A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUS HEALTH SERVICES

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This thesis is dedicated with love and gratitude to my late parents, Lambert and Madge Alexander, for their sound upbringing and also for teaching me from an early age that it pays to work hard in life. I know you would have been extremely proud of my achievements.
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God, I thank Thee for the abilities, wisdom and direction You have given me. Through prayer You have helped me to grow and improve in skills that I was lacking in order that I could do my work well so that the result of what I did was pleasing to others.

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ABSTRACT

Most students are adolescents and young adults, a group characterized by a new-found sense of independence, experimentation with sex and sometimes drugs and a feeling of invincibility (Gayle, Richard, Keeling, Garcia-Tunon, Kilbourne, Narkunas, Ingram, Rogers and Curran, 1990:1538). These behavioural, developmental and environmental issues may contribute to premature morbidity, mortality and reduced quality of life for university students (Patrick et al., 1992:260). The ages of staff on the other hand range from young adults to retirement age. The types of health problems that exist among staff who use the campus health service include First Aid treatment on site for injuries on duty and more chronic health problems such as, for example, hypertension and diabetes mellitus.

To date there is very little evidence as to whether or not the healthcare needs of students and staff are being met comprehensively or whether the practitioners rendering the service are knowledgeable and complying with the PHC norms and standards developed by the department of Health’s Quality Assurance Directorate. The lack of such empirical data can contribute to misconceptions and hamper the management of public health problems experienced in SA, for example sexually transmitted infections and the transmission of HIV.

Thus the purpose of this research was to develop a model that would assist registered nurses employed at a higher education campus health service in the Western Region of the Eastern Cape Province to render a healthcare service relevant to the healthcare needs of the students and staff on campus.

To achieve the purpose of this study, a theory-generating design based on a qualitative, explorative, descriptive and contextual research approach was implemented by the researcher to gain an understanding of how the students and staff (campus healthcare consumers) experienced the healthcare service being provided on campus and what their perceived healthcare needs were. The researcher was also interested in understanding how the campus
healthcare providers experienced the rendering of the campus health service and what they perceived the healthcare needs of the students and staff to be. The information obtained was used to develop a holistic healthcare model for higher education campus health services. The study design comprised the following four steps:

**Step One** of the research design focussed on the identification, classification and definition of the major concepts of the study. This involved describing and selecting the research population and the sampling process prior to conducting the field work which comprised six focus group interviews with students, nine depth individual interviews with the staff and eleven depth individual interviews with the campus healthcare providers. The information obtained indicated the need for a holistic healthcare service on campus.

**Step Two** of the research design focussed on the development of relationship statements in order to bring clarity and direction to the understanding of the phenomenon of interest.

**Step Three** of the design focussed on the development and description of the holistic healthcare model for higher education campus health services in order to meet the identified healthcare needs of the students and staff and to assist in ensuring balanced whole persons. A visual representation of the structure of the model for holistic healthcare at higher education campus health services was given and described as well as a detailed description of the process of the model which is based on four sequential steps, namely:

- **Initiating consultation**

In this step, the campus healthcare consumer (student or staff member) experiences an imbalance in either his or her internal or external environment and therefore needs to consult the registered nurse to correct the imbalance. The campus healthcare consumer then seeks assistance to promote or restore his or her health.
• Assessment and nursing diagnosis
This step focuses on the registered nurse who pays serious attention to the healthcare needs of the campus healthcare consumer and illustrates real concern for the quality of life of the individual. The registered nurse therefore conducts a thorough assessment of the campus healthcare consumer in order to make an accurate nursing diagnosis so that she can fulfil the following step competently.

• Planning and management
In this step the registered nurse will decide whether or not the problem that the campus healthcare consumer presents with, falls within her scope of practice. If she is unable to manage the problem of the campus healthcare consumer herself she will refer him or her to the appropriate multidisciplinary health team member. Total patient care is achieved through the rendering of an integrated, all encompassing healthcare service.

• Consequent resolution
In this step the campus healthcare consumer’s signs and symptoms gradually disappear or he or she has been empowered with knowledge and skills to take care of him- or herself. The imbalance is corrected and the individual could emerge as a balanced whole person who is able to realise his or her aspirations and maintain consistency with regard to optimum health and capacity.

Step Four was the last step of the research design and its focus was the development of guidelines for the operationalisation of the model for holistic healthcare for higher education campus health services. The evaluation criteria of Chinn and Kramer (1995:125-137) were used to evaluate the model.

It is therefore concluded that the researcher succeeded in achieving the purpose for this study because a model which is understandable, clear, simple, applicable and significant to nursing practice has been developed for use by registered nurses in rendering holistic healthcare services relevant to the healthcare needs of the campus healthcare consumers.
Please note that reference has been made to the registered nurse as ‘she’ throughout this study because all the registered nurses employed at the identified campus health service where this research was conducted were females.
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ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Campus health services, commonly referred to as college health services in the United States of America (USA) and campus occupational health services in the United Kingdom (UK) are internationally renowned for providing accessible and affordable healthcare services to students and staff on campuses at higher education institutions (HEIs).

The first college health service which was established in 1859 at Amherst in the USA, evolved as a result of a sentiment that was expressed in 1856 by President Stearns of Amherst who noted that many students abandoned their studies because of poor health. He felt that this was totally unnecessary if proper measures were taken to prevent this situation (Patrick, Grace and Lovato, 1992:256). The first campus health service in South Africa (SA) was established almost a century later. This is evident in an unpublished research document by Holtzhausen (1996:26) who indicates that the first two campus health services in SA were established in the 1940’s, at the University of the Witwatersrand and Rhodes University.

Moore and Summerskill (1954) in Patrick et al., (1992:256) postulate that, with an expanding economy and growth in size and number of higher education institutions, almost 85% of colleges offered some sort of student health service by the early 1950’s in the USA. In SA, a steady growth of campus health services ensued until the 1980’s. Currently almost every higher education institution in SA now has a campus health service. There were 35 campus health services throughout the country, including the campus health services in the Eastern Cape Province (ECP) located in the four universities.
The higher education system in SA has been undergoing a national rationalisation and transformation process. The implementation of mergers was gazetted on 24 June 2004 to bridge the divide between the apartheid past and a rapidly developing knowledge economy as the context of the future (SAUVCA, 2002:3). The number of institutions of higher education in SA was thus reduced from 35 to 23 nationally because of the merging of some higher education institutions.

The number of campus health service clinics, however, has not been curtailed in order to make adequate provision for healthcare services for both employees and students (Holtzhausen, 1996:26). The Nelson Mandela Metropolitan University (NMMU) in the Western Region of the ECP is one of the merged universities in SA. In January 2005, the merging of the University of Port Elizabeth (UPE), Port Elizabeth Technikon (PET) and Vista University was finalised to form one of the comprehensive universities in SA. For example, prior to the merger of the NMMU, there were 2 campus health services, one at UPE and one PET, with three satellite campus health clinics, but now the merged higher education institution, the NMMU, has one campus health service with one main campus health clinic and four satellite campus health clinics situated on four of its campuses. Thus adequate healthcare provision for both employees and students is still accessible and available.

Higher education institutions may be viewed from a public health perspective as complex combinations of schools and workplaces in which social, environmental, behavioural, political, economic, legal, philosophical and cultural issues conspire to create unique challenges for health promotion, disease prevention and medical care, unlike primary and secondary schools in which the local school district and parents share authority. They are also distinct from traditional workplaces, in which employer-employee relationships, management structures, collective bargaining rules and other hierarchical processes define issues of authority, accountability and responsibility (Patrick et al., 1992:254).

Student health centres (campus health services) range in size and scope of activity from small, nurse-directed facilities to comprehensive health facilities
that resemble multi-specialty group practices (Patrick et al., 1992:257). Some higher educational institutions render campus health services to staff and students, for example at Walter Sisulu there are two registered nurses rendering preventive, promotive, curative and rehabilitative healthcare services, while other campus health services may even render an occupational health service to the staff, for example at NMMU an occupational health nurse is employed to render an occupational health service. The discipline of occupational health which is concerned with the relationship between work and health is defined as being concerned with the promotion and maintenance of the highest degree of health of the employees, the prevention work-related conditions among the employees, the protection of employees from health risks and the correct placement of employees (Hattingh & Acutt, 2006:14). This is important when considering health education, health promotion programmes and injuries on duty because of the diverse health needs of staff and students.

Most students are adolescents and young adults, a group characterised by a new-found sense of independence, experimentation with sex and sometimes drugs and a feeling of invincibility (Gayle, Keeling, Garcia-Tunon, Kilbourne, Narkunas, Ingram, Rogers and Curran, 1990:1538). These behavioural, developmental and environmental issues may contribute to premature morbidity, mortality and reduced quality of life for college students (Patrick et al., 1992:260). The ages of staff on the other hand range from young adults to retirement age. The types of health problems that exist among staff who visit campus health services include first aid treatment on site for injuries on duty and more chronic health problems such as, for example, hypertension and diabetes mellitus.

According to Dr Susan Robson, Director of the University of Manchester’s campus occupational health service (personal interview, 17 July 2003), campus occupational health services in the UK mainly render an occupational healthcare service to staff and students in addition to a reproductive healthcare service. In the UK, minor medical conditions such as influenza and abdominal cramps are referred to the nearest health facility within the National Health System.
According to Patrick et al. (1992:256), college health services at most campuses in America have changed significantly over the years. For example, in the early days of college health services, physical activity and health education were among the most important influences, whereas in more recent years the college health services have become more comprehensive than previously. These changes are also evident in South Africa. The change from a predominantly curative model of healthcare delivery to a primary health care (PHC) philosophy in South Africa in 1994 resulted in a similar change in campus health services (Hotlzhausen, 1996:1).

According to the University of Nevada in Las Vagas (http://www.unlv.edu/studentserv/SHC/cohealth.html), most common physical and psychological conditions can be diagnosed and treated on an ambulatory basis by modern medicine. College health services specialise in “low tech” personalised health care by clinicians and educators who work in a cross-discipline mode with students. Attention is primarily paid to physical, psychological and preventive aspects at each clinical encounter. Nurse practitioners, physician assistants (USA) and certified registered nurses diagnose and treat most of the minor ailments of college students, but complicated illnesses are referred to physicians and other specialists in the community. Internationally the principles for the rendering of campus health services remain the same, even though there may be major differences in the types of health care services being rendered on campuses as well as in the manner in which these services are being administered and financed (University of Nevada, http://www.unlv.edu/studentserv/SHC/cohealth.html).

The American college health system appears to be well organised with a professional organisation called the American College Health Association (ACHA) that serves more than 2 400 individual college healthcare professionals and it acts as the primary advocate for the health of college students by integrating the critical role of college health into the mission of higher education (Fabiano, Undated:2). Since 1964, ACHA has offered recommended standards for college health services that provide direction for developing externally valid and consistent programmes. Revised on a periodic
basis, these standards address clinical, mental health, health promotion, environmental health and support services, as well as ethical and professional issues (American College Health Association, 2003:1).

The Department of Health in America recognises higher education as a key partner in achieving national health objectives. The ACHA appointed a Task Force on Health Promotion in 1996 to focus on health promotion in higher education settings so that standards of effective practice that both advance the personal health of students and the collective health of campuses, communities and the nation could be developed (Fabiano, Undated:2). The Standards, published in May 2001, embody a vision for effective practice of health promotion in higher education and for understanding health in a new way (American College Health Association, 2003:1). The Standards which can be used for strategic planning and professional development have a far-reaching impact, right into the core mission of higher education (American College Health Association, 2004:1).

South Africa also has a national association which is called the South African Association of Campus Health Services (SAACHS) which was established in 1978 to support academic activities at higher education institutions (SAACHS, http://www.saachs.com/history.htm). All campus health services in South Africa are members of this association and an annual general meeting and conference is held to encourage the exchange of ideas among members with regard to campus healthcare and also to initiate, promote, encourage, organise and foster liaison between members in the interest of campus healthcare (SAACHS, http://www.saachs.com/mission.htm. Accessed on the 15/01/08). The functions of SAACHS thus differ from the ACHA because SAACHS do not formulate policies and standards for the campus health services in SA. Therefore no similar standards have been established in higher education healthcare services in SA, resulting in diverse standards being implemented on different campuses. These services have been established through trial and error with no set standardised guidelines. The lack of standardised guidelines indicating the type of campus health service that should be rendered has therefore resulted in a diverse healthcare delivery system in the higher education system. For example, one campus
health service may employ a qualified occupational healthcare nurse to render an occupational healthcare service to employees whilst another may focus only on student health. Another campus health service, on the other hand, may have a 24-hour on-call service for students while similarly another service may even have students admitted to a ward on campus for conditions such as influenza and diarrhoea.

The findings of the study undertaken by Holtzhausen (1996:28) clearly indicate that the campus health services in SA are generally committed to rendering a PHC service to students and staff. This is congruent with the trend of national public PHC service delivery in SA. In SA, an integrated package of essential PHC services has been made available to the entire population in order to provide the solid foundations of a single, unified health system and the promotion of equitable healthcare services (Department of Health, 2000:4). Firstly, the PHC package entails standardised, comprehensive services to be delivered at primary health care level. There are seven core programmes, namely non-personal health services; disease prevention and control; maternal, child and women’s health; Human Immunodeficiency Virus/Auto Immune Deficiency Syndrome (HIV/AIDS) and Tuberculosis (TB); health monitoring and evaluation; mental health and substance abuse; and gender issues. The interventions that can be delivered together are clustered within each of these core programmes (van Rensburg, 2004:422). Secondly, the PHC package stipulates the common quality norms and standards that are required for each PHC service and are shared by those delivering the services (van Rensburg, 2004:422). The core norms set by the Department of Health (Department of Health, 2001a) as listed by van Rensburg (2004:430) are:

- Through a one-stop approach the facility provides comprehensive integrated PHC services for a minimum of eight hours per day, five days per week.
- Access, as determined by the number of healthcare recipients living within five kilometres of the facility is improved.
• The facility receives a supervisory visit at least once per month to assist staff, identify and prioritise needs and shortcomings and monitor the quality of services.
• The staff component includes at least one service provider who has successfully completed a recognised PHC training course.
• Medical officers and other specialists undertake periodic visits and are accessible for support, consultation and referral.
• Facility managers undergo training in facilitation skills and PHC management.
• An annual evaluation of the rendering of PHC services is undertaken to reduce the gap between service provision and actual needs.
• An annual PHC strategy, based on the evaluation, is planned.
• The facility has a method to monitor services and quality assurance.
• The perceptions and views of the community are assessed at least biannually by means of patient interviews or anonymous patient questionnaires.

These core norms are applicable to all public PHC facilities and therefore campus health services should take cognisance of these norms and standards because they fall within the realm of primary health care services. The core standards for PHC service delivery amount to the presence of the following (Department of Health, 2001a in van Rensburg, 2004:430):

• References, prints and educational material
• Equipment
• Medicines and supplies
• Competencies of healthcare providers
• Patient education
• Records
• Community and home-based activities
• Referral of patients
• Collaboration on an intersectoral basis
The Directorate of Quality Assurance within the Department of Health was responsible for defining and producing the norms and standards. The PHC norms and standards were largely derived from existing national policy documents. All these norms and standards should be verifiable by staff providing the service. The standards are practical, essential and comprehensive and describe the range of services that should be available to all South Africans (Department of Health, 2000:4).

In SA there has been a growing trend by the private sector to provide extended health services in support of the Department of Health. Similarly, campus health services have sought to improve accessibility and availability for staff and students of specific health services, for example family planning services, the management and treatment of sexually transmitted infections (STI’s) and tuberculosis (TB). More recently as a result of the escalating Human Immunodeficiency Virus (HIV) epidemic, voluntary HIV counselling and testing services have also been included. Mutual agreements between the Department of Health and higher education campus health services, increase access to health services to the broader communities. The agreements between the two types of institutions vary however: some contracts are in writing while others are merely verbal agreements. In SA great diversity thus exists at higher education institutions with respect to the healthcare needs of their students and employees and also the services that are rendered.

1.2. **PROBLEM STATEMENT**

The researcher, a professional nurse practitioner, was a pioneer in establishing a campus health service at an institution of higher education. During the establishment of these services, the researcher encountered many problems related to the rendering and management of the service due to the lack of formal guidelines, norms and standards that could have served as a guide at the time.
To date there is very little evidence as to whether or not the healthcare needs of students and employees are being met comprehensively or whether the practitioners rendering the service are knowledgeable and complying with the PHC norms and standards developed by the Department of Health’s Quality Assurance Directorate. Very little formal research has been conducted at institutions of higher education in South Africa to establish what the healthcare needs of students and staff are and how they experience these services. The lack of such empirical data can therefore contribute to misconceptions and indeed fuel the public health problems experienced in SA, for example STIs and transmission of HIV. Medical and public health professionals may conclude that relatively few and only minor healthcare needs occur among students and employees in the higher education sector. The provision of equitable, appropriate and cost-efficient healthcare services relies on health care data, the lack of which undoubtedly contributes to poor healthcare service planning and delivery (Patrick et al. 1992:259).

The South African economy depends largely on healthy graduates entering the arena of the world of work. Equally important is the high calibre of intellectual capital within HEIs, which must be nurtured and protected in order for these people to remain productive and innovative. Health plays a pivotal and critical role; for without health and wellness this human capital will undoubtedly suffer. Information is therefore required to establish what the actual needs of both students and employees are and also to determine what is needed at the campus health service in order to ensure optimal service delivery to the consumers of these services.

With reference to the above discussion, the following research questions could thus be posed:

*How do the campus healthcare consumers and the providers who render these services experience the healthcare provided by the campus health service at a HEI?*

*What are the perceived healthcare needs of the students and employees at a HEI in the ECP?*
How can registered nurses, employed in campus health services be assisted to render a campus health service relevant to the needs of the campus healthcare consumers at a HEI?

1.3 PURPOSE OF THE RESEARCH

This study aims to develop a model that would assist registered nurses employed at a higher education campus health services in the Western Region of the Eastern Cape Province to render a healthcare service relevant to the healthcare needs of the campus healthcare consumers.

1.4 RESEARCH OBJECTIVES

The following objectives are proposed in order to achieve the overall purpose of this study:

- To identify the central concepts of the model by conducting a field study. This will be done by exploring and describing how the campus healthcare consumers and providers at a HEI experience the healthcare provided by the campus health services. The perceived healthcare needs of the campus healthcare consumers will also be explored and described.

- To define and classify the identified concepts.

- To describe the relationship statements or propositions between the concepts.

- To describe a model to assist registered nurses at HEI campus health services to render a healthcare service relevant to the needs of the campus healthcare consumers. This description will be based on the results of the focus group interviews with students and the interviews...
with the staff and campus healthcare providers, direct observation and extensive literature control.

- To describe the guidelines that will assist with the implementation of the model.

1.5 **CLARIFICATION OF CONCEPTS**

Van der Merwe in Garbers (1996:290) state that multiplicity of interpretations of concepts in the human sciences necessitates that the main concepts be clarified in research. Thus theoretical definitions and explanations are given for the following concepts:

**PRIMARY HEALTH CARE**

Van Rensburg (2004:28) cites the definition of the World Health Organisation (WHO, 1978) with regard to primary health care as “essential healthcare based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing healthcare process”.

**CAMPUS HEALTH SERVICES**

These are primary health care services that are established and rendered on the campuses of HEIs by mainly registered nurses to students and staff. The registered nurses are employed by the HEIs.
CAMPUS HEALTHCARE PROVIDER

Mosby’s Medical, Nursing and Allied Health Dictionary (2002:784) defines the term “healthcare provider” as any individual, institution or agency that provides health services to healthcare consumers. The term “campus healthcare provider” will thus refer to all the healthcare professionals rendering a service to the campus healthcare consumers on campus.

CAMPUS HEALTHCARE CONSUMER

According to Mosby’s Medical, Nursing and Allied Health Dictionary (2002:784) a healthcare consumer is any actual or potential recipient of healthcare, such as patient in a hospital, a client in a community mental health centre or a member of a prepaid health maintenance centre. In the context of this study the term campus healthcare consumer will refer to all students and staff, who are associated with a particular institution of higher education either by registration as a student or employment and who have experienced what it is like to use the campus health service.

HEALTHCARE NEEDS

According to The Penguin English Dictionary (1985:549), a need is defined as a physiological or psychological requirement for the well-being of an organism. Therefore the term healthcare needs will refer to the physiological, psychological, social or psychological requirements for the well-being of students and staff at HEIs.

STUDENT

A student is a learner who attends a college or university (The Penguin English Dictionary, 1985) and is registered as such at a particular institution of higher education for various courses. The student population will mainly comprise adolescents and young adults although there could be a number of
non-traditional students who are older, part-time and working students. The students will be from diverse cultural and ethnic backgrounds.

**STAFF**

Staff can be defined as a body of people in charge of the internal operations of an institution or business and also as the teachers at a university (The Penguin English Dictionary, 1985:809). The staff at institutions of higher education has diverse occupations and could be employed permanently, part-time or be on contract. The occupations of staff members could range from cleaners to corporate executives.

**MODEL**

Chinn and Kramer (1995:76) state that models expressed in language are often called conceptual models and the authors are of the opinion that conceptual and theoretical models can be represented as a part of theory, can coexist with theory or can be constructed to show links between related theories. Burns and Grove (2003:138) indicate that conceptual models broadly explain phenomena of interest, express assumptions and reflect a philosophical stance.

**HIGHER EDUCATION INSTITUTION (HEI)**

According to the Government Gazette (1997:8) “a higher education institution means any institution that provides higher education on a full-time, part-time or distance basis which is

- established or deemed to be established as a public higher education institution under this Act;
- declared as a public higher education institution under this Act; or
- registered or unconditionally registered as a private higher education institution under this Act".
1.6 **METAPARADIGMATIC PERSPECTIVE**

Paradigms are fundamental models or frames of reference we use to organise our observations and reasoning (Babbie, 2004:34). A paradigm consists of theoretical ideas and technical procedures that researchers adopt and that are rooted in a particular worldview with its own language and terminology (Holloway and Wheeler, 2002:6). A paradigm creates its own cultural environment that regulates the behaviour of its followers and favours research conforming to its own rules. Thus the dominant paradigm can also define, what are legitimate or accepted topics of enquiry (Parahoo, 1997:46)

The researcher will use the model of *Health for All* propounded by the World Health Organisation (WHO) since 1978 as the foundation for the study. According to Bryar (1995:87) this is a model which has been developed at the international level of society but which seeks to bring about radical change in the structures of healthcare organisations, the wider views in societies regarding health, the attitudes of healthcare practitioners and members of the community and in the provision of healthcare.

The focus of this model is on the individual, family and community and it also provides a means of communication with healthcare organisations in other countries. The Declaration of Alma Ata emphasise the need for other sectors of society to be involved in healthcare and identifies primary health care as the focus for healthcare and the means of achieving the goal of *Health for All 2000 (HFA 2000)* (Bryar, 1995:87). Primary health care was thus viewed as the vehicle that would drive this process.

According to van Rensburg (2004:31) the WHO in 1998 responded to the HFA 2000 with a follow-up global policy now framed as *Health For All* in the 21st Century. Ten global health targets formed the essence of this global strategy. Four targets referred to health outcomes, two targets referred to determinant of health and four targets referred to health policies and sustainable systems.
In 2001 a modified version of a global strategy on health was formulated by the Declaration on “Healthcare for All” and endorsed by the conference on Healthcare for All in Antwerp, Belgium. The emphasis shifted from ‘health’ to ‘healthcare’. The Declaration on ‘Healthcare for All’ (2001) in van Rensburg (2004:31), call on national governments, international organisations, all agencies and individuals concerned with health and development to:

- Recognise access to healthcare for all requiring adequate human resources, infrastructure, essential drugs and commodities as a basic human right, and as essential for the control of the poverty-related diseases.
- Acknowledge the need for multisectoral approaches to reduce the burden of HIV and AIDS, tuberculosis, malaria and other infectious and non-communicable diseases.
- Ensure that specific disease-control programmes strengthen regular health systems and that they are co-ordinated with other programmes and interventions.
- Ensure that health systems are responsive to the needs and expectations of the populations, benefit from fair and sustainable financing and contribute to improving health outcomes.
- Strengthen in partnership the financial, logistic, operational and scientific capacities of the low-income countries to improve their healthcare services and disease-control programmes and to orientate international research to the needs of people and the health systems.
- Facilitate and encourage the development and management of human resources in the health sector and ensure that market mechanisms allow and promote global access to essential drugs and health-promoting commodities.
- Share this declaration and the goal of ‘Healthcare for All’ as a common agenda which all stakeholders can unite.

This declaration supports all health initiatives to realise ‘Health for All’ and renews the commitment of the International Community to provide ‘Healthcare for All’. The declaration is once again a reaffirmation that accessible, efficient,
adequate and equitable healthcare for all is the most urgent need for improving global health, fighting diseases and reducing poverty (van Rensburg, 2004:32).

1.7 RESEARCH DESIGN AND METHODS

A brief outline of the research design and methods that will be utilised in this study is described below.

1.7.1 RESEARCH DESIGN

A theory-generating design based on a qualitative, explorative, descriptive and contextual research approach will be implemented by the researcher to achieve the research objectives. A full description of this design will be presented in Chapter 2.

1.7.2 RESEARCH METHODS

The process of theoretical model generation will be conducted according to the steps of theory generation as proposed by Walker and Avant (1995:39), Dickoff, James and Wiedenbach (1968:423) and Chinn and Kramer (1995:108). These steps are as follow:

- **STEP ONE:** Concept analysis
- **STEP TWO:** Placing of the concepts in relationships
- **STEP THREE:** Description of the model
- **STEP FOUR:** Guidelines to operationalise the model
Each of these steps and how they will be applied to the study will be discussed in detail in Chapter two. The following Table 1.1 presents a summary of the research methods in the theory development process:

### TABLE 1.1: SUMMARY OF RESEARCH METHODS

<table>
<thead>
<tr>
<th>THEORY GENERATION LEVEL</th>
<th>RESEARCH METHOD</th>
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<th>DATA ANALYSIS</th>
<th>REASONING STRATEGY</th>
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<td><strong>STEP 1: CONCEPT ANALYSIS:</strong></td>
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<td><strong>Step 1.1:</strong> Identification and clarification of concepts</td>
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<tr>
<td>Population campus healthcare consumers and providers</td>
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<td>Sample method: purposive, criterion-based sampling</td>
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<tr>
<td>Methods of data collection: focus-group interviews, individual interviews</td>
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<td>Results from Step 1.1 concept identification from validated narratives, observation and literature</td>
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<tr>
<td>Coding according to Tesch’s method</td>
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<td>Dictionary and subject definitions of identified concepts</td>
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<td>Identification of attributes and concepts</td>
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<td>Induction Analyses</td>
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<td>Synthesis</td>
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<td>Syntheses</td>
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<td><strong>STEP 2: CONSTRUCTION OF RELATIONSHIP STATEMENTS</strong></td>
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<tr>
<td>A tentative model</td>
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<tr>
<td>Concepts are placed in relationship to each other to form relationship statements</td>
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<tr>
<td>Concepts from Step 1 are placed in context and relationship statements between the concepts of the model are formed</td>
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<td>Synthesis</td>
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### Theory Generation Level

<table>
<thead>
<tr>
<th>STEP 3: Description of Model</th>
<th>Literature review</th>
<th>Structure and process description according to Chinn and Kramer (1995:112)</th>
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<tr>
<td></td>
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<td>Evaluation of the model by using the strategies of Chinn and Kramer (1995:127-134) and through consultation with relevant experts</td>
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<td>Application of the model in practice, research and education</td>
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</table>

#### Step 4: Model Operationalisation

<table>
<thead>
<tr>
<th>Literature review</th>
<th>Guidelines to operationalise the model in practice, research and education</th>
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<tbody>
<tr>
<td></td>
<td>Deductions and recommendations</td>
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### 1.8 Approaches to Theory Building

Synthesis, derivation and analysis are the three basic approaches to theory building (Walker & Avant, 2005:30). The implementation of the aforementioned approaches in the development of a healthcare model for campus health services will be discussed in detail in Chapter Two.

### 1.9 Measures to Ensure Trustworthiness and Authenticity of the Study
Authenticity will be achieved by the researcher by being fair to participants and gaining their acceptance throughout the study. Continued informed consent will be obtained. According to Holloway and Wheeler (2002:254) trustworthiness in qualitative research means methodological soundness and adequacy. The researcher will make judgements of trustworthiness possible through developing credibility, transferability, dependability and confirmability. Each of these aspects will be discussed in more detail in Chapter Two.

1.10 CHAPTER DIVISION

The research study will be divided into six chapters and the format will be:
Chapter One: Orientation of the study
Chapter Two: Research design and method
Chapter Three: Discussion of results and literature control
Chapter Four: Development of the model
Chapter Five: Description and evaluation of the module
Chapter Six: Summary, conclusions, limitations and recommendations

1.11 SUMMARY

The aforementioned discussion is a brief review of the history and current practice of campus health services. The problem statement and research objectives are stated within the context of the research and the research methodology and ethical principles are outlined and discussed.
CHAPTER TWO

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

A brief background and orientation to the purpose of this study was given in the previous chapter. The research objectives were introduced and the paradigmatic framework was described. A brief description was also given in the previous chapter of the research design and methods which will now be discussed in more detail in this chapter. The research design and methods will be based on the four steps of theory generation mentioned in Chapter One. This chapter will also put the purpose and objectives of this study into context.

2.2 PURPOSE OF THE RESEARCH

This study aims to obtain information regarding the perceived healthcare needs of students and staff and also to establish how they and the campus healthcare providers experience the healthcare provided by the campus health service at an HEI in the ECP. This information will be used to develop a healthcare model that would assist registered nurses employed at HEIs campus health services in rendering a healthcare service relevant to the healthcare needs of the campus healthcare consumers.

2.3 RESEARCH OBJECTIVES

The following objectives are proposed in order to achieve the overall purpose of this study:
• To identify the central concepts of the model by conducting a field study. This will be done by exploring and describing how the campus healthcare consumers and providers at a HEI experience the healthcare provided by the campus health services. The perceived healthcare needs of the campus healthcare consumers will also be explored and described.

• To define and classify the identified concepts.

• To describe the relationship statements or propositions between the concepts.

• To describe a model to assist registered nurses at HEI campus health services to render a healthcare service relevant to the needs of the campus healthcare consumers. This description will be based on the results of the focus group interviews with students and the interviews with the staff and campus healthcare providers, direct observation and extensive literature control.

• To describe the guidelines that will assist with the implementation of the model.

The research design and methods to achieve the above purpose and objectives are described in the following paragraphs.

2.4 RESEARCH DESIGN AND METHODS

According to Burns and Grove (2003:195), “A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings”. The control provided by the design increases the probability that the study results will be accurate reflections of reality. Therefore the researcher must select the most appropriate design to meet the aims and objectives of the study (Parahoo, 1997:143). Research methods on
the other hand, consist of the systematic, methodical and accurate execution of the research design (Babbie & Mouton, 2002:74).

2.4.1 RESEARCH DESIGN

A theory-generating design based on a qualitative, explorative, descriptive and contextual research approach was implemented by the researcher to achieve the research objectives.

2.4.1.1 THEORY-GENERATING STUDY

Theory-generating studies are studies aimed at developing new models and theories to explain particular phenomena (Mouton, 2003:176). Chinn and Kramer (1995:20) viewed theory as “systematic abstraction of reality that serves some purpose”. Mouton (2003:177) states that theory- or model-building occurs mainly through inductive and deductive strategies. The researcher will be using inductive strategies for conceptualisation and deductive strategies for discussing the relationships between concepts. Hitchcock, Schubert and Thomas (2003:379) are of the opinion that theories enable community nurses to guide and strengthen their work with programmes. They state that theories provide nurses with different lenses through which to see situations, each lens providing a different view and understanding. Models are visual representations of theories. Thus this approach was appropriate for this study because the researcher envisaged developing a healthcare model based on the empirical data from the field that would serve as a frame of reference for registered nurses at higher education campus health services in the rendering of campus health services relevant to the needs of the campus healthcare consumers. There are three basic elements of theory building and three basic approaches for working with these elements.
• ELEMENTS OF THEORY BUILDING

The three elements are concepts, statements and theories.

 o Concepts

Concepts are the basic building blocks of theory (Hardy, 1974, in Walker & Avant, 2005:26) and are mental images of phenomena, ideas, or constructs in the mind about a thing or an action. Theory development frequently begins at the level of concepts and statements. A theorist might start with concept development. The researcher therefore identified concepts from the information received from all the participants in order to classify their experiences in a meaningful way. These concepts provided a foundation for developing a holistic healthcare model for campus health services. The four steps for theory-generation are discussed later in the chapter.

 o Statements

A statement is an extremely important ingredient in building a scientific body of knowledge. It is the mortar that binds the concepts together. Relational statements were used to declare a relationship of some kind between two or more concepts (Walker & Avant, 2005:27).

 o Theories

A theory is an internally consistent group of relational statements that presents a systematic view about a phenomenon and that is useful for description, explanation, prediction and prescription or control (Walker & Avant, 2005:28). This theory was constructed to express a how registered nurses at a campus health service could render healthcare services relevant to the needs of the campus healthcare consumers.
• APPROACHES TO THEORY BUILDING

A researcher needs to be clear about his or her area of interest in order to determine a suitable theory-building strategy. The researcher must also decide whether to focus on concepts, statements or the overall theory. A theory builder may move back and forth among the three basic approaches (Walker and Avant, 2005:30).

  o Synthesis

Much clinical research consists of collecting large amounts of data in the hope of sifting out important factors and relationships. Synthesis can aid in this sifting process (Walker & Avant, 2005:30). Synthesis was utilised in this research to construct new concepts, statements and a theory.

  o Derivation

Analogy and metaphor are the basis of derivation. Derivation, which allows the theorist to transpose and redefine a concept, statement or theory from one context or field to another (Walker & Avant, 2005:31), was used to derive a description of the concept holistic healthcare for this study.

  o Analysis

Walker and Avant (2005:31) cite Bloom (1956) as stating that the use of analysis allows a theorist to dissect a whole into its component parts so that it can be better understood. Analysis was used to clarify, refine and sharpen concepts for developing the model for this study.
2.4.1.2 QUALITATIVE RESEARCH

According to Strauss and Corbin (1998:10) the term “qualitative research” refers to the type of research that produces findings not arrived at by statistical procedures or other means of quantification. Thus qualitative research refers to a nonmathematical process of interpretation, carried out for the purpose of discovering concepts and relationships in raw data and then organising these into a theoretical explanatory scheme (Strauss & Corbin, 1998:11). Holloway and Wheeler (2002:3) state that qualitative approaches are used to explore behaviour, perspectives, feelings and experiences of people and what lies at the core of their lives.

This design was therefore appropriate for this study because the researcher intended exploring and describing what the perceived healthcare needs of the students and staff at a HEI in the ECP were, and also how they experienced the healthcare services provided on campus. The researcher also intended exploring and describing how the campus healthcare providers experienced the rendering of campus health services. Depth and focus-group interviews were implemented to obtain the data.

A non-mathematical process of interpretation, carried out for the purpose of discovering concepts and relationships in raw data was utilised for the purpose of identifying concepts that were used in a theoretical holistic healthcare model for higher education campus health service delivery in the ECP.

2.4.1.3 EXPLORATORY RESEARCH

Exploratory research begins with some phenomenon of interest, but rather than just observing and recording the incidence of the phenomenon, it aims at
exploring the dimensions of the phenomenon, the manner in which it is manifested and the other factors to which it is related (Polit & Hungler, 1993:14). The researcher explored and described what the perceived healthcare needs of students and staffs were at the identified HEI and also how they experienced the healthcare provided by the campus healthcare providers. The researcher also explored and described how the campus healthcare providers experienced rendering the campus health services.

2.4.1.4 DESCRIPTIVE RESEARCH

According to Cormack (2002:218) description is integral to the process of exploration. This type of design is appropriate for areas about which little theoretical or factual knowledge is available (Cormack, 2002:19). Thus this design was appropriate for this research study because very little information was available on campus health services and not much formal research has been conducted in this field in South Africa. A description is given of the perceived healthcare needs of students and staff at an HEI in the ECP as well as how they experience the services provided on campus. A description is also given on how the campus healthcare providers experience the rendering of campus health services. The model of holistic healthcare for higher education campus health services is also described.

2.4.1.5 CONTEXTUAL RESEARCH

Holloway and Wheeler (2002:34) state that the context includes the environment and the conditions in which the study takes place as well as the culture of the participants and location. This study was conducted at an HEI in the Western Region of the ECP, South Africa. It is one of the new comprehensive universities that manifested through the merging of two universities and one technikon. This resulted in this HEI having six different campuses that are spread across the region. The merger has also resulted in the merging of the two campus health clinics without reducing the number of
satellite campus health clinics; so this HEI has a campus health clinic on five of its six campuses.

The ECP is situated in the South East of the country and encompasses what is traditionally known as the Eastern Province, Border and North Eastern Cape areas, as well as the former homelands of Transkei and Ciskei. On the northern side, it borders the Kingdom of Lesotho and the Free State, while its western borders are formed by the districts of Middelburg, Graaff-Reinet, Aberdeen and Willowmore. The ECP is spatially the second largest province, covering 170,616 km² or 13.9% of the total surface area of South Africa and in 1993 had a total population of 6.665 million people (Erasmus, 1996:1).

The Western Region of the ECP has an 88% urban population of 1.165 million people (Erasmus, 1996:10). The identified HEI where this research was conducted has students enrolled for various undergraduate and post-graduate programmes and employs staff in very diverse categories of employment ranging from unskilled staff to artisans, administrative staff and academics.

The research population that was studied was therefore heterogeneous in terms of ethnicity, occupation, gender, qualifications and study year; and comprised all healthcare consumers, that is, students and staff on each campus who have used the campus health service, as well as all the campus healthcare providers employed by the HEI.

2.4.2 RESEARCH METHODS

Babbie and Mouton (2002:74) state that a research method consists of the systematic, methodical and accurate execution of the research design. In the process of the execution of the research process, various methods and tools are used to perform different research tasks. The process of theoretical model
generation will be conducted according to the steps of theory generation as proposed by Walker and Avant (1995:39); Dickoff et al. (1968:423) and Chinn and Kramer (1995:108). These steps are as follow:

- **STEP ONE:** Concept analysis
- **STEP TWO:** Placing of the concepts in relationships
- **STEP THREE:** Description of the model
- **STEP FOUR:** Guidelines to operationalise the model

Each of these steps will now be discussed and applied to the study.

2.4.2.1 **STEP ONE: CONCEPT ANALYSIS**

Concept analysis is a strategy that allows one to examine the attributes or characteristics of a concept (Walker and Avant, 1995:37). According to Dickoff et al. (1968:422) and Chinn and Kramer (1995:78) identifying concepts from fieldwork and creating conceptual meaning provides a foundation for developing theory. Thus concept analysis was conducted after relevant data had been collected. The data-collection process that resulted in concept analysis included the following:

2.4.2.1.1 **RESEARCH POPULATION AND SAMPLING**

According to Polit and Hungler (1993:173) “A research population is the entire aggregation of cases that meets a designated set of criteria”. The research population for this study comprised three groups, namely students and staff who use the campus health service as well as all the campus healthcare providers employed at the campus health service.
Cormack (2002:263) refers to a sample as “a group of people that a researcher selects from a defined population and these are the individuals about whom information will be collected”. According to Paton (1990) in Holloway and Wheeler (2002:122), the sampling strategies of the qualitative researcher are guided by the underlying principles of gaining rich, in-depth information.

The purposive sampling technique was utilised to select a sample of campus healthcare consumers and providers on all campuses of the identified HEI. According to Parahoo (1997:232) this method of sampling involves deliberate choice by the researcher of participants to include in the study on the basis that those selected can provide the necessary information. Holloway and Wheeler (2002:122) state that selection of participants is criterion-based, that is, certain criteria are applied and the sample is chosen accordingly.

Because three research population groups, namely students and staff (campus healthcare consumers) and campus healthcare providers were included in this study, the sampling was implemented as follows:

- **Group 1: Student campus healthcare consumers**
  The researcher met the registered nurses at the campus health services to discuss the purpose and objectives of the research with them as well as the selection criteria for inclusion in the study. The aim of this meeting was to inform them about the research and to ask them whether they would be prepared to enquire from the student campus healthcare consumers attending the health services whether they would be willing to participate in the research study.

  The researcher requested the registered nurses to compile a list of names, telephone numbers and e-mail addresses of all the student campus healthcare consumers who met the selection criteria and who agreed to participate in the study. The names, telephone numbers and e-mail addresses of students were emailed to the researcher by the registered nurses on each campus. The researcher contacted one to two students on each campus and
explained the purpose and objectives to them and thereafter enquired from them whether they were willing to get a group of ten students together for a focus group interview. The students were very co-operative and were all in agreement. Each of the students approached contacted the researcher when they had 10 students who were willing to participate in the research. The researcher then met the group after setting up a date, time and venue with them.

The criteria for inclusion of this group of participants included the following:

- The student campus healthcare consumer had to:
  - be a registered student;
  - be able to communicate well in English and be able to express him/herself clearly in order to avoid misinterpretations by the researcher;
  - be a voluntary participant and
  - have utilised the campus health service.

A total of 51 students participated in the focus group interviews.

- **Group 2: Staff campus healthcare consumers**

This group of participants was selected in the same manner as the first group of participants. The researcher once again approached the registered nurses at the campus health service to compile a list of names, telephone numbers and e-mail addresses of all staff campus healthcare consumers who fitted the selection criteria and who were willing to participate in the research study. The registered nurses were requested to submit this list to the researcher who contacted the participants personally to enquire from them whether they were willing to participate in the research study. Nine staff members participated and were individually interviewed. The criteria for inclusion for this group of participants included the following:

- The staff healthcare consumer had to:
  - be an employee;
be able to communicate well in English and be able to express him/herself clearly in order to avoid misinterpretations by the researcher;
- be a voluntary participant and
- have utilised the campus health service.

The sample size for Group 1 and Group 2 was determined by data saturation from the focus group and depth interviews which was experienced after 6 focus-group (51 students in total) interviews with student campus healthcare consumers and nine depth interviews with staff campus healthcare consumers. Data saturation was evidenced by the examination of data that yielded only recurrences of material that had already been discovered, coded and integrated (Compare Cormack, 2002:159).

- Group 3: Campus healthcare providers

There were nine registered nurses employed at this campus health service, one doctor and a registered pharmacist appointed in a head-of-department position. They were all included in the sample and were distributed among the 5 campuses. The criteria for inclusion in this study were:

- The campus healthcare provider had to be:
  - employed at the campus health service as a permanent or contract staff member,
  - employed at the campus health service for at least 6 months and
  - a voluntary participant.

2.4.2.1.2 ENTRY TO SITE

Formal permission is important in any research and protects both researchers and participants. Access is sought in various ways (Holloway & Wheeler,
Researchers negotiate with “gatekeepers”, the people who have the power to grant or withhold access to the setting. There may be any number of these at different places and levels in the hierarchy of the organisation. Researchers should not only ask the person directly in charge but also others who hold the power to start and stop the research (Holloway & Wheeler, 2002:40). The gatekeepers in this research included the senior manager of campus health services and all the registered nurses employed at the campus health services.

According to Holloway and Wheeler (2002:40), all gatekeepers have power and control of access; but those at the top of the hierarchy are most powerful and should be asked first because they can restrict access even if everybody else agrees. The Vice Chancellor and senior manager of campus health services was therefore approached by means of a formal written request (See Appendices A and B). Appointments for depth and focus group interviews were arranged telephonically or by e-mail with the participants as soon as the right to entry to the sites had been obtained from the faculty of Health Sciences, Advanced Degree Committee (See Appendix C), NMMU Ethics Committee (Human - See Appendix D) and the senior manager of the campus health service (See Appendix E).

2.4.2.1.3 DATA COLLECTION

Parahoo (1997:52) emphasises that selecting methods of investigation is not a neutral, value-free or haphazard exercise. Polit and Hungler (1993:200) stipulate that without high-quality data-collection methods, the accuracy and robustness of research conclusions are easily challenged. For the purpose of this study, the researcher has chosen the depth and focus-group interviews to obtain the relevant research data.
• **Phase One Data Collection – Focus-Group Interviews**

Focus-group interviews were utilised to obtain relevant information from the participants in Group 1, that is, the student campus healthcare consumers, regarding their perceived healthcare needs and their experiences when they utilised the campus health service. According to Katzenellenborgen, Joubert and Abdool-Karim, (2002:177) the focus-group method involves a number of people meeting in a group in which the participants talk to one another under the guidance of a facilitator. Ideally, a group should number between six and ten members, plus a facilitator.

The researcher who acted as the facilitator conducted six focus-group interviews with the student campus healthcare consumers. One focus-group interview was held on each campus with the exception of one campus where two focus group interviews were conducted because the students had assembled two groups for two different days. Each focus group comprised between 6 and 10 members on each identified campus. The six focus groups on the various campuses were composed as follows:

- three groups of male students
- three groups of female students
- the members for both groups were selected according to the selection criteria stated earlier

The participants were contacted and informed about the focus-group interviews via telephone or e-mail as indicated earlier. The reason for separating the sexes was to promote free and open discussions about sensitive topics.

Focus-group interviews differ from individual interviews in that they explore and stimulate ideas based on shared perceptions rather than on individual ideas (Holloway & Wheeler, 2002:111). Focus groups can be used flexibly to evaluate health projects and to obtain perceptions of what the major health needs are in a community (Katzenellenborgen et.al., 2002:178). Thus this method of data collection was appropriate for this research study because the
The researcher intended establishing how the students experienced the campus health services and also what they perceived to be their healthcare needs. Thus the following research questions were posed to each focus group:

*How do you experience the healthcare services provided on campus?*
*What are your healthcare needs?*
*How would you like your healthcare needs to be met?*

Probes and follow-up questions were used to deepen the responses to the questions posed and also to increase the richness and depth of responses and to maintain control over the flow of the interview (Paton, 2002:372). The detailed-oriented, elaboration, clarification and contrast probing was used to obtain in depth data from the participants (Paton, 2002:373). The detailed-oriented probes were the basic “who”, “what”, “where”, “when” and “how” questions that were used to obtain a complete and detailed picture of some activity or experience. Elaboration probes were used to keep a participant talking about a subject. The best cue utilised to encourage talking was non-verbal head nodding as positive reinforcement and the quiet ”uh-huh”. Direct verbal elaboration probes were also used, for example, ”Could you say more about that?” Clarification probes were used to tell the participant that more information was needed or to restate the answer. Contrast probing was used to help define the boundaries of a response for example, “How does this experience compare to some other experience?” (Compare Paton, 2002:374).

Prior to starting the group interviews, the researcher established a rapport with the participants by opening the discussion; welcoming the group and getting everybody introduced; providing an overview of the topic; outlining the ground rules of the discussion and getting permission for the use of the tape-recorder (See Appendix F). At the end of the discussion, group members were thanked for their participation and informed about what would happen to the information that was gathered in the group. The researcher kept an audiotape-recording and detailed notes on the body language and social processes, as well as brief notes on what was said for every group discussion (Compare Katzenellenborgen et.al., 2002:178).
Phase Two and Phase Three Data Collection - Depth Interviews

The depth interview is most common form of data collection in qualitative research (Holloway & Wheeler, 2002:79). The depth interview is also referred to as face-to-face and unstructured interview. This method is generally used when detailed information is needed from the participants (Katzenellenborgen et.al, 2002:177). The researcher selected this method of data collection to obtain information from Group 2 (staff campus healthcare consumers) and Group 3 (campus healthcare providers) because she needed rich and in-depth data that could become the basis for theorising. According to Holloway and Wheeler (2002:84), the researcher can use prompts and probing questions in search for elaboration, meaning or reasons.

The researcher informed the participants that the data-collection method would be on site and permission was requested from the participants to use a tape-recorder to record the interviews prior to interviewing (See Appendix F). The aforementioned was necessary to enable the researcher to record the exact words of the interview, inclusive of questions so that she did not forget important answers and words. Using a tape-recorder also allowed the researcher to have eye contact with the participants and pay attention to what the participants said. The tape was dated, labelled and checked immediately after the interview to establish whether it was functioning properly in case the researcher had to redo the interview. The researcher made contextual notes before the interview and field notes immediately afterwards when events and thoughts were still fresh in her mind (Compare Holloway & Wheeler, 2002:87). These notes complemented the interviews.

According to Holloway and Wheeler (2002:81) unstructured interviews start with a general question in the broad area of study. Questions asked from Group 2 were the same as the questions posed to Group 1. The following questions were posed to Group 3:

*How do you experience the rendering of campus health services?*
What do you perceive to be the healthcare needs of the students and staff on campus?

How would you like to meet the healthcare needs of students and staff on campus?

Probes and follow-up questions were also used for these participants. Interviewing was continued for both groups until data saturation was reached (Strauss & Corbin, 2002:292).

2.4.2.1.4 FIELD NOTES

According to Polit and Hungler (1993:216) it is essential for the researcher to record observations while still in the process of collecting information since memory failures are bound to occur if there is too long a delay. The researcher therefore made field notes every night after collecting information to make sense out of what was observed. The field notes were descriptive and dated.

Paton (2002:302) states that many options exist for taking field notes and there are no universal prescriptions about the mechanics of and procedures for taking field notes because different settings lend themselves to different ways of proceeding. The precise organisation of fieldwork is very much a matter of personal style and individual work habits. Basic information regarding where the observation took place, who was present, what the physical setting was like, what social interactions occurred and what activities took place were recorded by the researcher. This information established a context for interpreting and making sense of the interview later (Compare Paton, 2002:303). The researcher also kept a field journal to describe and interpret her behaviour within the research context in order to become aware of any biases and preconceived assumptions as she was campus healthcare provider for eight years.
2.4.2.1.5 FIELD TRIP

A trip to Mississippi in the United States of America was sponsored for the researcher to visit two of their campus health services. This was a fact-finding visit to obtain information regarding the structure and functioning of their campus health services. Notes were made and ideas were integrated with the other field notes. The latter was used in the literature control in Chapter Three.

2.4.2.1.6 DATA ANALYSIS

The research data needs to be processed and analysed in some systematic fashion so that trends and patterns of relationships can be detected (Polit & Hungler, 1993:269). The process of data analysis involves making sense out of text and image data. Coding and categorising were implemented throughout the research, the data having been coded from the start of the study. Data were transformed and reduced to build categories. Through the emergence of these categories theory can be evolved and integrated (Holloway & Wheeler, 2002:158).

The coding process and data analysis were conducted according to the steps suggested by Tesch (1990) in Creswell (2004:192):

- Get a sense of the whole. Read all the transcriptions carefully and make short notes.
- Pick one document at a time, go through it and try to make meaning of its contents; then write notes in the margin.
- When this action has been completed for several documents, make a list of all the topics. Cluster similar ones together and form them into columns that can be arranged as major topics, unique topics and leftovers.
• Take the list and go back to the data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text to see whether new categories and codes emerge.

• Find the most descriptive wording for the topics and turn them into categories. Reduce the total list of categories by grouping topics that relate to one another. Lines could be drawn between categories to show interrelationships.

• Make a final decision on the abbreviation for each category and arrange these categories alphabetically.

• Assemble the data material belonging to each category in one place and perform a preliminary analysis.

• Re-code existing data if necessary.

Transcripts of audio-taped interviews were made and sent to an independent coder with a data analysis guide to be used (See Appendix G). The independent coder was instructed to use the data analysis guide provided to analyse data from transcribed interviews so as to assist in excluding biases by the researcher and also to control haphazardness with data analysis (Kvale, 1996:208). A discussion between the researcher and the independent coder was held to finalise the findings of the study. Results of data analysis assisted with the development of the holistic healthcare model for campus health services; therefore verification of data was important and it was done through a literature control to place findings within the context of existing literature.

Concepts were identified from the data and fieldwork that was conducted in the three phases of data collection. The first two phases established how the campus healthcare consumers experienced the campus health services and what their perceived healthcare needs were, and the third phase established how campus healthcare providers experienced the rendering of campus health services and what they perceived to be the healthcare needs of the campus healthcare consumers. In order to identify the concepts from the fieldwork, the researcher made use of the survey list referred to by Dickoff et
al. (1968:423) “in the hope of revealing different features as point of view shifts”. The survey list included:

- Agency (Who or what performs the activity?)
- Patiency or recipiency (Who or what is the recipient of the activity?)
- Framework (In what context is the activity performed?)
- Terminus (What is the end point of the activity?)
- Procedure (What is the guiding procedure, technique or protocol of the activity?)
- Dynamics (What is the energy source for the activity – whether chemical, physical, biological, mechanical or psychological?)

These six aspects of activity served as an organising principle.

Chinn and Kramer (1995:80) state that creating conceptual meaning produces a tentative definition of the concept and a set of tentative criteria for determining if the concept exists in a particular situation. Once the concepts had been identified from the data obtained in the field, use was made of dictionary definitions and subject literature definitions in order to clarify concepts. Chinn and Kramer (1995:83) also refer to model cases that can be constructed to the best of current understanding. Thus a model case was constructed to demonstrate the best understanding of the concepts. Essential attributes of the concepts were identified and clustered together in categories.

2.4.2.1.7 MEASURES TO ENSURE TRUSTWORTHINESS AND AUTHENTICITY OF THE STUDY

According to Holloway and Wheeler (2002:256) a study is authentic when the strategies used are appropriate for the true reporting of the participants’ ideas; when the study is fair; and when it helps participants and similar groups to
understand their world and improve it. Authenticity will thus be achieved by the researcher’s fairness to all participants and gaining their acceptance throughout the study. Continued informed consent will be obtained. According to Holloway and Wheeler (2002:254) trustworthiness in qualitative research means methodological soundness and adequacy. The researcher will make judgements of trustworthiness possible through developing the following:

- **Credibility**

Credibility corresponds to the notion of internal validity. This means that the participants must be able to recognise the meaning that they themselves give to a situation and the truth of the findings in their own social context. The researcher must ensure that her findings will be compatible with the perceptions of the participants (Holloway & Wheeler, 2002:255). Credibility will be ensured by utilising prolonged and varied field experience, interviewing process, peer review, reflexivity and triangulation.

The researcher ensured prolonged and varied field experience by spending time establishing a rapport with the participants before commencing the interview so that the participants could become accustomed to the researcher. The researcher also stayed a while after the interview because the participants always continued talking after the conclusion of the interview. This was important because as rapport increased, participants volunteered different and increasingly sensitive information.

Credibility was also enhanced in the interviewing process as the researcher reframed questions, repeated or expanded questions on different occasions during the course of the interview process. Peer review on the other hand was ensured by discussing the research process and findings with impartial colleagues such as the two promoters who both have experience with qualitative research methods.
The researcher was a campus healthcare provider for eight years; and therefore it was important for her to be aware of and to reflect on the influence of her own background, perceptions and interests. Thus a field journal was kept to describe and interpret her behaviour and experiences within the research context in order to become aware of any biases and preconceived assumptions. If any biases or preconceived assumptions were evident the researcher would have altered the way the data was collected, for example, getting somebody else to collect the data to enhance the credibility of the research (Compare Krefting, 1991:9).

Triangulation is a powerful strategy for enhancing the quality of research (Krefting, 1991:9). Triangulation of data gathering methods and sources was utilised to ensure trustworthiness. Both focus-group and depth interviews were utilised to collect data. Data was obtained from three different groups of participants, namely, campus healthcare consumers (comprising two groups, that is students and staff) and campus healthcare providers, in order to cross-check data and interpretation. The data obtained was also analysed twice, that is by the independent coder and the researcher.

• Transferability

Holloway and Wheeler (2002:255) state that Lincoln and Guba use transferability instead of generalisability. This means that the findings of this research should be able to be transferred to similar situations or participants. The knowledge acquired in this study will be relevant in another, and those that carry out the research in another context will be able to apply certain concepts originally developed in this research study (Holloway & Wheeler, 2002:255).

A dense description of the background information is provided about the participants and the research context and setting in order to allow others to assess how transferable the findings are. According to Guba (1985) in
Chapter Two

A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUS HEALTH SERVICES

Krefting (1991:12) it is not the researcher’s job to provide an index of transferability; but it is his or her responsibility to provide an adequate database to allow transferability judgements made by others.

- **Dependability**

Holloway and Wheeler (2002:254) quote Lincoln and Guba (1985) and Guba and Lincoln (1989) as using the term “dependability” instead of “reliability”. If the findings of the study are to be dependable, they should be consistent and accurate. The strategies that were used to ensure trustworthiness included thick description, triangulation and peer review. An independent coder was also utilised to increase dependability.

- **Confirmability**

This again needs an audit or decision trail where readers can trace the data to their sources. They must be able to follow the path of the researcher and the way she arrived at the constructs, themes and their interpretation. Thus the details of the research and the background and feelings of the researcher will be made open to public scrutiny (Holloway & Wheeler, 2002:255). Triangulation of methods and sources and reflexivity were used to ensure trustworthiness.

2.4.2.1.8 PILOT STUDY

Cormack (2002:24) describes a pilot study as a smaller version of the proposed study which provides a trial run before embarking on the actual study. The purposes of pilot studies as highlighted by Cormack are:

- to facilitate the testing of the adequacy of the research design and logistics of the main study and possibly help the researcher to
identify problems with the study design which can be rectified before embarking on the actual study and

• to provide an opportunity for analysing the research data.

The pilot study was executed in the same manner as the main study. A focus group of students was formed after liaising with the senior manager of campus health services to have a practice run of the research questions and interviewing method. Pilot depth interviews were also conducted with one staff member and one registered nurse. Informed consent was obtained prior to data collection, after which data was recorded and transcribed. The information obtained from the pilot study was included in the data analysis.

2.4.2.2 STEP 2: PLACING OF CONCEPTS IN RELATIONSHIPS

Concepts are not viewed in isolation but in relationship to one another. Relationship statements describe, explain or predict the nature of the inter-relationship between the concepts of the theory (Chinn & Kramer 1995:96). The latter was conducted after the concepts were identified, clarified and defined.

2.4.2.3 STEP 3: DESCRIPTION OF MODEL

The definition of theory that is used by Chinn and Kramer (1995:105) refers to theory as “A creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena”. Thus the following questions were asked in order to describe the theoretical model that was developed for campus health services at institutions of higher education:
• What is the purpose of this theory?
• What are the concepts of this theory?
• How are the concepts defined?
• What is the nature of the relationships?
• What is the structure of the theory?
• On what assumptions does the theory build? (Chinn & Kramer 1995:117)

2.4.2.4 STEP 4: GUIDELINES TO OPERATIONALISE MODEL

According to Chinn and Kramer (1995:101) “deliberative application involves using the theory in practice to carefully assess and understand the effect of its use on the quality of life, the quality of nursing care or the processes of health”. The model to be developed will be utilised by registered nurses to optimise PHC care service delivery at HEIs to ensure that the healthcare needs of the healthcare consumers are adequately met. Chinn and Kramer (1995:101) also state that deliberative application of the model has three subcomponents, namely:

• Selecting the clinical setting – The clinical setting for deliberative application for this research will be an identified campus health service that will be situated at an HEI.

• Determining outcomes variables for practice – The outcomes variables for this study would be to ensure that the campus health services meet the health needs of the healthcare consumers on campus and to also ensure optimal service delivery (Chinn & Kramer 1995:102).

• The healthcare model that will be developed will not be implemented or tested in this study. Guidelines will be developed to operationalise the model.
2.5 **ETHICAL CONSIDERATIONS**

Parahoo (1997:78) states that there are ethical implications at every stage of the research process. The research proposal was therefore submitted to the faculty of Health Sciences, Advanced Degrees Committee for approval and permission was also obtained from the NMMU Ethics Committee (Human) (See Appendix D). The researcher requested permission in writing, from the Vice Chancellor and the senior manager of campus health services to conduct the research on their service (See Appendices A and B). Informed consent was obtained from the research participants by issuing each participant with a consent form (See Appendix F) explaining to them what the purpose and objectives of the study were. The consent forms were issued at the interview sites. The following ethical principles were observed throughout this study in order to protect the participants from any harm.

2.5.1 **PRINCIPLE OF BENEFICENCE**

Polit and Hungler (1993:356) state that beneficence is one of the most fundamental ethical principles in research. It encompasses the maxim, “Above all, do no harm”. The researcher ensured that no participant was subjected to any harm, exploitation or any risks. This was ensured by obtaining informed consent and recognising that all research participants were autonomous and that they had the right to refuse to participate and that they could also withdraw from the research project at any time. The research project had no real risk factors. Anonymity was maintained; thus there was no chance of participants being identified for victimisation if negative comments were made. This research study will benefit the participating individuals and society in general by contributing to the body of knowledge and designing a health care theoretical model for campus health services at an institution of higher education in the ECP.
2.5.2 PRINCIPLE OF RESPECT FOR HUMAN DIGNITY

According to Polit and Hungler, (1993:358), humans should be treated as autonomous agents, capable of controlling their own activities and destinies. The principle of self-determination means that the participants had the right to decide voluntarily whether or not to participate in the study. The researcher therefore ensured that all the participants had the right to decide at any stage to terminate their participation, refuse to give information or to ask for clarification about the purpose of the study. No participant was coerced to participate in this study at any stage.

Informed voluntary decisions about participants cannot be made without full disclosure. The researcher therefore fully disclosed to the participants the nature of the research, the participants' right to refuse participation, the researcher's responsibilities and the likely risks and benefits that could have been incurred. The right to full disclosure and the right to self-determination are the two major elements on which informed consent is based (Polit & Hungler, 1993:359). The researcher therefore ensured that the participants had adequate information regarding the research, were capable of understanding the information and had the power of free choice enabling them to consent voluntarily to participate in the research or decline participation. The participants were requested to give their consent in writing (See Annexure F).

2.5.3 PRINCIPLE OF JUSTICE

Participants have the right to fair and equitable treatment before, during and after their participation in the study (Polit & Hungler, 1993:362). The researcher therefore ensured that there was a fair and non-discriminatory selection of participants and non-prejudicial treatment of individuals who declined to participate or who withdrew from the study. The researcher also
honoured all agreements made and adhered to the procedures outlined in advance and was also respectful and courteous at all times.

Anonymity and confidentiality were also adhered to, this being ensured by not using any names or any other identifying data of participants and institutions. The researcher therefore ensured that no link with the data obtained and any particular participant could be made.

2.6 SUMMARY

The aforementioned discussion is an in-depth description of the research design and methods used to conduct this research. The purpose and research objectives are stated within the context of the research and the ethical principles are outlined and discussed. A description of the proposed process for the development of a healthcare model for campus health services is outlined in this chapter.
CHAPTER THREE

DISCUSSION OF RESULTS AND LITERATURE CONTROL

“As the trend toward ‘consumerism’ in healthcare nationally shifts the balance of power between providers and patients, concern about understanding and assessing experience of users of healthcare services grows. New techniques of ‘user experience research’ begin to offer more nuance views of consumers’ ways of understanding, using and evaluating products and services”

Keeling (2000:101)

3.1 INTRODUCTION

The research design and method was described in detail in Chapter two. The purpose of this chapter is to discuss the results that emanated from the depth individual and focus group interviews that were conducted with the research participants. The results will be discussed in conjunction with a literature control that allows for the verification of the findings. These research findings represent the first step in theory generation for this study, which is data collection and concept analysis.

3.2 CONTEXTUALISING CAMPUS HEALTH SERVICES

According to Creswell (2004:7), categories emerge from informants that provide rich “context-bound” information leading to patterns or theories that help explain phenomena. Thus contextualising campus health services will assist in the understanding and explanation of the emergent patterns in this research with regard to the perceived healthcare needs of the campus healthcare consumers and also their experiences with regard to the healthcare service provided on campus as well as the experiences of the
campus healthcare providers regarding the rendering of campus health service.

Prior to 1994 the South African higher education system was fragmented and characterised by considerable unnecessary duplication, gross inequalities in terms of funding and the quality of outputs, and inefficiency and ineffectiveness in developing the human resource base of the country due to unequal opportunities for access and success. This resulted in serious disparities between inputs and the quality of outputs, thus frustrating sustainable growth, global competitiveness and the achievement of a just and democratic society. The post-1994 reform agenda created an enabling legal and policy context to address most of the inefficiencies of this pre-1994 higher education system. Institutional restructuring effected through mergers and incorporations from 2004 has created a new institutional landscape as well as new institutional types: universities (with a refocused mission in some cases), universities of technology (technikons reconceived) and comprehensive universities (resulting from mergers of former universities and technikons) (Higher Education South Africa [HESA] Final Report, 2006:21).

The HEI where this research was conducted is one of the newly merged Comprehensive Universities in South Africa. Two universities plus one Technikon merged to form one HEI. Prior to the merger two of these institutions had their own health service on campus. One of the two aforementioned institutions had four different campuses, thus they had one campus health service with a full-time health clinic on three of the four campuses. The fourth campus only had a part-time clinic run by one of the registered nurses from the main campus health clinic of the institution. At the time of the merger one of the universities that formed part of the merger did not have a healthcare service on campus thus a satellite campus clinic was established on the aforementioned campus after the merger.

This new merged institution now comprises six campuses. The campus health services have also merged to form one unified campus health service with a health clinic on five of the campuses. A senior manager has been appointed
to oversee the campus health service with all its satellite health clinics. The health clinics on each campus, continue to operate as they did prior to the merger. The following table will provide an overview of the staffing and structural facilities available on each of the 5 campus health clinics of the identified HEI:
### Table 3.1: Overview of the Structural Facilities and Staffing Available at Campus Health Services

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<thead>
<tr>
<th>CHSs Year established</th>
<th>No. of consulting rooms</th>
<th>Size of waiting area</th>
<th>Consulting room for counsellor</th>
<th>Treatment room</th>
<th>Store room</th>
<th>Rest room</th>
<th>Kitchen</th>
<th>No. of toilets</th>
<th>No. of registered nurses (RN)</th>
<th>No. of doctors</th>
<th>No. of secretaries</th>
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<td>1  RN for PHC</td>
<td>1x Medical doctor for 2 hours per week</td>
<td>1</td>
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<td>1x1 bedded</td>
<td>1</td>
<td>2  RN for PHC</td>
<td>1 RN (OHN) wednes</td>
<td>1x Medical doctor for 1 hour per week</td>
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<td>1x Medical Doctor for 1 hour per week</td>
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<td>1x Medical doctor for 1 hour per week</td>
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<td>NO HEALTHCARE SERVICE ON CAMPUS</td>
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</tbody>
</table>
The aforementioned table, reflect that the staffing and facilities at these campus health clinics are not the same. There is an unequal distribution of resources. Thus some of the experiences expressed by the health care consumers and healthcare providers may be specific to a particular campus and some experiences may be generic to all campuses.

The following table will present the staff and student profile of the six campuses of this higher education institution:

<table>
<thead>
<tr>
<th>CAMPUS</th>
<th>STUDENTS</th>
<th>STAFF</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Time (F/T)</td>
<td>Part time (P/T)</td>
<td>PERMANENT</td>
</tr>
<tr>
<td></td>
<td>F/T</td>
<td>P/T</td>
<td>F/T</td>
</tr>
<tr>
<td>A</td>
<td>7 676</td>
<td>1 825</td>
<td>801</td>
</tr>
<tr>
<td>B</td>
<td>4 193</td>
<td>630</td>
<td>397</td>
</tr>
<tr>
<td>C</td>
<td>2 376</td>
<td>1 324</td>
<td>79</td>
</tr>
<tr>
<td>D</td>
<td>796</td>
<td>156</td>
<td>50</td>
</tr>
<tr>
<td>E</td>
<td>717</td>
<td>162</td>
<td>73</td>
</tr>
<tr>
<td>F</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15 758</td>
<td>4 097</td>
<td>1 403</td>
</tr>
</tbody>
</table>

### 3.3 OPERATIONALISING FIELDWORK

Prior to data collection, the researcher obtained formal written permission from the Senior Manager of campus health services to conduct this research at the identified HEI (See Appendix E). The senior manager and all the registered nurses employed at this service acted as “gatekeepers” to ensure the success of the data collection process and also to ensure that the participants were protected against harm. The researcher conducted a pilot study of one focus group interview with 8 student campus health care consumers, once the right of entry to the research site was obtained from the aforementioned persons. She also conducted two depth interviews as part of the pilot study, namely, one interview with a staff campus healthcare consumer and one with a campus healthcare provider. No problems were
encountered with the pilot study therefore the information obtained from the pilot study conducted was included in the data analysis.

Data collection was conducted in three phases from May to November 2006. **Phase One** of the data-collection process comprised of six focus group interviews that were utilised to obtain the necessary research data from the student campus healthcare consumers. Three of the focus groups comprised female students on campus and the other three comprised male students. The researcher preferred to interview the male and female campus healthcare consumers separately in order to ensure that the group members would be comfortable with one another and also to facilitate open discussions without any inhibitions. Five of the focus groups comprised between 8 and 10 members and the last male focus group only had five members as most of the students had started writing examinations. Out of a total of 51 students who participated in the research, 96% were Black and only two (4%) of them were Coloured. The latter findings are congruent with the race distribution in Olivera’s study (2007:36) that indicated that 60% of the participants in her study were Xhosa-speaking. Olivera indicated in her study that these findings were congruent with what is happening in reality because Black students are using the services more than other students (Olivera, 2007:36). All the members fitted the selection criteria as stipulated in Chapter Two.

The researcher visited each campus health clinic and explained the purpose and objectives of the research in depth to the registered nurses working in the campus health clinics. She requested their co-operation in selecting students who would be willing to participate in the research. Once the students had consented, the registered nurse either telephoned or e-mailed the students’ names and telephone numbers to the researcher. The researcher then contacted the students and explained the purpose and objectives of the research to him/her and requested them to get a group of students together who would be willing to participate in the research. Once the students had recruited ten willing students, he/she would contact the researcher; and a date, time and venue that suited all the students were set. All the focus-group interviews were conducted in the student lounges at the student residences.
on campus with the exception of one female-focus group interview that was
conducted in one of the student’s bedrooms. Prior to conducting the focus-

group interviews, the researcher obtained written informed consent from all
the participants (See Appendix F). The interviews were all recorded on an
audio-tape.

Phase Two of the data-collection process comprised nine depth interviews
conducted among staff campus healthcare consumers. The group of staff
members interviewed was diverse in terms of age, ethnicity, gender,
education and occupation. The purposive sampling and interview
appointments were implemented in the same manner as described above.
The interviews with the academic and administration staff were conducted in
their offices and the interviews with the technical staff were conducted in a
chemistry laboratory and the office of the registered nurse on campus
respectively. All the staff members fitted the selection criteria as outlined in
Chapter Two. Written informed consent had also been obtained from all of the
staff members prior to conducting the interviews and all the interviews were
recorded.

Phase Three of the data collection process comprised eleven depth
interviews conducted among the campus healthcare providers. The
researcher contacted all the campus healthcare providers telephonically and
per e-mail to set up interview dates and times. All the interviews were
conducted and recorded in the campus health clinics. The healthcare
providers also fitted the selection criteria as outlined in Chapter Two and
informed consent was obtained prior to the interviews.

3.4 DATA ANALYSIS

Data analysis was conducted simultaneously with data collection. The
voluminous amount of information was reduced to themes, sub-themes and
categories by implementing the eight steps of Tesch (1990) as described in
Cresswell (2004:155). These steps are described in detail in Chapter Two.
Tesch (1990) in Cresswell (2004:154) calls this process of taking the information apart into smaller pieces and then putting it together to form a large consolidated picture, de-contextualization and re-contextualization.

A descriptive narrative will be used to describe the research findings. Every theme, sub-theme and category will be substantiated by appropriate quotations from the raw data. It will then be compared and contrasted with relevant literature and research to determine current knowledge regarding the experiences and healthcare needs of campus healthcare consumers and providers. According to Cresswell (2004:21), the literature review in qualitative research should be used in a manner consistent with the methodological assumptions; thus it was used inductively so that it did not direct the questions asked by the researcher. One of the main reasons for conducting a qualitative study was the fact that not much had been written about the topic or population being studied. The researcher therefore sought to listen to the participants so that she could build a picture based on their ideas. Literature was used sparingly by the researcher in the beginning of this research in order to convey an inductive design.

3.5 DISCUSSION OF RESULTS

The discussion of the results will be presented in three different sections as the participants were from three different groups. The sections will be discussed as follows:

Section One
Section one will present the discussion of results that were obtained from the focus-group interviews with the student campus healthcare consumers in Phase One of the data-collection process. Their experiences relating to how their healthcare needs were being met by the campus health services and what their healthcare needs are will be discussed.
Section Two
Section two will present the discussion of results that were obtained from the depth interviews with the staff campus healthcare consumers in Phase Two of the data-collection process. Their experiences relating to how their healthcare needs were met by the campus health services and what their healthcare needs are will be discussed.

Section Three
Section three will present the discussion of results that were obtained from the depth interviews with the campus healthcare providers in Phase Three of the data-collection process. Their experiences of what they perceived to be the healthcare needs of both groups of campus healthcare consumers and how they experience the rendering of campus health services will be discussed.

3.5.1 SECTION ONE: IDENTIFIED THEMES OF THE STUDENT CAMPUS HEALTHCARE CONSUMERS

According to Almond (2001:893), patients and clients are increasingly being referred to as consumers in healthcare. The consumers of campus health services include all registered students and staff in the employ of the HEI selected for this research. Consumerism in healthcare is a belief and an attitude which regards patients as powerful, active and sentient participants in structuring and developing health services. Their opinions and involvement to assess the quality provision of services are sought and valued and form a pivotal role in providing optimum levels of care for all. Consequently health services strive to meet the needs of the consumers and not of the professionals (Almond, 2001:896).

A visual presentation of the themes, sub-themes and categories of the experiences of student campus healthcare consumers relating to what their healthcare needs are and how they experience their healthcare needs being met by campus health services is presented as follows:
### TABLE 3.3: THEMES, SUB-THEMES AND CATEGORIES OF THE EXPERIENCES OF STUDENT CAMPUS HEALTHCARE CONSUMERS RELATING TO THEIR HEALTHCARE NEEDS AND HOW THEIR HEALTHCARE NEEDS WERE BEING MET

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
</table>
| THEME 1: Students expressed a diverse range of experiences related to how their healthcare needs were being met at the campus health service | Sub-theme 1.1: Students had positive experiences when they used campus health services.  
1.1.A Campus health service were accessible and affordable.  
1.1.B Campus healthcare providers were passionate and they had good interpersonal skills.  
1.1.C Campus healthcare providers were professional and committed to rendering a quality service.  
Sub-theme 1.2: Students experienced certain shortfalls with regard to campus health service  
Students experienced:  
1.2.A a lack of information about the type of health-care services being rendered on campus;  
1.2.B the appointment system as a stumbling block to access the service when it was most needed;  
1.2.C a need for an after-hour emergency service and adequate transport for referrals;  
1.2.D the staffing, supplies, equipment and facilities as inadequate;  
1.2.E HIV testing to be intimidating; and  
1.2.F some administrative staff members as being lacking in awareness of consumer care principles. |
| THEME 2: Students experienced specific healthcare needs in order to maintain a state of optimal wellness | Sub-theme 2.1: Students expressed the need for knowledge on a diverse range of health-related topics to ensure physical and mental wellness.  
Sub-theme 2.2: Students expressed a need for a wide range of health-care services in order to maintain their health status.  
Sub-theme 2.3: Students expressed a need for the provision of various healthcare services that would improve their health when they were sick. |
3.5.1.1 DISCUSSION OF THEME ONE AND THE RELATED SUB-THMES AND CATEGORIES OF THE STUDENT CAMPUS HEALTHCARE CONSUMERS

A graphic presentation of theme one, its sub-themes and categories is presented as follows:

**STUDENT CAMPUS HEALTH CARE CONSUMERS**

**THEME I**
Students expressed a diverse range of experiences related to how their healthcare needs were met at the campus health service

Sub-theme 1.1: Students had positive experiences when they used the campus health service

1.1.A Campus health service were accessible and affordable
1.1.B Campus healthcare providers were passionate and they had good interpersonal skills
1.1.C Campus healthcare providers were professional and committed to rendering a quality service

Sub-theme 1.2: Students experienced certain shortfalls with regard to campus health service
Students experienced:

1.2.A a lack of information about the type of healthcare services being rendered on campus
1.2.B the appointment system as a stumbling block to access the service when it was most needed
1.2.C a need for an after-hour emergency Services and adequate transport for referrals
1.2.D the staffing, supplies, equipment and facilities as inadequate
1.2.E HIV testing to be intimidating
1.2.F some administrative staff members to be lacking in an awareness of consumer care principles

**FIGURE 3.1: STUDENTS’ DIVERSE RANGE OF EXPERIENCES RELATED TO HOW THEIR HEALTHCARE NEEDS WERE MET AT CAMPUS HEALTH SERVICES**
THEME 1: STUDENTS EXPRESSED A DIVERSE RANGE OF EXPERIENCES RELATED TO HOW THEIR HEALTHCARE NEEDS WERE MET AT CAMPUS HEALTH SERVICES

The researcher observed the students to be very enthusiastic about sharing their experiences related to how their healthcare needs were met at campus health services. They appeared to be sincere and honest in sharing their experiences. According to Collins Cobuild Essential English Dictionary (1989:271) the term “experience” is defined as a situation or feeling that happens to one or by which one is affected. The students come from diverse backgrounds at campus health services and therefore their experiences related to how their healthcare needs are met are diverse. Their experiences were both positive and negative. This will become evident in the discussion that follows in the sub-themes and categories.

SUB-THEME 1.1: Students had positive experiences when they used campus health services

The students were very appreciative and positive about the healthcare services being available to them on campus because they indicated that they would have to miss their lectures in order to attend the public or private healthcare services. These experiences were expressed in the following quotations by the participants:

“I was so happy, we were very happy because the service here – save time, save time. You start at 8 and your class starts early, you know, so that you go to the class and then you go to the clinic”

“I had to miss a class to go for my (family planning at a public clinic) and the nurse says, ‘are you in a hurry, man? Just sit, we’re all in a hurry! Been working the whole day, and you just came now, we’ve all got classes, why aren’t you wearing a uniform if you’re at school?’ “

They often compared campus health services with the public sector’s healthcare services and had a high regard for campus health services. One of
the participants indicated that he went to campus healthcare services for voluntary counselling and testing (VCT) and was pleasantly surprised to find the services that were rendered very professional and of a good quality. This is evident by the following quotation:

“Something that I found was very encouraging, I did go there for an Aids test and I got them (campus healthcare providers) to be very much professional that I have to compliment on that. You know it was just – I don’t know, the counselling, the free counselling and the after counselling and the test and everything there, no I think it was a bit up to standard because I have been to some clinics outside of school (public sector) and you don’t get that much care and much proficiency, so I’d have to compliment that. That was pretty world class when it comes to that department”.

The aforementioned experience described by the participant indicates that the campus healthcare providers treat their patients with care and concern. This could be attributed to the education and training that nurses receive to become competent qualified registered nurses. According to Mellish, Brink and Paton (2004:6), at the end of the student nurse’s basic period of education, she will be able to function as a competent, understanding, self-organizing practitioner. The work of the professional nurse is based on the motive of service, the welfare of the patient or client being the overriding consideration (Mellish et al., 2004:7). Castledine (2006:943) states that there have been a lot of comments recently about the standards and character of today’s nurses. The South African Nursing Council reported that there was an exodus of SA registered nurses to overseas countries due to poor salaries and working conditions here. Desperate staff shortages at the main hospitals in the Nelson Mandela Bay are increasing the pressure on the already overworked nurses and health professionals (van Staaden, 2003:3).

The positive experiences described by the students when they used the campus health service will be discussed and described in the following categories:
1.1.A Campus health services were accessible and affordable

Accessibility is one of the principles that is important in the planning and rendering of primary health care. According to Hattingh, Dreyer and Roos (2006:121), accessibility in primary health care is defined as “the continuing and organized supply of an equitable level of healthcare that is within easy reach of all citizens geographically, functionally, financially and culturally”. The students experienced campus health services to be geographically accessible because the clinics are situated on campus and they do not need transport to access the services on campus. The following quotations illustrate this:

“They're here – they're close to school, if you're at school and something happens, you can always come down here, you know”.

“….we have it here because we're living out here in the middle of a forest and doctors and nurses and clinics are all bundled in town and we can't get there in time but we have one right here, and it's convenient for us, which makes sense in the end”.

“I think it is good that we have a health service at our school because you know, incidents do happen”.

In view of the above quotations, it is evident that the students are grateful for campus health services being available to them on campus.

The principle of financial accessibility implies that the services provided can be afforded by the community and the state (Hatting et al., 2006:121). The community in this context will be all the students registered at this HEI and all the staff employed at the particular institution. A very minimal fee is being charged by the campus health service for certain services rendered, for example, for all minor ailments, pregnancy tests and flu vaccines. These services are being financed by the HEI; therefore the fee is being charged to recover some of the costs incurred. No fees are charged for services such as family planning, voluntary counselling and testing for HIV, Tuberculosis management and treatment and sexually-transmitted infections management.
and treatment. The reason for not charging any fee for the latter services is because of the primary health care network agreement between the Department of Health and the HEI. The public primary health care services are rendered free of charge to the community and therefore the HEI cannot charge a fee for these services because the Department of Health supplies all the medication for these services to the HEI.

According to the study undertaken by Olivera (2007:38), 40% of the participants indicated that their parents had no medical aid. Stanhope and Lancaster (2002:123) stipulate that insurance coverage is often used as a ticket to access health care, that is, insurance coverage provides the opportunity to get health services. The experiences regarding the affordability of campus health services expressed by the students are highlighted by the following quotations:

“I think they’re very useful in a way that, especially for students who are not on medical aid they’re quite useful …..it’s not that expensive for students”.

“It is less expensive, you know. You go to town, you have to pay much more for consultation”

“I know the doctor alone is like R80 to go and consult him….It’s much cheaper to use the services that are offered by the University…”

The aforementioned quotations indicate that students experience campus health services to be affordable as many of them are unable to access private health services because of financial constraints. One of the students said that he did not have money to pay for the private clinic “I don’t have money to go to the medi clinic”. Students also indicated that the fee for services rendered at the campus health clinic could be charged to their student account if they did not have the money readily available.

According to Hattingh et al. (2006:121) functional accessibility implies that the appropriate type of care is made available to those individuals who need it
when necessary. This is evident by the following experiences expressed by the students.

“Here we consult I think it’s R10 and it’s not that you need to break that R10 by the time you’re sick, you can be attended and pay the R10 later, and as you know, medication is not cheap”.

“From my point of view the service is good in terms of getting the medications in time, it’s not that expensive for students”.

These experiences indicate that the students are able to access the appropriate type of care when needed. Hattingh et al. (2006:64) state that accessibility and affordability are two of the ideal characteristics of a primary health care service. The aforementioned discussion of the research findings indicates that campus health services possess these characteristics.

1.1.B Healthcare providers were passionate and they had good interpersonal skills

According to Collins Cobuild Essential English Dictionary (1989:573) the term “passionate” refers to a person who has very strong feelings or beliefs about something and the term “passion” as a strong enthusiasm for something (Collins Dictionary of the English Language, 1986:1122). Therefore, in order to give of one’s best one needs to be passionate about what one does. If one is passionless one will be detached, uninterested and unable to provide one’s best. The experiences described by the students reveal that the campus healthcare providers are passionate about what they do because they give of their best and are enthusiastic about their work. The following quotations demonstrate this:

“I went to talk about tuberculosis and she gave me a pamphlet and she started talking and explaining about it and she was very excited because she kept talking and talking, and I kept listening. I think she is passionate about her job, because she kept going on and on about the TB.”
“...I also had a problem last year and the nurse was very supportive. I was.....on the other day on which the doctor wasn’t coming here and then she made an effort of taking me to the main campus and then she brought me back again, without charging me anything. I think that she’s very passionate about what she is doing”.

“From my point of view, okay, they are fine. They are more kind of welcoming and they give of their best”.

Healthcare providers do not only need to be passionate about what they do but they also need to have good interpersonal skills when communicating with and examining patients in a primary health care clinic in order to establish a good rapport with them. Establishing a good rapport with patients is fundamental to obtaining a complete and accurate health history which is essential for the accurate diagnosing and treatment of the health problem.

Grant (2006:54) states that research in communication shows communicative competence to be an important aspect of successful healthcare. Communicative competence is the ability to interact appropriately and/or effectively with people (Spitzberg and Cupach (1984) in Grant, 2006:55).

According to McCann and Baker (2001:531) the centrality of interpersonal relationships, within the context of consumer and nurse relationships, is well documented. Travelbee (1971) in McCann and Baker (2001:531) emphasises the importance of humanistic caring; establishing and maintaining an interpersonal relationship; and supporting and sustaining consumers. Peplau (1988:17) also, re-inforced the significance of interpersonal relationships between nurses and consumers and considered it to be critical to the caring process.

Hattingh et al. (2006:174) state that patients are usually under great strain and stress when visiting a healthcare professional and they need to trust and have confidence in the relationship. Thus it is imperative for healthcare providers to have good interpersonal skills in order for the patients to relax and be comfortable with them. According to the information obtained from the
students it is evident that the students experience the campus healthcare providers to have good interpersonal skills when they examine and communicate with them. The term “interpersonal skills” relates to relationships between people (Collins Cobuild Essential English Dictionary, 1989:415). The students indicated that they were not afraid to talk to the campus healthcare providers and that they experienced the healthcare providers to be pleasant, friendly and accommodating. The following quotations represent these experiences:

“…………you know as students we’re not afraid to talk with the nurses, so I think we have much more freedom like talking to them and feeling much more relaxed, other than in public clinics where I know you are a bit scared to say something like, some things you did or something, that you’d be scared to tell her. But here (campus health services), maybe because we’re students, like it’s my business so I don’t care if you don’t want to treat me or what, I don’t care, but I feel much more relaxed here”.

“For me it (the treatment received) was very well done because first of all the staff members were very nice and they tried to accommodate you, where you could – I don’t know, where you’re struggling a bit, even with your language or something like that, but they are very much accommodating”

“Well the time that I’ve been there, it was fine, I mean the nurse was quite nice, she was friendly, she explained things clearly to me the medicine and she gave me free Colgate, so I enjoyed it, ja!”

The abovementioned experiences, described by the students, indicate that the campus health care providers are faced with language challenges because the majority of the students that use the service do not speak in their mother tongue. Only one of the campus healthcare providers is from a Black ethnic group. According to Stanhope and Lancaster (2000:897) communication must be culturally sensitive to be effective; therefore it is especially critical to listen carefully, to make underlying assumptions clear and to avoid using professional jargon. The health professionals should thus speak in more commonly shared language or speak or attempt to speak in
their dominant language. In a research study conducted by Rush and Cook (2006:383) about the views of patients and carers regarding what makes a good nurse, the focus groups imply that communication is central to the nursing role across all branches and specialties. The importance of effective communication as a fundamental element of nursing has been acknowledged repeatedly (Wilkinson et al. (1998,1999), Booth et al. (1999) in Bowles, Mackintosh and Torn, 2001:348) and is regarded as integral to the provision of high-quality patient-focused nursing care (Bowles et al., 2001:348).

It can be deduced from the information obtained from the students that the campus healthcare providers are trying to use language that can be understood by the students. This is evident in the following quotation:

“The nurse is more understanding, she explains to you if you don’t understand something, she explains to you (and she) tries to make (it) as simple as possible so that is good.....”

Hattingh et al. (2006:174) on the other hand state that there are several aspects that health professionals need to keep in mind when examining the patients. For example, an attitude that is too formal may prevent the patient from speaking openly because this may be perceived as a cold, non-interested healthcare professional whereas an attitude that is too informal and casual in approach may be perceived as familiar which may also hamper the creation of a positive environment of trust.

Although the majority of the campus healthcare providers do not speak a Black language; the students do not appear to experience it as a problem because they indicated that they were more relaxed with the campus health care providers than with the healthcare providers at the public sector clinics. The students also indicated that the campus healthcare providers were very accommodating when they experienced language problems. No participant indicated that he or she had had a negative experience with regard to the campus healthcare providers. Instead the participants had this to say about
the registered nurse that always attended to them, when they used the campus health clinic:

“Every time I go to the clinic, the nurse is always okay with me, she’s a pleasant person, I feel comfortable talking to her about anything and the receptionist, I don’t have a problem with her because we connect, we talk about anything, so she was never rude or otherwise, moody or whatever to me. So I really don’t have a problem, I don’t have a problem with the nurse as well, I find it okay for me to go there”.

“Well, nice in a way that she doesn’t give you attitude – she smiles, she doesn’t judge you”

“Well I had a great experience I only went there for contraceptives. I was scared at first judging by the nurses that we have in general and when I got there they were very nice. They first counselled me and gave me a date to come back again. So it was OK; they made me feel comfortable”.

These findings are congruent with the findings of a research report that indicated that most patients (62.1%) who participated in a research study conducted in Taung district were satisfied with the attitude of health workers (Bediako, Nel and Hiemstra, 2006:12). However, the research findings of both the aforementioned studies are not congruent with what is being publicized about healthcare providers. In an article in the Eastern Province Herald dated 28 November 2005, Blatch and Dimbaza (2005:1) wrote that the frustrated Eastern Cape health workers lashed out at the health department over gross staff shortages at public hospitals and clinics. These authors reported that the health workers are exhausted and despondent and that it was normal for them to turn away hundreds of patients daily. The health workers often do double shifts at the public health facilities and therefore are unable to cope. The patients are therefore the ones that suffer. The Batho Pele principles stipulate that citizens should be treated with courtesy and consideration at all times (Department of Health, 2000:9).
1.1.C Healthcare providers were professional and committed to rendering a quality service

The students indicated that they experienced the campus healthcare providers to be professional and committed to rendering a quality service. One of the definitions of the term “professional” as cited in the Collins Cobuild Essential English Dictionary (1989:626) relates to a service performed or advice given of a high moral and / or academic standard and appropriate to the context or circumstances that is not too familiar, objective, but courteous and ethical. The students often used their experiences at the public sector clinics as a yardstick to measure the quality of the care and treatment received from the campus health service. The following quotations illustrate these experiences:

“Ma’am, you know, when you go to public clinics, you find that by actually going there, you’re actually setting yourself up in a trap because you find that the nurses are more willing to ask you probing questions – why did you do this, why did you even have to be here – you know, in a sense, vulgar questions you know, but when you get there (Campus health clinic) you are there for business, their business is about treating you – all they want to know is how you got this factor and they treat it simply straightforward. ....So, it’s, you know; they are pretty professional”.

“.......The service that is provided to us, it’s great.”

“I think the (campus) health service does offer good service.....”

“The service was good (at campus health clinic), like I was injured in my body and she (campus health care provider) gave me a roll of bandage and pills, ....but it is different at the government sisters, because when you go there whenever you are sick...you are given Panado”.

The latter experience that was shared with the researcher is congruent with the findings of a research study conducted by Bediako, Nel and Hiemstra (2006:12) to determine the patient’s satisfaction with healthcare in the Taung
district state health institutions. These researchers found that more than half of the patients (56.8%) were not satisfied with the availability of medicines and other supplies. According to a research study undertaken in the East Midlands of England, it appears that it is not only in South Africa that patients are dissatisfied with the healthcare that they receive because the findings of Rush and Cook’s study (2006:385) state that many patients indicated that they had not received the quality of service that they had the right to expect.

The researcher requested the students to give a more detailed description of what they meant by a “good” and a “great” service. The students responded by sharing the following experiences with the researcher:

“I also went there once for a headache. You know, I was very surprised because I thought actually they were just going to give me some pills and then let me leave, but in actual fact I wanted to leave actually, but I was persuaded to rest for a while in the clinic. They gave me a bed to just rest for a while so that they could monitor me for simple headache. So I felt there was that bonus”

“Ja, they give the personal touch because it doesn’t end there, if you see her around that conversation, so it’s like if you got a problem, you don’t hesitate to consider her as one of the confidential people you can consult with “.

“It is also helpful because I think two or three times a week, or once, a doctor comes here and that is very good because one day I went there and I was told the doctor was coming. I should have gone to another doctor in town which would charge me more but the one that came here, she helped me very, very much and I think that this is effective – very, very good”.

“……the sister is going the extra mile in terms of not focusing on dispensing medicines and stuff, but also to, in terms of problem-solving, psychology, can discuss problems, like giving solutions, or her opinions, or professional opinions and such things like that. I think she’s doing a good job”.

These shared experiences are very positive regarding the care that the students receive when using the campus health service. The students also
experienced the campus healthcare providers to be helpful and the medication to be effective. This is evident in the following quotes:

“Okay, I think the service is good and also like the nurses like, they seem to help us when we go there. Also the medication that we get there, I think its working. Ja”.

“…I went to the clinic, anyway I did buy some medication at the pharmacy and stuff, but used them for 3-4 days I was not getting well. But I went to the clinic, you know; they gave me two medications then one or two days, then I was fine.”

The students indicated a preference to be counselled by the healthcare providers instead of the Student Counselling Counsellors because they experienced the counsellors to be too theoretical and not in touch with their problems that they were experiencing. According to Vernon, Ross and Gould (2000:283), the challenge for nursing is to ensure that the assessment process encapsulates not just the physical aspect of health but is able to identify psychological factors which may have a significant impact on a person's ability to experience a sense of good health and well-being. Therefore information about health or illness should be gathered using objective quantifiable information as well as subjective qualitative information.

“I know we do have psychologists at the campus and all; but I feel it is also the duty of their (campus healthcare provider) to assist us with mental stuff….because sometimes you feel it’s physical but the roots of it all (physical problem) is actually psychological”.

“I do not feel comfortable with the counsellor”.

“Ja, they (the counsellors) don’t see the view like from your side. They will see more like the way it was learned or studied or….I don’t know – maybe they’ve never been in the situation”.

The Batho Pele principles stipulate that if the promised standard of service is not delivered citizens should be offered an apology, an explanation and an effective remedy; and when complaints are made, citizens should receive a sympathetic positive response (Department of Health, 2000:9).

**SUB-THEME 1.2: Students experienced certain shortfalls with regard to campus health services**

Although the students indicated that they had had various positive experiences when they used campus health services to meet their healthcare needs, they also indicated that there were some shortfalls that needed to be corrected, meaning that there was room for improvement. This is illustrated in the following quotations:

“…..it’s there, (but) a little improvement that needs to be done”.

“…..it’s vital to have the clinic services at the campus and I will be happy if they can improve upon it for the next students that will come”.

The students not only highlighted the shortfalls that they experienced when using the campus health service, but also made some useful suggestions on how these shortfalls could be addressed. I was surprised at their enthusiasm and innovativeness. The students did not only see problems but also solutions to the problems as well.

The shortfalls experienced by students with regard to the campus health service will be discussed and described under the following categories:
1.2.A Students experienced a lack of information about the consultation times and services being rendered on campus

The students indicated that they experienced a lack of information about the consultation times and the type of services being rendered on campus. Stanhope and Lancaster (2002:123) list the lack of information about the services as a barrier to accessing health care. If primary health care services are unavailable or inaccessible to the community because of lack of knowledge, optimal health cannot be achieved. If communities were not informed about primary health care services, in other words, if these services were not marketed, accessibility, equity and availability could not be ensured (Rali & Meyer, 2006:11).

The students experienced this lack of information as being inconvenient for them because it resulted in their not being attended to and being sent to and fro. One of the students indicated that he arrived at a scene of an emergency when one of his fellow-students had collapsed. He experienced being faced with an emergency situation and not knowing the telephone number of the campus health clinic he related that he had to run from the library to the campus health clinic to inform the healthcare providers. The following quotations illustrate this:

“…I think it (campus health service) does offer good services, we just need to know about them, to know what services they render”.

“I support that this clinic is only meant for a family (planning) clinic”.

“So we basically don’t know about them, although we know they are there, we never get information as to when their consulting hours are – I remember I had to accompany a friend here, when I got there (i.e. campus health service) they were closed, so we don’t actually know about their times of consultation”.

“I was walking next to the library this one time and this girl just fell out of nowhere, she just fell….or something so I actually had to run from the library to the clinic”.
“I think the thing (campus health service) does not expose itself that well because, like he’s saying, most students don’t even know the telephone number of the clinic and they don’t even know the procedure that they have to get an appointment first, then they get to be checked the next day. Some just rock up there and they are told you have to make and appointment, so they leave without being (seen)”. 

The suggestions made by the students to correct the aforementioned shortfalls are evident in the following quotations:

“ I think they could like – I don’t know, I wouldn’t say posters exactly but they need to publicise themselves more and make themselves know(n) among students, like that there is a clinic and like all the procedures and steps you need to go through before you can actually get something done, and not for students to go there only to be told what to do and then they have to go back and forth and try to get an appointment; just make themselves more known among the students”.

“We really need to have workshops for all these things because we hardly know anything. Everyone knows we’ve got a health clinic, but we don’t know where it's situated …..we don’t know where it is……we don’t know the times that they work, you don’t know when the doctor’s in – we don’t know anything, we’re very ignorant about it, the students”.

“….if we actually had maybe some kind of notice at the right campus that they are available in this place…to just probably telling the public that this is what’s happening, we were here and we’re here for you and these are the services we actually provide”.

The students also indicated that there should be a much improved link with the campus healthcare providers in the event of an emergency. They suggested that the security officers on campus should be more readily available and in possession of a two-way radio that could be used to communicate with the healthcare providers. They also suggested that intercoms be placed in strategic points on campus and used for emergencies to contact the healthcare providers. The Batho Pele principles stipulate that
citizens should be given full and accurate information about the service that they are entitled to receive and they should also know the level and quality of service they are to receive and know what to expect (Department of Health, 2000:9).

1.2.B Students experienced the appointment system as a stumbling block to access the service when it was most needed

The students indicated that the appointment system did not make sense to them and that they experienced it as inconvenient because they had to make an appointment before 08:10 on the day that they wished to see the healthcare provider. They indicated that appointments could not be made in advance and that on various occasions they experienced that the bookings were full for the day and they had to return the next day. They also indicated that they experienced the appointment system as time-consuming as they were not always seen on time even though they had made an appointment to be seen at a specific time. The students also expressed the need for the time spent at the campus health clinic to be reduced so that they could spend more time on their studies. The following quotes represent these experiences expressed by the students:

“Appointment business – you can't really predict when you get sick. It don’t make sense to me and it really doesn’t make sense why I have to make an appointment for half-past 12 when I don’t know if I’m going to be sick”.

“The thing is, this thing that you have to make an appointment early. What if I wake up and I’m sick, and you have to make an appointment ahead and I don’t have a car and as the day goes by I get (more) sick, so they can’t help me because I didn’t make an appointment. So that’s the bad part for me, and ja, that’s the bad part for me, but the sister is very OK, talks to me, easy to talk to”.

“There are times when your appointment was for 10 o’clock but you still have to wait for maybe 15 minutes, something like that....”.
The appointment system was the main complaint that the students experienced and they indicated that it was a stumbling block in accessing the services when it was most needed. Collins Cobuild Essential English Dictionary (1989:797) defines the term “stumbling block” as something which stops one from getting what one wants. Thus the students experience the appointment system as preventing them from receiving the healthcare that they need at a particular time. The students also indicated that the campus health service had a policy that prevented students attending a campus health clinic where they resided. They indicated that they could only attend the campus health clinic where they were registered for their course. For example, if a student lived in the student residence on Campus A but was registered for a course on Campus B, then that student could only attend the campus clinic on Campus B. The following quotations illustrate this:

“And if you go to that campus, you go (registered on) to this campus, they’ll tell you to go to your campus which is….I mean it’s really inconvenient for some of us because we actually live here. Some days we don’t even go to campus (classes) and then like, no, you’re not supposed to come to this campus, go to that one, when you go there, they’re like, no we are fully booked”.

“I live at this campus and you catch the shuttle to school and by the time you get there to make an appointment, it’s quite a short time. I mean classes start at 10 past 8 and they say you must make an appointment beforehand. I mean the shuttle only gets there at 8 o’clock or something, it’s really, there isn’t enough time for you to go to school, go make an appointment, go to class…I mean really some of us can’t make it at 10 past 8 and still have to rush to class. And it’s not only you who’s actually waiting for them, there are other individuals already waiting. ...there’s so many people waiting for them (healthcare providers), so I feel the timing is not perfect for some of us”.

The students indicated that they experienced the appointment system for HIV testing in particular to be very frustrating because they had prepared themselves psychologically to have the test done, only to be told that HIV
testing was only being done on certain days. The students shared the following experiences in this regard:

“It really takes something out of you to actually go for the (HIV) test and if they say to you, no, you should come back maybe tomorrow or so, they’re actually postponing the thing and if you have so much courage in yourself to actually do the actual test but now for them to say no, come tomorrow, come on that day, it actually is emotionally and mentally frustrating for you as a person so you endure so much and by the time you get the actual test, you’ve been through hell and back”.

“I did go there for HIV testing and I made an appointment. They said I must come back next week because it’s done Tuesdays at 2 o’clock, and I went there the following week and the nurse couldn’t attend me and I went then for a whole month and I just gave up”.

“…we’re fully booked, come back maybe next term especially when you go for an HIV test, they already have people (booked for the) term so they have to deal with those appointments first and then maybe you’re going to be, maybe 4 weeks or so and you like, Oh my goodness…is it going to take forever”.

In view of the HIV and Aids epidemic in the country, these are golden opportunities that are missed while the media are encouraging the public to know their status in order to curb the epidemic yet the campus health service is unable to accommodate the students.

The students also said that they experienced a problem with the actual procedure for making appointments. This is evident in the following quotes:

“I think the service is fine but then the only problem is before, all the procedures you have to go through to actually make an appointment and things like that”.

“Sometimes if you get there to make an appointment, that secretary takes forever to help you. You sit there and wait and wait until eventually you decided to get up and go”.

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The aforementioned discussions indicate that the students experience the appointment system as delaying access to healthcare and therefore they made the following suggestions to ensure that healthcare would be available to them when needed:

“...getting rid of this issue of making an appointment because we don’t know when we are going to get sick, I mean they must give attention immediately, not make an appointment”.

“If we do have to make appointments, then we should be allowed to make an appointment for the next day or the next week”.

“...if they could extend that time for us to make an appointment for at least an hour later or so.....I mean really if they could extend the time maybe until 9 o’clock”

“...maybe you can phone in and then book and then go pay before you actually go there on the day. I think that would improve it, ja”.

“They shouldn’t have days when to test for HIV....I feel that they should have like every day, if you want to and have an HIV test on a specific day, they should just attend to you and not tell you to come back next week”.

According to Stanhope and Lancaster (2000:259) accessibility of health services refers to the extent to which community and public health nursing services reach people who need them most; therefore services should be offered at times when those most in need of them are able to access them.

1.2.C Students experienced a need for an after-hour emergency service and an adequate transport system for referrals

The students experienced a need for an after-hour emergency service because they have to use the public or private sector healthcare services after hours. Stanhope and Lancaster (2002:123) state that the lack of after-hours
care, acts as a barrier in accessing healthcare. They commented that the service received from the public sector in the event of an emergency was inefficient and the private sector’s service on the other hand was too expensive. The following experiences were shared with the researcher:

“…over the weekends, there’s so much that can happen during that time for us not to have a clinic operating. I mean really, I think we really are entitled to such services. It should be open 24 hours, if the nurses can’t be there, have a student assistant….so they it could be more like a training for them. I mean really we do need such services – so much can happen within a weekend, I mean people get asthma attacks and all and someone has died because of an asthma attack”.

“And another concern is when somebody get sick, let’s say in the middle of the night, and you call the campus control, they call the ambulance. You know the services we get from the municipal ambulances, they’re quite not so alright because one day like the paramedics got here actually drunk, now how can you trust those people with somebody’s life, somebody who is sick you know, so I think maybe I don’t know they can find some other way of getting ambulances here much quicker and people with sober minds and something. Because the ambulances they’re using, they’re very slow, they actually take up to two hours to get here, which is why most of the people they prefer calling Netcare for example. It’s quite expensive for most students because most of us are not on medical aid, so now Netcare will charge you like R350 to take you to Mercantile or something, and most of us don’t have that kind of money”.

In view of the aforementioned experiences the students suggested that some of their fellow students be trained in First Aid in order to assist with the after-hour emergencies, for example, fainting, fractures and sports injuries. The following quotes illustrate this:

“I think maybe here at res we should have like maybe about six, seven people trained to do First Aid, reliable people who are always going to be around. If somebody falls and breaks their leg, I don’t know what to do, I’ll just stand and look”.

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“I don’t know if this is the duty of this health service here to say this, I think it would be good if we could have all the students that are appointed (in leadership positions trained in First Aid) and then they know about First Aid”.

“Maybe if they can take health to like have clinic reps in res”.

“The soccer guys, they really need like someone who knows First Aid because every time a soccer guy get hurt, they always bring a bottle of water, I mean they kick the guy on his back, they give him water to drink”.

The students also suggested that it would be very helpful to involve students in such a way that they assist in the training of other students for First Aid so that they can be of use when there is an urgent need.

The students also indicated that they experienced a great need for a reliable transport system for referrals to and from other healthcare facilities in cases of emergencies. They experienced the transport problem to be across all the campuses. Most of the students living in the student’s residence do not have their own transport and make use of public transport. Stanhope and Lancaster (2002:123) also list the lack of transport as a barrier to accessing healthcare. Students experienced the public transport as inappropriate to transport students who are sick to referral healthcare facilities because they are not equipped with oxygen and First Aid kits. The students indicted that it did not necessarily need to be a fully equipped ambulance at times, although there are incidences when a fully-equipped ambulance is needed for emergencies, for example, somebody with a severe asthma attack needing oxygen on the way to hospital. The students indicated that one of their fellow students had died on one of the campuses due an asthma attack. The students shared the following experiences with the researcher:

“I’ll be glad if we can be provided by a kind of a transport. I’m not going to say it’s ambulance, but kind of a transport which if someone is sick in you know, just now they could be called and say no, this man is sick. We have a transport that if the nurse here she can’t continue with the prescriptions and diagnosis, then that person can go to the nearest hospital with that transport which will
help the student because find also a time at night, students, if you’re going to get sick critically at night, you don’t get critically sick during the day, then you don’t have that kind of transport. It becomes a big problem and I would like to see that thing changing you know, kind of mini ambulance….for all campuses, I’m not just saying only this one”.

“…you know this thing of transport or students who are sick or who need to go to hospital, it’s always been an issue, a big one, because you find that like you know our policies here, they don’t actually allow, maybe there’s a student who has passed (drivers license), to actually drive any person who is sick to hospital, so you find out like we wait for an hour or two waiting for an ambulance to get here to collect someone”.

“I think just to be too loaded (the transport), the fact that we only have one medical vehicle in this whole university with the four campuses – it’s just ridiculous because say now somebody is at the clinic and they need to be transferred to the hospital at the same time, the same thing is happening at (one of the other) campus(es), how are we supposed, it’s strenuous for us students, and it’s strenuous to the sister and the clinic that we have to share one vehicle. So it’s one of the medical services that need to be upgraded and soon...because it’s ridiculous to have one medical vehicle, something that is essential.....it’s even an old vehicle, like broken down or something, its just ridiculous”.

In view of the aforementioned shared experiences it appears that the students do experience a need for an adequate transport system. They indicated that an ambulance would facilitate the process in getting students to hospital more quickly than the public ambulances. One of the students suggested that Volkswagen be approached for a sponsorship of vehicles.

1.2.D Students experienced the staffing, supplies, equipment and facilities as inadequate

The theme for the International Nurses’ day was “Safe staffing saves lives”. Safe staffing and accountability become difficult when there are insufficient
healthcare personnel (Geyer, 2006:3). The American Federation of Teachers (2005) in Geyer (2006:3) state that safe staffing means that an appropriate number of staff with a suitable mix of skills levels is available at all times to ensure that patient-care needs are met and that hazard-free working conditions are maintained. Geyer (2006:3) quotes Giovenetti (1978) as cited in McGillis Hall (2005) as stating that staffing goes beyond numbers: it includes other variables that affect staffing and provision of safe care, such as workload, work environment, patient complexity, skill level of nursing staff, mix of nursing staff, cost efficiency and effectiveness and linkage to patient and nurse outcomes.

The students indicated that there was a shortage of campus healthcare providers at all five campus health clinics of this HEI and they experienced the demand for the service as being greater than the supply. The following quotes illustrate this:

“…the first step they can take, is to provide us with another nurse”.

“…There’s one staff member working there, it’s kind of a disadvantage for students because every time there’s a bundle of students going in the clinic that day making appointments and there’s no one helping the sister. So I feel like if ever they could employ more staff in order to make it easier for the processing to go through easier, because everyone, if ever you come there with an urgent matter, they’re going to say make an appointment, however that matter could not wait, then it’s going to get worse and worse and worse. So employing more staff is going to lighten the burden upon one person that is working there”.

“Maybe there should also be a doctor with the nurses because from my experience there’s a certain day, you can only see the doctor on Thursday. What if maybe your problem is serious on Monday, if you need to see the doctor because the nurse can’t attend to the specific problem. I think we should also have a doctor at this campus because I think the doctor is only on the other campus (A) and campus (B)....”.

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“He’s (the doctor) got limited. …but there’s more students that need a doctor at the same time, …..So I think they should increase them (doctors)”.

The students who participated in the focus groups where only one registered nurse was employed at the campus health clinic indicated that the workload was too much for one person. They experienced this to be the reason for having such a long waiting list for VCT and also why they could not access the service at times. Three of the students summed this up:

“…I think the problem there is that one person is not enough and the sister could run HIV tests, pregnancy tests,….go there for family planning and having one sister is not enough and maybe if we had had two, maybe that test (HIV) would be able to be done for us. Because she can’t attend to all the problems...because she’s only one”.

“....too much work to do for a nurse”.

“I think it’s kind of hectic for them, like our sister, sometimes she has to go to like meetings or whatever. To us, we think like, okay she’s lazy whatever, whereas we don’t understand her needs too...”.

The students found the shortage of campus healthcare providers to be delaying their return to the classroom. For example one student stated:

“I also think of the fact that they (should) employ a lot of staff so as to pay attention to our individual needs, because now when there’s one person attending to everyone’s needs, then the process is being delayed a bit, because as ....just said that we have to get to class, now that (shortage of staff) delays the whole process”.

One of the students indicated that more doctors should be appointed because students perceived nurses to be inferior to doctors and would therefore feel more satisfied if there were a doctor who could attend to them. She described her feelings in this way:
“I think having learned people like doctors to help us with HIV would possibly better because you come here and you get nurses. Actually you get satisfaction when you see a doctor, I don’t know whether it’s just psychological but you know when you see a doctor you feel OK, I’ve seen someone because when you see a nurse, you think no, she’s inferior. So I think we really need doctors”.

A review of evidence-based practice was done by Bazian Ltd. (2005:179-191) to establish whether nurse practitioners provided equivalent care to doctors as a first point of contact for patients with undifferentiated medical problems in London, United Kingdom. The review found that people were significantly more satisfied with nurse practitioners’ care than doctor care in five studies, and in three studies there was no significant difference between groups. The review also found that the nurses’ consultations were longer and that there was no significant difference between the prescriptions of nurse practitioners and doctors (Bazian, 2005:179-191). Harkless (1989), Kinnersley et al. (2000) and Venning et al. (2000) in Clendon (2003:561) state that studies that have sought to compare nurse practitioner and physician outcomes have found that the nurses’ outcomes are equal to and in many cases superior to those of the doctors. Thus there appears to be sufficient evidence that could be used to convince the students that they should not fear that they would receive inferior treatment from the campus healthcare providers.

Thus in order to address the shortage of campus health care providers the students suggested that the nursing staff be rotated as a relief for those registered nurses who had to attend meetings or were sick, in order to ensure continuity of service to the students because the secretary, even though she was always available, was unable to do so. It was also suggested by the students that the doctors’ sessions be increased. The suggestions made by the students were:

“….I think if they can do some more kind of staff rotation, because the secretary she can’t give out like Panado ...”.
“Maybe the nurse should have a time limit or something….Maybe the nurse should like see a person and then say 30 minutes, I've got 30 minutes, not like more than one hour seeing one person….”.

“Even the doctor's visits – I think he must come twice a week, not once a week”.

“…so the doctor must at least come every day”.

“I think if the doctor can come like every day, maybe stay for maybe 2 hours and then he can go, then I think that can be fine because maybe you are going to find out you are sick on Monday, then they say you have to wait for him to come (on Thursday)…”.

The students expressed a need for the appointment of both male and female campus health care providers because they felt uncomfortable and delayed seeking help when being examined by the opposite sex, especially when it came to intimate care. Inoue, Chapman and Wynaden (2006:562) describe intimate care as the provision of physical care that is invasive and has the potential to cause embarrassment to the patient or the nurse. For example, it could include removing a part of clothing or procedures that involve inspecting and touching the patient’s genitals or an emotional connection with the patient.

Both male and female students expressed this need for the appointment of male and female campus healthcare providers but the male students felt more strongly about this than the female students did. This could be attributed to the fact that the Black culture perpetuates the minority status of women. The following quotes sums this up:

“Maybe we could have doctors of different sexes because we could feel better with a female doctor than a male for something serious, you can actually confide in a woman better than with a man and in the case of boys or men, they could actually confide in men better, so I think we should have doctors of both sexes“.
“...like its hard just to go to that person (Nurse), who will touch you there (genitalia) and looking at that (genitalia), those people are there you know, and you are looking at ways whereby you can accommodate (live with) this...because its fine, sometimes they stay with this thing (STI), thinking that, no man, let me persevere a bit, it will be okay, I don't want to be seen by the (nurse)....but as long as that thing is there, I think having someone who is a male...”.

“Having a male would be nice....let's face it, guys”.

“...we do have some STD and then I think it can be good if we can get another assistant there as a male because due to my culture, I'm not comfortable to show the sister my private parts”.

Healthcare service providers in South Africa are increasingly faced with the challenge of modelling their approach to healthcare to meet the needs and expectations of the diverse population groups that they serve (Andrews & Boyle, 1995:5). The norms and customs inherent in these indigenous cultures are fundamental in the day-to-day existence of the people concerned and may hold a key to the understanding of many aspects of their lives, including the understanding of sexually transmitted infections (Mulaudzi & Makhubela-Nkondo, 2006:52). According to Hoban and Ward (2003:140), cultural competency is a life-long process and college health programmes need to ensure that their environments, policies, programmes, services and staff are meeting the needs of students of all races. It is imperative that all students feel comfortable enough to seek VCT and discuss risky behaviours with their campus healthcare providers. Understanding the various indigenous cultures could assist towards solving some of the problems facing healthcare professionals in South Africa.

There were students who disagreed with what the aforementioned students had to say, indicating that it did not matter whether it was a male or female that examined them, as long as they received quality care. They indicated that the mind set had to change and that one should no longer think in terms of
male or female but rather focus on the healthcare that was needed. The following quotes emphasise this:

“I don’t have a problem with male doctor. I prefer a male to a female”.

“Ja, but myself I want to dispute what he said. I understand in terms of STIs. He might not want to show the nurse but what if he go to a clinic outside? You find that the doctor is a female. When you’re sick, you’re sick you know, it’s the same as – you can’t choose who you want to (see) – we are the same cultures – this is the service that is provided on my side it’s a service that is provided for students with the person that they could find in hand to help them (deliver the service). It’s for us to be open…How are you going to get help if he can’t let her see (the genitalia)? She’s just there to help people. I think this is a mindset we should like (adopt), I’m going to the clinic, I need help. Whatever the nurse has to do, it’s for your benefit, you know”.

In addition to the problem of inadequate staffing the students mentioned the problem of inadequate facilities. They related experiences of finding the structures of the campus health clinics to be small and overcrowded.

“I think the major part,… extend the health services, you know make it bigger and more available to the students”.

“I mean when you see there is more space,…you’re more likely to go to the clinic”.

“…I found that especially the one (campus health clinic) that’s on the….campus you know, it’s too overcrowded I think when you enter the reception area, it’s just so overcrowded at times”.

“….I Think the size of the campus health service should be enlarged like to accommodate more students during consultations”.

The findings of inadequate supplies and equipment emanated from the research data. The following quotes sums up the students’ experiences:
“...there must be more kind of equipment or like facilities...sometimes we need like high blood pressure machine (just to have a BP check) or whatever then they will tell you okay they’re (campus health care providers) busy using it”.

“Maybe you need to weigh yourself and there’s only one scale, one person at a time, it is very inconvenient for other people, ....because you have to go to class”.

“Even the information pamphlets must be like (available) ... each and every time....facing a high rate of HIV/Aids whatever, they must put more pamphlets in order to kind of motivate us to practice safe sex”.

“Like if you come and say you have a headache, there are no pills for a headache. Mainly its for prevention of (pregnancy..”.

“When my friend came to the clinic for a sore tummy, but the nurse told her that there are no pills or something for the tummy...she didn’t give her anything for the tummy”.

The students indicated that they were not very happy about the fact that two of the campus health clinics at this institution were bigger and had more staff than the other campus health clinics. Their experiences in this regard are reflected in the following quotes:

“...the (B) campus and the (A) campus they get much better attention than us, nê – so we as students, when we seek help from the sister, the sister she tries to refer us at (A campus) and (B campus)...those people (campus health care providers) they’re not paying attention to us as part of the.....and I think it’s high time for them to equip this healthcare service centre more as to be equal to the other people, because we’ve got the same problems as they have”.

“This campus has got only one person (health care provider) assisting, like 60 students per day approximately......the (B) campus has, say there’s two to three (health care providers). (A) campus has four or five? ..........The feeling that I have is that......... (this) campus is ignored in terms of everything,
especially the health care service because to me, the fact that we have one staff, doesn’t make me happy”.

According to van Rensburg (2004:581) inequity refers to those inequalities that are considered to arise from unfairness. Inequitable disparities in health have become a major focus of attention worldwide in recent years.

1.2.E Students experienced HIV testing to be intimidating

HIV testing was experienced as intimidating by the students because they were not comfortable about disclosing such personal information to the campus healthcare provider whom they regarded as a mother figure who may reprimand one when one has done something wrong. The students indicated that it would be easier for them to get the message across through other students. According to Collins Dictionary of the English Language (1986:798) the word “intimidate” means to make timid, frightened or scared. The following experiences were shared by the students:

“…you know you are going to be dealing with an adult, I mean we’re teenagers….. you go there and you think, she’s a mother – she’s a mother as much as a nurse, behind that nurse is a mother, you know how mothers are like – no, you were supposed to do this, you are supposed to do that and you go, oh my gosh, here it goes – I mean especially with the Black nurses and all, they give it to you like, you know, big time, any way before you even go there, you just feel okay is she going to ask me questions, why didn’t you do this and this and that and much as you are aware of your mistakes she’s going to rub it on you and rub it on you, it makes you feel so bad, you know, I mean really, the mere fact that you made the decision to go and do a test (for HIV), you’re already feeling bad about the whole thing if it say was due to a sexual encounter or something, why should the nurse feel it her obligation to – I mean yes I know they’re caring and all but the mere fact that you are there is a responsible step itself you know, so it kind of intimidates you”.

“You know, it can be very intimidating at times, like say for instance you go and be HIV tested you know, its kind of intimidating, you do not know how the
nurse is going to perceive you as a person, because in many cases let’s say you go for an HIV test, people think you are an irresponsible person and everything, they don’t know what is the motive behind you going for the test you know, in many instances some people, okay fine, obviously people go for HIV tests because they’ve been sexually involved and everything, but some of us have met people who are actually sick and you actually want to find out your status and all, so it can be intimidating you know when it comes to HIV tests”.

“It might be better getting the message across through other students, because when you first come here, it is quite intimidating, and ja, that walk down the stairs is actually quite intimidating as well, so ja, I think getting students to actually like talk to other people, like he says, the whole coordinators, ja, just make it a little easier,...then it won’t be such a bad thing to go to the clinic”.

“.....your VCT it is very intimidating you start thinking anything you know”.

Van Dyk (2001:162) states that it has been generally observed by researchers that children’s fears correspond to the times in which they live and the events with which they are familiar from the media and from listening to discussions. AIDS is one of the fears that today’s children live with. Some adolescents are afraid because they were already sexually active before they knew how to prevent HIV (van Dyk, 2001:188).

1.2.F Students experienced the administrative staff members to be lacking in an awareness of customer service principles

The students said that they experienced the administrative staff to be lacking in customer service principles because they were rude, moody and unfriendly. This made the students reluctant to attend the clinic. The following quotes illustrate this:

“...at times she (administrative staff member) can be very rude and at times she can be friendly, so when you go to the clinic, you go with that thing of not
knowing which mood she's going to be in today and ja, she's not a people's person. I don’t think she should be at the front desk because she's like the face of that clinic and the face....should be a friendly face. Because most of the people now don’t want to go to the clinic because of her, even if you’re sick, you find no they don’t want to go because that woman is there”.

“No, she’s not always rude. It's just that she’s in a bad mood; you don't know what put her in a bad mood. Its like she gives you those stares and those looks, its like she’s disgusted with something. You can see you know that she is not friendly today you know, when you talk to her its either she’s not listening to you or she shouts at you, or she just answers in a very snotty way”.

“.....she (administrative staff member) had a very cocky attitude and some people do not go to the clinic because of her”.

The students also indicated that they experienced the administrative staff as making them wait for long periods unnecessarily before they attended to them. The students revealed that they felt uncomfortable and frustrated regarding their experiences with the administrative staff. The following quotes sums this up:

“You can see that the person (administrative staff member) sitting there is basically doing nothing even though she’s – but you still have to sit and wait for them, for a certain number of times, I have always felt that was a bit uncomfortable”.

“And she gets frustrated towards us whenever we’ve got to be helped you know, she gets frustrated, That really frustrates you because you like get there and stay on those chairs for about an hour or so waiting for your appointment and when you get up to ask her when are you going to...then she tell you, no the nurse has gone to lunch.....so ja, it's really frustrating”.

“I'll sit and wait for help, as long as I know that they are – I know what is rude and you feel so bad, or so down after....".

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In view of the abovementioned expressed experiences the students made the following suggestions:

“…….they should be careful how they select a person”.

“…….they need to take her on a course on people’s skills”.

Gantsho (2007:105) quotes President Mbeki (2000) as asserting that the improvement of health service delivery is about re-aligning everything we do to “Customer Service” principles. He has further stated that it costs nothing to smile, treat someone with respect, and be honest when providing information and apologise if things go wrong. Customers in a healthcare facility are primarily referred to as patients, who have suffered from a variety of hurts, for example, physical, emotional and spiritual. Therefore, application of customer care principles in a healthcare facility will form part of the healing process.

3.5.1.2 DISCUSSION OF THEME TWO AND THE RELATED SUB-THEMES

A graphic presentation of theme two, its sub-themes and categories is presented as follows:
This theme emanated from the research information obtained from the participating students. According to the field notes gathered, the ages of the participants ranged from 18-25 years, with the average being 19-20 years, which is in keeping with the average university age (Oyedeji & Cassimjee, 2006:7). Adolescence is plagued by its own healthcare needs that demand appropriate healthcare delivery to deal with its specific healthcare issues. Risky sexual behaviour at this stage of life is not the only threat to health. During adolescence, young people are also increasingly exposed to harmful addictive substances that pose a threat to immediate health. For example, smoking, often started at school, is a major threat to health across the life span (van Rensburg, 2004:236). The following quotation is evidence of the high-risk lifestyle that adolescents lead and it is congruent with the comments...
of van Rensburg above “*We drink (alcohol), more, we smoke more than-, we go for chicks and – more than (the other members in the community)*”. According to Patrick et al. (1992:259), a wide range of acute and chronic health problems, which represents a substantial burden of morbidity and mortality, occurs among college (university) students. These include genito-urinary, respiratory or gastrointestinal infections.

Nardi and Peter (2003:2) cite the World Health Organisation’s definition (WHO, 2001) of health as the complete state of physical, mental and social wellness and not merely the absence of disease or infirmity. This broad definition of health emphasizes the importance of social factors such as socio-economic status, education, safety and the environment in the overall determination of the health of the community. On the other hand wellness refers to quality of life, a general satisfaction in all the areas of an individual’s life, including aesthetic, cultural, educational, economic, emotional, environmental, mental, physical, relational and spiritual (Nardi & Peter, 2003:3). Wellness has been divided into six distinct areas, namely emotional, intellectual, occupational, physical, social and values/spiritual wellness. Holistic healthcare has a direct relationship to educational excellence and is dedicated to promoting students to achieve their highest potential (University of Nevada, http://www.unlv.edu/studentserv/SHC/wellness.html. Accessed on 14 February 2003). Therefore student health programmes, policies and practices should be designed to ensure optimal wellness of all the students on campus.

**SUB-THEME 2.1:** Students expressed the need for knowledge on a wide range of health-related topics to ensure physical and mental wellness

Van Rensburg (2004:8) states that health knowledge refers to what people know about health, disease and care, that is, people’s health literacy. It includes people’s knowledge of the human body and its functioning, the causes and symptoms of disease, the applicable measures for maintaining
and restoring good health, as well as their knowledge of the healthcare system. The students expressed a great need for health knowledge to empower themselves so that they would be able to take informed corrective action when necessary. One student indicated that sometimes one could be infected with an STI because of ignorance regarding the disease. They also indicated that they were only knowledgeable about HIV and AIDS but tended to lack knowledge about other diseases that could be more dangerous than HIV and AIDS. The students acknowledged living a high risk lifestyle which could be due to ignorance. The following quotations illustrate the need for knowledge requested by the students across all campuses:

“I think my needs would be information because I think, I wouldn’t talk in general, but I think our black community...somehow we lack information because I might say this works for me, I can probably drink, smoke, what, what and...that works fine for me but if I pass that to Pat and Pat’s using the same thing, probably he might overdose, probably he might be allergic to that, so information relevant to different medications, information relevant to activities the students indulge in, because as students we tend to differ with the general community in terms of our activities. .....so information like that is very much vital because I think, one saw this video, they were saying there were things, diseases, and for us – not for us, for me, the only diseases I know is HIV and AIDS but that one they say is even worse, more that HIV and AIDS. So Information like that as a student whilst I’m here, I still have the capability and time and the capability to start, I think it’s one and the same information that I might as well as access”.

“....I think it is very important, like the point of being taught or, ja, being told about some other diseases – not actually diseases but other things that may affect our lives”.

“...the information is an important thing, and getting information you heal yourself, because without information, that is why we get sick. Some get STIs because you’re not informed. But for the health clinic to deliver my needs or maybe cater (for) my needs, I will say maybe if they can give us as much information as they can”.
Some of the students were very specific regarding the health-related knowledge that they required in order to ensure physical and mental wellness. Physical wellness focuses on the body which is like a finely-tuned engine that needs materials and mechanics to stay in good working order. Emotional wellness on the other hand refers to an individual’s ability to identify, understand, manage and use emotions in a way that promotes health and success. Emotional health is a vital aspect of all our lives and it has been indicated that individuals with a high degree of emotional wellness cope effectively with stress and are able to maintain good emotional balance (University of Nevada, http://www.unlv.edu/studentserv/SHC/wellness.html. Accessed on 14 February 2003).

Some students requested to be informed about emergency contraceptives. “Contraceptives, morning after pills, what you should do….during weekends you know, if you are to buy pills from the chemist, what you should do, things like that, because the clinic doesn’t open over weekends”. In a study conducted among adolescent mothers in Tshwane, South Africa, by Ehlers (2003:23), the results revealed that the majority of the adolescent mothers lacked information about contraceptives and emergency contraceptives. Emergency contraception refers to pregnancy prevention methods used after unprotected vaginal intercourse has taken place and is perceived as a contraceptive method rather than an abortifacient. Intercourse is considered unprotected when a contraceptive method is not used at all or is incorrectly used and inconsistently (McCarthy, 2002:15). Emergency contraception prevents pregnancy from occurring by altering women’s hormone levels to inhibit ovulation, ovum transportation and/or endometrial growth by using specific “morning after pills” or by using pre/calculated high doses of oral contraceptives (http://www.who.int/inffs/en/fact244.html in Ehlers, 2003:15).

Another student indicated “….some of the problems I actually feel are psychological…. And then we start having anorexia – and then we need to know about that, and what happens, basically.”.

Anorexia Nervosa, classified as one of the categories of eating disorders, comprises the third most common chronic illness in adolescents, after only
obesity and asthma in America. Although eating disorders affect both men and women, they affect women predominantly (Parker, Lyons, and Bonner, 2005:103). Anorexia Nervosa may emerge as a cry for help or for attention from family members (Slee (1993), Rosen (1996) in King & Turner, 2000:140).

Through self-knowledge one’s physical and emotional wellness potential can be enhanced. The following quotations illustrate some of the other specific health-related knowledge that the students requested in this context:

“I would say for me ……sister comes to talk to us about sexually transmitted diseases and all those other things…”.

“…..they should inform us in a manner, in specific balance in order to know how much to drink (alcohol)”.

“(need information on how to be) mentally and physically (fit), because before you can be physically fit you need to be mentally fit, you can’t really be fit physically if your mind is not fit. That’s what I think might be a way to take, might be important to the students, and even myself”.

One student indicated that she would like to receive information on “Breast cancer, cancer, HIV, TB, diabetes, high blood pressure, low blood pressure”. Another student indicated that she always worried about diseases such as “TB, HIV/AIDS, High blood pressure, stress -…..(need to) get more information”.

The aforementioned quotations indicate that a definite need was expressed by the students for a wide range of health knowledge.

A lot of emphasis was placed by students on the need for knowledge related to a well-balanced diet. According to Hattingh et al. (2006:201) the nutritional needs of adolescents are influenced by their physical alterations as well as by the psycho-social adjustments. Teenagers are generally free to eat when and where they choose and often snack outside the home and resort to fad foods and crash diets. All these factors contribute to the adolescent being at risk of
poor nutritional health. Teenagers’ nutrition should therefore be assessed regularly and should also be educated about nutritional needs and healthy habits within the context of their cultural food preferences (Vlok, 1996:277). The students indicated that they were not eating properly due to ignorance and a lack of funding. Since the nutritional status of individuals is influenced by a wide variety of socio-economic, psychological and biological factors (Compare Green & Watson, 2006:487), the following experiences shared with the researcher were significant to this study:

“If I can get more information on how to stay healthy, we’re all students, we don’t eat healthy, we don’t have money to buy those what do you call it, diet of the day, the daily diet…….”

“Things about diet and all, you know and I mean we live in the residence and all, I feel we really need (information on) a balanced diet and all of those things, especially (information on) junk (food). I feel we are entitled to such services. Every now and then they come tell us we shouldn’t eat this, this is correct, this is not good for you and I mean in this residence specifically, I mean its only girls I think if your diet’s not correct, that’s why some of our menstrual cycles are so messed up because we don’t eat the correct food at all. You only get to know that once you like hey, my cycle’s really not correct at all, then they (health care providers) tell you no, what are you eating? You lack iron, you lack this and that and that, you lack Vitamin C, you lack Vitamin B and that and that I mean why can’t they (health care providers) tell us beforehand, like no, you should eat enough of vitamin this, you should have iron in your body and that and that and that, to avoid such a situation. Some of us go to the clinic and then look OK, I haven’t seen my periods for this long and all and all, and I know you actually lack this and this and this in your diet and all, so if they could provide a service whereby they come every now and then to our campuses to inform us of such things, then those things could be avoidable”.

“I think maybe a good diet – I don’t – I don’t really know – okay I know the bad stuff but they say some of the bad stuff is actually good for you, so you know I can’t really differentiate, I like eating everything! So maybe we could have some sort of nutritionist at the clinic, or maybe you know send the sister on some course on nutrition …..so somebody can advise on diets”.

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The students emphasised that the health information should be provided in a fun way if learning was to take place, stressing that the manner in which the information was being communicated to them was extremely important. It needed to be planned and organized in such a way that they felt that they wanted to listen to what was being said and would not be bored. The following quotes illustrate this:

“I think also the other thing – information for students also goes with how it is delivered, because if I’m lectured in the same way the lecturer lectures me in class, I’ll be bored within a short space of time but if you add some bit of fun to the knowledge and a bit of creativity …..So I think the way the information is delivered to students, must also be taken into account”.

“This is what I’m saying, that they need to come across with something that we as students who want to come here, we’ve got something to look forward to. So I think it will work if they just bring fun into this whole thing because personally I wouldn’t go to a workshop where okay you see a notice board they say , workshop agenda, HIV/Aids, maybe just try and put it in a fun way so we can actually say OK I want to be part of that”.

I also think that in most cases when we think of workshops as just old people just telling us a whole lot of things and using special words, jargon you know, I think if they actually came up with like ways in which they can reach us as teenagers….we can actually feel that this is where we want to be”.

The students indicated that it would be better to get fellow-students to speak to their peers on health-related issues and they suggested that some of their fellow students be trained as peer helpers to assist the campus healthcare providers with disseminating information pertaining to health matters. They suggested that this be conducted on a voluntary basis by inviting interested persons to participate. The students suggested targeting students in leadership positions because they felt that these students would be able to influence their peers. Students felt that they had a responsibility to reach out to their fellow students with regard to disseminating information to their peers on health issues. The following quotes illustrate this:
“As a student, I think we have a responsibility to check the health services daily and be willing to volunteer so that we can reach out to the other students as well, .......I think as students we've got a responsibility to spread it (health information) and arranging some workshops, teaching each other in any way that I think we can manage with that”.

“Ma'am, Students should be more leaders and officers. ......They're just training them to relate basic information, you know communication skills”.

“...look for students that are in leadership positions right around the campus...I believe once they are in leadership I believe that they have certain influential position...and train them for two weeks”.

“Volunteering students can volunteer..”.

The students also felt that presently the health information being provided on campus was too infrequent and was not meeting their needs because they were given too much information at one time. They suggested that a well-planned health education programme be implemented on a regular basis and even repeated at times to ensure that as many students as possible get an opportunity to attend. They felt that the information should be visible all the time because presently they were having one-off events and if they were unable to attend them for some or other reason they had missed an opportunity to learn something new.

“... when it's like one thing (session), then only a few people go and the rest of them stay in their in their rooms, so if it's two, they can think or so look I didn't go for it during the first semester so I can go for the second semester”.

“Maybe they say on Monday we're discussing TB and we actually learn about that, maybe the other Monday they're discussing something else, Instead of them just throwing us with everything at once”.

“Having things on a calendar (for example) health awareness week, health awareness month”.
“Maybe it’s a cycle that will be repeated each and every beginning of the month so that students don’t get to forget”.

“I’d like the information to be all over, all over our place, all over our internet, whatever, everything, it should be in such a way that it’s sort of nagging us and then in that way you can’t miss it”.

Various ways were suggested by the students to disseminate the health information to their peers in a “vibey” way. Some students expressed the need to move away from pamphlets and e-mail as a means of communicating with their peers because they indicated that they did not read the pamphlets and/or their e-mails.

“Pamphlets doesn’t really work with students. You give them something but we don’t even read it”.

“For instance you do send e-mails telling us about campus health day you know, but seriously – not everybody checks their e-mail you know”.

There were some students, however, who suggested that pamphlets and brochures be used. Alternative means such as music, drama, billboards and notice boards were suggested to get the message across. This is evident by the following quotes:

“…there should be like pamphlets, brochures, those kind of things”.

“..if maybe they had people that make up song or something, people from the music department, something like that, they make up songs, drama things and then maybe we have that doctor in the middle of the thing, saying something, giving out the message about that it can help. I’m not saying let’s all have a party now, but just to bring someone professional and have a place, like a fun side to it, and we bring it all together and we learn in that way……so you tend to listen to the music and at the same time you’re actually listening to the message, so that’s why it comes across as being effective”. 
“...so when we get refreshments there. We call other people and say did you see that, you have to go there, and then we go because we saw.....refreshments!”.

“I want to be seen with a cool crowd or something like that, just say there, clinic dancers will be there and we’ve got like people of our own age group wearing tee-shirts of clinic health services it’s more fun and we relate to that, so I basically think that could work”.

“Even when you enter the gates, there should be maybe a billboard”.

“Or maybe visual aids like maybe a drugging person or something, to show what drinking does to you, whatever, for sure when you pass them in the corridors, big signs of whatever and then you can look at it and see what’s happens when you do such things. Maybe an explanation at the bottom – okay, this is what happens...”.

“...acting or something like that and not actually just sitting there and listening to long speeches because we tend to get bored. So I think if they actually made it fun then people would go”.

In view of the above discussion the students appear to be very innovative and creative.

SUB-THEME 2.2: Students expressed a need for a diverse range of healthcare services in order to maintain their health status

Many of the leading causes of death are related to lifestyle and therefore primary prevention can prevent or arrest the disease process in its earliest stages (Woolf & Atkins, File://F:\Theevolving role of preventioninhealthcare). In meeting health needs, emphasis is currently being placed on promoting good health and preventing ill health (Hattingh et al., 2006: 123). Health promotion and disease prevention are more significant and cost-effective for young people than any other age group. Primary health care and early
intervention for individuals can help prevent costly problems, suffering and human loss. Health promotion and disease prevention strategies for improving adolescent health come in many forms (Nies & McEwan, 2007:281). Therefore, broad-based strategies such as, for example, administering flu vaccines, VCT, family planning services, papanicolau (PAP) smears, breast examinations and vitamin supplements will assist greatly in improving the health of adolescents.

Students indicated that they needed to be informed of preventive health services that were available to them “...if there are some preventative measures that one can take, I think those should be communicated to that individual, apart from being cured but the preventative measures can be taken by that individual”. Regular physical screening was indicated as one of the services that were necessary in order to maintain their health status. The interpretation of the significance of the clinical findings of the physical assessment will result in either the recognition of abnormality or identification of a differential diagnosis (Bald, 2006:714). The following views were expressed:

“...I know there is campus health day or something where you actually go for an overall checkup I think or something like that. But I was thinking, instead of being for one day or something like that, can it be made for every day purposes, you know, when you feel that this is my time ......you might be busy with those days (the days that are especially set aside) (you must be able to go) when you feel like it because I think it will benefit me as a person to know where I stand with my health, instead of making the one day thing....”.

One student indicated that she would like a general checkup to establish certainty about basic health issues such as, for example “...maybe I have some spots here, I think they are basically nothing but by going there, this is something they could just pick up you know. Basic things, maybe symptoms that I as a person were not understood. Maybe if I went there early, just a general checkup from head to toe, simple and straight forward”.
The students indicated that they used the campus health clinic mainly for contraceptives. According to Ketting and Visser (1994:161) contraceptives are agents used to prevent the occurrence of conception temporarily, including oral pills, condoms, intra-uterine devices and injections. The students also indicated that their experience was that most of the students using the campus health clinic are mainly females; therefore they suggested that women’s health issues such as breast examinations and pap smears should be conducted to detect early cancer cells. After a needs assessment conducted by Rogers, Harb, Lappin and Colbert (2000:283) at the San Francisco State University, they established that male students underutilised campus health services as do the male students at this HEI. The following quotes illustrate the request for topics on women’s health issues:

“If they had like, just to check, to test you for like breast cancer, they do ok”.

“And pap smears – maybe they can have like, ......during the first semester and the second semester you know, and maybe they can actually educate people more about what pap smears are all about. A lot of people just see pap smear, pap smear – they don’t know what it is, they don’t know what it is about. They go for pap smear, they don’t know what they are going for. So maybe they can educate students, like female students, what pap smears are and maybe they can actually have them ......on a regular basis”.

Oyedeji and Cassimjee (2006:7) state that women’s reproductive health, rights and choices are of great importance to them as individuals and they undertook a study to explore contraceptive use among male and female students aged 18 – 25 years who visit the campus health clinic at a university in KwaZulu Natal. The results derived from this study imply that male and female respondents are willing to take responsibility for contraceptive use, if they are enlightened and given proper and adequate information about contraception (Oyedeji & Cassimjee, 2006:13).

Reportedly, 78% of adolescent girls and 86% of adolescent boys have engaged in sexual intercourse by the age of 20 years (United States Department of Health (1991) in Patrick et al. 1992:261). Similar statistics are
evident in a study conducted by Koumans, Sternberg, Motamed, Kohl, Schillinger and Markowitz, (2005:217) 14 years later when it was established that 86% of college students reported some sexual activity and 68% were currently sexually active.

Adolescents and young adults often engage in high-risk sexual behaviours, have multiple partners and have sex without a condom. These activities place them at high risk for infection with HIV and other sexually transmitted infections (Koumans et al., 2005:211). Tulloch, McCaul, Miltenberger and Smyth (2004:263) are also of the opinion that young adults, including college students, are at particularly high risk for sexually transmitted diseases because of the number of their sexual partners, high rates of unprotected intercourse and the prevalence of sexually transmitted diseases in their networks. An assessment of the prevalence of risk factors for HIV among college students suggests that, although the overall prevalence of infections is low and confined to high risk groups, the occurrence of behaviors that facilitate sexual transmission of HIV is high (Kotloff et al. (1991) in Patrick et.al., 1992:261).

According to Hawkins (2005:334) 47% of the university students surveyed indicated that they always used a condom during sexual intercourse, while 37% of the students indicated that they sometimes used condoms and only 13% indicated that they never used condoms. These results are contrary to the results of a survey conducted by Macdonald, Wells, Fisher, Warren, King, Doherty and Bowie (1990:3155) which stipulated that only 25% of males and 16% of females always used condoms during sexual intercourse. However, condom use does appear to have increased over the years among university students.

In light of the HIV and AIDS epidemics the students expressed the need for HIV testing and the increased availability of condoms on campus. This is evident in the following quotes:
“I can also say that I have HIV health needs.....I go there (campus health clinic) maybe when I do the HIV test”.

“You know at toilets, we do have that thing of condoms. That thing is very important to be filled every now and then. It has to be filled every day.....They could involve students (to fill the containers)”.

The importance of the use of condoms has increased in the light of the current HIV pandemic facing South Africa. Condoms are increasingly becoming a way of not only preventing an unwanted pregnancy, but also a method of preventing the transmission of STIs. Thus in the effort to stem the HIV pandemic, the promotion of the correct and the persistent use of condoms has to be priority in the primary health sector (de Wet, Ackerman, Crichton, 2002:4).

While good nutrition is an essential part of good health, it is also true that poor nutrition accounts for a large portion of the world’s disease burden. A deficiency of iron in the diet, for instance, reduces physical productivity and the capacity to learn in school (Stanhope & Lancaster, 2000:73). A variety of foods must be ingested to meet one’s daily requirements and diets should include a proper balance of carbohydrates, protein and fat with sufficient intake of vitamins and minerals (Nies & McEwan, 2007:614). The students expressed the need for the healthcare providers to conduct a survey to establish how many students were not eating a well-balanced diet on campus as they were aware of some students who did not. One student had this to say “I wake up at night, I’m hungry, I ate 4 slices of bread”. The students expressed the need for a nutritional programme and the supply of vitamins because they were unable to purchase well-balanced meals. This is illustrated in the following quotes:

“...I think if the clinic can maybe provide some multivitamins to the students, explain why we need multivitamins – anyway, the awareness of being health(y)”.
“(we need) vitamin supplements because we are always eating bread and chips”.

“Why we can’t get food for free even if we’re not in a kind of a war, I think clinics can get that kind of money to supplement students with those kind of food, those daily needs, you know”.

“…Whether you provided Morvite or something. I thought actually that was very good because,…it’s a basic food, it’s a basic nutrition for anyone, so the nurses can add on more things like that you know, instead of only Morvite, maybe milk or something once in a while…”.

The students also expressed the need for dental care and eye screening to detect any defects early and they also expressed the need to receive the influenza vaccine annually. There is considerable evidence supporting vaccination as a patient safety measure. The Centres for Disease Control and Prevention have reported that while influenza is highly infectious, the vaccine is effective in preventing up to 90% of cases in healthy people under 65 years when the vaccine strain is similar to the circulating strain (Olsen, 2006:77).

**SUB-THEME 2.3: Students expressed a need for the provision of various healthcare services that would improve their health when they were feeling sick**

As equity and access to healthcare have since 1994 been considered the key principles to steer the transformation of health services in South Africa, a mechanism was required to define parameters for service delivery, as well as to ensure comparability in the rendering of services. This mechanism was realised in the form of the comprehensive primary health care service package that firstly entails a standardised, comprehensive “basket” of services to be delivered at primary care level, and that may include preventive and promotive services, as well as basic curative and rehabilitative services. The interventions that can be delivered together are clustered in the primary health care package which then comprises the main primary health care programmes as well as the various sub-programmes and sub-sub-
programmes. These programmes comprise strategic interventions aimed at dealing with the leading causes of mortality, morbidity and disability in South Africa (van Rensburg, 2004:422). Health services provided by clinics and mobile clinics form part of the universal package and can be rendered by a professional nurse (van Rensburg, 2004:429). Campus health services thus fall within the aforementioned health services.

Because of the nature of the campus health service, the healthcare providers are only able to render some of the services, for example, occupational health services, health promotion, contraception, screening for cervical cancer, acute minor ailments, VCT and the management and treatment of tuberculosis and sexually transmitted infections. Other conditions beyond this scope are referred to the nearest healthcare facility within the patient’s means.

The students indicated that they used the campus health service for the treatment of various conditions as illustrated by the following quotations:

“Like where you have like a runny stomach…”.

“I am mostly physical (sick) – flues and the common stuff, headache”.

“Well some guys, they overdo it (drinking alcohol). Like me, it’s better to say I drank too much than my stomach was all messed up when I had to go to the clinic you know, for something to make it right”.

“TB treatment for people who get TB, and HIV. Because when the doctor says you must get TB treatment, you have to first, when you come to school, drop into the clinic, you know the situation – every morning – you must go there every day – and it’s a daily thing, you know, you have to understand that it’s a daily thing, you have to go there every day and just imagine, you’ve got 8 o’clock class”.

The students also indicated that there were some conditions that they were not able to receive treatment for or to consult the doctor about. The students shared the following experiences with the researcher:
“I think for the problem that is very small, and they only have tablets and things for what people usually come for, so if I come for something that’s rare, then I might find a problem. Do you know what I’m saying? Because I’ve got eczema and that should be least problem in many cases it is you know, because nobody knows about it and I’m not getting help with stopping that (eczema), it’s affecting me as an individual but if I had a headache, I would probably get tablets, do you understand?”.

“I think they should make some tests. For example I came here the other day. I was scared, I thought I had meningitis and I asked them what are the symptoms and then she told me, and then after that I wanted to see the doctor for it and she checked, checked, and looked at me and said, no you don’t have any symptoms of meningitis – I wanted him (the doctor) to check me, so I think there should be tests like these”.

In view of the aforementioned discussions it can be deduced that the students present with a wide range of healthcare needs that need to be dealt with by the campus healthcare provider.

3.5.2 SECTION TWO: IDENTIFIED THEMES OF STAFF CAMPUS HEALTHCARE CONSUMERS

A visual presentation of the themes, sub-themes and categories of the experiences of staff campus health care consumers relating to what their healthcare needs are and how they experience their healthcare needs being met by campus health services is presented as follows:
### TABLE 3.4: THEMES, SUB-THEMES AND CATEGORIES OF THE EXPERIENCES OF STAFF CAMPUS HEALTH CARE CONSUMERS RELATING TO THEIR HEALTHCARE NEEDS AND HOW THEIR HEALTHCARE NEEDS WERE MET

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES AND CATEGORIES</th>
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</table>
| **THEME 1:** Staff expressed a diverse range of experiences related to how their healthcare needs were met at the campus health services | Sub-theme 1.1: Staff had positive experiences when they used campus health services The staff experienced:  
1.1.A campus health service as convenient, affordable and accessible at times;  
1.1.B the campus healthcare providers as highly competent and the health care service delivery as excellent;  
1.1.C the campus healthcare providers as being friendly, caring, helpful and patient and  
1.1.D the environment of the campus health clinic at some campus sites as being user-friendly.  
Sub-theme 1.2: Staff experienced some shortfalls with regard to campus health service  
Staff experienced:  
1.2.A the campus health service as being inaccessible to the staff at times  
1.2.B discomfort when consulting a different campus healthcare provider at each visit  
1.2.C discomfort in sharing the waiting room with the students  
1.2.D the emergency services provided on campus as being inadequate  
1.2.E the physical facilities of campus health service on some campuses as being too small and the number of available campus healthcare providers as inadequate |
| **THEME 2:** Staff experienced specific healthcare needs in order to maintain a state of optimal wellness | Sub-theme 2.1: Staff experienced the need for knowledge on a wide range of health-related topics to ensure physical and mental wellness  
Sub-theme 2.2: Staff experienced a need for a diverse range of healthcare services in order to maintain their health status  
Sub-theme 2.3: Staff experienced a need for the provision of various healthcare services that would improve their health when they were sick  
Sub-theme 2.4: Staff experienced a need for continuous surveillance of occupational health-related conditions among staff members |
3.5.2.1 DISCUSSION OF THEME ONE AND THE RELATED SUB-THEMES AND CATEGORIES OF THE STAFF CAMPUS HEALTHCARE CONSUMERS

A graphic presentation of theme one, its related sub-themes and categories is presented as follows:

![Diagram](image)

**FIGURE 3.3: STAFF CAMPUS HEALTHCARE CONSUMERS’ DIVERSE RANGE OF EXPERIENCES RELATED TO HOW THEIR HEALTHCARE NEEDS WERE MET AT CAMPUS HEALTH SERVICES**
THEME 1: STAFF EXPRESSED A DIVERSE RANGE OF EXPERIENCES RELATED TO HOW THEIR HEALTHCARE NEEDS WERE MET AT CAMPUS HEALTH SERVICES

The same research questions were posed to the student and staff healthcare consumers and therefore the same themes and sub-themes were identified. The reason for discussing these two groups separately is because, although both groups of participants had positive and negative experiences, their experiences differed to a certain degree. For example, although there were similarities in their experiences, there were also differences between what each group of participants experienced as positive and negative.

The staff members who were interviewed were very enthusiastic about the availability of a campus health service and welcomed the opportunity to be heard. They expressed a concern that the service to staff members was so limited, which was particularly evident at Campus D where they were situated far from doctor’s consulting rooms; so a visit to the doctor could entail an absence from work for most of the day. They were not averse to charges being made to their medical aids for the service.

Sub-theme 1.1: Staff had positive experiences when they used the campus health service

The various positive experiences expressed by the staff when they used the campus health service included:

1.1.A The staff experienced the campus health services convenient, affordable and accessible at times

The staff indicated that the campus health service was convenient for them because it was so close by and accessible and suitable for their needs. They indicated that they did not need to leave work to seek healthcare elsewhere and that they considered themselves to be fortunate to have the service available to them on campus. This is highlighted in the following quotes:
“It's for me very convenient, because they are always there, so for me, it's something very helpful and sufficient on campus”.

“The accessibility was really, because it was in close range from my office, it was a walk, so I could just go past and see, okay there’s three people in the queue and then go back or whatever, because sometimes I’d just run in, quickly in to see if there was possibly a chance to quickly see the sister but on other occasions sometimes we phoned to make appointments, which also worked well when she got back to you and said, okay well there’ no people here now, why don’t you come around now”.

“I think for me that it’s adequate already because it is a huge help and a huge timesaver to have campus health available to the staff members as well, because for me to go off the campus somewhere to see a doctor or to a clinic or something, it’s just not always possible to just leave campus and go elsewhere and sit somewhere in a queue, I find it fortunate that staff members can also have that service available”.

The above experiences of the staff reflected in the quotations above indicate that the campus healthcare providers are trying to accommodate the staff members as best they can.

The staff also experienced that the fees charged for services rendered were very reasonable. This is evident in the following quotations:

“I think it’s (the fee charged) R15. It’s very cheap”.

“The other thing that I’ve noticed is that if you are sick, maybe you need tablets or medicine or something, you have to pay the fee, I don’t know if it's R10 or R15 and then they will give you whatever you need. ......I mean R10 or R15 for medication, to me it's nothing because at the end of the day it's your health and you pay that money and get the necessary medicine or pills that you need”.

The above quotations illustrate that the staff felt it was worth paying the prescribed fee because they valued their health.
1.1.B The staff experienced the campus healthcare providers to be highly competent and the healthcare service delivery as excellent

The staff members reported that the health care providers performed their duties well which made them feel relaxed. They also indicated that they appreciated the level of confidentiality experienced at the campus health service and that they had the confidence that the information shared would not be disclosed to anyone. The following experiences were shared with the researcher:

“And I felt that the staff at the facility (clinic) did their work very well, made me feel relaxed, chatted a bit, they would take your personal history, ask you why you came, and then do an examination, and then tell you what they think is the problem and where necessary, gave me the necessary medication with an open invitation to come back if you feel that the medication has not actually served well for what you want”.

“I would say our clinic staff, to me, it’s the staff – they know their work, they know what they are doing. I always feel better……even if I got a headache……She’s not going to say “come and take the pills”, …Firstly the sister take the blood pressure and see if everything is okay, you see other people will say “come and fetch the pills for a headache” but the sister will take the blood pressure, will take your sugar levels, just to see what’s going on and then eventually they will give you that care……That extra mile they go for you, that I like very much……for me our clinic is the best”.

“And what I like about the service here – each and every time, you see I use the clinic mostly for family planning – what I like is that they take your blood pressure. In the public clinics they don’t do that, they just look at your card, they give you your next date, if you are on a needle, they just put in a needle, if you are on pills, they just give you pills. They don’t take blood pressure, they don’t take your weight (at public clinics)…I told the sisters here in the clinic they must continue doing what they do…..and you know you just say to yourself, if every nurse should be this way, I am sure our health clinics will be much better”.
“Seriously, I feel free, even if I think to myself, well this is bit confidential and this, I know that it won’t go out. I know that I’m going to get the advice that I need”.

These shared experiences serve as evidence that these healthcare providers are indeed safe practitioners and they appear always to follow protocol. Thus the staff felt that the healthcare services rendered are excellent and the best. The following quotes illustrate this:

“From my personal experience I think they are doing well......I think their services are excellent”.

“Campus health services is very good for us who are working here, because sometimes you come home, you didn’t know you’ve got asthma that time, but it pops in when you come inside, then those people in the clinic they come to the emergency as soon as possible, they treat you very well, and if you need hospital they just phone the ambulance and get you the place where you can get to be treated. So I feel very good with the services at the campus clinic”.

“Dit is goed hierso, ek meen elke slag as ek nog na die suster gekom het vir iets, het……..en sy ondersoek my, gee my medikasie, want die volgende dag voel ek daar is 'n verbetering. (It is good here, I mean every time that I have come to the sister for something, …....and then she examines me, gives me medication, then the next day I feel there is an improvement)”.

The staff experienced the services as good because the campus healthcare providers took their work seriously and were passionate about what they did. They also indicated that they experienced the campus health service as providing a better service than the public sector did.

“It was always good because they take their work seriously you know, they don’t want somebody to sit there and panic and do all those things, there are times you spend time you see, they don’t say no, you must wait, you must do that, no – they just take you there and give you the treatment and if they can take me to hospital, they take me to hospital”.
“...You can see if a person is passionate about their work”.

“I used to use the Zwide clinic, which is a public clinic. The service there was bad, if I can put it that way, but when I was a student here and I started using this clinic, I thought that it was much better than the location clinics, because the sisters here were willing to help you, were willing to give you advice if you need advice – even if you're late they will tell you that look you're late (with the family planning) and you are in danger – don't do this, don’t do that – but in the our clinics there in the location, they don’t do that, they just shout at you and there’s no privacy. You see, here you in the room with the sister and she closes the door, and you feel safe and feel like you can express yourself”.

The aforementioned quotations illustrate that the manner in which the campus healthcare providers attended to the healthcare needs of the staff made them (the staff) feel safe and willing to express themselves without any fears of their privacy being violated.

1.1.C The staff experienced the campus healthcare providers as being friendly, caring, helpful and patient

The experiences shared with the researcher indicated that the staff experienced the campus healthcare providers as friendly caring, helpful and patient. Therefore the staff experienced a visit to the clinic as being therapeutic when they were feeling down. The following quotations illustrate this:

“I experience the service is very friendly, because I know the people actually who are working there, so they are very friendly and very cooperative and they help me when I go there. There is always time for me when I go there”.

“It’s always nice to go there (clinic) because she’s (health care provider) always friendly and every time she’s willing to put up a conversation and talk to you. It’s like going there and you sit and talk to a friend and you come back and you feel better if you did feel down the day, and as I say, friendliness is there and helpfulness is also there”. 
“You feel that they really care, there is a care in this clinic. I remember last time my tongue was very white and I thought to myself, this is unusual, and I thought to myself, maybe there’s something wrong with me, and I phoned the clinic and spoke to one of the sisters there and explained that I’m worried, my tongue is so white, I don’t know what’s wrong. She didn’t say well, that something you shouldn’t worry about, I mean each and everything that you report or you feel it’s not right, they don’t take it for granted, they give you advice…”.

In view of the above discussion the staff appears to be comfortable with the campus healthcare providers and also seem to have a very good relationship with them.

1.1.D The staff experienced the environment of the campus health service at some campuses as being user-friendly

In 1860 Florence Nightingale published her classic text “Notes on Nursing: What It Is and What It Is Not”, which above all else promoted the need for fresh air and natural light. Nearly 150 years later, studies are revealing the profound impact of the physical environment on a wide range of areas, from patient outcomes to medical errors and staff stress (Nelson, 2006:25).

The staff indicated in their shared experiences with the researcher that they experienced facilities as clean and tidy. “The facilities – neat and clean, tidy, I don’t have a problem with that”. Other staff members indicated that they experienced environment as being user-friendly. “Environment….it’s a warm and friendly environment. Maybe I like intimate things and it looks intimate enough for me, that’s why I feel it’s user-friendly environment”. “I like the service, they give you information, there’s resources, I think it is a user-friendly environment for me”.

Planetree which was founded in America in 1978, is a non-profit organization that works with hospital and health centres to develop and implement healthcare models that cultivate healing of mind, body and spirit, are patient-
centred and holistic. Planetree believes that the physical environment influences the healing process, and it has long supported much of the architecture and interior design that’s now being acknowledged as conducive to patient recovery and the health of the staff (Nelson, 2006:25). According to the director of research at the Centre for Health Design, Joseph (2006) in an article titled “Designing to heal” in the American Journal of Nursing (Nelson, 2006:26), a large number of studies has shown that exposure to natural light reduces depression and fatigue and improves alertness in hospitals and healthcare settings.

Sub-theme 1.2: Staff experienced some shortfalls with regard to campus health service

Although the staff described various positive experiences they had had when they used the campus health service, they also indicated that they had experienced some shortfalls with regard to, for example, accessibility, facilities, emergency services and the number of healthcare providers that are available. These shortfalls will be highlighted and described under the following categories.

1.2.A Staff experienced the campus health service as being inaccessible to the staff at times

According to van Rensburg (2004:16) accessibility of healthcare means that the care has to be appropriate and adequate in content and amount to satisfy the essential healthcare needs of the people and it has to be provided in a way that is acceptable to them. The staff indicated that they experienced the campus health service to be inaccessible to them at times for various reasons. The reasons that emanated from the research data included a lack of information about the services being rendered on campus, limited services available for staff members, time factors and the location of the campus health service.
The staff indicated that they experienced the campus health service as being under-utilised by staff because of a lack of information regarding the various types of services available to the staff. According to Stanhope and Lancaster (2002:123), two of the primary reasons for delay, difficulty and or failure to access healthcare are the lack of information and long office waits. The following quotations illustrate that the staff are not fully aware of the services available to them which is why they experience the service as being under-utilised by the staff:

“I don’t know how much interventions are targeted to staff members as I said, I don’t know if they (health care providers) are always aware of the needs of the staff”

“I think any admin people....if they’re aware of something that’s beneficial to them, they will make use of it. And I mean to have a health clinic at your work, it can only be beneficial to you and nothing else. So if they are aware, they will make use of it”.

“I personally don’t feel a lot of people (staff members) make use of it. I don’t know whether it’s true or what but I feel like the only person that makes use of it”.

The staff therefore expressed the need for the campus healthcare providers to market their services on campus effectively in order to inform them of what is available.

“.to make sure that people (staff members) know about the services of campus health, because we use campus health in a very limited manner, because we don’t know about so many other services that they can offer to us”.

“Maybe some more marketing, I don’t know how you market the clinic but maybe more awareness that we are here for you, that could help, make the staff aware that there is something like this on campus”.
“Like I say, more awareness campaigns, maybe more e-mails, maybe putting bold, bringing the clinic out to the attention of the staff actually. How to do that I don't know now – I think that is needed, to make them more aware, that we can actually (be of) service (to) you people, if you have a cough, if you are coughing, if you have a cold, we are equipped to react medically, you don’t have to phone the clinic, first try us”.

One of the staff members shared the following experience with the researcher on how she became aware of some of the healthcare services that were available to them on campus and also what services she was still uninformed about:

“I know that you go there for HIV testing and you get pre- and post-test counseling, you go there for family planning, I didn’t know that you go there for family planning until I asked. I know that you go there when you’re sick and consult with them, I’m not always sure whether you can go there for multivitamins, I’m not sure if you can ask for information. I happened to ask the secretary and say, hey – I’m struggling with this and then she'd say to me, come and see the nurses about it and sometimes I say, oh, can I talk to them about this and they would say, yes. So it’s basically – for me sometimes very reactive thing. I wait until I have something before I consult with them, and a thing that I would like to know is, can I go to them to be checked whether I have diabetes or not, can I go and check about my heart, can I go and check about so many other things – I don’t know if they are able to give me that kind of service”.

The staff indicated that they did not understand why they were unable to access all the healthcare services that were available on campus. Their experience was that the campus healthcare providers gave preference to the students and that they (the staff) had to utilise a doctor off campus because they contributed to a medical aid fund. The staff indicated that they were not averse to charges being made to their medical aids for the service. “I think for me that doesn’t make sense why it (campus health service) is strictly for the students and not for the staff”.

“They must make sure that the doctor is available for staff as well, not only for students, even if it means making sure that we can still use our medical aid to do that”.

“I would really like to see the doctor, even if the doctor is going to ask me to pay with my medical aid but I need to see the campus health doctor, and as a staff member I’m not able to do that”.

Some staff members had this to say about the limited services that are available to them, “…maar volgens my sal ek sê moet hulle dit ‘n bietjie breër uitbrei want daar is net sekere dinge waarvan ons kan gebruik maak soos byvoorbeeld pynpille en hoesstroop, sulke dinge (according to me I will say that they should expand it a little, because there are only certain things that we can make use of, for example, pain tablets and cough mixture, such things)’.

“The medication – like for instance when you go there and you have a headache, they will give you only two pills, they won’t give you like a packet of 10 tablets. I’ve never been there and asked for cough mixture or something, but I know that if, lets say you’ve got a headache now and you need pills, they will give you two pills for the headache for that time and then the rest you go to the chemist or somewhere to get the medication”.

One of the main complaints that the staff had was that the appointment system was not always working for them and that there were always long queues that they had to wait in before they were attended to. They also indicated that they as staff members did not always have the time to sit and wait for such long periods because of their workload. Although the staff indicated that they did not expect preferential treatment and that everybody should be treated in the same manner, they did however indicate that some plan should be implemented to speed up the process with regard to the staff being attended to timeously.

“….my main gripe….is just the waiting when you want something done”.

“However, there are instances where I would go to campus health and I would phone them initially you know, so it was, I need an appointment, you must know that as an academic staff member you don’t always have time, you’re
pressed for time, you make an appointment, they say to you, come now and then by the time you go there, you will still have to sit in a queue with so many students and then they take longer to assist you sometimes”.

“Maybe you should have a situation where we (the staff) have easy access, I don’t want to make a statement now for the staff but maybe sometimes you don’t at the time to go and sit there in long queues for example yesterday I couldn’t do all the things what I wanted to do you know, so maybe we should have some service where we can have easy access, to be helped in a timely fashion, not wait for long time in queues”.

“…having to wait in long queues which is difficult for a staff member and also I don’t know, obviously there’s no preference between patients”.

Some staff members suggested a call-out service in order to make the service more accessible to the staff, especially for the disabled staff members as they are not always able to access the services because of the buildings not having for example, lifts or ramps.

“…as far as the disabled people are concerned, obviously they also need some sort of service and these campuses must be done for them as far as I can see....these campuses aren’t designed for disabled...meaning no lifts, no ramps, that type of thing”.

“Maybe a call-out service – maybe, I don’t see how that would really work but it could, if someone can’t come to them and maybe they make appropriate appointments, along those lines and actually go see that staff members”.

“Maybe you order something – maybe you have to order health to come to your office and see you in your office when you feel bad, instead of going down, and maybe if there are a lot of students. ...sort of contact the medical people and they could come to your office if you have a problem, that would be nice”.

A suggestion was also made by the staff that the campus health service should be more centrally located to facilitate accessibility to the service.
1.2.B Staff experienced discomfort when consulting a different campus healthcare provider at each visit

Staff indicated that they would prefer to consult the same campus healthcare provider each time that they visited the campus health service because they felt more comfortable seeing the same person each time and not having to repeat the information already given to the previous campus healthcare provider.

“One feels comfortable with the particular individual (health care provider) that you normally go visit whenever you've got a medical condition. At times now where there are two nurses, on the facility there are times you would have preferred to be seen by somebody and you find that on that occasion another person (health care provider) is present, which takes some adjustments for you as a patient”.

“I just know that it's easy to talk to this particular person (health care provider) because I have come to know her quite well and it's easy to talk to her. It's not a case of a stranger, we've built a relationship as we go (along) and I find that helps a lot”.

“Although it’s obviously updated (the records) on your chart, I’m sure it wouldn't make a difference but I think the same person attend to you just makes it easier to deal with it, less explaining”.

The aforementioned quotations appear to be congruent with the observations of Nies and McEwan, (2007:226) with regard to the continuity of care as being associated with improved health outcomes and the establishment of ongoing relationships with a healthcare provider.
1.2.C Staff experienced discomfort in sharing the waiting room with the students

The staff indicated that they experienced discomfort in sharing waiting rooms with the students because they considered health to be a private matter and some of the students in the waiting room were in their class. They found it rather uncomfortable when they were asked in front of the students in a crowded waiting room the reason for their visit. The following quotations were extracted from the raw data reflecting what the staff had to say in this regard:

“..what is not nice is when they ask you when you enter the clinic, when they ask you “why are you here?” I don’t want to broadcast in front of 20 students that most probably some of them are in my class. I think health is a private matter although it might not be sensitive information, I think there must be a certain level of confidentiality”.

“I was thinking you know, I was thinking the other day after I saw a staff member there at campus health – in fact there were two staff members that I saw there, and they were standing there in that room, ....that room was very full with students. You know students are loud and I saw this one pacing up and down and I saw another one reading a book but looking anxious, and I wondered, I don’t know, I know that maybe it’s a resource matter, But I wondered if maybe they wouldn’t have a place for staff members to sit and wait, other than combining staff with students. ...The one was agitated and I sensed that his issue was a confidential one”.

According to Hattingh et al. (2006:66) one of the characteristics of a primary health care service is that it should be comfortable for the healthcare consumers. Overcrowded primary health care services are uncomfortable for the healthcare consumers and for the healthcare providers who have to cope with this general problem. Comfortable services provide safety, security and contribute towards human dignity.
1.2.D Staff experienced the emergency services being provided on campus as inadequate.

Staff expressed the need for the emergency healthcare services to be improved on campus because this aspect of the service was not being visible enough. They indicated that accidents and health crisis could occur at any time.

“...emergency services on this campus I know about ... the other campuses...you hear about emergencies but you do not see any emergency services”.

“...I think the emergency services could be bettered...as far as I'm concerned I don’t think they have something like that, I'm not sure I know  the other people (Staff) say they have...in my field there’s not much injuries but for example I could cut my finger off and then what? It can happen, because I mean I do work with sharp objects”.

Melby (2001:733) states that team work in emergency care is essential. During a major incident the emergency team comprises a multitude of professionals; for example, without effective teamwork and clear leadership care lacks co-ordination.

1.2.E Staff experienced the physical facilities of campus health service on some campuses as being too small and the number of available healthcare providers as inadequate

The staff indicated that the facilities were too small and needed renovation in order to enlarge the space and add extra consulting rooms and rest rooms. The staff also indicated that more modern equipment should be purchased to conduct some specialized examinations. The results that emerged from the information obtained indicate that the staff appear to have high expectations with regard to the campus health service.
“They can talk to NMMU and plan to do something about the clinic and make a big place to put all the facilities for sick people.....it must be like a private hospital – private clinic”.

“The venue is too small. I’m not talking about the passage area now, I’m talking about the consulting rooms...but I mean the examination room. The bed just about fit in there...one sorts of gets clostrophobic, it’s quite small”.

“If they can just renovate a little bit, maybe 2 to 3 rooms...and beds there, so they can take those people.....needs to rest”.

“...and equipment, I am sure the sisters and nurses know that equipment in our days are advanced, they are modern, so maybe if they can try to, maybe if they get an institutional budget for such equipment ...the advanced type of technological equipment”.

The staff also expressed the need to employ more healthcare providers because at times when the campus healthcare staff had to attend meetings the service came to a standstill.

“If they can employ more nurses and doctors – there must be doctors, experienced nurses you see, so they can’t rush everybody to hospital, there must be everything here”.

“If there is any changes....more staff...maybe an additional person or two you know to deal with it”.

“There are some occasions when they are not there, I am not sure, there’re probably reasons for that I don’t know, they are maybe somewhere on campus or something, but there were some occasions when I needed their services (an they were not there)”.

Thus there is a need to employ more staff to ensure that the characteristics of an ideal primary healthcare service are being upheld. Hattingh et al. (2006:65) state that services should be continuous and open at all times as there is an ongoing need for the service.
3.5.2.2 A DISCUSSION OF THEME TWO AND ITS RELATED SUB-THEMES AND CATEGORIES OF THE STAFF HEALTHCARE CONSUMERS

A graphic presentation of theme two, its sub-themes and categories is presented as follows:

![Diagram of Staff Health Care Consumers]

**FIGURE 3.4: SPECIFIC HEALTHCARE NEEDS EXPERIENCED BY STAFF TO MAINTAIN A STATE OF OPTIMAL WELLNESS**
THEME TWO: STAFF EXPERIENCED SPECIFIC HEALTHCARE NEEDS IN ORDER TO MAINTAIN A STATE OF OPTIMAL WELLNESS

The field notes reflect that the age groups of the staff members that participated in this study ranged from 27 years to 59 years. Thus the healthcare needs experienced by the staff are different from those experienced by the students. One of the staff members highlighted this very nicely by sharing the following experience with the researcher “When I was a bit younger than I am, it was an occasional flu, cold, as a male you don’t really have much else but I feel that now as I grew older besides the colds and the flu one really needs to also go for regular checkups – blood pressure, your status as far as sugar diabetes is concerned and have regular checkups about the condition of your heart and so on”.

Another staff member indicated that her healthcare needs ranged from colds and flu to reproductive health issues “my health needs obviously changes, obviously change from time to time, common cold, flu…sometimes headache, sometimes reproductive health issues. As I said if I had, they’d give me advice that helped, monitoring blood pressure and things in my pregnancy, so it really depends, it’s quite a huge range, it depends on the problem”.

According to Hattingh and Acutt (2006:253) the healthcare provider in the workplace must provide an acceptable and accessible health service to the workforce community in order to meet their healthcare needs. Thus provision must be made to ensure early identification of disease in the primary health clinic or during medical surveillance; treatment for acute and chronic conditions, for example, hypertension, diabetes, epilepsy and arthritis; emergency treatment for injuries and medical emergencies; health education on a large variety of requested or topical subjects; services to vulnerable groups including ante- and post-natal services, family planning; counselling of troubled persons and rehabilitation after accidents and serious illness; and medical surveillance for both occupational and general health.
The staff expressed a need for a questionnaire to be developed by the campus health-care providers in order to establish the healthcare needs of the students and staff on campus because they all had different needs. The staff stated that the male and female staff members’ healthcare needs differed and also the healthcare needs of students differed from those of the staff. The following quotation illustrates this:

“I think maybe a questionnaire should be developed and just for us the staff and the students, about the needs that they would like the health services to render for them. That's important because it's no use having services that are not needed. So I think the best thing is to ask the people that use the health care or that think that such-and-such needs are needed for this health care service”.

Gillam and Murray (1996) in Tones and Green (2006:144) state two of the things that influenced the growing interest in health needs assessment had been attributed to the increasingly consumerist nature of society and the current emphasis on effectiveness. Liss (1990) in Tones and Green (2006:145) notes that the interpretation of needs refers to matters of judgement in relation to what constitutes ill health, which health states require care and the services that ought to be provided. He suggests that there are two categories of assessors of need – the patient and the healthcare provider; and that the normative notion of a healthcare need is based on an “assessor” believing that healthcare ought to be provided.

**Sub-theme 2.1: Staff experienced the need for knowledge on a wide range of health-related topics to ensure physical and mental wellness**

Scot and Weston (2001:50) cite Tones’ (1967) definition of health education as “any intentional activity that is designed to achieve health- or illness-related learning, i.e. some relatively permanent change in an individual’s capability or disposition. Thus, effective health education may produce changes in knowledge and understanding of thinking; it may influence or
clarify values; it may bring about some shift in belief or attitude; it may facilitate the acquisition of skills; it may even effect changes in behaviour or lifestyle”.

The staff experienced a great need for health education on a wide range of health-related topics to ensure physical and mental wellness. They indicated that even if they were educated and working at an HEI they still needed to be informed about health matters. They felt that there was an assumption that staff members were able to cope better than students and therefore there was a lot of emphasis on helping students because they were unemployed. A question was posed by one of the staff members “If staff members are not able to cope with their own health related issues, how productive are they going to be and how can we be able to help our students?” Some of the staff indicated that they were not informed as children about how their bodies functioned because they grew up in a society where these things were never discussed, besides they received conflicting information from their peers and thus a state of confusion was created. They therefore experienced a need to be informed by professional people who could give them accurate information.

“Sister, I’m serious about the education, I’m very serious about that. I would be happy if you could follow that up. You might think that we work in an educational institution, we are aware of it – we are aware of these things. Yes, we might be educated, we might work in an educational institution, but that doesn’t mean we are aware of the importance of health. We are not. The reason for that is the background that we grew up from and all those talks that – you see when we are girls we sit there and talk and talk and talk, those talks create confusion, we need to be clear, we need to have professional – somebody who can explain these things”.

“Our parents they never talk about sex, they never talk about gynae, they never talk about pap smears, because they’ve never done it and because they were not aware”.

One of the staff members indicated that she had many health needs but first and foremost for her was information about certain conditions and how her
body worked in order to obtain a better understanding of it. “First and foremost for me, I need to – I like to get information about certain conditions, because I feel that if I know how something works out, I would be able – it’s almost as if I cope better when I know a lot of things, so I need to know how my body works, I need to know what causes certain things”.

The wide range of health-related topics indicated by the staff to ensure physical wellness included topics on HIV and AIDS, pregnancy, cancer, tuberculosis, diabetes mellitus, nutrition and reproductive health. Some of the staff members consider HIV and AIDS to be one of the most important topics to address whereas there were other staff members who indicated that other diseases such as cancer should not be ignored because they were aware of several people who had cancer. The following quotations are extracts from the raw research data:

“First of all, HIV and AIDS. That on top of all. It really is one of the important topics. Secondly pregnancy”.

“Now in this age and days we’re living it looks like cancer is taking over. It looks like it is overrunning Aids even because (it seems as if they) forgot about the other illnesses, we focus on one illness and for now that’s Aids and you forget about other things that’s happening and cancer is sticking it’s head out now, I know about 3, 5 people that died of cancers this whole year. ……I don’t say kick Aids out of the door, but make people aware that there’s other conditions”.

The staff also indicated that they required information on stress and how to manage it. “In terms of my mental health needs, I want to know about stress, about what it is that I’m doing that is not helping me or that is helping me to cope better with my stress”. According to Collins and Gibbs (2003:256), occupational stressors relate to organizational issues such as the demands of work impinging on home life, lack of consultation and communications, lack of control over workload, inadequate support and excess workload in general.
Staff indicated that they were not as well informed about health matters as was assumed. Information obtained by staff indicate that staff tends to obtain information in a more reactive than proactive way.

“...TB which is also sticking its head out now and we have a tendency – we only realize we have this illness when it's catching up with us because we are not educated, we don’t know what to look for”.

“I had a friend who was pregnant and didn’t know that she was pregnant, she’s a colleague, and she was taking these diet oils, which could have ben very dangerous. I don’t know how much we women know about women’s issues, and I don’t know how much we know about pregnancies. I know that I relied a lot on the internet information and I remember thinking this friend of mine could have lost her baby if she was not careful, and I wondered, because for me prevention is always better – you prevent something before it happens, and again it’s information related, it’s education related, that I would see the role of campus health very effective in that manner”.

The staff indicated that they were aware of the health education programmes on campus but at the same time they felt that they were too infrequent and that there should be a more varied, well-planned, continuous programme. A staff member had this to say:

“I need information, they normally have these programmes for example now it was Breast cancer Week – is a week enough? I doubt that, if it's enough. Must it be done once a year? No. Do you have to wait for October for you to get that kind of information? No. I know that they have these good programmes but I wish it can be done all the time, and I wish there could be a lot of intervention”.

The staff suggested that presentations for staff on various illnesses could be arranged through awareness campaigns once per term or every six months. These campaigns could be organized with staff members from the various departments and presented to them in their department. The campus healthcare providers could also address small groups of staff members in their lunch-times upon request. The information received could eliminate their fears about certain illnesses.
“When I hear something, when I hear people talk about certain illnesses I worry. For example they will talk about diabetes and they will talk about so many illnesses and then I would worry about what’s happening and again for me it’s related to information.....so that I can be educated enough to understand myself, to understand my body, to understand my needs, and then to know if I’m struggling with this, this is what I need to do”.

Sub-theme 2.2: Staff experienced a need for a diverse range of healthcare services in order to maintain their health status

Tones and Green (2006:145) cite Cuyler (1997) as considering a need for healthcare to exist when there is potential to improve health status or avoid reduction in it, but only if an intervention exists that can achieve positive outcomes. Thus according to Buchan et al. (1990) in Tones and Green (2006:145), people in need of a health service are defined as “those for whom an intervention produces a benefit at reasonable risk and acceptable cost”. The benefit may not necessarily be improved outcome. It may relate to information or reassurance or some other aspect of the care process.

The female staff members indicated that they mainly used the clinic for family planning and that they experienced a need for pap smear and breast examinations in order to detect cancer early.

“Ummm....I started using the health care campus mainly for family planning”.

“I would like campus health service to get may the function to do pap smears (on all the campuses) and not for us to go once a year to ....(A) campus. Only one day per year, it’s OK but to go once a year (A) campus is a little bit out of the way for something so important”.

“Maybe set aside a day to check women staff member’s breast for cancer, things like that you know, even if you get two, three people there at least you educated two, three people for that specific illness or condition”.
The male staff members on the other hand indicated that they experienced a need to be tested for diabetes mellitus, tuberculosis, HIV, cholesterol and to have their blood pressure monitored regularly. They indicated that they found the health days on which cholesterol, blood sugar levels and blood pressure were checked very worthwhile but they expressed a need for more of those days as one day per year was insufficient. The aforementioned research findings are congruent with Stanhope and Lancaster (2000:581) who state that men look at physical well-being when asked about the meaning of health.

The times are changing from focusing on diseases and treatments to a new healthcare focus on identifying health needs and preventing health problems. This preventive focus is a wise one (Stanhope & Lancaster, 2000:581). For instance, the staff indicated that they would like to have the influenza vaccine annually in order to protect them against the common strains prevalent at the time.

“…hier was ’n inspuiting maar ek sien dit het weer verval. Dit was hier so ’n paar jaar terug, dat ons elke jaar ’n inenting teen miskien die volgende siekte of iets wat hulle gesê het dit was op pad of so, maar ek sien dit het weer verval, ek meen as hulle kan net dit, miskien aanhou daarmee, sal dit miskien iets beteken. (“…here was an injection [that was administered to us] but I see that it has fallen by the wayside. A few years ago we used to get a vaccination here against illnesses that they said were on the way here, but I see it has fallen away, I mean if only they can continue with that, it will perhaps mean something)”.

One staff member indicated that she experienced a need for staff members to have a counselling service available to them because they needed somebody to talk to when they were encountering emotional problems and feeling low.

“I don’t know if do they offer counseling at the health clinic, otherwise then the psychology clinic, but I think students can go now and then to sister for just a talk and to let go of whatever. Staff also, I mean every person on a daily basis if you feel down you can go to the clinic and talk to someone, just someone to be there who’s neutral, not going to be biased or judgemental – just to listen to what you are saying because I don’t think it is so easy when you go to the
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psychology clinic to just go and sit and talk to the girls because they are actually working with study cases and you can’t go as a person, an ordinary person on a daily visit just to let go”.

The abovementioned quotation illustrate a real need for a counselling service for staff members.

Sub-theme 2.3: Staff experienced a need for the provision of various healthcare services that would improve their health when they were sick

The staff indicated that they experienced a need for the provision of various health care services that would improve their health when they were sick. These healthcare services included services that would treat both acute and chronic health conditions. According to the National Health Interview Survey, an acute condition is a type of illness or injury that usually lasts less than 3 months and either result in restricted activity or causes the patient to seek medical care. A chronic condition, on the other hand, is a condition that persists for at least 3 months or belongs to a group of conditions classified as chronic regardless of time of onset, for example, tuberculosis, arthritis and hypertension (Nies & McEwan, 2007:317).

The acute conditions which the staff experienced as a need that should be addressed by the campus healthcare providers included conditions such as headaches, migraine, superficial burns, indigestion, diarrhoea, colds and flu, and work-related injuries. These healthcare needs are reflected in the following quotations from the raw data:

“Now and then when I have the odd headache, I go to the clinic for some tablets. I once got a burn on the hand – not a deep wound, but I went to the clinic for that”.

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“...there was I think one or two occasions that I really had a terrible migraine or whatever you call it, and they helped me and I had a work related injury and without hassles and problems they assisted me”.

“I have on occasion made use of the services whenever I had flu, terrible headaches at times”.

“I also went there once when I had a tummy bug, so they gave me medication”.

The staff also experienced a need for the treatment and management of the following chronic health conditions, for example, hypertension, asthma, diabetes mellitus, heart conditions, tuberculosis and anti-retroviral therapy. The following quotes reflect this:

“I usually go for blood pressure and things like that because I am a blood pressure patient, sort of. So they actually give me the result and give me some advice, what not to do and things like that, keep me on my toes when my results are not good, so that’s”.

“Also the treatment of chronic conditions. I suppose sugar diabetes would be one, arthritis would be another and of course some heart problems that some people have as a result of age”.

“I usually go there, the time I was attacked by asthma, sometimes the asthma is just coming, then you have to go to the clinic, then they give you the oxygen to calm down”.

“....there must be a place where they can sit and do and have the ARV treatment”.

“There they diagnosed TB. ...said I must go to the (Public) clinic to get the treatment cheap, so I take the treatment for six months but then the (public) clinic they transferred (me) to this clinic (campus health clinic) so I had to go to the clinic in the morning to take the treatment”.
The above quotations expressed a need for a chronic disease healthcare service to be rendered on campus.

Sub-theme 2.4: Staff experienced a need for continuous surveillance of occupational health-related conditions among staff members

According to Hattingh and Acutt (2006:244), medical surveillance is the periodic health examination and special tests performed by a qualified occupational health practitioner as described in the Occupational Health and Safety Act, 1993 (Act no 85 of 1993). It is a control mechanism in the programme to protect a worker's health and prevent deviations from health due to workplace hazards. One of the staff members indicated that the campus healthcare providers should perform 3-monthly or 6-monthly periodical examinations on all staff members to detect disease early because some of them were exposed to working situations that could be detrimental to their health. The following quotation illustrates this:

"Byvoorbeeld soos ek wat 'paint' hier, en dit het nadeel op my. Sien, dis iets wat nedelig vir jou bors is, of....toetse, miskien een maal op drie maande, of elke sesde maand (For example like me that paint here, and it has a negative effect on me. See, it is something that effects your chest, or...tests, maybe every 3 months or every 6 months )."

According to Hattingh and Acutt (2006:18) each company should strive towards the goal of establishing a healthy and safe working environment.

3.5.3 SECTION THREE: IDENTIFIED THEMES OF CAMPUS HEALTHCARE PROVIDERS

The campus healthcare providers who participated in this study comprised nine registered nurses, one medical doctor and one non-practising registered pharmacist who holds an administrative position. The length of service at the
HEI for the healthcare providers ranged from 3 to 12 years. If the campus healthcare providers render a promotive, preventive, curative and rehabilitative healthcare service to the students and staff on campus, they should, according to Stanhope and Lancaster (2002:38) possess skills in health promotion and disease prevention, assessment/evaluation of undiagnosed symptoms and physical signs, management of common acute and chronic medical conditions and identification and appropriate referral for other needed healthcare services.

The registered nurses employed at these services are all in possession of a post-basic or post-graduate qualification in Community Health Nursing Science. They have also completed additional short courses in physical assessments; diagnosing and treatment of minor ailments; the treatment and management of sexually transmitted infections; family planning; voluntary counselling and testing for HIV and dispensing of medication.

These registered nurses have to work within their scope of practice which is regulated by the Nursing Act, No 50 of 1978 as amended by the Nursing Amendment Act, No 19 of 1997 and also by the health legislation and other relevant acts of the country that have an impact on their role (Dreyer, Hattingh and Lock, 1997:36). The following quotation illustrate this:

"Prior to the merger all, all the nursing staff within on campus health service had that particular kind of license (dispensing license) and post-merger one of our campuses did not have that particular license and I was able to assist the nurse there to obtain her license and thus provide a legal service. Within that Act there are various requirements that one needs to adhere to with regard to dispensing and prescribing of medications. There are certain requirements with regard to storing and ordering of medications and things and those were not adhered to on all campuses and I was able to assist the rest of the campuses to obtain that kind of legal compliance, so that as soon as we had an inspection we knew we were adhering to what the law require of us”.

“…jy moet jou medikasies oudit, hoor hierso, .....Al jou medikasies moet in ’n boek wees. Al jou verval datums (moet dop gehou word), is jou yskas reg?"
Werk jou temperature?....toe verlede jaar toe ons daardie dispensing licence gedoen het, toe gaan sommer die dinge sommer baie oop [...]you must audit your medicines, listen here, all your medication must be (recorded) in a book. All your expiry dates (must be checked) is your fridge right? Does the temperature work?...last year when we did the dispensing license, then everything became much clearer].

According to Hattingh et al. (2006:67), it is not realistic to expect that the healthcare provider who is involved in the day-to-day practice of community health should be an expert on health legislation that is applicable in the field of community health. But the healthcare provider in the community should make all attempts to keep abreast of amendments taking place in community health legislation and ensure that a copy of all health-related legislation is available and accessible to staff if and when it becomes necessary to consult it. Information regarding health legislation is, however, more important in the African context because healthcare providers (mostly registered nurses) generally practise in total isolation and are quite often the only member of the health team present.

A visual presentation of the themes, sub-themes and categories of the experiences of campus healthcare providers relating to how they experience the rendering of campus health services is presented in the following table:
### TABLE 3.5: THEMES, SUB-THEMES AND CATEGORIES OF THE CAMPUS HEALTHCARE PROVIDERS REGARDING THEIR EXPERIENCES IN THE RENDERING OF A CAMPUS HEALTH SERVICE

**THEME 1:** Campus healthcare providers experienced the rendering of campus health services as positive, rewarding and challenging

**Sub-theme 1.1:**
Campus healthcare providers had positive and rewarding experiences when rendering campus health services

- **1.1.A** working with the students and staff at a Higher Education Institution as being very enjoyable and stimulating;
- **1.1.B** experienced the healthcare services that were rendered on campus as being of a high quality and well organized;
- **1.1.C** Working as an extended primary healthcare network for the Department of Health as facilitating effective service delivery and
- **1.1.D** the secretaries who had been trained as basic ambulance assistants as being of great help to them.

**Sub-theme 1.2:**
Campus healthcare providers experienced various challenges in the rendering of campus health services

- **1.2.A** resource constraints as having an impact on service delivery;
- **1.2.B** campus health services as being fragmented because of the number of the satellite clinics situated on the different campuses of the HEI;
- **1.2.C** the referral system to other public health care facilities as being unstructured;
- **1.2.D** the diversity of cultures of the health care consumers as being challenging in rendering culturally congruent healthcare;
- **1.2.E** a lack of contextual research that informs practice in campus health service delivery;
- **1.2.F** the merger of the three Higher Education Institutions as causing additional stress and uncertainty among themselves and staff healthcare consumers and
- **1.2.G** lack of promotional opportunities as hampering career progression.

**THEME 2:** Campus healthcare providers experienced the need to render a more comprehensive primary health care service to address a wide range of healthcare needs of students and staff on campus

**Campus healthcare providers experienced the need:**

- **Sub-theme 2.1** to provide promotive and preventive healthcare services, including health education on a wide range of health related topics;
- **Sub-theme 2.2** to provide a curative and chronic healthcare service on campus;
- **Sub-theme 2.3** for supportive, counselling and social services to be available for students and staff at the HEI;
- **Sub-theme 2.4** for an occupational health service and an Employee Assistance Programme on each campus and
- **Sub-theme 2.5** for continuous staff development in order to keep themselves updated with new information and techniques.
3.5.3.1 DISCUSSION OF THEME ONE AND THE RELATED SUB-THEMES AND CATEGORIES OF THE CAMPUS HEALTHCARE PROVIDERS

A graphic presentation of theme one, its related sub-themes and categories of the campus healthcare providers is presented as follows:

**FIGURE 3.5: THE EXPERIENCES OF THE CAMPUS HEALTHCARE PROVIDERS REGARDING THE RENDERING OF A CAMPUS HEALTH SERVICE**
THEME 1: CAMPUS HEALTHCARE PROVIDERS EXPERIENCED THE RENDERING OF CAMPUS HEALTH SERVICES AS POSITIVE, REWARDING AND CHALLENGING

The campus health service and all its satellite clinics are nurse-led clinics with a contract medical doctor who is employed to do one-hour sessions per week at each campus clinic, with the exception of one clinic where the doctor does two one-hour sessions per week. Thus the registered nurses employed at these clinics have to be well qualified and have some clinical experience in order to function independently and competently. Wiles, Postle, Steiner and Walsh (2001:813) state that nurse-led units provide opportunities for nurses to develop enhanced roles in which they can work autonomously in providing elements of therapeutic nursing aimed at improving patient outcomes. Some of the registered nurses indicated that they experienced working alone as a big challenge because they had never been exposed to such a working environment in the past. One participant indicated that she was not used to functioning in an environment where she dealt mainly with adolescents and had to make all her own decisions without anybody instructing her what to do.

“…opset is heeltemal anders, dis regtewaar….Hier’s niemand medies hierso – absoluut niemand….Hier is dit net ’n ervaring van jy kom in en jy kom sit, maar jy moet wag en kyk, jy moet nou eers leer om met jong mense te werk en dan moet jy nou beginne uitkyk hoe jy jou gaan ‘promote’….en dit is nou iets waar ek vanaf kom nie vir (my) bekend was nie….ek was (by) gestigde plekke so dit was vir my ’n ervaring […setup is completely different, really…here is no medical person here – absolute no one….Here it is just an experience where you come in and you sit, but you must wait and see, you must first learn to work with young people and then you must begin to decide upon how you are going to promote yourself…and this is something that I have not been used to where I come from….I was at established places so this was an experience for me]”.

“…omdat ’n mens so afhanklik is van ’n senior suster daardie jare jy weet, en dan is sy die ene met verantwoordelijkheid, maar nou sit jy met ’n ding, het nooit besef hier is einlik nie suurstof (vir noodgevalle) nie,…eintlik moes ons lelik vasdraai – ons kon niemand sé dit is dit en ons kon niemand blameer nie, ons moes professieel genoeg wees om te sé wel, dit is seker ons eie fout ….jy
kom weer op die ou stand, jy moet onder 'n leier werk wat die dissipline en die ruglyne vir jou neersit [...] because a person was so dependent upon a senior sister those years, and then she was the person with the responsibility, but now you sit with a thing, did not realize that there is no oxygen here(for emergencies)…we were actually cornered – we could not tell anyone that this is this and we could not blame anybody, we had to be professional enough to say well it is actually our own fault….so you came back to the old way of you must work under a leader that ensures discipline and lays down the rules"

“Ek was nie 'n suster van 'campaigns’ – ek was mos net daardie susters wat net werk. Nou moet jy lesings aanbied, jy moet campaigns doen om jou te adverteer, … – jy moet hom 'jong mens friendly’ maak ….dit is iets wat ek moet regtewaar beginne aanler [I wasn’t a sister to do campaigns – I was just those sisters that just worked. Now you have to give lectures, you must do campaigns to advertise yourself,-you must make it ‘young people friendly’….but this is something that I really have to begin to learn]”.

The campus healthcare providers also indicated that they experienced working under the permit system as challenging because they did not need to obtain authorisation to practice as a primary health care nurse themselves at the public sector clinics.

“Byvoorbeeld, ek het nie die permitstelsel geken ook nie, ons het nie gewerk jy alleen onder a permitstelsel (nie), jy het gewerk onder n kliniek se stelsel en nie op jou eie nie, so die permitstelsel was vir my ook baie nuuts wat ek geleer het [For example. I did not also know the permit system, we did not work you alone under a permit system, you worked under a clinic system and not on your own, so the permit system that I learnt about was very new to me]”.

“..ek het hoeveel jaar sê maar nou 10 jaar onder die klinieke maar ek het nooit gehoor van hom (permitstelsel nie), ek het geweet ons het 38A maar dis al. Maar dit was nie vir ons gespesifiseer dat jy onder daardie permitstelsel werk nie […]I have how many years say about 10 years under the clinics but I have never heard about it (permit system), I only knew that we had 38A and that's all. It was never specified that you work under a permit system]”.

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Some of the registered nurses indicated that they were the pioneers in starting the clinics on their respective campuses and experienced this starting the service from scratch as being a huge challenge.

“The first 10 years was very challenging in the beginning. It (campus health service) was non-existent, I started this particular service and it was a huge challenge to start a health care service at a higher (education) institution”.

The campus healthcare providers also indicated that they were faced with many challenges in their day-to-day activities. These challenges ranged from keeping abreast with changes to life threatening incidences. This is evident in the following quotations from the raw research data:

“I mean I always feel challenged, changes all the time that you need to (keep) abreast of changes”.

“And you’re a nurse you know, somebody can get anaphylactic reaction and five minutes later be as dead as a doornail”.

“.we had to go to the residence and climb into the ceiling, walk right down to the bottom just about on our knees, to get a person who was electrocuted there”.

Although the campus healthcare providers indicated that they experience the rendering of campus health services to be very challenging, they also indicated that there were numerous positive and rewarding experiences as well.

“I suppose in a way being a primary health care nurse you have to fulfil so many roles, you’re a mother, and you’re a counsellor, and you’re a nurse, and you’re a First Aider, and you’re an administrator – I suppose in that way it suits my personality and I suppose that is why I enjoy it”.

So I actually enjoy it...I’m just enjoying my job and my goal is actually to see to it that we are functioning, you know the whole campus health services – each
and every staff member is actually doing occupational health service, primary healthcare – we’ve got a service to do, comprehensive”.

According to Muller (1998:3) the significant factors that have been identified as realities and challenges impacting on excellence in healthcare include contemporary human resource issues in South African healthcare services, legislation and national policy framework, health indicators, high technology, quality improvement and research. These challenges mentioned by Muller (1998:3) are similar to the challenges experienced by the campus healthcare providers. In fact the latter is illustrated in the discussion that follows hereafter.

Sub-theme 1.1: Campus healthcare providers had positive and rewarding experiences when rendering campus health services

The researcher observed the campus healthcare providers to be very positive about their work. They indicated that they experienced working at campus health service as being very rewarding and positive because it made them feel good to see the students all graduating as healthy young adults at the end of their course. According to the Collins Dictionary of the English Language (1986:1197), some of the meanings of the word “positive” refer to “tending to what is good or laudable, tending towards progress or improvement, constructive rather than sceptical”. The term “rewarding” on the other hand refers to “giving personal satisfaction, gratifying” (Collins Dictionary of the English language, 1986:1308). Thus the healthcare providers experienced being able to care for the students as rewarding and satisfying because it gave them personal satisfaction and gratification.

“….it really is a satisfying experience. It’s great to provide health care to young people and it brings one great satisfaction to see behaviour change in somebody that you’ve really counselled for a while. If you’ve walked the road with a young person then you see your health education has provided them with the motivation to bring about a behaviour change and to see somebody
take responsibility for their health care, for instance not having unprotected sex but using contraceptives, not engaging in risky behaviour and not having contracted another STI”.

“So that is satisfying and it’s very rewarding to see students graduate, healthy after three years, maybe you’ve assisted somebody, for instance, a diabetic and you’ve been able to provide them with health education and referral or support to complete their studies. That is quite satisfying”.

A graphic presentation of Sub-theme 1.1 and the related categories is presented as follows:

FIGURE 3.6: THE POSITIVE AND REWARDING EXPERIENCES OF CAMPUS HEALTHCARE PROVIDERS WHEN RENDERING A CAMPUS HEALTH SERVICE
1.1. A Campus healthcare providers experienced working with the students and staff at a HEI as being very enjoyable and stimulating

All the campus healthcare providers indicated that they enjoyed working at the campus health service. They stated that they experienced it to be very stimulating because they were working in an academic environment where the individuals were educated and they would ask challenging questions which forced the healthcare providers to read and keep themselves updated. This is evident by the following quotations extracted from the raw research data:

“I enjoy it very much. It is a pleasure for me to be here”.

“Well, firstly I do enjoy working with the people I work with. It is a wonderful working relationship. It’s just stimulating, it’s rewarding and it’s very pleasant”.

“Well, I can start off by saying I love the idea – I like working with students. There’s always new things to learn”.

“...the students and the staff members that we see here are a bit more say literate and educated as compared to the community, so you do have to – they sort of challenge you more as compared to somebody else (in the community), so you have to always make sure that the information you have is accurate, up to date”.

The campus healthcare providers also indicated that they felt good about being able to help the students when they presented with health problems. They also indicated that they rendered a service to a specific age group which more or less presented with the same health problems and this enabled them to become competent in diagnosing and treating certain conditions, for example, sexually transmitted infections and family planning.
“So there’s a lot of positive things that I experience in that, especially when you help certain individuals, if you can help them to solve their problems”.

“We are able to grow and it became a very satisfying experience to provide health care to a student body that needed something and we were able to provide it for them”.

“What I like about campus health is that you know that you’re working with a certain age group and you know what their healthcare needs are, you know what they (are)- they all basically come with the same type of problems, so you become competent in handling their problems, especially the STI, family planning”.

The campus healthcare providers indicated that their experiences when interacting with all the different students changed because students moved on after three to four years and every year new students registered at the HEI. They also indicated that they got different groups of nursing students from all over the world and from the local nursing schools for practica which also broadened their knowledge and outlook on life because they learned from one another.

“It’s just that I’m still enjoying it here! We deal with new people, new plans, new programmes, you know in a tertiary environment I think what is different, students are here for three to four years and they move on, we get new ones, even if you still wish (that they should) linger on following (their) health condition, she gets finished, she’s gone.”

“We do receive foreign students who are nursing students who come and join us to observe our functioning. We do have our local home students who are studying on the other … campus who are doing the four-year nursing course for their nursing studies so we are open to allowing students to come for practicals, to observe and that challenges us also because it keeps us on our toes even if you would be doing things, you know it’s nice to share information and to teach a younger person”.

“It is the little insights that I get, insights about how the youth think and the learning that I learn from them. Things that – I suppose, it is in the book but
you don’t always remember everything that’s in the book. You are reminded every now and then. And that means you want more knowledge, I think day by day, at least week by week, or month by month, your knowledge and your expertise is broadened”.

The aforementioned quotations indicate that the campus healthcare providers found the students very stimulating.

1.1.B Campus healthcare providers experienced the healthcare services that were rendered on campus as being of a high quality and well organized

According to Muller (1998:3), a person’s health is one of the most important assets, therefore healthcare delivery should be of the highest quality. The campus healthcare providers indicated that they ran a good quality service because they were always well stocked and they never ran out of medicines. They also indicated that they all had their own consulting rooms with the necessary equipment available for primary health care.

“I suppose when I said good quality, I was referring to where I came from because where I came from was the municipality and I felt that things were not that good there anymore, that’s why I left, so when I came to campus health service I saw that they attended to most of the students’ needs and you had that time actually to listen to the students and to attend to them properly. The medication that was available here on campus also was of a good quality because it was things that we didn’t have available at the state facilities”.

“Since arriving here at campus health services, I would say that I find that we provide a good quality service with good quality medicines”.

“…I think we’re very well stocked (with medicines)…..We never run out of stock of medication”.

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“Oh, well we all have our own consulting room, an I have everything that I need to render the service, I mean I have a scope (auroscope), I have a stethoscope, I have medicines”.

According to the Collins Dictionary of the English Language (1986:1084), one of the meanings of the word “organise” means to “arrange methodically or in order”. This is what the campus healthcare providers were referring to when they indicated that they were well organised.

“…the whole setup here is well organised compared to the previous environment I’ve been working in. If you request for something….you are able to get it immediately…..it’s not what I used to experience in the past, you wait for so long to get what you are in need of, orders would take so long, such delays, and honestly everything works so smoothly”.

“…my consulting room is ready and prepared (before hand), that Friday I fix everything up so that Monday can start well”.

“We are able to work in organised teams…..we do have meetings as I’ve mentioned before, so we plan together, we have started planning every end of the year so we can know and focus on what to do next year”.

The campus healthcare providers indicated that they introduced the appointment system in order to cope with the workload. They experienced the appointment system as a positive move for them as this enabled them to structure their days better.

“We recently developed a working schedule on all campuses where we work on an appointment basis. It gives us time to give quality care to the patients and when the patient go out of your consulting room you know that you did the best for the student because in the past I mean we used to see 35-40 students per day and that was definitely not quality, it was numbers that we saw but now with the appointment system I definitely think we give quality”.

“…So my day is basically worked out for me in that it’s very structured now in that the secretary would know if I will be away, most probably for a meeting or
whatever other reason, then she will not structure appointments around that time. So we do not take appointments in advance at this campus, if a student is to attend for that day, they need to come in the morning to make the appointment for that day.......So my day is very structured so that most of my day is spent on attending to the primary healthcare, seeing to minor illnesses or family planning, all the various problems in terms of campus health”.

The campus healthcare providers indicated that they were doing their best; treated the campus healthcare consumers courteously; and that the problem cases which they were unable to attend to were referred to off-campus healthcare facilities or to the doctor who came once or twice per week to the campus health service for an hour or two.

“I think I can only try my best...”.

“I think the students are having a great service. I really think they should be enjoying the service because from all the sisters they are getting an excellent service and I’m seeing the problem cases”.

“We always have students to refer to the doctor for situations we cannot cope with or we feel we need the further doctor’s scope – that service is being utilized very well, we do have interesting cases we leave for the doctor”.

The campus healthcare providers indicated that they were thorough in what they did and that they tried to help the students as best they could. They indicated for example, that prior to getting a student started on a family planning method for the first time they would first educate the student regarding the action and the pros and cons of the family planning method so that the student could make an informed choice. They also tried when educating the students to eliminate any myths that the students might have about family planning. The campus healthcare providers experienced the latter procedure as reducing the risk of the students defaulting thus increasing compliance. The campus healthcare providers also indicated that they were always trying to improve the campus health service.
“*When a client is initiated (for family planning) on campus, when a client is initiated I spend at least 40 minutes just to do the examination and to explain what the method does and how it works and how it prevents pregnancy and you find that if they started on a method outside the clinic, outside campus health service, they’re not given that education….so I find that I have a lot of success when that is instilled here*”.

“*Ummm what I can say, the service has grown, each year the service has grown in that we provide more and more for the students as the need arises and we’re looking at ways of improving the service*”.

The aforementioned findings are congruent with Davis’ (1994) definition of quality as cited by Stanhope and Lancaster (2000:440) “quality is continuous striving for excellence and a conformance to specifications or guidelines”.

1.1.C Campus healthcare providers experienced working as an extended primary healthcare network for the Department of Health as facilitating effective service delivery

Viljoen, Househam and Wessels (2000:61) state that in order to develop a strong and powerful South Africa, it is essential to develop strong and powerful communities and regions as well as partnerships. The campus healthcare providers indicated that they experienced working as an extended primary health care network for the Department of Health as facilitating effective service delivery, because they had entered into an agreement with the Department of Health regarding family planning, tuberculosis, and VCT services. The campus health service renders these services on behalf of the public sector to the students and staff on campus and in return they submit monthly statistics to the Department of Health. The campus healthcare providers experienced this as a huge cost saving to the HEI and at the same time it made the public health sector’s services more accessible to a wider community. Prior to this arrangement the public health sector used to send a registered nurse in a mobile clinic to render this service once per month at this HEI, which was not feasible because the demand for the service was far
greater than the supply. Thus this agreement was entered into when the campus health service clinics became established at this HEI ensuring a more innovative, comprehensive, affordable primary health care service (Compare Viljoen et al., 2000:61).

“We also render a fully functional service on behalf of the municipality, for example the family planning, the STIs and DOTS facility for TB patients. On behalf of them we render the service, we get our supplies free of charge from them, and we submit those stats every month to the”.

“We were able to grow because of increased co-operation with local authority, both Provincial…eventually National Departments of Health in that they provided us with resources such as contraceptives, treatment for sexually transmitted infections, and 2001 we were able to provide HIV testing free to the students. So the local authority assisted us to expand our service on campus”.

The campus healthcare providers indicated that they were therefore able to offer the abovementioned services free of charge because of this agreement with Department of Health. “...family planning is free, HIV testing is free”. Van Rensburg (2004:115) quotes McCoy and Kosa (1996) and McCoy and Barron (1996) as stating that the original “free health services” were followed in May 1996 by the introduction of free primary health care services at all public health centres and clinics.

One of the participants indicated that he did not think that management realised and appreciated how much money was being saved by having this agreement with the Department of Health. “Transcribe what we are doing into money – do they understand how much money we’re saving them?”

The campus healthcare providers also indicated that they would like to extend this agreement to include treatment management of chronic care patients, for example, for diabetes, hypertension and antenatal care.

“Just expand our service more and the chronics that is bothering me also, is to have, I wouldn’t expect the university to buy the medication, but to have
medication (from the Department of Health) with us, to supervise them and see that they take it on a regular basis because most of the treatment is daily it's not even BD that they need a doctor to give it here to them”.

“It could (antenatal care), that they (Department of Health) could pay for the costs of the bloods and things but I suppose it could be done, yes, if they (Department of Health) were willing to pay for the costs”.

The campus healthcare providers also indicated that they networked with NGO’s in their area and were therefore in a position to meet a wider range of the healthcare needs of the students and staff on campus than previously possible.

“We try and meet a wider range of their health needs in providing or in working together with the NGOs, like providing free eye screening or free PAP smears, or free breast examinations, those kind of things. So maybe to check and see if we have better resources outside in the community that we can build up a good working relationship with them, and ask them to come on campus and provide a service to the students”.

“We were able to negotiate various good working relations with a number of NGOs within our city as well, for instance the Cancer Association that would come in and provide a service to the students that we were not able to do and in that way we were able to see to the need of the students in providing free PAP smears, or free eye testing, so that we could see to their needs”.

It can be detected from the aforementioned discussion that networking enabled the campus healthcare providers to provide a more expanded service to the campus healthcare providers at no cost.

1.1.D Campus healthcare providers experienced the secretaries who had been trained as basic ambulance assistants as being of great help to them
The campus healthcare providers indicated that they experienced the secretaries who had done the Basic Ambulance Assistants course as being of great help to them because they could assist them with dressings and the taking of blood pressure in the clinic and render emergency care in an emergency. According to Gebbie and Qureshi (2002:46), the term “emergency” refers to any extraordinary event or situation that requires an intense, rapid response and that can be addressed with existing resources.

“These people are receptionists, they’re secretaries, they all have basic ambulance training for emergencies and first aid”.

“..our secretaries went for training and they’re now ambulance assistants and they’re quite helpful in the clinics. They can do anything now, put on dressings, do blood pressures, do rendering of emergency services as well”.

“And I do admit they’re helpful regarding that when a patient needs to go to the hospital, the nurses don’t physically need to leave the clinic and go to hospital, unless it’s an emergency like they had the other day, two nurses to see to the patient”.

“…we have trained the secretaries so they’re now sort of medical secretaries an able to do blood pressure and dressings, things like that, so they do assist us in that respect, so maybe it might not be necessary to have nursing assistants as usch because if we had this one big facility then there would be more than one secretary in the …position”.

According to the Health Professionals Council of South Africa, Professional Board for Emergency Care Personnel, a registered intermediate life-support practitioner may perform diagnostic and therapeutic duties in an emergency care situation within the scope of the profession in an independent capacity or under direct or indirect supervision of a registered medical practitioner or an Advanced Life-Support Practitioner under his/her instruction or on his/her oral or written request; and transport the patient to a medical facility or, on the written instruction of a medical practitioner, to a specific medical facility. The diagnostic and therapeutic duties of an intermediate life-support practitioner in an emergency include basic cardio-pulmonary resuscitation, administering
oxygen and entenox, emergency deliveries, nebulising, logrolling, application of a cervical collar, musculo-skeletal immobilisation, wound care and bandaging, blood pressure monitoring, suctioning of the mouth and pharynx, first aid for choking and blood glucose evaluation (Health Professionals Council of South Africa, 2003).

Sub-theme 1.2: Campus healthcare providers experienced various challenges in the rendering of a campus health service

The term “challenge” refers to something new and difficult which requires great effort and determination (Collins Cobuild Essential English Dictionary, 1989:119). The following quotation from the raw data illustrates this definition:

“Okay, eerstens toe ek hier gekom het, het niemand my ontvang nie, dit was n groot ervaring. Ek het nie geweet waar om te begin nie, nie geweet wat om te doen nie, hier was absoluut niemand [Okay, firstly when I got here, there was nobody to receive me, it was a big experience. I did not know where to begin, did not know what to do, here was absolutely nobody]”.

A graphic presentation of Sub-theme 1.2 and the related categories is presented as follows:
THEME 1:
Campus healthcare providers experienced the rendering of campus health services as challenging, positive and rewarding

Sub-theme 1.2:
Campus healthcare providers experienced various challenges in the rendering of a campus health service

1.2.A resource constraints as having an impact on service delivery;
1.2.B campus health services as being fragmented because of the number of the satellite clinics situated on the different campuses of the HEI;
1.2.C the referral system to other public healthcare facilities as being unstructured;
1.2.D the diversity of cultures of the healthcare consumers as being challenging in rendering culturally congruent health care;
1.2.E a lack of contextual research that informs practice in campus health service delivery;
1.2.F the merger of the three Higher Education Institutions as causing additional stress and uncertainty among themselves and the staff health care consumers and
1.2.G the lack of promotional opportunities as hampering career progression.

FIGURE 3.7: THE CHALLENGES EXPERIENCED BY CAMPUS HEALTHCARE PROVIDERS IN THE RENDERING OF A CAMPUS HEALTH SERVICE

The following discussion will highlight the various challenges experienced by the campus healthcare providers in the rendering of a campus health service.
1.2.A Campus healthcare providers experienced resource constraints as having an impact on service delivery

According to Smit and Cronje (2004:5) all organizations bring together society’s resources, namely people (human resources), money (capital or financial resources), raw materials (physical resources) and knowledge (information resources). These resources are utilised to produce products and services to meet the needs of society. Thus in order for the healthcare needs of the campus health care consumers to be met effectively at this HEI, management must ensure that the human, financial, physical and information resources are adequate.

The research information gathered from the campus health care providers indicates that they experience a number of resource constraints that have an impact on service delivery and that management do not share their vision for health care and that they (management) are not aware of the importance of the service and the risks that they (the healthcare providers) are taking each day. One campus healthcare provider had this to say: “But they do not have the vision you know, how important this is and what risks we’re taking every day”. Muller (1998:7) states that healthcare systems are universally faced with the problem of limited resources. Almost all the campus health care providers indicated that they would be able to meet the healthcare needs of the students and staff better if the resources were increased. “So if we are able to increase the resources we can meet their (students and staff) needs better”.

The main resource constraints identified by the campus healthcare providers included financial, human and physical resources. This is illustrated in the following quotation:

“The challenge for myself at this particular institution in the beginning was that the institution provided the facility but very limited, very small in funding, in staffing and in resources to provide the healthcare”.

The campus healthcare providers indicated that they were doing the best they could with the limited budget allocated to them for the smooth running of the
campus health service. “I think the financial is quite a huge problem….we’re doing the best we can with the budget that was allocated to us”.

The campus healthcare providers experienced the financial constraints as having a ripple effect and thus impacting on service delivery. They indicated that they were only able to keep a limited stock of medication and equipment and were unable to expand the services to address all the healthcare needs that the students and staff presented with. They also indicated that the budgetary constraints made it difficult for them to treat staff. The campus healthcare providers indicated that they would like to receive a far more realistic budget so that they could improve the services. The following quotations were taken from the raw research data to illustrate the aforementioned:

“Drug limitations – I think we are quite limited......there are certain drugs that I think that should be there, that's not available...They've got three or two antibiotics but you need a little bit wider selection on that. Anti-allergic things – they've got the lowest of the lowest on the allergex things – should be a little bit more there. There should be a bit more of a wide screen on fungals, or creams...”.

“All the services that we are doing now and they could even expand, we could even do minor procedures...I am doing it but I don't have a lot of instruments to work with....I can only do it (these minor procedures) at one campus....I can't do it at any other campus. A lot of those kind of cases (on the other campuses) have to be referred because they have to be referred and I don't think that they get any treatment in any case on the other places”.

“Say for instance a patient (staff member) has got rhonchi or creps....I must refer the patient (staff member), I can't issue antibiotics.....seeing that we're here, we could actually render that service but the budgetary constraints...because I mean if we must give each staff member that has got a medical aid these medications, we won't have enough for our students... but I think it’s the ideal situation to treat everybody with a whole course of treatment while they're at work”.
The campus healthcare providers also indicated that they experienced the available physical resources as impacting on service delivery because at some satellite clinics the facilities were too small to accommodate additional staff, for example, a counsellor. At two of the satellite clinics the campus healthcare providers indicated that the structure was of such a nature that the confidentiality of the patient was being compromised at times. The term “confidentiality” which refers to the privileged and private information provided during the healthcare transaction, is the cornerstone of the patient-healthcare provider relationship and is essential to the adolescent’s trust in the healthcare provider and thus the willingness to supply information candidly to his/her benefit (Jagananen, 1999:75).

“Staff and students wait in the corridor outside the waiting room, so I sometimes feel that the confidentiality is a bit infringed on. Students can listen in when you consult in the consulting room, so you have to consciously lower your voice when you speak and when you consult and counsel in the consulting room”.

“I would love a bigger waiting room where health educational programmes can take place – to use the opportunity while they’re waiting to be seen as a time for health education where videos can be screened”.

“I am foreseeing a situation where we will really have a bigger space to accommodate a counselor and even a lying-in room, a ward, you know. If I’ve got somebody in here whom I have to allow time for recovery for a while, it’s usually the young females with dysmenorrhoea. I cannot have somebody else in……so if I could just have a space with one couch to leave the person recovering there, in the meantime I’m busy with the other client”.

One of campus the healthcare providers indicated that the occupational health doctor that visited the clinic indicated to her that the clinic did not comply with regulations with regard to the toilets and the sink for dispensing. “…he did indicate that it is required by law …….the toilets that we are using here, we must have high enclosed walls and not have half walls as we do….in an environment where we are dispensing medicines…..we are keeping medicines
and there could be leakage or spills where you have to clean up...you can’t use your kitchen sink as a dispensing sink”.

The campus healthcare providers also indicated that they experienced the emergency equipment available as being inadequate and that they needed better equipped emergency transport to transport the patients to hospital.

“…that guy that got electrocuted in the student village, I mean those things are big things and you have to be ready for it. I don’t think that the equipment is completely adequate for it...”.

“..I would really love to see us having an ambulance that is fully equipped and everything, we try our best with the one we have but it’s not sufficient. We’ve got oxygen, we’ve got – the seat is taken out, its converted to a bed....the basics are there but the essential ones are not”.

All of the campus healthcare providers indicated that they experienced a shortage of staff as impacting on service delivery. “I would really like more staff available because if you haven’t got staff, you can’t put all these other structures in place and all these other needs can’t be addressed. Staff shortage is a big problem in the campus health service at the moment”.

The campus healthcare providers indicated that the demand for the service was greater than the supply; thus they experienced many students and staff being turned away because of the shortage of staff.

“…from my experience when I was doing primary health care alone on this campus there were students that needed to be turned around because we couldn’t cope with the workload. So I think we’re quite understaffed compared to students numbers”.

“...we find that the numbers (students) have increased quite a bit and that makes a major problem for a lot of students out there that we know at the moment we’re not coping with the amount....there’s just not sufficient staff to cope with the numbers....we are only seeing the tip of the iceberg”.
The campus healthcare providers indicated that they therefore introduced the appointment system in order to eliminate the problem of having the waiting room packed to capacity and having the students and staff waiting for long periods before they were being attended to. “..we were trying to avoid that long queue that stays there, waiting for so long, maybe even for 30 minutes and a little more, to come and see the sister”.

The campus healthcare providers indicated that they experienced the appointment system as working better for them since they could now plan their working days better. They also indicated that some of the students and staff were not too happy about the appointment system because they sometimes had to wait for an appointment and were unable to get one immediately. On the other hand, there were some students and staff that were in favour of the appointment system because it eliminated the waiting time for them. The following quotes were extracted from the raw data with regard to this:

“...at the beginning of last year (2005) –(we) introducing a new system that would book our students when they have to see the nursing sister at the clinic, so we know they (the students) are not very happy about it....they just want to be seen as they come in”.

“We have to work with appointment system at the moment, which I feel is actually, we had to do it because we have to cope with what we are doing, with the workload of students that visits our clinic, but its a bit unfair to the students because I mean having to send students away that comes to you knowing that he will be helped at that moment, and having to tell him he must come back tomorrow, make an appointment. I think that is not fair to the students but we can’t do otherwise because if we are burnt out in the end then we can’t even help the students”.

“...the nurses walk in the morning, they are fully booked for the day, and they go through until the end of the day. Now I don’t think one should work like that. I believe you should have a break”.

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“...we would like to see more patients. It's not like we don’t want to see them. It's that there are limited amounts of appointments available every day and the nursing staff are fully booked every day, and there are students and staff that maybe are not seen to because of a shortage of appointments”.

The campus healthcare providers also indicated that they were unable to cope with all the requests for VCT because of staff shortages. The public services on the other hand are encouraging people to make use of the VCT services to find out their HIV status. The Provincial Treasury in the Eastern Cape Provincial Government indicated in the Eastern Cape Budget 2007/2008 that HIV infections should be reduced by increasing VCT uptake (Eastern Cape Provincial Treasury). It is hoped that, if people know their HIV status and are sero-negative, they will be motivated to adopt preventative measures to prevent future infection. The hope is also that if people are sero-positive, they will learn to live positively, take the trouble to access care and support at an earlier stage, and learn to prevent transmission to sexual partners and plan for their own and their families’ futures (WHO, 2000a in van Dyk, 2001:57). The research data collected from the students indicated that this state of affairs was discouraging for those students wanting to access these services and they were being denied the opportunity to be tested.

“I've reduced the rate of doing VCT this year compared to the previous years but the need for the students is great. I've turned them away many a time here, requesting for VCT”.

“We do promote HIV testing a lot and students feel very disappointed when we are not able to surface in that area”.

The campus healthcare providers also indicated that they were unable to spend too much time on preventive healthcare because of the shortage of staff.

“...when I originally came here, my role was more supposed to be focused on HIV and AIDS type of campaigns in a preventive role, but my role has changed
a lot over the years, because the need for primary health care has become more by the students”.

“In all the years I was used to the fact that we would concentrate a lot on preventive care but we’re not able to do that here because we just (see) a person is sick they must come in and we give them medication for whatever problem they have, we don’t really have time anymore to give talks to students, maybe even we have to arrange it after hours in the residences to really speak to them on preventive care, on how to take care of themselves and what to do, do they really know what TB is…”.

DeAmicis (1997), Thomson & Kohli (1997) and Norton 91998) in Whitehead (2001:311) indicated that there had existed either an implied or a contractual obligation for many nurses to undertake and participate in promotional health activities as part of their routine clinical activity. Thomson (1998), and Piper & Brown (1998a) in Whitehead (2001:311) state that where nurses do implement these activities, they are far more likely to practise opportunistic and limited information-giving ‘health education’ techniques. Whitehead (2001:311) argues that the position that nursing finds itself in, is predominantly underpinned by the lack of any formally identified structured and ordered planning process, model or framework, for this sort of activity that is common in nursing practice.

Various suggestions were made by the healthcare providers to improve the existing resource constraints and thus improve service delivery. They all indicated that the staff complement should be increased by 3-5 additional registered nurses and increased doctor’s visits. One of the healthcare providers suggested that a full-time doctor be appointed as the workload warranted it. All the healthcare providers indicated a need to expand the service to include other healthcare professionals, for example, psychologists, social workers, health educators, pharmacists and counsellors, in order to render a comprehensive campus health service.

“I would like to see the service grow into a fully-fledged service that includes having a pharmacist, having counsellors, having a psychologist and if
possible, health educators, because that’s one thing (health education) that I feel the students really, really need a lot of”.

“(if) we could have a psychologist, we could have a social worker and we could have more frequent visits of the doctor”.

“Maybe a health educator who could run our health education programmes more actively on campus”.

“And the other thing I would like to see us having an ambulance driver with a fully functional ambulance because that could always relieve the nurses of the non-nursing duties like driving a patient to hospital...”.

The campus healthcare providers indicated that they presently did have psychology interns who did their practica at the campus health service but they did not find this adequate because the one counsellor being shared between the campuses could not be available every day at a particular clinic.

“We get interns who do their six months practicals from the Psychology Department....and a little money has been made available, so we have appointed registered counsellors who have finished but are not able to find employment, so they get appointed for specific periods of time to attend to all counsellings, it's not only HIV but mainly HIV/AIDS counselling, pre- and post-test counselling, and ongoing counselling but they do also attend to crisis pregnancy counselling and those things, and they are situated on the campus in facilities but unfortunately it's not available every day because we have to share the person between this campus and (another)campus”.

The campus health services in the USA are more comprehensive than here in South Africa. According to Rebecca Wilson, a staff nurse (Personal interview, June 2006), at the campus health services at the University of Mississippi in Oxford and Jennifer Fuller, a health educator (Personal interview June 2006) at the Mississippi State University in Starkville, in the USA, their services include a comprehensive pharmacy run by a pharmacist, a laboratory where all their specimens are tested and analysed by laboratory technicians, an x-ray department, 3-5 full-time doctors, a social worker and sub-categories of
nurses. The Mississippi State University in Starkville has an established health education department with a staff complement of 6 health educators who are responsible for all the health education on campus on a daily basis. This is an ideal set up that could be striven towards in the future.

According to the campus healthcare providers that were interviewed at the HEI where this research has been conducted, the campus health service should implement a third stream income to eliminate the financial constraints. They indicated that this could be achieved by increasing the fee charged for services rendered or all students should pay a compulsory medical fee at the beginning of the year that would be paid into the campus health service account. This would increase the budget of the campus health service without having an impact on the HEI’s budget. This money could be used to purchase the necessary medication and equipment and could even contribute to the expansion of the service. The students could then receive free consultations throughout the year.

“They have to develop, they have to put onto students’ accounts academic payments, they have to put payments there. To me, that’s a given. … They’re still subsidised, the consultations but that should be a little bit on par, at the moment it’s virtually nothing in and case, your R10, R15 is nothing to really pay for it”.

“...if you put a R10 levy on every student per year, you’ve got more than enough money just by doing that…..You cannot have a service and not pay for it. Somebody has to pay for it and you can’t have it susidised to that extent, so I mean it should be on the student, but then he gets the service, and he’s not getting the service for not paying anything.”

“... your only other third stream you can get, is if you start charging your staff but now then either the doctor has to charge, or he’s got to get a lump sum and they actually charge”.

Both Rebecca Wilson (Personal Interview, June 2006) and Jennifer Fuller (Personal Interview, June 2006) indicated that every student at their universities was charged a fee of about $100 per semester which was paid
into the account of the campus health service. Students thus received free consultations but they had to pay for medication, laboratory tests, x-rays and any other specialized procedures or examinations. They indicated that their services operated as a business, they generated their own funding and therefore they were almost self-sufficient.

1.2.B Campus healthcare providers experienced the campus health service to be fragmented because of the number of the satellite clinics situated on the different campuses of the HEI

According to the Collins Cobuild Essential English Dictionary (1989:310), something that is fragmented consists of a lot of different parts which seem unconnected with one another. The healthcare providers indicated that they experienced the campus healthcare service to be fragmented because of the number of the satellite clinics situated on the different campuses. The campus health care providers had this to say:

“Okay, the biggest problem in this setup that we have, is that it’s fragmented. That’s your biggest problem. It’s not one campus – okay. To me a campus health (service) must be co-ordinated, one setup team effort and not fragmented, and that’s been my biggest frustration, that everybody is on his own campus and I’m not sure whether it’s really a team effort that’s working, and they’re working as individuals, so that to me has been quite a big problem”.

“…the service is fragmented a little bit – it’s a team thing and if you can get the team right, you actually get a much better health service”.

Most of the healthcare providers indicated that one central campus health service for the three campuses situated within a radius of about 1 to 4 kilometers should be put in place. They indicated that this would have more advantages than disadvantages and many of the problems experienced presently would be eliminated. They also indicated that a central campus health service would be more cost-effective and it would facilitate continuity of
healthcare for the consumers. Campus healthcare consumers would have a wider choice of healthcare providers and they would be able to be followed up by the campus healthcare provider whom they preferred. This is illustrated by the following quotes:

“...the ideal again should have been to have a mainframe that you actually have – that’s your health service, but then you must have an effective shuttle service to be able to do that ideally”.

“So my suggestion would be that we have a medical centre on one of the two biggest campuses. We do have a transport service and I know people don’t want to travel like that but they could travel to the medical centre. ...it’s a lot better than having to travel from for example New Brighton to Provincial Hospital. They do have transport, the distance is much smaller, so if you have one medical centre with everybody working there, then you will also find that the nurses will be able to get relief”.

“I strongly feel it would be a very cost-effective measure for the institution as a whole if these three campuses could be made one facility, because you would always have that availability (of the staff) aspect.....one central situation because we are in very close proximity to each other and then one campus service on the....campus .....the doctors visits to the campuses could then be extended because at the moment he comes one visit (to each campus)....so if it’s one facility, all these problems will be erased, the doctor will be more available, almost every day. So in my view, one integrated service would rule out a lot of problems and would really be cost-effective in various ways and it would really be able to attend to the needs of the students”.

“I was thinking of a central campus health service for all the different campuses. Not a clinic on each campus but a central campus (health service) that will assist standardization with the patients. Education will improve and it will really facilitate treating that person that comes to you and to follow up the case, that is so important. .....I think the advantages are more than the disadvantages. I’ve worked with students and they really like to see one person all the time instead of seeing different staff members for specific problems. They’ve confided in me and would like me to follow them up. At the moment we also have a problem with record-keeping because students move up and
down all the time to the campuses, so that will also help to address that problem. You get a file at the (one) campus and you get a file here, and it’s difficult with the files”.

According to Booyens (1993:123) centralisation is more cost effective than decentralisation.

1.2.C Campus healthcare providers experienced the referral system to other public health institutions as being unstructured

The campus healthcare providers indicated that they experienced the referral system presently in practice as being unstructured because they did not know whom to contact in the public sector regarding the particular problem for referral at the time. They felt that the public sector was not presently organized enough for them to know whom to phone and where to go.

“The biggest problem I have found with students was when they have to be referred from campus health (service) to hospitals, to clinics. We’ve all found that everybody has worked some contracts with the hospitals but there’s not a real line of work and there should be a much better referral line, That’s been lacking quite a bit but it’s because the public sector in itself is not organized enough to accommodate it, but it would be nice to know that if you’ve got a problem wit a patient, who to phone, where to go, so that line should actually be straightened”.

“….the (referral) line must be right to Walmer, to Motherwell, to – and I’m not sure whether that’s really in place”.

“They might need a referral to a private facility, a more specialized facility like a gynae or an ENT or a surgeon and they need to go via a general practitioner and the doctor on campus is battling for the students (with the referral)”.

One of the campus healthcare providers indicated that he experienced it as better to refer the students who came from the smaller towns to the public
health services in their areas back home because of the referral system being unstructured in the area where this HEI is situated.

“….like this morning somebody was coming from Oudtshoorn and I said “Actually wait, just finish the exams and rather go there” because there’s not a correct (referral) line for me to be able to help her quickly. So it’s better for me to get her into a smaller place to have her helped”.

Essential to the efficient operation of a PHC system is an efficiently functioning referral system. The referral chain consists of institutions and providers of healthcare that provide different levels of care to healthcare consumers. The referral chain stretches from self-care and community health workers, through mobile, satellite and fixed clinics, community health centres, district and regional hospitals, up to the most specialised and sophisticated tertiary hospitals. One of the most important principles underlying a well-functioning referral system is that it should be a two-way process and that the retention of healthcare consumers in a referral institution should be as brief as possible (van Rensburg, 2004:150).

1.2.D Campus health care providers experienced the diversity of cultures of the health care consumers as being challenging in rendering culturally congruent healthcare

The campus healthcare providers indicated that they experienced working with students from various cultures as being challenging and interesting because it broadened their outlook on life and it made them aware of how the students from diverse cultures viewed and saw things. They indicated that the students that accessed the campus health service were from different cultures and also from different countries, from all over the world, for example, Kenya, Uganda, Nigeria, Botswana, China, America and from among the indigenous cultures of South Africa.

“…one thing that has been wonderful for me is that I have seen the students come from Kenya, Uganda, even Nigeria…”.
“And we have a lot of other cultures on campus as well. We have Chinese, we have Americans, we have Botswana students...”.

“Well, I do find it very interesting. I learn a lot working with students, because you know they come from all over the world and it’s exceptionally interesting. It does open up your mind to other – not only cultures, nationalities and people, the way they do things and the way they look (at things) and the way they see (things)”.

The campus healthcare providers indicated that the diversity of cultures on campus made their work challenging because they had to ensure that the campus health service was acceptable to students and staff from the various cultural groups. In order to achieve the aforementioned the campus healthcare providers must be culturally competent to provide culturally competent and appropriate care (Watts, Merrel, Murphy and Williams, 2004:532). Hoban and Ward (2003:138) quote the definition of cultural competence that was developed by the Office of Minority Health: “Cultural and linguistic competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities”. The following quotation illustrates the challenge experienced by the campus healthcare providers in ensuring that the campus health service is acceptable to the campus health care consumers:

“I would want the clinic to be much more acceptable by – the students and the staff members, where they know that if they come to the clinic that the kind of service that will be rendered is acceptable to their culture”.

The campus healthcare providers indicated that they found the male Xhosa students particularly challenging to work with because of their cultural beliefs.
“....The male Xhosa students ... a lot of times they say that it is not in their culture to speak about, and especially to what they find like a female, most of the counselors on campus are female, so to their culture it seems like it's not so macho, it's not so male, it's not so – ja, you don't find, they see themselves as the superior ones, the authority, the one that enforces the respect and the leaders of the community. Now for such an individual now to say that they have a problem, whatever emotional problem there is, would make them less of a male and it's not so macho to say you need counseling, you have a problem... So I find that that is one of the cultural problems”.

The results of a study conducted by Davies, McCrae, Frank, Dochnahl, Pickering, Harrison, Zakrzewski and Wilson (2000:259) reveal that college men were aware that they had important physical and emotional health needs but took little action to address them. Davies et al. (2000:259) quote Boehm, Selves, Raleigh et al. (1993) as stating that men are less likely than women to seek medical care. According to Davies et al. (2000:259) two factors associated with the gender differences are gender-role stereotypes and men's socialization. Traditional male stereotypes portray men as strong, self-reliant, stoic and aggressive. These stereotypes appear to restrict men's openness and willingness to seek help. From an early age, boys are discouraged from seeking help by their peers, their parents and other adults (Davies et al., 2000:260). Nurses at the forefront of health service provision are ideally placed to tackle the issue through the development of more responsive and effective interventions and services (Galdas, Cheater and Marshall, 2005:621).

In order for the campus health service to be acceptable to the students and staff on campus, the campus healthcare providers indicated that they had to be knowledgeable about the various cultures on campus in order to address all their needs in an acceptable way. The results of a study conducted by Ekblad, Martilla and Emilsson (2000:627) revealed that merely possessing knowledge about different religions and cultures was, however, not enough in multicultural healthcare. According to the data obtained from the interviews conducted in the aforementioned study, culture should be highlighted in the individual context. In the multicultural encounter there is a risk that things are
taken for granted as there are opinions and attitudes, for example, on how people from different cultures should behave.

“...if we’re not knowledgeable on what their cultural practices are, we would never be acceptable for those students to access our service”.

“What also improves my experience is when I have gained a better understanding of the situation (culture), then it makes my experience good because each one is so different”.

“So to be acceptable we need to know what these students are talking about and what lacks there (medicines received from sangoma) …and if it contradicts to what you’re giving, to educate them on why that (traditional medicine) is not enough…. You’re not saying that it is not acceptable but to give advice….scientific advice”.

One of the participants indicated that there was a lack of knowledge regarding alternative medicines among the campus health care providers. She indicated that they had to be knowledgeable of what was available to them in order to give the correct advice to the students. The latter research findings are important, because the results of a study conducted by Mdondolo, de Villiers and Ehlers (2003:86) reveal that the participants first sought help from traditional healers prior to seeking medical care from the hospital and/or clinics, thus it is important for nursing professionals to receive specific training so that they can be empowered to render culture-congruent care (Zeelie & Uys, 1996:17, Otto & Botes, 2001:19).

“Firstly at the moment I don’t think there is any of the campus health staff that is knowledgeable on alternative medicine and we’re moving into a dispensation where we need to educate ourselves on what is there in different cultures – what is acceptable for them so that we can have some understanding when students come to us and say that they’re tried this method (traditional method) or they’re on a specific herbal remedy that they got from home, or got from a health, faith healer or whoever they went to – we need to be knowledgeable on what is (available) outside, we can’t just take it for
granted, or discourage the client from using that method and insist on them using what is acceptable (to us) antibiotic, anti-inflammatory etc”.

In view of these findings, it is therefore important for the campus healthcare providers at the campus health service, to learn more about the religions and cultures with which they usually come in contact, thus enabling them to put their knowledge to practical use (Compare Ekblad et al., 2000:628).

1.2.E Campus healthcare providers experienced a lack of contextual research that informs practice in campus health service delivery

The nursing profession has long recognized the importance of research as an essential basis for its development. More recently, the movement supporting evidence-based practice has brought this point into focus (Retsas, 2000:599). According to Parahoo (2000:89), there are a number of factors which can impede or facilitate the use of research in practice; thus it is important for these to be identified and addressed.

A lack of contextual research that informs practice in campus health service delivery was experienced by the campus healthcare providers participating in this research project. They indicated that they experienced various problems relating to the campus health service that could be researched, but were unable to do so due to time constraints. The latter findings are congruent with the findings of research studies conducted by Hundley, Milne, Leighton-Beck, Graham and Fitzmaurice (2000:83), Clifford and Murray (2001:691) and Retsas (2000:605) that indicate that a ‘lack of time’ is one of the main barriers highlighted by nurses and midwives in doing research.

“Ummm….I just find that with campus health services, maybe because this is a tertiary institution, we should also follow suit if this is a tertiary institution, so I find our role, we could also play a big role with regard to research on campus and I mean we’re not really doing that as such, because there’s many things that we could (do), small mini-researches that could be done but then we’re also mainly not having time for, maybe we’re just not looking at that area as
well, that could be of benefit not only to our campus health services but I mean to any private health care facility”.

The campus healthcare providers felt that if research could be conducted on campus they could use the findings to improve their campus health service delivery. Hundley et al. (2000:79) state that the importance of transferring evidence of effective healthcare into practice is not a new concept and that studies which have explored ways of increasing the use of research in practice have had limited or no success in actually changing practice. Hodnett et al. in Hundley et al. (2000:79) state that some authors suggest that the problem arises from trying to change specific practices without first emphasizing the rationale and the process of research use. Thus if change in practice is to be accomplished, preparatory work is essential.

“At some stage, maybe do a survey to assess whether students feel we are meeting their needs, maybe to do some kind of survey and say, do you feel that we meet your needs – yes or no – and if we don’t meet them, what would you like to provide on campus?”

Parahoo (2000:97) states that emphasis should be placed on creating and promoting a research culture in which nurses recognize the need for improving their care, seek the knowledge and skills to do so, and feel supported, encouraged and valued.

1.2.F Campus healthcare providers experienced the merger of the three HEIs as causing additional stress and uncertainty among themselves and the staff healthcare consumers

The post-1994 reform agenda created an enabling legal and policy context to address most of the weaknesses of the pre-1994 higher education system (HESA Final Report, 2006:20). Since 1994 South African universities have been in great flux as they have sought to pursue a comprehensive transformation agenda that seeks to overcome our apartheid past, including the creation of a single, co-ordinated and differentiated university system
more suited to the needs of a socially equitable and developing democracy. Higher education transformation offers a particular opportunity to re-vision the purpose and roles of the higher education sector and its public institutions (HESA Final Report, 2006:25).

By mid-2002 there were some 30 policies governing higher education from a range of government departments, and these have not always been well-aligned. Institutional restructuring has had an immense impact on the sector in the intervening years. The Council on Higher Education (CHE) has noted that “there is considerable stress (and) strain within higher education”, and that the “system, institutions and actors are at the limits of their capacities to absorb further policy changes” (HESA Final Report, 2006:22). The mergers and the Programme and Qualifications Mix (PQM) exercise have created a palimpsest upon which new designations have been scrawled (HESA Final Report, 2006:25).

Consequently, the campus healthcare providers indicated that they experienced the merging of the three institutions as too drawn out and causing uncertainty and stress among themselves. The stress and uncertainty experienced by the healthcare providers was due to the merging of two campus health services without any clear-cut lines of communication and structures in place. They experienced confusion regarding which campus health service head to report to as there were now two Heads of Department. The following quotation illustrates this:

“…this merger process was too drawn out. It's having an effect on campus health services too”.

“…there's a lot of confusion now also with the merger so it's basically trial and error and because there's no real defined structures that we also seem a bit lost because you have basically two bosses to report to and everybody's still working out their lines of communication and their lines of reporting, so it is a bit difficult in this interim period. Also there is a lot of uncertainty as well with regard to your future role and campus health services, so that has an impact on your everyday experience”. 
“The past two years since we’ve merged I have had a turmoil of experiences, from severe frustration due to just the way the merger’s being handled, the fact that there’s no final structures, the way that it brings about insecurity has maybe affected the experience within the health care of the student”.

“I mean just like any merger,……there’s always that threat that the service could be outsourced”.

The campus healthcare providers indicated that they also experienced an increase in the number of staff campus healthcare consumers accessing the campus health service with stress-related conditions related to uncertainty with regard to the merger.

“…we’ve really picked up with the staff is stress and I mean …….. to be labelled’s directly related to the fact that with the merger dragging on and dragging on…. (there are) lots of staff members that are stressed”.

“Well I think it’s all the uncertainty. Being older, uncertainty is very difficult to handle and to be insecure, because we do – a great need is to be insecure, and it is so easy just to go on day by day in the same way. You have for a long time gone on like that and you have never thought that – and now something comes to rock the boat, and they’re rocking your life! So it takes quite a personality strength to be rocked and to be able to handle the situation”.

“…during the past three years, these I call them psychological disorders, but they’re stress related problems, we have seen a tremendous increase and you read in the newspapers you know, the staff are not under stress or anything but that’s nonsense, it’s utter nonsense because they don’t see the people that we see – we get phone calls from people who just want to talk, we don’t even know who they are because they’re scared they’re going to be labelled but I mean they are emotionally sick, they are stressed and I mean it’s three years with people not knowing where they’re going...”.

The campus healthcare providers indicated that human resources at the HEI had sent out an e-mail to all staff members who were interested to attend a workshop on stress management if they felt that they needed it. There were
two workshops that were held and one of the campus healthcare providers indicated that she attended one of the workshops and experienced it to be very poorly attended by the staff members on campus.

1.2.G Campus healthcare providers experienced a lack of promotional opportunities as hampering career opportunities

The campus healthcare providers experienced a lack of promotional opportunities as hampering career opportunities. They indicated that they experienced no upward movement in the hierarchy as de-motivating. This is evident in the following quotations:

“I would like to see for example, instead of having a number of nursing sisters with one position above that, namely the head of the service, that there should rather be another position in between these two, like a senior nursing sister for example. Then at least there will be an opportunity for people to work hard and excel because there’s and opportunity for promotion”.

“...but my only concern is the fact that your nursing staff, I mean these are the key figures, the campus health services, there’s no chance of promotion for them”.

“But promotion opportunities, opportunities to broaden your spectrum of activities, That is a problem because it's lacking. It’s very de-motivating as well”.

The above discussion is congruent with Booyens (1993:435) who is of the opinion that nurses are asking much more from their employers; instead of nurses simply serving their employers, they want to know how the employer can contribute to the quality of their work life and to their personal and professional development.
3.5.3.2 DISCUSSION OF THEME TWO AND RELATED SUB-THEMES

A graphic presentation of theme two and its related sub-themes of the campus healthcare providers is presented as follows:

**FIGURE 3.8: THE NEED EXPERIENCED BY THE CAMPUS HEALTHCARE PROVIDERS TO RENDER A MORE COMPREHENSIVE PRIMARY HEALTH CARE SERVICE TO ADDRESS THE HEALTHCARE NEEDS OF STUDENTS AND STAFF**
THEME 2: CAMPUS HEALTHCARE PROVIDERS EXPERIENCED THE NEED TO RENDER A MORE COMPREHENSIVE PRIMARY HEALTHCARE SERVICE TO ADDRESS A WIDE RANGE OF HEALTHCARE NEEDS OF STUDENTS AND STAFF ON CAMPUS

De Haan (1988:9) quotes Dr Gilliland as stating that a comprehensive primary health care service “provides the greatest number of people with maximum health benefits at the least cost”. A comprehensive healthcare system has promotive, preventive, curative and rehabilitative components.

Furthermore, van Rensburg (2004:422) states that as equity and access to healthcare have since 1994 been considered the key principles to steer the transformation of health services in South Africa, a mechanism was required to define parameters for service delivery, as well as to ensure comparability in the rendering of services. This mechanism was realised in the form of the comprehensive PHC service package that firstly, entails a standardised ‘basket’ of services to be delivered at primary care level, which may include preventive and promotive services, as well as basic curative and rehabilitative services. Secondly, the PHC package stipulates the common quality norms and standards that are required for each primary health care service and are shared by those delivering the services. The PHC package envisages an organization of services that allows for a ‘one-stop’ approach. A main advantage of the PHC package is that it provides guidance on which services should be made available at different levels of care and then unites these services into one seamless continuum of care.

The registered nurses (healthcare providers) employed at campus health services fulfil the role of a community health nurse practitioner. Dreyer et al. (1997:36) state that the role of a community health nurse practitioner in primary health care settings covers a wide field and is comprehensive in nature. Her role is to serve the community (the students and staff at this HEI) and to provide for all their health care needs. In the South African context the community health nurse practitioner is involved in the provision of a comprehensive healthcare service. As mentioned earlier, the scope of her
practice is regulated by the legislation and rules of the nursing practice, health legislation and other relevant acts of the country. Within the comprehensive healthcare system, the community health nurse practitioner fulfils the roles and functions related to prevention of disease, the promotion of health and the provision of curative and rehabilitative health care (Compare Smit & Roos, 2000:46). The community health nurse practitioner is also responsible for providing healthcare at primary, secondary and tertiary levels to all age groups, from before birth until death, in clinics, healthcare centres, at home or through mobile units in rural areas (Dreyer et al., 1997:36).

The campus health care providers who participated in this study indicated that they were presently rendering some of the services indicated in the PHC package; but they experienced a need on campus to expand these services to include more preventive and promotive healthcare services and equally important more curative healthcare services than were previously offered. The following quotations from the raw research data demonstrate the need experienced by the campus healthcare providers to expand the campus health service to meet the healthcare needs of the campus healthcare consumers:

“I would like to meet the health needs of the students by the clinic being (more) comprehensive in it’s being a ‘one stop’ where you know that a referral will only be when it’s absolutely necessary for your health needs, irrespective of what the need may be, whether it’s physical or emotional, where you have the assurance that the need will be met, you have that faith that when you go there, that everything in their power will be done to help meet that need”.

“For the first couple of years the profile was mainly towards a white population which had medical aid, which had a good support at home, which could take basically care of themselves. So to provide the service for them was in the beginning fairly focused on promoting and staying well, but soon after that the service changed as the profile of the institution changed with more students from disadvantaged backgrounds coming to the institution, having access and being given opportunities through national funding to study, they were able to be here and pay for there studies and that’s where the buck stopped and the healthcare services needed to change to meet their particular needs. They
have very limited access to private healthcare facilities, they had very limited access to private medical aids, so the kind of service that we rendered expanded quite a bit from being mainly focused on looking at general well-being and staying healthy, we needed to start providing primary health care and taking care of more basic needs which other students didn’t need in previous years”.

Researchers have shown globally that many college students engage in various risky health behaviours, including alcohol use, tobacco use, physical inactivity and unhealthy dietary practices, ignore preventive safety hazards such as wearing seat belts and/or using condoms which may have long-term implications for their health (Centers for Disease Control (1997) and Steptoe & Wardie (2001) in Von Ah, Ebert, Ngamvitroj, Park and Kang, 2004:464). Therefore, identifying factors that influence health protective behaviours in college students warrants further attention so that nurses, who often play a vital role in developing health promotion and prevention programmes, can then use this information to develop and/or enhance programmes targeted at college students (Von Ah et al., 2004:464). The findings of this research are congruent with the latter information because the campus healthcare providers indicated that ongoing health care needs assessments needed to be conducted on campus in order to render services that were congruent with the healthcare needs of the healthcare consumers on campus. A major reason for assessing population needs is to plan service provision and the successful implementation of needs assessments depends on ensuring that an appropriate approach is used (Cowley, Bergen, Young and Kavanagh, 2000:131).

“By ongoing assessment,......to hear from them what is it that we might not be doing correctly, what would be their contributions to wards improvement. That's how I think we can really be able to know (what they need)”.

“I think first of all, a formal needs assessment need to be done and then whatever you find to be priority, we need to start with priorities first. ....I’d just like to improve the service and expand the service to things that we don’t have".
Sub-theme 2.1: Campus healthcare providers experienced the need to provide promotive and preventive healthcare services, including health education on a wide range of health-related topics

Lucas and Lloyd (2005:6) state that before embarking on health promotion activity, it is essential to identify what should be the target for change. In order to do this, it is necessary to have a clear understanding of what “health” is before we can begin to set about “promoting”, “improving” or “developing” it. There are various definitions of health that have been presented over the years of varying degrees of usefulness. One concept of health, which has been adopted enthusiastically by health promoters in the past and which will be very appropriate for campus healthcare consumers, is that of achieving personal potential. Here, health is seen as being composed of a number of factors which enable, or at least help people to achieve all that they have the potential to become (Lucas & Lloyd, 2005:7). Hence, the information received reveals that the campus healthcare providers would like to ensure, by providing relevant health services that all students and staff maintain a state of health that will enable them to achieve their maximum potential at the HEI. These research findings are congruent with the statement made by the Department of Health (2001a) in the United Kingdom as cited by Croghan and Johnson (2004:157) “The role of the school health service is to ensure children reach their full academic and health potential through health promotion, health protection and health surveillance”.

Thus the campus healthcare providers indicated that they would like to place more emphasis on preventive healthcare than curative healthcare. “...my effort is much more directed to instil in a sense of prevention is better that cure, as the mentality of most students is much more curative than preventive”.

According to Hattingh et al. (2006:123) emphasis is currently being placed on promoting good health and preventing ill health in meeting health needs and this principle is applied at primary, secondary and tertiary level. Clemen-Stone, Eigsti and McGuire (1987:330), for instance, state that primary prevention includes the provision of health education, maintaining a good standard of nutrition, provision of agreeable working conditions, periodic
selective examinations, use of specific immunizations, attention to personal hygiene, protection against occupational hazards, use of specific nutrients and protection from carcinogens. Promoting and provision of condoms, antenatal care, family planning and VCT are also viewed as measures to promote health and prevent disease.

The preventive and promotive healthcare services for which the campus healthcare providers experienced a need included all the aforementioned services. To date they indicated that they only rendered health education on an infrequent basis; provided family planning and emergency contraceptive services, flu vaccines, VCT, annual PAP smears in October each year and a nutritional programme for the indigent students. The WHO (1986:4ff) in Peltzer (2001:47) legitimized the role of the nurse as an agent in health promotion, which is the process of enabling people to increase control over and improve their health (Peltzer, 2001:46).

The discussion that follows hereafter will describe the experiences of the campus healthcare providers that emanated from the research data with regard to the need to provide promotive and preventive health services, including health education on a wide range of health related topics.

The following quotations demonstrate the need experienced by the campus healthcare providers to render health education, which forms the basis of health promotion, on a wide range of health related topics (see annexure for the list of health education topics indicated by the health care providers) to the campus health care consumers:

“…you would think that they (the students) would know everything because they are literate but don’t be mistaken – there’s a lot they don’t know, so we all know it (health information) is always needed”.

“I explain it (contraceptive pill) to them and I find that when they know how it works over there, then they understand so much better why it is done like that. …I think much of health things is cleanliness and much of their health needs is...
their diet, because many of the men live on bread and when they are studying so hard, they live on coffee”.

“...so there's also on the health education side to bring awareness and to have them make the connection between the STIs and HIVs, between the TB and the HIVs, between pregnancies and HIV because you find that they come to you and they're devastated about the STI. They come to you and they tell you that they've had an STI not only with the symptoms, so they're knowledgeable about this, that they're having an STI but during the counselling and the consultation you find that the link between the STI and the HIV hasn't been made and that is also a big challenge on the curative side for us to have them make that connection between HIV and STI, TB/HIV, pregnancy”.

“...I think that the drugs, much more should be spoken about it because their lives, it endangers them and the poor students like the children at school are exposed to it around every corner, they come here and they tell me that they didn't know that the dagga was in the cake they ate. Oh yes, and their drinks – they can't go to the beach because their drinks are laced with all kinds of things”.

According to Whitehead (2004:313) the health education literature commonly describes it as having several functions including actions designed to impart health related knowledge that influences values, beliefs, attitudes and motivations; to achieve health or illness-related learning through knowledge acquisition, assimilation and dissemination and to lead to skills development and lifestyle/behaviour modification. These activities are generally targeted at the level of individuals and are identified within a framework of activities that range from information-giving through to enabling processes. Thus health education can be defined as “an activity that seeks to inform the individual on the nature and causes of health/illness and that individual's personal level of risk associated with their lifestyle-related behaviour. Health education seeks to motivate the individual to accept a process of behavioural change through directly influencing their value, belief and attitude systems, where it is deemed that the individual is particularly at risk or has already been affected by illness/disease or disability” (Whitehead, 2004:313).
As a result of these health education needs experienced by the campus healthcare providers, they have embarked on providing the campus healthcare consumers with health education programmes on a rather infrequent basis.

“On an annual basis, we organize various health education campaigns for the students. Once again it is the need we perceive they might have, to have information about drug abuse or alcohol abuse or reproductive health and it is because of our perceptions that we organise these campaigns. So I think it is about 4 or 5 times a year the campaigns are organized”.

“...then as part of a professional nurse’s daily duty to provide health education on a one-to-one basis for each client that she sees, whether it is to start contraceptives, or how to take antibiotics, or how to take care of their skin, it may be a student that has albinism and he needs special health education. Each client that you’re with has different needs with regards to health education, the situation is different and the professional nurse might meet that need of providing one-to-one health education”.

The campus health care providers indicated that they were all involved in the planning and implementation of the health education campaigns which were planned annually at their strategic planning meeting. According to Whitehead (2003:490) the planning and implementation stages of any health-related programme are vital for ensuring successful outcomes. Effective planning and implementation allows nurses to look ahead towards the most appropriate evaluation activity. The planning and implementation phases of a health promotion/education programme, however, are only part of the process and should therefore always be monitored and followed up by an evaluation phase. Not to do this would in most cases invalidate what had gone on previously, as well as provide no real means by which to measure the position, validity, outcomes or success of health promotion/education programmes as they progress. The campus healthcare providers indicated that they strove towards implementing the same campaign on each campus so that all the students received the same information across campuses. They also indicated that they tried getting the students involved in the planning and
implementation of these health campaigns but experienced a lack of commitment from the students.

“…we try and put aside one day per week when we have our staff meeting, to maybe have our planning session for that particular campaign as well, even if it’s just brief planning and then one or two days prior to executing of that campaign, we would set aside to organize a little bit more detail…for the period of time whether it’s 2 to 3 hours or a whole day that we plan and organize this, no primary health care service is available because the nursing staff are involved in that planning session”.

“We try and involve the students you know, say for instance like we speak about Health Week, we will draw in the SRC and the residences, the HK and persons like that and yet they come to one meeting or two meetings and then they don’t come and in the end you just have to go ahead and, you know, do the best we can”.

The campus healthcare providers indicated that despite all their planning and efforts for the organizing of the health education campaigns, they normally experienced a poor attendance at these campaigns on campus. They only experienced a good attendance in the residences and also when they had events such as a presentation by Pieter Dirk Uys, who used satire to highlight the epidemic of HIV and AIDS, his aim as a satirist being to change the situation, educate and entertain through humour (Lutrin and Pincus, 2003:42).

“I can say from my personal experience, if you organize any talks, any health education thing, anything, the attendance is poor. The only place where you have a good attendance is the residences. In all these years that we’ve organized HIV activities, the only good response we’ve ever had was with Pieter Dirk Uys where we had a full auditorium.Normally you would get 5 or 6 people to attend. …I suppose from the students’ side that the students feel that they sit in lectures all day, they don’t want to go to another lecture”.

They indicated that they were not reaching the day students, yet most of the students on campus are day students. They attributed the latter to the fact that there is no official lunch time on the lecture roster any more and they
therefore experienced difficulty in finding a convenient time to address the students and also the fact that they were not allowed to make a noise on campus. They indicated that the latter findings restricted their planning of events.

“...unfortunately staff don’t always come, not always staff but I’m sure it’s because of their working programme, staff don’t always come to these things”.

“As I said, I don’t know what we can do on campus because most of our students are day students that I know we’re not reaching, like I say, we’re not reaching them, we’re reaching very few of them”.

“And I think something that also contributes to (not) reaching all of them (the students), is the fact that we don’t have an official lunch-hour anymore. Classes run through the day, so there’s no off-time that you can easily (access)......you’re not allowed to make any noise on campus, so that restricts you”.

The campus healthcare providers indicated that health education was there to empower the healthcare consumers so that they could take care of themselves where possible and that health education could not be separated from primary health care. The campus healthcare providers indicated that providing health education to the healthcare consumers was worth their while even if they just reached one student who listened and was prepared to make changes in his or her lifestyle; but they experienced that in spite of their efforts to plan and implement these health campaigns on campus there was still a lot that was lacking with regard to this aspect of health promotion.

“And I think health education is always a great need because very much of health education...surely that is what we aim at, we don’t want them to be dependent on us and we want them to carry on without us”.

“...I had a student...... and she said that talk (on STIs) made her realize that she’s not going to be (sexually) active any more, she will abstain until she is married...which means even if we’ve got one person that changed, it could mean a lot to the university”.

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“Education is very important, there’s still a lot that’s really still lacking, the continuous education should be there”.

“Health education, I know it’s about the primary health care, you cannot divorce that from primary health care, but sometimes you just need to do more health education”.

The campus healthcare providers indicated that in addition to the health education campaigns on campus, there were health education posters on display in the campus clinics and health education literature was also available in various forms. Some of the campus healthcare providers indicated that they used the peer helpers and house committee members to distribute health pamphlets in the residences.

“Within each clinic there’s a huge number of pamphlets, posters, video screening that are available to the students to meet their health needs, that while they wait in the waiting room they could read about cancer or sun protection or Hepatitis B vaccination, or we are able to show them videos in the waiting room with regards to TB or various other minor ailments that are seen”.

“We utilize the electronic media of the institution to maybe meet some of the needs of the staff and students as well, in that e-mails are sent when campaigns are organized, and we would maybe during drug awareness (week) send daily snippets on various things on drug and alcohol abuse. That way the staff and students that have access to e-mail also educate themselves”.

“…we provide pamphlets or literature in the hostels, within the bathrooms or to the HKs to provide to the students’.

On the whole the campus health care providers indicated that they experienced a need to look at innovative ways of getting the message across to the campus healthcare consumers and getting them interested in attending the health campaigns on campus. They experienced that offering the students freebies had proved to be a very successful means of drawing the students; but they indicated that they experienced it to be very costly.
“...so a big challenge is to look at new innovative ways of getting them to listen and to bring your message across”.

“I still wonder what is the best way to win them as your audience?”

“I suppose one way to get them to attend is to have a lot of freebies but that costs a lot of money, and it’s very difficult to get sponsors, you might get them for one in a year, but that’s it. But that definitely is a draw card”.

According to Troskie and Raliphada-Mulaudzi (1999:41), reproductive health is very important as it shapes a woman’s whole future. The aforementioned authors state that the WHO considers the health status of women to be one of the most sensitive indicators of social development. The campus healthcare providers indicated that they experienced a great need for a family planning service on campus in order to prevent unwanted pregnancies among students and staff thus respecting their reproductive health rights. They indicated that various methods were available to the campus healthcare consumers on campus and that these methods included hormonal methods, such as the pill and the injectable and barrier methods. They indicated that the most common method of contraceptives used was the injectable, Nur Isterate. They did however indicate that they experienced that with the correct health education, more students were opting for the pill, but Nur Isterate still remained the method of choice. Troskie and Raliphada-Mulaudzi (1999:45) state that the quality and quantity of information as well as specific information on family planning methods used are important parameters. This information should include discussion on the range of methods provided, advantages, disadvantages and contra-indication. Advice should also be given on how to use the method, its potential problems and what the client should do if problems arise. The campus healthcare providers indicated that emergency contraception was also freely available to the health care consumers.

“I think there is a need (for family planning) because our teenage pregnancy is escalating”.

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“Family planning – much, much family planning. Like yesterday morning to quote, I had 5 family planning clients just before twenty to ten which is my tea time, and they were all Nur Isterate clients. It’s mainly family planning”.

“…die meisies kom vir die EC (emergency contraception), no doubt about it (‘…the girls come for the EC [ emergency contraception], no doubt about it)’.

The campus healthcare providers indicated that they experienced the rendering of the aforementioned service difficult at times because of all the myths associated with family planning. The following quotations reflect some of the myths with regard to family planning that have to be dealt with by the campus health care providers:

“That if you don’t menstruate, that the blood goes somewhere else, that it’s not healthy for them not to menstruate, that the longer you don’t menstruate, the more difficult it will be for you to fall pregnant one day’.

“The other myth on oral contraception is that that small tablet can’t possibly prevent a pregnancy”.

“And there is still people that can still fall pregnant irrespective of the use of an oral contraceptive”.

All the campus health care providers experienced that, despite their making family planning and emergency contraceptive services available to the campus healthcare consumers on campus, there were still students who fell pregnant every year and therefore they expressed a need to render an antenatal care service on campus. Some of the campus healthcare providers indicated that they experienced frustration because they were unable to provide an antenatal care service to the campus healthcare consumers because of staff and financial constraints. There was only one campus healthcare provider who indicated that she rendered an ANC service to the students in collaboration with the public primary healthcare clinic in her area.
“To offer services that we don’t render at this stage, like ante natal care – we actually try and prevent pregnancies but I mean that is a need there – we also have staff members that do fall pregnant and they need that type of service”.

“Elke jaar het ek ’n swanger student en ek doen self hulle se ante natals, omdat ek nie toestroom het nie, Daardie een student maak ’n afspraak op haar afdag, so oor vier weke en oor twee weke, so maak ek en daar is mos ’n dokter wat een keer ’n week kom wat daardie gedeelte doen, (publiek kliniek) doen hulle se bloede, so ek kan deur die (publieke klinieke) hul bloede doen, so ek doen hul ante natals en op ’n manier kry ons ’n bond met mekaar…jy kan dan daardie behoefte van hulle voorsien. (Every year I have a pregnant student and I do their antenatals myself, because I do not have a flood of students. That one (pregnant)student makes an appointment on her off day, over four weeks or over two weeks, that is how I do it and there is a doctor that comes once per week that does that part (which he needs to do), (public) clinic does their bloods, so I can do their bloods through the (public) clinic, and that is how I do their antenatals and in this manner we develop a bond with each other…you can provide that need to them)”.

“…ante natal facilities we do not provide, we would only help the student and we do provide in the aspect that we refer them to the nearest ante-natal clinic….that brings a kind of frustration because one is not able to take care of the students completely, holistically….”.

The campus healthcare providers indicated that they had formulated a pregnancy policy in which they advised the students to discontinue studies at 36 weeks in the best interests of both the unborn baby and themselves and that they could return after the birth of the baby. The policy stipulates that arrangements will be made for them to catch up with the backlog in their studies and that their room at the residence will be kept open for them until after the birth of the baby.

In light of the HIV and AIDS epidemic the campus healthcare providers experienced a need to render a VCT service and to make condoms freely available on campus in order for the campus healthcare consumers to protect themselves from being infected with STIs and HIV. They indicated that that they experienced a need to place condom dispensers in strategic points on all
campuses and that students assisted them in filling up these condom dispensers. The number of condom dispensers on campus depended on the size of the campus. One of the campus healthcare providers indicated that she issued approximately 3000 to 4000 condoms per month on her campus.

“and the one thing we (are) quite busy with is HIV testing, VCT. There’s a great demand for that”.

“There’s different (condom) points on campus. There’s bathrooms and cafeterias, the sports arena, in the clinic, there’s about 8 condom dispensers on campus”.

“One (student) assists me with replacing condoms in the condom containers on Fridays because we’re not really managing to do that. They are the better ones to know how these condoms are being utilized or consumed – what is the rate of consumption that they need to refill, how often”.

Jirojwong and MacLennan (2003:241) state that failure to diagnose cancer until it is in its later stages leads to a high cost of treatment, morbidity and mortality. Health personnel have important roles in increasing the use of breast screening and PAP smears to detect early cancer. The campus healthcare providers indicated that they experienced a need to do PAP smears and breast examinations in order to detect early cancers among the campus healthcare consumers. They indicated that they were currently following the guidelines of the public health sector and found this to be too infrequent. They indicated that they were therefore presently rendering an additional service on an annual basis during the month of October in order to make the service more accessible than previously to more campus healthcare consumers.

‘...we follow the guidelines of the Municipality, ......the criteria for pap smears is not what I’d like it to be, it’s every 5 years. If we can have money that we can do it yearly...”.

‘...once in a year we promote (PAP smears and breast examinations) among students and staff also, we make them pay, we don’t mind that they are on
medical aid at times, it depends on our numbers, to come and do pap smears in October, during cancer awareness month, they are being told to examine their breasts for cancer, pap smears are done”.

The campus healthcare providers indicated that they experienced a need to provide a nutritional programme on campus because of the large number of indigent students who were unable to purchase food for themselves. Because they experienced a number of students to be malnourished, they had decided to provide these students with Morvite and vitamin supplements.

“I think there are a lot of indigent students that don’t have finances so we really find that they are not eating healthily once again I think it’s a small amount that actually comes to us and we are very strict with our criteria as well, then we provide them with a kilogram of Morvite a week, which is one meal a day and I think there is a lot more out there that we don’t know about, possibly too shy or too proud to come and ask for it”.

“Students come to school and you find that they don’t have anything to eat…”.

“I also give them multivitamin replacement (supplement) tablets”.

The campus healthcare providers also indicated a need to render an annual eye-screening service in order to detect any eye defects among the campus healthcare consumers. According to de Wet and Ackerman (2000:36) one of the challenges facing primary health care in South Africa is the delivery of quality eye care to all South Africans. It is crucial that quality eye care begins at the very first point of contact, the primary health care sector. De Wet and Ackerman (2000:36) state that the WHO has warned that if attempts to improve eye care are not intensified, blindness and serious loss of vision could double by the year 2020.

The campus healthcare providers indicated that they provided Influenza vaccines to the campus healthcare consumers and that they would like to expand the immunizations provided on campus to include hepatitis B and A. According to Tillet (2000:225) immunizations are considered among the great
public health accomplishments of the 20th century. Vaccine use has become well accepted and has had an impact on the incidence of some diseases worldwide. Influenza epidemics normally occur in the winter months therefore vaccinations are administered to induce immunity. According to Tillet (2000:217), because of the prevalence of hepatitis B worldwide, the World Health Organisation has recommended the adoption of strategies to immunize populations against the disease.

“...we do offer vaccinations here, especially the flu vaccine, to make sure everybody remains healthy, there's less absenteeism.....And we have certain criteria for students, we do give the flu vaccine free of charge to our immuno-compromised students”.

“I'd like to increase immunisation as the only immunisation that we have at the moment is the flu vaccines that we give once per year. So I would love to increase it to Hepatitis A, Hepatitis B, to have like a travel clinic where we can expand on immunisations and treatments like that”.

The campus healthcare providers also experienced a need for the house superintendents to receive training in First Aid in order for them to recognize and manage emergencies.

“...I just think that the house superintendent needs to be fully trained, especially with this thingie of abortions now, what I find is that because they’re fully booked at Dora, they get dates according to me and according to them (students) after 12 weeks so what happens is that they go, they still get their induction and stuff and then they start bleeding at night. So I think the superintendents need proper First Aid Training, because this is now going to be the in thing because the people at 12 weeks and then they have the things done and how many times did we go in the morning and just find blood all over”.
Sub-theme 2.2: Campus healthcare providers experienced the need to provide a curative and chronic healthcare service on campus

The campus healthcare providers experienced a need to provide a curative and chronic healthcare service for the campus healthcare consumers on campus. According to Rothman, Gerber, Venter, Steyn and Monteith, (2000:43) the priority of the National Health System in South Africa is primary health care. The approach involves a health system led by primary health care services for acute minor ailments delivered by primary health care nurses. The nurses are also responsible for the treatment of these ailments with essential drugs according to protocols as proposed in the Essential Drug List. The vast majority of medical problems seen in primary health care consist of commonly occurring conditions. The campus healthcare providers indicated that they were rendering a primary health care service to the students and staff on campus. “We are rendering primary health care, so primary health care means to see to all minor ailments or minor diseases or illnesses that present with students and staff”. Evian (1989) in Rothman et al. (2000:43), states that most of these conditions are easy to recognize and basic treatment is readily available for them. According to Rothman et al. (2000:43) only approximately 10% of all medical problems encountered in the primary health care setting are of a more complex nature and require more sophisticated management approaches. The following quotations from the campus healthcare providers’ expressed experiences give an indication of some of the minor ailments diagnosed and managed by them:

“The most basic need is just to attend to whatever minor problems that they may experience. If they’re sick, then all they want, they want you just to make them better and they don’t want – I find that when they come to the clinic they just, if they’re sick or whatever problem they have, they just want to be made better”.

“Definitely there’s a need for a provision of primary health care, because of our students not having access to medical aid or private healthcare facilities,
treatment for flu’s and colds and stomach bugs and headaches and muscular pains and stress and STI’s, there’s definitely a need for that”.

“...staff will come with an ache, maybe dental, maybe headache, maybe muscular or skeletal pains, and then of course the new component, HIV and AIDS related problems...so those are the basic things but the students, the spectrum is very wide”.

The one campus healthcare provider indicated that there were differences in the health-care needs of students on the different campuses. “We service a very specific group of students, the students at (this) campus is mostly from the previous disadvantaged background, so I find their health needs are different that on the other campuses so the challenge on this campus is very specific when it comes to socio-economic background, health needs are different”.

She indicated that on this campus in particular she experienced a number of students attending the clinic because they had been involved in gang fights or assaulted either on or off campus. The following quotations illustrate this:

“...like the other campuses I’ve never had student’s that’s assaulted on their way from school to home where(as) here (at this campus) on a Monday you’ll find that they’ve been involved in gang fights and they’ve been assaulted on campus or off campus, so yes that is the difference between this student and that student, the student on the other campuses”.

The campus health care providers indicated that they did refer problem cases to the sessional medical doctor on campus or to the nearest public or private healthcare facility when they experienced the problem as being out of their scope of practice. The medical doctor that was interviewed had this to say about the referrals that he receives:

“...I see the bronchitis, pneumonias, the complicated tonsillitis or, you know, and unknown things and I think we’ve, I can’t, I don’t feel that there’s one that hasn’t been treated well or referred well or whatever we’ve done, so from the student part, I don’t think there’s been much of a moan except that
they can’t see me when they want to see me, and I think that’s probably your biggest problem”.

The campus healthcare providers also indicated that they provided medication at a reasonable cost to the staff members who did not contribute towards a medical aid and those that did contribute towards a medical aid fund, were referred to their family doctors for further management.

“We make a clear division in the sense that if somebody is on a medical aid and if they are ill, like say they have a urinary tract infection, we will refer them to the (their) doctor for treatment. If it’s somebody that not on a medical aid, we will assess the situation…”

As mentioned earlier, the campus health care providers indicated that they experienced a need to render a chronic healthcare service to the students and staff on campus because they had come across many students and staff members who were on treatment for chronic health conditions. According to Hattingh et al., (2006:234) chronic health problems are of concern to the healthcare professional because many of these conditions are preventable. If a chronic health condition exists, it should preferably be managed in the community by healthcare professionals and not in institutions. Hattingh et al., (2006:234) quote the South African Medical Research Council (http://www.mrc.ac.za,2006) as stating that: “Chronic diseases of lifestyle are a group of diseases that share similar risk factors as a result of exposure, over many decades, to unhealthy diets, smoking, lack of exercise and possibly stress. The major risk factors include high blood pressure, tobacco addiction, high blood cholesterol and diabetes. These result in various disease processes such as strokes, heart attacks, tobacco- and nutrition-related cancers, chronic bronchitis, emphysema and many others that culminate in high mortality and morbidity rates”.

According to Bradshaw, Bourne, Schneider and Sayed (1995) in Peltzer (2003:4) the proportion of deaths due to chronic diseases of lifestyle was 24.5% of all South African deaths and 28.5% of deaths among those aged 35-
64 years in 1998. The major causes of death contributing to these figures were cerebrovascular diseases and ischaemic heart disease.

The campus healthcare providers also indicated that they sometimes diagnosed these conditions themselves and then referred them for further investigation and management to the public or private healthcare sectors.

“Chronic diseases – we don’t treat any, whether staff or students, for that they also have to be referred and with the change in the (hyper)tension ……protocol – where now it’s 130/90, I mean even our students all of a sudden fall into that category which is very, very unreal. You won’t believe in the last I would say month, that we now are aware, I think about 5 of my students were encouraged to actually go for treatment that we, you know, tested them for a period of time and their blood pressures just are 100 (diastolic), starting to get high. I suppose that’s another need that we’re going to have to face up to here, to start thinking of chronic medication as well”.

“There’s a lot of chronic conditions, asthma, epilepsy, all those things, doctor don’t manage them here….he give them a prescription”.

“…on this campus specifically a lot of diabetes and high blood pressure has been diagnosed and that’s being unsuccessfully treated on medicine”.

The campus healthcare providers indicated that they were only able to monitor the blood pressures and glucose levels of the hypertensive and diabetic students and staff at the campus healthcare service.

“We are only able to do monitoring of the chronic but not able to provide the medication here because it’s too expensive”.

“I think we meet the needs of those who just come for monitoring of chronic illnesses, because we are able to measure their blood pressures and just check their blood sugar (levels)”.

million South Africans suffered from hypertension and had a pressure above 140/90 mmHg.

The campus healthcare providers indicated that they felt strongly about expanding their healthcare services to include the rendering of a chronic healthcare service because of the following experiences:

“...ek het 'n student verlede jaar hier gehad wat 'n ‘CVA’ gehad het. Sy is 18. Sy is 18, 19. En ek onthou haar, sy was 'n student wat hierso by die volgende jaar kom, is sy terug, sy's verlam aan die een kant. En toe ek haar eendag vir haar vra, jinne man laat ek bietjie hoor, ek roep haar, ek vra haar, jinne, wat het jy oorgekom, toe sê sy, nee ‘CVA’. Toe gesels ons en toe sê sy, sy het dit hier gehad in haar kamer. Die vriendin het die ambulans gebel, en sy is hospital toe, blygbaar op haar ma en pa se medies, en sy het daar hele heeltyd. (...I had a student here last year who had a CVA. She is 18. She is 18, 19. And I remember her, she was a student who returned the next year, she was paralysed on the one side. And when I asked her one day, gee wiz man let me listen a little, I called her, I asked her gee wiz what happened to you, then she said no CVA. Then we spoke and then she said she had it here in her room. The friend phoned the ambulance and she went to hospital apparently on he mother and fathers medical and she was there the whole time) ”.

“...lot of asthma that is not controlled and you find that students can easily access over the counter drugs and they are not so informed or knowledgeable on the conditions and you hear from family and people in the street that you can buy this drug over-the-counter, and you find that when they get to you, then they've been on over the counter drugs for a long time and if not controlled”.

“I find a lot of obesity, high blood pressure that is uncontrolled in young adults and students between the ages of 18-22 (years) having high blood pressure, diabetes, not diagnosed”.

Research findings are congruent with Hattingh et al. (2006:235) who state that anyone can develop a chronic disease at any age. Chronic health problems may date from birth or may originate in childhood, adolescence or early adult
life. All the aforementioned chronic conditions experienced by the campus healthcare providers among the students and staff on campus are listed as the major chronic health problems that place a huge strain on health budgets. In order for the health professional to understand chronic health problems that exist in the community (on campus), the following needs to be done: the causes of the chronic health problems as experienced above should be assessed; the effects of these health problems on the individual, family, community and health services as such should be assessed; the prevention of these chronic health problems should be assessed and the role that the healthcare professional can play in the management of these chronic health problems should be assessed (Hattingh et al., 2006:235).

The campus healthcare providers indicated that they implemented the Directly Observed Treatment Short-course (DOTS programme) on behalf of the Department of Health for the diagnosing and management of TB on campus. The DOTS programme, recommended by WHO, is the most widely known and accepted tuberculosis treatment programme available today. The treatment, monitored by a nurse or doctor, requires that a patient take four basic kinds of medication over a six-to-eight month period (Hattingh et al., 2006:277).

“We provide TB treatment as a monitoring, as a DOTS facility…”

“We do provide medication, for example if somebody has been diagnosed with TB in a local clinic outside, we do help in monitoring the taking of treatment. Like now I’ve got one client that’s on streptomycin – quite young, and a student getting TB for the second time”.

The campus healthcare providers therefore indicated that they could perhaps liaise with the Department of Health and render a chronic healthcare service to the campus healthcare consumers on the same basis as the tuberculosis DOTS system was being implemented.

“…one thing I’d like us to do is chronic services. I know it’s a bit much but especially I think we can DOTS here, like hypertensive treatments we don’t
supply but we can always have the DOTS system. Especially the contract workers, when they come here, you’ll see that they didn’t take their tablets or they forgot to take tablets, so if we can have a DOTS system here, that they come here in the morning, we give them the tablets and we sign the card or whatever”.

“At present we are only rendering chronic monitoring to patients and some patients cannot afford to, especially the contract workers either stay out (of work) to go and get their medication, or pay privately. So if we can render chronic service here, even if we need to speak to the municipality and liaise with them, they can drop the medication here, we could monitor the patient on a monthly basis and if need arise, refer the patient to one of the doctors to be seen”.

The campus healthcare providers indicated that they experienced the healthcare needs of the campus healthcare consumers to have changed over the last few years due to the HIV and AIDS epidemic. They indicated that the campus healthcare consumers were now presenting with opportunistic infections and therefore they indicated that they would like to become an accredited site for anti-retroviral treatment (ART) where they would be able to administer these drugs and monitor the CD4 counts of the infected individuals. Opportunistic infections are caused by certain micro-organisms that take advantage of an immune system that has been weakened by HIV (Soul City, 2005:3). Thus HIV-positive patients need regular check-ups and immune system monitoring by having a full examination and CD4 count performed annually in Stage I of the disease and six-monthly full examinations and CD4 counts in Stage II and III of the disease (Soul City, 2005:10). The CD4 count measures the number of CD4 cells present in a millilitre of blood. The result will indicate how healthy the immune system is, reflecting how much damage there is to the immune system and how likely the person is to get an opportunistic infection. A normal CD4 count is between 600 and 2 000 cells/mm³. The CD4 count will indicate when you start prophylaxis for opportunistic infections and also when to start ART (Soul City, 2005:4). The antiretroviral drugs stop HIV from multiplying, which enables the body to heal and the immune system to get strong. If the antiretroviral drugs work
successfully, the viral load decreases, and the virus becomes undetectable in
the blood after 6 months of treatment; but it does not mean that the blood is
free from HIV. It is still present, but the level is too low to measure. The CD4
count will improve and continue to improve after three months on ART. It is
important to start ART when the CD4 count is around 200 rather than later
(Soul City, 2005:11).

The following quotations illustrate the experiences expressed by the campus
health care providers relating to the needs identified in this regard:

“The needs of our students over the last couple of years has changed in the
sense that it’s become more HIV-focused and the needs with regards to that
has affected the kind of service that we were expected to provide. We were
having to take care of a different kind of needs basis where before the students
were maybe just focusing on minor ailments and reproductive healthcare, the
HIV brought a start where we had to take care of opportunistic infections, do
regular screenings and referral for the students which was not necessary in
the early years of our service”.

“I just feel very strong about the rendering of the ARV services. I know that this
whole procedure on its own to be accredited, the site...things like that but...to
render that....we do have patients that needs ARV...”.

“The other health needs would then be the CD4 counts that I’ve mentioned, if
we can do that on campus, that would be great”.

The campus healthcare providers indicated that they experienced the
rendering of anti-retroviral drugs (ARVs) on campus as being a necessity
because they had come across some staff members who were now becoming
sick and they needed the medication. They indicated that the staff members
could not go for treatment every morning before coming to work without their
supervisors querying the reason for their absence.

“...they’re becoming sick now, so it’s people that we’ve known about but it’s
just that they’re becoming sick now, so there is a need that has been identified
and the people they work with don’t always understand why they are away
from work, and then they look to campus health services, we must have an answer for them”.

According to Otto and Botes (2001:12), the occupational health nurse often becomes involved in ethical dilemmas with regard to the handling of HIV-positive people in the workplace in that the interests of the HIV-positive people conflict with the interests of the employer. The occupational health practitioners find themselves acting as mediators between the two parties, namely the employer and the HIV-positive person.

Sub-theme 2.3: Campus healthcare providers experienced the need for supportive counselling and social services to be available for students and staff at the HEI

The campus healthcare providers expressed a need for supportive counselling and social services to be available to the health care consumers on campus. They indicated that they experienced an increase in the number of psychological and social problems on campus.

“I’m getting a problem, I’m getting a lot of psychological problems, it’s a huge problem on campus, much more than before”.

“We’re having a lot of social problems in the way of poverty, of not having money to eat and I’m getting a lot of that type of problem which I think is huge”.

“And there’s a lot of students that when they get here, they have psychological or mental problems if I can put it that way and there is days that they are just down and they need to be counselled”.

The campus healthcare providers indicated that the campus healthcare consumers presented with a wide range of problems that included for example, depression, stress, substance abuse, anorexia, pregnancy crisis, termination of pregnancy, HIV-positive crisis, rape crisis, sick parent or relative at home, problems related to studies and financial problems. The
following quotations illustrate some of the campus health care providers’ experiences in this regard:

“And HIV obviously. That’s the main crisis if they test positive, that’s also one of the crisis”.  

“…not one week goes by here that I don’t get a staff member who comes to me with HIV and AIDS problems, not because he is HIV positive but because there’s a family member, a brother or a mother or a sister and the thing is they don’t know where to go where they can get help”.  

“How are rapes handled, are they being counselled enough?"  

“The ones who suddenly find themselves to be having positive pregnancy tests, it’s sort of a crisis situation for the individual at that moment the impact does work on her and you will have to deal with supporting her until the impact is over”.  

“…the students that go for TOPs (termination of pregnancy). They come back, we think they have been counselled but when they come back they said that they were never counselled and they get post-TOP depression if I can call it that and it’s really severe and they need to be counselled on that”.  

“I would guess 85 to 90% of them (those who tested positive for pregnancy) went and had abortions.....initially they protect themselves and say I’m fine, but six weeks down the line we see the wheels fall off, they can’t concentrate, they can’t sleep, they’re not coping with their studies, you know then you can actually see that there’s major problems”.  

“I am getting a lot of depressions which I never had before.....a lot is academically but a lot is also home problems, now they’re being sent from home and away from home".  

“Also substance abuse....those that come with a problem I try my utmost to help them".
“...we had a case like that where a brother was abusing his brother sexually because he had no other way of paying for staying with them while he was a student still studying...he was not harmed physically or so but emotionally”.

The campus healthcare providers also indicated that they experienced many of the campus healthcare consumers presenting with physical health problems that were actually related to stress or other underlying emotional problems.

“A lot of psychological problems as well, you know they manifest with a physical problem but if you have the time to go in depth then there’s normally a problem, can I give an example, like I had a student who came here, she could hardly walk because she had such terrible abdominal pains and when you started speaking to her, because when you examine somebody you can see but the two don’t correlate – the pain experience and your finding and then you discover that she’s here on a sports bursary so she needs to perform there, in the meantime her parent is sick at home and she’s not able to go and see the sick parent”.

“You find yourself dealing with people who are stressed for many reasons – students because of their studies, not coping well, feeling exhausted, not being able to study well, preparing for exams. You do find adult staff with their little family problems here and there, and that’s when you really find yourself having to chip in to support the individual because if somebody comes in thinking that he or she is very sick with a headache, with neck muscle spasms and only to find out at the end it’s more stress related and you can’t just leave the individual and your medication wouldn’t really have a place this time, this individual needs more counselling”.

“And then I find that in stress at work, they do have emergencies. Now, once I saw a lady with the most dreadful conjunctivitis – really that was only stress related and quite a few of them burst out in skin conditions – that was stress”.

As a result of all the aforementioned and latter problems that the campus healthcare providers indicated that they encountered at the campus health service, the campus healthcare providers expressed a need to expand their
counselling and support services because students did not always get appointments with the official student counselor when most needed. Thus, according to Otto and Botes (2001:19), it is strongly recommended that counselling skills become a requirement for any nursing student undertaking further study in any field requiring interaction with patients. The campus healthcare providers also indicated that the students viewed the student counsellor’s role as preparing them (the students) for a particular career rather than counselling them for personal problems encountered.

“So to make it more comprehensive, I would love to expand on the counseling side of it (campus health service)”.

“I would also love to have more support groups on campus but at the moment that lacks and I find that if support groups can be encouraged and increased, then that would also be assist the student and meet their need, because they don’t always or most of the times it’s not on the physical but emotional needs that need attention”.

“…the student counselling – that’s now gone over to another division, this is my personal feeling and I feel that with that, they’ve also accepted other responsibilities and it means that there’s less time available to the students and you find if a student needs to make an appointment, they have to wait very, very long”.

“I mean they even come to us with their psychological problems, home problems, they don’t go to student counselling.....they see them (student counsellors) more as counselling in terms of preparing for a particular job or particular course that you take, aptitude tests and that sort of things”.

The campus healthcare providers indicated that they were very appreciative of the financing made available to employ three full-time counsellors each year to do the HIV pre- and post-test counselling. They experienced the work load being reduced to a certain extent with the appointment of the three counsellors. Since the three counsellors were being shared by the four campus health clinics they expressed that this arrangement was by no means adequate because the counsellor was therefore not available every day and
they had also experienced a need to focus on other problems besides HIV/AIDS related issues.

“…they’ve got one on site now, a psychologist (counselor) here, so that’s helping”.

“…I’m glad that we now have a counsellor throughout the year to help as well, but it’s a full-time job, there’s not enough of us”.

“…we no have to use our intern here for other things than (HIV), you know it makes HIV-testing less”.

The campus healthcare providers expressed a need to have a full-time psychologist and counsellor available daily on each campus, and a social worker for about three days per week. They also indicated that this would facilitate continuity and confidentiality because presently the counsellors were being rotated and the students were not getting a chance to establish a good relationship with one person.

“The social worker maybe three times a week, but I think the psychologist and the counsellor daily because there’s a big need”.

“…I just feel for continuity and confidentiality and the students’ sake of seeing the same person encourages them more or gets them quicker to a place where they’re self-compliant or to deal with their emotional problems, it’s always better to see one person for the extent of your counseling that to see maybe 3 different counsellors with one problem where you have to repeat yourself over and over again. So I feel that is not so conducive for counseling purposes, to see more that one counsellor in the extent of your counselling”.

Hattingh et al. (2006:95) state that the multi-disciplinary team approach is important in dealing with all the needs of a patient. Many professionals from different disciplines form a multi-disciplinary team that should not work in isolation. The functions of this multi-disciplinary team include setting common goals; analysing ethical issues, such as professional secrecy and collaborating on ethical decision-making; collaborating on the planning of
strategies and protocols; sharing of unique talents and expertise to make a comprehensive and objective approach possible; sharing and allocating specific functions to the appropriate team members depending on their expertise, knowledge and experience and co-ordinating activities on a regular basis (Dreyer et al., 1997:111). The personal interviews conducted with Jennifer Fuller (June 2006) and Rebecca Wilson (June 2006) revealed that they implemented a multidisciplinary team approach at their campus health service. They indicated that their multi-disciplinary team comprised for example, registered nurses, doctors, pharmacists, laboratory technicians, psychologists and health educators.

**Sub-theme 2.4: Campus healthcare providers expressed the need for an occupational healthcare service and an Employee Assistance Programme on each campus**

The campus healthcare providers expressed the need for an occupational healthcare service and an Employee Assistance Programme to be established on each campus because of lack of available healthcare services for staff members on campus. “You must have WCA (workmen’s compensation) and a bit of occupational health. You have to have it. That should, to my mind, be completely integrated into a health center”. The campus healthcare providers indicated that they experienced a lot being done for the students but very little was being done for the staff.

“They (the staff) are being neglected, there is a lot of staff that are very unhappy at work and there are a lot of staff members that are very sick and we just don’t get to them because they know if they only get a stat dose and then we forget about them”.

“Also the staff have their own needs that I don’t feel we’re really meeting their needs because we feel, ag, they do have medical aid so they can go to their private doctor, so we concentrate more on the students”.
“I feel a lot is being done for students and we’re constantly looking at ways of improving and providing for them, but we’re not looking at what the staff needs are really and how we can address their needs”.

The campus healthcare providers indicated that an occupational health nurse practitioner was appointed to render an occupational healthcare nursing service on the one campus prior to the merger. They indicated that after the merger, the occupational health nurse practitioner then had to render this service on 4 of the six campuses. This they indicated was by no means adequate because there was only one occupational health nurse practitioner appointed to render the occupational health nursing service therefore she was only able to do certain aspects of occupational health and was unable to follow up the staff members as needed.

“But I strongly feel that we are neglecting the staff in the respect that she’s only able to do certain aspects of occupational health”.

“We actually need a more effectively run service for our staff members. That is what happens. That is why actually it’s very sad that you know that person, especially for me when I’ve screened a staff member and I discuss it with that person for diabetes uncontrolled, hypertension uncontrolled, then that person know I have to follow up tomorrow. He will come here, even if I tell him, come to the other sisters, they will take you blood pressure and monitor you for a week, they don’t come because they want to see the sister that, you know, they’ve given the information. With the result, the next moment you hear, oh this person had a stroke and is in hospital. You feel so bad because you don’t have a follow up chronic programme. ....it happened last year, I've had 4 staff members, 2 of them died and the other 2 got strokes....they were very uncontrolled, very uncontrolled. ...I so much want to see that person that I've seen in the beginning but there is not that continuity, you know”.

“I just feel that I’m a lone rider at the moment and I really don’t cope. So I’m just doing much less that the minimum required for the occupational safety because I actually know we’ve got 2 500 staff members in the whole and we’ve got all these students and I’m actually the only one doing occupational health…so it’s a very heavy workload and I feel I’m not complying”.

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Chapter Three  

A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUS HEALTH SERVICES

The occupational health nurse practitioner was one of the campus healthcare providers that were interviewed to obtain information for this research. She indicated that she was the pioneer in getting this service off the ground on one of the campuses prior to the merging of the three institutions. She indicated that she did not experience it as an easy task because no other healthcare provider was qualified or had experience in rendering this service at the time of her appointment and therefore she constantly had to justify her actions because of a lack of insight with regard to what occupational health nursing entailed. The occupational health nurse practitioner also indicated that the service had a slow start because initially the staff campus health care consumers were not aware of the service.

“In the beginning, staff (campus health care providers) were very skeptical about this because they thought that what I’m telling them actually is for industries…..but as time went by they understood what it was all about and the work was facilitated by them now knowing what it’s all about”.

“I still find that from the top, the...responsibility for the service, by delegating it down from the top we’ve got a problem. There’s still a lot of ignorance surrounding occupational health and that still needs to be addressed in order for people to come here.. and the top structures are not compliant, they still don’t accept liability as they should...very difficult to function because the structure must be in place from the top”.

“I must say rendering occupational health is something new at this the institutions and it’s a very big challenge. I am really enjoying it, I wish I had 10 hands! [laughs] Ja, I do enjoy working as an occupational health (nurse) and seeing that people are starting to…..appreciate the service and starting to know more about the service”.

The campus healthcare providers indicated that the main occupational health conditions that presented at the campus health service were injury on duty (IOD) cases such as, for example, back injuries, monkey bites, bruises and eye injuries. They indicated that the staff campus healthcare consumers mainly got to know about the campus health service when they got injured on
duty. She indicated that as more staff were becoming aware of the service on campus, the number of IODs being reported had increased.

“The one thing that, the focus then that the health service or the campus health service focuses on, that is IODs so staff identifies with campus health services on the basis of IODs you’ll find that the staff members that filters through the clinic here on my campus specifically, is those that have been involved in IODs so now they find that they know now there’s a sister because she is the channel where we need to go through, is to report the IODs to the clinic. So a lot of staff members come to know about the clinic through IODs”.

“All wat ek te doene is of was met die personeel, met my ondervinding vir hierdie vier jaar, is seker net in tye van IOD. Dan is hulle genoodsaak om na my toe te kom (All that I do or had to do for the staff, with my experience for this four years, is surely only in times of IOD. Then they are forced to come to me) ”.

“...in the past,....A lot of people got hurt but they didn’t report, at the moment the rate of Injury on Duty cases has increased, really increased, but I think it has not just really increased, it’s just that people become more aware now that they have to report, so there’s a lot of injury cases”.

Croghan and Johnson (2004:158) state that the impact of health on work, and conversely of work on health, is well established. Consequently the fundamental role of an occupational health service is to ensure that working adults reach and maintain their full working potential through health promotion, protection and surveillance activities (Rogers (1994) in Croghan & Johnson, 2004:158). The vast majority of people spend a huge portion of their adult life in a workplace, which is important when considering how and in what setting to achieve improvements in health. Thus occupational health nurses routinely aim to prevent ill health, promote good health and prolong life, in common with the stated aims of public health (Acheson (1989) in Croghan & Johnson, 2004:158).

The campus healthcare providers indicated that even though it was only staff that was covered by the Compensation for Occupational Injuries and Diseases Act, 1993 (No 130 of 1993) (COID Act), they could not turn a blind
eye to the safety of students on campus. They indicated that the staff campus healthcare consumers might submit claims for an IOD or a work-related condition or illness but not a student and that the occupational nurse practitioner would deal with all the IOD and occupational health-related matters on campus. Croghan and Johnson (2004;156) state that schools can be seen as the workplace of its students, where they typically spend 35 hours per week. The campus healthcare providers indicated that students were also subjected to injuries and other health hazards on campus.

“When I started in occupational health I focused on staff but I discovered that there were was a need for the students too because occupational health and safety Act, it was not only the staff but students too so I had to focus on the students safety also”.

“A staff member can put in a claim if the work made her sick, like for instance occupational asthma, they can put in a claim for it...compensation....A student can’t put in a claim COID Act doesn’t cover them so they can actually also sue the institution. That is where my role comes in, actually the team’s role comes in, is that they complain the incident is investigated…”

“It’s reported to me and I do the initial referral, the completion of the forms and informing the staff member how to go about doing it and it is followed up by (occupational nurse practitioner) who is the IOD sister employed for IOD purposes. Not IOD – occupational health on campus”.

The campus healthcare providers indicated that some of the hazards that students were exposed to on campus included exposure to various chemicals in the laboratory and being bitten by monkeys on campus. Thus the campus healthcare providers suggested that the cost of protective clothing and devices be covered by the students.

“…then our students work in the labs and they are exposed to all these chemical but because there are such a lot of students, protective equipment is a problem....the lecturer always say, oh, sister there’s a lot of students and for each one to get a mask and then they lose it and they back for another one to protect themselves, that is not under the budget”.
“...I think there is a need for us to look at how we can also include maybe the price of protective equipment in what they pay, the institution fee that they pay, so they are protected against spills”.

“The other health needs is in general to protect our students from being bitten by monkeys. I don’t know how that can be done because the only answer I got in the past is that this is a nature reserve. I don’t know if that justifies that they are being injured by monkeys. They don’t come here thinking that they’re coming to a nature reserve and monkeys that attacks them”.

The campus occupational health nurse practitioner indicated that an occupational health service was rendered as a team on campus. She indicated that presently the team, comprised a Safety and Health Environmental (SHE) manager, an outside hygienist, a sessional occupational health medical doctor and an occupational health nurse practitioner. The campus occupational health nurse indicated that they were responsible for conducting risk assessments on campus in order to identify risk areas so that intervention strategies could be developed and implemented in order to reduce the risks on campus. According to Stokes, Fox, Staines and Ozanne-Smith (2003:261), the costs and impact of work-related injury are considerable; and therefore it is important to develop effective and cost-effective interventions. The campus occupational health nurse indicated that they had identified a wide range of occupational risks on campus.

“I’m (occupational health nurse practitioner) the first contact person...they come to me and then they tell me all the symptoms and then they tell me what risks they feel made them sick, then my role is now to record it all and treat her if I can, otherwise refer her to the medical practitioner... and then from there I now have to consult with the SHE manager, he then goes to the site where the problem is and he will go there and identify it and just confirm whether it is really a risk .....in the meantime if he now discovers that there are fumes, say for instance fumes now, she feels the upper respiratory tract is affected. Then he will get a hygienist in to come and measure that exposure and correct what is found...That is actually how we work as a team”.

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“We as team...me and the SHE manager and the medical practitioner, we actually go around into each department but we have to prioritise because institutions are very big. We go for instance like departments like technical services, where the risks is identified, we go there and we see what, they actually will look at, what the worker is doing, how it’s doing, rate of exposure, if there’s like welding fumes, we take note of the duration of exposure, how many people are affected and if there’s any measure that can be taken to decrease these fumes, that is what the risk assessment is actually all about identifying hazards in the work environment...putting it on record, and calling a meeting to minimize the exposure, that can be done to protect the workers by wearing protective clothing”.

“The other risks in the Technical Department – actually a lot, for painters the fumes, the garden – gardening with all the chemicals, an insect bites, bee stings, monkey bites, specifically the students....In the labs you get thousands of hazardous chemicals, especially in the chemical department, there’s a lot of chemical risks there.....There’s a lot of dust, we’ve discovered also that there’s need for people to become aware that they shouldn’t inhale it...Noise from the technical services can come from the machines....it’s intermittent noise exposure...It’s actually not so detrimental to them”.

“I think, looking at especially (this HEI) staff....building syndrome is a big risk to our people, that’s why a lot of people have upper respiratory tract infections...and I actually have a feeling housekeeping is the problem. Keeping the place hygienically free of hazards and keeping it clean from dove...droppings”.

“The hostels in itself is in a very poor hygienic state and I feel there is a need for cleaners to clean the place more often. Our students do come with diseases like diarrhoea, rashes and I really do feel that it could cure the problems – their showers that are only cleaned once a week by the cleaner. I feel that’s a problem. I feel that waste removal is not done daily, so there’s room for improvement...we did have meetings in the past to get together to look at the problems of hygiene in the hostels but now that they’ve privatized we’ve never been approached again and then when I say ‘we’ it’s me and the SHE manager”.

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Health and safety legislation in South Africa is clear as regards requirement of the employer, that is, to ensure that safe and healthy conditions for workers are maintained (Schoeman (1999) in du Rand & Schoeman, 2003:44). Hence the campus healthcare providers expressed a need for the occupational health service to be expanded into a fully functional occupational health service in order to meet the healthcare needs of the campus healthcare consumers, especially the staff campus healthcare consumers. The campus healthcare providers indicated that the social needs of the staff campus healthcare consumers were being well met by all the social functions such as braais, big walks and dances on campus; but on the other hand their emotional and physical healthcare needs were being neglected. The campus healthcare providers indicated that the staff healthcare consumers sometimes become frustrated with them because they did not meet all their healthcare needs. They indicated that occupational health care was one of the cornerstones of primary health care. Occupational health care is listed as one of the core primary health care programmes in van Rensburg (2004:423). The campus healthcare providers indicated that this will only be possible if the all the staff members were qualified to render this service and if the number of staff members was increased.

“So I feel if the occupational health services could be expanded”.

“Because a lot of them (staff) come here and they've got their own stresses and things and we don’t necessarily have the time to attend always to their needs, and to attend to them as soon as they want it. So as a result they become frustrated with us because they’re not getting what they should be getting from us”.

“We intend having a fully functional one (occupational health service) by 2007. At the moment, within the healthcare service there are two qualified occupational health nurses and two of us is still busy doing the occupational health course so I suppose by 2007 this whole service will be fully functional. The occupational health nurse working in the service at the moment, the workload is too much for her so she’s quite behind with her medicals, hearing tests and all those things”.
The campus healthcare providers indicated that if they had a fully functional occupational healthcare service they would be able to do baseline medical and periodical medical examinations on all staff members in order to detect any problems early. The periodical medical examination is a full medical examination performed every six to twelve months according to a medical surveillance programme for the specific health risks the employee is exposed to. Should exposure limits or exposure duration increase or the tests results show deterioration, the periodical medical examination will be repeated more frequently than thought necessary before (Hattingh & Acutt, 2006:246). The campus healthcare providers also indicated that they could maybe set aside one or two days per month on which the staff could be monitored, for example, for blood pressure and cholesterol levels to detect warning signs for action to be taken and thus prevent expertise being lost or high rates of absenteeism. The campus healthcare providers also indicated that if staff members were all seen and examined by a qualified occupational health nurse practitioner, the chance of misdiagnosing occupational health related conditions would be eliminated.

“...we are in the process of having a fully functional occupational health (service) here. Service rendered at the campus, I'd like to see all the staff having, okay fortunately we can start with baseline medicals, then go to periodical and because fortunately for us we will pick up if people have problems”.

“...even the staff as well, a lot of them coming, presenting with chronic blood pressure, diabetes, those type of things, and that’s what I said in the past, that of the occupational health centre, it's supposed to have maybe it’s a day-to-day, once a month or twice a month we have one day to check all the staff for their blood pressure or check them for their cholesterol or whatever because they’re also becoming sick and I mean it’s a burden on the institutions in that it’s going to cost them, they lose expertise, you know those type of things and they have to pay out if people become sick, absenteeism – all those related problems”.

“...sicknesses can be occupational health-related but now it would be ideal if I can see...all staff members that are sick on campus, so that I can identify early
– maybe they come into the clinic with a headache and then not only a headache but they are affected by the environment. If you are a primary health-orientated, you won’t really notice that, you will just give the person treatment and send him back. So it would be ideal for me to see all staff but it won’t be able to materialize because I can’t do it on all the campuses at the same time”.

The responsibilities and goals of an occupational nurse proposed by various occupational health nurse leaders include advocacy; case management; clinical emergency and primary care; co-ordination of services; counselling; development, implementation, monitoring and analysis of health and safety interventions; health hazard assessment and surveillance; health promotion and protection; investigation, monitoring and analysis of illness and injury events; legal and ethical monitoring; management and administration; maintaining legal, regulatory and prevention principles; participation in research; programme development; referral and workplace assessment and surveillance (Rogers (1998), Salazar (2001), Slagle, Sun and Mathis (1998) in McKeown, Barkauskas, Quinn and Kresowaty, 2003:128 and Lusk (1990), Davey (1995), Peurela et al. (1997) in Naumanen-Tuomela, 2001:539).

The campus healthcare providers indicated that they experienced a definite need for an Employee Assistance Programme (EAP) on campus because they experienced the staff campus healthcare consumers to be very stressed and sometimes booked off for three to six months due to stress. They indicated that the EAP was like a wellness programme for it ensured happier employees. The campus healthcare providers indicated that the aforementioned problems could be dealt with by the EAP that would be driven by the Department of Human Resources.

“The health needs of the staff as I mentioned earlier on, is employee assistance programme, that is actually a priority for our staff members, because most of their illnesses are stress-related and also to curb absenteeism”.

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“It work, It consist of – it’s like a wellness programme, like you look at problems of the staff...and I’m sure you will get a better, I mean a happier employee not only the physical side but an emotional side as well”.

“We (EAP) get actually driven from Human Resources, it’s like a facility for us to resource, so if a staff member comes in, I have a lot of staff members that just broke down you know, all the problems that they have but they I feel I don’t have the resource to send those people (to). I haven’t got time to counsel those people and they need counseling, they need it here, somebody to listen to them, to follow them up and that is what the employee assistance programme is all about”.

The campus healthcare providers indicated that the EAP would comprise a multidisciplinary healthcare team who would attend to all the problems of the staff campus healthcare consumers. Organizations frequently follow a team approach in which medical, psychological, psychiatric, nursing, social and other services are offered, often in the form of integrated health promotion initiatives, such as Employee Assistance Programmes (Dickman, Challenger, et al., (1998), Cooper & Payne (1994), Plaggemars (2000) in Hattingh & Acutt, 2006:447). The campus healthcare providers indicated that the multidisciplinary team would comprise for example of:

“Somebody like the industrial relations person from the University Development Programme and SHE (manager), the Industrial Relations Officer from Human Resource, a personnel officer from Human Resource, a social worker, occupational health nurse, head of the campus health department, the chief department representative from here, a union member.....ja”.

“A social worker can listen to the that staff member and he can find out what’s happening with the family at home, you know go into depth with a problem and try and assist the staff member...so we need a social worker in the workplace so that...the pressure on the staff...can be relieved so that they can perform better”.

“...maybe we can let the occupational health doctor follow them up at work, like the students, you know, are seen twice a week, the doctor comes twice a
week for the students, if we can follow the same process for the staff member, I feel it will really assist the staff member”.

The campus healthcare providers indicated that policies regarding EAPs needed to be developed to facilitate the implementation of programmes such as chronic disease management, nutritional programmes for diabetics and support groups.

“We have to put policies in place for stress, how to deal with stress – problems…at work as well as at home, and also alcohol-related…it will actually be the ideal to have an EAP…because many alcohol-related problems comes from financial problems, a lot of issues – marital problems”.

“Things like chronic disease management and nutritional programmes for diabetics, maybe a support group for diabetics. If I can look at maybe one support group for dietary needs, something that would assist them in educating them on their blood pressure readings and their glucose readings, what it should be, how often it should be done, when to seek help, how to identify abnormalities in the body, if you’re diabetic, if you feel drowsy, tired and it may be you’re hypoglycaemic…things like that, because that directly influence your productivity and your job, so if those kind of programmes can be run”.

“There’s emotional side, there’s a lot of staff that goes through emotional trauma, you find people lose loved ones, a lot of times you read about children of employees being sick and you know tragic things happen all the time, so if support groups. Emotional support groups (could be started)”.

The campus healthcare providers also indicated that an EAP on campus would create an environment where the HIV-positive staff members would feel safe to disclose their HIV status and feel free to discuss their fears and problems related to their HIV status. They indicated that presently all the HIV-positive staff members that visited the campus health clinic lived in fear of being rejected and discriminated against once their status was disclosed.
The campus healthcare providers indicated that the current manner in which the occupational health service was structured on campus should be restructured because it did not facilitate the smooth running of this service at the moment for various reasons. Presently the campus healthcare provider indicated that she fell under two departments, namely the department of Support Services and the campus health service, a structure which was causing some confusion and frustration for her. The following quotations illustrate this:

“Budget-wise, I feel that because our head – I've got two head of departments – I've got the SHE manager who actually runs the health and I've got the head of campus health service. She doesn’t run my budget but there are specific items that she purchases from the budget. Now budget-wise actually it will facilitate the service if my budget can be taken away from the SHE manager, be done by the head of campuses (campus health), because I feel the SHE manager is not health, he’s not health. He’s not trained in health issues and anything I do has got to do with health – head of my department knows …it sometimes makes it very difficult because I report to him, the reporting, communication-wise, reporting, I have actually to report to him at the moment which makes it – it’s very uneasy for me to have two bosses, I must report to campus health head…and I must report to the SHE manager for the mere fact that he is running my budget”.

“My SHE manager reports to the Director of Support Services. (Thus) the service falls under Support Services….Support Services include printing, posting, security etc”.

Smit and Cronjé (2004:194) state that each employee should report to only one supervisor, since reporting to more that one supervisor can be very confusing to employees as supervisors may focus on different aspects of the work.
Sub-theme 2.5: Campus Healthcare providers experienced the need for continuous staff development in order to keep themselves updated with new information and techniques

The campus healthcare providers indicated that they experienced a need for continuous staff development in order to keep themselves updated with new information and techniques. Manion (2002:21) states that growth and development are important to most professionals and according to Hlahane, Greef and du Plessis (2006:92), professional nurses should be continuously kept up to date about developments in their profession because they play a vital role in the delivery of primary health care. The following quotations illustrate the expressed needs of the campus healthcare providers with regard to the continuous staff development:

“...the medical profession is such a dynamic profession, it grows, it develops on a daily basis. If you are going to sit here all day long and not go out and find out what is happening, that information is not going to come to you, so you’re not going to render the best service available. For you to get that information you’ve got to go to conferences”.

“...you’ve got to build on your knowledge and it’s got to be a continuous thing, you don’t do it now and then do it again next year. All the time you got to be aware of what’s happening out there”.

“But you stagnate if you sit with seeing patients hour after hour and you do nothing more that that”.

The campus healthcare providers experienced that they were unable to attend many conferences and short courses because of financial and staff constraints and this they experienced as a problem because they needed to know how to act appropriately in various and constantly changing situations. Therefore it is essential that campus healthcare providers have continuing education to ensure that they are always up to date in order to be able to respond to specific healthcare needs of the campus healthcare consumers (Compare Naumanen-Tuomela, 2001:538). Institutional financial support of
employee attendance at continuing education programmes or tuition fee reimbursement is ideal, but both practices have declined in recent years (Manion, 2002:21).

“…with the financial problems that we’ve got, there’s no such chance of them travelling, going to conferences, getting the latest, up-to-date information to do what they should be doing, and this is a bad influence on campus health services”.

“Just think in terms of the new resistant form of TB. You need to know how to act, what route to follow when you suspect something like that and what precautions to take, and how are you going to pick this up?”

“You see with these two campuses and the same for all other clinics, it’s just south and north (campuses) where you can let somebody go because at least there will be one other nurse. But otherwise it’s a problem, it’s a problem to let people go (to conferences, workshops) and I mean they should go because things change a lot”.

According to Hlahane et al. (2006:83) professional nurses are unable to treat their patients properly because of a lack of skills as they do not always have the opportunity to undergo further training to improve on their skills. Thus the campus healthcare providers indicated that they experienced the attending of workshops and other forms of in-service training as enabling them to function better because their knowledge and skills could be updated. They indicated that there were some in-service training programmes relevant to their work available at the Department of Health but unfortunately not all of them were able to attend.

“(If) I can really go for workshops…(it will) actually assist me to do my job better”.

“…There’s some seminars, workshops and stuff, like recently we had a workshop on HIV and skin conditions (at the Department of Health). I think that is the type of things that we need to attend so that we’d be able to identify
these things that is related to HIV. There’s STI workshops (at the Department of Health), but unfortunately everybody can’t go”.

Nurses need to develop new working methods and educate themselves continuously (Piispanen (1996) in Naumanen-Tuomela, 2001:539). Thus the campus healthcare providers indicated that they planned an in-service training schedule every year when they did their strategic planning. They indicated that staff members were allocated various clinical topics to prepare and present to their colleagues. Resources may not be available to support employees’ educational pursuits; but a warm and encouraging environment may be just as important, or even more so (Manion, 2002:21). The following quotations illustrate experiences expressed by the campus healthcare providers in this regard:

“Well with our strategic planning at the beginning of this year, we set aside certain people and, well, we do our in-service training schedule for the year and each one gets a turn to do it and then we go through the systems of the body”.

“I had to do the alimentary tract from the mouth to the anus…I took certain conditions that we see a lot…and then we talked a little about the stomach and small intestines and so on…."

Starfield (1992) in Hlahane et al. (2006:83) mentions that professional nurses must be able to manage several health problems all at once. Professional nurses seem to be frustrated with rendering comprehensive primary health care services if they do not have all the skills required. The campus healthcare providers indicated that if there was no personal and professional growth where they were employed, then they would have to move on to another job. This is illustrated in the following quotations;

“I left my previous employment because you just come in and there would be no growth”.
“...without any growth, then you have to move on, because I mean a person, an individual, needs that”

According to Adams and Bond (2000:541), achieving professional standards of practice and personal development are two of the elements that predict job satisfaction. Professional nurses need comprehensive nurse training to equip them fully in order to enhance the delivery of quality comprehensive primary health care services. Short courses like TB, HIV and AIDS management and computer literacy are equally important (Hlahane et al., 2006:92).

According to Snow (2002:24A), employees want a good work environment, challenging work and opportunities to learn and develop their skills. The campus healthcare providers therefore indicated that management would have to consider carefully the consequences when they cut down on things like access to the internet, the purchasing of medical books and journals and the funding of staff members who wished to attend conferences.

“I mean we’re sitting with a situation where even if you go into the internet nowadays, you can only go in few times then you start paying for it. And that’s education, it should be free, so you can’t go to conferences any more- we haven’t got money. We can’t buy medical books any more because they’re too expensive. So you see what I’m saying we’ve (management) got to think carefully about this”.

According to Manion (2002:22) if you want more opportunity for growth and development, start seeking it out. Look elsewhere in the organization, such as your community outreach and education departments, or see whether these needs can be met through activity in your professional association.

3.6 SUMMARY

This chapter focused on the discussion of the results that emanated from the data-collection phases and the process of data analysis of the study. The discussion of the results was divided into three sections namely, Section One,
Section Two and Section Three. **Section One** presented the discussion of results that were obtained from the focus group interviews with the student campus healthcare consumers in **Phase One** of the data collection process relating to their experiences regarding how their healthcare needs were met by the campus health services and what their healthcare needs were. **Section Two** presented the discussion of results that were obtained from the depth interviews with the staff campus healthcare consumers in **Phase Two** of the data collection process relating to their experiences with regard to how their healthcare needs were met by the campus health services and what their healthcare needs were. **Section Three** presented the discussion of results that were obtained from the depth interviews with the campus healthcare providers in **Phase Three** of the data collection process relating to their what they perceived to be the healthcare needs of both groups of campus healthcare consumers and how they experienced the rendering of campus health services. The findings were compared and contrasted with existing literature sources as a means of verifying the findings.
CHAPTER FOUR

A DESCRIPTION OF THE DEVELOPMENT OF A HOLISTIC HEALTHCARE MODEL FOR CAMPUS HEALTH SERVICES

4.1 INTRODUCTION

Chapter Three dealt with the analysis, discussion and interpretation of results that emanated from the depth phenomenological individual interviews as well as the focus-group interviews that were conducted with the research participants. The objectives of this study were to obtain information regarding the perceived healthcare needs of the healthcare consumers and also to establish how they and the healthcare providers experienced the campus healthcare services provided at a HEI in the ECP. The results were discussed in conjunction with the unique contributions of the researcher and a literature control that allowed for the verification of the findings. This information will now be used to identify the main concepts in order to create conceptual meaning that will provide a foundation for developing a holistic healthcare model for campus health services. The focus of this chapter will thus be a discussion of the process of the development of the aforementioned model.

4.2 CONCEPT ANALYSIS

Walker and Avant (1995:37) state that concepts are mental constructions and are our attempts to order our environmental stimuli. Thus concepts represent categories of information that contain defining attributes. Concept analysis is a strategy that allows us to examine the attributes or characteristics of a concept. It enables us to refine and define a concept that has originated in research and helps us to differentiate it from similar and dissimilar concepts (McKenna, 1998:57).
Concepts contain within them the defining characteristics or attributes that permit us to decide which phenomena are good examples of the concept and which are not. Concept analysis is therefore a formal, linguistic exercise to determine the aforementioned defining attributes (Walker & Avant, 1995:37). Concept analysis encourages communication and therefore the researcher must be precise about carefully defining the attributes of the concepts to be used in the development of the holistic healthcare model for a campus health service at a HEI in order to promote understanding about the phenomenon being discussed (Compare Walker & Avant, 1995:37). The end result of concept analysis is a way of reliably checking or operationalising the existence of that concept in nursing practice (McKenna, 1998:57).

### 4.2.1 IDENTIFYING, CLASSIFYING AND DEFINING THE MAIN CONCEPTS FOR THE DEVELOPMENT OF THE MODEL

Identifying, classifying and defining the main concepts for the model will facilitate the creation of conceptual meaning, in part, by increasing our awareness of the range of possible uses and meanings of words. Creating conceptual meaning formulates as exactly as possible what is intended so that members of the discipline can follow the reasoning and logic on which a theory is based (Chinn & Kramer, 1995:79).

#### 4.2.1.1 IDENTIFYING THE MAIN CONCEPTS FOR THE MODEL

The main concepts for the development of the model will be identified from the results of the analysis that emanated from the depth individual interviews and focus-group interviews that were conducted with the research participants. Table 4.1 below; reflects a summary of the themes, sub-themes and categories regarding the research findings. Copies of the aforementioned table were distributed and discussed with the supervisors, peers and a panel of research experts who were all experienced in the field of qualitative research and theory development. The aim of the aforementioned discussions
which took place at different times was to verify the researcher’s objectivity, provide credibility for the study and to identify the main concepts of the study.
<table>
<thead>
<tr>
<th>STUDENT CAMPUS HEALTHCARE CONSUMERS THEMES, SUB-THEMES AND CATEGORIES</th>
<th>CAMPUS HEALTHCARE PROVIDERS THEMES, SUB-THEMES AND CATEGORIES</th>
<th>STAFF CAMPUS HEALTHCARE CONSUMERS THEMES, SUB-THEMES AND CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THEME 1:</strong> Students expressed a diverse range of experiences related to how their healthcare needs were met at the campus health service</td>
<td><strong>THEME 1:</strong> Campus healthcare providers experience the rendering of campus health services as, positive, rewarding and challenging</td>
<td><strong>THEME 1:</strong> Staff expressed a diverse range of experiences related to how their healthcare needs were met at the campus health service</td>
</tr>
<tr>
<td>Sub-theme 1.1: Students had positive experiences when they used campus health services.</td>
<td>Sub-theme 1.1: Campus healthcare providers have positive and rewarding experiences when rendering campus health services.</td>
<td>Sub-theme 1.1: Staff had positive experiences when they used campus health services</td>
</tr>
<tr>
<td>1.1.A Campus health service were accessible and affordable.</td>
<td>1.1.A working with the students and staff at a Higher Education Institution as being very enjoyable and stimulating.</td>
<td>The staff experienced:</td>
</tr>
<tr>
<td>1.1.B Campus healthcare providers were passionate and they had good interpersonal skills.</td>
<td>1.1.B experienced the healthcare services that were rendered on campus as being of a high quality and well organized.</td>
<td>1.1.A campus health service as convenient, affordable and accessible at times;</td>
</tr>
<tr>
<td>1.1.C Campus healthcare providers were professional and committed to rendering a quality service.</td>
<td>1.1.C Working as an extended primary healthcare network for the Department of Health as facilitating effective service delivery and</td>
<td>1.1.B the campus healthcare providers as highly competent and the health care service delivery as excellent;</td>
</tr>
<tr>
<td>Sub-theme 1.2: Students experienced certain shortfalls with regard to campus health service</td>
<td>Sub-theme 1.2: Staff experienced various challenges in the rendering of campus health services</td>
<td>1.1.C the campus healthcare providers as being friendly, caring, helpful and patient and</td>
</tr>
<tr>
<td>Students experienced:</td>
<td>Campus healthcare providers experienced:</td>
<td>1.1.D the environment of the campus health clinic at some campus sites as being user-friendly;</td>
</tr>
<tr>
<td>1.2.A a lack of information about the type of healthcare services being rendered on campus;</td>
<td>1.2.A resource constraints as having an impact on service delivery;</td>
<td>Sub-theme 1.2: Staff experienced some shortfalls with regard to campus health service</td>
</tr>
<tr>
<td>1.2.B the appointment system as a stumbling block to access the service when it was most needed;</td>
<td>1.2.B campus health services as being fragmented because of the number of the satellite clinics situated on the different campuses of the HEI;</td>
<td>Staff experienced:</td>
</tr>
<tr>
<td>1.2.C a need for an after-hour emergency service and adequate transport for referrals;</td>
<td>1.2.C the referral system to other public health care facilities as being unstructured;</td>
<td>1.2.A the campus health service as being inaccessible to the staff at times;</td>
</tr>
<tr>
<td>1.2.D the staffing, supplies, equipment and facilities as inadequate;</td>
<td>1.2.D the diversity of cultures of the health care consumers as being challenging in rendering culturally congruent healthcare;</td>
<td>1.2.B discomfort when consulting a different campus healthcare provider at each visit</td>
</tr>
<tr>
<td>1.2.E HIV testing to be intimidating; and</td>
<td>1.2.E a lack of contextual research that informs practice in campus health service delivery;</td>
<td>1.2.C discomfort in sharing the waiting room with the students</td>
</tr>
<tr>
<td>1.2.F some administrative staff members as being lacking in awareness of consumer care principles.</td>
<td>1.2.F the merger of the three Higher Education Institutions as causing additional stress and uncertainty among themselves and staff healthcare consumers and</td>
<td>1.2.D the emergency services provided on campus as being inadequate</td>
</tr>
</tbody>
</table>

<p>| 1.2.G lack of promotional opportunities as hampering career progression. |</p>
<table>
<thead>
<tr>
<th>STUDENT CAMPUS HEALTHCARE CONSUMERS</th>
<th>CAMPUS HEALTHCARE PROVIDERS</th>
<th>STAFF CAMPUS HEALTHCARE CONSUMERS</th>
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<tr>
<td><strong>THEMES, SUB-THEMES AND CATEGORIES</strong></td>
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<td><strong>THEMES, SUB-THEMES AND CATEGORIES</strong></td>
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<tr>
<td><strong>THEME 2:</strong> Students experience specific healthcare needs in order to maintain a state of optimal wellness</td>
<td><strong>THEME 2:</strong> Campus healthcare providers experience the need to render a more comprehensive primary health care service to address a wide range of healthcare needs of students and staff on campus</td>
<td><strong>THEME 2:</strong> Staff experience specific healthcare needs in order to maintain a state of optimal wellness</td>
</tr>
<tr>
<td>Sub-theme 2.1: Students expressed the need for knowledge on a diverse range of health related topics to ensure physical and mental wellness.</td>
<td>Sub-theme 2.1: Campus healthcare providers experienced the need: Sub-theme 2.1 to provide promotive and preventive health services, including health education on a wide range of health related topics.</td>
<td>Sub-theme 2.1: Staff experienced the need for knowledge on a wide range of health related topics to ensure physical and mental wellness</td>
</tr>
<tr>
<td>Sub-theme 2.2: Students expressed a need for a wide range of healthcare services in order to maintain their health status.</td>
<td>Sub-theme 2.2: Sub-theme 2.2 to provide a curative and chronic health service on campus.</td>
<td>Sub-theme 2.2: Staff experienced a need for a wide range of healthcare services in order to maintain their health status</td>
</tr>
<tr>
<td>Sub-theme 2.3: Students expressed a need for the provision of various healthcare services that would improve their health when they are sick.</td>
<td>Sub-theme 2.3: Sub-theme 2.3 for supportive, counselling and social services to be available for students and staff at the HEI.</td>
<td>Sub-theme 2.3: Staff experienced a need for the provision of various healthcare services that would improve their health when they are sick</td>
</tr>
<tr>
<td></td>
<td>Sub-theme 2.4: Sub-theme 2.4 for an occupational health service and an Employee Assistance Programme on each campus.</td>
<td>Sub-theme 2.4: Staff experienced a need for continuous surveillance of occupational health related diseases</td>
</tr>
<tr>
<td></td>
<td>Sub-theme 2.5: Sub-theme 2.5 for continuous staff development in order to keep themselves updated with new information and techniques.</td>
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</table>
Table 4.1 reflects that all three groups of research participants expressed diverse experiences with regard to when the service was being used by the campus healthcare consumers as well as when the healthcare providers rendered the services. Both positive and negative experiences were expressed by the participants as well as a need for a more comprehensive healthcare service to be rendered on campus. The research participants expressed a need for not only their physical healthcare needs to be addressed, but also their mental, social and knowledge healthcare needs. This is evident from the fact that some of the participants indicated that many of the physical ailments that they presented with at the campus health clinic manifested from underlying mental health issues such as stress and depression. According to de Haan (2005:4), a comprehensive approach to attaining and maintaining optimal health for people requires that the factors affecting health be identified. The effect of these factors on people’s health can be both positive and negative. Therefore treatment to attain health cannot be confined to medical treatment alone. It should be more comprehensive in nature and include the improvement of the environment or the conditions in which people live and work, thus preventing disease conditions from occurring or re-curring.

Similar themes emanated from the information received from the participants because the same research questions were posed to both groups (students and staff) as they had all used the campus health service at some stage. Even though similar themes emerged from the information received, their experiences differed to a certain extent. It was evident from the information obtained that both groups of campus healthcare consumers were appreciative of the campus health service being rendered on campus.

The student campus healthcare consumers indicated that they experienced certain shortfalls with regard to the campus health service that hampered their access to the service when they most needed it at times. The shortfalls experienced by the student campus healthcare consumers included a lack of information about the type of healthcare services being rendered on campus; the appointment system as a stumbling block to access the services; a need
for after-hour emergency services; the facilities and staffing as inadequate; the HIV testing as intimidating and some administrative staff members as lacking in awareness of consumer care principles.

Despite the fact that the student campus healthcare consumers expressed the aforementioned negative experiences they also indicated that they had very positive experiences when they used the campus health service. Generally the student campus healthcare consumers experienced the campus health service to be accessible and affordable because many of them indicated that they did not have the means to access private healthcare services and they expressed their dissatisfaction with the service received from the public health sector in no uncertain terms. The student healthcare consumers spoke very highly of the campus healthcare providers and indicated that they experienced the campus healthcare providers as being very caring, passionate and possessing good interpersonal skills. They also experienced the services rendered as being very professional and of a high quality.

The staff campus healthcare consumers on the other hand, like the students, also experienced some shortfalls with regard to the campus health service. They had also had experiences like the students with regard to the campus health service being inaccessible at times due to the appointment system. The staff campus healthcare consumers also experienced the emergency services provided on campus, the number of available campus healthcare providers and some of the campus health service facilities as being inadequate. Some experiences such as discomfort when consulting different healthcare providers at each visit and discomfort in sharing the waiting room with students were specific to the staff campus healthcare consumers.

Nevertheless, the staff campus healthcare consumers also indicated that they had very positive experiences when they used the campus health service. Like the students, the staff campus healthcare consumers indicated that they also experienced the campus health service as being accessible, convenient and affordable. They indicated that they experienced the campus healthcare providers as being highly competent because they always appeared to follow
protocol and they found the service delivery to be excellent. They indicated that they experienced the campus healthcare providers as being very caring, friendly, helpful and patient with them and the environment of the campus health service was user-friendly.

Both groups of campus healthcare consumers experienced specific healthcare needs in order to maintain a state of optimal wellness. Although similar themes emanated from the information obtained from both groups of participants, the specific needs generic to each group in fact differed. For example, the need for knowledge on a wide range of health-related topics to ensure physical and mental wellness differed with regard to the staff campus healthcare consumers who indicated that they experienced a need for more information related to chronic health problems; whereas the student campus healthcare consumers experienced a need for more information on family planning, emergency contraception, sexually transmitted infections and nutrition. The staff campus healthcare consumers also indicated that they experienced a need for continuous surveillance of occupational health-related diseases. Thus in order to address the diverse healthcare needs, the campus healthcare consumers expressed the need for a more comprehensive healthcare service to be rendered on campus for students and staff.

The information obtained from the campus healthcare providers regarding their experiences relating to the rendering of campus health service and their perceived needs of the campus health care consumers was analysed. A brief description of the similarities and differences with regard to findings of the campus healthcare consumers and the campus healthcare providers will now be highlighted.

Like the campus healthcare consumers, the campus healthcare providers also experienced resource constraints such as staff, facilities and finance as having an impact on service delivery. They indicated that it was because of these constraints that they had to resort to the appointment system and to concentrate their service delivery on the students even though they felt that they could be doing more for the staff. The rest of the challenges experienced
by the campus healthcare providers were generic to them and included, the fragmentation of campus health service due to the number of satellite clinics situated on different campuses; the unstructured referral system to other public healthcare facilities; the diversity of cultures that poses a challenge in rendering culturally congruent health care; a lack of contextual research that informs practice in campus healthcare, the merging of the three HEIs as causing additional stress among the staff healthcare consumers and themselves, as well as a lack of promotional opportunities as hampering career progression.

The campus healthcare providers, like the campus healthcare consumers, indicated that they also had positive and rewarding experiences. For instance, they also experienced the services rendered on campus as being of a high quality and well organized. Furthermore, they experienced working with the students and staff campus healthcare consumers to be very enjoyable and stimulating. They also indicated that they experienced working as an extended primary health care network for the Department of Health as facilitating effective service delivery. The campus healthcare providers indicated that they experienced the secretaries who were trained as basic ambulance attendants as being a great help to them.

The campus healthcare providers, like the campus healthcare consumers, also expressed the need to render a more comprehensive primary healthcare service on campus in order to attain and maintain optimal wellness for the campus healthcare consumers. The campus healthcare providers indicated that they experienced the need to render a promotive and preventive healthcare service on campus in order to address the healthcare educational needs and needs such as nutritional supplements, family planning, VCT, flu vaccines, ante-natal care and barrier methods for protection against STI and HIV infections. The campus healthcare providers appeared to be satisfied with the range of curative health services on campus but experienced the need to render a chronic disease service because of the perceived high incidence of chronic conditions such Hypertension and Diabetes Mellitus on campus. Like the staff campus healthcare consumers also expressed the need for an
occupational health service on campus. Furthermore, they also expressed the need for supportive counselling and social services to be available for students and staff on campus and also for continuous staff development in order to keep them updated on new information and techniques.

After a number of different discussions held with the supervisors, peers and research experts’ one main concept emerged to optimise campus health services at a HEI. Firstly the concept *comprehensive healthcare* was identified because the research participants indicated that they experienced a need for a more comprehensive service to be rendered on campus in order for them to maintain a state of optimal wellness. After further discussions and deliberations with the aforementioned persons the concept *holistic healthcare* was considered more appropriate because the healthcare needs identified by all the research participants included physical, mental and social healthcare needs. The concept *comprehensive* is defined in the Oxford Advanced Learner’s Dictionary as “that includes everything or nearly everything” (Hornby, 1995:235) whereas one of the definitions of the concept *holistic* is “treating the whole person rather than just the symptoms of a disease” (Hornby, 1995:568). Thus the concept *holistic* healthcare was identified in preference to the concept *comprehensive* healthcare.

### 4.2.1.2 CLASSIFYING THE CONCEPTS

The survey list of Dickoff et al. (1968:423) was used to classify the concepts in the model by providing six ways to look at one thing in the hope of revealing different features as the point of view shifted. The survey list included the agent, recipient, context, dynamics, procedure and terminus.

- The *agent* in this model is initially the registered nurses, doctor and intern psychologist render the healthcare service to the campus healthcare consumers (students and staff). The campus healthcare consumers eventually also become agents when they assume
responsibility for their own health once the imbalance that they have experienced has been addressed.

- The recipient in this model is the campus healthcare consumer (including staff of the campus health clinic) who utilises the campus health service provided.
- The context in the model is developed and described within the context of the campus health service at an HEI where the study was conducted. The HEI comprises five campus health clinics which are widely dispersed.
- The dynamics in the model will include the agents, recipients, resources and the environment.
- The procedure will clarify what the holistic healthcare service model will comprise in order to meet the healthcare needs of the whole person.
- The terminus is the development of a holistic healthcare model for HEIs to ensure balanced whole persons who are able to realise their aspirations and needs and maintain consistency with regard to optimum health and capacity.

Figure 4.1 below illustrates the researcher’s thinking map regarding the identification and categorisation of the major concepts and associated concepts for further refinement later in the chapter.
Chapter Four

A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUS HEALTHCARE SERVICES

AGENT
The medical doctor
The registered nurse
The intern psychologist
The students and staff

RECIPIENT
The students and staff
(including clinic staff)

PROCEDURE
The procedure will clarify what the holistic healthcare model for campus health service will comprise in order to meet the healthcare needs of the whole person.

DYNAMICS
The dynamics in the model will include the agents, recipients, resources and the environment.

CONTEXT
A campus health service at an identified HEI. This campus healthcare service comprises five campus health clinics which are widely dispersed.

TERMINUS
A balanced whole person who is able to realise his or her aspirations and needs and maintain consistency with regard to optimum health and capacity.

Figure 4.1: THE THINKING MAP FOR THE CLARIFICATION OF CONCEPTS
4.2.1.3 DEFINING THE MAIN CONCEPTS

Concepts are words that describe objects, properties or events and are the basic components of theory. They are basically vehicles of thought that involve images. Concepts are said to be empirical, inferential or abstract depending on their ability to be observed in the real world. Empirical concepts are those that can be easily observed in the real world; inferential concepts are those that are indirectly observable; and abstract concepts are those that are non-observable. Thus abstract concepts require thorough clarification if they are to be used for practice or research (George, 1990:2).

Creating conceptual meaning is a logical starting point for developing theory although it does not necessarily have to be accomplished first. The process of creating conceptual meaning brings dimensions of meaning to a conscious, communicable awareness. Most theorists provide definition of terms used within theory; but providing word definitions is not the same as creating meaning. Conceptual meaning conveys thoughts, feelings and ideas that reflect the human experience of the concept. Conceptual meaning is created by considering all three sources of experiences related to the concept, the word, the thing itself and the associated feelings. The same word may be used to represent more than one phenomenon or a single phenomenon can also be represented by several different words. Each word conveys a slightly different meaning considering that the evolution of words and their multiple meanings are complex (Chinn & Kramer, 1995:78).

Definitions are one source that provides information about conceptual meaning. They help to clarify common usages and ideas associated with the concept. Existing definitions often help to identify core elements about objects, perceptions or feelings that can be represented by the word. They are also useful to trace the origin of words that give clues to the core meaning. Dictionary definitions provide synonyms and antonyms and convey commonly accepted ways in which words are used. They are not designed to explain the full range of perceptions associated with a word, particularly when the word has a unique use with a discipline or represents a relatively abstract concept.
Existing theories provide a source of definitions that sometimes extend beyond the limits of common linguistic usage. Theoretical definitions and ways in which concepts are used in the context of theory, convey meanings that pertain to the domain of the discipline from which the theory comes (Chinn & Kramer, 1995:82).

Thus in view of the above discussion, both dictionary and subject definitions will be used to give conceptual meaning to the main concept identified in this study. Various dictionaries, subject text books, internet sites, journals and peer-reviewed journals were explored and extensive reading done to describe and understand the main concept identified. A concept of a particular discipline is the way in which it is viewed, namely a classification system applied to a particular area (Pearson, Vaughan and Fitzgerald, 1997:11).

The main concept “holistic healthcare” will now be defined. The concepts will first be individually described, that is, “holistic”, “health”, “care” and “healthcare” in the following paragraphs. Various literature sources as indicated above will be used. A perfectly-analysed concept builds a well-structured theory, which will ensure a sound understanding of its use in practice (Walker & Avant, 1995:48).

• Dictionary definitions of the concept “holistic”

The concept “holistic” is the adjective of the noun holism. According to the Wikipedia (http://en.wikipedia.org/wiki/Holism accessed 02/07/2007) the concept “holism” is derived from the Greek word holos meaning “all, entire, total”. According to The Concise Oxford Thesaurus (1996:21) the concept all can be used as a noun, adjective and an adverb. It means the ‘every, the whole lot, everything, each thing, lock stock and barrel, the whole/total amount, the entirety, the sum total, the complete, the entire, the totality of, fully, altogether’ and similarly the concept entire can be used as an adjective to refer to ‘with no part left out; whole; complete’ (Hornby, 1995:386). The concept total like the two aforementioned concepts also refers to ‘complete;
absolute’ (Hornby, 1995:1263). In view of the aforementioned it is evident that all three words appear to have the same meaning.

According to Settani (1990:111) **holism** is the idea that *all the properties of a given system, (that is biological, chemical, social, economic, mental, linguistic and so forth), cannot be determined or explained by the sum of its component parts alone. Instead, the system as a whole determines in an important way how the parts behave.* Some of the various dictionaries consulted defined **holism** as “the theory that wholes are more than the mere sums of their parts are fundamental aspects of the real” (Barnhart & Stein, 1968:577; Cambridge Advanced Learner’s Dictionary, 2005:611; The Dictionary Unit for South African English 2002:). Similarly, Stein and Urdang (1967:677) define **holism** as “the theory that whole entities as fundamental components of reality have an existence other than as the mere sum of their parts”. The aforementioned and latter definitions indicate that it is more fruitful to study the whole culture or organism than its parts or symptoms (The World Book Dictionary, 2000:1009).

Hobson (2001:208) states that the concept “**holistic**” is “characterised by comprehension of the parts of something as intimately interconnected and explicable only by reference to the whole”. Thus in **holistic** medicine the person must be treated as a whole, taking into account mental and social factors, rather than just the physical symptoms of a disease (Longman Dictionary of Contemporary English, 1995:683; Hornby, 1995:, Thompson, 1995:647). McCulloch, Norris and Sanders (2002:) also state that social, economic and psychological factors must be taken into consideration when treating a person and one should not just focus on the person’s ailment or condition.

The concept of **whole** can be used as an adjective or a noun. According to the Longman Dictionary of Contemporary English (1995:1635) the concept **whole** is used as an adjective to illustrate “all of something; complete and not divided or broken into parts”. It is used as a noun to illustrate “the whole of all of something especially something that is not physical; ‘as a whole’ used to
say that ‘all the parts of something are being considered’; something that consists of a number of parts, but is considered a single unit”. The concept single unit can be viewed as ‘only one thing, person or group that is complete in itself, although it can be part of something larger’ (Oxford Advanced Learner’s Dictionary, 1995:1304). The concept complete refers to ‘having all necessary or appropriate parts; whole’ (Hornby, 1995:232).

According to the Oxford Advanced Learner’s Dictionary, Hornby (1995:1196) the concept sum can be defined as ‘the total obtained by adding together numbers, amounts, or items’. The concept part on the other hand can be used quite widely as a noun, verb and an adjective and is always used to denote the opposite of whole or entirety. When used as a noun the concept part can refer to ‘a portion, division, section, segment, bit, piece, fragment, scrap, slice, fraction, chunk, component, constituent, member, module’. The concept part is used as a verb to denote ‘separate, split, split in two, split up, break up, sever, disjoin’ (The Concise Oxford Thesaurus, 1996:569).

- Subject definitions of the concept “holistic”

Scientists have been exploring the holistic nature of the universe for decades. The idea of holism has ancient roots and examples can be found throughout human history and in the most diverse socio-cultural contexts (Potgieter, 1998:114). They have discovered that matter consists of elemental structures called atoms which, when grouped, produce nature’s wholes, called cells, which in turn produce bodies or organisms (Cheston, 2000:297). Ancient Greeks believed that human beings could not be understood unless nature as a whole was understood, and that the determining factors in nature were organisms which were complete wholes rather than reducible mechanisms (Taylor (1988) in Owen & Holmes, 1993:1688). Bohm (1980) in Owen and Holmes (1993:1688) suggests that the ancient past of the notion indicates that man has sensed that wholeness, or integrity is necessary to make life worth living, and has always pursued its explication.
The pre-Socrates’ thinkers’ primary concern was to explain how the *unity* or *wholeness* of reality was transformed into the plurality of appearance, and many subsequent thinkers were in sympathy with, or at least pondered, the central themes of *holism*. Thus, according to Aurelius (1960) in Owen and Holmes (1993:1689), *holism* “constantly regard the universe as one living being, having one substance and one soul; and observe how all things have reference to one perception, the perception of this one living being; and how all things act with one movement; and how all things are the co-operating causes of all things which exist; observe too the continuous spinning of the thread and the contexture of the web”.

According to Ansbacher (1961:487) the term “holism” was coined by Jan Smuts in his book *Holism* and Evolution in 1926 which was written after his political defeat in 1924. Owen and Holmes (1993:1689) state that Smuts postulated a philosophy in which the interdependent and interrelated parts were treated not within the dominant positivistic scientific paradigm, but from a new perspective which he described as “…the principle which makes for the origin and progress of wholes in the universe” (Smuts (1926) in Owen and Holmes, 1993:1689). Smuts entered into a substantial intellectual dialogue with his contemporaries, which promoted the acceptance of holism into mainstream philosophy. Whilst reflecting on the numerous states which comprised South Africa, Smuts recognised that they were greater as South Africa than as separate states. The inter-relationship between these states created forces which were more than the sum of their parts, each structure marking a new stage along the ascending path of evolution. Smuts considered *wholes*, then, as basic to the character of the universe, and as *irreducible*, *autonomous* and amounting to more than the *sum of the parts*. The whole includes all realized experience, a process by which reality and experiences are being extended, and an ideal towards which that process of realisation is tending (Owen & Holmes, 1993:1689). Therefore, Smut’s holism is an ontology to express the view that the ultimate reality of the universe is neither matter nor spirit but *wholes* (Cheston, 2000:297). According to Jaros (2002:13) Smuts defined holism as *the tendency in nature to form wholes that are greater than the sum of the parts through creative evolution*. 
Holistic philosophy gradually impacted upon a number of disciplines and was refined and modified in the process (Owen & Holmes, 1993:1689). Thus the concept holism has become widely accepted in disciplines like medicine, nursing science, physiology, biology and the social sciences, underlining the fact that organisms and systems are united wholes and that what happens in one part of the system always has an effect on other parts of the larger system to which it belongs (Potgieter, 1998:114).

According to Potgieter (1998:114) holism refers to completeness or wholeness of a system and emphasises the fact it is irreducible to the sum of its parts. Thus a holistic approach to social work and social welfare emphasised the fact that the system and environment should be seen as interrelated and that people should be treated in the context of the entirety of their environment. People should not only be viewed as interconnected biological, physiological, social, psychological and spiritual beings, but also be seen in the context of their social and cultural milieu, their educational attainments and their economic and recreational activity. Holism also refers to interdisciplinary teamwork that focuses on all the different facets of a system’s life in order to support, maintain or heal the whole. A holistic approach to social work and social welfare thus also highlights the needs for team-building, for co-ordination, management, policy formulation and planning. The holistic helper accepts the fact that people, families, groups and communities are all part of each other and that every expressed need of one strongly relates to the needs of others. O'Neil in Potgieter (1998:114) contends that any one service “can meet neither all the needs of any one person, nor one need of all persons”.

Scientific holism holds that the behaviour of a system cannot be perfectly predicted, no matter how much data is available. Holism states that by considering the whole picture one gets a more complete view than by analyzing it into its component parts. There is hardly a system without its component parts. Simple systems can produce surprisingly unexpected behaviour and it is suspected that behaviour of such systems might be computationally irreducible, which means it would not be possible even to
Chapter Four

A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUSS HEALTHCARE SERVICES

approximate the system state without a full simulation of all the events occurring in the system (Raman, 2005:252).

In philosophy, any doctrine that emphasises the priority of a whole over its parts is holism. In the philosophy of language this becomes the claim, called semantic holism, that the meaning of an individual word or sentence can only be understood in terms of its relation to a larger body of language, even a whole theory or a whole language. In philosophy of mind, a mental state may be identified only in terms of its relation with others. This is often referred to as content holism or holism of mental. Epistemological and confirmation holism are mainstream ideas in contemporary philosophy http://en.wikipedia.org/wiki/Holism accessed 02/07/2007).

In architecture and industrial design holism tends to imply an all-inclusive design perspective, which is often regarded as somewhat exclusive to the two design professions. Holism is often considered as something that sets architects and industrial designers apart from other professions that participate in design projects. This view is supported and advocated by practising designers and design scholars alike, who often argue that architecture and/or industrial design have a distinct holistic character (http://en.wikipedia.org/wiki/Holism accessed 02/07/2007).

Emile Durkheim was a socialist and concluded that the concept of totality is only the abstract form of the concept society; it is the whole which includes all things. Whether called society or totality, this notion had to be understood as expressing reality that was irreducible to its component parts (Jay, 1984:279).

According to Moulaert and Nussbaumer (2005:2072), a holistic definition in social economy does not pursue generality, but inclusiveness. A holistic theory focuses on the dialectics of general mechanisms and factors of explanation on the one hand, and specific situations on the other. A holistic definition in social economy looks more like a dialectical argument between generality and specificity, taking into account history, institutions and territorial
context, than an omni-valuable formula as is provided in an essentialist definition. Therefore, holistic definitions, more than essentialists definitions stress the role of institutions and governance in defining the social economy. A holistic approach will also address the historical context of the contemporary social economy and possibly compare it with that of, for example, the social economy within the welfare systems.

According to Gold (2005:3) Alfred Adler’s system of thought is essentially holistic in contrast to classic psychoanalytic thought, which is reductionist. The holistic approach lends itself to a much broader understanding of human thought processes and behaviour. Within the human condition, we see the continuous interplay between the individual’s subjective experience and his or her interacting with the external world. The inner functioning of the human is highly complex and always connected to the environment in which the individual exists. The construct of interdependency between self and the external world is an ongoing dynamic process which carries within it a concept that applies to the entire universe. Holism, interdependency, interactivity and movement are constants that create a dynamic universal force that affects every aspect of being in the universe.

Gold (2005:3) also highlighted that Adler believed that the individual as an integrated whole expressed through a self-consistent unity of thinking, feeling and action and moving toward an unconscious, fictional final goal, needed to be understood within the larger wholes of society, from the groups to which he belonged to the larger wholes of mankind. The recognition of our social embeddedness and the need for developing an interest in the welfare of others, as well as a respect for nature, is at the heart of Adler’s philosophy of living and principles of psychotherapy (Gold, 2005:3). Evans and Meredith (1991:543) assert that Adlerian Psychology is a comprehensive, cognitive and social theory, which fits Third-Force Psychology. Evans and Meredith (1991:544) quote Dreikurs-Ferguson (1984) as stating that Adlerian Psychology consists of three basic principles that make it unique from other approaches: purposiveness, holism and social interest.
According to Mosak and Dreikurs (1974) and Griffith and Powers (1984) in Evans and Meredith (1991:544), **holism** means individuals are a unity of thoughts, emotions and behaviours moving in one direction. The concept of **holism** does not reduce the person into separate parts like the psychodynamic model or medical model. **Holism** is the opposite of reductionism which believes that to understand the individual you must reduce him or her to the id, ego or superego, or more recently into biological, social and psychological parts. These parts are often viewed as being in conflict with one another and this conflict causes the person to behave in a disturbed manner. Thus to understand behaviour from a **holistic** perspective one must not get lost in reducing behaviour to separate conflicting parts; instead whatever one is doing must be viewed as one **holistic** approach.

Strauch (2003:452) contends that **holism** is an integral assumption of individual psychology, meaning that aspects of a person **connect** to other aspects of that person in systematic and dynamic ways. These aspects include thoughts and feelings and purposive symptoms (Ansbacher & Ansbacher (1956) in Strauch, 2003:452). Moses (1995) is cited in Strauch (2003:452) as stating that **holism** also means that activities toward a person’s life tasks **relate** to one another. For instance, stress that results from lack of self-care can affect work productivity or relationship satisfaction. Even within a single life task, certain elements or interactions can affect that life task.

The anthropological principle of **holism** emphasises the importance of the **whole** of the socio-cultural context when people and their behaviour are being investigated (Bouwer, Dreyer, Herselman, Lock and Zeelie, 1997:32). According to Claus (http://remoteculturesandonvirons.rwithcare.com/holism.html Accessed 02/07/07) anthropology looks at ‘the whole’ of what it means to be human, the body, culture and ‘soul’ of culture, and not just one culture. Thus the concept **holism** in anthropology denotes a ‘totalising, all-encompassing perspective’. A **holistic** analysis will therefore take the social **whole** into consideration, that is, the context that surrounds the phenomena. In the history of anthropology, **holism** is associated in part with a methodological ideal that is to see as many **connections** as possible, and in
part with a theoretical ideal in structural functionalism, which implied that social phenomena a priori were assumed to ‘maintain the whole’. As a methodological ideal, holism implies that one does not permit oneself to believe that our own established institutional boundaries for example, between politics, sexuality, religion and economics, may necessarily be also found in foreign societies. One of the great advances of structural functionalism was its detailed documentation of how, for example, religion, economy and politics were interconnected. Kinship was the glue that held these spheres together.

In theology, holism is the belief that the nature of humans consists of an indivisible union of components such as body, soul and spirit (http://en.wikipedia.org/wiki/Holism accessed 02/07/2007). Therefore marriage ministry, especially marriage education, must employ an integrated, holistic approach that offers a balanced presentation of people’s social, personal, and spiritual dimensions (Ponzetti & Mutch, 2006:215).

According to Stanhope and Lancaster (2000:288), the South African philosopher, Smuts, introduced the holistic view of health in 1926. The aforementioned authors cited Smuts (1926) as contending that holism was a way to understand whole organisms and systems as being greater than and different from the sum of their parts. Thus according to Weller (2003:194), holism is a philosophy which considers the person to be a functioning whole rather than as a composite of several systems. The WHO’s definition of health as a ‘state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ is accepted as the core philosophical view of health. Healthcare providers use this definition in the context of a holistic approach to assessing, delivering and evaluating healthcare (Nardi & Peter, 2003:50). Most literature emphasises the fact that health encompasses the well-being of body, mind and spirit and the harmonious integration of a person with himself, society and the environment (Dreyer et al., 1997:8).
According to Ledger (2005:220), the provision of holistic care includes the psychological, social, cultural and spiritual needs of individual people. Holistic health is defined by Edelman and Mandle (1990) in Dreyer et al. (1997:8) as ‘the integration of mind, body, spirit and the environment’. Holistic health is similarly defined by Stanhope and Lancaster (2002:449) as ‘understanding the body, mind, and spirit relationship of persons in an environment that is always changing’. Holistic healthcare is therefore a comprehensive approach to healthcare that implies body, mind and spirit consideration in all actions and interventions for the patient, while recognising the concept of the uniqueness of the individual and the influence of external and internal environmental factors on health (Weller, 2003:194).

The increasing acceptance of a holistic view of health has major implications for nursing (Hwu et al. (2001) in Pender, Murdaugh and Parsons, 2006:30). Dreyer et al. (1997:8) therefore state that nurses should provide holistic care for their patients and that healthcare delivery should meet the needs of the individual as a whole. Owen and Holmes (1993:1689) cite Sheally (1985) and Wilson-Barnett (1988) as stating that 19th century nursing, exemplified by Florence Nightingale, promoted holistic principles in that it challenged nurses to identify the influences of the patients’ social setting and focused attention on prevention and ‘natural’ response to disease. The concern was for the whole patient – mind, body and spirit, and higher total environment. Thus a philosophy of comprehensive healthcare to improve the quality of the physical, mental and social health of individuals, families and communities has been accepted by most countries.

Holistic concepts have been a notable feature in the work of a number of nursing theorists, for example, Rogers (1970) in Owen and Holmes (1993:1691) defines health as ‘a reflection of the whole individual, active, changing and creative, and characterized by progressive harmony and integration within a naturally healing organism’. A similar approach is evident in Levine (1971) in Owen and Holmes (1993:1691) whose view is that the conceptualisation of holism depends upon the recognition of continuous interaction of the individual with his or her environment. Levine has argued
that nursing intervention is essentially a conservation of wholeness, which focuses on identifying the patterns of adaptation for each individual, and tailoring interventions to enhance their effectiveness for the individual. She has maintained that the dualism of reductionist scientific thought is incongruent with the wholeness of human subjectivity, that the perception of wholes is dependent on the recognition of the individual within the context of the environment and that this recognition is fundamental to holism. Owen and Holmes (1993:1691) quote Sarter (1988) as stating that Jean Watson ‘would undoubtedly describe herself as holistic in the sense that harmony among all three spheres of body, mind and soul is held to be the highest form of health and the goal of nursing care’.

Ledger (2005:220) states that the Nursing and Midwifery Council (NMC) in the United Kingdom requires nurses to provide holistic care as a standard for entry to the register and cites the NMC (2004) standards of proficiency for pre-registration nursing education as: Nurses must:

“undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients/clients/communities” and “provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences”.

According to Poggenpoel (1996:60), Nursing for the Whole Person Theory is an umbrella theory; and all disciplines in nursing can be accommodated in it. It provides the flexibility to integrate different biological, social, psychological, anatomical and educational theories and models to present a comprehensive approach to man within his environment in order to promote health. Nursing for the Whole Person Theory addresses a person as a whole, consisting of multiple interacting dimensions focusing on health as a process and not as an end product. Nursing is viewed as a goal-directed service; so nursing actions are those of assisting and facilitating a patient’s mobilisation of resources. The patient is an active participant in the process and the patient is viewed as part of a family and a community.
According to McSherry and Ross (2002:479), there has been an increasing interest in the spiritual dimension of (holistic) healthcare in the last two decades. The guiding principle of human caring is to view the individual as a spiritual being (Mental Health Foundation (1999) in Koslander & Arvidsson, 2005:558). Coyle (2002:589) cites Koenig (1995), Fehring et al. (1997), Burton (1998) and Mathews et al. (1998) as all concurring that a growing body of evidence has found that spirituality enhances mental and physical well-being and provides health benefits in terms of prevention, improved health status, recovery from illness, or enabling people to cope with illness and adversity (Levin & Schiller (1987), Levin & Vanderpool (1989), Idler & Kasl (1992), Dein & Stygall (1997), Matthews et al. (1998) in Coyle, 2002:594).

How spirituality produces these improved health outcomes is less understood, however, Friedeman, Mouch and Racey (2002:331) all concur that spirituality needs to be included in patient care not only before death, but also throughout each patient’s lifespan. Nurses should therefore accept spiritual care as part of providing holistic care and should understand their clients’ perceptions, attitudes, and desires about nurse-provided spiritual care as they continue to research, teach, supervise and practise spiritual caregiving (Taylor & Mamier, 2005:266). Duldt (2002:24) contends that spiritual care cannot be ‘owned’ by any one profession. It is proposed that the human spiritual dimension must be addressed in healthcare according to each professional provider’s individual spiritual maturity.

The holistic approach requires the therapist to enquire and look deeply into the overall situation of the client, digging below the obvious symptoms when applied to the healing arts. Thus it may include the physical, psychological, living conditions and even the spiritual life of the individual (Fulder, 2005:775).

According to Spector (2004:214), the holistic concept as explained by Dr P K Chan (1998) is an important idea of traditional Chinese medicine in preventing and treating diseases. One of the components of traditional Chinese medicine in preventing and treating diseases is to regard the human body as an integral organism, with special emphasis on the harmonic and integral interrelationship between the viscera and the superficial structures in these.
close physiological connections and their mutual pathological connection. In Chinese medicine, the local pathological changes are always considered in conjunction with other tissues and organs of the entire body, instead of considered alone. A second component is the special attention that is paid to the integration of the human body with the external environment. The onset, evolution and change of disease are considered in conjunction with the geographic, social, and other environmental factors. Thus Cassidy (1998:190) contends that Chinese medicine fits a desired model of holistic care, that is, a patient-centred care that treats body, mind and spirit.

Thus holistic health is a system of preventive medicine that takes into account the whole individual, one’s own responsibility for one’s well-being, and the total influences, (social, psychological, environmental), that affect health, including nutrition, exercise and mental relaxation (Miller & Keane, 1987:542). Holistic nursing on the other hand is a philosophy of nursing practice that take into account total patient care considering the physical, emotional, social, economic and spiritual needs of patients, their response to their illnesses and the effect of illness on patients abilities to meet self-care needs (Mosbys’s Medical, Nursing and Allied Health Dictionary, 1996:745). Levine (1973) in Webb (1993:128) describes nursing as a human interaction, the aim of which is the promotion of wholeness. She advocates a holistic approach to nursing care that is dependent upon recognition of the integrated response of the individual to the external environment. Levine (1973) in Webb (1993:128) states that ‘the holistic approach to nursing presupposes that the nurse performs a conservation function – that is ‘keeping together’ which responds to the individual’s fundamental biological defense of his unique integrity’.

- Dictionary definitions of the concept “health”

The Longman Dictionary of Contemporary English (1995:660) defines health as “your physical condition and how healthy you are; the state of being healthy; the work of providing medical services to keep people healthy; how successful an economy or organization is”. Health is also defined as
“soundness of body; freedom from disease or ailment; the general condition of the body or mind with reference to soundness and vigor” (Barnhart & Stein, 1968:557 and Stein & Urdang, 1967:). The concept soundness refers to ‘in good condition, not hurt, diseased, injured or damaged’ (Hornby, 1995:1135). The definitions of health proffered in the SA Concise Oxford Dictionary (2002:533); Cambridge Advanced Learner’s Dictionary (2005:591) and the Concise Oxford Dictionary of Current English (1995:486) read as follows: “the state of being free from illness or injury; a person’s mental or physical condition”. The World Book Dictionary (2000:977) defines health as “the condition of being well and not sick; freedom from illness of any kind; the general condition of body and mind; sound condition; well-being; welfare”.

The concept healthy, the adjective of the concept health, refers to when a person is ‘in good health, fit, physically fit, in good condition/trim, shape/kilter, in fine fettle, in fine/top form, robust, strong, vigorous, hardy, flourishing, hale, hearty, bursting with health, blooming, active’ (The Concise Oxford Thesaurus, 1996:356).

The concept well can be used widely to illustrate that something is good or done or performed at a high standard, for example, the concept “well” can be used to illustrate the way someone behaves, for example, (well satisfactorily, in a satisfactory manner/way, correctly, rightly, properly, fittingly, suitably, nicely); whether they are getting along with somebody (get on well, agreeably, pleasantly, happily, famously); the extent of looking and listening (look at it well/listen to it well, closely, attentively, carefully, conscientiously) and so forth. When the concept well is used to illustrate health it means ‘good health, fit, strong, robust, hale and hearty, able-bodied, up to par, fine, all right, good, thriving, flourishing’ (The Concise Oxford Thesaurus, 1996:876).

According to the Concise Oxford Thesaurus (1996:876), someone’s well-being refers to their ‘welfare, health, good health, happiness, comfort, prosperity, security’.

- **Subject definitions of the concept “health”**

A brief review of the historical development of the concept health provides the background for examining definitions of health found in the professional literature. As far back as 1860, Florence Nightingale described health as “being well and using one’s powers to the fullest extent” (Spector, 2004:48). The word Health as it is commonly used did not appear in writing until approximately AD 1000. It is derived from the Old English word health, meaning being safe or sound and whole of the body (Sorochan (1970) in Pender et al. (2006:17). Historically, physical wholeness was of major acceptance in social groups. Persons suffering from disfiguring diseases, like leprosy, or from congenital malformations were ostracized from society. Not only was there fear of contagion of physically obvious disease, but there was also repulsion at the grotesque appearance. Being healthy was construed as natural or in harmony with nature, while being unhealthy was thought of as unnatural or contrary to nature (Dolfman (1973) in Pender et al., 2006:17).

With the advent of the scientific era and the resultant increase in medical discoveries, illness came to be regarded with less disgust and society became concerned about assisting individuals in their escape from its catastrophic effects. Health in this context was defined as “freedom from disease”. The notion of health as a disease-free state was extremely popular into the first half of the 20th century and was recognized by many as the definition of health (Wylie (1970) in Pender et al. 2006:17). Health and illness were viewed as extremes on a continuum; the absence of one indicated the presence of the other (Pender et al., 2006:17).

The WHO’s proposed definition of health in 1948, that health was considered to be more than just the absence of disease (Lucas & Lloyd, 2005:6), has become the core philosophical view of health and is widely quoted by many
authors. The WHO’s definition reads “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity” (WHO in Dreyer et al., 1977:7; De Haan, 2005:3; Lucas & Lloyd, 2005:6; Nardi & Peter, 2003:2; Bouwer et al., 1997:28; Hattingh & Acutt, 2003:464 and Pender et al., 2006:17). Since then many definitions have been suggested but the aforementioned definition remains one of the most accepted as it acknowledges the psycho-social aspects of health (de Haan, 2005:3). However, this definition has been criticised by many who state that the definition is too utopian, too broad, too abstract and not subject to scientific application (Larson (1999) in Pender et al., 2006:18). It suggests that anyone with the slightest imperfection in their bodily, psychological or social functioning cannot be ‘healthy’ (Lucas & Lloyd, 2005:6). In 1984 WHO advanced a revised statement that any measure of health must take into account ‘the extent to which an individual is able to realize aspirations and satisfy needs, and to change or cope with the environment’. Health in this sense is seen as a ‘resource for everyday life’. Health can be seen from many other viewpoints, and many areas of disagreements arise with respect to how this word can be defined (Spector, 2004:53).

When considering definitions regarding health, one has to take into account the range of models that have been proposed by various professional groups, such as biomedical researchers, sociologists, psychologists, as well as lay persons, who all construct models of health, disease and illness (Lucas & Lloyd, 2005:25). Parsons (1972) in Lucas and Lloyd (2005:7) suggested that health might be seen as ‘the state of optimum capacity of an individual for the effective performance of the roles and tasks for which (s)he has been socialised’. Like the WHO’s definition, this concept may be criticised for being too idealistic. Moreover, such a definition implies that the primary value of an individual’s health is that she or he can perform the tasks expected of them in society. While such a view might be attractive to some, it tends to minimise the importance of quality of life as being a legitimate goal in its own right (Lucas & Lloyd, 2005:7).
Health also involves an ability to perform within society, and to accommodate stresses, whether physical or mental. From an ecological viewpoint, the relative health of a group is evaluated according to whether that group might sustain its existence over time without major disruption to its own way of life or to the environment within which it functions (Stedman's Medical Dictionary, 1995:765). The ecological model of health emerged which was based on the relationship of man to his total environment (Rogers (1980), Blum (1974) in Payne, 1983:394). The intrinsic and extrinsic environment was considered as predispositions to the development of disease. Illness was seen as having multiple causes and individuals were not seen as passive but as active beings with the ability to resist illness. For example, King in Husband (1988:484) defined health as ‘dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of ones resources to achieve maximum potential for daily living’. In environmental-focused health models of health, health is related to the ability of individuals to maintain a balance with the environment, with relative freedom from pain, disability or limitations, including social limitations. Health exists when one is able to adapt to the environment successfully and is able to grow, function, and thrive (Verbrugge & Jette (1994) in Pender, 2006:20).

As the interactional process between man and his environment was seen to be in constant change, the equilibrium model emerged. In this model, health is viewed as the ability of the body’s self-regulating powers to maintain constancy of the internal milieu. Consequently, health is conceived of as a reaction of the whole organism, mind-body dualism no longer existing (Payne, 1983:394).

Similar to Parsons’ sociological model of health, Patrick, Bush and Chen (1973) and Feeney et al. in Pender (2006:20) have defined health in terms of functional norms. Their conception of health is the ability to perform socially valued activities usual for a person’s age and social roles with a minimum probability of change to less valued function levels. The desirability of the immediate function level, as well as the probability that the current condition
or state will change to a higher or lower preference function level, must be considered in assessing one’s present health status.

Psychosocial models later emerged envisioning the interaction of mind, body, and society. Philosophically, health became the pursuit of self-realisation and self-fulfillment (Tillich (1967) in Payne, 1983:394). In sociocultural models health is viewed relative to the individual’s social status in society (Twaddle (1974) and Wolinsky (1980) in Payne, 1983:394). The importance of mental health became obscured in the rapid stream of medical discoveries for treatment of physical disorders for several decades. Nevertheless, the psychological trauma resulting from the high-stress situations of combat during World War II expanded the scope of health as a concept to include consideration of the mental status of the individual. Mental health was manifest in the ability of an individual to withstand stresses imposed by the environment. When individuals succumbed to the stresses of life around them and could no longer carry out the functions of daily living, they were declared mentally ill. Despite efforts to develop a more holistic definition of health, the dichotomy between individuals suffering from physical illness and those suffering from mental illness persisted (Congdon (2001) and Sorochan (1970) in Pender: 2006:17).

According to Lucas and Lloyd (2005:7), one of the many definitions of health is that health is a form of commodity which can be ‘bought’ and ‘sold’, either metaphorically or literally. Seedhouse (1996) in Lucas and Lloyd (2005:7) suggests that health is often viewed as a commodity, “that is something, albeit an amorous thing, which can be supplied. Equally, it is something which can be lost”. Aggleton (1994) in Lucas and Lloyd (2005:7) points out, that it follows from the aforementioned that health can be bought by investing in private health care, sold via food shops, given by drugs or surgery and lost by accidents or disease.

Nine ‘images’ of health have been proposed by Arnold and Breen (1998) in Pender (2006:18), which include health as the antithesis disease, a balanced state, a growth phenomenon, functional capacity, goodness of fit, wholeness,
well-being, transcendence and empowerment. Each of these images reflect a different view or frame of reference for health, based on the life history of the beholder, which in turn is reflected in different personal preferences, programmes and policies.

Health can also be viewed as the freedom from and the absence of evil. In this context, health is analogous to day, which equals good light, whereas, illness is analogous to night, evil and darkness. Illness, to some is seen as a punishment for being bad or doing evil deed; it is the work of vindictive evil spirits. In the modern education of healthcare providers, these concepts of health and illness are rarely discussed; yet if these concepts of health and illness are believed by some healthcare consumers, understanding these varying ideas is important for the healthcare provider (Spector, 2004:49).

According to Pender et al. (2006:18), health is now recognised as a concept that is not only multidimensional but also applicable to both individuals and aggregates. Therefore there are definitions of health that focus on the individual, the family and the community. In the past, definitions of health for individuals received more attention in nursing and other health disciplines than defining health for families and communities. However, it has become clear that individual health is linked closely to both family and community health.

According to Pender et al. (2006:19), stability-based definitions derive primarily from the physiological concepts of homeostasis and adaptation. Dubos (1965) in Pender et al. (2006:20) defined health as a state or condition that enabled the individual to adapt to the environment. The degree of health experience is dependent on one’s ability to adjust to the various internal and external tensions that one faces. Optimum health is considered to be a mirage because in the real world individuals must face the physical and social forces that are forever changing, frequently unpredictable and often dangerous. The closest approach to optimum or high-level health is a physical and mental state free of discomfort and pain that permits one to function effectively within the confinement.
Several nurse theorists have proposed definitions of health emphasising stability. Neuman (1995) in Pender (2006:20) has defined health or wellness as a condition in which all subsystems, physiological, psychological, and socio-cultural are in balance and in harmony with the whole man. Health is a state of saturation, of inertness, free of disruptive needs, disrupting forces or noxious stresses with which individuals cannot cope and which create disharmony, reducing the level of wellness. In a wellness state, total needs are met and more energy is generated and stored than expended. A strong line of defense is maintained, providing the individual with considerable resistance to disequilibrium (Loveland-Cherry & Wilkerson (1989) in Pender, 2006:21). According to Roy and Andrews (1999) in Pender, (2006:21), health is a state and process of successful adaptation that promotes being and becoming an integrated whole person. The four adaptive modes through which coping energies are expressed are: physiologic, self-concept, role performance and interdependence modes. Adaptation promotes integrity, which implies soundness or an unimpaired condition that can lead to completeness and unity. The person in the adapted state is freed from ineffective coping attempts that deplete energy. Available energy can be used to enhance health.

Individual health can also be defined as actualisation of human potential. Lucas and Lloyd (2005:7) state that health is seen here as being composed of a number of ‘factors’ which enable or help people to achieve all that they have the potential to become. Seedhouse (1986) in Lucas and Lloyd (2005:7) describes these factors, present in each individual in a unique combination, as ‘foundations for achievement’. However, proponents of this concept of health generally offer little theory-based guidance on what such factors might be or how they might combine to produce potential, which itself is not always clearly defined. Aggleton (1990) in Lucas and Lloyd (2005:8) is dismissive of ‘achieving personal potential’ as a means of defining health on the grounds that it ‘remains a little mystical, perhaps no more easily attainable than the state of complete mental, physical and social well-being that the WHO talked about in 1946’. Dunn (1980) in Pender (2006:21) coined the term high-level wellness, which he has described as integrated human functioning that is
oriented toward maximizing the potential of which the individual is capable. This requires that individuals maintain balance and purpose within the environment where they are functioning. Though the definition identifies balance as a dimension of health, major emphasis is on the realisation of human potential through purposeful activity. There is a single optimum level of wellness, as individuals move toward their personal optimum level based on their capabilities and potential.

Loveland-Cherry (2000) in Pender et al. (2006:26) defines family health as possessing the abilities and resources to accomplish the development tasks of the family. Community health on the other hand can be defined as meeting the collective needs of its members through identifying problems and managing interactions within the community and between the community and the larger society (Hemstrom (1995) in Pender et al., 2006:28). Community health is more than the sum of the health states of its individual members: it encompasses the characteristics of the community as a whole. Individual, family and community health are intimately related (Pender et al., 2006:28).

To the general public, the term health is a very subjective and personal experience and health to most people refers to the way they experience their immediate environment (Hattingh & Acutt, 2003:464). Thus it is important to establish how lay people perceive their own health and what is important to them. According to Lucas and Lloyd (2005:8), Herzlich (1975) has demonstrated clearly that lay people distinguish much more sharply between health and illness than many health professionals habitually do. In a sample of French, predominantly middle-class subjects, Herzlich’s (1975) in Lucas and Lloyd (2005:8) respondents identified health as being not only the absence of disease, but also as a reserve of well-being, individually determined by constitution and temperament as well as a positive state of equilibrium.

Blaxter (1995a) in Lucas and Lloyd (2005:8) conducted a survey with a large sample in which she explored lay people’s beliefs about what they considered
healthy for themselves and others. Blaxter identified eight major categories of response to these questions. Respondents were more likely to describe themselves as healthy because of an absence of specific symptoms, while never or rarely attending a doctor was commonly seen as ‘proof’ of the health of others. A person is seen as healthy because he or she recovers quickly from illness, as a result of a ‘reserve’ of health on which to call which was occasionally seen as inborn or inherited. Health is described in terms of ‘virtuous behaviours’, including regular exercise, a healthy diet, non-smoking and moderate alcohol use. Respondents defined health in terms of physical fitness. ‘Energy’ was the word most commonly use by older men and all women when describing health. Women were much more likely than men to define their own health in terms of their relationships with other people. Many women mentioned their families in their definitions of health for themselves. Being in a position to help or to care for others was often cited in their definitions of health. For some people health was seen as being able to do the thing that they needed to do. Emphasis was placed on psycho-social issues such as being physically, mentally and spiritually one, and the importance of social relationships in assessing their own health (Blaxter (1995a) in Lucas & Lloyd, 2005:9).

**Dictionary definitions of the concept “care”**

The concept care is defined as “the provision of what is necessary for the health, welfare, maintenance and protection of someone or something; serious attention or consideration applied to an action or plan; look after and provide for needs of” (SA Concise Oxford Dictionary, 2002:172).


The Longman Dictionary of Contemorary English (1995:190) defines **care** as “to feel something is important, so that you are interested in it or worried about it; to mind about what happens to someone because you like or love them; to look after someone who is not able to look after themselves; looking after somebody or something”. The Collins SA School Dictionary (2004:121) defines the concept **care** as “if you care about something you are concerned about it and interested in it; if you care about someone you feel affection towards them; care is concern or worry; care of someone or something is treatment for them or looking after them; if you do something with care, you do it with close attention”.

The concept **concern** means ‘interest/involve oneself in, be interested/involved in, take/have a hand in, be busy with, solicitude, consideration, regard, attentiveness, caringness’ (The Concise Oxford Thesaurus, 1996:876).


**Subject definitions of the concept “care”**

Van der Wal cites Dunlop (1986) in Pera and van Tonder (2005:12) as stating that the word **care** comes from the Old English **carina** meaning ‘to trouble one’. According to the Longman Dictionary of Contemporary English
the word trouble refers to ‘problems that make you worry’. According to Jacono (1993:192) there are many definitions of caring proposed in the nursing literature. Many of these definitions contend that caring means assisting another individual, as well as feelings conveyed to that individual (Komorita et al. (1991) in Jacono, 1993:192). The alleviation of suffering has always been the cornerstone of caring. Suffering gives caring its own character and identity, and all forms of caring aim, in one way or another to alleviate suffering. Caring science does not deny the presence of suffering, even though its aim is soundness and health; suffering is the point from which caring begins (Eriksson (1992a), Eriksson & Herberts (1993) in Lindholm & Erickson, 1993:1354).

It is often said that caring is a universally accepted concept attributed to the nursing profession (Keogh & Gleeson, 2006:1172) and it is also considered to be its hallmark, therefore it is the central ethic in nursing (van der Wal quotes Klimeck (1990) in Pera & van Tonder, 2005:121) and also in other healthcare services. Caring for someone in a nursing context, is purposeful interaction intended to promote health or lead to a peaceful death (Phillips, 1993:1854). Brown et al. (2000) in Keogh and Gleeson (2006:1172) stated that Florence Nightingale considered the qualities ‘compassion, tenderness and unselfishness’ essential for caring. According to Nikkonen (1994:1193) the moral foundation of caring is to take responsibility for another person. A moral bond between the nurse and the patient exists; therefore it obliges the nurse to take responsibility for and to care about the patient. One problem is that caring has not yet been fully embraced by other healthcare services, which tend to focus instead on the distinctive professional knowledge and skill that they have to offer. Thus no single profession can claim caring as its unique professional possession (van der Wal in Pera and van Tonder, 2005:13).

In the nursing literature and the literature of moral philosophy the semantics of the term ‘care’ and ‘caring’ are important. Although ‘care’ and ‘caring’ are often used synonymously, care sometimes implies a procedure and a scientific orientation that is lacking in the innate human attributes of concern.
and empathy. Therefore, two nodes of meaning crystallise, namely feelings/emotions and doing/action (van der Wal in Pera & van Tonder, 2005:15). Caring has been described by Watson (1979, 1988) in Cossette, Cote, Pepin, Ricard and D’Aoust (2006:199) as a way of being rather than doing whereas Feally (1995), Halldorsdottir and Hamrin (1997) and Krebs (2001) in Brilowski and Wendler (2005:643) all concur that caring almost always includes some action, such as doing for the patient or being with the patient. These actions originate from the carer’s perception of another’s needs and result in motivation to act to meet those needs (Feally (1995) in Brilowski & Wendler, 2005:643).

According to Collins South African School Dictionary (2004: 316), the word feelings refers to ‘an emotion or reaction; your general attitudes or thoughts about something’ whereas the word emotions refers to ‘a strong feeling such as love or fear’ (Collins South African School Dictionary, 2004: 277). The word doing, on the other hand, refers to ‘perform and finish a particular activity or job’ and action refers to ‘something you do for a particular purpose’ (Collins South African School Dictionary, 2004: 9).

In the doing/action component of caring both the implementation of professional knowledge via procedure, skill and technology, as well as lay caring actions are indicated. According to Wells in (1981:507) individualised patient care can be achieved by use of the nursing process. This activity is undertaken as a sequential progression of steps, namely, assessment of the individual’s nursing needs, planning of care to meet the perceived needs, carrying out of the nursing care in accordance with the plan and evaluation of the effectiveness of the nursing care with reference to the perceived needs. The evaluation will usually result in revised need identification so that the ‘cycle’ is repeated.

A challenge in caring in the healthcare professions is to strike a balance between emotions and action within a caring relationship. To treat caring only as a verb, that is, as an action, procedure or technique, sets aside certain other senses of the word such as caring as a virtue or quality of human
character (Gaut (1979) as quoted by van der Wal in Pera & van Tonder, 2005:15). **Caring** involves more than just carrying out nursing procedures. Jacono (1993:193) contends that **caring** is and has always been a euphemism for the word **loving**. True **caring** is thus based on an attitude of **nurturing**, of **helping one another grow** (Lindberg, Hunter and Kruszewski (1990) as quoted by van der Wal in Pera and van Tonder, 2005:15). Human care ‘**consists of transpersonal human to human attempts to protect, enhance and preserve humanity by helping a person find meaning in illness, suffering, pain and existence; to help another gain self knowledge, control, and self healing in which a sense of inner harmony is restored regardless of the external circumstances**’ (Watson (1985) as quoted by van der Wal in Pera & van Tonder, 2005:15).

According to von Essen and Sjödén (1991:1370), the results of their research that they conducted indicated that to ‘**feel cared for**’ means to **feel safe** and **secure** for the patients. The results of a research study undertaken by Clarke and Wheeler (1994:1287) indicated that **being supportive to patients** was experienced as being a significant component of **caring** for nurses. It was felt that it arose from professional responsibility which was rooted in **personal feelings of respect** and **value for people**. Nurses have acknowledged that patients are individuals and need personal privacy; but may make decisions which may appear incongruous to the nurses themselves. Within the experiences of **caring** was the **closeness of love to caring**. This love was united with **concern** for the patients through the **demonstration of warmth** and **kindness**. It was distinguished from love that they experienced for family and friends in difference of intensity and meaning it held for them.

The nurses giving of themselves, a verbalised experience of **giving oneself to another**, was recognised as fundamental to **caring**. This involved **physical, psychological and emotional giving**, with **voluntary sharing of themselves** through disclosing personal information. Such a process develops friendship with patients as people and the **evolution of mutual trust**. Such giving of oneself to the patient was experienced as **communicating support** to patients with an understanding that the essential
presence of a nurse could consequently reduce anxiety for the patient. Empathy enabled the nurses to identify in their experiences that being a patient could create anxiety (Clarke and Wheeler, 1992:1287).

Nikkonen (1994:1191) contends that caring cannot be learnt from books alone, nor can mere examinations make one a ‘good nurse’. Some people are good nurses by nature while others can never become good, however much they study. Caring should be scrutinised in a wider cultural framework because no pattern or style of nursing, however well thought out, will of itself produce good care. The only person able to determine how well she will meet the needs of the patient is the nurse herself (Janforum, 1981:513). The carer’s understanding of himself is of prime importance in his understanding and implementing of care. Not only his understanding of himself, but also his understanding of man in general, his feelings towards his fellows, are they there to serve or be served, will also influence his understanding of the helping relationship and his part in it. Man’s understanding of what it means to care and be cared for grows out of his childhood, his family, school background, and the years he is assumed to grow to adulthood. His need to care and be cared for and the form this takes come out of these years. His past experiences will colour his understanding of caring and will be primary in forming not only his needs in this area, but also the means he uses to gain satisfaction (Hughes, 1980:22). The values of the carer and the institution will influence the methods of caring and the attitudes behind the methods (Hughes, 1980:24).

- Dictionary definitions of the concept “healthcare”

The concept healthcare is defined as “the set of services provided by a country or an organization for the treatment of the physically and mentally ill” (Cambridge Advanced Learner’s Dictionary, 2005:591). The Longman Dictionary of Contemporary English (1995:660) defines the concept healthcare as “the service looking after the health of all the people in the country or an area.”
According to the Concise Oxford Thesaurus (1996:721) the concept service can be used as a noun or a verb to denote different meanings, for example, conditions of service, years of service, doing somebody a service, ceremonial services, car services, be in the service of, willing to serve, serve on the committee, and so forth. When the concept is used in the context of healthcare it means ‘assistance, help, benefit, be of service for, be of use to, give help to, assist, lend a hand to, do a good turn to, aid, benefit, support, foster, minister to, succour’.

According to the Concise Oxford Thesaurus (1996:501) the concept minister to can be used as a verb: ‘minister to the patient/he ministered to their needs. Administer to, attend to, tend, look after, take care of, see to, cater to, serve’.

Healthcare also means ‘preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual’s physical, mental or behavioural condition, including individual cells or their components or genetic information, or affects the structure or function of the human body or any part of the human body’ (janus.state.me.us/legis/statutes/24-a/title24-asec2204.html Accessed 20/07/07). Healthcare thus refers to the ‘provision of services that helps individuals achieve optimal state of well-being, in any setting or stage in the human lifecycle’ (www.ilo.org/NonMedicalPrograms/chr/vocab.cfm).

- Subject definitions of the concept “healthcare”

Healthcare is an industry associated with the prevention, treatment and management of illness along with the promotion of mental and physical well-being through the services offered by the medical and allied health professions. Healthcare is one of the world’s largest and fastest growing industries, consuming over 10% of the gross domestic product (GDP) of most developed nations. The sociology of health and medicine is concerned with the distribution of healthcare services globally, in particular inequalities in healthcare, and how conceptions of health have changed over time.
During the days of the early colonists, the healthcare system was a system of superstition and faith. It has evolved into a system predicated on a strong belief in science; the epidemiological model of disease; highly developed technology; strong values of individuality, competition and free enterprise. But now there is a growing concern about realisation of the basic human right of health and healthcare. Mounting social problems, such as toxic waste, homelessness and millions of people without health insurance, confound the situation. These factors will affect the delivery of healthcare (Spector, 2004:166).

Under the old medical paradigm of healthcare the purpose was cure of disease and the relief of suffering. The healthcare enterprise has long since outgrown the conceptual straight-jacket of the disease-cure model; and has often stretched not only the limits of medical expertise but also the credibility of medical authority. Under the new multidisciplinary paradigm the aim is to participate in the creation of a lifestyle and personal philosophy conducive to the maintenance and enhancement of health. This is seen as lying beyond the scope of conventional medicine, subsuming as it does the facilitation of personal fulfilment and as unequivocally committing health carers to a direct concern for the quality of life of their clients (Pelletier (1997) in Holmes, 1989:833). Nurses everywhere need to be on guard to ensure that healthcare services are at least maintained and adapted and developed to meet changing healthcare needs. They should be fearless in their pursuits as advocates of their clients’ rights to health and a health-promoting society (Smith, 1984:1).

According to van Rensburg (2004:1), the health(care) system on the one hand is seen as an institution of ‘health(care) service delivery to promote, protect or restore the health of individuals and populations’. On the other hand, the health(care) system is viewed as ‘more than just health(care) services: it also comprises those aspects surrounding and influencing actual
or direct health(care) services’. Van Rensburg (2004:2) uses a threefold distinction of healthcare systems. Particular healthcare systems are those institutions in society that deliver healthcare services to the population, for example hospitals, PHC clinics, solo practices and so forth. National healthcare systems encompass the total healthcare service network in a country ‘the totalality of policies, programmes, institutions and actors that provide healthcare, organised efforts to treat and prevent disease’ (Berman (1995) in van Rensburg, 2004:2). These are total health systems which, on the one hand, include the entire national healthcare system and, on the other, all those extraneous or peripheral matters which are either directly or indirectly associated with health, specifically the surrounding environment of the healthcare system and the population served by the healthcare system concerned (van Rensburg, 2004:2).

It is necessary to draw a distinction between the healthcare system, the environment and the healthcare consumers. The tripartite relationship boils down to the following:

- The healthcare system of a society is directly and indirectly determined or influenced by the surrounding environment. This influence is felt particularly in so far as the environment contains socio-cultural and natural dimensions which have a structuring effect on the healthcare system, for example, deriving its guiding values from policy framework and cultural content from its environment.

- Likewise the healthcare consumers are embedded in the same larger environment and are varyingly influenced by this environment, for example, determining its prevailing disease and death profiles or transferring distinctive health and illness behaviour patterns onto the healthcare consumers.

- The healthcare, that is the nature and supply, is supposed to be attuned to (health)care needs of the healthcare consumers.
In this circular way, a healthcare system is conceptualised as a repetitive circuit between supply-and-need, care system-and-healthcare consumer and input-and output (van Rensburg, 2004:3).

4.2.2 IDENTIFYING ATTRIBUTES OF THE CONCEPTS

All the different instances of the concepts have been examined and a list of defining attributes will now be identified, analysed and synthesized to form a definition of the main concept, holistic healthcare. The effort is to try to show the cluster of attributes that are the most frequently associated with the concept and that allow the researcher the broadest insight into the concept. A large number of possible meanings has been identified; therefore the researcher will need to make a clear decision regarding which will be the most useful and which will provide the greatest help in relation to the aims of the research analysis (Compare Walker & Avant, 1995:41). A list of the attributes, that the researcher has clustered together for the concept ‘holistic’ from the dictionary definitions and subject literature is displayed in Table 4.2.

<table>
<thead>
<tr>
<th>ATTRIBUTES OF THE CONCEPT ‘HOLISTIC’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute</td>
</tr>
<tr>
<td>Addresses person as a whole</td>
</tr>
<tr>
<td>All</td>
</tr>
<tr>
<td>All encompassing</td>
</tr>
<tr>
<td>All inclusive</td>
</tr>
<tr>
<td>Having all necessary or appropriate parts</td>
</tr>
<tr>
<td>All of something</td>
</tr>
<tr>
<td>All the parts of something</td>
</tr>
<tr>
<td>Altogether</td>
</tr>
<tr>
<td>Aspects of persons are connected</td>
</tr>
<tr>
<td>Balanced</td>
</tr>
<tr>
<td>Body, culture and soul</td>
</tr>
<tr>
<td>Body, soul and spirit</td>
</tr>
<tr>
<td>Cannot be determined or explained by the</td>
</tr>
<tr>
<td>Interlinked</td>
</tr>
<tr>
<td>Interrelated parts</td>
</tr>
<tr>
<td>Intimately connected</td>
</tr>
<tr>
<td>Intimately interconnected</td>
</tr>
<tr>
<td>Irreducible</td>
</tr>
<tr>
<td>Life tasks relate to one another</td>
</tr>
<tr>
<td>Lock stock and barrel</td>
</tr>
<tr>
<td>Many connections</td>
</tr>
<tr>
<td>More than the mere sums of their parts</td>
</tr>
<tr>
<td>Multiple interacting dimensions</td>
</tr>
<tr>
<td>No part left out</td>
</tr>
<tr>
<td>Not divided or broken into parts</td>
</tr>
<tr>
<td>Ontology</td>
</tr>
<tr>
<td>Opposite to reductionism</td>
</tr>
</tbody>
</table>

270
<table>
<thead>
<tr>
<th>sum of its component parts alone</th>
<th>Ordered grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>Parts explicable only by reference to the</td>
</tr>
<tr>
<td>Complete in itself</td>
<td>Parts are all part of each other</td>
</tr>
<tr>
<td>Complete wholes</td>
<td>Patient-centred care</td>
</tr>
<tr>
<td>Completeness or wholeness of a system</td>
<td>Philosophy</td>
</tr>
<tr>
<td>Composite of several systems</td>
<td>Recognises the emotional, mental, spiritual and physical elements</td>
</tr>
<tr>
<td>Comprehension of the parts</td>
<td>Single unit</td>
</tr>
<tr>
<td>Comprehensive approach</td>
<td>Sum of component parts</td>
</tr>
<tr>
<td>Comprise a system</td>
<td>sum total</td>
</tr>
<tr>
<td>Concern for whole patient</td>
<td>System and environment interrelated</td>
</tr>
<tr>
<td>Connections</td>
<td>System as a whole</td>
</tr>
<tr>
<td>Conservation function</td>
<td>System of preventive medicine</td>
</tr>
<tr>
<td>Conservation of wholeness</td>
<td>Totality of</td>
</tr>
<tr>
<td>Do not focus on person’s ailment or condition</td>
<td>Total patient care</td>
</tr>
<tr>
<td>Each thing</td>
<td>Totalising</td>
</tr>
<tr>
<td>Entirety</td>
<td>Treated as a whole</td>
</tr>
<tr>
<td>Expressed need of one relates to each other</td>
<td>Understanding the body, mind and spirit relationship</td>
</tr>
<tr>
<td>Every</td>
<td>Unity</td>
</tr>
<tr>
<td>Everything</td>
<td>Unity of thoughts, emotions and behaviors</td>
</tr>
<tr>
<td>Fully</td>
<td>United wholes</td>
</tr>
<tr>
<td>Functioning whole</td>
<td>Well-being of body, mind and spirit</td>
</tr>
<tr>
<td>Harmonic</td>
<td>What happens in one part affect other parts of the system</td>
</tr>
<tr>
<td>Harmonious integration</td>
<td>Whole</td>
</tr>
<tr>
<td>Harmony among all spheres of body, mind and soul</td>
<td>Whole entities</td>
</tr>
<tr>
<td>Inclusiveness</td>
<td>Wholes irreducible, autonomous</td>
</tr>
<tr>
<td>Indivisible</td>
<td>Whole or all of something</td>
</tr>
<tr>
<td>Indivisible union of components</td>
<td>Whole lot</td>
</tr>
<tr>
<td>Individual word only understood in terms of relation to larger body of language</td>
<td>Whole/total amount</td>
</tr>
<tr>
<td>Integral relationship</td>
<td>Whole person</td>
</tr>
<tr>
<td>Integrated whole</td>
<td>Wholeness</td>
</tr>
<tr>
<td>Interconnected biological, physiological, social, psychological and spiritual beings</td>
<td>Wholes</td>
</tr>
<tr>
<td>Interdependent parts</td>
<td>Wholes</td>
</tr>
<tr>
<td>Interdisciplinary teamwork</td>
<td>Wholes amount to more that the sum of its parts</td>
</tr>
</tbody>
</table>
Based on the list of attributes of the concept ‘holistic’ as displayed in Table 4.2, the researcher extracted a list of essential and related attributes which are displayed in Table 4.3 below.

**TABLE 4.3: LIST OF ESSENTIAL AND RELATED ATTRIBUTES OF THE CONCEPT “HOLISTIC”**

<table>
<thead>
<tr>
<th>ESSENTIAL ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated whole person</td>
<td>Not divided or broken into parts</td>
</tr>
<tr>
<td></td>
<td>Interdependent parts</td>
</tr>
<tr>
<td></td>
<td>Interconnected biological, physiological, social, psychological and spiritual beings</td>
</tr>
<tr>
<td></td>
<td>Integral relationship</td>
</tr>
<tr>
<td></td>
<td>All encompassing</td>
</tr>
<tr>
<td></td>
<td>Expressed need of one relates to each other</td>
</tr>
<tr>
<td>Balanced whole</td>
<td>Harmonious integration</td>
</tr>
<tr>
<td></td>
<td>Recognises the emotional, mental, spiritual and physical elements</td>
</tr>
<tr>
<td></td>
<td>Single unit</td>
</tr>
<tr>
<td></td>
<td>Total patient care</td>
</tr>
</tbody>
</table>

The attributes gathered from the dictionaries and subject literature of the concept health, are displayed in Table 4.4 below.
TABLE 4.4: LIST OF ATTRIBUTES OF THE CONCEPT “HEALTH”

<table>
<thead>
<tr>
<th>ATTRIBUTES OF THE CONCEPT ‘HEALTH’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of specific symptoms</td>
</tr>
<tr>
<td>Ability to accommodate stresses</td>
</tr>
<tr>
<td><strong>Ability to adjust to various internal and external tensions</strong></td>
</tr>
<tr>
<td>Ability to perform</td>
</tr>
<tr>
<td>Ability to resist illness</td>
</tr>
<tr>
<td>Able bodied</td>
</tr>
<tr>
<td>Able to adapt to the environment successfully</td>
</tr>
<tr>
<td>Able to grow, function and thrive</td>
</tr>
<tr>
<td>Able to do things</td>
</tr>
<tr>
<td><strong>Able to realize aspirations and satisfy needs</strong></td>
</tr>
<tr>
<td>Absence of disease</td>
</tr>
<tr>
<td>Absence of evil</td>
</tr>
<tr>
<td>Absence of specific symptoms</td>
</tr>
<tr>
<td>Accommodate stresses</td>
</tr>
<tr>
<td>Accomplish development tasks of family</td>
</tr>
<tr>
<td><strong>Achieve maximum potential for daily living</strong></td>
</tr>
<tr>
<td>Active</td>
</tr>
<tr>
<td><strong>Actualisation of human potential</strong></td>
</tr>
<tr>
<td>Adapt to environment</td>
</tr>
<tr>
<td>Adjust to various internal and external tensions</td>
</tr>
<tr>
<td><strong>All subsystems are in balance with the whole man</strong></td>
</tr>
<tr>
<td>Antithesis disease</td>
</tr>
<tr>
<td><strong>Balanced state</strong></td>
</tr>
<tr>
<td><strong>Being mentally, physically and spiritually one</strong></td>
</tr>
<tr>
<td>Being well</td>
</tr>
<tr>
<td>Being well and not sick</td>
</tr>
<tr>
<td>Blooming</td>
</tr>
<tr>
<td>Bursting with health</td>
</tr>
<tr>
<td>Change or cope with the environment</td>
</tr>
<tr>
<td>Comfort</td>
</tr>
<tr>
<td><strong>Commodity</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Complete social and mental wellbeing

**Continuous adjustment to stressors in environment**
- Cope with the environment
- Dynamic life experiences
- Effective performance of roles and tasks
- Empowerment
- Energy
- Equals good light
- Fine
- Fit
- Flourishing
- Free from illness or injury
- Free of disruptive needs
- Free of discomfort and pain
- Freedom from disease or ailment
- Freedom from evil
- Freedom from illness of any kind
- Function
- Functional capacity
- General condition of body and mind
- Good
- Goodness
- Grow
- Growth phenomenon
- Hale
- Happiness
- Hardy
- Healthy Diet
- Hearty

<table>
<thead>
<tr>
<th>Sound condition</th>
<th>Soundness of body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soundness and vigor of body and mind</td>
<td>Stability</td>
</tr>
<tr>
<td>State of being healthy</td>
<td>State of optimum capacity</td>
</tr>
<tr>
<td>State of saturation</td>
<td>State of optimum capacity</td>
</tr>
<tr>
<td>State of inertness</td>
<td>Strong</td>
</tr>
<tr>
<td>Subsystems are in balance</td>
<td>Successful adaptation</td>
</tr>
<tr>
<td>Success</td>
<td>Thrive</td>
</tr>
<tr>
<td>Successful adaptation</td>
<td>Thriving</td>
</tr>
<tr>
<td>Transcendence</td>
<td>Up to par</td>
</tr>
<tr>
<td>Using one’s powers to the fullest extent</td>
<td>Vigorous</td>
</tr>
<tr>
<td>Virtuous behaviours</td>
<td>Well</td>
</tr>
<tr>
<td>Well</td>
<td>Well-being</td>
</tr>
<tr>
<td>Wellness state</td>
<td>Welfare</td>
</tr>
<tr>
<td>Welfare</td>
<td>Wholeness</td>
</tr>
</tbody>
</table>

Based on the list of attributes of the concept ‘health’ as displayed in Table 4.4, the researcher extracted a list of essential and related attributes which are displayed in Table 4.5 below. The following table is a list of essential and related attributes of the concept ‘health’.
### TABLE 4.5: LIST OF ESSENTIAL AND RELATED ATTRIBUTES OF THE CONCEPT “HEALTH”

<table>
<thead>
<tr>
<th>ESSENTIAL ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced state</td>
<td>Ability to adjust to various internal and external tensions</td>
</tr>
<tr>
<td></td>
<td>Homeostasis and adaptation</td>
</tr>
<tr>
<td></td>
<td>In harmony with nature</td>
</tr>
<tr>
<td></td>
<td>All sub-systems are in balance with the whole man</td>
</tr>
<tr>
<td></td>
<td>Being mentally, physically and spiritually one integrated whole person</td>
</tr>
<tr>
<td></td>
<td>Continuous adjustment to stressors in the environment</td>
</tr>
<tr>
<td></td>
<td>Maintain consistency</td>
</tr>
<tr>
<td>State of optimum capacity</td>
<td>Able to realize aspirations and satisfy needs</td>
</tr>
<tr>
<td></td>
<td>Achieve maximum potential for daily living</td>
</tr>
<tr>
<td>Provision of medical services</td>
<td>Actualisation of human potential</td>
</tr>
<tr>
<td></td>
<td>Maximising the potential</td>
</tr>
<tr>
<td></td>
<td>Empowerment</td>
</tr>
<tr>
<td></td>
<td>Commodity</td>
</tr>
<tr>
<td></td>
<td>Meeting collective needs of members</td>
</tr>
<tr>
<td></td>
<td>Multidimensional</td>
</tr>
</tbody>
</table>

The attributes gathered from the dictionaries and subject literature of the concept care, are displayed in Table 4.6 below.
<table>
<thead>
<tr>
<th>ATTRIBUTES OF THE CONCEPT ‘CARE’</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Absorbed</td>
<td>Loving</td>
</tr>
<tr>
<td>Affording</td>
<td>Mind</td>
</tr>
<tr>
<td>Alleviation of suffering</td>
<td>Mind what happens</td>
</tr>
<tr>
<td><strong>Assessment of needs</strong></td>
<td>More than just carrying out nursing procedures</td>
</tr>
<tr>
<td>Assisting another individual</td>
<td>Motivation to act</td>
</tr>
<tr>
<td>Attend to</td>
<td>Nurse</td>
</tr>
<tr>
<td>Attention</td>
<td>Nursing process</td>
</tr>
<tr>
<td>Attentive</td>
<td>Nurturing</td>
</tr>
<tr>
<td>Be busy with</td>
<td>Perform and finish a particular activity or job</td>
</tr>
<tr>
<td>Being supportive to patients</td>
<td>Personal feelings of respect</td>
</tr>
<tr>
<td>Captivated</td>
<td><strong>Planning care</strong></td>
</tr>
<tr>
<td>Carrying on</td>
<td>Precaution</td>
</tr>
<tr>
<td>Close attention</td>
<td>Precautionary steps/measures</td>
</tr>
<tr>
<td>Closeness of love</td>
<td>Preservation</td>
</tr>
<tr>
<td>Cogitation</td>
<td>Protect</td>
</tr>
<tr>
<td>Concern</td>
<td>Protection</td>
</tr>
<tr>
<td>Concentration</td>
<td><strong>Provide for needs</strong></td>
</tr>
<tr>
<td>Conservation</td>
<td>Provision of what is necessary for maintenance and protection</td>
</tr>
<tr>
<td>Consideration</td>
<td>Purposeful interaction</td>
</tr>
<tr>
<td>Curious</td>
<td>Quality of human character</td>
</tr>
<tr>
<td><strong>Cycle repeated</strong></td>
<td>Regard</td>
</tr>
<tr>
<td>Defend</td>
<td>Riveted</td>
</tr>
<tr>
<td><strong>Demonstration of warmth and kindness</strong></td>
<td>Rumination</td>
</tr>
<tr>
<td>Doing for patient</td>
<td>Safekeeping</td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td>Safety</td>
</tr>
<tr>
<td>Engrossed</td>
<td>Safeguard</td>
</tr>
<tr>
<td><strong>Equipping</strong></td>
<td><strong>Sequential progression of steps</strong></td>
</tr>
<tr>
<td>Fascinated</td>
<td>Shelter</td>
</tr>
<tr>
<td><strong>Feel concern or interest</strong></td>
<td>Shield</td>
</tr>
<tr>
<td><strong>Feel something is important</strong></td>
<td><strong>Serious attention or consideration</strong></td>
</tr>
<tr>
<td>Feelings conveyed to an individual</td>
<td>Sit with</td>
</tr>
<tr>
<td>Giving</td>
<td>Solicitude</td>
</tr>
<tr>
<td>Giving oneself to another</td>
<td>Supervise</td>
</tr>
<tr>
<td>Gripped</td>
<td>Supply</td>
</tr>
<tr>
<td>Grows out of his childhood, family, school background</td>
<td>Take care of</td>
</tr>
<tr>
<td>Guard</td>
<td>Take charge of</td>
</tr>
<tr>
<td>Heed</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 4.6: LIST OF ATTRIBUTES OF THE CONCEPT “CARE”
Based on the list of attributes of the concept ‘care’ as displayed in Table 4.6, the researcher extracted a list of essential and related attributes which are displayed in Table 4.7 below.

<table>
<thead>
<tr>
<th>ESSENTIAL ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Attention</td>
<td>Feel Concern</td>
</tr>
<tr>
<td>Giving oneself to another</td>
<td>Feel something is important</td>
</tr>
<tr>
<td></td>
<td>To trouble one</td>
</tr>
<tr>
<td></td>
<td>Assessment of needs</td>
</tr>
<tr>
<td></td>
<td>Transpersonal human to human attempts to protect</td>
</tr>
<tr>
<td></td>
<td>Feelings conveyed to an individual</td>
</tr>
<tr>
<td></td>
<td>Value for people</td>
</tr>
<tr>
<td></td>
<td>Take responsibility for another person</td>
</tr>
<tr>
<td></td>
<td>Empathy</td>
</tr>
<tr>
<td></td>
<td>Demonstration of warmth and kindness</td>
</tr>
</tbody>
</table>

**TABLE 4.7: LIST OF ESSENTIAL AND RELATED ATTRIBUTES OF THE CONCEPT “CARE”**
The attributes gathered from the dictionaries and subject literature of the concept healthcare, are displayed in Table 4.8 below.

### TABLE 4.8: LIST OF ATTRIBUTES OF THE CONCEPT “HEALTHCARE”

<table>
<thead>
<tr>
<th>Attributes of the Concept ‘HEALTHCARE’</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
</tr>
<tr>
<td>Administer to</td>
</tr>
<tr>
<td>Aid</td>
</tr>
<tr>
<td><strong>Appropriate assistance with disease or symptom management and maintenance</strong></td>
</tr>
<tr>
<td>Assist</td>
</tr>
<tr>
<td>Assistance</td>
</tr>
<tr>
<td>Attend to</td>
</tr>
<tr>
<td><strong>Basic human right</strong></td>
</tr>
<tr>
<td>Be of service for</td>
</tr>
<tr>
<td>Be of use to</td>
</tr>
<tr>
<td>Benefit</td>
</tr>
<tr>
<td>Cater to</td>
</tr>
<tr>
<td>Competition and free enterprise</td>
</tr>
<tr>
<td><strong>Concern for the quality of life</strong></td>
</tr>
<tr>
<td>Cure of disease</td>
</tr>
<tr>
<td>Do a good turn to</td>
</tr>
<tr>
<td><strong>Doing somebody a service</strong></td>
</tr>
<tr>
<td>Foster</td>
</tr>
<tr>
<td>Give help to</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Help</td>
</tr>
<tr>
<td>Highly developed technology</td>
</tr>
<tr>
<td>Industry</td>
</tr>
<tr>
<td>Institution</td>
</tr>
<tr>
<td>Look after the health</td>
</tr>
<tr>
<td><strong>Maintenance and enhancement of health</strong></td>
</tr>
<tr>
<td>Meet changing healthcare needs</td>
</tr>
<tr>
<td>Minister to</td>
</tr>
<tr>
<td><strong>Preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures or counseling</strong></td>
</tr>
<tr>
<td>Promote and restore health of individuals and populations</td>
</tr>
<tr>
<td>Provision of services</td>
</tr>
<tr>
<td><strong>Relief of suffering</strong></td>
</tr>
<tr>
<td>Repetitive circuit</td>
</tr>
<tr>
<td>See to</td>
</tr>
<tr>
<td><strong>Succour</strong></td>
</tr>
<tr>
<td>Supply and need</td>
</tr>
<tr>
<td>Support</td>
</tr>
<tr>
<td>Serve</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td><strong>Services offered by medical and allied health professions</strong></td>
</tr>
<tr>
<td><strong>Set of services</strong></td>
</tr>
<tr>
<td>Strong belief in Science</td>
</tr>
<tr>
<td>Take care</td>
</tr>
<tr>
<td>Tend</td>
</tr>
<tr>
<td><strong>Treatment of the physically and mentally</strong></td>
</tr>
</tbody>
</table>

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Based on the list of attributes of the concept ‘healthcare’ as displayed in Table 4.8, the researcher extracted a list of essential and related attributes which are displayed in Table 4.9 below.

**TABLE 4.9: LIST OF ESSENTIAL AND RELATED ATTRIBUTES OF THE CONCEPT “HEALTHCARE”**

<table>
<thead>
<tr>
<th>ESSENTIAL ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern for the quality of life</td>
<td>Basic human right</td>
</tr>
<tr>
<td></td>
<td>Promote and restore health of individuals and populations</td>
</tr>
<tr>
<td></td>
<td>Meet changing healthcare needs</td>
</tr>
<tr>
<td></td>
<td>Relief of suffering</td>
</tr>
<tr>
<td>Provision of services</td>
<td>Set of services</td>
</tr>
<tr>
<td></td>
<td>Services offered by medical and allied health professions</td>
</tr>
<tr>
<td></td>
<td>Doing somebody a service</td>
</tr>
<tr>
<td></td>
<td>Succour</td>
</tr>
<tr>
<td></td>
<td>Preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care services, procedures or counseling</td>
</tr>
<tr>
<td></td>
<td>Maintenance and enhancement of health</td>
</tr>
<tr>
<td></td>
<td>Treatment of the physically and mentally ill</td>
</tr>
<tr>
<td></td>
<td>Assistance with disease or symptom management and maintenance</td>
</tr>
</tbody>
</table>

Table 4.10 below, reflect an analysis of the concept “holistic healthcare”.
<table>
<thead>
<tr>
<th>HOLISTIC ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated whole person</td>
<td>* Not divided or broken into parts * Interdependent parts * Interconnected biological, physiological, social, psychological and spiritual beings * All encompassing * Integral relationship * Expressed need of one relates to each other * Harmonious integration * Recognises the emotional, mental, spiritual and physical elements * Single unit * Total patient care</td>
</tr>
<tr>
<td>Balanced whole state</td>
<td>* Ability to adjust to various internal and external tensions * Homeostasis and adaptation * In harmony with nature * All sub-systems are in balance with the whole man * Being mentally, physically and spiritually one * Integrated whole person * Continuous adjustment to stressors in the environment * Maintain consistency * Able to realize aspirations and satisfy needs * Achieve maximum potential for daily living * Actualisation of human potential * Maximising the potential</td>
</tr>
<tr>
<td>State of optimum capacity</td>
<td>* Feel real Concern * Feel something is important * To trouble one * Assessment of needs * Transpersonal human to human attempts to protect * Feelings conveyed to an individual * Value for people * Take responsibility for another person * Empathy * Demonstration of warmth and kindness * Plan care * Help another gain self knowledge * Equipping * Sequential progression of steps</td>
</tr>
<tr>
<td>Provision of health services</td>
<td>* Basic human right * Promote and restore health of individuals and populations * Meet changing healthcare needs * Relief of suffering</td>
</tr>
<tr>
<td></td>
<td>* Set of services * Services offered by medical and allied health professions * Doing somebody a service * Succour * Preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care services, procedures or counseling * Maintenance and enhancement of health * Treatment of the physically and mentally ill * Assistance with disease or symptom management and maintenance</td>
</tr>
</tbody>
</table>

Table 4.10: Analysis of the concept “Holistic Healthcare”
# A Holistic Healthcare Model for Higher Education Campus Healthcare Services

## Essential Attributes

<table>
<thead>
<tr>
<th>Integrated whole</th>
<th>Balanced whole person</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interconnected biological, physiological, social, psychological and spiritual beings</em>&lt;br&gt;<em>All encompassing</em>&lt;br&gt;<em>Harmonious integration</em>&lt;br&gt;<em>Total patient care</em></td>
<td><em>Serious attention</em>&lt;br&gt;<em>Concern for the quality of life</em>&lt;br&gt;<em>Provision of health services</em>&lt;br&gt;<em>Providing for needs</em>&lt;br&gt;<em>Giving oneself</em>&lt;br&gt;<em>Balanced state</em>&lt;br&gt;<em>Optimum capacity</em></td>
</tr>
</tbody>
</table>

## Related Attributes

<table>
<thead>
<tr>
<th>HOLISTIC HEALTHCARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESSENTIAL ATTRIBUTES</td>
</tr>
<tr>
<td><em>Feel real concern</em>&lt;br&gt;<em>Feel something is important</em>&lt;br&gt;<em>Assessment of needs</em>&lt;br&gt;<em>Promote and restore health of individuals and populations</em>&lt;br&gt;<em>Meet changing health care needs</em>&lt;br&gt;<em>Relief of suffering</em>&lt;br&gt;<em>Set of services</em>&lt;br&gt;<em>Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care services</em>&lt;br&gt;<em>Treatment of the physically and mentally ill</em>&lt;br&gt;<em>Planning care</em>&lt;br&gt;<em>Assistance with disease or symptom management and maintenance</em>&lt;br&gt;<em>Demonstration of warmth and kindness</em>&lt;br&gt;<em>Help another gain self knowledge</em>&lt;br&gt;<em>Equipping</em>&lt;br&gt;<em>Sequential progression of steps</em>&lt;br&gt;<em>Feelings conveyed to an individual</em>&lt;br&gt;<em>Value for people</em>&lt;br&gt;<em>Take responsibility for another person</em>&lt;br&gt;<em>Empathy</em>&lt;br&gt;<em>Ability to adjust to various internal and external tensions</em>&lt;br&gt;<em>In harmony with nature</em>&lt;br&gt;<em>Being mentally, physically and spiritually one</em>&lt;br&gt;<em>Maintain consistency</em>&lt;br&gt;<em>Able to realize aspirations and satisfy needs</em>&lt;br&gt;<em>Achieve maximum potential for daily living</em>&lt;br&gt;<em>Actualisation of human potential</em></td>
</tr>
</tbody>
</table>

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4.3 DESCRIPTION OF A MODEL CASE

A model case is an example of the use of the concept that demonstrates all the defining attributes of the concept. The model case should be a pure case of the concept, a paradigmatic example or a pure exemplar. Basically, the model case is one that we are absolutely sure is an instance of the concept (Walker and Avant, 2005:69).

**Model Case**

*It was almost 16:30 one afternoon when a student initiated consultation at the campus health clinic seeking assistance for symptom management of severe nausea. Individualised patient care was achieved by the use of a sequential progression of steps namely, initiating consultation; conducting an assessment and making a nursing diagnosis; planning and management and consequent resolution. Therefore after the student initiated consultation the campus healthcare provider conducted an assessment to make a nursing diagnosis by paying serious attention to what the student had to say. She requested the student to be seated and closed the door of the consulting room so that they could not be disturbed or overheard. The campus healthcare provider felt real concern for the student because the student appeared to be very anxious, pale and close to tears; and so, the campus healthcare provider demonstrated warmth and kindness by sitting in a position facing the student, maintaining eye contact and making use of therapeutic touch to reassure the student. The campus healthcare provider requested the student to relax and reassured her that she (the campus healthcare provider) would take care of her. The campus healthcare provider explained to the student that the campus healthcare consumers provided for the healthcare needs of the students and staff on campus by rendering an all-encompassing healthcare service that comprised promotive, preventive, curative and rehabilitative services and addressed the physical, psychological, spiritual and social healthcare needs of the students and staff on campus. The campus healthcare provider then listened attentively to the health history being given by the student and*
probed her further where insufficient information was provided. Further probing by the campus healthcare provider was important as it allowed her to obtain a more comprehensive history which is of the utmost importance when a nursing diagnosis is being made. On completion of the subjective history-taking the campus healthcare provider proceeded to examine the student in order to verify what the student had told her. The physical examination comprised taking the student’s temperature, pulse, respiration and blood pressure to obtain a database of the vital signs. The extent of any changes in the vital signs would have been the first indicator relating to the seriousness of the presenting problem. If the aforementioned findings were abnormal, it would have been a concern for the campus healthcare provider as it would have indicated that there was an underlying pathology. An examination of the gastrointestinal tract was then performed to further verify the subjective history obtained and to also ascertain underlying pathology. Throughout the history taking and examination the campus healthcare provider gave of herself by displaying empathy and making the student feel that she was valued and not just another number. The aforementioned was achieved by placing herself in the student’s shoes because she could identify with the student as she had been a student herself on many occasions. She therefore spoke kindly to the student and did not make the student feel that she (the campus healthcare provider) was in a hurry to go home as it was long past consulting hours. Instead she gave the student her full attention. After fully assessing the student physically and finding no physical abnormalities that could have caused the extreme nausea, the healthcare provider then probed the student further to establish a more holistic picture of the student’s mental, social and spiritual well-being. It is essential for healthcare providers to take a holistic health history because individuals are integrated whole persons and cannot be broken into parts because the parts are interdependent and an expressed need of one relates to the other. Thus, many mental, spiritual or social health problems could present themselves in the form of a physical ailment such as nausea. The student then started crying and she then related that she was under extreme stress because she had a number of assignments that she had to submit to her lecturers and that she was far away from home and had no support structures close to her. She
reported that she was not eating well and had experienced the nausea whenever she was under severe mental strain. The campus healthcare provider then informed the student that she did not find any underlying physical health problem that could give rise to her nausea and provided for her needs by counselling her and helping her gain self-knowledge about her problem. The healthcare provider equipped the student with knowledge pertaining to how individuals can sometimes present with physical health symptoms which are caused by stress-related problems. The healthcare provider explained to the student that individuals were integrated whole persons who comprised various interconnected dimensions such as physiological, psychological, spiritual and social, indicating that a change in one dimension would have an effect on the other dimensions. The campus healthcare provider also explained to the student that in order to achieve a balanced state there should be harmonious integration of all the aforementioned parts. The campus healthcare provider then drew up a plan of action for management of the student in order to assist the student in reaching a balanced state by providing treatment to relieve the nausea and advising her (the student) on proactive planning and time management in order to cope with all the assignments that she had. The campus healthcare provider also referred the student to the Student Counselling Department for further management so that she could become a balanced whole person again who would be able to realise her aspirations and maintain consistency with regard to optimum health and capacity. The campus healthcare provider emphasised treatment compliance in order for gradual resolution to take place and also advised the student to return to the clinic if she encountered any further healthcare need. The student then expressed her sincere gratitude and informed the campus healthcare provider that she was already feeling much better as she needed that counselling session to put things in perspective for her.
4.4 ESSENTIAL ATTRIBUTES OF THE CONCEPT

Table 4.11 below reflects the essential attributes of the concept holistic healthcare. These attributes should be present in all instances of holistic healthcare related to the specific context.

### TABLE 4.12: LIST OF ESSENTIAL AND RELATED ATTRIBUTES FOR THE CONCEPT ‘HOLISTIC HEALTHCARE’

<table>
<thead>
<tr>
<th>HOLISTIC HEALTHCARE</th>
<th>ESSENTIAL ATTRIBUTES</th>
<th>RELATED ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious attention</td>
<td>Feel real concern</td>
<td>* Feelings conveyed to an individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Empathy</td>
</tr>
<tr>
<td>Giving oneself</td>
<td></td>
<td>* Promote and restore health of individuals and populations</td>
</tr>
<tr>
<td>Concern for quality of life</td>
<td></td>
<td>* Preventive, diagnostic, therapeutic, rehaabilitative, maintenance or palliative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>care services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Assistance with disease or symptom management and maintenance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Total patient care</td>
</tr>
<tr>
<td>Provision of all encompassing integrated health services</td>
<td></td>
<td>* Help another gain self knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Equipping</td>
</tr>
<tr>
<td>Providing for needs</td>
<td></td>
<td>* Interconnected biological, physiological, social, psychological and spiritual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>beings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Ability to adjust to various internal and external tensions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Harmonious integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Maintain consistency</td>
</tr>
<tr>
<td>Balanced whole person</td>
<td></td>
<td>* Able to realise aspirations and satisfy needs</td>
</tr>
<tr>
<td>Optimum capacity</td>
<td></td>
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</tr>
</tbody>
</table>

4.5 DEFINITION OF THE MAIN CONCEPT OF THE STUDY

Holistic healthcare is an interactive process whereby an individual seeks attention from the registered nurse to promote or restore health. The registered nurse pays serious attention to the healthcare needs of the individual by giving of herself. Real concern for the quality of life of
the individual is illustrated by the nurse through the rendering of an all encompassing integrated health service that comprises promotive, preventive, curative and rehabilitative services, to provide for the healthcare needs of the individual, thus ensuring total patient care. This is achieved through assistance with disease or symptom management and equipping individuals with knowledge and skills to realise their needs. This process thus assists individuals in becoming balanced whole persons who are harmoniously integrated (that is biologically, physiologically, socially, psychologically and spiritually) and who are able to adjust to various internal and external tensions in the environment. Individuals will therefore be able to realise their aspirations and maintain consistency with regard to optimum health and capacity.
Chapter Four

A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUSS HEALTHCARE SERVICES

AGENT

The registered nurse
The medical doctor
The intern psychologist
The students and staff

RECIPIENT

The students and staff
(including clinic staff)

PROCEDURE

Holistic healthcare is an interactive process whereby an individual seeks help from the registered nurse to correct an imbalance experienced. The holistic healthcare process will comprise the following steps:

- **Initiating consultation**: Individual seeks assistance from registered nurse to promote or restore health.
- **Assessment and Nursing Diagnosis**: Registered nurse pays serious attention to the healthcare needs of individual by giving of herself and illustrates real concern for the quality of life of the individual.
- **Planning and Management**: Registered nurse ensures total patient care by rendering an all encompassing integrated health service.
- **Healthcare needs are addressed through assistance with disease or symptom management and equipping them with knowledge and skill to satisfy their needs**
- **Consequent resolution**: Individuals are thus assisted in becoming balanced whole persons who are harmoniously integrated (that is physiologically, socially, psychologically and spiritually) and who are able to adjust to various internal and external tensions in the environment.
- Individuals will therefore be able to realise their aspirations and maintain consistency with regard to optimum health and capacity.

DYNAMICS

The dynamics in the model will include the agents, recipients, resources and the environment.

CONTEXT

A campus health service at an identified HEI. This campus healthcare service comprises six campuses which are widely dispersed and only five of the campuses have a campus health clinic on campus.

TERMINUS

A balanced whole person who is able to realise his or her aspirations and healthcare needs and maintain consistency with regard to optimum health and capacity.

Figure 4.2: CLASSIFICATION OF CONCEPTS
Figure 4.3 below presents a provisional course of action for the procedure of the model of holistic healthcare for higher education campus health services:

**STEP 1: Initiating consultation**
Individual experiences an imbalance in either his or her internal or external environment and therefore seeks assistance from the registered nurse to promote or restore health.

**Step 2: Assessment and nursing diagnosis**
The registered nurse needs to pay serious attention to the healthcare needs of the individual and also illustrate real concern for his or her quality of life in order to conduct a competent assessment so that an accurate nursing diagnosis could be made.

**Step 3: Planning and management**
Once the nursing diagnosis is made the registered nurse will draw up an action plan for total patient care management of the individual which could either be accomplished by the healthcare provider through the rendering of an integrated all encompassing healthcare service or by referral to one of the other multidisciplinary healthcare team members.

**Step 4: Consequent resolution**
The intervention of the healthcare providers facilitates the gradual disappearance of the individual's signs and symptoms or the empowerment of the individual with skills and knowledge so that he or she becomes a balanced whole person again.

**Figure 4.3: PROVISIONAL EXPLANATION OF THE HOLISTIC HEALTHCARE PROCESS**
4.6 SUMMARY

The focus of this chapter was on concept analysis and the development of a holistic healthcare model for campus health services at HEIs. A visual representation and a detailed description of the model will be given in the next chapter.
5.1 INTRODUCTION

Chapter Four presented the development of the model for holistic healthcare that could serve as a frame of reference for registered nurses employed at campus health services to ensure balanced whole persons. This model is constructed from concepts derived from the information obtained during the focus-group interviews with the student campus healthcare consumers and the depth individual interviews conducted with the staff campus healthcare consumers as well as with the campus healthcare providers. The focus of the interviews conducted with the campus healthcare consumers was related to their experiences with regard to the healthcare provided at campus health services as well as what they perceived their healthcare needs to be. The interviews conducted with the campus healthcare providers related to their experiences regarding the rendering of campus health services and what they perceived to be the healthcare needs of the campus healthcare consumers. The approaches used for defining the main concepts identified were based on recommendations by Chinn and Kramer (1995:83) and Walker and Avant (1995:37-42).

The focus of this chapter is the description of the model which will be structured according to the following sub-headings:

- Overview of the model
- Structure of the model
  - Purpose of the model
  - Assumptions of the model
  - Context of the model
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- Theoretical definitions of concepts in the model
- Relationship statements of the model

- Structural description of the model
- Process of the model
- Guidelines for the operationalisation of the model
- Evaluation of the model

5.2 AN OVERVIEW OF THE MODEL

It has become evident throughout this study that even though the campus healthcare consumers and providers considered the current campus healthcare services rendered on campus to be of good quality, a need was expressed by all the participants for a more holistic healthcare service to address a wider range of healthcare needs. This appeared to be an important aspect for most campus healthcare consumers and providers because good health was considered important for students and staff to become balanced whole persons so that they could realise their aspirations and maintain consistency with regard to optimum health and capacity. The latter could be due to the fact that HEIs place a lot of emphasis on achievement. Health is therefore viewed as a process rather than an end-product in this model.

The registered nurse employed in a campus health service plays a pivotal role in assisting the students and staff on campus in achieving optimal health even though she is a member of a multidisciplinary healthcare team. She is the first point of contact for the campus healthcare consumers when they seek attention to promote or restore health. She therefore has to pay serious attention to their healthcare needs. Concern for the quality of life is expressed when she conducts needs assessments on campus and also assesses individuals holistically in order to make nursing diagnoses and plan for treatment and further management. Thus an all encompassing integrated healthcare service comprising promotive, preventive, curative and rehabilitative healthcare is necessary to ensure total patient care so that the campus healthcare consumers may become balanced, whole persons.
Figure 5.1: A holistic healthcare model for higher education campus health services
The process of the model progresses through four sequential steps as follows:

**Step 1: Initiating Consultation**
Individual seeks attention from the campus healthcare provider to promote or restore health.

**Step 2: Assessment and nursing diagnosis**
The registered nurse pays serious attention and illustrates real concern for the quality of life of the individual in order to address the healthcare needs of the campus healthcare consumer.

**Step 3: Planning and management**
The campus healthcare providers render an integrated all encompassing healthcare service comprising promotive, preventive, curative and rehabilitative services to ensure total patient care.

**Step 4: Consequent resolution**
This whole process contributes towards the gradual disappearance of the signs and symptoms or the empowerment of individuals with knowledge and skills for self-care resulting in the emergence of balanced, whole persons who are able to realise their aspirations and maintain consistency with regard to optimum health and capacity.

Holistic healthcare is considered an interactive process that could be repeated as the need arises.

### 5.3 STRUCTURE OF THE MODEL

In describing the structure of the model, the researcher will incorporate the following components as they apply to this model, namely:

- Purpose
5.3.1 PURPOSE

The purpose of this model is to provide a structured holistic healthcare frame of reference for registered nurses employed in a campus health service at a HEI in the Western Region of the Eastern Cape Province to assist all campus healthcare consumers to become balanced, whole persons who are able to realise their dreams and maintain consistency with regard to optimal health and capacity. This is achieved by rendering an all encompassing integrated healthcare service on campus that provides total patient care for all students and staff. The identified healthcare needs of the campus healthcare consumers could be holistically met through engaging with the model for holistic healthcare.

Within the discipline of nursing, the purpose of the model is a practice model that adds to a professional body of knowledge in the form of a holistic approach to healthcare in a campus health context.

5.3.2 ASSUMPTIONS

The model of Healthcare for All propounded by the World Health Organisation since 1978 serves as a point of departure for the assumptions of the holistic healthcare model.

- The model is based on the assumption that holistic healthcare takes into account total patient care considering the physical, psychological, social, economic and spiritual needs of the campus healthcare consumers, their response to their illnesses and the effect of illness on
their abilities to maintain consistency with regard to optimum health and capacity.

- The registered nurse will achieve holistic healthcare by focusing on primary health care as the means for achieving health for all on campus. Primary healthcare can thus be viewed as the vehicle for driving the process of holistic healthcare.

- Registered nurses must recognize that access to healthcare for all on campus is a basic human right which requires adequate human resources, infrastructure, essential drugs and commodities for the promotion of health and management of disease.

- Registered nurses acknowledge and facilitate the need for multidisciplinary approaches to reduce the disease burden and promote health on campus.

- Registered nurses ensure that specific disease control programmes are strengthened and co-ordinated with other programmes and interventions, for example, the Department of Health and student counselling services.

- Registered nurses ensure that the campus healthcare system is responsive to the healthcare needs and expectations of the campus healthcare consumers and contribute to improving health outcomes and assist in the development of balanced, whole persons.

- Registered nurses strengthen the partnerships with the financial, logistic, operational and scientific capacities to improve their campus health service and disease control programmes and to orientate management and others to the healthcare needs of the campus healthcare consumers.
5.3.3 CONTEXT

The context of this model is the campus health service situated on the campus of a HEI in the Western Region of Eastern Cape Province. It represents the work environment of the registered nurse who is confronted with a wide range of healthcare needs of a diverse campus healthcare consumer population. The campus healthcare population is extremely diverse in terms of gender, age, religion, culture, educational level and nationality. The registered nurse works independently and receives support from the doctor per telephone when needed or when he sees the patients that were referred at the campus health service for one to two hours per week. The registered nurse is therefore responsible for ensuring that holistic healthcare is being made available to the campus healthcare consumers.

The registered nurse at a campus health service is in a fortunate position because she has a “captive” healthcare consumer group and therefore she can get to know her community on campus. The students are normally on campus for three to four years and become regular patients at the campus health clinic. Most staff members on the other hand are employed at the HEI for many years. The healthcare consumers that use this service are not on the same level as the healthcare consumers that use the public healthcare services because the majority of the campus healthcare consumers on campus have a minimum level of education of grade twelve with a significant number having a tertiary level of education or busy studying towards a degree or a diploma. Thus, because many of the campus healthcare consumers are from higher income groups, the environment in which the registered nurse works is very stimulating and influences her to keep abreast of changes in healthcare so that she can implement these changes to ensure that the service rendered is of a high standard.
5.3.4 THEORETICAL DEFINITIONS OF CONCEPTS

Each of the concepts inherent in the central concept of the model for holistic healthcare was analysed in an effort to create conceptual meaning in Chapter Four. As the concepts of the theory are identified and conceptualised, theoretical definitions emerge that summarise the insights that are formed in creating conceptual meaning and concisely convey the essential meaning of concepts (Chinn and Kramer, 1995:94). The theoretical definitions of the central concept “holistic healthcare” and its essential and related concepts are defined in the following paragraphs.

5.3.4.1 Definition of the central concept: Holistic Healthcare

Holistic healthcare is an interactive process whereby an individual seeks attention from the registered nurse to promote or restore health. The registered nurse pays serious attention to the healthcare needs of the individual by giving of herself. Real concern for the quality of life of the individual is illustrated by the nurse through the rendering of an all encompassing integrated health service that comprises promotive, preventive, curative and rehabilitative services, to provide for the healthcare needs of the individual, thus ensuring total patient care. This is achieved through assistance with disease or symptom management and equipping individuals with knowledge and skills to realise their needs. This process thus assists individuals in becoming balanced, whole persons who are harmoniously integrated (that is biologically, physiologically, socially, psychologically and spiritually) and who are able to adjust to various internal and external tensions in the environment. Individuals will therefore be able to realise their aspirations and maintain consistency with regard to optimum health and capacity.
5.3.4.2 Definitions of essential and related concepts

The following definitions will provide conceptual clarity for the concepts applicable to the model holistic healthcare within the context of this study.

- **Interactive process**

Holistic healthcare cannot solely be the responsibility of the registered nurse on campus because the healthcare needs of the campus healthcare consumers are diverse and they are active participants in the process of holistic healthcare. Thus the nurse also finds herself in a situation where she exchanges information with other members of the multidisciplinary healthcare team in order to obtain expert input which is extremely important to satisfy the diverse healthcare needs of an individual.

- **Seeks assistance**

Individuals who experience a need to consult a healthcare professional for any health-related need will go in search of a healthcare service where they can be attended to and/or receive advice.

- **Promote health**

Not all campus healthcare consumers who visit the campus health service are sick since they sometimes visit the clinic to obtain health-related information, skills and preventive healthcare to maintain a healthy lifestyle. The registered nurse will contribute to the campus healthcare consumers’ well-being on campus by providing services that will ensure wellness of all students and staff.

- **Restore health**

Campus healthcare consumers who visit the campus health service because they are ill will be assisted with disease or symptom management by the
registered nurse who renders a curative healthcare service on campus in order to correct the health imbalance. If the registered nurse is unable to treat and manage the campus healthcare consumer herself she will refer to the next multidisciplinary team member who will assist with further management of the presenting health problem.

- **Pays serious attention**

The registered nurse allows the campus healthcare consumer to verbalise his or her reasons for using the campus health service without interrupting him or her. She listens attentively to the spoken and unspoken word. Observations are made of the campus healthcare consumer’s general appearance and the nurse probes him or her closely to obtain a comprehensive health history in order to make a nursing diagnosis. The registered nurse will also conduct a physical examination to obtain objective data to verify what the individual has reported.

The registered nurse will also focus on the healthcare needs of the rest of the students and staff on campus by conducting regular healthcare needs assessments on campus to establish a data base for future planning.

- **Giving oneself**

Giving of oneself to another, is recognised as fundamental to caring. This involves physical, psychological and emotional giving, with voluntary sharing of oneself through the nurse’s disclosing of personal information. Such a process develops a professional relationship with individuals as people and the development of mutual trust. Such giving of oneself to the individual is experienced as communicating support to individuals with an understanding that the essential presence of a registered nurse can consequently reduce anxiety for the individual. Empathy enables the registered nurse to identify with the experiences of the campus healthcare consumers with regard to the anxiety that arises due to being a patient.
• **Concern for quality of life**

The role of the registered nurse at campus health services is to maintain health and promote competence in self- or dependent-care activities so that individuals may become balanced, whole persons. Thus the registered nurses on campus will take immediate action if they are worried about a situation that could be detrimental to all aspects of life, including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. Therefore the nursing care rendered on campus comprises conducting regular needs assessments and making a nursing diagnosis in order to empower, treat and provide personalised and culturally congruent healthcare to individuals exposed to suffering, or recovering from physical, psychological or spiritual ill health.

Individuals should be able to access holistic healthcare services in order to maintain a healthy state so that they can fulfil their daily living activities to the best of their ability. The aforementioned will ensure that individuals become balanced, whole persons who are able to achieve their aspirations and maintain consistency with regard to optimum health and capacity.

• **Provision of all encompassing integrated health service**

Holistic healthcare is a comprehensive approach to healthcare that implies body, mind and spirit consideration in all actions and interventions for the patient, while recognising the concept of the uniqueness of the individual and the influence on health of external and internal environmental factors. A philosophy of comprehensive healthcare to improve the quality of the physical, psychological and social health of individuals is addressed by rendering promotive, preventive, curative and rehabilitative healthcare services on campus.
• Providing for needs

Individuals are whole persons comprising body, mind and spirit, therefore the physical, psychological, spiritual and social healthcare needs of individuals must be provided for by the registered nurses within the cultural context of the individuals so that total patient can be achieved.

• Balanced whole persons

The perception of whole persons is dependent on the recognition that individuals comprise body, mind and spirit within the context of the environment and that this recognition is fundamental to holism. Thus healthcare delivery should meet the healthcare needs of the individual as a whole in order to achieve harmony among all dimensions of body, mind and spirit. The highest form of health and the goal of nursing care are related to the ability of individuals to maintain a balance with the environment, with relative freedom from pain, disability, or limitations, including social limitations. A balanced, whole person is one who is able to adapt to the environment successfully and able to grow, function, and thrive to realise his or her aspirations and maintain consistency with regard to optimum health and capacity.

• Optimum capacity

This term refers to a state whereby an individual is able to effectively perform roles and tasks expected of him or her in society. Individuals should therefore be able to continuously adjust to stressors in the internal and external environment through the most appropriate use of his or her resources in order to achieve maximum potential for daily living.
5.3.5 RELATIONSHIP STATEMENTS

Developing statements is an important part of theory development. Concepts are the building blocks of theory and theoretical or relationship statements are the mortar that glues each block to its neighbour. In developing relationship statements between concepts, the theory builder starts to bring clarity and direction to the understanding of the phenomenon of interest. Statement synthesis is aimed at specifying relationships between two or more concepts based on evidence (Walker & Avant, 2005:87). The concepts identified in this research are based on the evidence of the focus-group interviews conducted with the student campus healthcare consumers and the depth individual interviews conducted with the staff campus healthcare consumers and providers regarding their experiences relating to the campus healthcare services provided on campus as well as the perceived healthcare needs of the campus healthcare consumers.

The concepts that have been identified, defined and classified will now be placed in relation to each other through the utilisation of relationship statements. The following relationship statements have been identified as emerging from the concepts in this model.

The campus healthcare consumer initiates consultation with the registered nurse by seeking attention either to promote or restore health. Something in the external or internal environment of the individual has resulted in an imbalance which makes it difficult for the individual to cope with daily living activities. The manner in which this initial consultation is conducted will set the tone for the interactive process of holistic healthcare.

The registered nurse pays serious attention to the healthcare needs of the campus healthcare consumer and illustrates real concern for his or her quality of life. The registered nurse therefore takes a comprehensive health history and conducts a physical examination in order to make a nursing diagnosis. If the campus healthcare consumer presents with a health problem that is not
within the scope of practice of the registered nurse, she will refer the individual to the relevant member of the multi-disciplinary healthcare team.

Once the registered nurse has made a nursing diagnosis, she plans for the management of the individual, rendering an all encompassing healthcare service comprising promotive, preventive, curative and rehabilitative healthcare services in order to ensure that all the healthcare needs of the campus healthcare consumers are provided for, thus resulting in total patient care which is culturally congruent. If the campus healthcare consumer does not respond to the treatment received from the registered nurse he/she can return to the campus health clinic for further management or referral.

The consequent resolution is the gradual disappearance of the signs and symptoms of disease or the empowerment of the individual with knowledge and skills for self care resulting in harmonious integration of the body, mind and spirit. A balanced, whole person emerges who is able to realise his or her aspirations and maintain consistency with regard to optimum health and capacity.

5.4 STRUCTURAL DESCRIPTION OF THE MODEL

The structure of a model emerges from the relationships of the theory giving overall form to the conceptual relationships within the theory (Chinn & Kramer, 1995:112). Figure 5.1 is a structural representation of a holistic healthcare model for higher education campus health services which will serve as a basis for the discussion and explanation that follow.

The main feature of the model is the registered nurse who is the main role-player in expediting the holistic healthcare process so that the campus healthcare consumers can become balanced, whole persons who are able to realise their aspirations and maintain consistency with regard to optimal health and capacity. The structure of the model comprises four sequential steps which flow from top to bottom. The black arrows running down the
middle of the model indicate the direction in which the steps flow. The yellow and grey colours which run parallel from Step 1 and gradually change into green which symbolises growth after Step 3 in the background of the model signify the relationship between the registered nurse and the campus healthcare consumer. Initially the campus healthcare consumer is dependent on the registered nurse for management and support; but gradually he or she will become empowered and well again and will therefore not need the support of the registered nurse. The relationship therefore gradually changes from one of dependence to independence. The two long dual-direction arrows on either side of the schematic centre structure of the model reflect that these four steps are interactive and that they comprise the holistic healthcare process. The yellow frame within which this structure exists represents the campus health services practice environment within which this whole process takes place.

Step 1 of the model indicates that the individual approaches the registered nurse because of a healthcare need that has arisen. The individual thus initiates consultation with the registered nurse either to promote or restore health. This step is illustrated by a light orange outer circle illustrating the external environment and a grey inner circle illustrating an individual in need of healthcare. A broken line separates these two circles indicating that the individual exists within the external and internal environments and that both these environments could have an impact on the individual’s well-being. The unbalanced scale in the internal environment signifies that the individual is experiencing an imbalance and therefore approaches the registered nurse to correct the imbalance.

The colour yellow signifying the SANC’s distinguishing device for community nursing science and primary health care is used to represent the registered nurse in Step 2 and Step 3. Step 2 forms the foundation for Step 3; therefore the registered nurse must pay serious attention to the healthcare needs of the campus healthcare consumers and illustrate real concern for their quality of life. The aforementioned will ensure that an adequate assessment is being
made in order to make an accurate nursing diagnosis that could be competently planned for and managed by the registered nurse.

Step 3 shows that the registered nurse could either immediately refer the campus healthcare consumer for further planning and management to the next multidisciplinary team member (depicted in the blue circle) without treating him or her if she feels that the current healthcare problem of the campus healthcare consumer is not within her scope of practice; or plan and manage the campus healthcare consumer herself. If the registered nurse plans and manages the healthcare consumer herself, she will address the physical, psychological and spiritual healthcare needs of the campus healthcare consumer to ensure that total patient care is being received. The aforementioned will be achieved by rendering an integrated all encompassing healthcare service comprising promotive, preventive, curative and rehabilitative healthcare. The different shades of yellow with dotted lines are used to illustrate that the latter services are not separate but an integrated service. The grey arrows leaving the yellow and blue circle and which are returning to Step 1 signify that the campus healthcare consumers did not respond to treatment and need to start the process again before becoming balanced, whole persons. Successful planning and management lead to Step 4.

Step 4 reflects that the consequent resolution of the whole process is a balanced, whole person who lives in harmony with the external and internal environments. The scale within the green circle symbolises the balanced state which may be permanent or transient. The grey arrow returning from Step 4 to Step 1 indicates that the healthcare consumer could experience a need to return to the registered nurse again for the same or a new healthcare need.
5.5 PROCESS OF THE MODEL

The process of holistic healthcare at higher education campus health services takes place in four sequential steps and it is an interactive process. The four sequential steps are:

- Step 1: Initiating Consultation
- Step 2: Assessment and Nursing Diagnosis
- Step 3: Planning and Management
- Step 4: Consequent Resolution

5.5.1 STEP 1: INITIATING CONSULTATION

The campus healthcare consumers are interconnected physiological, social, psychological and spiritual beings who are in constant interaction with tensions in the external and internal environments that could affect the harmonious integration of the various parts that make them balanced, whole persons. The campus healthcare consumers will also be seen in the context of their social and cultural milieu, their educational attainments and their economic and recreational activity.

The holistic healthcare process at higher education institutions commences when the campus healthcare consumer becomes aware of the healthcare services on campus and initiates consultation with the registered nurse at the campus health clinic to seek attention for either health promotion or restoration. Health is a private and sensitive matter and the nurse will acknowledge that the campus healthcare consumers are individuals who need personal privacy. Therefore the ethical principles of privacy, confidentiality, autonomy and beneficence will be adhered to at all times by those with whom the individual comes into contact at the campus health clinic.
The manner in which this initial step will be handled is extremely important because it could have an impact on the rapport and supportive relationship that will be established with the registered nurse and also the management of follow-up visits. The campus healthcare consumer is dependent on the registered nurse for support and management throughout Steps 1, 2 and 3. Therefore the initial consultation will be conducted with the necessary privacy and sensitivity to ensure that a relationship of respect and trust develops between all those concerned.

5.5.2 STEP 2: ASSESSMENT AND NURSING DIAGNOSIS

All the registered nurses at the campus health service are primary health care providers and therefore cater for the healthcare needs of the campus healthcare consumers in the absence of a doctor. The registered nurse will therefore be the first healthcare provider with whom the campus healthcare consumer will come into contact. She will pay serious attention to their healthcare needs and give of herself. The nurse’s giving of herself is recognised as fundamental to caring. This involves physical, psychological and emotional giving, with voluntary sharing by the nurse of herself through disclosing personal information. Such a process develops a professional relationship with individuals as people and the development of mutual trust. Such giving of oneself to the healthcare consumer is experienced as communicating support to healthcare consumers with an understanding that the essential presence of a nurse can consequently reduce anxiety for the healthcare consumer. Empathy enables the nurse to identify that in her experience too, being a patient can create anxiety.

Real concern, for the quality of life of the campus healthcare consumers will be demonstrated through warmth and kindness displayed by the registered nurse. The registered nurse will perform an assessment by taking an accurate health history and doing a physical examination in order to recognise abnormalities and make a nursing diagnosis. She will screen patients into those that she can help and those to be referred to other members of the
multidisciplinary healthcare team. The registered nurse will not replace the doctor but will remain inter-dependent upon him or her for referral, for consultation and the evaluation of her work.

5.5.3 STEP 3: PLANNING AND MANAGEMENT

The third step of the holistic healthcare process, planning and management, will take place after the registered nurse has assessed the campus healthcare consumer, made a nursing diagnosis and screened the healthcare consumer with regard to whether or not he or she will be referred to another member of the multidisciplinary healthcare team.

The registered nurse will then plan for the management of the healthcare needs of the campus healthcare consumer. She will assist with disease or symptom management or the maintenance of the campus healthcare consumers’ health status by prescribing and dispensing medication, counselling them and teaching them health-promotive principles. The registered nurse will therefore render an integrated all encompassing healthcare service on campus comprising promotive, preventive, curative and rehabilitative services to ensure that all campus healthcare consumers receive total patient care.

De Haan (2005:31) cites the Ottawa Charter’s health promotion definition as “…the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, satisfy needs and change or cope with the environment”. Thus the registered nurses at the campus health service will provide promotive health services such as health education, sex education, subsidised nutritional substitutes, counselling services and periodic selective screening, for example breast examinations, papanicoloau smears and cholesterol, glucose and blood pressure checks to facilitate this process. The registered nurses will also ensure a safe environment on campus for students and staff.
According to Stanhope and Lancaster (2000:43), disease prevention activities include activities that have as their goal the protection of people from the ill effects of actual or potential health threats. The registered nurses at the campus health service will therefore provide flu and Hepatitis B vaccines, vitamin therapy, family planning, condoms, voluntary counselling and testing for HIV, antenatal care and an occupational health service for protection against occupational hazards to ensure disease prevention.

Curative healthcare services on the other hand provide for the management of minor ailments or common endemic conditions or diseases (de Haan, 2005:25). Early diagnosis and prompt treatment of minor ailments and endemic diseases are thus essential for the achievement of optimum health by the campus healthcare consumers. Therefore registered nurses at the campus healthcare services will provide adequate treatment according to the essential drug list to arrest the disease process and to prevent further complications and sequelae. Selective health screening could also be conducted from time to time in order to detect disease early so that it could be promptly treated to prevent disability and further complications.

The aim of rehabilitation services is to return the person to his or her community, to ensure that his or her remaining capacities are fully utilised and that further deterioration is prevented (de Haan, 2005:24). The registered nurse will thus ensure that the campus healthcare consumer receives the necessary physiotherapy, vocational guidance and/or monitoring of chronic health conditions as needed in order to rehabilitate the individual.

By making all the abovementioned services available to the campus healthcare consumers, the registered nurses will ensure that all campus healthcare consumers receive total patient care which takes into account the physical, emotional, social, economic and spiritual needs of individuals, their response to their illnesses and the effect of illness on the individual’s abilities to meet self-care needs and realise their aspirations and maintain consistency with regard to health and capacity.
There will be times though when the campus healthcare consumers will not respond to the treatment provided by the registered nurses or the other healthcare professionals; they will then return to Step 1 and the whole process will restart before the individual proceeds to Step 4. If the planning and management is successful in Step 3 the individual will proceed to Step 4.

5.5.4 STEP 4: CONSEQUENT RESOLUTION

Stanhope and Lancaster (2002:136) indicate that the resolution of disease in the Stage of Disease Process is death, disability or recovery. The consequent resolution for this model will be the gradual disappearance of the signs and symptoms or the empowerment of an individual for self-care which will result in a balanced, whole person who is able successfully to adjust to the tensions in the external and internal environments resulting in harmonious integration of body, mind and spirit. Individuals will therefore be able to realise their aspirations and satisfy their needs by maintaining consistency with regard to optimum health and capacity. But this balanced state could be transient and the individual would then return to Step 1 of the holistic healthcare process to correct the imbalance again.

5.6 GUIDELINES FOR THE OPERATIONALISATION OF THE MODEL IN PRACTICE

Campus health services do not render the full range of primary health care services as indicated by the Department of Health in their primary health care package document (Department of Health, 2000:1-89) but only those services that are needed on campus. Thus broad guidelines for operationalising the holistic healthcare model for higher education campus healthcare services will now be described within the context of the campus health service using the research findings and literature as the basis for formulating the guidelines. Broad guidelines have been developed for each step of the holistic healthcare process with each of the guidelines having its own operational implications.
5.6.1 Guidelines for operationalisation of Step 1: Initiating consultation

The campus health service is the first stop for healthcare on campus and therefore the following guidelines are suggested to facilitate campus healthcare consumers in initiating consultation when they experience an imbalance in their external or internal environment which makes them to seek attention either to promote or restore health.

5.6.1.1 GUIDELINE I: The campus healthcare consumers must be made aware of the healthcare services on campus in order for them to initiate consultation

Operational Implications

- The campus healthcare consumers could be made aware of the campus health services through adequate marketing by the campus healthcare providers via:
  - orientation programmes on campus
  - flyers
  - e-mail
  - notice boards and
  - news bulletins

- The campus healthcare providers must provide the following information to the campus healthcare consumers:
  - the location of the campus health service;
  - the consultation times;
  - how to access the campus health service clinic;
  - the procedure for immediate treatment of emergencies;
  - the available healthcare services;
  - the name and telephone number of the person in charge;
  - the costs involved; and
the formal complaint procedure that could be followed by the campus healthcare consumer if he or she is dissatisfied with the standard of care received.

5.6.1.2 GUIDELINE II: The campus healthcare providers must ensure that an adequate and legible patient record is created for each campus healthcare consumer upon arrival at the campus health clinic

Operational Implications

Health is a private matter and therefore the administration assistant must only obtain the following information from the campus healthcare consumer upon arrival at the campus health service:

- name,
- address,
- telephone number,
- date of birth,
- student or staff number,
- religion,
- faculty or department in which they are registered as a student or employed and
- name, telephone number and address of next of kin

5.6.1.3 GUIDELINE III: The campus healthcare providers should create a therapeutic environment to ensure that the campus healthcare consumers feel comfortable, safe and secure when using the campus health service
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Operational Implications

Access to decent healthcare services is the rightful expectation of all citizens especially those who were previously disadvantaged (Department of Health, 2000:9). Thus the following operational implications are suggested:

- The Batho Pele principles and the Patients' Rights Charter should be displayed on the walls in the clinic
- All campus healthcare providers should wear name badges so that the campus healthcare consumers know by whom they are being assisted
- The campus health service clinic should be easily accessible to all campus healthcare consumers, even those who are disabled, for example, those campus healthcare consumers using wheelchairs.
- The environment of the campus health service should be clean, safe, comfortable and pleasant.
- The waiting area should be large enough to accommodate the campus healthcare consumers who are waiting to be attended to.
- All campus healthcare providers and administration staff should adhere to good customer-care principles.
- Educational posters which should be displayed on the walls or health education videos could be viewed whilst the campus healthcare consumers are waiting to be attended to

5.6.2 Guidelines for operationalisation of Step 2: Assessment and Nursing Diagnosis

In order to make an accurate nursing diagnosis the registered nurse needs to conduct a holistic health assessment by paying serious attention to the
healthcare needs of campus healthcare consumers and illustrating real concern for their quality of life. The following guidelines are therefore suggested to help the registered nurse to conduct the assessment and make an accurate nursing diagnosis. The registered nurse would pay serious attention and illustrate real concern for the campus healthcare consumer’s quality of life by implementing the following guidelines:

**5.6.2.1 GUIDELINE I: The registered nurse should conduct a holistic health history interview to obtain baseline data and establish a relationship with the campus healthcare consumer:**

**Operational Implications**

- Establish a climate of trust to promote interaction necessary for a therapeutic relationship that maintains a focus on the campus healthcare consumer’s healthcare needs.

- A climate of trust is established by:
  - paying attention to the way one introduces oneself, for example, including one’s full name, role in the campus health service and purpose of the interview;
  - asking the campus healthcare consumer how he or she wishes to be addressed;
  - acknowledging the campus healthcare consumer as an active participant in the interview by asking about his or her primary concerns and goals for the visit;
  - ensuring that the environment is comfortable, private and quiet;
  - using oneself therapeutically to support the campus healthcare consumer’s perspective or feelings in order to find a common connection that could facilitate communication.
• being skilful in communication techniques to enable the campus healthcare consumer to share fully life experiences relevant to his or her health status;

• asking for basic information such as establishing the campus healthcare consumer’s reason for seeking healthcare, his or her current health status, information about allergies, medications taken, levels of stress and support available to cope with health concerns, past health history, family history; and review of systems, for example, physical, sociological and psychological systems;

• varying the focus and types of questions asked according to the campus healthcare consumer’s presenting problem or concerns; and

• using the information obtained in the health history alert the registered nurse to areas that should be focused on during the physical examination.

5.6.2.2 GUIDELINE II: The registered nurse should perform a physical examination to verify the subjective information given by the campus healthcare consumer during the health history interview

Operational Implications

The registered nurse should:

• use the physical examination to identify variations from the normal state and the information obtained should become a part of the campus healthcare consumer’s database;
• explain the procedures to the campus healthcare consumer at the beginning of the assessment and restate them as the examination proceeds;

• assist the campus healthcare consumer in appropriate positioning and warn the campus healthcare consumer of any uncomfortable manoeuvres;

• use a head-to-toe approach in the examination because this sequence is generally more acceptable;

• move from external to internal with her examination of the campus healthcare consumer, therefore she will begin with observation and then use instruments or perform digital examinations; (Initial observations are general impressions such as the campus healthcare consumer’s appearance and later observations may include the use of an instrument).

• examine normal and unaffected areas before observing abnormal areas or parts of the body where the campus healthcare consumer describes symptoms;

• expose the regions that are to be examined completely to ensure an accurate finding;

• be sensitive to the campus healthcare consumer’s culture, anxiety and possible embarrassment when certain areas of the body are exposed;

• observe for body symmetry, comparing one side to the other;

• perform the physical assessment while standing on the campus healthcare consumer’s right side in order to assist in locating anatomical landmarks while the examination is being performed; and
• use examination techniques required for a particular system such as
inspection, percussion, palpation and auscultation throughout the
physical assessment.

5.6.2.3 GUIDELINE III: The registered nurse should make a nursing
diagnosis after taking the health history and performing a
physical assessment

Operational Implications

• The registered nurse analyses all the data obtained from the health
history and the physical assessment that was performed in order to
make a nursing diagnosis.

• The registered nurse then decides whether she will treat the campus
healthcare consumer herself or refer him or her to one of the other
members of the multidisciplinary team.

• If the registered nurse decides to refer the campus healthcare
consumer to one of the other multi-disciplinary team members, she
must make the necessary arrangements and give the campus
healthcare consumer a referral letter to the next level of care.

5.6.3 Guidelines for operationalisation of Step 3: Planning and
management

The following suggested guidelines are based on the research findings and
the Primary Health Care Package for South Africa – A set of norms and
standards (Department of Health, 2000: 12-84). The Primary Health Care
Package for South Africa stipulates the minimum norms and standards for all
PHC services rendered in South Africa.
5.6.3.1 GUIDELINE I: To render health promotion services by giving the campus healthcare consumers the knowledge they need, and ensuring that the environment in which they live and work on campus is healthy, will assist in preventing disease and also helping them in attain and maintain optimum health.

Operational Implications

- Health education will form the basis for the rendering of the health promotion services which should be ongoing throughout the year and not an annual event.

- A registered nurse who is creative and innovative should be appointed to plan and render this service on campus.

- A programme could be drawn up for the year with health promotion activities planned for at least each month of the year.

- The programmes should be planned in such a way as to attract the attention of the campus healthcare consumers and make them want to attend.

- Good marketing strategies should be implemented to advertise the health promotion programmes on campus.

- The registered nurse could liaise with the marketing department on campus.

- The following topics for health promotion were suggested by the campus healthcare consumers:
  - HIV/AIDS
  - STIs
  - Contraception (including emergency contraception)
o Nutrition
  o Chronic health conditions, for example, diabetes mellitus, hypertension, asthma, epilepsy, cancer
  o Women’s health issues, for example breast self-examination and PAP smears

- Pamphlets and brochures could be obtained from the Department of Health or designed and developed by the campus health service and freely distributed on campus and at the campus health clinic.

- The campus healthcare providers should fully integrate the National Guideline on Primary Prevention of Chronic Diseases

- Supplies of health-related learning material should be available in local languages and be culturally appropriate.

- The art department on campus could be approached and the art students be asked to design some health education pamphlets or participate in a health education pamphlet-designing competition. The topics could be selected and different competitions could be run in order to develop one’s own collection of pamphlets on various health-related matters.

- The campus healthcare providers must be vigilant with regard to environmental health hazards on campus and report them to the responsible persons or departments on campus so that action can be taken to correct them.
5.6.3.2 **GUIDELINE II:** To render preventive healthcare services to ensure specific protection of the campus healthcare consumers.

**Operational Implications**

- Administer flu and Hepatitis B vaccines upon request.

- Provide a comprehensive occupational health service on campus which ensures prompt reporting of occupational hazards and immediate attention to the employees healthcare needs.

- Establish an employee assistance programme that is easily accessible to staff.

- Perform periodic and selective examinations of high-risk employees should be performed annually and as the need arises.

- Provide a subsidised feeding scheme for all the needy campus healthcare consumers.

- Provide vitamin therapy for campus healthcare consumers who need additional vitamins to supplement their diet.

5.6.3.3 **GUIDELINE III:** To render curative healthcare services in order to detect and diagnose disease early so that prompt treatment could be implemented to prevent complications and sequelae.

**Operational Implications**

- The campus health service should render a comprehensive integrated PHC service for at least eight hours per day, five days per week.
• The registered nurses should all have completed a recognised PHC, occupational health nursing and dispensing course.

• The campus health service should be accessible to the campus healthcare consumers.

• Doctors and other specialised healthcare professionals should be accessible for consultation, support and referral.

• The doctors, counsellors and social workers should work sessions at the campus health clinic.

• The campus health service managers should receive training in facilitation skills and PHC management.

• The campus health service should be evaluated annually to reduce the gap between healthcare needs and service provision using a situational analysis of the campus healthcare consumers’ health-related needs and the regular health information data collected at the clinic.

• An annual plan should be based on this evaluation.

• The campus health service should have a mechanism for monitoring services and quality assurance at least one annual service audit should be conducted.

• The campus healthcare consumers’ perceptions of services rendered should be tested at least once per year through patient interviews or anonymous patient questionnaires.

• Annual treatment guidelines and the essential drug list manual should be available to all registered nurses.
• A library of useful health, medical and nursing reference books should be kept up to date.

• All relevant national and provincial health-related circulars, policy documents, acts and protocols that impact on service delivery should be available at the campus health service clinic.

• The following equipment should be available to all registered nurses:
  o a diagnostic set,
  o a baumanometer with appropriate cuffs and stethoscope,
  o scales for weights of adults and measuring tapes for heights,
  o haemoglobinometer, glucometer, pregnancy test and urine test strips,
  o speculums of different sizes,
  o a reliable means of communication,
  o emergency transport available reliably when needed,
  o an oxygen cylinder and masks of various sizes,
  o a working refrigerator for vaccines and medicines,
  o condom dispensers are placed where condoms can be obtained with ease,
  o a sharps disposal and sterilisation system is available,
  o equipment and containers for taking blood and other samples,
  o an adequate number of toilets for staff and campus healthcare consumers are available and accessible to wheelchairs,
  o a sluice room and a suitable storeroom or cupboard for cleaning solutions and linen,
  o suitable dressing/procedure room with washable surfaces,
  o a space with a table and operating room equipment for minor procedures referred to the doctor for his attention and management and
  o an adequate number of consulting rooms, with wash basins and diagnostic light.
• The following medicines and supplies should be available to the registered nurses:
  o suitable medicine room and medicine cupboards that are kept locked with burglar bars,
  o medicines and supplies as per the essential drug list for PHC with a mechanism in place for stock control and ordering of stock,
  o medicines and supplies should always be in stock with a mechanism for obtaining emergency supplies when needed,
  o batteries and spare bulbs should always be available for auroscopes and other equipment and
  o electricity, cold and warm water should always be available.

• The registered nurses should be competent with regard to:

  o Organising the clinic
    ▪ to reduce waiting times to a minimum and initiate an adequate appointment when necessary, and
    ▪ train peer helpers to educate peers and facilitate community action on campus.

  o Caring for the campus healthcare consumers
    Registered nurses should:
    ▪ be able to follow the disease management protocols and standard treatment guidelines and provide compassionate counselling that is sensitive to culture and the social circumstances of the campus healthcare consumers;
    ▪ be positive in their approach to campus healthcare consumers, evaluating their health related needs, correcting misinformation and giving each campus healthcare consumer the feeling of always being welcome;
always treat the campus healthcare consumers with
courtesy in a campus healthcare consumer-oriented
manner to reduce emotional barriers access of healthcare
facilities and prevent the breakdown in communication
between campus healthcare consumers and staff and
always ensure that the rights of patients are observed

• Running the campus health clinic
  • A clear system for referrals and feedback on referral
    should always be in place
  • All registered nurses should always wear uniforms and
    insignia in accordance with the South African Nursing
    Council’s specifications.
  • The campus health services should have a strong link
    with the Department of Health, relevant Non-government
    Departments and any other significant departments or
    organisations.
  • The clinic should be clean, organised and convenient and
    accommodate the healthcare needs of campus
    healthcare consumers’ confidentiality and easy access for
    people with disability.
  • The campus health service clinic should have a
    housekeeping system to ensure regular removal of waste
    and safe disposal of medical waste and refuse.
  • The campus health service should have a written
    infection control policy which is monitored and followed
    on protective clothing, handling of sharps, cleaning, hand
    hygiene, wound care and infection control data.

• Putting an accurate and standardised recording system in
  place
  • The campus health service should use an integrated
    standard health-information system that facilitates and
    streamlines the collecting and using of data.
Chapter Five  A HOLISTIC HEALTHCARE MODEL FOR HIGHER EDUCATION CAMPUS HEALTH SERVICES

- The campus health service should keep daily service registers, healthcare consumer treatment cards and all laboratory request and referral letter forms.
- All information on campus healthcare consumers should be correctly recorded on the registers and folders.
- All registers and monthly reports should be kept up to date.
- The campus health service should have a filing system that allows for continuity of healthcare for the campus healthcare consumers.

- Core management guidelines could include the following:
  - The senior manager should ensure that authorisation is received from the DoH to render a healthcare service on campus
  - The senior manager should ensure that all applicable health legislation, policies and regulations are being adhered to and are available
  - The campus healthcare service should develop a vision and a mission statement and post it on the wall of each campus health clinic.
  - Core values should be developed by the clinic staff and posted.
  - The senior manager should ensure that an operational or business plan is written each year.
  - New clinic staff should be orientated.
  - Policies on grievance and disciplinary procedures should be available in the clinic for staff to refer to.
  - Job descriptions for each staff member should be available in a file.
  - There should be a performance and training plan in place and performance appraisal should be carried out for each staff member annually.
  - Regular staff meetings should be held at least once per month.
o Services and skills that are lacking should be identified and new training sought.
o In-service training should take place on a regular basis.
o The campus health service should have a cost centre and a budget divided into main categories.
o The monthly expenditure of each main category should be known.
o Under- and overspending should be identified and dealt with including requests for the transfer of funds between line items where permitted and appropriate.
o Monthly supervisory support visits should be scheduled and a written record should be kept of the results of the visits.
o There should be an up-to-date inventory of clinic equipment and a list of broken equipment.
o Stocks should be secured with stock cards used and kept up to date.
o Orders should be placed regularly and on time and checked when received against the order.
o Stocks should be kept orderly with first expiry, first out followed and no expired stock.
o The drugs ordered should follow the essential drug list principles.
o New patient cards and medico-legal forms should be available.
o The monthly PHC statistics report should be accurate, done on time and filed or sent to the Department of Health.
o Monthly annual data should be checked, graphed, displayed and discussed with staff.

- The registered nurses at the campus health service clinic should provide services to those campus healthcare consumers with special healthcare needs and an adequate referral system should be in place for the aforementioned. These services could be rendered as an extended PHC network of the Department of
Health. A written agreement between the DoH and the campus health service could be drawn up and implemented accordingly.

- **Women’s reproductive health**
  The registered nurse at the campus health services clinic should ensure that the following services are available with regard to women’s reproductive health:
  - References, prints and educational material:
    - Midwifery protocols in the event of an emergency delivery on campus
    - Contraception protocols
    - Termination of pregnancy protocols
    - Sterilization act
    - All provincial circulars and policy guidelines regarding women’s health issues
    - A library of suitable references and learning material on women’s health issues
  - Equipment
    - A delivery set in cases of emergencies
    - Speculums
    - Fetalscope
    - Women’s health charts
  - Medicines and supplies
    - Contraceptive barrier methods, for example, condoms
    - Injectable hormonal contraceptives
    - Oral hormonal contraceptives
    - Post-coital contraceptives
  - Competence of health staff
    - The registered nurses should have training in contraception and post-abortion care management
- The registered nurses should be able to:
  * take a history and perform a physical examination and tests according to protocols and guidelines of the DoH,
  * provide routine management, observations and service according to the antenatal care protocol at each step of the pregnancy including at least three visits during pregnancy,
  * provide education and counselling to each pregnant woman on monitoring signs of problems, for example bleeding, STIs/HIV, family planning and child spacing,
  * offer appropriate counselling, advice and service to pregnant women requesting termination of pregnancy,
  * perform an emergency delivery,
  * make usual routine observations and select and prescribe appropriate family planning methods according to national protocol,
  * conduct breast and cervical screening for women as per protocols,
  * provide appropriate adolescent/youth services on family planning, sexuality, health education and counseling,
  * provide information to mothers on booking for delivery, care of breasts, and any other problems associated with pregnancy and
  * refer to appropriate antenatal clinics outside the campus health service.

- Sexually transmitted infections
  The registered nurses should be able to provide a daily service for the prevention and management of STIs.
- Registered nurses should be trained in the management of STIs and also as counsellors for HIV/AIDS/STI
- Standard treatment guidelines should be available
- The latest edition of the Diagnosis and Management of STIs in SA should be available
- Supplies of patient information pamphlets on STIs in local languages should be available in the campus health service clinic
- Posters on STIs and condoms should be on the walls in the campus health service clinic
- Condom dispensers should be placed in prominent places where condoms can be obtained without having to request them
- Supplies of condoms should always be available and should never run out
- Gloves should always be available
- Each campus health clinic should have a dildo that could be used to demonstrate proper use of the condom
- The registered nurses should be adolescent-friendly with friendly communication so as to be accessible and acceptable to shy patients whether male or female
- The campus healthcare consumers should have friendly, non-judgmental, confidential private consultations
- The registered nurses should be able to take an accurate history and examine the campus healthcare consumers correctly with dignity and respect.
- Campus healthcare consumers should be counselled on safe sex and HIV/AIDS should be explained to them
- Treatment should be provided according to the relevant protocol for each syndrome
- Contact cards should be issued and the reasons explained to the campus healthcare consumers
- The registered nurse should know when to refer to the next level of care
Patients records should be kept according to protocol and confidentiality adhered to at all times

- **HIV/AIDS**
  - A comprehensive range of services should be rendered to include:
    - the identification of possible cases;
    - performing tests with pre- and post-test counselling for HIV;
    - treating of associated infections;
    - referral of appropriate cases to the next level of care;
    - education about the disease to promote better quality of life and
    - promotion of universal precautions with the provision of condoms and the application of occupational exposure policies including needle stick injuries.

- The following reference prints and educational materials should be available in the campus health service:
  - HIV/AIDS Strategic Plan for SA;
  - summary results of the last National HIV Serological Survey on women attending public health services in SA;
  - Management of Occupational Exposure to HIV
  - the latest edition of HIV/AIDS Clinical Guidelines for Adults, Primary AIDS Care;
  - epidemiological notes relating to HIV/AIDS on a National or Provincial level and
  - strategies to reduce Mother to Child Transmission of HIV and other infections during pregnancy and childbirth

- The registered nurses should:
- know the contents of the guidelines on Management of Occupational Exposure to HIV;
- Relate to the campus healthcare consumers in a non-discriminatory and non-judgmental manner and maintain strict confidentiality about the campus healthcare consumer’s HIV status;
- be familiar with regulations and mechanisms to deal with confidentiality in notifying campus healthcare consumers with AIDS disease;
- provide warm and compassionate counseling on a continuous basis and which is sensitive to culture, language and social circumstances of the campus healthcare consumer;
- seek to reduce fear and stigma of HIV/AIDS and
- render a youth friendly service that help promoting improved health seeking behaviour and adopting safer sex practices

- **Tuberculosis**
  - The following references, prints and educational materials should be available in the campus healthcare service:
    - The latest edition of the TB training manual for health workers;
    - The SA TB control programme practical guidelines;
    - Tackling TB at work – Guidelines from SA’s national TB control programme;
    - Directly Observed Treatment Short (DOTS) course training material;
    - Flow charts for diagnosing TB; and
    - The latest essential drug list on TB management.
- The registered nurses should:
  - work closely with the nearest Department of Health PHC and act as DOTS supporters for the aforementioned clinic’s patients on campus and
  - be able to suspect and identify early symptoms of TB and refer to the nearest Department of Health PHC clinic for confirming diagnosis and initiating treatment

- Trauma and emergency
  - Local protocols relating to the relevant policy and procedures for trauma and emergencies on campus should be available and everyone on campus should be made aware of the procedures to follow in an emergency situation
  - These policies and procedures should be reviewed and renewed regularly by the campus healthcare providers
  - The campus health service clinic should have an emergency bag or trolley containing those items which are needed in an emergency, and a system in place for replenishing them when they have been used

- The registered nurses should:
  - be capable of dealing with any anticipated trauma or emergency in a safe and effective way and to stabilise and refer a patient as appropriate and
  - have skills to identify the nature of the injury and decide on the management needed and its urgency

- Victims of sexual abuse, domestic violence and gender violence
  - The registered nurses should establish a relationship with the nearest police department for referral of victims of sexual abuse, domestic violence and gender violence
Registered nurses could receive training in the identification and management of sexual, domestic and gender-related violence

The following references, prints and educational materials should be available in the campus health service clinic:
- A suitable library of references and journals on sexual offences, domestic and gender violence.
- A list of names, addresses and telephone numbers of the nearest accredited healthcare practitioners, police and social workers who are involved in dealing with these cases
- A list of names, telephone numbers and addresses of NGOs or other organizations which undertake appropriate counselling for violence and sexual abuse

The registered nurse should:
- counsel any rape victim in a confidential manner in a private room;
- help any person who alleges to have been raped or sexually assaulted to feel confident that she is believed and should treat the victim correctly and with dignity;
- record a detailed history on the patient card, take a brief verbal history of the alleged incident and note with an indication that this is not a full account. (These notes should be kept for three years);
- explain that a referral is necessary to an accredited health practitioner and make arrangements expeditiously and, while waiting for referral, give emergency treatment with the consent of the victim for prophylactic STI and post-coital contraception;
- in the event of a rape that has just occurred advise the victim not to wash or change clothing;
- give the victim information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre; and
- give the victim brief information about the legal process and the right to lay a charge

○ Mental health
  ▪ The registered nurses should be able to:
    - recognise the expression and signs of emotional distress and mental illness early especially in young people;
    - identify and refer for appropriate interventions for campus healthcare consumers with depression, anxiety, stress-related problems, male violence, substance abuse, special needs of women for example, child bearing, abortion, sterilization, disability; and
    - participate in the promotion of a healthy lifestyle in campus healthcare consumers

○ Substance abuse
  ▪ Registered nurses should:
    - build up a rapport with the campus healthcare consumers and are culturally accessible to substance abusing campus healthcare consumers to discuss their problems.
    - should identify tobacco, alcohol and marijuana or any other substance abuses and provide basic counselling for behaviour changes and referral to NGOs specialising in substance abuse; and
    - organise life skills programmes on campus where substance abuse could be discussed.
o Chronic diseases
According to the Department of Health (2000:62), priority chronic diseases include Asthma, diabetes type 2, hypertension, epilepsy, stroke, renal disease and obstructive lung disease. For the purpose of this research broad guidelines based on the DoH’s guidelines are suggested for the chronic diseases that are common among the campus healthcare consumers. These guidelines could be accessed on the DoH’s website for management and treatment of the condition.

- Management of Asthma
The registered nurses should be able to recognise, assess and initiate treatment and refer campus healthcare consumers presenting with acute attacks of asthma. The following broad guidelines are suggested:
  - Each clinic should have the National and provincial protocols and policy documents on management of acute asthma
  - Standard treatment guidelines of the Department of Health and the essential drug lists should be available in the campus health service clinic
  - Education material for campus healthcare consumers on allergy and avoidance of allergens and on the use of inhalers with or without spacers should be available
  - Oxygen and masks should be available in the campus health service clinic
  - The registered nurses should be able to provide psychological support before referral for further care
Diabetes

- The registered nurses should:
  * refer all suspected cases of diabetes to the nearest hospital or their private doctor for further investigation and management;
  * do periodic monitoring of blood glucose levels when needed;
  * counsel on disease acceptance, continuity of care and compliance;
  * further educate the campus healthcare consumer on return from diagnosis in an interactive problem solving way regarding:
    - prevention, detection and management of complications;
    - ability to self-monitor with urine or blood glucose strips and to maintain urine glucose free;
    - encouraging campus healthcare consumers to maintain a body mass index of 20-27 for males and 19-26 for females;
    - knowledge of the drugs used
    - knowledge of the symptoms and treatment for hypoglycaemia
    - contraception and pre-gestational counselling
    - advising of the campus healthcare consumers with regard to smoking

Hypertension

- Reference prints and educational material on hypertension to be available at the campus health services clinic
- Registered nurses should:
* measure blood pressure of all campus healthcare consumers who seek attention for health promotion or restoration;
* take at least two measurements of blood pressure to determine blood pressure on each campus healthcare consumer who use the clinic;
* refer campus healthcare consumers to a doctor for the start of treatment if they have a sustained systolic pressure of 160mm Hg or sustained diastolic pressure that is greater than 100mm Hg;
* refer campus healthcare consumers with a systolic pressure of 140-159mm Hg or a sustained diastolic pressure between 90-99 if they are obese, diabetic or have a strong family history of hypertension;
* monitor the blood pressure of the campus healthcare consumers who are on anti-hypertensive treatment – the target blood pressure for these campus health care consumers should be less than 140mm Hg for the systolic and less than 85mm Hg for the diastolic;
* monitor compliance and ensure continuity; and
* refer those campus healthcare consumers who are not being controlled by current medication.

- **Epilepsy**
  - Reference prints and educational material on epilepsy should be available at the campus health clinic
  - Registered nurses should:
5.6.3.4 GUIDELINE IV: To render rehabilitative healthcare services in order to recognise and rehabilitate those diagnosed with disabling conditions and to prevent complications and the worsening of the effects of the disability on the campus healthcare consumers’ functional abilities.

Operational Implications

The registered nurse should:

- be able to treat disabling and potentially disabling conditions;

- have knowledge of and refer campus healthcare consumers to the available resources for rehabilitation;

- teach basic maintenance of wheelchairs, hearing aids, calipers and crutches;

- teach an exercise programme for the prevention and treatment of backache;
• instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints;

• teach patient healthcare consumers with sensory loss how to prevent pressure sores;

• teach campus healthcare consumers diagnosed with chronic lifestyle diseases how to cope and adapt their lifestyle to the disease; and

• ensure that the campus healthcare consumer is as fully employed as possible or selectively placed.

5.6.4 Guidelines for operationalisation of Step 4: Consequent resolution

Operational implications

• The registered nurse should empower and prepare the campus healthcare consumer to take responsibility for his or her own health in the preceding steps because once the signs and symptoms have disappeared, the onus is on the individual to take care of him- or herself to maintain a balanced state.

• The campus healthcare consumer could become a balanced, whole person who is able to realise his or her aspirations and maintain optimum health and capacity by:
  o complying with the treatment and rehabilitation procedures prescribed by the healthcare provider;
  o living a healthy lifestyle;
  o knowing what healthcare services are available on campus and what they offer; and
  o utilising the campus healthcare service when needed again.
5.7 EVALUATION OF THE MODEL

The evaluation of the holistic healthcare model for higher education campus health services will be discussed according to the criteria suggested by Chinn and Kramer (1995:128-137). The model developed for this study has been evaluated by four independent experts who are experienced in qualitative research methodology and theory generation and are in possession of doctoral degrees. Several consultations and revisions resulted in the final product which is presented in this chapter.

5.7.1 CLARITY OF THE MODEL

All concepts are clearly defined thus ensuring semantic clarity and empiric meaning for concepts within the model for holistic healthcare at higher education campus health services. The concepts are used in ways that are consistent with the definitions making the model easy to understand. The concepts are interconnected and organised into a whole so as to ensure structural clarity.

5.7.2 SIMPLICITY OF THE MODEL

The number of concepts and interrelationships in this model was kept to a minimal to ensure simplicity of the model.

5.7.3 GENERALITY OF THE MODEL

This model for holistic healthcare has been designed to serve as a frame of reference for registered nurses employed in campus health services at HEIs to assist all campus healthcare consumers to become balanced, whole persons who are able to realise their dreams and maintain consistency with regard to optimal health and capacity. However, this model also has the
capacity for broader generalisation, for example, in other nursing practice environments where holistic healthcare is being rendered.

5.7.4 ACCESSIBILITY OF THE MODEL

The definitions provided for the concepts in the model adequately reflect their meanings thus ensuring accessibility of the model. The outcomes projected in the model are considered to be attainable.

5.7.5 IMPORTANCE/SIGNIFICANCE OF THE MODEL

The model for holistic healthcare has been developed as a practice model for nursing to promote or restore the health of individuals so that they can become balanced, whole persons. The model which addresses perceived healthcare needs as indicated by the campus healthcare consumers and providers comprises four sequential steps. The model does have the potential to influence positively nursing practice, education and research.

5.8 SUMMARY

The focus of this chapter was on the description of the model of holistic healthcare for higher education campus health services. A visual presentation was also presented. The following chapter will focus on the summary, conclusions, limitations and recommendations.
CHAPTER SIX

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

A description of the structure and process of the holistic healthcare model for higher education campus health services was provided in the previous chapter. Guidelines for the operationalisation of the model and a description of the criteria used to evaluate the model were also provided in Chapter Five. The focus of this final chapter will be on the summary, conclusions, limitations and recommendations for this study.

6.2 SUMMARY AND CONCLUSIONS

The purpose of this study was to obtain information regarding the perceived healthcare needs of students and staff and also to establish how they and the campus healthcare providers experienced the healthcare provided by the campus health service at an HEI in the ECP. This information was used to develop a healthcare model that would assist registered nurses employed at HEIs campus health services in rendering a healthcare service relevant to the healthcare needs of the campus healthcare consumers. The objectives to attain the purpose of the study were to:

- identify the central concepts of the model by conducting a field study which was done by exploring and describing how the campus healthcare consumers and providers at a HEI experienced the healthcare provided by the campus health services and by exploring
and describing the perceived healthcare needs of the campus healthcare consumers;

• define and classify the identified concepts;

• describe the relationship statements or propositions between the concepts;

• describe a model that would assist registered nurses at HEI campus health services in rendering a healthcare service relevant to the needs of the campus healthcare consumers, the development and description of the model was based on the results of the focus-group interviews held with the students and the interviews conducted with the staff and campus healthcare providers, direct observation and extensive literature control; and

• describe the guidelines that were developed to operationalise the implementation of the model.

A theory-generating design based on a qualitative, explorative, descriptive and contextual research approach was implemented by the researcher to achieve the abovementioned purpose and research objectives. The design comprised four steps, namely concept analysis, creation of relationship statements, development and description of the model and the description of guidelines to operationalise the model. A brief description of the criteria for evaluating the model was also included in Chapter Five.

**Step One** of the research design focused on the identification, classification and definition of the major concepts of the study. In order to achieve this step, data were gathered from the research participants to establish how they experienced the campus health services rendered at an HEI in the ECP and also to establish the perceived healthcare needs of the healthcare consumers. The research population used to obtain the necessary data for this research included all students and staff who used the service as well all healthcare
professionals who rendered the service. The method of data collection included focus-group interviews and depth individual interviews. Six focus-group interviews were held with students consisting of six to ten students in a group. A total of 51 students participated. Nine depth individual interviews were held with nine staff members who used the campus health service ranging from technical and support staff to academics, and eleven depth individual interviews held with all the healthcare providers.

The information gathered was transcribed, coded and analysed by the independent coder, researcher and promoters; and two main themes, sub-themes and categories were identified for all three groups of participants. The same two main themes were identified for the student and staff campus healthcare consumers because the same research questions were posed to them. The two main themes identified for the campus healthcare consumers were:

- Staff and student healthcare consumers expressed a diverse range of experiences related to how their healthcare needs were at the campus health service clinic
- Staff and students experienced specific healthcare needs in order to maintain a state of optimal wellness

The two main themes identified from the data analysis of the campus healthcare providers were:

- Campus healthcare providers experienced the rendering of campus health services as positive, rewarding and challenging
- Campus healthcare providers experienced the need to render a more comprehensive primary health care service to address a wide range of healthcare needs of students and staff on campus

Extensive discussions of the aforementioned experiences provided the researcher with the understanding that most of the participants who used the campus health service at the HEI had both positive and negative experiences relating to how their healthcare needs were met. The campus healthcare
providers indicated that they experienced the rendering of campus health services as positive, rewarding and challenging; but all three groups of participants expressed the need for a more comprehensive healthcare service to be rendered on campus in order to address the diverse range of perceived healthcare needs. The campus healthcare consumers expressed a need for not only their physical healthcare needs to be addressed but also their mental, social and knowledge healthcare needs. Therefore, according to de Haan (2005:4), treatment to attain health cannot be confined to medical treatment alone; but should be more comprehensive in nature and include the improvement of the environment or the conditions in which one works or lives, health education, counselling and support and so forth, thus preventing disease conditions from occurring or recurring.

The campus healthcare providers therefore expressed a need to render a diverse range of healthcare services on campus for the campus healthcare consumers in order to attain and maintain optimal wellness. The campus healthcare providers indicated that the diverse range of healthcare services should include a promotive, preventive, curative and rehabilitative healthcare service. They indicated that the preventive and promotive healthcare service would address the healthcare educational needs and other needs such as nutritional supplements, family planning, VCT, vaccines, ante-natal care and barrier methods for protection against STI and HIV infections. The campus healthcare consumers expressed the need to include the rendering of a chronic disease service as part of the curative healthcare services because of the perceived high incidence of chronic conditions such as Hypertension and Diabetes Mellitus on campus. A need was also expressed by the campus healthcare providers and the staff campus healthcare consumers for an occupational health service on campus and also for supportive counselling and social services. Thus a model for holistic healthcare for higher education campus healthcare services was identified.

The identified major concept was analysed by researching its meanings in several dictionaries and also in subject literature. The concept “holistic healthcare” was analysed so that its essential and related attributes could be
identified in order to arrive at a conceptual definition for the central concept of the study.

**Step Two** of the research design focused on the development of relationship statements in order to bring clarity and direction to the understanding of the phenomenon of interest.

**Step Three** of the research design focused on the description of the model that was developed for campus health services at HEIs. A visual representation of the structure of the model for holistic healthcare at higher education campus health services was given and described as well as a detailed description of the process of the model which is based on four sequential steps, namely:

- **Initiating consultation**
  The campus healthcare consumer experiences an imbalance in either his or her internal or external environment and therefore needs to consult the registered nurse to correct the imbalance. The campus healthcare consumer therefore seeks assistance to promote or restore his or her health.

- **Assessment and nursing diagnosis**
  In order for the registered nurse to make an accurate nursing diagnosis she needs to pay serious attention to the healthcare needs of the campus healthcare consumer and illustrate real concern for the quality of life of the individual. The registered nurse therefore conducts a thorough assessment of the campus healthcare consumer in order to fulfil the following step competently.

- **Planning and management**
  In planning for the management and treatment of the campus healthcare consumer the registered nurse will decide whether or not the problem that the campus healthcare consumer presents with, falls within her scope of practice. If she is unable to manage the campus healthcare consumer
herself she will refer him or her to the appropriate member of the multidisciplinary health team member. The registered nurse will treat the campus healthcare consumer herself if she considers the problem within her scope of practice by providing total patient care, taking into consideration the physical, psychological, social and spiritual healthcare needs of the campus healthcare consumer. Total patient care is achieved through the rendering of an integrated, all encompassing healthcare service.

- **Consequent resolution**
  The campus healthcare consumer could become a balanced, whole person again once the signs and symptoms have disappeared or he or she has been empowered with knowledge and skills to take care of him- or herself. The imbalance can be corrected and the individual should be able to realise his or her aspirations and maintain consistency with regard to optimum health and capacity.

**Step Four** is the last step of the research design and its focus was the development and recommendations of guidelines for the operationalisation of the model for holistic healthcare at higher education campus health services. Guidelines and operational implications for each of the four sequential steps of the holistic healthcare model were developed.

The five criteria as suggested by Chinn and Kramer (1995:125-137) were used to evaluate the aforementioned model, namely:

- Clarity
- Simplicity
- Generality
- Accessibility
- Importance and significance
In view of the above discussion it can therefore be concluded that the research purpose and objectives for this research have been achieved because the researcher succeeded in:

- Collecting the necessary data that assisted her in identifying the central concepts for the model which she intended to develop.
- defining and classifying the identified concepts;
- describing the relationship statements or propositions between the concepts;
- developing and describing a model that could assist registered nurses at HEI campus health services in rendering a healthcare service relevant to the needs of the campus healthcare consumers,
- describing the guidelines that were developed to operationalise the implementation of the model.

In conclusion, the purpose of this research project has been achieved because the researcher has succeeded in developing a model that could be used by registered nurses employed at HEIs campus health services in rendering healthcare services relevant to the healthcare needs of the campus healthcare consumers. The model is understandable, clear, simple, applicable and important to nursing practice.

6.3 LIMITATIONS

The following limitations were experienced with regard to this study:

- The results of this study cannot be generalised to all campus health services in South Africa because a qualitative study was conducted using only one campus health service with five satellite campus health clinics in the Eastern Cape Province.

- A paucity of literature with regard to campus health services in general in South Africa was experienced.
6.4 RECOMMENDATIONS

The following recommendations are made for the application of the holistic healthcare model for higher education campus healthcare services:

6.4.1 RECOMMENDATIONS FOR NURSING PRACTICE

The researcher recommends that:

- the model be used by registered nurses at higher education institutions in rendering a holistic healthcare service to students and staff on campus and in assisting them in becoming balanced, whole persons;

- registered nurses at higher education institutions use this model to reflect on their current practices and

- the model be used in any nursing practice or education situation to promote holistic healthcare.

6.4.2 RECOMMENDATIONS FOR NURSING RESEARCH

The following recommendations are made by the researcher with regard to research, namely, that:

- the model for holistic healthcare be applied to the nursing practice environment of campus health services and that its effectiveness be evaluated and refined during further post-doctoral research and

- further research could be conducted with regard to the development and implementation of an effective occupational health service on campus as well as a promotive and preventive health programme to promote healthy lifestyles.
6.4.3 RECOMMENDATIONS FOR NURSING EDUCATION

It is recommended:

- that the holistic healthcare model be included in and utilised as a frame of reference for nursing practitioners in undergraduate as well as post-basic nursing education programmes pertaining to holistic healthcare.

6.5 SUMMARY

This final chapter provided an overview of the overall research process and afforded the researcher the opportunity to account for the purpose and achievement of the objectives of the research study. The limitations of the study were highlighted and recommendations for nursing practice, research and education were made.

The researcher believes that the model for holistic healthcare could be implemented by registered nurses at higher education campus health services to assist campus healthcare consumers to maintain a balanced state or correct any healthcare needs imbalances that could interfere with the campus healthcare consumers becoming balanced, whole persons who are able to achieve their aspirations and maintain consistency with regard to optimum health and capacity.
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ADDENDUM A
Date: 03 March 2006

The Vice Chancellor
University name

Dear

A REQUEST FOR PERMISSION TO CONDUCT RESEARCH

A request is hereby submitted for permission to conduct research among the students and staff on campus. I am currently registered for my Doctor Curationis Degree in the Nursing Science Department, Faculty of Health Sciences at the Nelson Mandela Metropolitan University in Port Elizabeth. The study is being conducted under the supervision of Professor J Strümpher and Professor RM van Rooyen

The title of my research study is “A model for campus health services at institutions of higher education in the Province of the Eastern Cape”. A theory-generating, qualitative, explorative, descriptive, contextual survey design will be used to gather the necessary data.

You may contact my supervisors if there are any ethical concerns related to the study. A copy of the proposal will be made available to you, for your perusal, if you so wish.

Thank you

Yours sincerely

Mrs EJ Ricks
Doctoral Student
Contact No.: 5042114
Mobile: 084 800 1283
ADDENDUM B
Date: 03 March 2006

Dear Sister

A REQUEST FOR PERMISSION TO CONDUCT RESEARCH

A request is hereby submitted for permission to conduct research among the registered nurses employed in the campus health service. I am currently registered for my Doctor Curationis Degree in the Nursing Science Department, Faculty of Health Sciences at the Nelson Mandela Metropolitan University in Port Elizabeth. The study is being conducted under the supervision of Professor J Strümpfer and Professor RM van Rooyen.

The title of my research study is “A model for campus health services at institutions of higher education in the Province of the Eastern Cape”. A theory-generating, quantitative, explorative, descriptive, contextual survey design will be used to gather the necessary data.

You may contact my supervisors if there are any ethical concerns related to the study. A copy of the proposal will be made available to you, for your perusal, if you so wish.

Thank you

Yours sincerely

Mrs EJ Ricks
Doctoral Student
Contact No.: 5042114
Mobile: 084 800 1283
ADDENDUM C
Ref: 1820099720

Contact person: Ms G Ehbel

Date: 28 March 2006

Address:

Ms EJ Ricks
31 Adam Road
Charlo
PORT ELIZABETH
6070

Dear Ms Ricks

FINAL RESEARCH PROPOSAL: DCur

Congratulations on a well prepared final research proposal. Please be advised that your final research proposal was approved by Faculty Management subject to the following suggestions/recommendations being made to the satisfaction of your Promoter:

(i) that the budget total needed to be amended;
(ii) that references in the text were not always in the Reference List;
(iii) that paragraph 4 on page 8 needed to be linguistically edited;
(iv) that under paragraph 10 on page 29 next to chapter 5, the word "module" is to be replaced with "model".

Yours sincerely

[Signature]

OFFICE OF THE DEAN
FACULTY OF HEALTH SCIENCES

GE\vH/racha/letters/final research proposal/june
ADDENDUM D
Ref: N 01/11/03/07 [H06H-006/Approval]

Contact person: Mrs U Spies

29 March 2006

Ms E Ricks
Faculty of Health Sciences
Department of Nursing Science
NMMU

Dear Ms Ricks

A HEALTH CARE MODEL FOR OPTIMISING CAMPUS HEALTH SERVICE DELIVERY AT A HIGHER EDUCATION INSTITUTION

Your above-entitled application for ethics approval served at the March 2006 ordinary meeting of the Research Ethics Committee (Human).

The Committee APPROVED the application.

Please inform your co-investigators of the outcome. We wish you well with the project.

Yours sincerely

[Signature]

Prof R du Randt
Chairperson: Research Ethics Committee (Human)

cc: Department of Research Management
    Faculty Officer, Faculty of Health Sciences
ADDENDUM E
Mrs. EJ Ricks  
Doctoral student  
Nursing Science Department  

1 June 2006  

Dear Mrs Ricks  

PERMISSION TO CONDUCT RESEARCH  

It gives me great pleasure to inform you that your request dated 16 May 2006 is hereby granted.  

I would like to wish to well with the proposed research.  

Yours sincerely  

Sr. Antoinette Goosen  
Interim Director Campus Health Service  
Nelson Mandela Metropolitan University  
Port Elizabeth
ADDENDUM F
**Title of the research project**: A health care model for optimising campus health services at an institution of higher education

**Reference number**

**Principal investigator**: Esmeralda Ricks

**Address**: 31 Adam Road
Charlo

**Postal Code**: 6070

**Contact telephone number**: 084 800 1283

---

**A. DECLARATION BY OR ON BEHALF OF PARTICIPANT**

(Person legally competent to give consent on behalf of the participant)

---

I, the participant and the undersigned

I.D. number

**OR**

I, in my capacity as

of the participant

I.D. number

---

**A.1 I HEREBY CONFIRM AS FOLLOWS:**

---

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by

Esmeralda Ricks

Nursing Science

Health Sciences

of the Department of

in the Faculty of

of the Nelson Mandela Metropolitan University.

---

2. The following aspects have been explained to me, the participant:

---

2.1 Aim: The investigators are studying:

This study aims to obtain information regarding the perceived health needs of students and staff and also to establish how they and the registered nurses experience campus health care services at a HEI in the PEC.
The information will be used to develop a health care model that could be used by registered nurses for optimising service delivery relevant to the health needs of the health care consumers on campus.

2.2 Procedures: I understand that the interview will be recorded with a tape recorder

2.3 Risks: No risks involved

2.4 Possible benefits: As a result of my participation in this study the information obtained will add to a body of knowledge and enable the researcher to develop a health care model for campus health services.

2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.

2.6 Access to findings: Any new information/or benefit that develops during the course of the study will be shared as follows:

2.7 Voluntary participation/refusal/discontinuation:

| My participation is voluntary | YES | NO |

| My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle | TRUE | FALSE |

3. The information above was explained to me/the participant by

| (name of relevant person) | Esmeralda Ricks |

| (name of translator) | |

and I am in command of this language/it was satisfactorily translated to me by

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.
### A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT

<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th></th>
<th>on</th>
<th>20</th>
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<td>Signature of witness</td>
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<td>Signature or right thumb print of participant</td>
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<td>Full name of witness</td>
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### B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I,……………………………………………………………………………………………………………….………
…declare that
- I have explained the information given in this document to
  (name of patient/participant)
  and/or his/her representative
  (name of representative)
- he/she was encouraged and given ample time to ask me any questions;
- this conversation was conducted in
  Afrikaans | English | Xhosa | Other
  (language) by
- I have detached Section D and handed it to the participant
  Signed/confirmed at
  on | 20

| Signature of interviewer |
| Full name of witness |
C. DECLARATION BY TRANSLATOR

I, [Name]
I.D. number [ID number]
Qualifications [Qualifications]
and/or Current employment [Current employment]
confirm that I
- translated the contents of this document from English into [language]
- also translated the questions posed by [name] as well as the answers given by the investigator/representative; and
- conveyed a factually correct version of what was related to me.

Signed/confirmed at [Date] on 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential

Signature or right thumb print of translator [Signature]
Full name of witness [Full name]

D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:
- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

Kindly contact [Name]
at telephone [Phone number]

(it must be a number where help will be available on a 24 hour basis, if the research project warrants it)
ADDENDUM G
November 2006

Dear Mrs Klopper

INDEPENDENT CODING AND DATA ANALYSIS

With regard to our telephonic conversation I wish to thank you for agreeing to assist me with
the independent coding data analysis for my research. Please use the following process

- Get a sense of the whole. Read all the transcriptions carefully and make
  short notes.
- Pick one document at a time, go through it and try to make meaning of its
  contents; then write notes in the margin.
- When this action has been completed for several documents, make a list of
  all the topics. Cluster similar ones together and form them into columns that
  can be arranged as major topics, unique topics and leftovers.
- Take the list and go back to the data. Abbreviate the topics as codes and
  write the codes next to the appropriate segments of the text to see whether
  new categories and codes emerge.
- Find the most descriptive wording for the topics and turn them into
  categories. Reduce the total list of categories by grouping topics that relate to
  one another. Lines could be drawn between categories to show
  interrelationships.
- Make a final decision on the abbreviation for each category and arrange
  these categories alphabetically.
- Assemble the data material belonging to each category in one place and
  perform a preliminary analysis.
- Re-code existing data if necessary.

Please contact me as soon as you have completed the independent coding and analysis. My
telephone numbers have not changed.

Thank you

Esmeralda Ricks
ADDENDUM H
INTERVIEW 23.10.2006
FEMALE STUDENT HEALTH CARE CONSUMERS FOCUS GROUP NO. 3

This focus group comprised of 8 female black students ranging from 1st year to third year level. They represented various academic departments. This interview was conducted in one of the lounges in the female residence.

ER:

How do you experience campus health services that are provided on campus?

- It has everything that I think a student needs. The services they offer, they’re really relevant to our student life and for me, they just meet my every need. I don’t think there’s something extra that I need from them.

- I do know what she said. I think they’re very useful in a way that, especially for students who are not on medical aid they’re quite useful and you can also use them as a counselling resort because you can actually go to the sister and talk to her about maybe I mean personal problems if you feel comfortable and also if you’re not sure but if something is happening in your body, especially as ladies you know there are changes, some things happen to your body, if you’re not sure about something, you are able to go and ask, even if you don’t consult with them, just ask if you should consult a doctor or -

ER:

How was your experience when you went?

- The thing is, this thing that you have to make an appointment early. What if I wake up and I’m sick, and you have to make an appointment ahead and I don’t have a car and as the day goes by I get sick, so they can’t help me because I didn’t make an appointment. So that’s the bad part for me, and ja, that’s the bad part for me, but the sister is very OK, talks to me, easy to talk to.

- The sister is fine but I think the receptionist or the lady at the front needs a little bit of training in people skills you know, because at times she can be very rude and at times she can be very friendly, so when you go to the clinic, you go with that thing of now knowing which mood she’s going to be in today and ja, she’s not a people’s person. I don’t think she should be at the front desk because she’s
like the face of that clinic and the face of whichever organisation should be a friendly face, because most of the people now, they don’t want to go to the clinic because of her, even if they’re sick, you find no they don’t want to go because that woman is there. Or maybe if they can’t replace her, then they need to take her on a course on people skills or something. I remember the first time when I went, I didn’t know that I had to make an appointment at 8 and when I got there, just help with the problems and then I had to come back here to rest and then the next day pull myself together which was not very easy, knowing what I’ve had the previous day but because I had to go, I had to go there. Ja, just people skills.

**ER:**

*When you say she was rude, in which way can you describe that?*

- No, she’s not always rude. It’s just that most of the time she’s in a bad mood, you don’t know what put her in a bad mood. It’s like she gives you those stares and those looks, it’s like she’s disgusted with something. You can see you know that she’s not friendly today you know, when you talk to her it’s either she's not listening to you or she shouts at you, or she just answers in a very snotty way.

**ER:**

*How was your experience?*

- Well from my side, I have no problem very fortunately. As I come and go there, she’s okay, she will call me there and I don’t have a problem with her. The service is always good.

- Every time I go to the clinic, the nurse is always okay with me, she’s a pleasant person, I feel comfortable talking to her about anything and the receptionist, I don’t have a problem with her because we connect, we talk about anything, so she was never rude or otherwise, moody or whatever to me. So I really don’t have a problem, I don’t have a problem with the nurse as well, I find it okay for me to go there.

- I’ll sit and wait for help, as long as I know that they are - I know what is rude and you feel so bad, or so down after ... but I don’t ... talk to the sister and I decide at the end of the day, I know everything she said and I will ring her next time.
Well I’ve only gone to the clinic once this year and once last year, so my experience with those two occasions was okay, fine but my own problem is - ... I mean like if the campus health thingy that is actually fit for the students complaining, some of us ...

ER:
Speaking about the experiences, how was your experience when you used the clinic?

➢ The first time, I have a mixed feeling about the whole thing, ... okay I guess.

ER:
Why would you say it was just “okay, you guess”?

➢ ...

ER:
And have you used it again thereafter?

➢ Ja.

ER:
And how was it then?

➢ ... it was better for people ... and I say it was better for everyone than not making appointments, I mean you don’t have to sit there for hours and then ... don’t know what time you’ll be attended to ...

ER:
What do you mainly use the clinic for? Which services to you mainly make use of?

➢ Family planning.

ER:
Family planning - okay. Any other services?

➢ Flu. Take treatment.

ER:
Treatments, for?
Whether you’re diabetic or - because there are other students who take treatment.

HIV testing.

If you’ve had a headache for the past 2 weeks or something and you don’t know what’s going on.

ER:

*How do you experience the clinic for HIV testing?*

I did go to the clinic for HIV testing and I made an appointment. They said I must come back next week because they say it’s done Tuesdays at 2 o’clock, and I went there the following week and the nurse couldn’t attend me and I went for then a whole month and I just gave up. I don’t know about testing.

They shouldn’t have days when to test for HIV because this guy is on Monday and I still have to only go to the clinic and HIV test, now they tell me the test is on Thursday, I have to wait until Thursday. I just want to have it done on Monday, not on Thursday. So I feel they should like have every day, if you want to go and have an HIV test on a specific day, they should just attend to you, not tell you that you have to come back next week or sometimes they say but you know it’s exam time, that’s why you can’t have an HIV test before exam. Whose choice is it, anyway? My choice was to go there to have the test, so they can’t think for me that it’s exam time that I can’t have the test, so whichever time you want to go test, they can just allow a person to have the HIV test. Because you have decided that you want it so they can’t make up the decision for you, that they know that you won’t write the exam now if you know you’re HIV positive or negative.

I beg to differ - ja, I agree with her statement that it’s her decision to make, whether you want to have the test or not but then at the same time I think it’s best that they don’t do the test during exam time because a lot of people respond to their status in different ways. Those people who can be suicidal if they find out they’re positive, and you’ll find that they’ve been doing so well throughout the year in their academics and then when they find out they’re positive, they kill themselves - ja it’s good that they don’t do it during exam time. Even if you’re
not suicidal I mean, you’re going to think about that thing and it’s going to
distract you in some way or another, and you may not perform as well as you
would have if you hadn’t found out that you’re HIV positive.

ER:

*Let’s just give her a chance.*

- Ja, I was just thinking about what she just said now. I think if you decided to go
  with them, that you just do the test because if they don’t do it, say it’s exam time
  and they don’t do it, you won’t be thinking about that whole thing, what’s the test
  going to say when I go, like when am I going to get my test and all that, when
  you’re supposed to be starting. So I think ..., then everything will just follow
  after that.

- I think ... and going back to what she said, I think she said ... I think the problem
  there is that one person is not enough and the sister could run HIV tests, pregnancy
  tests, ... go there for family planning and having one sister is not
  enough and maybe if we had had two, maybe that test would be able to be done
  for us. Because she can’t attend to all the problems... because she’s only one.

- And as I was saying, the clinic is too small compared to the other campuses like
  Vista and UPE, south campus, and I think maybe the university can try and
  extend it because of the north side with the student services where they used to be
  - that side is not being used any more, so it’s like right next door to the clinic,
  maybe they can make some form of connection between those two venues, and
  make the clinic bigger. In that way they can accommodate the two nurses.

- Maybe the nurse should have a time limit or something, sometimes you know
  when you go there, then you have an appointment for quarter past nê, but maybe
  one person had an appointment maybe for quarter to, it takes an hour you know to
  get to her. Maybe the nurse should like see a person and then say 30 minutes,
  I’ve got 30 minutes, not like more than an hour seeing one person, whereas now
  ... or something like that. ... should also think for other students and whether they
  have class, or -
Earlier on what she said, I had an experience once where I had an appointment for 25 to 10 and I had class at 5 to 11 and I had an appointment for 25 past 10, I had a class at 5 to 11 and when I got there, somebody with appointment for half past 9 was already sitting there, she was still sitting there waiting for the nurse to attend to her. Now I think the last person for half past nine and there’s two more people before me, so I was like the fourth person and it was my time for my appointment and ja, the nurse really needs - I think it also goes back to that thing of having too much work to do for a nurse.

ER:
What if - you say half an hour per consultation, but what if your problem is bigger than half an hour?

➢ Then you should come back later or something. But what about the next student, the next person, considering maybe she has class or something else to do?

➢ I think with that same question, what if the problem is bigger than ...? It still boils down to that point, there is one person, which is just not enough because while she's still busy with that one person affecting her appointment, ... attending her. It’s too strenuous for one person.

➢ You can try to make ... management but I don’t think it will work. One morning I woke up, I had ... and I had to run there. I didn’t have an appointment, so someone who’d made an appointment for 8 o’clock ... because I couldn’t sleep the whole night, I was in the shower. So ... before that person because ... yes we can try that but it won’t always work. Even if you get - okay I know we have to get more nurses and everything but still we can pick and play but I mean I’ll have my own problem, you’ll have your own problem and if you just come down ... now.

ER:
Is there anything else you would like to add about your experiences?

➢ It’s not really my experience but I think just to be too loaded, the fact that we only have one medical vehicle in this whole university with the four campuses - it’s just ridiculous because say now somebody is at the clinic and they need to be
transferred to the hospital and at the same time, the same thing is happening at south campus, how are we supposed, it’s strenuous for us students, and it’s strenuous to the sister and the clinic that we have to share one vehicle. So it’s one of the medical services that need to be upgraded and soon ... because it’s ridiculous to have one medical vehicle, something that is essential, and have all these other people gathering around with the speakers, there are so many of them around but then there’s only one, it’s even an old vehicle, like broken down or something, it’s just ridiculous.

ER:
Anything else you’d like to add to your experiences?

➤ Maybe there should be also a doctor with the nurses because from my experience there’s a certain day, you can only see the doctor on Thursday. What if maybe your problem is serious on Monday, if you need to see the doctor because the nurse can’t attend to the specific problem. I think we should also have a doctor at this campus because I think the doctor is only on north campus or south campus, but maybe we should also have a doctor or something.

➤ There’s a doctor on Thursday?

➤ Only on Thursdays.

ER:
So how often would you like the doctor to come?

➤ Every day. Or at least twice a week.

➤ And another thing I once experienced. I’m based here at college, so I was attending something at north campus and somehow I got sick and I went to the clinic there and the nurse was like, no I can’t attend to you because you’re a college student. You have to go to the clinic at college, you can’t come to the clinic here, and I was like, but it’s the same institution, she’s like, no we don’t have your file here, you do have a file at college and I’m thinking if it’s the same institution, why can’t they record it and then you know transfer it to my part of
the college or something like that but the fact that they can’t attend to me when I’m at another campus whilst I’m still a student of the same institution, it’s too -

ER:
Any other experiences? Shall we move on to the next question?

The next question is, what are your healthcare needs?

➤ What do you mean?

ER:
A health need could refer to anything that you need in order to maintain a healthy state, so it could be a physical health need, it could be a mental health need, it could be a social health need, or it could even be spiritual health needs, but in order to be healthy there are certain things that we need in order to maintain that physical health, in order to maintain that mental health, in order to maintain that social health. So what are the things that you need in order to be healthy?

➤ I would say for me, okay I know that I think about once in a year the sister comes to talk to us about sexually transmitted diseases and all those other things but I think it’s really enough for me just that one session with her, I think we should really have maybe one session per semester because when it’s like one thing, then only a few people go and the rest of them stay in their rooms, so if it’s two, they can think or so look I didn’t go for it during the first semester so I can go for the second semester. Ja - more information.

➤ I think maybe a good diet - I don’t really know - okay I know the bad stuff but they say some of the bad stuff is actually good for you, so you know I can’t really differentiate, I like eating everything! So maybe we could have some sort of nutritionist at the clinic, or maybe you know send the sister on some course on nutrition and build balanced diets and all that, so that you can go and consult, the whole thing of blood sugar levels and cholesterol you know, you can know where to add, physically, you know your cholesterol levels and all those things, you know what you should eat, you shouldn’t eat. So somebody can advise on diets, would be bad for me.
ER:
Anything else?

➢ If they had like, just to check, to test you for like breast cancer, they do OK.

ER:
Anything else that you feel you need in order to be healthy?

➢ I go to the sister and she will tell me how to .... I spend 24 hours doing my ... and I come back so tired that ... some form of exercise that can be given to us in order to ...

ER:
Any other health needs that you’ve identified?

➢ ... condoms every day in the toilets.

ER:
Have you got any health needs?

➢ I think there should be some form of gynaecologist, because I think the sister doesn’t know what is wrong, because maybe you can go for a stomach ache or period pains, she’ll just say you’ve got period pains, what if the problem’s different than period pains and I think that perhaps the gynaecologist should come...

➢ And Pap smears - maybe they can have like, I know they have them this semester. Maybe they can have them during the first semester and the second semester you know, and maybe they can actually educate people more about what Pap smears are all about. A lot of people just see Pap smear, Pap smear - they don’t know what it is, they don’t know what it’s about. They go for a Pap smear, they don’t know what they’re going for. So maybe they can educate students, like female students, what Pap smears are and maybe they can actually have them during the first semester, maybe three times or whatever, on a regular basis.

➢ They should happen every month. Because you never know when you have cancer or whatever.
ER:

So who should go every month? The same people?

- No, not the same people but if you go in the first month, everyone feels like going. You can go even if you repeat, because maybe cancer was not detected in the first month that you went, maybe it can be detected in the second month or something.

- What are Pap smears?

[ER explains]

ER:

Any other health needs?

Okay, so basically what you said, you need more information on various health issues like STIs, like Pap smears, breast examinations, and you also said that you need condoms to be more freely available on campus and that the containers must be filled, and nutritional information as to what comprises a well balance diet, and you need a medical doctor.

- And another concern is when somebody gets sick let’s say in the middle of the night and you call the campus control, they call the ambulance. You know the services we get from the Municipal ambulances, they’re quite not so all right because one day like the paramedics that got here were actually drunk, now how can you trust those people with somebody’s life, somebody who is sick you know, so I think maybe I don’t know they can find some other way of getting ambulances here much quicker and people with sober minds and something. Because the ambulances they’re using, they’re very slow, they actually take up to two hours to get here, which is why most of the people they prefer calling Netcare for example. It’s quite expensive for most students because most of us are not on medical aid, so now Netcare will charge you like R350 to take you to Mercantile or something, and most of us don’t have that kind of money. It’s much cheaper to use the services that are offered by the University but at the same time those services are the ones that are failing us.
I think maybe here at Res we should have like maybe about six, seven people trained to do first aid. Reliable people who are always going to be around. If somebody falls and breaks their leg, I don’t know what to do, I’ll just stand and look... without doing anything to help the person, because the person who has been trained is not around.

ER:
So how many people do you think would be adequate to train?

Well, 10 - five ladies and five guys.

ER:
Are there any other health needs that you have identified?

If you’re wanting information, how often do you think that information should be provided?

Please rephrase the question.

ER:
How often do you think they should provide information to you?

Maybe we should have someone who’ll talk to us once a term which means four times a year. And we should have actually you know students around who can hand out pamphlets so that we are aware of what we can do about ... and our health.

On that note, we have some students called Peer Helpers around but then they are always ... and are always working with the health services and then the students themselves never take notice of us when we come with information to them so I think the idea of having students giving out pamphlets, it’s a good idea but then it’s not a very practical one because they never take us seriously. So maybe we can have some sort of pamphlet books in the corridor or whatever. I think most of the reason is that people are afraid to be seen going for information. Maybe we can help those with the information with the pamphlets and brochures, then anybody can just sneak a peek at the pamphlets or take one, without being
noticed by their peers or whatever, because most of us are suffering from peer pressure, we don’t want to be seen as you know, weak people going for help, ja.

- The pamphlet doesn’t really work with students. You give them something but we don’t even read it. We just look at it and then throw it away. Even if you could have those books where they - it wouldn’t - it would just be messed up, they won’t read, people won’t go, I think we should just get someone to talk to us, it doesn’t matter how many times - four times a year or something like that. That might work - that pamphlet thing is totally out.

- Or maybe visual aids like maybe a drugging person or something, to show what drinking does to you, whatever, for sure when you pass them in the corridors, big signs of whatever, and then you can look at it and see that’s what happens when you do such things. Maybe an explanation at the bottom - okay, this is that happens, ... or whatever.

**ER:**

*Any other health needs that you have?*

- No.

**ER:**

*Okay, so can we move on to the last question?*

*How can campus health services meet your needs, and I think we touched on some of it, so if we could just address that.*

- I think the major part, the first step they can take, is to provide us with another nurse - extend the health services, you know make it bigger and more available to the students. That’s the first step they can take.

**ER:**

*When you say “more available”, what do you actually mean by that?*

- I mean when you see that there’s more space, there’s actually more people to attend to, you’re more likely to go to the clinic, you won’t spend as much time as you did before when there was only sister available. So students will see that it’s
more readily available to them. And then they can also take on the medical vehicle issue, maybe supply us with two more vehicles or whatever, get a sponsorship from VW or something.

- I think the clinic should be open weekends also because you know if you don’t have medical aid then you just have to spend your whole weekend staying stick and not getting any help, or you go to Dora Nginza and wait there until the next day to be attended to.

ER:

*Any other means that campus health service can meet your needs?*

- ... the PA or Secretary or Receptionist at Reception, she had a very cocky attitude and some people do not go to the clinic because of her. I think that whoever they put there ... should be a very friendly kind of person because sometimes it takes a whole lot of pressure to go there and they get ... they should be careful how they select a person...

ER:

*Any other ways in which they can meet your needs?*

- Something that she mentioned earlier that the services should be for free because some people might not have the R10 to like pay for consultation.

- When you pay the R10, why do you pay the R10 for antibiotics?

- Ja, when you get medication.

- Okay.

ER:

*Anything else?*

- Appointment business - you can’t really predict when you get sick. It don’t make sense to me and it really doesn’t make sense why I have to make an appointment for half past 12 when I don’t maybe know if I’m going to be sick. Maybe they can find another mechanism toward this. I don’t know what, but something else.
If we do have to make appointments, then we should be allowed to make an appointment for the next day or the next week, because okay we stay here in campus, it’s much easier for us to go there but the students will stay off campus and they have to be there at 8 to make an appointment to go, which will be maybe at 11 and they miss class just to wait for 11 o’clock.

ER:

Anyway, then I’d like to thank you for your time and for agreeing to participate in this research - I really do appreciate it.
This participant was a young, black, female, academic staff health care consumer. She has been working at the university for 5 years. She has utilised the service on several occasions. She was very enthusiastic and bubbly.

ER:

*How do you experience the services provided by campus health services?*

I think for me having used that service, I found it a very good service. It’s for me very convenient, because they are always there, they are always available and willing to help, and it’s something that I can go to at any time and consult with them.

However, there are instances where I would go to campus health and I would phone them initially you know, so it was, I need an appointment, you must know that as an academic staff member you don’t always have time, you’re pressed for time, you make an appointment, they say to you, come now and then by the time you go there, you still have to sit in a queue with so many students and then they take longer to assist you sometimes. But I must say some of the staff at campus health are very friendly and they are very helpful but recently I had an experience where I had a problem with my throat and they gave me some medication. I went back after - it was an antibiotic - I went back I think after three weeks or two weeks and the condition was still there and the lady who was attending to me was insisting on giving me the same medication, even after I said to her this didn’t help and having consulted with somebody else and this person was saying, you don’t really need an antibiotic, they are making it worse for you, and this person was still insisting and I think due to age, I don’t think she’s as clued up as other members of staff. But other than that, I like the service, they give you information, there’s resources, I think it’s a user-friendly environment for me.

ER:

*When you say it’s a user-friendly environment, could you expand more on the “user-friendly”?*

First, the administrative staff, they make you feel comfortable, they make you feel at home. When you get there, there’s information on the table that you can help yourself
with. You can talk to them on the phone, you can consult with them about anything. I have never been to campus health where I feel, oh I can’t talk to this person about this, because I found them very open and even that environment for me, it’s a warm and friendly environment. Maybe I like intimate things and it looks intimate enough for me, that’s why I feel it’s a user-friendly environment. And the fact that they don’t ask you in front of everybody what the problem is, and the fact that somebody will take you into a private room and attend to your needs - that for me means user-friendly.

The only problem that I am experiencing with them is the fact that you get to wait and also sometimes you don’t really get what you’re asking for, even though they are willing to help. I’m not sure whether it’s - I don’t know. And also the fact that as staff members you can’t - sometimes I don’t have time, I would really like to see the doctor, even if the doctor is going to ask me to pay with my medical aid but I need to see the campus health doctor, and as a staff member I’m not able to do that. I think for me that doesn’t make sense why it is strictly for the students and not for staff.

ER:
Are there any other experiences that you might want to describe?

I was thinking you know, I was thinking the other day after I saw a staff member there at campus health - in fact there were two staff members that I saw there, and they were standing there in that room, even though initially I said it’s an intimate room, that room was very full with students. You know students are very loud and I saw this other one pacing around and I saw another one reading a book but looking anxious, and I wondered, I don’t know, I know that maybe it’s a resource matter, but I wondered if maybe they wouldn’t have a place for staff members to sit and wait, other than maybe combining staff with students. I’m not sure whether it’s possible but for me, when I stood there waiting and saw these other two staff members, it got me thinking, and the other one was agitated and I sensed that his issue was a confidential issue. I might be wrong with the perception but they are always saying who’s here and who’s not here, but it wouldn’t be different if you go to the doctor but with the doctor you would come at your own appointment and you don’t still have to sit and wait, and for everybody to still see you. It’s just, for me, it’s the service - once you get assisted then it’s fine.
ER:

What services do you mainly use at campus health service?

I’m asthmatic, so because of that I tend to go to them and ask for medication, when I have chest pains I get - I have to prevent myself from getting flu, so I would go to them for anti-flu injection as well as for any other flu-related or cold-related symptoms. I go to them for contraceptions because I’m not happy to go to the other clinics, and also I talk to them about if my son, because I also have a child, if my son has any problems and I’m not very clear about something, I would phone them and ask for advice. So in terms of for my own medication needs as well as information and advice, I would go to them and consult on those bases.

ER:

Are there any other experiences you would like to highlight?

No, not really, I think I have spoken about everything.

ER:

Then I would like to ask you the next question. What are your health needs?

I have so many health needs! First and foremost for me, I need to - I like to get information about certain conditions, because I feel that if I know how something works out, I would be able - it’s almost as if I cope better when I know a lot of things, so I need to know how my body works, I need to know in terms of what causes certain things. For instance, when I get them in terms of mental health needs, I want to know about stress, about what is it that I’m doing that is not helping me or that is helping me to cope better with my stress, so those would be my mental health needs. Being a woman, I need to know that my reproduction system and understand also what happens, because I’m not very enlightened about so many things. That’s why I would want to go to campus health, because I want them to tell me about things like cancer, how does one get cancer, is it important for me to get a Pap smear and how often do I get that. I want to know in terms of having had a baby and having complications - not necessarily complications but for me that experience was a very difficult experience, so I would have needed somebody to talk to about that, and also as I said to you, I’m asthmatic. Sometimes I know that it’s allergy-related, so I need to get a lot of information in terms of what do I need to do to prevent these allergies.
At the time when I was pregnant, my health needs was just to understand a lot about pregnancy, for me, understand a lot about eating - nutritional issues and I think also I have already mentioned about the mental health issues. Sometimes you know that you come with this syndrome that you don’t really know the underlying issues, so for me I need somebody who has an extensive knowledge to educate me and I am like sensitised about a whole lot of other things that I don’t know. I want to know my body from the toe to my head, so that I can know how to look after my own health and look after my own body. I want to know things that would help me to change certain behaviours and certain habits - things that would put me at risk, because I don’t want to experience at a later stage that I should have prevented something but I’m not able to prevent it. So in terms of reproductive system I want to know that, I want to know a lot about women’s issues.

ER:
What type of behaviour information would you like, behaviour change information?

For instance, before knowing anything about behaviour change things, I struggled with my eating habits. I wouldn’t eat at all here and so forth and I spoke to somebody at campus health because I wanted to know from them what do I need to do because I’m getting sick. I eat in a hurry and this and that and that. If they had explained to me what do I need, this person said to me you need to embark on a special diet but at that time I don’t think I was ready to embark on that diet, and if they - I’m not sure, maybe I’m expecting a lot - but if they knew something about behaviour change so that they can also help me to understand that it’s going to take a while, and you might not be at a place where you’re ready to do this, and because I’m not ready to do that, to get a lot of support from them in terms of getting me to a stage where I’m able to move and get ready. But as I said, maybe I’m expecting a lot from them. I say you can only change your behaviour when you have information, when you are educated about the risks of something, and I don’t think there’s a lot of that coming from campus health, to conscientise me and others about certain things that we’re doing.

ER:
So what you are actually saying is that you main need is information that you need on a variety of issues?
Exactly. I need information, they normally have these programmes for example now it was Breast Cancer Week - is a week enough? I doubt that, if it’s enough. Must it be done once a year? No. Do you have to wait for October for you to get that kind of information? No. I know that they have these good programmes but I wish that it can be done all the time, and I wish there could be a lot of intervention, there’s an assumption that staff members are able to cope better and that a lot of emphasis is placed on students but if staff members are not able to cope with their own health-related issues, how productive are they going to be and how can we be able to help our students? So I really wish that there could be a stronger emphasis, especially related to staff members. I have seen people around, I know their attitudes. If you’re talking about HIV and AIDS we think that it’s only the students who needs to be educated. No. Staff members also want to be educated about certain things. You talk to people, you walk around and you know how other people’s behaviour are putting them at risk of certain things, but again you are a staff member, you should be able to cope, which is a very dangerous assumption that could prevent people from utilising services because we think it’s only for students, not for us.

ER:
Are there any other health needs you would like to describe?

I did mention mental health issues, I did mention reproductive health. When I hear something, when I hear people talk about certain illnesses, I worry. For example they will talk about diabetes and they will talk about so many other illnesses and then I would worry about what’s happening and again for me it’s related to information and I wish there were interventions, particularly targeting on specific health-related issues, so that I can be educated enough to understand myself, to understand my body, to understand my needs, and then to know that if I’m struggling with this, this is what I need to do. Ja, that for me is the most important thing that can be done.

ER:
Tell me, how can campus health meet those needs?

Firstly, I don’t know how much interventions are targeted to staff members as I said. I don’t know if they are always aware of the needs of staff, exactly what you’re doing now. How do you get to improve your service - by talking to the people and
conducting things like needs assessments and hearing people what are they expecting and what do they want, and they must always have this awareness and education-related things where they just - I used to work at Student Counselling and they used to have messages through the Internet or not even the Internet, through e-mail, they would talk about an emotional-related issue. Then we learn a lot from those messages and we think, oh, wow! So if we can get quite a lot of information like that and also make sure that, I know staff members here, sometimes there’s apathy, they don’t attend things but I sometimes wish that they could have workshops where they enlighten us. For me, as wish here for me, the greatest need is to get information and be educated.

Something very simple is, I never knew the difference between cold and flu and I would say I had flu all the time until I got a pamphlet from campus health, that gave me all the symptoms. Things like that for me are very useful, that you think you know something unless you see it. And if I didn’t go to campus health, would I have received that information, what about so many people around campus who don’t go to campus health, who would benefit a lot from that information.

ER:
Any other ways that they could meet your needs?

I’m trying to think now. They must make sure that the doctor is available for staff as well, not only for students, even if it means making sure that we can still use our medical aid to do that. As I said before, that - I don’t know.

ER:
How could they make this information available to you?

Through awareness campaigns through messages that they send to staff members and to students about certain issues, giving out those handouts but my worry is why must I get that information only when I go to campus health?

ER:
Where else do you think they should provide that information?
You know, I used to see a wellness cart somewhere here at embizweni something, a roving cart where there were a couple of handouts that were put there. Couldn’t they negotiate with somebody who owns that cart to put some information, even if it means for this month we’re only focusing on this, and then next month we’ll focus on this one, so that people can be able to access that information. I know we don’t want to be bombarded by a lot of information but most of that information is very useful, and we won’t know how useful it is unless we’re given that information.

ER:

How often do you think they should have these health campaigns?

I won’t say once a month because maybe it would be too much for them, I don’t know, but at least the year here is divided into terms, if in a term they can focus on something and know that those are these campaigns. As I say, I know that there’s always HIV and AIDS awareness campaign but for me that campaign - I don’t know - I want something that’s going to focus on staff as well. I’m not saying students are not involved in it but find ways and means of educating staff for certain things related to HIV and AIDS. I know that during June, July they normally have an alcohol awareness - do something for staff members around that. I do know that they normally organise workshops and organise people from SANCA to do that, but you might be preaching to the converted if it’s only in terms of a workshop. I wish it can be taken outside of a workshop so that so many people can benefit. I have not thought about it carefully in terms of how, but there is a strategy that’s needed to get this information to everybody on campus.

ER:

Anything else you would like to add?

I had a friend who was pregnant and didn’t know that she was pregnant, she’s a colleague, and she was also taking these diet pills, which could have been very dangerous. I don’t know how much we as women know about women’s issues, and I don’t know how much we know about pregnancies. I know that I relied a lot on the Internet information and I remember thinking this friend of mine could have lost that baby if she was not careful, and I wondered, because for me prevention is always better - you prevent something before it happens, and again it’s information-related,
it’s education-related, that I would see the role of campus health very effective in that manner. There are so many students around who are also having issues - I know of a student who was pregnant but I’m not always sure whether that student was utilising campus health as much as she was supposed to, and for me I had a sense that she didn’t know if it was allowed for her to use it in that manner.

ER:
So basically what you’re saying, there’s a strong need for a strategy to make information available to everybody on campus?

Yes.

And to make sure that people know about the services of campus health, because we use campus health in a very limited manner, because we don’t know about so many other services that they can offer to us.

ER:
Which are the ones that you are aware of?

I know that you go there for HIV testing and you get pre- and post-stress counselling, you go there for family planning, I didn’t know that you go there for family planning until I asked. I know that you go there when you’re sick and consult with them. I’m not always sure whether you can go and ask for multivitamins, I’m not sure if you can go and ask for information. I happened to ask the secretary and say, hey - I’m struggling with this and then she’d say to me, come and see the nurses about it and sometimes I say, oh, can I talk to them about this, and they would say, yes. So it’s basically - for me sometimes it’s a very reactive thing. I wait until I have something before I consult with them, and a thing that I would like to know is, can I go to them to be checked whether I have diabetes or not, can I go and check about my heart, can I go and check about so many other things - I don’t know if they are able to give me that kind of a service but I do know that if I have flu, if I have asthma-related things, I would consult with them.

ER:
Anything else you would like to tell me?
Phew, I don’t think anything now!

*ER:*  
*Anyway, thank you very much for your time. I think it was very informative. Thank you very much for your time, I know you’re very busy.*

Okay, sure.
This participant was a registered nurse and has been employed at campus health services for 4 years.

**ER:**

*How do you experience the rendering of campus health care services?*

Since arriving here at campus health services, I would say that I find that we provide a good quality service with good quality medication, but what I can say is when I originally came here, my role was more supposed to be focused on HIV and AIDS type of campaigns in a preventive role, but my role has changed a lot over the years, because the need for private health care has become more by the students. So we had to look at alternative ways of somebody else providing the HIV/AIDS health service. Ummm what I can say, the service has grown, each year the service has grown in that we provide more and more for the students as the need arises and we’re always looking at ways of improving the service. The only place where I see it’s become very stagnated is with regard to the staff, but I see that nothing has really been done for the staff as such on campus. We do have an occupational health nurse since the incorporation, the merger of all these institutions, I find that it’s because of a lack of staff because there’s only one person that has to provide all these services on campus. I find that burden also – a lot falls on us nurses providing the primary health care. I feel that really a lot is being done for students and we’re constantly looking at ways of improving and providing the service for them. But we’re not looking at what the staff needs are really and how we can address their needs. Because a lot of them come here and they’ve got their own stresses and things and we don’t necessarily have the time to attend always to their needs, and to attend to them as soon as they want it. So as a result they become frustrated with us because they’re not getting what they should be getting from us. So I feel if the occupational health services could be expanded, I don’t know, would you want me to put that I work ... with regard to that? So that’s just where I see that we have been lacking in as the years go by, also, the only thing that I would say is there’s a lot of confusion now also with the merger so it’s basically trial and error and because there’s no real defined structures that we also
seem a bit lost because you have basically two bosses to report to and everybody’s still working out their lines of communication and their lines of reporting, so it is a bit difficult in this interim period. Also there is a lot of uncertainty as well with regard to your future role and campus health services, so that has an impact on your everyday service provision. What I can say also with regard to campus health services, it sort of defined as also one of the essential services on campus, so basically the service should be available to the staff and students when they need it, but it’s not always possible due to staff restrictions.

*ER:*

*How would you describe your day’s work from the time that you come in in the morning?*

Since I started working here, it was also very frustrating on the staff member because we would come on duty and find that maybe there would be a number of students sitting waiting to be seen and become upset maybe if you had to attend to an emergency or you couldn’t attend to their needs as quickly as possible, so we have improved on that from our side with the introduction of the appointment system because we discovered what other campus health services do over the rest of the country and then we found that many of them as far as possible work on the appointment system, so we found that it is working well most of the time in that the students would come and they would have set appointment times with the secretary and they would check their attendance schedules and they would make the appointments for the specific time that they are free. So we found that alleviates the frustration of them missing classes and becoming frustrated because they have to sit here and wait for an hour or two. But they do also understand that if there is an emergency or somebody who is sick, then we have to attend to that person first. So my day is basically worked out for me in that it’s very structured now in that the secretary would know if I will be away, most probably for a meeting or whatever other reason, then she will not structure appointments around that time. So we do not take appointments in advance at this campus, if a student is to attend for that day, they need to come in the morning to make the appointment for that day. We do that for the specific reason that many people make appointments in advance, they don’t pitch up for their appointments, they forget their appointments and you might become fully
booked if you take appointments before time, so somebody who is sick today might not be able to get an appointment because you’ve already taken appointments in advance. So to avoid all those hassles, we take on the day that you need to attend, and I mean sometimes the secretary might take appointments in advance and then the staff might be sick so there might not even be staff to attend to those appointments. So my day is very structured so that most of my day is spent on attending to the primary health care, seeing to minor illnesses or family planning, all the various problems in terms of campus health.

ER:

You said initially that you were appointed mainly for HIV and AIDS but primary health care took over your role mainly, and you said alternative ways for the HIV/AIDS programme had to be found. Could you please tell me what alternative ways were found for the HIV and AIDS?

We get interns who do their six months practicals from the Psychology Department on south campus, and a little money has been made available, so we have appointed registered counsellors who have finished but are not able to find employment, so they get appointed for specific periods of time to attend to all counsellings, it’s not only HIV but mainly HIV/AIDS counselling, pre- and post-test counselling, and ongoing counselling but they do also attend to crisis pregnancy counselling and those things, and they are situated on the campus in the facilities but unfortunately it’s not available every day because we have to share the person between this campus and Vista campus.

ER:

So you said on the programme money was made available – about how much money was made available?

I’m not really sure, because the interim director, she deals with the finances.

ER:

So does this affect how many patients you actually test for HIV?
It could affect it because we could be testing more people but because she’s not available here every day, that we’re not able to attend to all of the students or staff who require to be tested and like I said also that I really feel because I mean we’re dealing with more and more staff who are becoming sick and HR expect us to, because we’re the campus health service, to help and to attend to this person and make arrangements and things, and we don’t always have the time because we get 20 minute slots for each appointment, so it’s very difficult, that’s why I say no real programme has been put in place for staff who need to be off work for long periods of time and those type of things.

ER:

The staff you are referring to – is it staff who are just generally sick or staff who are sick related to HIV?

Related to HIV.

ER:

Do you find there is an increase in that number of staff?

I wouldn’t say there’s an increase, it’s just maybe because I mean testing isn’t really being done on the staff members but I would say that it’s just that they’re becoming sick now, so it’s people that we’ve known about but it’s just that they’re becoming sick now, so there is a need that has been identified and the people they work with don’t always understand why they are away from work, and then they look to campus health services, we must have an answer for them.

ER:

Are they aware of the people’s HIV status?

I don’t think the people who work directly with them but I’m not sure because we haven’t really gone into depth with these.

ER:
So as a campus health nurse, do you still do any pre- and post-test counselling and pregnancy counseling?

I personally still do but on a very ad hoc basis because I don’t really always have the time available to do it, so I would really do it if somebody requested me to do it personally for them, or the person is really in a crisis and they’re not able to wait for the counsellor, then I will do it, and I would see to that person.

ER:

You also said that you render very good quality services – I would like you to just be a bit more descriptive about what you actually mean by good quality.

I suppose when I said good quality, I was referring to where I came from because where I came from was the municipality and I felt that things were not that good there any more, that’s why I left, so when I came to campus health service I saw that they attended to most of the students’ needs and you had that time actually to listen to the students and to attend to them properly. The medication that was available here on campus also was of a good quality because it was things that we didn’t have available at the state facilities. So that’s what I meant by a good quality service, and there was a doctor that came in that you were exposed to, there was transport available to transport a patient if the need arises, so I felt that on the whole there were some things lacking like for instance dental care, things which would cost a bit more but I felt that the service here could attend to most of the needs of the students when they came with whatever problem, we could attend to their problems.

ER:

You also mentioned that there is a lack of staff. Could you please clarify that?

I would say lack of staff in the respect that to make the service – I don’t know how to put it now - I feel that the role we’re playing here is very much just a curative role. In all the years I was used to the fact that we would concentrate a lot on preventive care but we’re not able to do that here because we just a person is sick they just come in and we give them medication for whatever problem they have, we don’t really have that time any more to go and give talks to students, maybe even we have to arrange it
after hours in the residences to really speak to them on preventive care, on how to take care of themselves and what to do, do they really know what TB is, all those types of things. So that’s what I meant also by short-staffed. I would say that at this campus we are able to, if a student needs to be seen, we are able to really see to that student. It’s only that if a person needs like a bit more in-depth counselling, things like that, then we would have to refer that person because we’re not really able to sit here and speak to that person about his problems.

ER:

What would you consider to be an adequate staff complement here?

On this specific campus, the two sisters that are here I would feel is adequate but I feel we would need a counsellor every day. We would also need somebody who is able to do these health promotion programmes for us, who is able to whilst the students are sitting there inside waiting to be seen or go out and speak to the students, even if it’s in the cafeterias or wherever they are, about health-related issues and things like that. So in an ideal world that would be nice to have.

ER:

You also said that an occupational health service is rendered. Who renders that?

It’s the sister from south campus – she comes once a week to render the service here. I have offered my services so that I could help her on a half day but that hasn’t materialised yet. But I strongly feel that we are neglecting the staff in the respect that she’s only able to do certain aspects of occupational health but I personally feel that the staff should be really part of this occupational health and she should be able to see to the staff, so if a staff member comes in and is sick or a staff member comes in for whatever reason, they should be seen to by the occupational setup because as it is now, that person is pushed in to us who see to the students for primary health care so they’re also given appointment times, the staff members. Also the staff have their own needs that I don’t feel we’re really meeting because we feel ag, they do have medical aid so they can go to their private doctor, so we do concentrate more on the students I would say. And it’s not always that the staff want to come and sit and wait here with the students, it’s not always, I’ve experienced it already that become
very – because we also have our own internal issues with them, I mean you could tell a student, advise a student, look here, your blood pressure is high now, you need to go whatever. Now with a staff member it’s more difficult because it’s not that they’re undermining your authority but it’s just, they can’t leave now but – so it does take a little more out of you to explain to them because they don’t always understand but why – I’m not sick, so why do I need to – they don’t always accept your word for it, so it’s as if you’re like wanting to tell them, so it does take up a bit of your time too, because now we find a staff member, you’re liable for that person because if you let that person go out here and they have high blood pressure, maybe it’s a person working in whatever – they fall off the ladder whatever, you’re liable for that person. So it’s just a bit more difficult dealing with the staff, because the students accept us, what we say, more easily and if we say you need to go now to the hospital, they won’t try and you know argue – I don’t know how to explain it.

ER:

You have mentioned something about confusion with the merger, and there’s no definite structures. Could you please just clarify that for me, please?

I was referring to that there was an interim director appointed but we still have a head of the department who we still have to report to, so basically we have two bosses that we have to report to, so it does cause some conflict within the unit because we don’t know actually who to report to first. We have to report to our head and the head reports to the director, so they promised that they would have appointed a permanent director by now but that has not materialised, so last year we were told things continue as normal, we had our own budget to see to but now things are a bit different because there is only one budget and it’s controlled at the south campus by the interim director so it is a bit of a problem and it does cause a bit of confusion.

ER:

You also said that there is uncertainty regarding the role of the service. What did you mean by that?

I just mean like with any merger, like they said also that they need to have a certain quota like the 62% staff complement according to their income or whatever, so the
amount that they pay out for money just needs to be a percentage according to the gross income of the institution. So there’s always that threat that the service could be outsourced, so it was just with regard to that, that they look at cost saving measures and sort of look at outsourcing a service, there are a lot of companies that have outsourced their health services that are coming back to bringing it in-house again, because it’s to the benefit of an institution to [use its own service].

ER:

You also said that this was regarded as an essential service on campus and it must be available. Could you please clarify that for me?

It was just that I see that top management is referring to different services as being essential and things like for instance certain parts of technical services. I saw that they have said that campus health service is also one of the essential services, so with the result that we no longer – previously we used to all take holidays together but now we always as far as possible try to make sure that there’s always somebody to attend to the students within working hours, because there’s no service available after hours, primary health care service but in the pipeline there is a proposal has been submitted and accepted, it just needs to be signed off that there will be like an emergency after care service available that a contractor will provide to attend to any emergencies on campus after hours.

ER:

Is there anything else you would like to add?

Ummm…I just find that with campus health services, maybe because this is a tertiary institution, we should also follow suit if this is a tertiary institution, so I find that our role, we could also play a big role with regard to research on campus and I mean we’re not really doing that as such, because there’s many things that we could, small mini-researches that could be done but then we’re also mainly not having time for, maybe we’re just not looking at that area as well, that could be of benefit not only to our campus health services but I mean to any private health care facility.
**ER:**

*How do you experience working with the students and the staff on campus?*

I wouldn’t say it’s different from working in any other primary health care facility. Maybe because the students and the staff members that we see here are a bit more say literate and educated as compared to the community, so you do have to – they sort of challenge you more as compared to somebody else, so you have to always make sure that the information you have is accurate, up to date and to have that we need to update ourselves also regularly which I feel is not really happening because they don’t make the funds available, maybe they don’t think that it’s really that essential, so we’re really only able to go if it’s like free things offered but even now I would like to go to this health research conference that’s going to be held, so I requested I’d like to go but now I got the reply back to say I must ask the research committee if they will fund me to go on this conference when it’s like we in the health service should have our own budget to be able to go to these things and to empower ourselves because now basically that’s why I left my previous employment because you just come in and there would be no growth and in this time that I’ve been here, I mean I’ve grown tremendously and I’m enjoying it – growth in experience or growth in all aspects and I mean if we’re going to go back to where I come from, that you just cannot be required to come on duty, see to the students, sick students and staff and go off duty without any growth, then you just have to move on, because I mean a person, an individual, needs that.

**ER:**

*Anything else you would like to add?*

Maybe I’ll think of something else when we speak on the other questions.

**ER:** *What are the [health] needs of the staff on campus?*

Their most basic need is just to attend to whatever minor problems that they may experience. If they’re sick, then all they want, they want you just to make them better and they don’t want – I find that when they come to the clinic they just, if they’re sick or whatever problem they have, they just want to be made better. They
don’t really want to but it’s just you know, human nature, they don’t want you to educate them on taking some responsibility for their own health as well, so you find a lot of resistance to that, they don’t want to be educated on self-responsibility, what is my responsibility, it is not only a pill that will help make me better, what do I also need to do, is it I need to exercise, if I need to eat properly, and people don’t like to be educated on that, and I find a big need is also emergency care. You find that the students really, because it’s like a home away from home, a really stressful environment we’re living in now, I find more and more we’re called out for emergencies and a lot of them are stress-related we find. It’s not really a physical problem but it presents itself as being a physical problem but is more stress-related, because there’s a big need for everybody to perform and to succeed in the society we live in. So a lot of basic education is would say is needed for the students on basic preventive health care, whether it be HIV/AIDS they don’t really want to hear it, they become very resistant to being educated on HIV/AIDS so a big challenge is to look at new innovative ways of getting them to listen and to bring your message across. So that’s basically it, I would say, they just need whatever, this primary health care or if it’s family planning that they’re coming for, then they just need to tell me whatever problem they need to be taken care of.

ER:

*What type of problems would you say need to be taken care of?*

Students come for a whole range of things from ‘flu to family planning, a lot of psychological problems as well, you know they manifest with a physical problem but if you have the time to go in depth then there’s normally a problem, can I give an example, like I had a student who came here, she could hardly walk because she had such terrible abdominal pains and when you started speaking to her, because when you examine somebody you can see but the two don’t correlate – the pain experience and your finding and then you discover that she’s here on a sports bursary so she needs to perform there, in the meantime her parent is sick at home and she’s not able to go and see to the sick parent. So that’s just one example, you find a lot of them coming, even the staff as well, a lot of them coming, presenting with chronic blood pressure, diabetes, those type of things, and that’s what I said in the past, that of the occupational health centre, it’s supposed to have maybe it’s a day-to-day, once a
month or twice a month we have one day to check all the staff for their blood pressure or check them for their cholesterol or whatever because they’re also becoming sick and I mean it’s a burden on the institution in that it’s going to cost them, they lose expertise, you know those type of things and they have to pay out if people become sick, absenteeism – all those related problems.

With the students, their needs, I would say basically the only thing is that we’re not able to provide an antenatal service here, a dental service and chronic. We are only able to do monitoring of the chronic but not able to provide the medication here because it’s too expensive. So I would say that the rest of their needs are being attended to, or are in the pipeline of being attended to because a big need was also the emergency after-hours care and that’s being looked at now.

ER:

Any other health needs?

Nothing that I can think of, offhand that’s not been attended to.

ER:

Are there needs that are not being attended to?

But I did mention those that are not then attended to. But I can’t think of anything else because most things we do attend to, or we refer them to the appropriate service. I just think we’re not providing anti-retrovirals but we do refer them to the specific facility, we do provide a monthly nutritional care, we even provide to the students who are malnourished, who are not able to afford, we do provide them with something to supplement, Morevite porridge, things like that, so it’s just the anti-retrovirals that I would say and not everybody who comes for a [VCT] is able to get a VCT

You see, because of the formation of the AIDS unit, still nobody really understands who is what, whose role type of thing, so with the result there is still a lot of “who should be doing this” – we understand it as such as the clinics provide the clinical care and sort of things but I would say that there’s no real integration yet, even with regard to the other services, even with counselling, we do have a social worker on the
campuses but I mean if there’s a social worker problem I have never really referred anybody to the social worker because their role is sort of like another role, it’s not inter-related with our campus health services role. They’re more concentrating on this peer helpers, those type of things, so I find that everybody’s still just doing what they’re doing in each little corner and there’s no real integration of everybody’s roles here, so I don’t know when it’s going to come right.

ER:

How do you think the needs of students and staff could be met?

I strongly feel it would be a very cost-effective measure for the institution as a whole if these three campuses could be made one facility, because you would always have that availability aspect, you would address a lot of issues and it will rule out a lot of in-house conflicts as well so I strongly feel that there should be one campus health services for these three campuses, one central situation because we are in very close proximity to each other and then one campus service on the Vista campus because they’re envisaging to expand their campus so it only makes sense to invest in having one campus service there, and I feel that the doctor’s visits to the campuses could then be extended because at the moment he comes one visit to north, one visit to 2nd Avenue and two visits to south. So if it’s one facility, all these problems will be erased, the doctor will be more available, almost every day, to the students if the need arises. So less referrals for us to the state facilities and less time lost. That is only my opinion. There are so many benefits to this besides the cost involved of looking for one facility and relocating everything. I know the argument might be what about the emergencies response time but I strongly feel that our role is not really here to attend to emergencies but they’ve incorporated that in the contract workers’ conditions of getting the contract, so it is campus, I mean at south there is [Francois] who is always first on the line, here at north we have also a guy from the security services who is fully trained and they equip them fully to have these things available, so if there’s an emergency, they are the first ones that in any case go out and these campuses are in such close proximity so even if they give a vehicle to the campus health services, you could be there in a few minutes to attend to the person or whatever. So in my view, one integrated service would really rule out a lot of problems and would be really cost-effective in various ways and it would really be able to attend to the needs of the
students themselves. It could even expand in the occupational setting, because it wouldn’t be one person having to go to all these campuses. It’s just in my view.

ER:

What type of services do you see being rendered at this one integrated health service?

All the services that we are doing now and they could even expand, we could even do more minor procedures and things that are ... going to come every day.

ER:

Could you please tell me about the services that you are rendering now?

We are rendering primary health care, so primary health care means to see to all minor ailments or minor diseases or illnesses that present with students and staff; we do free family planning, which includes providing the post coital, we provide TB treatment as a monitoring, as a DOTS facility, we provide [VCT] counselling and testing, we provide an ongoing maintenance programme on providing nutrititional ..., we are doing chronic disease monitoring, we do referrals to dental facilities, we do STI treatments, ante-natal facilities we do not provide, we would only help the student and we do provide in the aspect that we refer them to the nearest ante-natal clinic and we provide support on campus in that there’s even a pregnancy policy now, so we sort of advise them on the policy and whatever problems they might be experiencing in their pregnancy and how they can go about making arrangements so that their room is kept for them and whatever, so even after delivery we provide termination referral for termination of pregnancy, we help the students to arrange for that, we arrange counselling for them, we also do some counselling on certain aspects as far as we are able to determine on such things.

ER:

You said you have a pregnancy policy. What does the pregnancy policy stipulate?

Because we can’t force the students to evacuate the residences, we strongly advise them 36 weeks and we educate them about the dangers of still being actively in their studies and things like that, so we do recommend to them that it will be in their best
interests and the baby’s interests for them to discontinue the studies at 8 months and have the baby and then after that they can come back as well. And then this policy allows for them to make arrangements with the faculties that they’re studying with so that they can write all tests or catch up with all work after the delivery, that their rooms are kept for them so that it’s not given to somebody else so after their delivery they are able to come back to their rooms as well and not really lose out on any ... and things like that, and they’re able to make up any studies that they lost.

ER:

How soon after the delivery do they come?

I’m not sure if it’s specified in the policy, I’m not really sure, it’s a new policy and I’m speaking under correction, I’m not really sure.

ER:

Coming back to the integrated services, you mentioned quite a number of services. How do you see the staff structure in that integrated service?

Do you mean integrated with other disciplines, or only nursing?

ER:

Well, the nursing and the other ancillary services.

I think that on campus there’s also no real upward movement for the staff in all aspects, I mean you could get like in the academic side you’ll get the junior lecturer and the senior lecturer and so forth and so forth, but in the nursing field there’s no real upward movement and if they should bring other ancillary staff, who should be more senior because it’s a bit difficult, we had submitted one big lovely organogram structure to council but it was rejected due to cost purposes, so it would be nice if the instructions could be available for upward movement of staff which is not available now.
Besides the staff, who else do you see situated at that centre?

It would be nice if we could have, like I said, the occupational health setup seeing to the staff, if we could have all the nurses with primary health care and so forth, we could have a psychologist, we could have a social worker and we could have more frequent visits of the doctor. Maybe a health educator who could run our health education programmes more actively on campus. I think that is it basically, because we have said that there are minor things that people come for, just for their dressings rather than to sit and wait for the sister. But what has happened, we have trained secretaries so they’re now sort of medical secretaries and able to do blood pressures and dressings, things like that, so they do assist us in that respect, so maybe it might not be necessary to have a nursing assistant as such because if we had this one big facility then there would be more than one secretary in the ... position.

I don’t know if we’d have a dental facility because it’s not really required that often but I was going to quote the State facilities that we have and here nearby are private facilities. Ante-natal facilities – I don’t know how practical that would be because there are a lot of costs involved there, because it would mean the doctor would frequently be here. ... a bit more cost involved.

Can you foresee that being rendered as an extended service of the state like you do all the other services, like your TB and VCT, do they pay for the costs of the ante-natal bloods?

It could, that they could pay for the costs of the bloods and things but I suppose it could be done, yes, if they were willing to pay for the costs.

For how long a period a day do you foresee a social worker and a psychologist and a counsellor working at the service?
Not really with the social worker I would say, but definitely the counsellor and the psychologist will be needed every day at the facility. The social worker maybe 3 times a week, but I think the psychologist and the counsellor daily because there’s a big need.

ER:

Anything else you’d like to add?

Not that I can think of.

ER:

Thank you very much for your time. I really do appreciate it and if there’s any other things, once I’ve listened to this, and I feel I need to get back to you, I will contact you. Enjoy your day.

Thank you very much.
INTERVIEW 31.05.06

HEALTH CARE PROVIDER NO. 2

This participant was a registered nurse and has been employed at campus health services for 4 years.

ER:

How do you experience the rendering of campus health care services?

Since arriving here at campus health services, I would say that I find that we provide a good quality service with good quality medication, but what I can say is when I originally came here, my role was more supposed to be focused on HIV and AIDS type of campaigns in a preventive role, but my role has changed a lot over the years, because the need for private health care has become more by the students. So we had to look at alternative ways of somebody else providing the HIV/AIDS health service. Ummm what I can say, the service has grown, each year the service has grown in that we provide more and more for the students as the need arises and we’re always looking at ways of improving the service. The only place where I see it’s become very stagnated is with regard to the staff, but I see that nothing has really been done for the staff as such on campus. We do have an occupational health nurse since the incorporation, the merger of all these institutions, I find that it’s because of a lack of staff because there’s only one person that has to provide all these services on campus. I find that burden also – a lot falls on us nurses providing the primary health care. I feel that really a lot is being done for students and we’re constantly looking at ways of improving and providing the service for them. But we’re not looking at what the staff needs are really and how we can address their needs. Because a lot of them come here and they’ve got their own stresses and things and we don’t necessarily have the time to attend always to their needs, and to attend to them as soon as they want it. So as a result they become frustrated with us because they’re not getting what they should be getting from us. So I feel if the occupational health services could be expanded, I don’t know, would you want me to put that I work … with regard to that? So that’s just where I see that we have been lacking in as the years go by, also, the only thing that I would say is there’s a lot of confusion now also with the merger so it’s basically trial and error and because there’s no real defined structures that we also
seem a bit lost because you have basically two bosses to report to and everybody’s still working out their lines of communication and their lines of reporting, so it is a bit difficult in this interim period. Also there is a lot of uncertainty as well with regard to your future role and campus health services, so that has an impact on your everyday service provision. What I can say also with regard to campus health services, it sort of defined as also one of the essential services on campus, so basically the service should be available to the staff and students when they need it, but it’s not always possible due to staff restrictions.

ER:

How would you describe your day’s work from the time that you come in in the morning?

Since I started working here, it was also very frustrating on the staff member because we would come on duty and find that maybe there would be a number of students sitting waiting to be seen and become upset maybe if you had to attend to an emergency or you couldn’t attend to their needs as quickly as possible, so we have improved on that from our side with the introduction of the appointment system because we discovered what other campus health services do over the rest of the country and then we found that many of them as far as possible work on the appointment system, so we found that it is working well most of the time in that the students would come and they would have set appointment times with the secretary and they would check their attendance schedules and they would make the appointments for the specific time that they are free. So we found that alleviates the frustration of them missing classes and becoming frustrated because they have to sit here and wait for an hour or two. But they do also understand that if there is an emergency or somebody who is sick, then we have to attend to that person first. So my day is basically worked out for me in that it’s very structured now in that the secretary would know if I will be away, most probably for a meeting or whatever other reason, then she will not structure appointments around that time. So we do not take appointments in advance at this campus, if a student is to attend for that day, they need to come in the morning to make the appointment for that day. We do that for the specific reason that many people make appointments in advance, they don’t pitch up for their appointments, they forget their appointments and you might become fully
booked if you take appointments before time, so somebody who is sick today might not be able to get an appointment because you’ve already taken appointments in advance. So to avoid all those hassles, we take on the day that you need to attend, and I mean sometimes the secretary might take appointments in advance and then the staff might be sick so there might not even be staff to attend to those appointments. So my day is very structured so that most of my day is spent on attending to the primary health care, seeing to minor illnesses or family planning, all the various problems in terms of campus health.

ER:

*You said initially that you were appointed mainly for HIV and AIDS but primary health care took over your role mainly, and you said alternative ways for the HIV/AIDS programme had to be found. Could you please tell me what alternative ways were found for the HIV and AIDS?*

We get interns who do their six months practicals from the Psychology Department on south campus, and a little money has been made available, so we have appointed registered counsellors who have finished but are not able to find employment, so they get appointed for specific periods of time to attend to all counsellings, it’s not only HIV but mainly HIV/AIDS counselling, pre- and post-test counselling, and ongoing counselling but they do also attend to crisis pregnancy counselling and those things, and they are situated on the campus in the facilities but unfortunately it’s not available every day because we have to share the person between this campus and Vista campus.

ER:

*So you said on the programme money was made available – about how much money was made available?*

I’m not really sure, because the interim director, she deals with the finances.

ER:

*So does this affect how many patients you actually test for HIV?*
It could affect it because we could be testing more people but because she’s not available here every day, that we’re not able to attend to all of the students or staff who require to be tested and like I said also that I really feel because I mean we’re dealing with more and more staff who are becoming sick and HR expect us to, because we’re the campus health service, to help and to attend to this person and make arrangements and things, and we don’t always have the time because we get 20 minute slots for each appointment, so it’s very difficult, that’s why I say no real programme has been put in place for staff who need to be off work for long periods of time and those type of things.

ER:

The staff you are referring to – is it staff who are just generally sick or staff who are sick related to HIV?

Related to HIV.

ER:

Do you find there is an increase in that number of staff?

I wouldn’t say there’s an increase, it’s just maybe because I mean testing isn’t really being done on the staff members but I would say that it’s just that they’re becoming sick now, so it’s people that we’ve known about but it’s just that they’re becoming sick now, so there is a need that has been identified and the people they work with don’t always understand why they are away from work, and then they look to campus health services, we must have an answer for them.

ER:

Are they aware of the people’s HIV status?

I don’t think the people who work directly with them but I’m not sure because we haven’t really gone into depth with these.

ER:
So as a campus health nurse, do you still do any pre- and post-test counselling and pregnancy counseling?

I personally still do but on a very ad hoc basis because I don’t really always have the time available to do it, so I would really do it if somebody requested me to do it personally for them, or the person is really in a crisis and they’re not able to wait for the counsellor, then I will do it, and I would see to that person.

*ER:*

You also said that you render very good quality services – I would like you to just be a bit more descriptive about what you actually mean by good quality.

I suppose when I said good quality, I was referring to where I came from because where I came from was the municipality and I felt that things were not that good there any more, that’s why I left, so when I came to campus health service I saw that they attended to most of the students’ needs and you had that time actually to listen to the students and to attend to them properly. The medication that was available here on campus also was of a good quality because it was things that we didn’t have available at the state facilities. So that’s what I meant by a good quality service, and there was a doctor that came in that you were exposed to, there was transport available to transport a patient if the need arises, so I felt that on the whole there were some things lacking like for instance dental care, things which would cost a bit more but I felt that the service here could attend to most of the needs of the students when they came with whatever problem, we could attend to their problems.

*ER:*

You also mentioned that there is a lack of staff. Could you please clarify that?

I would say lack of staff in the respect that to make the service – I don’t know how to put it now - I feel that the role we’re playing here is very much just a curative role. In all the years I was used to the fact that we would concentrate a lot on preventive care but we’re not able to do that here because we just a person is sick they just come in and we give them medication for whatever problem they have, we don’t really have that time any more to go and give talks to students, maybe even we have to arrange it
after hours in the residences to really speak to them on preventive care, on how to
take care of themselves and what to do, do they really know what TB is, all those
types of things. So that’s what I meant also by short-staffed. I would say that at this
campus we are able to, if a student needs to be seen, we are able to really see to that
student. It’s only that if a person needs like a bit more in-depth counselling, things
like that, then we would have to refer that person because we’re not really able to sit
here and speak to that person about his problems.

ER:

*What would you consider to be an adequate staff complement here?*

On this specific campus, the two sisters that are here I would feel is adequate but I
feel we would need a counsellor every day. We would also need somebody who is
able to do these health promotion programmes for us, who is able to whilst the
students are sitting there inside waiting to be seen or go out and speak to the students,
even if it’s in the cafeterias or wherever they are, about health-related issues and
things like that. So in an ideal world that would be nice to have.

ER:

*You also said that an occupational health service is rendered. Who renders that?*

It’s the sister from south campus – she comes once a week to render the service here.
I have offered my services so that I could help her on a half day but that hasn’t
materialised yet. But I strongly feel that we are neglecting the staff in the respect that
she’s only able to do certain aspects of occupational health but I personally feel that
the staff should be really part of this occupational health and she should be able to see
to the staff, so if a staff member comes in and is sick or a staff member comes in for
whatever reason, they should be seen to by the occupational setup because as it is
now, that person is pushed in to us who see to the students for primary health care so
they’re also given appointment times, the staff members. Also the staff have their
own needs that I don’t feel we’re really meeting because we feel ag, they do have
medical aid so they can go to their private doctor, so we do concentrate more on the
students I would say. And it’s not always that the staff want to come and sit and
wait here with the students, it’s not always, I’ve experienced it already that become
very – because we also have our own internal issues with them, I mean you could tell a student, advise a student, look here, your blood pressure is high now, you need to go whatever. Now with a staff member it’s more difficult because it’s not that they’re undermining your authority but it’s just, they can’t leave now but – so it does take a little more out of you to explain to them because they don’t always understand but why – I’m not sick, so why do I need to – they don’t always accept your word for it, so it’s as if you’re like wanting to tell them, so it does take up a bit of your time too, because now we find a staff member, you’re liable for that person because if you let that person go out here and they have high blood pressure, maybe it’s a person working in whatever – they fall off the ladder whatever, you’re liable for that person. So it’s just a bit more difficult dealing with the staff, because the students accept us, what we say, more easily and if we say you need to go now to the hospital, they won’t try and you know argue – I don’t know how to explain it.

ER:

You have mentioned something about confusion with the merger, and there’s no definite structures. Could you please just clarify that for me, please?

I was referring to that there was an interim director appointed but we still have a head of the department who we still have to report to, so basically we have two bosses that we have to report to, so it does cause some conflict within the unit because we don’t know actually who to report to first. We have to report to our head and the head reports to the director, so they promised that they would have appointed a permanent director by now but that has not materialised, so last year we were told things continue as normal, we had our own budget to see to but now things are a bit different because there is only one budget and it’s controlled at the south campus by the interim director so it is a bit of a problem and it does cause a bit of confusion.

ER:

You also said that there is uncertainty regarding the role of the service. What did you mean by that?

I just mean like with any merger, like they said also that they need to have a certain quota like the 62% staff complement according to their income or whatever, so the
amount that they pay out for money just needs to be a percentage according to the gross income of the institution. So there’s always that threat that the service could be outsourced, so it was just with regard to that, that they look at cost saving measures and sort of look at outsourcing a service, there are a lot of companies that have outsourced their health services that are coming back to bringing it in-house again, because it’s to the benefit of an institution to [use its own service].

ER:

You also said that this was regarded as an essential service on campus and it must be available. Could you please clarify that for me?

It was just that I see that top management is referring to different services as being essential and things like for instance certain parts of technical services. I saw that they have said that campus health service is also one of the essential services, so with the result that we no longer – previously we used to all take holidays together but now we always as far as possible try to make sure that there’s always somebody to attend to the students within working hours, because there’s no service available after hours, primary health care service but in the pipeline there is a proposal has been submitted and accepted, it just needs to be signed off that there will be like an emergency after care service available that a contractor will provide to attend to any emergencies on campus after hours.

ER:

Is there anything else you would like to add?

Ummm…I just find that with campus health services, maybe because this is a tertiary institution, we should also follow suit if this is a tertiary institution, so I find that our role, we could also play a big role with regard to research on campus and I mean we’re not really doing that as such, because there’s many things that we could, small mini-researches that could be done but then we’re also mainly not having time for, maybe we’re just not looking at that area as well, that could be of benefit not only to our campus health services but I mean to any private health care facility.

ER:
How do you experience working with the students and the staff on campus?

I wouldn’t say it’s different from working in any other primary health care facility. Maybe because the students and the staff members that we see here are a bit more say literate and educated as compared to the community, so you do have to – they sort of challenge you more as compared to somebody else, so you have to always make sure that the information you have is accurate, up to date and to have that we need to update ourselves also regularly which I feel is not really happening because they don’t make the funds available, maybe they don’t think that it’s really that essential, so we’re really only able to go if it’s like free things offered but even now I would like to go to this health research conference that’s going to be held, so I requested I’d like to go but now I got the reply back to say I must ask the research committee if they will fund me to go on this conference when it’s like we in the health service should have our own budget to be able to go to these things and to empower ourselves because now basically that’s why I left my previous employment because you just come in and there would be no growth and in this time that I’ve been here, I mean I’ve grown tremendously and I’m enjoying it – growth in experience or growth in all aspects and I mean if we’re going to go back to where I come from, that you just cannot be required to come on duty, see to the students, sick students and staff and go off duty without any growth, then you just have to move on, because I mean a person, an individual, needs that.

ER:

Anything else you would like to add?

Maybe I’ll think of something else when we speak on the other questions.

ER: What are the [health] needs of the staff on campus?

Their most basic need is just to attend to whatever minor problems that they may experience. If they’re sick, then all they want, they want you just to make them better and they don’t want – I find that when they come to the clinic they just, if they’re sick or whatever problem they have, they just want to be made better. They don’t really want to but it’s just you know, human nature, they don’t want you to educate them on taking some responsibility for their own health as well, so you find a
lot of resistance to that, they don’t want to be educated on self-responsibility, what is my responsibility, it is not only a pill that will help make me better, what do I also need to do, is it I need to exercise, if I need to eat properly, and people don’t like to be educated on that, and I find a big need is also emergency care. You find that the students really, because it’s like a home away from home, a really stressful environment we’re living in now, I find more and more we’re called out for emergencies and a lot of them are stress-related we find. It’s not really a physical problem but it presents itself as being a physical problem but is more stress-related, because there’s a big need for everybody to perform and to succeed in the society we live in. So a lot of basic education is would say is needed for the students on basic preventive health care, whether it be HIV/AIDS they don’t really want to hear it, they become very resistant to being educated on HIV/AIDS so a big challenge is to look at new innovative ways of getting them to listen and to bring your message across. So that’s basically it, I would say, they just need whatever, this primary health care or if it’s family planning that they’re coming for, then they just need to tell me whatever problem they need to be taken care of.

ER:

What type of problems would you say need to be taken care of?

Students come for a whole range of things from ‘flu to family planning, a lot of psychological problems as well, you know they manifest with a physical problem but if you have the time to go in depth then there’s normally a problem, can I give an example, like I had a student who came here, she could hardly walk because she had such terrible abdominal pains and when you started speaking to her, because when you examine somebody you can see but the two don’t correlate – the pain experience and your finding and then you discover that she’s here on a sports bursary so she needs to perform there, in the meantime her parent is sick at home and she’s not able to go and see to the sick parent. So that’s just one example, you find a lot of them coming, even the staff as well, a lot of them coming, presenting with chronic blood pressure, diabetes, those type of things, and that’s what I said in the past, that of the occupational health centre, it’s supposed to have maybe it’s a day-to-day, once a month or twice a month we have one day to check all the staff for their blood pressure or check them for their cholesterol or whatever because they’re also becoming sick.
and I mean it’s a burden on the institution in that it’s going to cost them, they lose expertise, you know those type of things and they have to pay out if people become sick, absenteeism – all those related problems.

With the students, their needs, I would say basically the only thing is that we’re not able to provide an antenatal service here, a dental service and chronic. We are only able to do monitoring of the chronic but not able to provide the medication here because it’s too expensive. So I would say that the rest of their needs are being attended to, or are in the pipeline of being attended to because a big need was also the emergency after-hours care and that’s being looked at now.

ER:

Any other health needs?

Nothing that I can think of, offhand that’s not been attended to.

ER:

Are there needs that are not being attended to?

But I did mention those that are not then attended to. But I can’t think of anything else because most things we do attend to, or we refer them to the appropriate service. I just think we’re not providing anti-retrovirals but we do refer them to the specific facility, we do provide a monthly nutritional care, we even provide to the students who are malnourished, who are not able to afford, we do provide them with something to supplement, Morevite porridge, things like that, so it’s just the anti-retrovirals that I would say and not everybody who comes for a VCT is able to get a VCT.

You see, because of the formation of the AIDS unit, still nobody really understands who is what, whose role type of thing, so with the result there is still a lot of “who should be doing this” – we understand it as such as the clinics provide the clinical care and sort of things but I would say that there’s no real integration yet, even with regard to the other services, even with counselling, we do have a social worker on the campuses but I mean if there’s a social worker problem I have never really referred anybody to the social worker because their role is sort of like another role, it’s not
inter-related with our campus health services role. They’re more concentrating on this peer helpers, those type of things, so I find that everybody’s still just doing what they’re doing in each little corner and there’s no real integration of everybody’s roles here, so I don’t know when it’s going to come right.

ER:

How do you think the needs of students and staff could be met?

I strongly feel it would be a very cost-effective measure for the institution as a whole if these three campuses could be made one facility, because you would always have that availability aspect, you would address a lot of issues and it will rule out a lot of in-house conflicts as well so I strongly feel that there should be one campus health services for these three campuses, one central situation because we are in very close proximity to each other and then one campus service on the Vista campus because they’re envisaging to expand their campus so it only makes sense to invest in having one campus service there, and I feel that the doctor’s visits to the campuses could then be extended because at the moment he comes one visit to north, one visit to 2nd Avenue and two visits to south. So if it’s one facility, all these problems will be erased, the doctor will be more available, almost every day, to the students if the need arises. So less referrals for us to the state facilities and less time lost. That is only my opinion. There are so many benefits to this besides the cost involved of looking for one facility and relocating everything. I know the argument might be what about the emergencies response time but I strongly feel that our role is not really here to attend to emergencies but they’ve incorporated that in the contract workers’ conditions of getting the contract, so it is campus, I mean at south there is [Francois] who is always first on the line, here at north we have also a guy from the security services who is fully trained and they equip them fully to have these things available, so if there’s an emergency, they are the first ones that in any case go out and these campuses are in such close proximity so even if they give a vehicle to the campus health services, you could be there in a few minutes to attend to the person or whatever. So in my view, one integrated service would really rule out a lot of problems and would be really cost-effective in various ways and it would really be able to attend to the needs of the students themselves. It could even expand in the occupational setting, because it wouldn’t be one person having to go to all these campuses. It’s just in my view.
ER:

*What type of services do you see being rendered at this one integrated health service?*

All the services that we are doing now and they could even expand, we could even do more minor procedures and things that are ... going to come every day.

ER:

*Could you please tell me about the services that you are rendering now?*

We are rendering primary health care, so primary health care means to see to all minor ailments or minor diseases or illnesses that present with students and staff; we do free family planning, which includes providing the post coital, we provide TB treatment as a monitoring, as a DOTS facility, we provide [VCT] counselling and testing, we provide an ongoing maintenance programme on providing nutrititional ... , we are doing chronic disease monitoring, we do referrals to dental facilities, we do STI treatments, ante-natal facilities we do not provide, we would only help the student and we do provide in the aspect that we refer them to the nearest ante-natal clinic and we provide support on campus in that there’s even a pregnancy policy now, so we sort of advise them on the policy and whatever problems they might be experiencing in their pregnancy and how they can go about making arrangements so that their room is kept for them and whatever, so even after delivery we provide termination referral for termination of pregnancy, we help the students to arrange for that, we arrange counselling for them, we also do some counselling on certain aspects as far as we are able to determine on such things.

ER:

*You said you have a pregnancy policy. What does the pregnancy policy stipulate?*

Because we can’t force the students to evacuate the residences, we strongly advise them 36 weeks and we educate them about the dangers of still being actively in their studies and things like that, so we do recommend to them that it will be in their best interests and the baby’s interests for them to discontinue the studies at 8 months and have the baby and then after that they can come back as well. And then this policy allows for them to make arrangements with the faculties that they’re studying with so
that they can write all tests or catch up with all work after the delivery, that their rooms are kept for them so that it’s not given to somebody else so after their delivery they are able to come back to their rooms as well and not really lose out on any ... and things like that, and they’re able to make up any studies that they lost.

ER:

How soon after the delivery do they come?

I’m not sure if it’s specified in the policy, I’m not really sure, it’s a new policy and I’m speaking under correction, I’m not really sure.

ER:

Coming back to the integrated services, you mentioned quite a number of services. How do you see the staff structure in that integrated service?

Do you mean integrated with other disciplines, or only nursing?

ER:

Well, the nursing and the other ancillary services.

I think that on campus there’s also no real upward movement for the staff in all aspects, I mean you could get like in the academic side you’ll get the junior lecturer and the senior lecturer and so forth and so forth, but in the nursing field there’s no real upward movement and if they should bring other ancillary staff, who should be more senior because it’s a bit difficult, we had submitted one big lovely organogram structure to council but it was rejected due to cost purposes, so it would be nice if the instructions could be available for upward movement of staff which is not available now.

ER:

Besides the staff, who else do you see situated at that centre?

It would be nice if we could have, like I said, the occupational health setup seeing to the staff, if we could have all the nurses with primary health care and so forth, we could have a psychologist, we could have a social worker and we could have more
frequent visits of the doctor. Maybe a health educator who could run our health education programmes more actively on campus. I think that is it basically, because we have said that there are minor things that people come for, just for their dressings rather than to sit and wait for the sister. But what has happened, we have trained secretaries so they’re now sort of medical secretaries and able to do blood pressures and dressings, things like that, so they do assist us in that respect, so maybe it might not be necessary to have a nursing assistant as such because if we had this one big facility then there would be more than one secretary in the ... position.

I don’t know if we’d have a dental facility because it’s not really required that often but I was going to quote the State facilities that we have and here nearby are private facilities. Ante-natal facilities – I don’t know how practical that would be because there are a lot of costs involved there, because it would mean the doctor would frequently be here. ... a bit more cost involved.

ER:

Can you foresee that being rendered as an extended service of the state like you do all the other services, like your TB and VCT, do they pay for the costs of the ante-natal bloods?

It could, that they could pay for the costs of the bloods and things but I suppose it could be done, yes, if they were willing to pay for the costs.

ER:

For how long a period a day do you foresee a social worker and a psychologist and a counsellor working at the service?

Not really with the social worker I would say, but definitely the counsellor and the psychologist will be needed every day at the facility. The social worker maybe 3 times a week, but I think the psychologist and the counsellor daily because there’s a big need.

ER:

Anything else you’d like to add?
Not that I can think of.

ER:

Thank you very much for your time. I really do appreciate it and if there’s any other things, once I’ve listened to this, and I feel I need to get back to you, I will contact you. Enjoy your day.

Thank you very much.
ADDENDUM I
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To Whom it May Concern

This is to certify that I edited and proofread the doctoral thesis of Ms. Esmeralda Ricks during the period from the end of December 2007 and early January 2008.

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