A DESCRIPTION OF THE SELF-PERCEIVED
ROLES OF REGISTERED NURSES IN
STUDENT HEALTH SERVICES IN SELECTED
TERTIARY INSTITUTIONS IN SOUTH AFRICA.

DISSERTATION IN PARTIAL FULFILMENT FOR
MSc (NURSING) AT UNIVERSITY OF CAPE TOWN

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DECLARATION

I, Bridget Adams, hereby declare that the work on this dissertation is based on my own original work, except where acknowledgments and references indicate otherwise. Neither has this dissertation or part of it, been or is being submitted for another degree at any other university.

I empower the University of Cape Town to reproduce the whole or parts of the dissertation for the purpose of research.

____________________________
Signature

28 March 2006.
ABSTRACT

The study was conducted to describe the self-perceived roles of nurses working at student health services in selected tertiary institutions in South Africa. The aim of the research was to describe the roles of nurses in order to portray the nurses' contributions to the health and welfare of students. Nurses at student health centres provide congruent health care services to a community of young adults who have specific age-related health risks. The objectives of the study were to identify and describe the roles within Orem's theoretical framework, specifically relating to Orem's supportive/educative nursing system sub-concept. In a primary health care context, it is usual for nurses to share self-care responsibilities with the patients, but also to act as a guide or instructor. Qualitative methods were used to gather and analyse data. Collection of data was via semi-structured interview. The population comprised nurses who met the inclusion criteria, and who consented to be interviewed, and who were currently employed at a tertiary educational institution that was a member of the South African Association of Campus Health Services. Data were analysed using content analysis, the units of analysis being the interviews. The descriptions were examined and findings were presented descriptively and in table format. The results indicated that nurses had a broad range of skills and knowledge appropriate to their work at student health services, incorporating technical, procedural and educative abilities. Two main themes emerged from the data were educational and supportive aspects of nursing care.. These findings are in keeping with the supposition that Orem’s supportive/educative component of the nursing system is a suitable method of caring and helping. Recommendations were made regarding additional training for nurses, based on the needs expressed by the participants.
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DEFINITION OF TERMS

Primary health care (PHC): A level of care that is the first point of contact with the health service (World Health Organisation 1978). Primary health care is essential care based on practical scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their participation and at a cost the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the county’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 the community to 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 care service (World Health Organisation 1978).

Registered Nurse (RN): A person registered as such under the Nursing Act 1978 (Act No.50 of 1978 as amended) and trained in terms of this Act (Nursing Act www.polity.org.za).

Primary Health Care Nurse: One who is a registered nurse and a person who has complied with the provisions of section 16 of the Nursing Act, 1978, (Act No. 50 of 1978), and who practices in a primary health care service in South Africa (Bierman & Muller 1994:30). Also known as a Clinical Nurse Practitioner.

For the purposes of this study, Registered nurses and Clinical nurse practitioners will be referred to as nurses.
Primary Health Care Nursing Service: In South Africa it is the wide range of services (promotive, preventive and curative), which nurses provide at the point of entry into the district health system (Strasser & Gwele 1998).

South African Association of Campus Health Services (SAACHS). Tertiary educational institutions that subscribe to a membership, in order to network and keep up to date with trends relevant to institutions that have health care facilities on campus.

Student Health Services (SHS): These are primary health care clinics for the use of registered students at tertiary educational facilities.
CHAPTER 1

1.1. INTRODUCTION

Student Health Services (SHS) provide ambulatory, primary care to students at tertiary educational institutions. The facilities vary widely and may range from limited first aid and referral facilities, to centres that are staffed by a team of health care providers with diagnostic and treatment capacities, including health education and counselling services (Olson and Autio 1999). According to Crihfield (1995) the campus or college health model of healthcare is delivered in an outpatient setting that provides students with accessible health care that enables them to remain in the educational institution, thereby supporting the institution's goal of student retention, as well as the student's goal of earning a degree. Thus the purpose of the university health centre is often rationalised as contributing to the retention plan of the university (Olson and Autio 1999). Registered nurses are frequently the front line providers of primary health care in South Africa. The aim of South African Primary Health Care (PHC) services is to provide basic health care needs to communities; as such students within a campus setting may be seen to form a community.

1.2. PROBLEM STATEMENT: The researcher realised, whilst working at a student health centre, and by talking to nursing colleagues, that many of the nurses had unclear definitions with regard to their roles as health care professionals in a PHC campus setting, beyond their clinical roles. Thus the research question was formulated.

1.3. RESEARCH QUESTION: What are the self-perceived roles of nurses working in campus health care settings in tertiary institutions in South Africa?
1.4. AIM OF THE RESEARCH: The aim of the study is to describe nurses’ self-perceived roles, within campus health services, in order to portray nurses’ contributions to the health and welfare of students at selected tertiary educational institutions in South Africa.

1.5. THE OBJECTIVES of the study are to identify the roles of nurses, and to describe those roles, within Orem’s theoretical nursing framework (Orem 1985).

1.6. THE SIGNIFICANCE OF THE STUDY: If nurses are to be viable and influential players in the health care field, it is important to describe their essential and extended roles and fundamental support to the health of students. Presentation of nurses’ contributions to patient care will allow for evaluation of practice and delineate the broad scope of registered nurses professional practice. Chang and Twinn (1995) assert the current changes in nursing practice which have placed a greater need than ever before for nurses to have clearly defined roles, has resulted from the demand for cost-effective care and for nurses to justify their contribution to that care.

It is necessary to delineate the perspective of Primary Health Care (PHC) because Student Health Services are PHC units. This is a philosophy of care, based on the Alma-Ata Declaration (WHO 1978) in which 5 principles underlie PHC. These are:

- Equitable distribution of resources, and this includes accessibility.
- Community participation in decision-making,
- Focus on preventative/promotive health service,
- Appropriate technology,
- A multi-sectoral approach.

Nurses working in a PHC clinic, in any setting, require skills that are congruent with the PHC principles. Any clinic that employs nurses to deliver health care to a specific community is a primary supplier of this service package. The South African
Department of Health White Paper (1997) for the transformation of the health service adopts a PHC approach and states that skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost-effectiveness. The PHC package outlined by the Department of Health (2001) comprises diverse services, many of which are provided by nurses. Mbambo, Uys and Groenewald (2003) affirm that in this regard, the composition of primary health care teams is important; particularly pertaining to nurses' input.

According to Crihfield (1995) the population of students in most tertiary educational settings in the USA has changed in the last few years, and the populations are not exclusively the traditional 18 – 25 year old students; many more non-traditional students are now on campus and have unique needs to be met. Olsen and Autio (1999) concur, noting that the current university population in Australia is an aggregate of diverse students, of whom about 40% are stereotypical, i.e. full-time, undergraduate students aged 17-24 years; the remaining 60% include older students, international students, disabled students and distance learning students. Subotzky (2000) reported that in 1999 there were 564,000 students enrolled in universities and technical institutions in South Africa, comprising local and international students. This is a significant number of young adults, with specific needs and health risks relating to their age. In many South African universities, there has been increasing diversification of the student demographics in the last 10 years, significantly in terms of gender and racial composition of the student body (Lehmann, Andrew and Saunders 2000). Large universities such as the University of Cape Town, University of Pretoria and University of Kwa-Zulu Natal state that their student population reflects the broad demographics of the South African population, as well as international students from up to 70 other countries. Lehmann et al (2000) however, maintain that the student profile representative of South African demographics continues to be regionally uneven. One commonality of the student population is that they are all in an
environment that predisposes them to accepting new ideas and change. The students are involved in learning and are in a period of transition and change. Paradoxically, stereotypical students are also at an age where they are not particularly motivated toward health promotion (Olson and Autio 1999).

This study has four further chapters. The literature review, recorded in Chapter 2, comprises four main sections. The first section explores the term 'nursing role', within the context of South African nurses in the PHC sector. Elements of nursing roles will be examined in the second section. Activities undertaken by primary health care nurses will be reviewed in the third section. Finally, the profiles of student health risks, internationally, as well as within the South African health risk context, are outlined. These sections will provide the framework for the literature review.

Chapter 3 discusses methodology, including qualitative research design, the criteria for inclusion of respondents, the development of the interview guideline and how it was administered, and data analysis.

The presentations of the findings are portrayed in Chapter 4.

Chapter 5 comprises discussion of findings and recommendations.
CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

Professional literature connected with the research question and topic was reviewed. The following databases were accessed: Medline, CINAHL, Journals@Ovid. These were searched for the period 1985-2005, using keywords such as nurses’ roles, primary health care role, tertiary education student health services, campus health, university health, student health risks. From the review it was possible to identify four areas contributing to understanding the roles of the nurse, these are:
- Exploration of the term ‘nursing role’.
- Elements of nursing roles.
- Activities undertaken by primary health care nurses.
- Student health risk profile.

These areas will provide the framework for the literature review.

2.2. THE TERM ‘NURSING ROLE’.

Doheny, Cook and Stopper (1997) explain that fundamental to the understanding of the role of the nurse is an understanding of the concept of role. Role is a goal-directed activity or behaviour that is considered acceptable to the culture or given situation; roles therefore have behavioural references, reflect goals, values and sentiments, and involve an action of an individual in a particular setting, with some identified expectations. Consequently, there are often activities and tasks associated with various roles. Doran, Sidani, Keatings and Doidge (2002) state that roles incorporate positions in organisations that have a set of expected behaviours attached to them. The single or multiple roles that confront nurses may not be clearly articulated in terms of the behaviours or performance levels expected. Furthermore, Trnobrański (1993) states, “nursing is an activity concerned with human welfare; its central purpose is to
improve the health status of individual people and of society as a whole; as such, nursing roles and activities are enormously diverse” (p.494).

In South Africa, the nurse’s role has shifted from traditionally being part of a team of health care professionals functioning in curative hospital-based, sites, to community-based settings. Nurses working in PHC centres are expected to combine aspects of the knowledge and expertise of several professionals in order to provide appropriate services that are driven by community needs (Strasser and Gwele 1998). The PHC approach moves from the bio-medical model, which has a focus on treatment of diseases, towards a health care model, which gives attention to prevention of disease and promotion of health. Ntoane (1993) described the changed meaning of primary health care by explaining that studies of disease in Europe provided a new understanding that health promotion was different from disease treating. Therefore, in PHC settings, nurses do have specific purposes, involving preventive, promotive and curative aspects of clinical care, but in fact they perform a number of other functions. Crihfield (1995) claims that nurses in a USA student health setting play an important role in the lives of many students. That role involves not only taking care of physical ills but also caring for emotional and spiritual ills. It can be seen therefore, that the term 'role' has characteristics, which can be broken down into discrete elements. These elements are discussed in detail in the following text. To some extent they overlap to create a holistic behaviour in terms of the nurse-patient interaction.

2.3. ELEMENTS OF NURSING ROLES

The South African Nursing Council (SANC) is a statutory organisation constituted in terms of the Nursing Act (number 50 of 1978, as amended) and is responsible for the professional and ethical regulation of nurses. The role of the nurse is defined, to an extent, by his or her scope of practice (for the purposes of clarity, in this study nurses will be referred to as female). Doheny, et al (1997) claim that there are elements or
aspects in the role of the nurse that remain constant in spite of differences in nursing practice spheres, and scope of practice. Fitzpatrick, While and Roberts (1992) developed the concept of the sub-roles of the nurse and identify distinct features, such as teacher, supervisor, planner, communicator, and carer. Benner (1984) described the nurse’s role in terms such as helping, teaching/coaching, patient diagnosing, monitoring and administering therapeutic regimes and interventions. Mackereth (1995) described nurses’ roles as practical tasks, screening activities, health promotion and disease prevention. Peplau (1957) specified certain roles for nurses such as change agent, counsellor, arbitrator. Robb (2001) broadly defined key tasks and responsibilities for clinical nurse practitioners, which may be transferred to other nurse practitioners, including research, education, health promotion, organisational and administrative roles. From the literature search, lists of elements of the nurses roles were compiled, and 15 discrete roles were identified (including 5 parts for clinical role), although this is not an exhaustive list. The following are main aspects of each identified role:

2.3.1. Organisational Role

This role has several components. Nurses are required to be conversant with the South African Nursing Council professional code of conduct, as well as the registered nurse scope of practice, and Robb (2001) maintains that having knowledge of appropriate policies and procedures is a valid role for all Registered nurses. The development of protocols to guide practice within a clinical establishment are considered part of an organisational role. According to Hewitt-Taylor (2003), the debate over changes in nurses’ roles will in part be resolved by using care protocols that detail the recommended treatment and care that should be used to manage any common conditions. Stump (1994) suggests that nurses who direct college health services without an on-site physician face legal issues that are not present when a physician directs the health service. The author maintains that in order to establish legally sound parameters for client care, protocols based on mutual agreement
between nurses and medical directors need to be developed. The protocols and guidelines are also to ensure clinically effective, evidence-based practice, however, nurses must practice within the current legislative framework that is the Nursing Act (No.50 of 1978 as amended), until revised legislation is promulgated, in which they may carry out procedures when proved competent (www.sanc.co.za).

The use of a nursing audit is considered under organisational role, as it is an assessment method. Booyens and Minnaar (2000) describe it as a process whereby performances are compared with previously set standards of care to reveal shortcomings. The main goal of auditing is to improve patient care. The auditing process does not only involve reviewing nursing care documents, either retrospectively or concurrently, but also conducting patient and staff interviews. Protocol development is a prerequisite to auditing. Cheater and Keane (1998) established in a UK study that nurses working in community or primary health care settings were most likely to support auditing processes. However, work pressures and lack of protected time, availability of practical support, and lack of knowledge and skills have been blamed for obstacles that make it difficult for nurses to contribute actively to the process.

This role also includes the development and maintenance of effective, appropriate communication networks with other professionals.

2.3.2. Administrative Role

This includes providing and maintaining accurate records, reports and statistics, whilst maintaining confidentiality, as well as managerial, clerical and administration work (Robb 2001; Rushforth and Glasper 1999). When compared to acute sector nurses, Hicks and Hennessy (1999) established that primary care nurses are attributed with having a greater focus on management and administrative tasks than hospital nurses.
2.3.3. Clinical role

According to Mofukeng and Roos (1999) clinical skill refers to the ability or competence to observe and treat patients during their attendance at a clinic. Within the clinical role are a number of sub-roles, including triage, conducting of physical assessments, undertaking of diagnostic processes and screening procedures, planning, implementing and evaluating nursing interventions, comprising administration of treatments and medical regimes, monitoring progress, and/or referral (Hicks and Hennessy 1999; Jenkins-Clarke, Carr-Hill and Dixon 1998; Strasser and Gwele 1998; Bierman and Muller 1994). This is often referred to as the Nursing Process, a systematic approach to nursing care.

The nursing process is theoretically based, devised from a broad base of knowledge, including the sciences and humanities, and can be applied to any of the theoretical models of nursing (Iyer, Taptich and Bernocchi-Losey 1991). It is a systematic methodology of nursing, comprising 5 phases: assessing, diagnosing, planning, implementing and evaluating. These steps overlap and recur throughout the period a person is receiving nursing care, the process is continuous and cyclic. Diagram 1 shows the nursing process diagrammatically.

![Diagram 1: Representation of the Nursing Process.](Edleman and Mandle 1994:76)
2.3.3.1. **Assessment** comprises appraisal of the patient, both objectively and subjectively. The emphasis is on holistic and comprehensive assessments that embrace the following categories of needs: activities of daily living, occupation, social integration, mood, and economic and environmental factors (Ross and Mackenzie 1996). Orem’s model emphasises health and views the individual as an integrated whole, with a motivation to achieve self-care (Orem 1985). During assessment the following data may be collected.

- A health history, including information on current and past medical problems, allergies, family medical history, psychological status, social history, environmental background and review of systems. (Edelman and Mandle 1994).
- Physical Assessment allows gathering of objective data, such as blood pressure measurement, weight, height, physical examination.
- Subjective assessment is regarded as what the patient reports.

2.3.3.2. **Diagnosis** refers to nursing diagnosis, which is different to medical diagnosis; it is a tentative statement or hypothesis regarding a health problem that is amenable to nursing interventions (Ross and Mackenzie 1996). Iyer *et al.* (1991) describe diagnosis as a statement of a health state or potential health problem, resulting from identification of a pattern, based on subjective and objective data. The diagnosis should be validated with the client whenever possible. Not only is the diagnosis derived from the assessment data, but nurses use logic, inductive, deductive and intuitive processes that guide to an opinion (Gordon 1994). Within their scope of practice, registered clinical nurse practitioners are able to prescribe treatments including medications. The introduction of nurse prescribing means that nurses are able to diagnose within their scope of practice.

2.3.3.3. **Planning and implementation** of treatment proceeds after assessment and diagnosis is made. Planning is a rational activity, drawing on knowledge of biological
and behavioural sciences (Edelman and Mandle 1994). Implementation of the nursing plan, based on priorities and goals, requires input from the nurse, the patient, and other health care professionals. Referral to and collaboration between health providers is essential. Interpersonal skills are vital if goal setting is to be viable. The plan must be within the nurse’s professional authority, and made in conjunction with the patient, as the patient’s participation will to some extent determine the plan’s effectiveness. Suitable interventions include observation, supportive measures, assistive measures, treatments or procedures, teaching, emotional support and coordination of care (Maibusch 1987). These are similar to Orem’s nursing system, i.e. Action or doing for others, guiding, supporting, teaching, providing a developmental environment (Orem 1985). The South African Nursing Council (1984) objectives state that treatment shall mean selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen. In PHC settings where a medical practitioner is not constantly available, it is imperative that the nurse initiates medical treatment in a variety of diseases, within her scope of practice (Bierman and Muller 1994).

2.3.3.4. Evaluation and monitoring follows implementation of actions by patients and nurses. According to Edelman and Mandle (1994), evaluation is a purposeful, goal-directed activity that occurs during attainment of short-term goals and after attainment of long-term goals. The purpose of evaluation is to measure the progress or lack of progress towards goal achievement, thus follow up consultations are important.

The nursing process can be seen to be a progression moving logically through steps, although it is cyclical in nature. Orem’s (1985) nursing systems concept incorporates the nursing process, although she has described it in three steps, namely:

Step one – diagnose and prescribe nursing care, observe and elicit information, interpret information and organise the information.

Step two – design and plan delivery of care with choice of wholly compensatory,
partly compensatory or supportive/educative.

Step three – implement and evaluate the care

2.3.3.5. Screening. This concept is based on the principle that disease is preceded by a period of asymptomatic pathogenesis when risk factors predisposing a person to the pathologic condition are building momentum toward manifestation of the disease (Edelman and Mandle 1994). Screening tests should be feasible and effective, should target a defined population using a validated test, so that treatment or support can be initiated to improve the quality of life and reduce the functional handicap produced by that disease (Ross and Mackenzie 1996). In South Africa, many screening programmes are relatively inexpensive, simple and readily deployable, with some exceptions, thus are generally cost effective and accessible to most of the population. Some of the common tests undertaken by nurses include breast examination, cervical smear, cholesterol test, blood glucose, blood pressure measurement, testicular examination, prostate examination, HIV test. A referral system is very important in screening programmes. The nurse’s role is a combination of health promoter, educator and technician. She also requires the ability to identify and report abnormal findings, and refer to appropriate sources. The patient may require education regarding risk factors, awareness of abnormalities, and to be taught to self-administer tests such as breast or testicular examinations. Healthy life style choices can enhance the disease prevention process. An example is the high incidence of cervical cancer in South Africa which has lead to a national screening programme. Carcinoma of the cervix is the second most common cancer among South African women, with 1 in 41 women developing the disease in her lifetime (Smith, Moodley and Hoffman 2003). Early detection is the best strategy, second to primary prevention (i.e. avoidance of exposure to cancer causing agents). Buga (1998) states that the success of such a programme may depend on the level of cervical cancer awareness among the target population. A study of university students found that overall knowledge of cervical cancer was poor,
with low appreciation of risk of cervical cancer, associated with unsafe sex, and of cervical smear services. Therefore nurses can increase individual women’s levels of awareness regarding cervical cancer and its prevention.

2.3.4. Caring role

In this role, nursing emphasis is on ‘care’ rather than ‘cure’. Nurses are concerned with human response to compromised health, by assisting patients to cope with health problems. Various authors, (Castledine 2005; Cook, Gilmer and Bess 2003; Melling and Hewitt-Taylor 2003; Benner 2000, Trnobranski 1993) have considered the “care” rather than “cure” line of reasoning, which argues that medicine is traditionally disease-oriented and concerned with abnormalities - a reductionist approach. Nursing, by contrast, is concerned with the human response to compromised health status and it is generally accepted that the nursing perspective has recently tended to take a more holistic view of man, ascribing to gestalt theory. Nursing intervention is not invasive but rather is concerned with action at the macro level. The emphasis is on care, such as assisting patients in coping with health problems, or by supporting them.

Orem (1985) uses the word ‘care’ to specify attention, service and protection provided by persons in a society who are in a position that requires them to ‘take care of’ others. The word care also signifies a state of mind of an individual characterised by concern for, interest in, and solicitude for another. Nurses use the word care in both senses. However, it must be noted that care is not the prerogative of nursing, but one of its elements, often implying emotional, social and psychological aspects. The commonalities among care situations include interpersonal, helping, and regulatory or adjusting features (Orem 1985).
2.3.5. Counsellor role

Doheny *et al* (1997:252) describe a counsellor as one who advises by identifying dysfunctional patterns of interaction and planning for methods of establishing functional patterns. De Bruyn and Joubert (2002) state that once students enrol at tertiary institutions they have access to unbounded freedom. This comes at a time of experimentation with alcohol and sex and it is the responsibility of each institution to develop and implement an information and counselling strategy sensitive to the needs and requirements of the particular student community it serves. At many tertiary institutions in South Africa, there are specific psychological counselling services. However, nurses regularly carry out counselling activities in their daily practice.

According to Pettifor *et al* (2004) voluntary testing and counselling (VCT) for HIV/AIDS infection is one strategy that has been shown to reduce high-risk behaviour and increase health-seeking behaviours among adults. Fischer, Reynolds, Yacobson, Barnett and Schueler (2005) add that the counselling and testing process can be a powerful tool for helping young people deal with peer pressure and begin to adopt and sustain healthy behaviours that will benefit them the rest of their lives. Counselling and advice are viewed as valuable elements of the nurses’ role (De Bruyn and Joubert 2002; Doheny *et al* 1997; Trnobranski 1994).

2.3.6. Coordinator role

A co-ordinator is a person who arranges services and referrals in proper order (Doheny *et al* 1997). Bierman and Muller (1994) state that in South Africa, nurses are the most available of all health manpower and play key roles as co-ordinators of the health teams as independent accountable practitioners. According to Hayes (2005) nurses are particularly skilled at creating alliances with a variety of professionals, setting up networks across different agencies, and enabling communities to address
problems that matter to them. Eve (2005) asserts that one important role of nurse practitioners is that she works collaboratively with other health care professionals.

2.3.7. Change Agent role

The process of change has been written about extensively (Schein 2004; Imel 2000; Ivancevich and Matteson 1993), showing that change happens over a period of time when a paradigm shift occurs, with a consequent changing of assumptions, values, and beliefs about how the world works. Mann (1999) acknowledged that there is a call for an effort to transform society or social behaviour in order to deal with HIV/AIDS. This process must start with the individual, as it is not poverty or lack of education alone, but social proficiency that is deficient within a number of cultures. Prevention efforts focusing on young people can achieve sustained behaviour change to reverse the course of the HIV/AIDS epidemic over the next 5–10 years (Pettifor et al 2004).

Nurses may facilitate other individuals’ change through empowerment processes by using planned, systematic, non-judgemental, collaborative methods to initiate changes in health beliefs, values and assumptions (Imel 2000; Doheny et al 1997). Empowerment is something that people do for themselves; however, change agents can facilitate the opening of ways for this to occur. It is tempting for nurses to occasionally want to change students’ behaviour, although Benson and Latter (1994) note that the nurse must be able to accept that a person may choose a course of action with which the nurse does not agree, or perceive to be the most healthy. Such situations are difficult and may cause interpersonal conflict, but should not necessarily be seen as a negative outcome. The concept of empowerment becomes fundamentally flawed if positive outcomes are only identified as situations when the client makes the choice that the nurse believes to be the best option. University students come into contact with persons from other cultures, with numerous worldviews, and so they are in an ideal milieu to be receptive to change.
2.3.8. Educational role

Traditional health education was characterised by authoritarian prescriptive information-giving, in which both the nurse and the patient were clear about their roles; the nurse would give information and advice, and the patient would receive it. More recently, the need for an empowering, client-centred and collaborative approach has been emphasised (Benson and Latter 1994). Van Wyk (1999) concurs, stating that the process of successful health education is nothing more than empowerment; professionals transferring the responsibility for health and well-being to the patient. The professional operates as a facilitator rather than a prescriber. Within this context, the patient is viewed as the partner rather than the recipient of health care. With regard to campus health services, Olsen and Autio (1999) maintain that academe is increasingly defining its mission as a community with a focus to transmit vital norms and traditions to its members. This means that the entire campus community, and not just the classroom, is the emerging locus of education. Thus health centres should no longer just focus on treating students’ illnesses but should also serve as educational providers. Crihfield (1995) claims that nurses should consider every interaction with a student to have an educational component.

According to Fitzpatrick, *et al.* (1992), it is necessary to make a distinction between health education, and health promotion. Health education is the process of giving information to persons, so that they are able to make informed choices regarding their health. Health promotion is slightly different. The aim is to prevent or improve potential health problems, through behavioural, environmental or social changes. In nursing practice the two overlap because health education is an essential and intrinsic part of prevention and health promotion.

2.3.9. Health Promotion role

Health promotion is defined as the process of enabling people to increase control over, and to improve their health incorporating both personal choice and social responsibility. To reach a state of complete physical, mental and social well-being, an
individual must be able to realise aspirations, to satisfy needs, and to change or cope with the environment (WHO 1986). Health is, therefore, seen as a resource for everyday life. Benson and Latter (1998) claim that in recent decades health education and promotion have assumed increasing importance within society generally, and in particular within the health professions. The nursing profession has been responsive to these changes and trends, with emphasis on the promotion of health and the prevention of illness as legitimate activities for nurses. The importance of developing nurses' role in health education and promotion has been given increased prominence in the Department of Health South African PHC Package (2001). As such, the emphasis on prevention of future health problems, wellness and quality of life by health promotion should be seen as an integral part of everyday practice rather than a separate 'add on' activity (Hayes 2005; Hale, Harper and Dawson 1996; Benson and Latter 1998). A study by Hicks and Hennessy (1999) found that one of the principal functions of primary care nurses is illness-prevention, which is consistent with the fundamental mission of health activity within their domain. However, Mackereth (1995) found that nurses did not generally perceive practical tasks to be health promotion, but did include certain screening procedures, (such as teaching breast and testicular examination, taking cervical smears) as disease prevention/health promotion, and the nurses perceived these activities as appropriate to their role. In order to deliver effective health promotion, Robb (2001) states that nurses need to have an in-depth understanding of health promotion and preventive policies.

2.3.10. Advocacy role

An advocate is defined as a person who defends and protects client rights, or acts on behalf of a client (Doheny et al 1997). It is the nurse's responsibility to assist the client (and family, if necessary) to interpret information from other health care providers, and to give additional information needed to make decisions concerning health care (Doheny et al 1997; Peplau 1952). Rushforth and Glasper (1999) state that the nurse is the health professional most likely to be the patient's key advocate, the one most
likely to note changes in the patient’s condition and initiate action, the one with whom the patient is most likely to build the closest relationship, the one most able to develop a complete map of the patient’s physical, social, psychological and spiritual well-being, and above all the one best able to assess, plan and evaluate the patient’s care needs. Edelman and Mandle (1994) add that the nurse can be an advocate by assisting clients to obtain what they are entitled to from the system and to try to make the system more responsive to their needs.

Dissemination of information regarding the South African Constitution and health rights are wide reaching especially at schools in South Africa (Rautenbach and Malherbe 1998), and therefore generally well understood by students. Tertiary educational institutions are considered to be learning organisations, defined by Marsick and Watkins (1999) as ones that continually learn and have the capacity to transform themselves, and are comprised of individuals with the ability to think critically and creatively. This type of environment stimulates discerning consumers of services, including health care. Therefore, as Rains and Caroll (2000) explain, political competence has become a crucial part of professional nursing practice, which requires the analytical ability to incorporate global trends in local health issues, to influence political processes and advocate for policy changes. Thus political socialisation is seen to be part of the nurse’s role.

2.3.11. Research role

Fitzpatrick et al (1992) proposed that the goal of nursing research be better quality of service resulting from more effective and efficient practice. Hewitt-Taylor (2003) states the current drive towards evidence-based practice is developed on the best evidence of clinical efficacy and cost-effectiveness. Therefore, knowing the latest medical and nursing research in a special interest area will encourage professionals to institute best practice and evidence-based health care. Robb (2001) asserts that professional nurses need to participate in audits, trials and research, to monitor the quality of the
service they offer, and importantly, to disseminate research findings relating to their specialist areas. Trnobranski (1993) is of the same mind, stating it is widely acknowledged that today's nursing care should be of the highest quality and performed by safe practitioners, and that future development should be 'rooted' in sound research inquiry. The author claims that a nurse practitioner should be a thinking person with analytical skills. Edelman and Mandle (1994) maintain that although many nurses do not carry out nursing research, all active and practising nurses have a responsibility to read about and critically analyse research studies and incorporate them into daily practice. In addition, Crihfield (1995) maintains that nurses working in college health settings are well suited to research on the college population. Nursing research should focus on students in order to learn about the clientele they care for. Until more research is focused on college health nursing, nurses will have a difficult time justifying their uniqueness to the rest of the health care community.

2.3.12. Leadership role

Leadership is often described as transactional or transformational. Clegg (2000) explains that transformational leadership is collaborative, consultative and consensus seeking, ascribing power to interpersonal skills and personal contact. Transactional leadership relies on the power of organisational position and formal authority to reward and punish performance. According to Porter-O'Grady (1992) transformational leadership is less like directing and controlling than it is like coordinating, integrating and facilitating. Thus it is more consistent with principles of humanism. Various authors have the issue of 'common good' as the heart of the leadership process (Burns 1978; Bass and Steidlmeyer 1998), in which the development of a sense of empathy in people enables them to complement their personal striving for advancement with that of the community, organisation or individuals, towards progress. According to Burns (1978) aspects of job satisfaction, job content and design, and individuals' sense of responsibility, recognition, personal growth and achievement are motivated by transformational leadership. In a PHC setting, this type of leadership may provide
nurses with more individual responsibility in planning and controlling their work, and being accountable to themselves, their peers, the patients and the organisation. Bass and Steidlmeier (1998) write that transformational leadership strives to achieve a true consensus in aligning individual and organizational interests, without coercion or dictation, but in a participative manner. This is particularly important with respect to change processes. In nursing, constant change is the norm, be it crisis management or adopting new legislative changes, and the interests of the patients, the nurse and the organization all have to be taken into consideration. Ethical decision-making in nursing is guided by ethical principles, and leadership is vital, especially when objective moral decisions are to be made. Verschoor et al (1997) note “few professions are more affected by the law than the nursing profession. The reason for this is that nursing (albeit with honourable intent) encroaches upon precisely those aspects of human life that are protected by the law” (p.43). Therefore adherence to ethical and moral principles is of vital importance, to protect the public and the nurse; and transformational leadership is protective of human rights.

2.3.13. Lifelong learner

Education and learning should be seen as lifelong processes that can be utilized by individuals, to develop themselves both personally and professionally (Maslin-Prothero 1997). Quinn (1995) claims that one of the goals of nurse education is to develop an autonomous professional, and Maslin-Prothero (1997) adds that the ultimate aim of the education and development of nurses must be to ensure that patients and clients benefit from optimum care. Lifelong learning appears to have gained impetus with the introduction in the UK of post registration education and practice (PREP), also triggered by nurses’ expanding roles and advancing technology (Gopee 2000).

In South Africa at present there is no such mandatory continuing education system for nurses. Therefore nurses have to take responsibility for their learning and career development. Maslin-Prothero (1997) recommends that a philosophy and commitment
to lifelong learning needs to pervade organisations (including practice areas, educational institutions and work environments), acknowledging that learning occurs in both formal and informal settings. In order to keep up to date with new medical advances, nurses undertake formal courses, attend symposia, congresses and conferences, attend in-service training, and read academic literature. The methodology of learning is relevant, as certain approaches are more effective than others. Problem-based learning, for example, enhances characteristics that are necessary for nurses to become expert practitioners. According to Ootim (1999) these characteristics include critical thinking, and lifelong learning skills in which intrinsic motivation becomes an important goal of education. As such, self-assessment seems to be an essential feature of life-long learning for professional nurses, and as Gopee (2000) notes, self-assessment is an important tool in achieving the goal of a self-directed practitioner. Robb (2001) adds that it is useful in the development and maintenance of individual professional portfolios and performance reviews.

2.3.14. Resource person role

Part of the nursing process is planning, and use should be made of appropriate resources, including referral to other health care professionals, utilization of peer support groups, families, and community resources. One of the most quoted activities for nurses working in a practice setting is that of acting as a resource person (Jenkins-Clarke et al 1998). Olsen and Autio (1999) state that in Australia, foreign students who make up an increasingly large segment of university student bodies, may have special needs such as immunisation needs, dietary and cultural practices, and an understanding of a foreign health system. This is also relevant to South African tertiary educational institutions, which enrol students from many parts of Africa and other countries. Thus nurses may be useful liaison persons.
2.3.15. Supportive role

The PHC approach places emphasis on the empowerment of individuals to take responsibility for their own health (Ntoane 1993). In a PHC setting, it is usual for the nurse to share the self-care responsibilities with the patient, but mostly to act as a guide or instructor. This principle is embodied in Orem’s nursing systems model of supportive/educative nursing. Orem (1985) explains “the supportive educative system is for situations where the patient is able to perform or can and should learn to perform required measures of externally or internally therapeutic self-care, but cannot do so without assistance. Valid helping techniques include combinations of support, guidance, provision of a developmental environment, and teaching. It is the only system where a patient’s requirements for help are confined to decision making, behaviour control, and acquiring knowledge and skills” (p.156). Eve (2005) states that the nurses’ supportive role includes helping people to manage and live with illness; or to develop with the patient an ongoing nursing care plan for health, with an emphasis on preventive measures.

2.4. ACTIVITIES WITHIN THE NURSING ROLES

When asked about the work they do, many nurses will offer a list of tasks as their job description; often other roles are seen as fundamental and unspoken (Atkin, Hurst, Lunt and Parker 1994; Chang and Twinn 1995; Eve 2005; Jenkins-Clarke et al 1998; Mackereth 1995; Mbambo et al 2003; Reveley 1998). Mbambo et al (2003) define a task as “a meaningful unit of work activity generally performed on the job by one worker within some limited time period. It is a discrete unit, which represents a composite of methods, procedures and techniques” (p.44). Rushforth and Glasper (1999) voice concern that roles dedicated or described in terms of tasks may run the risk of eroding the fundamental heart of nursing, namely the core concept of care, in favour of ‘techno-medical’ activities. However, the authors reiterate that expanded nursing roles can be combined with caring provided a careful balance is maintained,
and skill tasks are seen within the total context of care delivery, and not as an isolated
technical task. The literature review found little consistency about what SHS nurses do,
apart from concrete tasks, which seems to substantiate the essentially practical
features of the nurse’s work, with insufficient role definition.

2.5. STUDENT HEALTH RISK PROFILE.
Reif and Elster (1998) explain that the skills and tasks of development for young adults
include: acquiring good health habits, developing and acquiring the capacity for
intimacy, learning to develop a sexual identity, learning conflict resolution methods,
developing a personal value system, developing the ability to direct their educational
competencies towards academic and career goals. Health care providers in student
health services may offer students support regarding the acquisition of good health
habits. A broad range of unsafe behaviours constitutes health risks for student
populations. These include tobacco use; illicit drug and alcohol use; risky sexual
practices; unhealthy diets, violence and exposure to risk of physical injury; depression
and suicidal behaviour. These topics are discussed in detail in the following sections.

2.5.1. Tobacco, illicit drugs and alcohol use:
Alcohol and tobacco are legal in South Africa and can be used by persons over 18
years of age (Liquor Act No 59 of 2003). Recreational drugs such as cannabis and
cocaine are illegal substances. However, South Africa is encountering high levels of
alcohol and drug related problems (Parry 2000), and university students are part of the
group of young people at risk. Taylor, Jinabhai, Naidoo, Kleinschmidt, and Dlamini
(2003) state that political transformation, globalisation, urbanisation and the media
have impacted on the norms and values of young people. An example of the visible
pressure which fosters substance abuse in South Africa is the high profile advertising
linking alcohol with the glamour of sport (Parry 2001). There is extensive
documentation regarding alcohol, drug and tobacco use in South Africa, including
university students. In studies by Peltzer (2003b, 2001a) and Peltzer and Phaswana (1999), findings showed that drinking amongst male students was more common. Motives cited included social pressure followed by the perceived enhancement of coping mechanisms. The authors also found that youthful age and being male were significant factors that were associated with status and frequency of tobacco use. The students had high awareness of the link between smoking and lung cancer but knowledge of the correlation between smoking and heart disease was very low. Flisher, Ziervogel, Chalton, Leger and Robertson (1996) found that alcohol binging and smoking cannabis were predictors of early onset sexual intercourse, specifically unprotected sex, and this finding is borne out by Taylor et al (2003). A study by Myers, Parry and Pluddemann (2004) found that the substances used in Cape Town were primarily alcohol, followed by cannabis, Mandrax, crack/cocaine, heroin and ecstasy. Peltzer and Phaswana (1999) state that the use of alcohol, tobacco, and illicit drugs by university students is a matter of concern to all involved in student welfare. The authors state that it has been suggested that in Africa the combinations of traditional cultural practices (such as those involving smoking cannabis and using alcohol in ceremonies) and the increasingly pervasive ethos of ‘modernity’ and ‘Westernisation’ may be responsible for an increase in drug misuse. Whatever the reasons, it is known that alcohol is the main substance of abuse in South Africa (Parry 2000), which is a potential problem for young people as WHO (1993) has indicated that adolescence and early adulthood are periods when patterns of problem drinking are established. Nurses working with students must be cognisant of the potential problems of substance use or abuse. In a study by Peltzer, Seoka, Barbor and Tlakula (2004) it was found that PHC nurses, when trained to screen and implement a brief intervention package, became significantly more knowledgeable and effective in helping students with alcohol related problems.
2.5.2. Risky sexual practices.

Such practices include having unprotected sexual intercourse leading to unwanted pregnancies and sexually transmitted infections, including HIV/AIDS. Flisher, Reddy, Muller and Lombard (2003) state that adolescents and young adults are living in a dynamic psychosocial environment and their behavioural choices and preferences depend on prevailing social influences. These include increased social liberty and access to information, urbanisation and HIV educational programmes. The study found that the proportion of sexually active students has increased since 1990. Galloway (1999) stated that awareness and knowledge about HIV/AIDS is high among young adults in South Africa, but this has not translated into substantial behaviour change. Various studies show that in general, adolescents and young adults do not practice safe sex. Use of preventive measures is poor. Failure to practice safe sex is related, amongst others, to peer pressure to engage in early and unprotected intercourse, lack of access to user-friendly reproductive health services and low perceptions of personal risk (Buga 1996; Richter 2000; Harrison, Smith and Myer 2000; Dept of Education 2001). The link between unprotected sexual intercourse and drug or alcohol use is well documented (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, MacPhail, Vermaak and Kleinschmidt 2004; de Bruyn and Joubert 2002; Jewkes and Abrahams 2002).

A study by Mashegoane, Moelusi, Peltzer and Ngeoep (2004) found that university students, although knowledgeable about HIV risks, continued to engage in risky sexual behaviour; specifically males, who often assumed the dominant role in sexual relations; females were expected to be passive partners. It is extremely difficult to obtain prevalence data regarding students’ HIV/AIDS status, as most universities have not done baseline scientific studies of prevalence (Barnes 2000). According to Stremlau and Nkosi (2001), at this point, the only valid South African survey of HIV prevalence among college students was undertaken at the University of Durban-Westville in 2001 (www.kzn.ac.za), which revealed that 26% of female students, and
12% of male students were HIV positive. This is consistent with other South African government statistics for the region (Freeman 2004). MacGregor (2001) states that undisclosed estimates are that one of four undergraduates at South African universities may be infected with HIV/AIDS. In a national survey, Pettifor et al (2004) surveyed young South Africans and found that the peak incidence of HIV/AIDS occurs in young people aged 15-24 years. This is an important study because until recently South Africa’s annual antenatal clinic data was the only national measure of HIV prevalence. Pettifor et al (2004) explain that antenatal data by definition is limited to only sexually active, pregnant women and does not effect what is happening amongst youth populations overall.

Termination of pregnancy (TOP) is a method of dealing with unplanned pregnancy. The Choice on Termination of Pregnancy Act, (Act No 92 of 1996) substantially liberalised abortion law, and has resulted in a decrease in cases of incomplete abortion being admitted to gynaecological wards. However, illegal TOP is still prevalent, and there is a need to place more emphasis on the delivery of efficient contraception services and reproductive health education for women, including emergency contraception and safe TOP (Moodley and Akinsooto 2003; Engelbrecht, Pelser, Ngwena, and van Rensburg 2000). Unplanned pregnancy is partly explained by women not using contraception, thus Van Bogaert (2004) urges better education of both service providers and users in order to improve use, compliance and perseverance with contraception. Siebert and Steyn (2002) add that emergency contraception is one way of decreasing the number of TOPs, however, the study indicated that lack of knowledge regarding emergency contraception was a problem that required urgent measures to address current education for users and providers, namely nurses.
2.5.3. Rape and sexual violence.

According to the South African Rape Crisis Centre Organisation website (www.rapecrisis p.1) rape is a violent, traumatic and life-changing experience that can happen to anyone, in many situations. Rape is an act of power and control; sex is used as the medium to achieve this. Males and females can be raped, although it is more commonly perpetrated against females. Rape is fundamentally an infringement of human rights. The act and consequences of rape cause intimidation and humiliation and challenge the security of person and self-respect, including physical moral and mental integrity (Jewkes and Abrahams 2002). Rape can cause physical injury, unwanted pregnancy and sexually transmitted infections, including HIV/AIDS. Psychological, emotional and behavioural changes may manifest as an increased incidence of depression, suicide and post-traumatic stress disorder. Rape is primarily a societal problem, grounded in the issues of gender-based violence and discrimination. Factors such as poverty, sexual exploitation, social tolerance, drug and alcohol abuse, as well as misconceptions regarding male sexual entitlement, exacerbate the problem. Schonteich (2000) states that by global standards, South Africa has extraordinary high levels of crime. In 1997 South Africa had the highest per capita rates of murder and rape of 110 countries with crime levels listed by Interpol. Kim, Martin and Denny (2003) describe South Africa as a country notable for both a rapidly escalating AIDS epidemic and high levels of sexual violence. The issue of HIV post-exposure prophylaxis (PEP) following rape has recently come to the fore, and a policy supporting provision of PEP has been approved by the national government. However, delays in accessing PEP caused by the public justice system and lack of training for service providers constitute significant obstacles to effective implementation.

According to the Rape Crisis Centre Organisation website secondary traumatisation may occur when caregivers and police respond in an insensitive or negative manner.
As nurses, the ethical principles of justice, advocacy, beneficence and non-maleficence must be adhered to (Verschoor, Fick, Jansen and Viljoen 1997).

2.5.4. Unhealthy diets.

Senekal, Steyn, Mashego and Nel (2005) found that students from both urban and rural populations had body weight concerns, and recommended that universities need to provide innovative programmes that recognise the diversity within student populations. Students often eat 'junk food' i.e. high in fat, salt, sugar and caffeine, low in fibre and nutrients, particularly if they have not got adequate nutritional knowledge, or during periods of stress. Le Grange, Telch and Tibbs (1998) reported that in student populations eating disorders such as bulimia and anorexia nervosa are prevalent in developing non-Caucasian societies. The findings challenge the notion that eating disorders are primarily a western Caucasian phenomenon. They raise the possibility that the risk of eating disorders may rise in developing societies. A study by Steyn, Senekal, Brits, Alberts, Mashego and Nel (2000) of black female students found that women younger than 24 years of age exhibited few risk factors associated with obesity and chronic diseases of lifestyle. However, women older than 26 showed significant increases in body mass index, blood pressure and waist circumference measurement. A large number of students of all ages exhibited moderate to severe depression and anaemia was prevalent.

2.5.5. Depression and suicidal behaviour.

This has been notoriously difficult to diagnose in primary health care, according to Mkize, Nonkelela and Mkize (1998), who found no research studies of depression in a student population in South Africa. Hysenbegasi, Hass and Rowland (2005) state that depression is a common disorder that impacts an individual's ability to perform life activities, including the academic performance of undergraduate students. The effect of depression on college students has not been well documented. However Mhlongo
and Peltzer (1999) point to stressors including parental loss or absence, family conflicts or broken romantic relationships, financial issues regarding university fees, poor study habits, and peer pressure, along with the stress of being a student. Parasuicide is one of the commonest emergencies in hospital practices, especially age group 19-24 years. Peltzer (2003 a) suggests there is an association between depressive symptoms and alcohol use in students, but not with tobacco use. However, alcohol and tobacco use were highly correlated. Sexual abuse of girls has been found to lead to depression, anxiety and hopelessness (Pillay and Schoubben-Hesk 2001).

Mkize et al (1998) recommend that health care professionals be aware that somatic symptoms such as headache and stomachache can be possible depression presentation factors. The authors also iterate the importance of educating students about the signs and symptoms of depression.

Review of the literature illustrates that adolescents and young adults, who make up a significant portion of most student populations, have age-specific health risks.

2.6. CONCLUSION

Information regarding health risks amongst university students was accessed, in order to explain the context of nurse interactions with adolescents and young adults in a PHC setting. Literature regarding the roles of nurses in various settings was retrieved, and fifteen distinct roles were identified as relevant to this study. The use of Orem's (1985) theory of nursing was examined to establish if it would be useful as a theoretical framework for the study. Based on the literature search, the research design was developed.
CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

The aims and objectives of the study are described. The research design and methodology are explained, including the development of the interview guidelines, which were based on the literature review and refined during the pilot studies. Ethical considerations are described, and data analysis outlined.

3.2. RESEARCH QUESTION

What are the self-perceived roles of nurses working in campus health care settings in tertiary institutions in South Africa?

3.3. AIM OF THE RESEARCH

The aim of the study is to describe the nurses' self-perceived roles, within campus health services, in order to describe nurses' contributions to the health and welfare of students at tertiary educational institutions.

3.4. RESEARCH DESIGN

A qualitative design will be used to generate descriptions of nurses' self-perceived roles and associated activities within a tertiary level student health service.

3.4.1. Theoretical Framework

Orem's (1985) General Theory of Nursing forms the theoretical underpinning of the study. Orem's theory has three main constructs, which represent a substantial contribution to nursing knowledge by providing explicit and specific focus for nursing actions. The general theory is developed in three related theoretical constructs, and explanations concentrate on relationships between entities. Each of these constructs is clearly set forth in terms of its central unifying idea, its
theoretical propositions, and its underlying presuppositions (Orem 1985).

A brief summary of these major constructs follows.

The theory of Self-care

Self-care and care of dependent family members are learned behaviours that purposefully regulate human structural integrity, functioning and human development.

This theory denotes the relationship between the deliberate self-care actions of mature and maturing members of social groups and their own development and functioning, as well as the relationship of the continuing care of dependent family members. Self-care and dependant care are systematized, deliberate actions that, when continuously and effectively engaged in, regulate structural integrity, human functioning, and human development. The theory explains why these forms of care are necessary for the continuance of life, and that persons need to know what is required and what they should be doing, or have done for themselves, to regulate their own functioning and development (Orem 1985).

The theory of Self-care Deficit

The central concept is that people can benefit from nursing because they are subject to health-related or health-derived limitations that render them incapable of continuous self-care or dependant-care, or that result in ineffective or incomplete care (Orem 1985). The theory postulates the focus or purpose of the diagnostic process, in which the persons demand for care can be calculated, and the relationship between the demand and capabilities can be identified. According to Gast (1996) what is important about the self-care deficit concept is that it identifies the need for nursing; nursing is needed only in the case of an existing or potential self-care deficit.

The theory of Nursing Systems

These are formed when nurses use their abilities to prescribe, design, and provide nursing for legitimate patients (as individuals or groups) by performing discrete
actions and systems of action. These actions or systems regulate the value of or the exercise of individuals' capabilities to engage in self-care and meet the self-care requisites of the individual therapeutically (Orem 1985). The theory provides the context within which the nurse and patient(s) relate, the nurse diagnoses and prescribes, designs and delivers the required nursing care, based on the self-care deficits. It explains how persons can be helped through nursing. The nursing process is described by Orem in Nursing Systems, which is the third construct in her general theory of nursing.

Orem's theory is appropriate for this study as the conceptual framework presents an optimistic view of patients' contributions to their own, and their dependents', health care, which is in keeping with the evolving social values (McEwan and Wills 2002). This is particularly relevant in South Africa, a country with limited health resources. The accent on self-care agency and recognition of individuals' ability to care for self could lead to more effective and efficient use of health care services, according to Gast (1996). The choice of an appropriate nursing system within Orem's third theoretical construct is based on the answer to the question "who can or should perform self-care actions?" (Fawcett 1989, p219). Depending on the answer, the nurse would calculate and plan appropriate nursing actions, within one of the three nursing systems, namely:

- Wholly compensatory,
- Partly compensatory,
- Or supportive/educative.

It is the Supportive/Educative sub-concept that is of interest in this study, and deemed an appropriate frame of reference to illustrate the relevance of perceived roles of Registered Nurses in Student Health Services. The Supportive/Educative component of the nursing system is a suitable method of helping, in which the nurse may provide education and support for the patient so that he/she will be able to successfully meet his/her self-care requirements. This nursing care is clearly stated as encompassing:
Action or doing for others,
Guiding,
Supporting,
Teaching.

Providing a developmental environment (Orem 1985, p.138).

In a PHC setting, it is usual for the nurse to share the self-care responsibilities with the patient, but largely to act as a guide or instructor. Orem’s theory will inform and guide data collection, and the descriptions generated by the study will be interpreted in light of Orem’s theoretical framework.

3.5. RESEARCH OBJECTIVES

Main objective: To describe the self-perceived roles and aspects of tasks and activities of nurses at selected tertiary institutions in South Africa.

Subsidiary objective: To describe the nurses’ roles within Orem’s theoretical frame of reference.

3.6. POPULATION AND SAMPLING

3.6.1. Population of interest (Target population)
The population comprised nurses currently working at SHS at selected tertiary educational campuses in South Africa.

3.6.2. Accessible population
These comprised the nurses working in the SHS of campuses that are members of the South African Association of Campus Health Services (SAACHS). There are 21 institutions that are members of SAACHS. The sampling frame was therefore the list of SAACHS institutions. This was justified, as a manageable communication network exists between the campuses that are members of the association.
3.6.3. Inclusion criteria (Eligibility criteria).

The nurses were required to be registered with the South African Nursing Council, and to be working as nurses at a SHS (one that is a member of SAACHS) in South Africa.

3.6.4. Size of population

It was estimated that there were approximately 50 nurses working at SAACHS institutions. This data was taken from the SAACHS membership list.

3.6.5. Sample

Non-probability sampling was used, as the researcher used a sample that would be able to best answer the research question. Sampling in this manner is biased in that the researcher is looking for participants who are most knowledgeable and have the greatest experience related to the topic (Waltz, Strickland and Lenz 2005). The researcher assumed that nurses at tertiary educational facilities would know most about their roles, and would be able to explain nuances to the researcher. It was not possible to interview all the nurses, due to financial constraints; therefore a sample of convenience was used. The researcher planned to interview (consenting) nurses from as many of the SAACHS institutions as possible, taking into consideration time constraints and individual nurses' willingness to participate. The interviews were carried out at the January 2006 SAACHS conference held in Johannesburg. The norm is for all SHS to be represented at the conference by at least one nurse, making the sample purposive, convenient and accessible. Usually the nurses who attend the conferences are permanent staff (as opposed to contract staff), regardless of length of service at the institution, thus the level of staff experiences would be varied. The sample size was initially estimated at eighteen participants. However, there were a number of issues that decreased the estimated sample size. Due to free-time constraints at the conference, it was not possible to interview as many participants as projected. Not all the institutions had a nurse represented at the conference, in
addition, several of the delegates were reluctant to be interviewed. Four participants were interviewed in Cape Town after the conference, which was convenient to persons working in local SHS. The final sample was fourteen.

3.7. DATA COLLECTION

Descriptions of the participants’ perceptions of their roles were gathered via a semi-structured interview, after obtaining informed consent from the participants.

3.7.1. Development of the interview guideline.

The interview guideline was based on the literature review that yielded information regarding the variety of roles nurses have in general, and specifically in SHS. The researcher planned to audiotape the interviews. Prior to data collection, pilot studies were carried out.

3.7.2. Pilot Study

The pilot study was carried out in order to assess the effectiveness of the data-gathering tool, namely the interview. Brink (1996) explains that one of the reasons for doing a pilot study is to investigate the feasibility of the study and detect flaws, such as inadequate time limits and practical aspects. The semi-structured interview was piloted on three nurses, known to the researcher as having previously worked at a student health service. Brink (1996) notes that the pilot study must comprise subjects from the same population as that intended for the eventual project. Participants from the pilot study were not included in the research, as they were not currently working at a SHS. The researcher conducted the interviews twice with each person. The first phase pilot study was undertaken at the end of November 2005, and the second phase pilot study two weeks later. The pilot interviews took place at a predetermined convenient location. The purpose was to ensure that the questions could be answered in the way intended, and that the nurses and researcher understood the meanings of the
questions. Participants were asked to comment on their understanding of the questions, and to identify any difficulties they experienced when answering the question(s).

3.7.2.1. The first phase pilot study.

This was done using a semi-structured interview with 2 sections (Appendix A and B).

The researcher noticed:

- The first two questions in Section 1 did not seem to have any relevance to the study (namely, date of qualification and length of time working at SHS).
- That the audiotaped replies were difficult to hear at times, for example if the participant turned in a different direction.
- Difficulty was experienced during the transcription process as all of the participants tended to digress frequently.
- Each participant's interview took approximately 90 minutes.

The participants feedback included the following:

- All of the participants suggested a more structured, guided approach to the clinical role question, as they felt there was a certain amount of repetition regarding 'nursing interventions' and 'administering nursing interventions'.
- Two of the participants found it difficult to distinguish between organisational role and administrative role.
- One participant felt the research role was difficult to justify.
- One participant thought the leadership role was unwarranted.
- The structured approach to delineation of roles was helpful; they stated that the formula allowed them to give specific examples of the work they do related to the key words.
- Two participants thought the clinical role subdivisions were repetitive.

Based on the responses, the researcher instituted the following changes:
1. A time limit of one hour was negotiated with the participants prior to commencing the interviews.

2. To change aspects of the interview guide, as follows:

   **Section 1:** The first and second questions were excluded, as they did not seem to have practical relevance to the study.

   **Section 2:** - The subdivisions of the Clinical roles were re-named, to follow the nursing process model more closely.

   - Addition of Supportive role was added to the interview guide in order to be able to describe data within Orem’s (1985) framework of Nursing systems.

   - Retain the leadership and research roles.

   - The researcher to take notes on the interview guide in addition to tape recording the interviews. Space was allocated for field notes on the interview guide

Therefore the interview guide was altered accordingly (Appendixes C and D).

**3.7.2.2. Second phase Pilot Study.**

The pilot participants were re-interviewed, using the restructured interview guide (Appendix C and D).

*The researcher noticed:*

- The interview progression was more defined, less digression by participants.

  This may have been because they knew how to respond, having been involved in the first pilot study.

- The transcription process was more straightforward, as brief notes were taken during the interviews.

*The participants gave the following comments:*

- The flow of the roles was more natural, and all could identify with the stages of the nursing process.

- The process was not as long as the first phase interviews.
Therefore the interview guideline was accepted as an adequate qualitative method for collecting descriptive data.

3.7.3. Gaining access

Potential participants were initially contacted telephonically by the researcher in November/December 2005, to explain the research, and were asked if they would mind being approached at the conference with an information letter regarding the research. Most of the nurses agreed, however many of the nurses were on leave over that period, i.e., November/December 2005, thus could not be reached telephonically. It is common for SHS staff to take leave over this period, as universities have skeleton staff during the long summer vacation. Therefore, many participants were initially contacted at the conference. Those who expressed interest in taking part in the study were given an information letter and consent form (Appendix E). After having ascertained that the participant was willing to participate in the study, an appropriate time and place was set for the interview. Informed consent was obtained. The researcher gave the conference convenors an information letter (Appendix F).

3.7.4. Method of data collection

Miles and Huberman (1994) describe aspects of data management, storage and retrieval as important systems to have in place prior to actual data collection. A list of tasks that needed to be done prior to the interview was drawn up (Appendix G). A system of storage for notes and tapes was put into place, namely a locked cupboard accessible only by the researcher. The interviews were conducted in English, which is justified as the language that is commonly understood and/or used by nurses in South Africa. The interviews took place privately in the researcher’s hotel room during the SAACHS conference, and in a private office in Cape Town. Only the researcher and the participant being interviewed were present. The interviews were audiotape-recorded (with prior consent). The researcher introduced the research topic and began
the interview by asking each participant for a general overview of her work (for the purposes of this study, participants will be referred to as females as a matter of convenience). After listening to the response, the researcher then explained that during the literature review, specific roles were identified. The researcher asked participants to comment on each of the identified roles, and to describe her own perception of whether or not those roles were undertaken by her in the course of her work. In effect, the interview was semi-structured. She was asked to elaborate on some of the activities she perceived undertaking within that role. The researcher was able to request clarification if required, and was able to confine the participants’ responses to an extent, within the boundaries of the interview guide. The researcher did this to curtail extensive digression by the participants. According to Barker (1996) the interviewer invites the respondent to develop his/her response by asking supplementary questions of the interviewer's own choosing. All participants agreed that at the end of the process they had described all aspects of their work.

An interview guideline, based on findings from the pilot study, (see Appendix D) served to standardise the interviews, so that each participant was asked the same questions in the same sequence, in a similar manner, thus treating the interview schedule as a scientific instrument (Barker 1996). According to Atkin, et al (1994), this type of questioning will not assess how often the tasks are undertaken, the amount of time taken, or the level of responsibility given to nurses when they undertake a procedure, but will give an indication of the activities and functions required to fulfil the role.

The questions were grouped into two main sections:

**Section 1** – Professional profile of the nurses was included in order to define the population within certain professional parameters (Appendix C).

**Section 2** – Roles and activities of the nurses (Appendix D).
3.7.5. Data Management

Raw data comprised notes made on the interview guide, as well as the audiotape interviews. Miles and Huberman (1994) suggest that raw field notes require some processing, they may need to be extended, corrected, edited typed up. Audiotapes need to be transcribed, corrected, edited. Cresswell’s (1998) general data analysis strategy begins whilst data is being gathered and generated. Sketching ideas includes making notes on the interview guide, regarding salient issues during interview. Short descriptive notes were taken during the interview. Immediately after each interview the notes were expanded upon, as the researcher reflected upon the interview process.

3.7.6. Consistency, Dependability, Repeatability of instrument

The term ‘reliability’ in qualitative descriptive research refers to the degree of accuracy with which the instrument, i.e. the interview, measures subjective attributes (Carter 1996). It is concerned with consistency, stability and repeatability, and trustworthiness of the informants’ accounts, as well as the interviewer’s accurate collection and record of information (Brink 1996). The researcher used the same, or comparable, methods to attempt to obtain consistent results during each interview, by carrying out the interviews in a similar manner.

3.7.7. Accuracy, Truthfulness, Trustworthiness of instrument

The term ‘validity’ is concerned with accuracy and the truthfulness of the data collection method, i.e. the interview, to ensure that the instrument accurately measures what it is supposed to measure (Brink 1996). Waltz, Strickland and Lenz (2005) add that the trustworthiness of the data not only relevant during data collection, but extends to the resultant analysis and interpretation of data. Internal validity or truthfulness was enhanced during data collection by the researcher probing and requesting clarity on some issues, from the participant. Also, the researcher occasionally asked the participants to clarify or explain aspects of information given during the interviews. The content of the interview guide was based on the literature review, to reveal essential
aspects that must be included in the content. The validity of the interview was investigated and improved through the pilot study.

3.8. DATA ANALYSIS

3.8.1. The Aim of Data Analysis.
The aim was to accurately report the participants' perspectives and perceptions of the work they do in the specific environment of SHS, within pre-defined role descriptions. This was done in order to understand their experiences of their reality, thus the individual's views were paramount. Miles and Huberman (1994) state this type of analysis is subjective; socially constructed through individuals' interaction and interpretation.

3.8.2. The Process of Data Analysis.
In order to describe the participants' own account of the roles, three main steps of analysis were employed.

3.8.2.1. Summarising Field Notes. Miles and Huberman (1994) suggest that marginal notes on field notes add clarity and meaning to notes. These proved useful during the summary process. Cresswell (1998) suggests the interview by drafting main points onto a computer; a summary, not verbatim. This is referred to as 'winnowing' by Cresswell (1998, p.140), when main phrases, sentences and ideas are captured. This process was initiated soon after each interview, in order to remember significant features of the interview. Each interview was numbered 1, 2, 3 etc. This was the beginning stage of analysis.

3.8.2.2. Data Reduction.
Cresswell (1998) suggests that all the collected information is read through in order to obtain a sense of the overall data. This was a method of getting the data into
context, prior to the reduction progression. Graneheim and Lundman (2004, p.106) use the term 'condensing', which refers to a process of shortening while still preserving the core, as opposed to reduction, which refers to decreasing the size, but indicated nothing about the quality of what remains. The use of pre-identified roles identified in the literature review had reduced or delineated the data to an extent. Abstracting is the process whereby condensed text is aggregated or grouped together. Data from each participant about each role was placed together (e.g. all information regarding the care giving role). Coding, finding themes, and clustering are instances of further data selection and condensation (Graneheim and Lundman, 2004). The term abstraction emphasises description and interpretations on a higher logical level, e.g. the creation of codes, categories and themes on varying levels (Graneheim and Lundman, 2004). Data was then analysed by content, using those methods.

3.8.2.3. Content Analysis.

Graneheim and Lundman (2004) describe concepts related to qualitative content analysis. The unit of analysis was the interview text. This contained descriptions of all the roles, as perceived by each participant, within the context of a PHC setting for students at tertiary educational institutions, in which nurses are part of a team of providers of health care.

Each part of the text dealing with specific issues, i.e. each role, was referred to as a content area (Graneheim and Lundman, 2004). Therefore a description from each participant regarding each role was a content area. The next stage of analysis required the content area to be condensed. This condensed text was then coded. Words and phrases were identified by a code. According to Graneheim and Lundman (2004) a code is the label of condensed content area, which allows the condensed data to be understood in relation to the context. Once each participants unit of analysis (the interview) and content areas (the delineated roles) were condensed
and coded, all the participants descriptions were combined to form one content area. After the content areas had been coded, the researcher began to look for similarities regarding what each participant had described in each role. Table 3.1 presents an example of content area, condensed content, and codes.

<table>
<thead>
<tr>
<th>Content area</th>
<th>Condensed content</th>
<th>Code</th>
</tr>
</thead>
</table>
| Participant 1’s perception of caring role:  
"I use the term 'surrogate mother' as I care for the students emotionally, physically, mentally and spiritually, in a way, because I have teenagers of my own, and if they were away from home I would like someone to give them support, and teach them sometimes, they don’t know a lot of things about life, especially living on their own". | Surrogate mother, providing holistic care to young adults. Supportive and educative care is appropriate. | 1 - mother  
2 - holistic care  
3 - age appropriate  
4 - supportive care  
5* - education  
* - words/phrases found in other content areas. |

| Participant 2’s perception of caring role:  
"Nurses need to be seen as professional persons who the student can come to, and be assured of confidentiality and not to be judged. I help them by teaching them to take care of themselves, and taking time to listen to their problems, such as if they are homesick, or have boyfriend or girlfriend problems, or are having financial difficulties". | Nurse be professional, confidential, non-judgmental and approachable, able to listen to students problems and teach self care skills. | 6 - professional  
7 - approachable  
8 - confidentiality  
9 - non-judgemental  
5* - education  
10 - self-care skills  
11 - listening  
12 - problems: relationship, financial, homesick. |

Table 3.1 – Example of content area, condensed content, and codes.

Once all the data was merged into content areas, condensed, abstracted and coded, it was possible to identify categories emerging from the coded text. Graneheim and Lundman (2004) state that a category is a group of content that shares a commonality; a core feature of qualitative content analysis.
Within each role (or content area), between 2 and 5 categories were identified, and the coded data was inserted into the appropriate category. Ideally, no data should fall between two categories or fit into more than one category. However, owing to the intertwined nature of human experiences, it is not always possible to create mutually exclusive categories when a text deals with experiences (Graneheim and Lundman 2004). These categories were given headings, such as 'qualities of nurses', 'types of care given' and 'problems that required care'. Table 3.2 presents an example of categories and the coded data that make up the categories.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Caring Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
<td>Qualities of nurses</td>
</tr>
<tr>
<td>Codes</td>
<td>'mothering'</td>
</tr>
<tr>
<td></td>
<td>non-judgemental</td>
</tr>
<tr>
<td></td>
<td>listening skills</td>
</tr>
<tr>
<td></td>
<td>confidentiality</td>
</tr>
</tbody>
</table>

Table 3.2 - Example of categories and the codes within the caring role.

Each role or content area has its own categories identified by the codes, although to an extent these overlapped in some roles, such as qualities of nurses, which was a category in several roles.

After analysis, each content area was presented descriptively and in table format in Chapter 4. In the final stage of analysis, themes emerged, which were viewed within the context of the study, aimed at describing nurses' perceptions of their roles at SHS within Orem's (1985) framework. These themes were educational and supportive, and the methods of helping were discussed in Chapter 5.
3.8.2.4. Data Display.

Data display is defined as an organised compressed assembly of information that permits conclusion drawing. The researcher has to see a reduced set of data as a basis for thinking about its meanings. This may include structured summaries, synopses, network-like diagrams, vignettes and matrices with text rather than numbers (Miles and Huberman 1994). This is represented in Chapter 4, presentation of findings, as structured summaries, vignettes and tables.

3.9. ETHICAL CONSIDERATIONS

The proposal was approved by the research ethics committee of the Health Sciences Faculty, University of Cape Town prior to the commencement of the study (Appendix H). Ethical principles and reasoning are adhered to, in order to ensure a just balance between the rights of the participants and pursuit of knowledge (Neuman 1997). Respect for persons, and mutual benefit are the key principles that will be discussed.

3.9.1. Respect for persons

3.9.1.1. Informed consent

This was required from all participants before being included in the study. The researcher assured each participant had a clear understanding of what was required from her at all stages of the research process. Each potential participant received an information letter concerning the study.

This letter included:

- The purpose of the study.
- The research design.
- Data collection procedures.
- Any expectations of the participants.
- Any possible risks to the participants.
- Steps to protect the participants’ anonymity during and after the study.
- Plan for dissemination of results.
- The voluntary nature of the study
- The researcher's contact details.

The information letter was written in English. A consent form was incorporated into the participant's information letter (Appendix E).

3.9.1.2 Confidentiality

According to Brink (1996) confidentiality means only the study investigator knows the identity of the research subjects. This was maintained by non-disclosure of information to others, and by storing data in a safe place (see 3.9.1.8).

3.9.1.3 Anonymity

The participants' identity details were protected by providing each participant with a number on the interview sheet, instead of a name, so that although the researcher would know which individuals were approached to participate in the study, their names would not be associated with their details, to ensure anonymity.

3.9.1.4 Privacy

Neuman (1997) asserts that privacy ensures that no private details are shared. In this study, participants were invited to contribute to the research, and assured of privacy at all times, including if they voluntarily withdrew from the study.

3.9.1.5 Truthworthiness

This researcher was required to make sure that all information audiotaped and documented in the research process and the findings were replicated honestly and truthfully (Neuman 1997). The researcher endeavoured to attain this principle.
3.9.1.6. Trustworthiness

Clarke (1995) states that qualitative analysis seeks to unearth information, and consists of attempting to establish both the ‘adequacy’ of evidence, as well as its ‘credibility’ (p.587). This is called trustworthiness; i.e. how can the researcher know that what the participants say is true? The researcher presumed that the participant would describe her perceptions faithfully.

3.9.1.7. Right of refusal

Potential participants were informed about continued confidentiality if they did not wish to participate in the study, or if they withdrew from the study.

3.9.1.8. Data storage

The audiotapes and interview guides (with additional notations) were stored in a locked cupboard, which was accessed only by the researcher.

3.9.2. Mutual benefit

3.9.2.1. Gaining necessary permission

Permission to carry out the research was necessary in order to protect the participants (Appendix H). As a courtesy the SAACHS conference convenors were informed of the proposed research. The participants gave permission to be interviewed in their own time, i.e. not whilst at work or during the conference official hours.

3.9.2.2. Non-duplication of research

As far as the researcher knows, no other study of this nature has been undertaken in South Africa, although studies regarding the roles of nurses have been carried out in various areas of nursing practice, including: public health (Hayes 2005), paediatrics (Drew, Nathan and Hall 2002), Hospital and PHC in rural KwaZulu-Natal (Mbambo, Uys and Groenewald 2003), acute and primary care UK (Hicks and Hennessy 1999;

3.9.2.3. Feedback of research findings

One potential benefit would be increased knowledge about nursing practice, specifically the delineation of the roles of nurses in the SHS setting. There will be no risk to the participating nurses regarding personal disclosure of their interview details. Neuman (1997) asserts that the body of knowledge is enhanced thorough feedback that is as inclusive as possible. The researcher plans to send a summary report to all the participants and SAACHS chairperson, as well as being made available to the broader nursing population via publication in an appropriate journal.

Although there was not direct benefit to individual participants, it is anticipated that the services may benefit from the information contained in the final report.

3.10. Conclusion

A qualitative research design was used to generate descriptive data regarding nurses' perceptions of their roles at SHS. The participants were those who met the selection criteria. Following ethical approval and informed consent, the participants were interviewed. The interviews were standardised by use of an interview guide, which was based on the literature reviewed, and Orem's general theory of nursing was used as a theoretical framework. The descriptions were analysed using content analysis. Findings are presented in chapter Four.
CHAPTER 4

PRESENTATION OF FINDINGS

4.1. INTRODUCTION

This chapter comprises descriptions of concepts that emerged via data analysis, from the interviews with the participants.

The interview guide was in two sections, the first requested information regarding educational background of each participant. The second section of the interview asked the participants to describe their roles as nurses in SHS, within the framework of the interview guide.

4.2. EDUCATIONAL PROFILE OF NURSES.

All the nurses were registered with the South African Nursing Council (SANC) as General nurses. In addition, they had a wide range of other SANC registered professional qualifications, as displayed in Table 4.1. Four of the nurses had tertiary degrees. All the nurses had attended a variety of continuing educational courses. This finding shows the extended level of nursing education undertaken by nurses (Appendix K and Appendix J).

<table>
<thead>
<tr>
<th>Nursing educational level attained</th>
<th>Diploma</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional registered qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midwifery</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>- Community Health</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>- Paediatric nursing</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Nursing Education</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>- Nursing Administration</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>- Psychiatric nursing</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>- Primary health care - 3 months</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>- 12 months</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Additional nursing related courses</td>
<td>Listed in Appendix J</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.1. Educational profile of Nurses.
4.3. THE ROLES OF NURSES.

The nurses' perceptions of each role were described in some detail, to get an overview of the range of nurses' work. Each role is presented descriptively and in table format, in the following sections.

4.3.1. Organisational Role

Five main categories emerged from the data analysis for this role. These are planning, liaison, protocol and local policy formation, stock management and regular routine work. The theme related to planning identified several aspects that nurses described as appropriate to this role. Having a year plan, being involved in contributing to strategic planning for the unit, having some input on budget plans and organising staff cover and staff annual leave over a year were described. Activities planned for orientation week and health promotion campaigns for the year were also mentioned. Liaison with other health care professionals within or off campus, medical representatives, student bodies and student development services, were described as activities undertaken by nurses. Several practitioners spoke about organising and attending meetings and networking with other agencies, in the unit and off campus. Supervision and liaison with reception and cleaning staff were also considered appropriate activities within the organisational role. One practitioner said that knowing the personal strengths and aptitudes of staff members was useful for delegating tasks appropriately.

The formation of protocols was considered by a few participants to be suitable work for nurses within the role.

Nurse 1: “The nurses formulate protocols and they are peer reviewed by the medical staff in the clinic before being approved.”
One participant stated that she was not involved in formulating protocols, the doctors wrote them out as guidelines for the nurses, to standardise their practice.

Two participants stated that keeping up to date with legislation and policies that affect nursing practice was important. Acts relevant to their practice were cited as Termination of Pregnancy Act and dispensing policies.

Activities relating to stock management included ordering, most participants described controlling and stocktaking, and distribution of stock, such as condoms.

Several participants suggested that the maintenance and repair of equipment were part of the role. One participant described introducing cost effective measures, by suggesting all practitioners be made accountable for stock.

Routine work comprised tasks such as checking drug stocks, checking the drug fridge, checking emergency equipment and oxygen, sterilisation and disinfecting equipment and work areas, plus disposal of sharps.

See page 53 for Table 4.3.1. – Categories within the organisational role.

4.3.2. Administrative Role

Categories that emerged from the data analysis were record keeping, ordering and non-nursing duties. Record keeping was described by all practitioners as an important activity, and included managing patient files and writing nursing notes in patients' records, sending reports to directors and other health care practitioners and support services. Several participants noted computer literacy was a necessary skill.

Participants mentioned the compilation of statistical data, and sending the information to provincial departments of health, specifically family planning, STI and HIV data. One participant mentioned the auditing of records. Ordering pharmaceutical and other stock was listed as administrative work. Non-nursing duties ranged from supervision of reception and cleaning staff to actually carrying out those people's work, as well as training that level of staff, managing laundry, balancing cash intake and making appointments for students.
## Administrative role Categories

<table>
<thead>
<tr>
<th>Record keeping</th>
<th>Ordering</th>
<th>Non-nursing duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Writing notes in patient files.</td>
<td>- Procurement of stock.</td>
<td>- Domestic work, cleaning.</td>
</tr>
<tr>
<td>- Managing the filing system</td>
<td>- Stock taking.</td>
<td>- Cleaning of sluice, treatment, rooms.</td>
</tr>
<tr>
<td>- Statistics, compiling and sending to relevant departments, for F.P, STI, HIV tests.</td>
<td>- Management of medications, dispensary.</td>
<td>- Receptionist work.</td>
</tr>
<tr>
<td>- Taking minutes at meetings</td>
<td></td>
<td>- Make appointments for patients.</td>
</tr>
<tr>
<td>- Auditing records.</td>
<td></td>
<td>- Accounts clerk.</td>
</tr>
<tr>
<td>- Sending reports to directors, peers, other HCP’s, student support services.</td>
<td></td>
<td>- Train or orientate staff, eg reception, cleaning.</td>
</tr>
<tr>
<td>- Computer skills.</td>
<td></td>
<td>- Balancing budget, cash intake.</td>
</tr>
</tbody>
</table>

**Abbreviations:**

- HCP – Health Care Professional
- STI – Sexually transmitted Infection
- FP – Family planning
4.3.3. Clinical role.

This role was subdivided into five categories to reflect four stages of the nursing process and screening procedures.

4.3.3.1. Triage and Assessment.

Nurses almost always carried out triage, with assistance from reception staff. The process stated by most participants began with taking a history and/or physical examination in order to prioritise each patient. All participants said they administered first aid when required, then made appointments or referrals according to the need. The types of problems that students presented with as walk-in patients included asthma, pyrexia, colds and flu, dysmenorrhoea, abdominal pain, diarrhoea and vomiting, headaches, panic attacks and requests for emergency contraceptives. Some participants said they often spent triage time giving advice and guidance to students for simple self-limiting illnesses. Referrals were made at triage level, one nurse said she would take students to hospital or call an ambulance and if necessary.

Of note was a comment from a participant regarding referral routes:

*Nurse 1* – "I always ask students about their health related financial means, because this will give me an indication of which referral pathway to use, students on medical aid should be sent for private referrals, and others will use state amenities".

Nursing assessment comprised taking a past and current history and carrying out a physical examination. Measurement of vital signs and other tests were cited as part of the assessment process. More than half the participants mentioned holistic assessment, incorporating physical, psychological and emotional assessment to be important.
Nurse 2 – "It’s important to assess the students coping skills and mechanisms, find out how they have helped themselves at this time and in the past".

<table>
<thead>
<tr>
<th>Clinical role – Nursing triage and assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage management</td>
</tr>
<tr>
<td>- Done by nurse</td>
</tr>
<tr>
<td>- Done by reception staff</td>
</tr>
<tr>
<td>- Done by medical secretary</td>
</tr>
<tr>
<td>- Prioritisation based on history.</td>
</tr>
<tr>
<td>- Prioritisation includes examination.</td>
</tr>
<tr>
<td>- Give first aid treatment.</td>
</tr>
<tr>
<td>- See immediately.</td>
</tr>
<tr>
<td>- Make later appointment.</td>
</tr>
<tr>
<td>- Refer to other HCP.</td>
</tr>
<tr>
<td>- Call an ambulance if necessary.</td>
</tr>
<tr>
<td>- RN to take student to hospital.</td>
</tr>
</tbody>
</table>

Table 4.3.3.1. Categories within Clinical Role – Nursing triage and assessment.

4.3.3.2. Nursing diagnosis

Nursing diagnosis generated three categories appropriate to the role. These were the characteristics of nurses, the basis of diagnosis and outcomes of the diagnosis. Participants described communication skills, developing trust and a holistic approach as important attributes of nurses. A diagnosis was made when information was available from the physical examination, history, observations and vital signs, as well as analysis of diagnostic tests and laboratory findings. All of the participants stated that based on the diagnosis, treatment was given or the patient was referred to an appropriate source of help, either within the unit or off campus.

Nurse 1 – "I think it is important to be able to send the patient to the person who is most skilled in their field, especially in the clinic where I work, because each practitioner has special interests or aptitudes".
Several participants also expressed the opinion that it was very important to discuss the diagnosis made, and the treatment pathway planned, to incorporate the students' views.

<table>
<thead>
<tr>
<th>Qualities of Nurses</th>
<th>Basis of diagnosis</th>
<th>Outcome of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Communication skills.</td>
<td>- Information gathering process</td>
<td>- Discussion regarding treatment.</td>
</tr>
<tr>
<td>- Holistic approach, diagnose physical, mental,</td>
<td>* from physical examination</td>
<td>- Treatment.</td>
</tr>
<tr>
<td>emotional issues.</td>
<td>* past and present history</td>
<td>- Referral.</td>
</tr>
<tr>
<td>- Trust</td>
<td>* observations, vital signs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Information from diagnostic tests.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* urinalysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* blood chemistry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* specimens.</td>
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</tr>
</tbody>
</table>

Table 4.3.3.2. Categories within Clinical role – Nursing Diagnosis.

4.3.3.3. Nursing interventions

There was one main category, which was treatment, within this category were variations, such as 'treatment according to diagnosis', 'types of treatment by nurses, and 'administering doctors prescriptions'. Participants described administering treatments according to protocol formula. The types of treatment described comprised technical aspects, for example nebulisation of patients diagnosed with acute bronchospasm, intravenous infusion for dehydration. Procedural treatments included minor surgical procedures, wound dressings and ear syringing. All participants described pharmacological treatment as appropriate to their role, when prescribing within their scope of practice. They stated they prescribed family planning medications; level one analgesia, STI medications, vitamins. Most of the participants explained they were able to administer medications when prescribed by a medical doctor, antibiotics and analgesia were mentioned. One participant stated that the clinic supported management of directly observed therapy (DOT) for students diagnosed with tuberculosis.
Liaison with the patients was considered important in order to improve compliance and the effectiveness of treatment. One nurse stated that it was important to discover the student’s health philosophy to help guide a nursing management plan.

_Nurse 1: “It is necessary in culturally diverse situations, to talk and explain treatments to students, who may not understand or believe in the type of treatment and it’s significance. The prescriptive approach is not appropriate. We can negotiate the management together so that the student can buy into it, and feels empowered”._

The majority of participants included counselling, health education, life skills education, as well as emotional support as legitimate nursing interventions.

<table>
<thead>
<tr>
<th>Clinical Role – Nursing Interventions Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat according to diagnosis</td>
</tr>
<tr>
<td>- Within nurses scope of practice.</td>
</tr>
<tr>
<td>- According to PHC principles.</td>
</tr>
<tr>
<td>- According to protocols.</td>
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</tr>
</tbody>
</table>

_Dr. Table 4.3.3. Categories within Clinical Role – Nursing Interventions._

4.3.3.4. Evaluation and monitoring
All participants described follow up processes as the basis of this role. Following acute medical conditions to evaluate the patient's condition, the efficacy of treatment, and compliance. Examples given were acute bacterial, viral and fungal infections, students who presented with acute bronchospasm. It was deemed important by three participants to follow up students who had undergone termination of pregnancy.

Participants stated they spent follow up time with students with chronic conditions such as acne, TB, HIV, headaches, dysmenorrhoea, epilepsy, hypertension, anaemia, depression, anxiety, stress and other conditions. Several participants described part of their work to include follow up of well students, consisting of family planning, ante-natal care, weight management, and coping mechanisms of disabled students. Follow up of laboratory reports was a necessary task.

<table>
<thead>
<tr>
<th>Clinical Role – Evaluation and Monitoring Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Follow up.</strong></td>
</tr>
<tr>
<td>- Post TOP</td>
</tr>
<tr>
<td>- Bacterial, viral, fungal infections.</td>
</tr>
<tr>
<td>- Check efficacy of medication.</td>
</tr>
<tr>
<td>- Wound check</td>
</tr>
<tr>
<td>- Acute asthmatic peak flow and treatment.</td>
</tr>
<tr>
<td>- Pathology results.</td>
</tr>
<tr>
<td>- Feedback from other HCP's.</td>
</tr>
<tr>
<td><strong>Chronic Follow up.</strong></td>
</tr>
<tr>
<td>- Skin conditions, eg dermatitis, acne.</td>
</tr>
<tr>
<td>- HIV positive</td>
</tr>
<tr>
<td>- TB</td>
</tr>
<tr>
<td>- Anaemia (Hb)</td>
</tr>
<tr>
<td>- Hypertension</td>
</tr>
<tr>
<td>- Diabetics.</td>
</tr>
<tr>
<td>- Asthmatics.</td>
</tr>
<tr>
<td>- Headaches</td>
</tr>
<tr>
<td>- Pain</td>
</tr>
<tr>
<td>- Epilepsy</td>
</tr>
<tr>
<td>- Dysmenorrhoea.</td>
</tr>
<tr>
<td>- Depression</td>
</tr>
<tr>
<td>- Anxiety, Stress.</td>
</tr>
<tr>
<td><strong>Wellness Follow up.</strong></td>
</tr>
<tr>
<td>- HIV positive.</td>
</tr>
<tr>
<td>- Family planning.</td>
</tr>
<tr>
<td>- Weight management, over or under weight.</td>
</tr>
<tr>
<td>- Blood pressure</td>
</tr>
<tr>
<td>- Ante natal</td>
</tr>
<tr>
<td>- Disabilities coping mechanisms.</td>
</tr>
</tbody>
</table>

**Abbreviations:**

- TOP – Termination of pregnancy.
- STI – Sexually transmitted infection.
- TB – Tuberculosis.
- Hb – Haemoglobin.

| Table 4.3.3.4. Categories within Clinical Role – Evaluation and Monitoring |

4.3.3.5. Screening.
Testing techniques and education were the main themes identified from participants descriptions. Testing included diagnostic tests, preventative measures and referrals for specialised testing. All participants said that they carried out voluntary counselling and testing (VCT) for HIV, STI checks and pregnancy tests. Several participants added that blood pressure measurement and rapid blood analysis for haemoglobin, glucose and cholesterol screening were done in the clinics, as well as eye testing, body mass index and weight measurement. Preventative testing incorporated breast and testicular examination and cervical smear tests. Referral for further testing was required for suspected TB, and for students requiring specialist services.

Education was a significant part of the screening role, according to most participants.

_Nurse 1: “I teach students how to do simple exclusion tests such as breast and testes examination, to know their own bodies. These are vital life skills”._

<table>
<thead>
<tr>
<th>Screening Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing Techniques</td>
</tr>
<tr>
<td>Diagnostic</td>
</tr>
<tr>
<td>- VCT for HIV</td>
</tr>
<tr>
<td>- Pregnancy tests, urine and/or blood.</td>
</tr>
<tr>
<td>- STI, visual or blood.</td>
</tr>
<tr>
<td>- Pathology.</td>
</tr>
<tr>
<td>- Body mass index.</td>
</tr>
<tr>
<td>- Blood pressure measurement</td>
</tr>
<tr>
<td>- Self examination of breast, testicles.</td>
</tr>
<tr>
<td>- Weight measurement</td>
</tr>
<tr>
<td>- Normalise women's health issues.</td>
</tr>
</tbody>
</table>

_Table 4.3.3.5. Categories within Screening Role._
4.3.4. Caring Role

The categories within this role were the qualities of nurses, types of care given and issues requiring care, and the nurses' characteristics. The nurses' qualities included being non-judgmental with good listening skills, for nurses to be approachable and professional and empathy and an understanding of cultural differences were highlighted.

Several participants described the caring role as incorporating 'mothering':

Nurse 1: "I use the title 'surrogate mother', as I care for students emotionally, physically and spiritually, in a way. I have teenagers and if they were away from home I would like someone to give them support; they don't know a lot of things yet".

The participants emphasised the holistic nature of nursing, as well as being sensitive to age appropriate care. They described emotional support and teaching self-care skills as necessary to increase students' confidence as well as their knowledge. Comfort measures were described as important aspects of this role.

Nurse 2: "Offers of comfort to a girl with dysmenorrhoea include giving hot water bottles, analgesia and medical certificates. The students appreciate this approach, but need to be able to manage this condition themselves. I teach them by giving information and help them choose management techniques that best suit them".

Participants described issues requiring care to include students with stress, homesickness, relationship problems, sexual anxieties, fears of mortality and dilemmas regarding morality.
### Caring Role Categories

<table>
<thead>
<tr>
<th>Qualities of Nurses</th>
<th>Type of care given</th>
<th>Issues requiring care</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 'Mothering'</td>
<td>- Holistic.</td>
<td>- Stress.</td>
</tr>
<tr>
<td>- Non-judgemental</td>
<td>- Age appropriate.</td>
<td>- Homesickness.</td>
</tr>
<tr>
<td>- Listening skills</td>
<td>- Emotional support.</td>
<td>- Relationship issues.</td>
</tr>
<tr>
<td>- Confidentiality</td>
<td>- Self care skills</td>
<td>- Financial problems.</td>
</tr>
<tr>
<td>- Kindness</td>
<td>eg confidence, knowledge.</td>
<td>- Anxiety.</td>
</tr>
<tr>
<td>- Approachability</td>
<td>- assertiveness training.</td>
<td>- Academic issues.</td>
</tr>
<tr>
<td>- Professionalism</td>
<td>- Guidance.</td>
<td>- Personal problems.</td>
</tr>
<tr>
<td>- Empathy</td>
<td>- Comfort measures.</td>
<td>- Sexuality issues.</td>
</tr>
<tr>
<td>- Cultural understanding.</td>
<td>- Information and or advice.</td>
<td>- Fears of mortality.</td>
</tr>
<tr>
<td></td>
<td>- Like a social worker.</td>
<td>- Morality dilemmas.</td>
</tr>
<tr>
<td></td>
<td>- Help get issues in perspective.</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.3.4. Categories within Caring Role.

#### 4.3.5. Counsellor role

The majority of participants thought this role was very important and that every consultation with students required elements of counselling. Qualities of nurses were specified, and included listening skills, being non-judgmental and empathic, being non-prescriptive, non-threatening and approachable.

Participants explained the processes of counselling as containment, not pressurising students, offering information, advice and guidance. The role included educational and supportive aspects. Several participants felt that nurses had inadequate counselling skills, and that they needed more training and to be debriefed at regular intervals.

*Nurse 1*: “A lot of nurses only give advice or prescribe. It is very important to listen with empathy. I think most nurses do not have adequate skills in counselling”.

The reasons for counselling were broad. All described VCT and counselling for pregnant students; several participants said they regularly offered couple counselling. Counselling was required for students who had relationship problems with family.
friends or sexual partners. The youthfulness of students was also stated by participants as being a common reason for needing counselling, for self-image problems, alcohol or drug use, and stress and anxiety relating to sexual relationships and academic issues.

Nurse 2: “Students are young and unsure of themselves, it is easy to tell them what to do, but better to give them time and information to make their own decisions. The consequences of unprotected sexual intercourse can be pregnancy and STI or HIV/AIDS. Do not scold the student, listen to their reasons, they may have sexual pressure from the boyfriend, or no self-confidence”.

Being a victim of crime, sexual harassment, rape and post-traumatic stress were described by participants as reasons for students seeking counselling from a nurse.

<table>
<thead>
<tr>
<th>Characteristics of nurses</th>
<th>Issues requiring counselling</th>
<th>Process of counselling</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Very important role.</td>
<td>- Student anxiety, stress.</td>
<td>- Containment.</td>
</tr>
<tr>
<td>- Like a social worker.</td>
<td>- Adolescence.</td>
<td>- Give advice.</td>
</tr>
<tr>
<td>- Listening skills</td>
<td>- VCT for HIV</td>
<td>- No pressure.</td>
</tr>
<tr>
<td>- Non-judgemental</td>
<td>- Pregnancy.</td>
<td>- Give information.</td>
</tr>
<tr>
<td>- Empathy</td>
<td>- TOP.</td>
<td>- Help students make</td>
</tr>
<tr>
<td>- Approachability</td>
<td>- Relationship issues.</td>
<td>informed decisions.</td>
</tr>
<tr>
<td>- Non-threatening</td>
<td>- Sexual issues.</td>
<td>- Support student’s</td>
</tr>
<tr>
<td>- Non-prescriptive</td>
<td>- Post traumatic stress.</td>
<td>decision.</td>
</tr>
<tr>
<td>- Preference over</td>
<td>- Crime.</td>
<td>- Educational</td>
</tr>
<tr>
<td>psychologist.</td>
<td>- Rape.</td>
<td>component.</td>
</tr>
<tr>
<td>- Nurses training needs.</td>
<td>- Academic issues.</td>
<td>- Consultations have</td>
</tr>
<tr>
<td></td>
<td>- Self-image issues.</td>
<td>elements of counselling.</td>
</tr>
<tr>
<td></td>
<td>- Alcohol and/or drug abuse.</td>
<td>- Regular debriefing.</td>
</tr>
<tr>
<td></td>
<td>- Couple counselling.</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.3.5. Categories within Counsellor Role.


### 4.3.6. Coordinator role

Descriptions produced three categories, namely referrals, liaison and distribution.

Referrals and liaison were activities most quoted by participants. Referrals primarily to other health care professionals, but also to colleagues within the unit, student support services, and student health representatives. They mentioned cooperation was on occasion required with academic departments and residential staff.

* Nurse 1: "Intercampus and off campus referrals are a big part of my role, and I must be able to refer to the correct service for the student’s needs."

Participants regarded liaison with local clinics, government departments and hospitals for stock such as condoms, HIV test kits, state medications such as family planning and STI medications, as legitimate work within this role. Distribution of stock such as male and female condoms, and health related pamphlets were part of this role.

<table>
<thead>
<tr>
<th>Coordinator Role Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referrals</strong></td>
</tr>
<tr>
<td>- To other HCP’s.</td>
</tr>
<tr>
<td>- Make appointments.</td>
</tr>
<tr>
<td>- Write referral letters.</td>
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</tbody>
</table>

Table 4.3.6. Categories within Coordinator Role.
4.3.7. Change agent role

A number of the participants acknowledged they had some role as a change agent with individual students. They described giving information and facts, being accessible to students, and motivating them to use the knowledge in a proactive way, to be appropriate to this role. Enabling or empowering students to be able to deal with the pressures attendant on young adults, especially regarding issues of sexuality, such as peer or partner pressure to practice unprotected sexual intercourse, were seen as legitimate activities for nurses. As one nurse stated:

*Nurse 1: “It is not my job to make students fearful, but to give them information and to help them gain confidence and the capability to stand up for their rights, values, to teach them social responsibility especially regarding sexual practices”.

Individual consultations for voluntary counselling and testing (VCT) and sexually transmitted infections were seen as opportunities to initiate behavioural and lifestyle changes. Participants said that they helped facilitate students’ ability to make informed choices in order to change or modify their behaviour, and that it was important for nurses to support students choices.

<table>
<thead>
<tr>
<th>Change Agent Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>How nurses help students</td>
</tr>
<tr>
<td>- Give facts and information.</td>
</tr>
<tr>
<td>- Enable students to make choices.</td>
</tr>
<tr>
<td>- Motivate by imparting knowledge.</td>
</tr>
<tr>
<td>- Be accessible to students.</td>
</tr>
</tbody>
</table>

Table 4.3.7. Categories within Change Agent Role.
4.3.8. Educational role

Participants thought that the educational role involved individuals, rather than health promotion, which was for many persons. They described individual education as influential, because nurses were better able to give information in context, and students were able to get information for their individual knowledge deficits.

_Nurse 1: “One-to-one education is effective, because each individual can ask questions regarding their own circumstances, so education is tailor-made, depending on the student’s particular needs.”_

Information had to be current, correct, factual, especially regarding sexual practices, family planning choices and the dangers of alcohol and drugs. Participants said they facilitated group education for support groups, such as weight and diet management, the individuals in the group motivated each other. Group methods were also used to educate student bodies, residence wardens, peers and colleagues. Methods of education included use of posters and pamphlets, health information talks on campus radio, and role-play to help students to understand concepts. The participants said they used education in each interaction with students.

<table>
<thead>
<tr>
<th>Educator Role Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing information</td>
</tr>
<tr>
<td>- Information current, correct, factual.</td>
</tr>
</tbody>
</table>

Table 4.3.8. Categories within Educator Role
4.3.9. Health promotion role

The categories within this role incorporated activities undertaken by nurses, as well as prevention of disease and promotion of wellness. Health promotion activities included organising campaigns on campus, displaying posters and pamphlets and even writing health promotion pamphlets and liaison with other health promotion bodies on campus.

_Nurse 1: “I use the World Health Organisation calendar to focus on health campaigns, such as AIDS day on 1st December, and TB week in March. This way there is a focus and information can reach many people”._

Prevention of disease included activities to promote safer sex and prevent HIV and STI's, breast examination and cervical smears. Also, to bring awareness of importance of immunisations such as influenza and hepatitis and information regarding prevention of malaria. Participants said that this was a very important role, to transfer responsibility for health to individuals, to make them independent and socially responsible.

Some said there was no difference between health promotion and educational roles.

<table>
<thead>
<tr>
<th>Health Promotion Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurses Activities</strong></td>
</tr>
<tr>
<td>- Aimed at many people.</td>
</tr>
<tr>
<td>- Display posters.</td>
</tr>
<tr>
<td>- Write health educational pamphlets.</td>
</tr>
<tr>
<td>- Distribute pamphlets.</td>
</tr>
<tr>
<td>- Organise health promotion campaigns on campus.</td>
</tr>
<tr>
<td>- Liaise with other health promotion bodies.</td>
</tr>
<tr>
<td>- Transfer responsibility for their health to students.</td>
</tr>
<tr>
<td>- Campus radio talks.</td>
</tr>
<tr>
<td>- Coach health represent</td>
</tr>
</tbody>
</table>

Table 4.3.9. Categories within the Health Promotion Role.
4.3.10. Advocacy role

The participants’ responses produced three categories. These were the issues requiring advocacy, the qualities of nurses, and the tasks undertaken within the role. Issues requiring advocacy included non-medical problems, such as academic, family and relationship difficulties, crime, trauma and rape. Management of emotional, psychological, acute and chronic illnesses, including assisting students to connect with other student services. Helping students deal with financial difficulties by referring to appropriate offices, and residence problems including hygiene and noise issues, as well as catering requirements were mentioned.

The participants indicated that teaching problem solving techniques were within this role. Correct information regarding examination deferments and issuing medical certificates were a task that nurses perceived to be advocacy. Giving students information regarding their constitutional rights was perceived to be relevant.

Several participants explained that there was a need for nurses to be sensitive to cultural differences, to be supportive and be a spokesperson.

* Nurse 2: “I am in the student’s corner, so to say. I believe them if they say they can’t cope or have a specific problem. Sometimes I feel like a social worker”.

<table>
<thead>
<tr>
<th>Advocacy Role Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues requiring advocacy</td>
</tr>
<tr>
<td>- Financial difficulties.</td>
</tr>
<tr>
<td>- Residence problems.</td>
</tr>
<tr>
<td>- Catering problems.</td>
</tr>
<tr>
<td>- Communication problems</td>
</tr>
<tr>
<td>with support services.</td>
</tr>
<tr>
<td>- Emotional or psychological problems.</td>
</tr>
<tr>
<td>- Poor coping skills.</td>
</tr>
<tr>
<td>- Illness, acute or chronic.</td>
</tr>
<tr>
<td>- Academic problems.</td>
</tr>
<tr>
<td>- Family problems.</td>
</tr>
<tr>
<td>- Crime, trauma, rape.</td>
</tr>
<tr>
<td>- Disciplinary hearings.</td>
</tr>
</tbody>
</table>

Table 4.3.10. Categories within the Advocacy Role.
4.3.11. Research role

The main categories identified was the informality of the role, some of the methods participants used to do informal research, and barriers to conducting research. Participants said they did no formal research, but carried out aspects of data collection for other health care professionals and were recipients of their research. They were involved in sending statistical data to other departments. Barriers to conducting research were felt to be participants' lack of time and access to courses that taught research skills; and some stated that others did not see research as important for nurses:

Nurse 1: According to my manager, I am employed to provide health care to students. Research is not my job. But how am I supposed to improve the practice if I do not either carry out research or at least read and understand it?

The term 'evidence-based practice' is not really a feature of the place I work in, we just do things the same old way."

Some participants acknowledged that they were involved in collecting information for quality assurance purposes and to assess students' needs. These methods comprised using questionnaires and use of statistical data collected from patient's records, having a 'suggestion box' for students comments. Participants said they read nursing journals.

<table>
<thead>
<tr>
<th>Research Role Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Role</td>
</tr>
<tr>
<td>- No active role.</td>
</tr>
<tr>
<td>- Recipient of others research.</td>
</tr>
<tr>
<td>- Help in research trials for other HCP's.</td>
</tr>
<tr>
<td>- Give statistics to other departments.</td>
</tr>
<tr>
<td>- Give information to others for their own research.</td>
</tr>
<tr>
<td>- Collect data for others.</td>
</tr>
</tbody>
</table>

Table 4.3.11 – Categories within the Research Role
4.3.12. Leadership role

Participants felt there was no leadership role, they identified themselves as independent practitioners accountable for themselves, not others. There were other people such as directors in charge of the SHS, and these people were seen as leaders. Some added that there were no financial incentives or recognition in assuming a leadership role. Several participants thought that their peers saw them as unofficial leaders because of the number of years of service and seniority within the unit. Others thought that the role was more formalised because of their seniority, experience and qualifications.

<table>
<thead>
<tr>
<th>Leadership Role Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No role</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>- Nurses get no recognition.</td>
</tr>
<tr>
<td>- No financial incentives.</td>
</tr>
<tr>
<td>- The director is the leader.</td>
</tr>
<tr>
<td>- Nurses independent practitioners, self accountable.</td>
</tr>
</tbody>
</table>

Table 4.3.12. Categories within the Leadership Role.

4.3.13. Resource person role

Giving correct, up-to-date information and referrals pathways were the categories identified by descriptions. One participant illustrated her role as a resource person as follows:

*Nurse 1* "I direct students to the right source of help. For example, after rape a girl’s friends may give her wrong information, or she may not have told anyone, and she doesn’t know what to do. I explain about the places to go, which are the hospital, where she can get medicines for preventing pregnancy, STI’s and HIV, also forensic evidence can be taken. I can give her emergency contraception and STI triple therapy as prevention, but we don’t stock post exposure prophylaxis"
ARV (anti-retrovirals). The police station is where she can report the rape, and press charges if she wants to. Many girls are very scared to go to the police.

I must tell her she is not forced to go, she could go later with a friend if she wants to. Rape crisis is very helpful, and I give the girl a card with phone numbers. She can also come back to the clinic at any time she is worried.

The participants made referrals made to a wide variety of health sources, such as the disability unit, counselling and psychological services, off-campus HIV testing facilities. Also to services not directly pertaining to health matters, such as legal and financial offices, home affairs departments, police and campus security, and academic support services. Several participants stated that there were elements of other roles within the resource role, such as counsellor, caregiver and supporter.

<table>
<thead>
<tr>
<th>Resource Person Role Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information</strong></td>
</tr>
<tr>
<td>- Correct information.</td>
</tr>
<tr>
<td>- Up to date information.</td>
</tr>
<tr>
<td>- Stock fliers and pamphlets for off-campus services.</td>
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<tr>
<td></td>
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Table 4.3.13. Categories within the Resource Person role.

### 4.3.14. Lifelong learning role

The need for learning, the types and methods of learning were the categories that emerged from the data. Participants said they thought lifelong learning was important for keeping up to date with medical and nursing issues, in order to improve nursing practice.
Nurse 1: “All the courses and diplomas I do improve my nursing practice, make me a more competent and more holistic practitioner, and enhance my life also”.

Most of the participants described learning as enjoyable and stimulating, and the effect was to enrich life and enhance self-fulfilment. Particularly by learning about other topics, not only medical ones. One nurse referred to it as learning for life.

Nurse 2: I have learnt something about traditional healers work, because it is an important part of South African culture. Nurses and other health providers should be aware of traditional practice”.

Most of the participants acknowledged the importance of informal learning, by networking with colleagues and by reading nursing journals, as well as the need to attend courses, conferences and workshops, to study to keep up to date with local legislation such as the pharmaceutical dispensing laws, and anti-retroviral rollouts.

<table>
<thead>
<tr>
<th>Lifelong learning Role Categories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for learning</td>
</tr>
<tr>
<td>- To update knowledge and skills.</td>
</tr>
<tr>
<td>- To improve nursing practice.</td>
</tr>
<tr>
<td>- To enrich life.</td>
</tr>
<tr>
<td>- For stimulation and enjoyment.</td>
</tr>
<tr>
<td>- Self fulfilment.</td>
</tr>
</tbody>
</table>

Table 4.3.14. Categories within Lifelong Learner Role.
4.3.15. Supportive role

Four categories were identified from descriptions. The participants thought the supportive role to be similar to other roles such as care giver, educator, counsellor and resource person. Giving information, advice and guidance regarding lifestyles and behaviour, and teaching self-assertiveness and responses to peer pressure was seen as building students confidence. Teaching students self-care was noted as an effective way of using nursing skills.

Nurse 1: “It is important to teach students how to take care of themselves and manage common conditions such as colds, dysmenorrhoea, diarrhoea, so that they don’t have to come to the clinic each time, and this is life skills also”.

Self-care included stress management, relaxation techniques, coping skills. Emotional support was cited as similar to counsellor characteristics, and deemed a very important aspect of being supportive.

<table>
<thead>
<tr>
<th>Supportive role Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similarity to other roles</td>
</tr>
<tr>
<td>- Role similar to care giver role, educational role, counsellor role, resource role.</td>
</tr>
</tbody>
</table>

Table 4.3.15. Categories within the Supportive Role.
4.4. CONCLUSION

This chapter presented the results identified from analysis of the interviews with nurses regarding their perceived roles as health providers in SHS. Data was portrayed both descriptively and in table form.

In Chapter 5, these descriptions are discussed in light of campus health services, and with reference to Orem’s supportive/educative nursing system.
CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

5.1. INTRODUCTION

Nurses’ roles as identified by them, regarding the extent of their practices and the range of their roles, may be useful in order to delineate their contributions to the health and well-being of students within the milieu of student health services.

The contribution that nurses make is described, in order to enable the nurses, other health care professionals and SHS directors to comprehend the roles of nurses in campus health care settings. The roles are discussed in this chapter, and the implications for nursing will be a description of the contribution of nurses to student health services.

5.2. Organisational and administrative roles.

The organisational and administrative roles have common characteristics to some extent, and are discussed together. The formulation and use of protocols, aspects of record keeping and statistics, as well as stock management, liaison, and routine as well as non-nursing duties are discussed. See Tables 4.2.1 and 4.2.2 (p. 52) for categories identified within these roles.

Hewitt-Taylor (2003) notes that when nurses roles are extended to take on a range of roles traditionally undertaken by medical personnel, the aim is to introduce protocols of care that will identify how common conditions are to be treated. The author acknowledges that the concept of standardization of practice and clinical guidelines are important, but may be in conflict with the idea of nurses achieving greater autonomy in their practice. It appeared from participants’ descriptions that the use of protocols to guide nursing practice was usual in SHS clinics, and that some nurses
had input into their development and the protocols were peer reviewed in some instances. A few participants were not involved in protocol formation and Jenkins-Clarke et al (1998) suggest that unless protocols are truly a team effort, and not driven by doctors only, they may lead to an ever-increasing disease orientation in primary health care.

With reference to evaluation of nursing practice, the researcher noted that one participant said she had nursing audit procedures in her workplace but none of the participants mentioned any methods of assessment or evaluation of their nursing practice. Troskie (2000a) states that the goal of auditing is to improve patient care by reviewing patient files and documents, by supervisors, directors and through nurses peer review.

The participants discussed aspects of record keeping as important, to ensure effective communication between everyone involved in delivery of care. According to Troskie (2000a) records are kept for a number of reasons, such as reporting an incident provides protection to staff and gives information on possible risks in the service. Records have legal status, meaning they must be kept meticulously to protect nurses, patients and the institution. Computer record keeping was noted by participants, which necessitates them to be computer literate, it must be assumed that they were, as none of the participants said otherwise.

Management of statistical information was described as an important part of administrative work and issues of confidentiality were mentioned. This type of clerical work is acceptable work for nurses according to Robb (2001), especially as the data is of a confidential nature. Statistics provide information for the SHS unit as well as other departments. Troskie (2000a) states statistical information is useful for future planning, for comparison purposes, for cross-referencing and to follow trends.
The participants described how they were involved in planning staff cover for the unit, and utilising staff effectively, especially in vacation times, when the campus is quiet. Aspects of planning were described as acceptable work, especially health campaigns which are relevant in light of the well documented age-attendant risks of young adults. Keeping updated with the Nursing Act and Acts that affected SHS practice were poorly described by participants, possibly due to lack of time and interest. Liaison and networking with other nurses and health care professionals was described as a large part of the organisational role. Nurses dealt with many campus bodies in order to deal with issues that affect students academically, and those that cause a student stress may be issues that are taken to the clinic nurse for help with referral to the appropriate source of help.

Participants included management of stock as both organisational and administrative work. Routine work was perceived to be legitimate nurse’s work, as they have the training and ability to order and maintain stock appropriately, including maintenance of the drug fridge which has to have precise cold-chain procedures in place to be effective. Checking drug expiry dates, medical equipment, and sterilising and keeping work area clean is valid work for nurses. However, Troskie (2000b) states that it is not the duty of nurses to do stock-taking, they should only be involved in care of specialised equipment such as emergency and oxygen equipment and Schedule 4,5, 6 drug stock take. Rushforth and Glasper (1999) query whether nursing time employed in clerical and, aspects of which could also perhaps more appropriately be undertaken by non-nursing personnel, thereby yielding more nursing time for direct client care.

5.3. Clinical role.

By separating aspects of clinical work in the interview, it appeared to enable participants to focus on issues within the role. All participants noted triage
management, most of who stated they were responsible for carrying out triage, but said reception staff also did triage, with some training from the nurses. In a PHC setting, triage often comprises making appointments, referral or first aid treatment, see Table 4.3.3.1. (p.54) for categories within nursing triage and assessment. McCutcheon (1996) described a telephone triage system used in a college health unit in USA, where many requests for information or service came from students who were basically healthy and whose complaints stemmed from either self-limiting illnesses, requiring coaching in self-care, or from students' lack of understanding of their health status, leading to anxiety that responded readily to information and reassurance. This type of assistance explains the PHC emphasis in triage work.

The assessment activities described by the participants are in keeping with Edelman and Mandle's (1994) recommendations, comprising past and current history, as well as physical, psychological assessments.

Participants' description of nursing diagnoses included diagnostic techniques, as well as personal interaction with the student. This is confirmed by Iyer et al (1991) who explain that the nursing diagnosis should be validated with the patient whenever possible. According to Peplau (1952) when the nurse and client first identify a health problem and begin to focus on a course of action, they approach this path from diverse backgrounds and individual uniqueness. As the nurse-client relationship develops, they mutually share in a collaborative manner towards resolution of the problem. See Table 4.3.3.2. (p.55) outlining nursing diagnosis categories within the clinical role.

The descriptions of nursing interventions were comprehensive, with nurses stating they needed to work within their scope of practice and according to PHC principles, i.e. focusing on preventative and promotive health care, using appropriate technology. See Table 4.3.3.3. (p.56), for categories identified for nursing interventions within the clinical role. These included making referrals, giving advice, information and
counselling. These interventions are similar to those outlined by Maibusch (1987), who included treatments or procedures, supportive measures, teaching, and emotional support as relevant nursing interventions. Those nurses who had undertaken a dispensing course had a wider scope of practice regarding pharmaceutical dispensing. Participants mentioned pharmaceutical legislation at present time being in a state of transition as far as their prescribing capability were concerned.

Evaluation and monitoring comprised aspects of follow up procedures, and the participants descriptions were widely encompassing. Edelman and Mandle (1994) explain that the purpose of evaluation is to measure progress, or lack of, towards goal achievement. This point was clearly made by participants. See Table 4.3.3.4, (p.57) for outline of evaluation and monitoring categories identified within the clinical role. None of the participants explained or expanded on the evaluation process regarding re-diagnosis, in light of the nursing process, the practice of evaluation is ongoing, cyclical and progressive in nature.

The participants described a wide variety of tests appropriate to screening at PHC level, and also indicated that they were instrumental in increasing awareness of health issues, especially women’s health, see Table 4.3.3.5. (p.58) regarding categories within the screening role. Eve (2005) states that screening patients for disease risk factors and early signs of illness is a legitimate role for nurses. Slusher (1999) states that the success of self-care depends on the active participation of individuals in their own health care. Orem’s concept of self-care has been one of the most widely applied nursing models to date according to Callaghan (2003), and teaching young adults basic screening techniques is part of the enabling process, shifting responsibility for health to the individual.
5.4. Caring role

Marks-Maran (1999) claims that relevance for nursing decisions must take cognisance of the values held by patients and nurses. The culturally diverse South African society necessitates nurses being able to render congruent cultural care. This is particularly relevant to university students, who come from socially, culturally and economically, diverse walks of life, and the participants were cognisant of this fact. Slusher (1999) identifies some of the dangers for adolescents and young adults; the age is characterised by peer pressure, egocentric thinking, and risk-taking behaviours. Participants appeared to be cognisant of these facts, and described sensitivity to age appropriate care. See Table 4.3.4. (p.60) outlining categories of the caring role.

5.5. Counsellor role

Orem (1985) states that guiding another person as a method of assisting is appropriate in situations where persons must make choices or pursue a course of action with some direction and supervision. Although Orem does not mention counselling per se, aspects of this are similar to ones perceived as counselling by nurses. According to Baldwin-Ragaven, de Gruchy and London (1999) health care professionals need to be aware of their own position in society, and how their values and loyalties may put them in inconsistent or conflicting situations, they need to clarify their own values before they can be effective in a counselling situation. Thus, the need for debriefing, as noted by participants, is necessary. Values clarification exercises are useful methods of managing ethical dilemmas and conflicts (Edelman and Mandle 1994). Tnobreiski (1994) and De Bruyn and Joubert (2002) confirm that counselling is a valuable use of nurse’s time. See Table 4.3.5 (p.61) showing categories identified within the counsellor role.
5.6. Change agent, educational and health promotion roles

According to Pettifor et al (2004) voluntary testing and counselling (VCT) for HIV/AIDS infection is one strategy that has been shown to reduce high-risk behaviour and increase health-seeking behaviours among adults. Fischer et al (2005) add that the counselling and testing process can be a powerful tool for helping young people deal with peer pressure and begin to adopt and sustain healthy behaviours that will benefit them the rest of their lives. This is particularly relevant in South Africa as Sub-Saharan Africa has the highest rate of HIV infection in the world (WHO 2005). See Table 4.3.7. (p.63) for categories within the change agent role. Orem (1985) explains that helping methods include providing a developmental environment, which requires the nurse to motivate the person to establish goals and adjust behaviour to achieve results specified by the goals. The needed environment may be psychological or physical, and developmental results include the forming or changing of attitudes and values, the creative use of abilities, and the adjustment of self-concept.

Mann (1999) described the deficit of social proficiency skills within a number of cultures, and that social behaviour must start with the individual. Nurses may be instrumental at grass roots level, by providing relevant, congruent one-to-one education. From the participants descriptions, it was noticed that they thought these roles were very important, and they used aspects of education health promotion in almost every interaction with students. See Table 4.3.8. (p.64), and Table 4.3.9. (p.65) for categories within the educator and health promotion roles. Crichfield (1995) endorses this attitude, as does Slusher (1999), who asserts that health promotion is critical to the development of adolescents and young adults. The emphasis on prevention of future health problems, wellness and quality of life by health promotion should be seen as an integral part of everyday practice rather than a separate ‘add on’
activity according to Hayes (2005), Hale, Harper and Dawson (1998), Benson and Latter (1998). Teaching is a legitimate method of helping a person who needs instruction in order to develop knowledge or particular skills. Learning may not take place if the person to be taught is not in a state of readiness to learn, is unaware that he or she does not know, or is not interested in learning (Orem 1985). Thus, the client-centred, empowering approach to education is emphasised by Benson and Latter (1998). Slusher (1999) claims that education benefits patients by enhancing patient satisfaction, responsibility, control, independence, autonomy coping skills, increased health knowledge and improved quality of life. Several participants explained that they facilitated support groups for students, and Orem (1985) states that group teaching may be an effective way of helping individual persons become efficient in self-care activities.

The importance of developing nurses’ roles in health education and promotion has been given increased prominence in the South African PHC Package (2001). Thus by supporting personal and social development through providing information, and enhancing life skills, it is possible to increase options available to people to exercise more control over their own health and environments, and to make choices conducive to health. According to Peltzer (2000), a study regarding attitudes of nurses in primary health care showed that nurses felt they were most appropriate people to get involved in health promotions. Nurses felt that counselling about health promotion was cost effective. Hayes (2005) states that in the UK the public have conveyed clear expectations regarding their need for advice, support and access to health promoting services via nurses, although they do not want to be dictated to about their health and health behaviour.

None of the participants spoke about the need to have in-depth understanding of health promotion and prevention policies, as advocated by Robb (2001).
5.7. Coordinator, Advocacy and Resource person role

These roles have elements of other roles, such as counsellor, caregiver and supporter. Trnobraški (1993) states nursing is an activity concerned with human welfare, its central purpose is to improve individual health status and society as a whole, and nursing activities are enormously diverse, which endorses Jenkins-Clarke et al (1998) suggestion that one of the most quoted activities for nurses in practice settings is that of resource persons. The participants’ descriptions of nurse coordination are confirmed by Bierman and Muller (1994) who state that in South Africa nurses are key coordinators within the health service. See Table 4.3.6. (p.62) for an outline of categories within the coordinator role, and Table 4.3.13. (p.69) regarding categories within the resource person role.

Participants noted that they were interested in all aspects of students’ lives, which reinforces Rushforth and Glasper’s (1999) statement that the nurse is the health worker most likely to be the patient’s key advocate, the one most able to develop a complete map of the patient’s physical, social, psychological and spiritual well being. As such, nurses meet the definition of Doheny et al (1997) who stipulate that an advocate is a person who defends and protects clients rights or acts on behalf of a client. This is in keeping with Edelman and Mandle’s (1994) claim that assisting clients to obtain what they are entitled to from the system and trying to make the system more responsive to their needs is part of being an advocate. See Table 4.3.10. (p.66) for categories within the advocacy role.

None of the participants mentioned aspects of political competence and political socialisation as part of their roles, which Rains and Caroll (2000) claim is a crucial part of professional nursing practice.
5.8. Research role

In general, the participants did not participate actively in research. See Table 4.3.11. (p.67) regarding categories within the research role. Edelman and Mandle (1994) state that although some nurses do not carry out research, they have a responsibility to read, analyse and incorporate information into daily practice. The participants did carry out student needs surveys, and according to Fitzpatrick (1992), Robb (2001) and Crichfield (1995) finding out patients needs is considered appropriate work for nurses.

5.9. Leadership role

None of the nurses mentioned that leadership skills were relevant to furthering nursing as a profession. This is borne out by Borthwick & Galbally (2001) who claim that there is currently a weakness in self-concept in nursing that goes hand-in-hand with a weakness in political status, and nursing leadership must build the foundations for both advocacy for others, and self advocacy for the nursing movement. See Table 4.3.12. (p.68) identifying categories within the leadership role.

5.10. Lifelong learning Role

The participants described learning to improve their nursing practice, which is endorsed by Benner (1984) who claims that nurses should become competent nurses on qualifying, but substantial further learning is required throughout their professional careers to maintain high standards, to achieve higher levels of practice at proficient or expert levels, and to enhance clinical practice. The participants were interested in learning a variety of topics, which is in keeping with Maslin-Prothero’s (1997) claim that nurses should develop both personally and professionally. One nurse referred to it as learning for life. See Table 4.3.14. (p.70) for lifelong learning categories.
5.11. Supportive role

According to Orem (1985) supporting another is extensively used in situations where individuals are in the process of developmental change. This is relevant to the majority of student populations at tertiary educational facilities. Participants' descriptions of their supportive role included aspects of education and information, specifically to improve students self-confidence and knowledge. They described how teaching self-care skills may lead to improved lifestyle and behaviour modification. These aspects are in keeping with Orem's methods of helping or giving assistance to others, namely, guiding another, supporting another. See Table 4.3.15. (p.71) for supportive role categories. Orem (1985) emphasises that the patient must be capable of controlling and directing the process.

The popularity of Orem's self-care theory is attributable to a number of reasons beyond those intended by Orem, including consumerism and the self-help movement in health care, with contemporary health problems often related to life-style, and the shift to own care as an alternative to hospitalisation as a way to control health care costs (Gast 1996). The concept of self-care could become a process of empowerment and an instrument for behavioural and social transformation within tertiary educational student health care facilities.

5.12. RECOMMENDATIONS

There are a number of issues that emerged from the data analysis that have implications for nurses. The educational profile suggested that all the participants had undergone a significant amount of nursing education, at formal level. However, additional knowledge and skills would be beneficial to them in their capacity of nurses at SHS. Several proposals are made.

5.12.1. Protocol writing. The writing of protocols to guide practice is a skill, and if nurses are to use them appropriately, they should be involved in formulating them, as
buying in to a concept does encourage people to be enthusiastic supporters of the ideas. Individuals can formulate protocol effectively, but the protocols need to be peer reviewed, before being accepted, and they need to be regularly updated.

5.12.2. Nursing audit procedures. These are necessary for quality assurance purposes, and require teamwork. Both protocol and audit processes should be part of nurses’ organisational and administrative work, and it is suggested that nurses are taught the necessary knowledge and skills to participate in these activities. Nurses with administrative and management qualifications could be asked to run workshops to teach these skills.

5.12.3. Nursing Acts and Policies. The participants’ weak knowledge regarding relevant Nursing Acts and Policies informing nursing practice, as well as health promotion and prevention policies and general political competence, was of some concern. Those documents are formulated to inform nursing practice. Suggestions include offering in-service training with experts in policy and administration, in order to make the understanding and relevance of current policy issues amenable to nurse practitioners. This will improve nurses’ knowledge of advocacy pathways, and co-ordination skills.

5.12.4. Research knowledge and skills. Insufficient knowledge regarding the process of research as well as reading research articles is not uncommon amongst nurse practitioners, according to Brink(1996). However, evidence-based practice is important for cost effectiveness and best practice; therefore nurses should be enabled to keep up to date with latest developments in their sphere of practice.

Brink (1996) maintains that research is an integral part of nursing practice, education and administration, and practitioners of nursing must be aware of and knowledgeable about the application of research in nursing. Ways in which nurses can participate in
research include keeping abreast of new knowledge evolving from research, particularly in their own spheres of practice, such as issues involving adolescents and young adults. Assessment of the implications for nursing and applications in relevant practical situations are constructive. Subscription to relevant journals, and beginning a journal club to debate issues or bring to attention innovations could be done during inservice education and training sessions. Journal clubs could be within each unit, or within the SAACHS forum. Due to geographical differences between the units, this could be carried out via electronic mail, with a nursing mentor to guide the discussions. Nurses should be encouraged to identify nursing problems in their field which may benefit from research. These problems or issues could be communicated to people who carry out research, or the nurses could be taught how to do the research themselves, from a nurse who has some experience in research. The use of questionnaires and surveys, and the evaluation of the results are part of the research process. However, experienced nurse researchers would be useful in guiding these practices. Nurses at SHS could be included in capturing field data, with the proviso that the findings will be sent to them.

5.12.5. Clinical knowledge and skills. With reference to clinical roles, nurses' knowledge and skills were perceived to be reasonably current and relevant. However, access to short courses that would update and benefit nurses and patients could include, for example, aspects of pharmacology, first aid, wound management and TB management. Motivation for attending the courses must come from the nurses, who are in the best position to know what their educational needs comprise.

5.12.6. Cultural diversification. This was a point mentioned by participants, who appeared to be cognisant of the importance of sensitivity to all cultures and beliefs. Values clarification exercises, usually in workshop format, are beneficial to everyone working with the public.
5.12.7. Counselling. Of note is the amount of counselling the participants described in their daily work. Most participants had not attended formal counselling courses, except during HIV voluntary counselling and testing courses, or as part of their psychiatric nursing diplomas. The importance of counselling cannot be over estimated, because without a thorough knowledge of the processes and skills of counselling, nurses may be prescriptive. The participants spoke of counselling students who had been raped or traumatised in other ways, probably suffering from post-traumatic stress syndrome. If a nurse is the first person to see such students, she must be conversant with methods of containment, before referring them to other counselling bodies. Couple counselling and advanced counselling courses are highly recommended for all nurses working in a campus health setting.

There are courses offered by the Higher Education HIV/AIDS Programme (HEAIDS), run by the Centre for Disease Control and Prevention, a training body that offers HIV counselling and management courses annually, for practitioners in tertiary educational facilities. It is suggested that nurses themselves ask to be sent on the courses. These particular courses are run at no cost to the tertiary education facility, so are extremely accessible.

With the ability to counsel comes the responsibility to attend debriefing and supervision. Participants felt that these opportunities were not always available to them. However, nurses could (and should) motivate for the requirement of being debriefed by an experienced psychologist or counsellor.

5.12.8. Education and health promotion. The importance nurses attached to educational and health promotion roles were evidenced in almost every description of each role. The key is to keep nurses motivated and up to date with current changes in medical and nursing fields. Medical representatives spend a lot of time with doctors, but it is suggested that nurses from SHS clinics approach the representatives and ask them to visit their work places to inform them on new or updated products, especially
regarding aspects of reproductive health. Pharmaceutical representatives are usually willing to visit institutions when requested to give information regarding on-going and new innovations. For example, vaccines available for meningitis, hepatitis, influenza, as well as up to date medications for treatment and prophylaxis, for example antiretroviral regimes, Hepatitis C treatment and the contraceptive patch.

5.12.9. Institutions mission statements Not all the participants knew everything about their institutions regarding referral procedures for students. It is recommended that nurses request such information, or attend orientation courses every few years if they are offered, in order to be effective co-ordinators and resource persons. As far as the researcher knows, many tertiary institutions run orientation courses for new employees, to inform them of the institutions mission statements and the services available for students.

Suggestions for further research include investigating each of the roles in depth to establish how nurses utilise their skills to maximum effect. For example, how the nurse practitioner relates to challenges in the role of change agent in a VCT consultation at a student health centre.

5.13. CONCLUSION

This chapter has discussed the findings of data analysis, and the overriding themes that have become evident from the participants descriptions are twofold, namely, education and support, which are important aspects of every interaction with students. Orem’s theory has been of use as the framework for this study, as it has shown value in teaching, and recognising individuals’ needs and abilities to care for themselves, which is in keeping with evolving social responsibility. Both international and local changes affect nursing as a profession. The increased use of information technology enables
more clients to have knowledge and expectations regarding their relationships with nursing professionals. Students are becoming cognisant of their rights as patients, thus professionals are expected to have the knowledge, skills and attitudes to effectively teach, guide and support students, as discerning consumers of their services.
CHAPTER 6

SUMMARY AND CONCLUSION

This study has shown that nurses working in SHS at tertiary educational institutions are aware of the importance of appropriate care aimed specifically at adolescents and young adults, particularly with regard to supportive and educational aspects of nursing. According to Fawcett (1989) Orem is explicit in articulating assumptions, and these indicate that Orem values the individual's abilities to care for themselves without intervention from health care professions except when actual or potential self-care deficits arise. Support and education leading to self-care skills are relevant to contemporary health problems often related to life style, particularly in young adults, who have a number of age related health risks, which may be lessened by behaviour modification. Nurses working in a PHC clinic that are accessed by young adults are in a position to establish relationships of trust and confidentiality, to deal with the variety of health concerns of young people.

Strasser and Gwele (1998) report that nurses constitute the majority of all health workers, and thus form the backbone of the health service. Nurses need to become more influential and be able to clearly articulate and describe their work and the benefits it brings to individuals and communities (Hayes 2005).

Orem (1985) points out that nursing science seeks to describe, explain and verify the type of work that nurses, within their sector of reality, are undertaking. Use of Orem's theory by nurses may indicate its value to them in their search for clearer, developing, and more accurate views of the world of the nurse.
REFERENCES


University of Cape Town (Student demographics). Available from: www.uct.ac.za. Cited on: 12/10/2005


APPENDIX A: Interview guide.

Section 1: Educational profile of Nurses
(First phase Pilot Study).

Section 1: Educational Profile of Registered Nurses

1.1. What is the highest nursing educational level you have attained?

Nursing diploma  Nursing degree  Post graduate degree

1.2. Do you have any additional advanced or post-basic qualifications you have registered with SANC, such as:

Midwifery ...........  Community health .............. ...
Paediatric nursing......  Nursing education ..............
Psychiatric nursing...........  Nursing administration...........
Primary health care course: 3 Months duration ..........  1 year duration ...........
Other..........................................................

1.5. Have you undertaken any additional nursing-related courses? Give details

........................................................................................................

........................................................................................................
## APPENDIX B: Interview guide.

### Section 2: Roles of Nurses

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>(This section may be used by researcher to make brief notes)</td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
</tr>
<tr>
<td>Clinical Role</td>
<td></td>
</tr>
<tr>
<td>* Triage</td>
<td></td>
</tr>
<tr>
<td>* Diagnostic</td>
<td></td>
</tr>
<tr>
<td>* Nursing interventions</td>
<td></td>
</tr>
<tr>
<td>* Monitoring</td>
<td></td>
</tr>
<tr>
<td>* Administering therapeutic interventions</td>
<td></td>
</tr>
<tr>
<td>* Screening</td>
<td></td>
</tr>
<tr>
<td>Care giver role</td>
<td></td>
</tr>
<tr>
<td>Counsellor role</td>
<td></td>
</tr>
<tr>
<td>Co-ordinator role</td>
<td></td>
</tr>
<tr>
<td>Change agent</td>
<td></td>
</tr>
<tr>
<td>Educator role</td>
<td></td>
</tr>
<tr>
<td>Health Promoter role</td>
<td></td>
</tr>
<tr>
<td>Client Advocate role</td>
<td></td>
</tr>
<tr>
<td>Research role</td>
<td></td>
</tr>
<tr>
<td>Leadership role</td>
<td></td>
</tr>
<tr>
<td>Resource person role</td>
<td></td>
</tr>
<tr>
<td>Life-long learner role</td>
<td></td>
</tr>
<tr>
<td>Other (state)</td>
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</table>
APPENDIX C: Interview guide.

Section 1: Professional profile of Nurses

(Second phase Pilot Study)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Nurse Reply</th>
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<tbody>
<tr>
<td>1.1. What is the highest nursing educational level you have attained?</td>
<td></td>
</tr>
<tr>
<td>Nursing diploma</td>
<td></td>
</tr>
<tr>
<td>Nursing degree</td>
<td></td>
</tr>
<tr>
<td>Other degree</td>
<td></td>
</tr>
<tr>
<td>Post graduate degree</td>
<td></td>
</tr>
<tr>
<td>1.2. Do you have additional post-basic qualifications registered with SANC, eg:</td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td></td>
</tr>
<tr>
<td>Paediatric nursing</td>
<td></td>
</tr>
<tr>
<td>Nursing education</td>
<td></td>
</tr>
<tr>
<td>Psychiatric nursing</td>
<td></td>
</tr>
<tr>
<td>Nursing administration</td>
<td></td>
</tr>
<tr>
<td>Primary health care course: 3 Months duration</td>
<td></td>
</tr>
<tr>
<td>12 months duration</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>1.3. Have you undertaken any additional nursing-related courses? Give details</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D: Interview guide.

Section 2: Roles of Nurses
(Second phase Pilot Study).

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
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<tr>
<td>Administrative</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Role</strong></td>
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</tr>
<tr>
<td>* Triage / Assessment</td>
<td></td>
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<tr>
<td>* Nursing Diagnosis</td>
<td></td>
</tr>
<tr>
<td>* Nursing Interventions</td>
<td></td>
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<tr>
<td>* Evaluation/ Monitoring</td>
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</tr>
<tr>
<td>* Screening</td>
<td></td>
</tr>
<tr>
<td>Care giver role</td>
<td></td>
</tr>
<tr>
<td>Counsellor role</td>
<td></td>
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<tr>
<td>Co-ordinator role</td>
<td></td>
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<tr>
<td>Change agent</td>
<td></td>
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<tr>
<td>Educator role</td>
<td></td>
</tr>
<tr>
<td>Health Promoter role</td>
<td></td>
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<tr>
<td>Client Advocate role</td>
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<td>Research role</td>
<td></td>
</tr>
<tr>
<td>Leadership role</td>
<td></td>
</tr>
<tr>
<td>Resource person role</td>
<td></td>
</tr>
<tr>
<td>Life-long learner role</td>
<td></td>
</tr>
<tr>
<td>Supportive role</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E: Information Letter and Consent Form for Participants

Research Ethics Committee details:
Research Ethics committee,
Faculty of Health Sciences,
E52, Room 24,
Old Bldg, Groote Schuur Hosp.
Observatory, 7700

Researcher Contact details:
11 Spring Gardens,
Pinelands,
Cape Town, 7405.
Cell: 072 288 2266
Fax: 021 531-4048
e-mail: bmadams@mweb.co.za

DATE: January 2006

Dear

Information regarding the proposed research.

Title of the proposed research: "A description of the self-perceived roles of Registered Nurses in student health services in selected tertiary institutions in South Africa".

I am a Registered Nurse currently undertaking a Masters degree at the University of Cape Town, and am also employed as a nurse at the Student Health Service at the University of Cape Town. I am interested in finding out about your perceptions of the work you do at the student health service (SHS), regarding the roles of nurses, and the activities you carry out regularly in order to fulfil certain roles. The purpose of the study is to describe these roles and activities, in order to portray how nurses contribute to the health and welfare of students at tertiary institutions.

The nature of the study requires your voluntary participation, which will be appreciated. Data collection will be done by audiotaped interview, and the information you impart will be completely private and confidential, your name will not appear in the interview, and your professional particulars will not be divulged to any other person. The interviews will take place at the SAACHS conferences in January, at a time arranged to suit you. You may be asked to confirm the information given during the interview, by the researcher, as a method of checking the researchers interpretations of your descriptions. A summary of the findings of the study will be sent to you, and to the director of the student health service. At no time will there be a risk of disclosure regarding your personal input, as individual persons and institutions will not be identified. Suggestions may be used for quality assurance purposes and may be published in a nursing journal.

If you are willing to participate in this study, please sign the consent form.

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If you do not wish to participate in the study, or if you wish to withdraw from the study, you are assured of continued confidentiality, and no pressure will be put on you to do so. Should you not wish to participate, this will in no way affect your current employment state, role and functions. My contact details are listed above.
This study proposal has received ethical approval from the UCT Research Ethics Committee. Their contact details are listed above.
Yours Sincerely,

Bridget Adams

------------------------------------------------------------------------------------

PARTICIPANT CONSENT FORM

A description of the self-perceived roles of Registered Nurses in student health services in selected tertiary institutions in South Africa.

If you consent to participating in the study, please sign the consent form, stating that you understand and acknowledge the following:

- I have been given information pertaining to the above titled study.
- I understand that my participation in the study is voluntary, and that my name will not appear on any document or audiotape, my anonymity will be assured.
  The information I disclose will remain private and confidential. The information generated will be used by the researcher for descriptive purposes.
- My professional details will not be disclosed, and in no way will my employment status, role and functions as a Registered Nurse in the Student Health Service be affected.

I agree to take part in the study, and give my permission to B. Adams to use the information in her research.

Name.................................................................................. Date...........................................

Signature.............................................................................................................
APPENDIX F: Information letter to SAACHS Conference Convenor.

Dear

Research Study. A description of the self-perceived roles of Registered Nurses in student health services in selected tertiary institutions in South Africa.

I am a Registered Nurse currently undertaking a Masters degree at the University of Cape Town. I am interested in finding out about registered nurses’ perceptions of the work they do at the student health service (SHS), regarding the roles of nurses, and the activities they carry out regularly in order to fulfil certain roles. The purpose of the study is to describe the roles undertaken by registered nurses in South Africa at SHS’s, in order to portray how nurses contribute to the health and welfare of students at tertiary institutions.

The institutions chosen to be included in the study are those who are members of the South African Association of Campus Health Services (SAACHS), as there is a good communication network between the campus members of the association, who would seem to have similarities of interests. The method of selection of participants will be purposive sampling, as the nurses who attend the SAACHS conference in 2006 will be asked to participate. The researcher will arrange to interview the consenting nurses during the January 2006 SAACHS conference, at a time and place convenient for this purpose.

The possible participants will be given an explanatory letter, and will be asked to sign a consent form. Confidentiality and privacy will be ensured, as the participants names will not appear in the interview, and their particulars will not be divulged. This study proposal has been granted ethical approval by the Research Ethics Committee, Faculty of Health Sciences, University of Cape Town. Their contact details are listed above.

A summary of the study will be sent to you, to the SHS directors, and to the participants. Information generated may be useful to your association, and the results of the study may be published in a nursing journal. My contact details are as above.

Yours Sincerely,

Bridget Adams
APPENDIX G: Pre interview checklist

<table>
<thead>
<tr>
<th>DATE</th>
<th>TASK</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial contact – introduction and explanation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Willing to be interviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hand out information letter and consent form</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Get signed consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan a date, time and venue for interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carry out interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Get participant contact details</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miscellaneous</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INSTITUTION: .................................................................................................................

NAME OF PARTICIPANT: ........................................................................................................

CONTACT NUMBER: ............................................................................................................

APPENDIX H: Letter from research ethics committee.

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E53-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 466 6338 • Facsimile [021] 466 6411
e-mail: pendar@nurse.uct.ac.za

29 November 2005

REC REF: 430/2005

Mrs B Adams
C/o Mrs P Mayers
Nursing & Midwifery
Health & rehabilitation

Dear Mrs Adams

PROJECT TITLE: A DESCRIPTION OF THE SELF-PERCEIVED ROLES OF REGISTERED NURSES IN STUDENT HEALTH SERVICES IN SELECTED TERTIARY INSTITUTIONS IN SOUTH AFRICA

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has formally approved the above-mentioned study on the 21 November 2005.

Please quote the REC. REF in all your correspondence.

Yours sincerely,

[Signature]

PROF. T. ZABOW
CHAIRPERSON
APPENDIX J: Educational profile of nurses: Additional nursing courses

Additional nursing-related courses:

- Dispensary Course.
- Reproductive health course.
- HIV/AIDS Voluntary testing and counselling (VCT).
- Diploma in psychology.
- Childhood illnesses.
- Nursing management.
- Syndromic management of sexually transmitted diseases.
- Computer courses.
- Educational management.
- Dip in Natural science stress relief.
- Anti Retroviral rollout.
- Wound management.
- Adolescent health
# APPENDIX K: Nursing educational profile of Nurses.

<table>
<thead>
<tr>
<th>NURSE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. What is the highest nursing educational level you have attained?</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>Nursing diploma</td>
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<tr>
<td>Nursing degree</td>
<td>y</td>
<td></td>
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<td>Post graduate degree</td>
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<td>y</td>
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<tr>
<td>* Other degree</td>
<td>y</td>
<td></td>
<td>y</td>
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<tr>
<td>1.1. Do you have additional post-basic qualifications registered with SANC:</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<td>y</td>
<td>y</td>
<td>y</td>
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<td>y</td>
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<td>y</td>
<td>y</td>
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<td>y</td>
<td>y</td>
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<td>Nursing education</td>
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<tr>
<td>Primary health care course: 3 Months duration or 1 year duration</td>
<td>1yr</td>
<td>1yr</td>
<td>3mths</td>
<td>1yr</td>
<td>1yr</td>
<td>3mths</td>
<td>1yr</td>
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<td>1yr</td>
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<td>1yr</td>
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<tr>
<td>** Other</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1.3. Have you undertaken any additional nursing-related courses?</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<td>y</td>
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<tr>
<td>*** Give details</td>
<td></td>
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<td></td>
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</table>

* Other degrees obtained: B.Tech in public health  
B.A (psychology)  
B.A (social science)

** Other SANC qualifications:  
Occupational Health nursing  
Intensive care nursing

Self-Care Requisites
Purpose of actions directed towards provision of self-care. Termed TSCD*

Universal Developmental Health deviation

↓

1. Air
2. Water
3. Food
4. Elimination
5. Activities
6. Solitude
7. Hazards
8. Normal

↓

1. Maintain conditions to support life & development
2. Acknowledge specific needs in stages of development

Self-Care Deficits
Core concept: People with health derived limitations can benefit from nursing. TSCD is assessed & actions required to meet SCRs are compared to patients SCA. TSCD sufficient = SCR met TSCD inadequate = SCR unmet = nursing required

↓

1. Seek medical assistance
2. Tend to effects of pathology
3. Act on prescribed measures
4. Care for side effects of prescribed measures
5. Accept modified self-concept
6. Alter life style to promote development

↓

5 areas of activity for nursing practice

↓

Step 1
Diagnose, prescribe nursing care
4 phases
1. Observe, elicit information
2. Flow of information
3. Interpret information
4. Organise information

Step 2
Design nursing care
Plan delivery of care
Choice of:
1. Wholly compensatory
2. Partly compensatory
3. Supportive/educative

Step 3
Implement Evaluate
Nurses role:
1. Assist in SCR
2. Collect evidence
3. Evaluate results

Nursing Systems
Tridimensional practice: social, technological, interpersonal. 3 steps in the nursing process

↓

Relationships

Determining

Responding

Prescribing

Co-ordination

within these 3 systems of care

Acting/Doing
Teaching
Guiding

Supporting, Providing developmental environment

* TSCD = Therapeutic Self-Care Deficit
* SCR = Self-Care Requisites
* SCA = Self-Care Agency