Pharmacy Students' Lived Experiences of the Mental Health Support Structure at Rhodes University

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ABSTRACT

Mental health is a global concern and an increasingly important issue at universities as students face unique stressors that can significantly impact their wellbeing. Academic pressures, social challenges, and financial constraints contribute to a high prevalence of mental health issues among university students. Effective support structures are crucial in helping students navigate these challenges and maintain their mental health.

This study examined the mental health support structures available to pharmacy students at Rhodes University, as well as the students' perceptions of their effectiveness and the challenges they face in accessing these services. The research employed a constructivist-interpretivist approach, phenomenology, and the Health Policy and Systems Research (HPSR) framework to gain a comprehensive understanding of students' lived experiences and perceptions of the available mental health support structures and services at the university.

Data collection and analysis were conducted in two phases. The first phase involved analysing accessible university documents related to mental health policies and support services. In the second phase, a phenomenological approach was employed, and qualitative interviews were conducted with a stratified purposive sample of pharmacy students to gather in-depth insights into their experiences and perceptions. These interviews explored students' perceived need for mental health support, as well as the availability and accessibility of such services at the University.

For data analysis, a thematic approach was employed to identify, analyse, and report patterns within the data. Interview responses were transcribed and uploaded into ATLAS.ti®, a qualitative data analysis software. A coding scheme was developed based on the research questions and emerging themes. The data were coded and organised into categories to explore recurring themes and patterns in-depth. Document analysis was also conducted using relevant university policies, guidelines and supplementary materials on mental health policies and support services. The data were coded to provide contextual understanding and complement the interview findings.

The findings revealed that although mental health support services were available at the university, students experienced significant barriers to access, including long waiting times, limited awareness of services, stigma associated with help-seeking, and concerns about confidentiality. Academic pressure, financial stress, and emotional distress were identified as major contributors to poor mental health. While some students reported positive experiences with counselling services, many perceived the available support as insufficient to meet student needs.

The study concluded that a gap exists between the availability of mental health services and students' ability to access and utilise these services effectively. Greater institutional visibility of services reduced structural barriers, and the development of a comprehensive, contextually responsive mental health policy was identified as a key priority for strengthening mental health support at Rhodes University.

Keywords: Mental health, Mental health support structures, lived experiences, phenomenology, pharmacy students, universities, South Africa.

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“Start where you are, use what you have, do what you can” – Arthur Ashe

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CHAPTER 1 - INTRODUCTION

1.1. INTRODUCTION AND CONTEXT

Mental health, like any other form of health, is influenced by multiple factors. A thorough understanding of these factors is essential for effective management. The World Health Organisation (WHO) defines mental health as a state of mental wellbeing that enables individuals to cope with the stresses of life, realise their abilities, learn and work productively, and contribute to their community, highlighting its multifactorial nature (World Health Organization, 2022b).

This definition emphasises the significance of environmental and contextual factors in shaping mental health. In January 2022, Director-General Ghebreyesus provided an update at the WHO Executive Board meeting on the global response to mental health concerns, including depression. Globally, it is estimated that one billion people live with a mental health disorder, with 81% residing in low- and middle-income countries (LMICs) (The Lancet, 2022; World Health Organization, 2022a).

Freeman (2022) argues that poor mental health in LMICs such as South Africa is partly attributable to poverty and historical trauma stemming from colonisation and disease. Recent data suggest that 25.7% of South Africans live with a probable diagnosis of depression (Craig et al., 2022). Given a national population of 62 million in 2022 (Statistics South Africa, 2022) this equates to approximately 16 million individuals possibly living with depression. These figures highlight the urgent need to prioritise mental health, particularly in LMIC contexts like South Africa.

Moreover, mental health is a particularly pressing concern among students in higher education. Findings from the inaugural national student survey in South Africa indicate high rates of mental health disorders, with 12-month rates often exceeding 70% for any form of mental distress amongst university students (Bantjes, Kessler, Lochner, et al., 2023). Such findings and the demands of academic life raise important questions about the tools and interventions students can access to support their wellbeing during their studies and in their future professional lives (Kaminer & Shabalala, 2019). This underscores the need to investigate the context, purpose, interpretation, understanding and implementation of mental health support structures within South African universities.

Addressing disparities in mental healthcare among students is critical for upholding human rights and fostering social progress. In South Africa, a legacy of inequality in healthcare, education, and economic opportunity continues to shape access to services. Unequal access to mental healthcare exacerbates social inequality and further marginalises vulnerable student populations (Bantjes et al., 2020).

For the purposes of this research, the term 'mental health support structure' is defined as a comprehensive framework comprising services and resources designed to promote the mental wellbeing of students, faculty, and staff within the university. This includes counselling services, health centres, outreach programs, institutional guidelines, protocols and policies that foster a supportive environment (Council on Higher Education, 2020; Minas & Cohen, 2007).

Using a phenomenological approach and an ethnographic lens, this exploratory study adopts Rhodes University as a case study to explore pharmacy students' lived experiences with the mental health support structures provided by the institution. It also investigates the perceived prevalence of mental health challenges, awareness of available services, and the accessibility and perceived effectiveness of those services. A document analysis of the university's mental health-related policies and protocols further informs the institutional context and resources underpinning student support. Together, these elements contribute to a comprehensive understanding of the university's mental health support structures, culminating in a set of recommendations aimed at enhancing student wellbeing at Rhodes University and potentially across South Africa's higher education sector.

1.2. PROBLEM STATEMENT AND RATIONALE FOR THE STUDY

The Eastern Cape province reports a high prevalence of mental health issues, particularly among students in higher education institutions (Mutinta, 2022). This creates an urgent imperative for institutions such as Rhodes University, located in the Eastern Cape, to implement comprehensive and inclusive mental health policies and support systems.

Currently, Rhodes University lacks a formal mental health policy, a concerning gap given its publicised commitment to transformation and its evolving identity as a previously white institution (O'Halloran, 2016). While existing structures, such as the university's counselling centre and the Student Mental, Academic, and Social Health program (SMASH), provide some level of support, the absence of a dedicated policy calls into question the effectiveness, coherence, and long-term sustainability of these initiatives. This gap presents a critical opportunity to assess how students perceive the university's existing mental health services and how they might be improved through the development of a robust, contextually responsive mental health policy.

This study contributes to the broader discourse on improving mental health in the higher education sector, offering insights that can inform future research and policy across South African institutions. Pharmacy students are the primary focus of this research due to the intense academic pressures, heavy workload, and high-stakes environment that characterise their clinical training. These students often face a

rigorous curriculum, long hours, frequent assessments, financial stress and career uncertainty, all of which can affect their mental wellbeing and heighten the need for reliable support structures (Elnaem et al., 2022; Fischbein & Bonfine, 2019; Silva & Figueiredo-Braga, 2018).

In addition, pharmacy students' clinical and theoretical academic engagement with healthcare systems and patient care requires them to develop a nuanced understanding of the interplay between mental health issues and pharmaceutical care. This positions them uniquely to contribute to the broader conversations around mental health support and advocacy within the university setting and across the student body. This research, therefore, critically assesses Rhodes University's current mental health support structures through an ethnographic lens, offering evidence-based recommendations to improve mental health awareness and support in this vital sector.

1.3. STUDY AIMS AND OBJECTIVES

This study aimed to investigate the mental health support structures at Rhodes University, with a focus on the lived experiences of pharmacy students. The goal was to develop a detailed understanding of how mental health dynamics are navigated within the university context and how support systems are accessed and perceived.

To achieve this aim, the study addressed the following specific objectives:

1. Examined the mental health support structures at Rhodes University
    - Identified the components of the university's mental health support system, including direct and indirect structures
    - Identified and analysed existing mental health guidelines, affiliated policies and institutional protocols

2. Understand pharmacy students' perceptions of mental health and their lived experience of mental health support at Rhodes University.
    - Explored how pharmacy students conceptualise and understand mental health
    - Described their knowledge and experience of the university's mental health support systems, including non-use
    - Examined the factors influencing these perceptions and how they shape students' understanding of the university's mental health support structure.

1.4. CHAPTERS OUTLINE

What follows is an outline of the chapters that make up this dissertation, each contributing to the overall exploration of mental health support structures for pharmacy students at Rhodes University.

CHAPTER 1: INTRODUCTION

- This chapter introduces the study by outlining the background, problem statement, rationale and research aims and objectives. This chapter also provides a roadmap for the dissertation's structure.

CHAPTER 2: LITERATURE REVIEW

- This chapter provides a comprehensive review of the literature on mental health, with a focus on the South African context. It examines mental health in higher education institutions and narrows the lens to the experiences of pharmacy students, identifying relevant gaps in existing research.

CHAPTER 3: METHODOLOGY

- This chapter outlines the theoretical frameworks underpinning the study, describes the research design, process, data collection methods, and analytical approaches. It also addresses ethical considerations and discusses the measures taken to ensure trustworthiness and rigour of research

CHAPTER 4: RESULTS

- This chapter provides an overview of the study participants and reports the key findings related to mental health support structures at Rhodes University. It includes an analysis of pharmacy students' lived experiences and perceptions, identifying key themes and patterns emerging from the data.

CHAPTER 5: DISCUSSION

- This chapter interprets the research findings in relation to existing literature, highlighting points of convergence and divergence. It considers the implications of the findings for theory, practice, and policy and concludes with a discussion of the study’s limitations and recommendations for future research

CHAPTER 6: CONCLUSION

- This section summarises the study’s key findings and contributions to the understanding of mental health support in higher education. It offers

recommendations for strengthening mental health support at Rhodes University and provides final reflections on the research process and directions for further inquiry

REFERENCES

- This section provides a comprehensive list of all sources cited in the thesis.

APPENDICES

- The appendices include supplementary materials, such as coding books, consent forms and the participant information and invitation letter.

CHAPTER 2 - LITERATURE REVIEW

2.1. INTRODUCTION

This chapter provides a comprehensive review of the literature relevant to this study. It explores the evolving definitions of mental health, its cultural representations, and the understanding of mental health diagnoses across different settings. As part of a broader investigation into how pharmacy students in South African universities perceive and experience mental health, this chapter aims to lay a conceptual and contextual foundation for the study. It begins by defining mental health and tracing its cultural and historical development, with a particular focus on how modern society influences attitudes and responses to mental health challenges.

Section 2.1 introduces the fundamental concepts of mental health, including key definitions, cultural interpretations, and diagnostic perspectives. Section 2.2 shifts the focus to the South African context, outlining the state of mental health services, the broader health system, and the socio-demographic influences that shape mental health outcomes.

In Section 2.3, the topic of mental health within higher education institutions is addressed, highlighting the unique stressors faced by university students, especially those studying pharmacy, whose training is known for its intensity and demands. Section 2.4 synthesises existing research on pharmacy students' mental health, shedding light on their specific needs and vulnerabilities.

Section 2.5 reviews international and national mental health policies and frameworks, examining efforts to improve access, equity, and quality of care. By situating the concept of mental health within various contexts—cultural, institutional, and policy-driven—this chapter prepares the ground for the subsequent exploration of pharmacy students' lived experiences at Rhodes University. The chapter concludes with Section 2.6, which presents the theoretical framework of the study and lays the groundwork for the methodology chapter.

2.2. UNDERSTANDING OF MENTAL HEALTH

2.2.1. Definitions of Mental Health

Over the past six decades, the understanding of mental health has evolved significantly beyond the more simplistic notion of merely the presence or absence of mental illness. A brief review of archival documents from the WHO illustrates the progressive evolution in terminology used to describe mental health and the types of interventions introduced to help manage it. For example, a 1977 report by the then WHO Director-General used the now-outdated term "mentally retarded" to refer to individuals with mental health

challenges – a term that has since been revised because of its negative connotations and the stigma it carries (Federal Register, 2013; World Health Assembly, 1977). A more nuanced perspective emerged in the 1983 WHO Bulletin, where Sartorius (1983) defined “mental health” as a layered and socially embedded concept. He stressed the importance of linking mental health to broader societal aims such as education, research and care organisation (Sartorius, 1983).

This broadening of perspective aligns with foundational work by anthropologists such as Helman (1981), who explored the distinction between disease and illness in clinical settings. Helman (2007) later, introduced a trichotomous framework linking culture, health, and illness, defining culture as the shared knowledge, beliefs and behaviours that shape individuals' perceptions and responses to health and illness. Accordingly, health is viewed not only as a state of physical wellbeing but as something influenced by cultural norms that define what is considered "normal" or "healthy" This framework substantiates Sartorius’s (1983) view, articulating three dimensions of mental health: (1) the absence of a clinically defined disorder, (2) the capacity to cope with unexpected stress and life challenges, and (3) a sense of harmony within oneself and with one’s environment. Thus, mental health is a dynamic construct shaped by biological, behavioural, sociological and cultural dimensions.

This multidimensional understanding remains the backbone of contemporary definitions. The WHO currently defines mental health as a state of wellbeing in which individuals realise their abilities, cope with life’s stresses, work productively and contribute to their communities (World Health Organization, 2022b, 2024). Similarly, the American Psychological Association (APA) defines mental health as a “state of mind characterised by emotional wellbeing, good behavioural adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life” (American Psychological Association, 2018).

The apparent variability of mental health experiences among different individuals and different cultures, however, makes it a concept that is difficult to confine within a single definition or measure with a universal standard. The range of values, cultural norms, and social contexts across countries makes the achievement of a universally acceptable consensus on the definition both challenging and potentially reductive (Galderisi et al., 2015). Given its complex and layered nature, an anthropological lens is essential for a comprehensive study of mental health. Eriksen (2017) contends that mental health research rooted solely in empirical and biomedical approaches neglects the experiential dimensions of human life. Scholars such Fernando (2014) and Kohrt et al. (2016) also advocate for anthropological frameworks that integrate lived experience and cultural context into global understandings of mental health.

Helman's (2007) widened understanding of health as a subjective experience shaped by social and cultural interpretations, suggests that individual's perceptions of symptoms, their willingness to seek help and the kinds of support they consider acceptable will all be influenced. The United States (US) Surgeon General's 2001 report affirms this, noting that "cultural meanings of illness have real consequences" for treatment pathways, coping strategies, familial and communal support, and outcomes. These layered understandings form a necessary foundation for exploring mental health as a socially and culturally constructed phenomenon. (US Surgeon General, 2001).

2.2.2. Mental Health Across Cultures

As aforementioned, the perception of mental health varies widely across different contexts and cultures, shaped by historical background, traditional perspectives, experiences of trauma, and socioeconomic realities. This diversity challenges the notion of a one-size-fits-all understanding of mental health and a universally accepted framework for this understanding.

One of the central debates in this area involves the contrasting conceptualisations of mental health within Western and Indigenous knowledge systems (Mental Health Literacy Organization, 2021). Triandis (1995), was among the first to explain the differences between Western individualistic and Indigenous collectivist approaches to mental health. In Western contexts, mental health is often viewed as an individual problem and responsibility that is understood in terms of self-actualisation and is addressed through personal coping strategies. In contrast, collectivist cultures – such as those found in Eastern and African regions – tend to view mental health as a community concern, prioritising interdependence, group harmony, and collective support systems. (Eaton & Louw, 2000; Schermer et al., 2023)

While Western approaches typically emphasise pathology and treatment through clinical interventions such as psychotherapy and pharmacology, African perspectives tend to be more holistic. Mental health is understood as intricately linked to spiritual, familial, cultural and communal relationships[1] (Deacon, 2013). Traditional healing practices often include rituals, ceremonies, and consultation with healers or elders, which may complement or replace Western medical interventions (Audet et al., 2017; Shange & Ross, 2022). Research by Salicru (2020) suggests that the prevailing bias towards a Western framework in the diagnosis and treatment of mental disorders often overlooks the rich cultural and indigenous African viewpoints. (Salicru, 2020) argues for broader recognition of indigenous knowledge systems in mental health care.

[1] This statement does not imply that all African perspectives are homogeneous, but they do share similarities.

An example of a Southern African philosophy that emphasises the understanding of care is Ubuntu, often summarised as "I am because you are," which provides a key ethical and cultural framework for understanding ideas of care within the context of mental health in African settings (Edwards et al., 2004). It emphasises relational existence, shared humanity, and mutual responsibility, contrasting with many Western clinical models that promote self-management and personal coping within the lens of mental health (Kagola & Abur, 2023).

Cross-cultural psychiatry, as described by Shiraev and Levy (2016), highlights how mental illness symptoms and interpretations vary significantly across cultures. For example, *hwa-byung,* a Korean culture-bound syndrome[2] that refers to insidious, long-standing, serious discontent that is projected into the body and is manifested by numerous symptoms such as insomnia, fatigue, panic, palpitations, dyspnoea, and others) (Suh, 2013). *Spiritual possession* in Southern Africa, another example of a culture-bound syndrome, is a phenomenon in which an external spirit, entity, or supernatural force is believed to take control of a person's body, mind, or actions, either temporarily or permanently, which challenges the conventional Western diagnostic framework (Igreja, 2018; Rashed, 2020). Overall, the indigenous lens views mental health within broader social and cultural contexts and thus approaches it with cultural sensitivity, which is an ongoing limitation of the dominant Western approach (Amuyunzu-Nyamongo, 2013; Kpanake, 2018).

2.2.3. Understanding the Diagnosis

Mental health diagnoses are largely guided by Western-based tools such as the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM)[3]. These systems, however, present challenges in cross-cultural contexts. One notable example is how the ICD-11 groups secondary mental syndromes, while the DSM-5 separates them based on symptom clusters (First et al., 2021; Garralda, 2024). Patel and Hall (2021) argue that Western psychiatric tools like the DSM-5 lack the cultural sensitivity necessary for effective global application since they fail to capture the lived experiences of individuals from diverse backgrounds.

Recent literature expands on this by critiquing the categorical approach of the ICD-11 and the DSM-5, suggesting that rigid classifications have the potential to oversimplify

[2]A culture-bound syndrome is a group of psychological and physical symptoms that are recognized as an illness within a specific culture but may not fit standard biomedical or psychiatric diagnostic categories. These syndromes are shaped by cultural beliefs and influence how illness is expressed and treated, including the use of medications.

[3] Mental health diagnoses are largely guided by Western-developed classification systems, particularly the International Classification of Diseases (ICD), produced by the World Health Organization, and the Diagnostic and Statistical Manual of Mental Disorders (DSM), developed by the American Psychiatric Association in the United States. These manuals undergo regular revisions, with the current versions being ICD-11 and DSM-5-TR.

the complexity of mental health and may exclude nuanced or culturally embedded experiences (Tanaka, 2024).

Notably, Hamamura et al (2018) point out that individualism and collectivism can co-exist within individuals and societies, further complicating diagnosis. They highlight how important the understanding of core cultural differences is in the treatment of disease, since mental illness cannot be separated from the cultural environment in which people live and experience health. Moreover, Campo-Arias et al. (2021) Emphasising the need for cultural psychiatry beyond the DSM-5 highlights how cultural dynamics permeate clinical practice, reinforcing the need for cultural competence in healthcare delivery.

The WHO's 2024 ICD-11 publication on diagnostic requirements reinforces this view, stating:

> Culture can influence how disorders are conceptualised, experienced and expressed; what is considered normal or pathological; how functioning is affected; where and how people seek care; and the ways that patients and families participate in treatment ... *p.92*

It further cautions that diagnostic tests must be adapted for cultural relevance and language proficiency. Cultural competency, therefore, is essential for ensuring mental health research and clinical practice reflect the diverse realities of those they aim to serve. (World Health Organization, 2024)

2.2.4. Urban Culture Understanding of Mental Health

Urban culture [4]and digital technology, particularly social media, are transforming how young people perceive and interact with mental health. In many low- and middle-income countries, stigma surrounding mental illness discourages formal help-seeking. As a result, young people increasingly turn to digital platforms for information and support. (Naslund et al., 2020; Naslund & Deng, 2021)

A notable emerging trend is "Instagram therapy", a colloquial term referring to the dissemination of psychoeducational material by mental health professionals and influencers via social media. (Pretorius et al., 2022). Yang (2023) suggests that these digital platforms have played a positive role in raising awareness and improving access to mental health knowledge, particularly among young people who might otherwise lack support. Social media serves as an accessible source of mental health information, particularly for individuals who are hesitant to seek help due to stigmatisation and those who are unaware of the help they need (Okoro et al., 2024).

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[4] The term "urban" culture refers to the meanings, ways of life, and social practices associated with the modern city. Urban culture is made at the interface of society, community, and the built environment. Link to definition: https://sk.sagepub.com/ency/edvol/urbanstudies/chpt/urban-culture#_

However, while these digital spaces provide important resources, researchers caution against over-reliance on unverified or oversimplified information (Amon et al., 2024; Pretorius et al., 2022). Concurrently, excessive use of social media has been associated with adverse mental health outcomes such as anxiety, depression, low self-esteem, and poor sleep hygiene (Aubry et al., 2024; Budenz et al., 2022; Mackson et al., 2019). A South African study by Lukose et al. (2023) found that excessive social media engagement among young adults correlated with worsened mental health and sleep disturbances.

Thus, while digital media can facilitate greater awareness, it also presents risks. A balanced approach - one that integrates the accessibility of digital platforms with professional oversight is desirable for fostering meaningful mental health engagement among youth.

In summary, the conceptualisation of mental health has evolved significantly over the past six decades, reflecting broader shifts in healthcare, social science and cultural understanding. Current definitions emphasise multidimensional wellbeing, while highlighting the need for culturally responsive care. A growing body of literature challenges the dominance of Western diagnostic tools and underscores the value of integrating Indigenous knowledge, community perspectives, and digital innovations.

As Ahad et al. (2023) argue, redefining mental health through culturally competent lenses is vital. Without this, global mental health interventions risk being ineffective or even harmful. A culturally grounded understanding of mental health, sensitive to both local realities and global standards, can improve access, relevance, and equity in care, especially in African and other multicultural contexts.

2.3. OVERVIEW OF MENTAL HEALTH IN SOUTH AFRICA

Recent statistics suggest that mental health conditions are highly prevalent in South Africa, with an estimated 27% of the population affected by depression (Employee Assistance Professionals Association of South Africa, 2024). According to the second Annual Mental State of the World Report by Sapien Labs, released in March 2022, South Africa ranks amongst the lowest globally in mental health outcomes (Sapien Labs, 2021)[5]. A subsequent report released in 2024 reinforced the gravity of the situation, indicating that Brazil, South Africa, and the United Kingdom had the highest proportions of respondents classified as “distressed or struggling”, with prevalence rates between 34-35% (Sapien Labs, 2023). Further, the United Nations International Children’s Emergency Fund (UNICEF) South Africa U-Report survey of 2023 found

[5] Sapien Labs is a non-profit organisation that conducts global mental health research using large-scale digital assessments. Its Annual Mental State of the World Report is based on data collected from over one million respondents across more than 60 countries.

that around 60% of South African children and youth in South Africa felt that they required mental health support in the previous year (UNICEF, 2023). These figures collectively highlight the severity of the mental health crisis in South Africa.

Understanding the contributing factors behind this crisis is essential. One of the most significant contributors is the structure and challenges of South Africa's healthcare system. Despite the inclusion of mental health in the Sustainable Development Goals, which reflect a global commitment to prioritising mental health, LMICs such as South Africa, face major obstacles, including financial constraints and an overburdened public health system (Docrat et al., 2019). South Africa's dual-sector health care model comprises an underfunded public sector serving approximately 85.1% of the population and a better-resourced private sector serving the remaining 14.9% of the population (Steyn & Bartels, 2023). While the private sector often avoids service backlogs, the public sector frequently suffers from staff shortages, overcrowding, and limited resources. Although the government's introduction of the National Health Insurance (NHI) aims to reduce these disparities, implementation challenges and funding limitations continue to strain the already stretched mental health infrastructure (L. Morris et al., 2021).

South Africa's history of apartheid further complicates the mental health burden. The apartheid regime (1948–1994) institutionalised racial segregation and systemic violence, particularly impacting Black South Africans through forced displacement, socio-economic marginalisation, and intergenerational trauma (Clark & Worger, 2016). Research conducted by van Staden (2024) and earlier research by William (2006) suggests that thirty years on, apartheid's legacy continues to manifest in inequalities across education, employment, and healthcare access, factors that significantly contribute to the current mental health landscape of the country. (Hirschowitz & Orkin, 1997; Padmanabhanunni, 2020)

Cultural beliefs and social stigma also shape how mental health is perceived and addressed in South Africa. In some African cultures, mental illnesses such as schizophrenia or depression may be attributed to spiritual causes, including *ukuthwasa*[6] witchcraft or ancestral displeasure, beliefs that remain prevalent among the Xhosa and Zulu populations (Campbell et al., 2017; Ngubane & De Gama, 2024). Cultural rites of passage, such as *umemulo* for Zulu maidens and *ulwaluko* or *ukusokwa*[7] for Xhosa and Zulu boys, also influence perceptions of resilience and

[6] Ukuthwasa is a traditional initiation and training process in many Nguni-speaking cultures of Southern Africa through which an individual is called to become a traditional healer (sangoma). It is understood as a spiritually guided journey that involves illness, dreams, and visions, followed by apprenticeship under an experienced healer to learn healing practices, ancestral communication, and cultural rituals

[7] Umemulo is a traditional Zulu coming-of-age ceremony for young women, marking the transition to womanhood. It is usually performed after the onset of menstruation and involves family rituals, ceremonial dress, and cultural celebrations that affirm maturity, respect, and readiness for adult responsibilities.

coping strategies in young adulthood (Messow, 2022; Qambela, 2022; Ulwazi Programme, 2008).

Religion and spirituality also play a central role in shaping many South Africans' mental health responses. Prayer, traditional rituals, and faith-based healing practices are often preferred over professional therapy (Ngubane & De Gama, 2024). Stigma is further perpetuated by derogatory terms used in everyday language - such as *iphara*, *uhlanya*, or *igeza*[8] in Nguni languages - to describe individuals with mental illness. These terms frequently conflate mental illness with homelessness, drug dependence, or criminality, thereby intensifying social exclusion and discouraging individuals from seeking help (Campbell et al., 2017; Dlodlo & Moyo, 2022). Cultural norms around masculinity also contribute to this silence; in many communities, men are socialised not to express vulnerability, reinforcing a reluctance to seek mental health support (Qambela, 2022). These cultural beliefs, combined with societal prejudices, have the effect of silencing many people, thus perpetuating cycles of abandonment and increasing the incidence of mental illness within the country.

The socio-economic disruption caused by the COVID-19 pandemic has intensified these challenges. Widespread job losses, isolation, and uncertainty have exacerbated mental health distress, particularly among individuals in impoverished and rural regions such as the Eastern Cape (Craig et al., 2022). These communities often face ongoing cycles of disadvantage, including poor access to education, high unemployment, and limited healthcare services, which further compound the risk of mental illness (Mutinta, 2022; Nduna et al., 2013; Schierenbeck et al., 2013).

The Eastern Cape is particularly notable for its high prevalence of mental health distress. A recent study reported that 53.3% of university students in the province experienced symptoms of mental distress (Mutinta, 2022). While youth in traditional communities, like many of those in the Eastern Cape, are generally less likely to engage in substance use, those experiencing depression or anxiety may turn to alcohol or other substances as a coping mechanism, especially given alcohol's affordability and accessibility (Nduna et al., 2013; Tindimwebwa et al., 2021).

Given these intersecting factors, historical, cultural, economic, and systemic, it is imperative to focus on the lived experiences of young people, particularly university

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Ulwaluko is a traditional Xhosa male initiation rite that marks the transition from boyhood to manhood. It involves circumcision and a period of seclusion, during which initiates are taught cultural values, discipline, and social responsibility.
Ukusokwa is a traditional Zulu male initiation practice similar in purpose to ulwaluko, marking the transition from boyhood to manhood through circumcision and cultural instruction related to identity, responsibility, and adulthood.

[8] Iphara is a derogatory slang term referring to a person seen as a hobo or mentally unstable. A commonly used Zulu/Ndebele term meaning “madness” or permanent mental illness, often implying loss of rationality, is uhlanya. Igeza is a derogatory Xhosa term used for someone perceived as mentally disturbed, reckless, or socially deviant.

students, in mental health research. Their perspectives offer crucial insight into the prevalence, challenges, and support needs related to mental health, and can inform the development of contextually appropriate and culturally sensitive interventions.

2.4. MENTAL HEALTH AND HIGHER EDUCATION INSTITUTIONS

There has been a growing global concern regarding the mental health of university students. This issue is increasingly recognised as a significant public health challenge, particularly given the critical developmental stage of young adulthood and the complex pressures associated with higher education (Auerbach et al., 2016; Hernández-Torrano et al., 2020; Lipson et al., 2019). A multinational study that was conducted across 19 higher education colleges in eight countries[9] highlighted the global extent of this challenge, reporting lifetime prevalence estimates for common mental disorders at 35% and 12-month prevalence at 31% (Auerbach et al., 2018). These findings underscore the substantial proportion of university students who experience mental health challenges during their academic journey.

In the South African context, data from the inaugural national student mental health survey revealed alarmingly high rates of mental health disorders within the university student population. Approximately 53.3% of respondents screened positive for at least one 30-day mental disorder[10]. (Bantjes, Kessler, Lochner, et al., 2023). Notably, the incidence was higher at institutions historically designated for white students, suggesting that generational trauma, apartheid legacies, institutional culture and sociodemographic disparities continue to shape students' mental health outcomes. Padmanabhanunni (2020) explored the influence of historical and contextual traumas on South African university students and concluded that many students arrive at university already burdened by past trauma, which can significantly affect academic performance and social adjustment. The pressures of higher education, including high academic demands, often lead to anxiety, depression, and burnout (Di Mario et al., 2024).

Among South African provinces, the Eastern Cape has been consistently reported as having the highest prevalence of poor mental health (Mutinta, 2022). Within this regional context, Rhodes University emerges as a significant site of concern. Research has identified a high prevalence of mental health difficulties among its students, raising questions about the adequacy and responsiveness of existing mental health support structures. Moreover, the university bears the imprint of recent socio-political unrest, including the FeesMustFall movement, student-led protests against sexual assault,

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[9] Australia, Belgium, Germany, Mexico, Northern-Ireland, South-Africa, Spain, United States

[10] A “30-day mental disorder” refers to a mental health condition for which a person meets the diagnostic screening criteria within the past 30 days prior to assessment. This means the symptoms were recent and currently active, rather than occurring at any point in the person’s lifetime.

and the disruption caused by the COVID-19 pandemic, all of which occurred between 2015 and 2022 (Khuhlane & Grant, 2022; Macleod et al., 2018; O'Halloran, 2016). While some research has explored students' experiences of campus mental health structures at other universities (Turosak & Siwierka, 2021), little work has been done that focuses on student voices within the specific historical and institutional context of Rhodes University.

The *UCKAR Student Body Facebook* page, created in 2016, has become an informal yet telling reflection of the mental health concerns among Rhodes University students. Posts and comments regularly highlight academic pressure, personal struggles, and mental health challenges such as anxiety and depression. These digital narratives are particularly prominent during exam periods or periods of peak academic workload. Students frequently share experiences of emotional distress, isolation, and burnout, painting a compelling picture of the mental health landscape on campus.[11]

In addition to these lived experiences, recent research by Dr Jonathan Davy, a senior lecturer in the Department of Human Kinetics and Ergonomics at Rhodes University, alongside his master's student, has examined the role of sleep hygiene in student mental health and academic performance. Their findings suggest that poor sleep practices, such as irregular sleep schedules and screen use before bed, are common among students in academically demanding programmes. These practices contribute to sleep deprivation, which in turn negatively impacts cognitive function, emotional regulation, and overall wellbeing (Davy & Young, 2024). The study concluded that inadequate sleep could exacerbate mental health issues such as depression and anxiety and impair academic outcomes.

An initial review of publicly available documents suggests that Rhodes University has a Student Wellness Division composed of four primary branches: Career Services, Counselling Centre, Health Care Centre, and an HIV/AIDS section. (Rhodes University Division of Student Services and Development, 2024). Institutional policies relevant to student and staff wellness are accessible through the Institutional Planning Unit's website (Rhodes University Division of IRPQP, 2024). There appears, however, to be a notable absence of explicit directives specifically addressing mental health or delineating the university's mental health support infrastructure. This gap in policy and institutional planning is concerning, given the high mental health burden among students, particularly within the Eastern Cape. It highlights the urgent need for a comprehensive review and the development of contextually relevant mental health policies that respond to both the challenges faced by students and the broader socio-cultural environment in which the university operates.

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[11] This information was taken from a focused perusal of the UCKAR page available on the link https://www.facebook.com/groups/561869313975166/

2.5. PHARMACY STUDENTS AND MENTAL HEALTH

The mental health of pharmacy students is a growing area of concern. While pharmacy students are subject to many of the stressors faced by students in higher education more broadly, they also encounter unique pressures specific to their field of study. A 2022 international assessment across pharmacy students in 14 countries found that one in three students reported low levels of mental wellbeing (Elnaem et al., 2022). This finding reflects the demanding nature of pharmacy programmes, which are widely recognised for their academic intensity, heavy workload, and high-performance expectations.

Pharmacy students are often required to manage long study hours, frequent and complex assessments, and the need to memorise and apply vast amounts of detailed knowledge. These academic demands frequently contribute to elevated levels of stress, anxiety, and burnout (Fischbein & Bonfine, 2019; Shangraw et al., 2021). Beyond the classroom, students must also complete clinical rotations and engage in service-learning experiences prior to graduation (Al-Qerem et al., 2021; Yousif et al., 2022). While these practical components are essential for professional development, they introduce additional stressors. Students are required to adapt to clinical settings, perform in high-pressure environments, and take on patient care responsibilities, all while continuing their academic work.

The expectation to consistently demonstrate clinical competence, ethical decision-making, effective communication, and the ability to function as part of a healthcare team can be overwhelming (Almanasef, 2021; Frajerman et al., 2022). These pressures may lead to feelings of inadequacy and imposter syndrome, particularly when students are simultaneously trying to meet academic, interpersonal, and professional expectations (Sullivan & Ryba, 2020).

Despite facing these challenges, pharmacy students are often reluctant to seek help due to the stigma associated with mental health concerns (Fischbein & Bonfine, 2019; Nguyen et al., 2012). There is frequently a perception that disclosing mental health struggles may be viewed as a weakness or may negatively impact one's professional image. This reluctance can result in untreated mental health issues and exacerbate feelings of isolation.

In response, many pharmacy schools and universities have begun implementing mental health support services specifically designed to assist students. These include on-campus counselling, mental health first aid programmes, stress management workshops, peer support initiatives, and faculty-led wellness interventions (Almanasef, 2021; El-Den et al., 2020; Gable et al., 2011; Schlesselman et al., 2020). Some institutions have also begun to incorporate wellness and resilience training directly into the curriculum to help students develop long-term coping strategies.

While these efforts represent important steps, there remains a need to explore how students experience these support mechanisms. A deeper understanding of pharmacy students' lived experiences can offer valuable insight into the effectiveness of existing interventions and inform more responsive, student-centred approaches to mental health support.

2.6. POLICIES AND FRAMEWORKS CONCERNING MENTAL HEALTH

The WHO developed the Mental Health Action Plan 2013-2030 to support governments in strengthening their mental health systems, combating stigma and improving access to quality care. The plan focuses on promoting mental wellbeing, preventing mental health illness and delivering care within communities (World Health Organization, 2021). Similarly, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) upholds the rights of individuals with mental health conditions, advocating for non-discrimination, dignity and equal access to health services. These international frameworks recognise mental health as a fundamental human right, prompting many countries to adopt aligned national policies (United Nations, 2008).

In South Africa, mental health policies and frameworks play a pivotal role in responding to the considerable burden of mental illness across the population. These policies aim to reduce stigma, improve mental health services and promote wellbeing. Key policies and frameworks include the National Mental Health Policy Framework and Strategic Plan, as well as various legislative acts and initiatives by governmental and non-governmental organisations. (Draper et al., 2009)

The National Mental Health Policy Framework and Strategic Plan 2013-2020 served as a guiding policy document outlining the country's approach to mental health care (National Department of Health, 2015). Its successor, the National Mental Health Policy Framework and Strategic Plan 2023–2030, builds on this foundation and articulates a vision for "comprehensive, high-quality, integrated mental health promotion, prevention, care, treatment and rehabilitation for all in South Africa by 2030" (National Department of Health, 2023). This framework emphasises the integration of mental health services into primary health care, prioritising prevention and promotion, and establishes mechanisms for monitoring and evaluation.

Complementing this is the Mental Health Care Act of 2002, which governs the care, treatment, and rehabilitation of individuals with mental health conditions (Government Gazette Republic of South Africa, 2002). It protects the rights of mental health users, regulates involuntary care, and supports community-based care through the establishment of mental health review boards. Additionally, the proposed National Health Insurance (NHI) initiative seeks to provide universal health coverage, inclusive

of mental health services (Department of Health, 2020; National Health Insurance Bill [B 11-2019], 2019).

Despite these commendable frameworks, significant challenges persist. Mental health services remain underfunded, receiving less than 5% of the total national health budget(National Department of Health, 2023). This underinvestment contributes to poor infrastructure, a shortage of specialists, overcrowded psychiatric hospitals and limited preventive and community-based care. In addition, cultural stigma, poverty and unemployment further hinder access to mental health services in rural and township settings.

The South African Human Rights Commission (SAHRC) has repeatedly called for stronger policy enforcement, citing the Life Esidimeni tragedy, where over 140 psychiatric patients died due to government negligence, as a clear indication of a failure in mental health governance. Structural limitations, such as workforce shortages, inadequate infrastructure, and under-resourced systems, continue to undermine the effectiveness of health service delivery[12] (Morar et al., 2024; World Health Organization & Department of Psychiatry and Mental Health, 2007). Additionally, social stigma deters individuals from seeking help, which, when coupled with implementation challenges, particularly in rural and remote areas with limited access to mental health care, needs special attention and exploration (Benjamin et al., 2021). Although South Africa's mental health policies are in line with international standards, the limitations of implementation, access to the services and combating stigma are still significant issues.

At the university level, implementing mental health support systems presents its own challenges. Beyond financial constraints, barriers include persistent stigma, limited professional development for faculty and staff, and the lack of comprehensive institutional policies (DiPlacito-DeRango, 2016; Kaminer & Shabalala, 2019). These challenges highlight the need for a closer examination of how policies and practices translate into tangible support within the higher education context.

Some South African universities, such as Stellenbosch University and the University of Cape Town (UCT)[13] have recognised the importance of addressing student mental health and have implemented specific policies in response. However, these initiatives have emerged under pressure from growing national and international awareness, advocacy from student-led movements and the increasing visibility of mental health

[12] The Docrat (2019) survey from Section 2.2 found that, in the public sector in South Africa (i.e. for the uninsured population), there were approximately 0.31 psychiatrists per 100,000 people, reflecting severe human-resource constraints in mental health care provision.

[13] It is worth recognizing that both these universities are historically white institutions similar to Rhodes University.

needs within academic settings. (Kaminer & Shabalala, 2019; Stellenbosch University, 2019; University of Cape Town, 2018)

Given the global significance of mental health, particularly in LMICs like South Africa, it remains essential to continue advancing research in this area. In higher education institutions, understanding how students perceive and experience mental health support is critical. Such inquiry helps evaluate the relevance and effectiveness of current interventions, opening space to reimagine mental health in ways that are culturally sensitive, inclusive, and tailored to the evolving needs of university students.

This literature review has demonstrated that mental health is a complex, multidimensional phenomenon shaped by cultural, social, economic, and institutional factors. Across global and South African contexts, students in higher education are consistently identified as a high-risk group for psychological distress due to compounded academic, social, and financial pressures. Within South Africa, these challenges are intensified by historical trauma, systemic inequality, under-resourced mental health services, and persistent stigma surrounding mental illness.

2.7. GAPS IN THE LITERATURE

The literature further highlights that pharmacy students face additional profession-specific stressors, including academically demanding curricula, pressures from clinical training, performance expectations, and the formation of a professional identity. Despite increasing global attention to pharmacy student wellbeing, there remains limited qualitative research foregrounding pharmacy students' lived experiences of institutional mental health support within the South African context, particularly at historically white institutions located in high-burden provinces such as the Eastern Cape.

While national and international mental health policies articulate strong human rights commitments, significant gaps persist between policy intent and institutional implementation, especially within higher education settings. Critically, existing research tends to prioritise prevalence statistics and biomedical understandings of mental illness, with comparatively little attention paid to how students experience, interpret, and navigate institutional mental health support structures in everyday university life.

This gap in the literature directly informs the focus of the present study. By centring pharmacy students' lived experiences at Rhodes University and examining both formal institutional structures and student perceptions through a combined anthropological and Health Policy and Systems Research lens, this research responds directly to the

need for contextually grounded, student-centred scholarship on mental health support in South African higher education.

2.8. THEORETICAL FRAMEWORK

The term “mental health systems” is multifaceted within the healthcare domain, serving as an umbrella term for all the processes that influence and align with mental health. Existing literature highlights the term's versatility as it is interchangeably used with “mental health services” and “mental health resources” (J. Morris et al., 2012; World Health Organization, 2001). However, Minas & Cohen (2007) offer a more concise definition, describing mental health systems as encompassing policies, plans, programs, legislation, regulations, and sociocultural arrangements that are explicitly focused on mental health. Moreover, the term also encompasses financial schemes, health personnel, and broader socioeconomic and political factors that directly impact mental health. Such a definition enables analysis at both a macroscopic and microscopic level, recognising the variabilities of mental health profiles across different levels.

Building on this definition, this study draws on the principles of Health Policy and Systems Research (HPSR), particularly the work of Gilson et al. (2012) to examine the institutional support structures. Gilson and colleagues suggest that system functioning, and policy shifts are shaped by the convergence of health systems and health policy while also being influenced by global and national dynamics. This framework extends from Gilson’s earlier work with Walt (1994), which introduced the policy triangle model. The model outlines three interconnected elements of policy analysis: (1) context, referring to the broader social, political, and economic environment, (2) content, the substance of the policy including its goals and strategies, and (3) process, the mechanisms through which policy is formulated, implemented, and evaluated. This interaction of these elements is particularly relevant to understanding mental health policy development in South Africa (Draper et al., 2009; Walt & Gilson, 1994).

HPSR, as an interdisciplinary field, integrates economics, sociology, anthropology, political science, public health, and epidemiology. This broad base enables a comprehensive understanding of how health systems and health policies interact, adapt, and respond to contextual influences. For this study, HPSR offers a valuable lens through which to examine Rhodes University’s mental health support structures, particularly through document analysis. (Gilson et al., 2012)

Given the apparent absence of a specific mental health policy at Rhodes University, the HPSR framework provides a valuable foundation for identifying and mapping informal support mechanisms and institutional resources. It also facilitates a more nuanced understanding of the cultural and relational dynamics shaping students’

experiences of mental health support at the university. The anthropological dimension of HPSR is especially relevant in this context, offering critical insights into how cultural beliefs, stigma, and social support networks influence mental health outcomes. Incorporating anthropological perspectives underscores the importance of cultural competence in service delivery, especially within a culturally diverse university setting (Drake, 2015; Gopalkrishnan & Babacan, 2015).

Therefore, this theoretical framework, grounded in HPSR and enriched by anthropology and phenomenology, provides a robust foundation for the study. It supports a comprehensive assessment of the mental health support structure and the lived experiences of pharmacy students. It is particularly well-suited to exploring the interplay between institutional structures, cultural perceptions, and the potential for responsive policy development and implementation that aligns with the diverse realities of the student population.

2.9. CHAPTER SUMMARY

This chapter has traced the evolution of mental health as a multidimensional, culturally embedded construct, moving beyond narrow biomedical definitions towards more holistic understandings that emphasise emotional, social, spiritual and functional wellbeing. It has highlighted how experiences and expressions of mental health are shaped by cultural meanings, Indigenous knowledge systems, and broader socio-political contexts, thereby challenging the universality of Western diagnostic frameworks such as the DSM and ICD. These perspectives underscore the importance of cultural competence and anthropological insight in both research and practice.

Situated within this broader conceptual landscape, the chapter then examined the South African mental health context, drawing attention to the intersecting effects of historical injustice, socio-economic inequality, stigma and health system constraints. Emphasis was placed on the Eastern Cape and Rhodes University, where high levels of psychological distress among students intersect with limited resources, contextual trauma and uneven access to support. The literature on higher education and pharmacy training further demonstrates that pharmacy students face both general student stressors and profession-specific pressures, including demanding curricula, clinical responsibilities and expectations of high professional competence, all of which may heighten vulnerability to mental health difficulties and reduce help-seeking.

Finally, the chapter reviewed international and national mental health policies and frameworks, highlighting both their alignment with human rights-based approaches and the persistent implementation gaps, especially in under-resourced settings. Within the university sector, policy and practice responses to student mental health remain fragmented, with limited evidence on how students themselves experience available

structures and services. Against this backdrop, the chapter introduced Health Policy and Systems Research, enriched by anthropological and phenomenological perspectives, as the guiding theoretical framework for this study. This framework offers a lens for examining Rhodes University's formal and informal mental health support structures in conjunction with the lived experiences of pharmacy students. The next chapter outlines the methodology employed to explore these experiences in depth and to analyse how institutional, cultural and policy dynamics shape students' mental health realities.

CHAPTER 3 – METHODOLOGY

3.1. INTRODUCTION

This chapter outlines the research design, data collection methods, and analytical techniques used to investigate the mental health support structure at Rhodes University. The study employed a qualitative research approach to explore institutional policies, available resources and pharmacy students' experiences and perceptions of mental health support at Rhodes University. Qualitative research was chosen for this study because it provides a comprehensive approach to examining social phenomena, such as mental health support, within a university context.

A two-phase methodology was adopted. The first phase involved analysing relevant institutional documents, including academic and policy documents, to examine the direct frameworks underpinning mental health support. Document analysis allowed for a critical examination of official policies, guidelines, and institutional efforts related to student mental wellbeing. The second phase consisted of semi-structured interviews with pharmacy students, aimed at capturing their lived experiences, perceptions and challenges in accessing mental health services at the university. The semi-structured interviews complemented Phase 1 by providing rich, first-hand insights into the barriers, enablers and unmet needs experienced by students.

Thematic analysis was employed to identify recurring patterns and themes across the qualitative data. Data coding and management were conducted using ATLAS.ti® qualitative data analysis software, ensuring a rigorous and systematic approach to analysis.

Ethical principles were strictly adhered to throughout the research process. Participants provided informed consent, and all data were treated as strictly confidential and anonymised. Ethical clearance was obtained (2024-8031-9040), and the study adhered to the relevant institutional ethical guidelines for research involving human participants.

This integrated methodological approach, combining document analysis with in-depth interviews, was designed to offer a holistic perspective of Rhodes University's mental health support system, with the potential to illuminate both its strengths and limitations. While not drawing definitive conclusions, the approach aimed to explore how institutional policies and student experiences might interact to shape mental health support in higher education institutions. The remainders of this chapter describe in detail the research design, data collection methods, analytical techniques, and ethical considerations that informed the study.

3.2. RESEARCH DESIGN

The research process depends on the research paradigm, which refers to a set of basic assumptions that guide the research approach. According to Guba and Lincoln (1994) a paradigm identifies, directs and frames the entire research process, including the way the researcher thinks about the study and interprets its findings. Central to this paradigm are three core components: ontology, epistemology, and methodology.

Given that mental health is a subjective and fluid concept, constructivism is an appropriate ontological lens for this study. Constructivism proposes that individuals develop their understanding of the world through experience and reflection and, therefore, encounter reality not as an objective truth but as a constructed understanding (Adom et al., 2016; Cobern, 1993; Guba & Lincoln, 1994). In the context of mental health, this suggests that people define and interpret mental health through the lens of their own lived experiences and cultural orientations (Ojagbemi & Gureje, 2021).

From an epistemological standpoint, this study draws on interpretivism, which acknowledges the diversity of experiences and beliefs that shape individuals' understanding of mental health. Interpretivism rejects the notion of a single, universally valid understanding of mental health, recognising instead that knowledge is constructed through the interpretation of subjective experiences. (Alharahsheh & Pius, 2020)

With ontology and epistemology briefly outlined, methodology, the third component of the research paradigm, refers to the approach taken to conduct the research. Creswell (2014) defines methodology as the process that spans from philosophical assumptions to the interpretation and dissemination of findings. To gain deeper insights into students' lived experiences, phenomenology was selected as the methodological approach. As both a philosophical orientation and a qualitative research strategy, phenomenology focuses on the subjective experiences individuals ascribe to (Chamberlain, 2009; Greening, 2019). It seeks to understand the essence of human experiences without imposing predefined theories or interpretations, examining how individuals perceive, interpret, and make sense of their lived experiences, emotions, perceptions, and consciousness (Creswell & Poth, 2016; Laverty, 2003; Moustakas, 1994),. Phenomenology is closely aligned with constructivism in that it also centres the perceptions and interpretations of individuals' lived experiences, particularly in contexts like mental health, where these perspectives can vary significantly.

In this study, a phenomenological approach was chosen to allow the researcher to explore students' lived experiences with the mental health support structures at Rhodes University. The description and analysis of these lived experiences had the potential to reveal underlying patterns, structures, and themes.

This approach, grounded in Health Policy and Systems Research and enriched by anthropology and phenomenology, set the stage for a comprehensive assessment of Rhodes University's mental health support structure and students' lived experiences. It was selected and refined to meaningfully explore the existing support structure and mechanisms, the cultural context of mental health perceptions and services, and the potential for policy development and implementation that reflects the diverse needs of the student population.

3.3. RESEARCH PROCESS

3.3.1. Research Process – Overview

The study followed a three-phase qualitative design comprising: (1) document analysis, (2) semi-structured interviews and (3) integration of findings. The phases are illustrated in the schematic diagram below and described in detail as follows:

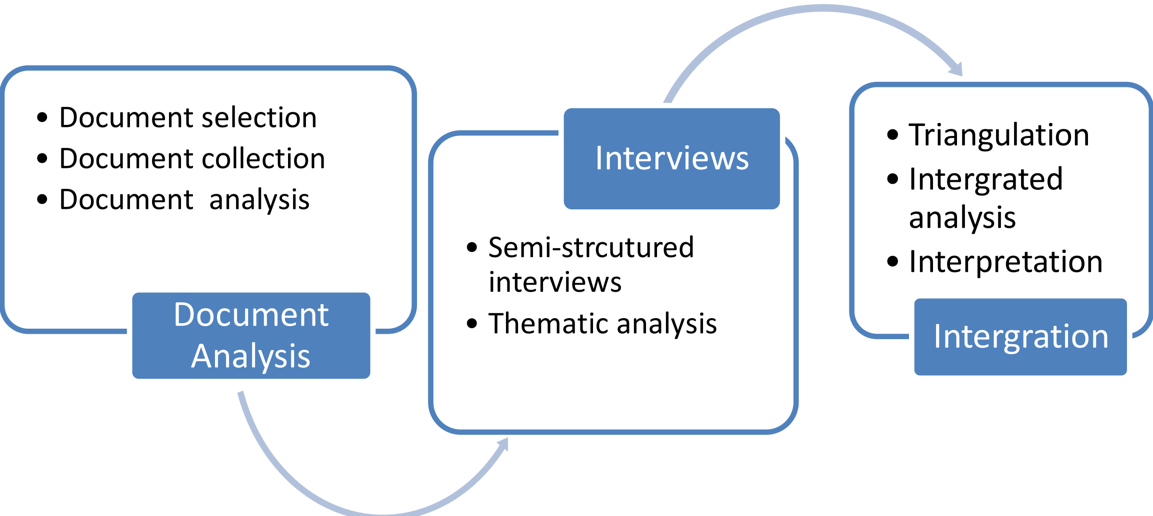

Figure 1. A schematic of the research design process

1. Document Analysis (Phase 1)

   The research process commenced with a qualitative document analysis aimed at identifying and exploring components of the university's mental health support structure (*see Section 4.1* Table 2). This phase involved the systematic selection, collection, and analysis of institutional documents related to mental health policies, programmes and services. The use of ATLAS.ti® qualitative data analysis software facilitated efficient data management and supported the coding and analysis process to ensure rigour and consistency.

2. Interviews (Phase 2)

   The second phase involved conducting semi-structured interviews with pharmacy students to elicit their perceptions, lived experiences and challenges concerning mental health services and support systems. Key areas of exploration included students' awareness of services, experiences of access and utilisation, perceived stigma, and sociocultural influences on help-seeking behaviour. This phase provided in-depth, qualitative data that reflected the complex dynamics shaping mental health among university students.

3. Integration of Findings

   In the final phase, findings from the document analysis and interviews were integrated and comparatively analysed. Thematic analysis was used to identify recurring patterns, core themes and underlying issues within the university's mental health support system. By synthesising data across both sources, the study achieved a holistic and contextualised understanding of mental health support at Rhodes University. This integrative approach highlighted both strengths and areas for improvement, offering practical insights into how institutional mental health support structures might be enhanced.

The research process began with a qualitative document analysis aimed at exploring various aspects of Rhodes University's mental health support structure. This first phase involved the purposeful selection of documents to gain an understanding of the policies, frameworks and resources related to student mental health support. ATLAS.ti® software was used to assist with data management, coding and thematic analysis of the collected materials.

Following this, semi-structured interviews were conducted with pharmacy students to gather insights into their perceptions, lived experiences, and challenges concerning mental health services, support systems, stigma, and accessibility. These interviews yielded a rich, in-depth, and nuanced view of the social, cultural, and institutional factors that shape students' mental health experiences.

In the final stage, findings from both phases were analysed, integrated and compared to develop a comprehensive understanding of the university's mental health support structure. Thematic analysis was employed across all data sources to identify key themes, recurring patterns and critical issues related to mental health in the university context.

Triangulation of the findings from document analysis and interview data enabled the development of a rich, holistic and credible account of the strengths and limitations of Rhodes University's mental health support system (Carter et al., 2014). This approach also helped identify potential areas for enhancement, contributing to a deeper

understanding of how institutional structures and environments affect student wellbeing.

3.4. RESEARCH SITE AND POPULATION

3.4.1. Research Setting

This study was conducted on the campus of Rhodes University, a historically white institution (Maylam, 2017). The university is situated in the town of Makhanda (formerly known as Grahamstown), in the Eastern Cape, South Africa.

3.4.2. Research Population

According to Rhodes University (2023) statistics, the student population ranges between 8700 and 9300. Of those students, approximately 30% are postgraduates, and around 20% are international students from 54 countries, contributing to the university's status as a diverse and dynamic institution of higher learning.

The population for this research consisted of pharmacy students enrolled at Rhodes University in 2024. The total number of students in the pharmacy programme was 740. This included 184 first-year students, 180 second-year students, 185 third-year students, and 135 fourth-year students. Additionally, 56 postgraduate pharmacy students were registered.

The composition of the student body, spanning various academic years and levels of study, provided a broad base for exploring the mental health support needs and experiences of pharmacy students. This diversity enabled a comprehensive understanding of how mental health is perceived and navigated across various stages of the pharmacy education journey.[14]

3.5. RESEARCH SAMPLE

Purposive sampling is a non-probability sampling technique in which participants are intentionally selected based on specific characteristics or qualities relevant to the study's objectives (Campbell et al., 2020). In this study, stratified purposive sampling was employed to focus on the lived experiences of pharmacy students across all years of study. Approximately three or four students were sampled per academic year (years one to four), and overall, 5 postgraduate students were sampled to ensure

[14] This information was obtained formally obtained from the Dean of Pharmacy's office with updated 2024 records

representation from each level in relation to their engagement with mental health support structures.

To be included in the study, participants were required to be at least 18 years of age and registered at Rhodes University for either a Bachelor of Pharmacy (BPharm) degree or a pharmacy-related postgraduate degree (MPharm, MSc, PhD). These inclusion criteria ensured that the study captured insights from students who were experiencing academic and professional demands specific to the pharmacy discipline. By targeting these groups, the study generated detailed and contextually relevant insights into the stressors, challenges, and mental health concerns specific to each stage of pharmacy education (Fischbein & Bonfine, 2019).

Participants were recruited through a general invitation emailed to all pharmacy students (*see Appendices B and C).* The invitation process helped ensure broad accessibility and transparency, increasing the relevance and potential applicability of the study's findings to inform tailored mental health interventions (Campbell et al., 2020; Lopez & Whitehead, 2013).

In addition to the emailed invitation, students were approached in person during lectures after receiving permission from all relevant gatekeepers, as outlined in *Appendix D*. During these sessions, the researcher provided a brief verbal explanation of the study and invited students to ask questions. Interested students were provided with an invitation letter and informed consent form. Those who wished to participate were asked to return the signed consent form to the researcher.

An email version of the study explanation and invitation, along with the consent form, was also circulated via the class mailing list. Students were encouraged to contact the researcher directly with any questions or concerns. Once they confirmed their participation, they received follow-up communication via email with logistical details regarding the venue and flow of the interview process.

3.6. DATA COLLECTION

This study collected data through two phases: document analysis (Phase 1) and semi-structured interviews (Phase 2).

3.6.1. Phase 1 - Document analysis

In this phase, the researcher selected documents directly related to university mental health services, relevant policies, and supporting initiatives. Credibility was guaranteed since all documents sourced from within the university were considered. Additional documents, such as official reports, strategic plans and guidelines that could be obtained, were requested from the administration, specifically Dr Christine Lewis, under the Wellness Division within the Division of Student Services and Development.

Documents from the five-year period between 2020 to 2024 were included to ensure that the information obtained was both current and reflective of recent practices and policies. Documents that were excluded were those that were irrelevant, outdated, non-credible, redundant, or lacked sufficient detail. This approach ensured the inclusion of high-quality, relevant materials that provided essential contextual and background information and helped to identify systemic issues and patterns (Bowen, 2009; Morgan, 2022).

3.6.2. Phase 2 – Semi-Structured Interviews

Semi-structured interviews were conducted using a purpose-designed interview guide which allowed for flexibility and depth in exploring pharmacy students' experiences with mental health services. *(see Appendix A)*

The researcher followed the guide but remained responsive to participants' input, allowing for new ideas to emerge based on the direction of the conversation. This approach facilitated a nuanced exploration of lived experiences and uncovered specific stressors unique to each participant (Adeoye-Olatunde & Olenik, 2021; Kallio et al., 2016). Data collection continued until data saturation was reached – defined as the point where no new information, themes or insights emerged from the interviews (Merriam & Tisdell, 2015). Saturation occurred at twenty interviews. This exceeded the general recommendation for phenomenological studies, which typically require six to ten participants due to the depth of inquiry (Morse, 2000). Given the stratification across five academic levels, a minimum of three participants was required per level. To maintain the study within the scope of a master's programme, the initial sample was capped at thirty participants. Ultimately, twenty students participated in the interview phase *(see Table 3)*. The combination of semi-structured interviews and document analysis provided a comprehensive and methodologically sound approach. It enabled the collection of rich, qualitative data while also grounding the findings in existing institutional documentation. Together, these methods offered a nuanced understanding of the mental health challenges faced by pharmacy students and informed strategies for more effective mental health support.

3.7. PILOT STUDY

A small-scale trial run of research methods was conducted through three semi-structured interviews with pharmacy students who were not included in the final study sample. The primary aim of the pilot was to identify and address any potential issues with the research tool and process before commencing the full study. The number of participants included in a pilot interview in research typically goes to a maximum of ten; however, for this study, three were deemed sufficient (Merriam & Tisdell, 2015). Although small, the pilot sample size of three allowed for effective testing and

refinement of the interview protocol. It helped to identify issues related to question clarity, the flow of the interview, and the overall practicality of the method (Doody & Doody, 2015). The pilot interviews were conducted and recorded in the presence of the research supervisor, who offered direct feedback on the interview technique and structure.

Participants also provided immediate feedback following the interviews, which informed minor revisions to the interview guide and helped refine the logistics of the data collection within the available resources and time frame. Ultimately, the pilot study contributed to ensuring the feasibility and methodological soundness of the research design, enhancing the study's effectiveness in capturing the lived experiences of pharmacy students regarding mental health support structures at Rhodes University. (Connelly, 2008; Thabane et al., 2010)

3.8. DATA ANALYSIS

3.8.1. Phase 1 – Document Analysis

The iterative process of document analysis involved a systematic and cyclical approach to explore the selected materials thoroughly. Using an inductive approach of coding, documents were initially skimmed to gain a general sense of their content and context, assisting in the identification of central themes and key topics (Morgan, 2022). This was followed by a detailed reading phase during which key information, recurring ideas, and notable findings were recorded. The next step involved interpreting the content to understand its meanings, implications, and significance, taking into account the context in which the documents were produced and the perspectives of their authors.

A coding scheme was developed based on identified themes and topics emanating from the theoretical framework and literature review. Using ATLAS.ti®, documents relevant to mental health support at Rhodes University (e.g., policies, strategic reports) were systematically uploaded, coded, and categorised. The software's flexible coding tools facilitated effective organisation of the data. A key feature of this phase was the iterative review process, which entailed multiple rounds of coding and thematic refinement. This ensured a nuanced analysis and helped identify any gaps or inconsistencies (Bowen, 2009).

Analytical tools, such as word frequency tables, supported pattern recognition, and memos were written throughout to record the researcher's reflections and summarise emergent insights.

3.8.2. Phase 2 – Interviews

Interview transcripts were analysed to identify recurring themes related to mental health challenges and lived experiences. Thematic analysis, as outlined by Braun & Clarke (2006) was used to guide the interpretation of data from both interview and document sources. The process consisted of six steps:

1. Familiarisation: involved immersing oneself in the data by reading and re-reading the transcripts and documents and noting initial observations.
2. Generating initial codes: key features of the data were inductively and systematically coded across the dataset, using ATLAS.ti® for data management.
3. Searching for themes: entailed collating codes into potential themes and gathering all data relevant to each theme.
4. Reviewing themes: involved refining the identified themes to ensure coherence within coded extracts and across the dataset. This led to the creation of a thematic map to visualise the relationships between themes.
5. Defining and naming themes: each theme's scope was refined, and clear definitions and names were developed to capture the essence of what each theme represented.
6. Producing the report involved selecting compelling data extracts to support each theme, conducting a final analysis of the selected extracts, relating the analysis to the research questions and existing literature, and producing a scholarly report of the analysis. (Braun & Clarke, 2019; Merriam & Tisdell, 2015)

By analysing data across these two phases, the study employed a rigorous and systematic approach that enabled a comprehensive and nuanced understanding of Rhodes University's mental health support structures and pharmacy students' lived experiences of them.

3.9. TRUSTWORTHINESS OF STUDY

The Lincoln & Guba's (1985) framework was used to guide the assessment of trustworthiness in this qualitative study. The specific application of each criterion within this research is detailed in Table 1.

Table 1. Provisions that the researcher made to address Lincoln and Guba's four criteria for the trustworthiness of data

Quality Criterion	Provision made by the researcher
Credibility	• Using two qualitative methods (document analysis and interviews) to corroborate findings and reduce the likelihood of bias or errors associated with using a single method. • Adoption of appropriate, well-recognised research methods, such as thematic analysis within a triangulated approach • Conducting member checks with participants to confirm accuracy and relevance, fostering transparency and ensuring their voices are accurately represented. Their signed review letters can be found in Appendix F • Debriefing and engaging with supervisors who will be familiar with the research topic to review and discuss the data, analysis process, and interpretations.
Transferability	• Providing a thorough context and background of this study to allow others to explore how findings from this study context might be relevant and applicable to other contexts with similar characteristics or challenges.
Dependability	• The researcher thoroughly documented the research methods, procedures, and analytical techniques used throughout the study. Transparency in this way enables readers to assess the reliability and validity of the research process and findings
Confirmability	• Methodological triangulation was employed to mitigate investigator bias in the study. The research provides a detailed methodological description, ensuring transparency and allowing scrutiny of the results' integrity. • Reflecting on, making clear and acknowledging the researcher's biases, beliefs, assumptions, and perspectives that might have influenced the research process and interpretations. To promote reflexivity and confirmability, the researcher maintained a reflexive

	journal in which they recorded personal reflections, biases, and insights. Additionally, there were two supervisors who could critically review the study as it progressed.
Positionality	• The researcher wrote a positionality statement (*Section 3.11*) acknowledging being a postgraduate pharmacy student, a practical facilitator, and a former peer educator and having had personal experience with the university's mental health support structures. • The statement also acknowledged that the researcher recognised that their personal characteristics, background, beliefs, and experiences may have influenced some aspects of the research process, from selecting the research topic to interpreting the findings. However, as the researcher brought their subjectivity to the study, which shaped how they perceived, understood, and analysed the data, they also practised reflexivity and regular debriefs with their supervisor.

3.10. ETHICAL CONSIDERATIONS

Ethical considerations in research involve ensuring that studies are conducted in a morally responsible manner, with respect for participants' rights, dignity, and wellbeing, particularly when considering the sensitivity of mental health issues. Fundamental principles applied in this study were compiled using the policy publications and specifications from the Rhodes University Research Ethics Forum (RUREF) (Rhodes University Research Ethics Forum (RUREF) et al., 2021)

3.10.1. Informed Consent

This was ensured by providing all participants with sufficient information that clearly explained the purpose, what their involvement would entail, and the potential risks and benefits. Written consent to participate was obtained via email or at the start of the interview *(see Appendix C),* and verbal consent was obtained at the beginning of each interview to reiterate the nature of the study and confirm that participants were in complete understanding of their participation within this study.

3.10.2. Confidentiality and Anonymity

A key objective was protecting participants' privacy by maintaining confidentiality throughout the research process. Codes were used to anonymise participants'

identities in any publications or reports that included disclosed information. Participants' names are only known to the researcher, who was responsible for:

- the collection and storage of signed consent forms
- the transcription of the recordings
- the substitution of any names on the transcripts with codes, e.g. Participant 1, 2, and so on
- the removal of any characteristics that might identify individual participants
- the member-checking process of transcripts to ensure all identifying features are removed
- ensuring that any quotations used in the dissertation were not linked to participant names, and that their participation in the study remained known only to the researcher.

All data was stored primarily on secure university servers that are regularly backed up to prevent data loss. To enhance security, all digital files were encrypted, and access to these files was password-protected. Additionally, backup copies of the data were kept on encrypted external hard drives, stored in a secure, locked location accessible only to the researcher. These measures ensured the integrity and confidentiality of the data throughout the research process.

3.10.3. Voluntary Participation

Another critical point was ensuring that participation in the research was entirely voluntary. Any pressure or incentives that could influence participants' decisions to participate were avoided. The researcher also ensured that participants understood they could withdraw from the study at any time without consequences.

3.10.4. Avoiding Harm

The researcher was mindful of the sensitive nature of mental health topics and the potential distress that discussing them might cause. Therefore, participants were proactively informed of available support or counselling resources should they experience distress during or after participation. Rhodes University's counselling centre offers an after-hours psychological emergency line, the number of which was provided to participants. During office hours, a psychologist on call could assist students experiencing a psychological emergency. The researcher also had an alternative on-call psychiatrist who volunteered to assist telephonically should the university's services reach full capacity. Additionally, participants were informed about other free 24/7 national resources, such as the South African Depression and Anxiety

Group (SADAG) hotline and trauma response lines, for support before or after the interview, if required.

3.10.5. Cultural Sensitivity

The study recognised and respected cultural differences in how mental health is perceived. As such, the research approach was designed to be culturally sensitive and inclusive of diverse perspectives.

3.10.6. Beneficence and non-maleficence

The goal was to maximise the benefits of the research while minimising any potential harm to participants. The interviews were anticipated to be a potentially therapeutic or cathartic experience for participants, offering them the opportunity to express their experiences and feel empowered to tell their stories (Bukar et al., 2019). This study also allowed participants to feel that their experiences could contribute to the improvement of university mental health support structures for future students. It is hoped that the research will promote a deeper understanding of mental health support systems and foster the wellbeing of pharmacy students and the broader student body.

3.11. POSITIONALITY STATEMENT

As a postgraduate pharmacy student at Rhodes University, I approach this research from both an academic and experiential standpoint. Multiple intersecting roles shape my positionality: I am a former peer educator, a current practical facilitator in the Faculty of Pharmacy, and someone who has personally engaged with the university's mental health support structures[15] . These experiences have offered me intimate insight into the complexities of navigating student life, wellbeing, and institutional support systems.

My identity as a Black queer student from Emganwini, a township in Bulawayo, Zimbabwe, further informs my perspective, particularly in understanding how race, gender, class, and culture impact mental health experiences in academic settings. I recognise that these personal characteristics, beliefs, and experiences have shaped not only my choice of research topic but also how I engaged with participants and interpreted the data.

As both an "insider" and a researcher, I acknowledge that my subjectivity inevitably influenced aspects of the research process, from designing the study to analysing and representing participant voices. I view this subjectivity, however, as a resource rather

[15] Positionality refers to the recognition that a researcher's background, identity, and lived experiences shape how research is conducted and interpreted, and that acknowledging this promotes reflexivity and transparency in the research process (Okely, 2012)

than a limitation. Throughout the research process, I actively practised reflexivity: regularly writing memos, engaging in supervisor debriefs, and reflecting critically on how my positioning impacted the research. These strategies were vital in maintaining analytical rigour while allowing me to conduct the study with empathy, cultural sensitivity, and a commitment to ethical research.

Ultimately, this study is shaped by my desire to advocate for more responsive, inclusive, and equitable mental health support structures, particularly for students whose voices are often overlooked within institutional systems.

CHAPTER 4 - DATA ANALYSIS & FINDINGS

4.1. INTRODUCTION

This chapter presents the findings of the study, which explored the mental health support structures available at Rhodes University and the lived experiences of pharmacy students in navigating them. The main objective is to identify how institutional provisions, direct and indirect, are understood, accessed and experienced by the students, particularly within the academically demanding and emotionally complex environment of pharmacy education.

Two primary data sources were used: (1) nine institutional documents related to mental health and student wellbeing; and (2) semi-structured interviews with twenty pharmacy students, across all years of undergraduate and postgraduate study. Together, these sources offer a textured understanding of both what is officially offered by the university and how these offerings are perceived and encountered in practice. The document analysis provides insight into the university's formal commitments, policies, and processes, while the interviews explored the lived experiences of students, revealing the complex, often deeply personal ways in which students relate to, make sense of, and respond to mental health challenges during their academic journeys.

This chapter is situated within an interpretivist epistemological framework, recognising that knowledge is contextually situated, socially constructed, and shaped by cultural and institutional dynamics *(Section 3.2)*. The analysis is further informed by a critical perspective that attends to power, access, and equity, especially as these intersect with identity markers such as race, gender, nationality, and class. These frames guide the thematic reading of both institutional texts and lived student narratives, foregrounding the relational nature of mental health support within a postcolonial higher education setting.

The chapter begins with the findings from the document analysis, structured around five key themes. The second major section begins with a presentation of the demographic profile of interview participants. This is followed by the interview findings, thematically organised to reflect dominant patterns in student perceptions, challenges, and behaviours regarding mental health and support systems. The chapter concludes with a summary of the key themes, which will be critically explored in relation to existing literature in Chapter Five.

As both researcher and participant in the institutional life of Rhodes University, as a postgraduate pharmacy student, peer educator, and facilitator, I recognise the role my own standpoint plays in shaping this inquiry. While a fuller positionality statement is provided *(Section 3.2)* it is important to acknowledge here that my dual role as insider

and researcher informs both my access to and interpretation of these narratives. By reflexive journaling and supervisory dialogue, I have sought to ensure that this proximity is used as a lens for insight rather than bias.

4.2. DOCUMENT ANALYSIS: INSTITUTIONAL FRAMING OF MENTAL HEALTH SUPPORT

To explore the formal framing of mental health support at Rhodes University, nine institutional documents were analysed. These included policies, protocols, strategic plans, and communication from university leadership. The goal was to identify the types of support officially available, how they are represented, the procedural and cultural assumptions embedded within them, and the extent to which they align with student experience. Table 2 provides a summary of the documents included in the analysis.

Table 2. Institutional documents included in the analysis

DOCUMENT TITLE	YEAR	ABBREVIATION/ IDENTIFIER	PURPOSE/FOCUS
Protocol for Suicide and Attempted Suicide	[16]N/A	PSAS	Procedures for responding to suicidal behaviour
Student Disability Policy	N/A	SDP	Framework for accommodating students with disabilities
Letter to Staff and Students by the Vice Chancellor	2022-05-31	LSSVC	Official communication addressing institutional concerns after the May 2022 mental health protest
Pregnancy Protocol	2022	PP	Guidelines for managing student pregnancies
Students Protocol on Sexual Assault	2022	SPSA	Protocol and processes to follow in the instance of sexual assault
Wardens' Manual	2023	WM	Outlines the roles and responsibilities of residence wardens
Leave of Absence Policy	2023	LOAP	Regulates temporary student withdrawal from academic activity
Thuthuka Academic Initiative (TAI)	2025	TMH	Guidelines for peer mentorship within the TAI programme

[16] N/A here means that the documents were undated but confirmed to be in current practice and thus accepted into the study criteria. The table is arranged by years in ascending order.

Mentor Handbook			
Integrated Development Plan (IDP)	2023–2028	IDP	Strategic vision and development goals of the institution

Following Bowen's (2009) iterative model of document analysis, documents were coded both deductively (themes were derived from the research questions and theoretical framework, as outlined in *Appendix E*) and inductively (emergent insights were captured). Key concerns identified in the literature around visibility, accessibility, equity, responsiveness, and cultural relevance informed codes. The documents revealed the absence of a dedicated mental health policy alongside an inconsistent but evolving landscape of student wellbeing provision, with mental health often framed within broader themes of academic success, resilience, and crisis response.

4.2.1. Emerging Themes from Document Analysis

The findings from the analysis were categorised into five key themes and set out as follows:

1. Direct and centralised support structures
2. Academic emphasis and support provided
3. Service Accessibility and Procedural Processes
4. Recognition of cultural and religious needs, and
5. Institutional responsiveness

The subsections that follow describe each theme, supported by relevant excerpts from the analysed documents.

4.2.1.1. Direct and Centralised Support

Mental health services at Rhodes University are largely centralised through the university's Student Counselling Centre[17], which is consistently identified across institutional documents as the primary structure for psychological support. Located on the top floor of the Steve Biko Building, the Counselling Centre is presented as the first point of contact for mental health needs. It is described as offering professional, confidential services to all students, including emergency consultations during operational hours:

[17] Link to description of the counselling centre: https://www.ru.ac.za/counsellingcentre/.
Of the nine documents included in the analysis, seven referred to the Counselling Centre, predominantly in its capacity as a referral service for students experiencing psychological distress or crisis situations. The documents offered minimal discussion of the Centre's role in long-term mental health care or preventive interventions.

> “The Student Counselling Centre provides a professional service to all Rhodes Students… The Counselling Centre is on the top floor of the Steve Biko Building” (WM, p. 25)
>
> “The Counselling Centre is open every day between 8h00 and 16h30 for emergency support” (LSSVC, p. 2)

The Counselling Centre also plays a key role in academic accommodation processes. It is responsible for conducting both psychological and emotional assessments related to educational needs, including learning disabilities and conditions requiring exam or timetable adjustments. The counselling centre is also responsible for the “referral to private practitioners if Centre capacity is exceeded.” (SDP, p. 8)

This layered approach demonstrates institutional recognition of students’ various mental health needs. However, it also reveals critical limitations. Even though referral pathways to public institutions like Fort England[18] exist, the move to receiving holistic care from external practitioners, often at the student’s personal cost, may exacerbate inequalities for those without medical aid or financial means.

Rhodes University has a health care centre. The Health Care Centre (HCC)[19] provides professional and confidential medical support to students throughout the academic year, offering accessible services to both in-residence and off-campus students. It also provides referrals to counselling services and external practitioners when necessary. As such, the Health Care Centre is referenced as a potential initial referral point in mental health cases; its role is primarily triage-based. While staff may identify mental health concerns during consultations and refer students to the Counselling Centre or external medical providers in cases of severe crisis, ongoing mental health treatment is not formally offered within the HCC itself:

> If a student undergoes a medical crisis, the first port of call is the Health Care Centre… All medical expenses… are the student’s responsibility, and if the student does not have any medical aid, they will have to rely on state medical services. (WM, p. 12)

The university’s formal crisis-response protocols are laid out in the PSAS, which specifies steps to be followed in the event of an attempted or completed suicide. These include contacting emergency services, notifying next of kin, and making postvention counselling available to affected students: “The Counselling Centre will be available to offer counselling to students affected by the death.” (PSAS, p. 3)

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[18] Fort England Psychiatric Hospital is a government-funded psychiatric hospital and drug rehabilitation centre for the Makana Local Municipality area in Makhanda, Eastern Cape in South Africa.

[19] Information about the Health Care Centre: https://www.ru.ac.za/orientationgateway/thingstoknow/healthcarecentre/

Procedures such as postvention counselling alongside the LOAP, which allows temporary academic withdrawal due to psychological distress, suggest a system designed to respond to acute emergencies. However, the documentation makes no mention of providing support to re-integrate the student, therapeutic aftercare, or structured pathways for students returning from mental health-related leave. The Counselling Centre is expected to intervene only after a crisis has occurred:

> "If a student has been admitted to hospital because they have made a suicide attempt or have been considered a serious risk… they should immediately consult a psychologist at the Counselling Centre once discharged from hospital." (PSAS, p. 2)

The documentation thus reveals a model of support that is reactive rather than preventative, where the onus is on students to seek out help after a crisis has unfolded. Furthermore, several services require hierarchical approvals and documentation from registered psychologists. For example, a leave of absence application must be signed by a licensed psychologist (or countersigned by a supervisor if provided by an intern): "A request for support for an LOA is a professional decision and is granted at the discretion of the Psychologist." (LOAP, p. 5)

While these protocols establish a clear institutional structure, they can pose barriers to timely care, particularly for students navigating complex emotional distress or financial constraints. The direct and formal system, while well-documented, depends heavily on student self-advocacy, clinical diagnosis, and procedural compliance. As such, it may not adequately accommodate students who experience cultural stigma around mental illness, struggle with access to private care, or require long-term therapeutic support.

In summary, Rhodes University has a centralised system of directed mental health interventions that are structured and protocol-driven but does not have a dedicated mental health policy. The system functions with the Counselling Centre at its core, which is supported by referral mechanisms involving the Health Care Centre and external practitioners, alongside documented procedures for responding to crises.

4.2.1.2. Academic Emphasis and Support Provided

The document analysis revealed that the university places a strong emphasis on academic achievement and performance as central to the student experience. Across multiple documents, including the manual for wardens[20], the IDP and the TAI Mentor Handbook frame student success primarily in academic terms, with mental health referenced only insofar as it supports or threatens academic resilience.

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[20] A warden is a staff member or mature student responsible for the day-to-day running, welfare, and discipline of a student residence. Link to definition:
https://www.ru.ac.za/foundershall/contacts/wardens/

For instance, the WM emphasises staff dedication to helping students realise their academic potential: “Our academics, administrators and support staff work hard to create an environment that will help you to realise your potential.” (WM, p. 9)

Students are encouraged to seek help if they feel overwhelmed, but the only direct avenue consistently referenced is the Counselling Centre: “Students are encouraged to seek help if they are feeling overwhelmed… by contacting the Counselling Centre.” (WM, p. 15)

Similarly, the IDP articulates an institutional goal to foster “holistic development,” but this is immediately linked to academic success, with little attention given to the social and emotional dimensions of student life: “Goal 3: Create an engaging and transformative student experience that promotes holistic development, growth and academic success.” (IDP, p. 48)

The emphasis on performance extends to mentorship initiatives. Programmes such as the TAI are described as indirect support systems, designed to assist first-year students in adjusting to the university environment through context-specific mentorship with senior pharmacy students as mentors: “Through TAI, first-year mentees are introduced to the complexities of their new environment in a supportive context…” (TMH, p. 23)

While these programmes do provide a degree of psychosocial support through peer relationships, they are not integrated with direct mental health services and are not explicitly framed as wellbeing interventions. Additionally, the mentors are not equipped or trained to deal with mental health issues. The IDP also proposes the establishment of informal social hubs on campus to facilitate peer interaction, as is reiterated by the quote: “Establish a social hub where students can interact informally and socialise.” (IDP, p. 50)

However, such gestures appear largely symbolic in the absence of integrated mental health literacy programmes, structured resilience training, or embedded care practices within academic departments.

Notably, while the LOAP permits students to take time off due to psychological distress, no documents outline a reintegration process. There is a lack of guidance on therapeutic aftercare, academic re-entry planning, or structured follow-up, gaps which may leave returning students vulnerable and unsupported. While “Psychological distress” is recognised as valid grounds for academic leave, no mention is made of reintegration protocols, peer inclusion strategies, or counselling continuity post-return. This suggests a reactive system that lacks proactive and preventative measures towards mental health support. (LOAP, inferred).

4.2.1.3. Service Accessibility and Procedural Processes

While the University has direct structures in place for mental health support, the analysis of institutional documents reveals that access to these services is governed by layered procedural requirements, which may create unintended barriers, particularly for students navigating psychological distress.

Applications for mental health-related support, such as a Leave of Absence (LOA), are bound by a framework of professional verification and hierarchical approval. As outlined in the LOAP:

- "All applications must be supported by a registered Psychologist."
- "In the event that a student was seen by an Intern Psychologist, the supervising Psychologist must countersign."
- "A request for support for an LOA is a professional decision and is granted at the discretion of the Psychologist." (LOAP, p. 5)

These stipulations assume that students are not only aware of the protocol but also able to access a registered psychologist promptly.

When internal capacity at the Counselling Centre is strained, students may be referred to private and public practitioners (*see Section 4.2.1.1*). While this system offers continuity of care, it also introduces cost barriers for students without medical aid, effectively making access to support a function of financial privilege. It also adds strain to the public healthcare platforms that are already under-resourced.

In medical emergencies, the WM specifies that the HCC is the first point of contact. Staff at the HCC determine whether a doctor or ambulance is needed, but again, costs are transferred to the student:

> "All medical expenses (apart from the basic services provided by the Health Care Centre) are the student's responsibility, and if the student does not have any medical aid, they will have to rely on state medical services." (WM, p. 12)

This underscores a broader institutional model that is technically inclusive but practically exclusive, particularly for students who are socioeconomically marginalised. Mental health support is thus not simply a question of availability but of navigability: access requires not only emotional readiness and self-advocacy but also procedural literacy and financial capacity.

Furthermore, the documentation places substantial responsibility on students to initiate contact, articulate their needs, and persist through administrative gatekeeping. These requirements may disproportionately disadvantage students experiencing high levels of distress, cultural stigma around mental illness, or low familiarity with institutional procedures.

4.2.1.4. Cultural and Social Recognition

The document analysis reveals a partial yet conditional recognition of students' cultural and religious identities, primarily in relation to leave-of-absence protocols. Cultural and religious observances are acknowledged as valid grounds for academic leave, alongside illness and sporting commitments. However, this recognition is highly regulated and constrained by administrative procedures that prioritise academic continuity and departmental discretion.

As stated in the LOAP:

- "Leave of absence shall be granted in cases of genuine ill-health, sporting, cultural or religious activities on condition that the application meets the requirements."
- "The leave of absence approval is at the discretion of the Head of Department." (LOAP, p. 4)

Even when leave is granted, students are required to catch up on missed work within a week of approval, regardless of the nature or duration of the event: "Leave of Absence does not excuse students from work… submissions will be deemed due within 1 week of the submission and approval of the LoA." (LOAP, p. 4)

This framework positions cultural and religious needs as legitimate but subordinate to academic obligations, effectively rendering support conditional upon institutional convenience.

Traditional ceremonies such as initiation rites, weddings, or community-specific observances are also formally recognised, but only if verified by a recognised authority:

- "All applications must be supported by a recognised traditional leader, religious leader, ward or local government councillor, or a justice of the peace."
- "In the cases of cultural ceremonies… students are required to get approval at least one week before the ceremony." (LOAP, p. 5)

These provisions reflect an attempt to accommodate cultural diversity within institutional processes. However, the requirements for early planning, formal documentation, and official verification present practical challenges, particularly for students from communities where planning is fluid or authority structures are informal. Moreover, final approval remains at the discretion of a single individual (Head of Department), which introduces a significant power imbalance and potential for inconsistent application.

While these protocols acknowledge cultural and social dimensions of student life, they also reflect a bureaucratic model of inclusion, where legitimacy is granted only through institutional mechanisms of control. This model assumes a standardised view of

cultural practice and may exclude students whose traditions do not conform to administrative timelines or recognised hierarchies. This highlights the excessive emphasis placed on academic performance to the detriment of other crucial aspects of wellness, which include the cultural and spiritual dimensions of wellbeing.

4.2.1.5. Institutional Response to Mental Health Events

The document analysis also considered how Rhodes University has responded to acute or large-scale mental health events, including the COVID-19 pandemic, the student suicide and mental health protest of 2022, cases of sexual assault, and the institution's broader historical legacy. These events reveal moments when mental health moved to the forefront of institutional discourse, though often temporarily or symbolically, while also exposing deeper systemic patterns of inequality and resistance to transformation.

A notable example is the Vice-Chancellor's letter issued in response to the 2022 student-led mental health protest. In response to rising distress on campus, the university outlined several immediate interventions:

> In order to deal with the increased need for mental health support, the University has contracted an additional six psychologists. In addition, group therapy has been introduced to provide more students with support in a group setting, rather than waiting for individual therapy to become available. (LSSVC, p. 1)

The letter also described infrastructural initiatives intended to improve student wellbeing, such as creating social spaces and installing outdoor benches: "The University is currently increasing spaces for students to socialise and relax or de-stress on campus… Plans are underway to transform Steve Biko into a Student Centre." (LSSVC, p. 2)

Similarly, the WM refers to the provision of remote counselling for students affected by the disruptions and isolation caused by the COVID-19 pandemic: "If students feel overwhelmed by COVID-19 and associated events on campus, the Counselling Centre offers remote counselling." (WM, p. 15)

While the university has formal procedures for responding to trauma, including crisis counselling for sexual assault survivors (SPSA, p. 3), the overarching institutional culture appears bureaucratic and top-down, with limited emphasis on inclusive co-creation of wellbeing policies. The institutional drive appears to prioritise maintaining control and academic order, rather than investing in long-term structural transformation of mental health services.

These responses reflect a degree of institutional responsiveness to a collective crisis, but they remain largely reactive, lacking integration into broader strategic frameworks.

Despite the apparent urgency and visibility of student mental health issues during these moments, the Integrated Development Plan (IDP) makes no mention of mental health as a strategic priority. There are no dedicated mental health policies, objectives, budgetary allocations, or performance indicators. Instead, mental health is embedded vaguely within broader discourses of student success and resilience.

Mental health, despite its occasional mention, is largely absent from institutional strategic priorities. This absence is particularly stark considering the university's complex historical context. As the IDP acknowledges, Rhodes was founded in 1904 as an extension of a colonial elite institution, serving exclusively white male students: "All the students were White; academic and administrative staff were White, and Black employees undertook manual work." (IDP, p. 5) This historical legacy may continue to influence aspects of institutional culture.

4.2.2. Summary Of Document Analysis Findings

The institutional documents analysed reveal a direct, centralised structure for mental health support at Rhodes University, with the Student Counselling Centre positioned as the primary point of access. The Counselling Centre provides assessment, emergency response, and referrals, including for academic accommodations through the Student Disability Policy. However, when internal capacity is limited, students are often referred to external practitioners, which raises equity concerns for those without medical aid or sufficient financial resources. The Health Care Centre is also listed as an initial point of referral in medical emergencies but plays a minimal ongoing role in psychological care.

Institutional protocols for mental health crises are well-defined, particularly in the case of suicide or hospitalisation, but the system remains largely reactive. There is limited evidence of proactive mental health promotion or structured reintegration support following psychological leave. Support tends to depend on student initiative and compliance with procedural requirements, including approvals by registered psychologists.

Academic performance remains the university's dominant priority, with documents frequently highlighting student success, resilience, and responsibility. While some indirect peer support systems, such as TAI, exist, there is minimal structural space for addressing the underlying academic pressures that contribute to distress. Mental health is referenced primarily in relation to maintaining academic function rather than as a concern in its own right.

Mental health support must be culturally and contextually relevant. Cultural and religious observances are formally recognised as valid reasons for leave; however,

access to such leave is conditional on providing documentation, planning, and departmental discretion. Traditional ceremonies must be approved by recognised community authorities and submitted in advance, reflecting a bureaucratic model of inclusion that may not accommodate cultural contexts which are crucial for overall wellbeing, especially in African communities.

The institutional response to large-scale mental health events such as the COVID-19 pandemic and the 2022 mental health protest has included temporary increases in psychological staff and the introduction of group therapy. However, mental health remains absent from policy and the university's strategic objectives, budgets, and measurable priorities. This suggests a gap between short-term responsiveness and long-term systemic commitment.

In summary, the institutional documents reflect a structured but limited approach to student mental health, one that is centralised, conditional, and often administratively constrained. While provisions exist, they are shaped by academic priorities, procedural requirements, and a culture of delayed or crisis-driven response.

4.3. INTERVIEW FINDINGS

Following the analysis of institutional documents, this section presents the findings from semi-structured interviews with pharmacy students. These narratives offer more profound insight into how direct mental health support structures are perceived, accessed, and experienced in practice. While policy documents outline institutional commitments and procedures, student accounts reveal the lived realities of navigating these systems, shaped by personal, cultural, academic, and structural complexities.

The interviews were designed to explore students' awareness of available mental health services, their experiences in accessing support, and the factors influencing their wellbeing during their time at university. Participants reflected on academic pressure, institutional responsiveness, personal coping strategies, and the role of identity and belonging in shaping mental health experiences.

Twenty in-depth interviews were conducted with pharmacy students to explore the mental health support structure at Rhodes University and to understand how students interpret their experiences, attitudes, and beliefs regarding mental health. Interview transcripts were analysed and thematically coded inductively, and the findings were grouped into emergent themes reflecting common patterns and divergences across the dataset.

Finally, to ensure the trustworthiness of the study and the credibility of the interpretations, I engaged in the process of reflexivity throughout the data analysis. My positionality statement *(Section 3.11)* reflects the steps taken to examine and bracket

my own biases as a researcher situated within the academic and institutional context of the study.

The following section presents participant demographics and assigned participant codes, followed by a discussion of the findings under five interrelated themes. A table *(Table 3)* summarising the student participant demographics, along with an allocated unique identifier, follows.

Of the twenty participants interviewed, the majority were female students, which aligns with 2024 enrolment statistics, where 439 out of 684 undergraduate pharmacy students identified as female[14]. To protect the anonymity and confidentiality of participants, race was not included in the demographic table; however, the sample included one Coloured student, one Indian student, and eighteen African students. Furthermore, six of the twenty were international students from other African countries, contributing to a broader diversity of perspectives and cultural insights.

Table 3 Participant Demographics and Unique Codes.

LEVEL OF STUDY	PARTICIPANT TITLE	GENDER	CODE*
FIRST YEAR	Participant 1	Female	UG1-1
	Participant 2	Female	UG1-2
	Participant 3	Male	UG1-3
SECOND YEAR	Participant 4	Female	UG2-1
	Participant 5	Male	UG2-2
	Participant 6	Female	UG2-3
THIRD YEAR	Participant 7	Female	UG3-1
	Participant 8	Female	UG3-2
	Participant 9	Female	UG3-3
	Participant 10	Female	UG3-4
	Participant 11	Female	UG3-5
	Participant 12	Female	UG3-6
FOURTH YEAR	Participant 13	Female	UG4-1
	Participant 14	Male	UG4-2
	Participant 15	Female	UG4
POSTGRAD	Participant 16	Male	PG1
	Participant 17	Male	PG2
	Participant 18	Male	PG3
	Participant 19	Female	PG4
	Participant 20	Male	PG5

*CODE KEY

CODE	MEANING
UG1-1	UG: Undergraduate 1: First year 1: Participant
UG2-1	UG: Undergraduate 2: Second year 1: Participant
UG3-1	UG: Undergraduate 3: Third year 1: Participant
UG4-1	UG: Undergraduate 4: Fourth year 1: Participant
PG1	PG: Postgraduate 1: Participant

4.3.1. Structures Identified

Upon analysing the interview transcripts, the researcher took notes on all the structures that the participants identified as their mental health support structures, based on their responses to the questions on the interview schedule *(see Appendix A)*. The structures were then organised and turned into a visual representation as a diagram, which is shown in *Figure 2*.The diagram illustrates the mental health support structures identified by the participants. They are categorised under two sections, direct and indirect structures[21]. This differentiation shows the avenues through which the students access support for their mental health, ranging from the institutional to much more personal resources.

Under direct structures, the participants highlighted the counselling centre as a key space for therapeutic support. They also mentioned the SMASH events[22] and workshops offered by the Rhodes University Counselling Centre.

The indirect structures mentioned were those that they preferred, which are centred around their residential living spaces, peer support, and community support (community and social support). Additionally, they noted that the harassment office addresses the issue of student safety, which is closely linked to psychological wellbeing.

The indirect structures that they identified included a wide range of impactful resources that they turn to for support. These structures included university-affiliated individuals and groups, such as pharmacy staff, TAI, residence mentors, peer educators, and representatives for transformation and wellness. They also mentioned the significance of house wardens and house committee members who often bring emotional support and guidance within residential spaces. Beyond these structures, students also found support in student societies on campus, as well as Rhodes University Community Engagement activities and the care of surrounding religious spaces.

Furthermore, a vital avenue of support that they identified was the support coming from personal social networks, which include family, friends, and classmates, all of whom play a crucial role in mental support and day-to-day coping strategies.

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[21] Direct support systems refer to formal, institutionally provided university services, while indirect support systems refer to informal, external, and self-developed support mechanisms that students use for mental health support even though they may not be directly intended for that purpose.

[22] The SMASH events are regularly advertised on the Rhodes University Counselling Centre Instagram page, which can be accessed on this link: https://www.instagram.com/rucc_media?utm_source=ig_web_button_share_sheet&igsh=cXBlYWhjcm53bWVs

This diagram and its underlying categorisation reveal the layered and interconnected support ecosystem at Rhodes University. It highlights the importance of both structured institutional mechanisms and indirect structures in student mental health. The reliance on a combination of direct and indirect supports reflects students' diverse needs and preferences in seeking help.

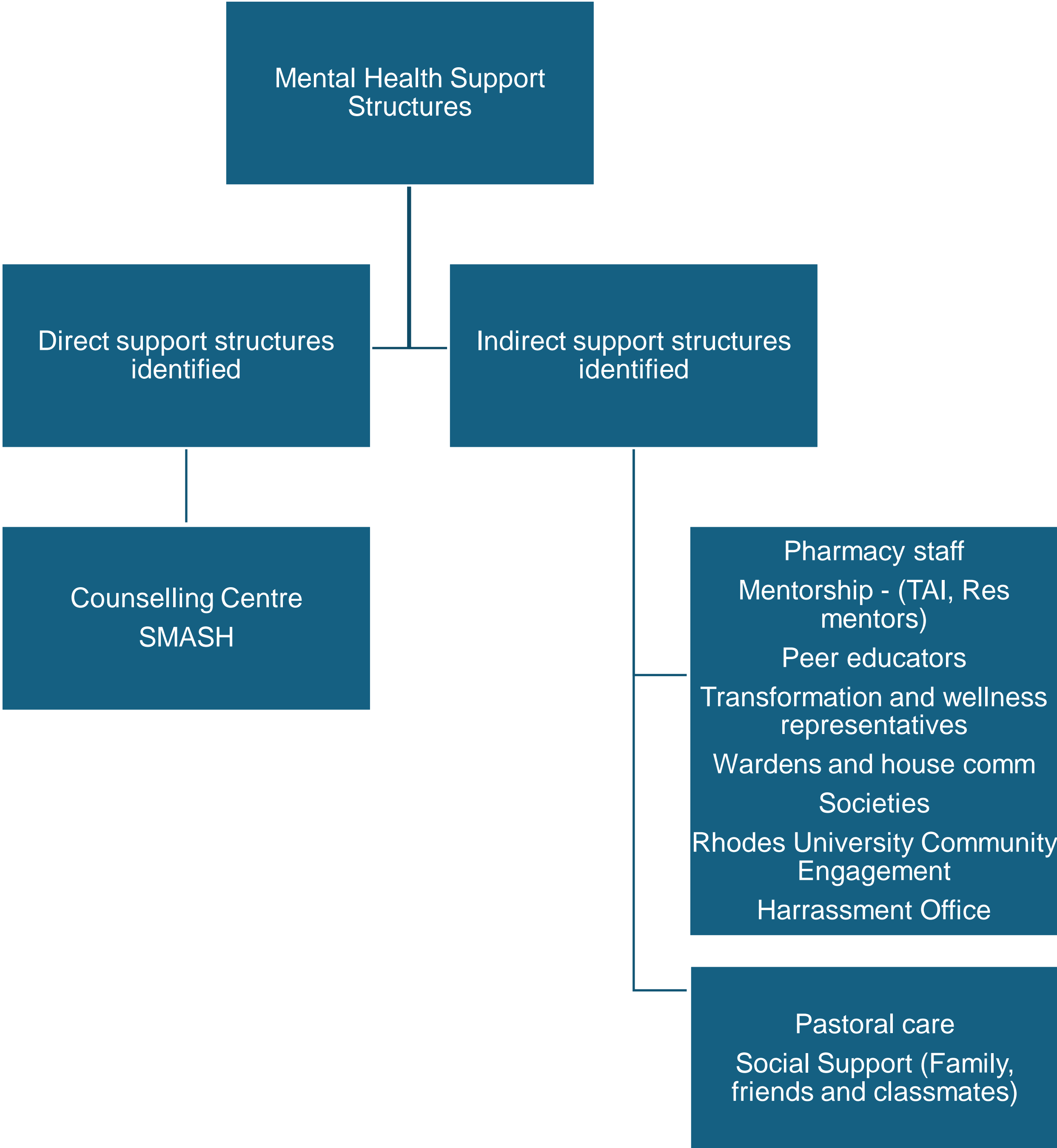

Figure 3. Mental health support structures that the participants identified within their interview responses

4.3.2. Student Voices on Mental Health and Support Systems at Rhodes University

The analysis of interview transcripts revealed six key thematic areas that reflect how pharmacy students understand and experience mental health and institutional support at Rhodes University. These themes not only echo some of the patterns found in institutional documents but also expand upon them, offering insight into some of the complexities that shape student wellbeing. The following sections report the findings; verbatim quotations[23] from participants support each theme and aim to offer a grounded account of student realities:

1. Student Perspectives and Experiences of Academic Pressure
2. Accessibility and Support-Seeking Barriers
3. Support-Seeking Behaviours - Formal and Informal
4. COVID-19 Pandemic and Institutional Response to Mental Health Issues
5. Visibility, Experiences and Relevance of Mental Health Support Structures
6. Campus Climate and Institutional Culture

4.3.2.1. Student Perspectives and Experiences of Academic Pressure

This theme captures students' personal perspectives on studying for a Pharmacy degree and their views on how it has impacted their mental health. There is a notable mention of academic pressure and how pharmacy students perceive the Faculty of Pharmacy's role in this area. The responses from the participants below show that the students see this degree as one that has much demanding work that sometimes leads to the neglect of one's wellbeing in an attempt to achieve the qualification:

> I can say uhm first year in pharmacy, compared to BSc like the work is too much, so it can affect some of the students' mental health UG1-1 (54)
>
> With all this, you know academic workload that is within us. Yoh! There's so much work I'm not going to lie so much work. UG1-2 (67)
>
> What I can say is that pharmacy is a lot and it has a lot of work, so sometimes we actually neglect our wellbeing and be more focused on this course cause like it's a lot of work, it's draining. So, we tend to actually lose our self in the process of wanting to achieve this. UG2-3 (97-99)

Other participants candidly shared how the academic pressure of having to study pharmacy impacted their wellbeing to the point of breaking down for one, to the point of neglecting sleep and diet for another and one primarily summed it up by sharing how

[23] The bracketed numbers after each student quote are from the corresponding line number of the transcripts on ATLAS.ti® to assist with the credibility and review process done by supervisors of the analysis done.

it needs to be an act of balance as the degree carries an intense workload that can affect mental health.

> ... when your mental health is like declining and you're struggling already, I feel like the pressure that comes with pharmacy also just exacerbates it. UG3-1 (132)

> Yeah, because I remember I'd cry, like literally. I remember it from the first or second year. I think it was the end of year, like during the November exams, or it was so bad, like Pharm Chem [Pharmaceutical Chemistry] was kicking me in the gut. It was so bad, I remember crying in the library, I just broke down. I couldn't do it. UG4-1 (55)

> I wasn't managing; I think I was struggling with time management. So, I wasn't managing my time well, so, it would get to a point where I don't sleep because I don't want to fail and I don't want to underperform because I have a bursary as well so there's a lot of things hanging on me passing so yeah, I wasn't sleeping, I wasn't eating right. UG3-2 (111)

A participant summed it up by sharing that the degree is quite challenging and requires a balance of things:

> I think this degree is very difficult on its own and having to like now deal with mental health issues it's kind of tricky, but then you need to find a balance because this degree and its workload and having to face issues with your mental health, can cause a discord because you can never find a healthy balance between the two, like if one of it is lacking, the other one is obviously gonna start lacking too, because one thing I've realised is that every time I found a topic or a major difficult, it would mess up my mental health UG3-4 (137)

Moreover, participants noted that lecturers tend to focus heavily on knowledge retention, often overlooking students' mental health. Some of them added that the faculty staff needs to look at situations in their entirety so they can best see how to help students. This notion was reinforced by students stating that there needs to be a holistic approach towards students, and the lack of visibility towards mental health support is what makes students feel like they are going through these situations alone, with no support.

> Like I feel like for lecturers their primary goal or their primary work that they focus on is us knowing the work. There I'm not going to lie, they would want to be assured that we know the work, but mentally they wouldn't really, you know, make sure that we are okay mentally. I feel like for that it's just up to you that you must be okay mentally. “I don't care” not in a bad way but they don't really

> you know put it out there. But for them it's just like you must understand the work UG1-2 (79)

> But I think it needs to be in an entirety like looking at the entire pharmacy class and being like you know, are you guys okay? Are you guys managing, you know what I mean is the workload too much? How can we space things out? You know what I mean? Yeah UG4-2 (49)

> Oh yeah, maybe I may not answer like the question directly, but I do feel like BPharm is like more like difficult and yoh! Yeah, it is difficult. I feel like it could be better, like if we had like support like just for BPharm you know like to be able to talk to someone like who has like more understanding of what we go through. UG4-3 (173)

Other responses from participants who were further along in their studies (fourth year and postgraduate students) in pharmacy highlighted that there is no visible support from the faculty for students, and they need more practical guidance.

> There needs to be more outline, there needs to be sort of more practical experience and there needs to be more sort of like support from the lecturers to say that, but I know our students are going through a lot how can we help them in any way? UG4-2 (135)

> I feel like there was a smaller number of people I've spoken to, and there really isn't any like support from the faculty right. Like in terms of emphasising the need for one to look after themselves, like, not just physically, but mentally as well. Like, how does one go about that? So, I feel like maybe if they, the schedule is tight, I know, right but I think it's much needed because I think we can't really continue running away from the need or for people to really assess themselves and that is okay … like I think that's another thing, because people, I think when you go through something you feel like the only one, so it then makes it worse PG5 (101)

> So yeah, I think it would be better to find, like, well-equipped people for certain situations, especially like each faculty, like, say, to just help students in the faculty feel more like familiar with them and yeah, like I really think that would help in terms of like yeah… PG3 (93)

Additionally, there was mention of student deaths by suicide in 2022 and how that influenced students' perspectives on studying pharmacy by making them think deeply of the impact of academic pressure.

> … I mean, when I was in second year, there was a third-year pharmacy student that committed suicide. Pretty sure you heard about it, he hung himself. That

was a shocker for me because I was like, I'm coming to third year now, you know, I mean, is that how it's going to be like, is it so much? UG4-2 (145-147)

Another participant went on to mention that within the faculty, they would appreciate it if they could get more peer-centred support from people who have gone through this journey, who can share contextually based advice on navigating mental health as a pharmacy student. This suggests that while a mentorship structure exists in the first year, students perceive a lack of continuity in peer support beyond this point, particularly during the more demanding senior years of study.

> … people who have done this module right they can come to us and tell us *ukuthi bona* (that) how do they learn to manage both their physical and their mental health, so that maybe they can just give us guidance on how to actually find that balance UG2-3 (107)

Some students alluded to the support they have received from the Faculty of Pharmacy (the TAI mentorship)[24] and went on to add that it would be helpful if the mentorship continued beyond the first year, as it would serve as a valuable source of mental health support. A response below summarises that as follows:

> In that sense, and the fact that just because we're pharmacy students doesn't mean that the extra support that we have in the first year has to stop in the other years, you know, because I feel like that's also something that just makes people tip into everything because once you see your marks decline, you don't have everything going well, then you just slowly but surely without even realising it tap into just the dark space and everything like. Yeah, I hope your research does amazing work and they can see that it's actually a problem UG3-3 (96)

In summary, this theme demonstrates that the pharmacy students interviewed believe that they experience sustained and intense academic pressure that significantly affects their emotional wellbeing. This highlights the need for mental health support structures that are responsive to the unique workload and performance demands of the pharmacy programme.

4.3.2.2. Accessibility and Support-Seeking Barriers

A prominent theme that emerged from the data was the issue of accessibility and barriers to seeking support for mental health resources available within the institution. Student experiences of the mental health support structures seemed to vary, with some being satisfied and others being dissatisfied, but the responses leaned towards dissatisfaction. While resource awareness contributes to this theme, other factors that

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[24] The TAI mentorship programme at Rhodes University is a structured peer-support initiative designed primarily to assist first-year students with academic and social transition into university life. The programme pairs senior students with first-year mentees to provide guidance, academic advice, and general support during the initial adjustment period of university study.

influenced the overall theme included the protocols and procedural systems, the lack of urgency, the long waiting lists reported by students, and the secondary perspectives they received from fellow students regarding the mental health support structures at Rhodes University.

Some participants shared that when they had an issue with time management, they felt a lack of urgency and agency from the counselling centre. Three third-year participants noted that they were placed on a waiting list to book a counselling appointment and see a counsellor. Additionally, other students shared that even with a referral to the counselling centre, one will still arrive and find a backlog, leaving them stranded in their search for support. Others even shared that by the time they received the help (or were able to secure an appointment at the counselling centre), they no longer saw the benefit, and it made them stop counselling because it did not feel beneficial anymore.

> Yeah. It was. I don't know, cause number one, the problem was time management, number two, it was just like, I don't know how to put it, but like you know how, like the urgency of when your mental state is not okay and then you go there to seek help and then they make you wait two weeks, and they put you on a waiting list UG3-1 (57-60)

> I think it was the reception at the front desk and then they took down my details and they told me that it takes long for you to get a session, so you know there's a line, like that, just so it takes a while for you to get a session, and they'll get back to me. UG3-2 (73)

> Because you cannot say backlog and then when you give them referrals they too are backlogged like, okay, so where do we go to like where do we go to? UG3-4 (147)

> Yeah. The waiting period for me I don't know at the time I was obviously pissed off and annoyed but also by the time that, like "I got the help that I needed', I can say quote-unquote, I feel like I had already, like navigated most of what I was going through by myself. So, by the time I got help ... Maybe that's why I also ended up stopping because I didn't see the use of it anymore by the time I was there, so yeah, it didn't feel very useful. PG3 (87)

A key response was captured from a fourth-year participant (UG4-3) who shared that they booked an appointment in the first term but only got a response towards the end of the year. The same participant also shared how this was during the COVID-19 pandemic (a point discussed further in theme 3), so they had to book online:

> And then with the counselling centre yes, first year I booked an appointment to see, the psychologist and it took very long, like for them to respond even like to

gather confirmation of my appointments like imagine like you've been like wanting to have like the appointment from first term only for you to get like the actual session towards the end of the year. So, it was that thing like there like they were not responsive because I remember it was COVID, so we had to book online, even the session that I had, it was like online UG4-3 (71)

The same participant - UG4-3, however, stated that they had tried the counselling centre for a second time in 2024. In this instance, they had gone with a friend, who at the time was suicidal, and their friend was attended to whilst UG4-3 did not receive any assistance, leaving them feeling unimportant and not catered for:

> … I went there with a friend and then like they were like suicidal and then they attended to them and then not me. And I felt like I felt somehow, I was like Okay, is my case not very important? But then at the same time I did understand okay like I don't know in terms of staff members if maybe like they don't have enough to attend like many students at the same time, but at the same time, we're not many, we just two. I felt somehow about that, like choosing to attend like someone and not me UG4-3 (129-131)

Other participants shared how they have seen from the various social media platforms that students freely express their opinions and experiences on, that the direct institutional structures are not helpful, and they consequently struggle to know whom they can turn to for support.

> … because I know of people who went there to the counselling centre to get help, but they couldn't. Like they would fill in the form but couldn't get a response, so my warden was mediating all of this because she made sure that I got the right resources UG3-6 (73-75)

> They hear what I said like Steve Biko doesn't help or maybe they go on to this page called RU Confessions, where just students say they problems and they see that it's not helpful and they're not really sure who to turn to. And it's usually something that it's shied upon. UG3-3 (67)

> And I think because I, as I said, I do stay on social media and people always complain about having or finding it hard to access these kinds of services, so I don't think I even try after seeing that I'm like ayii you know, it’s disheartening UG3-5 (79)

One participant shared that he does not want to use the services offered on campus, as he would feel judged by the staff there if he were to open up due to his observations of their behaviour towards other students.

> I know some of the people based on people that are wardens at reses or whatever like that and I've seen how they *(the staff)* behave to some extent from

> past people's occurrences and based on that, I'm like if I go there, does that mean that, you know what I mean, people are going to judge me, people are not going to help appropriately you know what I mean? UG4-2 (117-119)

A few of the participants, however, shared that they found the counselling centre to be easily accessible, and others went on to state that, due to financial reasons, they found the counselling centre sessions helpful because they were free and thus more accessible:

> So, it was quite easier to like, navigate the whole thing, like get a slot and all that. And there were no delays every time I'd go for my slot and all that. So, I think that that's an improvement. UG4-1 (87)

> I was going through something, and I wanted to go to a psychologist, but I didn't have the medical aid at that time because I was using a permit that didn't need me to use medical aid. So, I didn't have medical aid and yeah, I was trying to avoid paying so I looked around and then I was told about the like the counselling centre and that's where I found the psychologist who helped when it comes to mental health support. PG1 (51-53)

In summary, this theme reveals that although mental health services exist at the university, multiple structural and social barriers continue to limit effective access. These barriers contribute to delayed help-seeking and reinforce students' sense of isolation during periods of psychological distress.

4.3.2.3. Support-Seeking Behaviours

The data also revealed the various factors that shape the way students seek support within the institution. Under this theme, some prominent aspects were mental health stigmatisation, the relevance of cultural nuance and how race and gender affect the dynamics of seeking and receiving mental health support. In this theme, there is also an unveiling of how masculinity shapes the understanding and experiences of mental health.

Participants emphasised the importance of receiving therapy from someone with a similar background and belief system to their own. Some Black participants mentioned that they received significantly better support from Black psychologists. One participant expressed that the lack of a language barrier made it easier to express herself because the counsellor understood exactly what she would be saying, with nothing lost in translation.

> Yeah, it was. In first year, my psychologist was a white lady, but still, yeah. I mean like it, it was okay. I did feel like okay since I'm an international student, maybe she's not going to, like, get what I'm saying and all that. But then like from second year, third year, fourth year, it's been like black people. Okay, you

> know what? Yeah, I feel like the black psychologists, like, do really get it. They get it better unlike the white psychologists because of just how different we are like, but they do try shame. She did try, but then sitting here I'm like no, I need a Black psychologist, so yeah. UG4-1 (69-71)

> In a sense of like following the African way I'm assuming so she did kind of help and it was much better cause she was a black woman so I didn't have to feel like now I have to filter certain things because I can easily speak to her in my own language. I even told her that it was very helpful because I didn't, I wasn't restricted with my language because if you fail to say something in English, then it loses meaning, because what if what you wanna say now you can only say it in vernacular, and then she couldn't understand what I was trying to say so yeah, so it was helpful. UG3-4 (79-81)

Another participant particularly shared his experiences as an international student whose culture played a vital role in shaping his understanding of what counselling and therapy are, making him wary of seeking support for a very long time. He hinted at mental health stigmatisation in connection with his upbringing.

> … but like within, with my culture per se, like they'll be saying like culture, that's Shona culture. The way I see it like I'm really not sure about everyone else, though, like from how I was raised, you'll be hearing like when they're talking about someone who had to go for therapy, you like, and he was going mad, so, like, they had to go there. PG2 (93-95)

He then went on to share that, since his views have changed by seeing people share mental health awareness on social media, he still has not used the mental health support structures here, but remains open to it as he shares, "so yeah, that's the whole reason why I haven't really engaged with the ones offered by Rhodes. But it's something that I do wish to engage with them, like, particularly the counselling centre, I guess" PG2 (93-99)

While exploring support-seeking behaviours, another aspect that surfaced from other participants was that of masculinity and how certain perceptions attached to being male influenced their ideas of mental health and how they seek support in that area. A participant shared that growing up, he would be told to keep his emotions to himself as a man and not express them. He recounted how, even in his school days, when he would be bullied, he was brought up with the mentality to isolate and defend himself first before reporting or seeking help.

> So you'd be like, "Nah, I'm a boy so I'll be fine" Even if you are feeling down like other things, you would refer them to your parents but if maybe in Grade 7, there's a guy that hit you at school you don't want to report that because they're going to say like, "why are you shy, you could have fought back or everything?"

So, I think it's that background that sometimes you try to be strong even when people are teasing you. UG1-3 (75)

He further went on to mention that this tendency to “bottle up” is something that has carried over to how he avoids seeking mental health support as well.

Another participant shared his story in two parts by first sharing that he grew up in an environment where men do not talk about their problems. He expressed that society makes men isolate and keep things within themselves:

> Right, so there was always that connotation of you as a man, right, where I come from you just go through it. You know, just it's like it's silly to go through emotions. You always have to smile, you know, you can't be vulnerable in any particular situation which is obviously not ideal because so where I come from currently there is like a rampant abuse in drugs among young men and obviously clearly, it's not hard to tell why, given that there really isn't a lot of channels for them to speak because people just go through stuff and they just told by society, you know, that no you’re a man, you should, you know and there's also like, pressures, just, I don't know why it is where I come from, it's like when you're man you there's a lot of expectations as well like you need to have done certain things by a certain age, so those kind of things I think you know, you end up internalising them… PG5 (71-73)

He continues to further link the ideas of masculinity in the context of culture, particularly the Shona culture in Zimbabwe and the stigma attached to mental health as weakness:

> Oh okay, I come from Zimbabwe and well, the culture is quite complicated because, well, even though we all Shona people are just called Shona, but it's kind of like many dialects and tribes, and so the cultures are slightly different, but they are all kind of the same. So, especially where I come from, if you're like a man, obviously it's like you’re a provider and you’re the guy, you know, you so you can't- So, like you traditionally, any form of weakness would be frowned upon, like how can you do that as a man? You know, like, if you cry, then society will look down upon you. You know that sort of stuff. Yeah, so there's kind of a little bit of stigma around that. PG5 (77-79)

Another participant also shared that from her Zulu family background, mental health is not something that is taken seriously like other illnesses, to the point that when you share something, you can be ridiculed for it.

> Most blacks neh, we don't take mental health as something that is a disease or something that needs attention. If you say, "Eyy, I'm stressed", they’ll say No, just go, and you'll be fine, you see. So, we actually take it lightly. We don't focus more on it, so even back at home, mental health is something that we don't take

> as something major like diabetes, like something that needs attention you see? Yeah, so even with talking, you will say something and then you'll end up being- that thing that you've said, it will turn to a joke, and then they will joke about it. So, it's not something that we take seriously, yeah UG2-3 (117-121)

She further went on to mention that from her background, the first point of help when one faces a mental crisis is to pray and not talk about one's problems to anyone. This is outlined in her words: "*Yabo cause thina we are taught ukuthi* (You see because we are taught that) eyy you don't cry, you need to be strong if you feel like this, just pray you don't need to talk, just talk to God you see." UG2-3 (155)

Another participant shared the experience of growing up in an environment where he would wake up early at dawn for school and still had to do major household chores. He noted that this underpinned his experience and understanding of mental health as a peripheral aspect of life, which shaped his support-seeking mechanisms when he eventually got to university:

> … at school, you play sports, you do school, you come back. You still have to go fetch water, look for firewood, make sure the cows are home, the goats are home, and by the time you sleep, you're tired. The next day, it repeats. So, you just know you have to do your duties, and everything goes on. So, you don't have much time to sit and think. Yes, so it was never an issue, even all the way to my high school. But in my high school, I remember like, there's a time where my school was tough, school was tough, and it's about okay we're supposed to pass, but how am I doing it? Like it's tough, but there's nothing to do about it. You know, there is a problem like you are feeling overwhelmed, but there's nothing much other than knowing what I have to do the work and pass. So, there was nothing much about mental health and I got start thinking more about it in university second year upwards, yeah. PG1 (127)

Another participant added to the stigma of mental health illness by sharing that people will name-call individuals who suffer from mental health issues with derogatory labels. She emphasised the need for candid conversations upon reflection of her journey while learning about central nervous system drugs in class, which related to the conditions she suffers from:

> And the fact that people tend to juggle things in themselves and then they bottle up and then they explode. So, really, having those conversations to just understand and also informing people about the mental health disorders, because people think having the symptoms means that you are crazy, they use words like "crazy" and all of that. So, the idea behind mental health, I think, is that people should really be informed about the medication and the support structures we have. UG3-6 (109)

Lastly, one other participant also added to the need for destigmatisation through open dialogue within a university setting:

> Just that we need to take mental health seriously and we have to say it out loud without any shame, because it's the new normal and we just have to like just to embrace the whole idea and just yeah, keep moving forward. It's normal for someone to be in counselling every week. UG4-1 (101)

In summary, this section shows that students adopt diverse help-seeking strategies, ranging from formal counselling to informal peer and family support. This reflects both adaptive coping practices and the ongoing challenges students face in engaging with institutional mental health services.

4.3.2.4. COVID-19 pandemic and Institutional Response to Mental Health Issues

The institutional response to students' mental health was a strong theme that surfaced in the study. A key focus was the 'mental health' benches installed in the courtyard of the Bantu Stephen Biko (Student Union) Building response to the suicide events that led to a protest on campus in 2022 (*see* *Section 4.2.1.5*). During the pandemic, the university expanded counselling services, initiatives and added remote (online) support. Students shared their experiences and perspectives on these changes:

> So, upon arrival at Rhodes University, I was told about -well informed about- the depression benches at Steve Biko that if you are maybe depressed or you're having a stressful day, just go to those depression benches. And to me, it was like, but oh, okay, me being in my room alone and I'm in a stressed state, I'm going to those benches, I'm still alone. It just takes me to a different space, but it does not solve the problem, right, so that's my take on that one UG2-2 (29)

> We have mental health benches, I'm joking, Ha-aah I'm not joking, it's true! In 2022, which was my first year, we had this incident where I think a student [*gestures a hand signal of suicide*], yeah. And then they had, like a young march protest to like say that let us extend, well not extend, but move the exam days to a later date, because us as students are clearly mentally not okay and then the university thought the best thing to do is give us mental health benches by Steve Biko. UG3-4 (29-31)

> Like they did have the mental health benches, but come on, what are you going to do that like, sit there and think about how messed up things are going in life like? UG4-1 (55)

Another participant shared how he found the benches to be of help to him, although not directly related to his mental state:

> And also, yeah, now that I think of it, I think they have wellness benches. I have sat there once, but not necessarily for that … I tend to sit outside a lot; I tend to find being outdoors and fresh air and generally just being refreshing in general. So, I just utilised them, and I found them to be helpful. PG5 (45)

An important factor that emerged was the COVID-19 pandemic and its impact on the way students received mental health support. Some participants share that they blame the pandemic for their experience being slightly ineffective because of the help being relayed online rather than in person. Participants shared that their experiences were not helpful and they stopped going to therapy because of that experience:

> So, my first encounter with the counselling centre was in 2021 and okay, I feel like I can blame COVID for that cause I feel like. It was just not, you know, as effective for me as I would have hoped. UG3-1 (72)

> I think also it was like during COVID. So, there was a lot of like confusion, just being stuck at home all day, not being able to go to class, I hadn't been home in a year because I had to, like, not go home because of like the borders closing (63) ... And then also I think the time that we spent together, it being online via Zoom, it felt very like, it didn't feel natural. So, to me, I would say, like, it wasn't the most helpful experience because, like, if it's happening online via a person I've never met before in my life through a screen, I didn't feel comfortable enough to like, share and open up with everything else going on. So, I mean, I didn't really get help from that whole experience I wouldn't know about now, but for me personally, I just ended up stopping the whole thing, so I just stopped going for therapy altogether. PG3 (73)

In summary, this theme illustrates that the COVID-19 pandemic intensified existing mental health challenges while also exposing limitations in the university's capacity to respond to large-scale psychological distress. This period highlighted both student vulnerability and institutional fragility in times of crisis.

4.3.2.5. Visibility, Experiences and Relevance of Mental Health Support Structures

Participant responses highlighted how they discovered mental health support structures, providing insight into the visibility of these services. Participants also shared their experiences of engaging with the counselling centre and their perceptions of the effectiveness and adequacy of these direct resources.

In terms of awareness, one second-year student expressed that they had never heard of the counselling centre or its location:

> Eish, I don't think I know, but I think I've heard of like there is a place where you can say I'm not okay and mostly the clinic they say you can go there, but I've

never really like seen what's like the institution or the building or what or where it is and everything, so I'm not sure, UG2-1 (27)

Another participant cemented this by suggesting that most students are unaware of these resources, especially first-year students, so the university must do more. Furthermore, she shared her personal experience with how she had to help her friend get mental health support:

> Yeah, but I feel like there's a lot that need to be improved like in this university, in terms of like the support structures for students with like mental health problems. Yeah and then like the awareness, I feel like this so much that needs to be done in terms of promoting like and encouraging, like children to, like, come to like and use like these services cause like I feel like for example like my friend like they didn't know about like counselling centres and so when they showed me that they are suicidal and then with like all the problems that they were like experiencing I just told them, okay let's go book UG4-3 (139-141)

Many other students shared that they receive emails from the university communique about direct mental health support structures, but they either ignore the notifications or only pay attention when they need the resources/support. This sentiment is summarised in the two quotations below:

> Yes, so I think that we do get sent regular emails about the fact that maybe there's a mental health talk that's going to be posted or rather, hosted by the university like on this day. So, we do get regular emails, but then it goes back to the thing of the student or the students that they're sending it to, are they in need of the services or not? Are they going to go or not? But in terms of communication, we have been receiving the communication from the university. UG2-2(63)

"Oh yeah, we used to get emails from them, I would just ignore them but yeah, I got to know of them through emails yeah, that emailing list." UG3-6 (41)

While many students shared their knowledge of resource spaces, others also shared their hesitancy and negative secondary experiences with the counselling centre. The following responses described the counselling sessions at the Bantu Stephen Biko Building as an effective space for their mental health.

> OK, so uhm I remember I would come into the sessions feeling very weary, very worried, distressed, feeling all sort of emotions that this put me down. But after leaving those sessions, you know I'd be feeling very elevated. I feel very, you know, like something in me was just taken off like a burden on me was taken off UG1-2 (59)

> The lady I was working with was amazing, honestly, because I get ... I'd always have an appointment. I think I had to submit a timetable or I had to let her know about my availability and she would try to, like, squeeze me in or because you know how busy we get so she'd try to find ways to squeeze me in. UG3-2 (59)

One participant noted how the centre has tried to improve in service delivery over the years by comparing her experiences across the different years:

> Mmhm Yeah in first year, it left me feeling very okay. Yeah, it left me feeling okay and in second year yeah it was okay, but I think in third year in fourth year like it really played like a bigger role. Like I felt okay, you know what this is. I felt very helped. Yeah, I felt very helped and I was really helped. It just made me navigate my way through everything. Life, social, everything. So yeah, it was really good. It was a good experience. UG4-1 (75-79)

Coincidentally, participants in the same year also shared having had a terrible experience with the counselling centre after they went for group counselling at the university following the loss of a close friend. They were attended to by a lady who they say did not take the situation seriously. One participant shared that:

> She really didn't care, like I feel like firstly she was late for the appointment. She didn't apologise in that regard when we got there, she's busy there chewing bubble gum, she's busy swinging on her chair, rocking back and forth. UG3-4 (97)

Both participants, although interviewed separately, raised this issue, and their descriptions matched. They also said she ruined their image of the counselling centre, and that the lady in question did not conduct any follow-up sessions, even though the incident had just occurred. The other participant shared they instead got through it themselves:

> … and I think that's why we never went back, because I don't think we got help there. I think what helped us is the fact that we spoke about it amongst each other. We sort of counselled each other, yeah, it wasn't a nice experience. UG3-5 (53)

This experience leads to the idea of the perceived adequacy of the mental health support structure at Rhodes University, which is a key element of this theme. A participant summed up the experience by saying, "I don't wanna say they don't take it seriously, but I feel like there's not enough resources and enough staff to accommodate everyone in the university." UG3-1 (64)

Other participants got more candid by sharing that the centre seemingly has six psychologists to cater for the whole university. They also expressed that they were told

they can only have a maximum of six sessions, which is not adequate for their needs as students:

> You meet them six times because I met mine once a week, and that was for six weeks, and yeah, it helped, but I feel like six weeks to treat something that's been happening for a long time, I don’t think helps a lot. It just covers the basis of it, and then it just helps you navigate everything else, but then doesn't really solve the situation. UG3-4 (33-37)

> … I thought it's unlimited like, I can go there like as often, but then they will like, no, like, you can only have four sessions and then that one being counted, so I was like after that one, I’ve only got like three left I can use, so yeah. UG4-3 (85)

Some postgraduate participants shared that the counselling centre is understaffed and unable to meet the demands of the institution:

> I think when it comes to like the university itself, just from my experience, especially with the counselling department, which is meant to be available for every student, clearly there's like a shortage or they can't cater because that's the same story I've heard with, like a lot of people, my friends who seeked out help at the university, it seems that they are, there's too much demand and they can't exactly supply enough people to help students out... PG3 (91)

> … Considering that, I think they've got like, what, six psychologists, if not four or five, and all of those have to cater for the whole student body. So, they also need to, in a realistic sense, they also need to kind of try and cut down on people that they can actually see, and they prefer seeing psychological emergencies… PG4 (67-69)

The last participant went on to share that the counselling centre is not for you if you need consistency, but that it is financially better because it is free and forms part of your tuition. They concluded this remark by stating that “the whole health issue is actually a business, but also at the same time, we're trying to save lives.” PG4 (68)

Contextual relevance of the mental support structures is something that needs to be considered when conversations about mental health in higher education come up. From the responses, it appears that the counselling did not meet their expectations, and there was inconsistency in the support provided. Another participant expressed the following:

> …I feel like my main issue with my university-appointed therapist was that there was no familiarity whatsoever. We had no common ground to the point where she thought of like recommending it to someone else who she maybe thought would be more … we would have more common ground. I don't know. Maybe

> it's the lack of training on their part because I think she was also like doing her master's, so maybe that's the case. PG3 (93)

Another participant shared on the efficacy and relevance that the counsellor she got would reprimand her for using terms like “panic attack” lightly without actually asking her background, which could have revealed to her that she had an actual diagnosis of a panic disorder:

> … she just assumed that I was just using it lightly and also when I went in 2022, because I remember my mental state was like bad at that time. I went to the healthcare centre; I did not get help. They told me they'd get back to me, and they never did. Yeah, I had to, like, follow up again. And yeah, it was just really stressful. UG3-1 (76-78)

Another participant added to this by stating that she would rather use her own personal counselling platforms than the university's one, because if you go by yourself without being motivated by a staff member like a warden, then you will not get a response. The participant also shared how frustrating it was to work with the university counselling system, as when you need documents to apply for a leave of absence or aegrotats, you have to go through a lengthy process of speaking to multiple people due to frequent staff changes.

> That was draining because you're working with different people. The psychologist that you saw last year is not the one who's here, this one doesn't know your history, and now you have to keep on sending emails, I needed to send an e-mail to the student bureau also to the counselling centre, so it was a lot of sending off emails. Yeah, there was a time when my mum was so frustrated she just called the original, the one we had, the psychologist we had last year because yeah, the changing of staff members, it was just too much, but we managed UG3-6 (65)

She further describes that with the personal services she uses, she is guaranteed a continuity of care, and she can get the one-on-one attention she needs:

> The personal ones are better because you know that you will get that help. With this one, if you don't go through your warden and you go by yourself, fill in the form, because I did, I filled in the form, I never got any response. I don't know why, and I'm not the only one. That's why I opted for my personal ones because I know that I will definitely have an appointment next week, so we have to have a waiting period for these ones. I get that they are making groups, focus groups to do all of that, but sometimes we need a one-on-one and they don't offer that UG3-6 (99)

One other participant remarked that the university claims to put students first, yet they have been complaining about a backlog for the past three years, which has influenced the health of some students who have passed away through suicide:

> But then, with this university, inasmuch as they are saying they are for the students, there are necessarily no structures in place to handle that at a larger scale, because now, since 2022, they've been complaining about a backlog at the counselling centre. What happened to the people who have now committed suicide, and some of them are well known to have tried to go to the healthcare centre or the counselling centre, and they didn't get the assistance they need, you see? UG3-3 (143)

In summary, this section indicates that while some students recognise and value existing mental health services, many remain unaware of or uncertain about how to access them. This points to important gaps in institutional communication and service visibility.

4.3.2.6. Campus Climate and Institutional Culture – Student Perspectives

Participants also shared their perspectives on how they view Rhodes University and the institutional culture they have come to experience regarding mental health. Some participants stated that they do not see Rhodes as a space that deals with mental health issues, but as a learning institution only:

> I think of Rhodes as an institute where you can learn not an institute where they have to handle your issues so I never like thought as far as maybe I should go and get help. But even if, let's say I needed help I wouldn't think Rhodes would help me because I feel like … I don't know, but it's kind of like made to you are made to think like, okay, you're here to study, have to show up. Either way, there's no time to be like sad or be like I have mental health issues and everything. So, I don't feel as far as, okay, maybe it's a system where I can like express, my emotions and everything UG2-1 (35)

Another participant shared that in her view, Rhodes does not seem to really deal with mental health because every year, suicide events happen around that issue:

> Rhodes doesn't really have much of like a space where they really deal with mental health issues because Rhodes has this thing of every year someone passes away because of committing suicide. So, I think they don't really focus much on it, which is kind of … I mean, I mean, they're trying I guess, but I think they could do a whole lot better because clearly, it's a cycle and it's not gonna end anytime soon. And if they don't see an issue with it then that's the problem UG3-4 (39)

One participant expressed that, despite the initiatives in place, students suffer from mental health issues:

> So, like, it's quite sad that despite the fact that at the institution, we have counselling services, we have these mental and psychological programs that are at our disposal as students, right? You would still find that there are students that are experiencing mental health problems. UG2-2 (79)

Another aspect of the theme that emerged from the responses was that of procedures and protocols that are part of the institutional culture when dealing with mental health issues and their consequences on academic continuance. One participant shared that there are no procedures in place to support individuals who need to take a break academically:

> People know that okay fine, I'm going through something now obviously I can't study but then now I don't know what I'm supposed to do. Should I go write? If I don't write, where am I gonna get a doctor's note from? Because again, the only issue now to my mental health. How do I explain that I'm mentally not okay or fit to write the exam? Like what other measures are put in place for a student to be like okay, if I mentally I'm not okay, can I sit these ones out? What happens? What are the procedures? UG3-4 (165-167)

Another participant openly shared that these procedural channels, such as the LOAP, are not helpful because one still has to speak up to explain why they are struggling. The university channels are not effective, and there does not seem to be a specific channel for them to voice out their concerns within the faculty:

> Yeah, like sure we're told guys if you're struggling you can just tell us about it or like, you know, voice it out because there was that issue of apparently or the only reason the topic of us speaking if we're struggling even came about is because a lot of people had just been applying for LOAs and stuff like that. So, our class reps just told us that I think the lecturers said if there's someone that is struggling with anything, they can just, you know, speak out, but then the thing is, who do we speak out to? Which channel are we voicing ourselves to? And is it safe enough for me to even open up? And even if I do open up, this is something that can be done about it. Will I get the help that I need, or will it just be a thing of, okay we understand that you're going through this, so we'll just try and make leeway for you throughout the degree, which doesn't really help. UG3-3 (82)

The participant went on to mention that there is no specific channel for help within the faculty, and they seem to rely on the counselling centre for assistance, which does not appear to be effective for everyone. She shared, "I think they just rely on the measures

that you're asking me about that the university has in place for us to go to which has proven to not be that effective for everyone, so yeah.” UG3-3 (82)

Lastly, a participant suggested that the university still has high rates of mental health issues, and they must introspect and find other methods towards supporting mental health:

> But we still have this high rate of mental health and other social ills which exist within the population or within the student body or student population itself. So, I think that it's very important that we then look into other alternative methods or conventions through which or like from a hierarchical approach that the university actually introspects or looks at this again UG2-2 (83)

He further shared in his response that the resources need to be diverse and accommodate everyone: “… there should be more alternatives available as opposed to the limited facilities, the limited resources and the limited programs that we have at the university to accommodate everyone, encompassing their diversity” UG2-2 (89)

In summary, this theme highlights that campus culture, stigma, and institutional climate play a powerful role in shaping students’ willingness to seek mental health support. These findings demonstrate that service availability alone is insufficient without a supportive and inclusive institutional environment.

4.3.3. PARTICIPANT FEEDBACK ON FINDINGS

As part of enhancing the trustworthiness of the study, three participants were invited[25] to review the results, discussion, and conclusions (*see* Appendix F). All three confirmed that the analysis accurately reflected their views and experiences and did not identify any major discrepancies between their accounts and the researcher’s interpretations. One participant described feeling “seen” by the findings, noting that the study captured not only surface-level difficulties but also the emotional and structural tensions of student life at Rhodes University, including the gap between symbolic gestures of care and the deeper systemic changes needed to support student wellbeing. The same participant affirmed the nuanced portrayal of peer dynamics, competitive pressures within pharmacy, and the limitations of online counselling during COVID-19, emphasising that the discussion recognised mental health support as relational and embodied rather than merely procedural.

[25] For the purposes of member checking, the participants were selected through convenience-based random outreach and invited to review chapters four and five of the research. Participation was voluntary, and three participants responded. This process contributed to the trustworthiness and credibility of the data interpretation.

The other two participants similarly endorsed the analysis as fair, balanced, and well aligned with the study's focus on pharmacy students' mental health. They highlighted that the work offers valuable insight into the interconnections between institutional structures, cultural context and student wellbeing, and saw its potential to inform future policy and practice, particularly within the Faculty of Pharmacy. One explicitly linked the study's relevance to the training of "today's and future health care givers," arguing that empathetic, holistic educational practices are essential for cultivating graduates who are attentive to their own mental health and that of their patients. Overall, the member checking process (*Appendix F*) strengthened the credibility of the findings and underscored their resonance with participants' lived experiences, while also affirming the study's contribution to ongoing conversations about mental health support and institutional responsiveness at Rhodes University.

4.4. SUMMARY

The findings in this chapter revealed a complex and fragmented sphere of mental health support at Rhodes University. Although various forms of assistance exist, the absence of a formal mental health policy or guideline points to significant barriers and shortcomings within the current institutional support structure.

Students expressed differing opinions on understandings of mental health shaped by cultural and social factors. While some students appreciated the services, others highlighted the barriers and shortcomings of the current support structures; the overall response was one of general dissatisfaction. The students shared their own experiences and understandings of what mental health is, which influenced how they went about seeking mental health support when they got to university. Their responses were also related to the findings of the document analysis portion of the research, allowing patterns to be identified between institutional support structures and students' lived experiences.

Additionally, the students identified various forms of mental health support structures when asked which structures they were aware of and those that they identified as their own sources of mental health support. The schematic in Figure 2 shows the platforms they identified and was compiled by the researcher for easy navigation.

Altogether, these insights highlight the connections between institutional frameworks, lived experiences and the status of mental health support across the context of Rhodes University.

CHAPTER 5 - DISCUSSION

This chapter discusses the findings presented in relation to existing literature and theoretical frameworks. Drawing on the lens of Health Policy and Systems Research (HPSR), the discussion interprets how structures, cultures and relationships within the university setting shape students' lived experiences of mental health and wellbeing. HPSR, combined with anthropological viewpoints, positions mental health as an interconnected system of elements, policies, institutional culture and social relationships that influence how students understand and seek support.

The analysis of documents and interviews highlighted interconnected structures and themes that helped to explain how mental health is experienced, supported, and understood within the university context. Each theme reflects both the institutional structures in place and the perspectives of students navigating them, and together they form the basis of this chapter's examination. The analysis highlights the tensions between policy frameworks and lived experiences by examining the students' perceptions alongside institutional documents. These themes include:

1. Student perspectives and experiences of academic pressure – exploring how the demands of pharmacy education affect student wellbeing and identity formation
2. Support-seeking behaviours – looking into social, cultural and gendered influences on student engagement towards mental health services
3. Service accessibility and barriers – focusing on the gap between policy institutional intentions and student experiences of care
4. Visibility, experiences and relevance of support structures – considering awareness, trust and cultural resonance of support structures.
5. Campus climate and institutional culture – analysing how institutional norms shape help-seeking and belonging
6. Institutional responsiveness and notable mental health events – reflecting on symbolic versus structural approaches to student wellbeing

Taken altogether, themes provide a structured basis for discussion. Using a health policy and systems lens, along with theoretical frameworks, allows for an exploration of how institutional strategies, cultural contexts, individual experiences, and socialisation intersect to shape mental health within the university. The chapter will therefore consider the strengths and limitations of current practices, drawing connections with the literature and identifying areas where the study offers new insights.

5.1. STUDENT PERSPECTIVES AND EXPERIENCES OF ACADEMIC PRESSURE

This section examines the multifaceted ways in which academic pressure impacts the mental health of pharmacy students at Rhodes University. Instead of interpreting these accounts through a clinical lens, this section situates student experiences within broader institutional, cultural, and socioeconomic contexts that shape how mental health and academic success are negotiated at Rhodes University.

Pharmacy students may occupy a uniquely stressful niche within the university system, combining the high expectations of clinical professionalism with the developmental stages of young adulthood. For students from historically marginalised communities, these academic demands are further complicated by structural inequalities, cultural silences around mental health, and legacies of educational injustice (Padmanabhanunni, 2020). As such, there is a need to examine how academic intensity functions as a social pressure before exploring the institutional dimensions of faculty engagement, the symbolic and cultural meanings of distress, and the perceived absence of tailored support.

Participants in the study consistently referred to and referenced the intensity of their academic workload as a primary source of psychological strain. Their accounts confirmed a well-documented pattern within the literature where curricula, high-stakes assessments and the demands for constant knowledge retention were shown to increase students' stress levels significantly (Elnaem et al., 2022; Fischbein & Bonfine, 2019) . However, beyond simple stress, students described a sense of existential exhaustion (a feeling of being consumed by the degree to the point of losing touch with their own wellbeing and personal identities):

> Pharmacy is a lot, and it has a lot of work, so sometimes we actually neglect our wellbeing. And be more focused on this course cause like it's a lot of work, it's draining. So, we tend to actually lose ourselves in the process of wanting to achieve this. UG2-3 (97-99)

This tension speaks closely to the distinction between institutional structures and lived experience. Institutional documents note that mental health is only recognised by its support or threat to academic success (*see* Section 4.2.1.2). Additionally, pharmacy as a discipline not only relays skill and knowledge to students but also enforces a cultural script where productivity, resilience and emotional control are implicitly encouraged.

Helman (2007) argued that health and illness are culturally defined, as are educational success and burnout. Within this context, academic pressure becomes more than a set of deadlines; it becomes a moral terrain in which students must prove their worthiness to belong academically and emotionally. The health systems framework by

Gilson et al. (2012) supports this analysis if one conceptualises academic spaces as policy-driven spaces embedded within broader social and economic systems (*see Section 2.8*). This portrays them as spaces that deliver education and enforce invisible rules around what kinds of distress are permissible, how resilience is defined, and who is seen as coping (Hanna et al., 2022). This aligns with the experiences of some students who felt compelled to sacrifice sleep, nutrition, and emotional wellbeing in order to succeed:

> … it would get to a point where I don't sleep because I don't want to fail, and I don't want to underperform because I have a bursary as well, so there's a lot of things hanging in the balance of me passing, so yeah, I wasn't sleeping, I wasn't eating right. UG3-2 (111)

Through an HPSR perspective by Gilson et al. (2012), such neglect reflects not individual weakness, but institutional design. Pharmacy curricula in South Africa, as in many parts of the world, are modelled on high-performance and clinical standards that rarely accommodate the emotional labour demanded of students (Bheekie & Huyssteen Van, 2017). This resulting dissonance between academic expectations and human capacity reveals a systemic misalignment that surfaces the absence of embedded support.

The narratives of pharmacy students also reveal the presence of what Kleinman (1988) referred to as idioms of distress, which are culturally shaped ways of expressing suffering that are not always easily defined within the biomedical framework. Behaviours like crying in the library, skipping meals, or struggling to find motivation are not merely symptoms of burnout; they indicate that something is amiss in the relationship between students and their academic environment. Such expressions suggest a broader cultural dissonance within the institution, where emotional vulnerability is seen as marginal to the academic space (Naidoo & Cartwright, 2018).

A recurring perception in this study is that the Pharmacy faculty appeared distant, if not indifferent, to the emotional wellbeing of their students. While some participants acknowledged isolated moments of support, such as first-year mentorship programmes, many described a structural absence of care. This perception reflects a deeper tension between the institutional structure and human connection. In bureaucratic systems, such as universities, support is delivered through formal channels, including the counselling centre, academic advisors, and institutional policies. Yet, as Gilson et al. (2012) notes, policy presence is not directly linked to policy impact. Student support is reflected in how authority figures make students feel seen, heard, and understood:

> … there really is no support from the faculty right, in terms of emphasising the need for one to look after themselves not just physically, but mentally as well.

> Like, how does one go about that? …… the schedule is tight, I know, right but I think it's much needed because I think we can't really continue running away from the need or for people to really assess themselves PG5 (101)

Despite their expertise, some faculty staff members can occupy positions which distance them from the human consequences of the system they uphold. This disconnection is especially evident in pharmacy education, where the biomedical model prioritises objective knowledge over relational knowledge informed by lived experiences (Deacon, 2013; Kohrt et al., 2016). The result, as observed in the study, is a culture where distress is acknowledged but not addressed, where students are only visible in their academic performance, but not in their emotional struggles (DiPlacito-DeRango, 2016). This strengthens earlier findings, which suggested that the faculty often appeared more invested in cognitive outcomes than emotional support. In such professional spaces, mental health struggles are then seen as personal weaknesses rather than structural or cultural outcomes.

Ahmed (2012) reminds us that institutions expect power not only through explicit rules, but through the protection of norms. In this case, the norm is that students should be able to endure suffering silently in pursuit of academic excellence because it builds resilience, as described by Hanna et al. (2022). This norm of silence around mental health is not neutral. In South Africa, where racial, historical and spiritual frames often shape discussions of psychological distress (Hirschowitz & Orkin, 1997). The university's failure to address mental health explicitly contributes to what Ahmed (2012) calls cultural erasure, where there is a systemic disregard of social meanings of suffering.

Perhaps one of the significant, sobering moments in the participant narratives was the mention of a suicide by a third-year pharmacy student, who, for those who knew the student or heard about it, the event was not just a personal tragedy, but a more profound structural critique:

> … when I was in my second year, there was a third-year pharmacy student who committed suicide. I'm pretty sure you heard about it; he hung himself. That was a shocker for me because I was like, I'm coming to third year now, you know, I mean, is that how it's going to be like, is it so much? UG4-2 (145-147)

Suicide in this context became what Cahill et al. (2023), within the field of relational anthropology, would term as a moral rupture/moral injury, an event that exposes the hidden cost of institutional life. It disrupts the norm and order, forcing reckoning with the social and emotional costs of academic pressure. However, participants suggested that the institution failed to properly mourn or address the implications of this event, reinforcing a culture of silence. From a systems perspective, such events should prompt policy implementation, enhance support structures and open dialogue;

however, the persistence of stigma and structural inertia often renders them invisible (Ahmed, 2012; Naidoo & Cartwright, 2018). As Padmanabhanunni (2020) argues, universities in South Africa still grapple with the layered traumas that students bring with them, including historical injustice, economic disadvantages and cultural silence around mental health, which elucidate the idea of suffering and increase the likelihood of further tragedies.

In contrast to the perceived indifference of the faculty, participants expressed a strong desire for peer-led support systems, noting that this could potentially provide invaluable emotional and practical guidance. The emphasis on peer mentorship reflects a sense of relational knowledge and collectivism, often absent in Western models of mental health care but deeply embedded in African philosophies of personhood (Amuyunzu-Nyamongo, 2013). Concepts like Ubuntu (*see* Section 2.2.2), which foreground interdependence and community care, offer a more culturally attuned framework for holistic student support. This affirms that healing and wellbeing are rarely individual journeys; instead, they are collective processes shaped by social networks, spiritual beliefs, and moral frameworks (Indigenous Services Canada et al., 2015).

5.1.1. Summary

In summary, this section's discussion highlights the multifaceted ways in which academic pressure affects student mental health. It showed how mental health distress can be a systemic misalignment between what students can handle and what is expected of them. Pharmacy education demands sustained cognitive, emotional expectations, and moral effort; however, current support structures seldom cater to the lived realities of students who face financial constraints, family expectations, and cultural silences surrounding mental health, as well as biomedical frameworks and culturally embedded needs. Drawing on the literature and anthropological perspectives, this section proposes reimagining mental health support structures that view mental health as a collective, institutional, and cultural responsibility, rather than an individual burden.

Pharmacy students are not just custodians of knowledge and medicines but whole persons navigating complex terrains of identity, care, responsibilities and professional expectations. Reimagining mental health support through this lens requires systemic change, aligning academic practices, relational culture and institutional policies with human wellbeing.

5.1.2. Implications and suggestions for practice

Curriculum-embedded wellbeing would be crucial in higher education spaces. This can be achieved by integrating reflective wellbeing modules and flexible assessment design to balance academic intensity with rest and recovery. Another avenue worth exploring is faculty development, which involves training staff in relational awareness

and the early identification of distress. This would be vital in emphasising human connection alongside academic prowess.

Additionally, institutional mentorship and peer circles grounded in the values of community and care would be vital in shaping robust peer support structures. As these structures shape up, they should be supported by compassionate, policy-driven responses, especially in the case of student death, to ensure postvention protocols that are rooted in open dialogue and collective healing.

5.2. SUPPORT-SEEKING BEHAVIOURS

Students' accounts revealed that a web of interlinked influences, such as mental health stigma, cultural nuance, race, gender dynamics and the social construction of masculinity, shaped decisions to seek or avoid support. These elements do not operate in isolation; instead, they intersect and reinforce one another, producing patterns of either engagement or avoidance regarding mental health services at Rhodes University. This aspect of the discussion will draw on literature from pharmacy practice and anthropology and apply it in the context of higher education to interpret and expand upon participants' accounts.

Several participants described a strong sense of comfort and trust when working with psychologists whose cultural and linguistic backgrounds align with their own. Their ability to converse in a shared language without needing to translate or modify expressions was particularly valued (*see* Section 4.3.2.3). These experiences strengthen perspectives from the research which emphasise the role of cultural frameworks in building therapeutic rapport (Fernando, 2014; Ngubane & De Gama, 2024). Language is more than a mere medium of communication. It carries cultural meanings, emotional norms and identity markers in cross-cultural psychiatry; the loss of meaning during translation can diminish the therapeutic value of the interaction (Dein, 1994; Kohrt et al., 2016).

From a pharmacy education standpoint, this resonates with the principle of patient-centred care. Effective communication in health care depends on understanding the patient's lived context, including language and cultural values (Majzub et al., 2010). The ability of the counsellor to relate to the student's worldview mirrors the importance of cultural competence in pharmacist-patient relationships, where miscommunication can affect adherence, trust and health outcomes (Irshan & Wahyuningsih, 2025).

For some participants, cultural background influenced the perception of mental health itself, often in ways that discouraged help-seeking. A Zimbabwean participant described how, in his Shona cultural context, attending therapy was associated with "*going mad*", creating a strong barrier to engagement: "… from how I was raised, you'll

be hearing like when they're talking about someone who had to go for therapy … he was going mad, so they had to go there." PG2 (95).

Even when such views had softened due to increased exposure to mental health awareness, the early socialisation left a lasting imprint on behaviour. This finding is consistent with studies that show how cultural narratives about mental health can persist across the lifespan, shaping attitudes long after individuals leave their original communities (A. Patel & Hall, 2021; Qambela, 2022).

Within pharmacy, these internalised beliefs may contribute to reluctance in both seeking care and discussing mental health with peers or faculty. The literature suggests that pharmacy students in many contexts hesitate to disclose mental health concerns due to the fear of being perceived as weak or incompetent (Frajerman et al., 2022; Nguyen et al., 2012). When these fears are reinforced by cultural stigma, the barriers become even stronger.

Another prominent theme in the findings was the influence of masculinity on help-seeking behaviour. Participants recounted being socialised from childhood to manage problems independently, avoiding displays of vulnerability and meeting cultural expectations of strength saying things such as "Nah, I'm a boy, so I'll be fine" and "…traditionally, any form of weakness would be frowned upon, like how can you do that as a man? … if you cry, then society will look down upon you" (*see Section 4.3.2.3*).

These accounts reflect broader observations that gender norms, particularly in African contexts, often position emotional restraint as a marker of masculine identity (Ratele, 2019). This discourages men from verbalising distress or seeking professional support, leading to "silent suffering" (Mfecane, 2018). This idea of silent suffering matches work written by Goffman (1963) on the idea of "passing" (i.e. attempting to appear *normal* and avoid detection of a stigmatised condition or phenomenon). In this case, male students actively masked distress in order to avoid being categorised as weak or unstable. Their avoidance of counselling, reluctance to report negative experiences and the tendency to deal with mental health alone demonstrate the extent to which stigma operates socially.

The connection between masculinity and mental health is also increasingly recognised in global health literature, which documents high rates of untreated mental illnesses amongst men and the greater likelihood of maladaptive coping strategies such as substance abuse (Seidler et al., 2016). For pharmacy students, this dynamic may have professional implications, as male-identifying students are less likely to seek help for themselves and may also be less inclined to encourage help-seeking among patients, particularly male patients, in their future practice.

Some participants described growing up in environments where prayer was considered the primary response to distress, and where speaking openly about mental health was discouraged: "… you don't cry, you need to be strong if you feel like this, just pray you don't need to talk, just talk to God you see." UG2-3 (155)"

In many African contexts, spirituality and religious practice form central pillars of coping, resilience and identity (Ngubane & De Gama, 2024). While such practices can offer valuable emotional support, they can delay or replace engagement with clinical services. Within the field of health, this underscores the need for culturally sensitive approaches that integrate rather than dismiss spiritual coping strategies, creating a bridge between biomedical and traditional world views (Gopalkrishnan, 2018). Another crucial thing to piece together is understanding the viewpoint of collectivism and how, borrowing from the fields of anthropology and sociology, we can better understand how we can cement cross-cultural and patient-oriented care within mental health support services, allowing us to develop Indigneous wellness frameworks that actually fit the patient's needs (Gopalkrishnan & Babacan, 2015).

One of the participants' recollections of a childhood filled with demanding chores, long school days, and minimal opportunity for rest illustrated how early experiences can normalise endurance and resilience, while discouraging emotional reflection (*see Section 4.4.3*). This aligns well with the concept of habitus described by Bordeaux in 1977 and formally explained by Harker (1984), where patterns of thought behaviour become ingrained through daily routines and activities. In this case, resilience is learned not through deliberate coping strategies but through necessity. While this may force the determination, it can also limit an individual's capacity to recognise when professional support is needed.

Another interesting point noted was the continued use of terms such as "crazy" to describe people with mental health illnesses, which was viewed as a source of stigma and alienation: "People think having the symptoms means you are crazy, they use words like crazy and all of that" (UG3-6). Derogatory labels reinforce social exclusion and discourage disclosure, which supports the findings from Southern African studies that document the enduring impact of stigmatising language on help-seeking behaviour (M. Campbell et al., 2017; Dlodlo & Moyo, 2022; Ngubane & De Gama, 2024).

For pharmacy students, such labels can create internalised stigma, affecting their confidence in seeking help and shaping their boundaries towards patients with mental illness in their professional roles (Turosak & Siwierka, 2021). However, in Zimbabwe, there is a longstanding description of concepts like "*kufungisisa*", which means "thinking too much", where it is viewed not only as a symptom of mental distress but also becomes a social diagnosis tied with deeper systemic issues like poverty and pressure (V. Patel et al., 1995). Recognising such culturally rooted expressions may help the university respond to mental health issues with more nuanced interventions

while combating stigma. As shown by a participant's expression, there is a need for mental health to be discussed openly and without shame: "… we need to take mental health seriously and we have to say it out loud without any shame … it's normal for someone to be in counselling every week." UG4-1 (101)

Such perspectives are crucial for change within higher education settings, as peer-led initiatives and visible role models have been shown to shift norms and encourage help-seeking. Documents such as the wellness strategy acknowledge stigma and propose peer-to-peer stigma reduction workshops, which the university has introduced through initiatives like SMASH and group therapy sessions, however, students reported little awareness of these initiatives (*see* *Section 4.3*). This suggests that addressing such issues in documents and policies does not always translate into effective student engagement. If peer-led initiatives are integrated within pharmacy educational spaces, embedding the values of collectivism and contextual relevance into the culture can produce graduates who are more resilient and empathetic as practitioners within the healthcare setting.

5.2.1. Summary

To close this theme, most of the barriers identified within this theme were cultural mismatch, stigma, gender norms, spiritual beliefs, and early socialisation, which interact in ways that are both cumulative and self-reinforcing, and male students from a culturally conservative background may face overlapping issues. Some key issues that arose were the fear of being judged, the belief that problems should be managed alone, a lack of culturally resonant providers and a social environment where stigma is normalised.

These concepts are key for pharmacy students to recognise and navigate these complexities in their wellbeing and patient care. These findings from this theme make it clear that more than individual choices shape support-seeking among pharmacy students. This is embedded in cultural narratives such as gender norms, spiritual practices, and legacies of early socialisation. These influences determine not only whether students seek help, but also how they experience the support they receive from Rhodes University and for pharmacy education more broadly. The challenge is to create mental health support systems that recognise and respond culturally to this complexity. Doing so will not only improve student wellbeing, but it can also prepare future pharmacy professionals who deliver care that is culturally attuned, stigma-free and rooted in empathy. These qualities are essential for effective healthcare delivery in a much more diverse society

5.2.2. Implications and suggestions for practice

Culturally responsive counselling is needed where extensive training is conducted for counsellors to familiarise them with the cultural idioms of distress. Additionally, there

could be a consolidation of the already existing men's wellbeing group therapy and adding queer group sessions to normalise and expand the dialogue on gender-inclusive support. There also remains room for integrating spirituality into wellness by developing partnerships with societies and organisations to bridge the biomedical and spiritual understandings of mental health.

5.3. SERVICE ACCESSIBILITY AND SUPPORT-SEEKING BARRIERS

Pharmacy students at Rhodes University encounter a complex combination of structural, relational, and cultural barriers in accessing mental health services. These challenges are not unique to Rhodes University; yet they carry significant weight in pharmacy education, where academic demands, professional identity formation, and the pressure to meet high standards create a uniquely intense environment for students.

A prominent structural barrier that participants described was the length of time between requesting support and receiving it; waiting lists and delayed responses were common, with some students reporting that they had to manage their mental health struggles alone by the time they were offered an appointment (see Section 4.3.2.2). Through an HPSR lens, these experiences highlight the barriers to the structural, cultural, and relational components of the support structure at Rhodes University.

While university documents, such as the WM and other guidelines, advertise a maximum two-week turnaround for counselling appointments, this does not align with the experience on the ground (*see Section 4.3.3.2)* Such delays are not merely logistical inconveniences but demonstrate a gap between policy and lived experience. They fundamentally undermine the effectiveness of support. Mental health interventions are most beneficial when provided in proximity to the onset or escalation of distress (Bantjes, Kessler, Hunt, et al., 2023)**.** If a student reaches out for help during a crisis but receives it only after the immediate emotional intensity has subsided, the service may feel redundant or irrelevant.

Research by Bantjes, Kessler, Hunt, et al. (2023) on student mental health in Southern Africa consistently shows that even when services are technically available, many students are unable to access them in a timely way. In the context of pharmacy students, these delays carry added risk given the overlap between peak academic deadlines and periods of mental strain.

One participant highlighted the frustration of navigating institutional processes during the COVID-19 pandemic: "… imagine like you've been like wanting to have like the appointment from first term only for you to get like the actual session towards the end of the year." UG4-3 (71) Such mismatches in timing are what create a gap between

expectation and delivery. Students expect the university as a community to respond urgently to their distress. When this does not happen, it fails to alleviate the problem and can erode the sense of belonging and trust that underpins the student-institution relationship.

Pharmacy education demands significant time, mental energy and emotional resilience. Students must manage extensive coursework, laboratory sessions, clinical placements, group work, and individual assignments. The cumulative effect is that they have what Davy & Young (2024) describe as “time poverty”, where they have limited time for wellbeing, coming at the cost of sleep health, leading to less flexibility to navigate lengthy or complicated support systems. Studies suggest that pharmacy students experience higher than average stress compared to other health disciplines, partly due to the volume of material they must master, and the performance expectations then placed upon them (Almanasef, 2021; Elnaem et al., 2022).

If counselling services require long waits or rigid scheduling, students may find it logistically impossible to engage, even if they want to. This highlights the growing importance of mental health first aid and peer-based early intervention approaches which emphasise immediate and accessible support at the point of distress rather than delayed specialist-oriented care. A notable event is the ‘ACTNow’ campaign that was launched in 2025 in the United Kingdom, which reflected the growing recognition within the profession that pharmacy students' mental health must be treated as a priority equal to academic performance (Dineshwori, 2025). This emphasis on readily accessible wellbeing resources echoes the frustrations voiced by participants in this study, suggesting that the problem is logical and global.

In addition to structural delays, students discussed their perceptions of counselling centre staff and the interpersonal dynamics of seeking help (*see* Section 4.3.2.2). Perceptions of judgment, whether based on personal experience or observed behaviour, can be deemed as powerful a deterrent as negative interactions. Literature emphasises that trust is a prerequisite for disclosure in any care setting (Fernando, 2014; Irshan & Wahyuningsih, 2025), without it, individuals may withhold important information, trivialise their struggles, or avoid engagement altogether**.** Pharmacy students are trained to project competence, reliability and emotional stability, which can make expressions of vulnerability very risky. If counselling staff are perceived as critical or unsympathetic, the perceived cost of disclosure increases even further.

Several participants in *Section 4.3.2.2* also reported that they understood the necessity of prioritising urgent cases, such as those involving suicidality. However, they also felt excluded when their needs were deprioritised without an alternative arrangement. From a clinical standpoint, triage systems are essential in resource-limited settings (Kellett, 2021); however, other research cautions that care is never purely technical, it is also relational and symbolic (Emmerich et al., 2015). A student who feels overlooked

may internalise the message that their struggles are unimportant, which can have lasting effects on their willingness to seek help in the future and their overall sense of inclusion within the university community.

Other participants noted that peer discussions in social media posts significantly shaped their views of the counselling centre: "… it's not helpful …", or "on social media and people always complain finding it hard to access these kind of services … it's disheartening" (*see* *Section 4.3.2.2*). These narratives can function as informal "reputation networks" for institutional services. If a service is widely described as slow and unhelpful, unfriendly, or inaccessible, this collective perception can deter individuals from even attempting to use it (Yang, 2023). Other studies suggest that peer-to-peer communication can be more influential than official messaging, especially amongst university students who rely on social media for both information and social connection (Pretorius et al., 2022). This then creates what we call a feedback loop in which negative experiences, once shared, reduce engagement, which in turn limits opportunities for the service to demonstrate improvement (Carreno, 2024). Thus, breaking this cycle requires proactive communication strategies that highlight positive outcomes and respond openly to criticism.

5.3.1. Summary

While most accounts highlighted barriers, some students described positive and timely experiences. Such cases are important because they demonstrate that spaces like the counselling centre can effectively meet student needs under certain conditions, such as flexible scheduling, consistent follow-up, and good alignment with academic timetables. These examples can be studied to identify transferable practices that could be applied more broadly. Therefore, taking together all the findings from the interlinked themes, accessibility for pharmacy students could include structural responsiveness, relational trust, and cultural perceptions under which students begin to experience timely appointments, minimal waiting lists, flexible scheduling, staff who actively build rapport and avoid behaviours that could be perceived as judgmental, peer narratives, and online discourse must be addressed directly to counteract deterrent effects and normalising mental health supportive spaces for students.

5.3.2. Implications and suggestions for practice

Structurally under-resourcing limits timely access to support. In the absence of greater resources being available, this introduces the need for operational reform by introducing a digital triage and booking system with a more flexible response time. This could be enhanced by aligning counselling availability with academic timetables, especially during assessment peaks.

The reform could incorporate feedback transparency by publishing quarterly satisfaction summaries to close the gap between policy and practice.

5.4. VISIBILITY, EXPERIENCES AND RELEVANCE OF MENTAL HEALTH SUPPORT STRUCTURES

Whilst key literature consistently points to the importance of accessible, culturally competent and well-resourced mental health services for students in higher education (Bantjes, Kessler, Hunt, et al., 2023; El-Den et al., 2020), the findings from this study revealed a complex picture of pharmacy students' awareness, perceptions and experiences of mental health support structures at Rhodes University. The participants' narratives suggested significant challenges in both visibility and delivery of these support services. This discussion section integrates the results with insights from the literature, considering the South African higher education context, to interpret the implications of these findings.

A recurring theme in the findings was the limited visibility of the counselling centre for some students. Awareness is a critical step in mental health engagement, and the absence of clear, consistent communication can significantly impede access. There was uncertainty about its location or even its existence. One participant reflected, "Eish, I don't think I know … I've never really seen what's like the institution or the building or what or where it is and everything" UG2-1 (27). Such limited awareness is concerning because pharmacy students operate within an environment where mental health challenges can escalate quickly due to academic and clinical demands and high-performance expectations, as previously discussed. This speaks to the symbolic visibility of support structures; their physical and communicative presence signals their relevance within the community, and if they are invisible, their perceived role in the social fabric is also weakened.

Even when communication was present, often in e-mail bulletins, students reported that messages were easily ignored or only noticed in times of need. This reinforces research findings by Naslund et al. (2020) which shows that the mode, timing, and perceived relevance of health communication are as important as the message itself.

Despite challenges in visibility, several participants shared positive experiences with the counselling centre, particularly when they could establish consistent relationships with the counsellor: "after leaving those sessions, you know I'd be feeling very elevated" UG1-2 *(see Section 4.3.2.5*). Accounts such as these underline the transformative potential of well-delivered psychological support and align with international evidence showing that the relationship quality between client and counsellor is one of the strongest predictors of therapeutic success (Wampold & Imel, 2015). For pharmacy students whose training is deeply relational and requires empathy with patients, collaboration with peers, trust, and clinical teams, these therapeutic

encounters may provide a vital model of supportive engagement that could carry over into professional practice.

The findings also revealed instances where students' trust in the counselling centre was compromised due to a lack of professionalism, lack of empathy or insufficient follow-up (*see* Section 4.3.2.5). Such encounters disrupt the therapeutic ritual in many cultural contexts. The act of seeking help is not merely functional but also symbolic, involving expectations of respect, attention, and care (Hardy et al., 2025). When these expectations are not met, the perceived legitimacy of the service can be undermined for the individual and their peer network. The effect is magnified in tight-knit student communities where word of mouth shapes collective perceptions.

Many participants perceived that the counselling centre was under-resourced and unable to meet demand, with reports of limited session allowances (six sessions), long waiting periods, and the small number of psychologists being common (*see* Section 4.3.2.5). The restriction to a finite number of sessions is problematic because chronic stress burnout and mental health disorders often require long-term interventions (Schlesselman et al., 2020). Within a health systems perspective, this reflects misalignment between service capacity and user needs, compounded by systemic underfunding of mental health at both national and institutional levels (National Department of Health, 2023).

5.4.1. Summary

A recurring frustration amongst participants was the lack of continuity of care due to staff turnover or inconsistent assignment of counsellors. This instability was contrasted with private services, where students experienced greater consistency and felt more secure in disclosing personal information. Such disruptions can be particularly harmful for pharmacy students, who may already face stigma when seeking help and therefore require sustained trust to engage fully.

Moreover, these findings also indicated that cultural fit and perceived relatability of counsellors influenced students' willingness to engage. One participant described the counsellor's assumption that her use of the term “panic attack” was casual, when in fact she had a diagnosed panic disorder. This reflects a lack of personalised inquiry, which could be addressed through training in culturally competent communication.

Within the sphere of pharmacy practice, the parallel is also clear: misinterpreting patient-reported symptoms without adequate exploration of risks can lead to misdiagnosis and ineffective care. The narratives of pharmacy students at the university paint a complex picture, where moments of transformative support coexist with experiences of neglect, under-resourcing, and misalignment between service provision and student needs. Addressing these challenges requires a multi-pronged approach, strengthening structural capacity and ensuring that services are culturally

resonant, relationally consistent, and contextually relevant. In doing so, universities can better support their students, particularly in this case, pharmacy students whose future roles in healthcare depend not only on their academic and clinical training, but also on their mental resilience and understanding of patient-centred care.

5.4.2. Implications and suggestions for practice

The findings suggest the need for a structure that has strategic visibility, which can be achieved by integrating mental health messaging into course portals, such as RU Connected, faculty orientation, and visible campus signage. To enhance the continuity of care, there could be an option to improve case-transfer protocols, as highlighted by some of the findings and prioritise counsellor consistency for long-term clients.

An additional means of improving the structure could be capacity expansion, where session allowances are increased for chronic cases through partnering with postgraduate psychology programmes and students. In doing so, room for narrative engagement becomes feasible, where student stories (with consent) can be used in campaigns to normalise help-seeking and humanise the support services offered by the university.

5.5. CAMPUS CLIMATE AND INSTITUTIONAL CULTURE

The findings from this theme revealed that the campus climate and institutional culture at Rhodes University play a central role in shaping pharmacy students' mental health experiences. The interplay between institutional norms, peer dynamics, and administrative decision-making influences how students perceive their wellbeing and access to support. This discussion interprets these findings by situating them within broader literature on higher education environments, mental health, and professional identity formation.

Campus climate refers not only to the physical and administrative infrastructure of the university, but also the unspoken rules, values, and interpersonal dynamics that frame student life (Strayhorn, 2018). Ruihua et al. (2025) suggests that wellbeing is dependent not only on access to professional services but also on fostering a supportive and empathetic campus culture. As previously discussed, the state of the campus climate can foster resilience or exacerbate struggles for pharmacy students who face unique academic and professional pressures. Participant narratives highlighted a dual reality: while Rhodes University promotes ideas of inclusivity and academic excellence, the students often encounter bureaucratic rigidity and a lack of responsiveness to mental health concerns: " … there's too much demand and they can't exactly supply enough people to help students out …" (*see Section 4.3.2.6*). This gap aligns with what (Chandler, 2025) describes as institutional dissonance, a

mismatch between lived realities and symbolic structures, which often results in disinvestment from existing institutional systems. Such inconsistencies erode trust in institutions. This erosion is particularly significant in healthcare, where patient engagement depends on the alignment between proclaimed values and actual practices.

Another prominent finding was that social connections among students were described as both a buffer against and a contributor to stress (*see Section 4.3.2.6*). For some participants, peer networks provided critical emotional support, while for others, competitive dynamics and stigma surrounding mental health discouraged help-seeking. This pattern is consistent with research showing that health professional students often internalise a culture of toughness, where seeking help is equated with weakness or incompetence (El-Den et al., 2020; Nguyen et al., 2012). Such tendencies reflect a broader cultural script that defines which forms of vulnerability are deemed acceptable within a given social group (Roch, 2017).

Several participants also described experiences where university responses to mental health concerns felt very procedural rather than person-oriented. For pharmacy students who are trained to think about holistic patient care, this lack of empathy is especially noticeable. The absence of a relational approach mirrors what happens when healthcare delivery becomes overly mechanised, neglecting the human connection that is the basis for effective care (Schlesselman et al., 2020) . Such responses, therefore, risk reinforcing a perception of the institution as a faceless bureaucracy, which can further alienate vulnerable students.

Participants also reflected on the power imbalance between students and staff, which students felt limited their ability to influence decisions affecting their wellbeing. Requests for changes, such as flexible deadlines or adjusted workloads during high-stress periods, were often perceived as being dismissed without serious consideration (*see Section 4.3.2.1*). Understanding and negotiating power dynamics is essential not only between pharmacists and patients but also within healthcare teams (Elnaem et al., 2022). This reflects the structural dimension of institutional culture, where hierarchies shape which voices are heard and which concerns are prioritised (Bourdieu, 1990).

The pharmacy programme's demanding curriculum is not just about technical knowledge; it also shapes students' professional identities. If the campus climate normalises, high stress, limited empathy, and procedural rigidity, these values risk being internalised as part of the student's professional worldview (West & Shanafelt, 2007). Conversely, a supportive campus environment models the kind of compassionate, flexible care that pharmacy graduates will be expected to deliver in practice. This insight connects directly to early literature on hidden curricula in health

professions education, where implicit lessons about values and behaviours are often more influential than formal teaching (Hafferty, 1998; Lempp & Seale, 2004).

The findings also suggested that institutional events, traditions and even architecture contribute to the symbolic climate of the university. While some rituals foster a sense of belonging, others may inadvertently reinforce exclusion. Some institutional systems, for example, formal ceremonies, may celebrate an academic achievement without acknowledging the mental health struggles that accompanied it. This type of selective visibility shapes how students interpret their place in the institutional narrative (Ahmed, 2012).

5.5.1. Summary

The campus climate and institutional culture at Rhodes University have a profound impact on pharmacy students' mental health experiences, shaping their perceptions of care agency and sense of belonging. These findings suggest that improving mental health outcomes for pharmacy students requires more than expanding counselling services. It demands an intentional shift in which the institution embodies its stated values in everyday interactions and decision-making. For pharmacy education specifically, the alignment between institutional culture and the professional values expected of graduates is critical. A culture that models empathy, responsiveness and inclusivity will not only support student wellbeing but also prepare future graduates to deliver care that is both clinically competent and person-centred.

5.5.2. Implications and suggestions for practice

To improve recognition of student voices, it may be advisable to introduce participatory governance, including student wellbeing representatives in faculty, faculty board, and senate decision-making. This would help integrate the student voice into the campus governance. Another suggestion is that of cultural modelling to introduce staff to student wellbeing dialogues, normalising the discussion to raise awareness of vulnerability. Lastly, creating communal spaces that become informal commons could help promote connection beyond academic hierarchies and formal setups.

5.6. INSTITUTIONAL RESPONSIVENESS AND NOTABLE MENTAL HEALTH EVENTS

The findings from this study illuminate complex experiences of students at Rhodes University during the COVID-19 pandemic, particularly in relation to how the institution responded towards mental health issues. The discussion situates these findings within conceptual frameworks outlined in the literature, drawing connections between pharmacy practice, anthropology, and broader public health discourses, highlighting

the significance of contextually relevant and culturally sensitive mental health support structures in higher education.

As previously discussed, pharmacy education sits at the intersection of clinical competency, academic intensity, and professional ethics, creating a high-pressure environment. The international literature highlights the elevated mental health risks pharmacy students face within this context (Elnaem et al., 2022; Fischbein & Bonfine, 2019; Shangraw et al., 2021; Silva & Figueiredo-Braga, 2018). These pressures were further compounded by the COVID-19 pandemic, which reshaped the forms and spaces through which mental health support was offered. Participants' accounts reveal how these changes were received and negotiated, with responses ranging from scepticism to acceptance of institutional responsiveness and initiatives.

Similarly, a significant finding was the introduction of what is colloquially called mental health benches following the COVID-19 pandemic-related student protests in May 2022 (*see Section 4.2.1.5*). This initiative emerged as a symbolic gesture of care on the part of the institutional higher authorities, yet its reception by the students was divided. Some participants saw the benches as the university's symbolic attempt to address mental health concerns, whilst others saw it as an insufficient response to deeper structural problems. The critical question, therefore, is not whether the benches exist, but how students interpret their presence and purpose.

A second-year participant expressed scepticism towards the initiative:

> So, upon arrival at Rhodes University, I was told … well informed about- the depression benches at Steve Biko that if you are maybe depressed or you're having a stressful day, just go to those depression benches. And to me, it was like, but oh, okay, me being in my room alone and I'm in a stressed state, I'm going to those benches, I'm still alone. It just takes me to a different space, but it does not solve the problem, right? UG2-2 (29)

Here, the critique is not of the bench itself, but of the assumption that physical relocation equates to emotional resolution. However, symbols of care, such as the benches, need to be embedded within relational and culturally resonant forms of support to be effective. This aligns with anthropological observations that emphasise care as a socially embedded practice rather than a purely spatial or symbolic intervention (Gopalkrishnan & Babacan, 2015).

Some students highlighted the gap between the severity of the crisis and the perceived inadequacy of the response. This highlights the tension between public health policies, symbolic measures, and the provision of substantive and sustained interventions. It reflects a mismatch between institutional action and student interpretations of care, revealing the importance of aligning interventions within the lived realities and expectations of the target community (Ahmed, 2012; Chandler, 2025). However, not

all participants dismissed the benches outright. One student found personal benefit in the space, albeit not in the intended therapeutic manner. This reflects the principle that meaning is not fixed by the designer of an intervention but is instead constructed by those who use it (Sekhon et al., 2017). The students' engagement with the benches as a space for a break in the fresh air reflects a potential avenue for reframing wellness initiatives in ways that incorporate environmental and sensory being alongside the traditional forms of counselling.

The pandemic also brought forth shifts in the way mental health support services were provided. Counselling services had to be moved online, which posed significant implications for the accessibility and the perceived efficacy of support. Participants expressed that the virtual format hindered the development of trust and relational connection with counsellors. This aligns with findings that telehealth, while valuable in maintaining continuity of care, can be less effective for building rapport, particularly for first-time clients (Wind et al., 2020). In this case, pharmacy students whose training is heavily relationship-based, both in academic and clinical contexts, found this lack of embodied presence especially detrimental. This illustrates how the sensory and spatial dimensions of human interaction, such as tone, posture, and shared physical environment, are integral to therapeutic relationships. It emphasises that mental health interventions for healthcare students must recognise the embodied nature of clinical and learning encounters.

Furthermore, the benches initiative and the shift to online counselling must also be interpreted against the broader institutional and policy landscape. As noted from document analysis, Rhodes University lacks a dedicated, comprehensive mental health policy, yet the Eastern Cape province has some of the highest rates of mental health distress amongst university students (Mutinta, 2022). This structural absence limits the sustainability and responsiveness of the support initiative.

Drawing on the HPSR framework (Gilson et al., 2012), the findings suggest that institutional responses have tended to be reactive and event-driven rather than proactive and embedded in policy. Symbolic gestures such as the placement of benches hold value only when integrated into a broader, coordinated strategy that includes strengthening human resources, reducing stigma, and enhancing cultural competence. Moreover, further analysis must consider the cultural narratives that shape how students seek and engage with support.

In Southern Africa, mental health stigma remains pervasive, often deterring students from accessing available services (Christinah et al., 2024; Ocansey & Sefotho, 2022). Participant accounts showed that even when services were available, the delivery, perceived cultural distance and lack of continuity reduced their value.

5.6.1. Summary

The experiences of pharmacy students during the pandemic revealed the interplay between institutional action, cultural nuances and individual needs. Symbolic gestures, such as mental health benches, carry meaning, but they risk being perceived as insufficient when not supported by systemic and culturally competent interventions. The shift to online counselling, while maintaining service delivery, disrupted the relational and bodily dimensions crucial to therapeutic success. These findings suggest that effective mental health support for students, particularly pharmacy students, must be relational, policy-driven, and contextually embedded.

5.6.2. Implications and suggestions for practice

Comprehensive policy development could help establish a university-wide mental health framework with clear roles, crisis protocols and evaluation metrics. Such implementation creates the potential to construct hybrid support to improve accessibility and relational depth. This could also help harmonise the pairing of physical wellness symbols (such as mental health benches) with embedded programs, such as peer mentorship.

5.7. OVERALL SUMMARY & INTEGRATIVE REFLECTION

Across all themes, the discussion demonstrates that student mental health is co-produced by institutional structures, cultural narratives and relational practices. Through the HPSR framework, anthropological insights and phenomenology, wellbeing emerges as interconnected rather than an individual attribute.

The convergence of document analysis and student accounts revealed a consistent gap between institutional goals and student experiences. On paper, Rhodes University positions wellness as an integral part of its academic mission. The findings indicate that these commitments are often undermined by limited awareness, uneven accessibility and insufficient resourcing of mental health services. The absence of a formal mental health policy or dedicated guideline further exposes institutional ambiguity around responsibility. This leaves students to navigate support systems that are fragmented and inconsistently implemented.

Student experiences illustrated the influence of social, cultural, and structural factors on their mental health and help-seeking behaviours. Cultural understandings of mental wellbeing, particularly the tension between African collectivist notions and Western individualist frameworks, shaped how students perceived and engaged with available support structures.

By situating these findings in the context of a historically white institution, it becomes clear that institutional culture, legacies of inequality, and structural underinvestment all intersect with individual experiences of stress and support. The discussion, therefore, not only reflects gaps in service provision but also highlights broader questions about equity, cultural responsiveness, and innovation in student mental health support.

Overall, the chapter emphasises that improving student mental health necessitates more than simply expanding service provision; it requires an institutional shift toward inclusivity, transparency, and responsiveness. Sustainable change depends on aligning institutional documents with lived experiences, valuing diverse student voices on wellbeing and cultivating an environment that normalises mental health support as an essential component of academic and personal development.

CHAPTER 6 - CONCLUSION, LIMITATIONS & RECOMMENDATIONS

6.1. OVERVIEW OF THE STUDY

This study investigated the lived experiences of pharmacy students regarding the mental health support structure at Rhodes University. Employing a constructivist interpretivist orientation and the HPSR framework, it combined document analysis and phenomenological interviews to uncover how mental health support is framed institutionally and experienced personally. The aim was to understand both the visible system, comprising policies, services and programs, and the invisible one formed by culture, relationships, and values.

Across five chapters, the study demonstrates that student mental health is shaped at the intersection of academic culture, social identity, and institutional design. The findings highlighted three broad realities. Firstly, academic pressure is a defining feature of pharmacy education and shapes how students perceive themselves (Elnaem et al., 2022). Secondly, barriers of visibility, accessibility, and stigma persist despite available services (Ahad et al., 2023; Turosak & Siwierka, 2021); and thirdly, that the institutional culture at Rhodes University remains ambiguous about vulnerability and wellness.

These insights reveal that the pharmacy education environment both reflects and produces broader social narratives about academic achievement, mental health ideologies, and mental health support. Understanding how these dynamics operate is essential for designing support systems that are responsive and culturally grounded.

6.1.1. Integrating pharmacy practice with anthropology

Within pharmacy practice, mental health is often approached through clinical care and pharmacological management. This study broadened that focus by showing that student wellbeing is also an ethical and relational matter. Pharmacy students' accounts revealed that professional formation occurs not only through knowledge acquisition, but also through learning how to provide care for themselves, peers, and patients. From anthropology, the study drew on the notion that health and illness are socially constructed and culturally mediated. Together, these fields enabled a holistic view of mental health, encompassing both biological and socio-cultural aspects.

A lens of anthropology further hints at how institutional rituals such as examinations, work-based learning, and continuous assessments shape help-seeking behaviours (Bheekie & Huyssteen Van, 2017; Fischbein & Bonfine, 2019). Students often perceive academic success as a moral signal of worth. A purely biomedical reading of stress cannot capture that complexity. An anthropological one situates stress within systems of meaning and culture.

Therefore, the integration between pharmacy and anthropology contributed to a much more comprehensive understanding of mental health and wellbeing. It recognised that mental health is a biomedical matter and it is also a product of cultural and social interpretation, institutional power and belonging.

6.1.2. Synthesis of key findings

6.1.2.1. Academic pressure and identity

Participants consistently linked academic intensity with anxiety and self-doubt. Many felt that success required constant performance, which produced exhaustion and a fear of failure, the culture of productivity often eclipsed attention to rest and reflection. This performance-driven environment often reinforced feelings of inadequacy and isolation, which in turn affected confidence and identity formation as emerging professionals (Shangraw et al., 2021; Sullivan & Ryba, 2020).

6.1.2.2. Support-seeking behaviours

Students employed a mix of coping strategies like counselling, faith, family, friends, exercise, and digital communities. However, help-seeking was filtered through stigma and perceived expectations of professionalism. Some feared that disclosing distress would compromise their image as future pharmacists. This internalised pressure is reflected in institutional dissonance, where vulnerability and mental health challenges are concerned. (Chandler, 2025)

6.1.2.3. Accessibility and institutional response

While the counselling centre and the SMASH programme exist, students describe long waiting times, limited staff, and uncertainty about procedures. Many did not know where to start, and those who accessed support valued it but wished for follow-up and continuity. The findings suggest that although structures exist, their fragmented nature reduces thei5r effectiveness. (Ahmed, 2012)

6.1.2.4. Cultural and social recognition

Students from diverse cultural backgrounds highlighted that institutional approaches often reflect Western therapeutic models that overlook spiritual and community-based concepts of Wellness. Participants from African and non-Western backgrounds felt that their own understandings of healing, which are centred on spirituality, family, and collective care, were seldom acknowledged in available services. This limited cultural inclusivity undermines the relevance and accessibility of mental health support for many students (Mental Health Literacy Organization, 2021; Subudhi, 2014).

6.1.2.5. Institutional climate

The broader institutional culture was described as one that celebrates resilience yet discourages open discussions about distress. Students noted that vulnerability was often interpreted as weakness, leading them to depend heavily on peer networks for emotional support. Informal and indirect spaces of care, such as friendship circles, mentorships, and study groups, thus became essential in maintaining wellbeing, where formal and direct structures proved insufficient.

6.1.2.6. Overall conclusion

This research concludes that mental health support at Rhodes University is fragmented rather than integrated. Pharmacy students navigate these fragments through creativity and perseverance, but the responsibility for coping remains largely individualised. A truly supportive environment would distribute that responsibility across the institution, embedding care within teaching, assessment and policy. Mental health as experienced by these students is both a clinical issue and a cultural narrative about belonging and worth. Addressing it requires not only services but shifts in institutional ethos. The study, therefore, affirms that adequate support must be structurally coherent, culturally sensitive and ethically grounded.

6.2. CONTEXT AND SCOPE

The research centred on a single institution in the Eastern Cape and focused exclusively on pharmacy students. This narrow scope enabled depth but restricts broader generalisation. Mental health experiences vary across faculties with different workloads, gender ratios, and racial dynamics. The study provides insight rather than universality. Comparative multi-site research could test whether similar patterns occur elsewhere in South Africa.

Considering the sample context and representation, twenty students across all academic levels produced rich qualitative data. However, the number remains modest compared to the total number of pharmacy students. Certain groups, such as international students, those studying part-time or students with disabilities and queer students, may have felt underrepresented. Since recruitment relied on voluntary participation, the sample may lean towards students who are already interested in mental health issues, leaving silent the ones who avoid the topic entirely.

Additionally, the fieldwork took place two years after the COVID-19 pandemic restrictions were legally lifted and thus represents a period of adaptation during which campus routines normalised, suggesting a shift in perceptions of stress and access to support. Thus, the data represented a transitional phase rather than a steady state.

In terms of data and document access, institutional transparency posed another limitation. Several internal documents, including those on staff training, budget allocations, and counselling statistics, were not accessible. Consequently, the document analysis reflects what students, and the public can see rather than a deeply detailed administrative landscape. This partial visibility mirrors the problem itself, which is the opacity of mental health governance.

Furthermore, interviews were conducted in English, and for multilingual participants, translation from their mother tongues may have reduced the emotional nuance of their expressions. Some concepts of distress or healing in isiXhosa, chiShona, isiNdebele and isiZulu carry meanings that resist direct translation. Anthropological sensitivity to these linguistic textures is vital for future research.

6.3. IMPLICATIONS FOR KNOWLEDGE

This study reshapes the understanding of mental health within the context of pharmacy education. Pharmacy curricula often emphasise pharmacology, pathophysiology, and clinical reasoning while treating the wellbeing of students as peripheral. Yet, the data reveal that emotional resilience, empathy, and self-awareness are crucial to professional competence, alongside clinical skills.

A central implication is that caring for oneself is foundational to caring for others, a unique feature that we find in the principles of Ubuntu section. Students who experience compassionate mentorship are more likely to transfer that empathy to patient care. The research, therefore, encourages pharmacy students and faculty to embed structured reflection, peer dialogue, mental health literacy, and mental health first aid within core courses, rather than in elective workshops (Frick et al., 2021; McCormack et al., 2018; Pham et al., 2022). This integration aligns with professional ethics, ensuring that future pharmacists recognise mental health as part of holistic care, rather than as a separate domain (International Pharmaceutical Federation (FIP), 2022b, 2022a; Rubio-Valera et al., 2014).

Faculty members act as role models; their openness about stress management can challenge stigma and institutional commitment to wellbeing, thereby becoming a teaching tool that shapes the next generation of healthcare professionals.

Anthropologically, the research contributes to the growing field of the anthropology of mental health. It demonstrates that institutions are cultural systems that express values through architecture, policy and ritual (Drake, 2015; Kohrt et al., 2016). The counselling centre, for instance, functions not only as a service, but also as a symbol of how care is envisioned. When access is restricted or communication is unclear, students interpret that as a moral statement about whose distress matters and why.

The findings extend debates on health pluralism, how participants blended biomedical, spiritual, and social explanations of distress. Some used prayer, nature, or community service as coping mechanisms alongside counselling or medication. These hybrid practices highlight the coexistence of diverse epistemologies of healing. This then highlights the need to examine how institutions balance Western therapeutic norms with local understandings of mental health.

Students feared that seeking help could label them as weak, particularly in competitive academic spaces that have historically been shaped by colonial ideas of discipline and endurance (van Staden, 2024; Williams, 2006). The study reveals that such fears are socially produced rather than individual shortcomings. The convergence, then, of pharmacy and anthropology offers a methodological contribution to qualitative health research.

By pairing HPSR with phenomenology, the study demonstrated how policy analysis and lived experience can be read together. This dual lens exposes the disjunction between institutional discourse and student reality. It also advances theory on institutional culture as a determinant of health. Universities, similar to hospitals, are systems of care whose organisation affects mental wellbeing, recognising them as such invites cross-disciplinary collaboration between pharmacists, psychologists, anthropologists, and educators to design interventions grounded in both evidence and empathy.

6.4. RECOMMENDATIONS

There is a need to develop a comprehensive mental health policy. The absence of a coherent policy at Rhodes University perpetuates fragmentation. A dedicated policy should be formulated which outlines prevention, intervention, and follow-up procedures with clear lines of accountability. Policy development should involve participatory consultation with students and staff to ensure it reflects diverse cultural understandings of wellbeing. A mental health coordination office under the Division of Student Services could unify counselling, healthcare, resident support, and faculty initiatives. Centralised data collection on utilisation, satisfaction, and outcomes could allow evidence-based planning.

Within the Faculty of Pharmacy, there should be embedded seminars and Wellness Days on topics such as emotional resilience, ethics of care, mental health first aid, and interprofessional teamwork. Linking these sessions to pharmacotherapy modules can illustrate the human context of medication use and mental illness treatment. Additionally, staff development programs offering annual training on recognising distress, active listening, and referral pathways could equip lecturers to identify and refer students in distress, fostering a culture of understanding and empathy.

Establishing student wellness ambassadors within each year group, training them in basic listening and referral skills, encouraging peer solidarity, and early detection of crises could also improve student support. Lastly, Faculty Wellness days and mobile counselling services, such as those already existing on campus (like the peer educators' First Things First campaign week, which occurs every term on campus[26]), can bring services closer to students and reduce stigma.

Moreover, there is a need to align institutional strategies with national policy. University-level initiatives should align with the national mental health policy framework and strategic plan (2023-2030) to ensure consistency and accountability (National Department of Health, 2023). Partnerships with community-based healers, chaplains and cultural practitioners could extend the reach and relevance of support services (Gwala, 2021). Hosting intercultural dialogues and story-sharing events where students share their mental health experiences without fear of stigma, promoting the visibility of diverse voices that can transform vulnerability into collective strength, as seen with the Meqoqo Playback Theatre Collective and the Rhodes University drama staff[27]. Collaborative efforts, such as this one, could even give rise to a South African consortium for student mental health, sharing research, training modules, and crisis management protocols that could advance mental health support in higher education institutions. Joint efforts towards support could reduce duplication and strengthen advocacy for funding

For future research, multi-campus studies must be done, which could reveal structural patterns and region-specific challenges. Also, tracking cohorts from their first year to graduation would clarify how mental health trajectories evolve and which interventions sustain wellbeing over time. Moreover, co-designing mental health initiatives with students and staff could translate findings into practice while empowering participants. Within the realm of digital health innovations, there is potential to explore mobile applications, teleconsulting, and online peer networks as tools for expanding access in resource-limited settings, such as the Eastern Cape. An in-depth ethnography could map how spatial arrangements, language, and symbols within the university influence feelings of safety or exclusion

6.5. FINAL REFLECTIONS

Conducting this study required sustained reflexivity. Engaging with peers about their distress was both intellectually illuminating and emotionally demanding. It reinforced that research itself is a social encounter shaped by empathy, trust, and shared

[26] A webpage describing the full scope and role of peer educators at Rhodes University: https://www.ru.ac.za/latestnews/peer_educators.html

[27] An intervention of healing through theatre to mark suicide prevention day at Rhodes, done by Meqoqo collective: https://www.ru.ac.za/latestnews/suicidepreventionmonth-1.html

vulnerability. Through listening to participants' stories, the researcher came to appreciate that data are lived realities carrying weight beyond analysis.

A core insight from this journey is that care cannot be confined to clinical spaces; it is distributed across various settings, including corridors, lecture halls, and digital forums, where students support one another. These micro-practices of care, like checking in on a classmate, sharing study notes, or sending a message of encouragement, constitute an informal mental health infrastructure that deserves recognition. Universities, as hubs of learning, should foster environments that allow such care to flourish. Doing so redefines academic excellence as the capacity to learn with others rather than at their expense. This understanding resonates with Pharmacy ethics, which emphasise service to humanity, and anthropological tenets which view healing as a social act.

The findings also suggest that institutional transformation in post-apartheid South Africa must expand beyond policy reform to social justice. Creating equitable learning environments involves addressing psychological safety and belonging, particularly when students feel unseen or overburdened. Historical inequities are produced in new forms, and mental health initiatives therefore become part of the broader project of decolonising higher education. Further research has affirmed that vulnerability and scholarship can coexist. For the researcher, writing about mental health demanded honesty and personal experience while maintaining analytical discipline. It demonstrated that academic inquiry can itself be a healing act, generating knowledge that speaks to both intellect and humanity.

Looking forward, the study envisions Rhodes University and other South African universities as communities where wellbeing is woven into the fabric of teaching, research and social life. A future where counselling services are visible, stigma is challenged and mental health is treated as a shared concern is attainable if institutions listen carefully to student voices and act with consistency and compassion.

In closing, this research ultimately aimed to explore the question of support structures but ultimately shed light on a deeper question: what it means to belong in an academic community. Pharmacy students at Rhodes University navigate demanding paths with resilience and creativity, yet they continue to seek affirmation that their struggles are recognised. Their narratives invite universities to move from reactive service provision to proactive cultures of care. In bridging pharmacy practice and anthropology, the study demonstrates that wellbeing is both a clinical condition and a cultural relation. It calls for ethics of care that values emotional life as integral to learning. In doing so, it offers a modest but hopeful contribution to reimagining higher education as a space where knowledge and compassion can co-exist.

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APPENDICES

APPENDIX A

INTERVIEW SCHEDULE:

Sample of Questions and Prompts for the Research.

1. **What is your year of study, and how long have you been at Rhodes University?**

- To gauge their familiarity with Rhodes University and if that has played any role in their understanding of the mental support structure at Rhodes University.

2. **What does mental health mean to you?**
   Prompt: What is meant by the term "mental health"?
   Use probes for information on the following aspects:
   - Meaning of mental health
   - Understanding lived experiences of mental health or mental health illnesses should they disclose

3. **Could you please tell me about the mental health support structures offered by Rhodes University that you know?**

4. **Could you please share your personal experiences with the mental health support structure offered by Rhodes University if you have used it? If not, please share why.**
   Prompt: Can you please tell me how you identified the services and obtained information on them?
   Use probes for information on the following aspects:
   - What do you think led you to seek the services?
   - Which services did you use and why? If you have not, why
   - How was that experience?

   Prompt: Kindly elaborate on how you felt while navigating the whole experience.
   Use probes for information on the following aspects:
   - Cultural fitness
   - Contextual relevance
   - How did the experience leave you feeling?

RHODES UNIVERSITY
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APPENDIX B

PARTICIPANT INVITATION LETTER

Project Title: Pharmacy Students Lived Experience of the Mental Health Support Structure at Rhodes University.

Summary

Nqobani Mathew Dabengwa, an M.Pharm student from the Faculty of Pharmacy at Rhodes University, has received ethical clearance [2024-8031-9040] to conduct a study on exploring the mental health support structure at Rhodes University and Pharmacy students' lived experiences. The aim of this study is to explore and understand the mental health support structures available to pharmacy students at Rhodes University, along with their lived experiences and perceptions of these services. The study seeks to identify the types of mental health support services offered, evaluate their accessibility and effectiveness, and uncover any barriers that students might face in utilising these resources. Additionally, the research aims to gather insights into the overall satisfaction levels of students with the mental health support provided and to identify areas for improvement.

Benefit to participants

Participants in this study will contribute to a deeper understanding of the mental health support structures available to pharmacy students at Rhodes University. By sharing their experiences and perspectives, participants will help shape future policies and services that could lead to more effective and accessible mental health resources for themselves and their peers. Additionally, participants may find personal benefit in discussing their mental health experiences in a supportive, confidential setting, which can be therapeutic and empowering.

Your participation

Participants will be asked to engage in a semi-structured interview lasting approximately 60 minutes. During the interview, they will be asked to share their experiences with and perceptions of the mental health support services at Rhodes University. They will also be required to sign an informed consent form, ensuring they understand the study's purpose, procedures, and their rights as participants, including the right to withdraw from the study at any time without penalty. The nature of this research might be very personal or triggering to some people; hence, a provision is made to have a psychologist on call from the counselling centre and a volunteer

psychiatrist. Participants' confidentiality will be strictly maintained, with all personal identifiers removed from the data.

How to become a participant

1. You must be at least 18 years of age and registered at Rhodes University for either a BPharm degree or a Pharmacy related postgraduate degree (MPharm, MSc, PhD)
2. Respond to this email

Afterwards, a separate consent form will be provided to you, and once you have signed the consent form, you will be a participant in the study.

If you require further information, please contact Nqobani Mathew Dabengwa (g19d1235@campus.ru.ac.za), the researcher, Prof. Sue Burton (s.burton@ru.ac.za), the research supervisor, Dr Shabnam Shaik (s.shaik@ru.ac.za) the co-supervisor or the Rhodes University Human Research Ethics Committee (see details below)

Rhodes University, Research Office, Ethical Review
Ethics Coordinator: ethics-commitee@ru.ac.za
t: +27 (0) 46 603 7314
Room 204, Main Admin Building, Drostdy Road, Makhanda, 6139

APPENDIX C

PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participant/s)

Project Title: Pharmacy Students Lived Experience of the Mental Health Support Structure at Rhodes University.

Nqobani Mathew Dabengwa from the Department of Pharmacy Practice in the Faculty of Pharmacy at Rhodes University has requested my permission to participate in the above-mentioned research project.
The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The research project aims to explore the mental health support structures available to pharmacy students at Rhodes University, focusing on their experiences and perceptions of it.
2. Rhodes University has given ethical clearance to this research project ***(Ethics Approval Number: 2024-8031-9040),*** and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za)
3. By participating in this research project, I will contribute to a deeper understanding of the mental health support structures available to pharmacy students at Rhodes University. By sharing my experiences and perspectives, I will help shape future policies and services that could lead to more effective and accessible mental health resources for myself and my peers.
4. I will participate in the project by fully sharing my experiences and/or perceptions of the mental health support services as a pharmacy student at Rhodes University in a semi-structured interview that will be recorded.
5. My participation is entirely voluntary, and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.
6. I understand that I have the right to refuse to respond to any question that I would prefer not to answer.
7. I will not be compensated for participating in the research.
8. The risks associated with my participation are minimal but may include emotional discomfort when discussing personal mental health experiences. I may feel stressed or upset when recalling challenging or sensitive situations. However, the research team will provide support resources and ensure a respectful and confidential environment throughout the study, which I can utilise if that happens.

9. The Researcher intends to publish the research results in academic journals specialising in healthcare, education, or mental health. The results could also be presented at relevant conferences or seminars attended by professionals and researchers in appropriate fields. Before publication, the data will be analysed, and findings will be interpreted per the study's objectives. However, confidentiality and anonymity of records will be maintained, and my name and identity will not be revealed to anyone who has not been involved in conducting this research.
10. Regarding the Protection of Personal Information Act (No. 4 of 2013), it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity of the data I provide will be achieved. I may also ask to know exactly how my personal information will be stored securely and for how long it will be stored.
11. Data collected from me for this research project will not be used for any further study. If any data collected from me for this research project is to be used by the Researcher for any further study, I am to be informed in writing, and my written consent must be requested again. I need not consent to the new research if it is incompatible with the initial purpose of the present study (POPIA, s15(3)). Equally, I can simply reject the request. In such cases, a formal request needs to be made to me by the researcher via the Ethics Coordinator (ethics-committee@ru.ac.za).
12. In terms of the POPI Act, I possess the right to receive feedback about this research. This will take the form of a presentation where the researcher will present the findings to a broader audience, including stakeholders interested in enhancing mental health support at Rhodes University. Confidentiality and respect for participants' privacy will be strictly maintained throughout this feedback unless ***I elect not to receive this feedback.***
13. Any further questions that I might have regarding the nature of the research and/or my participation in it will be answered by the principal researcher, Nqobani Dabengwa (g19d1235@campus.ru.ac.za)
14. I am not waiving any legal claims, rights, or remedies by signing this informed consent declaration. A copy of this informed consent declaration will be given to me, and the researcher will keep the original on record.
15. I ***agree*** to the Researcher’s use of voice recording of my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views/responses. Furthermore, I have the right to request a copy of the interview transcriptions to confirm that my opinions are accurately recorded

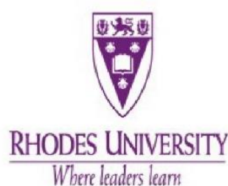
I, …………………………in my year……of studying BPharm / MPharm / MSc / PhD, have read the above information / confirm that the above information has been

explained to me in a language that I understand, and I am aware of this document's contents. I have asked all questions that I wished to ask, and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressured in any way, and I voluntarily agree to participate in the above-mentioned project.

………………………………….	…………………………	…………………………..
Participant's signature	**Witness**	**Date**

APPENDIX D



Rhodes University Human Research Ethics Committee
Room 8 & 24 Truro House, St Peters Campus
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t: +27 (0) 46 603 7314 & 8073
e: ethics-committee@ru.ac.za
https://www.ru.ac.za/researchgateway/ethics
NHREC Registration number:RC-241114-045

26 August 2025

Mr Nqobani Dabengwa

Email: g19d1235@campus.ru.ac.za

Review Reference: 2025-8031-10250

Dear Mr Dabengwa,

Re: Human Ethics Renewal Application: Pharmacy Students' Lived Experience of the Mental Health Support Structures at Rhodes University.

Researcher: Mr Nqobani Dabengwa

Supervisor(s): Dr Shabnam Shaik, Prof Sue Burton

Thank you for informing us about the closure of your project. This letter confirms that the above Annual Report has been reviewed and approved.

Sincerely,

Janet Hayward

Dr Janet Hayward

Chair: Rhodes University Human Research Ethics Committee, RU-HREC

cc: Ethics Coordinator

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APPENDIX E

Coding Scheme Informed by HPSR

This coding scheme was developed by adapting the conceptual elements from the theoretical framework and aligning them with the aims of the research. Focusing on the anthropological concepts, phenomenology and the HPSR terrain described by Gilson et al. (2012) all of which are explained in chapter three. It focused on the integrated direct institutional structures (“hardware”), underlying cultural and social logics (“software”) to explore how mental health is supported, managed, and lived within the university context.

Code Name	Focus Area	Link to Theoretical Framework
Institutional and direct Support	Direct infrastructure, services, and policy structures designed to support mental health	Reflects HPSR’s "hardware" focus; anthropologically seen as the built environment and organisational logic that governs wellbeing
Access to services	The way services are accessed or limited through documentation, hierarchical approval, and formal protocols	Connects to health policy instruments in HPSR; anthropological attention to institutional power, barriers and procedural burden
Institutional response to mental health	Immediate institutional responses to acute and global mental health events (e.g. COVID-19, Campus protests, historical trauma)	Aligns with HPSR system performance under stress; phenomenologically related to student experience of trauma and institutional response
Cultural & Social Recognition	Inclusion (or exclusion) of religious, cultural, or community-based mental health understandings in support structures	Represents software in HPSR; anthropological focus on cultural tonality, identity recognition and social support in institutional space
Academic support and student integration	Support for reintegration into academic life following mental health leave or disruption	Reflects gaps in policy continuity in HPSR

Institutional Narratives & Messaging	How student wellbeing is framed rhetorically in official communication	Aligns with policy discourse in HPSR
Mental Health Visibility & Prioritisation	The degree to which mental health is recognised as a strategic goal or funded priority	Shows agenda-setting and silences in HPSR; phenomenology highlights absence as a lived tension and institutional neglect as an embodied gap

APPENDIX F

PARTICIPANT REVIEW LETTERS[28]

MEMBER ONE

Reading through the findings and discussion, I found myself reflecting a lot on my own time at Rhodes University and how accurately this research captures the atmosphere students often find themselves in. It doesn't just describe surface-level problems, it touches on the emotional and structural layers that shape everyday student life. The discussion about how campus culture influences wellbeing felt particularly real. It reminded me how the environment can make you feel both proud to belong and deeply frustrated at the same time. There's this ongoing tension between the image the university projects, inclusive, caring, academically excellent and the reality of how students sometimes have to fight to be heard or supported.

What stood out to me most was how clearly the study shows that mental health on campus isn't just about access to counselling. It's about how the whole system, the people, policies, traditions, and values either helps or hurts students' ability to cope. I've seen that gap between symbolic care and genuine responsiveness myself. Things like the mental health benches are nice in theory, but when the bigger structures don't shift, it feels like the university is addressing symptoms rather than causes. That sense of disconnection between words and actions is exhausting, and I think the study captured that really well.

I also related strongly to how the research described peer dynamics. The people around you can be your biggest support, but they can also be your biggest source of stress. Especially in pharmacy, where everyone is under constant pressure, competition becomes part of the culture whether you want it to or not. There's an unspoken rule that you just have to push through, even when you're not okay. I've felt that personally, and it can make it really hard to be honest about how you're doing. Seeing that reflected in the findings made me feel understood, like someone had finally put words to experiences many of us never articulate out loud.

Another part that resonated was the discussion about online counselling and the sense of disconnection during COVID-19. It was such a strange time — everyone struggling quietly behind screens, trying to stay functional. Counselling helped some people, but for many, it lost that human element that's so essential for real support. The research doesn't just point that out; it recognises that emotional support is relational and embodied, it's about connection, not just service delivery. That distinction really

[28] The participants all consented to the disclosure of their identities; however, the use of unique identifiers ensures that their actual identities remain anonymous and cannot be traced back to them.

matters, especially for students in healthcare, where empathy and presence are part of what we're being trained to value.

What I appreciated most is that the discussion didn't fall into the trap of blaming either students or staff. Instead, it paints a realistic picture of a system that's trying but often falls short — not because people don't care, but because the structures in place aren't built to respond flexibly or compassionately. I think many of us have felt that frustration of being met with procedure instead of understanding. It's not that the university is cold-hearted, but that the way it's organised often makes it hard for care to feel human.

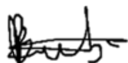
For me, this research highlights an important truth: real wellbeing in a university setting can't be achieved through isolated programmes or symbolic gestures. It requires a culture that consistently values empathy, responsiveness, and inclusivity in the same way it values academic achievement. When the institution models that kind of care, students internalise it and it shapes the kind of professionals they become.

Overall, reading this discussion made me feel seen. It captured the quiet struggles, the contradictions, and the resilience that define what it's like to study in a demanding programme at a university still finding its balance between tradition and transformation. It also reminded me that while change can be slow, conversations like these are where it starts by naming what hasn't been working, and imagining what a more genuinely caring institution could look like.

I, Brendon P Dube, have reviewed Chapters 4 and 5 of Nqobani Mathew Dabengwa's research report on Pharmacy students' lived experiences and perceptions of the mental health support structure at Rhodes University.

I confirm that the content and interpretations presented accurately reflect my views and responses as a participant. I find the analysis to be a true and fair representation of my input.

Signature:



Date: 31 October 2025

MEMBER TWO

I, Charles Arineitwe, have reviewed Chapters 4 and 5 of Nqobani Mathew Dabengwa's research report on Pharmacy students' lived experiences and perceptions of the mental health support structure at Rhodes University.

I confirm that the contents and interpretations presented accurately reflect my views and responses as a participant. I find the analysis to be a true and fair representation of my input and has well been interlinked with the researcher's topic of study.

I believe the work provides meaningful insights into the topic and is well-articulated. I also think that this study, and further wider studies are crucial in shaping and implementing policy framework changes pertaining to mental health at Rhodes University, and more specially in the faculty of pharmacy as this is the training faculty for todays and future health care givers whose role and purpose is to ensure that patient centred care is realized in South Africa.

Moreover, we are now living in a dynamic health setting where matters of mental health are taking centre stage due to the evolving socio-economic factors, among others, which then requires one's mental health to be in check due to the numerous increasing daily demands that might affect one's mental health. Now, more than ever before, academics need to adapt and find ways to deliver their courses to students (pharmacy students in this instance) empathetically and wholly in that they pay attention to mental readiness and coping of their students to ensure that students' mental health is not jeopardized in their journey to attain the pharmacy degree qualification. Wholly and empathetic graduates, who are in close touch with their mental health wellness will embody the same in the workplace, producing a dignified and impactful profession of pharmacy.

Signature:

Date: 2025/10/31

MEMBER THREE

I, Munyaradzi Chiwundura, have reviewed Chapters 4 and 5 of Nqobani Mathew Dabengwa's research report titled "Pharmacy students' lived experiences and perceptions of the mental health support structure at Rhodes University."

I confirm that the content and interpretations presented accurately reflect my views and responses as a participant. I find the analysis to be a fair and balanced representation of my input.

I believe the work offers valuable insights into the realities faced by students regarding mental health support and effectively captures the complex relationship between institutional structures, cultural context, and student wellbeing. It is a thoughtful and authentic representation of our shared experiences.

Signature:

Date: 03/11/2025