can be used to secure social capital through established networks. Feelings of alienation among participants confirmed their status as children of the working-class despite being admitted to study at UCT. In a study by Nel et al. (2016), participants reported their social adjustment discomforts as they struggled to socialize, and they reported that they lacked a sense of purpose. Concerns with being different are supported by findings in research conducted by Brosnan et al. (2016) and Hines et al. (2015). Bourdieu and Passeron (1977) described these experiences as "the anxiety about the future characteristic of students who have come from the social strata that are furthest away from academic culture and who are condemned to experience that culture as unreal" (p.53).

Bourdieu (see Grenfell, 2009, p.442) asserts that language is not simply a means of communication, it is also a medium for exerting dominance of the middle-class on children of the working-class. In the world of the classroom, "polished" language has a higher market value and dominates, and this may be in contrast with the world of the family (1994, p. 9). Despite English being one of eleven official languages in South Africa, as linguistic expressions are the product of the relationship between a linguistic habitus and a linguistic market (Bourdieu, 1994), individual choices are conditioned by the demands of the university and its middle-class students.

In such settings, students of rural origin are likely to be excluded from participation, as experienced by several of the participants of this study (see also Lee and Kramer, 2013; Bagley, 2019). Participants in the study by Ross (2016) likewise experienced feelings of despair associated with perceived linguistic inabilities. They also had to process being taught by a white lecturer for the first time and struggled to keep up with the pace of the lecturer. Reay et al. (2009) reported students' feelings of being displaced and "out of habitus" (see also Heinisch, 2017), as working-class students navigated spaces that middle-class students claimed through parental and historical privilege (2009, p.1110). Bourdieu and Wacquant (1999) argue that the dominant class is also perpetuated by subdued responses by working-class students. These reports support the lived experiences of students of rural origin and justify subsequent school hopping by many participants as parents sought to mediate the school's institutional habitus. Accordingly, Naidoo (2004) argues that the strict relational theory by Bourdieu (1994) misrepresents universities as closed systems detached from the socio-political complex or as mere reflections of external power relations. Naidoo points to existing hierarchal structures that continue to perpetuate class domination: "Through acts of subjective and objective selection, a high proportion of students originating from different regions in social space are selected by institutions that traditionally supply the very same regions of social space" (2004, p.467).

This was true for study participants who presumably were selected as having matriculated from rural schools but, through the misclassification of rural schools, were allocated into a class of dominance where they still stood out as they were of a lower social class. Consequently, the class variables that they were confronted with, and the individualisation of a system structured around the experiences of middle-class students, caused their withdrawal (Reay, 2017). Similarly, in a study by Bangeni and Kapp (2007), UCT students in the faculty of humanities also struggled with the environment, referring to it as "overwhelming" and as "a very English white academic

culture" (p.7). However, they did not mention being excluded from participating in curriculum activities. UCT was historically a white institution, and its efforts to transform to a multicultural and multilingual institution (Mafofo and Banda, 2014) have not been adequate to erase the dominance of English culture. Consequently, every linguistic interaction between students and their lecturers reproduces and generates privilege for middle-class students (Goke-Pariola, 1993, p.222) as the curriculum still reflects Eurocentric dominance (Heleta, 2016). The linguistic capital that accrues with mastering the right tone of English is described by Hashimoto (2020) in a doctoral study as a form of specialised cultural capital.

In this study, participants were drawn from rural schools that are prioritised to access resources in a corresponding political redress that justified the need for the implementation of the Rural Education Policy (No. 41399, p.14). Yet, despite the policy objectives that were supposed to respond to the imbalances of the past, the lived reality is that many participants in this study attended schools that lacked basic resources such as a school library and computers. This historical, political discourse can be harmful to students of rural origin as they feel marginalised by the context (Lehmann, 2001) when they enter HEI and are still computer illiterate (Czerniewicz and Brown, 2014). In such instances, these forms of redress sometimes perpetuate feelings of discomfort as participants experience out-of-habitus experiences as "strangers in paradise" (Reay et al., 2009, p. 1115). On the other hand, such experiences are often embraced as character building by students of rural origin and have reportedly contributed to resilience that is grounded in a durable habitus (Reay et al, 2009; Huang, 2019).

7.5.1 Becoming a Health Sciences Student: An Honour and a Burden

A few participants had assumed their performance in matric would sustain them, confirming findings by Ross (2016) where selected rural students reflected on their educational journeys to become health professionals. They were ill prepared for the demands of their respective academic programmes (see also Heinisch, 2017), in addition to having to cope with their rural English. Even the one participant who had a sibling just a year ahead struggled in his first year to get a feel of the game described by Bourdieu (1998); he had not expected that it would be that difficult. Li (2013) argues that the acculturation process, becoming and being a health sciences student of rural origin is fluid, time-bound, dynamic and context dependent. The views about curriculum challenges,

faced by students of rural origin in their first year, are consistent with findings reported by Diab et al. (2015), in a multi-institutional study that compared experiences of rural origin students with those of their urban peers. Considering that curriculum content is structured around social class (Steinmetz, 2013) and constitutes narratives and rules that continue to epitomise the middle-class students, adaptation can be a disorientating process for rural students as their habitus is disrupted. Having gained admission to UCT, their excitement contrasted sharply with feelings of being underlings as their classmates attributed their admission to a relaxation of admission rules. A participant who was a high achiever spoke of these contradictions, of being celebrated by fellow Black students for representing other Blacks. At the same time, his academic profile was subjected to scrutiny by white students who could not understand how he managed to be among the top 15 in a class of over 200 students. Reay (2005) reported on class privileges that manifest as arrogance, contempt, and a sense of entitlement as middle-class participants in her study complained about teachers who made them sit next to working-class students (see also Manderson and Turner, 2006). Equally, working-class students complained about being disregarded by their teachers and other middle-class students even though there were a few high achievers in their class (Reay, 2005, p.9).

A participant in the study by Ross (2016) also reported becoming a top achiever in his programme, but there is no reference to him being subjected to the scrutiny that was reported by my study participant. Bourdieu and Wacquant (1992) refer to "socialized subjectivities" (p.126) that are associated with a rural habitus and fluctuations that are described as "reasonable or unreasonable…suitable or unsuitable" (Yenney-Henderson, 2019, p141). Other participants would eventually find their rhythm despite the initially disorientating experiences when their performance in the first semester was below standard and experienced failure for the first time. Prior to joining UCT, several participants had experienced various forms of hardship such as walking long distances to school *siwel'umfula* (crossing a river) and coping despite limited resources but their motivation sustained them as they were focused and disciplined. Likewise, Ross (2016) reported on self-determination, tenacity, problem solving and self-belief as attributes in students of rural origin (p.54).

Some struggled as they had not met criteria to be admitted to their preferred degree, although they had assumed that being a top achiever in their school would secure their place in medicine. They were ill informed about their second options, although they would later acknowledge becoming better (in this example, as rehabilitation therapists) to the extent that they

considered this to be their destiny. The fluctuating emotions that were reported by my participants are associated with interruptions in an aspirational habitus and presented as episodes of settled and unsettled lives in a model conceptualised by Swidler (1986). Among Danish students from diverse cultural backgrounds, Holmegaard et al. (2014) reported on episodes of disorientation and a disrupted habitus following unsuccessful attempts to register as university students in elite science, mathematics, and technology streams. These students were misinformed by family members and career counsellors about the suitability of their career choices.

An earlier assumption that, by becoming a health sciences student, participants would automatically be able to transfer into health professional trainees, demonstrates how they experienced the "socialized subjectivities" (Bourdieu and Wacquant, 1992) that flow from family and society. Even among university students, health sciences students were perceived as being of a higher class. At times, these perceptions extended to labelling as they were projected as being anti-social and always in a rush. Confirming the burden that comes with being a health sciences student, one participant spoke of expectations she had of herself, that she would care and show compassion while also improving patients' lives (Levett-Jones et al., 2015). While they earned the respect of their peers for joining a "noble" profession, this came with constraints; in relation to other students, they could not dye their hair any colour, nor readily display bodily art. As denoted by one participant, the expectation of what they would achieve far surpassed their capabilities:

> The only thing the student at upper campus student (non-health sciences student) is worried about is maybe turning an assignment in late. While you are worried that today if you miss somebody's hearing loss or bleeding eardrum or something a perforation and then that progresses or what. You feel so much pressure that you can make a mistake any time and that mistake could land you in a lot of trouble (AudF1/LP).

Similarly, putting on their working tools (stethoscope, white coat and scrubs) afforded participants varying levels of respect. They were keen to acquire institutional cultural capital and considering that habitus becomes active in relation to a field (Bourdieu, 1990a). In the first few days, a few participants took to wearing their scrubs (uniforms for health sciences students) in public, hoping to accrue symbolic capital and symbolic power (Sorrell and Ibrahim, 2020). Later, they realised that there was a corresponding burden of responsibility as members of the public assumed they were practicing professionals and approached them for their professional opinion. This is reminiscent of the experiences of participants in a study by Sorrell and Ibrahim, who earned

"trust and confidence from patients, regardless of their medical knowledge or clinical skills" (2020, p.4), although not all participants attached value to the wearing of professional attire. Swidler (1986) defined a role for culture in decision making as requiring a "tool kit" comprised of academic skills and non-cognitive habits (p.273). This is relevant to my participants as they later determined a place and time for displaying their working tools. In a study that examined the under-representation of working-class students in medical schools in the UK, Mathers and Parry (2009) observed the disjuncture between working-class perceptions of medicine and individual identities and held perceptions by working-class students about being misfits as a self-defeating prophecy that is associated with their working-class backgrounds. Davey (2009) argues that a collision in habitus (scrubs as objectified forms of cultural capital) and the field should not be viewed as negative experience as it often leads to insightful reflections.

7.5.2 Becoming a Health Sciences Student: Generating a Relational Habitus

At UCT, health sciences students are introduced to professionalism and to communication skills in their first year (Mapukata and Toto, 2021). Students practice interview skills in classroom settings and do not get an opportunity to practice with patients. A greeting shows respect and is a desirable attribute among health care professionals, particularly in the 21st-century where provision of health care is patient-centred (Mapukata-Sondzaba et al., 2014). Participants thrived in the clinical space as they could draw from their habitus in their interaction with patients. Multilingualism and multiculturalism in clinical spaces were qualities that allowed participants to draw from their social capital in their interaction with patients. These embodied actions and interactions generated a relational habitus (Stone and Hart, 2019) for study participants whilst they were also learning about their profession. As an outcome of ongoing engagement with their working tools, guided by their clinical supervisors, participants were learning to manage patients who presented with a range of disorders. Considering that habitus is a system of durable, transposable dispositions, it is shaped by one's past and present circumstances and informs one's present and future practice (Bourdieu, 1977). Participants in this study could draw from their primary habitus (greeting, acknowledging, and showing respect) to generate a reciprocal relationship as patients in turn contributed to their learning experiences.

Accordingly, relational habitus (Stone and Hart, 2019) is a tool for understanding the reciprocal relationship between health sciences students' engagement in regulated task-oriented activities and their successful engagement with patients. Bourdieu argues that engagements in the field are limited to objective relations: "what exist in the social world are relations – not interactions between agents or intersubjective ties between individuals, but *objective relations*" (Bourdieu and Wacquant, 1992, p.97).

The intersubjectivity of the ties that bind participants and patients in this study was facilitated by context and socio-cultural dynamics of a consultation that are valuable among Africans. Mothibe and Sedibe (2019) argue that as many as 80% of patients prefer the personalised patient-centred approach of traditional health practitioners compared to allopathic medicine (p.8). Given this point, it is possible that the positive encounters that are reported by patients are attributable to the value that is assigned to relational engagement. Equally, participants described encounters with patients as fulfilling moments of validation as they were welcomed and accepted by patients. A few participants were using the shared identity to gain academic capital and achieve clinical tasks that they would not have achieved as they were rejected by patients they were allocated to examine on racial grounds. These patients would pretend to be tired when approached by Black students but would later consent to the physical examination when approached by non-Black students.

Participants resorted to migrating towards Black patients and would benefit from those encounters as patients became their teachers and their motivators. This concurs with findings I reported of the experiences of clinical associate students where patients became generators of knowledge for students (Mapukata-Sondzaba et al., 2014). However, in this study, patients also became mediators of negative experiences. Ross (2016) described inherent benefits associated with being of rural origin as participants in his study intentionally self-selected rural primary health care facilities as spaces where they could engage with patients in their home language (see also Mapukata et al., 2017b). At the same time, a few participants were somewhat bewildered by the extent of influence of urban life as they considered themselves to have become 'uncultured' when they forgot to greet when they returned home during their summer or winter vacation. Bourdieu (1990a) asserts that habitus can alter one's value system and influence everyday choices and ways of being unless these are grounded in sound cultural practice. For this reason, clinical spaces

became a proxy for what is acceptable cultural practice, showing respect, greeting and acknowledging people irrespective of their social class.

One participant, who attended an Afrikaans school, initially refused to converse in Afrikaans with a patient who struggled to follow English. He later changed his mind and undertook the entire consultation in Afrikaans. This changed the course of the consultation and his attitude to Afrikaans; he had previously harboured ill-feelings based on his experiences of being invisible in his Afrikaans school. In such cases, the participants' social capital (in using language to acknowledge the patient – "I see you; I hear you") transformed into cultural capital which translated into academic capital with the potential to generate symbolic capital. Bourdieu (1984) refers to the adaptation in habitus whenever it encounters a new field, as either facilitating an adaptation by reinforcing knowledge and skills or transforming an approach to learning (p. 116).

In this study, patients acknowledged and celebrated achievements of study participants as they overheard feedback from consultants when they had positive bedside encounters. For study participants, this evoked feelings similar to those they experienced back home where personal achievements were celebrated by community. Elsewhere, in this study I alluded to positive patient-student interactions as symbiotic encounters as patients were a proxy for their parents. For the participant who previously could not bring himself to acknowledge his competency in Afrikaans, the encounter encouraged him to engage in a deep reflection about his attitude to Afrikaans and reconcile with the decision of his parents who sent him to an Afrikaans school to generate cultural capital. These interventions that are forward-looking are often associated with parenting styles of parents of middle-class children (Lareau, 2002; Reay et al, 2009).

In a study by Levett-Jones et al. (2015), nursing students, as they were preparing for their first clinical encounter, expressed their concern at perceived lack of knowledge and skills, were anxious that they might be bullied, and were fearful of making mistakes (p.4). In this study, in their first year, quite a few participants had an opportunity to observe their peers in a student-run community clinic where they were supervised by community service doctors before they engaged formally in the clinical setting. These sessions were considered valuable in preparing them for what they would experience when they had to manage real patients (under supervision) as part of their training. Only one participant shared a concern about breaking expensive clinical equipment and misdiagnosing a patient, but the primary concern of study participants was being trusted by patients prematurely (see also Sorrell and Ibrahim, 2020). At times, they felt overwhelmed as

family members had mistaken them for board certified health professionals. Sometimes patients confused rehabilitation therapists for doctors, leading one participant to express that it is important to take the time to describe your role and describe what you hope to achieve at the end of the consultation (Mapukata-Sondzaba et al., 2014).

Multidisciplinary teamwork contributed to their personal development and there was a stated preference for district hospitals, clinics and community health centres as these facilitated opportunities to manage undifferentiated patients (Green-Thompson et al., 2012; Diab et al., 2014; Ross, 2016; Mapukata et al., 2017b; Reid et al., 2018). A few participants confirmed that they were not bothered about the level of the facility, provided the facility was adequately resourced. There were also participants who openly declared a stated preference for rural health care practice, confirming a prevailing view about rural students' preference to return home to practice (de Vries and Reid, 2003; Wilson et al., 2009; Tumbo et al., 2009; Walker et al., 2012; Gumede et al., 2017; MacGregor et al., 2018; Reid et al., 2018). However, not all participants openly declared their preference, suggesting that socialisation in rural contexts must be facilitated during training (Ross et al, 2015; Mapukata et al., 2017; MacGregor et al., 2018; Zihindula et al. 2019).

Confirming the level of comfort in clinical settings, one participant captured the experience as follows: "It was the first time I could use the phrase 'my patient'," and reported being trusted by patients and their families. In developing attributes of professionalism, the clinical context is a space that is affirming even for marginalised students. The concept of ownership ("my patient") also featured in the reflections of final year clinical associate students from Wits who were based in primary health care settings in the Gauteng and North West Provinces (Mapukata-Sondzaba et al., 2014, p.8).

7.5.3 Becoming a Health Sciences Student in Gendered Spaces

Many participants in this study were female, confirming a changing profile of the student body in the Faculty of Health Sciences which mirrors a global phenomenon (Tiwari et al., 2021). Accordingly, Tiwari and colleagues acknowledged that while the number of Black women who qualify as doctors has increased, equity remains a challenge as this workforce is still dominated by men. The geographical distribution of medical doctors in their study was concentrated in the three densely populated metropolitan cities in South Africa – in Gauteng, Western Cape, and KwaZulu

Natal Provinces (Tiwari et al., 2021, p.4). The distribution reflected the dominant gender profile of academic clinicians.

In an editorial published in 2011, Ncayiyana addressed this issue, and the challenges of achieving gender equity in key positions despite workforce transformation. Access to medicine was for a long time limited to men, with women assigned to subordinate roles as nurses. In a discussion paper that focused on the achievements of early Black male doctors in South Africa (1883-1940), Mayosi (2015) reported that the majority qualified in foreign medical schools but would return to South Africa and make meaningful contributions as academic clinicians and contribute to efforts to eliminate racism, colonialism, and apartheid. On the other hand, the first Black female doctor – Dr Mary Malahlela-Xakana – would only qualify from Wits in 1947. Her achievements as a clinician and community activist were only recognised posthumously by the Office of the Presidency (South Africa)[18].

Black female participants in this study were relegated to subordinate roles, one complaining about being allocated tasks often assigned to nurses despite that she was in her final year of medical training. Citing an episode where a group tutorial was redirected to a private space, only a male white counterpart was tutored even though the group had all been waiting to participate in the tutorial. Other incidents were related as instances where the attending consultant refused to acknowledge Black students who were also in attendance, and events where patients they had identified as meeting learning outcomes were transferred to white students. One participant confirmed that they resorted to "cat and mouse" games to secure patients in selected disciplines. Navigating the clinical training space in this way was also mentioned by Green-Thompson et al. (2012). This deviation that accrued clinical privilege to white male students in small groups, denied Black female participants an opportunity to accumulate core clinical knowledge. Ncayiyana (2011) in his editorial referred to prevailing perceptions that women should stay away from "hardcore" specialities, confirming Bourdieu's (1984) presentation of three principles along which the labour market is gender-segmented.

The first principle prescribes functions that are appropriate to women as an extension of their domestic functions – education, care, and service, as confirmed by the expectation that the female medical student should assume the role of a nurse. Bourdieu's second principle assumes

[18] Order of the Baobab for her pioneering medical career, Office of the Presidency, Government of South Africa

that a woman cannot have authority over men, and for that reason men will always be favoured for a position of authority. In this study, participants referred to a hierarchal order where their male counterparts were assigned privileges that were not extended to female participants. To that end, two white male students – Michael and John – had authority over them even though they were all at the same level as final year medical students and members of their clinical group. The third principle affords men the monopoly of handling technical objects and machines so that women are denied an opportunity to assist anaesthetics registrars in theatre, for example.

Bourdieu and Wacquant (1992) argue that while society perceives women as unfit, women should not blame men for held perceptions about their inferiority complex as society expects women to serve others, and such values "were inculcated (at home, school, church) with a 'bodily hexis' that constitutes a veritable embodied politics" (p.172). The liberties that extend to men have forced female participants to assign value to their scrubs as protective armour – "a battle suit" – as they are exempted from scrutiny and being inappropriately touched by patients and others. The symbolic violence inflicted on my study participants reflects ingrained attitudes about class supremacy and sexism. Acts of violence are not enacted and are not punishable, and are therefore reproduced many times over with different groups of vulnerable students:

> The agent engaged in practice knows the world . . . too well, without objectifying distance, takes it for granted, precisely because he is caught up in it, bound up with it; he inhabits it like a garment . . . he feels at home in the world because the world is also in him, in the form of the habitus (Bourdieu 2000: 142–3).

These reports confirm concerns of participants about experiences of institutionalised acts of racism that had financial implications and perceptions of compromised competency, for example, if they were not taught for eight weeks during a clinical rotation or if they were denied an opportunity to acquire clinical skills. Equally, where participants were adequately taught and had opportunities to manage their own patients, they became confident about their competencies to safely practise as interns.

Women as gendered selves occupy contested spaces according to Fathi (2018). Examining the experiences of 14 UK based first-generation female Iranian doctors and dentists, Fathi asserted that doctorhood confers class and cultural capital and is revered by families as it confers marriageability and the future of the new family. This notion of confirming social capital for self and extended family confirms views shared by Shope (2006) about the value of *Lobola* in South

Africa's culture. The elite profession is associated with financial stability (economic capital). Yet, despite these privileges, even when they had earned the respect of their colleagues (Fathi, 2008), as migrant doctors they face constant challenges.

In a country where gender-based violence is pervasive (Dlamini, 2021), concerns shared by female participants cannot be ignored. A decade later, true to Ncayiyana's projection, "it is not yet uhuru [not yet freedom]" (2011, pp. 1-2). In a survey reported in the *New England Journal of Medicine* by Dzau and Johnson (2018), US female medical students experienced double the risk of being sexually harassed compared to their peers in sciences and engineering. Dzau and Johnson (2018) described three sexual-harassing systemic behaviours that included gender-based harassment, unwanted sexual attention and sexual coercion, and linked these to gender inequity. When these are ignored, they enforce existing hierarchal structures as well as dominance and exclusion. In contrast to Dzau and Johnson (2018), in my study, these experiences were reflected on by female participants and were not limited to medical students. As such, wearing scrubs as a "battle suit" and a protective armour was the participants' response in moderating what was simulated as a war scenario. With calls for increased access to dignified gender-affirming health care for transgender and gender-diverse clients (Tomson, 2021), a concern is that the lived experiences of Black female participants who reported incidents of exclusion from participation and discrimination mirrored those of Black women in academia. These were reported as experiences of (un)belonging and exclusion (Mokhele, 2013; Maseti, 2018). Tied to this, Black women were revered as role models by study participants in their capacity as teaching staff and heads of departments.

On the other hand, health and rehabilitation programmes were reported to be highly feminised. Although being outnumbered did not expose the male participants to potential contact crimes, the gender inequity among rehabilitation therapists (95% female) was a concern (see also Tiwari et al. 2020). In addition to gender inequity, racial inequality was reported as a concern by participants who felt marginalised in group settings as no effort was made to integrate students. To that end, one participant declared that the "OT department is whiter than UCT.*"* Ned et al. (2020) likewise expressed concerns about racial inequality as 65% of OTs were white, with corresponding concerns about the inequitable distribution of the workforce as 75% of OTs were based in the metropolitan cities, similar to what is reported about doctors (Tiwari et al., 2021).

While being of rural origin is revered in context, for some participants it was also associated with feelings of being different in a higher education institution or an urban setting. This brought about a level of discomfort: “I only realized that I had that identity, when I was put amongst other people that I think I would identify as not from that identity.” A conscientisation to being different heightened an awareness of being previously disadvantaged, which confers an identity crisis and a displaced habitus (Reay et al., 2009; Ross, 2016; Bazana and Mogotsi, 2017). Bangeni and Kapp (2005) addressed this issue of shifting identities among first-generation university students. It follows that where students of rural origin can claim their identity, this validates their clinical experiences, for example, rural clinical attachment is highly sought after (Diab et al., 2014; Ross, 2016; Reid et al., 2018; Mapukata et al., 2017b).

7.6 Becoming a Health Professional

In this study, the effectiveness of academic clinicians was evaluated based on three variables, whether the teaching was extended as once-off or not: person-specific, methodology-specific or topic-specific sessions. Participants defined a role for preclinical lecturers as conferring sound theoretical knowledge that would later facilitate learning in the clinical space. Participants also reflected fondly on lecturers of all races who were not only good teachers but also extended support beyond the classroom.

Rural students reported on positive community experiences where they were constantly validated and sustained through interpersonal relations. They were challenged when their presence was not acknowledged, and they became incapacitated. An ongoing challenge in clinical platforms is identification of a process that responds to professional lapses and unprofessional conduct with impact on training outcomes for health sciences students (see Vivian et al. 2011). Incidents of discrimination and issues of ethnicity were also reported by Green-Thompson et al. (2012). This disputes a view by Woolcock and Narayan (2000) who assume that all students will readily engage with their lecturers. In the absence of personal contact between lecturers and students, Knapper (2001) argues that a didactic approach to teaching and learning perpetuated symbolic domination in HEI. This validates the experiences of my participants.

In a paper that examined the experiences of final year medical students graduating from a transforming curriculum (Green-Thompson et al., 2012), participants reflected on the positive

aspects of a basic clinical sciences curriculum as they were taught to master a systematic approach to examining patients before they interacted with real patients. However, they also criticised much of the problem-based learning (PBL) process, as they felt that it did not add value to the learning experience, and they identified gaps in the microbiology and pharmacology content (p.3-4). In this study, participants were more comfortable in PBL and in Becoming a Professional/Becoming a Health Professional (BP/BHP) as these were spaces where they were learning in smaller groups and could find their voices (Mapukata and Toto, 2021). The only discomfort were instances where a facilitator assumed that being of rural origin implied their expertise on topics such as poverty. The positive experiences associated with small group learning are similar to experiences of health sciences students of rural origin based at Wits in the WIRHE programme (Mapukata et al., 2017a).

Good teachers were described as doctors who made participants feel competent about their clinical skills and were prepared to assume an internship role (see also Green-Thompson et al. 2012). A range of academic clinicians including clinical supervisors were recognised as good role models if they employed good teaching methods, had a good bedside manner, encouraged lifelong learning, and provided constructive feedback. Black women were an inspiration if they also occupied leadership roles. According to Paice et al. (2002), a good role model is not only a competent clinician, but a good teacher who cares about their patients and is able to demonstrate professional integrity (see also Bergh et al., 2006; Green-Thompson et al., 2012; Diab et al., 2014; Mapukata et al., 2017b). In addition, such clinicians must demonstrate exemplary behaviour in theatre (Curry et al., 2011), contrary to reports as lived experiences by a few study participants.

Although Warner (2004) argues that good role models are clinicians who influence every student they encounter, in this study not all encounters were reported as positive. Participants referred to two types of academics (academic clinicians) – the ones described above and those who created misery and suffering in their lives and objectified patients. This was particularly true in their first year, confirming findings by Ndofirepi and Maringe (2020), who pointed to the tendency of academic staff to ignore and socially exclude rural students, pushing them into disengagement and withdrawal (p.51). In the extreme, one participant engaged in self-study in the first two years of a four-year degree. Such academics, according to Gaiser (2009), are considered to have failed to meet the three goals of health sciences education if students cannot reflect realistically on their experiences as follows: “I heard, I saw, I discovered.”

Classmates, on the other hand, were judged on three aspects depending on whether they contributed to the co-construction of knowledge, were indifferent or were disruptive. In addition, their willingness to share common spaces, learn from each other, and prioritise the needs of patients over their own, were some of the factors that facilitated constructive engagement. Participants felt isolated if they could not make friends and were not part of a "social milieu" (Vallerand 1997). However, where they achieved this, whether with one or two friends, the social capital was converted to academic capital (see also Ndofirepi and Maringe 2020). Male participants seemed to fare better than female participants as sport facilitated access to social capital. In a study by Bergh et al. (2006), classmates were acknowledged for the role they played in the development of soft skills. This was in addition to good teaching and observing role models. In a facilitated engagement similar to UCT, Bergh et al. reported that participants placed much value on the interplay between being and becoming (2006, pp 3-4). In contrasting roles, in a study that examined factors that influenced choice of site in preparing for a six-week rural attachment (Mapukata et al., 2017b), some participants were motivated to choose either urban or rural sites, if they could also confirm a place for their clinical partner. Others chose sites that would facilitate a complete learning experience that included academic, social, and cultural learning (2017b, p4.)

In this study, faculty support was considered effective if services were extended to cover academic, emotional, financial, and social support. Not all participants could access these resources. In a study by Bagley (2019), lack of financial support was mentioned as a source of stress and participants felt vulnerable as they had no control over academic outcomes – both manifestations reported by my participants. In addition to financial challenges, participants in this study who could not access resources, such as a computer, felt unsupported and withdrew their engagement (see also Reay et al. 2009). Recognising the challenges that are likely to trigger stressful events, as part of the WIRHE programme (Mapukata et al. 2017a), three protective factors emerged as ensuring the continuity of students of rural origin by addressing their vulnerabilities. These were finances, catered accommodation, or self-catering accommodation with a monthly meal allowance for senior students, and access to textbooks. Similar provisions were extended to students who were part of the Umthombo Youth Foundation programme (Ross et al., 2015; Zihindula et al. 2019).

Access to mental health services was reported as variable. Some of these experiences were exceptional with positive outcomes "Oh my God (The Manager) is a lifesaver. I don't think I

would have done it without her. She is very supportive, she is very patient, she is just amazing, especially with us students she makes us feel like we were heard". A few participants felt discriminated against particularly if the rules were applied selectively. The tutoring programme was embraced as it offered peer to peer support; its success is well documented (Ross et al., 2015; Mapukata et al., 2017c). The Intervention Programme (IP), on the other hand, was viewed with suspicion: "everyone stigmatised IP and how you look at other students that went to IP, like oh that one is IP as if they have a virus on them that's contagious." IP drew attention to the inefficiencies of South Africa's education system and the under-preparedness of students of rural origin to become university students (Letseka and Maile, 2008; Letseka et al., 2009; Dhunpath and Vital, 2012*;* Letseka, 2014; Ross, 2016; Ndofirepi and Maringe, 2020). Reported as it was perceived by others, with only Black students in the programme, participants disclosed that even the kitchen staff in the residence dining rooms were aware of IP and would encourage students to study hard to avoid being redirected into that programme (IP).

Ross (2016) argued that such interventions, whether referred to as bridging, foundation, additional or extended programmes (p.16), present a challenge as their implementation is in response to an outcome, hence the subsequent resistance from students. Participants in a doctoral thesis by Ndofirepi (2015) retreated to their rooms in what the researcher referred to as "mute spaces"' if they lacked courage to engage with their lecturers (p.45), supporting my comments about the experiences of study participants. Despite the stigma associated with IP, one participant acknowledged that ultimately, the programme achieved what the mainstream programme could not achieve - it brought Black students together in a safe space and thus generated social capital for the group.

7.7. Becoming Trainee Health Care Professionals

Many participants' reflections in this section confirm findings in studies that evaluated the experiences of final year health sciences students ready to practise their trade. As they approached the end of their training, study participants confirmed that they were clear about their role as future health care providers. Having acquired the requisite competence (Eyal and Cohen, 2006; Bergh et al. 2006; Nyangairi et al., 2010; Green-Thompson et al., 2012; Diab et al., 2014; van Stormbroek and Buchanan (2016), based on sound theoretical knowledge and good clinical skills, the

curriculum now made sense. In the study by Green-Thompson et al. (2012), participants acknowledged that clinical teaching played a central role in preparing them for internship (p. 6) and in preparing them for community work (Diab et al, 2014). They had the confidence to work independently and were appreciative of the support and encouragement of their clinical supervisors, particularly the team in internal medicine. In a study by Cameron et al. (2011), participants reported that "they gained a deeper insight into their development as clinicians" (p.2) (see also Nyangairi et al. 2010; Dreyer et al. 2021).

In this study, five significant findings linked participants back to their identity as students of rural origin. Considering that the proportion of rural students in this study is far lower than recorded averages reported by Tumbo et al. (2009) as their study was a multisite study, participants offered insightful reflections. Firstly, they associated the success of the programme to patient outcomes, as a reward and confirmation of their achievements, and noted the role of the patients in affirming their passion to practise as health professionals. This was the case for students trained to become an audiology therapist, a doctor, a physiotherapist, an occupational therapist or a speech-language pathology therapist. A similar finding was reported by van Stormbroek and Buchanan (2016) and Mapukata et al. (2017) "starting to become a doctor!" (p.4).

Secondly, participants confirmed that in attaining their knowledge and skills, it was possible to "pay it forward" by contributing to the development of others in their role as tutors and mentors (see also Ross, 2016). This was a critical reflection as it would spare other students of rural origin from similar experiences. Confirming a value-based approach that is associated with *ubuntu* as exhibited by participants, similarly, a participant who was part of the WIRHE programme (Mapukata 2017a) had established a youth programme in her community and used that platform to prepare rural students for their post matric education. The benefit of having social and academic mentors was reported by others (see Wee, 2013; MacGregor et al., 2018; Zihindula et al., 2019)

Thirdly, as they had good exposure to common conditions during their clinical placement in clinics and CHCs, participants reflected on a shift from being mark-centred to becoming people-centred health care professionals. In contrast to Hafferty (2002), participants in this study presented objective opinions, acknowledging their role not only as health care providers, but as people who care about their patients (Branch, 1998). Similarly, in a study by Orpin and Gabriel (2005), participants acknowledged that rural practice afforded them an opportunity to establish relations

with their patients. This is a common reflection by health sciences students of rural origin (Baingana et al., 2010; Ross 2014; Mapukata-Sondzaba et al., 2014; Mapukata et al., 2017; Gumede et al., 2021). This confirmed that relationships are central to the provision of rural health care (Worley, 2002; Reid, 2011) and defines a role for graduates committed to addressing issues of equity and justice (Couper and Worley, 2010; Reid, 2011).

Fourthly, clinics were presented as places that facilitated an opportunity to practise whole person care (Green-Thompson et al., 2012), confirming a defined role for district health platforms in enabling learning space (Nazareth and Mfenyana, 1999; Nyangairi et al., 2010; de Villiers et al., 2018), as derived from lived experiences (Dreyer et al., 2021). A significant finding in this study was reported as the role of clinics in facilitating the integration of palliative care at community level.

Lastly, a few participants who were first-generation university students attributed their success to hard work and an appreciation of their background and family circumstances (see also Gumede et al, 2021). In their study, Mathers and Parry (2009) reported that both primary and institutional habitus shaped individual students' habitus and perceptions of their likely success in medicine. Reflecting on approaching the end of the training period, these participants were of the view that it was time to enjoy the fruits of their hard-earned labour: "Next year I am going to be thanking myself, obviously I have already thanked UCT for the opportunity. I just want to thank myself now."

7.8 On Being Black, Female and of Rural Origin

In a university setting, participants reported having to maintain dual identities; sometimes they felt like imposters. A few participants provided unambiguous details about their lived experiences. Their efforts to navigate the institutional culture were cited as emotionally depleting experiences: "I am overly emotional…" They associated their experience to running a "Comrades Marathon"[19] and wished that their classmates could take the time to walk a mile in their shoes: "they don't know

[19]The Comrades Marathon is considered the ultimate human marathon. It is an ultramarathon of approximately 89 kilometres which is run annually in the KwaZulu-Natal province of South Africa between the cities of Durban and Pietermaritzburg. It is the world's largest and oldest ultramarathon race. URL: https://www.comrades.com/

how being from a rural area has disadvantaged me." As they approached the end, they were exhausted and no longer had the energy to fight the system: "I am tired…tired of fighting…". One participant, who had left the programme and returned to complete the degree, was filled with regret: "my weaknesses was, I guess, coming into this space."

Validating these experiences, Steinmertz (2013) refers to a bias of the university whose pedagogy favours middle- and upper-class students who enter the system endowed with cultural capital. In a doctoral thesis by Yenney-Henderson (2019), participants of rural origin acknowledged their multiple identities but also confirmed that the academic identity was the most difficult to navigate. As well, they reflected on fluctuating experiences of disconnection and connection. Study participants spoke of shifts as episodes of disconnection, connection, and disconnection, the latter attributable to negative clinical experiences. This is consistent with other studies (see also Dreyer et al., 2021).

For example, Reay et al. (2009) describe overwhelming sadness and anxiety-evoking stressors for working-class students who were also high achievers. Similarly, Bagley (2019) reported a range of stressors among pre-nursing students from racially and ethnically under-represented backgrounds. Focusing on "beating the odds," Wee (2013) explored different aspects that constitute educational success for working-class students. Wee's participants had already accrued an educational inheritance as first year students, as many of their siblings had obtained higher education qualifications or had extended family members with post graduate qualifications and had accrued cultural capital by the time they registered as students. In this study, only a few participants had family members with post matric qualifications, and some were first-generation university students with no reference point (Brosnan et al., 2016). Many came with aspirational habitus supported by their families (Nash, 2002) and cultural capital they had accrued through school participation.

Black female participants in this study were at the bottom of the ladder among students and in relation to inter-faculty and inter-programme hierarchies as captured by one participant and echoed by others:

> Okay let me tell you what the hierarchy is. You see there is a bottom, there is a bottom of the bottom, and the bottom of the bottom has a basement, and that's where you will find the Black female students…at the top of the hierarchy is the white male student...(MedF5/GP)

Reay et al. (2001) argue that by gaining acceptance to a HEI, students are considered cultured individuals while the university is considered a cultured organisation. My participants did not always feel this way, at least, not in the first four months. Before they could lift their heads, they were required to take their first exam, and some would experience failure for the first time.

Hierarchy was an institutionally enacted phenomenon, influenced by societal structures and the power within those structures. Likewise, in a doctoral thesis also based at UCT, Mitchell (2019) reported that fourth year medical students as study participants observed unjust practices during their obstetrics rotation. They reported "finding themselves in powerless positions, feeling helpless, undermined by the hierarchy in medicine, their own vulnerability and fears, and the established norms of practice" (2019, p.151). Luke (2003) examined the medical habitus of junior doctors and argued that becoming a doctor is a survival tactic that required his participants to learn how to play the game if they wished to remain a player, i.e., if they were likely to be considered for a registrar position (p.126). Luke described the practice of medicine as restricted, defined and fostered through relationships mediated by individual habits (2003, p.138).

While this was true for a few of my participants some of the time, at other times Black women were not even allowed to go near the field, let alone touch the ball. These experiences were not limited to medicine. Participants described varying levels of discomfort of their experiences of the hierarchies. What is most significant is that enactments of an institutional culture were framed around gendered and racialised encounters as moments of misrecognition where participants became misfits. One example is when the junior intern (final year medical student) was instructed to perform a nurse's job. Misrecognition and misfit as outcomes of racism were the drivers of the #FeesMustFall student protests and calls by students for decolonisation of the curriculum (Langa, 2017). The symbolic violence of lived experiences was captured by one participant as follows: "Being a Black woman in medicine is an extreme sport." Diab et al. (2015) writing about the experiences of health sciences students in their final year reported no differences in performance and outcomes whether students were of rural or urban origin. In this study, in contrast, some participants were still reporting challenges similar to their first-year encounters. Bazana and Mogotsi (2017) call on HEI to be mindful of the experiences of Black students and create an environment that considers the profile of rural students.

The complexity and fluidity of identity of my study participants is similar to those Canadian law students (Manderson and Turner, 2006). I reflect on our intersecting identities in a

forthcoming publication where I centre a black narrative as I pursue reflexive knowledge. While it was possible to migrate from non-professional to professional spaces, participants could not raise literacy brokers that are reported by Gennrich (2015) to moderate their lived experiences. While Bourdieu defines symbolic violence "as a gentle violence, imperceptible and invisible even to its victims" (2001 p.2), he also extends a responsibility to victims to disarm the dominators. Recognising that efforts must reflect outcome, drawing from the experiences of navigating a successful 2010 Soccer World Cup and the global acceptance of the Vuvuzela horn as a symbol of unity in SA, Cross and Naidoo (2012) recommended the adoption of strategies that are likely to mediate racist pedagogies. These anti-racist pedagogies should extend beyond the superficial celebration of diversity to facilitate a transforming racist habitus by empowering teachers and students to unlearn dominant racist practices. Cross and Naidoo (2012) motivate for re-learning processes through disruption and creation of safe spaces. Furthermore, Fataar (2018) argues that rather than using language and politics to dismantle the prevailing culture, a decolonising curriculum must place (rural) students at the centre of pedagogical effort.

Through their lived experiences, it was possible for study participants to accrue academic capital that is attributable to the generative nature of their inherent habitus. Although it is possible to remove the boulder on their path (Yenney-Henderson, 2019), their experiences continue to mirror the lived experiences of other working-class students (Reay 2005; Reay et al., 2009; Bagley, 2019). Despite attaining symbolic capital, they are yet to arrive home (*abakafiki ekhaya, basengabahambi, umthwalo usesecaleni kewendlela)"* If we follow Bagley's (2019) recommendation, this calls for critical self-reflection (*imbizo*), so that we can address the inequities and injustices embedded in the system.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

8.1 Presentation of Thesis

In undertaking this research, I examined the habitus of students from rural South Africa and explored its influence on the professionalisation of health sciences students. Using Bourdieu's concepts, I sought to understand the relationship between habitus, capital, and the field. The stated objectives were to describe and analyse student experiences of their transition from home to school to university; determine the role of a university in student continuation and explore the coping strategies of health sciences students while at university; describe and analyse the experience and professionalisation of the students as they become health care professionals; and describe and analyse different forms of capital and how they produce habitus for students of rural origin. In that regard, I examined the relationship between rural origin and rural education in relation to its impact on performance in the field and in practice (Ch 1: 1.8). As an outcome of the research process, as a theory of practice, I offer a relational multiprofessional framework (Figure 8.1).

The diagram represents the experiences of health sciences students of rural origin, registered either for a six-year or a four-year degree, as they embarked on an academic journey from a rural area to an urban-based university. In this U-shaped diagram, the field is represented as a yellow bar just above the constricting and expanding habitus (middle). It comprises of the school in a rural area, academic programmes that constitute the five traditional degrees that are offered by the faculty of health sciences, namely: audiology; medicine; occupational therapy; physiotherapy; and speech and language pathology. The clinical context as part of the field includes Groote Schuur Hospital and affiliated centres as part of the academic training complex, and district health platforms (clinics and community health centres). On the lower end of the U-shaped diagram is habitus, presented in a green block and comprising four forms of capital in blue blocks. Cultural capital (above habitus) is primarily generated in a school setting with the support of teachers and family through school hopping and later within the university. The other forms of capital on the right in blue boxes include social, symbolic and economic capital. Components of the constricting and expanding habitus in the middle of the U-shaped diagram are discussed later.

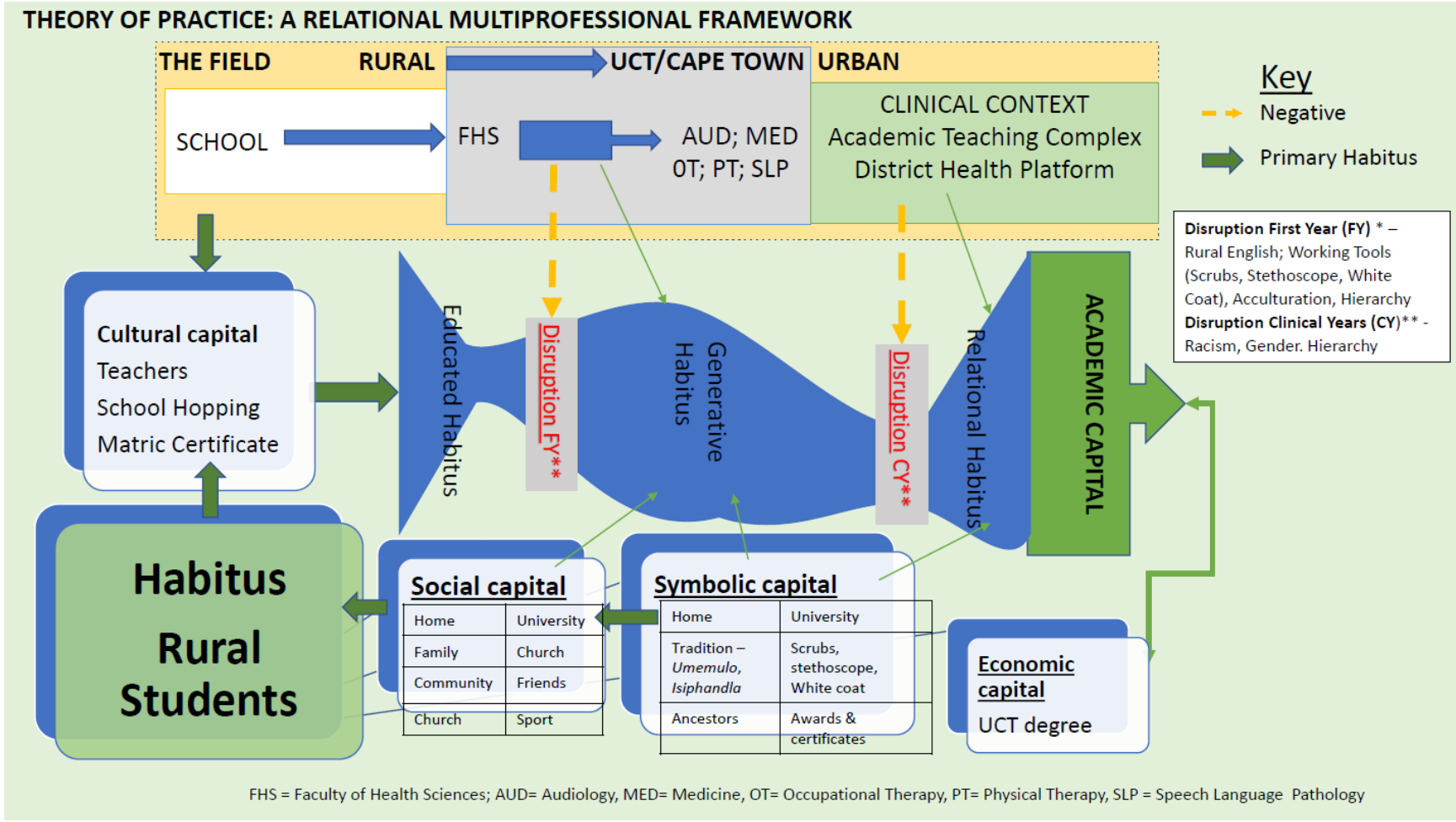

Figure 8.1 Theory of Practice: A relational multiprofessional framework

In this diagram, the green arrows represent positive experiences. Participants had access to social forms of capital from home (family, community, church). from university, friends, sport and church (religious services they attended as university students). Symbolic capital was sourced through traditional practice. Cultural capital was sourced in the first instance from school. Drawing from their social and symbolic capital, input from lecturers in the Faculty of Health Sciences, classmates and friends transformed an educated habitus to become a generative habitus. Later, drawing from symbolic capital (working tools – scrubs, stethoscope and white coat), based in a range of contexts (academic training complex and the district health platform) input from clinical educators, clinical partners and patients transformed generative habitus to a relational habitus. This contributed to attaining academic capital, which generated economic capital at the end of academic year when participants were confirmed as having completed their studies. Represented by broken yellow arrows (negative experiences), this sequence was disrupted twice in their first year and again during their clinical years. The discussion that follows elaborates on these aspects and is guided by assumptions I made in relation to the study objectives.

8.2.1 Habitus Creates Capacity to Accumulate Different Forms of Capital

Rural origin: In this section I link identity to primary habitus and present the different forms of capital generated through rural upbringing. Rural identity derives from an individual's primary habitus that is informed by acts, rituals and performances observed during childhood. This social context afforded participants access to different forms of capital (Bourdieu, 1986, p. 242). Participants' understandings of rurality and their descriptive representation of their own communities conformed with that described elsewhere. The varying pluralistic definitions of their own communities as heterogenous, complex, dynamic and ambiguous were reported as subjective and objective representations of rural spaces within the same country, as reported by several other authors (Bell, 2007; Heley and Jones, 2012; Hlalele, 2014; Finn and Kobayash, 2020). Considering the rural-urban divide, participants spoke of "living in two worlds at the same time," highlighting tensions experienced by them when studying in Cape Town. An understanding of their background and personal circumstances cultivated a sense of purpose, as reported by Li (2013) of rural students studying in elite Chinese institutions. Their lived experiences were constant reminders of the challenges they encountered: they had to cross rivers (*siwel'imifula*) to get to school and navigate difficult weather conditions, both literally

and metaphorically. According to Romero et al. (2018), geographic characteristics are risk factors for poor participation in school. In this study "living in two worlds" was a source of constructive tensions and unintended benefits, as it provided participants with the capacity to navigate other disjunctures.

Primary habitus is represented in Figure 8.1 by the box in green at the bottom left of the diagram. The different forms of capital are represented in the blue boxes in Figure 8.1 to the left of habitus (social, symbolic and economic) and cultural capital is just above habitus, also in blue. Participants accrued primary habitus as values and embodied actions that were instilled by family and community members. As social capital is generated from established relationships and bonds, participants had strong bonds with family members and extended family. Habitus was thus created through social rather than individual processes, leading to patterns that were enduring (Navarro, 2006); it was embedded deep into the core of their being, and thus cannot be altered easily (Mozumder, 2020). In addition, multidimensional forms of capital (Bhandari and Yasunobu, 2009) were generated through religious affiliation. Participants also reflected on the interconnectedness and values associated with *ubuntu* (you are/because we are) and emphasized that everyone in the community had their best interests at heart, "it takes a village to raise a child." Habitus creates practices from an internal point of view (Bourdieu and Wacquant, 1992, p.129), and for these participants, this was performed through multiple mundane acts. Participants spoke, for example, of personal greetings and the importance of this in acknowledging people and in particular their patients.

Considering that habitus comprises of systems of durable, transposable disposition, having mastered lessons that were instilled at community level, participants' identity was constantly validated (Mapukata, 2020). They in turn knew how to relate to others, and their personal achievements were celebrated by the community at large. Their participation in church activities provided the basis for moral development as they embraced the teaching philosophy of *ubuntu* as Sunday school teachers. Others mentioned their contribution as altar servers and lay preachers. Accordingly, participants had access to durable forms of primary habitus (Power, 1999) from various sources (family, church, and community). In other studies (see Harker, 1984; Nash, 1990; Archer et al., 2012; Atkinson, 2011; Huang, 2019), participants only had access to family habitus as their primary habitus. In this study, drawing from pooled resources, participants had access to a generous amount of social capital.

Symbolic capital is evidence of a habitus with both objective and subjective elements (Bourdieu, 1984). Few participants could claim access to the symbolic capital described by Bourdieu (1984) as a form of capital whose net worth depends on others recognising and appreciating its value. For some, symbolic capital was associated with traditional practices including participation in *umemulo* (coming of age ceremony) and being gifted with *isiphandla* (cultural bracelet), which affords divine protection to the owner. The third source was derived from a perceived cultural value that accrues to individuals following visits to their ancestral homes. Although a number of participants had limited access to economic capital *"*I was computer illiterate, we never had computers at my school", both *umemulo* and *isiphandla* have potential to generate economic capital at a later stage.

8.2.2 Cultural Capital Facilitates Capacity for Adaptation to Disruptions and Tensions

An educated habitus: Certain capabilities are associated with having access to cultural capital. Participants had access to embodied cultural capital as forms of knowledge with intrinsic value, such as mannerisms, home language and accents, and habits. There was no evidence of participants having access to objectified forms of cultural capital such as books and related resources. Even when they had access to computers, many were not competent enough to use them, as their schools lacked basic amenities. On the other hand, they had access to institutionalised cultural capital through their matriculation certificate and awards from participating in debating competitions and related activities.

Considered from the descriptive presentation of their communities, with a dual education system that comprises of 25% of schools for the rich and wealthy (Spaull, 2013), participants had limited cultural capital. Students who attended rural schools up to grade 12 had no access to computers and libraries, confirming reports by Letseka (2014) about a pending crisis as SA public schools lacked resources, these were considered to be risk factors for poor academic performance (Nkambule et al., 2011; Romero et al., 2018). Their English lacked the acceptable "white tone" (Hunter, 2019) linked to cultural capital and equated to "whiteness" in students' minds (see also Bangeni and Kapp, 2007, p.7). In the absence of an intervention, Harker (1984) predicted poor performance in learners from rural schools, reflecting Bourdieu and Passeron's (1977) characterisation of schools as places that reproduce social inequalities. However, in a study by Ogbonnaya and Awuah (2019), Quintile 1 learners had the capacity to accumulate capital quantitatively and only struggled with synthesis, implying that some rural

students are high achievers (Reay, 2005; Li, 2013). Accordingly, Ogbonnaya and Awuah argued that the discrepancy in the English language efficiency of learners in Quintile 1 schools may reflect parents limited capacity to support their children linguistically, as they lacked access to study materials and high-level English themselves. Reporting on education outcomes in South Africa, highlighting challenges facing early childhood development, the Statistician-General estimated that in 2016, three million Black Africans had dropped out with only a primary school education (Stats SA, 2016).

The negative predictions for students of rural origin were overcome through individual effort (see also Ogbonnaya and Awuah, 2019). For many participants moral support received from parents and extended family members, particularly female caregivers, were associated with positive education outcomes (see Jo, 2013); teachers were often also positive influences (Li, 2019; Romero et al., 2018). Bourdieu (1984) argues that habitus as a system of internalised values is responsible for positive attitudes about the benefits of enrolling for higher degrees. The efforts of individuals and their families were successful in increasing the value of their cultural capital as participants changed schools in pursuit of a good English school, engaging in a phenomenon referred to as school hopping prior to matric. The benefits of strategic school moves echo findings by Xu et al. (2009). One participant transferred from a day scholar to become a boarder in the second semester of her matric year so she could save on travelling time. Even at high school level, that participant struggled to adapt to the culture in boarding school as many learners were from middle-class families.

Despite their circumstances, study participants were high achievers in their matric year (Reay, 2005; Li, 2013; Ross, 2015) and had received support from their teachers and school principals in addition to their parents (Agbenyega, 2014; Romero et al., 2018). Bourdieu (1977) held that an educated or a "cultured" habitus is likely to inform progress in school and influence the acquisition of "real" knowledge and argued that "among the pupils of grandes écoles, a very pronounced correlation may be observed between academic success and the family's cultural capital" (p.497). Nash (2001) on the other hand argues that the positive effects of an educated habitus on educational attainment are attributable to non-cognitive dispositions such as held attitudes about the role of school and teachers (see Mapukata, 2020), family perceptions as well as the individual's positive self-concept about their academic performance, as I noted above with regard to aspirational habitus. This study has demonstrated that parental/family support rather than the class status of the family (Laurette and Weininger, 2013) is the source of an educated habitus (see also Archer et al., 2012; Jo, 2013; Romero et al., 2018).

8.2.3 Health Sciences Students are Likely to Experience a Disrupted Habitus

A disrupted habitus: In this section, I argue that health sciences students are likely to experience a disrupted habitus as they encounter power in the field. Habitus "is not fixed or permanent and can be changed under unexpected situations or over a long historical period" (Navarro 2006: 16). Participants assumed that their schooling had prepared them adequately to become students in the Faculty of Health Sciences at UCT, and that their educated habitus would facilitate an acquisition of academic capital. Their relocation from small towns, small holding farms, and villages to Cape Town initially disrupted their habitus, which they evidence in terms of social distance – for example, people did not bother to greet them. Li (2013) referred to this disruption as not only a class issue, but also a geographical challenge, when rural students encounter a metropolitan milieu following their relocation to an urban based elite institution.

Participants encountered similar challenges in lecture halls as the classroom settings they were familiar with did not compare in size and orientation. Lecture halls can accommodate hundreds, making the space physically intimidating compared to the standard classroom. Some had never been taught by a white lecturer (see also Bangeni and Kapp, 2007; Ross, 2016). Muted by their rural English just as they were silenced by the "level and speed of the English spoken" (Bangeni and Kapp, 2007, p.6), participants felt that they were misfits – some started to isolate, others disengaged (Li, 2013) as they experienced what Bourdieu (1999) describes as a cleft habitus – a habitus divided against itself (p.511). A few participants had no computers even at UCT, or if they did, they lacked computer skills (see Czerniewicz and Brown, 2014) and experienced failure for the first time, leading to both a crisis in a sense of their own competence (Reay et al., 2009) and in their mental health (Pearson et al., 2015). As argued by Webb et al. (2002), the amount of power rural students had access to was determined by their position within the field and the amount of capital to which they had access, which was not much to start off with, as asserted earlier. However, their intrinsic motivation to succeed compelled them to commit to their studies (see also Pillay and Ngcobo, 2010).

Participants had to contend with dual identities as students of rural origin and as health sciences students in an elite institution (Brosnan et al., 2016). As health sciences students, other university (upper campus cf. chapter 4) students assumed they had access to privileges associated with medicine as an elite profession (Mathers and Parry, 2009). Participants made three attempts to moderate their circumstances. Firstly, they wore professional attire (scrubs, white coats and a stethoscope) in public, emulating symbols of power, future wealth and

education (Jenkins, 2014) until they realised that they were misrepresenting themselves. Luke (2003) argues that clothing such as scrubs are tools for displaying capital and negotiating institutional hierarchies, which validates the actions of the participants. They later decided as individuals to only use their working tools when they were in clinical facilities. Secondly, a few used their social and cultural capital (church, sport, identity) to make friends. Lastly, considering that a primary habitus is much more resilient than a secondary habitus (Power, 1999), in instances where they encountered episodes of racism from their supervisors, peers and patients, they regrouped and sought support from clinical partners and supportive classmates.

8.2.4 Relational Habitus Has Generative Capacity to Transform

A generative habitus: A relational habitus has generative capacity to facilitate transformation from non-professional to professional spaces. Habitus is transferrable from one context to another, but there can also be shifts in relation to specific contexts and over time (Navarro, 2006). Habitus changes according to new experiences (Bourdieu, 2000). In this study, participants experienced transformation in clinical spaces at five levels. Firstly, as they had previously attempted to accrue cultural capital by wearing their scrubs in private spaces, in clinical facilities, scrubs translated into "professional armour" and became a marker of their professional identity (see also Luke, 2003; Jenkins, 2014). They felt safe from abuse, from those who, for example, had previously tried to touch them inappropriately when they were wearing their own clothes, and they gained respect from patients and their families. Secondly, participants experienced a shift from theory to practice as they advanced their technical knowledge: "I was finally seeing theory come alive. Not only that, I also started feeling like I knew what my profession was about; all the confusion started going away, it was clearer."

Thirdly, they reported a shift from being students to becoming health care professionals as they managed their own patients under supervision: "I started seeing myself as a health care worker in my final year. When I was responsible for patients from admission to discharge". Fourthly, there was a shift from standard patient encounters to an appreciation that patient management required a holistic and a biopsychosocial approach; participants' concerns extended to patient outcomes and effectiveness of their interventions: "What I have realized, is that an intervention is not only physical, but it involves social and economic angles. You have to think broader than just the physical, you have to think for when you are not seeing the patient

anymore." Lastly, participants experienced a shift in their approach to work as they learnt to function as part of a multidisciplinary team (see also Nyangairi et al., 2010; Cameron et al., 2011; Diab et al., 2014; Joubert et al., 2019). "It was a nice way to see a multiprofessional team in action… This clinic allowed us to get exposure in working not only with the patient but also with their families and put into perspective each team members role which was always in theory until then." Bourdieu (2007) defined HEI as places for acquiring a transforming cultural capital and spaces where one's life is likely to take shape and form, confirming the range of lived experiences reported by my participants.

Relational habitus: Habitus comprises a set of historical relations (Bourdieu and Wacquant, 1992) that are "deposited" within individual bodies in the form of mental and corporeal schemata of perception, appreciation, and action (p.16). In the field, participants were involved in structured objective relationships with all the other actors who were part of the clinical environment. Participants were able to draw from their social attributes and through interactive engagement with patients, under the supervision of their clinical supervisors and sometimes on their own (Stone et al., 2012). Clinics and district hospitals were spaces that facilitated reciprocal learning experiences (see also Nyangairi et al., 2010; Cameron et al., 2011; Diab et al., 2014). In those facilities, their social attributes transformed into professional attributes. They greeted and acknowledged patients, they showed respect and so earned the trust of patients and their families. As tutors and mentors, it was possible for participants to generate symbolic capital as their contribution was acknowledged by faculty. A distinction between generative habitus and relational habitus is that in the former, shifts occurred in-situ whereas with relational habitus, participants had to draw from historical events (primary habitus) to generate cultural knowledge that contributed to a relational habitus.

8.3 The Process: Constrictions and Expansions of a Habitus

In this section, I discuss the constrictions and expansions of a habitus as the process by which my participants navigated through an educated habitus to acquire academic capital. I represent this by the blue shape of varying size in the middle of Figure 8.1, and in Figure 8.2 I focus on the birthing of a new habitus.

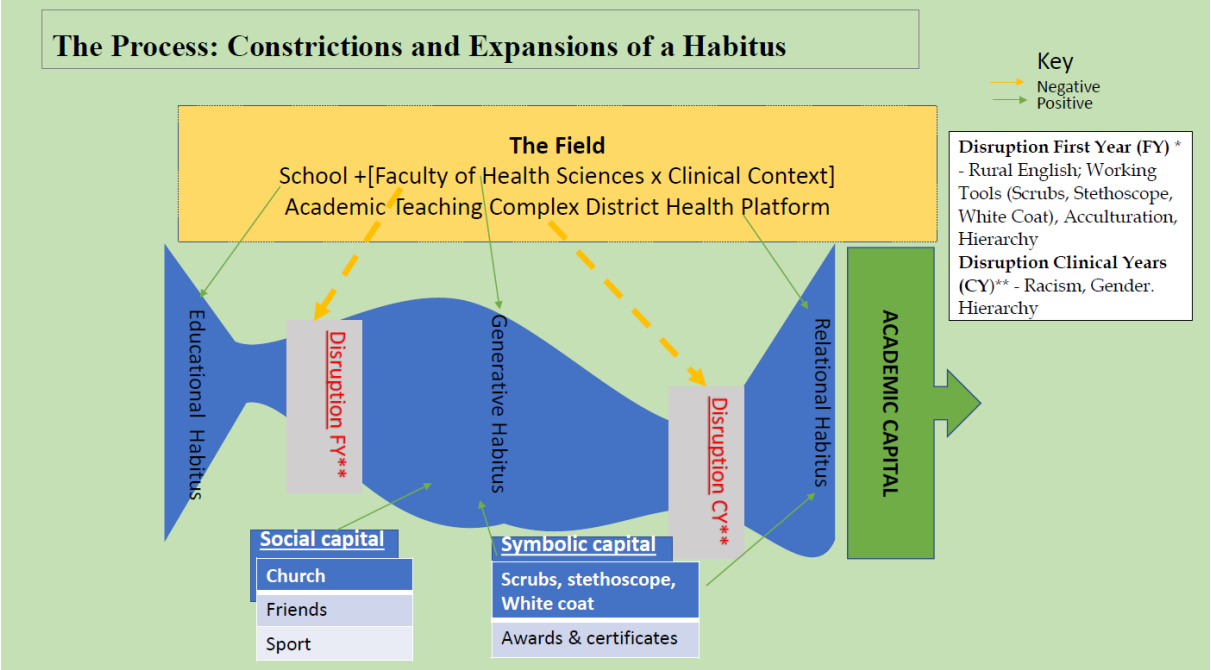

Figure 8.2 Constrictions and expansions of a habitus

Bourdieu (2000) describes the field as the place where you must have a feel for the game with its own established positions and practices; learning about the profession focuses on objective rather than subjective experiences (Grenfell and James, 1998). Participants' exposure to the field was at school level where they were the big fish in a small pond and left school with an educated habitus (Bourdieu, 1977). As they entered university, being positioned in an unfamiliar field not aligned to their schooling experience (Mathers and Parry, 2009; Brosnan et al., 2016; Li, 2013), they reported their first experience of a "destabilized habitus" (Bourdieu, 2000, p.160). In such instances, their experiences of the field were as small fish in a big pond, where they felt like "fish out of water" (Tranter, 2003; Reay et al., 2009), leading to the first phase of constrictions, manifesting as disruptions in their first year. Participants reported these as disorientating experiences.

In this study, participants struggled to locate their positions in the field as they could not keep up with peers (Mathers and Parry, 2009; Brosnan et al., 2016; Li, 2013). This was due to their rural English, lack of resources, and the struggle to keep up with the level or speed of their lecturers. They tried to position themselves and generate cultural capital (Jenkins, 2014) when they wore their working tools (scrubs, stethoscope and white coat) in public spaces, and in the process, they subjected themselves to public scrutiny on the presumption that they were licensed to practice as health professionals. This positional suffering (Bourdieu, 1999) led to isolation

and feelings of despair (Bangeni and Kapp, 2007; Brosnan et al., 2016) as disjunctures in a field where everything was new and strange (Reay, 2005). Beyond the first semester in first year, they tapped into three sources of social capital through church, personal friends and socialisation through different sporting codes. In line with a habitus that is adaptable (Bourdieu, 2000), and modifiable whenever it encounters new experiences (Di Maggio, 1979), participants began to embrace new ways of knowing (Bourdieu and Wacquant, 1979). As they became familiar with the style of their lecturers and began to participate in small groups supported by classmates and a few friends, they began to behave like "fish in water" (Bourdieu and Wacquant, 1979. p.127).

The duality of a habitus described by Wacquant (2006) facilitated both continuity and change and, working towards a generative habitus, participants identified a place for their working tools as professional armour (scrubs) confirmed their place in the field of practice. Having adjusted to the field, they experienced the second round of constrictions in the clinical context – participants experienced incidents of racism and misrecognition and felt like they were misfits. In this study, only Black female participants reported that they were denied access to teaching spaces, "In my first rotation in fourth year we had a white registrar and in our group we were 4 Black students and 1 white. We received no teaching for a duration of eight weeks from the registrar but he would have private sessions with the white student whilst we were busy taking bloods, drips. I came out knowing how to perform procedures but my clinical knowledge was so poor that I did not pass my clinical exam and had to have a supplementary exam." In addition to the above, they also experienced resistance from a few patients who refused to consent to physical examination but would comply if students were of a different race.

Being disregarded in the clinical space was also reported by UK based first-generation female Iranian doctors and dentists (Fathi, 2018). Tapping into a relational habitus, through their social capital, they managed to source their own patients by gravitating towards African patients: "they were so much more appreciative of me. They were encouraging as my own mother was." They used their professional armour in navigating institutional hierarchies and as they gained support from clinical partners, they embraced positive teaching experiences. Wacquant (2006) posits that when a habitus encounters new fields, through the acquisition of new dispositions, it triggers its innovative capabilities (p.268). This was the case as participants decided to approach patients who would be receptive to their requests. Through their relational habitus, they engaged in mutually beneficial partnerships as patients became a source of support

– “Some, if not too sick, would even have a chat with me about life and impart wisdom” – and helped to moderate negative experiences. As field and habitus function fully (Bourdieu and Wacquant, 1992) only in relation to one another (p.19), as participants engaged in a transforming habitus (1990), it was possible to birth a new habitus, thereby generating academic capital.

8.4 Contribution of the Study

Through this study it has been possible to present a relational multiprofessional framework for exploring the habitus of students of rural origin. Participants were registered for degrees in audiology, medicine, occupational therapy, physiotherapy and speech-language pathology. Other studies that have reported on habitus of rural (working-class) students were discipline specific (see Luke, 2003; Manderson and Turner, 2006; Mathers and Parry, 2009; Light and Evans, 2011; Czerniewicz and Brown, 2014; Gennrich 2015; Brosnan et al., 2016; Bagley, 2019) or focused on rural students as a generic group (Reay et al., 2009; Wee, 2013; Pather and Chetty, 2015; Yenney-Henderson, 2019).

Participants contributed new descriptors based on their understanding of rurality as places that lacked resources: “No ATM, no CBD, no YouTube, no Instagram, no internet café”. They consistently drew on modern technology and communication systems to highlight the separation of rural and urban. In other SA based studies, participants demonstrated an understanding of their backgrounds in relation to what they had access to or were lacking as they joined HEI (Czerniewicz and Brown, 2014; Pather and Chetty, 2015; Gennrich 2015; Ross et al., 2015). However, they did not contribute to new ways of understanding rurality from a student perspective.

The study provided an understanding of different forms of capital that students of rural origin have access to that included an abundant social capital through multidimensional input from family, church and community at large; some cultural capital through efforts of family and teachers and by embracing school hopping; and limited symbolic capital from traditional practice. Although participants in a study by McCulloh (2020), who were also rural first-generation college students, had parental, extended family, and community support, theirs did not include church and ancestors. In this study, participants had little economic capital when they entered university. Despite these fluctuating values, there is evidence of the relational nature of a habitus at play as the lived experiences of study participants provided for the

interplay between their socialisation and a range of experiences, they accrued in the process of becoming health professionals. As they engaged in clinical activities in the field, their social attributes became active as professional attributes in the clinical context.

Participants entered the university with an educated habitus. However, transitioning from a rural to an urban setting, and their conception and representation of a university as a cultural system, was experienced as a series of shocks and subsequent disruptions to their habitus (Bourdieu and Wacquant, 1992; Mathers and Parry, 2009; Brosnan et al., 2016; Li, 2013). Their reflections provided evidence of an understanding of the university as a structured social space, a field of forces with many players. As a group that was dominated, it was possible to trace the vulnerability of health sciences students of rural origin to mental illness particularly in their first year (Reay et al., 2009; Lee and Kramer, 2013; Czerniewicz and Brown, 2014; Pather and Chetty, 2015; Li, 2019; McCulloh, 2020). An understanding of their background motivated them to persevere in the face of adversity as they became resilient (Reay et al., 2009; Brosnan et al., 2016; Li, 2019; Bagley, 2019).

The challenges of being different in the field (university) provided opportunities for their habitus to constrict and expand, and in different phases of the field it generated and produced an academic habitus. Participants experienced a series of shifts as they transformed from being health sciences students to becoming health care professionals. Different fields provided space for shifts in their professional practice as they gained technical knowledge and an evolved understanding of the practice, as they adopted a holistic and biopsychosocial approach and participated in multidisciplinary teamwork.

The university space was a field of power, it became a space for symbolic violence as acts of racism had an impact on their learning experiences. This was particularly the case for Black females, with likely impact on their self-perception of competence to practice safely as interns or community service practitioners. The university was also a space for a transforming habitus and critical reflection: “It took me seeing my own people being mistreated in my field of work to reflect on how I may also be a perpetuator of racial injustice in this country”. Through socialisation in different aspects of the field, participants could generate symbolic capital and their primary habitus generated value for patients.

8.5 Research Limitations

In Chapter 7, I reflected on my research journey, the profile of my participants and a recruitment process that extended over two years as the study was initially conceptualised at Wits and later transferred to UCT. The two-year hiatus had an impact on the research process and timeline. On the one hand, I had to prioritise the best interests of my participants and balance this with the financial implications and the ethical dilemmas I was faced with as a post graduate student and a practice researcher (see Coy, 2006). On the other hand, as this was a study that sought to solicit views of health sciences students from rural South Africa, lack of consensus on the definition of rural and ambiguity associated with rural contexts may have influenced the selection of participants.

A secondary challenge was that I based rurality on the framework classification of rural schools that is used by the Department of Basic Education and discovered that this process was flawed. In addition to the above, undertaking research during a global health crisis (COVID-19) required adaptations to the process, as there were challenges associated with a disrupted academic calendar such as the temporary suspension of all research projects. This had an impact on the number of participants willing to participate in Phase 2 (journal reflections) of the study. It is possible that data quality was impacted by memory lapses as participants had to contend with major events on campus during their studentship, including the untimely death of their dean; the death of a first-year student to femicide; and events around #FeesMustFall student protests, in addition to COVID.

8.6 Opportunities for Further Research

As this is the first study to explore the lived experiences of health sciences students across five programmes, there are opportunities to:

- Extend this study to other universities and faculties of health sciences in South Africa and include other disciplines such as dentistry, nursing, and pharmacy.
- Compare forms of capital that students of rural origin have access to across programmes.
- Conduct a comparative study with traditional (non-rural) students.
- Replicate the study with future cohorts.
- Undertake the same study through a longitudinal lens and track the generative capabilities of habitus across fields.

8.7 Making a Rural Workforce

In this study, I presented students of rural origin with a generous social capital. This is based on the cumulative value of their social capital, its multidimensional forms, and the benefits that have accrued to patients. Throughout this study there was evidence of the tensions and shifts participants had to contend with as they navigated the different fields. They also had to contend with the change from being high achievers at school to being failures at university in the space of a few months.

Their rural English rendered them misfits and strangers, and only a few could draw from their symbolic capital to sustain themselves. However, their motivation and the volume of their social capital sustained them. They had to contend with challenges of being and becoming in spaces where they were silenced for their linguistic (dis)abilities and subjected to racial and gender discrimination while at the time being celebrated by patients for their social attributes that translated into desirable attributes of professionalism. Through their generative habitus, it was possible to employ a relational habitus to attain an academic habitus and symbolic habitus. All participants expected to accrue an economic habitus as they exited with a UCT degree.

Employing a Bourdieusian lens has been useful in providing insights into how students of rural origin negotiate difficult university spaces and to analyse their initiatives to generate the kinds of capital that have sustained them as students of rural origin to become health care professionals. In conclusion, by employing habitus as a theory and a methodological tool, it was possible to examine this interplay between identity of health sciences students of rural origin and thus their rural habitus and how this facilitated interplay between socialisation, experience, and practice. In that regard, through a relational multiprofessional framework, using a constructivism approach different to critical realism (Archer, 1982), it has been possible to focus on individual constructions of social reality to generate the collective realities that are evident in this study. By navigating through a range of disorientating dilemmas in a few clinical departments, my participants could generate reflexive knowledge that is likely to transform future practice in defined social structures.

In the absence of a policy review, this understanding about the influence of habitus on professionalisation of health sciences students and its value in graduating health professionals, who prioritise a patient-centred approach, does not on its own generate a future workforce. Current policies must be reviewed to realise the social accountability that is aspired to by the National Department of Health (DoH, 2020) and was recommended by the *Lancet* Commission

(Frenk et al., 2010). As the mandate to produce socially accountable health sciences graduates falls within the ambit of South Africa's universities, this is contrary to findings from a PhD thesis on social accountability by Green Thompson et al. (2017), whose participants struggled to define their role as socially accountable graduates. Different to quantitative research, findings from this study suggest a relational link to habitus is derived from actions of students of rural origin, their sensitivity to the needs of patients and concerns about effectiveness of their encounters beyond the therapeutic. This is in addition to participants defining a role for district health platforms in facilitating student directed learning (see also Villiers et al., 2018).

Based on the primary habitus of students of rural origin rooted in culture and in community, I suggest a shift in the recruitment of a future workforce to prioritise students of rural origin. Kaufman et al. (2021) argue that social accountability is possible in community-based settings, and they point to the effectiveness of community health workers (CHWs) as a practice that has had great success in South Africa. Likewise, Murphy et al. (2021) contend that CHWs continue to promote health and link their communities to health facilities, despite reported implementation challenges. Similarly, if one considers the success of the medical training programme at Walter Sisulu University (Kwizwera and Iputo, 2011), context facilitates a greater interaction between university and the community (see also Forgan et al., 2011), patients and students, in addition to a primary habitus that draws students to their patients. As one of their recommendations, Kaufman et al. (2021) suggested a review of institutional requirements to reflect a student profile that mirrors the diversity of the community the program serves (p.635). Considering that my participants have already navigated some of the complexities and tensions that are associated with rural practice (Croker et al., 2021), with a stated preference for rural practice, such graduates should be afforded preferential treatment when allocating placements for community service in rural facilities. Based on the study findings, the shift I am proposing should also consider the policy recommendations, as presented below.

8.8 Recommendations

As this study is nested in public health, the lived experiences of health sciences students from rural South Africa have exposed gaps in policy implementation. In undertaking this study, I analysed the policies below and thus recommend their review. I also offer recommendations in addressing practice related challenges.

8.8.1. Rural Education Policy: **National Education Policy Act, 1996** (Act No.27 of 1996)

This policy was instituted with the intention to improve the quality of education in public schools that are based in the rural areas of South Africa. In addition to this, in a post-apartheid era, a mandate was issued to HEI "to redress past inequality and transform the higher education system to serve a new social order to meet pressing national needs and to respond to new realities and opportunities" (DOE, 1997: 1:1). While the enrolment of Black students in HEI has improved greatly to better reflect the demographics of South Africa, the high visibility of Black students is not matched by throughput rates (Otu and Mkhize, 2018) as some are still under-prepared for higher education (Bangeni and Kapp, 2007; Czerniewicz and Brown, 2014; Pather and Chetty, 2015; Ross, 2016; Ndofirepi and Maringe, 2020). Beyond what has been stated above, the policy needs to address the following:

- The current approach in profiling rural schools where the classification only focuses on geographical location of schools continues to perpetuate the dominance of privileged upper- and middle-class students in HEI.
- With the government substituting lower quintile schools (mostly rural schools) with schools that are classified as elite schools through geographical misclassification, this is likely to impact the delivery of services such as library and computers that are required to improve the quality of education in rural schools. With poor matric outcomes, the pool of students of rural origin who are likely to meet entry requirements of HEI is reduced.
- If students of rural origin are continuously under-represented and under-prepared as reflected above, the critical mass of health care workers that is required to provide health care in rural communities will never be realised.
- Consequently, the Rural Education Policy in its current form is contributing to health inequities as the objectives of the policy are not met. As access to basic education and to primary health care are both constitutional obligations, public health facilities will be continuously understaffed, and patients will continue to be underserved.

8.8.2 Education and Training of a Future Workforce

The urban-rural dichotomy in the distribution of the health workforce, considered a global challenge by the World Health Organization (2018), will continue to present a challenge. Both

the WHO report, “Global Strategy on Human Resources for Health: Workforce 2030” (WHO, 2020) as well as the National Department of Health report, “2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage” (DoH, 2020) rely on the rural pipeline approach as a solution. In Chapter 2, following an analysis of the two policies, I presented key findings that highlight challenges in the making of a rural workforce if the pursuit of the pipeline approach is presented as the only solution.

I argued that although prevailing evidence confirms a correlation between rural origin and rural intent, in South Africa, the number of practitioners who are willing to take up rural practice for extended periods is not adequate to cover the prevailing human resources for health challenges. Empirical evidence supports a likelihood of rural students returning to their community to stay and practice. However, rural exposure alone is not adequate in retaining graduates in rural South Africa. Contextual factors must be considered in planning for health care provision. As noted, in a baseline survey Reid (2004) conducted a year after the initial allowances were introduced, only senior health care professionals were likely to commit to a rural area. In that regard, the existing policies only presented a linear view to the prevailing challenges and simplified what is a complex problem that requires multistakeholder input. I suggest a review of these policies based on the following:

- Exposure to rural practice through community service has limited impact as it has only culminated into a retention rate of 16% of practitioners in rural areas beyond the compulsory community service (Reid et al., 2018).
- In addition to the above, two studies that focused on practice intentions of final year health students that were mostly based in urban institutions, point to an apathy for rural placements by doctors beyond community service (both at Wits and at UCT, see George et al., 2019; Jose et al., 2020). Similar findings are reported for rehabilitation therapists (Tiwari et al., 2020; Ned et al., 2020).
- A highly feminised rehabilitation therapist workforce and racial profiles do not reflect policy reforms that were a directive to HEI. Although this presents a challenge, issues of personal safety prioritised by young female professionals are a genuine concern in a country with high rates of gender-based violence (Dlamini, 2021).
- Coupled with issues raised above about the implementation challenges of the Rural Education Policy (Act No.27 of 1996), beyond policy provisions and contractual obligations, the making of a rural workforce calls for a targeted recruitment and retention strategy.

- With limited success in implementing the LIC model in South Africa (Nazareth and Mfenyana, 1999; Villiers et al., 2018) and a gap between the objectives of the two policies (WHO and NDOH) and the intentions of students of urban origin, policies in their current format will not address prevailing health inequities.
- Even when students are identified and steered towards a career in health sciences they may be discouraged from rural practice if the following provisions persist:
    - If provision of student funding does not consider the missing middle and if students joining universities have had no access to libraries and computers during the schooling years.
    - Targeted mentoring and a nurtured commitment to a rural career is absent.
    - If rural areas are only presented as places of deficit, limited exposure is likely to discourage students of rural origin as they may opt out of returning to their communities to practise despite what is documented in literature.

The policy framework must consider a multimodal approach in the making of a rural workforce. In that regard, through the Rural Education Policy, students of rural origin should be adequately prepared for post matric education. Universities should admit students whose profiles mirror the communities where they will be providing services; address the feminisation and racial profile of students enrolling for degrees leading to health sciences qualifications; and plan for positive learning experiences. In strategic partnerships with faculties of health sciences, bonded scholarships should be linked to targeted peer mentoring and early exposure to rural health practice. Additionally, in partnership with other stakeholders and alumni, HEI should facilitate the targeted recruitment and retention of rural students.

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APPENDICES

APPENDIX A: PLAGIARISM DECLARATION

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I, **Nontsikelelo Olga Mapukata (Student number: 13131)** am a student registered for the degree of Doctor of Philosophy (Public Health) in the academic year **2022**.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: _____ Date: _24 February 2022_____

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Appendix B: Published Article

Introduction

The narrative that follows takes an autobiographical approach, defined by Abrahao (2012) as a methodology that employs various empirical sources and techniques. In defining my habitus, I present memories of critical points in my life. These are moments, as described by Thorne (1995) that define who I was and am, from my early childhood to the present, mainly viewed from Bourdieu's theoretical framework. Using different approaches, in reflecting on personal experiences that shaped my journey from the rural village of Idutywa in the former homeland of Transkei, now known as Eastern Cape Province (South Africa), to a higher education institution, I have considered and deliberated on the attainment of my habitus. According to Abrahao (2012), the critical component of this methodology is informed by the memory of the narrator as the most defining element and, also as the critical component in the reconstruction of narrative facts.

> In describing early experiences of my childhood, I had to validate some of the facts with my two older sisters. This was not necessarily to bridge memory lapses, but to test my interpretation and to gain meaning and nuance. We spoke regularly, face to face or by telephone.

Wall (2006) argues that this form of narrative allows the author to draw from a highly personalized narrative. This conception of narrative seeks to establish the link between personal memory and an autobiographical narrative as a process of continuous construction, defined and refined through social, political and economic interactions (Smorti, 2011). The interpretation of the narrative draws from social learning theory, where learning is derived from social interactions and derives meaning for the participants as it contributes to the construction of their identity. Through this form of engagement, the actions of others inform practice, and cultural symbols produce meaning for the observer. Lave and Wenger (1991, 108-9) are of the view that for newcomers to social learning "the purpose is not to learn *from* talk as a substitute for legitimate peripheral participation; it is to learn *to* talk as a key to

legitimate peripheral participation." This form of social learning is situated in context as described by Lave and Wenger[1].

> In writing this narrative, I describe myself as I am known at home in the Eastern Cape, eDutywa, where I was born and raised as Nontsikelelo. Both my parents were college-trained educators. If I take on my clan name, then I am known as Mankwali.[2] Growing up, I needed to get these basic facts right as they define my lineage, my values, my parents' and my family's standing in society. There were times where I needed to take on my father's or mother's identity to short circuit a conversation with strangers or other people who knew my family. In that context, I was my father's or my mother's daughter. Within that social structure, my personal identity was valid and continuously affirmed.

Reid and colleagues (2010) refer to the elements that are revered in rural areas, such as the fact that everyone knows you about your lineage and genealogy, as well as in regard your spatial and own social identity in the community. In 1990, Bourdieu defined habitus as how the culture of a particular social group is embodied in their being. He alluded to the attainment of habitus as a series of unconscious acts or mental habits that include beliefs, values, norms and attitudes that are internalized through socialization into the family. Yet, he also asserts that the process by which habitus is attained is through the deliberate actions of others in acclimatizing an individual to a social context (p.116). This understanding

[1] According to Lave and Wenger, "(l)earners inevitably participate in communities of practitioners and… the mastery of knowledge and skill requires newcomers to move toward full participation in the sociocultural practices of a community. "Legitimate peripheral participation" provides a way to speak about the relations between newcomers and old-timers, and about activities, identities, artefacts, and communities of knowledge and practice. A person's intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. This social process, includes, indeed it subsumes, the learning of knowledgeable skills". Lave, J. & Wenger, E. (1991).

[2] Like the clan system amongst Scottish people, Xhosa clan names facilitate a process whereby one is able to trace his or her genealogy as it relates to family history and a specific ancestor register. In terms of cultural practice, a clan name is fixed and carries a lot more value as it is unaffected by one's marital status.

can be applied to my extended interactions with others, both within and outside my family structure.

Habitus and intersecting social identities

Bourdieu's definition of habitus as "society written into the body, into the biological individual" (1990a: 63) reflects the intersectionality of social identities as performed and established practices of culture. Beyond this imprint of habitus through social interactions, Bourdieu (1990a: 70) presents habitus in its durable forms as ways "of standing, speaking, walking, and thereby of feeling and thinking." Bourdieu's forms of habitus define the common thread that exists amongst people of rural origin, judged in the way in which they demonstrate their intersecting social identities.

> In my case, story-telling became an integral part of [our] upbringing. Occasional visits by my maternal grandmother would reduce my sisters and I to tears as she loved to relate bedtime stories about the supremacy of the animal kingdom. To this day, I can still recall her howling like a hyena. Her stories always had beautiful endings as she finished off by describing her role as a matriarch protecting her family. Growing up, child-rearing was not exclusively my mother's responsibility - the entire community was involved.[3]

It follows that at least among those with whom I grew up; there is a prevailing understanding that the "self" is not separate from the world. The greeting encapsulates this: it is expected that you will greet everybody, even total strangers and that you will acknowledge and give respect to all elders. Visser's poem © (2005) demonstrates this very well:

[3] "It takes a whole village to raise a child" is an old African proverb that derives its meaning from a value-based approach where the rearing of children was the responsibility of the entire community (and made popular by Hillary Clinton). In that era, as a child you had to account to all the adults - guardianship was extended beyond the boundaries of the family. However, this practice is threatened by an imploding social contract. As recently as the last decade, Meel (2008) suggested that the breakdown in the social fabric of a community, together with a corresponding decline in cultural values, has led to the vulnerability of children with increasing incidents of sexual assault reported within the realm of the community.

"When Africa honors her elders my head is bowed in respect…I am an African for her people greet me like family and teach me the meaning of community". This understanding is likewise embedded in the spirit of Ubuntu – I am because you are/we are - a humanistic philosophical approach that defines the inter-connectedness of people. In an article on Nelson Mandela and the Power of Ubuntu, Oppenheim (2012) demonstrates this as she presented the many forms of Ubuntu. She referenced the existence of the idea of Ubuntu (and variations on the term) in the many cultures across Africa, with the term carrying the same core meaning to all. This is both concerning its goals and the guide it provides as a social contract in (and for) a just society. My grandmother's transfer of knowledge and skills through storytelling, as a form of social learning (Lave and Wenger 1991), was an authentic form of learning about everyday life, norms and ethics, and requisite cultural practices that were acceptable and consistent with family values. Agbenyega (2014), in an article theorizing rural transformation through a Bourdieusian lens, defined cultural knowledge as a family/affiliation-oriented, an inter-generational and a value-based approach that draws on cultural tools to define sustainable living and the collective acquisition and sharing of knowledge. Similarly, Navarro refers to the acquisition of habitus as a socialization process rather than the outcome of intentional individual effort. The definition he offers is that habitus is "not fixed or permanent and, can be changed under unexpected situations or over a long historical period" (2006:16). Navarro extends habitus to shifts that are influenced by specific contexts and over time.

Patriarchy as a form of social capital

In my community[4], patriarchy prevails as men are heads of households and are generally revered even in their absence. Patriarchy is described as a social system that has hierarchy as one of its main features and is linked to the 'father and ruler of the family' when framed from a Biblical perspective. Plaatjies van Huffell (2011) refers to patriarchy as an empire that continues to defy the Constitutional provisions in a post-apartheid

[4] World Bank (1995) describes a community as a group of people who live, work and interacts together in a form that may result in organized activities, views and opinions.

South Africa. Historically, patriarchy as a form of women subordination was fostered by a legal framework and sustained by the cooperation of women where "class privileges are bestowed upon conforming women, dependent women of upper classes and the artificially created division of women into respectable and non-respectable women (Lerner, 1986:9). In an article that links patriarchy to women abuse in Ancient Israel and Africa, Ademiluka (2018) presents patriarchy as a systematic organization of learned dominance of males over females that is perpetuated by attitudes, values and the culture of established institutions. According to Coetzee (2001), in South Africa, patriarchy is idolized to the extent it has been promoted to a hyper-normative state and has assumed a 'God' like state. This is something we can attest to in this day as the former President of South Africa, Mr J.Z. Zuma, often declared in public spaces that the African National Congress was the party to lead South Africa until the second coming of Jesus. Campaigning in Hammanskraal, Pretoria North he was quoted making this declaration *"I hear people complaining when we say the ANC will rule fully until Jesus comes back but we have been blessed. Pastors have prayed for us"*.– (NEWS24, 5th July 2016). These pronouncements were often followed by a rousing applause.

> Although my father was not your typical traditional African man – he cooked, made beds, and was very involved as a parent – we could not escape the fact that my mother had not given birth to a son. But my mother defied the label that was placed on her by prevailing societal norms as she set out to prove to the community that existing gender binary was not a disability. We dabbled in the traditional roles of both sexes. At an early age, we had a heightened awareness of forms of gender discrimination.

In the community where I grew up, the habitus of a young girl reflects a set destiny to become somebody's wife. In that regard, my mother's efforts diverted from cultural expectations. She defied the expectations that my sisters and I would take on a subservient role. Bourdieu asserts that in a traditional community setting where patriarchy prevails, gender discrimination is inherent and that "sexual properties are as inseparable from class properties as the yellowness of lemon is from its acidity" (1984:107). By dabbling in activities that were men's traditional roles, community members assumed that you would "wear the pants" in a relationship; some of the men were threatened by your strength. This

often led to labelling where you were referred to as '*unongayindoda*', - an assertive woman who resists the idea that men should be the custodians of authoritarian/patriarchal order. She is not submissive and, is considered a threat to both men and women. She is known by the derogatory label '*unongayindoda*' as a means to disempower her.

In her research conducted in Soweto, Pakade (2013) suggests that this term is akin to lesbian and, is specifically attached to women in same-sex relationships, in a context in which heteronormative identities (and relationships) were the only accepted behaviour at a community level. Her findings reflect the challenges faced by women who love other women. But, as Pakade (2013) recounted, their own sometimes ill-defined identities tended to be self-discriminatory and harmful, and women's pursuit of belonging forced them into a precarious position as they sought to frame their sexuality within a binary masculine/feminine construct. Schuhmann (2010) reflecting on body politics, refers to the self-limiting ideology that seeks to classify gender as a 'two-sex' model and a heteronormative ideal that does not consider gender fluidity. Gqola also reflects on this topic of name-calling in her book, *Rape: A South African Nightmare,* where she refers to her own earlier experiences of name-calling as she was "sexually harassed and slut-shamed" (2015:23). Consequently, Gqola's definition of rape is associated with "an extreme act of aggression and power, always gendered and enacted against the feminine". Further to this, her view is that "the feminine may not always be embodied in a woman's body; it may be enacted against a child of any gender, a man who is considered inappropriately masculine, and any gender non-conforming people (2015:21)". These experiences present a daily challenge to those who are perceived as different as determined by constructs of societal norms.

Patriarchy and the harm it is likely to invoke on society is best described by Gqola who makes references to the history of South Africa and its ability to infantilize grown men whose masculinity could only be affirmed in their household (2015:154). Referencing scholarly work presented by Suttner (2015:155) who presented African masculinity as both freedom and patriarchal power, this may explain some of the contractions that exist in a modern state – where women are in charge but, not in control. The role of women is to maintain the household and prepare girl children for their roles as future wives whilst the boy children are prepared for their role as heads of households. This form of

rearing assumes that it is men in a household and the community, who have the sole responsibility to discipline and prepare boy children for their future role. Bourdieu (1984:94) identified three principles along which the labor market is gender-segmented through patriarchy. He suggested as the first principle that the functions appropriate to women are an extension of their domestic functions—education, care, and service. Bourdieu's second principle is that a woman cannot have authority over men, and, for that reason, men will always be favored for a position of authority. This implies that women should be confined to subordinate and ancillary functions. Bourdieu's third principle affords men the monopoly of the handling of technical objects and machines. In modern-day culture, these principles still apply to spaces where there is power such as politics, education or large businesses. Consequently, Bourdieu's principles continue to extend patriarchal privilege and accumulation of social capital.

The acquisition of cultural capital

In the rural area where I come from in Idutywa, the school was an integral part of the community; and because the school provided a space to support community development, it was also a place for behavior modification and thus a focal point for community activities. As migrant labor, which provided meaningful employment for men, was the most common form of employment, and households were typically headed by women in men's absence, both the school and the older men in the community at large had to assume guardianship of young boys, and so met out discipline during school hours. The school principal was responsible for securing places for all learners who desired to pursue secondary school education. A reciprocal relationship implied that the community had oversight of all school activities. The school governing body was responsible for delegating a range of activities to defined groups, including supporting the feeding scheme, the different sporting codes, and ensuring that newly appointed school teachers were inducted into existing community structures and provided with secure accommodation.

> Even though our home was a nurturing environment, my parents were rather strict. Everything was about school, chores, church and choral

> music. My father was an avid reader so we grew up surrounded by encyclopedias - he subscribed to the Reader's Digest, listened to Springbok Radio and always had a copy of the daily local newspaper. Our everyday activities were meticulously planned to fit in with the school calendar.

Whilst Bourdieu cited in Eggleston was reluctant to give credit to schools for all that was positive, he acknowledged the influence of the school on the aspirations of an individual, and in our case, the aspirations of the community:

> *Although* success at school directly linked to the cultural capital transmitted by the family milieu, plays a part in the choice of options taken up, it seems that the major determinant of study is the family attitude to the school which is itself, as we have seen a function of the objective hopes of success at school which define each logical *category* (1974:35).

Dumais (2002) on the other hand, refers to the acquisition of cultural capital, i.e. "linguistic and cultural competence," as a gendered activity that has an impact on educational outcomes. In her study, conducted amongst Grade 8 learners in public schools in the United States, she alluded to the fact that girls gained a cumulative advantage for their cultural participation compared to boys. This implied a privilege for girls in the future as they accrued better grades. Nash (1999) similarly, argued that cultural capital has incremental qualities that facilitate the acquisition of cognitive habitus. Further to this, he asserted that it is possible to exploit these qualities later in life to generate concrete forms of capital. This assertion of the correlation between accumulated social capital and propensity to acquire economic capital is relevant to the extent to which patriarchy exists in any community (Bourdieu, 1984:105).

An educated habitus

Growing up in an environment which was loving yet strict, we had to be creative and resourceful. We exploited moments where we could create playtime. It was the minutes that ticked into hours, the minute my mother walked out of the gate to attend a community gathering, church or some other meeting that was an adult's only event. We had a range of

games to choose from depending on who was available to play with us – the neighbors' kids and their friends.

> Each game was a skilled activity with a measurable outcome. Our play tools were home-made. Unopuca is a game best played against an opponent to show off your mathematical/hand-eye coordination skills. Unochele is a game of two or more people and, is concerned about the art of maintaining balance and accuracy of your measurements. Uqumbu is about teamwork and leadership. Undize provided the opportunity for one to demonstrate the strength of their vocal abilities by projecting their voice and identifying a tune that, while unique, navigated familiar and sometimes foreign spaces. Poor vocal abilities meant that you were relegated to perform other duties. In our district, our school was well respected for its achievements in choral music competitions. An invitation to join the school choir entitled you to certain privileges in the school and in the community.

In a five-year longitudinal study in the UK, Archer and colleagues (2012) tracked the experiences of the middle class and working-class children aged 10-14 years and their family's capacity to contribute to an aspirational career in science. Their findings suggest that the extent to which middle income families facilitated learning about science as a family habitus increased the likelihood for their children to be successful in their career aspirations in science. Archer and colleagues further concluded that children of working-class families who aspired to pursue studies in science did so as an individual project. As their parents lacked science capital, they could not extend support to their children thus creating a distance between the learner and parent/s "…science was less "familiar," being more "peripheral" to parents' and children's everyday lives." (2012:903).

> I was fortunate that my older sister set a precedent for my higher education. By the time it was my turn to go to high school, post-primary education had been demystified. I was not threatened by the fact that my teachers were both Black and White. My sister had narrated many of her encounters with her English teachers. Besides, my father had prepared us for that environment. He would periodically challenge us to listen to the weather forecast in English. I recall running to my father to tell him that it was going to be 'heartly cloudy'. He did not correct me but would ask me time and again to tell him about that

> day's weather forecast. It would be some weeks later that I realized that I had misheard the weatherman - and that is was 'partly cloudy'.

Bourdieu and Passeron argue that an educated habitus is likely to inform progress in school and influence the acquisition of 'real' knowledge: "among the pupils of grandes écoles, a very pronounced correlation may be observed between academic success and the family's cultural capital measured by the academic level of the forebears over two generations on both sides of the family" (1977:497). This should not be confused with habitus as the internalization of cultural inheritance. Rather, what he describes is the correlation between the success of a student and the extent to which parents were able to provide intellectual, emotional and material resources to support the learning process.

Our interactions were greatly influenced by the disposable resources to which we had access. These, in turn, influenced our mannerisms and the choices we made regarding our careers, fashion, music genres and so on, although we never acted beyond the scope of what was acceptable in our context. Bourdieu (1990b:77) declares that habitus predisposes individuals to develop their agency, but he also acknowledges the role of others and the expectation to behave in a certain manner acceptable to the group. He submitted that in such social settings, behaving unacceptably would most likely lead to social exclusion.

> My parents often digressed to converse in English when they had disagreements in our presence. I longed to understand and converse fluently in English if only to make sense of those encyclopedias that donned the bookshelf in our living room. Our education would evolve beyond our parents' expectations, as my older sister taught us to steam the envelopes that contained our school results for a sneak preview of our June/December reports. We would reseal the envelope using a hastily assembled sugary paste. Not long after, we graduated to reading fictional and non-fictional novels, and to my mother's displeasure, started buying the True Romance magazines.

We never read any of my parents' letters. There was an understanding amongst us girls that the school reports were an outcome of our efforts. Of course, the truth was that we were curious to see our results and could not handle the suspense and a potential four-hour waiting period from the time we collected the mail. When my parents finally opened the

envelope, I would feign a surprise at the mark I got and would have come up with an acceptable excuse where the marks below the acceptable bar set by our parents. Even at that level, we could satisfy our curiosity only as children can but, also maintain a semblance of sanity by showing respect to our parents. Waquant describes this form of navigation as a form of habitus that is "mediating notion that helps us revoke the commonsense duality between the individual and the social by capturing 'the internalization of externality and the externalization of internality', that is, the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel, and act indeterminate ways, which then guide them in their creative responses to the constraints and solicitations of their extant milieu" (2004: 316).

Rural transformation: the acquisition of economic capital

Primary school was the first place that provided me with objective and structured learning. Secondary school built on this. My habitus in these spaces facilitated a process whereby I was able to accumulate cultural and social capital. For the first seventeen years of my life, I was shielded from the world view that perceived my upbringing as violent, deprived, depressed and deficient. Whilst Bourdieu and Wacquant have agonized much about the language and symbolic violence assigned to rural communities in their book *Interest, Habitus and Rationality* (1992), they offered a show and tell as a means to deal with the negative perceptions about rurality. On the other hand, authors Reid and colleagues (2010) in their article on regenerating rural social space, recommended a 'coming to know' or a visit as an alternative approach to experience the various forms of social and symbolic capital that exist in rural communities. In that regard, my rural upbringing is supported by Reid et al. as it provided me with rich contextual knowledge through an oral history that was validated and, a set of skills that propelled me into leadership positions from the time I started high school.

My college experience in Cape Town was an intimate affair. It was a space where my schooling was refined as I was preparing for professional practice and the acquisition of economic capital. In our final year, there were only nine students in our class. Before I chose cytology, I was destined for a career in haematology. The persistence of Mr van Wyk in

getting us to appreciate the female genital tract would change my destiny. As a sessional lecturer, he would walk into the venue and move straight to the board to draw the female genital tract and start the lecture from that point onwards – the smallest living thing - the cell – captured my interest. Later, at the University of the Cape Town in the Cytology Laboratory, Dr Durcan would magnify my world as she drummed into us the value in visualizing the patient behind every slide or specimen. I would later understand these to be lessons in empathy.

In his article on rural transformation through a Bourdieusian lens, Agbenyega (2014) places in the hands of the teachers - the responsibility to transform habitus to achieve rural transformation. He is of the view that the capital of the teacher is relevant to the extent to which it is likely to add incremental value to the student. The series of structured interactions with my sessional lecturer captured my interest, defining for me a pathway through which I was able to make a meaningful contribution to communities beyond the confines of my bench. This intimate knowledge and familiarity with a woman's body provided a platform to address my earlier discomfort about gender norms. It allowed me to use my voice to support those who were bothered in a community if, they were perceived as different.

Agbenyega (2014) asserts that an educator who is keen to contribute to rural transformation must accentuate the various forms of capital that people possess and assign them roles that will facilitate maximum participation. Further to this, he declares that the hierarchy of the educator is affirmed by the ability to change the attitude of students so they become teachable learners. Above all, the educator's approach to education sets the path for rural transformation. Agbeyenga's findings are supported by other researchers. In a research conducted among Welsh rural students, for example, Baker and Brown (2008) reported that one rural student attaining any form of higher education was often an inspiration for others to do the same. Through it all, there was a common understanding that education was a lifeline to a better life. In that regard, an educated habitus would lead to the acquisition of economic capital.

Conclusion

Through this narrative, I presented my experiences of early childhood as they are rooted in culture, in family, and community values and practices. The rural setting is for me a place where there is a validation of self through others and about others. I perceive the rural setting as being much more than a social space: it is also an academic setting. My inquisitiveness to acquire new forms of knowledge was rooted in my upbringing and the aspirational habitus that was instilled in me by my teachers. My habitus described by Bourdieu as '…the product of social conditionings, and thus of history…is endlessly transformed, either in a direction that reinforces it, when embodied structures of expectation encounter structures of objective chances in harmony with these expectations, or in a direction that transforms it and, for instance, raises or lowers the level of expectations and aspirations' (1990: 116) - was attained through the sustained efforts of others.

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Conflict of interest

None

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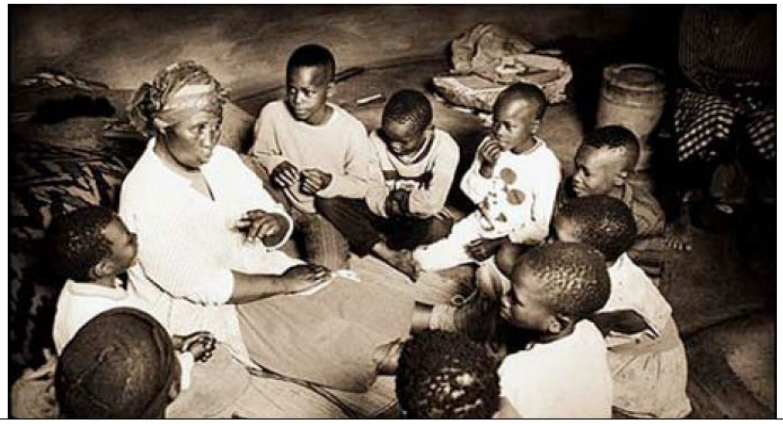
APPENDIX C: FLYER: OPPORTUNITY TO TELL YOUR STORY

Appendix C

Opportunity to tell your story as a Final Year Health Sciences Student from Rural South Africa



Title: Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa
PhD Student: Nontsikelelo (Ntsiki) Mapukata
Supervisors: Prof Lenore Manderson (Wits) and Prof Steve Reid (UCT)
Ethical clearance obtained from Wits HREC Committee **M180308**/ UCT HREC **613/2019**
Participants must be students of rural origin and must registered for their final year of study in 2020 in one of the following programmes: Audiology; Medicine; Occupational Therapy; Physiotherapy, Speech and Language Pathology.
Study Design: Single in-depth interview 60-90 minutes to be conducted.
Date and time of the interview will be confirmed in consultation with the participant.
Consent forms will only be signed once a student has agreed to participate.
Confidentiality will be maintained throughout.

Meal vouchers will be provided to all participants

Direct queries to: Researcher - Ntsiki.Mapukata@uct.ac.za Tel: 021 4066442
Supervisor Steve.Reid@uct.ac.za Tel: 021 4066781
UCT Research Office: Shuretta.Thomas@uct.ac.za Tel: 021 4066626

Adapted from storytelling for kids http://simonlewisphotography.co.uk

APPENDIX D: INVITATION TO PARTICIPATE IN A RESEARCH STUDY

Dear Participant,

Thank you for taking the time to read this information sheet.

My name is Nontsikelelo Mapukata, a Doctor of Philosophy student in the School of Public Health at the University of the Witwatersrand. To fulfil the requirements for my degree, I am required to undertake research as part of my thesis. The title of my study is:

Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa

The proposed study seeks to understand your lived experiences as a health science student of rural origin in response to this question - *How does habitus influence professionalization of health sciences students of rural origin*? In meeting the requirements of this degree, I will be conducting face to face in-depth interviews and request that you keep a journal for one block. I invite you to participate in this research.

Aim of this study

The proposed study seeks to understand your lived experiences as a final year health sciences student of rural origin and to determine the influences of the learning environment as you adapt to become a health care professional.

Process to be followed:

Final year health sciences students registered for degrees in audiology, medicine, occupational therapy, physiotherapy, and speech language pathology will be invited to participate in the study. The study seeks to address the research question in a face-to-face interview that is expected to last between 60-90 minutes. In addition to that, you will be asked to keep a reflective journal for the duration of one clinical rotation. All the interviews will be conducted in English and your notes must also be written in English.

When and where will the study be conducted?

The study will be conducted in the period August - November 2019. Individual interviews will be conducted when it is most convenient for you to participate, in a venue that will ensure we can speak without interruption and afford us privacy in designated university spaces.

Confidentiality

In order to ensure confidentiality to the participants, I will use a code that is understood by the researcher but does not give away your identity – for example, I will not ask for student number or other personal information. Consent forms and data transcript will be stored in a locked cupboard that is only accessible to the researcher. These will be disposed five years after the study is concluded.

Costs

Participants will incur no personal costs by participating in this research study. All related costs will be covered by the researcher.

Risk

By consenting to participate in this study, you will not be subjected to physical harm during the study period. The study is about your experience as a student, and there is no risk to you in answering these. However, if talking about your experiences is distressing, I will arrange a debriefing session with one of the Student Support counsellors at no cost to the participant.

Possible benefits

There are no direct benefits to participants. It is possible that the findings from this study may inform future practice. All findings from this study will be shared in relevant academic platforms.

Participation in the research

Participation in this study is entirely voluntary and you are free to withdraw at any time during the study process. Any questions related to the study may be directed to the researcher or the supervisor.

Ethical Approval

The protocol for this study has received written approval from the Human Research Ethics Committees both at the University of the Witwatersrand and the University of Cape Town.

Information

Any questions related to the study may be directed to the:

Researcher

Ms. Nontsikelelo Mapukata

School of Public Health and Family Medicine

Level 2 Falmouth Building

Anzio Road, Observatory

021406 6442

Email: ntsiki.mapukata@uct.ac.za

Co-Supervisor

Professor Steve Reid

HOD: Primary Care Directorate

Groote Schuur Hospital

Anzio Road, Observatory

Office: 021 406 6781

Email: steve.reid@uct.ac.za

If you have any concerns about your rights as a research participant you can contact Ms Shuretta Thomas, UCT Research Office, at +27 21 406 6626. Alternatively, you can send an email to hrec-medical.researchoffice@wits.ac.za Ms Mkansi will put you in contact with Prof Angela Woodiwiss (Chair), Health Research Ethics Committee at the University of the Witwatersrand.

APPENDIX E: PARTICIPANT INFORMED CONSENT LETTER

Dear Participant,

I am studying towards a Doctor of Philosophy in Public Health. The title of my study is *Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa*. The proposed study seeks to understand your lived experiences as a health science student of rural origin in response to this question - *How does habitus influence professionalization of health sciences students of rural origin*? In meeting the requirements of this degree, I will be conducting face to face in-depth interviews and will also request that you keep a reflective journal for the duration of one clinical rotation. I invite you to participate in the research study.

It is my intention as a researcher to use this information to develop a framework that will help respond to human resources challenges facing health care facilities in the rural areas of South Africa. The study will not interfere with your academic calendar or working schedule. The interview will be conducted when it is most convenient to you. All information gathered from this research will be kept strictly confidential. Personal information will be omitted from the thesis and from publications that may arise from this study.

If you agree to participate, this research will not benefit you directly but may benefit future students of rural origin as there will be a better understanding of what constitutes their lived experiences in and out of the classroom. Once the analysis is completed, you will have access to the results and you will also be informed of any future publication(s) that will be an outcome of this research.

By signing the consent form:

I am willing to be a participant in the study.

I understand the aim of the study.

I understand that I will remain anonymous.

I understand that I may request for a section of the interview to be deleted.

I hereby confirm that I have read and understood all the details associated with the research.

I have received a copy of the signed consent form.

Name of participant: Signature: Date: / /

Name of researcher: Signature: Date: / /

APPENDIX F: PARTICIPANT INFORMED CONSENT FOR AUDIO RECORDING

Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa

The research study will include an audio recording of the face-to-face interview that will be conducted by the researcher. Your personal details will not be included during the audio-recording process. A pseudonym will be used to identify you. Only the researcher and the supervisor will have access to the recorded conversations. The tapes will be kept in a secure cupboard that is only accessible to the researcher. The tapes will be deleted five years after the study is completed. As a participant, your right to listen to the recorded conversation will be observed.

By signing this form, I agree that:

1. The researcher can audio record my interview as part of her research.
2. I understand that the audio recordings will be shared with the study supervisor and a research intern who will be employed by the researcher during the study period.
3. I understand that the researcher will present her findings in academic meetings, publish the findings in approved scientific journals and that my personal details will not be included in any of the academic processes.
4. I understand that the audio recording of my interview is a process I consent to voluntarily.
5. I have a right to request the researcher to stop recording at any time during the interview or to erase a portion of the recording.

Name of participant: Signature: Date: / /

Name of researcher: Signature: Date: / /

APPENDIX G1: INTERVIEW GUIDE

These questions were used as prompts to guide the interview process.

A. Identity

You identify as a "student of rural origin" – could you tell me about that identity? What does this mean to you**?**

B. How do students of rural origin attain different forms of social assets (capital?)

I would like to learn more about your background, including your family, community, and schooling. Could you tell me a bit about where you grew up, and what kinds of things you did?

C. How do students of rural origin adapt to higher education institutions (HEI)?

I would like to know more about your decision to come to university, your expectations of this, and your experiences in the past [n] years you have been studying at UCT.

D. How do students of rural origin attain contested occupational privilege?

Can you tell me what you think makes a health sciences student? Are there differences from other kinds of students?

E. You are now in your final year

- What are you looking forward to the most?
- What are you looking forward to the least?
- What are your family expectations at the end of the study period?
- What are your professional plans beyond internship/community service?

Thank you. I wonder if I have left anything out. Is there anything else you would like to add about your experience as a student of rural origin at UCT?

APPENDIX G2: GUIDED REFLECTION ON BECOMING A HEALTH PROFESSIONAL

Dear Participant,

This is Phase 2 of the study. Use this pocket journal to document your experiences of becoming a health care professional by following the guide below. You are requested to reflect on clinical encounters with patients, consultants (supervisors) and other health care workers for at least one clinical rotation (4 or 7 weeks depending on the programme). In documenting your experiences include a start date and an end date. This journal will form part of the data set and will be kept in locked cabinet. Do not include personal details of any of the people you are required to reflect on. Use acceptable standards of reporting e.g. Mrs B or Sr. X or Dr D.

What is involved in being a Health Care Professional (HCP)? Use the journal presented to you to reflect on your experiences of becoming a health care professional [Audiologist; Doctor; Occupational Therapist; Physiotherapist; Speech-Language Pathologist].

1. As a health sciences student, what are your earliest memories of working [in; with] and what was most significant about these encounters?
2. In what year of study did you begin to see yourself as a [health care professional]?
3. What are the factors that contributed to you perceiving yourself as a [health care professional]?
4. Did your gender identity influence your experiences of the clinical environment? If so, how?
5. During this clinical rotation, how have clinicians (supervisors) and or other health care professionals; patients; clinical partner (s) contributed to your continuation as a health sciences student and why?
6. Do you have a stated preference for a particular training facility? If so, why?
7. As you approach the end of your training period, what do you consider to be successes/challenges of your training programme? Why?

Is there anything else that is not included in the guide above that you would like to reflect on regarding your clinical training?

Thank you

Nontsikelelo Mapukata

PhD Candidate

Tel: 021 406 6442

Email: ntsiki.mapukata@uct.ac.za

APPENDIX H1: PERMISSION LETTER FROM THE DEAN

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | FACULTY OF HEALTH SCIENCES

03 October 2017

Ms Nontsikelelo Mapukata
Student No: 13131

Dear Ms Mapukata

Research Project: Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa

Thank you for your request to conduct interviews with final year Wits health sciences students of rural origin towards your PhD study. These students include those studying towards professional degrees in dentistry, medicine, nursing, occupational therapy, pharmacology and physiotherapy.

This letter serves to grant you permission to interview students from the identified groups and is subject to you first obtaining ethics clearance and approval of your protocol. It is also conditional upon you abiding by all the University regulations for conducting such research and subject to individual informed consent being obtained.

We wish you every success in obtaining your PhD and look forward to the outcomes of your study.

Yours sincerely

Martin Veller
Dean, Faculty of Health Sciences

Office of the Dean
Phillip V Tobias Health Sciences Building | 29 Princess of Wales Terrace (cnr York Road), Parktown 2193, Johannesburg, South Africa
T +27 11 717 2555 | **E** poovy.govender@wits.ac.za | www.wits.ac.za

APPENDIX H2: CLEARANCE CERTIFÍCATE (MEDICAL) Wits M180308

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Ms Nontsikelelo Mapukata

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M180308

NAME: (Principal Investigator)	Ms Nontsikelelo Mapukata
DEPARTMENT:	School of Public Health Faculty of Health Sciences
PROJECT TITLE:	Making a Rural Workforce: Exploring the Habitus of Health Science Students from Rural South Africa
DATE CONSIDERED:	06/04/2018
DECISION:	Approved Unconditionally
CONDITIONS:	
SUPERVISOR:	Profs L. Manderson and L. Green-Thompson
APPROVED BY:	Doctor CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	13/09/2018

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **March** and will therefore be due in the month of **March** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

14/09/18
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX H3: PERMISSION LETTER FROM THE DEPUTY REGISTRAR (Wits)

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

OFFICE OF THE DEPUTY REGISTRAR

30 May 2018

Nontsikelelo Mapukata
Student number 13131
PhD Candidate
School of Public Health
Faculty of Health Sciences

TO WHOM IT MAY CONCERN

"Making a rural workforce: Exploring the habitus of Health Sciences students from rural South Africa"

This letter serves to confirm that the above project has received permission to be conducted on University premises, and/or involving staff and/or students of the University as research participants. In undertaking this research, you agree to abide by all University regulations for conducting research on campus and to respect participants' rights to withdraw from participation at any time.

If you are conducting research on certain student cohorts, year groups or courses within specific Schools and within the teaching term, permission must be sought from Heads of School or individual academics.

No research can commence before ethical clearance has been obtained. Kindly forward a copy of the clearance certificate to this office.

Nicoleen Potgieter
University Deputy Registrar

Private Bag 3, Wits, 2050, South Africa | T +27 11 717 1204/8 | F +27 86 553 2271 | www.wits.ac.za

APPENDIX I: CLEARANCE CERTIFÍCATE (MEDICAL) UCT (REF 619/2019)

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6626
Email: olivia.langenhoven @uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

24 October 2019

HREC REF: 613/2019

Prof S Reid
Director: Primary Health Care Directorate
E47-66
OMB GSH

Dear Prof Reid

PROJECT TITLE: ***MAKING A RURAL WORKFORCE: EXPLORING THE BHABITUS OF HEALTH SCIENCES STUDENTS FROM RURAL SOUTH AFRICA (DR DEGREE - MS N MAPUKATA)***

Thank you for submitting your response to the concerns raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has formally **approved** the above-mentioned study.

Approval is granted for one year until the 30 October 2020.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC reference no in all your correspondence

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

We acknowledge that the student: Ms N. Mapukata will also be involved in this study.

Yours sincerely

PROFESSOR MARC BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007

HREC/ref: 613/2019

APPENDIX J: PERMISSION LETTER: EXECUTIVE DIRECTOR OF STUDENTS (UCT)

	RESEARCH ACCESS TO STUDENTS	DSA 100

NOTES

1. This form must be **FULLY** completed by all applicants who want to access UCT students for the purpose of research or surveys.
2. Return the fully completed **(a) DSA 100** application form **by email**, in **the same word format**, together with **your: (b) research proposal inclusive of your survey, (c) copy of your ethics approval letter / proof (d) informed consent letter** to: Moonira.Khan@uct.ac.za. Cc: Nadierah.Pienaar@uct.ac.za. You application will be attended to by the Executive Director, Department of Student Affairs (DSA), UCT.
3. The turnaround time for a reply is **approximately 10 working days.**
4. NB: It is the responsibility of the researcher/s to apply for and to obtain **ethics approval and to comply with amendments that may be requested;** as well as **to obtain** approval to access UCT staff and/or UCT students, from the following, at UCT, respectively: (a) **Ethics:** Chairperson, Faculty Research Ethics Committee' (FREC) for ethics approval, (b) **Staff access:** Executive Director: HR for approval to access UCT staff, and (c) **Student access:** Executive Director: Student Affairs for approval to access UCT students.
5. **Note:** UCT Senate Research Protocols requires compliance to the above, **even if prior approval has been obtained from any other institution/agency. UCT's research protocol requirements applies to *all* persons, institutions and agencies from UCT and external to UCT who want to conduct research on human subjects for academic, marketing or service related reasons at UCT.**
6. **Should approval be granted to access UCT students for this research study, such approval is effective for a period of one year from the date of approval (as stated in Section D of this form), and the approval expires automatically on the last day.**
7. **The approving authority reserves the right to revoke an approval based on reasonable grounds and/or new information.**

SECTION A: RESEARCH APPLICANT/S DETAILS

Position	Staff / Student No	Title and Name	Contact Details (Email / Cell / land line)
A.1 Student Number	13131	Ms Nontsikelelo Mapukata	ntsiki.mapukata@uct.ac.za / 0214066442 / 0824148766
A.2 Academic / PASS Staff No.	01467491		
A.3 Visitor/ Researcher ID No.			
A.4 University at which a student or employee	University of the Witwatersrand/ Academic staff member at UCT	Address if *not* UCT: Wits School of Public Health, 3rd Floor, 7 York Road, Parktown, 2193	
A.5 Faculty/ Department/School	Health Sciences/ Public Health Medicine/ School of Family Medicine and Public Health		
A.6 APPLICANTS DETAILS If different from above	Title and Name	Tel.	Email

SECTION B: RESEARCHER/S SUPERVISOR/S DETAILS

Position	Title and Name	Tel.	Email
B.1 Supervisor	Prof Lenore Manderson	011 7172703	Lenore.Manderson@wits.ac.za
B.2 Co-Supervisor/s	Prof Steve Reid	021 4066781	steve.reid@uct.ac.za

SECTION C: APPLICANT'S RESEARCH STUDY FIELD AND APPROVAL STATUS

C.1 Degree – if applicable	Doctor of Philosophy, Public Health
C.2 Research Project Title	Making a Rural Workforce: Exploring the Habitus of Health Sciences Students from Rural South Africa
C.3 Research Proposal	Attached: Yes ■ No ☐
C.4 Target population	UCT Final Year Health Sciences Students
C.5 Lead Researcher details	If different from applicant: Prof Steve Reid, 01411273, 021 4066781, steve.reid@uct.ac.za
C6. Will use research assistant/s	Yes ■ No ☐ If yes- provide a list of names, contact details : Ms Ntombizanele Rini 94 David Atkins Street, Charlesville, 7490 Cell No: 0827062690 ID No: 5212260802083
C.7 Research Methodology and Informed consent	Research methodology: In-depth interviews and Journal Reflection Informed consent: Required, participant consent form advised.
C.8 Ethics clearance status from UCT's Faculty Ethics in Research Committee /Chair (EiRC)	Approved by the UCT EiRC: Yes ■ With amendments: Yes ☐ No ■ (a) Attach copy of your UCT ethics approval. Attached: Yes ■ No ☐ (b) State date / Ref. No / Faculty of your UCT ethics approval: 24/10/2019 Ref. / Faculty: 613/2019

SECTION D: APPLICANT/S APPROVAL STATUS FOR ACCESS TO STUDENTS FOR RESEARCH PURPOSE
(To be completed by the UCT - ED, DSA or Nominee)

	Approved / With Terms / Not	* Conditional approval with terms	Applicant/s Ref. No.:
D.1 APPROVAL STATUS	(i) Approved ■ ~~(ii) With terms~~ ~~(iii) Not approved~~	a) Access to students for this research study must only be undertaken after written ethics approval has been obtained. b) In event any ethics conditions are attached, these must be complied with before access to students.	13131/01467491 / Ms Nontsikelelo Mapukata

	Designation	Name	Signature	Date of Approval
D.2 APPROVED BY:	Executive Director Department of Student Affairs	*Dr Moonira Khan*		*31 October 2019*