Evolution of a community-centred experiential learning module: A mixed-methods approach to promote social accountability and community partnership in undergraduate medical education

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Abstract

Background: Education in social determinants of health (SDH) has become an important part of medical curricula, facilitated increasingly through students’ experiential learning with communities. The Community and Workplace Centred Learning Experience (CWCLE) module of the University of Saskatchewan, Canada, aims to integrate and extend second-year medical students’ attitudes, skills, and knowledge about SDH and community resources. We aimed to 1) Assess module impact on student achievement of learning objectives, 2) Assess module impact on student attitudes toward SDH, 3) Obtain feedback from community partners and students about their community experiences, and 4) Use feedback to collaboratively develop recommendations to enhance the CWCLE module.

Methods: We used a mixed-method approach to combine quantitative data with stories and personal experiences. We developed an online survey for two cohorts of students after completing the module, evaluating students’ perceived abilities to perform the module’s learning objectives and attitudes towards SDH. We invited representatives from community agencies involved in the CWCLE module to participate in focus groups. We also held separate focus groups with students who participated in the online survey to elaborate on their survey comments.
Results: In total, 145 students participated in the online survey (response rate=72.5%). Eleven community agency representatives and seven students participated in five focus groups. Our results demonstrate that medical students benefit from community-based experiential learning of SDH and community resources. We trace evaluations and discussions in the ongoing development of this community-based experiential learning module from its initial, primarily medical-school driven designs, towards a substantial involvement of community-based organizations in its operation and continuing redevelopment.

Conclusions: Our mixed method offered us a better understanding of module impact and opportunities for improvement. This module evaluation and reform generated opportunities for community partners to influence decisions in medical education and led to a collaborative evolution of a community-centred learning experience. Medical schools should actively engage community partners in teaching behavioural and social components of the curriculum and acknowledge their partners’ expertise to promote community engagement and social accountability in medical education.

Keywords: social determinants of health; community-based education; service learning; undergraduate medical education; community engagement

Introduction

Education in social determinants of health (SDH–the conditions, forces, and systems that influence people's health) is recognized as an important component in medical curricula (Karen et al., 2019). This training involves fostering, in medical students, a sense of social accountability to address social inequities, particularly among disadvantaged communities (Yeo, 2017). The WHO (2020) emphasizes the implications of health disparities caused by SDH and medical schools' obligation to direct their activities towards priority community health concerns (Boelen and Heck, 1995). Since it is difficult to teach social aspects of medicine in traditional classroom settings (Meili, Fuller, and Lydiate, 2011), medical education is often complemented by experiential learning in the communities, requiring partnership between Colleges and communities. One important form of this learning is Community-Based Education (CBE; Doobay-Persaud et al., 2019).

CBE that involves learning activities carried out in community settings is becoming an essential component in medical curricula (Magzoub and Schmidt, 2000), and can take different forms at pre-clerkship level: service project, community-based participatory research, and/or neighbourhood visits (Choulagai, 2019; Doobay-Persaud et al., 2019). CBE can include short-term initiatives, whether as singular program (Duffy et al., 2014) or course component (Asgary et al., 2016). Other initiatives seek longitudinal community collaborations, for example, as four-year nonclinical, urban population health program (Girotti et al., 2015), or as longitudinal policy and advocacy service project (Bakshi et al., 2015). One essential CBE component utilizes reflection, as both instructional strategy (Bullock, Jackson, and Lee, 2014; Meurer et al., 2011) and assessment (Bernstein, Ruffalo, and Bower, 2016). CBE program-level assessments commonly take the form of student surveys, including self-assessment of knowledge, skills and attitudes, affective assessment of program elements (Doobay-Persaud et al., 2019).

Introduced in the 1990s (Seifer, 1998), service learning has become CBE's most common form (Doobay-Persaud et al., 2019), providing "a structured learning experience that combines community service with explicit learning objectives, preparation, and reflection" (p. 273). It has been effective in teaching social accountability and in encouraging work in underserved areas (Meili, Fuller, and Lydiate, 2011). As community agency representatives actively participate in CBE’s service-oriented programs and contribute to teaching medical students, medical schools
and community agencies should all benefit (Choulagai, 2019). However, community educators’ contributions to advising and facilitation are not well acknowledged nor compensated (Doobay-Persaud et al., 2019). Little research examines medical students’ and community partners’ experiences with, and opinions about, CBE. For example, Haq et al. (2013) asked community leaders to comment on students’ performances, and on the formers’ capacity to accommodate student involvement; DeHaven (2011) surveyed community partners’ attitudes towards the students and programs they were involved with; and other researchers identified needs, to evaluate community-defined outcomes (O’Brien et al., 2014), to recognize and acknowledge community agencies’ supports, and to engage the latters’ expertise in CBE development, implementation, and evaluation (Choulagai, 2019). The goal of CBE is for students to learn medicine not only in the community but also from the community (Choulagai, 2019).

At the University of Saskatchewan's College of Medicine, its undergraduate medical curriculum has four "Medicine and Society" courses with multiple experiential learning modules. One of these modules, the CWCLE (Community and Workplace Centred Learning Experience) provides 14 hours of experiential learning for second-year medical students to integrate and extend attitudes, skills, and knowledge about SDH, and learn about community resources. Our Medical College offers this module to medical students in Regina and Saskatoon (the province’s two largest cities) in collaboration with local community agencies (i.e., non-profit community-based organizations or community-based programs). Feedback received from students and community agencies involved in this module suggested needs for improvement. Therefore, we aimed to: 1) Assess module impact on student achievement of learning objectives, 2) Assess module impact on student attitudes toward SDH, 3) Obtain feedback from community partners and students about their community experiences, and 4) Use feedback to collaboratively develop recommendations to enhance the CWCLE module.

**Methods**

At the beginning of our study, the CWCLE module had six learning objectives (Table 1) and eight activities that span the program’s two terms in second year (Figure 1).

**Figure 1.** Original Module Design promoted by Medical College.
**Mixed methods approach**

To evaluate the CWCLE experiential learning module, we devised a mixed-methods data-analytic approach, for utilitarian reasons: to combine statistical measures (quantitative data) with stories and personal experiences (qualitative data). We selected this mixed approach, convinced that "this collective strength provides a better understanding of the research problem than either form of data alone" (Creswell, 2014, p. 2). The University of Saskatchewan Research Ethics Board provided an exemption from ethics review based on article 2.5 of the Tri-Council Policy Statement.

**Quantitative component**
We developed an online survey for two cohorts of students who had completed the module at the end of the 2016-17 and 2017-18 academic years. All students in these two cohorts were invited to participate anonymously through One45 (software used by the College to manage the medical program).

The survey included a self-assessment, evaluating students’ perceived abilities to perform each of the module’s learning objectives, both after the module and retrospectively to before the module, on a Likert scale from ‘Not at all’ (1) to ‘Very much’ (5). Items to measure attitudes towards SDH were derived from a questionnaire previously developed (Fuller et al., 2016; Lemstra, Neudorf, and Beaudin, 2007) with permission from the senior co-author of the questionnaire, Cory Neudorf. An item asked participants "Would you say that people with low income or low education are much less likely, less likely, equally likely, more likely, or much more likely to suffer from poor health than people with a high income?", on a scale from 1 (much less likely) to 5 (much more likely). Another five items explored participants’ beliefs whether unhealthy eating, lack of physical activity, illegal drug use, alcohol abuse, and smoking are individual choices or associated with low income and educational level; these items were rated on a scale from 1 (individual choice) to 5 (associated with income and education). Students' satisfaction with the module components was also measured on a scale from 1 (very dissatisfied) to 5 (very satisfied); see Supplementary File 1 for a questionnaire sample.

Means, standard deviations (SD), medians, and interquartile ranges (IQR) were reported. Wilcoxon Matched-Pairs Signed Rank tests were used to compare differences in students' perceived abilities to perform learning objectives and attitudes towards SDH before and after module completion. Friedman's ANOVA test was used to determine rank differences in students' satisfaction across module components, with posthoc analysis using Wilcoxon Matched-Pairs Signed Rank Tests. Analyses were completed using SPSS® software (version 24) and the level of significance was 5%.

Qualitative component

We invited representatives from community agencies that were involved in the CWCLE module to participate in focus groups, with the purpose of evaluating and revising the module to review and improve medical students’ learning with community agencies. Eleven agency representatives (out of 26) accepted our invitation. The representatives were divided into three focus groups, guided by two interviewers. Due to scheduling conflicts, one representative was interviewed individually. We also held two separate focus groups with students who had participated in the online survey to elaborate on their survey comments (seven out of 145).

Interview guides were used, including questions for general feedback; module activities; time management; students' achievement of learning objectives; and communication among students, community agencies, and the College of Medicine. Much of the discussions in the focus groups centred on the Plunge and placements. Interviews lasted between 30 minutes (individual interview) and one hour (focus groups).

Following transcription, the interviews were systematically coded and analyzed for themes, following a common six-step process outlined by Braun and Clarke (2006). We aimed for a representative selection, in terms of breadth and depth of materials discussed in the groups and single interview. All interviewed participants were assigned fictitious names and they provided written consent for any quotes attributed to them to be released only under their assigned fictitious names.

Collaborative Working Group to enhance the module

A Working Group was formed to evaluate the analyses and formulate recommendations for improving the CWCLE
module. This ad hoc Working Group included a medical student representative, four community agency representatives, and four university researchers who had led the data analyses. Following a discussion of the analyses, the Working Group collaboratively highlighted module strengths, identified opportunities for improvement, and agreed on a list of recommendations for restructuring the module. During the 2018-19 and 2019-20 years, a multistage process was developed to consider and implement the formulated recommendations.

Results/Analysis

Students’ assessment of learning outcomes and module components

In total, 145 medical students participated in the online survey (response rate=72.5%). The students reported an enhanced ability to perform the module learning objectives after completing the CWCLE module, p-values <0.001 (Table 1).

Table 1. Self-evaluated ability to perform learning objectives before and after completing CWCLE.

<table>
<thead>
<tr>
<th>Module learning objective</th>
<th>Before</th>
<th>After</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain how selected community agency or workplace addresses the SDH of its clients, employees and/or volunteers</td>
<td>Mean (SD) 3.14 (1.07)</td>
<td>Median (IQR) 3 (2)</td>
<td>4.17 (0.76)</td>
</tr>
<tr>
<td>2. Identify how socio-political context affects the work of community agencies in addressing SDH</td>
<td>Mean (SD) 3.24 (1.05)</td>
<td>Median (IQR) 3 (1.75)</td>
<td>4.09 (0.75)</td>
</tr>
<tr>
<td>3. Explain the role of work, working conditions, and occupational health and safety policies on health and well-being of employees/volunteers at the agency or workplace selected</td>
<td>Mean (SD) 3.11 (1.05)</td>
<td>Median (IQR) 3 (2)</td>
<td>3.99 (0.76)</td>
</tr>
<tr>
<td>4. Explain the roles physicians can play in working with community agencies and workplaces to enhance health and well-being</td>
<td>Mean (SD) 3.25 (1.01)</td>
<td>Median (IQR) 3 (1)</td>
<td>4.07 (0.72)</td>
</tr>
<tr>
<td>5. Promote relationships with community agencies or workplaces selected to collaborate with and advocate for initiatives addressing SDH</td>
<td>Mean (SD) 3.15 (1.09)</td>
<td>Median (IQR) 3 (2)</td>
<td>4.01 (0.73)</td>
</tr>
<tr>
<td>6. Recognize examples and non-examples of patient- and family-centred care</td>
<td>Mean (SD) 3.56 (1.02)</td>
<td>Median (IQR) 4 (1)</td>
<td>4.18 (0.72)</td>
</tr>
</tbody>
</table>

When comparing students’ attitudes towards SDH before and after the module, students tended to consider somewhat more (following the module) that people with low income and education are more likely to suffer from poor health (Z=-4.78, p<0.001). The mean increased from 4.14 (SD=0.79) to 4.43 (SD=0.76) and the median from 4 (IQR=1) to 5 (IQR=1). Also, after the module, students tended to associate low education and income more with specific risk behaviours than with individual choices, observing changes in the scores of unhealthy eating (p<0.001), lack of physical activity (p<0.001), illegal drug use (p=0.015), and alcohol abuse (p=0.003).

The mean of students’ satisfaction with the CWCLE module as a whole was 3.09 (SD=0.96), with a median of 3 (IQR=1). Significant differences across module components were identified, χ²(3)=55.18, p<0.001, Table 2. Higher medians of satisfaction were identified for the placement in comparison to other module components (p-values<0.001). Students’ satisfaction with client/patient informal conversations was also higher than the other
module components (p-values<0.005). By contrast, satisfaction with online discussions and in-class mixer were rated lower than any other module components (p<0.01).

Table 2. Students’ satisfaction with the module components (n=145).

<table>
<thead>
<tr>
<th>Component</th>
<th>Mean (SD)</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community placements</td>
<td>3.78 (1.09)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Informal conversation with a client/patient</td>
<td>3.32 (1.14)</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Patient Narrative sessions</td>
<td>3.08 (1.09)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Community Plunge</td>
<td>2.90 (1.39)</td>
<td>3 (2.5)</td>
</tr>
<tr>
<td>In-class introduction</td>
<td>2.78 (1.02)</td>
<td>3 (1.5)</td>
</tr>
<tr>
<td>Module reflective assignment</td>
<td>2.54 (1.08)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>In-class mixer</td>
<td>2.47 (1.09)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Online discussions</td>
<td>2.36 (1.13)</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

In-depth understanding of learning and working experiences with the CWCLE module

In this section, we address the main themes identified in students’ and agency members’ discussions. These themes included: the values of experiential learning; the pros and cons of the Plunge; experiences with placements; and relative presence or lack of reciprocity in the partnership between agencies and the College of Medicine.

The value of the module – experiential learning

In the focus group discussions, we identified "experiential learning" as one of the central themes. According to community agency representatives, the goal is for students to "interact with our newcomer clients or interview them and learn about their [SDH]" (Vicky) so that "they really, empathetically, understand what's going on for people" (Dolores). The value of experiential learning was also acknowledged by students, as stated by Amanda: "...how can we serve people if we don't understand where they're coming from...having this first-hand exposure is extremely valuable for us in the curriculum". This theme of experiential learning signifies, as agreed to by all focus group participants, that community-learning provides opportunities for students to observe first-hand, rather than read in textbooks about, the conditions of the underserved communities and the conditions that their future patients live in. Thereby, students learn social accountability and, in partnership with communities, come to understand how different organizations provide services to those who are affected by SDH.

Community Plunge – can it be improved?

There was considerable feedback from both medical students and community agencies about the neighbourhood walk of the Plunge, revealing strong divisions between and within the groups. Some believed it to be a promising component of experiential learning, while others considered it inappropriate or disrespectful. For example, some students preferred exploring the community service locations by a walk, rather than listening to an in-class presentation. This value of the walk was well explained by Amanda:

... another positive with the walking...and actually going to the place instead of having a PowerPoint is I realize some of the barriers that were there for someone who may have a disability, for someone who might have kids, for someone who doesn't even practice getting dressed in the morning, for someone who has severe mental illness to even get to these places to get the support is a challenge.
Others acknowledged an initial fear or anxiety before the Plunge but saw value in the event after completing it. Plunge participants also appreciated their community-savvy tour guides' knowledgeable in matters of community and available resources. In addition, students mentioned the potential benefit in having the Plunge at the module opening to familiarize themselves with community agencies and programs before selecting a placement. Several community members, too, appreciated the neighbourhood walk, perhaps best captured by Jennifer (“awesome idea”; “students were blown away by the number of diverse services”). However, other students and community agency members had very strong, negative feelings towards the Plunge, finding it “uncomfortable”, “disrespectful”, “embarrassing”, akin to “tourists visiting a zoo”, or “window shopping poverty”. According to one student: “I felt like we are kind of putting people in fish bowls and we’re kind of just staring at it from this outside perspective” (John). Several community members cautioned that there was not enough time to connect with community members to hear lived experiences and that the Plunge would provide little more than a glimpse into the actual difficulties of life in the community.

**Placements – immersed in the community or not enough?**

The module component that students regarded the most beneficial was the placement. For example, one student considered that “the experiences with the agency that I had were great and I definitely took away way more than I was expecting to” (Michael). Others suggested to further “decrease the amount of in-class time we spend talking about these things and increase the amount of time we’re actually present” (John) so that they could “be doing more participation and be a bit more actively involved” (Michael). Also, students appreciated the variety of placement options to choose from, while those who were unable to select their first choices came to recognize the value of attending an unfamiliar agency. Several community agency members considered the placements a very positive experience (e.g., “I love having students come in”, Darlene). However, some felt that the placement was “too short, needs more time; . . . is that truly helping them to just learn so little about so many things?” (Vicky), leaving students with too little opportunity to understand local backgrounds of poverty and its effects on health. As Dolores explained, “[i]t's difficult, within seven hours . . . (to) understand what's going on for people who have lived experiences of living in poverty”. Moreover, Jennifer noted that "people in our community take a long time to build trust with people". The variation in responses may have to do with agencies where social justice issues are more in the foreground then, say, acute physical health issues. In any case, rather more than less immersion with the communities was wished for by all.

When asked about the module’s reflective components (i.e. reflective essay, online discussions, and in-class mixer), students felt that they seemed forced and redundant, should be shortened and combined, and any time saved used for more experiential learning. Moreover, students requested more flexibility in choosing their own preferences for reflection and sharing lessons learned with medical students in other years.

**Reciprocity – what is in it for community agencies?**

First, most students and agencies agreed that the CWCLE module was a worthy pursuit. Perhaps because students perceive themselves as learners in their community placements, reciprocity did not present itself as an issue to them, unlike for the community agencies who would see their role as contributors to medical education (albeit without remuneration or programming authority). When asked about the interactions between students, agencies, and College of Medicine, two agency members’ answers captured the general sentiment, “I don't have any complaints” (Val), and “No problem at all. Everybody has been so nice and accommodating” (Debra). Some agencies, likely those that had students from multiple universities and institutions participating, were finding themselves "getting to the point of fatigue" (Michelle). However, the theme most often discussed, and controversially, among agency members was "reciprocity", regarding a need for benefits not only for medical students but also for community
agencies. Several members appreciated perceived benefits; in the words of one member, the placements hold "mutual benefits for both sides,… [students] talk one-on-one with [a client’s] family which builds appreciation for how the agency supports families and we [agency] benefit from people [students’] understanding what [the agency] is about” (Stacey). Another noted that agency members and their clients can also "learn from students” (Jason) who could share their medical knowledge usefully. Some focus group participants went further, discussing reciprocity on a systems level, as the College, so far, had been retaining the authority for CWCLE module design while shouldering the agencies with the facilitation of students’ placements. One member pointed out that any expertise with community engagement and impact of SDH in the community does reside with the agencies who, in the interest of reciprocity, should be given module design authority and be compensated for their work. In this way, agencies were hoping for a comprehensive partnership not only with the medical students but also with the College.

**Working Group recommendations and module reforms**

Following discussions of the evaluations, the ad hoc Working Group recommended to the College to keep the module in the medical curriculum, but to improve students’ community learning experiences and community agency engagement. Main recommendations included: 1) Redesign the Plunge in close collaboration with community agencies; 2) Enable students to make more informed choices regarding placements (e.g., provide more materials from the agencies and/or previous medical students who completed the module); 3) Emphasize reciprocity and other community engagement principles in all module components; 4) Promote student self-directed learning and modify module assessment plan; 5) Increase hours spent in communities.

Subsequently, the module was redesigned in close collaboration with community agency representatives (Figure 2). The Plunge was integrated as an introduction to the placements. Rather than a neighbourhood walk, the new format is a four-hour experiential learning activity, featuring structured visits to selected community agencies, as well as so-called Community Learning Café Conversations, a Community Agencies Fair, community members sharing lived experiences, and small group discussions around case scenarios designed by community agencies to address SDH, community needs, and agency services. While versions of the Plunge may vary between the two sites (Regina and Saskatoon), based on local community agency recommendations, the core concept and activities (i.e. module introduction, community agency visits, debriefing session) are equivalent. In both cities, the Plunge begins with Indigenous Elders’ prayers (Elders are individuals with the highest degree of understanding of Indigenous traditions and practices, and the foremost teachers and role models) and the activities are led by community agency representatives. This new version of the Plunge is meant to contextualize the placement experience upfront, enhancing understanding and underscoring the importance of collaboration between students and community members.

**Figure 2.** Redesigned Module developed in partnership with community agency representatives.
The College also now provides students with donation boxes (i.e., boxes filled with items that community agencies need for their clients, such as hygiene products, non-perishable foods, etc.), to give to the agencies during their visits at the Plunge. These donations serve as one form of reciprocity and a way to give back to the community, as was
recommended by community agency representatives when co-designing the Plunge. Moreover, Community agencies are now receiving a compensation for the time they dedicate to the module, especially the Plunge. At the current time, a small amount is offered as a token of appreciation for agencies’ commitment and time.

In the redesigned module, students are more engaged in their community learning experiences. Before the Plunge, they can access online materials (e.g. pamphlets, videos, reports, etc.) about the community agencies and programs developed by agencies and previous student cohorts. Following the Plunge, students select their placements, define their placement-learning objectives, and propose and submit module assignments in ways that they find to be more meaningful. The assignments (e.g. posters, infographics, slide presentations, videos, poems, painting, draft surveys, etc.) can be used by community agencies to potentially benefit their members. Lastly, to increase placement hours, three other components of the original module (Patient Narratives, Mixer, and online discussions) were removed, leading to the Plunge, placements, and assignments to be three integrated elements of the new module (Figure 2).

Since the implementation of the recommendations, community agencies have been generally appreciating their engagement in the redevelopment of the module and the changes put in place, expressing gratitude for "the partnership" and "the opportunity to be involved and the token of gratitude". Similarly, students generally have been appreciative of the module's new format as well, in written feedback (e.g., "CWCLE experience is extremely valuable"); "I really enjoyed the CWCLE component of the course"; "enjoyed the Plunge in September and thought it was really well done"; "the Plunge [was] a fantastic use of our time…a great introduction to some of the community resources"). Further recommendations (e.g., formal collaborative agreements between the College and community agencies) are currently under review for implementation in the coming years.

Discussion

The module evaluation reported here demonstrates some of the many beneficial opportunities that CBE can provide for medical students learning the relevance of SDH, confirming current literature on SDH teaching (Claramita et al., 2019). The two experiential components of the module, Plunge and placement, offer students first-hand experiences of the significance of SDH and health disparities, and an understanding of community agencies’ commitments to address those issues. The module thereby confirms the value of service-learning in the field and the collaborative teaching of SDH. We think of CBE through a Systems Thinking framework; such frameworks assert that "the effects or outputs of any system are dependent on the interactions of its parts and that studying the parts in isolation will not provide an accurate picture of the system" (Waldman, 2007, p. 279). From this view, CBE, and especially service learning, bridges the gap of social-and-clinical medicine and facilitates collaboration between medical school and community organizations (Bullock, Jackson, and Lee, 2014).

This research also reveals the value of engaging and empowering community agencies in the module’s operation and continuing redevelopment. Since the Working Group recommendations were put into practice, community agencies have been designing and leading module activities (e.g., Plunge); the College and medical students have put reciprocity into their actions, and the College actively seeks community agency feedback on their working experiences with medical students and the College. The module leaders will continue to identify and nurture what we have collaboratively identified in this study as common interests and goals. As Bullock, Jackson, and Lee (2014) suggest, needs assessments should be conducted to create the foundation upon which students’ learning and services build, to ensure that the program "upholds the mutuality and maintains integrity of community partnerships" (p. 137).

Our research could provide curriculum guidance on CBE, identified by Claramita et al. (2019) as much needed in
the CBE literature to enhance undergraduate medical education. Our findings demonstrate that collaborative partnerships between community agencies and Medical Colleges are indeed necessary for modules such as CWCLE to work and to continue growing. Efforts in soliciting feedback from community agencies to promote engagement have so far proven to be successful. While challenges remain in moving forward (e.g. limited curriculum time, limited community and University resources, crowded medical curricula, priority given to clinical experiences, etc.), this is also a time for opportunities. Both medical students and community agencies have expressed interest in having more hours in the community, either within this module or by collaboratively developing a more longitudinal module dedicated to community engagement and experiential learning. A continuous growth of this module can contribute to Community-College partnership and act as a channel to further support our College’s vision of social accountability, dedicated to "health equity, anti-racist education, community-based research, advocacy, authentic partnerships and the health needs of underserved and marginalized communities" (College of Medicine, 2020).

There are some limitations to our study. Comparative studies among different medical schools would be beneficial to understand the impact of contextual and structural factors on students’ learning experiences in the communities. We recognize that few students participated in the focus groups; however, the qualitative data supported and expanded on the students’ survey results and its good response rate. Also, a two-survey approach (before and after module completion) would be better but might suffer from responder fatigue and low response rates.

**Conclusion**

In conclusion, it seems very worthwhile to evaluate CBE modules, such as our CWCLE module, together with students and community agencies. Our mixed method offered us a better understanding of module impact and opportunities for improvement. Indeed, it made a difference to collaboratively redesign this CBE module with community agency representatives. We recommend that, in future modifications of modules like this and in any learning opportunities that involve communities, medical schools should actively engage community agencies. Medical colleges should acknowledge these agencies for their expertise in community work and local challenges in SDH, offering them adequate compensation. Opportunities for community partners to influence decisions and recognition of their contributions to the training of medical students are forms of compensations beyond economic payments. Medical students’ engagement with such communities is crucial for their training and future practice. A mutual relationship between community agencies and medical colleges can benefit both medical students and community partners. It can sustain community-based programs that help students to become competent, socially accountable physicians who are better prepared to address the community needs and health disparities in society.

**Take Home Messages**

- According to students and community agency representatives, medical students benefit from and appreciate community-based experiential learning of social determinants of health (SDH) and community resources.

- Medical schools should acknowledge the expertise of community-based organizations as these work with communities addressing SDH that affect their clients.

- A collaborative approach among community-based agencies, medical students, and medical schools benefits the development of community-based education opportunities to improve students' learning experiences, promote community partnership, and deepen social accountability.
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Figures 1 and 2. Source: the authors.

**Bibliography/References**


**Appendices**

None.

**Declarations**

The author has declared that there are no conflicts of interest.

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**Ethics Statement**

The University of Saskatchewan Research Ethics Board provided an exemption from ethics review based on article 2.5 of the Tri-Council Policy Statement.

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