LIST OF ACRONYMS USED IN THE STUDY

AH	Academic Hospital
AKU	Aga Khan University
ANC	African National Congress
CEO	Chief Executive Officer
CGFNS	Commission on Graduates of foreign Nursing Schools
COSATU	Confederation of South Africa Trade Unions
CV	Curriculum vitae
DENOSA	Democratic Nurses Organization of South Africa
DHS	District Health Service
DHs	District Hospitals
DHA	District hospital A
DHB	District hospital B
DHC	District hospital C
DOH	Department of Health
DPSA	Department of Public Service and Administration
ENA	Enrolled Nursing Assistants
EN	Enrolled Nurses
ENPF	Extended Nurse Prescribers' Formulary
GST	General System's Theory
HC	Hospital Comparison
HCS	Health Care Services
HPCSA	Health Professions Council of South Africa
HSU	Health Services Union
ICN	International Council of Nurses
ICU	Intensive Care Unit
IDASA	Institute of a Democratic Alternative in South Africa
ILO	International Labour Office
IT	Information Technology

IVF	Invitro Implantation
LRA	Labor Relations Act
MEC	Member of the Executive Committee
MMed	Master of Medicine
MOH	Minister of Health
MOU	Memorandum of understanding
NGOs	Non-governmental organizations
NHP	National Health Plan
NHS	National Health Service
NMC	Nursing and Midwifery Council
NSMs	Nursing Service Managers
OEP	Overseas Exchange programme
ONA	Overseas Nursing Association
OSD	Occupational Specific Dispensation
OSHA	Occupational Safety and Health Administration (OSHA)
PA	Physician's Assistants
PH	Private Hospitals
PHs	Private Hospitals
PFMA	Public Financial Management Act
PHC	Primary Health Care
PHSD	Public Health Service Delivery
PHSDSBC	Public Health and Social Development Sectoral Bargaining Council
PHs	Private Hospitals
PHS	Public Health Sector
PHWSBC	Public Health Welfare Sectoral Bargaining Council
PSCBC	Public Service Co-ordinating Bargaining Council
PSI	Public Services International
RCN	Royal College of Nurses
RDP	Reconstruction and Development program
RH	Regional Hospital
RNs	Registered Nurses

RSA	South Africa
SA	Saudi Arabia
SAHR	South African Health Review
SANC	South African Nursing Council
SAQA	South African Qualifications Accreditation
SAS	Statistical Analysis Systems
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
USA	United States of America
US	United States of America
VCA	Value Chain Analysis
WHO	World Health Organisation
WMA	World Medical Association

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1   INTRODUCTION

The dawn of a democratic government in South Africa (RSA) began with the 1994 elections and the Bill of Rights. The Constitution adopted in 1996 became the basis for policies that had an impact on health care services (HCS). Among other measures, significant changes that followed saw the revision of the health policies and the transformation of the moribund bureaucratic mode of governance in public health service delivery (PHSD). Government policy laid a strong foundation for restructuring initiatives, which are encapsulated within the African National Congress' (ANC) *National Health Plan (NHP) for South Africa* (1994), Department of Public Service and Administration's *White Paper (Batho Pele – "Putting people first" Principles) on Transforming Public Service Delivery* (1997), Department of Health's *White Paper for the Transformation of the Health System in South Africa* (1997), the national *Patient's Rights Charter*, Resolutions of the 2001 Health Summit and other related charters. These have been hailed as the most comprehensive and progressive policy documents in the world.

While the democratic government was attempting to redress previous political and social imbalances, new challenges and unique opportunities for registered nurses (RNs) also emerged. These were based on the good intentions of the Freedom Charter adopted at the Congress of the People in 1955, which states that "All shall be free to travel without restriction... from South Africa abroad" (ANC 1955). The 1996 Constitution of the Republic of South Africa also makes provision for freedom of movement and residence, meaning that every citizen has the right to leave the RSA. The public health sector (PHS) then began to experience a severe shortage of RNs as internal and international migration took a toll on State hospitals. Many RNs enlisted with recruiting agencies for overseas employment or migrated to private

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hospitals, laboratory services, and medical aid scheme companies as case managers and promoters of medical equipment (Kahn 2004:4). Some RNs migrated permanently to other countries while others settled for private practice within the country.

Internal migration came to the fore when nurses began to move from other provinces and rural areas of the country for better conditions of service and opportunities for part-time work in an urban environment (Ndaki 2004). This situation seems to have led to government's efforts to introduce a Rural Health Strategy for South Africa in order to attract RNs to rural areas and improve their health services in the periods 2006-2009 (Department of Health [DOH] 2006). Furthermore, there was a proliferation of opportunities for urban nurses to work overtime (part-time or full-time moonlighting) in their HCS and in private hospitals on their days off and leave days, resulting in an overworked, frustrated and worn-out nursing workforce. This created instability within the PHS and in most cases; HCS seem to have been devastated particularly by nurse migration in that there was a serious loss of skilled health professionals in public hospitals (Ndaki 2004). As a consequence, the media and circumstantial evidence revealed that those who remained in the PHS engaged in strike actions led by unions to negotiate better salaries, amongst other grievances (Ngqiyaza 2007:1) (also see Appendix F).

The resultant state of instability in public hospitals seemed to suggest that there was discontent among RNs in the PHS. For this reason, this study wishes to investigate discontent among RNs in the PHS, with a view to minimizing disruptions in the provision of health care. A deeper probe could assist in developing strategies that could counter this ordeal, so that nurses' issues can be addressed in ways other than employing strike actions.

The focus will be on RNs in particular because they are generally considered the backbone or pillars of all HCS. It is also the intention of this research to investigate and establish if there are RNs from other countries in public hospitals, their number and the duration of their employment, which could also

give an indication of the state of the PHS in the RSA, and how it is linked to the degree of discontent among RNs.

1.2   PARAMETERS OF THE STUDY

This study will be conducted in the Tshwane Metropolitan area, where three district hospitals, one regional hospital and one academic hospital have been selected for the study. Two private hospitals will also be incorporated for the purpose of capturing views and perceptions of RNs with previous experience in the PHS, with the aim of enhancing the richness of the data.

1.2.1   Tshwane Metropolitan area

Since this study aims to identify the root cause of discontent among RNs in the PHS in Tshwane Metropolitan area, it is necessary to delineate the region for the purpose of contextualizing the research setting.

Tshwane is a Metropolitan municipality area which was promulgated only in the year 2000, in the sixth year of the democratic government in the RSA. It is located within the Gauteng province, a highly urbanised province, also regarded as the country's economic powerhouse, 'place of gold', a name derived from its mining history (Ligthelm, Martins & van Wyk 1995:15). Tshwane Metropolitan municipality consists of sixteen areas and has a total land area of 3,200 square kilometres with a population of about 3.2 million people (*Statistics SA* 2007). In the context of this study, it has two academic hospitals, one regional hospital, five district hospitals, four specialised hospitals and two chronic care and rehabilitation centres. In addition, there are about thirty private hospitals, several primary health care (PHC) centres and two nursing colleges (DOH 2004). Patients also come from surrounding provinces and neighbouring African States like Mozambique for health care.

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1.2.2 Geographic distribution of health facilities in Tshwane

Figure 1.1 is a graphic presentation of a map of the geographic distribution of HCS in Tshwane Metropolitan area.

MAP OF HEALTH FACILITIES
IN TSHWANE METROPOLITAN AREA

Figure 1.1 Health facilities in Tshwane Metropolitan area

Tshwane Hospitals

Provice: Gauteng

District or Metropolitan Municipality:

City of Tshwane

Local Municipality:

City of Tshwane Metropolitan

Legend

- ● Private _Hospitals
- ⊞ Public Hospitals
- □ Place Name Boundary
- ⊡ municipal Boundary

N
W E
S
0 5 10km

Amandebele A Lebelo
Jubilee Hospital
Hammanskraal Part 1
Temba Part 2
Temba Part 1
Temba Part 3
Hammanskraal Part 2
Tinsano
Soshanguve Part 2
Soshanguve Part 1
Mabopane Part 2
Odi District Hospital
Mabopane Part 1
Ga-Rankuwa Part 2
Ga-Rankuwa Part 3
City of Tshwane Metro Part 2
Ga-Rankuwa Part 4
George Mukhari Hospital
Ga-Rankuwa Part 1
City of Tshwane Metro Part 1
Akasia
Pretoria Academic Hospital
Pretoria
Pretoria West Hospital
Weskoppies Hospital
Tshepong TB Hospital
Atteridgeville
Kalafong Hospital
Saulsville
Centurion
Knopjeslaagte
Olievenhoutbos
Mamelodi
Mamelodi Hopital
Nellmapius

Original source - Statistics South Africa: Geography Division. Updated through other sources

1.3   BACKGROUND INFORMATION

In an attempt to determine the root cause of discontent among RNs in the PHS, it is necessary to briefly reflect on the experiences of the Overseas Nursing Association (ONA) during the British colonial period in South Africa. Sweet (2004:181) cites Lady Mabel Piggot, the founder of ONA, which was operating as a recruiting agency to African countries then, as saying: "When the right woman goes out, all is well; the gratitude and the recognition of the country she serves are hers forever."

This statement reveals that there were very stringent rules undergirding the selection criteria for students for training. Amidst these stringent rules from the British colony, there were also cultural differences and expectations, which did not favour the course of young black recruits who wanted to join nursing, as most of them did not satisfy the ONA selection criteria. This appears to indicate that much as it was a good intention to expose the African students to training as nurses, the white missionary nursing supervisors lacked an understanding of the dilemma and cultural adjustment the students had to endure.

In those days, ONA noted that a number of candidates were submitting applications for nursing and made the following declaration: "There is a tendency to a lower standard as regards the class of candidates… where out of a total of one hundred and fifty new candidates that were interviewed, only fifty-one qualified for nursing positions" (Sweet 2004: 179). In the ONA's view, the rest of the recruits were simply the wrong brand for nursing in that era. The right brand was a virtual paragon of virtue that should "be 'of good character', pleasant and capable, with common sense, discretion and tact together with a good past behaviour and reputation". Furthermore, "a responsible attitude towards life with distinct standards of right and wrong" was mandatory, as well as having "the capability of taking responsibility, with an ear and confidence of the people she serves" (Sweet 2004: 180). These criteria seemed to suggest that the younger nurses were preferred over the older nurses because they were less likely to question the colonial authority

(Sweet 2004:182). This therefore implies that nurses' discontent was suppressed under the colonial rule.

Stack and Hlela (2002:41) concur that nursing and teaching once carried high status in society and were the only professions with opportunities for intelligent women. Mashaba (1995:13-14) added that training of professional nurses was slow to progress due to a lack of suitably qualified candidates in those days, as "most of the black girls who were suitably educated were being recruited into the teaching profession".

Discontent among nurses, then, has deep historical roots which manifested in strict selection criteria for indigenous students and the provision of health care in South Africa that portrayed a disjointed course of colonial development (Sweet 2004: 178).

1.3.1 History of nursing in South Africa

It is not within the remit of this study to discuss South Africa's colonial history and the early domestic nursing care for the Dutch and British families on the South African soil in great detail. A brief examination of the roots of nursing in South Africa revealed how discontent existed in historical times, primarily because health care was distributed in a discriminatory manner, including delegation of certain duties. Therefore, this study aims to highlight historical sources and potential areas of discontent among the indigenous people, in relation to the administration of nursing issues and health care delivery in South Africa.

- **Rudimentary home nursing**

While early domestic nursing was provided for family members of the Dutch Settlers by approved Dutch midwives, African health care was the responsibility of family members and wise older women in the community in the nineteenth century. The early missionaries provided their own medical and nursing care (Sweet 2004:178). They used remedies and a manual that

spelled out guidelines for treatment while the blacks relied on Sangomas and traditional healers for treatment (Mashaba 1995:15). By 1900, training for white professional nurses was well established, but black candidates were not admitted for training, which in modern society could have manifested in overt discontent and instability within the health sector. However, in spite of their naivety, many factors emerged later, which necessitated the training of black nurses. Missionary campaigns, benevolent and philanthropic movements played a major role in restoring all mankind's social and physical health, without discrimination (Mashaba 1995:11-12). This reveals disparities that had great potential to divide people that had the same vision for a better health care system for all, yet with varying insights, capabilities and persuasions.

- **Mission hospitals**

According to Mackenzie (1969: 2) and Sweet (2004:179), unlike the settlers' hospitals, mission hospitals only emerged in most rural areas in the late 1920s. They started as clinics and dispensaries staffed by nurses. In contrast to settler's hospitals, they were mud huts accommodating few patients, including a dispensary run by a mission nurse. As a result, mission hospitals found it hard to retain staff because there was broad experience and modern equipment in urban settlers' hospitals (Sweet & Digby 2005:117).

The training provided catered mainly for enrolled nursing assistants (ENAs) and enrolled nurses (ENs), qualifying them for a hospital certificate, which made employment outside mission hospitals impossible (Sweet 2004:180). More African nurses qualified from mission hospitals for many years thereafter. This posed a problem in 1927 when nursing posts previously allocated to few bilingual nurses were now given to British nurses in the Dutch Nationalist village because their performance out-classed the indigenous nurses when they were sent to relieve these nurses, meaning that they lost their positions. Even though adverse acts of discontent were not recorded, this kind of situation suggests that discontent was evident in these parts of South African HCS, howbeit suppressed under repressive colonial laws.

In 1949, the Nessie Knight Mission Hospital in Sulenkama manifested overt discontent among nurses. Though the missions had assisted many disadvantaged patients, there was a tense and unhappy working milieu for the staff. As a result, nurses decided to embark on a strike because of the legitimate recognition they felt they were being deprived of, and abusive terms of service which included domestic labour in the houses of their white superiors. Aware that these nurses emerged from a socially conservative African background, the medical superintendent was amazed by their intractability and described them as silent, sullen and resentful nurses who were influenced by the 'hotheads' and agitators amongst them (Mashaba 1995:12; Sweet & Digby 2005:114). Sweet and Digby (2005:116) note that surprisingly, a letter was submitted thirty-six hours before the strike to the superintendent, raising the following issues:

> Sir,
> The complaints run as follows: (1) we are working very hard, e.g. (the domestic work) polishing, laundry, and kitchens etc. (2) Preparatories [i.e. Probationers] not wanted by the Sister in Charge and beginners and juniors are not allowed to take temperatures, giving of medicines, nor treatments. How will they be perfect? As we believe that practice makes perfect. (3) We would like to know the difference between a nurse and a worker in your hospital, e.g. working with the workers in the field. (4) Vulgar language used on nurses, called pigs, brass monkeys, and Africans with little education. ALL THIS WE ASK IN LOVE. We would like all these to be abolished. Doctor we can be pleased if you can answer us tomorrow.
> We remain,
> Your nurses.

Thereafter, a strike ensued. Coincidentally, another strike also took place in Lovedale's Victoria Mission Hospital, which was triggered by a probationer nurse who was dismissed for challenging her supervisor. Subsequently, all student nurses were dismissed for insubordination when they stood in solidarity with a colleague, and the hospital was closed for a considerable period. These two mission hospitals clearly indicate the degree of discontent among black nurses on issues of status and identity encountered in the early development of a South African nursing profession.

The white bureaucratic rule continued to dominate the administration of many hospitals until the 1960s when black matrons and sisters gradually began to take over and guide the training programmes and hospital administration to the period when the mission hospitals were transferred over to State control (Sweet & Digby 2005:116).

- **Military and Settler's hospitals**

In the late nineteenth century, the first trained white nurses were sent from Europe to South Africa in large numbers, signifying that reforms in hospital nursing were creating opportunities for nursing as a career for educated women (Abel-Smith 1960:17; Deacon 1997:45-46). At that time, a proliferation of military hospitals that employed their own, predominantly white males also began (Sweet & Digby 2005:110). Professional nurses' training for whites was well underway, pioneered by Sister Henrietta Stockdale. Out of two black students who were trained in 1903, Cecilia Makiwane succeeded and became the first black woman to be registered as a professional nurse (Mashaba 1995:12).

Settlers' hospitals were also established in major cities and became areas for political organization by discontented nurses. They used mainly black, and other mixed race women as assistant nurses for menial tasks. Makhubela-Nkondo (2001: vii) notes that when insufficient attention is given to women's views, it usually means that women (particularly poor women) will be forced into margins of health systems.

These developments further introduced a hierarchical order of power in health institutions, where control meted out discipline in a discriminatory manner which observed race, gender and social class status (Deacon 1997:84). This was followed by the controversial transfer of two nurses, one from Kroonstad Hospital in Orange Free State to perform district work "on her own", with reports that she was troublesome and had a difficult temperament, the other to Nongoma in rural Natal. Requests followed for the two to be replaced by young nurses who were unlikely to question the status quo (Sweet 2004:182).

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This situation was exacerbated by the fact that the white nurses did not take kindly to black nurses, judging them as unworthy of the nursing profession (Mashaba 1995:16).

In 1921 black nurses at a mine hospital in the Rand expressed grievances because of the appalling working and living conditions to which they were subjected (Marks 1994:114). This was followed in 1924 by white nurses at Addington Hospital also threatening a strike. Three years later the white nurses in Mafikeng's Victoria Hospital protested against working with a black medical practitioner. By the 1940s unrests among African nurses had increased tremendously, commencing with disturbances in Fort Beaufort Hospital, where police and soldiers had to intervene. Shortly after, a stoppage by probationer nurses at Sir Henry Elliot Hospital in Umtata followed. Heightened political awareness among African nurses was fully realized by 1947 when a twelve-day strike was staged by clinic nurses in Johannesburg's Alexandra Township. Thereafter, a strike in Johannesburg's Baragwaneth hospital in 1949 was launched (Sweet & Digby 2005:115; 119). Based on these occurrences, Mashaba (1995: 16) postulates that a lot of internal conflicts which caused discontent among black nurses were a result of poor communication and lack of consultation with nurses because white matrons could not fully understand black nurses' problems.

1.3.2 The National Party government and the health care system

In addition to repressive laws, the British settlers' hegemony exacerbated the situation by introducing disparities in nurses' salaries between racial groups, which continued even after the Afrikaner apartheid government came into power in 1948. In this segregation, black nurses suffered a further diminution of status, which bred discontent and tension among nurses of different racial groups (Buthelezi 2004:3-5; Digby 2006:233).

Under apartheid law, the health care system was structured to cater for "the needs of the urban, predominantly white members of society so that the supply was least where the need was greatest" (Jansen 1991:296). Even

though these areas were sources of discontent for black nurses, nurses were not allowed to strike under the Nationalist government, as this would have required disciplinary action by the South African Nursing Council (SANC) (Mashaba 1995:66).

- **Bureaucratic structure in the former health dispensation**

Swanburg and Swanburg (1999:355-358) describe bureaucracy as a dominant organisational form of administration and organising, constituting centralised and highly structured hierarchical authority. Management is found at the top of the pyramid in the bureaucratic structure, responsible for formulating policies and making decisions independently. It is believed that this administrative approach enforces subordination to authority, thus stifling innovation and creativity among RNs.

Because of the authoritarian and oppressive nature of bureaucracy within the health care system in the previous health dispensation, health and nursing structures were traditional and rigid. It became impossible for nurses to implement advanced knowledge acquired by highly educated nurses within these hierarchies, as they had to follow instructions, which did not always accommodate change. The nursing workforce resembled a pyramid within the strong hospital hierarchy, causing much discontent among nurses who had no freedom of expression. Nursing was characterised by impersonal work relationships and clear lines of demarcation of authority. Superintendents were male doctors at the top of the pyramid while the exploited and oppressed female nurses were found lower on the hierarchical ladder of the system. The senior nursing manager (chief matron) was subordinate to the medical superintendent, followed by the nursing service managers (senior matron), chief professional nurses (matrons), senior professional nurses and professional nurses (PNs). The ENs (staff nurses) were next in the hierarchy, followed by student nurses and ENAs (Jansen 1991:165).

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An organogram illustrates the bureaucratic organisational structure, culture and climate schematically (see figure 1.2).

Figure 1.2 Chain of command
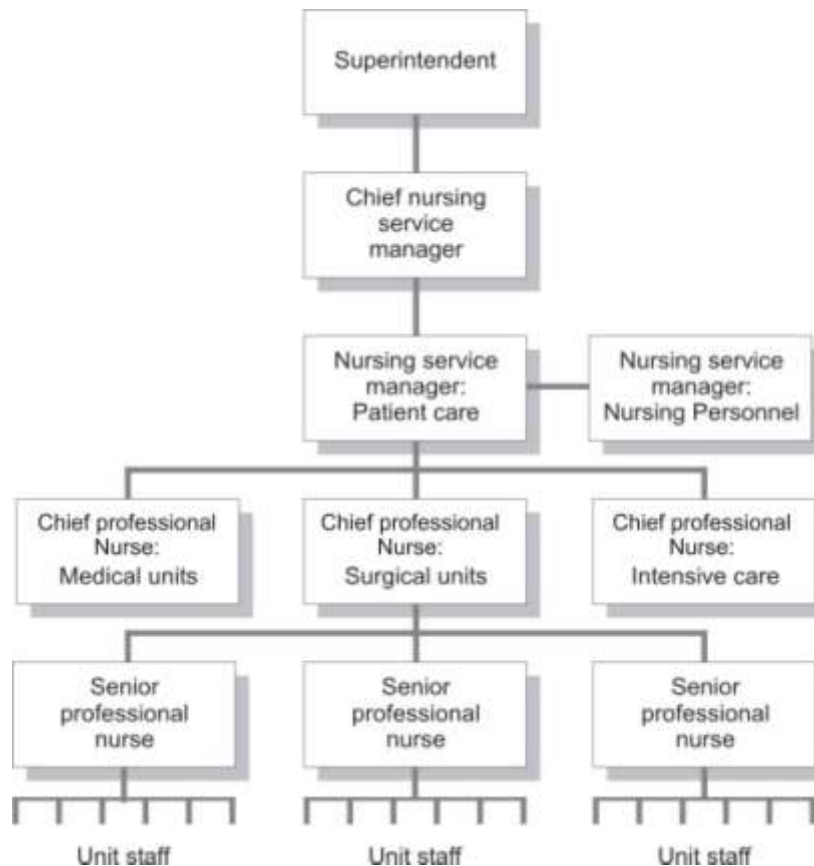
Digby (2006:236) refers to the discontent and state of depression among especially black nurses in the former Transvaal Province in that health dispensation. According to Digby (2006:236), after training as a nurse in the liberal Cape, Maggie Resha took employment in Pretoria General Hospital in the Transvaal. Shortly thereafter, she discovered that discriminatory practices such as unfair promotions, pay differentials, unfair delegation of duties and inequity regarding accommodation of nurses had left RNs discontented, disillusioned and devastated. Talents, creativity and innovations were said to have been indisputably stifled within the rule-bound health institutions. Moreover, Mashaba (1995: 83) points out that black male nurses earned more

than their female counterparts within the bureaucratic system, yet still lower than the White, Coloured and Indian nurses.

1.3.3 Public health service transformation in the new democracy

The democratic transition in 1994 scrapped all apartheid laws in every social stratum. Pragmatic changes in transformation of the health care system also began with hospital rationalization and restructuring, even though manifestations were slow to unfold in other areas. The new government had to first dismantle apartheid legislation by evenly spreading health facilities to improve access to previously disadvantaged citizens. This was followed by the implementation of the new health policies which shifted the focus from curative care to supporting primary health care services (PHC) (Digby 2006:434; South Africa 1997b; Stack & Hlela 2002:8).

Restructuring also involved a demarcation of health regions and districts, staff appointments and re-deployment in 1995. This era also saw the emergence of the ANC's reconstruction and development programme (RDP), which increasingly introduced preparatory workshops in all the provinces for restructuring HCS. Objectives were formulated and indicators and health goals for the new health dispensation developed. In 1995 and 1997 respectively, the DOH issued policy documents on the district health system and the White Paper on health system transformation, which were based on the ANC's national health plan. The 1997 White Paper provided a framework for the unification of the fragmented HCS to promote equity, accessibility and community participation (South Africa 1997c:10). For effective governance, a decentralized approach was adopted, which denoted a shift of authority, power and functions away from the centre to the peripheral units to afford them a semi-autonomous status, thus reducing excessive bureaucracy in the process (DOH 2001).

- **Department of Health (DOH)**

The National Department of Health deals with policy and funding of public services through local government systems. There are nine provincial health departments and several local authorities in the RSA. PHSD strategies are structured in such a way that patients from primary, secondary and tertiary level form part of this system (DOH 2001; Stack & Hlela 2002:11). One of the major challenges currently facing the DOH is provision of human resources for the PHS. The 2008 ANC conference at Polokwane once again emphasised recruitment and retention of health professionals.

Figure 1.3 depicts the different levels of authority in the DOH.

Figure 1.3   RSA Ministry of Health, 2008
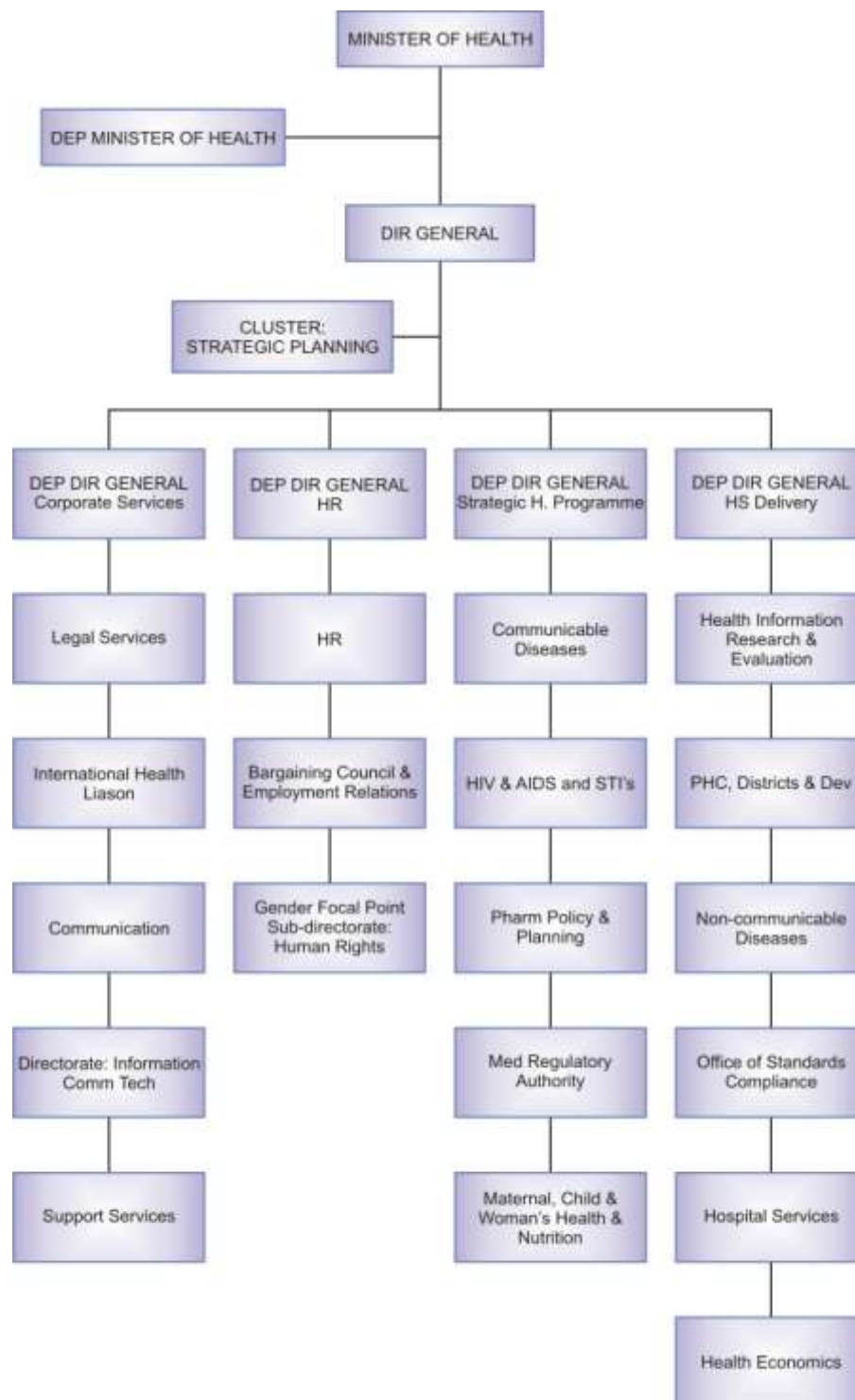
- **Issues of discontent among nurses**

Predicated upon previous discussions and circumstances, it is surmised that most previous studies approached the dilemma surrounding nurses'

discontent in the PHS from legal, moral, constitutional, and psychological premises to explicate and delineate discontent among RNs in the PHS. These factors together with social, economic and political aspects seem to have a negative impact on employee performance in the workplace, and migration from the PHS. Furthermore, nurses' influence on policy-making processes, political debates, and community involvement does not appear to have been properly catalogued. For example, Dendaas (2004:12) points out that macro-level "variables associated with political, economic and social aspects of the work environment have received less attention".

The aforementioned factors therefore warrant investigation to verify the grounds and intensity of discontent among RNs in the PHS, in order to consolidate amicable solutions and pertinent strategies to these debilitating issues. Therefore, exploration regarding the congruence and harmony of legal, social, political, professional and practical aspects in the workplace is crucial, particularly in resolving this perceptible demise.

1.4   PURPOSE OF THE STUDY

The purpose of this study was to

- Explore and contribute to the knowledge base on discontent among RNs in the PHS within the Tshwane Metropolitan area.
- Establish reasons for discontent among RNs and describe how RNs in the PHS perceive the effects of discontent on their personal and professional lives.
- Provide a scientifically proven argument regarding factors that contribute to or exacerbate the RNs' discontent in public hospitals.

The broader goal of this study on discontent among RNs in the PHS, then, is to "explicate the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations" (Miles & Huberman 1994:7). This could assist in clarifying whether nurse

migration from the PHS and the involvement of nurses in strike actions are related to discontent among RNs, with the aim of developing support systems to assist them to be more passionate, efficient and effective in public health service delivery.

1.5   RESEARCH QUESTIONS

To achieve the purpose, the study wished to answer the following questions:

- What do RNs perceive as the source or cause of discontent among RNs in the PHS?
- How do RNs perceive the effects of discontent on their personal and professional lives in the PHS?
- What are the factors contributing to discontent among RNs in the PHS?
- How can RNs be supported to be more passionate, efficient and effective in public health service delivery?

1.6   RESEARCH OBJECTIVES

The objectives of the study were to

- Identify the source or cause of discontent among RNs in the PHS.
- Describe RNs' perception of the effects of discontent among RNs on their personal and professional lives.
- Elucidate the factors contributing to discontent among RNs in the PHS.
- Explicate ways in which RNs can be supported to be more passionate, efficient and effective in public health service delivery.

1.7   SIGNIFICANCE OF THE STUDY

The significance of this study can be explained from Daft's (1999:248) carrot and stick[1] method of rewards argument, with particular reference to the PHS, and Maslow's[2] hierarchy of needs. Daft's argument has therefore placed a demand on this study to explore other avenues that could provide internal stability within the HCS in the RSA.

In the context of this study, several attempts by government to increase salaries negotiated by unions appear not to have produced lasting resolves or effect. From that premise, it can safely be concluded that salary increments are a lower level of satisfaction in Maslow's hierarchy of needs. Because salary increments are not suitable for highly complex settings like health institutions in Daft's (1999:243) view, this study could therefore see the beginning of nurses' representation in political spheres as an avenue that could allow for the negotiation of their own rights with government to stimulate and provide a higher level of satisfaction. Significantly, this could afford RNs the opportunity to influence policy processes at a higher level, lobbying the state legislature for necessities relative to the practice of nursing, including a definite salary structure commensurate with qualifications in a competitive

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[1]   ***Carrot and stick*** is a method which reimburses employees performance [*or demands, as in strike actions*] with pay. Though other organizations commend this method, its critics denigrate it and classify it as an inadequate and non-productive strategy. Among other reasons, its critics believe extrinsic rewards of this nature diminish intrinsic rewards; they are short lived, organizations and their departments are overwhelmingly complex for this approach, and it presumes workers are driven by lower needs.

[2]   *Maslow's* hierarchy of needs is an assessment of employees' fulfillment on the job. The lowest category of needs is based on the need for salary [*increments*] and basic personal needs. These are followed by safety needs such as fringe benefits, need for belonging, [*implied in the South African workers slogan, 'An injury to one is an injury to all'*], esteem needs in the form of high status, and lastly, self-actualization needs, whose focus is on autonomy, personal and organizational growth, as well as opportunities for advancement [italics are the researcher's own emphasis].

world. Secondly, this study could arouse the need to incorporate the subject of Political Science in the nursing curriculum so that nursing produces politically astute RNs, who will assume active participation in political issues in order to advance the cause and course of nursing, because in most cases, decision-makers are not conversant with nursing and health care needs. This could help diversify the nursing profession and possibly pave a way for nursing students and RNs who aspire to be political analysts and lobbyists, as well as public office appointments. Thirdly, the decline of strike actions and migration among RNs could be realized in a considerable way when more nurses are appointed in leadership positions in the PHS. Fourthly, the observable dissonance among RNs and the fragmentation of nurses between professional associations and unions could be minimised in a significant way. Lastly, this crucial step could also see the dawning of unity and collaboration between hospital management and nurses in their common goal of ensuring a healthy society.

1.8   PROBLEM STATEMENT

The problem to be explored or probed is discontent among RNs in the PHS. Firstly, despite previous salary increments by government to appease both unions and public servants (including nurses), strike actions have not been totally abated. Therefore, salary increments as a way of preventing strike actions in the PHS seem not to be the only solution for discontent among RNs. Accordingly, alternative ways should be explored to bring amicable resolves and stability in the PHS. Secondly, RNs are divided between unions and professional associations in the RSA, which seems to have soured relationships between nursing service managers (NSMs) and RNs. This could reveal unresolved issues leading to discontent among RNs. Thirdly, there seems to be an unprecedented nurse migration from the PHS. Areas of attraction for RNs in particular are the private health sector, case management, laboratory services and overseas recruitment.

As such, the dispersion of RNs abroad and migration of RNs to the private sector, the mayhem experienced with the June - July 2007 national strike

action in the RSA are inexplicable problems that warrant the development of progressive and workable strategies to prevent their recurrence, other than engaging more aggressive and counter-productive methods.

1.9   THESIS STATEMENT

The research proposition probed in this study is the cause of discontent among RNs in the PHS. The main argument of this study is that if nurses could be represented by nurses in political arenas and at government level, discontent among RNs could be significantly reduced. However, this will require that nurses be empowered with political astuteness by introducing Political Science in the nursing curriculum and exposing RNs to part-time political schools. Secondly, while there are unions representing nurses in negotiations with government and bargaining councils in the RSA, RNs seem not to be pacified by these confederations as they continue to fall prey to strike actions, overseas recruitment, and employment in the private sector, case management and laboratory services.

The reality of the divisive nature of nurses between unions and professional associations appears to be one of the maladies entangling the nursing profession in the RSA. This could signify a leadership problem in HCS, particularly where HCS are led by bureaucratic-minded nurse leaders, and professions other than nurses and medical doctors with practical ward experience. Union representation for nurses both at provincial and national level also appear not to be appropriate because nursing issues are unique and warrant deeper understanding and insight. Consequently, a mechanism that could unite the nurses under one body, without downplaying freedom of association provided by the Constitution of the RSA, should be explored and implemented. This assumption concurs with Mantashe's (1995:82) statement that nurses are "highly fragmented, frustrated and trapped in a 'cycle of action' that has been damaging to their professional status".

This study will therefore argue that even if RNs are exercising their constitutional rights at any level of public health service, it does not mean that nurses should not explore other alternatives that could better serve their

interests than unions, strike actions or migration from the PHS. Significant changes in the political climate of the country over the past decade make the reaching of reasonable conclusions in this study highly probable. This is why representation of nurses by nurses in leadership positions in the PHS, at government level, bargaining councils and parliament becomes the central argument of this study.

1.10   RESEARCH METHODS

A methodological triangulation of qualitative and quantitative approaches will be used to collect data from RNs, whose responsibility it is to deliver health care to the communities they serve. In the final analysis the findings of these two methods will complement each other in a way that will enhance the authenticity of the results (Morse 1997:230).

Polit and Hungler (1999:428) describe triangulation as "the use of multiple referents to draw conclusions about what constitutes the truth". Loiselle, Profetto-McGrath, Polit and Beck (2007:219), and Polit and Hungler (1999: 257) advocate the integration of qualitative and quantitative approaches dealing with a single study because none of the methods is so perfect that even in its area of greatest potential it cannot be supported by other methods. The rationale behind blending qualitative and quantitative methods is to minimize biases in terms of the convenience sampling method that will be used to distribute questionnaires in this study. The statistical data derived from the questionnaires will then be verified by clarifying comments from open-ended questions of the questionnaires, and vice versa. According to Sheppard (2004:215), even though each of these methods provides something different, they are complementary. This means that they encompass both words and numerical data to communicate results. In this way, Webster's dictionary explains them as uniting 'two at a time' for a common purpose or end (Finnegan 1975:315). Therefore, by mutually supplying each other's lack, the limitations of a single method are minimized.

This study will also engage Morse's (1997:230) simultaneous and sequential methodological triangulation. This means that the first stage of the study will comprise a questionnaire with closed and open-ended questions at the same time (simultaneous), as indicated above. In the second stage, the methods are used independently and in sequence (sequential). In other words, after the questionnaires have been completed and analysed, individual and focus interviews will be conducted to support, extend or challenge the results of the questionnaires.

1.10.1 Qualitative

Brink (1998:337) purports that qualitative designs seek to discover knowledge or uncovering new insights, meanings and understandings. Afterwards, data is transcribed, organized and analysed to determine any consistency with quantitative data, as is the case with this study. According to Morse (1997:227), the findings can then be used in other settings to bring understanding of the phenomenon under study, thus forestalling the need for further research.

Since qualitative studies are largely descriptive and exploratory, Mouton (2001:271) postulates that in-depth descriptions and understanding of actions, events and experiences from the respondent's viewpoint benefit studies. Therefore, data will be reported word for word as written by respondents in the open-ended questions. These written comments should enhance the understanding of the context in which situations that cause discontent among RNs in the PHS occur.

Individual and focus interviews will also be conducted to provide substantial data. The respondents will be asked to respond to four questions in the topic guide. With the permission of the respondents, these interviews will be audio taped to enhance validity. Spoken words will then be transcribed verbatim and analysed to determine thematic categories and subcategories that will emerge.

1.10.2 Quantitative

In this method triangulation, a quantitative approach will be instrumental in quantifying the construct being studied, thus, maximizing the results. As indicated before, self-administered questionnaires will be distributed to RNs in five selected public health institutions and two private hospitals to measure discontent among RNs in the PHS in Tshwane Metropolitan area, which will be numerically analysed. The strength of quantitative data lies in their ability to provide generalizability, precision and control over extraneous variables. Since Morse (1997:230) refers to simultaneous methodological triangulation as the usage of the qualitative and quantitative methods at the same time, the questionnaire will therefore include open-ended questions for respondents to comment on the items of their choice in this study.

1.10.3 Research design

A descriptive and exploratory research design will be adopted for the purpose of gaining new insights and answers to the research questions. These questions will endeavour to probe discontent among RNs in the PHS, which seems to prevail in spite of government efforts to increase salaries of public servants across the board. Polit and Beck (2008:19-20) and Loiselle, Profetto-McGrath, Polit and Beck (2004:21) state that quantitative descriptions focus on the prevalence, incidence, size, and characteristics of the phenomena. By contrast, the qualitative aspect of this study will deal with descriptions of the dimensions, variations, and importance of the phenomena. Polit and Beck (2008:20) emphasise that the exploratory component, rather than observing and describing, goes further to investigate the full nature of the phenomenon, the manner in which it occurs and related contributory factors. For this reason, both methods will be employed in this study to answer the research questions and to further explore the intricacies, dilemmas and other factors surrounding discontent among RNs in the PHS.

1.10.4 Population and target group

The target population for this study will be RNs, males and females of all racial categories, from five public health institutions and two private hospitals in the Tshwane Metropolitan area. Views from all levels of the registered category of nurses such as chief professional nurses (CPNs), senior professional nurses (SPNs), and professional nurses (PNs) will be sought and incorporated in this study.

1.10.5 Data collection

A method triangulation is used. The questionnaire includes open-ended questions with sufficient space provided for the respondents to write their comments and remarks about items they choose (see section 1.9.1).

The self-administered questionnaires will be distributed among RNs in the selected public health institutions. The researcher will conduct a pilot study prior to data collection.

1.10.6 Data analysis

The study will use percentages in frequency tables and bar charts to present the views and perceptions of RNs on discontent among RNs in the PHS. A comparison of the district cluster, followed by a comparison of different hospitals in percentages will also be presented. The SPSS statistical analysis and excel programme will be incorporated with the help of a statistician. This will assist in contextualising the discontent among RNs in the PHS.

1.11 DEFINITION OF CONCEPTS USED IN THE STUDY

For the purposes of this study, the following terms are used as defined below.

- **Administrative policy**

This is a policy that facilitates efficiency in the administrative operations of a specific department. Policy issues addressed at this level include personnel, finance, organization, procedure and control (van Wyk 2002:30). In the RSA, it is assumed that nurses do not contribute to policy making in their country, yet they are experts in public health service delivery and provide daily statistics, patient acuity levels and have the potential to negotiate patient care, organizational, and nurses' needs. In the context of this study, nurses can be represented by nurses to influence policy-making processes at government level, parliament and bargaining councils, based on the negotiation skills explicated above. At present, nurses are represented by unions.

- **Authority**

King (1981:123) describes authority as being endowed with power by holding a certain position and possessing certain expertise to make decisions and guide the actions of others in order to achieve the goals of the organisation. In the context of this study, it is assumed that health organizations cannot be led by officials who do not possess the relevant qualifications, experience, understanding and insight regarding the delivery of health care. Medical and nursing expertises are considered key to success, order and excellence in delivery.

- **Benefits**

Benefits are incentives paid by the employer to employees besides the regular salary. They are not usually performance related but considered part of the conditions of service. In the case of RNs, apart from regular medical

aid schemes, leave, pension and study leave opportunities; Nieman and Bennet (2002:270) maintain that risk, uniform, intensive care unit (ICU) and rural allowances are crucial in retaining and attracting skilled personnel in the PHS.

- **Discontent**

Collins English Dictionary (1991:449) defines discontent as "n. lack of contentment, as with one's condition or lot in life"; adj. dissatisfied". This means the state of unhappiness caused by failure to satisfy the hopes, desires or expectations of someone, which in this study refers to RNs in the PHS.

- **Empowerment**

Collins English Dictionary (1991:511) defines empower as "vb. (tr.) to give or delegate power or authority to; authorize". Empowerment of workers implies the creation of an environment that enables employees within an organization to acquire power to be innovative and creative. The organizational structures with multiple layers of management usually prohibit the realization of empowerment of employees. In a decentralized system, employees are encouraged to take calculated risks, make mistakes and grow together with the organization because growth comes from risk-taking. Empowerment also "speaks of employees exercising control over certain activities such as budgets, patient care issues and other unit management activities. When empowering employees, relevant information is allowed to filter to the functional level through memorandums, newsletters, meetings informational discussions and formal announcements" (Booyens 2000:442).

- **Human resources administration**

Human resources activities refer to the administration of personnel affairs. A comprehensive personal information file is kept for each staff member. For the

purpose of this study, human resources administration implies the calculation of leaves, payment of salaries and other financial benefits for nurses, which if not done satisfactorily, could result in discontent among RNs. It is crucial to constantly update nurses' details of information to avoid erroneous decision-making in human resources processes. Examples of errors include miscalculated leave days, years of experience, and salary structures, which could account for disputes and discontent among RNs in the PHS.

- **Labour Relations Act (LRA)**

The Labour Relations Act, 66 of 1995 is based on all the aspects and matters that deal with relationships between employer and employee, both in the public and private sectors. Within the framework of this Act, trade unions negotiate salaries, conditions of service and settlement of disputes between employer and employee. Unionization of HCS seems to have placed the nursing workforce in this category because unions negotiate on behalf of nurses at the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) and the Public Service Co-ordinating Bargaining Council (PSCBC). The purpose of the Act is to advance economic development, social justice, peace in the work environment, and democratization of the workplace in order to accomplish the fundamental rights of employees and employers, as required by the Constitution of the RSA (South Africa 1996:10).

- **Migration**

Stilwell, Diallo, Zurn, Vujicic, Adams and Dal Poz (2004:596) describe migration as a response to spatial diversity within the systems of production, which emanates from the spatial and tentative inequalities in the levels of economic development. It is a global trend where skilled workers have become increasingly mobile in a world that has become small. In the context of this study, nurses exercise their constitutional right to move (migrate) from the PHS to overseas countries, find employment in the private health sector and for other personal reasons.

- **Nursing**

Nursing is a caring profession which supports, cares and treats clients to achieve or maintain health. This process of care is practised by individuals who are registered in terms of section 31 subsection (1) and (2) of the Nursing Act, 33 of 2005 to ensure that a client "lives in comfort and with dignity until death" (South Africa 2005:6).

In the RSA, as a way of protecting the public from harm, an employer is not allowed to employ or retain in employment any individual who is not registered with the SANC.

- **Political party policy**

This is the policy on which political parties contend elections. When the party wins the elections, the policy is implemented. For example, the Reconstruction and Development Programme (RDP) policy framework was formulated by the ANC prior to the 1994 elections in the RSA, and was implemented when the party came to power (van Wyk 2002:30, 41).

The Constitution of the RSA affords political rights to "vote in elections for any legislative body established in terms of the constitution, and to do so in secret" (South Africa 1996:9). Nurses are voters and are free to vote for the party of their choice as its policies have an impact on the practice of nursing, nurses' salaries and other benefits. The legislative outcome also affects the health policy that regulates free antenatal care, and budgetary restrictions on the purchase of equipment and expansion of health facilities, including mother and child services in the RSA. These issues have a grave impact on issues surrounding discontent and job satisfaction of RNs under PHSD.

- **Power**

King (1981:127) describes power as the position and authority one has to influence others in an organisation. Those who have more power in an

organisation have delegated authority and more control within an organisation to mobilise resources through decision-making by virtue of the power vested in them, in order to achieve goals (King 1981:127; Sullivan & Decker 2005:90). Without devolution of power, RNs cannot make decisions and are restrained from contributing to the development of the organization. As a result, decisions are made for them, without them, thereby leading to discontent.

- **Private health sector**

In the context of this study, private hospitals refer to 'for-profit' health institutions which fall outside the direct control of government. These health care institutions cater exclusively for medically insured (private patients), which form about 20% of the South African population (Hanson & Berman 1998:197). Some of the critical shortages of specialized nursing and medical staff experienced by the PHS is accounted for by the growth of private hospitals that offer generous remuneration packages, modern facilities and equipment that make up better conditions of services (McIntyre & Gilson 2002:1645). RNs who migrate to the private health sector are covered by section 21 (1) of the Constitution of the RSA, which makes provision for freedom of movement (South Africa 1996:10).

- **Public Health Sector**

The public health sector is a body that has workers employed at national, regional and local government to provide health services to the public. It is estimated that in the RSA, approximately 80% of the population is state dependant for the provision of accessible and affordable health care (WHO 2000:5). The public health sector is comprised of primary health care services and district hospitals which are (level one) HCS, regional (level two) and academic (level three) hospitals (DOH 2002).

- **Registered nurses**

Blackwell's Dictionary of Nursing (1994:459) defines a registered nurse as "an individual who is specially educated and registered by an accredited Nursing Council to provide care to the sick, wounded and other health problems". For the purpose of this study, a registered nurse is a person who is "educated and competent to practice comprehensive nursing", takes responsibility and accountability regarding independent decisions in such a practice and is registered and licensed as a professional nurse under the Nursing Act, 33 of 2005 (SANC 2005). RNs are an indispensable commodity in HCS and proportionately form the largest part of the total health human resources (personnel) in HCS.

- **Strikes**

Bendix (1996:521) defines strike action as "a temporary, collective withholding of labour" with the purpose of compelling the employer to be cognizant of the demands of employees.

In the past, strikes were illegal under section 40 (2) of the Nursing Act, 50 of 1978. Following the inception of the new democratic government in 1994, nurses could belong to any professional association or union of their choice and engage in strike actions under the provision of Section 5 of the LRA 66 of 1995. However, under the provision of this law, nurses provide essential services and are therefore prohibited from abandoning their duties.

- **Transformation**

Transformation in the South African context refers to the restructuring of the health system, which means a change in health policy in line with international trends promoted by the World Health Organization (WHO). This is a move away from curative tertiary medicine which is dependent on doctors and technology, towards a preventive primary health care system which

emphasises prevention of illness and injury and ensuring equity in resource allocation (ANC 1994).

Transformation of HCS and decentralization of decision-making processes came with the new political dispensation of a democratic South Africa in 1994. The DOH in the *Batho Pele* White Paper on public service delivery proposed that decision-making be defused for the purpose of improving PHSD and management processes (DOH 2001; South Africa 1997c: 12).

Since transformation of HCS is a broad term, in this study it encompasses transformational initiatives that define the new levels of care, the Occupational Specific Dispensation (OSD) salary adjustments, constitutional rights of nurses, allocation of budgets for different levels of care, legislation regulating conditions of service for nurses and many other issues that are pertinent to the practice of nursing within the country.

The PHS areas where RNs are found include community-based supplementary health services offered by mobile clinics, fixed clinics and community health centres, which are components of a district health system that delivers a comprehensive primary health care system in the RSA (DOH 2002:3). Next are level one district hospitals that support PHC services and are a gateway to more specialized care. These are followed by regional hospitals, which are level two HCS that cater for basic treatment and surgeries beyond the scope of district hospitals. Academic hospitals are level three HCS, which offer highly specialized services and other sophisticated procedures (Marais 2007).

- **Tshwane metropolitan area**

Tshwane is a metropolitan municipality area located within the Gauteng province. It has a total land area of 3,200 square kilometres with a population of about 3.2 million people (Statistics SA 2007).

In the context of this study, Tshwane metropolitan municipality area has two academic, one regional, five district, and four specialised hospitals and two chronic care and rehabilitation centres. There are also two nursing colleges, about thirty private hospitals and several primary health care centres (DOH

2004). Out of these, three district, one regional, one academic and two private hospitals were selected for the study.

- **Unionism**

A trade union is "an association of employees whose principal purpose is to regulate relations between employees and employers" (South Africa 1995**:**112). Unionism in the health sector is powered by the Constitution of the Republic of South Africa Act, 108 of 1996, which makes provision for fair labour practice. This means that nurses are free to join trade unions of their choice and to participate in union activities (South Africa 1996:10). Section 5 of the LRA (1995) prohibits employers from victimizing employees who join unions. In the RSA, nurses choose whether to support the professional associations or unions (Bezuidenhout, Garbers & Potgieter 1998:278).

1.12   OUTLINE OF THE STUDY

Chapter 1 describes the problem, purpose and significance of the study, research design and methodology, population, sample, data collection and analysis; defines key terms, and discusses ethical considerations.

Chapter 2 discusses the literature review conducted on discontent among RNs, transformation of HCS, management and leadership, and nurse migration.

Chapter 3 discusses the theoretical framework for the study, with particular reference to the general systems theory (GST).

Chapter 4 discusses the research design and methodology, including data collection, data-collection instruments, pilot study, and ethical considerations.

Chapter 5 discusses the data analysis and interpretation and findings.

Chapter 6 presents the respondents' views verbatim, discusses the limitations of the study, and makes recommendations for practice and further research.

1.13   CONCLUSION

This chapter described the background to, purpose and significance of the study. The history of the South African health care system, including the bureaucratic structure in the previous health dispensation and the transformation of the HCS in the new democracy, were also discussed. Finally, key terms were defined and the thesis was outlined.

Chapter 2 discusses the literature review conducted for the study.

CHAPTER 2

LITERATURE REVIEW

2.1   INTRODUCTION

Chapter 1 provided the rationale for this study, the history of public health service delivery (PHSD) in the Republic of South Africa (RSA), a map of the different service areas in the Tshwane Metropolitan area and the background to the practice of nursing in the public health sector (PHS). This chapter discusses the literature review on discontent among registered nurses (RNs) in the PHS. The literature review covered national and international issues including transformation of health care services; management and leadership problems; career development; registered nurses as medical assistants; workplace violence; stress; registered nurses and international migration; registered nurses and unions; the Occupational Specific Dispensation (OSD) for nurses, and nurses and politics.

In the South African society, public health issues and discontent among RNs in the PHS are political issues because health care services (HCS) form the largest part of social services. The success of HCS is dependant on national and provincial legislative competency because HCS derive their finances directly from government through nationally collected general taxes and other revenues. As a result, they are issues often included in political debates, which sometimes do not promote objective, clarifying discourse.

Among other variables, international migration and unionization of the PHS are considered RNs' constitutional rights in the RSA (South Africa 1996:10). This would then seem to indicate that these privileges should also be exercised in moderation, since only when nurse migration is influenced by personal interests other than the existence of 'push factors' from the PHS, can discontent be ruled out. For this reason, the researcher examined whether nurse migration and unionization of the PHS among other things, had gone

beyond merely exercising constitutional rights to becoming national problems that could signify the existence of discontent among RNs in the PHS.

As a general principle, RNs are obliged under the following policies and laws not to abandon their patients:

- Their ethical code with regard to care of the patients
- *Patients' Rights Charter*
- South African Nursing Council's (SANC) rules on the acts and omissions of RNs in the *Nursing Act, 33 of 2005*
- The 1997 *Batho Pele White Paper on Public Service Delivery*
- The *Labour Relations Act (LRA), 66 of 1995*
- The *National Health Bill*
- The *Health Charter*

2.2   TRANSFORMATION OF HEALTH CARE SERVICES

The process of restructuring HCS to ensure equity in resource allocation, with decentralized management and local accountability in the provision of high quality care, had a significant impact on the South African health care system (ANC 1994; Department of Health [DOH] 2001). The government's aim was to build a unitary but decentralized national health system in which the centre and the periphery work together to ensure efficiency and equity with the delivery of health care (DOH 1997a). In addition, the *Batho Pele* White Paper on transforming public service delivery introduced an approach that puts pressure on "systems, procedures, attitudes and behaviour" to put customers first in public service (South Africa 1997c:12). These policies promote relationships that foster unity, efficiency and coherence between management in HCS, employees and the community in order to attain the goals of a progressive and effective health care system.

The South African health care system has competent, committed and highly skilled health care professionals, who have made significant contributions to

the transformation of HCS in the PHS (Sait 2001:5). At the same time, however, national and global factors negatively impacted policy implementation in the RSA, immediately after 1994 when the RSA was undergoing transformational changes. Opportunities for alternative vocations or incomes became available to most health professionals, particularly RNs with different specialties in nursing. Consequently, significant numbers of RNs migrated from the PHS to the private sector, laboratory services, case management and abroad.

To counteract international migration, the Gauteng Department of Health (GDOH) introduced an Exchange Programme for South African RNs with Kings College Hospital in London in 2001. The main objective of this venture was to provide RNs with the opportunity to learn new skills, with specific reference to areas of specialty in which the South African HCS was deficient. It was hoped that this would allow them to return at the end of the contract to plough back into the country (Gauteng DOH 2002; Kingma 2006:135). To follow up on this endeavour, the South African Health Minister and her British counterpart sought ways to combat poaching of health professionals by the British HCS from developing countries, including the RSA. They further explored ways on how to strengthen the *International Code of Practice on Ethical Recruitment of Health Workers*, which provides guidelines for the international recruitment of health workers by considering the potential impact of recruitment on health services in the source country. This was revealed in a media address after deliberations that took place in the 'SA/UK' Bilateral Forum in Parliament in 2004 (Kingma 2006:126-127; Pretorius 2004).

The following discussions highlight developments in other countries, issues and problems surrounding RNs, strategies followed in the restructuring processes, how they handle nursing workforce shortages, and how legislation affected RNs positively or negatively in their endeavour to find better places of employment.

2.2.1 Restructuring initiatives in the United Kingdom (UK)

In the UK, health professionals were at some stage emotionally drained by restructuring initiatives and daunting top-down instructions, which were thought to undermine nurses' value and self-worth (Doult & Scott 2007:6). These authors further indicate that Prime Minister Gordon Brown took a bold step when he committed to giving nurses an opportunity for major contributions to strategic planning for the National Health Service (NHS) in order to enhance their professionalism. The main purpose for this move was to solicit nurse's opinions regarding salaries, entitlements and conditions of service, among other issues (Doult 2007:9). This was intended to bring a period of stability among health professionals so that they would spend more time with patients, be empowered, their professionalism respected and they would have a major say in how the NHS should develop (Doult & Scott 2007:1). These promises were later followed by his appointment of Ann Keen, a registered nurse, as Minister of Health (Snow 2008:12-13).

Regarding aspects of foreign policy, the British Health Minister fortified the *International Code of Practice on Ethical Recruitment of Health Workers* by signing a memorandum of understanding with the Minister of Health in 2004 in the RSA. Among other things, it was agreed that Britain would not expand the NHS by taking advantage of South Africa and other developing countries, and that they would use bi-literal agreements with countries of high volume and impact. This bi-lateral agreement was a commitment to create education and practice opportunities within the NHS for South African health professionals for specific periods. Furthermore, failure to comply with the Code would cause ties with recruiting agencies to be severed, particularly regarding health professionals targeted for private hospitals in Britain (Aiken, Buchan, Sochalski, Nichols & Powell 2004:69; Health Services Union (HSU) 2007: 6; Kingma 2006:126-127; Pretorius 2004). However, this decision was short-lived in that two years later, the level of recruitment from South Africa once again increased tremendously (Kingma 2006:131).

2.2.2 The Philippines

In the Philippines, the export of nurses to developed countries has been practised for years with government sanction because overseas employment is a key source of economic growth. The Philippines trains nurses in order to post them to developed countries as an attempt to boost the country's economy with wages that are regularly sent home to family members. This factor therefore makes the Philippines the largest source country. To enhance this effort, the Philippine government has established protective government offices in countries where most Filipino migrant workers are located, as an attempt to service these workers in their destination countries. On the other hand, what makes the pattern of migration of the Philippine nurses unique is that once they have settled abroad, they bring their families, parents and siblings for permanent citizenship, consequently leaving serious staff shortages in their HCS (Kingma 2006:203).

In contrast, the International Council of Nurses' (ICN) position regarding migration is that quality health care has a direct link to adequate supply of suitably qualified and committed nursing personnel in all countries (ICN 2007). While the ICN recognizes the right of individual nurses to migrate and the potential benefits derived from nurse migration, it also acknowledges the adverse effects that could be imposed by international migration on HCS in the source countries, which are usually immensely depleted of their nursing workforce. At the same time discontent with low salaries and staff shortages could possibly be largely responsible for nurse migration. Because the Filipino nurses' education provides them a college degree with good communication skills and English proficiency, there is a great demand for nurses from the Philippines around the world. Saudi Arabia, the UK, Ireland, the USA and Singapore are the common 'receiving' countries that benefit from the Philippines development plan (Aiken et al 2004:69).

Less developed countries like China, India, and some of the newly independent States of the former Soviet Union aspired to follow the Philippines example of training nurses to export them to developed countries,

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but were restricted by limitations to provide suitable infrastructure for nursing education consistent with world standards (Aiken et al 2004:75).

2.2.3 The Kingdom of Saudi Arabia (SA)

Mufti (2000:37-38) examined HCS in the kingdom of Saudi Arabia and found that the country was completely dependent on foreign human resources. Hospitals mushroomed due to increased wealth from oil revenues, which was devoted to development of the country. The huge expansion in health facilities and services placed great pressure on health planners to deal with staffing matters by recruiting foreign personnel from different parts of the world. This shortage of nurses and health personnel was a major concern for health authorities, who were devoted to the process of Saudisation of human resources within the kingdom. Since Saudisation was a long-term process, tentative measures had to be put in place to run the services. Concomitantly, the number of physicians, nurses and allied health personnel increased tremendously, especially with regard to high technology facilities within the kingdom. This increase was reportedly comparable to developed countries, which revealed progress made within the kingdom (Kingma 2006:107; Mufti 2000:36-37). In order to keep RNs on the cutting edge of nursing practice, continuing education as a tool of human resources planning and development was instituted with annual recertification of RNs in their specific fields of specialty. This practice was consistent with the recommendations of the ICN (2007) that opportunities be made available for nurses to access programmes that ensure competence, advancement, skill and high level of knowledge that guarantees the provision of quality care.

The process of recruiting expatriates was not without problems, however, in that their dependence on foreign personnel made the HCS vulnerable to wastage of expensive resources. Continuity of other essential programmes and services experienced serious problems because most expatriate professionals stayed for only short periods, due mainly to discontent with the constrained lifestyle imposed on them by religious rule, and left the country

before most services could reach a reasonable level of maturity and stability. Consequently, a great deal of expensive equipment became either 'white elephants' or obsolete. This gave the impression that expatriate professionals came to the Kingdom for financial gain, which placed professional ethics in question. This, in turn, required that Saudisation efforts be intensified because Saudi nationals would be more committed to health care delivery within the Kingdom than expatriates (Mufti 2000:37).

2.2.4 United States of America (USA)

The USA is considered one of the largest 'receiving' countries of foreign nurses because of the vastness of the health care system in that country, the lucrative salaries and the recruiting potential of its agencies. Nurses from countries in which English is not the official language have to pass an English proficiency test. In addition, all foreign nurses are required to pass the US Commission on Graduates of Foreign Nursing Schools (CGFNS) in order to practise nursing in the USA. The CGFNS is a neutral, non-profit organization which handles immigration procedures worldwide. This prepares foreign-trained RNs to pass the National Council Licensure Examination, in order to reduce disappointment and discontent of RNs who travel to the USA expecting to be employed but fail the prescribed examination. Moreover, RNs who pass the CGFNS are not guaranteed a visa in a timely manner because the USA does not have immigration legislation that gives nurses a priority. These delays also create areas of discontent among RNs who sometimes have to wait for one to two years for their visas. On the other hand, the US nurses tend to believe that overseas recruitment took the place of finding solutions for workplace problems that contribute to staff shortages (Ellis & Hartley 2003: 262; Khadria 2007:1431).

The level of secondary school education is not recognised by the USA, which requires nursing education to be post-secondary level. Consequently, very few Mexican nurses immigrate to the USA, which frustrates many in that country (Aiken et al 2004:72-73).

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2.2.5 India

As the demand for recruiting nurses continued to increase worldwide, commercial recruiters also took more interest in recruiting nurses from India to the USA, the UK and other first-world countries. Much of the recruitment focused on some of the best hospitals in India, leading to a serious exodus of nurses to hospitals abroad, leaving much discontent among RNs who had to grapple with a shortage of staff. India was second to the Philippines in supplying these countries with well-trained, English-speaking nurses. The problem faced by most RNs is that licensing and visa processes as well as the waiting period for departure vary with different countries, which becomes a source of frustration for most nurses (Edward 2005:35). In response to growing interest among nurses, the Indian hospitals took advantage of the situation by recruiting, training and preparing more Indian nurses for foreign nurse examinations in what they called "business process outsourcing" (Khadria 2007:1429). In this process, hospitals could make a profit of up to US $47, 000 when nurses were accepted in overseas hospitals, in contrast to an average of US $700 to $7 000 invested in training a nurse. One recruiting agency, for example, disclosed its ultimate goal of exporting about 100 000 Indian RNs to the USA by 2010. These huge profits further led the Indian government to take an interest in facilitating international nurse migration in some of the States of India (Khadria 2007:1431). Like the Philippines, India now faces a dual challenge of providing human resources for the country's HCS and for posting more RNs abroad. As a result, India experienced a dire shortage of nurses particularly in rural areas. According to Khadria (2007:1431), none of the authorities seemed concerned about the future impact of international migration on the country's HCS. Instead, hospital managers in India appeared to be joining forces with these organized profitable commercial ventures whose objective was to train and recruit nurses, confirming the future growth of these agencies.

2.2.6 African States

Most of the African States frequently suffer setbacks with minimal resources and inadequate qualifications as most health professionals settle for recruitment in overseas countries (ICN 2006:1). Amidst growing global demands for nurses then, nurses would appear to be holding the continent's HCS together. Without development of strategies to recruit and retain health professionals, it would seem unlikely that the Millennium Development Goal for maternal health in Sub-Saharan Africa would be achieved. This emphasises that qualified nurses, better working conditions and retention strategies are needed in the entire continent. East Africa depends largely on nurses, who form the first contact for patients in HCS, especially in rural areas. The remaining skeleton staff is over-burdened with increasing numbers of patients with HIV/AIDS, tuberculosis (TB) and malaria, resulting in many nurses being discontented and leaving the country. Many rural dispensaries are staffed with a single nurse with a certificate course, who often attends up to 550 patients per month. This problem is compounded by the poor roads and long distances to more advanced health facilities, which indicates the scarcity of transportation in the region (Gerein, Green & Pearson 2006:40; ICN 2006:1).

According to the ICN (2006:1-2), Kenya needs an estimated more than double the number of existing RNs to attain the 'Millennium Development Goals' by the year 2015. To accelerate human resource development in Africa, the Aga Khan University (AKU) introduced a part-time study programme for enrolled nurses, who form a larger part of the nursing workforce, to advance to positions of RNs in a five-term distance learning course. These developmental initiatives were designed to earn RNs academic credits for further career advancement. The success of these programmes allowed expansions to reach Tanzania and Uganda. In Ghana, the Senior Registered Nurses program was reintroduced to empower RNs with post-basic specialization skills desperately needed by the population (Kingma 2006:123). In the process, RNs seeking career development opportunities would be rewarded.

The foregoing indicates clearly that discontent among RNs is a blanket problem experienced in different forms in other countries, inclusive of receiving countries as well. The ICN (2007:75) points out that in some host countries nurses are exploited and made to perform duties inconsistent with their qualifications. Furthermore, migrant health workers are subjected to non-recognition of extra qualifications, unfavourable working conditions, bullying attitudes, second citizen attitude of patients and co-workers, discrimination in work assignments and cheating of agents with job destinations (HSU 2007:7-8; Kingma 2006:110, 114; Oulton 2001:78). With these and other complaints, expatriates choose to remain anonymous in order to protect their jobs and confiscation of their visas.

2.2.7 Restructuring of HCS in South Africa

In the RSA, the policy on restructuring of HCS came as a major reform and effort to dismantle the former apartheid laws and structures. The focus was on the development of new health policies that would drive the health sector to equitable public health service delivery among its citizenry, with standards commensurate with world trends. In order to accomplish these goals, a macro-economic policy was developed, which would ensure quality and equity in access to HCS (ANC 1994; DOH 2001). To achieve this objective, some of the hospital allocated budget was diverted towards the proliferation of Primary Health Care (PHC) services, a policy which has deep roots in the RSA (Stack & Hlela 2002:8). These policies were based on the ANC's newly formulated health plan for South Africa, which also became the basis for the *Batho Pele* White Paper for the transformation of the health system in the RSA. Despite being more advanced than policies in other public sectors, its implementation nevertheless seemed to have experienced serious service delivery problems. This could have been influenced by the magnitude of migration of health professionals from the PHS.

- **Hospital rationalization**

In their study of the reasons for the apparent gap between policy making and implementation, Stack and Hlela (2002:6,12) found inconsistencies that imposed budget restrictions on health care expenditure and the concurrent expansion of HCS, among other things. This included improved access to health services for more people, reduced drug prices, free health care for pregnant women and young children, and much improved patients' rights. In other words, hospital budgets did not match expenditure and expansion of public health service delivery. Consequently, lack of equipment, poor supply of medicines, staff shortages and other problems ensued. The shortage of staff was largely ascribed to migration of RNs from the PHS and redeployment of staff to cover the expansions of PHC services (Shonisani 2008:3). Buthelezi (2004:243) maintains that the "exodus among Black South Africans was inevitable as transformation of the country did not accommodate the plight of, in particular, the African women". Thus, overworked and underpaid nurses and doctors, in general, had to look for alternatives. However, Nduru (2004:2) points out that the exodus was predominant among white practitioners migrating to Australia, the UK, Canada, the USA and the Middle East countries. Thereafter, the number of black South Africans rapidly began to increase as they joined their white counterparts in overseas recruitment after the inception of democracy.

Since the new health policy required the redistribution of health personnel from tertiary hospitals to lower levels of care that included PHC services, HCS were subsequently divided into level one (district hospitals and PHC services), level two (regional hospitals) and level three (academic hospitals) (DOH 2001). This process came with the reallocation, freezing and cutting of posts. According to Stack and Hlela (2002:12), the whole restructuring process resulted in discontent among health professionals and job insecurity, thus leading to migration of health personnel from the PHS. The unfortunate results were compromised standards of care in the PHS, with patients and remaining health providers bearing the brunt.

- **Management of hospitals**

In the RSA, traditionally, hospitals were managed by senior medical superintendents, who did not possess other essential skills for these posts, such as financial, information and human resources management (Jansen 1991:165). In 1999, new legislation made provision for the appointment of Chief Executive Officers (CEOs) in public hospitals. Even though the *Batho Pele* White Paper mandated decentralization of management to promote efficiency and cost effectiveness as a basic principle to guide restructuring of HCS, hospital managers were very restricted as the provinces maintained control over finances and administrative powers (Rantho 1999:12-13). To this, the DOH (2001) stated that decentralization did not intend to put central control at loggerheads with the peripheral units. The intention was rather to inculcate a working relationship promoting the realization of a decentralized system. In this context, power and authority would be shared in a non-polarized system comprising different echelons of responsibility that ensure coherence, efficiency and accountability in public health service delivery. The development of a unified but decentralized NHS was a result of the transition of the overall policy from the past health dispensation which started in 1995. Decentralization generally implies the shift of authority, power and functions away from the centre to the peripheral units to afford them a semi-autonomous status. This mechanism is believed to be effective in facilitating greater equity and efficiency, as well as community involvement. In the process, excessive bureaucracy would be reduced.

Stack and Hlela (2002:13) argue that devolution of powers to hospital management has been slow and in stark contrast to the intentions of the policy for improved management systems. Staff appointments and the cutting and creation of posts were no longer under the jurisdiction of hospital managers. However, the provinces maintained that there were legal implications to consider, such as devolution of power to hospitals that "do not have the capacity to exercise them" and the "fear that devolving human resource management to hospital managers may result in government's

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equity in employment policies not being optimally followed" (Stack & Hlela 2002:13)

- **Empowerment of employees**

In their study on the experiences and perceptions of nursing service managers (NSMs) regarding transformation of health services in selected provincial academic health complexes, Buys and Muller (2000:52-53) found that NSMs felt that they were not empowered enough to exercise complete authority over situations in the new HCS.

Given these restrictions, it is believed that managers who have positions and principles of democratisation without power cannot successfully fulfil organisational goals. At the same time, managers who have power, position and no principles to guide the process may find it difficult to implement transformational policies they have been charged with (Moji 2006:6).

According to Booyens (2000:133), in a decentralized system, it is crucial to determine who is responsible for human resources, who handles the budget, who deals with disciplinary matters, transfers, promotions and how the grievance procedure are managed as an empowerment strategy. Booyens contends that if the organization does not have sufficient empowered managers to take responsibility, policies will not be implemented effectively and units will not receive adequate attention.

2.3 MANAGEMENT AND LEADERSHIP PROBLEMS IN NURSING

Nurse Managers in the twenty-first century are faced with unique challenges and the reality of managing diverse groups of health workers with different needs and persuasions. In the RSA, the *Batho Pele* principles require that transformation display participative, decentralized, change and outcome-based management processes (South Africa 1997c:11). These principles were also intended to help foster collaborative relations between NSMs and RNs in the workplace.

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While there were positive aspects to unionization of the health sector, such as representing their members in bargaining councils where important decisions are made, and protection of nurses' rights from exploitation by employers, the process was not without negative effects. A rift developed between NSMs and RNs as more nurses took membership with unions, where many processes and procedures had to be decided in conjunction with union representatives on behalf of their members. Inevitably, nurses were caught up in conflicting interests between working with management and becoming involved in strike actions in consonance with union decisions under the provisions of the Constitution of the RSA, leaving a fragmented nursing profession (Bezuidenhout, Garbers & Potgieter 1998: 57, 281; Mantashe 1995:82).

With regard to management problems in the workplace, Bezuidenhout et al (1998:279) point out that before formalised grievance procedures were introduced, suggestions from RNs to top management were usually not welcome because of the structure of power in place, which in most instances resembled a closed system. Buys and Muller (2000:53) found that some RNs felt alienated from hospital management, except for receiving 'tailor made' orders for implementation at the functional level.

Sullivan and Decker (2005:7-8) contend that even though tradition had NSMs at the top of HCS, they are expected to function at the centre of a complex web of inter-connected networks. This means that NSMs have to bond well with a plethora of different professions and civil society comprising RNs, patients, local community members and the multi-disciplinary team, trade unions, professional bodies and government (see figure 3.2). They are also required to take into account multiple points of view while at the same time providing advice and guidance on health care policy where appropriate. Consequently, decision-making is more complex for NSMs as they are confronted with increasingly diverse demands and political pressures arising from policy initiatives and other issues. In this complexity, Neuhauser (2002:478) maintains that nurse managers can exercise a habit of kindness to minimize dissatisfaction among nurses. Tshikwatamba (2003: 36) and Stack

and Hlela (2002:13) concur, citing the importance of retraining existing personnel administrators for a new management style, namely from personnel administration to human resource management. Buys and Muller (2000:53) are of the opinion that the main problem is the lack of professional development among NSMs because of insufficient study opportunities.

To make up for this deficit, Booyens (2000:125) suggests that managers invest in modern management tools and theories that could be used in the current health dispensation. This author cautions, however, that there is no universal theory of management useful to all managers in different settings. This means that managers should carefully analyse problems inherent in their health care institutions in order to select managerial style(s) that suit their establishment. In this way, management and staff would be able to formulate objectives, action plans and strategies adequately informed about the internal and external environmental influences facing them. This approach was illustrated by President-elect of the USA Barack Obama, who, together with his team first identified and prioritized the problems and needs of the American society, then set out to establish strategies to address them "head on" even before he was sworn into Presidency (Obama 2008a).

2.4   CAREER DEVELOPMENT

The ICN (2007) emphasises that the quality of nursing determines the effectiveness of health care delivery. This means that more focus and effort should be directed towards advanced practitioner roles to facilitate planning for health service delivery and to meet the needs of the population. As part of career development, many institutions use "career pathing" to promote staff to the next higher grade, which considers the nature of work as required in the next grade. Grossman and Valiga (2005:75) postulate that nurses do not have to be in nursing management positions to be true leaders in nursing due to the paucity of management positions in the nursing profession. Consistent with this view, the clinical ladder programme was designed in some USA hospitals to reward nurses who chose to remain at the bedside because by

empowering them, the institution would benefit equally. Some programs designed enabled RNs to write policies, conduct in-service training, and participate in different committees (Bergman, James & Solove 2006:475). In Ireland, career pathways were introduced as an effort to maximize RNs' level of responsibility, enhance skill development and expertise, for staff retention and better service provision (McClellan 2007:34). These clinical career pathways enable RNs to move from generalist, then specialists to advanced practice in nursing. Moreover, they are remunerated on a different pay scale which is consistent with additional qualifications, responsibility and autonomy (McClellan 2007:30). Neuhauser (2002:473) recommends that this strategy be followed by organizations that experience loss of staff because of aspirations to advance their careers. This would mean creating an internal environment that allows nurses to move from one specialty to another if they so wish. In addition, providing resources such as rewarding additional qualifications and special achievements, study leave opportunities and hosting special issues forums could substantially reduce the level of discontent among the nursing staff.

Another approach for enhancing career development in HCS mentioned by McClellan (2007:28) is to encourage nurses to acquire masters and doctoral degrees, because high qualifications in nursing elevate the status of a profession. Pauline and Seamus (2007:626) found that 99% of the respondents indicated that promotion to higher positions and extensions of clinical roles were key motivations for engaging in further study. Becze (2007:30) concurs and recommends further private practices be established for suitably qualified RNs in the area of their specialty. In addition, lower categories of nursing could also advance their education through a variety of study programmes, or choose to venture into managed care programmes or entrepreneurships (Becze 2007:30). Nevertheless if they love bedside nursing, it is not necessary for these nurses to move to management positions after acquiring higher degree qualifications, since they could use their expertise to mentor others, serve as preceptors or become clinical experts.

According to Becze (2007:30), an additional useful option for RNs who seek higher positions in other organizations would be to keep a portfolio, which has proved to be more helpful than curriculum vitae (CV) because it has the advantage of providing interviewers with a quick overview of the nurses' employment and achievements history.

To highlight the importance of career development in nursing, the ICN (2006:1) found that in third-world countries nurses were leaving the services mostly due to lack of opportunities for career development. Moreover, RNs were often the first or only point of contact for patients where larger portions of the required HCS were obtained. Besides scarce financial and material resources, appropriate qualifications were seriously declining due to the influence of global factors, leaving behind the less qualified to care for the sick. The current state of HCS in the African continent therefore required innovative ways to meet these tremendous challenges, especially in rural areas. Consequently, the Aga Khan University (AKU) developed an innovative part-time study programme (distance learning) to assist nurses in the African countries to learn and apply new skills while working. The advantage of this programme was that academic credits would be given for career advancement.

This further emphasises that health institutions need to develop ways to enhance career development programmes and develop career pathways to assist RNs to advance to higher levels without necessarily moving into managerial positions.

In the RSA, the OSD for RNs, Staff Nurses and Nursing Assistants provides the following structure for career pathing in the PHS (Department of Public Service and Administration [DPSA] 2007:3):

- **Career pathing by means of grade progression at production level**

This is a periodic remuneration system based on above-average performance in performance appraisals, qualifications and experience to facilitate

progression at the production level without RNs necessarily moving to supervisory or specialty post for salary increase. This strategy endeavours to motivate RNs for better performance and discipline in the workplace through the accumulation of points.

- **Dual career paths**

This strategy enables RNs to progress to higher levels when entering specialised fields, with salaries equal to or higher than those of managers in general nursing without moving into management or supervisory positions. It is also a strategy that is influenced by specialty nursing requirements, where RNs are remunerated according to qualifications in specialty areas such as PHC, intensive care and the others. More importantly, this strategy is intended to serve as a means of retention and recruiting nursing personnel, to counteract nurse migration from the PHS.

2.5 REGISTERED NURSES AS MEDICAL ASSISTANTS: AN EXTENDED ROLE

2.5.1 The United States of America

Medical Assistants have been part of the health care system for decades in the USA, and are known as 'Physician's Assistants' (PA). Their educational preparation entails a three-year university degree, and they work under the direct supervision of a qualified doctor, usually a specialist, visiting patients under the care of the specialist, prescribing medicines for the patients and giving instructions to nurses including Intensive Care Unit (ICU) nursing staff (US Department of Labour 2008:1-2). They are also found in hospitals, outpatient care centres and the Federal government, and some are self-employed.

2.5.2 The United Kingdom

The UK uses nurse prescribers to assist with the shortage of doctors. This is a fairly new concept that needs further exploration for a clearer understanding of the professional background, the rationale behind the choice, and the perception of the new role of RNs, in order to enhance the selection, educational preparation and support for nurses in that country (Bradley, Campbell & Nolan 2005:439). To delineate this new innovation, two types of nurse prescribers are presented:

- *Supplementary prescribers.* This category of prescribers are guided by the entire British National Formulary, which excludes Controlled Drugs (narcotics and addictive drugs), as well as unlicensed medicines. This type is a highly collaborative activity, which requires persistent monitoring of its effects.
- *Independent prescribers.* Independent nurse prescribers are restricted to stipulated items in the Extended Nurse Prescribers' Formulary (ENPF) (Bradley et al 2005:440,445).

Bradley et al (2005:442) found that most RNs were enthusiastic about the innovation as it would advance their practice and enhance their autonomy while others thought it would only serve to legitimize what they were already doing. Accordingly, Bradley et al (2005:442) maintain that as interest continues to grow among nurses to become prescribers, the appropriateness of the course should be examined in order to inform further developments.

Scott (2004:348) contends, however, that the attraction of nurses into the medical model could influence the profession's image and the traditional professional nursing role could easily dissipate in the current economic and political trends. Furthermore, the medical model has different objectives and as such, does not cater for the caring values and nursing philosophy.

2.5.3 South Africa

The medical assistant, also called a mid-level medical worker, is a new concept in the RSA, introduced in 2004 as a resolve for the poorly resourced rural areas, where they would mainly be based. In addition, their job description would include emergency services, out-patients' departments, surgical and other services in urban areas, where doctors have been sharing certain tasks with nurses. Their role in district hospitals would obviate the overlap and uncertainty with PHC nurses, who were also invited to enrol for the programme. The feasibility of this programme began with a fact-finding delegation from the DOH and the Health Professions Council of South Africa (HPCSA) to the USA and Tanzania. A task team was then appointed by the DOH to consult with various stakeholders regarding the implementation of this programme in 2004, and it was subsequently launched. Candidates would be subjected to three years training in Medical schools as part of the Family Medicine Training, where undergraduate, intern and postgraduate, as well as training for PHC nurses would be undertaken (DOH 2008a; Hugo 2005:155).

Hugo (2004:3) asserts that, general medical practitioners have been working with nurses as midlevel medical workers for many years. They also contributed immensely in the training and development of nurses as PHC nurse practitioners. However, the recommendation for the extended role of RNs to be medical assistants (Clinical Assistants) did not receive much corroboration from all nurses, as some NSMs regarded it as tremendous pressure and an attempt to divert the nursing role away from caring to practising medicine. Hugo (2004:3) contends that since PHC nurses have been the backbone of the nationwide PHC system for decades, they would appear to be more valuable in this new role, given their vast experience with PHC services and the under-resourced rural and peri-urban areas in the RSA.

An extended period of one year training for interested RNs, beyond their four-year course in the South African context, was recommended. This exercise was considered cost effective since it engaged minimal training, to expedite

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the process of assisting doctors, particularly in district hospitals, which are instrumental in reducing workload from regional and academic hospitals. However, based on the overwhelming shortage of nurses and escalating health needs, the important question yet to be answered is whether medical assistants are a replacement for health professionals where shortage of nurses, doctors and other health professions has crippled HCS (Hugo 2005:156).

Broekman (2008b:17) maintains there are negative aspects to this new venture, such as masking the urgency with which the entire health care system in the RSA needs to be re-modelled in terms of identifying and addressing the root cause and continual migration of skilled health professionals from the PHS and rural areas. Broekman is concerned that in the future, this problem could leave medical assistants functioning without supervision, therefore, defeating the intended purpose. Secondly, the overlapping of the scope of practice for RNs and medical assistants both in PHC services and hospitals could result in tension and confusion because nurses are highly skilled and highly regarded by patients. This could result in discontent among nurses and consequently destabilize the working environment. Thirdly, there are certain legal liabilities pertaining to patient care that have not been defined with this emerging role. Lastly, the clinical assistants (including nurses interested in this new role) in the future could appeal to the South African Qualifications Authority (SAQA) to be recognized as medical practitioners without necessarily going through medical university training.

van Niekerk (2006:1209) is concerned that the stable relationships among existing health professionals could be negatively affected by disputes over status, pay and the boundaries to be attached to this emerging role. Furthermore, their role could become redundant with the increase of nurses and doctors.

- **The private health sector**

According to Mills, Brugha, Hanson and McPake (2002:325), there are for-profit and non-profit providers. Private ownership includes those whose focus is on profits, clinics and hospitals that are privately owned, mission hospitals, non-governmental organizations (NGO's) and "private wards" (*Folateng*) located in public hospitals, among others. In Tunisia, there are no private hospitals at all. Hospitals are demarcated from clinics by virtue of conditions of employment for physicians. According to their regulations, hospitals are staffed by full-time salaried doctors while physicians in clinics depend on fee-for-service methods, since they have no contractual relationship with health facilities (Hanson & Berman 1998:197-198). Nepal is rated the lowest with 6.9 beds per million in supply of for-profit private beds in comparison to Argentina which is rated the highest with 1456.9 beds per million. However, in general terms, sub-Saharan Africa and Asia have the lowest supply of beds, both in the private and the public health sector (Hanson & Berman 1998:7; 201).

In the RSA, the key characteristic distinguishing the public health sector from private hospitals is the very nature of their definitions which connote government jurisdiction for the former and private ownership for the latter. The bed capacity of private hospitals is far less than that of public hospitals, and they cater mainly for medically insured patients (Mills et al 2002:325; Moorman 2001:84).

The public health care system in the RSA is still burdened by about 80% of the State dependant population and is subsidized by the State to provide basic emergency services to all clients, while the private health care system is geared towards fulfilling the needs of the affluent; that is, it caters mainly for medically insured/private patients who form only 20% of the population (Benatar & van Rensburg 1995:5).

The 1997 *Batho Pele* White Paper requires that the activities of the public and private health sector be integrated in a manner to make optimal use of all

available health care resources. This was intended to promote equity in public health service delivery (ANC 1994; McIntyre & Gilson 2002:1637). However, the private health sector has had a negative impact on the PHS from its inception. Among issues of concern, is the draining of the majority of highly skilled health personnel and paying patients out of public hospitals, resulting in inefficiency in the PHS. The return of expensive cases back to public hospitals once their medical funds have been exhausted exacerbates a situation already out of control (McIntyre & Gilson 2002:1644; Moorman 2001:84). Stack and Hlela (2002:35) describe the proliferation of private hospitals as thriving by siphoning doctors, nurses and medically insured patients from the PHS.

Benatar and van Rensburg (1995:6) affirm the disparities that exist in health care provision and access to HCS because of market-driven private sector services and maintain that effective policies could support a fair and equitable distribution of human resources. Stack and Hlela (2002:35) point out that health expenditures between the private and public health sectors is highly skewed with the PHS catering for the vast majority of the citizenry and providing all the medical training in the country.

In order to bridge the gap, a model was developed that enabled some private patients to be admitted in private wards within public hospitals. This in turn would allow State hospitals to derive finances from medical insurance while also acting as a 'pull factor' for medical doctors and specialists (Mills et al 2002:325). In one province, the local doctors' association reached an agreement with the DOH for doctors to admit their private patients to neighbouring public hospitals and pay certain fees for using the facilities. This, in turn, enabled them to contribute to additional equipment and services through a trust fund. Some motor industries also agreed to a payment of low premium health plan for their workers to utilize state hospital facilities. These measures are a means by government to augment public hospital revenues to improve working conditions, which could help to retain RNs in the PHS (Stack & Hlela 2002:35).

2.6   WORKPLACE VIOLENCE

The incidence of violence in health care settings in recent years is a phenomenon which seems to be escalating in many parts of the world (Kingma 2001:207). Workplace violence, and not salaries, is a common theme among nurses (Oulton 2006:91). According to Makhubela-Nkondo (2001:34), workplace violence is defined as incidents where "staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health". This type of violence or abuse manifests in different forms such as slapping, stabbing with a knife, shooting, punching and verbal abuse. Richards (2003:4-6) found that the most common form of violence was verbal abuse of nurses and other health care workers by patients and their families, doctors, managers from different echelons of the organization and even their associates within the system. This made the workplace unbearable, stressful and not conducive to expected patient care outcomes. Stainsby (2004:42) emphasises that the well-being of nurses determines their ability to care for others.

In 2000, the ICN, the World Medical Association (WMA) and the International Pharmaceutical Federation called for measures to be designed and implemented to secure the safety of health personnel providing PHC and working in conflict zones (Kingma 2001:207). After the murder of a State employee in the USA in 1993, the Californian Occupational Safety and Health Administration (OSHA) provided the following guidelines for workplace violence prevention programme (McPhaul & Lipscomb 2004:8):

- Management involvement and commitment to the policy and its implementation
- Involvement of employees in policy development, post assault counselling, debriefing and follow up
- The installation and maintenance of alarm systems in high risk areas, including training and posting of security personnel in emergency areas

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- Staff shortages to be addressed, adequate lighting to be provided and control of access to staff offices and secluded areas
- Periodic and pre-placement training and education of staff members regarding risk factors for violence and control measures
- Worksite assessment and job hazard analysis are mandatory, including timeous reporting of incidences and threats that do not necessarily cause physical injury.

In the RSA, the Democratic Nursing Organization of South Africa (DENOSA) condemned the state of violence in some of the provinces and appealed to government for urgent and vigilant security in HCS since hospitals were considered places of taking care of the sick and the vulnerable (Fongqo 2007; Seshoka 2005:32). However, Neuhauser (2002:476) argues that the 'Gen X' generation does not rely on government or corporations to provide security because of their state of independence and confidence that they can take care of themselves. According to Oosthuizen and Ehlers (2007:16), like all citizens of the country, nurses are exposed to acts of violence and crime in their personal capacity and as health care providers in the workplace, since they are obligated to care for the victims of violence and crime.

Noting that today's nurses were faced with one of the most complex and dangerous occupational hazards in HCS, McPhaul and Lipscomb (2004:8) found that the common sources of exposure were related to taking care of violent patients, staff shortages, emergency rooms, psychiatric wards, unrestricted movement of the public and lack of "strong violent prevention programs and protective regulations". The International Labor Organization (ILO), the World Health Organization (WHO), the ICN and the Public Services International (PSI)'s joint programme on workplace violence in the public health sector refers to the following categories: Type 1: 'external violence', Type 11: 'client initiated' and Type 111: 'internal violence (Richards 2003:2-3).

Based on these subtypes, Richards (2003:6-25) provides detailed responses to acts of violence in the workplace under the following headings:

- Immediate response to violence
- Responsibility to an abusive telephone call
- Procedures for responding to incidents
- Basics of a reporting form
- Physical treatment, Mental health debriefing, Mental health counselling
- Five essential functions of a counselling service
- Representation, legal aid and union/professional association initiatives
- Time of and return to work for the victims of violence
- Training staff on how to respond to violent attacks and involvement in policy making.

The ILO also designed a similar code of practice in workplace violence in services sectors designed to develop practical responses in the workplace and provide guidance in developing national laws and policies that would minimize or eliminate workplace violence (ILO 2003).

2.7   STRESS

Rees (1997:35) defines stress as the inability to cope with the pressure of work. When the coping mechanism is compromised, Makhubela-Nkondo (2001: viii) points out that personal factors such as age, gender, socio-economic status, lifestyle and stress become important determinants of disease. According to Carter (2007:9), as a result of stress and hopelessness, some nurses and other health care workers progressively indulge in alcohol and drugs, even though the magnitude of the problem is still uncertain. To this end; ethical, legal and moral obligations clearly endorse the notion that the nurse be in good health in order to care for others. Stainsby (2004:42) is of the opinion that the pressing needs of patients, doctor's orders and routine care of patients add to the mounting pressure on nurses in the midst of staff shortages and exacerbate stress among nurses in the workplace.

According to Booyens (2000:145), hospitals are seen as extremely stressful environments to work in, on account of constant interaction with the sick and as such, nursing is considered a very stressful occupation. Because of this, Buthelezi (2004: 361) believes that the greatest plague in nursing today is stress. Moreover, apart from afflicting nurses as individuals, stress is also a consequence of the stressful conditions under which nurses work.

McLeod (2007:16) found that stress in the workplace among RNs sometimes came as a result of harassment from nurse managers as they questioned RNs' competencies and ability to make decisions. Rees (1997:35) adds that some of the causes were striving for excellence in the public sector against budget constraints, the drive for cost-effectiveness, organizational restructuring, fear of redundancy, increased workload, feelings of inadequacy, failure and guilt. Dendaas (2004:17) found that poorly equipped patient rooms sometimes hinder the nurses from completing their tasks, leading to job stress commonly reported among nurses.

2.7.1 Organizational environment and leadership

According to Booyens (2000:146), restructuring of HCS is one of the factors that exacerbate stress in the work place. Employees may find that there is no clarity or adequate information regarding what is expected of them. As a result, employees could feel that they lack support from management to implement change within the organization. The unprecedented enormity of resignations during reform initiatives has therefore stress-related consequences. Frequent changes in instructions, policies and procedures, especially where staff is deficient, also exacerbate stress for workers.

2.7.2 Employees

Decisions and changes that affect employees without prior notice and active involvement where applicable have a negative impact on employees. This can further be compounded by increased amount of work and little time to

accomplish the tasks at hand, due to shortages of staff. Living in a legal wise society with liability issues increases pressure for efficiency, thus resulting in stress among workers (Booyens 2000:146).

The multiple roles of nurses also play a major role in stress-related activities, especially in the case of married nurses. Conflict arises where there is a shift from professional context at work to the role of a mother and spouse at home. Added to this is the strain of working cumbersome and exhausting shifts, which is further compounded by the fact that an individual's biorhythm takes long to adjust to changes in sleeping patterns. Fatigue from shortage of staff as well could lead to divorce and confrontation with in-laws among nurses (Booyens 2000:146).

2.8   REGISTRED NURSES AND INTERNATIONAL MIGRATION

In recent years, migration of health professionals from developing countries has become a universal subject of academic inquiry. International migration is a phenomenon that has both positive and negative implications worldwide. The global movement resulted in understaffing, which was rated among the top six nursing workforce issues of global concern (Armstrong 2001:1). Kline (2003:108-109) found that the primary donor countries were the Philippines, South Africa, Canada, Australia and the UK. The receiving countries were the USA, UK, Canada, Australia and Ireland. Chikanda (2006:667) found that this trend also manifested in movement of health providers from the public to the private health sector within their countries. It is generally agreed that low salaries are not the only "push factors," but a number of reasons that influence global mobility.

Ahmad (2004:797) argues that it is in leaving this dilemma of skilled migration to market forces that defeats the purpose, as opposed to developing strategies to counteract the flow. The resultant problem is that developed countries find themselves indirectly being subsidized by developing countries, in their quest to patronize them, which constitutes ethical and moral implications. Whereas recruitment used to take place between the relatively

rich countries and regions, the pattern of migration of nursing personnel has now generally spread from the PHS to the private sector, rural health services to urban and from under-developed to the developed countries (Kingma 2001: 211). Similar findings have been cited by Chikanda (2006:670) that doctors and nurses in Zimbabwe were also attracted to private hospitals and overseas countries.

While international recruitment remains a global issue, South Africa is a unique case because of previous exclusion from the Commonwealth countries, as a result of apartheid. With the inception of the democratic government, the 1996 Constitution enabled freedom of movement and residence to the South African citizens. According to Nduru (2004:2), the number of black South Africans has rapidly increased since the enforcement of the constitution. Broekman (2008a:17) found that the push factors for South African health professionals were mainly pathetic working conditions, poorly maintained facilities, lack of equipment and increased workload because of staff shortages. Buthelezi (2004:243) maintains that the exodus among nurses was inevitable as transformation of the country did not accommodate the plight of nurses. As a result, overworked and underpaid nurses and doctors looked for alternatives. Nduru (2004:2) contends that the issue is not so much their departure, in pursuit of better qualifications, but their return to plough back in the country. Therefore, efforts should focus on strategies for recycling them back into the job market to the benefit of the country.

Jordan (2001: 3) states that migrant nurses are exercising their constitutional rights and have the support of the organization. Kingma (2001: 205) postulates that while low salaries and other benefits rank high in the migrant phenomenon in other studies, career interests remain key incentives among most expatriates. Nurses are considered 'resolute' in their pursuit for personal and professional development. Therefore, to deny them the liberty to apply their newly acquired theoretical and clinical experience in new locations or health settings in other countries would be to deprive them of a more rewarding professional career. Kingma (2001:206) adds that talent, as a

general principle, usually goes to the higher bidder. Ahmad (2004:797) cites the example of Germany persistently developing emigration policies to woo expertise from developing countries.

As a control measure, South Africa and Jamaica lobbied the UK to put in place strategies that would minimize the influx of nurses, especially from the RSA (Kingma 2006:126-127; Kingma 2001:211). Oulton (2004:138) condemns such a move as a "regressive method" and unacceptable option of banning emigration of nurses. Oulton goes on to state that governments should rather work towards strategies that retain nurses.

According to Parish (2004:9) it is paradoxical that, while the WHO was working on strategies to regulate the medical and nursing carousel around the globe, the US National Council of State boards of nursing was removing barriers of entry into the US for health professionals. National Council licensure examinations are now taken outside the US to accelerate migration process. The major objective of this move is to woo specialist nurses in particular, by offering free flights home, health insurance and subsidized housing (Parish 2004:9). Buthelezi (2004:246-247) points out that Saudi Arabia also offers benefits or incentives. In addition to free well-furnished apartments, there are also recreation facilities, free daily shopping bus trips, affordable international group tours, library and numerous other benefits, which the source countries do not provide. Thus, in Iliffe's (1999:1) view, this is a positive side of migration in that cross-fertilization of experience and ideas gained from receiving countries could add value to source countries.

Neuhauser (2002:477) contends that it is a serious oversight for HCS not to endeavour to devise means to retain their top performers as most private hospitals do. Since top performers are valuable financial and professional assets of the health institution, they are often irreplaceable at the same performance levels. These nurses are also cognizant of the fact that their skills are always in demand irrespective of the state of the economy, and will therefore stay where they are made to feel valuable. Secondly, hospital managers tend to think that their top performers are happy with the status quo

because of their continuous excellent performance. Conversely, they could still be providing excellent services because it is their nature to be excellent, even though plans to leave the establishment could be far advanced without the knowledge of the hospital's administrative staff. Lastly, Neuhauser (2002:477) advocates that nurse managers exercise patience and kindness towards RNs. A caustic culture within the organization usually results in depression, fatigue, despair and burnout instead of a friendly and supportive environment.

According to Duffin (2005:10), several member countries have called on the ICN to suggest minimum nurse-patient ratios across the globe when lobbying governments for safer staffing levels. However, this request did not yield favourable outcomes as the new ICN President reported the mammoth task of working around world standards, as opposed to relegating the responsibility to individual countries (Duffin 2005:10). The retention of nurses is considered of paramount importance in the current global deficiency of the nursing workforce. This invariably implies that it is the 'push factors' that need to be addressed by individual source countries (Armstrong 2001: 1; Zondagh 2005:38).

2.9   REGISTERED NURSES AND UNIONS

The LRA 11 and 95 (1) of 1995 makes provision for the registration, recognition and admission of trade unions to collective bargaining structures, as well as the representation of public servants in the RSA. Olivier (1993: 1375) states that this radical development introduced the RSA to developments in other parts of the world and to enjoy the benefits of participating in international guidelines.

According to Gwagwa and Webber (1995:79), nurses' concerns have been high on the agenda of professional and governing bodies since 1957, when the Nursing Act was introduced in the RSA. Commenting on the history of nursing in the RSA, Ehlers (2000:77) alludes to the mandatory membership

imposed by professional bodies on nurses. The main purpose was to establish an indemnity cover for South African nurses. With the rise of numerous movements in the 1990s, the Concerned Nurses of South Africa (CONSA) emerged, which would later give birth to DENOSA. This new professional body also did not succeed in completely unifying the South African nurses (Gwagwa & Webber 1995:82). With the advent of the new democratic government, the 1996 Constitution of the RSA afforded nurses the opportunity to join unions of their choice and to participate in union activities. Thereafter, most nurses defected to the unions as a rebound, leaving a small segment with the professional associations.

Gwagwa and Webber (1995:79) add further that the affiliation of nurses to unions proved to be futile since unions were not keen to handle specific nursing issues, other than salaries. As a result, nurses were virtually left severely fragmented and unable to organize themselves into a united front to defend their course and solve their problems (Ehlers 2000:77).

2.9.1 Trade unions and health care services

The role of trade unions in the PHS became prominent when 900 Baragwaneth hospital student nurses in Soweto embarked on a strike action in November 1985 (Bezuidenhout et al 1998:4). At that time, nurses were prohibited from affiliating to trade unions. Therefore, any involvement in strike actions was illegal. According to Mashaba (1995:66), even though the Nursing Act 50 of 1978 was endorsed to suit the prevailing situations then, section 40 (2) of that Act still forbade nurses from participating in strike actions.

When strikes for nurses became popular in the PHS after 1994, media coverage entertained patients' ordeal as opposed to nurses' grievances (Ehlers 2000:78). Arguing against this practice, Ehlers questions the support provided by their nurse leaders whom she describes as lacking "political assertiveness".

The preceding argument therefore finds common ground with this study, which seeks to explore discontent among RNs from the PHS, in view of providing alternative panacea. The main argument of this study is that if nurses could unite under one body and be represented by nurses at government level, as opposed to unions, discontent among RNs could be significantly reduced in the PHS.

2.9.2 Conflicting values and interests

The dichotomy between nursing ethics and strike actions is another aspect that needs to be addressed in the RSA. As indicated earlier, RNs are torn between two conflicting interests, that of the unions that seem to be successful in addressing nurses' plight regarding salaries through industrial actions, and the continuity of care, which is the core of nursing entrenched in the nurses' pledge and has the support of the LRA. This situation requires an amicable strategy that will foster a balanced work relationship between the employer and the employees. According to Khushf (1994:397), this kind of situation has competing values and different implications for public policy, since some of the rules have to bend in order to work out a compromise. By focusing on political and economic issues, the parties involved in disputes (*unions and nurses)* lose sight of ethical concerns which are at the core of health care delivery (italics are the researcher's own emphasis). In such a case, the extrapolation of Khushf's exposition becomes relevant in that unions act as the protector of a privileged interest group, while government becomes an advocate of abandoned patients in the PHS during a strike action. Problems of this nature seem to be the result of political rhetoric and lack of vital information on the part of health care providers (Khushf 1994: 397).

Based on this dichotomy, conflicting visions in the PHS appear to be twofold. On the one hand, government advocates social solidarity and equity, confidence in government, and capacity of the health industry to promote efficiency in the delivery of care. On the other hand, pluralism, moral diversity and *confidence in unions to represent their members effectively*, seem to take

its toll among interest groups, including nurses (italics are the researcher's own emphasis) (Khushf 1994: 397). It can therefore be concluded that the sharing of nurses' concerns and moral vision with trade unions need to be reviewed in terms of competing values and moral preferences espoused by the two parties.

At the time of writing, the RSA was at another defining moment in her history. The country was approaching another democratic election, which would further determine the future of HCS and the nursing profession. It is against this background that Mantashe (1995:82) recommends a representative leadership that can "hear their issues and negotiate a path forward". Ehlers (2000:74) maintains that it is therefore imperative for the nursing profession to find its place within the current political climate by defining its values and projecting its undeniable existence and contribution to society at large. This could assist in bringing the nursing profession to centre stage, and perhaps placate discontent among RNs that seems to have brought so much instability within the PHS and the nursing fraternity.

2.9.3 Labour relations

Labour relations and nurses' issues are well documented. Most of what has been written on strikes seems to suggest that it is inappropriate for nurses to get involved in strikes actions. Heunis and Pelser (1997:42) point out that strikes have become an inescapable social reality in the RSA, just as in other parts of the world.

Since nurses provide essential services in the context of the LRA's definition (LRA 66 1995), it is often argued that the citizenry should not be deprived of services to which they are entitled, because of domestic disputes between civil servants and the State (Heunis & Pelser 1997:41). These authors add further that if the right for nurses to strike were to be legitimized, it would only be reasonable to put in place strategies that would protect the patients from harm during the course of stay-aways. Ehlers (2000:79) maintains that if

nurses could be well organized within their own profession, they could engage ways that would not only uphold the profession's ethical convictions, but also avoid dereliction of duty.

2.9.4 Nurses and strike actions

In the RSA, nurses have long been involved in strikes. Marks (2005:114) refers to an incident where discontented black nurses went on strike in a mine hospital on the Rand in 1921, over working and living conditions. By the 1940s concern about 'African unrests' had risen high amongst authorities, as several disturbances had mushroomed in health care institutions, including Fort Beaufort Hospital in the Eastern Cape where police intervention was engaged to restore order (Sweet & Digby 2005:115; 119). In 1948, a secretary who was dismissed by the medical superintendant from Nessie Knight Hospital in Sulenkama with accusations of disloyalty, wrote as follows to the authorities in Scotland (Sweet & Digby 2005:113):

I cannot say I am sorry to leave Sulenkama for there are certain elements in its make-up which do not make for happiness… If the church of Scotland feels that the amount of unhappiness experienced here is normal on the Mission Field, and must be – because of the type of life – and that it has no repercussions on the evangelistic side in the mind and heart of the African – then people will go and come and come and go here.

This incident was followed by Nessie Knight Hospital nurses embarking on a strike action in 1949. The protest was mainly over the domestic labour they were officially engaged with in their white supervisors' houses, but also about the food they were given (Mashaba 1995:12; Sweet & Digby 2005:113). Further discontent was expressed in Nessie Knight Hospital when a probationer nurse challenged her supervisor and was dismissed, an incident which provoked another strike action, which led to the dismissal of all student nurses. These unrests were later followed by a strike in Loveday Hospital a month later, which was construed by authorities to be a heightening of political consciousness among young African nurses.

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In other parts of the country, a strike action was waged by the Baragwaneth hospital in Johannesburg, after a confrontation between junior non-European staff and their senior white staff. It then became clear that the electoral success of the National Party government in 1948 did not abate the unrests in hospitals and schools, as blacks increasingly became not prepared to acquiesce to that government's apartheid laws (Mashaba 1995:49-50). Consequently, strike actions and protest marches were banned by the National Party government until the inception of the new democratic government (Sweet & Digby 2005:115, 119).

Increasing levels of discontent among RNs in the PHS continued through 2007, with escalating strike actions in HCS and around the world. In South Africa, labour unions staged a countrywide public service strike, demanding a 12% salary increase for their members. The majority of the strikers were nurses from the PHS (Wines 2007:12). Sidley (2007:1240) points out that although the government strongly condemned the nurses' participation since they render essential services, that did not deter nurses from striking as "tens of thousands of them" joined protest marches across the country.

In Australia, the Health Minister expressed concern over the right of nurses to be politically active (Iliffe 2007c:1). This author argues that political activism is a long and proud tradition held by the nursing profession from the days of Florence Nightingale. Furthermore, Australia's Minister of Workplace criticised the idea of unionization of HCS and schools, stating that perhaps this reflects "a basic lack of understanding about unions and why people join unions". In response, Iliffe (2007a:11) emphasises that nurses are intelligent and make wise decisions, the same way they do when voting, by assessing the situations and responding appropriately regardless of the political parties involved. Olivier (1993:1371) also seems to support the notion of collective bargaining and adds that it ensures fairness in addressing various types of labour disputes.

In the USA, the Boston Medical Centre declined mandatory summer vacations encapsulated within the nurses' contracts. Also, the refusal of the authorities to honour scheduled meetings intended to address nurses concerns, which included staffing issues and the negative work milieu, exacerbated the situation (Boston Medical Centre 2007:1).

In the UK, nurses at the Barnsley hospital protested at a plan to reduce the number of posts (Hicks 2007:7). The hospital administration expressed dissatisfaction with the RNs for the choice of an industrial action when dealing with their discontent.

From the literature review, it would appear that to date the best weapon RNs ever engaged across the world was strike actions, most of which concluded on a positive note, with authorities agreeing to address the nurses' concerns presented. For this reason, the present study wishes to investigate discontent among RNs in the PHS, with a view to minimizing disruptions in the provision of health care. A deeper probe could assist in developing strategies that could counter this ordeal, so that nurses' issues can be addressed in ways other than employing strike actions.

2.10 THE OCCUPATIONAL SPECIFIC DISPENSATION (OSD)

In 2007, the then Minister of Health alluded to the DOH's occupational specific dispensation (OSD)[3] salary structure, which was intended to be instrumental

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[3] The OSD is a strategy to recruit and retain employees with the required competencies in certain occupations (DPSA 2007:1). A separate salary structure applies to nurses performing duties in designated specialty fields, which include Primary Health Care and Nursing Education, as identified in the OSD for the occupation Professional Nurse. The inclusion of other specialties for this purpose is subject to the relevant one-year post-basic qualification in the context of R48 and R212 of the SANC (DPSA 2007:19). The OSD agreement was signed in September 2007 between government and five health sector unions: the Democratic Nursing Organisation of South Africa (DENOSA), the National Health and Allied Workers Union (NEHAWU), the Public Servants Association (PSA), the Health and Other Service Personnel Trade Union of South Africa (HOSPERSA), and the National Union of Public Service and Allied Workers (NUPSAW), in order to address public servants' salaries in the country (DOH 2007b).

in attracting and retaining nurses in the PHS. Since nurses form the backbone of the health care system, intentional efforts were made to start the implementation of the OSD with nurses (DOH 2007a).

The present study argues, however, that if salary increments did not offer permanent resolves for RNs' discontent in the past, what would make the same strategy, applied within the same context yield different results for the PHS? There are various alternatives that can be followed to satisfy nurses. Daft (1999:248) maintains that methods that address challenges or give rewards as financial remuneration have short-term results. Whatever the cause of the problem is, it has the potential to recur, causing the company to find itself in a philosophical conundrum.

Governments can introduce new salary structures, but salaries are not the only push factor from the PHS. Career development, adventure, exposure to the international world and better conditions of service are among the reasons besides economic ramifications that explain this peculiar move.

As opposed to salary increments, such as the OSD, Ehlers (2000:79) maintains that the only way forward for the nursing profession in the RSA is to be fully organized and professionally represented in political arenas. This would not only make them politically relevant to the changing socio-politico-economic climate, but would also afford them the right platform to articulate their claims.

2.11   NURSES AND POLITICS

According to Feldman and Lewenson (2000: ix), at no other time in recent history has there been a greater need for nurses to get involved in political processes. Hadley (1996:6) emphasises that nursing in the twenty-first century is faced with the challenge of overcoming an oppressed mentality and should rather take aggressive steps towards getting involved in administrative and government positions to give exposure to the true meaning of the nursing profession. To this, Ehlers (2000:78) adds that nurses should become

politically relevant by organizing themselves into one united voice that would make a successful political standpoint. Nurses are diligent, committed and have the necessary skills to motivate and mobilize others to get involved in political and policy-making processes (Feldman & Lewenson 2000: ix). Clement-Stone, Eigsti and McGuire (1998:24) advocate a move from political awareness to political leadership by developing political leadership capabilities among RNs, to enable them to influence policy at national level.

According to Cohen, Mason, Kovner, Leavitt, Pulcini and Sochalski (1996:260), nurses should be highly involved in the formulation of health policy since it directly affects them. Not only would this impact the interest of nurses, but it would also allow the permeation of nursing values to the communities they serve. Furthermore, a broad range of health and nurses' issues not previously represented at policy tables could finally be deliberated before decision makers. These views support the core of this study which seeks to explore the discontent among RNs evident in strike actions, with the aim of finding non-violent strategies and methods to resolve disputes between government and nurses. Moreover, reasons for nurse migration from the PHS would also be established, so that equitable solutions to retain nurses could be implemented through political processes.

The USA already involves nurses in political arenas through appointments to public office positions, significant posts in government, presidential positions in universities, political positions in health policy development and discussion meetings with Senators and Congressmen. This has further extended the influence of nurses to other policy arenas because of their active participation. This would appear to indicate that nurses elsewhere could also take up positions in political debates about public policy in health care issues for the benefit of the nursing profession and their communities, instead of relying on unions. To do so, however, would require an understanding of how to lead both in the clinical and political spheres by developing their political leadership skills (Cohen et al 1996:260). For this reason, the nursing curriculum in the USA is structured in such a way that nursing students are afforded an

opportunity to experience the political process in action in the State House, where the nursing profession is welcome, valued and applauded by legislative leaders for their participation in political processes. Among other things, nursing students learn how a law starts with an idea, which is later translated into a bill, how a bill becomes a law and the concepts of voting and lobbying (Byrd, Costello, Shelton, Thomas & Petrarca 2004:503).

According to Hadley (1996:9), the fact that nurses are an observable large group in every society and have a positive public image affords them a prominent place in the political arena. The reason for this political strength is that numbers have the power to translate into political strength. This is why Jansen (1991:172) states that the struggle to transform the health care system in the RSA must be part of the entire political struggle. Makhubela-Nkondo (2001: viii) points out, however, that many questions have been raised about women having greater influence on the formulation of policies.

Mason, Talbott and Leavitt (1993: xxxi) contend that it is not advisable for nurses to react politically to already published policy, as that may be too late. On the contrary, it would be far better for them to submit their proposals at the initial stages of planning and development. For nurses to make a meaningful contribution, then, calls for timely political and financial astuteness among them. If nursing does not shift its paradigms, the struggle to authenticate its potential, worth or value will continue, and eventually split the profession (Hadley 1996:6). Ehlers (2000:74) points out that unless "nurses in the Republic of South Africa collaborate proactively as a united group representing the largest proportion of health care professionals in the country, the nursing profession and nursing education might become irrelevant to the political realities of the country and its people". In order to achieve this goal, nurses should exploit administrative, government and political arenas.

2.12 CONCLUSION

This chapter reviewed some of the basic concepts relating to discontent among RNs in the PHS, including transformational initiatives and discontent among RNs in the PHS; management and leadership problems; career development; global changes and nurse migration, and developments to balance supply by source countries and demand from developed countries. The literature review also covered problems with unionization in HCS, including conflicting interests between nurses' rights and the ethical code; workplace violence and preventative measures, and national and international political trends within the nursing profession.

Chapter 3 discusses the theoretical framework undergirding this study.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The literature review on discontent among nurses in the public health sector (PHS) was discussed in chapter 2. The researcher explored different perspectives on discontent among registered nurses (RNs) in the PHS. Consequently, the theoretical framework for this study attempts to delineate the interconnectedness and interactions of different concepts, factors and structures that share the premise for the study. LoBiondo-Wood (2006:118) describes a theory as "a set of interrelated concepts that structure a systematic view of phenomena for the purpose of explaining or predicting". Theories provide a framework within which information about clients and situations is collected and synthesized (Clement-Stone, Eigsti & McGuire 1995:216). Therefore, this study attempts to outline the RNs' strengths and activities within this framework, identify and describe the impact of different structures and statutory bodies on health care services (HCS). The implication is that discontent among RNs in the PHS may have serious repercussions on public health service delivery (PHSD) and untoward consequences may implicate RNs in various ways. Finally, this chapter also includes factors that address any other extraneous variables that have the potential to confound the findings. The researcher selected a General Systems Theory as relevant to deal with the issues.

3.2 GENERAL SYSTEMS THEORY

General systems theory (GST) is known as the science of wholeness and was first introduced by Ludwig von Bettalanffy, a biologist, in 1968. According to von Bettalanffy, GST specializes in "the formulation of principles that are valid for 'systems' in general, whatever the nature of their component elements, and the relations or 'forces' between them" (Clement-Stone et al 1995:218).

Comparatively, GST offers a framework that blends well with the holistic nature of humankind and professional practice. It provides various methods to integrate all the factors that influence the nursing profession and link them together into a meaningful whole. In broad terms, it forms the basis for a humanistic philosophy of professional practice. Therefore, it has the ability to analyse the whole of any given system, as opposed to a cause-and-effect premise (Clement-Stone et al 1995:218). This is consistent with the World Health Organization's (WHO) (2000:5) definition of a health system as "all the activities whose primary purpose is to promote, restore or maintain health".

In the light of this definition, diverse inherent social forces between components or elements of the health care system exist, which sometimes have a tendency to destabilise the effectiveness of the system. Examples of such social forces are global factors (overseas recruitment), private hospitals, laboratories, case management and others, which attract nurses away from the PHS. Added to these factors are unions, professional associations, government, the South African Nursing Council (SANC) and the community, which are common elements that have either a positive or negative impact on the nursing profession and the delivery of care.

Both functional and dysfunctional patterns of behaviour within a system are products of the system's functioning (Clement-Stone et al 1995:220). In order to determine why adaptive or maladaptive behaviours under the influence of social forces take place; the structure, functions and processes of the HCS should be analysed. The reason for this is to obviate individual blame and rather direct attention to how the system must change in order to function efficiently, peacefully and productively.

3.2.1 The Public Health Sector within a GST

In the context of this study, the PHS is a body that has workers employed at local, regional and national government to provide health services to the public. It is estimated that in the RSA, approximately 80% of the population is

state dependant for the provision of accessible and affordable health care (WHO 2000:5). The PHS is comprised of primary health care (PHC) and district hospitals, which are level one HCS, regional (level two) and academic (level three) hospitals (Department of Health [DOH] 2002).

Figure 3.1 depicts the different health care service areas and how they are related within the GST.

Figure 3.1   Health care service areas within the GST
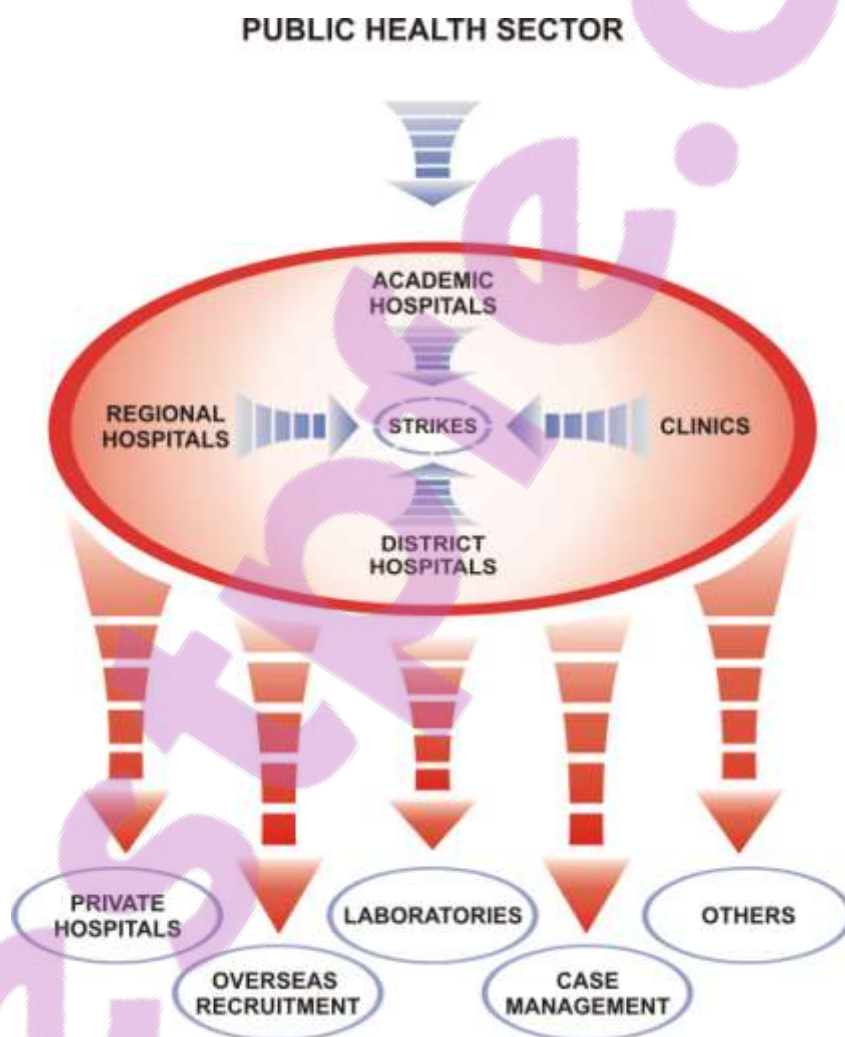
3.2.2 Public health service areas

Clinics and hospitals provide public health services as follows:

- **Clinics**

Community-based supplementary health services are offered by mobile clinics, fixed clinics and community health centres (CHC), which are components of a district health service (DHS) that delivers a comprehensive PHC system in South Africa (RSA) (DOH 2002:3). These are level one HCS, which render PHC services from 0-24 hours. They form the first level of contact since they are community-based and most are nurse-driven. Services offered in these areas are minor ailments, rehabilitative, maternity and mother and child health care.

- **District hospitals**

District hospitals are also level one HCS and are a significant part of the DHS in the new health policy. While they support PHC services, they are also a gateway to more specialized care. It should be noted that the health service provided in district hospitals is fully integrated with health services provided in PHC. In other words, their governance, management and functions are relative to the governance, management and functions of the entire DHS system. Therefore they are called level one (generalist) services that cater for both in- and outpatients referred from clinics. District hospitals are expected to provide family medicine, rehabilitation, surgery and medicine, obstetric, geriatric, and paediatric services from 0-24 hours. The 24-hour emergency and operating theatre services also form an integral part of district hospitals. They distinguish themselves by easing the workload on specialized health centres, which are regional and academic hospitals (DOH 2002:3-4).

- **Regional hospitals**

Regional hospitals are level two HCS that cater for basic treatment and surgeries beyond the scope of district hospitals. They offer secondary-level services from 0-24 hours. Regional hospitals also serve patients from curative PHC services in the residential areas surrounding them. Ambulances bring in patients from district hospitals, other provinces and neighbouring African states for curative care. Patients with conditions beyond the scope of regional hospitals are then referred to tertiary (level three) hospitals for sophisticated procedures (Ndaki 2004).

- **Academic hospitals**

Academic hospitals, also referred to as teaching hospitals, are level three HCS which offer advanced medical imaging techniques such as Magnetic Resonance Image (MRI) scanner, computed tomography (CT) scanners, and highly specialized services which include totally digital radiology, In vitro fertilization (IVF), picture archiving communication system and other sophisticated procedures and services (Marais 2007). In conjunction with medical universities in their vicinity, these institutions offer practical training for students from medical, nursing and medical-related fields of study such as physiotherapy, occupational therapy, radiology, social work, pharmacology, and dietetics.

3.2.3 Areas of attraction for health professionals

The main areas of attraction for health professionals are private hospitals, overseas recruitment, and laboratories.

- **Private hospitals**

Private hospitals are divided into profit-making (for-profit) and non-profit health institutions, which both fall outside the direct control of government. These

health care institutions cater exclusively for medically insured (private) patients, which form about 20% of the South African population (Hanson & Berman 1998:195). The increasing number of private hospitals, which offer generous remuneration packages, modern facilities and equipment that make up better conditions of service, has also caused some of the critical shortages of specialized nursing and medical staff experienced by the PHS.

- **Overseas recruitment**

International migration has both positive and negative effects on the global village (see chapter 2). In the RSA, the British Health Minister fortified the *International Code of Practice on ethical recruitment* of health workers by signing a memorandum of understanding (MOU) with the South African Minister of Health in 2004, as an agreement that Britain would not expand their National Health Services (NHS) by taking advantage of South Africa (Kingma 2006:126-127; Pretorius 2004).

- **Laboratories**

Many nurses who left the PHS found employment in laboratories in the country. Some RNs had been in that field long before transformational initiatives were introduced in the RSA. The circumstances surrounding this early migration are outside the scope of this study.

3.2.4 Case management

Booyens (2000:180) defines managed care as a "system which manages the health-and illness-continuum of an individual successfully through the efficient utilization of resources, i.e. the management of costs". Managed care approach in the provision of HCS is the most recent trend in the containment of health care costs. The energy and productivity of nurses is usually sought after by medical schemes for the purpose of administering issues pertaining to

the length of stay, procedures and costs incurred by patients (Discovery
Holdings 2008).

3.2.5 Others

Health facilities operated by parastatal firms, the South African Defence
Force, private practicing nurses, doctors' rooms, occupational nursing, local
municipalities, NGOs and mining hospitals are among the examples
represented by 'others' in the conceptual frame work.

3.3   COMPONENTS OF A HEALTH CARE SYSTEM

A system has interdependency characteristics, therefore change in any part of
the system will influence change in other parts. In the context of this study,
any change in government policies, union activities within the PHS, SANC's
interventions, including discontent among RNs in the PHS, has a serious
impact on government, communities, the multidisciplinary team, hospital
management and patients' outcomes.

Figure 3.2 is a graphic presentation of how the components of a health care
system are interrelated and interdependent, depicting the significance of GST
in this investigation.

Figure 3.2   Interactions of elements in a health care system
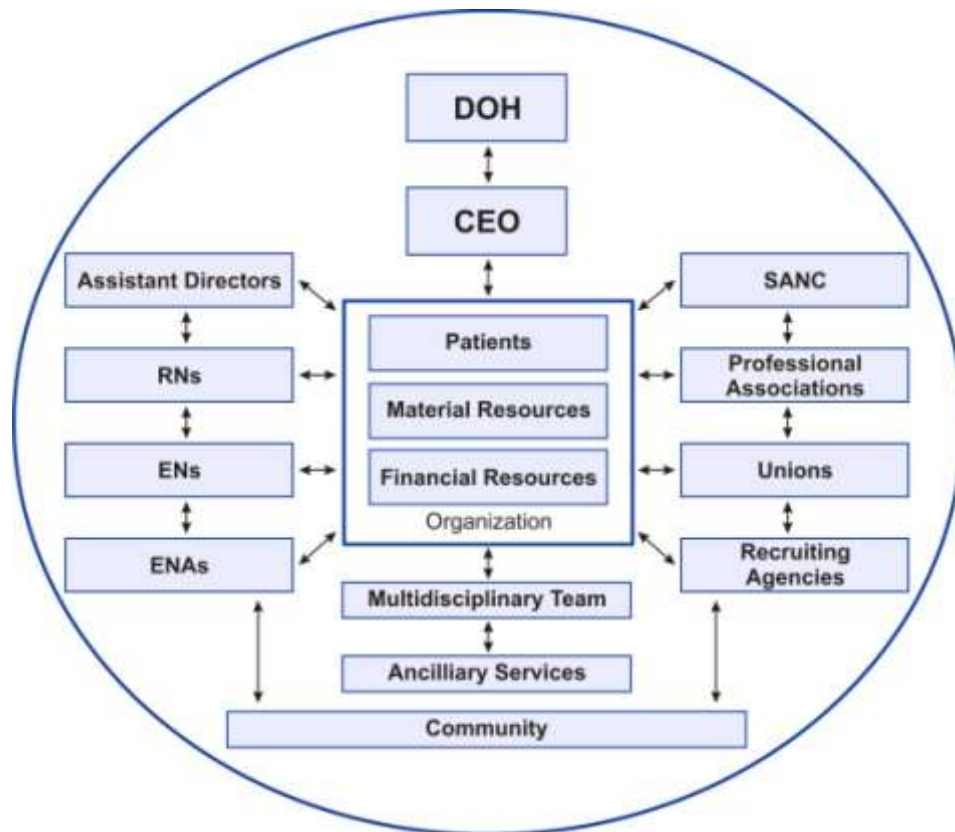
3.3.1 Department of Health (DOH)

Health systems comprise groups of people and activities within the system whose primary purpose is to improve health (WHO 2000:1). Government, as a steward of its citizenry, has the ultimate responsibility for the overall performance of its country's health care system. Therefore, the entire system is centrally directed by government through the DOH, which oversees and guides the developments and processes of the nation's health activities (WHO 2000:119). One of its key roles is to ensure that stewardship percolates through all echelons of the HCS in order to maximize the attainment of each provincial department's goals.

Cognisance should be taken that systems are not static, but constantly evolving, thus requiring continual monitoring of formal planning for significant changes in any of its components to avoid implementing obsolete strategies.

In the context of this study, as inflation increases and global trends shift, it becomes necessary to perpetually evaluate remuneration policies and other benefits for health professionals in order to prevent incongruence between personal and organizational needs (Ntuli 2001: x).

It is the prerogative of the DOH to ensure the achievement of the right size and skills mix of the human resources produced for the health system within the framework of the overall reform of public administration. However, because of the myriad of responsibilities they face each day, there is a tendency to be myopic about the needs of the working sector of the population. The rising discontent and tension among employees then influence RNs to engage bargaining agents in political arenas and negotiation tables (WHO 2000:120). Ntuli (2001: x) emphasises that budgeting systems "are not flexible enough to address changing circumstances or the realities on the ground". These views seem to support the strike actions existing among health professionals in the PHS and why RNs move into diversified directions in search of greener pastures, which is core to this study.

3.3.2 Chief Executive Officer (CEO)

The CEO is responsible for devising strategies and formulates policies that help meet the organizational goals in collaboration with other top executives. The CEO remains accountable and oversees decisions made by executives who also oversee the day-to-day activities of the departments they supervise. This gives them overall responsibility for the proper functioning of their organizations. CEOs are required to possess good personal skills, endurance and an analytical mind that can process large amounts of information at a given moment. The policy of rationalizing hospitals in the democratic South Africa is to "appoint, wherever possible, CEOs, who do not have to be medical doctors but possess management skills, or to convert the posts of superintendents to CEOs and provide the requisite management training" (DOH 2002; Stack & Hlela 2002:13).

3.3.3 Assistant Directors

Nursing service managers are commonly found in assistant director positions and are mainly responsible for management of personnel, employees' skills and morale, labour relations, equal distribution of incentives used to motivate performance, efficiency and effectiveness of personnel policies. They level peaks and valleys of employment, employee turnover and absenteeism, specialized skills and experience (Pearce & Robinson 2003:134).

3.3.4 Registered nurses (RNs)

The RNs' scope is to provide comprehensive nursing, which entails taking responsibility and accountability for the management of health care for the patients and communities, provision of emergency care and safeguarding patients against incompetent practitioners (SANC 2005).

RNs are the mainstay behind HCS. Unlike other disciplines, RNs are versatile in their function and this makes them indispensable in the workplace, since they can cope with the magnitude of responsibility in and beyond the context of their specialty. Their expertise affords them flexibility and well-paying job opportunities abroad. The LRA (1995:8) classifies RNs as personnel that offer "essential services". Jansen (1991:161) maintains that RNs are "at one point strategically placed to implement new policies and programs, but at another they are politically constrained to do so," within the system in which they function. Bezuidenhout, Garbers & Potgieter (1998:399) point out that employee *discontent* is usually expressed in several organized collective actions in order to register their concerns with the employing body.

3.3.5 Student nurses (SNs)

Student nurses learn from formal classroom settings, clinical areas and other community arenas. Nursing students are required by the SANC to register for admission to the registers (Government Notice No. R.3735). The SANC also

issues cards for all nursing students to assure them of the authenticity of the nursing programme they have enrolled with in any institution. For the protection of the public, they function under direct supervision of RNs and ENs, as well as their lecturers, as an important contingent within the system. Following the successful completion of their course, students are registered as 'registered nurses' in the appropriate register.

3.3.6 Enrolled nurses (ENs)

Enrolled nurses, also called staff nurses, are persons educated to make independent decisions in the practice of basic nursing care and treatment in the manner and to the level prescribed by the SANC in the RSA. Since they are registered and licensed as staff nurses under the *Nursing Act, 33 of 2005*, their practice allows them to carry out such nursing care as their enrolment permits "under the direct or indirect supervision or direction of a registered nurse or, where applicable, under the direct or indirect supervision of a medical practitioner or a dentist or on his direction or written or verbal prescription" (Government Notice no. R.1649 as amended by no. R.480). Their scope of practice includes basic emergency care, and the assessment and development of nursing care for stable and uncomplicated health conditions in all health settings. ENs are not permitted to take responsibility and accountability for the overall management of nursing care in HCS (SANC 2005).

3.3.7 Enrolled nursing assistants (ENAs)

According to Government Notice no. R. 1648 as amended by No. R. 482, enrolled nursing assistants "shall carry such nursing care as their enrolment permits under the direct or indirect supervision or direction of a registered nurse, an enrolled nurse or, where applicable, under the direct or indirect supervision of a medical practitioner or a dentist or on his direction or written or verbal prescription". Their scope of practice does not allow them to administer drugs or engage in any medical intervention procedures. Their role

mainly entails assistance with elementary nursing care, where support for daily living and self-care are offered to an individual, provision of nursing care directed by a registered or staff nurse, basic first aid and compliance with a standardized plan of care in the execution of these tasks (SANC 2005).

3.3.8 South African Nursing Council (SANC)

The SANC is a progressive body responsible for the preparation of nurses to provide comprehensive nursing care to communities. It was established by section 2 of the *Nursing Act, 50 of 1978*, as amended by Act 33 of 2005 and continues to exist as a juristic person, with the aim of protecting the public from harm regarding PHSD, with specific reference to nursing services provided by all categories of nurses (SANC 2005:6-7).

3.3.9 Professional associations

Professional associations are statutory bodies established under the *Nursing Act, 50 of 1978* (as amended). Their role contrasted that of the SANC in that they were for the interest of nurses in matters pertaining to their discontent in the workplace and where their rights had been breached. They also represent their members in the SANC disciplinary hearings. After 1994, the single professional association that existed went through several name and other changes until the inception of the current Democratic Nurses Organization of South Africa (DENOSA) (Mashaba 1995:33). Apart from other comprehensive and progressive activities, they play a bargaining role like unions (Gwagwa 2005:32-33).

3.3.10 Trade unions

Trade unions utilize collective bargaining and political action to achieve their goals. Over the years their actions or strategies have impacted significantly on employment conditions in the health sector (Bezuidenhout et al 1998:282). Since the interrelatedness and interdependence of HCS make them open

systems, from 1994 nurses could also voluntarily subscribe to trade unions of their choice for the first time in terms of the *Constitution of the Republic of South Africa Act, 108 of 1996* section 23 (2) (South Africa 1996:10).

3.3.11 Recruiting Agencies

Recruitment agencies are organizations that link job seekers to employers who wish to hire staff both locally and around the world. Most health institutions depend on recruitment agencies to provide capacity, particularly skilled personnel from other countries. There is a plethora of nurse recruitment agencies across the globe with the promise of higher salaries. Agencies publish exciting positions in nursing journals, internet and newspapers among others. Most of them are legitimate and are responsibly run, however, they have a vested interest in making large profits from every contract they sign, because health institutions pay a fee for each nurse hired (Kingma 2006:105; 110). In India, profits of up to US $47, 000 when nurses are accepted in overseas hospitals have been reported, in contrast to an average of US $700 to US $7 000 invested in training a nurse. One recruiting agency, for example, disclosed its ultimate goal of exporting about 100 000 Indian RNs to the USA by 2010 (Khadria 2007:1431).

Since they are not monitored, some have manipulated these legal contracts which once signed, could subject nurses to burdensome obligations. Agencies that maintain a good track record evidenced by good behaviour and long stay of RNs are rewarded with more business.

3.3.12 The multidisciplinary team, ancillary and other supportive services

Pearce and Robinson (2003:138) describe the interdependence and interaction of the multidisciplinary team within the context of the value chain analysis (VCA). The activities that transform inputs into outputs valued by customers are called a value chain (Pearce & Robinson 2003:137) (see section 3.4). Examples of the multidisciplinary team (not in order of

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importance) are: medical doctors, dieticians, physiotherapists, social workers, x-ray, laundry, ambulance services, cleaning companies and the catering department.

3.3.13 Ancillary services

These are services other than medical and nursing services that are provided to hospital patients in the course of care. They include such services as ambulance, laundry, laboratory, x-ray, catering, blood bank, physiotherapy, security and other services. In some instances, these services are outsourced by HCS.

3.3.14 Communities

Communities are a crucial part of any system since every operation, industry or government structure exists for and because of the people they serve (Pierre-Louis, Akala & Karam 2004:7). In the 1986 Ottawa Charter for health promotion, the WHO defined health promotion as the "process of enabling people to increase control over, and to improve, their health" (Tang, Beaglehole & O'Byrne 2005: 884; WHO 1986:1). In response to this definition, the government of South Africa introduced the *Patients' Rights Charter* in an effort to improve participation in decisions pertaining to PHSD, in line with the Constitution. However, few nursing services managers initially began building relationships with their communities and taking part in community health forums (Leon, Bhunu & Kenyon 2001:209).

The promotion of health depends on interventions geared towards helping people to be healthy. It also means ensuring a healthy environment in cities, villages, educational institutions and places of work. Pierre-Louis et al (2004:7) emphasise that "sound economic policies contribute to health and health in turn contributes to economic and social development". It is therefore critical to develop health promotion competencies in health professionals through academic and skill-based training programmes to benefit communities they serve.

3.4   INPUT-PROCESS-OUTPUT-FEEDBACK OF THE SYSTEM

In Figure 3.2, subsystems are connected elements that interact with each other to form an organized whole. Figure 3.3 therefore, depicts the structural arrangement and mutual interaction of its parts as an input-process-output-feedback development.

Figure 3.3   Input-process-output-feedback
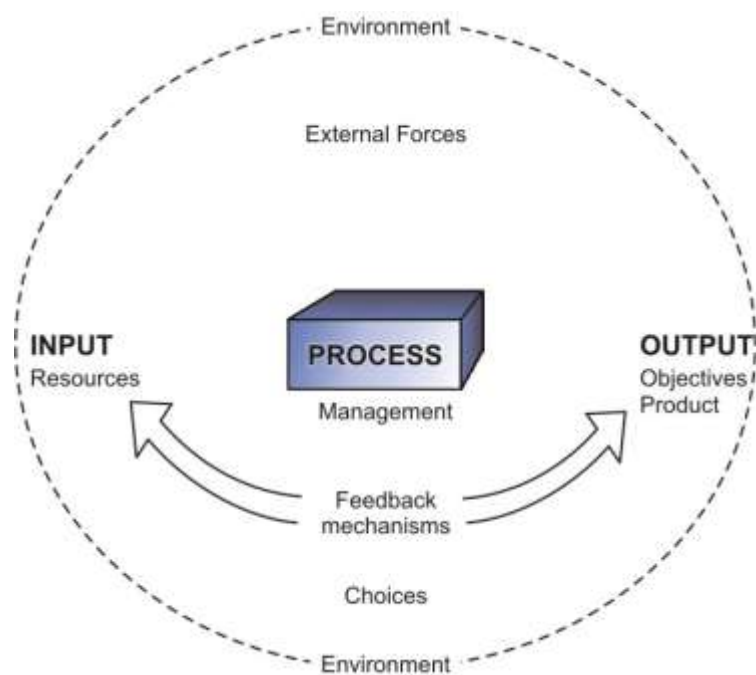
Adapted from Clement-Stone et al (1995:218)

3.4.1 Inputs

Every system has *inputs* or resources, which go through *process* within the organization, thus enabling the system to achieve its objectives or *outputs*. *Inputs* in a HCS come in the form of patients and material, human and financial resources in the quest to produce quality patient care outcomes. Through hospital management, the DOH is responsible for providing the right quantity and quality (skills mix) in order to obtain optimum results for the communities they serve (WHO 2000:120).

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3.4.2 Process

Clement-Stone et al (1995:219) define a process as the "action needed to get the work done". A plethora of activities take place within the *input-process-output-feedback* process. This *process* is the integral part of the system since that is where the system is qualified as being effective or disqualified as malfunctioning, based on the interaction of processes within the system. Moreover, the processing of inputs (patients and resources) from the environment is subject to a series of dynamic, interrelated transactions. It is from these transactions that the environment, the inputs and the system's outputs are connected (Clement-Stone et al 1995:219).

In order to accomplish the system's objectives, the following processes of interest to the community are necessary:

- **Planning and control processes**

Planning and control are the pillars and success of every organization. Being cognisant of its purpose and the direction it should take, and devising a feasible plan to get there stabilises the organization. At the same time, control assists with the proper implementation and supervision of these plans.

Finkler and Kovner (2000:217) define planning as "an analytical process, which involves an assessment of the future, the determination of desired objectives in the context of that future, the development of alternative courses of action to achieve such objectives and the selection of the course or (courses) of action among those alternatives". In other words, the order and stability of the system is necessary for the stability and success of its environment.

One of the requirements of the GST is that management, especially those in the upper echelons of the organization, should devote enough time to planning instead of being bogged down by the day-to-day activities. Planning and control in the PHS are therefore at the core of this study to establish the

existence of collaborative relationships and the degree of involvement of RNs, as a way of dealing with discontent among RNs in the PHS.

- **Quality process**

According to Finkler and Kovner (2000:221), improved quality of care at decreased cost, is the theme for the provision of care in the twenty-first century. Finkler and Kovner recommend total quality management (TQM), which connotes responding to the needs of the community in a cost-effective manner and continuous quality improvement within a system. Therefore, discontent among RNs could seriously hamper quality processes if left unabated. Stainsby (2004:42) contends that sometimes RNs can strengthen themselves, in conflicting demands, "leading to under-performance, sickness and low morale". This implies that even if pressing needs can be bottled up, they tend to undermine the nurses' immune system in the long run. Other physical symptoms in the form of poor health and low morale could manifest at a later stage, further compromising quality standards.

- **Management process**

Clement-Stone et al (1995:218) emphasise that management of the system is the core of the HCS with the responsibility of providing and managing resources to maintain equilibrium within the HCS. Internal analysis of the system is mandatory as it focuses on the assessment of the strengths and weaknesses of the organization's management and organizational structure (Pearce & Robinson 2003:13). In GST, analysing the organization's financial, human and material resources, the past successes, emerging concerns and its present capabilities are contrasted in order to predict its future potentials.

3.4.3 Outputs

Finkler and Kovner (2000:501) describe outputs as the end product or services produced by the system at the end of the process, such as discharge

of patients, patient days and visits. The input-process-output-feedback process, therefore, includes taking full accountability for *outputs*, which determine the quality and the genuineness of patient care outcomes (Clement-Stone et al 1995:218). Healthy communities constitute healthy societies, and healthy societies create a healthy nation, which is the goal of every government system (WHO 2000:119).

3.4.4 Feedback

Pearce and Robinson (2003:17) define feedback as the "collection of post-implementation results to enhance future decision making".

The *feedback* mechanism is the most significant aspect of the system. It assists the system to identify its strength and needs, as well as evaluating how well it is accomplishing its goals. It also provides data essential for effective adaptation to internal and external system changes. The information that helps the system to select corrective actions when problems exist marks the success of the organization.

A system also needs a mechanism that facilitates the sharing of both positive and negative feedback. If staff receives only negative feedback, they become discouraged and find it difficult to use their creative talents to benefit the system (Clement-Stone et al 1995:219). Lack of positive feedback can also lead to dysfunctional behaviour. Positive feedback helps employees to maintain healthy patterns of functioning and to stimulate creative ideas in a health care system (Clement-Stone et al 1995:219).

3.5   ACTIVITIES WITHIN THE ORGANIZATION

The processing of inputs involves a concerted effort by different departments within the system in order to realize the goals of the organization. This chain of activities within a business or service that transforms inputs into outputs valued by customers is called a value chain (Pearce & Robinson 2003:137). Many organizations in strategic management, therefore, use the VCA to

describe the dynamics of processes within a system. The VCA assists managers to make a proper assessment of the strengths and weaknesses of the organization. The VCA is a process or a chain of activities within a system rather than "arbitrary organizational dividing lines or historical accounting protocol" (Pearce & Robinson 2003:137).

Figure 3.4 graphically illustrates Pearce and Robinson's (2003:138) typical value chain framework.

Figure 3.4   Value chain
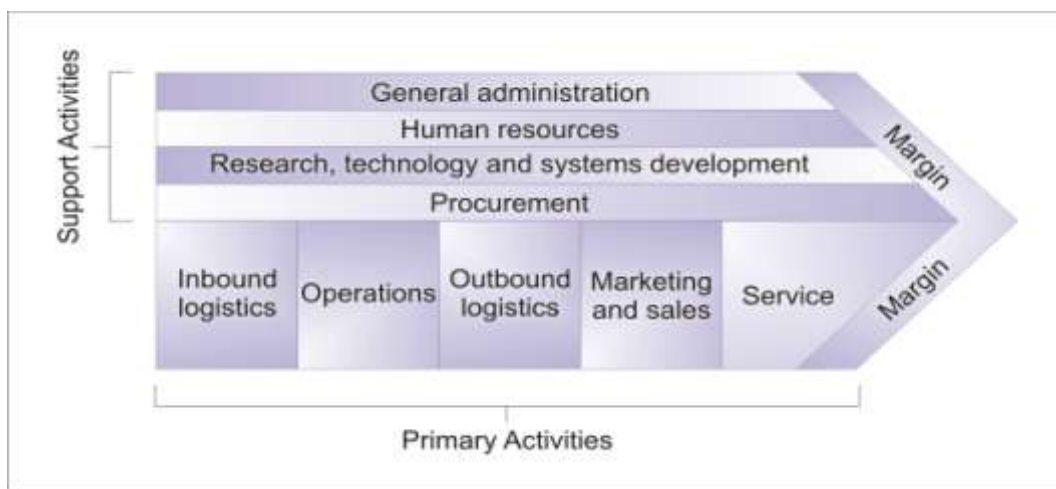
Adapted from Pearce and Robinson (2003:138)

In Figure 3.4 above, the activities within the organization are divided into two broad categories known as *primary* and *support* activities. These are discussed in the context of a health care service.

3.5.1 Primary activities

Primary activities are sometimes called line functions because they deal with actual production, marketing, and services to the patients and communities through multidisciplinary activities within a health care system. The end product is satisfied clients and healthy communities.

- **Inbound logistics**

These are activities**,** costs and assets related to obtaining capacity or energy to accomplish the vision of the organization. HCS deal with different activities performed by different disciplines, assembling of equipment, costing of activities, personnel to execute different tasks, collaboration with suppliers, receiving orders from vendors, storage and control of stock as well as distribution of resources across departments. These are usually followed by periodical inspections and inventory (Pearce & Robinson 2003:138).

- **Operations**

Operations are activities closely connected with converting inputs into outputs. In this process, all the departments apply their skills, expertise and specialties towards efficient and effective patient care. The process of operations also involves maintenance of equipment, quality assurance programmes, environmental protection and quality of the whole structure of the facility in general. The Information Technology (IT) system plays an important role by coordinating all the departments to facilitate the dissemination of accurate and up-to-date information on the website and across the system (Booyens 2000:647). Ambulance services also form a major part of the activities by transporting patients to specific HCS, including transfers to tertiary hospitals for specialized care.

- **Outbound logistics**

In the context of a health care system, outbound logistics refer to the discharging of recovered patients back into the community, referrals to clinics, rehabilitation centres, and home-based care. The success of this outcome also depends on the effectiveness of supportive activities within the system.

- **Marketing and sales**

Marketing and sales refer to activities, costs and assets dealing with sales, advertising the product, promotions, market research and overall planning. Most private hospitals market their services based on their profit-making orientation and competitiveness. The cost of services provided is usually marked above the cost of the organization's value-adding activities, which is then billed on the patient's account (Pearce & Robinson 2003:138; Siegel & Lotenberg 2007:111).

3.5.2 Supportive activities

These activities include:

- *General administration*, which refers to the quality of strategic planning systems to attain the objectives of the organization, proper coordination of activities between organizational subunits, relationships with public policy-makers, and the appropriate handling of information that pertains to strategic and routine decisions.

- *Human resource management*, which refers to adequate staffing and training; equitable allocation of incentives to all levels of employees; effective reward systems to motivate and challenge employees, and creating an environment that reduces absenteeism and turnover.

- *Technological development*, which deals with quality of facilities and equipment; research that precedes implementation of new projects; a working milieu that stimulates creativity and innovation; new database capabilities; computerized support, and telecommunication systems that are fully developed, improved or revamped through continued research (Booyens 2000:648; Pearce & Robinson 2003:138; 142).

- *Procurement*, which encompasses all the activities, costs and assets directed towards the purchase and provision of services, supplies, and outsourcing of services required by the organization and its activities. Ambulance, laundry, laboratory, x-ray, catering, blood bank, physiotherapy, security and other services are examples of the services outsourced by HCS. In the RSA, RNs from other African countries are not recruited because of the vast need for knowledge-based skills in those countries (Ehlers 2000:76).

3.6 CONCLUSION

This chapter discussed the logistics and dynamics of the GST, including the components of the HCS; the input-process-output-feedback mechanism of the HCS within the GST, and primary and supportive activities of a health care service.

Chapter 4 discusses the Research methodology that will be followed by this study and the research design that will be used to answer the research questions.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1   INTRODUCTION

The preceding chapters explained the problem, rationale for, purpose and significance of the study, discussed the literature review, and described the theoretical framework, which addresses the interconnectedness and interrelatedness of the elements of a health care system within the General System's Theory (GST). This chapter describes the research design and methodology, including the population, sample, data collection and analysis, validity and reliability, and ethical considerations.

4.2   PURPOSE OF THE STUDY

The purpose of this study was to explore and extend the knowledge base on discontent among registered nurses (RNs) in the public health sector (PHS) within the Tshwane Metropolitan area; describe how RNs in the PHS perceive the effects of discontent among RNs on their personal and professional lives, and provide a scientifically proven argument regarding factors that contribute to or exacerbate RNs' discontent in public hospitals.

The study examined these issues because they are of current interest and enduring importance to the nursing profession and the South African society in minimizing factors perceived to account for destabilization within the PHS.

4.3 RESEARCH DESIGN

Burns and Grove (2003:494) define a research design as "a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings". Polit and Beck (2008:66) describe it as "an overall plan for obtaining answers to the questions being studied". The

research design guides the planning and implementation of a study in a way most likely to achieve the intended goal. Therefore, the research design is the manner in which the entire research process unfolds to the final stage of report writing. Polit and Hungler (1999:166) emphasise the overarching consideration of choosing a design that will yield the best possible trustworthy answers to the research questions.

4.4   TRIANGULATION OF THE QUALITATIVE AND QUANTITATIVE METHODS

The choice of research method is not arbitrary, but determined largely by the context of the research and the questions asked (Talbot 1995:415). This study used methodological triangulation to explore the phenomenon of discontent among RNs in the PHS. The researcher was of the opinion that the combination of these methodological strategies was the most suitable because they are complementary, encompassing both words and numerical data to communicate results (Sheppard 2004:215). Therefore, by mutually supplying each other's lack, the limitations of a single method are minimized. Polit and Hungler (1999:257-258) and Loiselle, Profetto-McGrath, Polit and Beck (2007:219) recommend the integration of qualitative and quantitative approaches in a single study because no method is so perfect, even in its area of greatest potential, that it cannot be supported by others.

4.4.1 Advantages of triangulation

According to Polit and Hungler (1999:258), if quantitative data is collected and analysed first, the researcher can thoroughly probe the rationale for the data obtained and seek answers and interpretations from the second-stage data collection. Information derived from the first stage can also be instrumental in the selection of informants with particular qualities, which could be useful in unpacking the intricacies of the key constructs.

Polit and Beck (2008:310) maintain that quantitative methods generally only reveal the interrelatedness of variables but fail to provide explicating descriptions, whereas insightful understandings of qualitative data corroborate and validate statistical findings by providing dynamic views on the construct in question, sometimes using illustrative examples. In this study the researcher wished to integrate the quantitative approach with individual and focus interviews of the qualitative component. In this regard, Morse (1997:230) adds that the "findings related to each method are used to complement one another at the end of the study to enhance theoretical or substantive completeness".

In addition, the information obtained from the open-ended questions would also be used to clarify meanings conveyed by the numerical data (Polit & Hungler 1999:258). Miles and Huberman (1994:266) contend that while triangulation is expected to confirm or support the findings, if its independent measures contradict the findings, the researcher is faced with the question of which method to believe. Nonetheless, Loiselle et al (2007:219) strongly advocate linking qualitative and quantitative data because this allows for complementarity, incrementality, creating new frontiers, and enhancing validity. Consequently, the researcher utilised triangulation because of the complexity of the topic to be investigated, given the circumstances surrounding RNs, evidenced by past widespread strike actions and unprecedented migration of RNs from the PHS, which could be indicative of discontent among RNs in the PHS.

The quantitative approach measured the magnitude, size or extent of discontent among RNs in the PHS statistically (Loiselle, Profetto-McGrath, Polit & Beck 2004:21; Polit & Beck 2008:19-20). The qualitative approach wished to discover and describe the different dimensions and patterns of discontent in the respondents' own words, in order to further clarify, confirm or challenge the quantitative data.

4.4.2 Quantitative

The strength of quantitative data lies in their ability to provide generalizability, precision and control over extraneous variables (Polit & Hungler 1999:258). However, quantitative studies also have weaknesses that allow the validity of the results to be called into question. One of their substantial deficits lies in the tight controls they impose, which fail to capture the full context of the situation. They tend to be too superficial because of the exclusion of complex human experiences such as behaviour, mannerism, posture and tone of voice, which are crucial and rich information fundamentals in qualitative research. Therefore, the study's ability to yield valid and meaningful results is jeopardized by the tightly structured questions that open the study to biases in capturing the phenomenon under study.

In this study, the questionnaire provided sufficient space for the respondents to comment in their own words. de Vos (2002:179) contends that having a large number of open questions in a questionnaire undermines cost-effectiveness, and is time-consuming and liable to error. However, in the final analysis, the final decision rests with the project leader. To overcome this apparent weakness, the researcher emphasised the respondents' liberty to expound on the questions of their choice. At the same time, numerical data added more value to the study by providing percentages to assess the degree of discontent among RNs in the PHS, where comments from respondents were not provided.

The researcher used self-administered questionnaires to collect data from RNs in selected health care services (HCS) in Tshwane Metropolitan area which, in the context of the quantitative approach, were numerically analysed. The respondents were requested in the covering letter to be as honest and open as possible to advance the objectives of this study. The study assumed that the deliberate omission of the respondents and the institutions' names on the questionnaire, as a means of assuring them of complete anonymity, would facilitate achieving the study's goal.

The in-depth literature review, which is an important aspect of quantitative research, assisted the researcher to identify relevant existing tools and pertinent questions, and further define the construct to be measured, namely discontent among RNs in the PHS (Burns & Grove 2003:112).

4.4.3 Qualitative

Talbot (1995:415) describes qualitative research as research with, rather than on people. Qualitative studies focus on people's perceptions, expressed opinions, feelings and experiences, and the unique context in which they occur, rather than on numbers (Creswell 1994:162). Brink and Wood (1998:192) refers to qualitative studies as "non-numerical, usually in the form of written words". Their main objective is to elucidate various ways in which people in particular settings come to understand, account for, act on and manage their day-to-day situations (Miles & Huberman 1994:6). According to Marshall and Rossman (2006:3), qualitative studies

- Focus on the context.
- Are emergent rather than tightly prefigured.
- Take place in a natural world.
- Are fundamentally interpretive.

Creswell (1994:162-163) lists the following characteristics:

- The focus is on the process and outcome of a phenomenon.
- Qualitative data is not quantifiable in the traditional sense of the word, much as it is based on the application of tacit and felt knowledge, in order to appreciate the nuances of multiple realities.
- While objectivity and truthfulness are at the core of both of these research methods, the qualitative approach "seeks believability, based on coherence, insight and instrumental utility".

The value to be derived in this study was that the emerging descriptive data would assist in understanding how discontent progressively affects the personal and professional lives of the RNs in the PHS, patients, government and the community at large.

Polit and Hungler (1999:259) point out that, in-depth qualitative studies have the potential of revealing relevant theoretical information on the construct under study to project the need for further study. Accordingly, the open-ended questions and interviews were intended to provide mainly descriptive data based on insights rather than statistical descriptions.

Polit and Hungler (1999:258) state further that though qualitative studies use small and unrepresentative samples to provide insights into the nucleus of a complex phenomenon, the information they present is not gratuitous, but serves as strengths for qualitative studies. However, their lack of generalizability and reliability becomes their weak point in that they employ data-collection and analytic methods that rely on subjective judgments. In this study, this potential weakness was overcome by the use of qualitative and quantitative data, which though complementary remain mutually exclusive. In view of the above, triangulation using questionnaires, individual and focus group interviews were the tools of choice for generating required data from five public and two private hospitals in the Tshwane Metropolitan area.

4.5   DESCRIPTIVE AND EXPLORATORY

The researcher chose a descriptive and exploratory design to identify and describe factors that contribute to or seem to be the source of discontent among RNs in the PHS.

Descriptive studies seek to document the degree and percentage of respondents experiencing the phenomenon under study while exploratory studies investigate factors that exacerbate or minimize the phenomenon (Polit & Beck 2008:20). Descriptive and exploratory studies are interested in

accumulating detailed descriptions of existing variables to assess the current situation and its activities in order to "make plans for improving health care practices" as was the case in this study (LoBiondo-Wood & Haber 2006:240). Variables of interest to this study were the respondents' attitudes, opinions, experiences, facts and feelings in relation to discontent among RNs in the PHS.

Quantitative descriptions focus on the "prevalence, incidence, size, and measurable attributes of phenomena" and qualitative researchers deal with descriptions of the "dimensions, variations, and importance of phenomena" (Polit & Beck 2008:19-20). Consequently, the exploratory component, rather than observing and describing, goes further to investigate the full nature of the phenomenon, the manner in which it occurs, and related contributory factors, and to determine if there are any interesting patterns in the data (Polit & Beck 2008:19-20; Mouton 1996:103). For this reason, the researcher employed both methods in this study to answer the research questions and unpack the intricacies, dilemmas and other factors surrounding discontent among RNs in the PHS.

Descriptive and exploratory studies have the following advantages (Polit & Beck 2008:277; Seaman 1987:185):

- A broad range of rich, newly discovered data is collected.
- It is possible to reach a holistic view by describing, comparing and classifying data as a way of understanding patterns and processes in their totality.
- The researcher can progressively move from observations and descriptions to classification and conceptualization.
- When analysing descriptive data, the researcher can also move from description of data to generalization.

LoBiondo-Wood and Haber (2006:140) stress the further advantage of attaining a thorough investigation of the characteristics of a particular group and the frequency of the occurrence of a phenomenon, especially when little is known about the phenomenon.

The target group in this study therefore consisted of RNs and the circumstances surrounding their personal and professional lives, which seem to culminate in discontent in the workplace. This assumption was based on circumstantial evidence and media reports on strike actions and nurse migration from the PHS (Ngqiyaza 2007:1).

Since this study was descriptive and exploratory, the main focus was on describing factors which constitute discontent among RNs in the PHS in Tshwane Metropolitan area. Descriptive research focuses on delineation of the status quo of a situation; therefore the researcher can conduct a study guided only by the research questions (Loiselle et al 2004:107). Accordingly, the research questions, and not the hypothesis, guided this study even though a critical reader actively looks for assumptions or accepted truths, supporting examples, parallel experiences or any other structural features of the written text (LoBiondo-Wood & Haber 2006:31). Loiselle et al (2004:106) nevertheless insist that qualitative researchers want their inquiry to be guided by participants' views rather than by their own assumptions, as was the case in this study.

4.6   DATA COLLECTION

Collecting data from respondents requires some form of measuring instrument (Mouton 2001:100). This study sought the respondents' written and verbal information in relation to discontent among RNs in the PHS. The researcher chose questionnaires and interviews as data-collection instruments in order to generate not only statistical data, but descriptive information to verify statistical interpretations.

4.6.1 Questionnaires

A questionnaire is an instrument designed to gather data about knowledge, attitudes or feelings from respondents through questions in a paper-and-pencil format (LoBiondo-Wood & Haber 2006:325; Loiselle et al 2004:269). Sheppard (2004:65) states that questionnaires "provide information through

which researchers can determine the scale of any particular construct they want to investigate".

Burns and Grove (2003:289) argue that the questions designed for questionnaires usually have less depth than interviews. However, Sheppard (2004:65) prefers questionnaires because they "provide the basis for identifying with any particular group, the frequency with which any particular item is sought, preferred or viewed, and do so (often) in comparison with alternative items". For the purpose of this study, questionnaires were used to collect data from the respondents to determine the source and scale of discontent among RNs in the PHS, because the researcher was not as restricted by the availability of respondents as in the interviews.

4.6.1.1 Advantages of questionnaires

Whether disseminated by hand, post, e-mail or via the Web, questionnaires have the following advantages (Eiselen 2007a):

- Respondents can complete them at a time and place convenient for them.
- They are more cost effective to administer than face-to-face interviews.
- Interviewer bias is minimized.
- Respondents are at liberty to respond more truthfully to sensitive questions than in intrusive face-to-face surveys.

Questionnaires overcame the restrictions imposed by staff shortages and the respondents' shifts. Furthermore, respondents were not intimidated by the presence of the researcher when providing sensitive information. One disadvantage, however, was that the researcher had no control over who completed the questionnaire, even though delivered to the intended individuals. According to ethical standards, participation remains the respondents' choice, and they can withdraw from the study at any time (Polit & Hungler 1999:141).

4.6.1.2 Content of the questionnaire

A well-defined research question and clarification of intended goals are critical for formulating relevant questions to be included in the questionnaire (Eiselen 2007a). Therefore, each question should be directly linked to the research question(s) and the intended goals.

The researcher scrutinised the existing body of knowledge to identify relevant questions that would address the purpose of this study. Then she identified items for each hospital involved in the study, and compared research findings in these hospitals. The questionnaire comprised mainly opinion-related questions and very few factual questions. Opinion-related questions reveal respondents' attitudes or perceptions or their perception of the frequency of a particular behaviour. Factual questions mainly relate to facts surrounding the respondents' demography, habits or hobbies. They can also test the respondents' knowledge on a specific subject (Eiselen 2007a). However, Bless and Higson-Smith (2000:116) contend that with opinion-related questions, possible bias can stem from the fact that the respondent is the only person who knows the true answer. Consequently, the researcher used triangulation to overcome this deficiency because data from the one verified the results of the other.

The opinion-related questions assessed the respondents' attitudes, perceptions and views regarding discontent among RNs in the PHS. Demographic information established the respondents' age, rank, qualifications, residential areas and family responsibilities, which could add to life's demands that influence the state of discontent among RNs in the PHS with respect to salaries, career pathing and conditions of service, among others. Both open-ended and closed questions were used.

4.6.1.3   Open-ended questions

With open-ended questions, the researcher explored the phenomenon under investigation to establish the respondents' perceptions on the subject, and respected the presentation of their experiences and subjective views (Marshall & Rossman 2006:101). Therefore, the respondents were given the opportunity to express their views in writing in the space provided. This allowed the respondents' views to reflect their perspective (the emic perspective) rather than the researcher's (the etic perspective). This reinforced the "insider's perspective; quotations, commentaries and examples" to add to the richness of the data presented from the respondents' first-hand experience (Streubert & Carpenter 2003:18, 24). Furthermore, LoBiondo-Wood and Haber (2006:325) point out that, open-ended questions enable respondents to express any concerns or provide additional information in their own words. Valuable insights can be derived from this format. Bless and Higson-Smith (2000:119) emphasise that open-ended questions are suitable for exploratory studies because they do not focus on preconceived ideas.

Open-ended questions were therefore essential because of the convenient sample of respondents. The responses would prove or negate the evidence obtained through statistical analysis of the quantitative data. Eiselen (2007a) warns that open-ended questions should only be considered when absolutely necessary because coding is time consuming as it is done at the end of the survey. Streubert and Carpenter (2003:30) maintain that the advantages nevertheless outweigh the disadvantages. The advantage in this study was the ability to reach many respondents in a short time and obtain a large quantity of data from many respondents.

Although the data was not pre-coded, this did not affect data analysis because written narratives from the different hospitals were grouped together for common items, thereby analyzing different perspectives on a central issue (Patton 1990:376). This approach thus unveiled the respondents'

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experiences, feelings and opinions regarding the reasons and extent of discontent among RNs in the PHS. In this way, the value of qualitative studies in capturing perceptions, expressed opinions, feelings, experiences of people and the unique context in which they occurred was achieved (Creswell 1994:162; Talbot 1995:415). Open-ended questions were included in the questionnaire to complement the quantitative data by providing mainly descriptive information in a less restrictive mode, based on insights rather than statistical descriptions (Creswell 1994:162; Talbot 1995:415).

4.6.1.4   Closed questions

Multiple-response questions or fixed alternatives, as they are sometimes called, provide categories of responses where respondents select answers of their choice to indicate the level of detail required from them (Eiselen 2007b). Closed questions have the advantage of confining the respondents to options available in the questionnaire (Talbot 1995:294). Bless and Higson-Smith (2000:119) argue that restricting the number of options introduces bias if important categories are left out. However, Talbott (1995:294) emphasises that this restriction enables the researcher to code and analyse responses, where only the required information is obtained, thus enhancing the reliability of the study. In this study, the questionnaire included closed and open-ended questions to allow freedom of expression for respondents who wanted to provide further information.

In order to elicit the level of detail required about discontent among RNs in the PHS, the respondents were asked to indicate the degree to which they agreed or disagreed with questions according to a five-point Likert scale (LoBiondo-Wood 2006:325; Polit & Hungler 1999:340). The researcher included a neutral category in order not to force the respondents in a direction they might not want to go (Polit & Beck 2008:415). According to LoBiondo-Wood and Haber (2006:325), however, respondents have a tendency to avoid direct questions. This makes interpretation difficult in terms of establishing their position regarding a particular item. Though the nature of the topic for this study called

for the respondents to take a stance other than the neutral category, the researcher concurred with Neuman (2006:307) that a supplement with open-ended questions would allow respondents to choose areas they wished to comment on or provide more information, which would further enrich the study.

Polit and Beck (2008:415) emphasise that a serious disadvantage of closed questions is that more important information can be forfeited and limited responses can frustrate the respondents who might want to provide additional information. Hence in this study, the respondents had the opportunity to make additional comments in the space provided. The researcher personally distributed the questionnaires in order to establish good rapport and answer questions. A covering letter constituted the first page of the questionnaire, explaining the purpose of the study and providing instructions on accurate and honest completion of the questionnaires (de Vos 2002:176).

4.6.2 Individual interviews

Neuman (2006:305) describes an interview as "short-term, secondary social interaction between two strangers with the explicit purpose of one person's obtaining information from the other". Personal interviews are regarded as "the best method of collecting survey data because of the quality of information they yield" (Polit & Beck 2008:324). Although it was intended that semi-structured individual interviews also be conducted in this study, these interviews were curtailed due to data saturation from the first stage (written narratives). With the permission of the respondents, the interviews would have been audio taped to enhance validity. The researcher would then transcribe the interviews verbatim and analyse them to determine thematic categories and subcategories that emerged (see chapter 5, section 5.10).

Trust and rapport with respondents comes with prolonged engagement (Polit & Hungler 1999:427; Streubert & Carpenter 2003:28). Miles and Huberman (1994:6) add, "Prolonged contact with a "field" or life situation" has the benefit

of portraying the everyday life of individuals, groups and organizations. In view of the foregoing requirements, the researcher has had sufficient opportunity to interact with RNs both in private and the PHS from many years of service in the PHS, as well as part-time work and research in both sectors during her full-time Masters' programme.

4.6.2.1   Unstructured interviews

Polit and Beck (2008:396) describe unstructured interviews as conversational and interactive, without a series of prearranged questions. However, this does not mean that they should be approached casually. Advanced planning is also required to provide impetus for extracting appropriate responses from participants (Polit & Hungler 1999:333). Nevertheless, this study did not involve unstructured interviews.

4.6.2.2   Semi-structured questions

In semi-structured questions, the interviewer asks prearranged questions and records answers as the interviewee responds (LoBiondo-Wood & Haber 2006:324). A topic guide or list of questions is prepared in advance for the interview sessions. Respondents are free to provide explanations and examples as they deliberate freely about topics in the list. Effective listening is a prerequisite for researchers so that probes and follow-up questions can be used effectively (Polit & Beck 2008:394). Probes serve to elicit more useful information than was initially volunteered by respondents (Polit & Hungler 1999:347). However, only neutral probes should be used to avoid influencing the content of responses provided.

In this study the researcher intended to use semi-structured interviews to allow the respondents to share their views, relate their experiences and expand freely on the topic in a narrative form (Bless & Higson-Smith 2000:105). As indicated earlier, data saturation was reached after the first stage of the research was accomplished, where data was collected using

questionnaires with open-ended questions (see chapter 5, section 5.10). Bless and Higson-Smith (2000:105) emphasise that researchers should be cautious of the influence they could exert on respondents by the manner in which they ask questions.

Neuman (2006:305) points out that there is a possibility for respondents not to understand the questions as they were intended by the researchers. In this study, the researcher had already conducted a pilot study to obviate the possibility of misinterpretation of questions.

The researcher would have followed Neuman's (2006:306) rules in the interviews:

- Use the exact wording without rephrasing or adding words. This includes not skipping questions unless necessary.
- Listen carefully and record responses verbatim without correcting grammar or slang. This nullifies paraphrasing or summarizing, which account for a lot of information lost.
- Use probes when necessary to clarify ambiguous answers.
- At the end of the session, thank the interviewee, and retreat to a solitary place to record the details of the information obtained without delay.

According to Streubert and Carpenter (2003:28), an interview can be brief if the objective is to verify previously obtained information, as was the case in this research.

4.6.3 Focus group

Focus groups are at the core of qualitative studies and rely totally on a focused group interaction to produce data and insights that would otherwise not be accessible through other means (Burns & Grove 2005:542; Morgan 1997:2). The researcher basically supplies the questions, called the interview

or topic guide, and becomes the moderator to keep the story going in the right direction (Krueger 1994:20; Polit & Beck 2008:394).

Krueger (1994:6-7) describes a focus group as "a special type of group in terms of purpose, size, composition, and procedures" or "a carefully planned discussion designed to obtain perception on a defined area of interest in a permissive, nonthreatening environment". Respondents are at liberty to tackle open-ended questions by making comments, explanations and sharing their experiences and perceptions in the flow of discussions. This opens up other avenues for new topics and lays a foundation for thematic categories that emerge with different meanings to the construct under study.

Neuman (2006:412) points out that it is common for researchers to combine focus groups with quantitative research, even though there are strengths and weaknesses to this procedure.

- **Dynamics of a focus group**

In a focus group, members are free to react to what others say, precipitating further discussion that produces deeper and richer data (Bless & Higson-Smith 2000:110; Krueger 1994:6; Polit & Beck 2008:395). Although stimulating to respondents, a common disadvantage is that some of the respondents may be reluctant to express their views in the presence of others, and some may dominate or even hinder others from expressing their views (Polit & Beck 2008:395; Bless & Higson-Smith 2000:111).

Since method triangulation was employed in this study, it was assumed that the focus group would complement the other techniques by providing substantial data. This means that the quantitative data obtained from the questionnaires would later be verified by views and experiences emanating from the focus group. It was also the researcher's intention to use tape-recorders with dicta-phone for individual interviews and focus group as a means of enhancing reliability.

Nevertheless, both individual and focus interviews were discontinued as mentioned before (see also chapter 5, section 5.10). Individual and focus interviews would have been conducted on the days and times suitable for the respondents. The nature of services provided by RNs, work commitments and time at their disposal would largely have determined the duration of the interviews. Burns and Grove (2005:543) and Neuman (2006:412) point out that though there are no definite time-frames, twenty to forty-five minutes for individual interviews and an hour or two for focus interviews should suffice, depending on the nature of the topic.

Streubert and Carpenter (2003:29) emphasise that focus groups are most useful especially when a sensitive topic is being addressed. The researcher was aware of the controversies, complexities and sensitivity of the study, particularly about unionization of hospitals, changes within the statutory bodies governing the nursing profession, market-related salaries and other transformational issues confronting the government. Therefore, the respondents would have been assured of confidentiality, would not be coerced to participate in the focus groups, and would be free to withdraw at any stage of the study.

4.7   POPULATION

A research population is "all the individuals or objects with common, defining characteristics" (Polit & Beck 2008:56). Burns and Grove (2003:491) define a population as "all the elements (individuals, objects, events, or substances) that meet certain criteria for inclusion in a study; sometimes referred to as a target population". Babbie (2001:110) describes a population as "that group (usually of people) about whom you want to draw conclusions".

The target population for this study comprised RNs in the Tshwane Metropolitan area. The researcher wished to purposely isolate the correct types of people to whom the results would be generalized by ensuring that an appropriate sample was obtained. In order to find answers to the research

questions, the researcher administered questionnaires to RNs in two different health settings, namely PHS and private hospitals.

The researcher selected five out of eleven PHS institutions, where a convenient sample was chosen. The selection of these HCS was guided by a map of the geographical distribution of HCS in Tshwane Metropolitan area, provided by the National Statistics South Africa Institute (Stats SA) (see chapter 1, figure 1.1). The researcher assumed that the targeted population would provide the necessary information since the past decade had seen unprecedented migration of RNs from the PHS. There had also been strike actions involving nurses, which could be indicative of salient discontent among RNs in the PHS (Ngqiyaza 2007:1).

Questionnaires were also distributed to two out of thirty private hospitals within the Tshwane Metropolitan area, specifically directed to RNs with previous employment in the PHS. In this case, the researcher used a purposive sample in order to solicit their opinions, perceptions or experiences (Brink 1998:319). This was intended to assist in identifying the source of RNs' discontent in the PHS, which might have contributed to their decision to move to private hospitals. In-depth information from information-rich sources is very valuable, even from a small number of people. The researcher therefore considered this group as a rich information source, in respect of their experiences with the PHS.

The respondents were requested to complete the questionnaires, which were collected within forty-eight hours from determined depots within the hospitals.

4.7.1 Inclusion criteria

Consideration was given to both male and female RNs of all racial groups from selected public and private health services in the Tshwane Metropolitan area with experience of one year or more in any PHS institution, irrespective of age. RNs that came from other hospitals for part-time schedules were not included.

To impose strict control over extraneous variables, the researcher did not select RNs in management positions because they were seen as part of hospital management and could be a source of bias in the study. In addition, in the private hospitals, RNs who had been out of the PHS for more than five years were intentionally excluded since they could possibly not be *au fait* with the latest developments in the PHS.

The researcher expected the target population to yield sufficient information to provide insight into and clarity on the source(s) of discontent among RNs in the PHS, to ensure the validity of the study.

4.7.2 Hospital sampling criteria

In order to achieve representativeness and to benefit RNs in other public health care settings, the study involved the following levels of care in the city, suburbs and townships in the Tshwane Metropolitan area:

- Three district hospitals (level one)
- One regional hospital (level two)
- One academic hospital (level three).

Furthermore, the PHS institutions had to

- Be classified as a public health care institution.
- Have experienced an exodus of RNs through various ways during the past five years (because hospital records are kept for five years in accessible archives).
- Have been involved in strike actions in some way.

Two private hospitals in the Tshwane Metropolitan area also formed part of the study. The researcher was of the opinion that RNs from these hospitals would benefit the study because they had experience of previous PHS employment. In addition, these private hospital RNs also portray the same

distinctiveness of RNs in the PHS that could have served as an attraction for RNs from the PHS.

Other HCS such as military, mine, specialized TB and psychiatric hospitals, including clinics, NGOs, old age homes, hospices and home-based care in the Tshwane Metropolitan area were outside the scope of this study.

4.7.3 Space and person triangulation

Space triangulation deals with gathering data on the same phenomenon from multiple sites. This study collected data from respondents at district, regional, academic and private hospitals to address discontent among RNs in the PHS. Person triangulation refers to "the collection of data from different levels of persons, with the aim of validating data through multiple perspectives on the phenomenon" (Denzin 1989:237; Polit & Beck 2008:761; Polit & Hungler 1999:428). Therefore, the researcher sought and consolidated views from different levels of the registered category of nurses, namely chief professional nurses (CPNs), senior professional nurses (SPNs) and professional nurses.
Due to the magnitude of this study, the researcher also used investigator triangulation by involving an assistant researcher in data collection, data capturing and analysis (Burns & Grove 2005:225). Denzin (1989:237) and Polit and Beck (2008:543) point out that the three units (time, space and person) of data triangulation are interrelated. However, the researcher only used space and person triangulation as they were relevant to this study.

4.8   SAMPLING

Sampling refers to selecting some of a particular population "to draw conclusions about that entire population" (Sheppard 2004:93). The main consideration in sampling is that the sample should be as representative as possible with minimal sampling error. LoBiondo-Wood and Haber (2006:280) emphasise that unless "representativeness is ensured, all the data in the world become inconsequential". A representative sample is one that reflects

the characteristics of the population under investigation (Polit & Hungler 1999:279).

4.8.1 Convenient sampling

Qualitative researchers "do not consider randomness a useful tool for understanding phenomena" (Loiselle et al 2007:45). Instead, they tend to pursue their studies with a specific purpose in mind (non-random) in order to obtain information-rich sources that will answer the research questions and refine their conceptualization of the construct under study.

The researcher considered convenient sampling appropriate in the public hospitals because of staff rotations on night and day shifts; off-duty schedules; vacation, sick, maternity, study and compassionate leaves taken by RNs, and most importantly the staff shortages observed during informal visits to these HCS.

Sheppard (2004:94) defines a convenient sample as "one that is selected without using random procedures or a known probability of selection". It relies on subjects who are readily available for the study. Individuals who are easy to identify and contact for the purpose of inclusion in the study on account of the needed characteristics are considered. Babbie and Mouton (2001:168) maintain that getting responses only from those who are willing to talk introduces distortions in a study. LoBiondo-Wood and Haber (2006:266) concur, stating that the probability of researchers recruiting opportunists is greater than in any other type of sample, thus increasing the risk of bias.

The researcher was aware of possible recruitment of contaminating factors such as those who feel strongly about the construct under study, thus introducing the Hawthorne effect. In the context of this study, strike actions within the PHS and migration of RNs from the PHS to private hospitals, overseas recruitment and other organizations, which could point to existing discontent among RNs in the PHS, had received wide publicity in the media

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both nationally and internationally, even before this study began. Moreover, different strategies of dealing with grievances are already in place, such as the prescriptions of the LRA (1995) in addition to affiliation to unions and professional associations. Therefore, the researcher considered the risk of these factors contaminating the study minimal. Burns and Grove (2003:248) pointed out that even though a convenient sample is considered a poor approach due to minimal control over biases, there are usually no serious biases. In this study, it was not a case of 'self-selection' per se. The respondents were requested by the researcher to participate voluntarily as in random sampling, to advance the objectives of the study (LoBiondo-Wood & Haber 2006:266). The researcher also used discretion in selecting the respondents to obtain a convenient sample. However, LoBiondo-Wood and Haber (2006:266) warn that this method be used in quantitative research only, when it is not possible to obtain data by other means. These authors have also noted the struggle of nurse researchers to get respondents for their research.

Further weaknesses of convenient sampling are that the informants could display some degree of unwillingness and intimidation; view the tool as too personal to respond to questions, thus affecting the representativeness of the sample. In addition, the respondents' views could contrast with those who had already left the PHS for reasons known only to them, thus introducing possible bias in the study. However, the researcher was of the opinion that discontent among RNs in the PHS is a common factor experienced by a homogenous group; therefore there should be no reason for a different set of results, regardless of the sampling method followed.

In the PHS, the respondents were conveniently selected from three district hospitals (level one), one regional (level two) and one academic (level three) hospital.

4.8.2 Purposive sampling

The researcher selected a purposive sample of respondents from the private hospitals. Sheppard (2004:94) describes a purposive sample as one selected with a particular purpose in mind. According to Brink (1998:319), a purposive sample is ideal when the researcher seeks a particular characteristic of the population for inclusion in the study. In other words, specific cases are selected because they illustrate some features or processes that are of interest to the study in question (de Vos 2002:334; Polit & Beck 2008:356). The choice of this sample relies completely on volunteers for the study and the judgment of the researcher (de Vos 2002:207).

Patton (1990:174) points out that purposive sampling can serve a number of purposes among which is sampling for the purpose of obtaining explanations for typical cases. Loiselle et al (2004:241) recommend that this technique be used to select those who are considered typical of the population to be studied and have the necessary knowledge of the phenomenon. Therefore, the researcher wished to generate data from volunteer RNs previously employed in the PHS as well, for information that would contextualize the state of discontent among RNs in the PHS.

According to Babbie (2001:179), the researcher's knowledge of the population and its elements can be used to hand pick components to be included in the sample in order to gain insights from which much could be derived. Burns and Grove (2003:255) contend that "it is difficult to evaluate the precision of the researcher's judgment". Polit and Beck (2008:343) emphasise that "sampling in this subjective manner, provides no external, objective method for verifying the distinctiveness of the chosen participants".

For the purpose of this study, the researcher had sufficient knowledge of issues surrounding HCS, stemming from many years of employment in the PHS and sessional duties in the private health sector. Moreover, the researcher was involved in a Master's programme that involved both the PHS

and private hospitals for three consecutive years. Lincoln and Guba (1985:102) maintain that it is "only reasonable to assert that the investigator's judgment can be relied upon to the extent he or she interacts with the phenomenon over time so that its etiology, including its history and its present context, can be fully understood and appreciated".

4.9   SAMPLE AND SAMPLE SIZE

A sample is a subset of the population selected to participate in a study in order to obtain information on the construct being studied (Burns & Grove 2003:495; Polit & Beck 2008:765). Patton (1990:184) points out that the sample size depends on what the researcher wants to know, and the purpose for the investigation. The rule of thumb is, the larger the sample, the more representative it will be for both probability and non-probability samples (LoBiondo-Wood & Haber 2006:278). However, Polit and Beck (2008:349) argue that there is no assurance of accuracy in larger samples, because in a non-probability study, even a larger sample has the potential of extensive biases.

Most nursing studies are based on smaller samples "because of the availability of small clinical populations in a given location and the difficulty of organising multisite studies" (Brink 1998:147). According to Polit and Beck (2008:348), there are no prescribed formulas as to how large the sample needs to be in qualitative studies. While there are no set criteria for sample size, a sample should be determined by informational needs, that is, to the point of data saturation in qualitative studies (Loiselle et al 2004:249).

Five public hospitals and two private hospitals were selected for the study in order to capture the views and perceptions of RNs regarding discontent among RNs in the PHS. The rationale was that even though accurate statistics are not available, circumstantial evidence and the media reveal that most RNs left the PHS for overseas recruitment and employment in the private health sector. The researcher considered these public hospital RNs and those in the private hospitals with previous PHS experience information-

rich sources that would adequately answer the research questions for this study. Since convenient and purposive sampling were used, the sample size depended on how many respondents were available, to the point of data saturation. After obtaining permission to enter the premises and conduct the study, the names of the institutions and participants were kept anonymous as an ethical requirement (see appendix D).

- **Biases**

According to Polit and Beck (2008:295), there could be reason to challenge the findings if researchers do not exercise caution in dealing with extraneous variations from the outset. Polit and Hungler (1999:167) warn that there will always be a risk of bias with non-random sampling. Therefore, every effort should be made to deal with extraneous variables.

Many factors are responsible for bias in research. Though bias cannot be completely eliminated, Polit and Hungler (1999:349) maintain that it can be minimized. Researchers' preconceived ideas could unintentionally introduce bias to a study. To deal with this risk, the current researcher was not present when the respondents completed the questionnaires. With regard to interviews, Marshall and Rossman (2006:105) and Patton (1990:408) hold that researchers should endeavour to bracket themselves from interviewees' experiences by acknowledging their own presuppositions in order to identify data in pure form without contamination by extraneous intrusions.

Another factor is that respondents could be influenced to take a particular direction by cues displayed by researchers. In this study, the open-ended questions in the questionnaires eliminated the possibility of this bias, as the respondents provided anonymous descriptive data in their own words. Of cardinal importance, too, it was intended for semi-structured interviews to be audio-taped with the respondents' permission, without expressions of surprise, approval or disapproval from the researcher (Polit & Hungler 1999:346).

The method triangulation incorporated in this study also eliminated bias by allowing comparison through statistical means, in relation to the narrative descriptions obtained from the respondents.

There could be factors that affect the heterogeneity of the population with respect to the dependant variable, namely 'discontent' among RNs. In this case, attempts were made to identify extraneous variables by providing written criteria for eligibility; for example, only respondents with one year and onwards of experience in the PHS and only full-time employees were legible (Polit & Beck 2008:198). In respect of the private hospitals, only RNs with previous employment in the PHS were considered eligible for the study. These measures were used to obtain a more homogenous sample for the study.

To impose strict control over extraneous variables in the quantitative approach of this study, the selection criteria excluded RNs in management positions. In the private hospitals, resignations of more than five years from the PHS were intentionally excluded from the study, since they could not be *au fait* with the latest developments in the PHS.

Finally, it was the researcher's intention to keep a record of personal convictions that could affect data collection and interpretation during the interviews that would have been conducted (Loiselle et al 2007:45). The incorporation of an assistant researcher was going to be instrumental in ensuring trustworthiness of the findings (see chapter 5, section 5.10). However, the statistician remained highly involved both in the qualitative (written narratives) and quantitative data analysis. Thereafter, the researcher undertook to keep the questionnaires for a period of two years.

4.10   PILOT STUDY

A pilot study is a small-scale study or "trial run" used by researchers to test instruments for effectiveness in a larger study, using the same topic (Polit &

Beck 2008:213). These authors also point out that researchers who intend to conduct a study that will yield high quality evidence normally incorporate a feasibility study. The pilot study, then, becomes the preliminary method that evaluates the feasibility of the study.

4.10.1   Questionnaires for pilot study

The pilot study was conducted in health care settings other than those targeted for the main research. The purpose of the pilot study was to:

- Determine the relevance, credibility, any ambiguity and level of difficulty of the questions, including the approximate time needed to complete the questionnaires (Eiselen 2007a).
- Ensure that the respondents understood the questions as the researcher intended.
- Remove questions that would be of no value to the study.

Polit and Beck (2008:213) maintain that a pilot study prevents "an expensive fiasco - the misfortune of undertaking a costly but flawed large-scale study".

4.10.1.1   First draft of the questionnaire for the pilot study

The researcher formulated questions to address the study topic and grouped them into themes to form an initial draft questionnaire for the study. To establish content validity, five questionnaires were given to the supervisor, the research directorate (a registered nurse with PhD) of an academic hospital, the statistician, a lecturer and an experienced medical doctor in an academic hospital. Talbot (1995:281) points out that the experts "are chosen based on their practical or academic knowledge, or both, of the domain of interest". The group was selected because they understood the problems of nurses, and would provide guidance on the questionnaire to add value to the study.

4.10.1.2 Setting for pilot study

The clinics were found suitable for piloting since they are classified as public health service areas, and did not form part of the major study. The reason for their choice is that they were easily accessible, especially in the afternoons, compared to highly structured routines in hospitals. de Vos (2002:177) points out that, questionnaires can be given to a captive group, allowing time for completion while the researcher waits. Twenty questionnaires were distributed among RNs and enrolled nurses (ENs) as a pre-test. Though the ENs function within their scope of practice, they were considered resourceful as they rank second to RNs and usually display leadership potential in the absence or shortage of RNs.

The pilot group members completed and returned the draft questionnaires within 24 hours of receiving them, and provided feedback as well. Information derived from these participants was seen as the prelude to the findings of the main study, thus, enhancing its feasibility.

4.10.1.3 Feedback from experts

The experts highlighted the following areas for consideration:

- The draft questionnaire provided space for certain questions only, thus limiting the freedom of choice for respondents. It was recommended that space be provided for all questions in the questionnaire for respondents to select items they might wish to comment on. This recommendation gains support from de Vos (2002:177, 179) who maintains that it is necessary to leave space for respondents to comment so that the researcher can obtain some idea of the spectrum of possible responses, especially when little is known about the variable explored.
- The closed questions were found to be consistent with the multi-purpose nature of this study, which aimed to describe and explore discontent among RNs in the PHS.

- Some questions could provoke emotions, but had to be included in the questionnaire, otherwise how could HCS be improved if issues were not confronted.

- The length of the questionnaire was suitable for the topic under investigation. The experts recommended further that after distribution of the questionnaires, respondents be given time to think deeply over items included, and questionnaires rather be collected after 48 hours.

4.10.1.4 Feedback from the pilot group

Some questions were initially considered to be irrelevant. However, upon further deliberation it was realised that incorrect phrasing of some of the questions was the main problem. These questions were rephrased to reflect the meaning that they were intended to provide. Eiselen (2007a) emphasises that unnecessary questions should be eliminated. Consequently, questions that were found completely irrelevant for the study were removed. It should be noted that the question: "RNs leave the PHS because of fear of infection with HIV/AIDS", was considered irrelevant to the context of the study. All the respondents of the pilot exercise indicated no support for this item. Further probing revealed that RNs did not leave the PHS because of HIV/AIDS, except where it caused increased workload in the midst of shortage of staff. The questionnaire was rated comprehensible and precise.

4.10.1.5 Finalisation of the questionnaire

After feedback from the experts and the pilot group, the questionnaire was amended. The researcher then consulted the promoter and personnel in questionnaire design from the university's Department of Statistics and Communication. Thereafter, irrelevant questions were deleted, new questions added, and questions that did not convey the whole meaning as intended were rephrased. As indicated earlier, more space was added below each item to enable respondents to comment on the questions of their choice. The study leader (promoter), Professor O Makhubela-Nkondo and the statistician, Dr SM

Seeletse of the Department of Statistics of the University of South Africa, were involved throughout and their input incorporated.

4.10.2   Interviews

The researcher conducted three individual interviews with a registered nurse, an enrolled nurse, and an enrolled nursing assistant for the pilot study. With these interviews, the researcher first wrote a case analysis for each person interviewed, using all the data for each respondent (Patton 1990:376). Then a cross case or cross interview analysis for each question in the interview guide followed. Information from different respondents was grouped by topics from the interview guide to facilitate analysis. However, Patton (1990:376) warns that the relevant information will not necessarily be found in the same place with each interview, which turned out to be true.

A focus group interview was also conducted with three RNs, which lasted approximately forty minutes. Neuman (2006:305) points out that even in "a well-designed, professional survey, follow-up research found that only about half the respondents understand questions exactly as intended by researchers". Of utmost importance is that respondents "often interpret straightforward questions differently than intended by the survey designer" (Neuman 2006:307). Consequently, a tape recorder was used with the permission of the participants, for careful assessment of comprehension of questions, and to indicate how the major study would unfold so that flaws and weaknesses could be dealt with before the launch of the main study.

In analysing the focus group data for the pilot study, the researcher clustered related types of narrative information together that described the phenomenon under study. Then the researcher identified themes, categories and subcategories, which provided a rich description and meaning of discontent among RNs in the PHS. The recorded and written transcriptions of the interviews were subsequently submitted to the supervisor for verification and

further identification of recurrent themes and categories (Marshall & Rossman 2006:105; Polit & Beck 2008:71).

4.11   VALIDITY

Validity and reliability are important criteria by which a questionnaire, which can be used both as a qualitative and quantitative instrument, is evaluated in relation to its adequacy and quality (Sheppard 2004:242). Validity refers to the ability of the instrument to measure the truthfulness or falsity (real meaning) of the construct under consideration (Babbie 2001:143). According to de Vos (2002:166), a valid instrument "actually measures the concept in question" and accurately yields results whose form reflect the true nature of the variable being measured.

In this study, validity referred to the extent to which the information provided by respondents reflected the truthfulness or falsity about discontent among RNs in the PHS in the Tshwane Metropolitan area.

4.11.1   Internal validity

Neuman (2006:259) describes internal validity as "when the hypothesised independent variable alone affects the dependant variable". A threat to internal validity occurs when a variable other than the one in focus affects the dependant variable. Polit and Beck (2008:286) emphasise that it would be better if researchers could identify threats to validity and devise means to control them so that the findings of the study could be more convincing. According to Neuman (2006:260), threats to internal validity emanate from selection bias. Therefore, to rule out the possibility of factors other than those presumed accounting for the observed behaviour; the researcher took the following precautions:

RNs employed in management positions (area supervisors) did not take part in the study.

Professional nurses, SPNs and CPNs from the PHS were selected for participation in the study. The health care institutions were district, regional

and academic hospitals. This step ensured that the group was homogenous from the start so as to minimize threats to internal validity.

In the private hospitals, RNs who had resigned more than five years from the PHS were not included because it was possible that their views could not be congruent with current developments in the PHS.

4.11.2   Content validity

Content validity has to do with "the representativeness or sampling adequacy" of the topic and items comprising the content of the instrument (de Vos 2002:167). Talbott (1995:281) emphasises that to be accurate, the instrument "must assess the whole domain of interest". Dempsey and Dempsey (1996:69) describe content validity as how well items in a questionnaire portray the meaning of the phenomenon under study. The researcher used Talbot's (1995:281) guidelines for designing the questionnaire (see section 4.10).

4.11.3   External validity

External validity has to do with "the extent to which relationships observed in a study hold true over variations in people, conditions and settings" (Polit & Beck 2008:301). This means the degree to which the findings of a study can be generalized beyond the study context and setting. This study can therefore be generalized to a larger population because the hospitals were selected according to levels of care (level one, two and three), as discussed under criteria for selection of hospitals (see section 4.7.2). All levels of care were represented from district, regional, and academic to private hospitals within the Tshwane Metropolitan area. After the quantitative data was analysed for the individual hospitals, the findings from the different hospitals were compared to determine variations and commonalities, leading to generalization. Moreover, the study assumed that all these public health institutions had experienced strike actions and migration of RNs from the PHS as attested by media sources, hospital reports and circumstantial evidence.

- **Threats to external validity**

The external validity of a research could be threatened by the type of sampling method selected because of the subjective nature of researchers' judgement in the selection of participants. The sampling method "provides no external, objective method for verifying the distinctiveness of the chosen participants" (Polit & Beck 2008:343). Burns and Grove (2003:255) emphasise that "it is difficult to evaluate the precision of the researcher's judgment". To overcome that weakness, the researcher used a triangulation of methods, where the results of one method would either confirm or negate the findings of the other. Consequently, open-ended questions were included under each item for those who would want to provide additional information.

The Hawthorne effect could also pose a threat to the study. This is a pseudo behaviour induced by the expectations of the participants from the awareness of their involvement in the study (Polit & Beck 2008:264). Respondents might give responses that suit the study in their opinion.

In the researcher's view, the Hawthorne effect would not pose a threat to this study, since the phenomenon under investigation is of current importance and a concern to government, the nursing fraternity and the South African society. Nevertheless, to avert this threat, the respondents were put at ease by sufficiently explaining the purpose of the study and not coercing them to give any responses. The researcher assured the respondents that the study in no way intended to indict them for the alleged neglect of patients during strike actions reported by the media. They were asked to be as natural and candid as possible. Moreover, the anonymity of the selected HCS and participants' details was strictly maintained. The researcher and the research assistant also endeavoured to conduct themselves in a neutral and non-judgemental way (Polit & Beck 2008: 372). Furthermore, the multisite engaged in this study would assist in eliminating the threat of the Hawthorne effect.

4.12 RELIABILITY

Babbie and Mouton (2001:119) describe reliability as a matter of whether repeated application of a particular method to a different population or group of similar characteristics would consistently produce similar results. Instruments that produce less variation in repeated measurements of the same attribute are said to be reliable. This, therefore, implies that there is consistency, stability and dependability of a measuring tool (Neuman 2006:189).

Mouton (1996:156-158) recommends the following steps to minimize threats to validity and reliability:

- Use multiple sources of data collection, because this has the potential of increasing reliability.

- Include various methods and techniques to gather information in a single study for complementarity and incrementality.

- Guarantee privacy and anonymity by open-ended questions in a questionnaire format to facilitate the extraction of reliable information, especially with sensitive topics.

- Build a good rapport with respondents to create a relationship of trust and build a strong relationship between the researcher and respondents, thereby yielding good support for the study.

- Obtain more reliable information through follow-up in-depth interviews.

Miles and Huberman (1994:38) maintain that reliability and validity depend largely on the skills of the researcher as an information-gathering instrument in qualitative research. Therefore, the researcher in this study satisfied this condition in the following ways:

- Familiarity with the phenomenon and the setting where the research was conducted from many years of service as a professional nurse, senior professional nurse and chief professional nurse in the PHS in various provinces, in line with Neuman's (2006:379) view. Although the

researcher was a full-time student at the time of the research, a lot of interaction with the hospital setting was achieved through the Master's programme research and sessional duties in some of the private hospitals. Several visits to the public hospitals and the Department of Health (DOH) were also undertaken during the current research to observe and acquire information on issues pertaining to transformational initiatives and the latest developments in the PHS. Additional information was accessed through the extensive literature review.

- The researcher's strong conceptual interest was motivated by broad media coverage on strike actions and the unprecedented migration of RNs from the PHS, among other things.

- As a previous tutor and mid-level manager in different public hospitals, the researcher used the expertise and experience acquired to establish rapport with the respondents.

- It was intended that premature closure of the study would be averted by remaining engaged until data saturation in the qualitative aspect of the study was achieved.

- The pilot study was also conducted to refine questions both in the questionnaire and the interview guide, so that they extracted the kind of information expected without being misunderstood.

4.13 TRUSTWORTHINESS

As indicated earlier, this study used method triangulation. According to Polit and Beck (2008:546), using multiple methods is an attempt to ensure both analytic integrity and high quality data, by providing a basis for convergence on the truth. Therefore, to establish the trustworthiness of the study in a method triangulation; credibility, transferability, dependability and confirmability were applied to address the qualitative paradigm of this study.

4.13.1 Credibility

Polit and Beck (2008:546) define credibility as a principle that deals with confidence in the truth of the data, and is analogous to internal validity in quantitative studies (see section 4.12.1).

- The researcher used a combination of qualitative and quantitative data-collection methods. Consequently, the results produced by one method were validated by data acquired through another method, exemplified by written narratives that proved or disproved the status of quantitative data in the study (Morse 1997:230).

- The inclusion of several respondents from seven different hospitals in the Tshwane Metropolitan area, which comprise first, second and third levels of care in the PHS, and two private hospitals, was an attempt to enhance credibility by gathering evidence from a wider spectrum.

- Apart from the researcher's many years of nursing in the PHS, the data was collected from April to July 2008. This afforded the researcher sufficient time to travel around hospitals in the Tshwane Metropolitan area, reflect on the complexities of public hospitals, and demonstrate to the respondents that their confidence would not be used against them (Lincoln & Guba 1985:303).

- The research process was continually supervised by and discussed with the promoter. The statistician used questionnaires to verify, compute and guide the data analysis process. To address Burns and Grove's (2005:225) concerns of potential biases in a single-investigator study, the investigator triangulation was achieved by involving the assistant researcher to assist with data collection, data capturing and analysis due to the enormity and magnanimity of this study. Polit and Beck (2008:546) assert that the "underlying premise is that through collaboration; investigators can reduce the possibility of biased decisions and idiosyncratic interpretations of the data".

- The researcher undertook to keep the questionnaires as evidence for a period of two or more years after completion of the study.

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4.13.2   Transferability

Polit and Hungler (1999:716) refer to transferability as a standard to establish the extent to which the findings can be transferred to other groups or areas, comparable to generalizability in quantitative research. Lincoln and Guba (1985:316) contend, however, that while a conventionalist is expected to use statistical evidence to make precise statements about external validity, the naturalist can only use hypotheses with a description of the "time and context" in which they occurred. In the context of this study, the construct under investigation has the relevance of time and context because, according to media reports and circumstantial evidence, all the provinces in the RSA appeared to have experienced the problems outlined in the problem statement at the same time (see chapter 1, section 1.8). Method triangulation and the inclusion of seven HCS from the Tshwane Metropolitan area would also enable generalization of the findings.

4.13.3   Dependability and confirmability

Dependability refers to "the stability of data over time and over conditions", similar to reliability in quantitative studies, while confirmability refers to "the objectivity or neutrality of the data and interpretations" (Polit & Beck 2008:705-751). The questionnaire, which included open-ended questions, was expected to consistently produce similar results because it was a reliable, consistent, stable and dependable measuring tool. Lincoln and Guba (1985:317) maintain that if credibility of a study can be provided, it is not necessary to establish dependability separately, though it is arguable that a strong solution will require that dependability be dealt with directly.

4.14   DATA MANAGEMENT AND ANALYSIS

A statistician processed and analysed the closed questions using the excel programme and the computer Statistical Package for Social Sciences (SPSS).

Frequency tables and bar charts were used to present the data in percentages and compare the data from different hospitals.

The researcher processed and categorised the open-ended questions manually. Data from each hospital was first analysed individually. Then common items from the written narratives from the different hospitals were grouped together, thereby "analysing different perspectives on central issues" (Patton 1990:376). Since the focus of the study was on discontent among RNs in the PHS, the analysis included the description of variations in responses to common questions, commonalities, and patterns of major experiences. The standardized open-ended structure of the questionnaire provided an added advantage to organizing the data in this form.

4.15   ETHICAL CONSIDERATIONS

Polit and Hungler (1999:701) define ethics as "principles or moral values which regulate or govern research processes to comply with professional, legal and social obligations" in an attempt to safeguard participants under study. Ethics, therefore, is concerned about the protection of subjects from harm. Many professions have developed a code of ethics and principles that safeguard their clients (Pera & Van Tonder 1996:5). According to Burns and Grove (2005:83), even though there are risks in every study, "the value of the knowledge generated should outweigh the risks". Streubert and Carpenter (2003:318) emphasise that researchers must assume ultimate responsibility for ethical decision-making and protection of participants in any given study they undertake.

Accordingly, the researcher obtained permission to conduct the study and upheld the principles of beneficence, respect for human dignity, justice, privacy, anonymity and confidentiality.

4.15.1 Permission

The researcher obtained written permission from the University of South Africa, the DOH, and the relevant hospital authorities to conduct the study (see Appendix C and D).

4.15.2 Beneficence

The principle of beneficence means that no harm shall come to participants and above all, that nurse researchers should do good, not harm. Where information seems to implicate the respondent, the welfare of the respondent should be protected, even if it means terminating the interview sessions (Streubert & Carpenter 2003:314). Mouton (2001:243) emphasises that conditions of anonymity extend beyond personal details to encompass the use of tape recorders in face-to-face interviews. In this study, ways that linked participants to information provided were avoided as a guarantee of anonymity and confidentiality. The researcher also prepared the respondents by holding informal information sessions to answer questions and inform them of the research process and purpose in detail. Furthermore, they were also at liberty to disallow the use of any data-gathering devices they disapproved of, if they so wished.

4.15.3 Respect for human dignity

Respect for human dignity is concerned with the right to self-determination and to full disclosure. Burns and Grove (2003:165) emphatically state that all participants should be given the status of autonomy, which means freedom to participate or not to participate in the study. In this respect, the respondents were regarded as self-governing persons capable of making independent decisions. For that reason, the researcher provided adequate information regarding the study during debriefing sessions and the respondents could voluntarily consent or decline participation. The information included confidentiality, anonymity and the fact that this study or their refusal would by

no means jeopardise their jobs. Finally, a letter clarifying the nature and purpose of the study accompanied all the questionnaires.

Polit and Hungler (1999:285) maintain that information derived from participants should be kept in the strictest confidence possible. In this study, all the returned questionnaires were returned without any personal or organizational details on them, to ensure anonymity. Thereafter, the researcher coded all the returned questionnaires by allocating numbers to them, to help identify a particular questionnaire in the event of missing any information during data capturing. Confidentiality was further ensured in that it was impossible even for the researcher to link information to any participant (Burns & Grove 2003:172). The names of the selected HCS were protected through the usage of codes as follows:

- District Hospital A (DHA)
- District Hospital B (DHB)
- District Hospital C (DHC)
- Regional Hospital (RH)
- Academic Hospital (AH)
- Private Hospitals (PHs)

4.15.4 Justice

The principle of justice means the right to fair treatment and equity (Polit & Beck 2008:173-174). This implies treating people who withdraw after consenting to participate, and those who decline participation in the study, in a non prejudiced manner. Therefore, within the principle of justice, the right to privacy becomes a critical factor for the study not to be more intrusive than is necessary, meaning that the privacy of respondents be respected throughout the entire research. Accordingly, the researcher

- Ensured fair and non-discriminatory selection of respondents.

- Included her contact details in the covering letters for further clarification or asking of questions if necessary.
- Adhered to all appointment times made with respondents, with special consideration of the nature of their work and times they volunteered.
- Observed anonymity and confidentiality (Polit & Hungler 1999:138).

4.16   CONCLUSION

This chapter described the research design and methodology in this study, including triangulation, population and sample, data collection and analysis, data-collection instruments, validity and reliability, trustworthiness, and ethical considerations.

Chapter 5 presents the data analysis and interpretation, and the findings.

CHAPTER 5

DATA ANALYSIS AND INTERPRETATION, AND FINDINGS

5.1   INTRODUCTION

Chapter 4 described the research design and methodology, including the population, sample, data-collection instruments, data collection, trustworthiness, and ethical considerations. This chapter covers the data analysis and interpretation, and the findings. The open-ended questions in the questionnaire elicited the respondents' personal opinions, feelings and experiences as well as the unique context in which they occurred (Creswell 1994:162). The main objective was to elucidate ways in which *registered nurses (RNs)* in particular settings come to understand, account for, act and manage their day-to-day situations (Miles & Huberman 1994:6) [italics researcher's own emphasis]. This assisted the researcher to obtain the correct meaning, rationale for and context of discontent among RNs in the public health sector (PHS) (see chapter 6 for detailed discussion of these narrative descriptions).

With respect to the quantitative data analysis, the variables reflected in the questionnaire items depicted the entire range of the personal, professional, economic and social context of the respondents' way of life. These variables were included to explore the potential influence of various situations on the lives of RNs that tend to provoke discontent, which seems to account for instability within the PHS, as observed through strike actions and nurse migration from the PHS. It should be noted that RNs' totality of existence is not only limited to their role in the workplace. Booyens (2000:146) points out that nurses' multiple roles play a significant part in their lives and entail a shift from a professional context at work to the role of mother and spouse at home. Furthermore, there are socio-economic issues to be considered, personal duties and aspirations which are largely determined by the

dynamics of management systems and the effectiveness of the policies governing their organizations. If the working milieu is no longer conducive for professional practice, employees' expectations and aspirations continually degraded, and there is confusion over the direction taken by the organization, it is to be expected that employees will leave to find areas that will serve their needs. This emphasises the need to view RNs' discontent and input against the background of a larger political, professional, organizational and socio-economic climate.

In order to obtain maximum results from this study, three district, one regional, one academic and two private hospitals were selected to participate in this study. For confidentiality, the following codes were used to identify specific health care services (HCS) in the data: DHA: District Hospital A; DHB: District Hospital B; DHC: District Hospital C; RH: Regional Hospital; AH: Academic Hospital; and PHs: Private Hospitals.

The data for the individual district hospitals will be presented first and analysed, followed by the comparison of data for the district cluster. Then the data for the regional hospital will be presented, followed by a presentation of the results of the academic hospital. The combined results of the two private hospitals will be presented last. Towards the end of this chapter, the data from the district cluster, the regional, academic and private hospitals will be compared. Different statistical methods will be used in the presentation and comparison of the quantitative research findings.

The eight items the questionnaire addressed were *'demographic information', 'transformation of health care services', 'management and leadership problems', 'workplace violence', 'stress', 'registered nurses and international migration', 'nurses and strike actions',* and *'nurses and politics'.*

These items were explored for each hospital involved, and data presentation will address all the items for each one, thereby providing a detailed account of the findings obtained from respondents of different HCS.

Since this was an in-depth study involving seven hospitals, Pearson's correlation coefficient that measures the magnitude or significance of the relationship between variables was not used. On the statistician's advice, an analysis of variance (ANOVA) scale to test the mean group differences was also not used. The reason for this was that method triangulation was used for all the selected hospitals and the data for each individual hospital was analysed separately, which broadened the scope of the study.

Lastly, this study will also make reference to racial classification according to the racial descriptions of the previous political dispensation; as Black, White, Coloured, Asian and 'other', in order to inform demographics in terms of how it influence HCS and nurses.

5.2 DISTRICT HOSPITAL "A" (DHA)

This hospital is a level one health care service located in Tshwane Metropolitan area, which caters for in- and out-patients, community members and referrals from neighbouring clinics. As a district hospital, it provides a gateway to more specialized care in nearby regional or academic hospitals (Department of Health [DOH] 2002:3-4). The health service provided in this district hospital is fully integrated with health services provided in primary health care (PHC). The governance, management and functions of this district hospital are relative to the governance, management and functions of the entire district health care system in the Tshwane metropolitan area, which makes it a level one (generalist) service provider. Services provided include surgery and medicine, obstetrics, paediatrics and one ward for psychiatric patients from 0-24 hours. The 24-hour emergency and operating theatre services are also an integral part of this district hospital.

At the time of the study, this hospital did not have modern equipment and had no computers in the wards. However, progress had been made by the Gauteng provincial government in that this hospital was one of the hospitals that was selected to run a pilot project (the *Baoki* project) for computation of

hospital statistics and to minimize paperwork by entering patients' details in computers.

District Hospital A is a 230-bed hospital and employed 55 RNs. The hospital records revealed that 69 RNs had resigned for different reasons within the past five years. Out of 35 questionnaires distributed to RNs on day shift, 23 were completed and returned, resulting in a response rate of 65.7%. This was attributed to the interest RNs took in this study and the support provided by management for this research.

In the data analysis, the number of respondents varied from item to item because not all the respondents responded to all the questions.

5.2.1 QUANTITATIVE DATA ANALYSIS FOR DISTRICT HOSPITAL "A"

(NB: In the tables and figures, DHA indicates District Hospital 'A'.)

SECTION A: Demographic information

5.2.1.1 Age

Table 5.1 presents the respondents' age.

Table 5.1 DHA respondents' ages (n=23)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	2	6	9	4	2	0	0
Percentage	8.7	26.1	39.1	17.4	8.7	0.0	0.0

Of the respondents, two (8.7%) were between 18 and 25 years old; six (26.1%) were between 26 and 33, nine (39.1%) were between 34 and 41; four (17.4%) were between 42 and 49, and two (8.7%) were between 50 and 57. No respondents were older than 57 and most of them were 34 to 41 years old. The pension age limit set by government at 55 could have highly influenced the fact that there were no RNs older than 57 years. According to

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Kupperschmidt (1998:36), RNs between 34 and 41 are known for their quick, decisive and fearless confrontation of situations that threaten their contentment as opposed to the older generation. As a result, they are often found largely involved in strike actions and prone to international migration in their quest to explore new dimensions and success.

5.2.1.2 Race

Of the respondents, 17 (73.9%) were black and six (26.1%) were white (see table 5.2). There were no Coloured, Asians and other races. This could have been influenced by the fact that more white RNs were found in private hospitals in this study.

Table 5.2 DHA respondents' race (n=23)

Race	Black	Coloured	Asian	White	Other
Frequency	17	0	0	6	0
Percentage	73.9	0.0	0.0	26.1	0.0

5.2.1.3 Gender

Of the respondents, two (9.1%) were male and 20 (90.9%) were female (see table 5.3). One respondent did not indicate gender. Nursing generally attracts more females than males around the globe.

Table 5.3 DHA respondents' gender (n=22)

Gender	Frequency	Percentage
Male	2	9.1
Female	20	90.9

5.2.1.4 Marital status

Of the respondents, 10 (43.5%) were single; 10 (43.5%) were married, and three (13.0%) were divorced (see table 5.4). None of the respondents was widowed.

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Table 5.4 DHA respondents' marital status (n=23)

Marital status	Single	Married	Divorced	Widowed
Frequency	10	10	3	0
Percentage	43.5%	43.5%	13.0%	0.0%

Marital status was assumed to be of significance in this study in terms of establishing the general distribution of married RNs in a health institution, with particular reference to the family commitments in relation to the demands of their vocation. This could imply that in their multiple roles as RNs, mothers, wives, students and members of society, they still need time to be with their families, attend to their studies and fulfil their other roles and commitments. Prescribed hours of work should fit into their work schedules to avoid overextension. Satisfactory salaries and other benefits are also of necessity to care for their families.

5.2.1.5 Dependants

Table 5.5 lists the respondents' number of dependants.

Table 5.5 DHA respondents' number of dependants (n=23)

Dependants	None	1 – 3	>3
Frequency	6	17	0
Percentage	26.1%	73.9%	0.0%

Of the respondents, six (26.1%) had no dependants; 17 (73.9%) had between 1 and 3 dependants, and none had more than three dependants. The majority of the respondents (73.9%) had 1 to 3 children, which could add to discontent if they worked compulsory night shifts. This item wished to determine the respondents' responsibilities since children of all ages need the attention of both parents for healthy growth. This would then require that long working hours be reviewed, and weekend schedules adjusted so that they worked alternate weekends to accommodate their families. Salaries also play an important role in this aspect since all parents wish to take their children to good schools and provide for their needs.

5.2.1.6 Residential area

The respondents were asked to indicate their residential area as it concerns the cost of living and affordability of housing (see table 5.6).

Table 5.6 DHA respondents' residential area (n=23)

Residence	City/Town	Township	Village	Informal settlement
Frequency	17	5	1	0
Percentage	73.9%	21.7%	4.3%	0.0%

Of the respondents, 17 (73.9%) lived in the city suburbs; five (21.7%) in townships, and one (4.3%) in a village. No one came from an informal settlement. Table 5.6 indicates that most of the respondents resided in city suburbs, which could exert additional strain on their budgets, particularly given the high cost of living and rising inflation. That none of the respondents came from an informal settlement and only one came from a village indicates clearly that nurses, as middle-class society members, need good salaries to maintain that lifestyle. The migration, tedious overtime and strike actions in the country could be signals of their desperate attempts to acquire salaries commensurate with their obligations.

5.2.1.7 Type of health care service

All the respondents worked for DHA (see table 5.7).

Table 5.7 DHA respondents' PHS (n= 23)

Hospital	Academic Hospital	Regional Hospital	District Hospitals	Private hospitals
Frequency	0	0	23	0
Percentage	0.0%	0.0%	100.0%	0.0%

5.2.1.8 Positions

The respondents were asked to indicate the positions they held (see table 5.8).

Table 5.8 DHA respondents' position held (n=21)

Positions	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	6	3	12
Percentage	28.6%	14.3%	57.1%

Of the respondents, six (28.6%) were chief professional nurses (CPNs); three (14.3%) were senior professional nurses (SPNs), and 12 (57.1%) were professional nurses (PNs). Since this was a convenient sample, the results do not conclusively indicate the distribution of positions held in the hospital. A random sample could have enabled an equal selection of respondents from each category, which might have provided an accurate assessment of the distribution of staffing and promotions (see chapter 4, section 4.8.1).

5.2.1.9 Years of experience since registration

The respondents were asked to indicate their experience in years since registration (see table 5.9).

Table 5.9 DHA respondents' years of experience (n=22)

Experience	1-5	6-10	11-20	21-30	31-40	41-50	51-60
Frequency	7	4	8	2	1	0	0
Percentage	31.8%	18.2%	36.4%	9.1%	4.5%	0.0%	0.0%

Of the respondents, seven (31.8%) had between one and five years' experience; four (18.2%) had between six and ten years' experience; eight (36.4%) had between 11 and 20 years' experience; two (9.1%) had between 21 and 30 years' experience, and one (4.5%) had between 31 and 40 years' experience after registration. No respondent had more than 40 years' experience since registration with the SANC. One respondent did not indicate

years of experience. Of the respondents, then, eight (36.4%) had between 11 and 20 years of experience, followed by seven (31.8%) with 1 to 5 years' experience after registration with SANC. This would indicate that few RNs remain after approximately 30 years of experience, probably due to the ageing factor for RNs.

5.2.1.10 Qualifications

The respondents were asked to indicate their qualifications (see table 5.10).

Table 5.10 DHA respondents' qualifications (n=21)

Qualification	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hons	M	D
Frequency	7	8	1	4	1	0	0
Percentage	33.3%	38.1%	4.8%	19.0%	4.8%	0.0%	0.0%

Of the respondents, seven (33.3%) had the Basic Nursing Diploma (BND); eight (38.1%) had a post-BND qualification; one (4.8%) had the basic four-year nursing degree; four (19.0%) had a BA Cur degree, and one (4.8%) had an Honours degree in nursing. Two respondents did not indicate their qualifications. From table 5.10 it is clear that some of the respondents are engaged in further studies, which are important endeavours in the nursing profession, worthy of recognition and fair recompense.

SECTION B: Transformation of health care services

5.2.1.11 Public health care service transformation has been successful

The respondents were asked to indicate whether, in their opinion, PHS transformation had been successful (see figure 5.1).

Figure 5.1 DHA respondents' view of successful transformation (n=21)
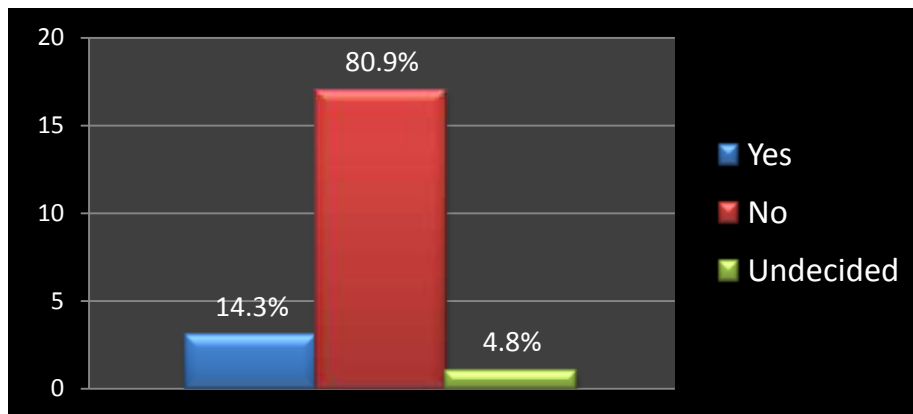
Of the respondents, 17 (80.9%) disagreed that transformation in HCS had been successful and three (14.3%) indicated that it had been successful. This seemed to suggest that most of the respondents were discontent with the manner in which transformational initiatives had been implemented. This could indicate that the process of transformation did not evolve according to their expectations. The reason for this could be that the new government had an enormous task in redressing past imbalances and dismantling apartheid structures in all provinces and departments, which took longer than expected by employees. Moreover, most respondents seemed to have been overwhelmed by negative aspects, and only 14.3% reflected on observable transformational changes that had emerged; such as discontinuance of delivery of care in a discriminatory manner, reprioritization of resources and budgets by reducing the delivery of sophisticated curative health care and focusing resources on PHC, free health care for pregnant women and young children, transformation of statutory bodies (Councils) that regulate registered health professionals, and much improved patients' rights. There is a high probability that the majority of respondents were overburdened by some of the changes indicated above.

5.2.1.12 Promotions are allocated fairly in the PHS

The respondents were asked to indicate whether promotions in the PHS were equitable (see figure 5.2).

Figure 5.2 DHA respondents' view of PHS promotions (n=23)
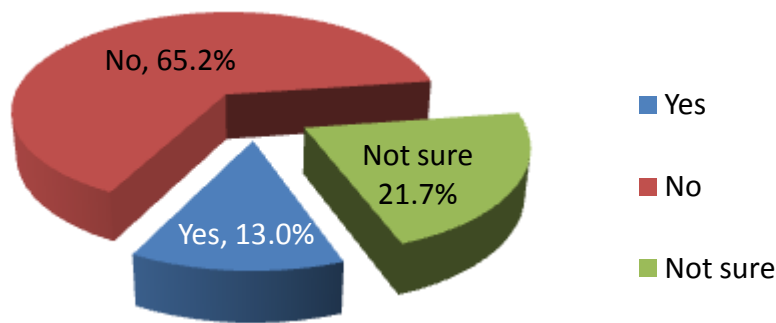
Of the respondents, 15 (65.2%) indicated that promotions were not allocated fairly in the PHS; five (21.7%) were undecided, and only three (13.0%) regarded promotions as fair. This could imply irregularities with regards to promotions, such as favouritism, disregard of additional qualifications and negative attitudes of nursing service managers (NSMs). It should be noted that at the time of this study, a new salary structure was introduced which uses grade promotions and pay progression for nurses, with different salary scales attached to different qualifications. Grade promotions allow the salary scale to increase without the incumbent necessarily moving into a managerial position. As such, it is now possible to find RNs with certain specialty qualifications earning more than managers in a generalist stream. This system, entrenched within the occupational salary dispensation (OSD), also seemed to upset some of the respondents because it appeared to work mostly in favour of RNs with specialty qualifications.

5.2.1.13 Young South Africans are attracted to nursing

The respondents were asked to indicate whether, in their opinion, young people were attracted to nursing (see figure 5.3).

Figure 5.3 DHA respondents' view on youth attracted to nursing (n=22)
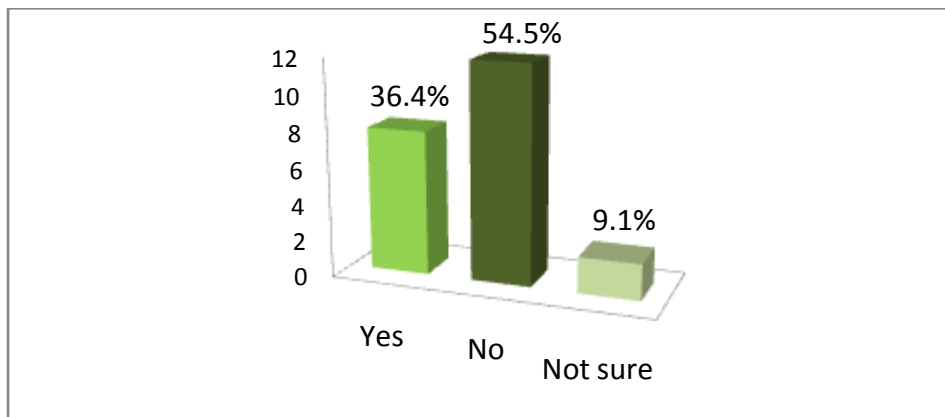
Of the respondents, 12 (54.5%) disagreed that young South Africans were attracted to nursing; eight (36.4%) agreed that young people were attracted to nursing, and two (9.1%) were not sure. This could be ascribed to a proliferation of more marketable career opportunities now open to all races or the respondents' personal (subjective) perceptions (see chapter 6 for further discussion).

5.2.1.14 National workforce forum to investigate nurses' issues

The respondents were asked to indicate whether a national forum existed to investigate nurses' issued (see figure 5.4).

Figure 5.4 DHA respondents' knowledge of national nursing forum (n=20)
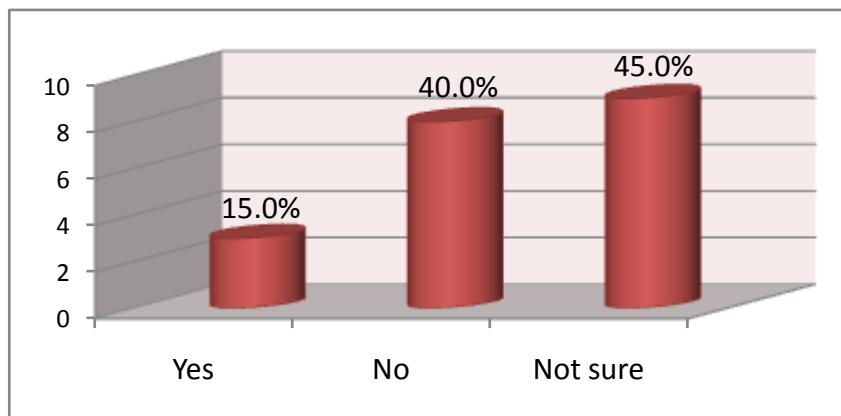
Of the respondents, nine (45.0%) indicated that they were not aware of any nursing forum existing in the PHS to address nurses' issues; eight (40.0%) disagreed that a nursing forum existed, and three (15.0%) agreed that there was a national nursing forum. The narrow variation between those who disagreed and those who were not sure could indicate a lack of an authentic national nursing forum of their choice to investigate and address nurses' concerns professionally. This study is cognizant that task teams are usually appointed on an ad hoc basis whenever there is a crisis in HCS in affected provinces, to investigate and report the problems.

5.2.1.15 Employing body communication with nurses

The respondents were asked to indicate whether the PHS employing body communicated with nurses (see figure 5.5).

Figure 5.5 DHA respondents' on employer communication with nurses (n=20)
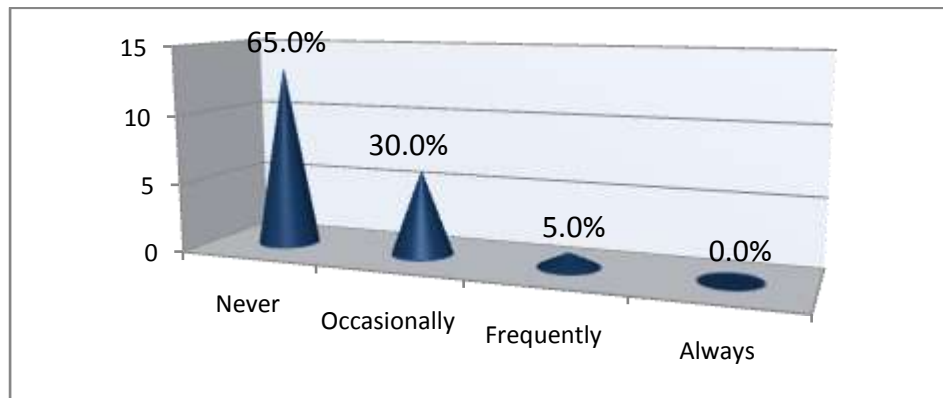
Of the respondents, 13 (65.0%) stated that the public health employing body did not communicate with nurses; six (30.0%) indicated that the provincial government occasionally communicated with nurses, and only one (5.0%) stated that the provincial government frequently communicated with nurses. Three respondents did not answer this item, and none indicated that the provincial government always communicated with nurses in the PHS. This could indicate discontent, especially in the absence of a single body to represent all nurses to government. This could also imply that unions only

provide their members with information. That none of the respondents agreed that provincial government always communicated with nurses could indicate that information from the DOH does not filter through to the employees at the production level and vice versa.

5.2.1.16 Occupational Specific Dispensation (OSD) a perfect solution for discontent

The respondents were asked to indicate whether the OSD was a perfect solution for discontent (see figure 5.6).

Figure 5.6 DHA respondents' view of the OSD (n=21)
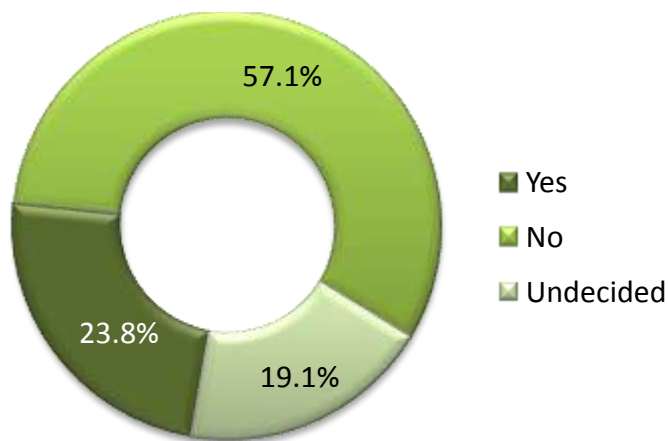
Of the respondents, 12 (57.1%) disagreed while five (23.8%) agreed that the OSD was a "perfect solution" for nurses. Four respondents (19.1%) were undecided and two did not answer the question. The researcher had expected contentment with the OSD as it was finalized and introduced after the national strike action in 2007. This finding could imply that not all nurses benefited from the OSD. Consequently, discontent is to be expected, coupled with possible divisions and dissension among RNs, especially where prior information was not provided regarding the purpose and scope of the OSD. Figure 5.6 thus suggests an information gap between the relevant authorities and nurses at the operational level.

5.2.1.17 Stakeholders in agreement on the OSD

The respondents were asked whether there was stakeholder consensus on the OSD (see figure 5.7).

Figure 5.7 DHA respondents' perception of stakeholder consensus on the OSD (n=22)
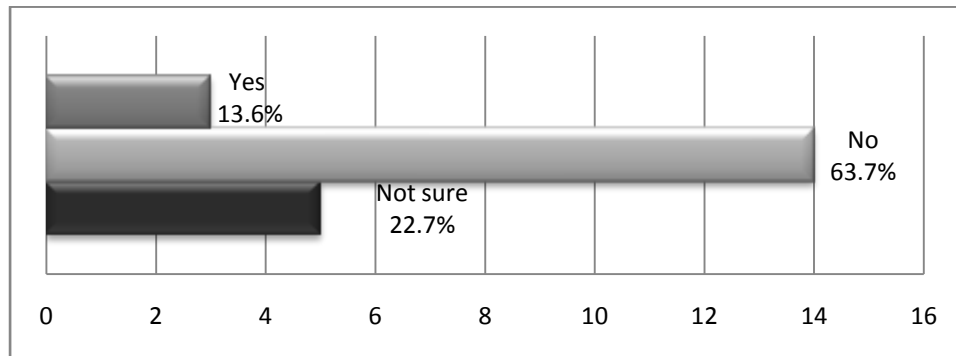
Of the respondents, fourteen (63.7%) disagreed; five (22.7%) were not sure, and only three (13.6%) agreed that there was agreement among all stakeholders regarding the implementation of the OSD in the PHS. This finding created the impression that there was no prior soliciting of input from RNs and consequently a lack of awareness of decisions taken by their representatives regarding the OSD. In this regard, the provincial government has a responsibility not to rely on certain structures to convey important information to workers. Government needs to interact with employees when introducing new methods, particularly concerning salaries, the purpose and allocation of funds, and reasons for disparities, thereby proactively dealing with problems before they generate discontent, division and dissension.

5.2.1.18 Success of overseas exchange programme

The respondents' perceptions of the overseas exchange programme were sought (see figure 5.8).

Figure 5.8 DHA respondents' and overseas exchange programme (n=18)
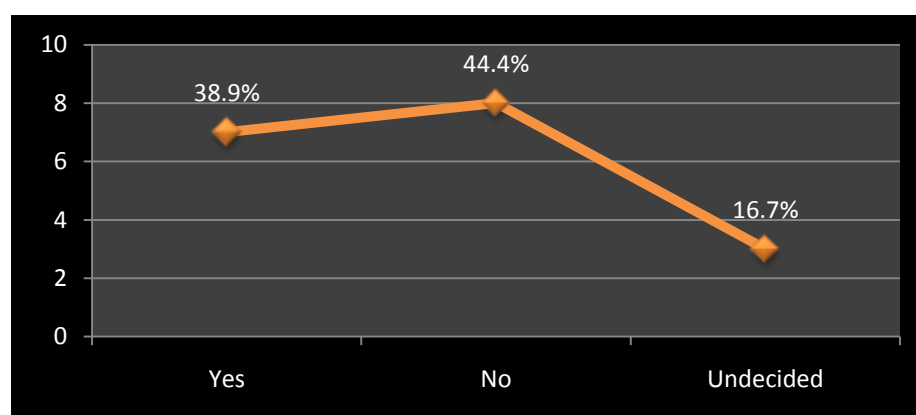
Of the respondents, seven (38.9%) agreed and eight (44.4%) disagreed that the overseas exchange programme was successful, while three (16.7%) did not know. The overseas exchange programme for RNs was not implemented in this hospital; therefore the respondents' responses could be an assessment of the programme implemented in DOH-selected academic hospitals (see section 5.9.18 for comparison of data for all HCS involved in the study).

5.2.1.19 Discontent among registered nurses is an observable reality

The respondents were asked whether discontent among RNs was an observable reality (see table 5.11).

Table 5.11 DHA respondents' observation of discontent among RNs (n=21)

Response	SD	D	N	A	SA
Frequency	4	1	2	6	8
Percentage	19.0%	4.8%	9.5%	28.6%	38.1%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 66.7% (28.6% agreed + 38.1% strongly agreed) indicated that discontent among RNs was an observable reality. This confirmed the initial assumption of this study that there could be discontent among RNs in the PHS. A further 23.8% (19.0% strongly disagreed + 4.8% disagreed) did not agree and two (9.5%) were undecided.

5.2.1.20 Low morale associated with low salaries in public hospitals

The respondents were asked whether low morale was associated with low salaries in the PHS (see figure 5.9).

Figure 5.9 DHA respondents' perception of low morale and low salaries (n=21)
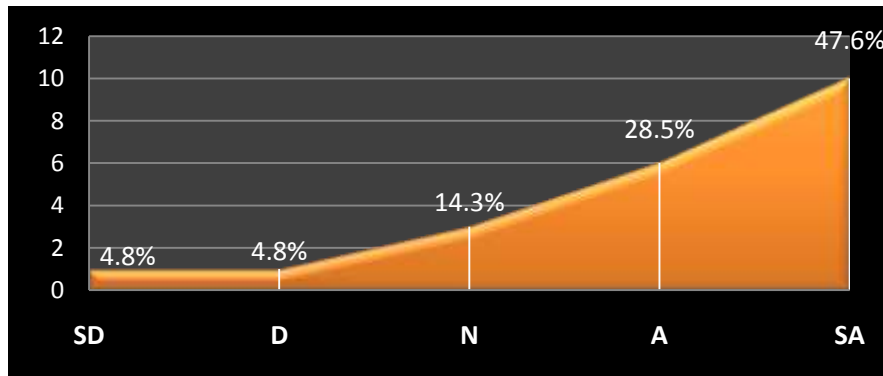
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 76.1% (47.6% + 28.5%) strongly agreed/agreed and 9.6% (4.8% + 4.8%) strongly disagreed/disagreed while 14.3% were not sure that low morale among RNs was associated with low salaries in the PHS. From this, the researcher concluded that low salaries influenced low morale among RNs and perhaps explained the instability in the PHS, manifested in strike actions, absenteeism, frequent sick leave, and lack of enthusiasm. This implies that even though some do not leave the PHS, standards of nursing care and productivity could be severely compromised in the units because nurses were demoralized and disillusioned.

5.2.1.21 Registered nurses contribute to changes in hospitals

The respondents were asked whether RNs contributed to change in hospitals (see table 5.12).

Table 5.12 DHA respondents' perception of RN contributions to change (n=20)

Response	SD	D	N	A	SA
Frequency	4	1	4	10	1
Percentage	20.0%	5.0%	20.0%	50.0%	5.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 55.5% (50.0% agree + 5.0% strongly agree) agreed that RNs contribute to change in their hospitals. This finding revealed a good working relationship between RNs and NSMs. The *Batho Pele* white paper encourages involvement of employees in important decisions that affect their organizations. This district hospital has therefore set a good example of reducing discontent among RNs in the PHS, by acknowledging the value of their ideas. However, a total of five (25.0%) of the respondents disagreed and four (20.0%) were undecided.

5.2.1.22 Registered nurses are sponsored for conferences

The respondents were asked whether RNs were sponsored for conferences (see figure 5.10).

Figure 5.10 DHA respondents' sponsored for conferences (n=21)
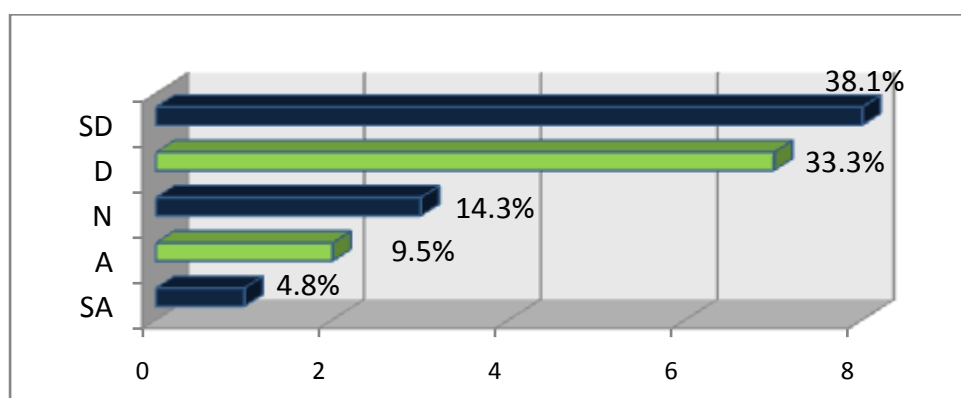
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 71.4% (38.1% + 33.3%) strongly disagreed/disagreed that RNs were sponsored to attend conferences; 14.3% (4.8% + 9.5%)

strongly agreed/agreed, and three (14.3%) were undecided. This result implied that RNs received no sponsorship for conferences. Conferences are important for personal, professional and organizational growth. Government need not always provide finance for these events as there are other structures that can sponsor nursing events for networking and professional development.

5.2.1.23 Registered nurses are financed to do research

The respondents were asked whether finance was available for research (see 5.11).

Figure 5.11 DHA respondents' perception of available finance for research (n=21)
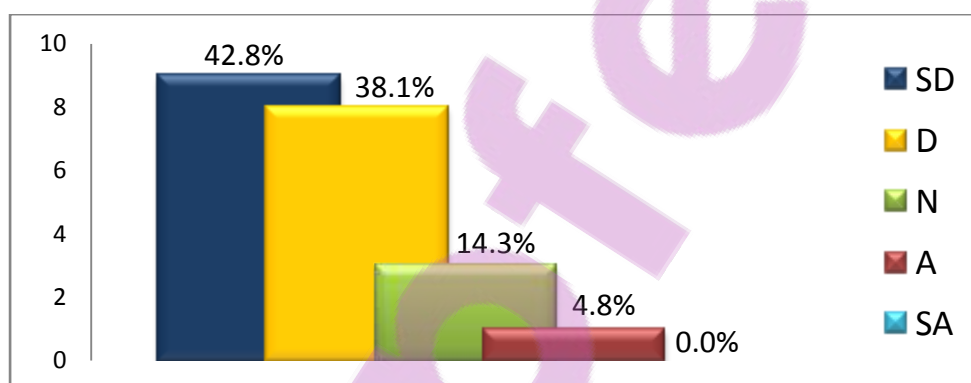
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 80.9% (42.8% + 38.1%) strongly disagreed/disagreed and 4.8% agreed that RNs were granted financial assistance to do research, and three (14.3%) were undecided. This finding revealed that research did not receive financial support in the PHS. The item was included in the questionnaire because numerous problems found in the clinical area can be investigated through research. This study assumed that a possible source of discontent and frustration could be when people who deal with issues on a daily basis are convinced that there are problems that can be researched and resolved, but receive no support to research them.

5.2.1.24 Opportunities for career development

This item investigated the respondents' perceptions of opportunities for career development (see table 5.13).

Table 5.13 DHA respondents' perceptions of opportunities for career development (n=21)

Response	SD	D	N	A	SA
Frequency	7	7	2	5	0
Percentage	33.3%	33.3%	9.5%	23.9%	0.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 66.6% (33.3% + 33.3%) strongly disagreed/disagreed while five (23.9%) agreed that there were opportunities for career development in the PHS. Only two (9.5%) were undecided. This could be one of the reasons why RNs opt to move away from the PHS, as this could be a serious hindrance to their professional advancement as well as a source of discontent. Moreover, the current shortage of staff in the PHS is an obstacle to study leave opportunities. However, the OSD's new methods of career pathing, using pay progression and grade promotions, despite a tendency to benefit mostly RNs with certain specialties, nevertheless allow RNs to progress to higher notches without necessarily occupying higher posts.

5.2.1.25 RNs agree with their extended role as medical assistants

The respondents were asked whether they agreed with their extended role as medical assistants (see table 5.14).

Table 5.14 DHA respondents' extended role as medical assistants (n=21)

Response	SD	D	N	A	SA
Frequency	1	1	5	12	2
Percentage	4.8%	4.8%	23.8%	57.1%	9.5%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 66.6% (57.1% + 9.5%) agreed/strongly agreed with their extended role as medical assistants with an additional one year training to qualify for this position; a total of two (9.6%) disagreed, and five (23.8%) were undecided. This factor could be influenced by the fact that most RNs are acquainted with PHC services, where most possess qualifications in PHC. The fact that the OSD salary structure recognizes this qualification as a specialty is an added value, which could further be enhanced by this new role in terms of financial remuneration. It is therefore RNs' prerogative to indicate their preference.

SECTION C: Workplace violence in the public health sector

5.2.1.26 Security system for nurses in the workplace is satisfactory

The respondents were asked whether there was adequate security for nurses (see figure 5.12).

Figure 5.12 DHA respondents' security satisfactory (n=23)
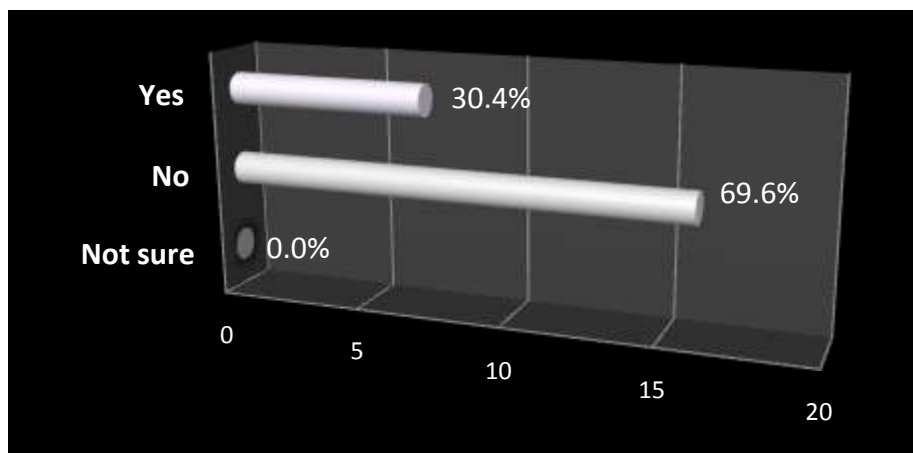
Of the respondents, 16 (69.6%) indicated that the security was not adequate, therefore they did not feel safe on the premises; seven (30.4%) indicated that the security at the hospital was satisfactory, and no respondents were not sure. Security therefore appeared to require urgent government attention (see 6.2.14 for further discussion).

5.2.1.27 Patients are safe in hospital under the current security system

The respondents were asked whether the current security system ensured patients' safety (see figure 5.13).

Figure 5.13 DHA respondents' perception of patients' safety (n=22)
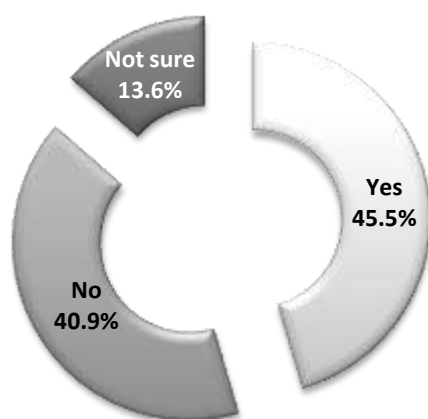
Of the respondents, ten (45.5%) agreed, nine (40.9%) disagreed that patients were safe in hospital, while three (13.6%) did not know. This could indicate that patients did not feel safe under the current security system, or that the constant presence of staff on duty guaranteed their safety. The data therefore suggested that security was questionable. This item was included because RNs follow a holistic approach in the care of the sick; hence the safety of patients is one of their responsibilities both legally and ethically. This implies further that where the health environment promotes patients' vulnerability to harm, RNs cannot function optimally thus making it a source of discontent.

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SECTION D: Stress

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5.2.1.28 Stress is intolerable among RNs in the PHS

This item examined the level of stress among nurses in the PHS (see figure 5.14).

Figure 5.14 DHA respondents' assessment of stress (n=23)
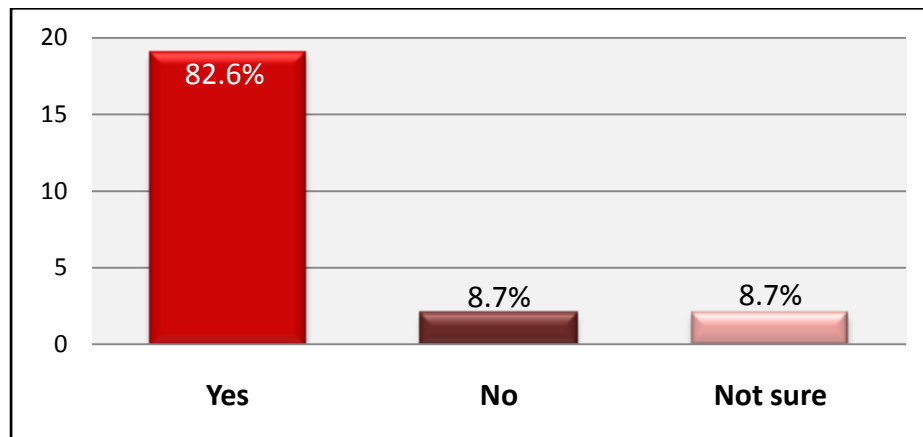
Of the respondents, 19 (82.6%) agreed and two (8.7%) disagreed that stress had reached intolerable limits among RNs in the PHS, while two (8.7%) were not sure. Stress is experienced in all areas of life, but in some situations stress can overwhelm individuals because of circumstances beyond their control. For example, the increased workload in the PHS due to staff shortages requires strategies to prevent loss of staff. Besides dealing with the rate of absenteeism and sick leaves, government and organizations should endeavour to retain and take care of staff.

5.2.1.29 Have you personally used your vacation to rest?

The respondents were asked to indicate whether they used vacation leave to rest (see figure 5.15).

Figure 5.15 DHA respondents' use of vacation to rest (n=33)
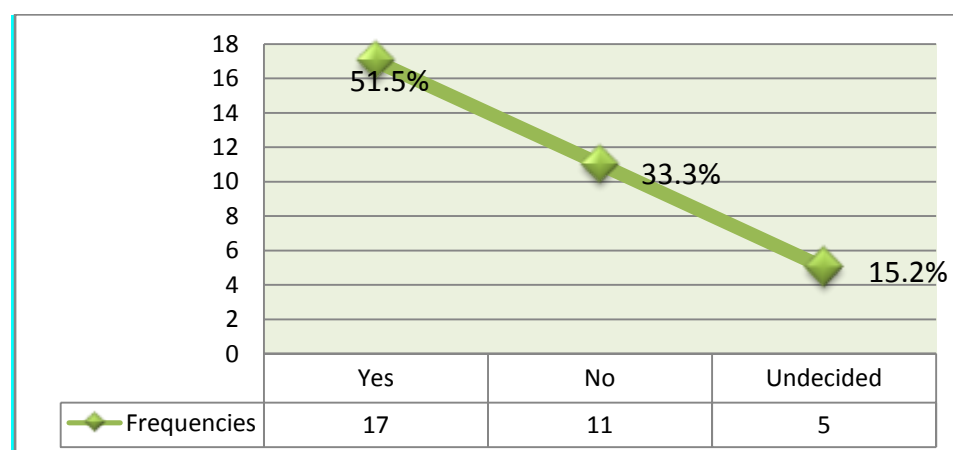
Figure 5.15 indicates that of the respondents, 17 (51.5%) used their vacation to rest while 11 (33.3%) did not and five (15.2%) did not answer the question. The result indicated that most of the RNs used their vacation simply to rest. Those who did not rest during their vacation could have worked overtime, studied or looked for new jobs, which deprived them of the needed rest.

5.2.1.30 Physical signs of exhaustion

The respondents were asked whether they experienced physical signs of exhaustion (see figure 5.16).

Figure 5.16 DHA respondents' physical signs of exhaustion (n=23)
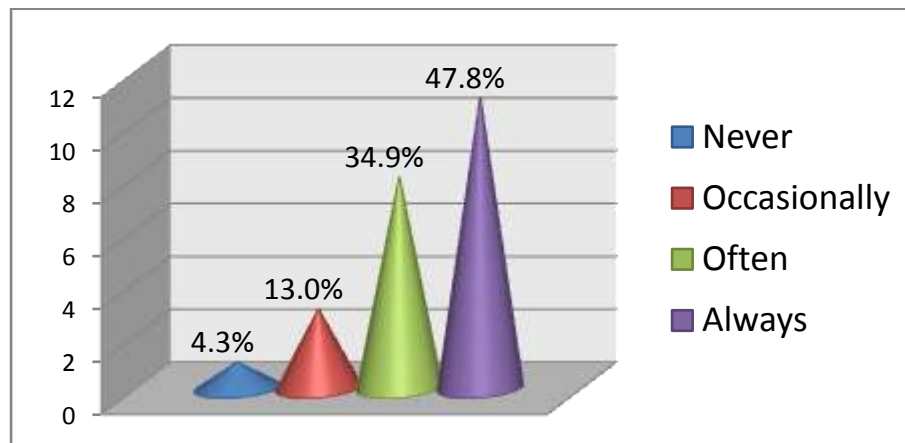
According to figure 5.16, of the respondents only one (4.3%) did not experience physical signs of exhaustion; three (13.0%) indicated occasional physical signs of exhaustion; eight (34.9%) indicated frequent physical exhaustion, and 11 (47.8%) always experienced physical signs of exhaustion. This corresponded with the findings in figure 5.14 where 82.6% respondents agreed that stress had reached intolerable limits in the PHS.

5.2.1.31 Do you intend to leave the PHS for other institutions?

The respondents were asked whether they intended to leave the PHS (see figure 5.17).

Figure 5.17 DHA respondents' intention to leave (n=22)
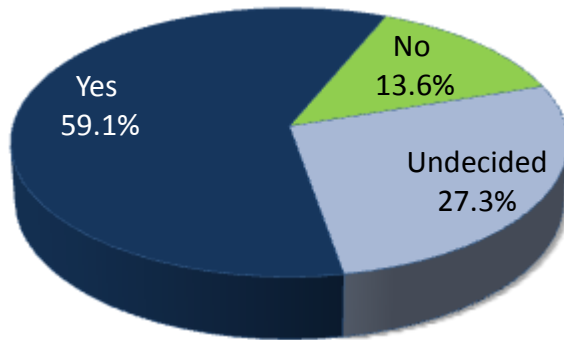
Of the respondents, 13 (59.1%) intended to leave the PHS for other health institutions; six (27.3%) were undecided, and only 3 (13.6%) stated that they would not leave (see 6.2.18 for detailed discussion). The responses to this item concurred with the findings on stress and physical signs of exhaustion (see figures 5.14 and 5.16). This emphasised the gravity of the respondents' intentions to leave the PHS in the midst of the current shortage of staff. Consequently, nurses' issues require urgent investigation and resolution, particularly inadequate and inequitable salaries, staff to ease workload, and the provision of equipment. In order to achieve this, consultation with nurses is an absolute necessity since they are implementers of policies.

SECTION E: Management and leadership problems

5.2.1.32 NSMs' persistent bullying attitudes

The respondents were asked whether NSMs still displayed bullying attitudes (see figure 5.18).

Figure 5.18 DHA respondents' perception of NSM bullying attitudes (n=22)
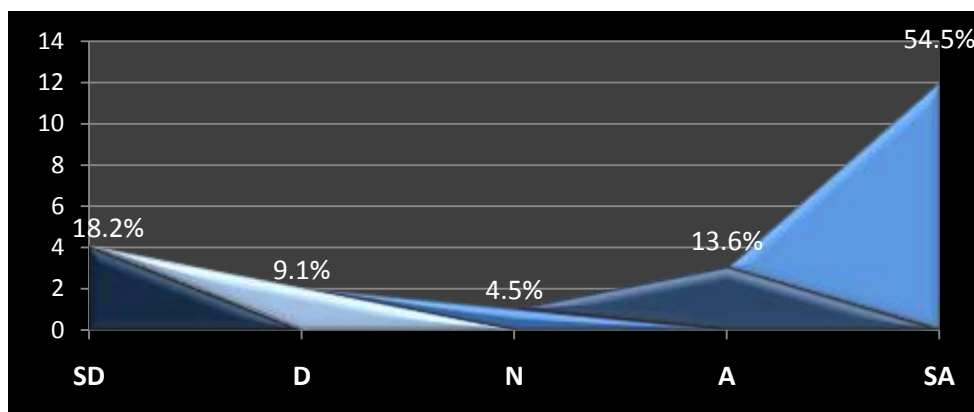
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 68.1% (54.5% + 13.6%) strongly agreed/agreed that some NSMs still displayed bullying attitudes towards RNs. However, 27.3% (18.2% + 9.1%) strongly disagreed/disagreed with the statement. From figure 5.18 it is clear that most of the respondents were disturbed at some managers' bullying attitude. The absence of good working relationships and mutual respect between RNs and NSMs results in tension and conflict. This could explain the reason for the assumed strained relationships between RNs and their leadership as well as defection to unions, especially if there are benefits to this affiliation. Nursing leaders should endeavour to create a friendly and understanding atmosphere. Their position at the bedside of very sick patients cannot compare with administrative duties undertaken by their leaders, and therefore require practical support in all areas of health care delivery.

5.2.1.33 RNs are acknowledged for outstanding contributions

This item investigated whether nurses were acknowledged for outstanding contributions (see table 5.15).

Table 5.15 DHA respondents acknowledged for outstanding contributions (n=22)

Response	SD	D	N	A	SA
Frequency	12	2	3	2	3
Percentage	54.5%	9.1%	13.6%	9.1%	13.6%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 63.6% (54.5 + 9.1%) strongly disagreed/disagreed while 22.7% (13.6% + 9.1%) strongly agreed/agreed that RNs were acknowledged for outstanding contributions, and three (13.6%) did not indicate. These findings revealed a degree of discontent among the respondents. This data could indicate a de-motivated nurse workforce especially where extra efforts were made to ensure the smooth running of the services. Some form of positive acknowledgement is necessary to encourage nurses and assure them of management's support.

5.2.1.34 Feedback on problems reported

The respondents were asked whether they received feedback on reported problems (see table 5.16).

Table 5.16 DHA respondents feedback on reported problems (n=22)

Response	SD	D	N	A	SA
Frequency	8	4	4	6	0
Percentage	36.4%	18.2%	18.2%	27.3%	0.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 54.6% (36.4% + 18.2%) strongly disagreed/disagreed, 27.3% agreed that feedback was provided, and 18.2% did not indicate. This pointed to communication problems between managers and the respondents. Lack of feedback causes frustration to nurses especially regarding problems over which they have no control. This finding would appear to imply a need for NSMs to change their approach or style of leadership to put units first

because of the 1997 *Batho Pele* white paper requirements, the ethical obligation of caring for the sick, and the moral responsibility to recognize that nurses need their help to be effective in their daily duties.

5.2.1.35 RNs are acknowledged for their sacrifices

The respondents were asked whether their sacrifices were acknowledged (see table 5.17).

Table 5.17 DHA respondents' sacrifices acknowledged (n=21)

Response	SD	D	N	A	SA
Frequency	13	3	2	2	1
Percentage	62.0%	14.3%	9.5%	9.5%	4.8%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 76.3% (62.0% + 14.3%) strongly disagreed/disagreed and 14.3% (9.5% + 4.8%) agreed/strongly agreed that their sacrifices were acknowledged, while 9.5% were not sure. Cognizance should be taken that nurses make sacrifices such as staying late on very busy days, forfeiting tea and lunch breaks, and responding when called back on their days off to assist with the workload. For this reason, their sacrifices should be acknowledged and reported to the provincial authorities rather than focus on mistakes and negative reports from patients and the community.

5.2.1.36 Management discuss problems with RNs

This item investigated whether management discussed problems with the respondents (see figure 5.19).

Figure 5.19 DHA respondents' joint discussion of problems (n=22)
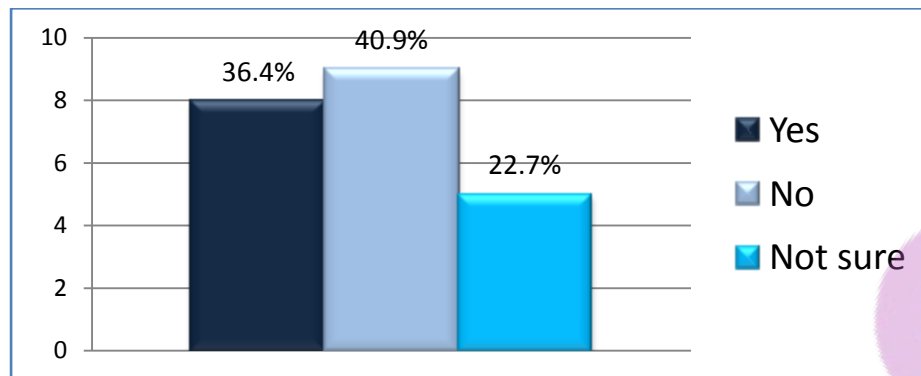
Of the respondents, eight (36.4%) agreed while nine (40.9%) disagreed that hospital management discussed problems with them, and five (22.7%) were not sure. Some of the problems were possibly communicated to the nurses to craft solutions on how to address them, while at other times the nurses were not aware of what problems management dealt with. At the same time, however, NSMs might inform RNs of solutions without soliciting their input.

SECTION F: RNs and migration

5.2.1.37 Nurse migration is due to inadequate salaries

This question sought the respondents' perceptions of reasons for RNs' migration (see figure 5.20).

Figure 5.20 DHA respondents' perception of RN migration due to inadequate salaries (n=23)
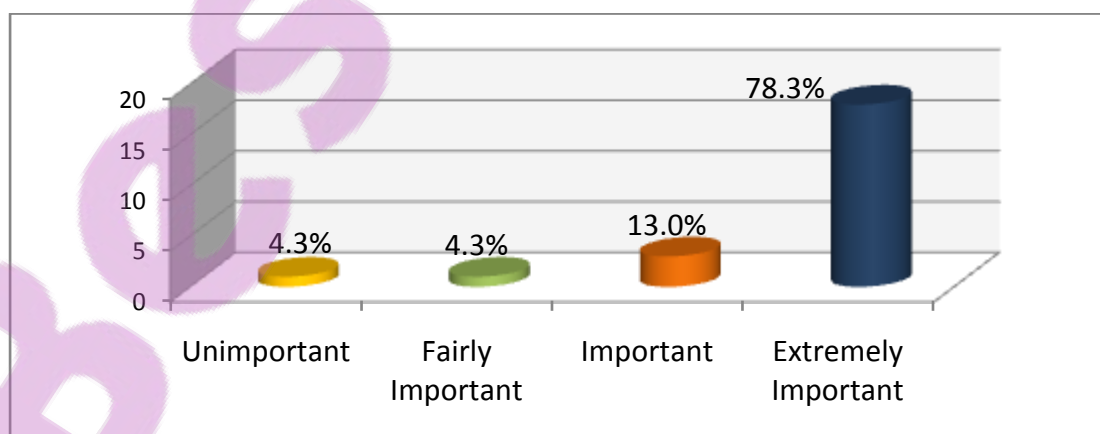
Of the respondents, 18 (78.3%) indicated that inadequate salaries were the main reason for nurse migration from the PHS; three (13.0%) considered inadequate salaries important in triggering migration; one (4.3%) found salaries fairly important for migration from the PHS, and one (4.3%) found inadequate salaries unimportant for migration.

5.2.1.38 Poor leadership contributes to nurse migration

Of the respondents, nine (39.1%) indicated that poor leadership was an extremely important cause of migration from the PHS, ten (43.5%) considered poor leadership an 'important' reason, three (13.0%) indicated poor leadership as a 'fairly important' reason, and only one (4.3%) indicated it as an 'unimportant' reason for migration (see figure 5.21).

Figure 5.21 DHA respondents' view of poor leadership and migration (n=23)
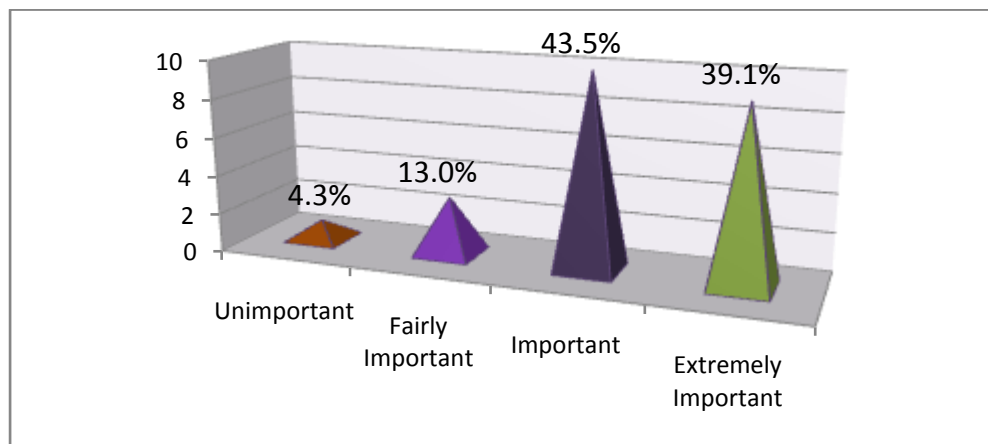
These findings could imply a lack of support from NSMs, especially where nurse managers tend to be mistake finders rather than leaders in problem resolution, as well as the intrusion of unions in HCS where NSMs could have lost sight of their leadership role in HCS, and have relegated some of their responsibilities to unions.

5.2.1.39 Poor working conditions lead to nurse migration

Regarding poor working conditions as a reason for nurse migration, ten (43.5%) of the respondents felt that working conditions were an extremely important reason for migration from the PHS; ten (43.5%) regarded them as an important reason for migration of RNs from the PHS; two (8.7%) rated them fairly important, and only one (4.3%) rated them unimportant for migration (see figure 5.22).

Figure 5.22 DHA respondents' assessment of poor working conditions and migration (n=23)
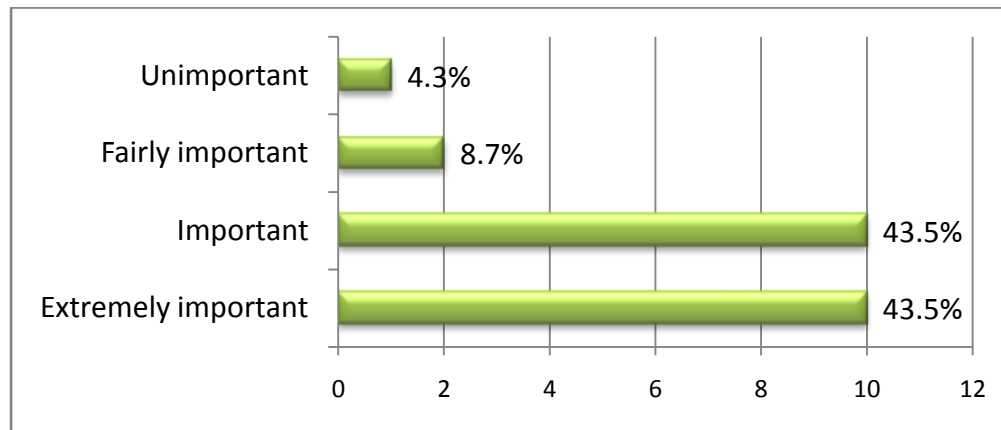
It is generally accepted that employees tend to gravitate towards areas where conditions of service are satisfactory. Well equipped, adequately staffed and well paying hospitals usually attract specialized nurses because they are given an opportunity to negotiate the salaries they want, and all employees are well cared for.

5.2.1.40 RNs migrate for "different" experience

With regard to RNs migrating for a different experience, eight (36.4%) considered it a fairly important reason for migrating; seven (31.8%) respondents considered this an unimportant reason; five (22.7%) considered it an important reason, and two (9.5%) considered it an extremely important reason (see figure 5.23).

Figure 5.23 DHA respondents' view of migration for a "different" experience (n=22)
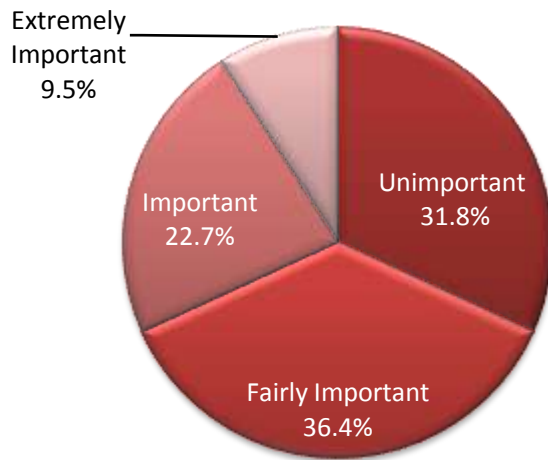
This finding implies that the respondents were more concerned about inadequate salaries, poor working conditions and poor leadership in nursing than gaining a "different" experience.

SECTION G: Nurses and strike actions

5.2.1.41 RNs prefer strikes to solve nurses' problems

With regard to strikes as a means to solve nurses' problems, eighteen (78.3%) of the respondents preferred strikes to solve nurses' problems in the PHS; three (13.0%) did not, and two (8.7%) were not sure (see figure 5.24).

Figure 5.24 DHA respondents' preference for strikes to solve nurses' problems (n=23)
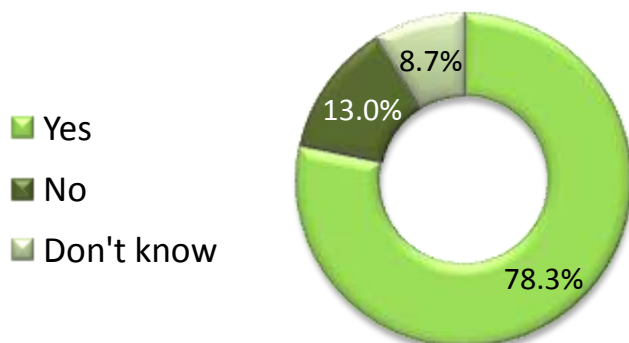
This data could imply that the respondents wished to engage government in nurses' struggles and issues, particularly with regard to negotiations for better salaries and conditions of services. This could be influenced by the benefits derived from successful negotiations by unions.

5.2.1.42 RNs and unions share the same values regarding patient care

With regard to whether nurses and unions share the same values regarding patient care, eight (38.1%) of the respondents disagreed with this notion; seven (33.3%) were not sure, and six (28.6%) agreed that nurses and unions supported patient care (see figure 5.25).

Figure 5.25 DHA respondents' perception of union and nurse patient care values (n=21)
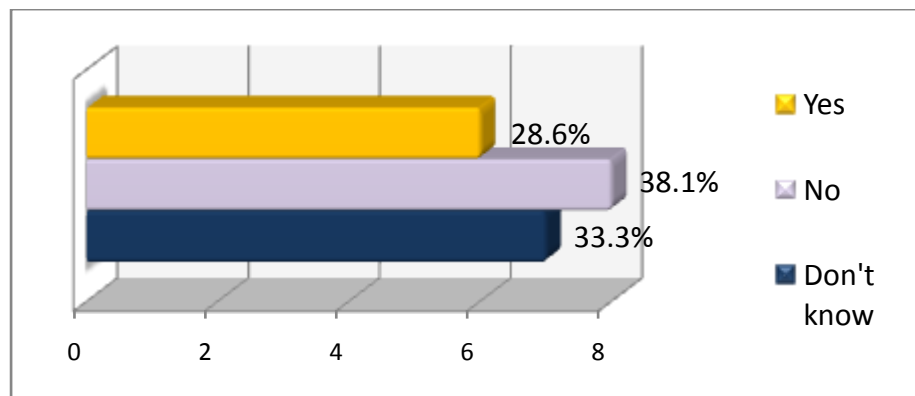
This result could imply that the nursing profession differs significantly from unions in relation to the employment of certain strategies to accomplish their objectives. However, unresolved issues with government appear to persuade RNs to agree with unions. Furthermore, this finding agrees with figure 5.24 where 78.3% of the respondents preferred strike actions to solve their problems.

5.2.1.43 RNs support division between unions and professional associations

Regarding support for division between unions and professional associations, ten (45.5%) of the respondents disagreed and five (22.7%) agreed with the division of unions and professional associations, while seven (31.8%) did not know (see figure 5.26).

Figure 5.26 DHA respondents' perception of division between unions and professional associations (n=22)
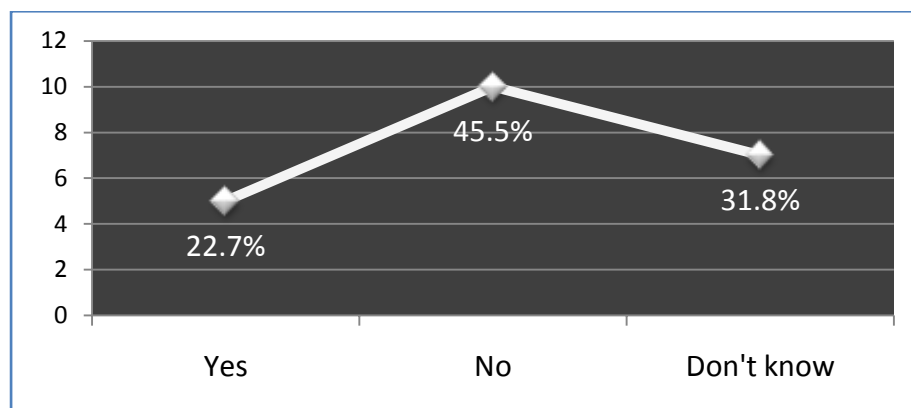
The respondents appeared to favour an independent body to address their own problems, negotiate and have meaningful interactions with legislators. This data also supports the finding in figure 5.25 where most of the respondents (38.1%) did not agree that nurses and unions shared the same values regarding patient care. This therefore creates the impression that the affiliation of RNs to unions was for collective bargaining purposes.

SECTION H: Nurses and politics

5.2.1.44 Poor nurse representation in government contributes to migration

Of the respondents, 17 (77.3%) indicated the need for representation of nurses by nurses at government level, three (13.6%) did not agree and two (9.1%) were not sure (see figure 5.27).

Figure 5.27 DHA respondents' view of poor nurse representation in government and migration (n=22)
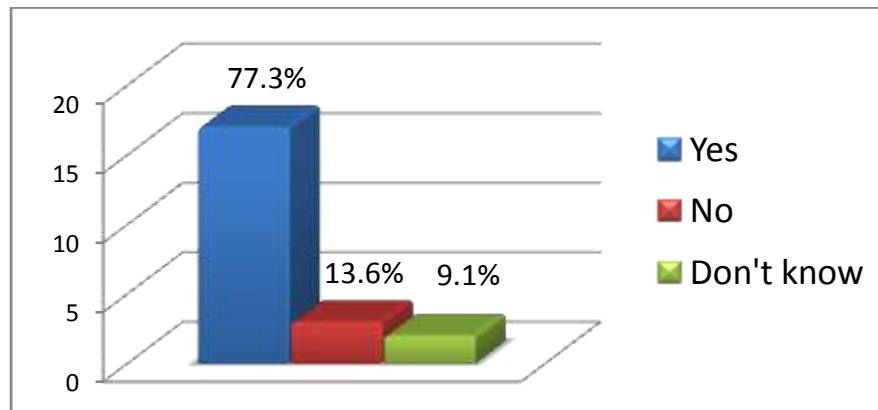
From figure 5.27 it is evident that the respondents were aggrieved over non-nursing representation on nursing issues. The findings suggest that work-related problems such as lack of equipment and severe staff shortages still require urgent attention.

5.2.1.45 RNs vote for parties that add value to nursing

This item examined whether the respondents were well informed politically (see figure 5.28).

Figure 5.28 DHA respondents' vote for parties that add value (n=21)
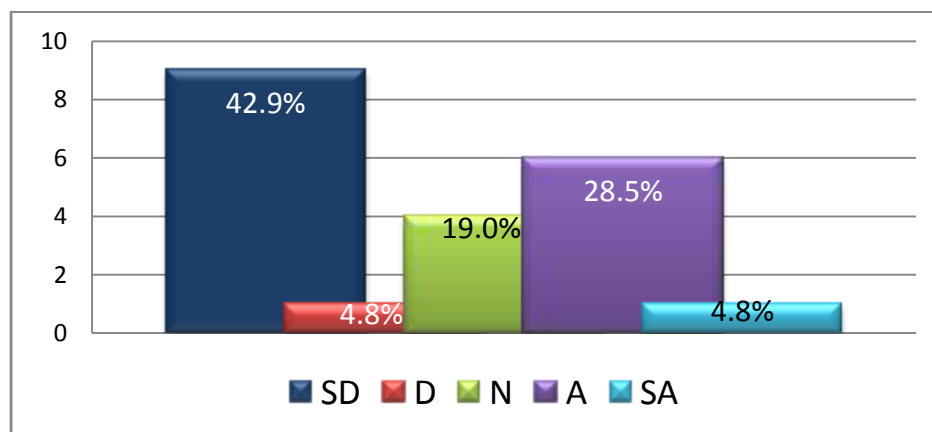
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

With regard to nurses voting for parties that add value to nursing practice, 47.7% (42.9% + 4.8%) of the respondents strongly disagreed/disagreed and

that 33.3% (28.5% + 4.8%) agreed/strongly agreed with the statement, while four (19.0%) did not know. This appeared to signify that nurses are not well informed about political matters, with specific reference to voting for parties that would favour the course of health care services in the country. This question was intended to assess the respondents' awareness of the support needed from the ruling party for the recognition of the nursing profession. Moreover, political leaders and legislators generally do not have detailed information about the core and the needs of nurses and health care provision.

5.2.1.46 Nurses' issues are supported in political debates

Regarding whether policy-makers support and seriously consider nurses' issues in political debates, 52.4% (38.1% + 14.3%) of the respondents strongly disagreed/disagreed and 23.8% (19.0% + 4.8%) agreed/strongly agreed with the statement, while five (23.8%) did not know (see table 5.18).

Table 5.18 DHA respondents' perception of political support for nurses' issues (n=21)

Response	SD	D	N	A	SA
Frequency	8	3	5	4	1
Percentage	38.1%	14.3%	23.8%	19.0%	4.8%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From table 5.18 it is clear that the majority of the respondents were aware that their issues did not receive adequate attention in politics. This is where important decisions regarding the country's affairs are made, including annual budget allocations. The enormity of health care needs can only be clearly articulated by nurses who are politically astute.

5.2.1.47 RNs can become policy analysts in South Africa

Regarding RNs being policy analysts in the RSA, 75.0% (45.0% + 30.0%) of the respondents agreed/strongly agreed, 15.0% strongly disagreed with this statement, and 10.0% did not know (see figure 5.29).

Figure 5.29 DHA respondents' perception of RNs as policy analysts (n=20)
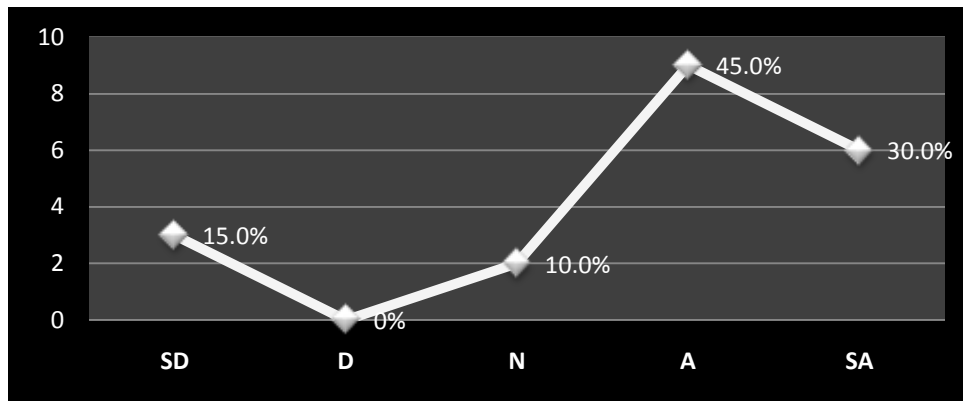
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This result implies that the respondents wished to be more involved in politics in order to make a meaningful contribution to the direction the HCS should take in the current changing political and socio-economic climate.

5.2.1.48 RNs know how policies are made in government

This item examined the respondents' knowledge of policy-making at government level (see figure 5.30).

Figure 5.30 DHA respondents' knowledge of policy-making at government level (n=22)
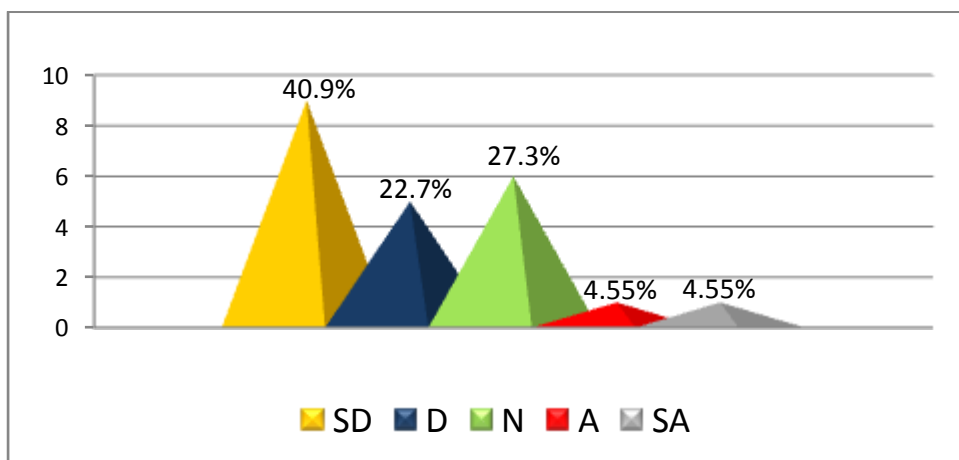
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 63.6% (40.9% + 22.7%) strongly disagreed/disagreed while 9.1% (4.55% + 4.55%) agreed/strongly agreed that nurses knew how policies were made at government level, and 27.3% did not know. Knowledge of policy formulation is crucial in the workplace because policy guides the activities undertaken in organizations.

5.2.1.49 RNs can influence policy making

Of the respondents, 85.0% (40.0% + 45.0%) agreed/strongly agreed, 5.0% strongly disagreed, and 10.0% were undecided that nurses could influence policy making (see figure 5.31).

Figure 5.31 DHA respondents' view of influence on policy making (n=20)
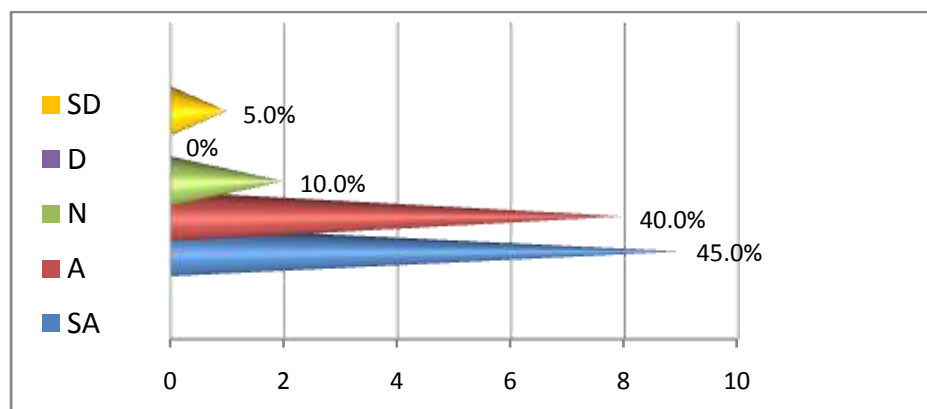
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This would seem to indicate that the respondents wished to proactively influence decisions in order to have policies that favour the course of nursing and health care delivery. This result supported figure 5.30's finding that nurses did not know how policies were made at government level. This implies that political science should be introduced as a subject in the nursing curriculum and attempts be made to bridge the gap for qualified RNs.

5.2.2 Qualitative data analysis for district hospital "A"

Most of the respondents provided written narratives to some of the questions. These are presented and discussed in chapter 6.

5.3 DISTRICT HOSPITAL "B" (DHB)

This hospital is a level one health care service located in Tshwane Metropolitan area. As a district hospital, it provides access into more specialized care in regional or academic hospitals (DOH 2002:3-4). Of note is that the health service provided in this district hospital is fully integrated with health services provided in PHC. In other words, its governance and management are relative to the entire district health care system. That is why it is called a level one (generalist) service. It also caters for in-patients and out-patients, community members and attends to referrals from neighbouring clinics. According to WHO's functional definition, it is expected of district hospitals to provide family medicine, rehabilitation, surgery and medicine, obstetric, geriatric, and pediatric services from 0-24 hours. The 24-hour emergency and operating theatre services also form an integral part of this district hospital.

There were 86 RNs employed in this hospital and a bed capacity of 120 at the time of the research. The number of beds is indicative of the size of the hospital. The number of RNs who resigned for different reasons from this hospital was 34 in the past five years. Modern equipment and computers in the wards were found to be lacking in this hospital at the time of the research. This study gained a lot of support from RNs and management in this hospital in that about 40 questionnaires were distributed to RNs working the day shift and 27 were completed and returned. Therefore, a 67.5% response rate was achieved.

In the analysis of data, the total number of respondents will vary from item to item because some of the respondents did not respond to certain items in the questionnaire.

5.3.1 QUANTITATIVE DATA ANALYSIS FOR DISTRICT HOSPITAL "B" (DHB)

(NB: In the tables and figures, DHB indicates District Hospital 'B')

Section A: Demographic information

5.3.1.1 Age distribution

Of the respondents, one (3.7%) was between 18 and 25, seven (25.9%) were 26 to 33 years old; seven (25.9%) were between 34 and 41; six (22.2%) were between 42 and 49; five (18.5%) were between 50 and 57; and one (3.7%) was between 58 and 65 (see table 5.1).

Table 5.1 DHB respondents' ages (n=27)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	1	7	7	6	5	1	0
Percentage	3.7%	25.9%	25.9%	22.2%	18.5%	3.7%	0.0%

Table 5.1 indicates that in DHB, no respondents were older than 65 and most were between 26 and 41. It is possible that the one (3.7%) respondent aged between 58 and 65 was a retired RN who had been recalled to make up for shortage of staff in the PHS. This hospital appeared to have more young RNs, whom Kupperschmidt (1998:36) refers to as the Generation 'X' who are adventurous and decisive in pursuing their aspirations. Since there was no database to determine reasons for nurse migration from the PHS, the above assumption could not be scientifically proven in the context of HCS in Tshwane metropolis.

5.3.1.2 Race

Table 5.2 indicates the respondents' racial distribution in DHB.

Table 5.2 DHB respondents' race (n=27)

Race	Black	Coloured	Asian	White	Other (Please specify)
Frequency	27	0	0	0	0
Percentage	100.0%	0.0%	0.0%	0.0%	0.0%

All the respondents (n=27, 100.0%) in DHB were black. This could have been because the hospital is situated in the heart of a township.

5.3.1.3 Gender

Table 5.3 indicates the DHB respondents' gender.

Table 5.3 DHB respondents' gender (n=26)

Gender	Female	Male
Frequency	25	1
Percentage	96.2	3.8

Of the respondents, 25 (96.2%) were females and one (3.8%) was male, and one (3.8%) did not indicate gender. A significant number of males could have enabled a fair contrast of views.

5.3.1.4 Marital status

Of the respondents, 14 (53.8%) were married; ten (38.5%) were single, and two (7.7%) were widowed. None were divorced (see table 5.4).

Table 5.4 DHB respondents' marital status (n=26)

Marital status	Married	Single	Widowed	Divorced
Frequency	14	10	2	0
Percentage	53.8	38.5	7.7	0.0

Marital status was intended to assess the respondents' commitments and obligations that could be hampered by long hours of service, night shifts and excessive workload which could interfere with their social lives, resulting in

discontent and possible disintegration of families. From table 5.4, it is clear that most of the respondents were married, which would necessitate consideration and adjustment of some of the areas in the workplace.

5.3.1.5 Number of dependants

Of the respondents, two (7.7%) had no dependants; 23 (88.5%) had 1 to 3 dependants, and one (3.8%) had more than four dependants (see table 5.5).

Table 5.5 DHB respondents' number of dependants (n= 26)

Dependants	None	1 – 3	> 3
Frequency	2	23	1
Percentage	7.7	88.5	3.8

Table 5.5 reveals that the majority of the respondents at DHB had between 1 and 3 children, which corresponded with their marital status (see table 5.4). Makhubela-Nkondo (2001:vii) found that "women impact on the health and well-being of the family as a whole, and children in particular". In the context of this study, this would imply that even though nurses are indispensable in providing care for the sick, there should be a balance in working conditions to enable them to care for their families.

5.3.1.6 Residential area

Of the respondents, ten (35.7%) lived in cities/towns, sixteen (60.7%) lived in townships, none came from a village, and one (3.6%) came from an informal settlement (see table 5.6).

Table 5.6 DHB respondents' residential area (n=27)

Residence	City/Town	Township	Village	Informal settlement
Frequency	10	16	0	1
Percentage	35.7%	60.7%	0.0%	3.6%

Since DHB is located in a township, a vast majority of the respondents could have been expected to reside in the township. Such information is critical in the assessment of employees' liabilities and financial obligations with regard to areas of residence, which could exacerbate their discontent over salaries that do not match their needs.

5.3.1.7 Type of health care service

All the respondents worked for DHB (see table 5.7).

Table 5.7 DHB respondents' PHS (n=27)

Hospital	Academic hospital	Regional hospital	District hospitals	Private hospitals
Frequency	0	0	27	0
Percentage	0.0%	0.0%	100.0%	0.0%

The respondents all worked for DHB.

5.3.1.8 Positions

The respondents were asked to indicate the positions they held (see table 5.8).

Table 5.8 DHB respondents' position held at hospital (n=27)

Position	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	7	9	11
Percentage	26.0%	33.3%	40.7%

Of the respondents, seven (26.0%) were CPNs, nine (33.3%) were SPNs, and eleven (40.7%) were PNs. The convenient sample used did not provide a clear picture of the distribution of positions held in the hospital. In comparison, a random sample could have enabled a selection of equal numbers of respondents from each category, which would have enabled an accurate

assessment of the spread of different ranks in this hospital (see chapter 4, section 4.8.1).

5.3.1.9 Years of experience since registration

Of the respondents, eight (29.6%) had between one and five years' nursing experience since registration; six (22.2%) had between six and ten years' experience; nine (33.3%) had between 11 and 20 years' experience; three (11.1%) had between 21 and 30 years' experience, and only one (3.7%) respondent had between 31 and 40 years' nursing experience since registration (see table 5.9).

Table 5.9 DHB respondents' years of experience (n=27)

Experience	1-5	6-10	11-20	21-30	31-40	41-50	51-60
Frequency	8	6	9	3	1	0	0
Percentage	29.6%	22.2%	33.3%	11.1%	3.7%	0.0%	0.0%

Table 5.9 indicates that no respondents had between 41 and 60 years' experience after registration. Most of the respondents had between 11 and 20 years' experience, suggesting that they preferred this hospital due to its proximity to their homes since most of them were township residents (see table 5.6).

5.3.1.10 Qualifications

The respondents were asked to indicate their qualifications (see table 5.10).

Table 5.10 DHB respondents' qualifications (n=27)

Qualifications	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hons	M	D
Frequency	14	7	5	1			
Percentage	51.9%	25.9%	18.5%	3.7%	0.0%	0.0%	0.0%

Of the respondents, 14 (51.9%) had the Basic Nursing Diploma (BND); seven (25.9%) had a post-BND qualification; five (18.5%) had the basic four-year nursing degree, and one (3.7%) had a BA Cur degree. None of the respondents had Honours, Masters or Doctoral degrees. Advanced Midwifery, Intensive Care Unit, Orthopaedic nursing and other post-basic qualifications were not included in the questionnaire. Some of the respondents could therefore have been in these categories, which could have assisted in determining the advancement of career development in this hospital.

SECTION B: Transformation of health care services

5.3.1.11 Success of PHS transformation

Of the respondents, 56.0% indicated that HCS transformation was not successful; 40.0% indicated that transformation was successful, and 4.0% were not sure (see figure 5.1).

Figure 5.1 DHB respondents' perception of PHS transformation (n=25)
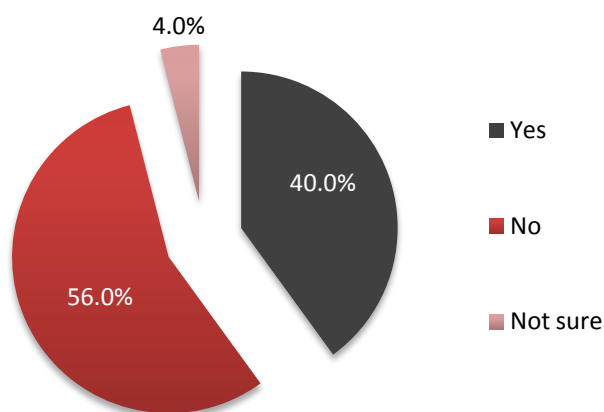
Most of the respondents therefore did not regard the transformational changes as what they had expected, perhaps due to budgetary constraints, new salary structures that did not meet their expectations or other issues in the restructuring of HCS. Nevertheless dramatic changes have taken place, such as discontinuance of delivery of care in a discriminatory manner, reprioritization of resources and budgets by re-focusing resources on PHC

services, free health care for pregnant women and young children, improved patients' rights, establishment of more training schools to increase diversity of skills for health professionals, and transformation of statutory bodies (Councils) that regulate registered health professionals.

5.3.1.12 Promotions allocated fairly in the PHS

Regarding the fair allocation of promotions, 15 (55.6%) of the respondents in DHB indicated that promotions were not fairly allocated; three (11.1%) indicated that promotions were fair, and nine (33.3%) did not know (see figure 5.2).

Figure 5.2 DHB respondents' perception of promotions (n=27)
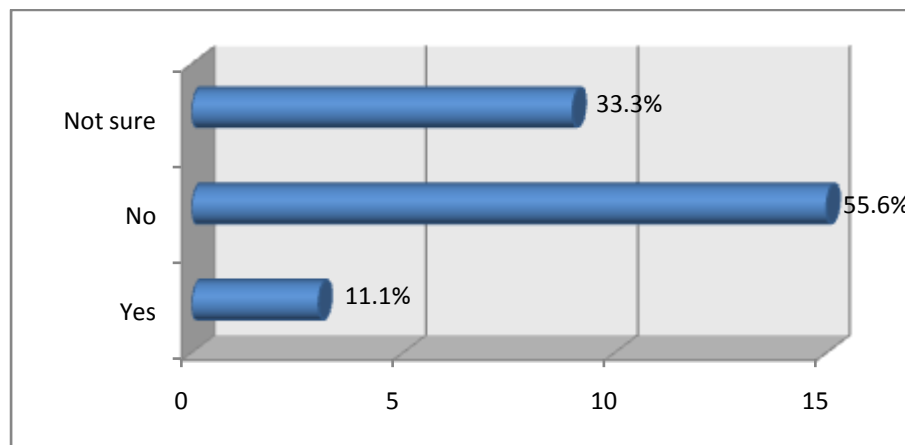
The results in figure 5.2 could imply unfair practices in promotions. However, the new OSD salary structure emerged with grade promotions and pay progression, with different salary scales attached to qualifications. At the same time, this system also caused discontent among RNs through apparently favouring those with specialty qualifications.

5.3.1.13 Young South Africans are attracted to nursing

The respondents were asked to indicate whether, in their opinion, young people were attracted to nursing (see figure 5.3).

Figure 5.3 DHB respondents' view of youth attracted to nursing (n=27)
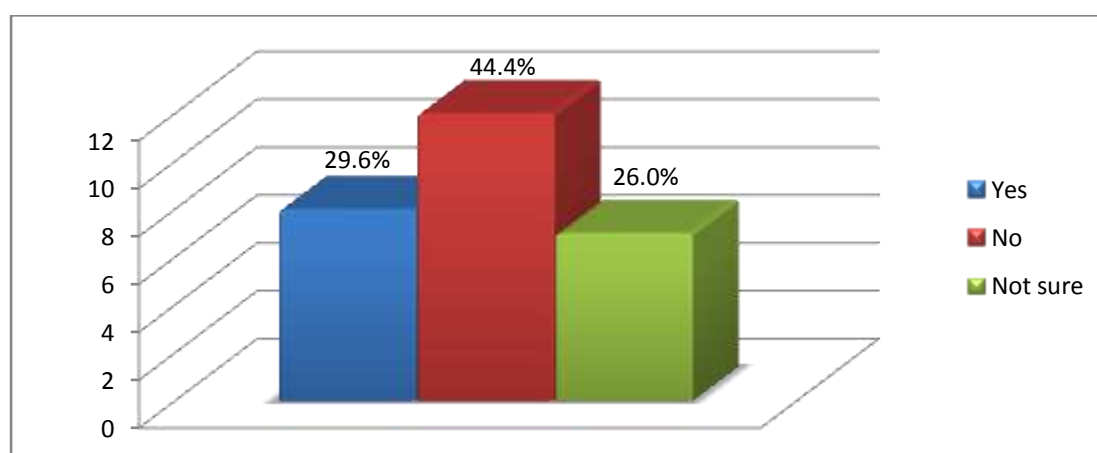
Of the respondents, eight (29.6%) respondents agreed that young South Africans were attracted to nursing; 12 (44.4%) disagreed, and seven (26.0%) were not sure. This item was intended to elicit the respondents' perceptions of the image of the nursing profession projected to the South African society.

5.3.1.14 National workforce forum to investigate nurses' issues

Of the respondents, only three (11.1%) stated that they knew that a national nursing forum existed; nine (33.3%) indicated that it did not exist, while 15 (55.6%) did not know (see table 5.11).

Table 5.11 DHB respondents' awareness of national nursing forum (n=27)

Response	Yes	No	Not sure
Frequency	3	9	15
Percentage	11.1	33.3	55.6

The respondents' lack of awareness of a national work forum to investigate and address nurses' issues professionally could be due the unionization of HCS where problems are directed to unions. This could present problems since unions are not conversant with needs for delivery of health care in the entire health environment.

5.3.1.15 Employing body communicates with nurses

Of the respondents, nine (34.6%) stated that the employing body never communicated with nurses in this hospital; 15 (57.7%) indicated that the employing body occasionally did; two (7.7%) indicated that government always communicated with nurses, while none indicated that provincial government frequently did.

Figure 5.4 DHB respondents' experience of communication with nurses (n=26)
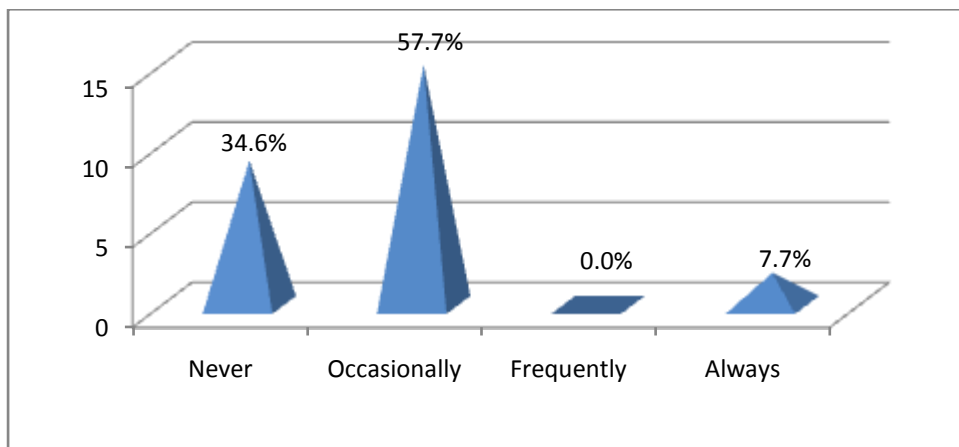
Figure 5.4 indicates that most of the respondents were of the opinion that government occasionally communicated with nurses, howbeit insufficient. Communication between government and employees is vital for information to the trickle down to operational levels as intended, unlike relying on third parties such as unions to convey government decisions.

5.3.1.16 OSD as a perfect solution for discontent

Regarding the OSD, nine (33.3%) of the respondents agreed and 12 (44.5%) disagreed that the OSD was a perfect solution for nurses' discontent in the PHS, while six (22.2%) did not know (see figure 5.5).

Figure 5.5 DHB respondents' perception of the OSD as a perfect solution (n=27)
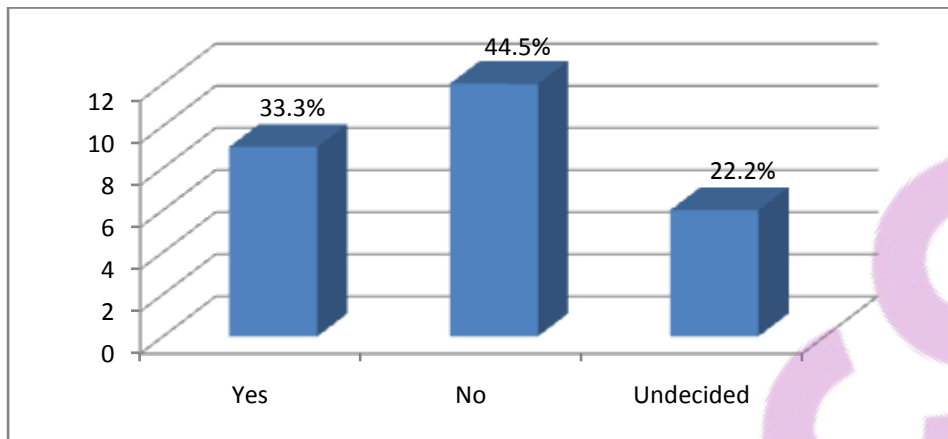
These results suggest that most of the respondents did not benefit from the new salary structure, probably due to government's intention to use it as a recruiting and retention strategy for specialty qualifications. Most importantly, those who disagreed and who were not sure would seem to indicate no prior information had been provided on the distribution of the OSD, in terms of who would benefit and what was required to qualify for the OSD.

5.3.1.17 Stakeholders agree on the OSD

The respondents were asked to indicate whether there was consensus over the OSD among stakeholders (see figure 5.6).

Figure 5.6 DHB respondents' perception of consensus over OSD (n=27)
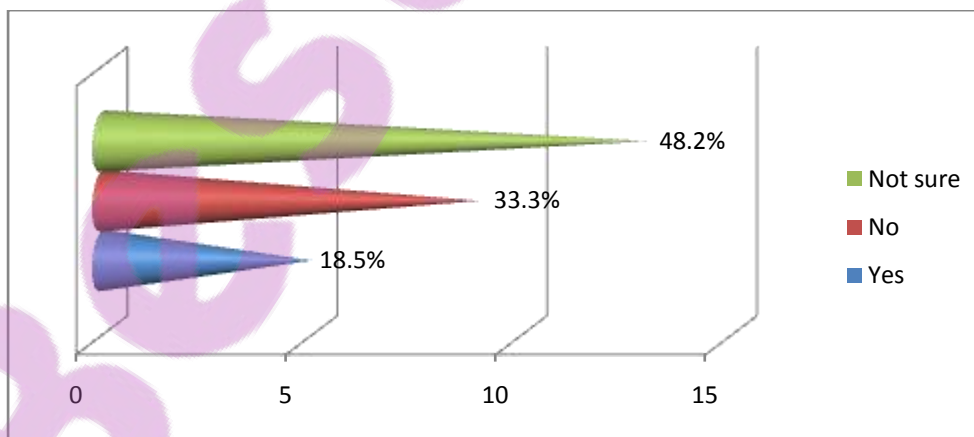
Of the respondents, five (18.5%) agreed and nine (33.3%) disagreed that there was consensus among all stakeholders on the OSD implementation in the PHS, while 13 (48.2%) were not sure. This indicates that more respondents were not sure what was happening with regard to the OSD, and more disagreed than agreed. This data therefore suggests a lack of consensus among parties involved in the implementation of the OSD or that the process of implementation was not clearly articulated to RNs at the operational level. That the majority of the DHB respondents were not sure could be an indication that nurses were not correctly and adequately informed about issues surrounding the implementation of the OSD.

5.3.1.18 Overseas exchange programme successful

Of the respondents, 15 (57.7%) disagreed, eight (30.8%) agreed and three (11.5%) were not sure that the overseas exchange programme for RNs was a success (see figure 5.7).

Figure 5.7 DHB respondents' perception of the overseas exchange programme (n=26)
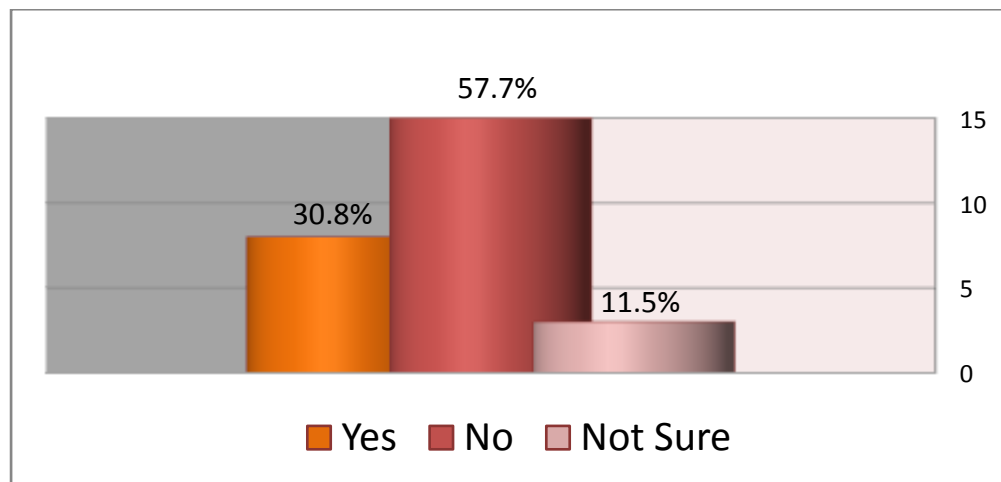
Even though the respondents responded to this item, it was later discovered that DHB did not participate in the overseas exchange programme initiated by the Gauteng DOH, because it was implemented only in academic hospitals.

5.3.1.19 Discontent among RNs is an observable reality

Of the respondents, 80.8% (53.8% + 27.0%) strongly agreed/agreed while 15.3% (3.8% + 11.5%) strongly disagreed/disagreed that discontent among RNs was an observable reality (see figure 5.8).

Figure 5.8 DHB respondents' observation of discontent among RNs (n=26)
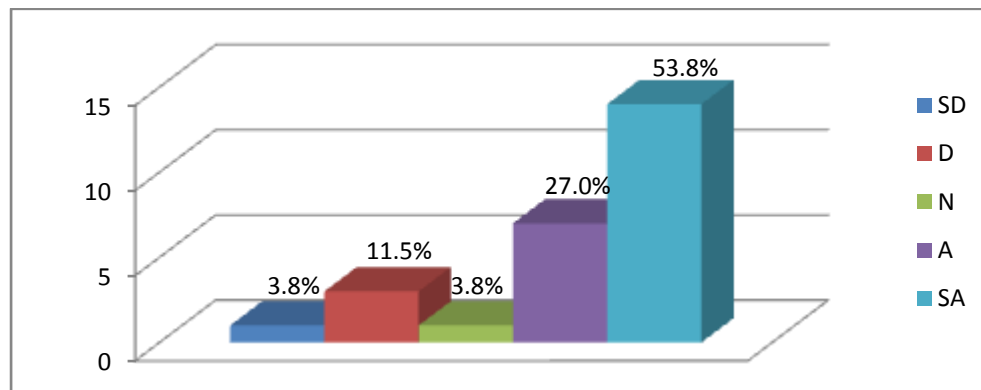
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding suggests that this is a situation requiring urgent attention by relevant authorities. Although discontent can exist in organizations, it can reach a point where it becomes observable, manifesting in several ways. Such a situation has the potential to work against organizations if left unabated.

5.3.1.20 Low morale associated with low salaries in public hospitals

Of the respondents, 84.6% (42.3% + 42.3%) strongly agreed/agreed and only 7.6% (3.8% + 3.8%) strongly disagreed/disagreed that low morale among RNs was associated with nurses' low salaries (see figure 5.9).

Figure 5.9 DHB respondents' perception of low morale and low salaries (n=26)
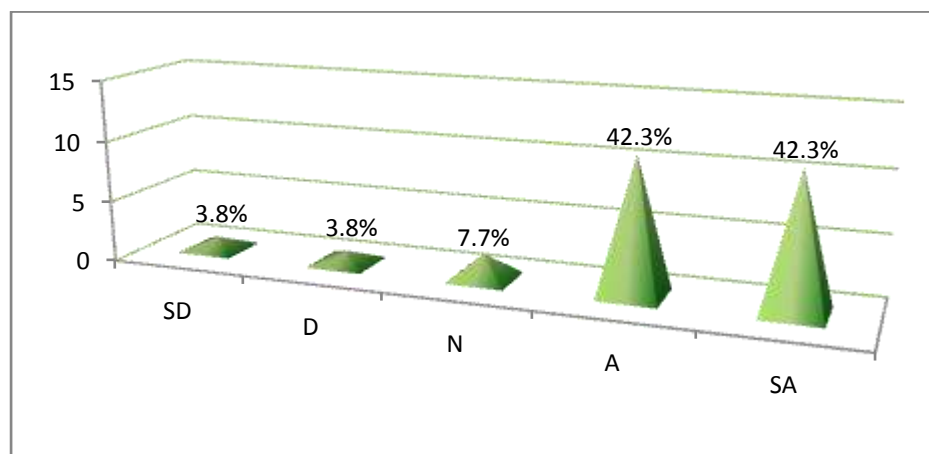
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

These results concurred with figure 5.8 where 80.8% of the respondents agreed that discontent among RNs was an observable reality. This data further emphasises that salaries are critical to nurses, and if efforts to address this issue are unsuccessful, they will seek other alternatives.

5.3.1.21 RNs contribute to change in hospitals

Of the respondents, 55.5% (18.5% + 37.0%) strongly agreed/agreed and 22.3% (18.5% + 3.8%) strongly disagreed/disagreed that RNs contribute to change in hospitals.

Table 5.12 DHB respondents' contribution to changes in hospitals (n=27)

Response	SD	D	N	A	SA
Frequency	5	1	6	10	5
Percentage	18.5%	3.8%	22.2%	37.0%	18.5%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding is positive for nurses and health institutions in the long term, and necessary for building good relationships between RNs and NSMs.

5.3.1.22 RNs are sponsored for conferences

Of the respondents, 61.6% (34.6% + 27.0%) strongly disagreed/disagreed and 19.2% (7.7% + 11.5%) strongly agreed/agreed that RNs received financial support to attend conferences on nursing and health care issues, while five (19.2%) were undecided (see figure 5.10).

Figure 5.10 DHB respondents' sponsored for conferences (n=26)
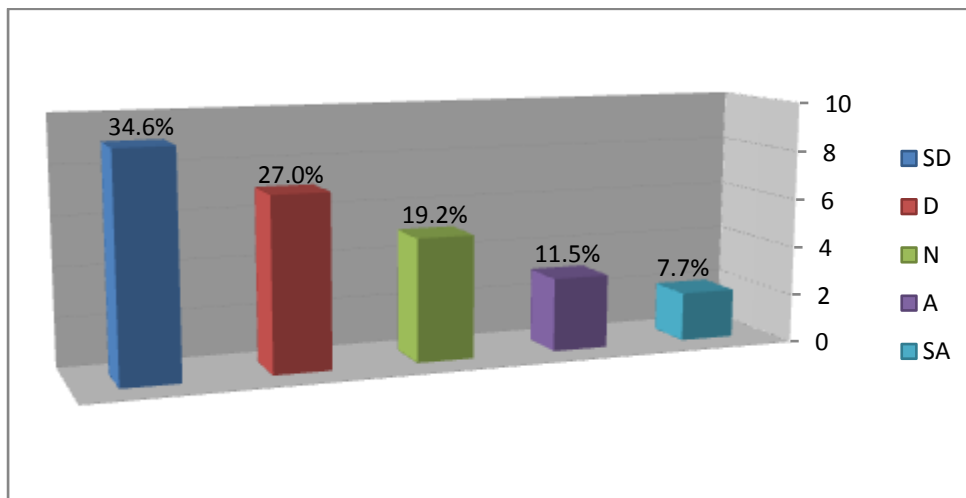
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This could be a potential area for discontent if there are no activities for RNs to participate in, and no effort to assist them to contribute in conferences and gain knowledge and inspiration through networking and trying out new things.

5.3.1.23 RNs are financed to do research

Of the respondents, 66.7% (26.0% + 40.7%) strongly disagreed/disagreed and 22.2% (7.4% + 14.8%) strongly agreed/agreed that RNs were financed to do research (see figure 5.11).

Figure 5.11 DHB respondents' finances for research (n=27)
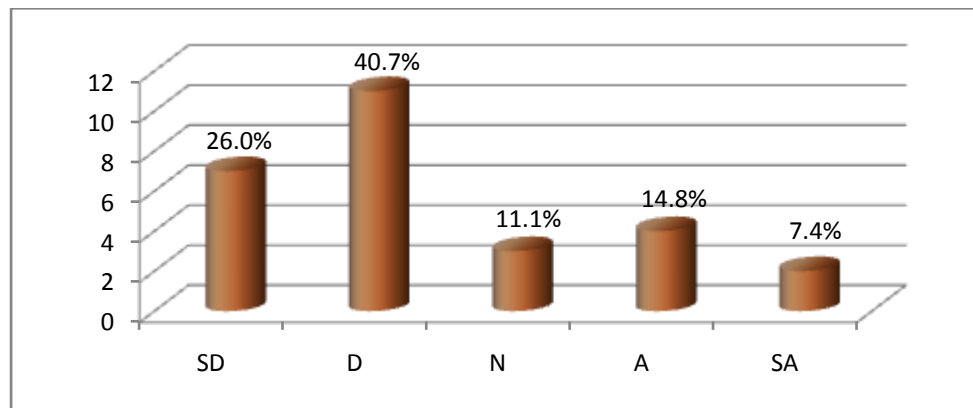
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.11 suggests that financial support for research is not available. A potential source of discontent can be identified in this area when nurses are financially restricted from investigating areas requiring research. This could cause despondency and frustration.

5.3.1.24 Opportunities for RNs' career development

Of the respondents, 51.9% (11.1% + 40.8%) strongly agreed/agreed and 33.3% (11.1% + 22.2%) strongly disagreed/disagreed that RNs had opportunities for career development in the PHS, while four (14.8%) were undecided (see table 5.13).

Table 5.13 DHB respondents' opportunities for career development (n=27)

Response	SD	D	N	A	SA
Frequency	3	6	4	11	3
Percentage	11.1%	22.2%	14.8%	40.8%	11.1%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From table 5.13, it can be safely concluded that DHB places a high premium on career development, through study leave opportunities, study days, or financial incentives.

5.3.1.25 RNs agree with their extended role as medical assistants

Of the respondents, 53.8% (19.2% + 34.6%) strongly agreed/agreed, 15.4% (3.9% + 11.5%) strongly disagreed/disagreed with their extended role as medical assistants, and eight (30.8%) were undecided (see table 5.14).

Table 5.14 DHB respondents' view of their extended role as medical assistants (n=26)

Response	SD	D	N	A	SA
Frequency	1	3	8	9	5
Percentage	3.9%	11.5%	30.8%	34.6%	19.2%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Although not mandatory, this new role was made available to interested RNs, particularly PHC RNs, who would be offered an additional one-year course to be assistant physicians. DHB is a community-based level one HCS in a township and delivers comprehensive PHC services (DOH 2002:3).

SECTION C: Workplace violence in the PHS

5.3.1.26 Workplace security system for nurses is satisfactory

Of the respondents, 20 (77.0%) disagreed and five (19.2%) agreed that the hospital security system was adequate, while 3.8% were not sure (see figure 5.12).

Figure 5.12 DHB respondents' perception of security for nurses (n=26)
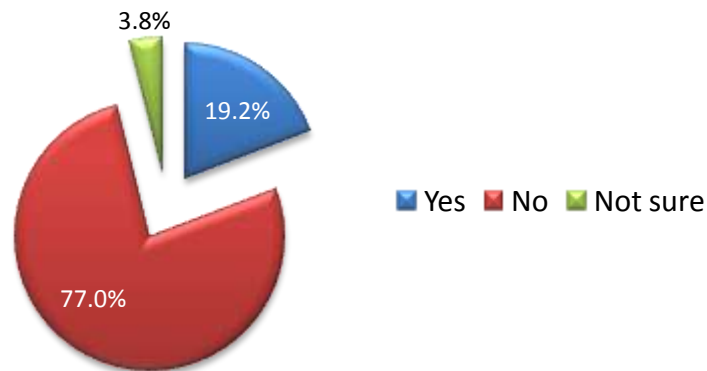
From figure 5.12 is evident that the DHB security system is inadequate and requires reinforcement, particularly in the light of the increased crime rate in the country. The responses could be an indication of serious concern about their cars, cell phones, money and other possessions because of the free flow of visitors on the hospital premises.

5.3.1.27 Patients are safe in hospital under the current security system

Of the respondents, 14 (53.8%) disagreed, six (23.1%) agreed and six (23.1%) were not sure that hospital patients were safe under the current security system (see figure 5.13).

Figure 5.13 DHB respondents' perception of patients' safety (n=26)
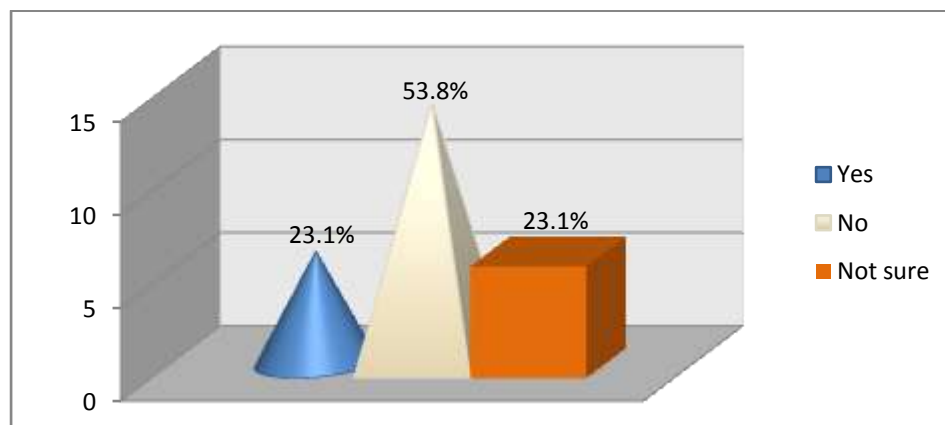
From figure 5.13 it is evident that patients were also not safe under current security measures. It should be borne in mind that nurses provide holistic

care, and the patients' safety is part of their ethical, moral and professional responsibility.

SECTION D: Stress

5.3.1.28 Stress is intolerable among RNs in the PHS

Of the respondents, 16 (61.5%) agreed and three (11.5%) disagreed that stress had reached intolerable levels in the PHS while seven (27.0%) were not sure (see figure 5.14).

Figure 5.14 DHB respondents' perception of stress (n=26)
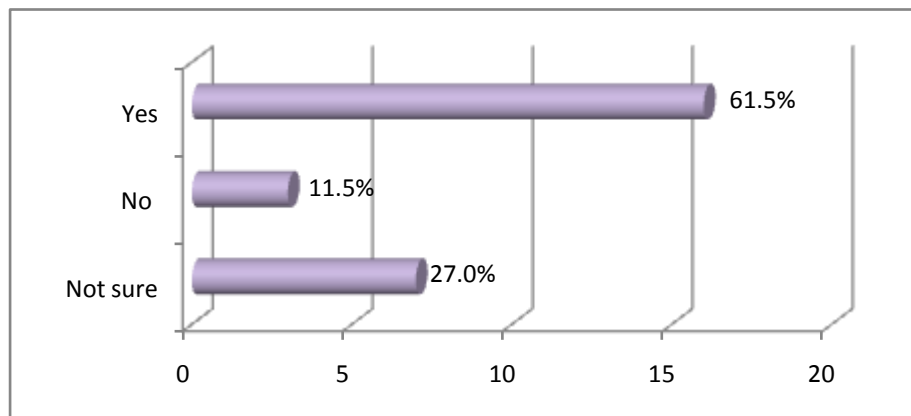
Since most of the respondents' perception of stress in the PHS was that it had become intolerable, it can be assumed that the level of stress in the PHS could become toxic, aggravated by increased workload in the face of staff shortages, lack of equipment, strike actions and other problems.

5.3.1.29 Have you personally used your vacation for resting?

The respondents were asked to indicate whether they had used vacation leave simply to rest (see figure 5.15).

Figure 5.15 DHB respondents' use of vacation for resting (n= 26)
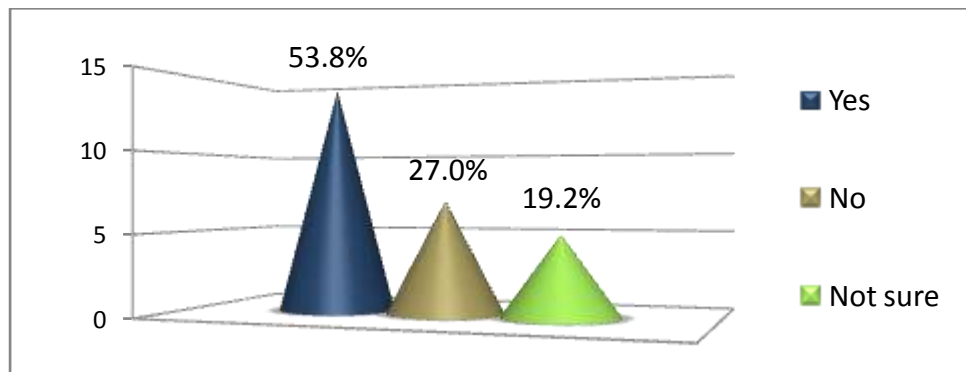
Of the respondents, 14 (53.8%) confirmed having used their vacation for resting while seven (27.0%) did not and five (19.2%) were not sure. Since the majority purported to have used their vacation for resting, it could be a good indication of self care, particularly in the era of unlimited overtime work.

5.3.1.30 Experience of physical signs of exhaustion

The respondents were asked whether they had experienced physical signs of exhaustion (see figure 5.16).

Figure 5.16 DHB respondents' experience of physical signs of exhaustion (n=27)
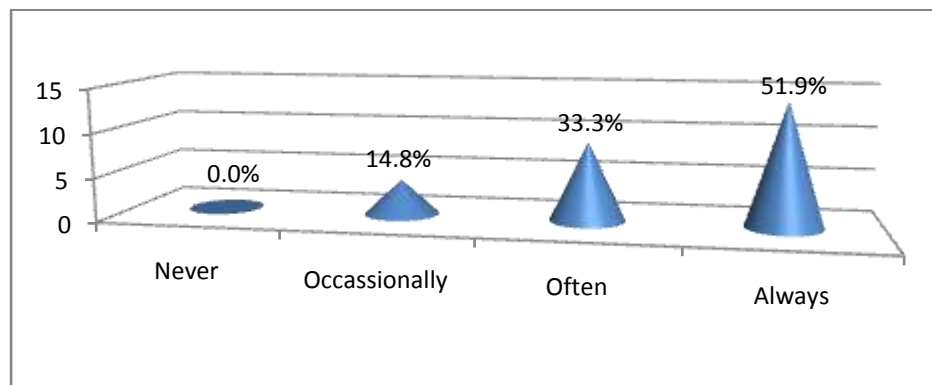
Of the respondents, 15 (51.9%) indicated having always experienced physical signs of exhaustion; nine (33.3%) reported frequent experiences and four (14.8%) reported occasionally experiencing physical signs of exhaustion. No respondent denied experiencing physical signs of exhaustion. This result

concurred with figure 5.14, where 61.5% of the respondents reported high levels of stress. This kind of situation usually results in high turnover, increased absenteeism and sick leave, which only further aggravate the situation.

5.3.1.31 Do you have intentions to leave the PHS for other institutions?

The respondents were asked whether they intended leaving the PHS (see figure 5.17).

Figure 5.17 DHB respondents' intention to leave the PHS (n=27)
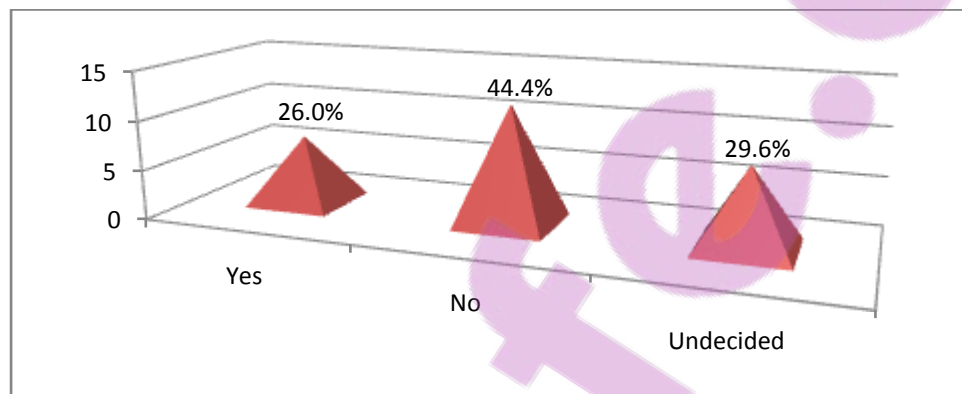
Of the respondents, 12 (44.4%) did not intend leaving the PHS, seven (26.0%) did intend leaving the PHS, and eight (29.6%) were undecided.

<p style="text-align:center">**SECTION E: Management and leadership problems**</p>

5.3.1.32 NSMs still display bullying attitudes

Of the respondents, 61.6% (38.5% + 23.1%) agreed/strongly agreed while 26.9% (7.7% + 19.2) strongly disagreed/disagreed that some NSMs still displayed bullying attitudes towards RNs (see figure 5.18).

Figure 5.18 DHB respondents' perception of NSMs' bullying attitudes (n=27)
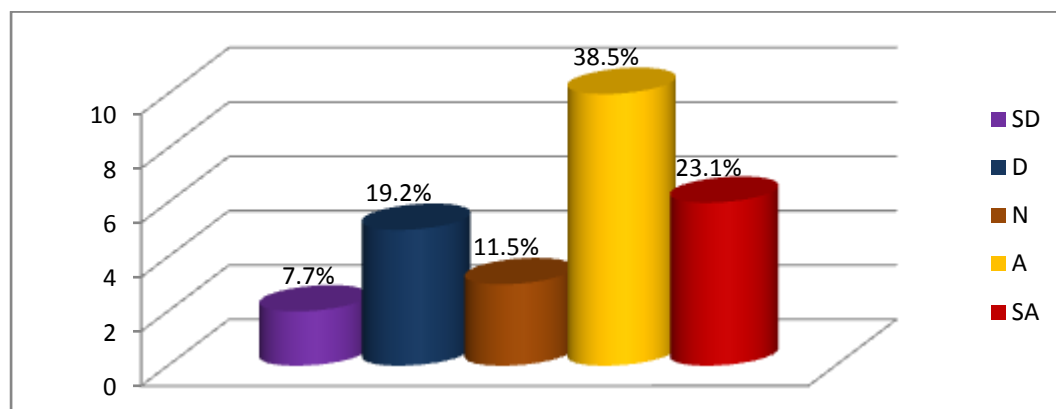
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.18 indicates that some of NSMs still follow the bureaucratic approach, which means that even if policies and guidelines change, government cannot change people's attitudes.

5.3.1.33 RNs acknowledged for outstanding contributions

Of the respondents, 44.0% (12.0% + 32.0%) strongly disagreed/disagreed and 32.0% (20.0% + 12.0%) agreed/strongly agreed that RNs were acknowledged for outstanding contributions (see table 5.15).

Table 5.15 DHB respondents' acknowledged for outstanding contributions (n=25)

Response	SD	D	N	A	SA
Frequency	3	8	6	5	3
Percentage	12.0%	32.0%	24.0%	20.0%	12.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

These findings might indicate that RNs were given recognition at other times, thereby implying inconsistencies in this practice, possibly depending on individual managers.

5.3.1.34 NSMs give feedback on problems reported

Of the respondents, 61.5% (46.1% + 15.4%) agreed/strongly agreed that NSMs provided feedback on problems reported; 7.7% strongly disagreed, and 30.8% remained neutral (see table 5.16).

Table 5.16 DHB respondents' experience of feedback on reported problems (n=26)

Response	SD	D	N	A	SA
Frequency	2	0	8	12	4
Percentage	7.7%	0.0%	30.8%	46.1%	15.4%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding portrays a good working relationship between NSMs and the respondents in DHB, which assists in facilitating delivery of care.

5.3.1.35 RNs are acknowledged for their sacrifices

Table 5.17 presents the respondents' perceptions of acknowledgement for sacrifices.

Table 5.17 DHB respondents' perception of acknowledgement for sacrifices (n=25)

Response	SD	D	N	A	SA
Frequency	5	7	3	5	5
Percentage	20.0%	28.0%	12.0%	20.0%	20.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 48.0% (20.0% + 28.0%) strongly disagreed/disagreed and 40.0% (20.0% + 20.0%) strongly agreed/agreed that nurses' sacrifices were acknowledged. This could imply that RNs' sacrifices were acknowledged on occasion. Acknowledgement requires visibility of NSMs at the operational level.

5.3.1.36 Hospital management discuss problems with RNs

Of the respondents, 10 (40.0%) agreed, five (20.0%) disagreed and ten (40.0%) were not sure that problems were jointly discussed (see table 5.18).

Table 5.18 DHB respondents' experience of joint discussion of problems (n=25)

Response	Yes	No	Not sure
Frequency	10	5	10
Percentage	40.0%	20.0%	40.0%

This finding also reveals a harmonious working relationship between the respondents and their leaders in DHB. Involvement of RNs in problem solving implies a sense of self-worth among RNs because their opinions are valued. Though the results indicate a split between those who agreed and those who were not sure, the opinions of those who agreed were considered.

SECTION F: RNs and migration

5.3.1.37 Nurse migration due to inadequate salaries

Of the respondents, 19 (70.4%) indicated inadequate salaries as the main cause of nurse migration from the PHS; eight (29.6%) indicated inadequate salaries as an important cause of nurse migration, and none indicated inadequate salaries as unimportant or fairly important in nurse migration from the PHS (see figure 5.19).

Figure 5.19 DHB respondents' perception of migration and inadequate salaries (n=27)
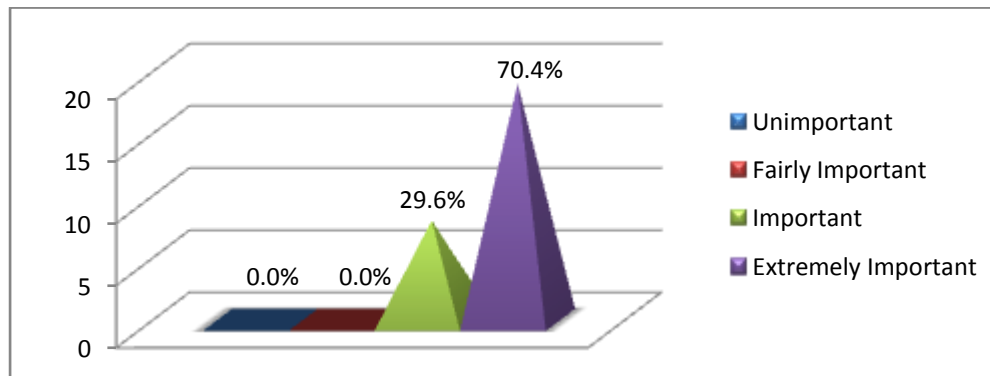
Therefore, it could be surmised that salaries remain the main factor in migration from the PHS. It should also be noted that this study found that even after the implementation of the new OSD salary structure, 44.5% of the respondents disagreed that the OSD was a perfect solution for discontent (see figure 5.5).

5.3.1.38 Poor leadership in nursing contributes to nurse migration

Of the respondents, 13 (50.0%) indicated poor leadership as an important reason for nurse migration; nine (34.6%) indicated it as an extremely important reason, three (11.5%) indicated it as a fairly important reason, and one (3.9%) indicated it as an unimportant reason for migration (see figure 5.20).

Figure 5.20 DHB respondents' perception of poor leadership and migration (n=23)
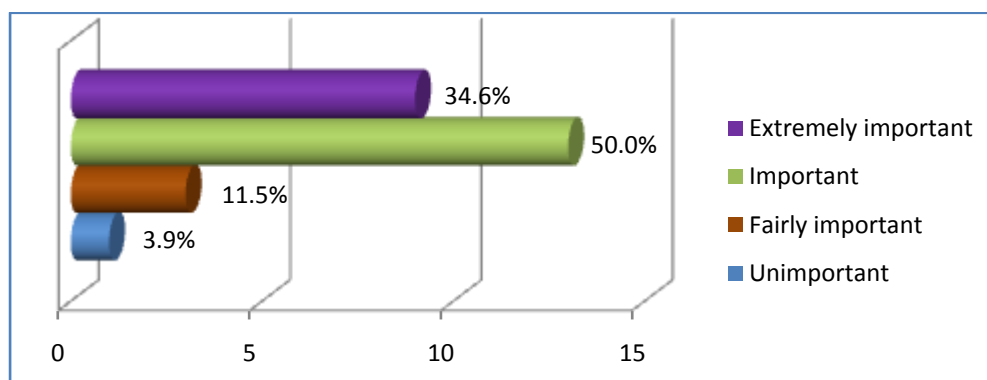
Figure 5.20 indicates the majority of the respondents agreed that poor leadership in nursing was an important cause of migration from the PHS. This concurred with figure 5.18 where 61.6% of the respondents agreed that some NSMs still displayed bullying attitudes towards RNs. This seems to imply that even though there are problems with leadership in nursing, they are not the main reason for nurse migration from the PHS.

5.3.1.39 Poor working conditions lead to nurse migration

Of the respondents, 20 (76.9%) indicated poor working conditions an extremely important reason and six (23.1%) indicated poor working conditions as an important reason for migration from the PHS (see figure 5.21). None of the respondents perceived them as unimportant or fairly important reasons for migration.

Figure 5.21 DHB respondents' perceptions of poor working conditions and migration (n= 26)
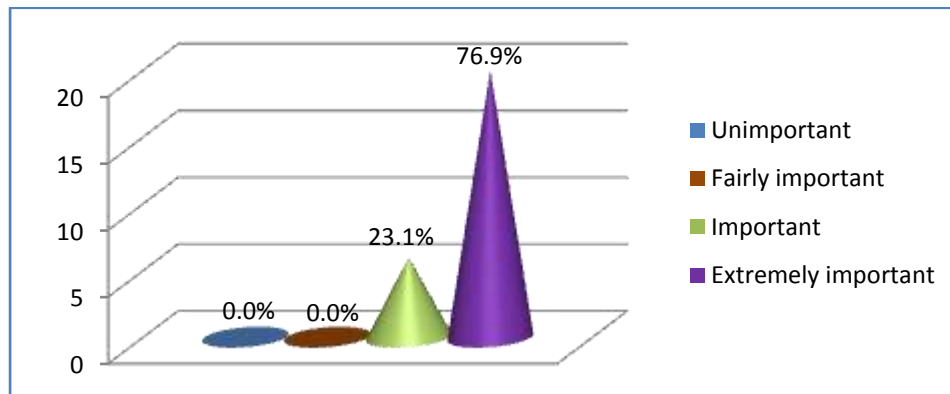
From figure 5.21 it is clear that poor working conditions are an important reason for migration from the PHS. This would appear to indicate that government needs to consider the PHS working conditions by increasing budget allocations, filling vacant posts, providing equipment for quality and efficient services, and improving nurses' salaries.

5.3.1.40 RNs migrate for "different" experience

The respondents were asked whether RNs migrated for "different" experience (see figure 5.22).

Figure 5.22 DHB respondents' perception of migration for "different" experience (n=25)
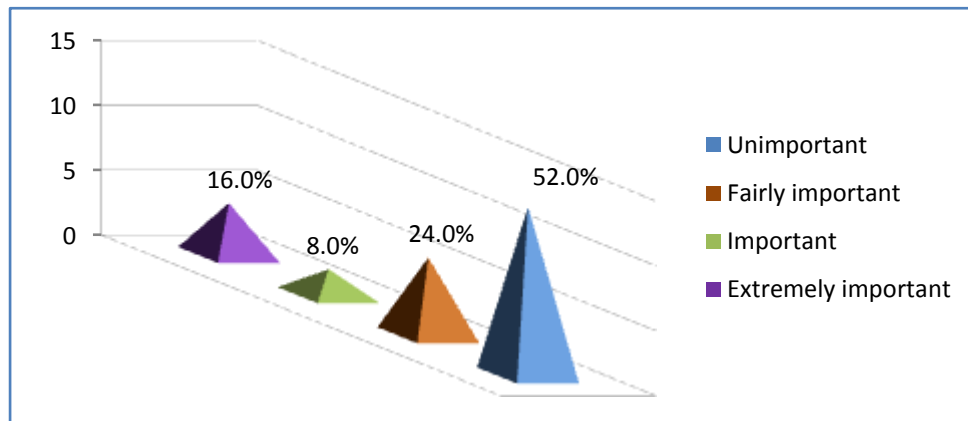
Of the respondents, 13 (52.0%) regarded "different" experience as an unimportant reason for migration; six (24.0%) regarded it as a fairly important reason; two (8.0%) regarded it as an important reason while four (16.0%) regarded it as an extremely important reason. Most of the respondents did not place much value on migration for a "different" experience. The results indicate that the DHB respondents had a concise and decisive approach to life and few would migrate just to experience life elsewhere.

SECTION G: Nurses and strike actions

5.3.1.41 RNs prefer strikes to solve nurses' problems

Of the respondents, 18 (72.0%) agreed that nurses preferred strikes to solve nurses' problems, six (24.0%) disagreed and one (4.0%) did not know (see figure 5.23).

Figure 5.23 DHB respondents' perception of strikes to solve nurses' problems (n=25)
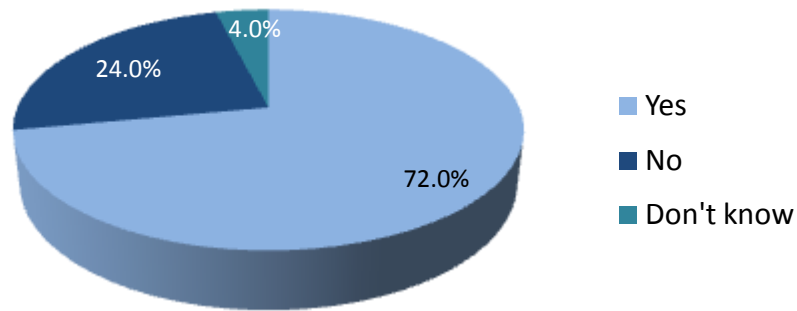
The majority of the respondents appeared to prefer strikes to solve their problems, possibly due to the influence of unions in the PHS, and that they did not know any other way to convince government to respond to the concerns.

5.3.1.42 RNs and unions share same values regarding patient care

Of the respondents, 11 (45.8%) agreed that RNs and unions shared the same values regarding patient care in this hospital; six (25.0%) disagreed, seven (29.2%) did not know (see figure 5.24).

Figure 5.24 DHB respondents' perception of nurse and union values regarding patient care (n=24)
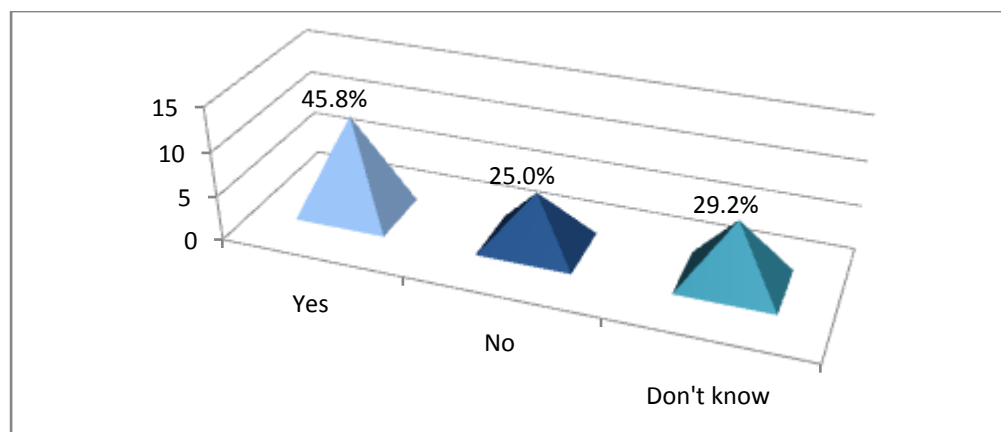
Since most of the respondents agreed that unions and nurses shared the same values regarding patient care, possibly due to the impact of strike

actions that had yielded positive outcomes for nurses, it can be assumed that nurses will continue to be involved in strike actions with unions.

5.3.1.43 RNs support division between unions and professional associations

Of the respondents, seven (30.4%) agreed and seven (30.4%) disagreed with the division between unions and professional associations, while nine (39.2%) were not sure (see figure 5.25).

Figure 5.25 DHB respondents' perception of division between unions and professional associations (n=22)
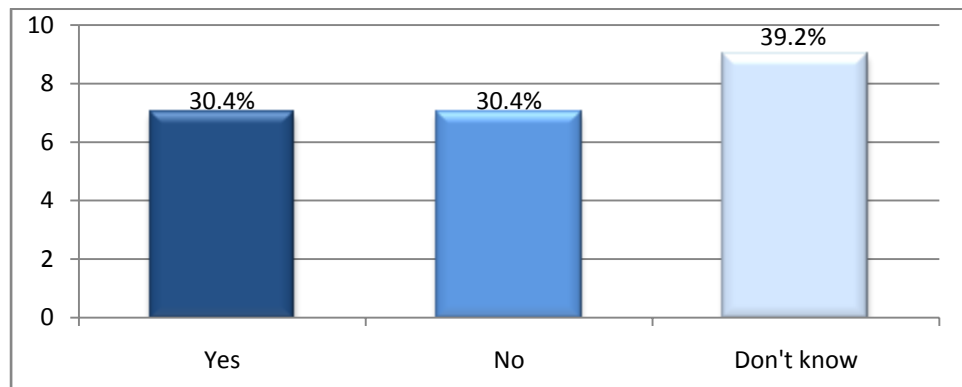
The results indicate divided opinion among the respondents on the division between unions and professional associations. This concurred with the findings that 72.0% preferred strikes to solve nurses' problems (see figure 5.23) and 45.8% agreed that nurses and unions shared similar values regarding patient care (see figure 5.24). The respondents (39.2%) who were not sure could be reflecting a dilemma for nurses of not knowing which organization would best serve the interest of nurses.

5.3.1.44 Poor nurse representation in government contributes to migration

Of the respondents, 20 (80.0%) agreed and three (12.0%) disagreed that poor nurse representation in government contributed to migration, while two (8.0%) did not know (see figure 5.26).

Figure 5.26 DHB respondents' perception of poor nurse representation and migration (n=25)
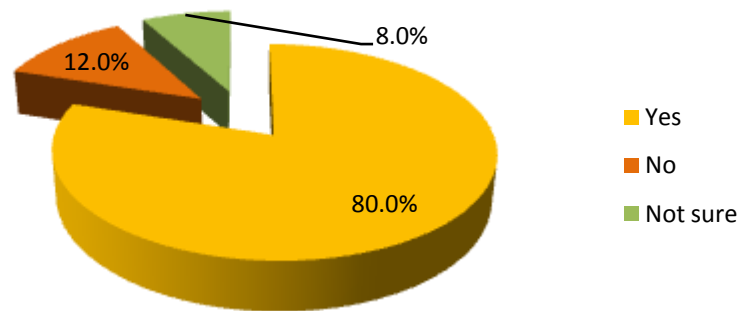
The results indicate that the respondents' were of the opinion that major dissatisfaction with nurses' representation in government contributed to migration. This implies that there could be a sense of despair and disillusionment because of a feeling that their views were not represented as intended. Only two (8.0%) respondents were not sure whether poor representation in government or other factors triggered migration.

5.3.1.45 RNs vote for parties that add value to nursing

Of the respondents, 46.2% (30.8% + 15.4%) disagreed/strongly disagreed and 23.0% (11.5% + 11.5%) agreed/strongly agreed that nurses voted for parties that add value to nursing practice, while eight (30.8%) were not sure (see figure 5.27).

Figure 5.27 DHB respondents' perception of voting for parties that add value (n=26)
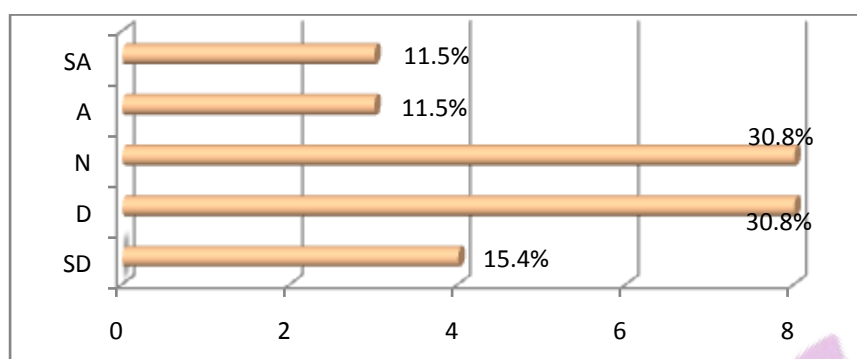
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding therefore creates the impression that most nurses are not well informed about the importance of voting for parties that support nursing issues. This was also supported by the eight (30.8%) respondents who were not sure whether nurses voted for parties that add value to nursing, revealing a lack of political astuteness. This could be ascribed to the legacy of previous laws that prohibited nurses from participating in politics.

5.3.1.46 Nurses' issues are entertained in political debates

Of the respondents, 65.4% (23.1% + 42.3%) strongly disagreed/disagreed and 15.4% (11.5% + 3.9%) agreed/strongly agreed that nurses' issues were entertained in political debates (see table 5.19).

Table 5.19 DHB respondents' perceptions of political consideration of nurses' issues (n=26)

Response	SD	D	N	A	SA
Frequency	6	11	5	3	1
Percentage	23.1%	42.3%	19.2%	11.5%	3.9%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This implies that the respondents believed that nurses' issues were not considered in political debates, possibly because decision makers did not receive information concerning these issues. The results were also consistent

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with the respondents (80.0%) who attributed nurse migration to poor nurse representation at government level (see figure 5.26).

5.3.1.47 RNs could become policy analysts in South Africa

Of the respondents, 73.1% (50.0% + 23.1%) agreed/strongly agreed and 15.4% (7.7% + 7.7%) strongly disagreed/disagreed, while three (11.5%) were not sure that, given the right educational preparation, RNs could become policy analysts in the RSA (see figure 5.28).

Figure 5.28 DHB respondents' view on RNs as policy analysts (n=26)
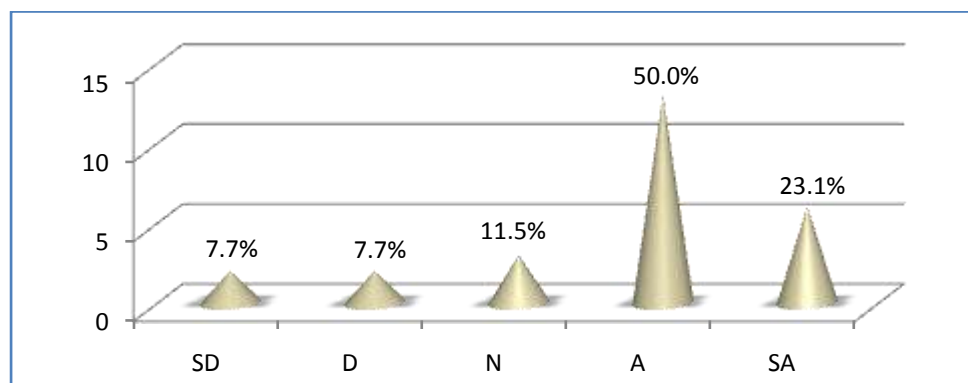
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The data seemed to suggest the respondents' confidence that RNs could do well as political analysts. It can also be surmised that RNs are becoming aware of the need to expand the horizons of the nursing profession.

5.3.1.48 RNs know how policies are made in government

Of the respondents, 42.3% (38.5% + 3.8%) agreed/strongly agreed and 42.3% (19.2% + 23.1%) strongly disagreed/disagreed that nurses had knowledge of policy making, and four (15.4%) did not know (see figure 5.29).

Figure 5.29 DHB respondents' perception of policy making at government level (n=26)
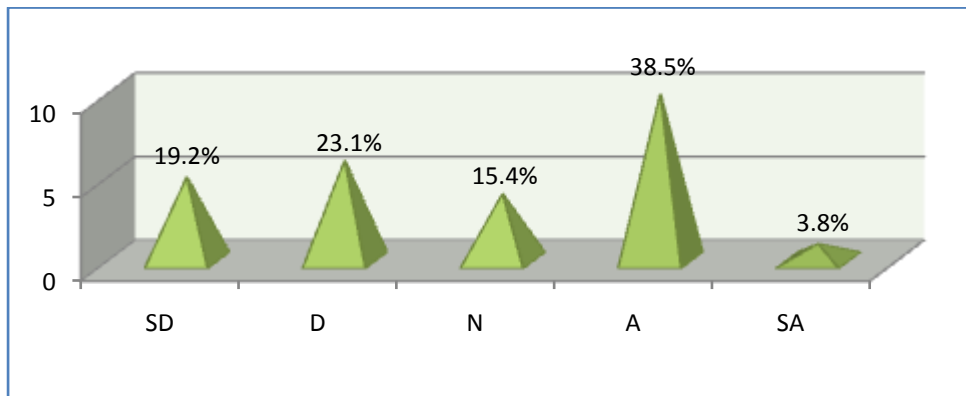
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This data could indicate a need to expose RNs to knowledge pertaining to policy-making processes and the degree to which they could be involved because the division could signify uncertainty regarding knowledge on policy making.

5.3.1.49 RNs can influence policy making

Of the respondents, 65.4% (42.3% + 23.1%) agreed/strongly agreed and 23.1% (7.7% + 15.4%) strongly disagreed/disagreed that given the opportunity, nurses could influence policy making (see figure 5.30). This could imply the respondents' determination to expand their knowledge and professional activities.

Figure 5.30 DHB respondents' view of influence policy making (n=26)

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

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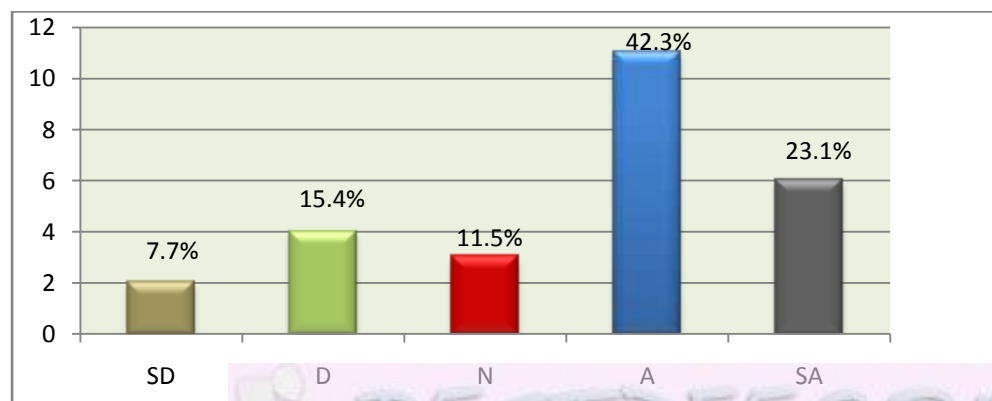
5.3.2 Qualitative data analysis for district hospital "B" (DHB)

Most of the respondents provided written narratives to questions of their choice. These are presented and discussed in chapter 6.

5.4 DISTRICT HOSPITAL "C" (DHC)

This hospital is a level one health care service located in Tshwane Metropolitan area. It serves as an entry level to more specialized care in regional or neighbouring academic hospitals by screening patients and referring complicated cases to level two or three hospitals, depending on which was nearest (DOH 2002:3-4). It should be noted that the health service provided in this district hospital is fully integrated with health services provided in a PHC clinic, which is located within the same hospital premises. Its governance and management are relative to the entire district health care system in Tshwane metropolitan region hence it is called a level one or generalist service area. It also caters for in- and out-patients, community members and attends to referrals from neighbouring clinics. This district hospital provides 24-hour family medicine, rehabilitation, surgery and medicine, obstetric and paediatric services. In addition, a ward is segregated exclusively for psychiatric patients in the hospital.

The hospital had 147 beds and employed 55 RNs at the time of the study. Twenty-five RNs had left the establishment in the past two years, which indicated a steady turnover in contrast to other HCS. This was the only hospital where some of the respondents provided reasons for leaving the establishment. Among those who left for the private sector, two left within a month of employment because the service conditions did not suit them.

Out of 30 questionnaires distributed to RNs working the day shift, 16 were completed and returned, resulting in a response rate of 53.3%. This was considered a reasonable response rate in that nursing covers day and night shifts while others were on leave. In the data analysis, the total number of respondents varied from item to item because some respondents did not respond to certain items in the questionnaire.

5.4.1 QUANTITATIVE DATA ANALYSIS FOR DISTRICT HOSPITAL "C" (DHC)

(NB: In the tables and figures that will follow, DHC indicates data for District Hospital 'C')

SECTION A: Demographic information

5.4.1.1 Age distribution

Of the respondents, two (13.3%) were between 18 and 25 years old; four (26.7%) were between 26 and 33; four (26.7%) were between 34 and 41, and five (33.3%) were between 42 and 49 (see table 5.1).

Table 5.1 DHC respondents' ages (n=15)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	2	4	4	5	0	0	0
Percentage	13.3%	26.7%	26.7%	33.3%	0.0%	0.0%	0.0%

Table 5.1 indicates that no respondents were older than 49 and most were between 42 and 49. Only one respondent did not indicate age.

5.4.1.2 Race

Of the respondents, 15 (93.8%) were Black and one (6.3%) was Coloured (see table 5.2).

Table 5.2 DHC respondents' race (n=16)

Race	Black	Coloured	Asian	White	Other (Please specify)
Frequency	15	1	0	0	0
Percentage	93.8%	6.3%	0.0%	0.0%	0.0%

There were no Asians and White respondents. Since so few respondents volunteered to participate, the races of RNs could possibly not depict an accurate picture of the overall staff racial distribution.

5.4.1.3 Gender

Of the respondents, 15 (93.8%) were females and one (6.3%) was male (see table 5.3). This could be the result of more female nurses than males in HCS.

Table 5.3 DHC respondents' gender (n=16)

Gender	Female	Male
Frequency	15	1
Percentage	93.8%	6.3%

5.4.1.4 Marital status

Of the respondents, seven (43.8%) were single; eight (50.0%) were married, and one (6.3%) was divorced. There were no widowed respondents (see table 5.4).

Table 5.4 DHC respondents' marital status (n=16)

Marital status	Single	Married	Divorced	Widowed
Frequency	7	8	1	0
Percentage	43.8%	50.0%	6.3%	0.0%

The results could indicate that generally there are more married RNs in HCS. This means that discontent could be more manifest, particularly if their schedules interfered with their family obligations, where husbands and children expect them to assume their roles as wife and mother after work. Financial obligations apply to all categories of RNs since all need adequate salaries to care for their families.

5.4.1.5 Number of dependants

Of the respondents, five (31.3%) had no dependants; ten (62.5%) had between 1 and 3 dependants, and one (6.2%) had more than three dependants (see table 5.5).

Table 5.5 DHC respondents' number of dependants (n=16)

Dependants	None	1 – 3	> 3
Frequency	5	10	1
Percentage	31.3%	62.5%	6.2%

Most of the DHC respondents had children, which could contribute to discontent if they worked compulsory night shifts, or came home to find the children sleeping, only to leave them sleeping in the morning again. This constitutes an abnormal lifestyle, particularly with regard to the number of dependants and age range, as opposed to working shorter hours that would eliminate this problem.

5.4.1.6 Residential area

Of the respondents, six (37.5%) lived in the city/town; nine (56.3%) lived in a township; one (6.3%) resided in a village, and none came from informal settlements (see table 5.6).

Table 5.6 DHC respondents' residential area (n=16)

Residence	City/Town	Township	Village	Informal settlement
Frequency	6	9	1	0
Percentage	37.5%	56.3%	6.3%	0.0%

Since this hospital is far from townships, and most of the respondents resided in a township, there could be additional financial burden for transportation, which could be a potential source of discontent.

5.4.1.7 Type of HCS

All the respondents were employed by the DHC (see table 5.7).

Table 5.7 DHC respondents' PHS (n= 16)

Hospital	Academic hospital	Regional hospital	District hospitals	Private Hospitals
Frequency	0	0	16	0
Percentage	0.0%	0.0%	100.0%	0.0%

5.4.1.8 Positions

Of the respondents, three (18.8%) were CPNs; four (25.0%) were SPNs, and nine (56.2%) were PNs (see table 5.8).

Table 5.8 DHC respondents' positions held (n=16)

Positions	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	3	4	9
Percentage	18.8%	25.0%	56.2%

The study used a convenient sample; consequently the respondents and table 5.8 might not portray the distribution of positions held in DHC. With a random sample, equal proportions of respondents from each category of nurses could have been selected, to enable an accurate assessment of the spread of different ranks (see chapter 4, section 4.8.1).

5.4.1.9 Years of experience since registration

Of the respondents, eight (50.0%) had from one to 10 years' nursing experience; five (31.3%) had from 10 to 11 years' experience; three (18.7%) had from 11 to 20 years' experience, and none had over 20 years' experience since registration with the SANC (see table 5.9) .

Table 5.9 DHC respondents' years of experience (n=16)

Experience	1-10	10-11	11-20	21-30	31-40	41-50	51-60
Frequency	8	5	3	0	0	0	0
Percentage	50.0%	31.3%	18.7%	0.0%	0.0%	0.0%	0.0%

5.4.1.10 Qualifications

Of the respondents, six (40.0%) had the Basic Nursing Diploma (BND); one (6.7%) had a post-BND; five (33.3%) had a basic four-year nursing degree; and three (20.0%) had the BA Cur degree. None of the respondents had Honours, Masters or doctoral degrees (see table 5.10). One respondent did not indicate qualifications.

Table 5.10 DHC respondents' qualifications (n=15)

Qualifications	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hons	M	D
Frequency	6	1	5	3			
Percentage	40.0%	6.7%	33.3%	20.0%	0.0%	0.0%	0.0%

These higher qualifications were specially selected to establish career advancement among RNs. Acquisition of these qualifications raises expectation of salary increments, which could constitute discontent if not realized.

SECTION B: Transformation of health care services

5.4.1.11 Public health transformation has been successful

This question sought the respondents' perceptions of the success of transformational initiatives in the PHS.

Of the respondents, five (33.3%) agreed and 10 (66.7%) disagreed that PHS transformation had been successful (see figure 5.1).

Figure 5.1 DHC respondents' perception of PHS transformation (n=15)
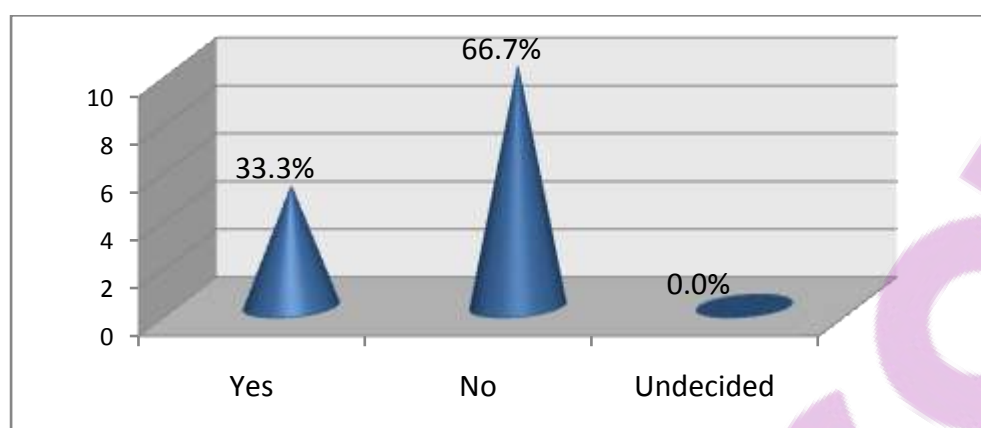
According to the majority of the respondents, transformational initiatives could not as yet be rated successful in DHC, probably due to financial constraints or other problems encountered in the delivery of care. It should be noted that nurses are the largest cadre in HCS. Therefore, if plans to transform HCS do not unfold according to expectations and efforts to voice their concerns seem to fail, they could easily consider migrating. At the same time, however, great strides have been made in transforming HCS, including discontinuance of delivery of care in a discriminatory manner, reprioritization of resources and budgets, improved patients' rights, the proliferation of PHC services, free health care for pregnant women and young children, and transformation of statutory bodies (Councils) that regulate registered health professionals.

5.4.1.12 Promotions are allocated fairly in the PHS

The respondents were asked to indicate their experience of the allocation of promotions in the PHS.

Of the respondents, twelve (75.0%) disagreed and three (18.8%) agreed that PHS promotions were fair, while one (6.2%) did not know (see figure 5.2).

Figure 5.2 DHC respondents' perceptions of promotions (n=16)
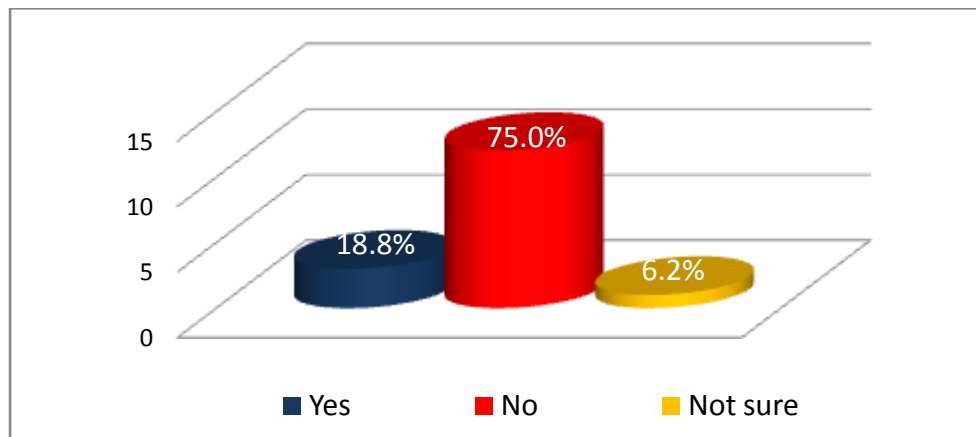
The respondents who disagreed could have problems with how candidates are selected for higher posts, including the way the OSD seems to favour nurses with specialty qualifications.

5.4.1.13 Young South Africans are attracted to nursing

This question sought the respondents' perceptions of the success of recruitment of young South Africans in the PHS.

Of the respondents, eight (50.0%) agreed and eight (50.0%) disagreed that young South Africans were attracted to nursing (see figure 5.3).

Figure 5.3 DHC respondents' perception of youth attracted to nursing (n=16)
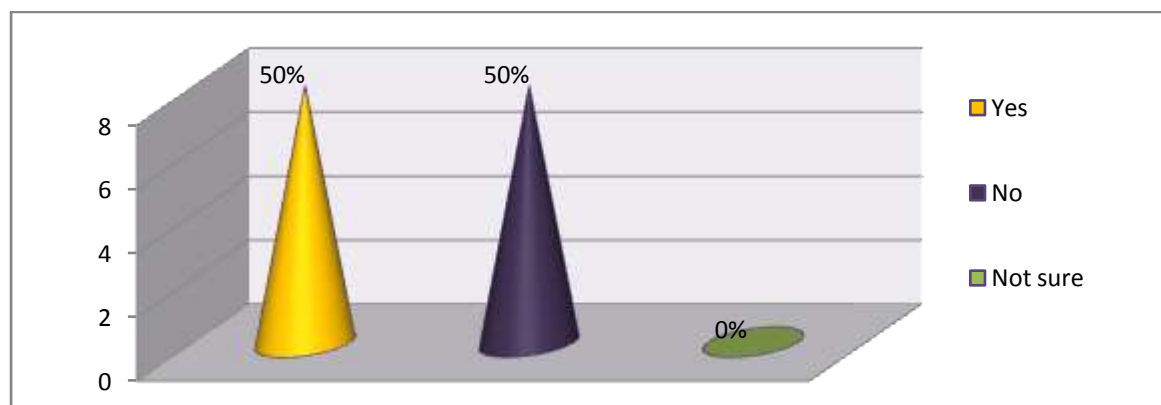
Some respondents indicated that young people were interested in professions other than nursing, while others indicated that they still enrolled for nursing courses (see chapter 6 for discussion of reasons).

5.4.1.14 National workforce forum investigates nurses' issues

This item investigated the respondents' perceptions of a national workforce forum that investigates nurses' issues.

Of the respondents, five (31.3%) agreed and seven (43.8%) disagreed that a national workforce forum existed for nurses' issues, while four (25.0%) were not sure (see figure 5.4).

Figure 5.4 DHC respondents' knowledge of national workforce forum (n=16)
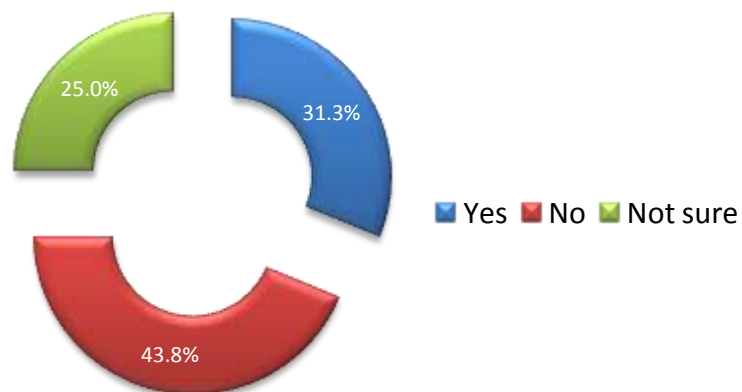
From figure 5.4 it is clear that most of the respondents were not familiar with the nursing forum, or it does not exist, which could explain why some PHS RNs joined unions to help solve their problems.

5.4.1.15 Employing body communicates with nurses

This question sought the respondents' perceptions of the efficiency of communication channels between government and RNs.

Of the respondents, seven (46.7%) indicated that government never communicated with nurses, seven (46.7%) indicated occasional communication, and one (6.6%) indicated that government frequently

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communicated with nurses. None of the respondents indicated that government always communicated with nurses (see figure 5.5).

Figure 5.5 DHC respondents' perception of communication with nurses (n=15)
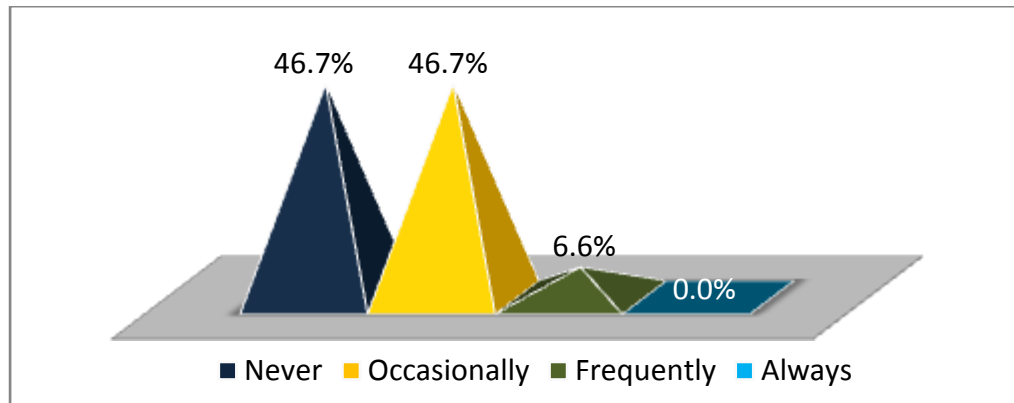
From figure 5.5 it can be construed that there is some form of communication between government and hospitals, though not necessarily regular. Regular communication is crucial and it is imperative that it not be left to unions because not all nurses subscribe to unions. NSMs can play a major role in connecting government with nurses at the functional level.

5.4.1.16 Occupational Specific Dispensation (OSD) a perfect solution for discontent

This item investigated the respondents' perceptions of the implementation of the OSD in the PHS.

Of the respondents, only two (12.5%) agreed and eight (50.0%) disagreed that the OSD was a perfect solution for nurses' discontent, while six (37.5%) were not sure (see figure 5.6).

Figure 5.6 DHC respondents' perception of OSD as solution (n=16)
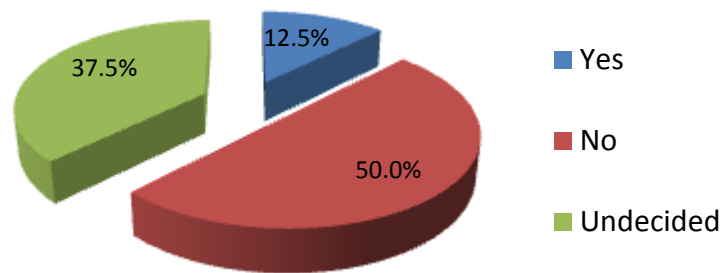
The results seem to imply that the respondents who agreed could have been among those who benefited while those who disagreed could be among those whom the new salary structure did not favour. However, most of the respondents disagreed with the OSD thereby suggesting that they possibly did not have the required specialty skills or were not informed about the government's intention to reward specialty skills for the purpose of recruiting and retaining them. The undecided respondents are also of concern because they could have serious questions about the OSD and its implementation, thus revealing a lack of information from the employing body or their representatives.

5.4.1.17 Stakeholders agree on the OSD

This question sought the respondents' perceptions of consensus among stakeholders regarding the OSD for nurses.

Of the respondents, only one (6.7%) agreed while ten (66.7%) disagreed that there was consensus among all stakeholders on the OSD and four (26.6%) were not sure (see figure 5.7).

Figure 5.7 DHC respondents' perception of consensus on OSD (n=15)
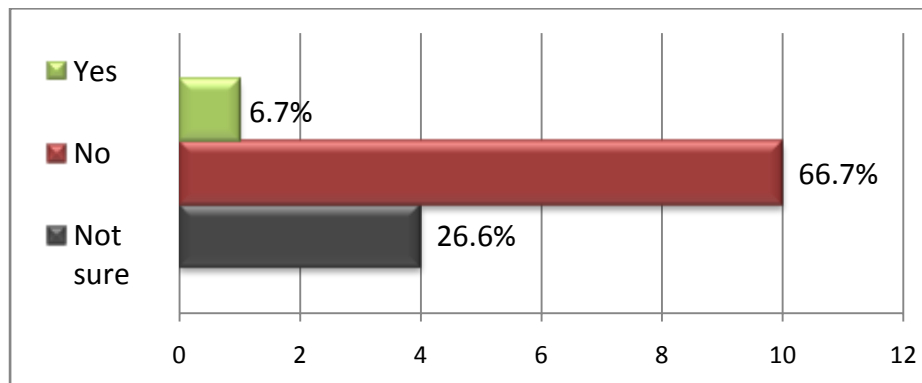
From figure 5.7 it seems there was no agreement among the parties involved concerning the implementation of the OSD, revealing possible exclusion of nurses from this important decision. It would have seemed appropriate to actively involve nurses throughout, particularly since it was a decision that directly affects them.

5.4.1.18 Overseas exchange programme is a success

This item examined the success of the overseas exchange programme launched by the Gauteng department of health as an attempt to benefit the country from nurse migration.

Of the respondents, six (46.2%) agreed and six (46.2%) disagreed that the overseas exchange programme was a success, while one (7.6%) did not know (see figure 5.8).

Figure 5.8 DHC respondents' perception of success of overseas exchange programme (n=13)
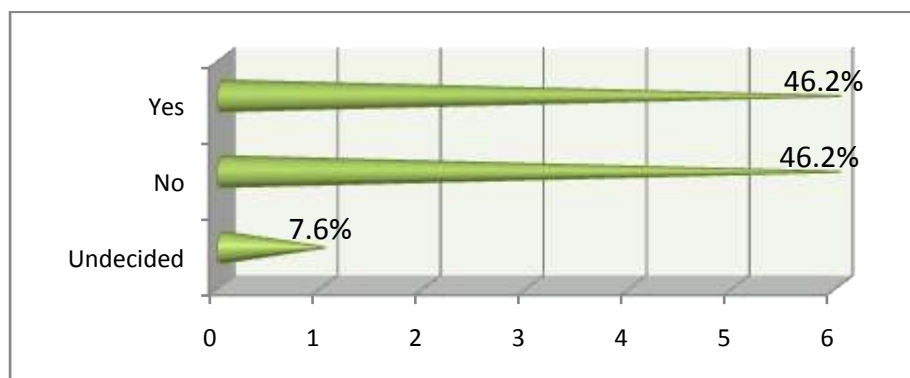
These results were subsequently discounted as precise/reliable reflections, since the researcher later learned that DHC did not participate in the overseas exchange programme. The respondents' opinions could be based on hearsay from colleagues at academic hospitals where it was implemented.

5.4.1.19 RNs discontent is an observable reality

The respondents were asked to indicate if discontent was observable among RNs in the PHS.

The overwhelming majority of the respondents, namely 86.6% (53.3% + 33.3%) agreed/strongly agreed that RNs discontent is an observable reality (see table 5.11).

Table 5.11 DHC respondents' observation of RNs' discontent (n=15)

Response	SD	D	N	A	SA
Frequency	0	1	1	8	5
Percentage	0.0%	6.7%	6.7%	53.3%	33.3%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From this data it can safely be concluded that discontent among RNs in the PHS has possibly reached alarming proportions where it has become observable. The respondents could be referring to observable acts such as strike actions, migration from the PHS and other signs that reveal the state of unrest in the PHS. That only one (6.7%) respondent disagreed and one (6.7%) did not know confirms the seemingly pathetic state in public hospitals.

5.4.1.20 Low morale associated with low salaries in public hospitals

This item sought to find out if low morale was associated with low salaries in public hospitals.

The overwhelming majority of the respondents, namely 93.7% (43.7% + 50.0%) agreed/strongly agreed that low morale is associated with low salaries in the PHS, and only one (6.3%) respondent disagreed (see figure 5.9).

Figure 5.9 DHC respondents' perception of low morale and low salaries (n=16)
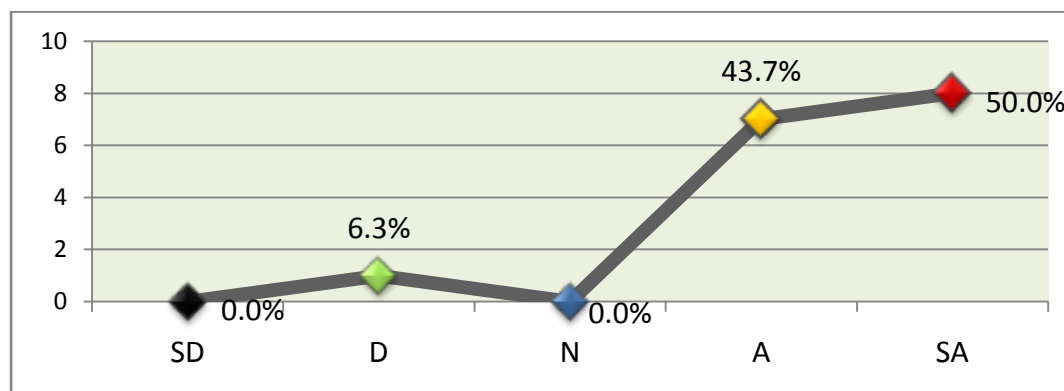
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This result gives the impression that salaries are a major source of discontent among RNs in the PHS. This supports the findings in figure 5.6 where 50.0% of the respondents disagreed that the OSD was a perfect solution for discontent because it seemed to have benefited only some nurses. This implies that where there is low morale, productivity and standards of excellence could be severely compromised, which raises serious concern.

5.4.1.21 RNs contribute to change in hospitals

This item investigated the respondents' perceptions of RNs' contributions towards changes in their establishments.

Of the respondents, 43.7% (37.5% + 6.2%) agreed/strongly agreed and 37.5% (6.2% + 31.3%) strongly disagreed/disagreed that RNs contribute to change in hospitals (see table 5.12).

Table 5.12 DHC respondents' perception of contributions to change in hospitals (n=16)

Response	SD	D	N	A	SA
Frequency	1	5	3	6	1
Percentage	6.2%	31.3%	18.8%	37.5%	6.2%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The result suggests a somewhat balanced working relationship between RNs and NSMs in DHC. This would seem to indicate that RNs participate meaningfully in collaboration with their nursing leaders at times and at other times are not included in some of the decisions, which could require hospital management only. The *Batho Pele* white paper encourages involvement of employees in important decisions that affect their organizations. Changes to which RNs can contribute ideas encompass expansion or extension of HCS, changes in visiting times, uniforms for nurses, and equipment necessary for accomplishing nursing responsibilities.

5.4.1.22 RNs are sponsored for conferences

This question sought the respondents' perceptions of financial support to attend conferences.

Of the respondents, 62.4% (25.0% + 37.4%) strongly disagreed/disagreed and a total of 12.6% (6.3% + 6.3%) agreed that RNs were sponsored to attend conferences, and 25.0% were not sure (see figure 5.10).

Figure 5.10 DHC respondents' knowledge of sponsorship for conferences (n=16)
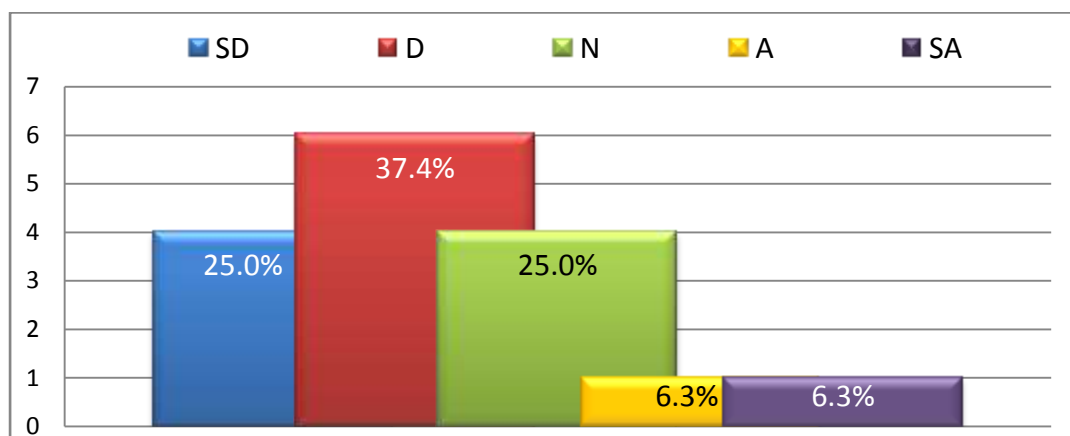
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

These results could imply that efforts have not been made to obtain financial support from organizations that could volunteer sponsorship, or that RNs are preoccupied with other commitments and working overtime. Nursing

conferences are informative and stimulating, and provide a platform for networking.

5.4.1.23 RNs are financed to do research

This item intended to establish if research in public hospitals received financial support.

Of the respondents, 33.3% agreed and 46.7% (26.7% + 20.0%) strongly disagreed/disagreed that nurses were financed to do research (see figure 5.11).

Figure 5.11 DHC respondents' perception of finance for research (n=15)
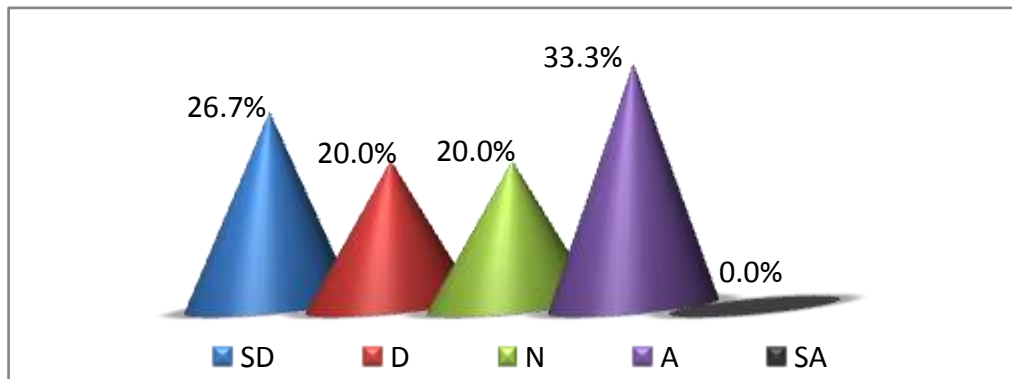
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From the majority who disagreed, it can be construed that there is inadequate support for research efforts in the PHS, particularly for RNs who have Masters and Doctoral degrees. There are researchable problems in hospitals. Forums for presentation of results could also be formed or nurses could join existing forums in the medical field where different perspectives could add value to nursing care.

5.4.1.24 Opportunities exist for registered nurses' career development

This item investigated the respondents' perceptions of opportunities for career development.

Of the respondents, 50.1% (31.3% + 18.8%) agreed/strongly agreed and 37.6% (18.8% + 18.8%) strongly disagreed/disagreed that there were opportunities for career development for nurses in the PHS (see table 5.13).

Table 5.13 DHC respondents' perception of opportunities for career development (n=16)

Response	SD	D	N	A	SA
Frequency	3	3	2	5	3
Percentage	18.8%	18.8%	12.5%	31.3%	18.8%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

These findings seem to imply that DHC attempted to assist RNs to ascend the career ladder by providing opportunities for career development.

5.4.1.25 RNs agree with their extended role as medical assistants

Of the respondents, 56.2% (31.2% + 25.0%) agreed/strongly agreed and 31.3% (6.3% + 25.0%) strongly disagreed/disagreed with the extended role as medical assistants (see table 5.14).

Table 5.14 DHC respondents' perception of extended role as medical assistants (n=16)

Response	SD	D	N	A	SA
Frequency	1	4	2	5	4
Percentage	6.3%	25.0%	12.5%	31.2%	25.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Since this was a district hospital, it could be that working closely with PHC services, the respondents had become familiar with the responsibilities and benefits entailed in these posts. More RNs might move to PHC services, particularly as the new salary scales attach several benefits for PHC RNs as a specialty. It should be borne in mind that this was not mandatory, but an open

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opportunity for interested RNs, who would be offered an additional one-year course to qualify for these positions.

SECTION C: Workplace violence in the PHS

5.4.1.26 Security system for nurses in the workplace is satisfactory

This question sought the respondents' perceptions of the state of security in public hospitals.

Of the respondents, 14 (87.5%) indicated that the security for nurses in DHC was not satisfactory, none (0.0%) indicated it was satisfactory, and two (12.5%) were not sure how to rate the state of security (see figure 5.12).

Figure 5.12 DHC respondents' perception of the security system (n=16)
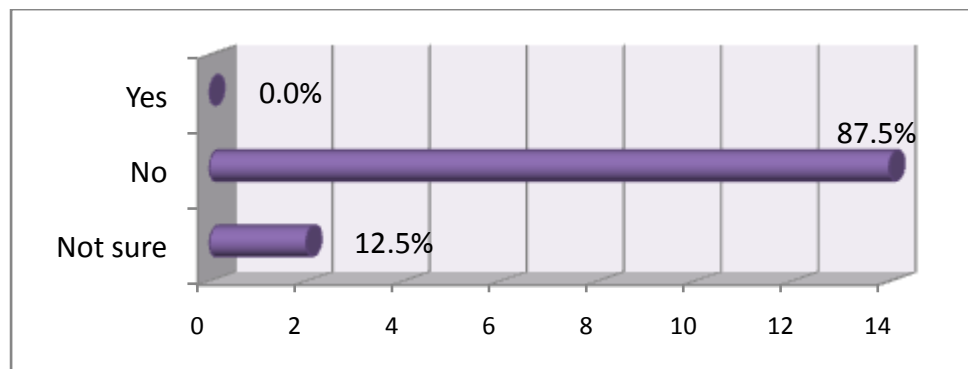
The findings indicate that security at DHC requires urgent attention. From this data, it can be deduced that very few nurses can endure unsafe conditions, particularly if their cars are vandalized during working hours; they are threatened during visiting times and have to walk long corridors on night duty. This could be one of the reasons why nurses leave the PHS.

5.4.1.27 Patients are safe in hospital under the current security system

Of the respondents, eight (50.0%) indicated that security for patients was also not adequate; four (25.0%) indicated that patients were safe in hospital, and four (25.0%) did not know (see figure 5.13).

Figure 5.13 DHC respondents' perception of patient safety in hospital (n=16)
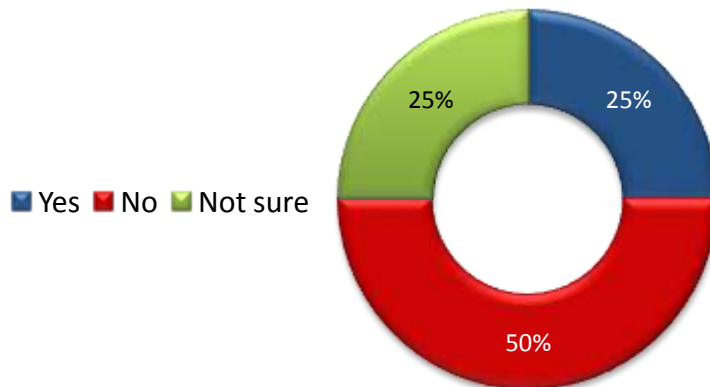
This result suggests that not only nurses are vulnerable, but patients' lives could be in danger, which reveals the urgency of providing adequate security.

SECTION D: Stress

5.4.1.28 Stress is intolerable among RNs in the PHS

The respondents were asked to indicate their experience of stress levels in the PHS.

Of the respondents, twelve (75.0%) agreed while three (18.8%) disagreed that stress had reached intolerable levels among RNs and one (6.3%) was not sure (see figure 5.14).

Figure 5.14 DHC respondents' perception of intolerable stress (n=16)
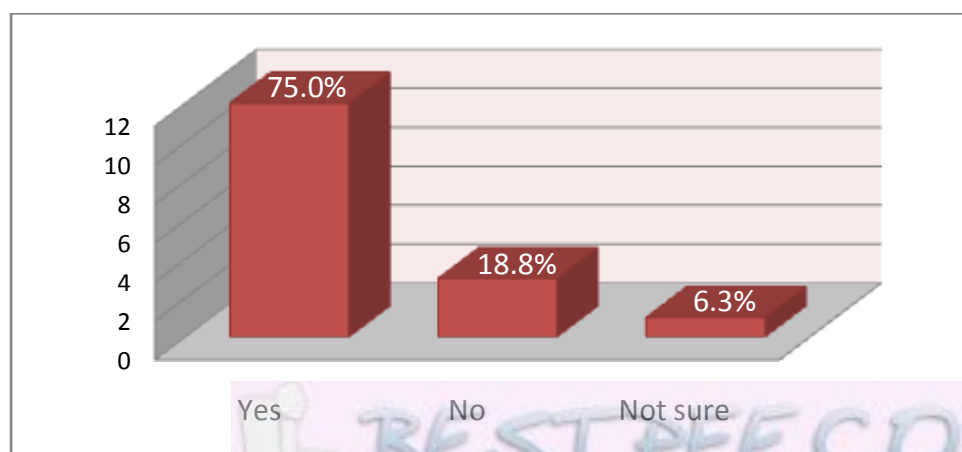
This finding implies that most RNs are stressed beyond resilience. This state is indicative of discontent with regard to factors that could be responsible for high levels of stress such as shortage of staff, lack of equipment, and inequitable salaries.

5.4.1.29 Have you personally used your vacation for resting?

Of the respondents, eight (50.0%) indicated that they had used their vacation to rest while eight (50.0%) had not (see figure 5.15).

Figure 5.15 DHC respondents' use of vacation for resting (n=16)
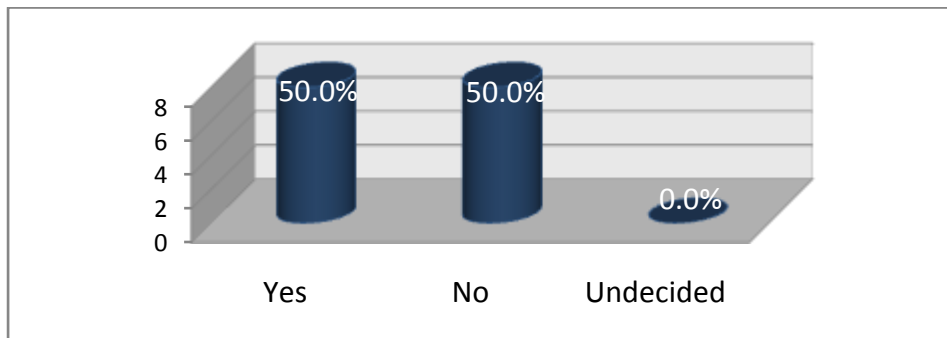
This suggests a serious situation if many pursue overtime opportunities to augment their salaries instead of taking time to rest. This supports the findings that stress in the workplace was intolerable, and low morale was largely due to low salaries (see figures 5.14 and 5.9). If fair measures to address nurses' salaries are not implemented, the PHS will continue to lose RNs to migration.

5.4.1.30 Nurses experience physical signs of exhaustion

The respondents were asked to indicate their experience of physical exhaustion.
Of the respondents, twelve (75.0%) indicated that they always experienced physical signs of exhaustion; four (25.0%) often did, and none (0.0%) never or occasionally did (see figure 5.16).

Figure 5.16 DHC respondents' experience of physical signs of exhaustion (n=16)
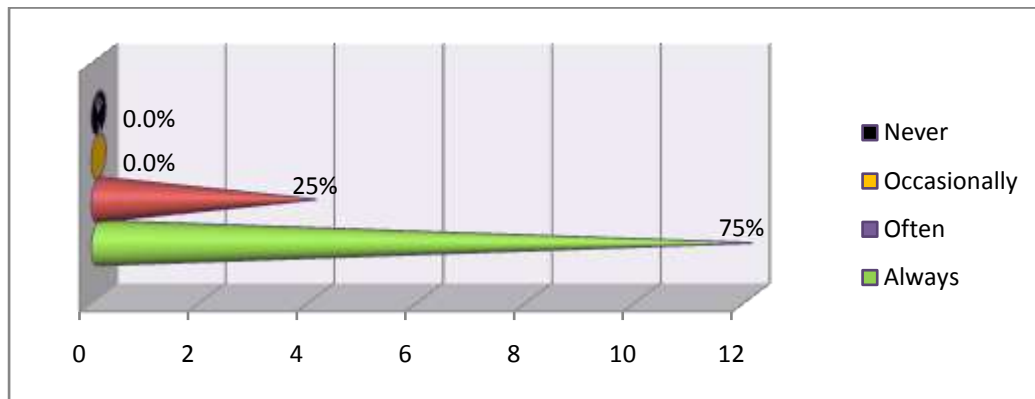
This concurs with the finding that half of the respondents did not use their vacation leave to rest, which led to the assumption that they used their vacation for working overtime (see figure 5.15). Working overtime should not be a problem for RNs, but the reason for doing so needs to be addressed. Shortage of staff and other problems in the workplace also contribute to physical exhaustion.

5.4.1.31 Do you have intentions to leave the PHS for other institutions?

Of the respondents, six (37.5%) indicated that they intended leaving the PHS; six (37.5%) did not, and four (25.0%) were undecided (see figure 5.17).

Figure 5.17 DHC respondents' intention to leave the PHS (n=16)
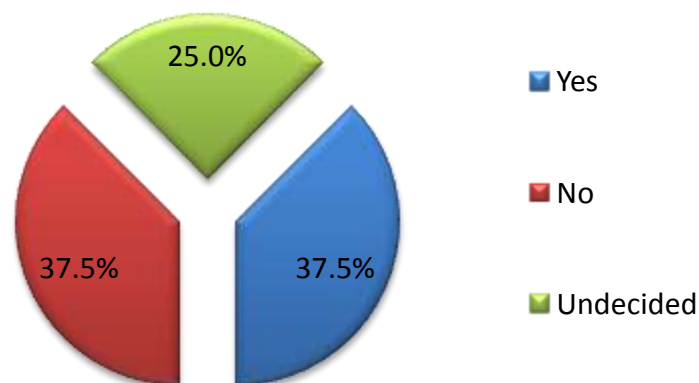
These findings support the respondents' experiencing physical signs of exhaustion, high levels of stress, and low morale largely due to poor salaries

(see figures 5.16, 5.14, and 5.9). These matters are of serious concern since PHS is already losing skilled and experienced staff in unprecedented numbers.

SECTION E: Management and leadership problems

5.4.1.32 NSMs still display bullying attitudes

This question sought the respondents' perceptions of nursing management's attitudes particularly after a major shift from bureaucratic practices and the implementation of the 1997 Batho Pele principles.

Of the respondents, 68.8% (25.0% + 43.8%) agreed/strongly agreed while 25.0% (18.8% + 6.2%) strongly disagreed/disagreed that some NSMs still displayed bullying attitudes towards RNs, and 6.2% did not know (see table 5.15).

Table 5.15 DHC respondents' perception of NSMs' bullying attitudes (n= 16)

Response	SD	D	N	A	SA
Frequency	3	1	1	4	7
Percentage	18.8%	6.2%	6.2%	25.0%	43.8%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This data then suggests strained relationships between RNs and NSMs, which could be one of the reasons why some nurses join unions and others leave the PHS.

5.4.1.33 Acknowledgement for outstanding contributions

Of the respondents, 57.1% (7.1% + 50.0%) strongly disagreed/disagreed and 14.2% (7.1+ 7.1%) strongly agreed/agreed that RNs were acknowledged for outstanding contributions, while 28.6% were not sure (see table 5.16).

Table 5.16 DHC respondents' perception of acknowledgement for outstanding contributions (n=14)

Response	SD	D	N	A	SA
Frequency	1	7	4	1	1
Percentage	7.1%	50.0%	28.6%	7.1%	7.1%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From these results, it can be surmised that some of the discontent emanated from this deficit, especially in areas where some over-extend themselves to improve the working place and facilitate delivery of quality care.

5.4.1.34 NSMs give feedback on problems reported

This question sought the respondents' perceptions of feedback mechanisms in the PHS.

Of the respondents, 53.3% (33.3% + 20.0%) strongly disagreed/disagreed and only 6.7% agreed that NSMs provided feedback on problems reported, and 40.0% did not know (see table 5.17). This is a potential source of discontent, especially if RNs have to deal with problems beyond their jurisdiction. That the majority of respondents were undecided, it could reveal a state of frustration or despondency due to failure to resolve issues.

Table 5.17 DHC respondents' experience of feedback on reported problems (n=15)

Response	SD	D	N	A	SA
Frequency	5	3	6	1	0
Percentage	33.3%	20.0%	40.0%	6.7%	0.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

5.4.1.35 RNs acknowledged for their sacrifices

Of the respondents, 66.7% (40.0% + 26.7%) strongly disagreed/disagreed and only 6.7% agreed that RNs were acknowledged for their sacrifices (see

table 5.18). These sacrifices could be in the form of forfeiting their tea and lunch breaks during busy times in their units. Due to a shortage of porters, RNs sometimes wheel patients to other departments for further examination or treatment. This is an area that needs acknowledgement.

Table 5.18 DHC respondents' perception of acknowledgement for sacrifices (n=15)

Response	SD	D	N	A	SA
Frequency	6	4	4	1	0
Percentage	40.0%	26.7%	26.7%	6.7%	0.0%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

5.4.1.36 Hospital management discuss problems with RNs

This question sought the respondents' perceptions of the extent of their involvement in problem-solving discussions.

Of the respondents, six (37.5%) agreed that hospital management discuss problems with RNs while eight (50.0%) disagreed, and two (12.5%) were not sure (see figure 5.18).

Figure 5.18 DHC respondents' perception of joint discussion of problems (n=16)
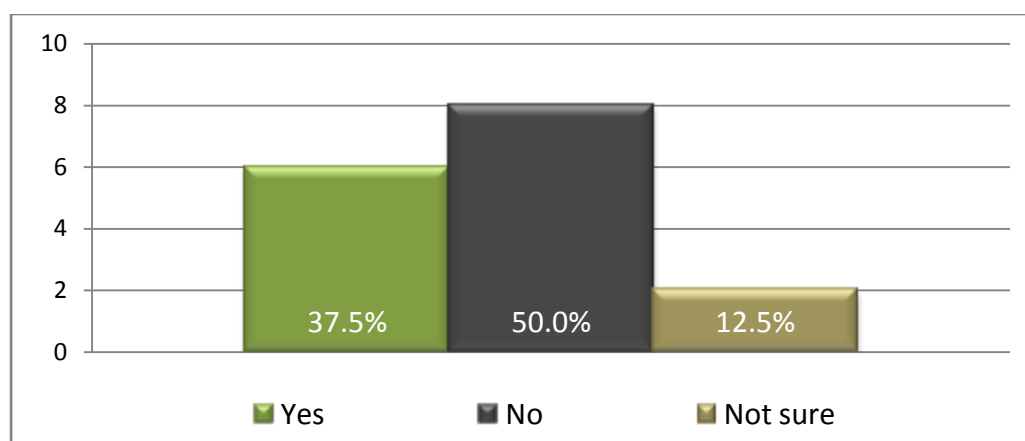
The results create a general impression of considerable discontent in DHC over salary issues, nurses' exclusion from discussions on hospital matters

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and problems affecting them, as well as collaboration with nursing leadership. This could be attributed to the unionization of the hospital with management feeling disempowered by the unions.

SECTION F: Registered Nurses and migration

This section examined the main reason for nurse migration from the PHS.

5.4.1.37 Nurse migration is due to inadequate salaries

Of the respondents, 62.5% indicated that inadequate salaries were an extremely important cause of migration; 31.3% indicated inadequate salaries as an important reason; 6.3% indicated this as a fairly important reason, and none (0.0%) indicated inadequate salaries as unimportant for migration (see figure 5.19). This emphasises that nurses' salaries need urgent and serious government attention.

Figure 5.19 DHC respondents' perception of inadequate salaries and migration (n=16)
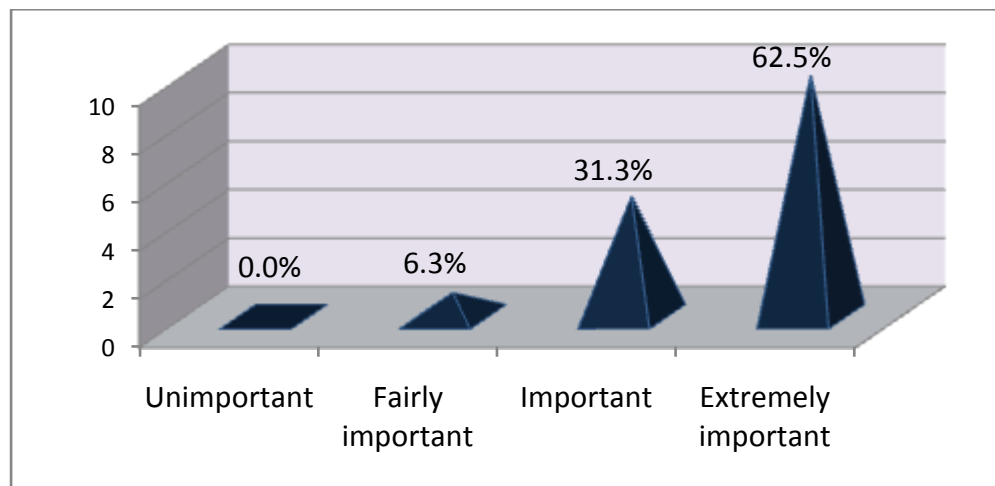
5.4.1.38 Poor leadership in nursing contributes to nurse migration

Of the respondents, five (31.3%) found poor leadership an extremely important reason for nurse migration; eight (50.0%) found it important; one

(6.3%) found it fairly important, and two (12.5%) found it unimportant for migration (see figure 5.20).

Figure 5.20 DHC respondents' perception of poor leadership and migration (n=16)
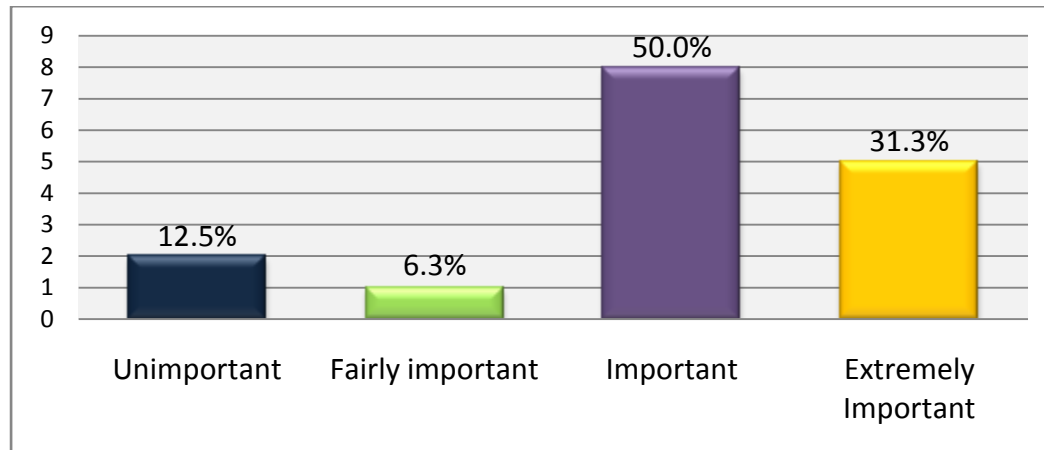
These results indicate that leadership is an essential aspect of HCS and should not be construed as mere administration or management, because how staff is treated and supported is important. This could also be why some RNs joined unions.

5.4.1.39 Poor working conditions lead to nurse migration

As a reason for nurse migration, 37.5% of the respondents found poor working conditions extremely important; 50.0% found them important; two (12.5%) found them fairly important, and none (0.0%) found them unimportant (see figure 5.21). These results clearly suggest that without improved working conditions, such as salaries, equipment and facilities, RNs will continue to migrate.

Figure 5.21 DHC respondents' view of poor working conditions (n= 16)
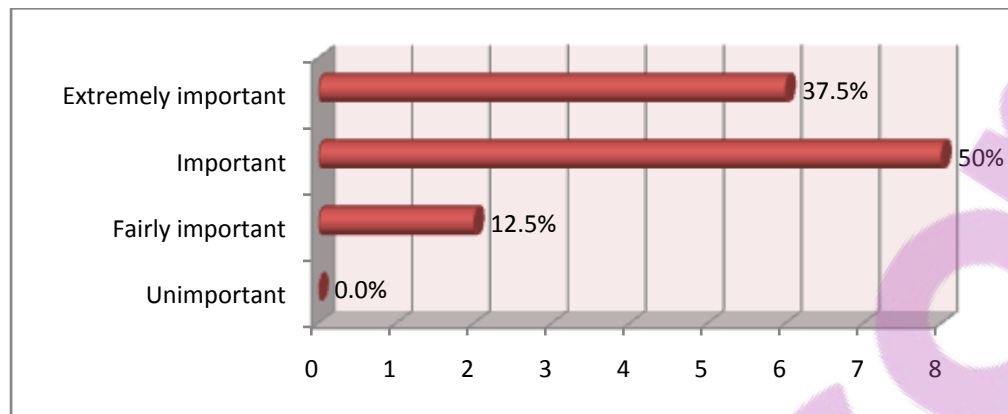
5.4.1.40 RNs migrate for "different" experience

Of the respondents, three (18.8%) found acquiring "different" experience an extremely important reason for migration; four (25.0%) found it important; seven (43.8%) found it fairly important, and two (12.5%) found it unimportant as a cause for nurse migration (see figure 5.22). This could imply that having tried several strategies to get help and effect change without success, nurses felt gaining "different" experience was the only solution. From the findings, however, it was concluded that this was not a prime reason for migrating.

Figure 5.22 DHC respondents' perception of migrating for "different" experience (n=16)
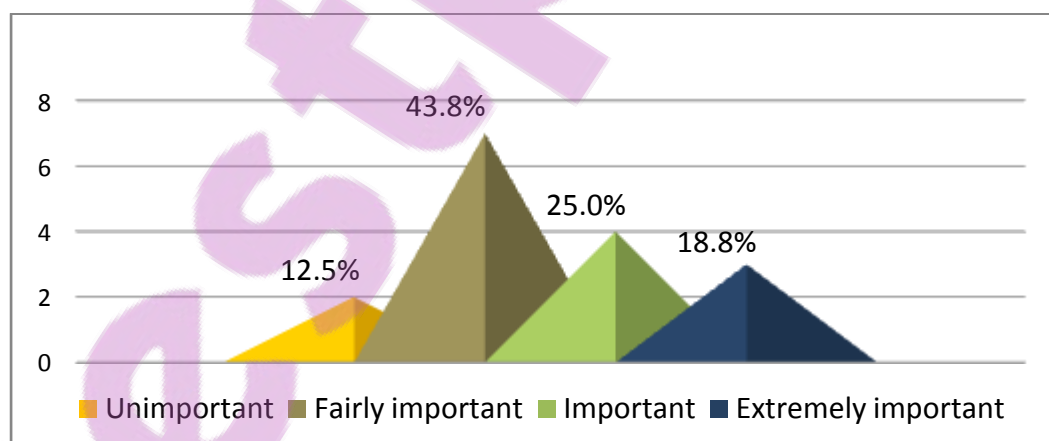
SECTION G: Nurses and strike actions

5.4.1.41 RNs prefer strikes to solve nurses' problems

Of the respondents, 13 (81.3%) agreed that nurses preferred strikes to solve nurses' problems, and three (18.8%) disagreed (see figure 5.23).

Figure 5.23 DHC respondents' perception of strikes to solve nurses' problems (n=16)
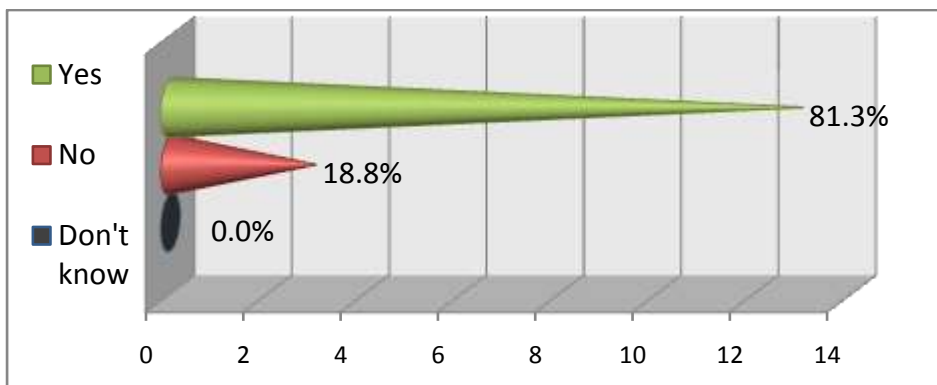
The majority of the respondents therefore preferred strikes to solve their problems, possibly due to the influence of unions in the PHS, and that they did not know any other way to convince government to respond to the concerns. This position is an important indicator that could denote the determination of RNs to engage in strike actions to solve nurses' problems; probably due to lack of effective leadership in nursing or other avenues they could exploit. It should be noted that even though it is nurses constitutional right to join unions, the constitution does not deny them the right to organize themselves into one group, which could be one of the ways they could be effective in charting the way forward for the nursing profession.

5.4.1.42 Registered nurses and unions share same values regarding patient care

Of the respondents, eight (50.0%) agreed that RNs and unions shared the same values regarding patient care in this hospital; six (37.5%) disagreed, and two (12.5%) did not know (see figure 5.24).

Figure 5.24 DHC respondents' perceptions of unions and nurses shared values (n= 16)
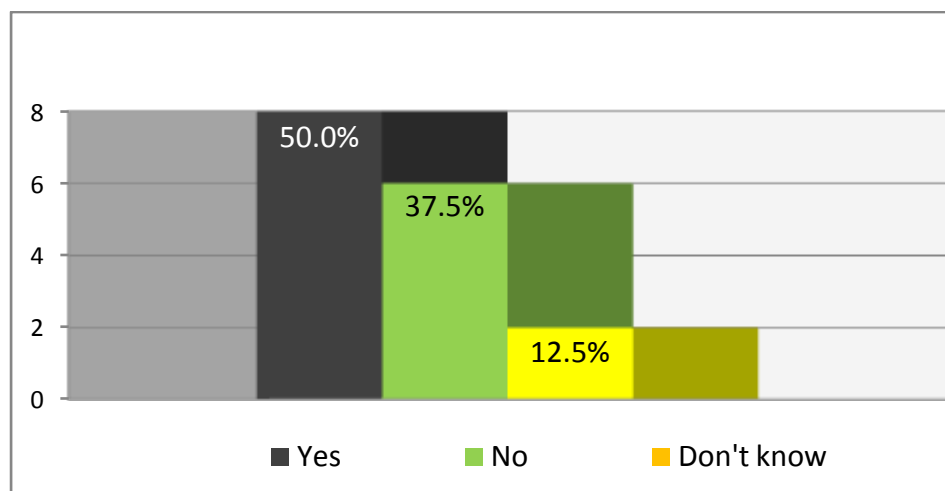
Most of the respondents, then, were of the opinion that their values were consistent with those of unions in DHC. Since the rules governing strike actions sometimes require that nurses leave patients, a move in sharp contrast to nurses' values regarding patient care, this appears to present an ethical dilemma where RNs are caught between two conflicting opinions.

5.4.1.43 RNs support division between unions and professional associations

This question sought the respondents' perceptions of the division between unions and professional associations.

Of the respondents, seven (43.8%) did not support the division between professional associations and unions while four (25.0%) did, and five (31.3%) did not know (see figure 5.25).

Figure 5.25 DHC respondents' perception of division between unions and professional associations (n=16)
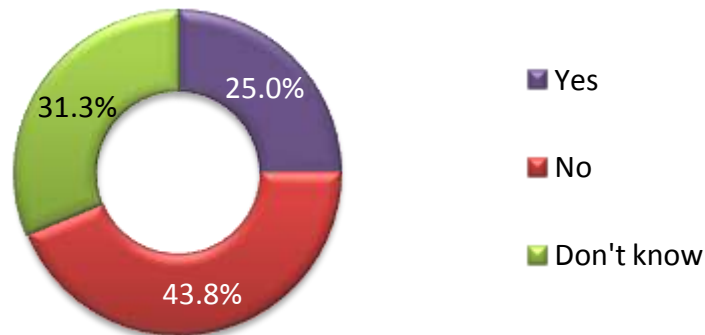
This finding contrasted with those in item 5.4.1.42, and could imply that RNs still express a desire for a united nursing fraternity.

SECTION H: Nurses and politics

This section investigated the respondents' perceptions of politics in relation to healthcare delivery and the nursing profession.

5.4.1.44 Poor nurse representation in government contributes to migration

Of the respondents, 11 (78.6%) agreed and five (21.4%) disagreed that poor nurse representation in government contributed to migration figure 5.26).

Figure 5.26 DHC respondents' view of poor nurse representation in government (n=14)
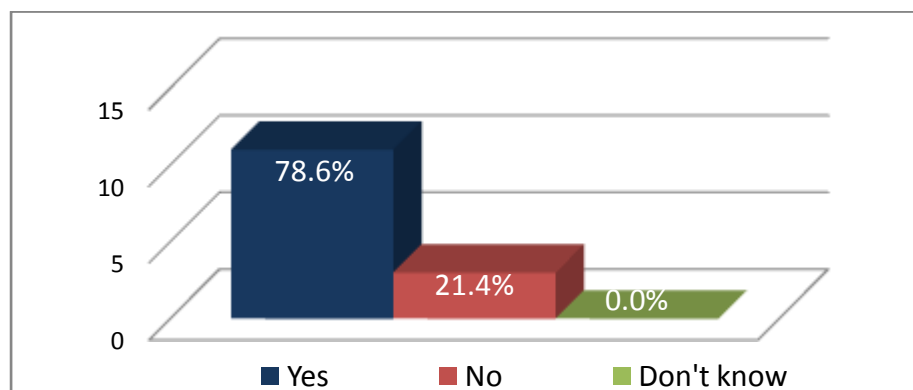
This finding could indicate awareness that strong representation is required for them at government level. Although unions and professional associations currently represent nurses, the findings in figure 5.25 revealed that the majority (43.8%) disagreed with the division between them. This could indicate the respondents' desire for nurses to be united again.

5.4.1.45 RNs vote for parties that add value to nursing

Of the respondents, 56.3% (18.8% + 37.5%) strongly disagreed/disagreed while 31.3% (6.3% + 25.0%) agreed/strongly agreed that RNs voted for parties that added value to nursing, 12.5% did not know (see figure 5.27). These findings suggest that many RNs do not consider political parties that add value to nursing, possibly due to lack of political astuteness because the nursing curriculum does not include political science. This kind of educational preparation could assist nurses to make informed choices.

Figure 5.27 DHC respondents' perception of voting for parties that add value (n=16)
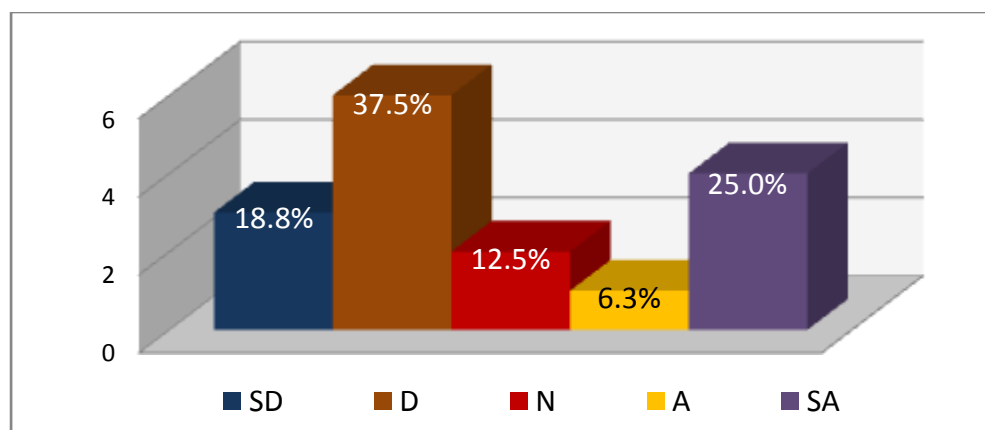
This finding therefore creates the impression that most nurses are not well informed about the importance of voting for parties that support nursing issues. This was also supported by the eight (30.8%) respondents who were not sure whether nurses voted for parties that add value to nursing, revealing possible lack of political astuteness.

5.4.1.46 Nurses' issues are entertained in political debates

Of the respondents, 62.6% (31.3% + 31.3%) strongly disagreed/disagreed, 12.4% (6.2% + 6.2%) strongly agreed/agreed and 25.0% were undecided that nurses' issues were entertained in political debates (see table 5.19).

Table 5.19 DHC respondents' perceptions of nurses' issues in political debates (n=16)

Response	SD	D	N	A	SA
Frequency	5	5	4	1	1
Percentage	31.3%	31.3%	25.0%	6.2%	6.2%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The finding that the majority disagreed clearly indicates that nurses' issues are not entertained in political debates. This could be attributed to budget restrictions, inequitable salary structures and other issues nurses still struggle with. This finding is consistent with reality in that if nurses' issues are entertained in political debates, these decisions would clearly be manifested and implemented in HCS.

5.4.1.47 RNs can become policy analysts in South Africa

Of the respondents, 68.8% (31.3% + 37.5%) strongly agreed/agreed and 18.8% (6.3% + 12.5%) strongly disagreed/disagreed, while two (12.5%) were undecided two (12.5%) were undecided that, given the right educational preparation, RNs could become policy analysts in the RSA (see figure 5.28).

Figure 5.28 DHC respondents' perceptions of RNs as policy analysts (n=16)
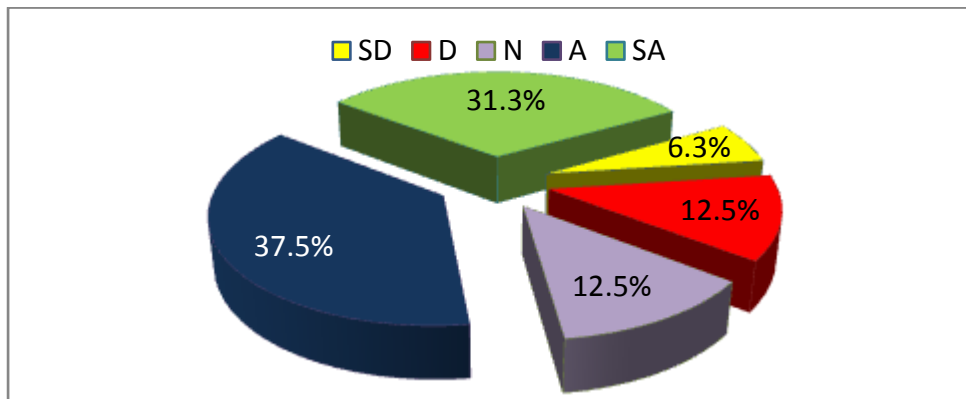
The finding revealed that the respondents agreed that RNs could become policy analysts in the RSA. This suggests that RNs are confident that they could become policy analysts if given the opportunity and the right educational preparation.

5.4.1.48 RNs know how policies are made in government

Of the respondents, 50.0% (31.3% + 18.7%) strongly disagreed/disagreed and 18.7% agreed that nurses know how policies are made at government level, while 31.3% were undecided (see figure 5.29).

Figure 5.29 DHC respondents' knowledge of policy-making at government level (n=16)
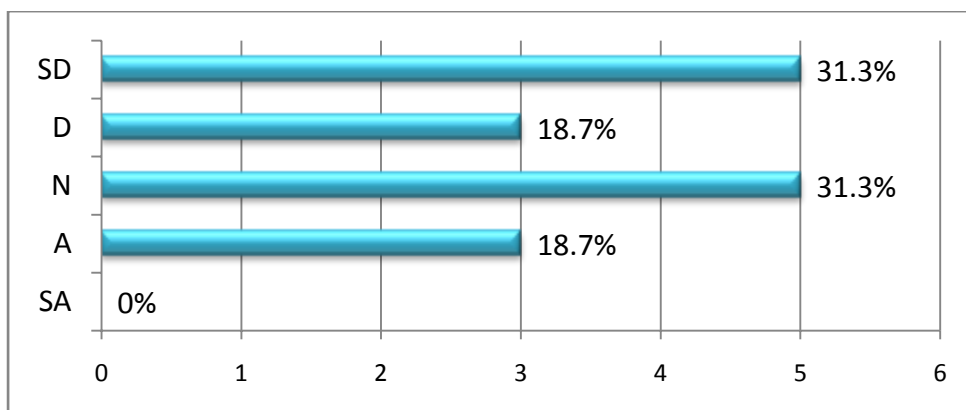
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding revealed a possible deficit in RNs' knowledge on how policies are made at government level, since the current curriculum for nurses does not include political science.

5.4.1.49 RNs can influence policy making

Of the respondents, 75.0% (25.0% + 50.0%) agreed/strongly agreed and only 12.5% disagreed that nurses could influence policy making on health issues (see figure 5.30).

Figure 5.30 DHC respondents' perception of RNs influence on policy making (n=16)
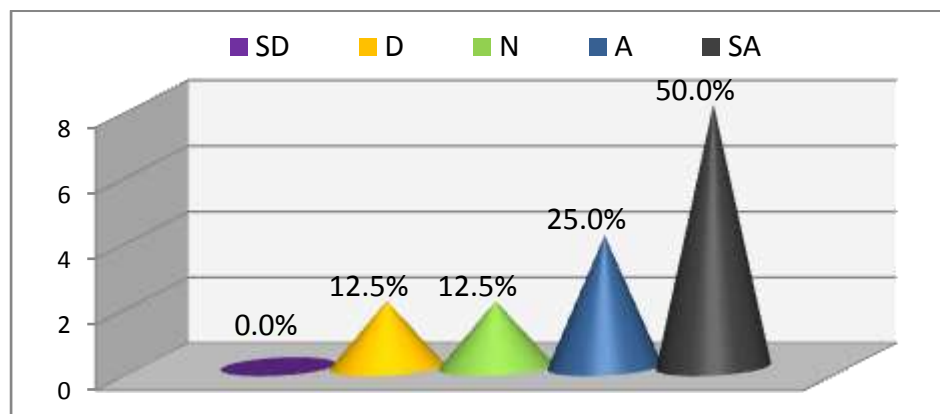
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This could be an indication that RNs generally wish to be empowered to influence policy making politically. This further suggests that the nursing curriculum should incorporate political science as a subject for interested students.

5.4.2 Qualitative data analysis for District Hospital "C" (DHC)

Most of the respondents provided written narratives in some questionnaire items, which are discussed in chapter 6.

5.5 A COMPARISON OF THE HOSPITALS IN THE DISTRICT CLUSTER

This section compares the three hospitals in the cluster of district hospitals in Tshwane Metropolitan area, with the use of percentages, tables and bar charts. It should be noted that Pearson's correlation co-efficient was not used to compare age, race, qualifications and variances on the statistician's advice. The reason for this is that the study used an in-depth method triangulation to analyse and present data for each individual hospital.

5.5.1 Comparison of responses from district hospitals "A", "B" and "C" (DHA, DHB and DHC)

(NB: DC in tables and figures indicates District Cluster.)

SECTION A: Demographic information

5.5.1.1 Age distribution

Table 5.1 DC respondents' ages (n= 65)

Hospital	Frequency	Percentage						
		18-25	26-33	34-41	42-49	50-57	58-65	65-72
DHA	23	8.7	26.1	39.1	17.4	8.7	0.0	0.0
DHB	27	3.7	26.0	26.0	22.2	18.5	3.7	0.0
DHC	15	13.3	26.7	26.7	33.3	0.0	0.0	0.0
Average	21.7	8.6	26.3	30.6	24.3	9.1	1.2	0.0

Figure 5.1 DC respondents' ages

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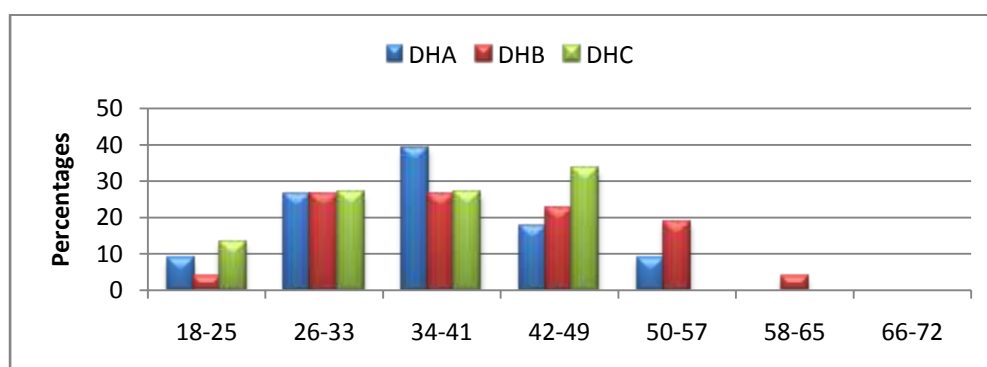
All three hospitals start from 18-25 years, but DHB concludes with 58-65 years. Most of the respondents are 34-41 and 26-33 years old, followed by 42-49 years. Data reveals that there were more middle aged RNs in all three hospitals, which could be the reason for migration and strike actions in the PHS because of the experience and skills acquired over the years.

5.5.1.2 Race

Table 5.2 DC respondents' races (n= 66)

Hospital	Frequency	Percentage				
		Black	**Coloured**	**Asian**	**White**	**Other**
DHA	23	73.9	0.0	0.0	6.0	0.0
DHB	27	100	0.0	0.0	0.0	0.0
DHC	16	93.8	6.3	0.0	0.0	0.0
Average	22.0	89.2	2.1	0.0	2.0	0.0

Figure 5.2 DC respondents' races
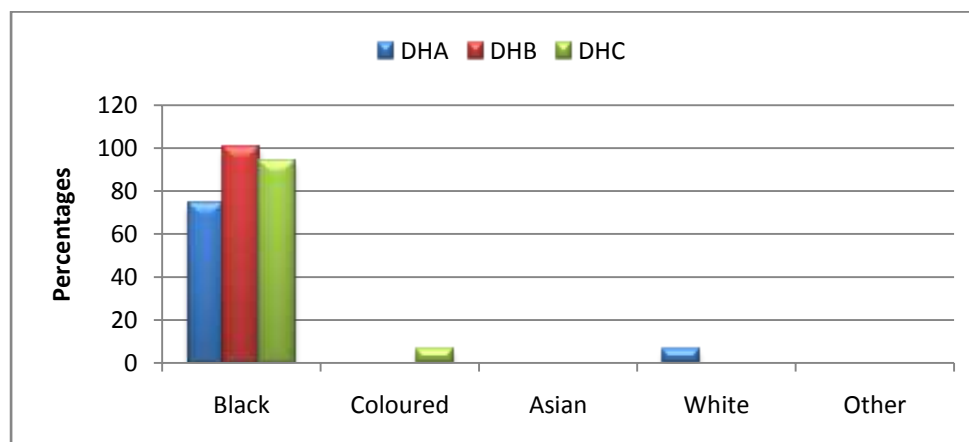
DHB had only Black respondents (100.0%), DHC had an overwhelming majority of Black respondents (93.8%), and DHA had predominantly Black respondents (73.9%). Only DHC had Coloured respondents (6.3%) and DHA was the only one with White respondents (6.0%). There were no Asian respondents in this district cluster.

5.5.1.3 Gender

Table 5.3 DC respondents' gender (n= 64)

Hospital	Frequency	Percentage	
		Male	**Female**
DHA	22	9.1	90.9
DHB	26	3.8	96.2
DHC	16	6.3	93.8
Average	21.3	6.4	93.6

Figure 5.3 DC respondents' gender
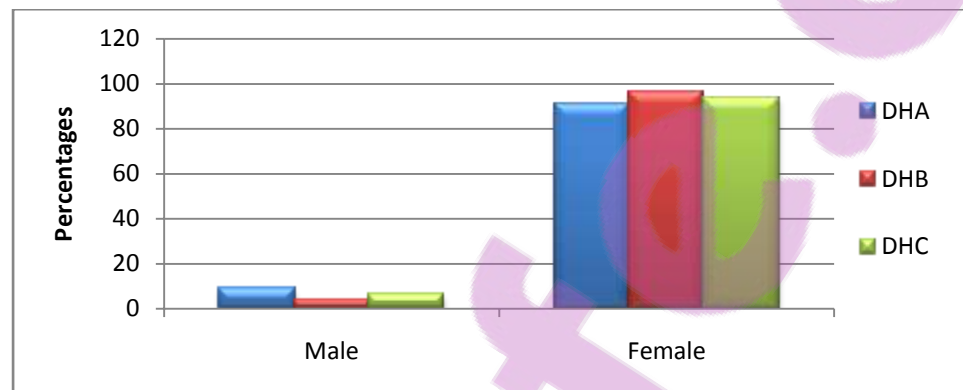
Female respondents outnumbered males in all the district hospitals. DHA had the most Black males (9.1%), followed by DHC (6.3%) and lastly DHB (3.8%). Regarding female respondents, DHB had 96.2%; DHC had 93.8%, and DHA had 90.9% in this study.

5.5.1.4 Marital status

Table 5.4 DC respondents' marital status (n= 65)

Hospital	Frequency	Percentage			
		Single	**Married**	**Divorced**	**Widowed**
DHA	23	43.5	43.5	13.0	0.0
DHB	26	38.5	53.8	0.0	7.7
DHC	16	43.8	50.0	6.3	0.0
Average	21.7	41.9	49.1	6.4	2.6

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Figure 5.4 DC respondents' marital status
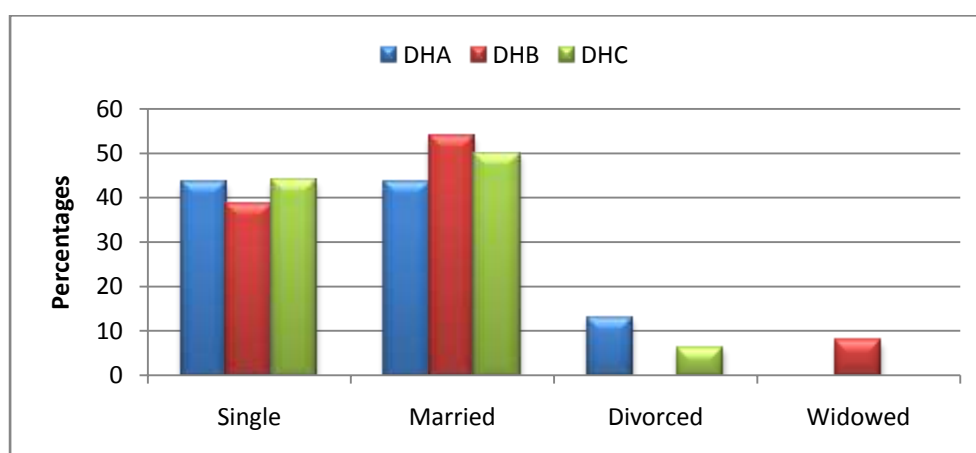
The majority of the respondents were married. DHB had 53.8%; DHC had 50.0%, and DHA had 43.5%. In respect of single respondents, DHC had 43.8%; DHA had 43.5%, and DHB had 38.5%. DHA had 13.0% and DHC had 6.3% divorced respondents. Only DHB had widowed respondents (7.7%). All categories of respondents represented in the above table and figure indicate the need for better salaries and conditions of service for a better living.

5.5.1.5 Number of dependants

Table 5.5 DC respondents' number of dependants (n= 65)

Hospital	Frequency	Percentage		
		None	1 – 3	> 3
DHA	23	26.1	73.9	0.0
DHB	26	7.7	88.5	3.8
DHC	16	31.3	62.5	6.4
Average	21.7	21.7	75.0	3.4

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Figure 5.5 DC respondents' number of dependants
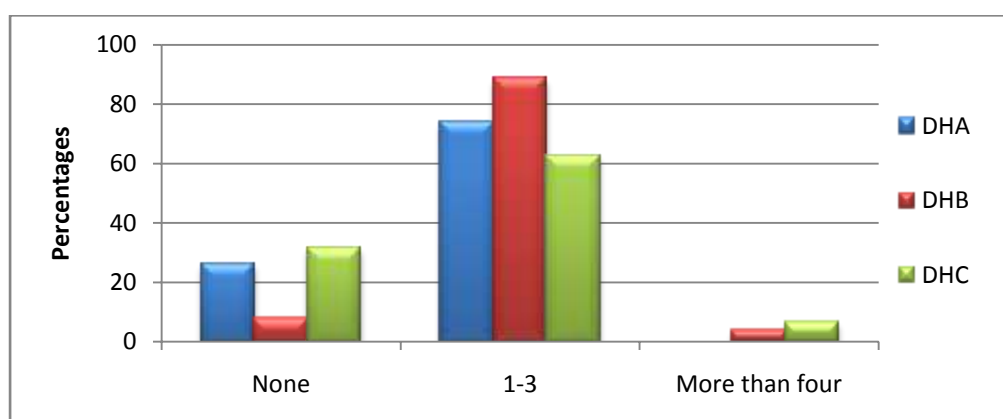
Regarding respondents with no dependants, DHC had 31.3%; DHA had 26.1%, and DHB had only 7.7%. DHB had 88.5%, DHA had 73.9%, and DHC had 62.5% respondents with 1-3 dependants. Regarding respondents with four or more dependants, DHC had 6.4% and DHB had 3.8%. Therefore, the majority of respondents had 1-3 dependants, which require reasonable salaries that can sustain families, and also that match their qualifications.

5.5.1.6 Residential area

Table 5.6 DC respondents' residential area (n= 66)

Hospital	Frequency	Percentage			
		City/Town	Township	Village	Informal settlement
DHA	23	73.9	21.7	4.3	0.0
DHB	27	35.7	60.7	0.0	3.1
DHC	16	37.5	56.3	6.3	0.0
Average	22.0	49.0	46.2	3.5	1.0

Figure 5.6 DC respondents' residential area
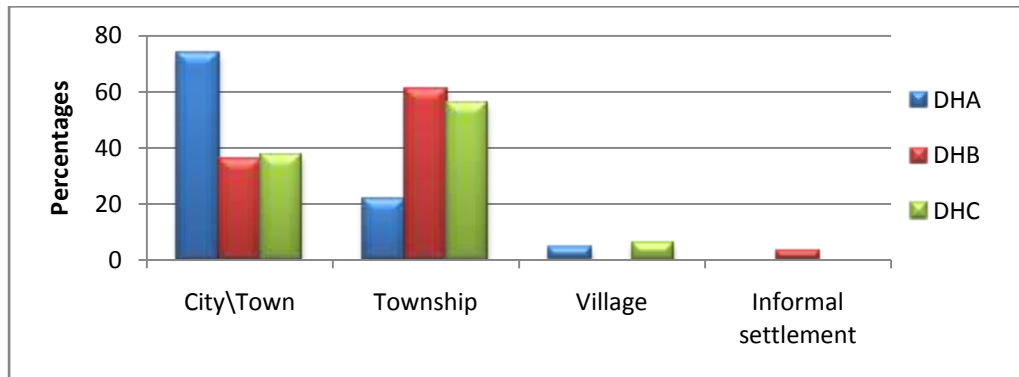
Most of the respondents resided in town and townships. DHA and DHC had a few respondents from villages, while only DHB had respondents from an informal settlement. Regardless of the respondents' residential area, the study notes that affordability and appropriate salaries are necessary for RNs, which could be the reason behind unprecedented migration and strike actions.

5.5.1.7 Type of health care service

Table 5.7 DC respondents' type of PHS (n= 66)

Hospital	Frequency	Percentage
DHA	23	100
DHB	27	100
DHC	16	100

Figure 5.7 DC respondents' type of PHS
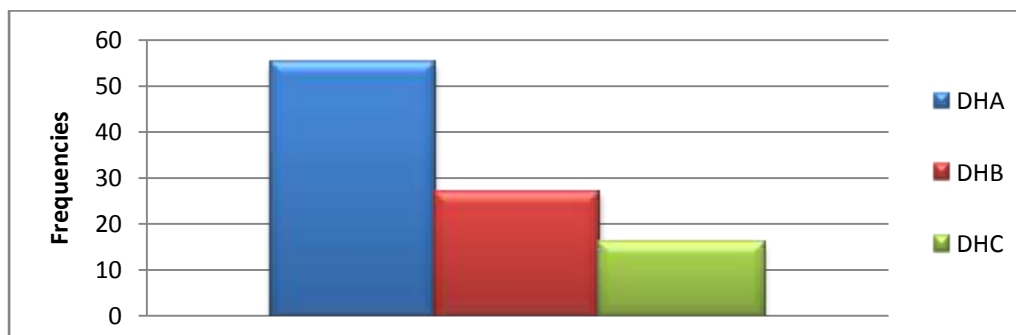
All the respondents worked in the PHS in district hospitals: DHA had 23; DHB had 27, and DHC had 16 respondents.

5.5.1.8 Positions

Table 5.8 DC respondents' positions held at hospital (n= 64)

Hospital	Frequency	Percentage		
		CPN	SPN	PN
DHA	21	28.6	14.3	57.1
DHB	27	26.0	33.3	40.7
DHC	16	18.8	25.0	56.2
Average	21.3	24.5	24.2	51.3

Key: CPN = chief professional nurse; SPN = senior professional nurse; PN = professional nurse

Figure 5.8 DC respondents' positions held at hospital
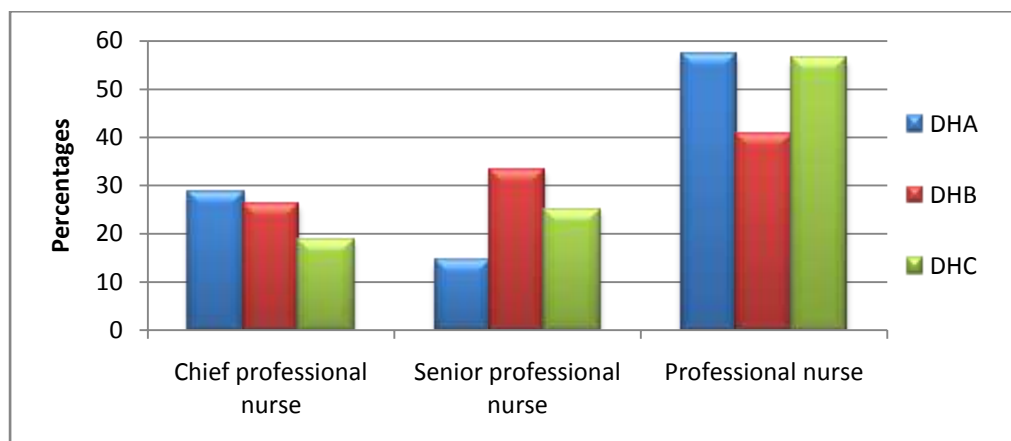
DHA had 28.6% CPNs, 14.3% SPNs, and 57.1% PNs. DHB had 26.0% CPNs, 33.3% SPNs, and 40.7% PNs. DHC had 18.8% CPNs, 25.0% SPNs, and 56.2% PNs. Most of the respondents in all three hospitals were PNs.

5.5.1.9 Years of experience since registration

Table 5.9 DC respondents' years of experience (n= 65)

Hospital	Frequency	Percentage						
		1-5	6-10	11-20	21-30	31-40	41-50	51-60
DHA	22	31.8	18.2	36.4	9.1	4.5	0.0	0.0
DHB	27	29.6	22.2	33.3	11.1	3.7	0.0	0.0
DHC	16	50.0	31.3	18.7	0.0	0.0	0.0	0.0
Average	21.8	37.1	23.9	29.5	6.7	2.7	0.0	0.0

Figure 5.9 DC respondents' years of experience
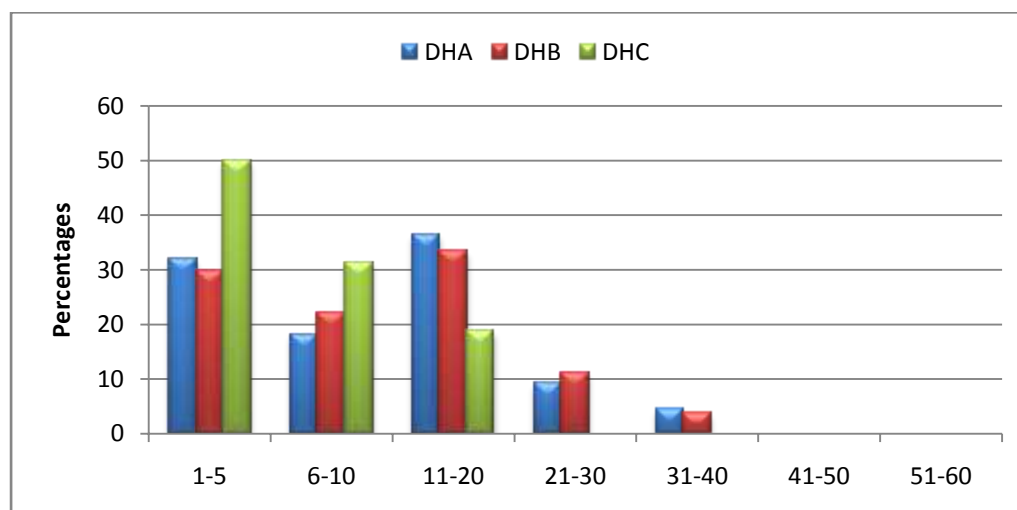
DHC had more respondents with 1-5 and 6-10 years' experience. DHA had more respondents with 11-20 years' experience, and also dominated the others. DHB had 11.1% and DHA had 9.1% respondents with 21-30 years' experience. DHA had 4.5% and DHB had 3.7% respondents with 31-40 years' experience. None of the hospitals had respondents with 41-60 years of experience since registration with SANC. Experience seemed to be a valuable asset to RNs, therefore, most would consider migration in order to sell their skills elsewhere, particularly if their expectations have not been met.

5.5.1.10 Qualifications

Table 5.10 DC respondents' qualifications (n= 63)

Hospital	Frequency	Percentage						
		BND	Post-BND	Basic 4-year nursing degree	BA Cur	Honours	M	D
DHA	21	33.3	38.1	4.8	19.0	4.8	0.0	0.0
DHB	27	51.9	25.9	18.5	3.7	0.0	0.0	0.0
DHC	15	40.0	6.7	33.3	20.0	0.0	0.0	0.0
Average	21.0	41.7	23.6	18.9	14.3	1.6	0.0	0.0

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Figure 5.10 DC respondents' qualifications
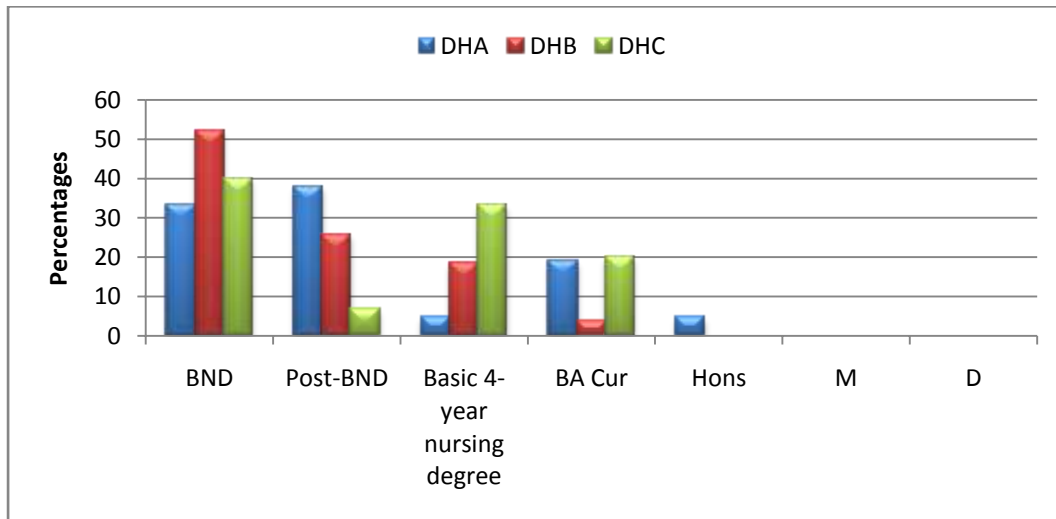
The statistics revealed that DHB had the most respondents with BND; DHA had the most with Post-BND; DHC had the most with a Basic 4-year nursing degree; only DHA had respondents with an Honours degree; and all three hospitals had respondents with a BA Cur degree. The number of academic qualifications in this data reveals a need for a reward system commensurate to the time and effort, similar to post-BND remunerations.

SECTION B: Transformation of health care services

5.5.1.11 PHS transformation has been successful

Table 5.11 DC respondents' perception of successful transformation (n=61)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	21	14.3	80.9	4.8
DHB	25	40.0	56.0	4.0
DHC	15	33.3	66.7	0.0
Average	20.3	29.2	67.9	2.9

Figure 5.11 DC respondents' perception of successful transformation
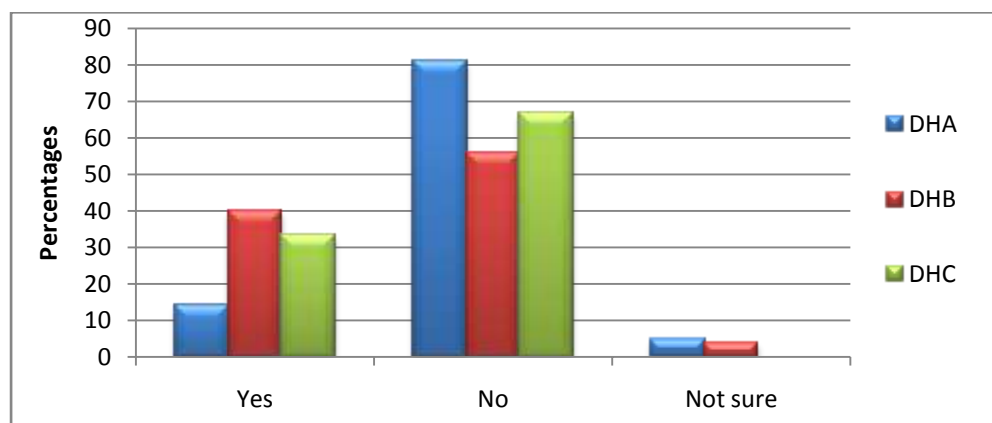
The majority of the respondents in all three district hospitals disagreed that transformational initiatives were successful in the PHS. DHA had 80.9%; DHC had 66.7%, and DHB had 56.0%. DHB had 40.0% and DHC had 33.3% respondents who agreed, giving the impression that some were satisfied with the progress made in their hospitals. DHA only had 14.3% thus revealing a high level of discontent, which seemed to imply that not much had happened in the hospital. Five respondents did not answer this item.

5.5.1.12 Promotions are allocated fairly in the public health sector

Table 5.12 DC respondents' perception of promotions equitable (n= 66)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	23	13.0	65.2	21.7
DHB	27	11.1	55.6	33.3
DHC	16	18.8	75.0	6.2
Average	22.0	14.3	65.3	20.4

Figure 5.12 DC respondents' perceptions of promotions equitable
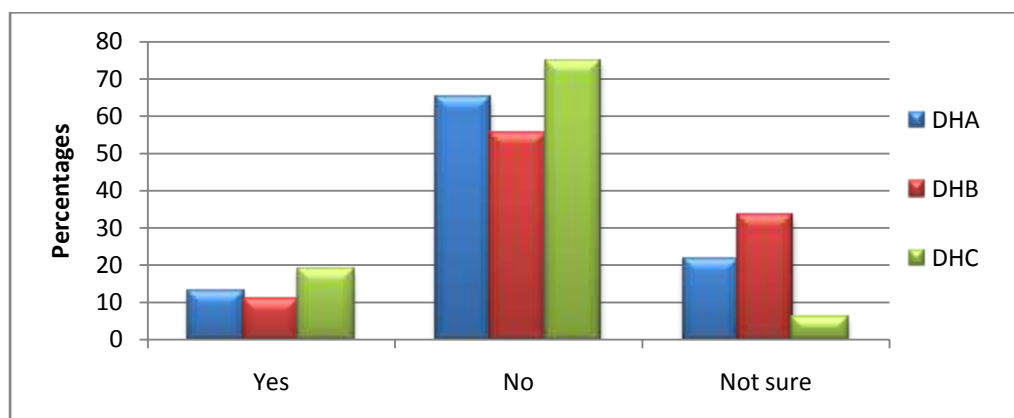
The findings revealed that most of the DC respondents disagreed that promotions in the PHS were allocated in a fair manner. DHC had 75.0%, DHA had 65.2%, and DHB had 55.6% who disagreed. From this finding, DHB seemed to be less discontent than the other two. Among those who agreed that promotions were equitable, DHC had 18.8%, DHA had 13.0%, and DHB had 11.1%.

5.5.1.13 Young South Africans are attracted to nursing

Table 5.13 DC respondents' perceptions of youth attracted to nursing (n= 65)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	36.4	54.5	9.1
DHB	27	29.6	44.4	26.0
DHC	16	50.0	50.0	0.0
Average	21.7	38.7	49.6	11.7

Figure 5.13 DC respondents' perceptions of youth attracted to nursing
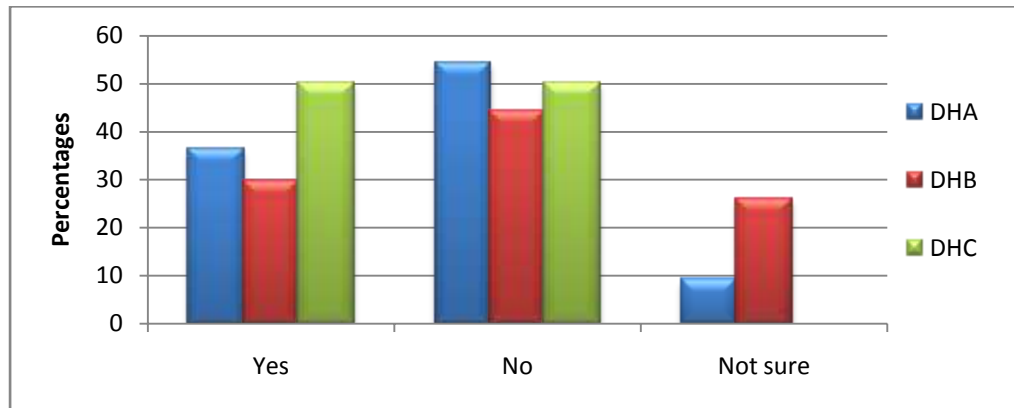
DHA had 54.5%, DHC had 50.0%, and DHB had 44.4% of respondents who disagreed that the youth were attracted to the nursing profession. These were more than those who agreed. DHC had 50.0%, DHA had 36.4%, and DHB had 29.6% of respondents who agreed that the youth were attracted to the nursing profession. The majority that disagreed, however, would seem to imply negative impressions in the public about the nursing profession.

5.5.1.14 A national workforce forum investigates nurses' issues

Table 5.14 DC respondents' knowledge of national nursing forum (n= 63)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	20	15.0	40.0	45.0
DHB	27	11.1	33.3	55.6
DHC	16	31.3	43.8	25.0
Average	21.0	19.1	39.0	41.9

Figure 5.14 DC respondents' knowledge of national nursing forum
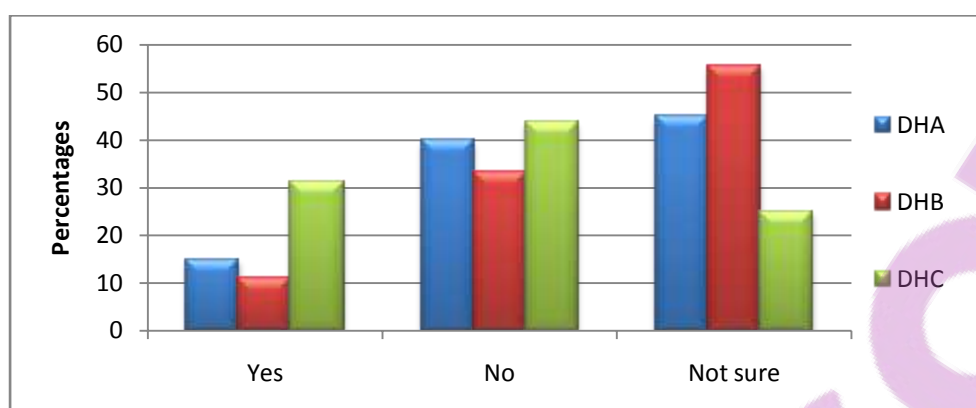
The data revealed that the majority of respondents in all three hospitals disagreed that a national workforce exists to investigate nurses' issues. DHC had 43.8%, DHA had 40.0%, and DHC had 33.3% respondents who disagreed. DHC had 31.3%, DHA had 15.0%, and DHB had 11.1% respondents who agreed.

The number of respondents who were not sure is of grave concern, as it seems to suggest that nurses in general do not have surety or confidence in existing groups that represent their interests, or do not know what to do with their problems.

5.2.1.15 Employing body communicates with nurses

Table 5.15 DC respondents' perception of communication with nurses (n=61)

Hospital	Frequency	Percentage			
		Never	Occasionally	Frequently	Always
DHA	20	65.0	30.0	5.0	0.0
DHB	26	34.6	57.7	0.0	7.7
DHC	15	46.7	46.7	6.6	0.0
Average	20.3	48.8	44.8	3.9	2.6

Figure 5.15 DC respondents' perception of communication with nurses
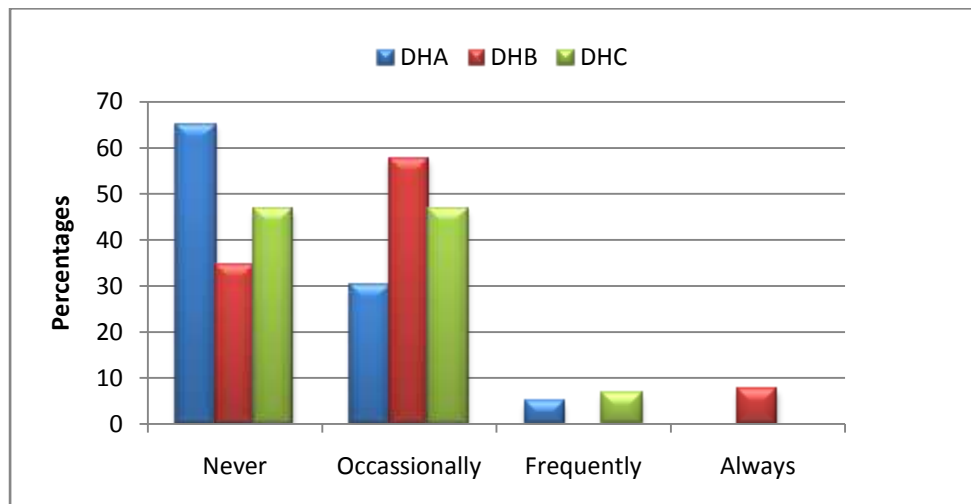
The research findings revealed that DHA had 65.0% in the "never" column, DHC had 46.7%, and DHB had 34.6%, which suggest a serious communication gap between government and the nurses.

In the "occasionally" column, DHB had 57.7%, DHC had 46.7%, and DHA had 30.0%, signifying minimal communication between provincial government and nurses.

In the "frequently" column, DHC had 6.6%, DHA had 5.0%, and DHB had 0.0%, which would indicate no regular communication between government and nurses, particularly at the production level.

In the "always" column, DHB was the only hospital with responses (7.7%), which appears to be a serious omission, signifying that communication between government and nurses had possibly been left to the unions.

5.5.1.16 The Occupational Specific Dispensation (OSD) is a perfect solution for discontent

Table 5.16 DC respondents' perception of the OSD as solution (n= 64)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	21	23.8	57.1	19.1
DHB	27	33.3	44.5	22.2
DHC	16	12.5	50.0	37.5
Average	21.3	23.2	50.5	26.3

Figure 5.16 DC respondents' perception of the OSD as solution
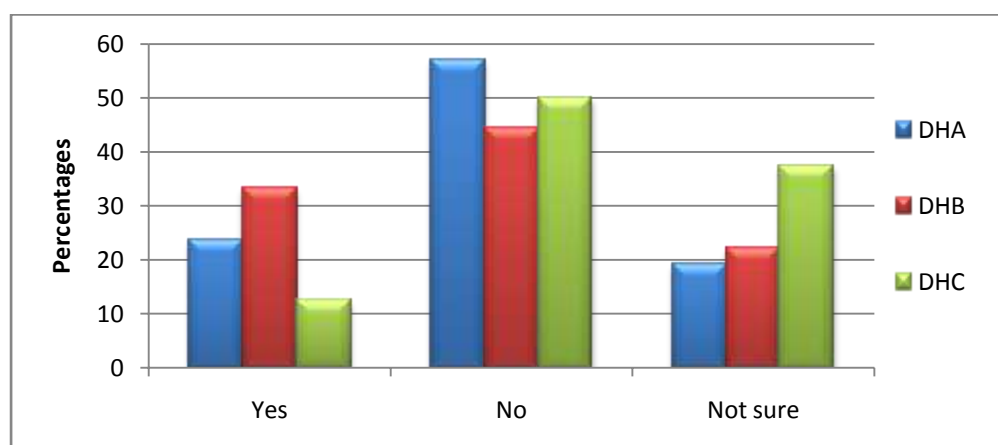
The findings revealed that all the DC respondents disagreed that the OSD was a perfect solution for discontent among RNs in the PHS. DHA had 57.1%, DHC had 50.0%, and DHB 44.5% respondents who disagreed. DHB had 33.3%, DHA had 23.8%, and DHC had 12.5% respondents who agreed. The study also revealed that DHC had the highest number of respondents who were unsure. This group is of concern because it might indicate lack of information regarding the implementation of the OSD.

5.5.1.17 All stakeholders agree on the Occupational Specific Dispensation

Table 5.17 DC respondents' perception of consensus on OSD (n= 64)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	13.6	63.6	22.7
DHB	27	18.5	33.3	48.1
DHC	15	6.7	66.7	26.6
Average	21.3	12.9	54.5	32.5

Figure 5.17 DC respondents' perception of consensus on OSD
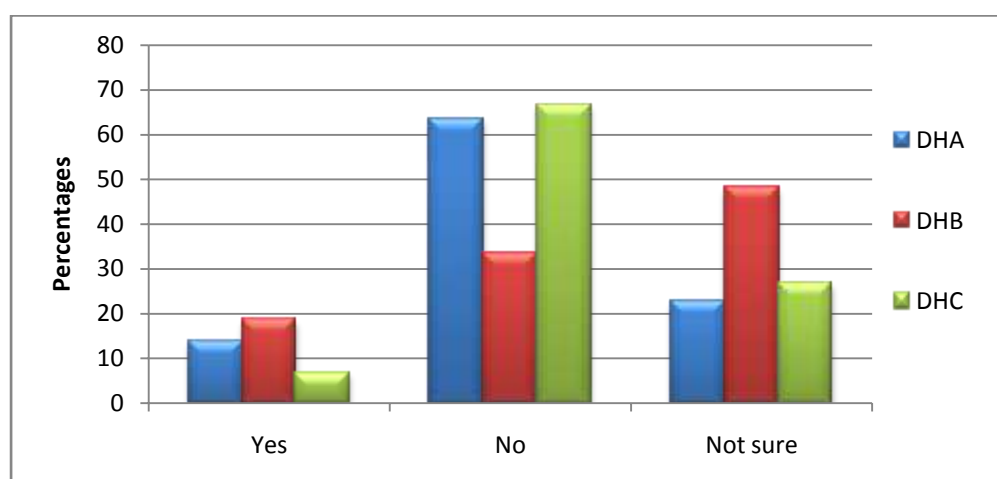
The majority of respondents in all three district hospitals disagreed that there was consensus among all stakeholders on the implementation of the OSD for nurses. DHC had 66.7%, DHA had 63.6%, and DHB had 33.3% respondents who disagreed. DHB also had 48.1% respondents who were undecided. DHB had 18.5%, DHA had 13.6%, and DHC had 6.7% who agreed. This data seemed to depict a state of disagreement among stakeholders, lack of information and confusion among RNs regarding the OSD in all three hospitals.

5.5.1.18 Overseas exchange programme is a success

Table 5.18 DC respondents' view of overseas exchange programme success (n= 57)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	18	38.9	44.4	16.7
DHB	26	30.8	57.7	11.5
DHC	13	46.2	46.2	7.6
Average	19.0	38.6	49.4	11.9

Figure 5.18 DC respondents' view of overseas exchange programme success
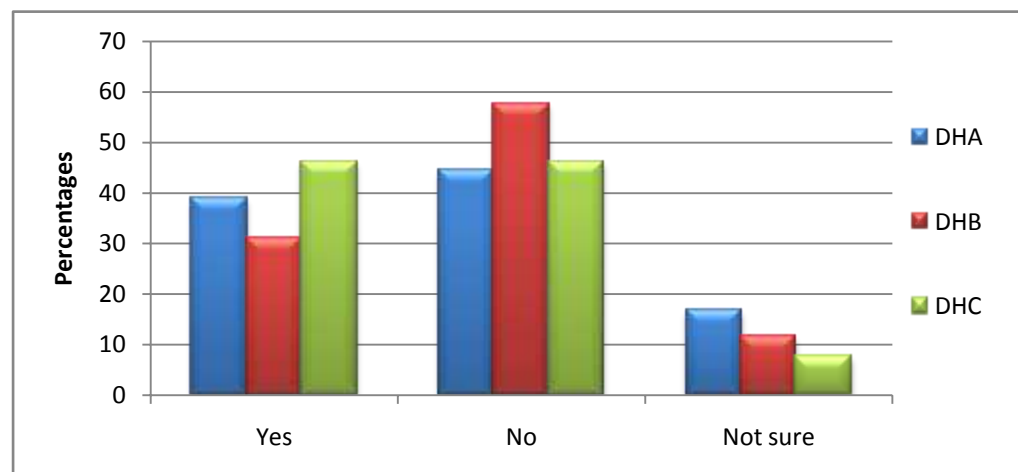
Most of the DC respondents disagreed that the overseas exchange programme was a success, except for DHC that had an equal number who agreed and disagreed (46.2%). DHB had 57.4% respondents who disagreed. DHA had 38.9% and DHB had 30.8% who agreed. It was later learned from the DOH that the overseas exchange programme was not implemented in these three district hospitals, but only in academic hospitals. There were nine missing values on this item.

5.5.1.19 Discontent among RNs is an observable reality

 (NB: In this section, the total scores of the 'strongly disagree' and the 'disagree;' the 'agree' and the 'strongly agree' percentages reflected in table and figure format have been combined in the discussions that follow.)

Table 5.19 DC respondents observation of discontent among RNs (n= 62)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	19.0	4.8	9.5	28.6	38.1
DHB	26	3.9	11.5	3.9	27.0	53.8
DHC	15	0.0	6.7	6.7	53.3	33.3
Average	20.7	7.3	7.7	6.7	36.3	41.7

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.19 DC respondents' observation of discontent among RNs
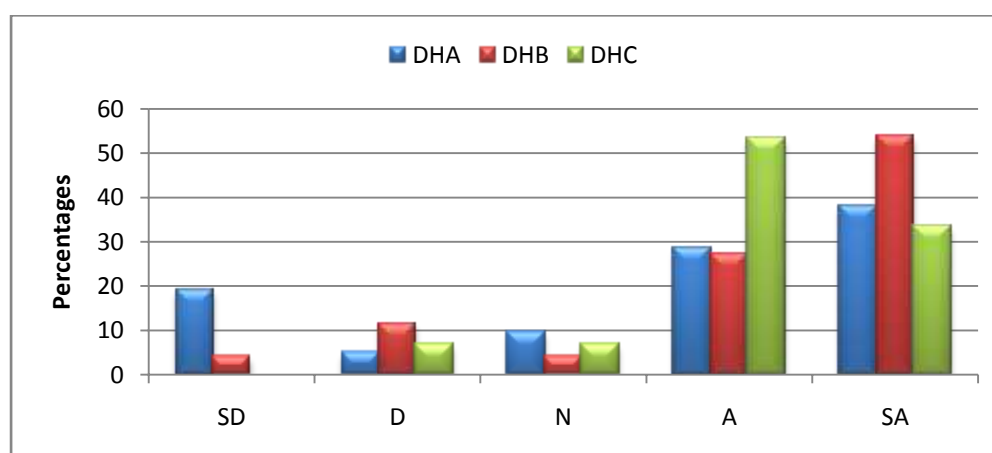
The findings revealed that most of the DC respondents agreed that discontent was observable among RNs in the PHS. DHC had 86.6%, DHB had 80.8% and DHA had 66.7% respondents who agreed that discontent was observable among RNs in the PHS. DHA had 23.8%, DHB had 15.4%, and DHC had 13.4% who agreed. This indicated that discontent is a general phenomenon in the PHS. There were 4 missing values.

5.5.1.20 Low morale associated with low salaries in public hospitals

Table 5.20 DC respondents' perception of low morale and low salaries (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	4.8	4.8	14.3	28.5	47.6
DHB	26	3.9	3.9	7.7	42.3	42.3
DHC	16	0.0	6.3	0.0	43.7	50.0
Average	21.0	2.9	5.0	7.3	38.2	46.6

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.20 DC respondents' perception of low morale and low salaries
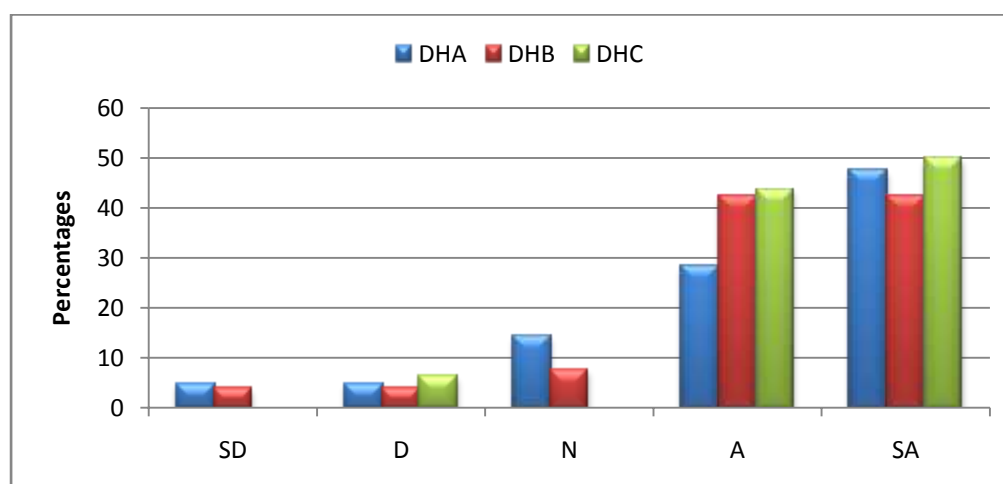
The DC respondents generally associated low morale among RNs in the PHS with low salaries. DHC had 93.7%, DHB had 84.6%, and DHA had 76.1% respondents who agreed that low morale was associated with low salaries. DHA had 9.6%, DHB had 7.8%, and DHC had 6.3% respondents who disagreed. The findings appear to suggest that low salaries are the main issue in all three hospitals, not only in precipitating strike actions, but also in exacerbating migration.

5.5.1.21 RNs contribute to change in hospitals

Table 5.21 DC respondents' perception of contribution to change in hospitals (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	20	20.0	5.0	20.0	50.0	5.0
DHB	27	17.3	10.3	20.7	34.5	17.3
DHC	16	6.3	31.2	18.7	37.5	6.2
Average	21.0	14.5	15.5	19.8	40.7	9.5

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.21 DC respondents' perception of contribution to change in hospitals
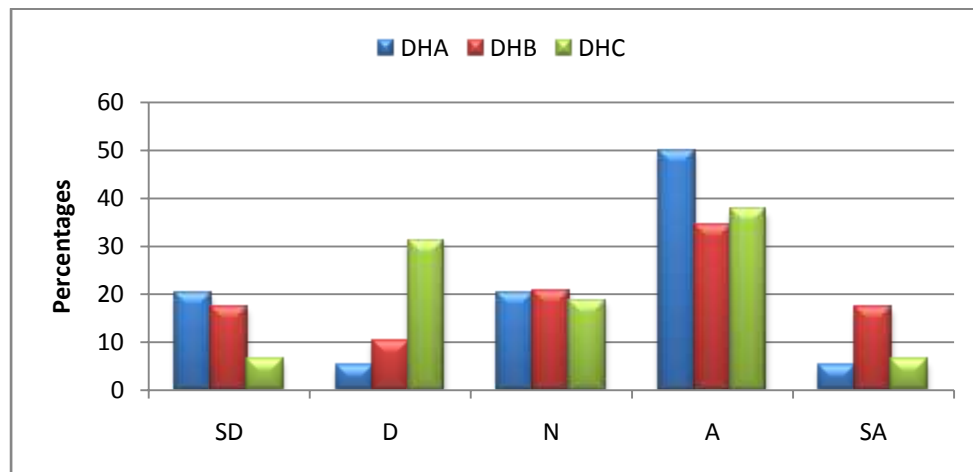
The data revealed that DHA had 55.0%, DHB had 51.8%, and DHC had 43.7% respondents who agreed that RNs contributed to change in hospitals. DHC had 37.5%, DHB had 27.6%, and DHA had 25.0% who disagreed. Generally, the results show a positive response in the three hospitals, implying that RNs' ideas are solicited.

5.5.1.22 RNs are sponsored for conferences

Table 5.22 DC respondents' perception of sponsorship for conferences (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	38.1	33.3	14.3	9.5	4.8
DHB	26	34.6	27.0	19.2	11.5	7.7
DHC	16	25.0	37.6	25.0	6.2	6.2
Average	21.0	32.6	32.6	19.5	9.1	6.2

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.22 DC respondents' perception of sponsorship for conferences
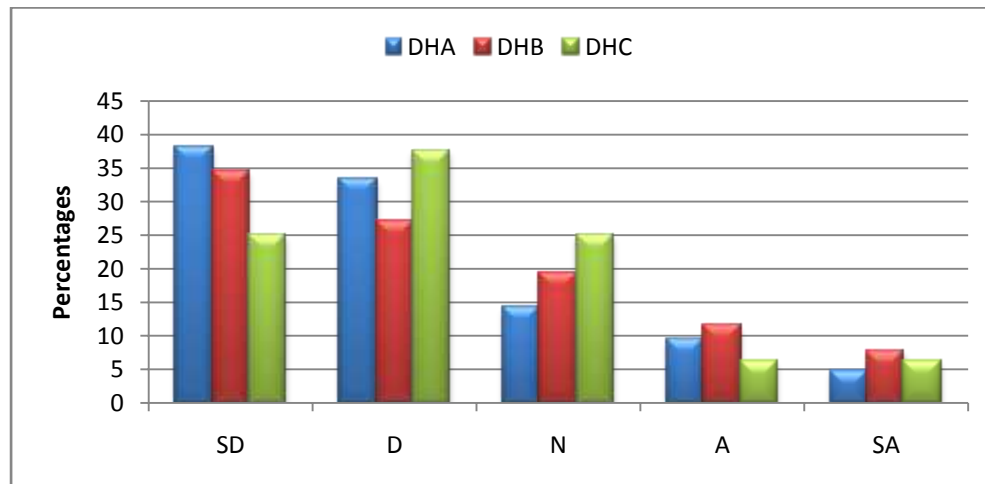
The majority of the DC respondents disagreed that RNs were sponsored to attend conferences. DHA had 71.4%, DHC had 62.6%, and DHB had 61.6% respondents who disagreed. DHB had 19.2%, DHA had 14.3%, and DHC had 12.4% respondents who agreed. An average of 19.5% DC respondents were not sure. However, the majority disagreed, giving the impression that not much is done to encourage RNs to attend conferences.

5.5.1.23 RNs are financed to do research

Table 5.23 DC respondents' perception of finance for research (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	42.8	38.1	14.3	4.8	0.0
DHB	27	26.0	40.7	11.1	14.8	7.4
DHC	15	26.7	20.0	20.0	33.3	0.0
Average	21.0	31.8	32.9	15.1	17.6	2.5

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.23 DC respondents' perception of finance for research
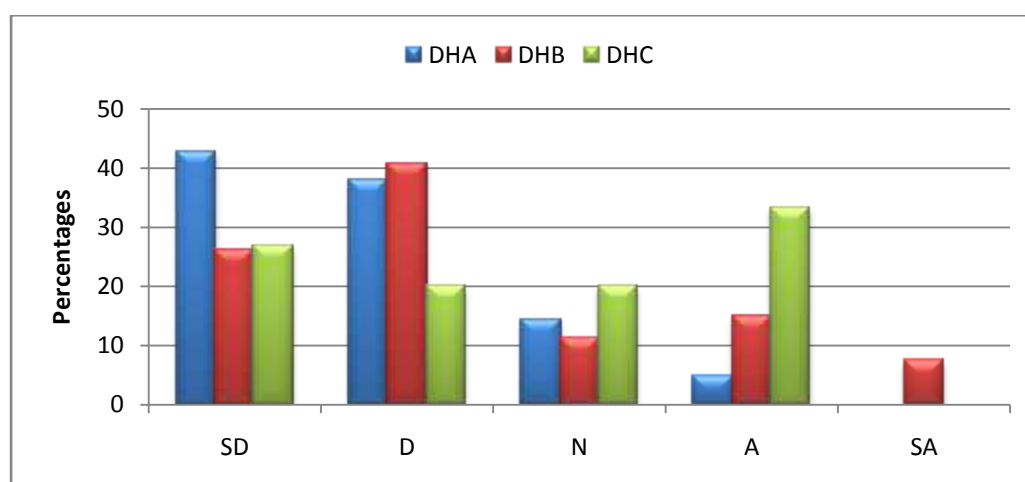
The findings revealed that most of the DC respondents disagreed that RNs were financed to do research. DHA had 80.9% respondents who disagreed and only 4.8% who agreed that RNs were financed to do research. DHB had 66.7% who disagreed and 22.2% who agreed. DHC had 46.7% who disagreed and 33.3% who agreed. The overall impression could indicate that research is not well supported in public hospitals.

5.5.1.24 Opportunities exist for registered nurses' career development

Table 5.24 DC respondents' perception of opportunities for career development (n= 64)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	33.3	33.3	9.5	23.9	0.0
DHB	27	11.1	22.2	14.8	40.7	11.1
DHC	16	18.8	18.8	12.5	31.3	18.8
Average	21.0	21.1	24.8	12.3	32.0	10.0

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.24 DC respondents' perception of opportunities for career development
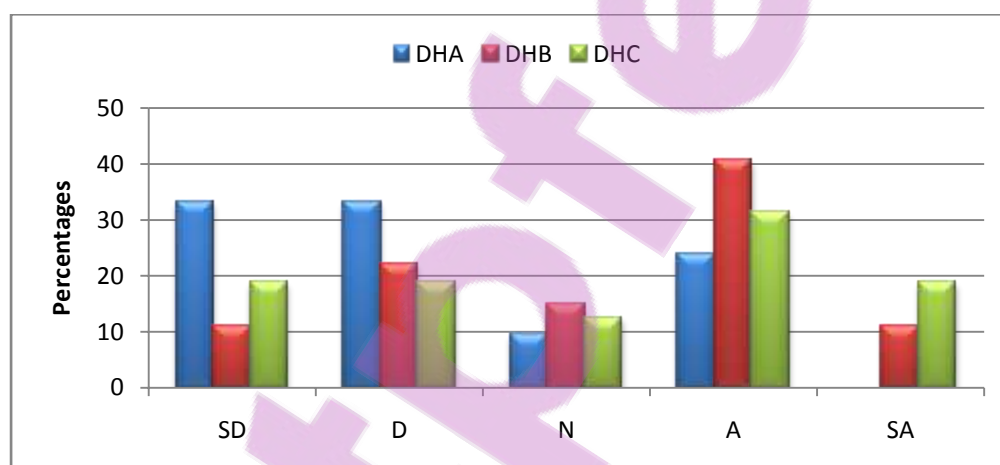
From the data it emerged that the DC respondents were divided regarding the availability of career development opportunities in the PHS. Those who were stronger in agreeing with the foregoing statement were DHB with 51.8% respondents who agreed and 33.3% who disagreed. These were followed by DHC with 50.1% who agreed and 37.6% who disagreed. However, DHA had 66.6% who disagreed and only 23.0% who agreed that career development opportunities were available. This would seem to indicate progress regarding career development opportunities in DHB and DHC, but a struggle for personal and professional growth in DHA.

5.5.1.25 RNs agree with their extended role as medical assistants

Table 5.25 DC respondents' perception of extended role as medical assistants (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	4.8	4.8	23.8	57.1	9.5
DHB	26	3.9	11.5	30.8	34.6	19.2
DHC	16	6.2	25.0	12.5	31.3	25.0
Average	21.0	5.0	13.8	22.4	41.0	17.9

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.25 DC respondents' perception of extended role as medical assistants
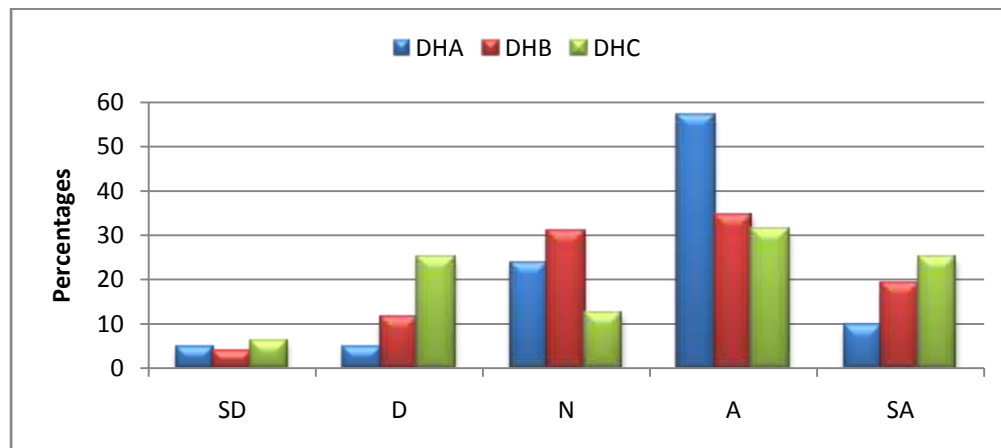
The findings indicated that more DC respondents agreed than disagreed with the extended role as medical assistants. DHA had 66.6%, DHC had 56.3%, and DHB had 53.8% respondents who agreed with the extended role as medical assistants. DHC had 31.2%, DHB had 15.4%, and DHA had 9.6% who disagreed.

SECTION C: Workplace violence in the PHS

5.5.1.26 Security system for nurses in the workplace is satisfactory

Table 5.26 DC respondents' perception of security for nurses (n= 65)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	23	30.4	69.6	0.0
DHB	26	19.2	77.0	3.8
DHC	16	0.0	87.5	12.5
Average	21.7	16.5	78.0	5.4

Figure 5.26 DC respondents' perception of security for nurses
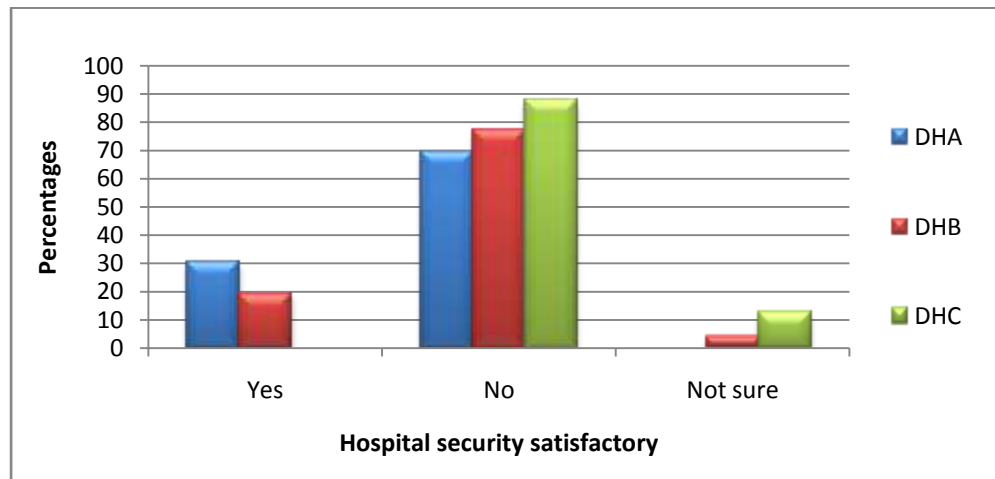
The data revealed that the overwhelming majority of DC respondents disagreed that their security for nurses was satisfactory. DHC had 87.5% who disagreed and none who agreed. DHB had 77.0% who disagreed and 19.2% who agreed. DHA had 69.6% who disagreed and 30.4% who agreed. The findings seemed to suggest that all three hospitals experienced the same problems with regard to security in their hospitals.

5.5.1.27 Patients are safe in hospital under the current security system

Table 5.27 DC respondents' perception of patients' safety in hospital (n= 64)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
DHA	22	45.5	40.9	13.6
DHB	26	23.1	53.8	23.1
DHC	16	25.0	50.0	25.0
Average	21.3	31.2	48.2	20.6

Figure 5.27 DC respondents' perception of patients' safety in hospital
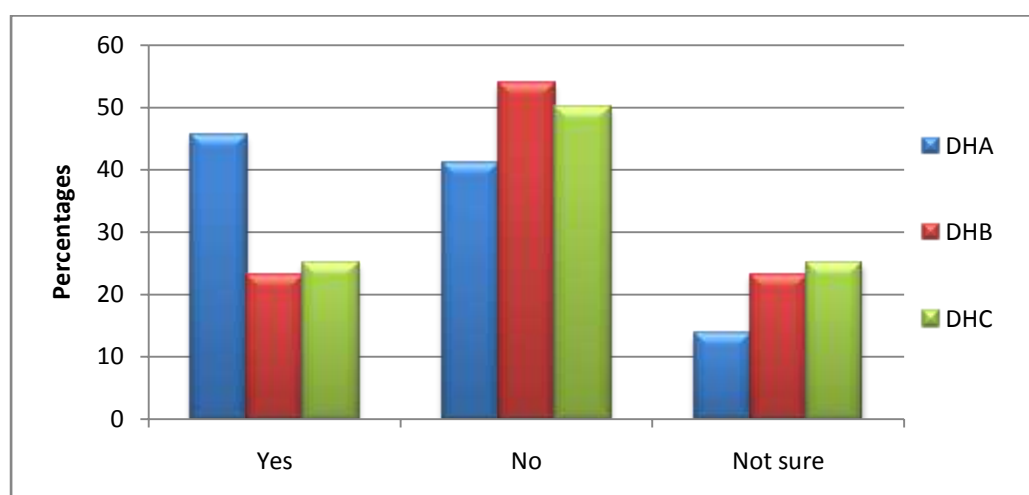
The DC respondents were divided over the question of patients' safety under the current security system. DHA had 45.5% respondents who agreed and 40.9% who disagreed that patients were safe under the current security system. DHB had 53.8% who agreed and 23.1% who disagreed. DHC had 50.0% who agreed and 25.0% who disagreed that security was adequate for patients. The comparison reveals that security measures could be available in district hospital A but not adequate, while district hospitals A and C lack security for patients.

SECTION D: Stress

5.5.1.28 Stress is intolerable among RNs in the PHS

Table 5.28 DC respondents' observation of stress (n= 62)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	23	82.6	8.7	8.7
DHB	23	61.5	11.5	27.0
DHC	16	75.0	18.8	6.3
Average	20.7	73.0	13.0	14.0

Figure 5.28 DC respondents' observation of stress
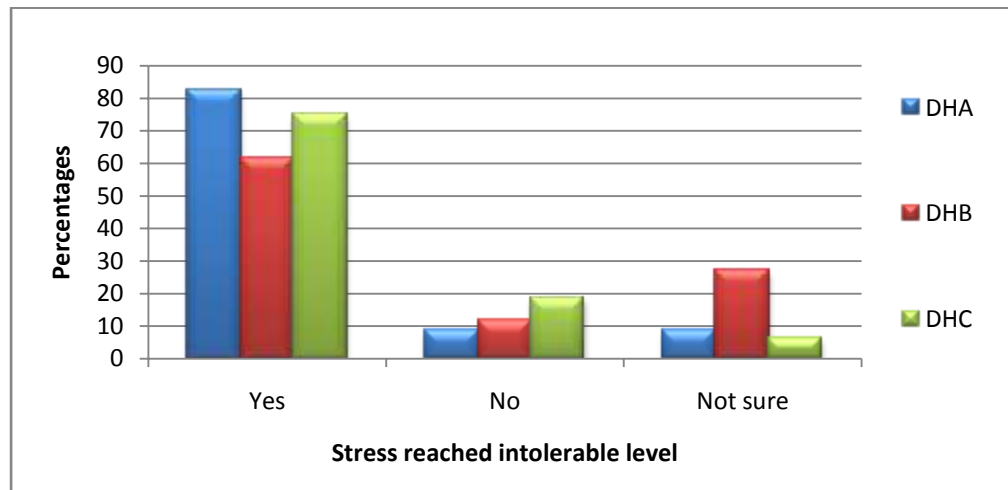
The data indicated that the DC respondents generally agreed that stress had reached intolerable levels in their hospitals. DHA had 82.6%, DHC had 75.0%, and DHB had 61.5% of respondents who agreed. DHC had (18.8%), DHB with (11.5%) and DHA had (8.7%) respondents who disagreed that stress had reached intolerable levels in their hospitals. This would imply that all three hospitals had similar experiences and factors that induce stress.

5.5.1.29 Have you personally used your vacation for resting?

Table 5.29 DC respondents' use of vacation to rest (n= 65)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
DHA	23	38.5	42.3	19.2
DHB	26	53.8	27.0	19.2
DHC	16	50.0	50.0	0.0
Average	21.7	47.4	39.8	12.8

Figure 5.29 DC respondents' use of vacation to rest
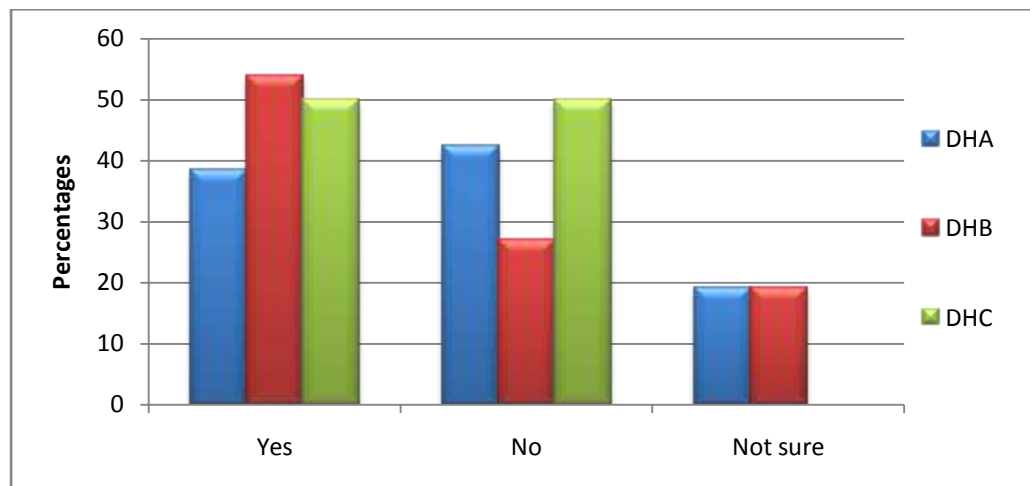
The data revealed that DHC had 50.0% who rested during vacation and 50.0% who did not. DHA had 42.3% who did not rest during their vacation and 38.5% who did. DHB had 53.8% who rested during vacation and 27.0% who did not. The number of respondents who did not rest during vacation led the researcher to assume that their vacation was used for working part-time or overtime. DHB had more respondents who rested than the others, which could have been due to DHB being the only hospital that had respondents aged 58-65. As a result, they could possibly not have opted for overtime work.

5.5.1.30 Nurses experience physical signs of exhaustion

Table 5.30 DC respondents' experience of physical signs of exhaustion (n= 66)

Hospital	Frequency	Percentage			
		Never	Occasionally	Often	Always
DHA	23	4.3	13.0	34.9	47.8
DHB	27	0.0	14.8	33.3	51.9
DHC	16	0.0	0.0	25.0	75.0
Average	22.0	1.4	9.3	31.1	58.2

Figure 5.30 DC respondents' experience of physical signs of exhaustion
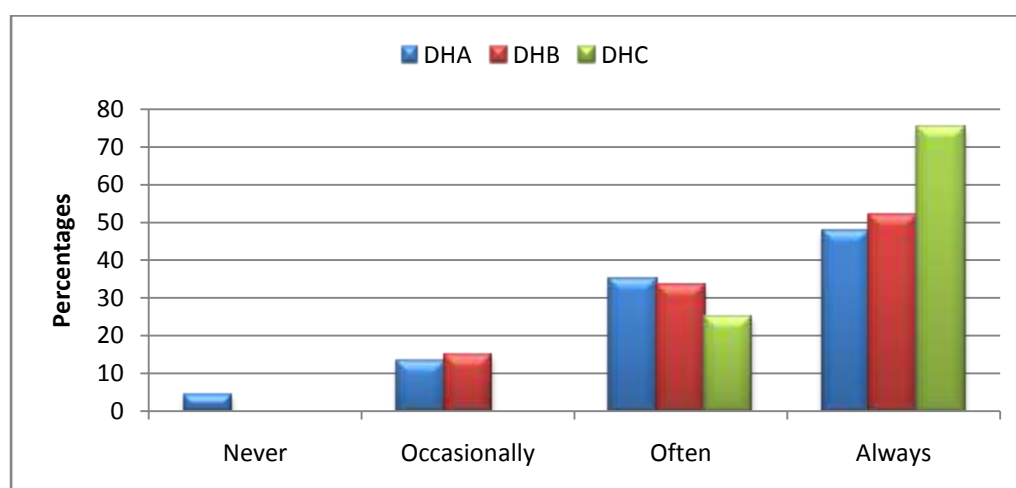
Regarding whether the respondents' had experienced physical signs of exhaustion, the data revealed that in the "never" column, DHA had 4.3% who did not experience physical exhaustion, while DHB and DHC had none.

In the "occasionally" column, DHB had 14.8% and DHA had 13.0% who occasionally experienced physical exhaustion, and none in DHC.

In the "frequently" column, DHA had 34.9% and DHB had 33.3% who agreed, with DHC at 25.0%.

In the "always" column, DHC had 75.0%, DHB had 51.9%, and DHA had 47.8% respondents who agreed.

This finding seemed to suggest that the DC respondents were not coping well with the workload, possibly due to shortage of staff, especially as most indicated that stress had become intolerable in the workplace (see table 5.28).

5.5.1.31 Do you have intentions to leave the PHS for other institutions?

Table 5.31 DC respondents' intentions to leave PHS (n= 65)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	59.1	13.6	27.3
DHB	27	26.0	44.4	29.6
DHC	16	37.5	37.5	25.0
Average	21.7	40.9	31.8	27.3

Figure 5.31 DC respondents' intentions to leave PHS
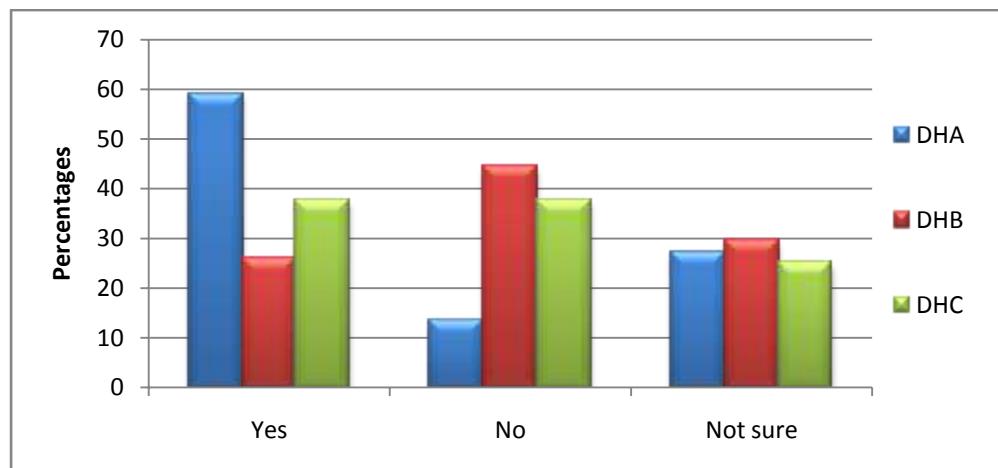
The data revealed that DHA had 59.1% who indicated their intentions to leave the PHS and 13.6% who did not. This finding revealed the highest level of discontent in the hospital cluster. DHB, however, had 44.4% who did not intend leaving and 26.0% who were contemplating leaving. This appeared to indicate that DHB had more internal stability than the other two. DHC had an even number of respondents intending to leave and not intending to leave, namely 37.5%. A significant number from each hospital were not sure.

(NB: In this section, the total scores of the 'strongly disagree' and the 'disagree;' the 'agree' and the 'strongly agree' percentages reflected in table and figure format have been combined in the discussions that follow.)

5.5.1.32 Some NSMs still display bullying attitudes

Table 5.32 DC respondents' perceptions of NSM bullying attitudes (n= 65)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	22	18.2	9.1	4.5	13.6	54.5
DHB	27	7.7	19.2	11.5	38.5	23.1
DHC	16	18.8	6.2	6.2	25.0	43.8
Average	21.7	14.3	11.5	7.4	25.7	40.5

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.32 DC respondents' perceptions of NSM bullying attitudes
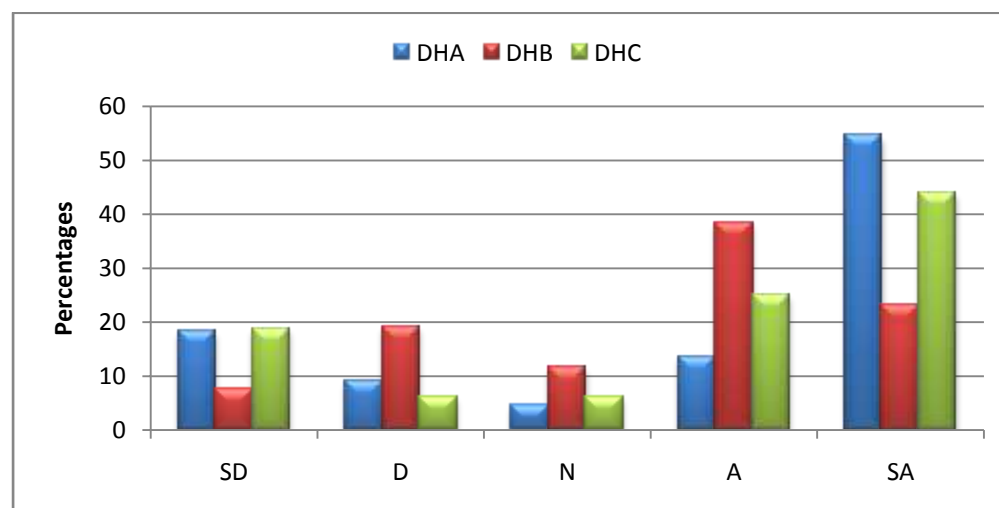
The data revealed that most of the DC respondents agreed that some NSMs still displayed bullying attitudes towards RNs. DHC had 68.8%, DHA had 68.1%, and DHB had 61.6% respondents who agreed, which would seem to imply that RNs generally still struggled to have good working relationships

with nursing managers. DHA had 27.3%, DHB had 26.9%, and DHC had 25.0% respondents who disagreed.

5.5.1.33 RNs acknowledged for outstanding contributions

Table 5.33 DC respondents' perceptions of acknowledgement for outstanding contributions (n= 61)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	22	54.5	9.1	13.6	9.1	13.6
DHB	25	12.0	32.0	24.0	20.0	12.0
DHC	14	7.1	50.0	28.6	7.1	7.1
Average	20.3	24.5	30.4	22.1	12.1	10.9

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.33 DC respondents' perceptions of acknowledgement for outstanding contributions
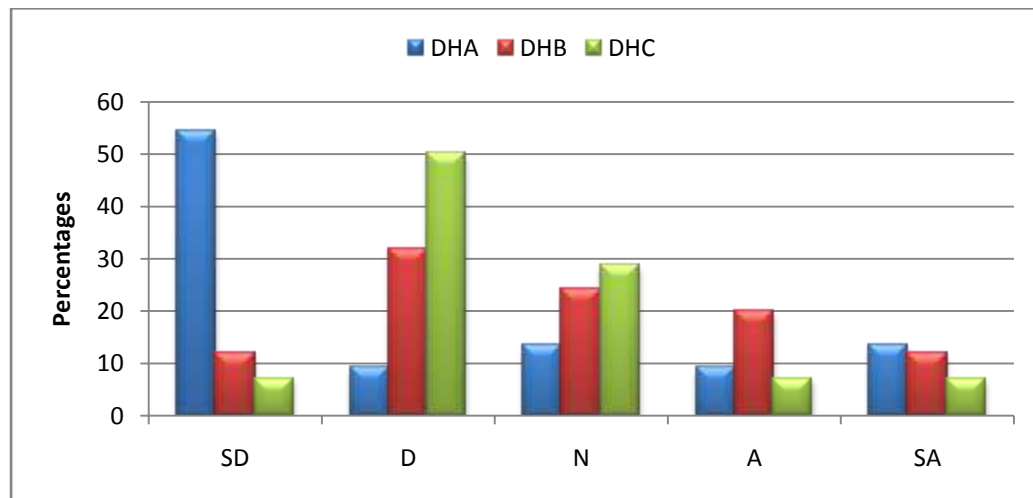
Most of the DC respondents disagreed that RNs were acknowledged for outstanding contributions. DHA had 63.6%, DHC had 57.1%, and DHB had 44.0% respondents who disagreed. DHB had 32.0%, DHA had 22.7%, and DHC had 14.2% respondents who agreed that RNs were acknowledged for contributions. At the same time, however, a considerable number of respondents were not sure.

5.5.1.34 NSMs give feedback on problems reported

Table 5.34 DC respondents' perceptions of feedback on reported problems (n= 64)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	22	36.4	18.2	18.2	27.3	0.0
DHB	26	7.7	0.0	30.8	46.1	15.4
DHC	16	33.3	20.0	40.0	6.7	0.0
Average	21.3	25.8	12.7	29.7	26.7	5.1

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.34 DC respondents' perceptions of feedback on reported problems
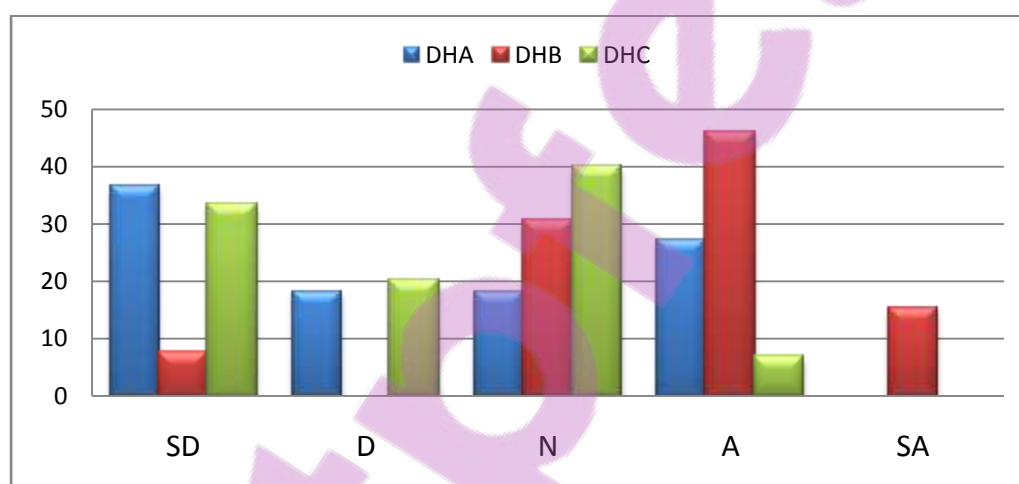
The data indicated that DHA had 54.6% respondents who disagreed and 27.3% who agreed that feedback was given on problems reported. DHC had 53.3% who disagreed and 6.7% who agreed that feedback was given. DHB, however, had 61.5% who agreed and only 7.7% who disagreed, thereby suggesting a harmonious working relationship with their nurse managers.

5.5.1.35 RNs are acknowledged for their sacrifices

Table 5.35 DC respondents' perceptions of acknowledgement for sacrifices (n= 61)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	62.0	14.3	9.5	9.5	4.8
DHB	25	20.0	28.0	12.0	20.0	20.0
DHC	15	40.0	26.7	26.7	6.7	0.0
Average	20.3	40.7	23.0	16.1	12.1	8.3

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.35 DC respondents' perceptions of acknowledgement for sacrifices
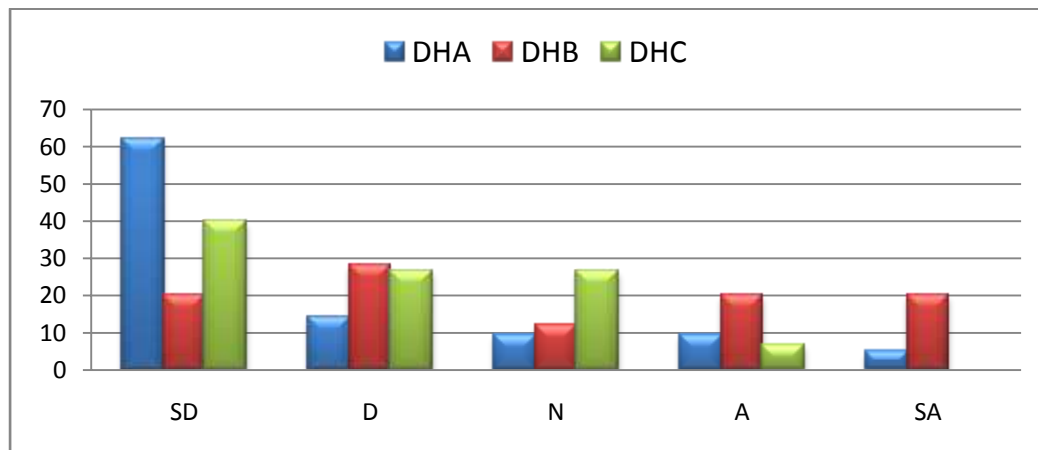
The data revealed that most of the DC respondents disagreed that RNs were acknowledged for the sacrifices they made. DHA had 76.3% respondents who disagreed and 14.3% who agreed. DHC had 66.7% who disagreed and 6.7% who agreed. DHB had 48.0% who disagreed and 40.0% who agreed that RNs were acknowledged for sacrifices made. There were five missing values on this aspect.

5.5.1.36 Hospital management discuss problems with registered nurses

Table 5.36 DC respondents' perception of joint discussion of problems (n= 63)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	36.4	40.9	22.7
DHB	25	40.0	20.0	40.0
DHC	16	37.5	50.0	12.5
Average	21.0	38.0	37.0	25.1

Figure 5.36 DC respondents' perceptions of joint discussion of problems
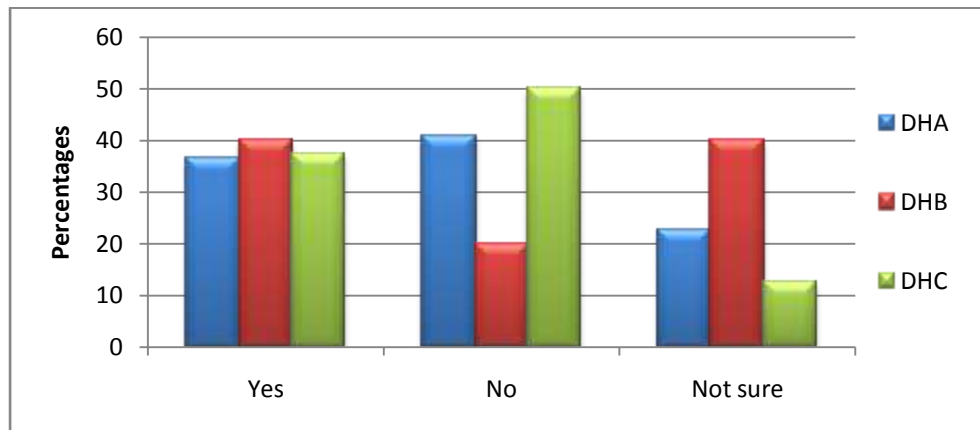
The data revealed that DHC had 50.0% respondents who disagreed that, RNs were involved in problem-solving and 37.5% who agreed. DHA had 40.9% who disagreed and 36.4% who agreed. DHB had 40.0% who agreed and 20.0% who disagreed that NSMs discuss problems with RNs, statistically expressing orderly management.

SECTION F: Registered nurses and migration

5.5.1.37 Nurse migration and insufficient salaries

Table 5.37 DC respondents' perceptions of nurse migration and inadequate salaries (n= 66)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
DHA	23	4.3	4.3	13.0	78.3
DHB	27	0.0	0.0	29.6	70.4
DHC	16	0.0	6.3	31.3	62.5
Average	22.0	1.4	3.5	24.6	70.4

Figure 5.37 DC respondents' perceptions of nurse migration and inadequate salaries
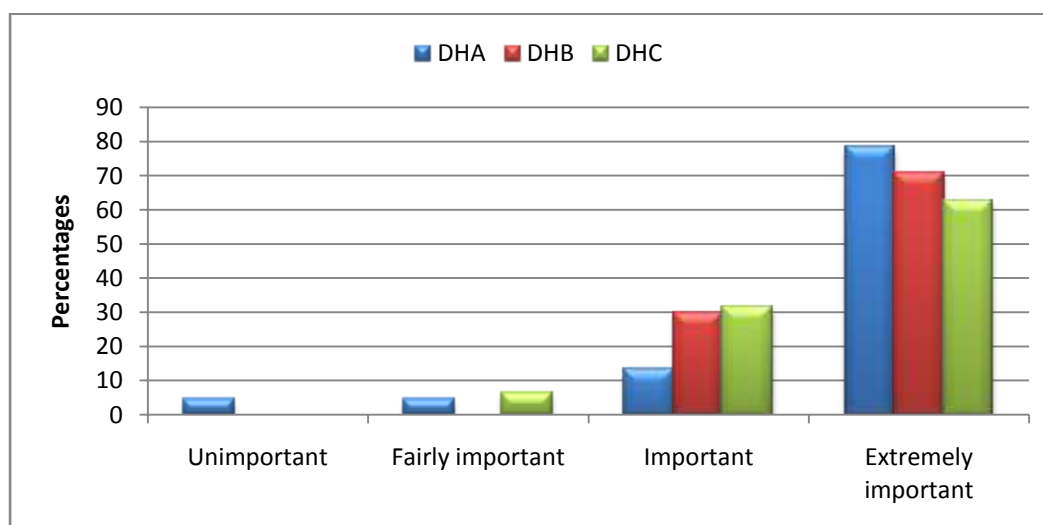
The respondents were asked to rate inadequate salaries as a reason for migration. Percentages were generally lower in the "unimportant" column, and showed a gradual increase towards the "extremely important" column. In the "unimportant" column, DHA had 4.3%, while DHB and DHC had no respondents regarded inadequate salaries as unimportant for migration. Responses in this column indicate that insufficient salaries are not important as there could be other reasons for nurse migration.

In the "fairly important" column, DHC had 6.3%, DHA had 4.3%, and DHB had no respondents, which would seem to indicate that inadequate salaries could mildly influence nurse migration.

In the "important" column, DHC had 31.3%, DHB had 29.6%, and DHA had 13.0% who judged inadequate salaries important 'push factors' in migration.

In the "extremely important" column, DHA had 78.3%, DHB had 70.4%, and DHC had 62.5% respondents who judged it an extremely reason. Because of the vast majority who agreed on this item, this implies that insufficient salaries have a serious bearing on nurse migration from the PHS.

5.5.1.38 Poor leadership in nursing and nurse migration

Table 5.38 DC respondents' perception of poor leadership in nursing (n= 62)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
DHA	23	4.3	13.0	43.5	39.1
DHB	23	3.9	11.5	50.0	34.6
DHC	16	12.5	6.3	50.0	31.3
Average	20.7	6.9	10.3	47.8	35.0

Figure 5.38 DC respondents' perception of poor leadership in nursing
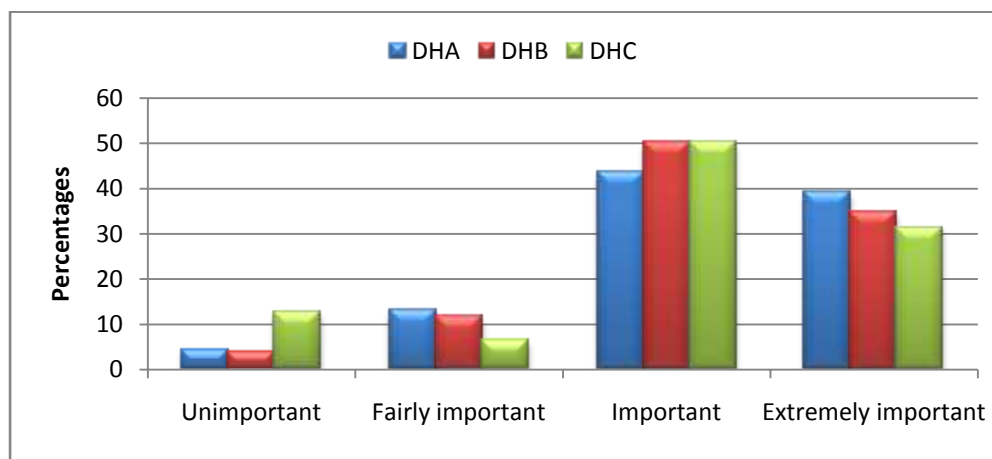
The findings revealed lower percentages in the "unimportant" column. DHC had 12.5%, DHA had 4.3%, and DHB had 3.9% respondents who considered poor leadership in nursing is not responsible for nurse migration.

In the "fairly important" column, DHA had 13.0%, DHB had 11.5%, and DHC had 6.3%. These respondents considered poor leadership in nursing as partly responsible for nurse migration from the PHS.

In the "important" column, DHB and DHC both had 50.0%, while DHA had 43.5%, which indicated poor leadership in nursing was an important cause of nurse migration from the PHS.

In the "extremely important" column, DHA had 39.1%, DHB had 34.6%, and DHC had 31.3% respondents, thereby suggesting that poor leadership in nursing was considered largely responsible for nurse migration. This result is also consistent with the findings that the majority of respondents agreed that some NSMs still displayed bullying attitudes, and disagreed that RNs were acknowledged for outstanding contributions or sacrifices (see tables 5.32, 5.33 and 5.35).

5.5.1.39 Poor working conditions and nurse migration

Table 5.39 DC respondents' perceptions of poor working conditions (n= 65)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
DHA	23	4.3	8.7	43.5	43.5
DHB	26	0.0	0.0	23.1	76.9
DHC	16	0.0	12.5	50.0	37.5
Average	21.7	1.4	7.1	38.9	52.6

Figure 5.39 DC respondents' perceptions of poor working conditions
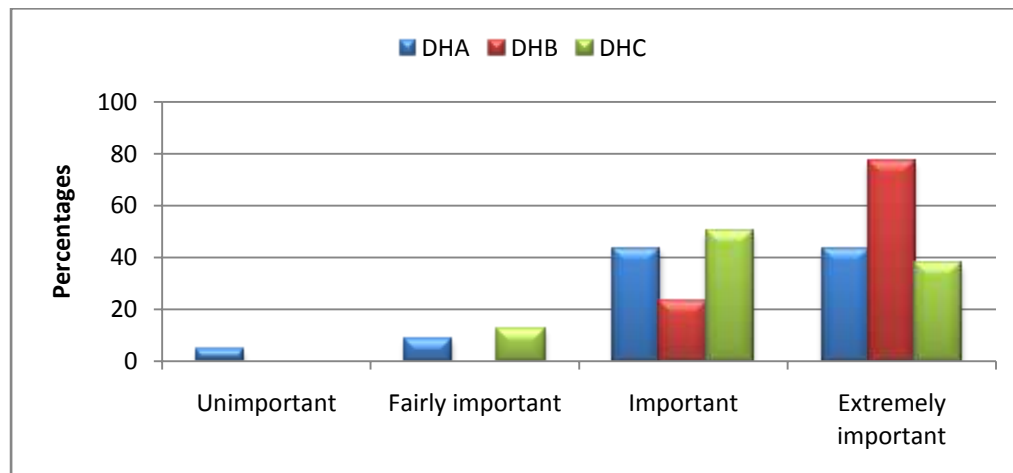
The data revealed that in the "unimportant" column, DHA had 4.3% while DHB and DHC had no respondents who agreed that poor working conditions accounted for nurse migration. This, then, would suggest that there were other reasons for nurse migration.

In the "fairly important" column, DHC had 12.5%, DHA had 8.7%, and DHB had no respondents, which again suggest that poor working conditions do not account for nurse migration.

In the "important" column, DHC had 50.0%, DHA had 43.5%, and DHB had 23.1%. This data revealed that poor working conditions are an important factor in nurse migration.

In the "extremely important" column, DHB had 76.9%, DHA had 43.5%, and DHC had 37.5%, thereby giving the impression that poor working conditions are mainly responsible for nurse migration.

5.5.1.40 RNs migrate for "different" experience

Table 5.40 DC respondents' perception of migration for "different" experience (n= 63)

Hospital	Frequency	Percentage			
			Fairly		Extremely
		Unimportant	important	Important	important
DHA	22	31.8	36.4	22.7	9.1
DHB	25	52.0	24.0	8.0	16.0
DHC	16	12.5	43.8	25.0	18.8
Average	21.0	32.1	34.7	18.6	14.6

Figure 5.40 DC respondents' perception of migration for "different" experience
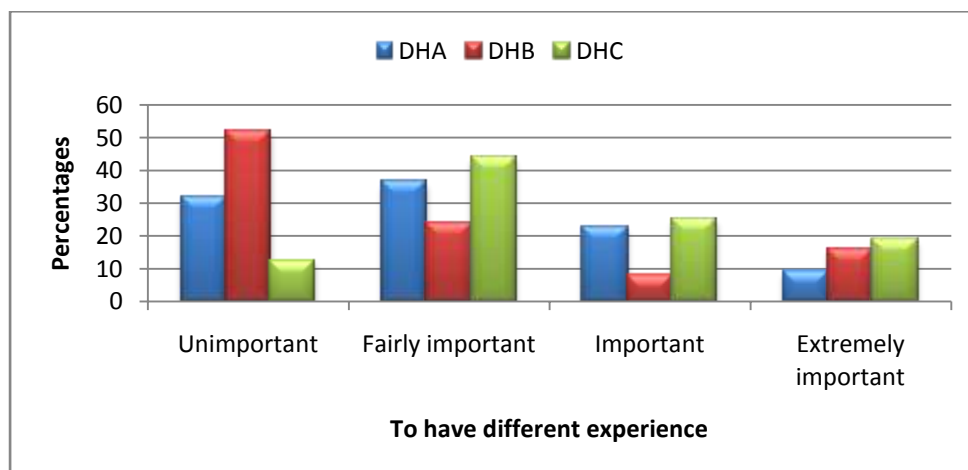
The data revealed that in the "unimportant" column, DHB had 52.0%, DHA had 31.8%, and DHC had 12.5%, which implied that RNs did not migrate just to have "different" experience, but there could be other reasons as well.

In the "fairly important" column, DHC had 43.8%, DHA had 36.4%, and DHB had 24.0%, which therefore, acquiring "different" experience could to some extent contribute to nurse migration.

In the "important" column, DHC had 25.0%, DHA had 22.7%, and DHB had 8.0% thereby indicating that these respondents considered obtaining "different" experience an important factor in nurse migration.

In the "extremely important" column, DHC had 18.8%, DHB had 16.0%, and DHA had 9.1%. This indicated that for the majority of the respondents having "different" experience was a trivial reason for migrating, especially in the light of the results in table and figure 5.37 that inadequate salaries were largely responsible for nurse migration.

SECTION G: Nurses and strike actions

5.5.1.41 RNs prefer strikes to solve nurses' problems

Table 5.41 DC respondents' views on strikes to solve nurses' problems (n= 64)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	23	78.3	13.0	8.7
DHB	25	72.0	24.0	4.0
DHC	16	81.3	18.8	0.0
Average	21.3	77.2	18.6	4.2

Figure 5.41 DC respondents' views on strikes to solve nurses' problems
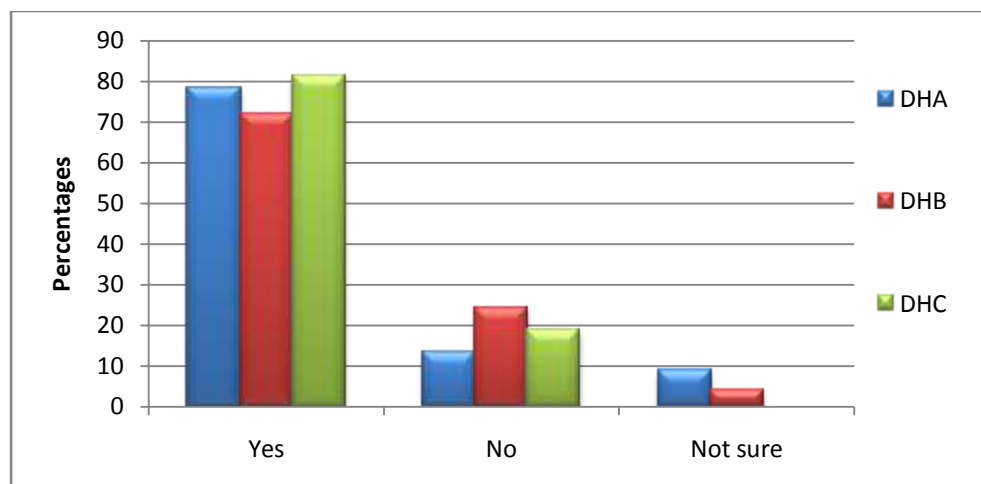
The findings indicated that many of the DC respondents agreed that RNs preferred strikes to solve nurses' problems. In other words, strikes appeared to be an effective tool to expedite response from government as a union strategy. DHC had 81.3%, DHA had 78.3%, and DHB had 72.0% respondents who agreed. DHB had 24.0%, DHC had 18.8%, and DHA had 13.0% respondents who disagreed. DHB had a lower level of discontent than DHC and DHA, irrespective of whether the respondents disagreed or agreed.

5.5.1.42 RNs and unions share similar values regarding patient care

Table 5.42 DC respondents' perceptions of unions' and nurses' values (n= 61)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	21	28.6	38.1	33.3
DHB	24	45.8	25.0	29.2
DHC	16	50.0	37.5	12.5
Average	20.3	41.5	33.5	25.0

Figure 5.42 DC respondents' perceptions of unions' and nurses' values
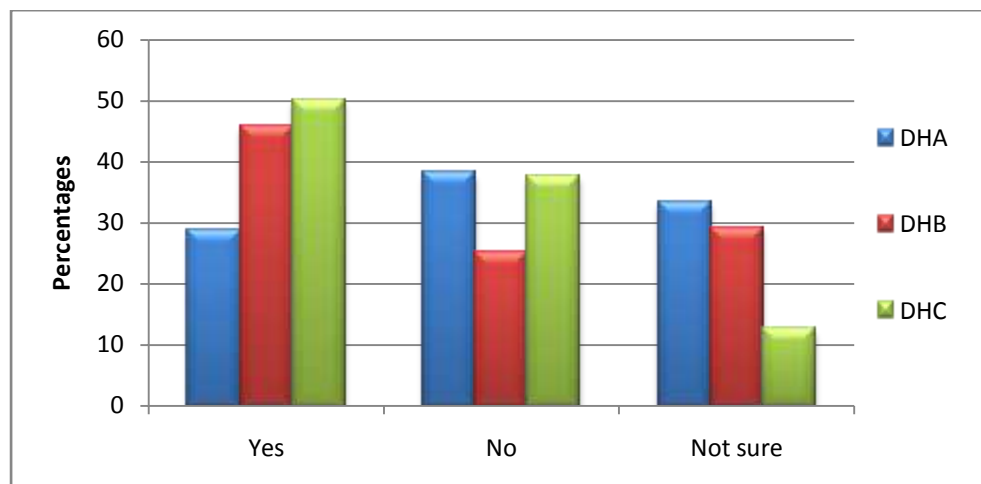
On the matter of values, the data revealed that DHC had 50.0% who agreed and 37.5% who disagreed that nurses and unions shared the same values about patient care. DHB had 45.8% who agreed and 25.0% who disagreed.

However, DHA had 38.1% who disagreed and 28.6% who agreed, thereby possibly revealing conflicting interests between nurses and unions.

5.5.1.43 RNs support division between unions and professional associations

Table 5.43 DC respondents' perceptions of division between unions and professional associations (n= 60)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	22.7	45.5	31.8
DHB	22	30.5	30.5	39.1
DHC	16	25.0	43.8	31.3
Average	20.0	26.1	39.9	34.1

Figure 5.43 DC respondents' perceptions of division between unions and professional associations
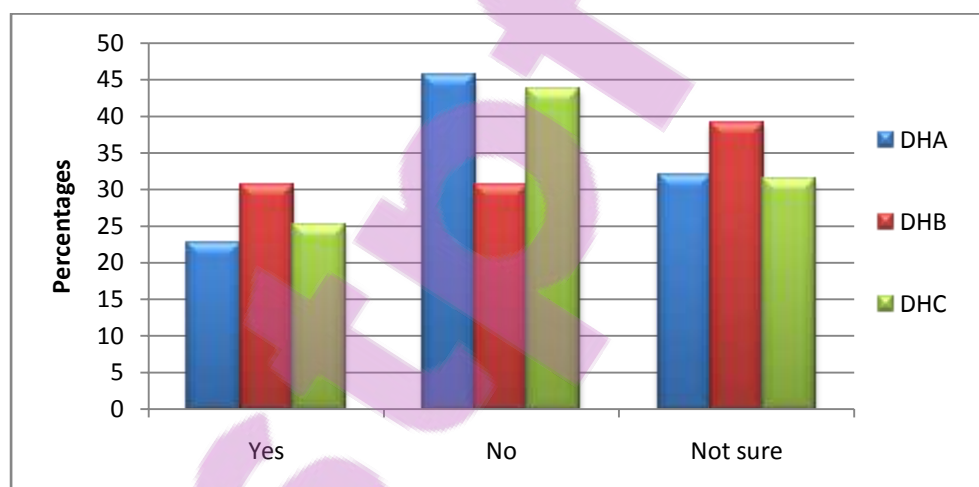
The data revealed that DHA had 45.5% and DHC had 43.8% respondents who disagreed that RNs supported the division between unions and professional associations. At the same time, both DHA and DHC had significant and almost similar numbers of respondents who were not sure. Conversely, DHB respondents were largely divided in that 30.5% agreed while 30.5% disagreed, and most respondents were not sure (39.1%), thereby suggesting possible dilemma and confusion regarding the way forward.

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SECTION H: Nurses and politics

(NB: In this section also, the total scores of the 'strongly disagree' and the 'disagree;' the 'agree' and the 'strongly agree' percentages reflected in table and figure format have been combined in the discussions that follow.)

5.5.1.44 Poor nurse representation in government contributes to migration

Table 5.44 DC respondents' views on poor nurse representation in government (n= 61)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
DHA	22	77.3	13.6	9.1
DHB	25	80.0	12.0	8.0
DHC	14	78.6	21.4	0.0
Average	20.3	78.6	15.7	5.7

Figure 5.44 DC respondents' views on poor nurse representation in government
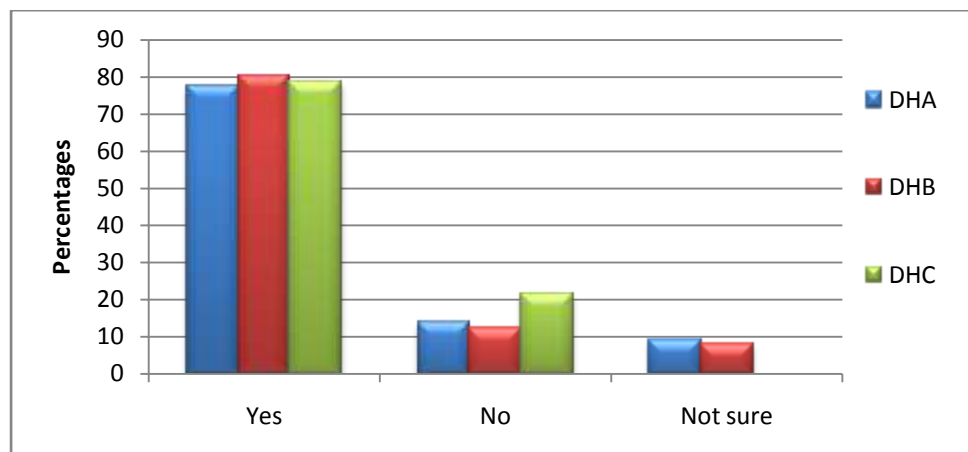
The data indicated that DHB had 80.0%, DHC had 78.6%, and DHA had 77.3% respondents who agreed that poor nurses' representation in government was responsible for nurse migration. DHC had 21.4%, DHA had 13.6%, and DHB had 12.0% respondents who disagreed. These findings

seemingly implied that respondents in all three hospitals considered it critical for nurses to be represented by nurses at government level.

5.5.1.45 RNs vote for parties that add value to nursing

Table 5.45 DC respondents' perceptions of nurses' voting for parties that add value (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	42.9	4.8	19.0	28.5	4.8
DHB	26	15.4	30.8	30.8	11.5	11.5
DHC	16	18.8	37.5	12.5	6.3	25.0
Average	21.0	25.7	24.4	20.8	15.4	13.8

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.45 DC respondents' perceptions of nurses' voting for parties that add value
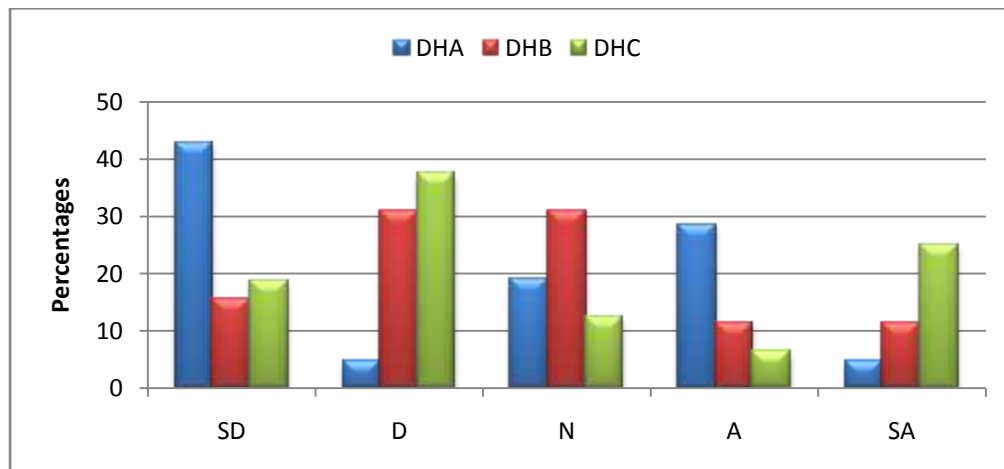
The data indicated that the majority of the respondents disagreed that RNs voted for political parties that add value to the practice of nursing. DHC had 56.3%, DHA had 47.7%, and DHB had 46.2% respondents who disagreed. DHA had 33.3%, DHC had 31.3%, and DHB had 23.0% who agreed. These findings indicate that more needs to be done to educate nurses regarding the importance of voting for parties that have nurses and health care issues as high priorities.

List of research project topics and materials

5.5.1.46 Nurses' issues are entertained in political debates

Table 5.46 DC respondents' perceptions of nurses' issues in political debates (n= 63)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	21	38.1	14.3	23.8	19.0	4.8
DHB	26	23.1	42.3	19.2	11.5	3.9
DHC	16	31.2	31.2	25.0	6.3	6.3
Average	21.0	30.8	29.3	22.7	12.3	5.0

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.46 DC respondents' perceptions of nurses' issues in political debates
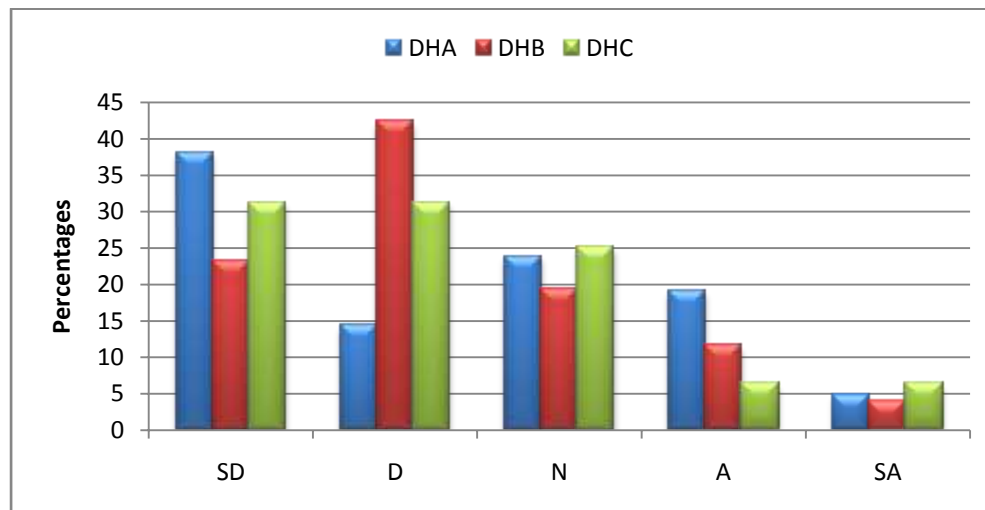
The data indicated that the majority of the respondents disagreed that nurses' issues were entertained in political debates. DHB had 65.4% who disagreed and 15.4% who agreed that nurses' issues did not receive attention in political debates. DHC had 62.4% who disagreed and 12.6% who agreed. DHA had 52.4% who disagreed and 23.8% who agreed. These findings reveal a pattern of possible lack of political astuteness among many of the respondents in all three HCS.

5.5.1.47 RNs can become policy analysts in South Africa

Table 5.47 DC respondents' views on RNs as policy analysts (n= 62)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	20	15.0	0.0	10.0	45.0	30.0
DHB	26	7.7	7.7	11.5	50.0	23.1
DHC	16	6.3	12.5	12.5	37.5	31.3
Average	20.7	9.7	6.7	11.3	44.2	28.1

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.47 DC respondents' views on RNs as policy analysts
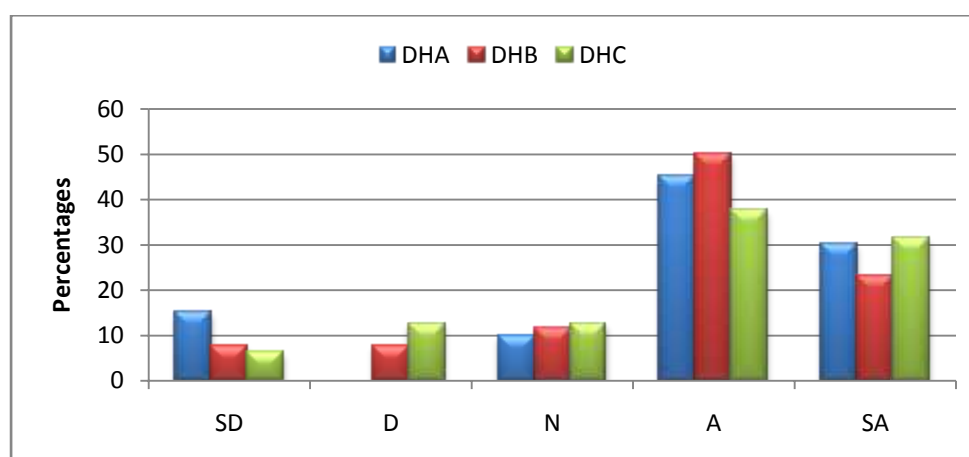
The data revealed that the majority of the DC respondents consistently agreed that RNs could become policy analysts in South Africa. DHA had 75.0%, DHB had 73.1%, and DHC had 68.8% respondents who agreed that RNs could become policy analysts if given educational preparation. DHC had 18.8%, DHB had 15.4%, and DHA had 15.0% who disagreed. These findings suggested that most of the respondents were optimistic about uplifting the nursing profession in RSA.

5.5.1.48 RNs know how policies are made in government

Table 5.48 DC respondents' perception of RNs' knowledge of policy making at government level (n= 64)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	22	40.9	22.7	27.3	4.6	4.6
DHB	26	19.2	23.1	15.4	38.5	3.8
DHC	16	31.2	18.8	31.2	18.8	0.0
Average	21.3	30.4	21.5	24.6	20.6	2.8

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.48 DC respondents' perception of RNs' knowledge of policy making at government level
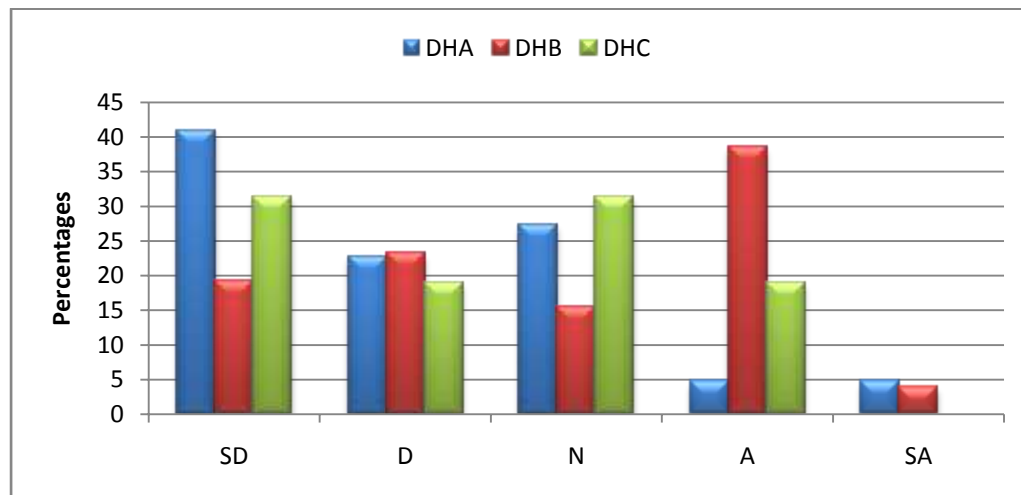
The data indicated that the DHA had 63.6% and DHC had 50.0% respondents who disagreed that nurses knew how policies were made at government level. DHB had an equal disagreement and agreement rate of 42.3%. However, DHC had 18.8% and DHA had 9.2% who agreed that nurses knew how policies were made at government level. At the same time, DHC and DHA both had a significant number of respondents who were unsure. The findings seem to imply that nurses generally did not know how policies are made at government level, which could be attributed to the nursing curriculum not including political science as a subject.

5.5.1.49 RNs can influence policy making

Table 5.49 DC respondents' perceptions of nurses' influence on policy making (n= 62)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
DHA	20	5.0	0.0	10.0	40.0	45.0
DHB	26	7.7	15.4	11.5	42.3	23.1
DHC	16	0.0	12.5	12.5	25.0	50.0
Average	20.7	4.2	9.3	11.3	35.8	39.4

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.49 DC respondents' perceptions of nurses' influence on policy making
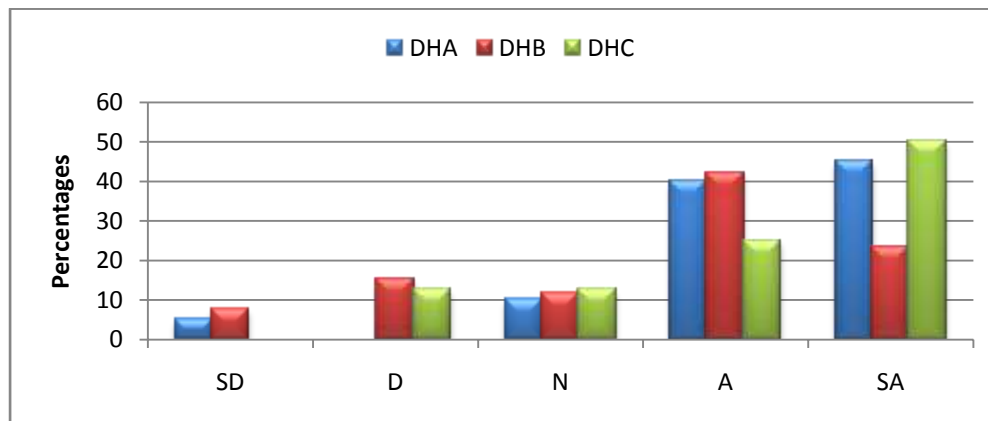
The data revealed that most of the respondents agreed that given the opportunity, nurses could influence policy making processes. DHA had 85.0%, DHC had 75.0%, and DHB had 65.4% who agreed. DHB had 23.1%, DHC had 12.5%, and DHA had 5.0% who disagreed. The overall findings implied that RNs were eager to develop knowledge on political issues in order to make a difference in the nursing profession and health care delivery.

5.5.2 Qualitative data for the district cluster (DC)

The respondents provided written narratives on the questions of their choice, which are discussed in chapter 6.

5.6 REGIONAL HOSPITAL (RH)

The regional hospital (RH) was a level two health care service situated in Tshwane Metropolitan area, which offers 24-hour secondary-level services, namely basic treatment and surgeries beyond the scope of district hospitals. Ambulances bring in patients from district hospitals, other provinces and neighbouring African states for curative care (DOH 2002:3-4; Ndaki, 2004). Conditions of patients beyond the scope of this RH are referred to tertiary (level three) hospitals for sophisticated procedures. Because of its affiliation to a medical university, it provides practical training for students in the nursing profession, medical field and other medical-related disciplines including physiotherapy, occupational therapy, radiology, social work, pharmacology, and dietetics.

The RH had a bed capacity of 857 and 325 RNs at the time of the study. The number of beds is indicative of the size of the hospital, and not the bed occupancy. According to the hospital records, 204 RNs had resigned over the past five years for various reasons. At the time of the study, this hospital had no modern equipment and no computers in the wards due to budget constraints.

Questionnaires were distributed to RNs on day shift, which constituted almost half the total number of RNs employed. Out of 135 questionnaires distributed, 54 were completed and returned, resulting in 40.0% response rate.

In the data analysis, the total number of respondents will vary from item to item because some respondents did not answer all the questions.

5.6.1 Quantitative data analysis for RH

(NB: In the tables and figures, RH indicates data for Regional Hospital)

SECTION A: Demographic information

5.6.1.1 Age distribution

Table 5.1 presents the respondents' age.

Table 5.1 RH respondents' ages (n=53)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	3	8	8	9	21	3	1
Percentage	5.7%	15.1%	15.1%	17.0%	39.6%	5.7%	1.9%

Of the RH respondents, three (5.7%) were between 18 and 25 years old; eight (15.1%) were between 26 and 33; eight (15.1%) were between 34 and 41, nine (17.0%) were between 42 and 49; 21 (39.6%) were between 50 and 57; three (5.7%) were between 58 and 65, and only one (1.9%) was between 65 and 72. Most of the respondents were between 50 and 57. One respondent did not indicate age. This was the only hospital in the study with staff over 65 years of age, because these nurses were apparently recalled to make up for shortage of staff.

5.6.1.2 Race

Of the respondents, 52 (98.1%) were Black and one (1.9%) was Coloured. One respondent did not indicate race. The respondents' race could be due to the hospital's location near a predominantly Black area/township (see table 5.2).

Table 5.2 RH respondents' race (n=53)

Race	Black	Coloured	Asian	White	Other (Please specify)
Frequency	52	1	0	0	0
Percentage	98.1%	1.9%	0.0%	0.0%	0.0%

5.6.1.3 Gender

Table 5.3 indicates the respondents' gender in the RH.

Table 5.3 RH respondents' gender (n=53)

Gender	Frequency	Percentage
Male	3	5.7%
Female	50	94.3%

Of the respondents, three (5.7%) were males, 50 (94.3%) were females, and one did not disclose gender. The males were critical in this study for comparison and a male perspective.

5.6.1.4 Marital status

Of the respondents, 19 (35.2%) were single; 26 (48.1%) were married; three (5.6%) were divorced, and six (11.1%) were widowed (see table 5.4).

Table 5.4 RH respondents' marital status (n=54)

Marital status	Single	Married	Divorced	Widowed
Frequency	19	26	3	6
Percentage	35.2%	48.1%	5.6%	11.1%

Most of the respondents were married, which could indicate a source of discontent in relation to long hours of service, night shifts and inadequate salaries, though salaries are a blanket problem for all RNs.

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5.6.1.5 Number of dependants

Table 5.5 lists the respondents' number of dependants.

Table 5.5 RH respondents' number of dependants (n=54)

Dependants	None	1 – 3	> 3
Frequency	6	39	9
Percentage	11.1%	72.2%	16.7%

Of the respondents, six (11.1%) had no dependants; 39 (72.2%) had between 1-3 dependants, and nine (16.7%) had more than three dependants. The majority of the respondents had between 1 and 3 dependants. This could be an area of concern that adds to discontent if RNs work compulsory night shifts, particularly that most RNs had up to three dependants and more so if their salaries cannot meet their needs.

5.6.1.6 Residential area

The respondents were asked to indicate their residential area to inform the study about the cost of living and affordability of housing (see table 5.6).

Table 5.6 RH respondents' residential area (n=54)

Residence	City/Town	Township	Village	Informal settlement
Frequency	17	37	0	0
Percentage	31.5	68.5	0.0	0.0

Of the respondents, 17 (31.5%) lived in city flats and suburbs and 37 (68.5%), were township residents. None of the respondents came from a village or informal settlement. Most of the respondents came from the township, possibly because the hospital is situated near one of the townships that form part of the Tshwane Metropolitan area. From this data, regardless of place of residence, all nurses have financial obligations and need good salaries to enable them to maintain a good standard of living.

5.6.1.7 Type of health care service

Table 5.7 RH respondents' type of PHS (n=54)

Hospital	Academic hospital	Regional hospital	District hospitals	Private hospitals
Frequency	0	54	0	0
Percentage	0.0%	100.0%	0.0%	0.0%

All the respondents were employed by the RH.

5.6.1.8 Positions

Of the respondents, 29 (53.7%) were CPNs, six (11.1%) were SPNs and 19 (35.2%) were PNs (see table 5.8).

Table 5.8 RH positions held at hospital (n=54)

Positions	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	29	6	19
Percentage	53.7%	11.1%	35.2%

Because of the convenient sample used, the respondents do not provide a definite picture of the distribution of ranks held in the hospital that a random sample would have done (see chapter 4, section 4.8.1).

5.6.1.9 Years of experience since registration

The respondents were asked to indicate their experience in years since registration (see table 5.9).

Table 5.9 RH respondents' years of experience (n=53)

Experience	1-5	6-10	11-20	21-30	31-40	41-50	51-60
Frequency	10	5	18	13	6	1	0
Percentage	18.9%	9.4%	34.0%	24.5%	11.3%	1.9%	0.0%

Of the respondents, ten (18.9%) between one and five years of nursing experience after registration with the SANC; five (9.4%) had between six and 10 years; 18 (34.0%) had between 11 and 20 years; 13 (24.5%) had between 21 and 30 years; six (11.3%) had between 31 and 40 years, and only one (1.9%) had between 41 and 50 years' experience. No one had more than 50 years' experience since they registered. Only one respondent did not indicate years of experience.

5.6.1.10 Qualifications

The respondents were asked to indicate their qualifications (see table 5.10).

Table 5.10 RH respondents' qualifications (n=53)

Qualifications	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hon	M	D
Frequency	18	23	3	9	0	0	0
Percentage	34.0%	43.4%	5.7%	17.0%	0.0%	0.0%	0.0%

Of the respondents, 18 (34.0%) had a Basic Nursing Diploma (BND); 23 (43.4%) had a post-BND; three (5.7%) had the Basic four-year nursing degree and nine (17.0%) had a BA Cur. None of the respondents had Honours, Masters or Doctoral degrees. One of the respondents did not disclose qualifications. There are other post-basic qualifications that were not included in the questionnaire such as Advanced Midwifery, Intensive Care Unit, Orthopaedic nursing and the others.

SECTION B: Transformation of HCS

5.6.1.11 PHS transformation has been successful

This question sought the respondents' perceptions of the success of transformational initiatives in the PHS (see figure 5.1).

Figure 5.1 RH respondents' perceptions of HS transformation (n=45)
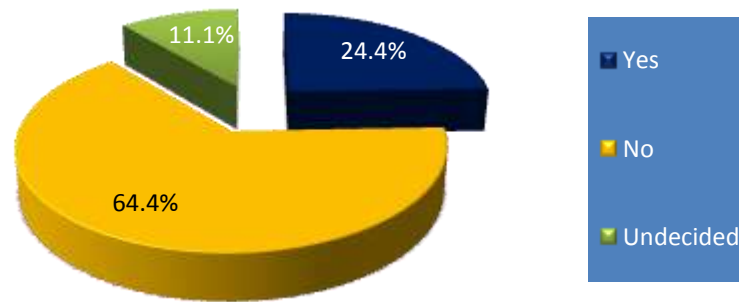
Of the respondents, 29 (64.4%) disagreed and 11 (24.4%) agreed that transformation of HCS had been successful. This data could indicate that while policies for transforming HCS were good, they had encountered problems during implementation for various reasons. Nevertheless, there had been observable changes including improved patients' rights, discontinuance of delivery of care in a discriminatory manner, the reduction of delivery of sophisticated curative health care, fortifying PHC services, free health care for pregnant women and young children, transformation of statutory bodies (Councils) that regulate registered health professionals, and the introduction of medical assistants to make up for shortage of doctors.

5.6.1.12 Promotions are allocated fairly in the PHS

The respondents were asked to indicate their experience with the allocation of promotions in the PHS (see figure 5.2).

Figure 5.2 RH respondents' perceptions of promotions (n=51)
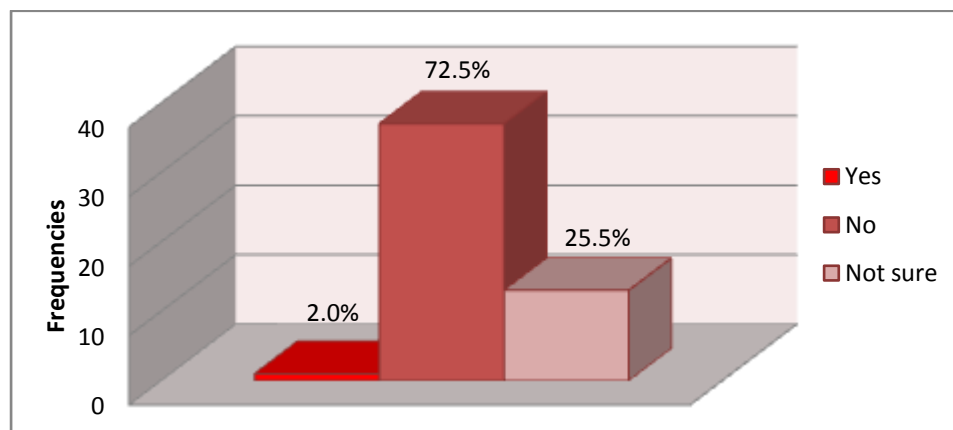
Of the respondents, 37 (72.5%) disagreed, one (2.0%) agreed, and 13 (25.5%) were not sure that promotions in the RH were fair. This could imply that promotions were allocated in a subjective manner. However, the new OSD salary structure emerged with grade promotions and pay progression, with different salary scales attached to qualifications. Although the OSD appears to favour those with specialty qualifications, it allows RNs to advance to the next salary scale without necessarily occupying the position at a higher level, depending on their specialty qualification.

5.6.1.13 Young South Africans are attracted to nursing

This item investigated the respondents' perceptions of the ability of the nursing profession to attract young South Africans to nursing (see figure 5.3).

Figure 5.3 RH respondents' perceptions of youth attracted to nursing (n=50)
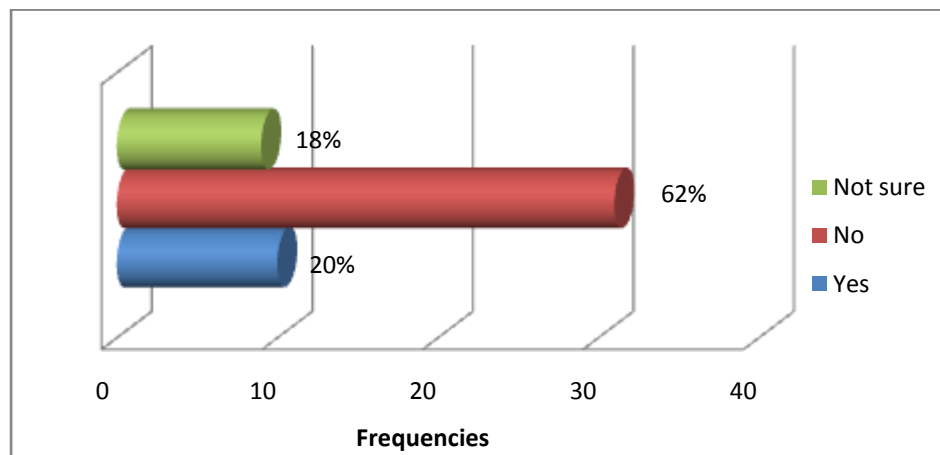
Of the respondents, ten (20.0%) agreed, 31 (62.0%) disagreed, and nine (18.0%) were not sure that South African youth were attracted to nursing. This item was included to establish the respondents' perception of public opinion on the status of nursing, in terms of attracting more young people to address the shortage of staff in HCS.

5.6.1.14 National workforce forum investigates nurses' issues

This item investigated the respondents' perceptions of a national workforce forum (see figure 5.4).

Figure 5.4 RH respondents' knowledge of national workforce forum (n=50)
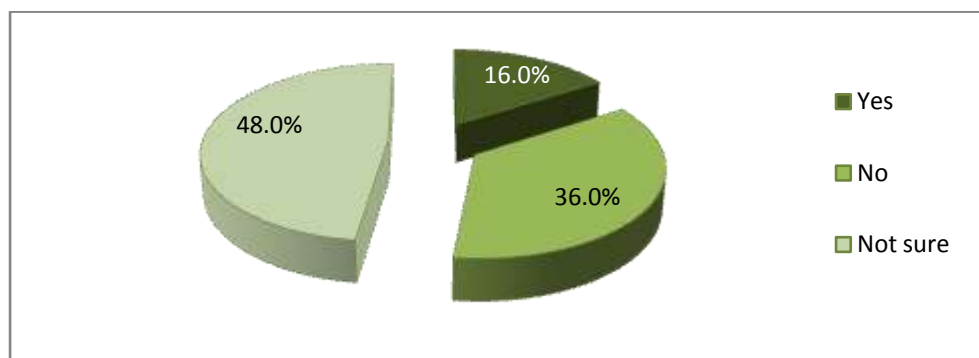
Of the respondents, eight (16.0%) agreed and 18 (36.0%) disagreed that there was a national nursing forum, while 24 (48.0%) were not sure. This could be an indication that the respondents had hoped that unions would not only address salaries but also tackle other issues.

5.6.1.15 Employing body communicates with nurses

This item sought to establish whether there were any channels of communication between government and nurses in the PHS (see figure 5.5). Of the respondents, 24 (46.2%) indicated that government occasionally communicated with nurses; 27 (41.0%) indicated never; none indicated frequently, and only one (2.0 %) indicated that government always communicated with nurses. Official communication could be through circulars, memorandums or policies, which are a one-way communication.

Figure 5.5 RH respondents' perception of communication with nurses (n=52)
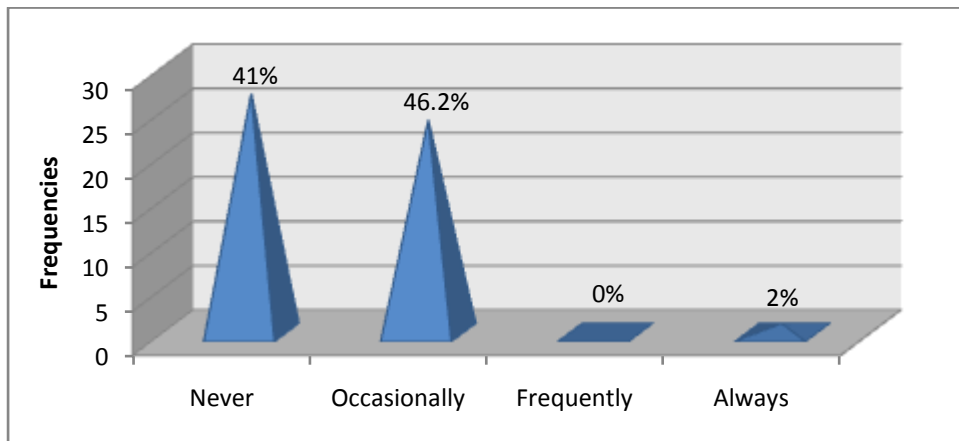
From the data there appears to be some form of communication as opposed to other hospitals involved in the study where the main source seemed to be unions.

5.6.1.16 OSD is a perfect solution for discontent

This item investigated the respondents' perceptions of the OSD as a strategy to minimize nurses' discontent in the PHS which seemed to have led to strike actions and unprecedented migration of RNs from the PHS (see figure 5.6).

Figure 5.6 RH respondents' perception of the OSD as solution (n=50)
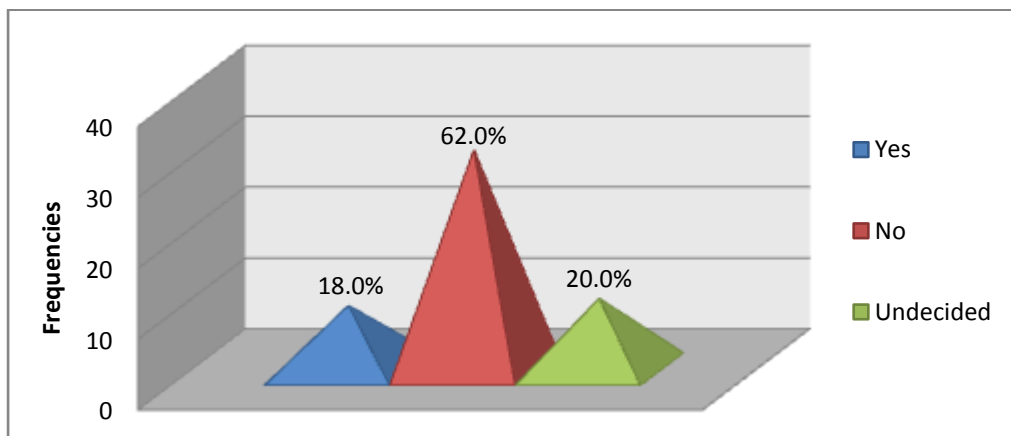
Of the respondents, 31 (62.0%) disagreed; nine (18.0%) agreed, and ten (20.0%) were undecided that the OSD was a perfect solution for discontent

among RNs. Ten (20.0%) other respondents remained silent on this issue. It should be borne in mind that the OSD was a strategy implemented coincidentally with the discontinuance of the national strike action in 2007. However, the findings above suggest that most of the respondents did not benefit from the OSD strategy, for some reason. The respondents may also have lacked vital information regarding the distribution of the OSD, prior to implementation for the purpose of calling for amendments or opposing its intention.

5.6.1.17 Stakeholders agree on the OSD

Figure 5.7 RH respondents' perception of stakeholder consensus on OSD (n=51)
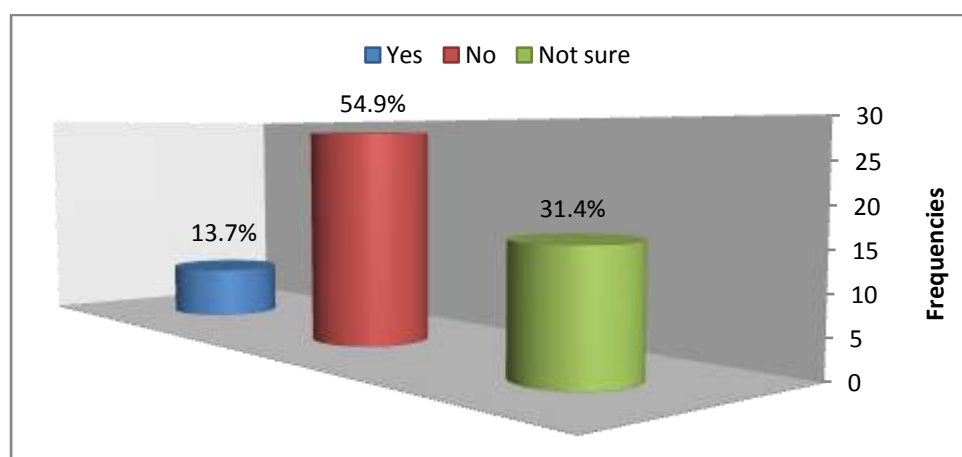
Of the respondents, 28 (54.9%) disagreed and seven (13.7%) agreed that there was consensus on the OSD, and 16 (31.4%) did not know. Moreover, similar to the previous item, it could be that the respondents were not well informed about the whole new salary structure in order to make meaningful and informed contributions and queries, which would imply that there was no consensus from the RNs side.

5.6.1.18 Overseas exchange programme is a success

This item intended to establish if the overseas exchange programme was a success in decreasing nurse migration from the PHS (see figure 5.8).

Figure 5.8 RH respondents' perception of overseas exchange programme success (n=45)
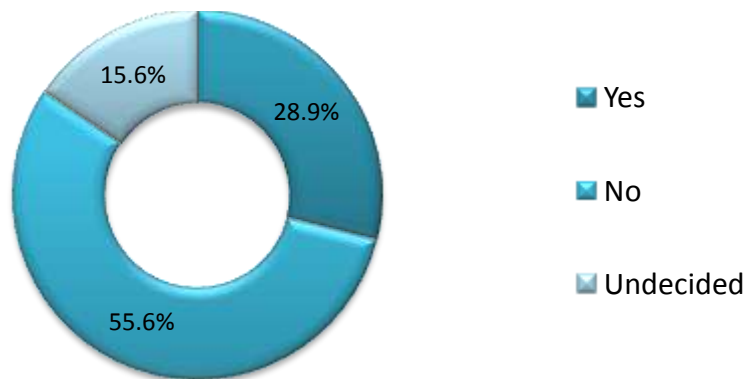
Of the respondents, 25 (55.6%) disagreed and 13 (28.9%) agreed that the overseas exchange programme was successful, while seven (15.6%) were not sure. Though the respondents attempted to answer this question, the researcher only subsequently learned from the DOH that the programme had only been implemented in academic hospitals selected by the Department.

(NB. In the following table and figure, 'strongly disagree' and 'disagree' frequencies and percentages; the 'strongly agree' and 'agree' frequencies and percentages have been combined respectively. Only the totals are presented.)

Table 5.11 RH respondents' perception of factors associated with discontent in the PHS

Statement	Disagree	%	Agree	%	Undecided	%
Discontent among RNs is an observable reality	5	9.6	44	84.6	3	5.8
Low morale and low salaries	1	1.9	45	90.0	4	7.7
RNs contribute ideas towards changes	21	40.4	23	44.3	8	15.4
RNs sponsored to attend conferences	41	71.4	5	10.0	5	10.0
RNs are financed to do research	35	70.0	5	10.0	10	20.0
Opportunities exist for RNs' career development	29	56.9	11	21.6	11	21.6
RNs' extended role as medical assistants	14	28.0	17	34.0	19	38.0

Figure 5.9 RH respondents' perception of factors associated with discontent in the PHS
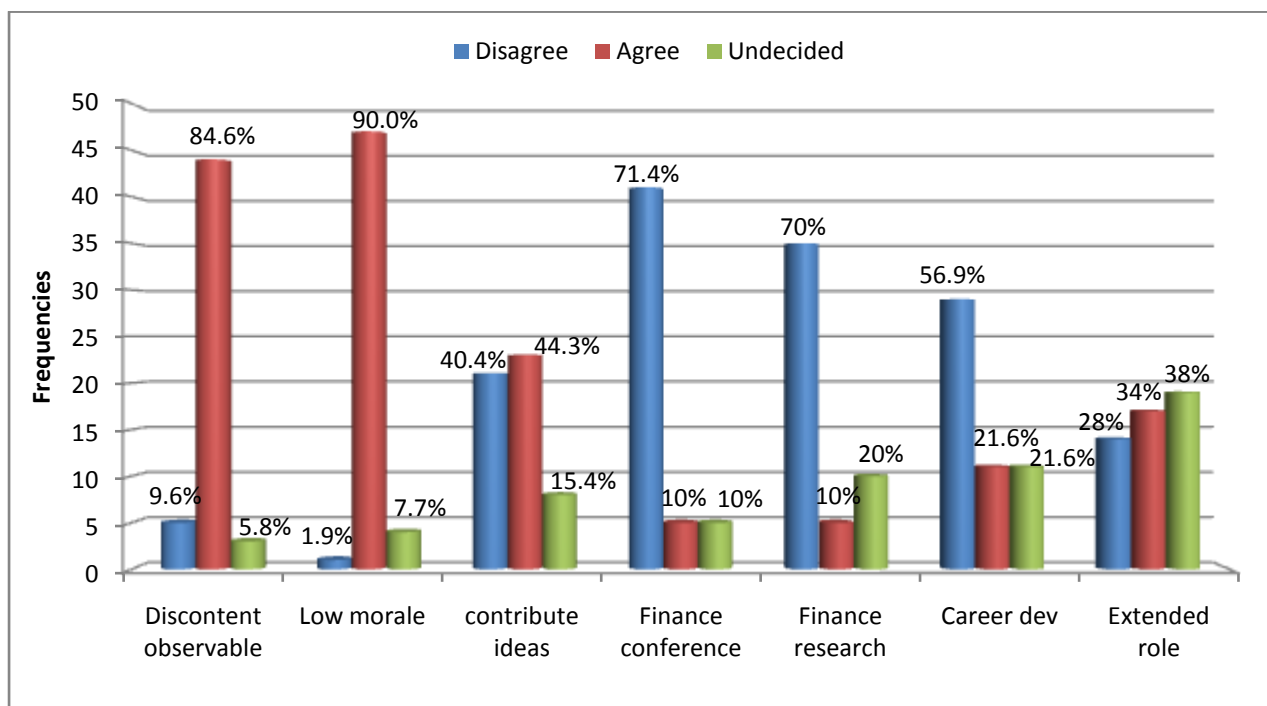
5.6.1.19 Discontent among registered nurses is an observable reality (n=52)

The data revealed that of the respondents, 44 (84.6%) agreed and five (9.6%) disagreed that discontent was observable, while three (5.8%) did not know. From the majority who agreed, it could be surmised that RNs are displeased or even frustrated by possible long-standing problems, expected changes as yet not attained, or the observable instability in the PHS where strikes and nurse migration have manifested HS.

5.6.1.20 Low morale is associated with low salaries in PHS (n= 50)

Of the respondents, 45 (90.0%) agreed and one (1.9%) disagreed that salaries were a major problem in the PHS associated with low morale among RNs, while four (7.7%) did not know. This could be an indication why many migrated, because this study assumed that not all RNs were in favour of strikes for better salaries. This could also perhaps refer to other factors such as conditions of service which entail long working hours, lack of equipment and relationships with their nursing leaders.

5.6.1.21 RNs contribute to change in hospitals (n=52)

Of the respondents, 23 (44.3%) agreed and 21 (40.4%) disagreed that RNs contributed to change in hospitals, while eight (15.4%) were undecided. This data could suggest that management involves RNs on occasion, but at other times decisions are made without their input.

5.6.1.22 RNs are sponsored for conferences (n=51)

Of the respondents, 41 (71.4%) disagreed and five (10.0%) agreed that nurses were sponsored to attend conferences, and five (10.0%) were undecided. From the majority, it would appear that RNs are not given financial

support to attend conferences. Conferences provide networking opportunities and help shift focus to a broader perspective.

5.6.1.23 RNs are financed to do research (n=50)

Of the respondents, 35 (70.0%) disagreed and five (10%) agreed that RNs were financed to conduct research, and ten (20.0%) were undecided. This finding created the impression that research initiatives are not supported in this RH.

5.6.1.24 Opportunities exist for RNs' career development (n=51)

Of the respondents, 29 (56.9%) disagreed and 11 (21.6%) agreed that there were opportunities for career development, and 11 (21.6%) did not know. This data could imply that the respondents were not able to advance as they would have liked to, possibly due to staff shortages or other reasons. The new career pathing strategy encapsulated in the OSD also seems not to have benefited most of the respondents.

5.6.1.25 RNs agree with their extended role as medical assistants (n=50)

Of the respondents, 14 (28.0%) disagreed and 17 (34.0%) agreed that RNs were satisfied with their role as extended medical assistants, while 19 (38.0%) did not know. From the data, most of the respondents appeared to be comfortable with the idea of being given the opportunity with one year's additional training to become medical assistants.

SECTION C: Workplace violence in the PHS

5.6.1.26 Security system for nurses in the workplace is satisfactory

The respondents were asked to indicate their experience of stress levels in the PHS (see figure 5.10).

Figure 5.10 RH respondents' perception of security system (n=54)
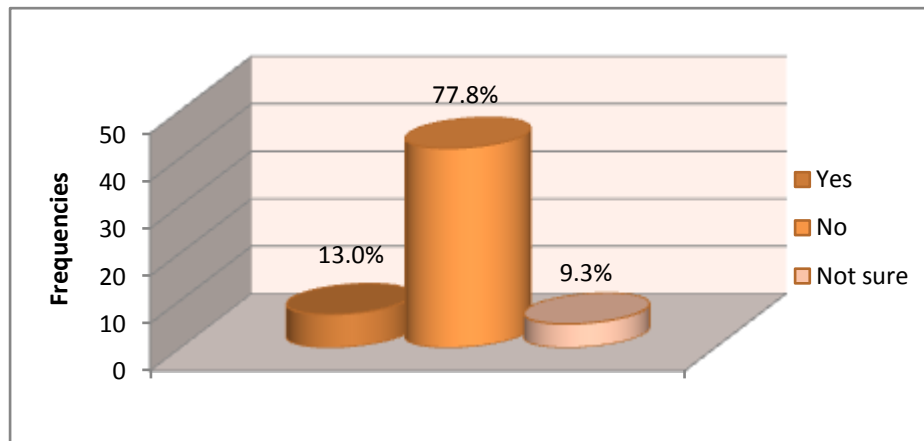
Of the respondents, 42 (77.8%) disagreed and seven (13.0%) agreed that the security system was satisfactory and they felt safe at work, while five (9.3%) did not answer the question. The finding therefore suggests that the security for nurses in this RH is inadequate or severely compromised. This is a matter of concern that requires urgent attention.

5.6.1.27 Patients are safe in hospital under the current security system

Of the respondents, 17 (32.1%) agreed while 24 (45.3%) disagreed that patients were safe under the current security system, and 12 (22.6%) did not know (see figure 5.11).

Figure 5.11 RH respondents' perception of patients' safety in hospital (n=53)
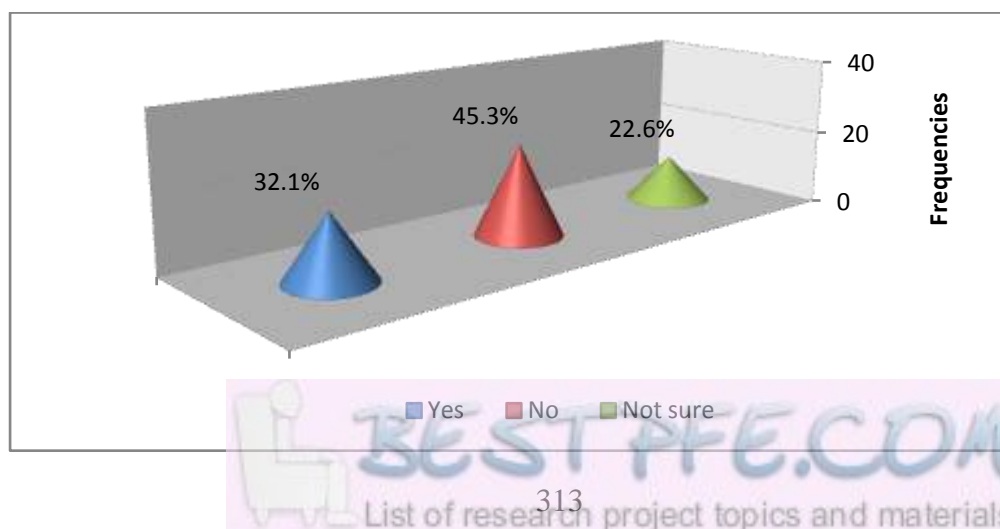
This data revealed that despite a degree of security in place, some areas could still be lacking. This question was included because nurses have a responsibility to ensure that both bedridden and mobile patients are always safe in hospital, in terms of their identity, diagnosis, and personal possessions and safety.

SECTION D: Stress

5.6.1.28 Stress is intolerable among RNs in the PHS

The respondents were asked to indicate their experience of stress levels in public hospitals.

Of the respondents, 40 (81.5%) agreed and four (7.4%) disagreed that stress had reached intolerable limits, while six (11.1%) did not indicate. The four respondents who disagreed could possibly still cope in spite of growing demands in the workplace (see figure 5.12).

Figure 5.12 RH respondents' perception of stress (n=50)
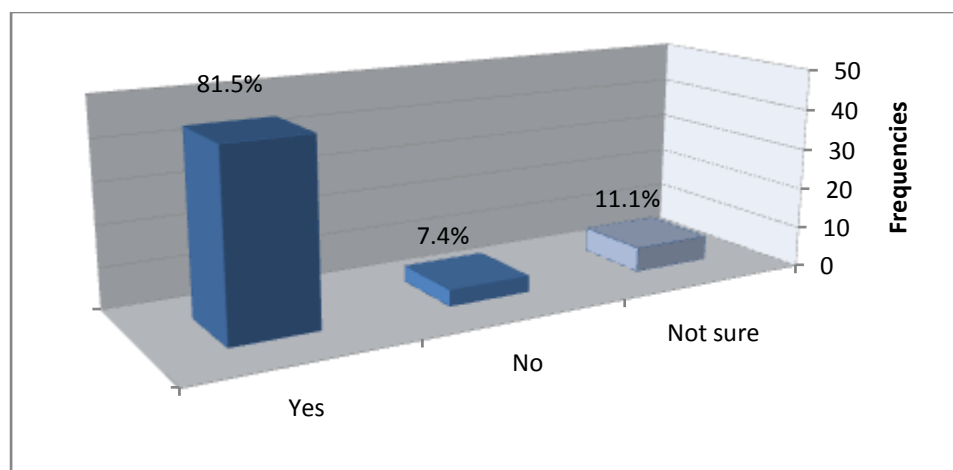
The majority of the respondents described the situation as intolerably stressful which, in turn, could emanate from poor salaries, poor working conditions and strike actions because some nurses perceive strikes as destabilizing the health environment.

5.6.1.29 Have you personally used your vacation for resting?

This question item sought to establish if RNs used their vacation for resting (see figure 5.13).

Figure 5.13 RH respondents' use of vacation to rest (n=54)
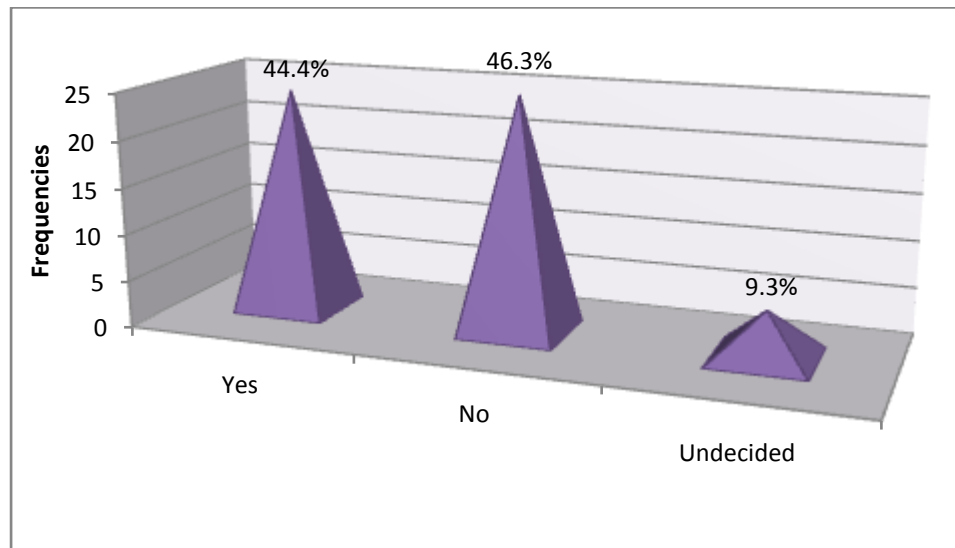
Of the respondents, 25 (46.3%) indicated that they did not and 24 (44.4%) indicated that they did use their vacation to rest, while five (9.3%) did not indicate. These findings could imply that the respondents who did not rest during their vacation leave had to work overtime to augment their salary. Those who did rest during vacation could also have been the older ones in particular, since this RH had staff members older than 65 (see table 5.1).

5.6.1.30 RNs experience physical signs of exhaustion

Figure 5.14 RH respondents' experience of physical signs of exhaustion (n=52)
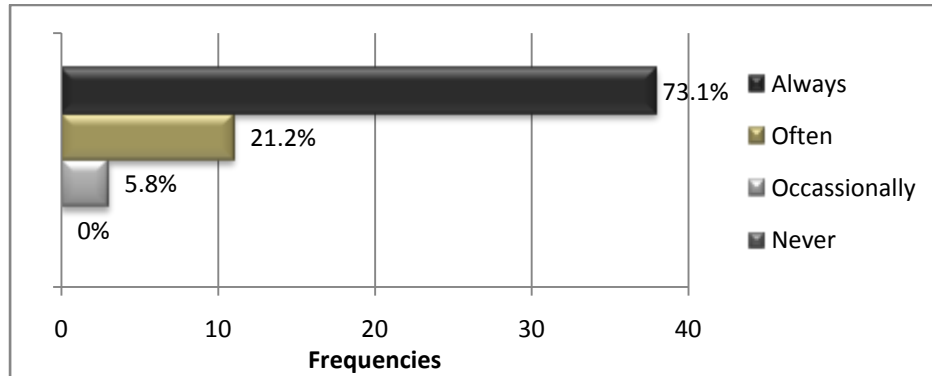
Of the respondents, 38 (73.1%) indicated that they always felt physical signs of exhaustion; three (5.8%) occasionally did; 11 (21.2%) often did, and none indicated that they never did. Data seem to suggest remarkable physical exhaustion among RNs in RH, which could be a result of increased workload due to shortage of staff.

5.6.1.31 Do you have intentions to leave the PHS for other institutions?

The respondents were asked if they had intentions to leave the PHS due to discontent (see figure 5.15).

Figure 5.15 RH respondents' intention to leave (n=53)
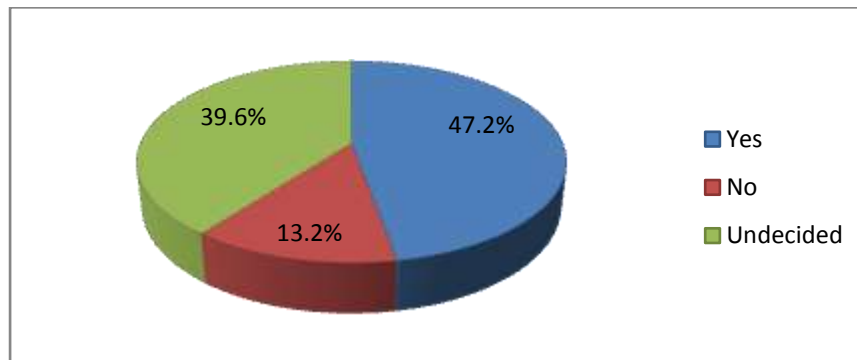
Of the respondents, 25 (47.2%) intended leaving the PHS and seven (13.2%) did not, while 21 (39.6%) did not know. These findings are of concern and raise serious questions about the future of PHS. These responses should not be viewed as mere threats since many who have left have set an example of what could follow. Nurses' discontent needs to be taken seriously and addressed as a matter of urgency to get the PHS back into excellent service in line with the *Batho Pele* white paper requirements. This data also confirms the findings that discontent among RNs was an observable reality (see figure 5.9).

SECTION E: Management and leadership problems

(NB. In the following table and figure, 'strongly disagree' and 'disagree' frequencies and percentages; the 'strongly agree' and 'agree' frequencies and percentages have been combined respectively. Only the totals are presented.)

Table 5.12 RH respondents' perception of management and leadership problems

Statement	Disagree	%	Agree	%	Undecided	%
Nurse managers' bullying attitudes	11	20.4	41	75.9	2	3.7
Outstanding contributions acknowledged	29	54.7	12	22.6	12	22.6
Nurse managers give feedback on problems reported	16	32.0	22	44	12	24.0
RNs are acknowledged for sacrifices	37	74.0	7	14.0	6	12.0
Hospital management discuss problems with RNs	20	37.0	20.0	37.0	14	25.9

Figure 5.16 RH respondents' perception of management and leadership problems
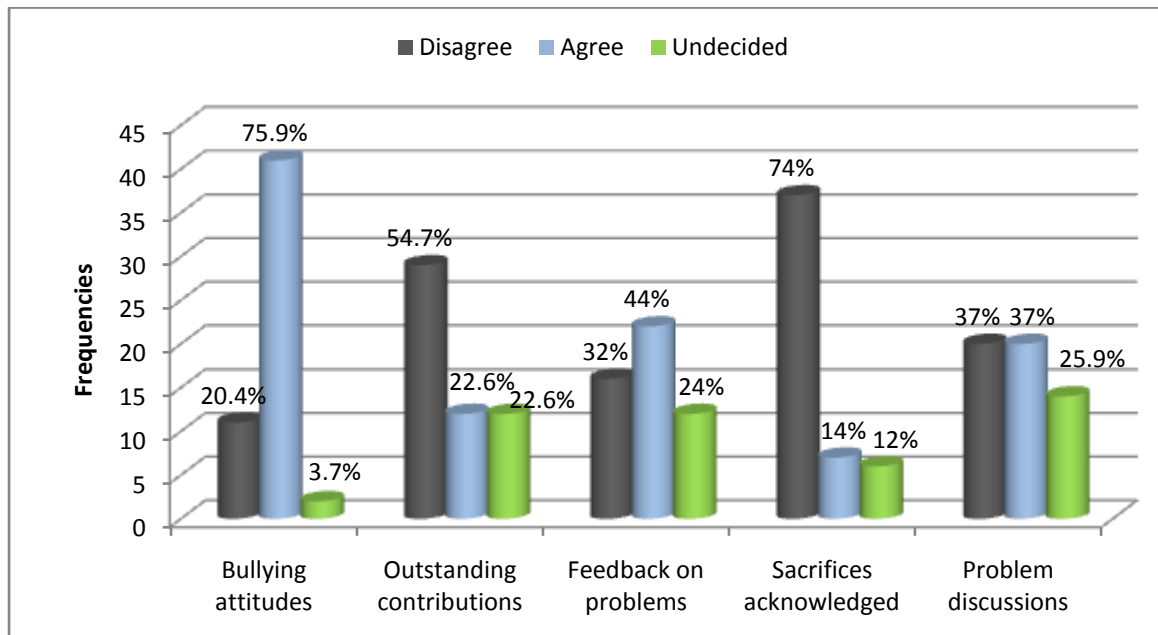
5.6.1.32 Some NSMs still display bullying attitudes (n=54)

The data revealed that of the respondents, 20.4% (16.7% + 3.7%) disagreed and 75.9% (33.3% + 42.6%) agreed that some NSMs still displayed bullying attitudes towards RNs, while two (3.7%) respondents were not sure. This data revealed the possible disharmony and internal conflicts existing between RNs and NSMs in the PHS and could also explain nurses' inclination to join unions. At the same time, however, NSMs' animosity towards RNs could be due to a sense of losing RNs to unions and possible union intimidation making it difficult to lead a divided workforce in hospitals.

5.6.1.33 RNs acknowledged for outstanding contributions (n=53)

Of the respondents, 54.7% (35.8% + 18.9%) disagreed and 22.6% (13.2% + 9.4%) agreed that RNs were acknowledged for outstanding contributions in their units, and twelve (22.6%) were undecided. This could signify the existence of discontent and demoralization among the respondents. Nursing leaders need to be more visible in the wards in order to acknowledge and

encourage the nurses that they are with them and are cognizant of their contributions.

5.6.1.34 NSMs give feedback on problems reported (n=50)

Of the respondents, 44.0% (34.0% + 10.0%) agreed and 32.0% (12.0% + 20.0%) disagreed that NSMs gave feedback on problems reported, while 12 (24.0%) did not answer the question. These findings suggested that NSMs in this RH provided RNs with feedback on problems reported.

5.6.1.35 RNs acknowledged for their sacrifices (n=50)

Of the respondents, 74.0% (38.0% + 36.0%) disagreed and 14.0% (10.0% + 4.0%) agreed that RNs were acknowledged for their sacrifices, while six (12.0%) did not know. This data implied that the majority of the respondents were dissatisfied because they were not acknowledged for the sacrifices they made. This further suggested that the respondents probably sacrificed their tea and lunch breaks or even their days off due to shortage of staff.

5.6.1.36 Management discuss problems with registered nurses (n=54)

Of the respondents, 20 (37.0%) agreed and 20 (37.0%) disagreed that hospital management discussed problems with RNs, while 14 (25.9%) did not know. This division could imply that some problems were discussed with RNs while in other instances, their input was not solicited. In addition, even though RNs are invited to meetings, they might on occasion be given solutions concluded by management.

SECTION F: Registered nurses and migration

This section intended to examine the RNs' perception of nurse migration from the PHS.

5.6.1.37 Nurse migration is due to inadequate salaries (n=54)

Figure 5.17 RH respondents' perception of inadequate salaries and migration
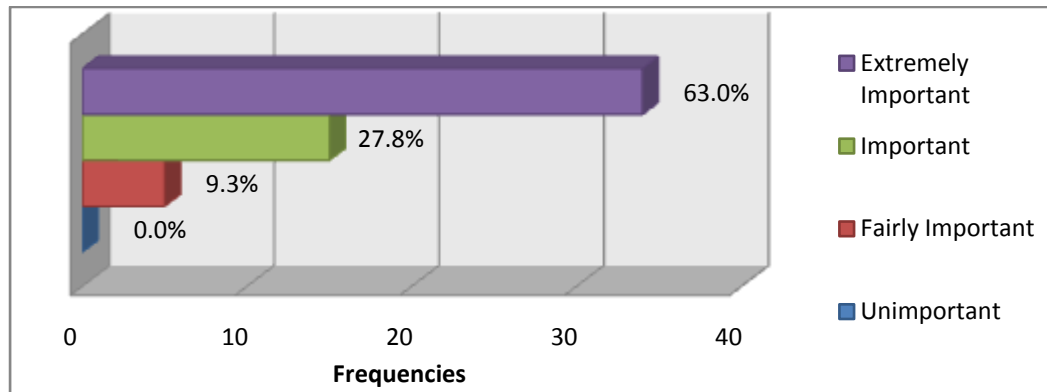
The respondents were asked to rate inadequate salaries as a reason for migration. Of the respondents, 34 (63.0%) indicated inadequate salaries as an 'extremely important' reason for migration; 15 (27.8%) considered inadequate salaries an 'important' reason; five (9.3%) considered them 'fairly important', and none (0.0%) considered them 'unimportant'. This concurred with the finding that the respondents largely disagreed that the OSD was a perfect solution for discontent among RNs because it appeared to benefit RNs with specialty qualifications (see figure 5.6).

5.6.1.38 Poor leadership in nursing contributes to nurse migration

Figure 5.18 RH respondents' perception of poor leadership in nursing (n=52)

320
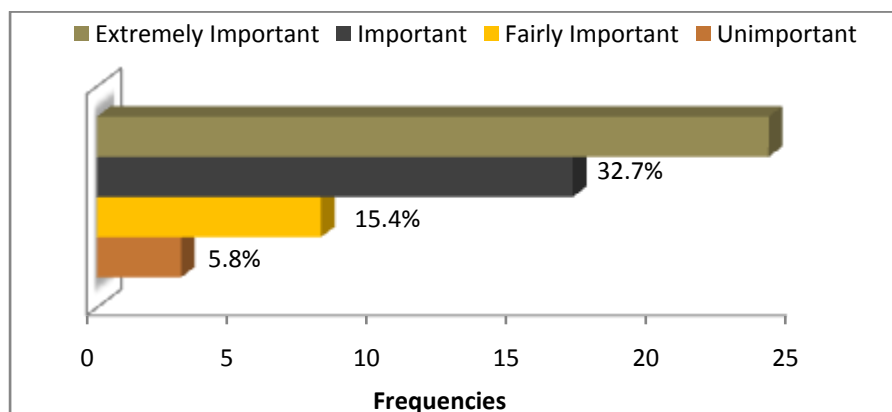
Of the respondents, 24 (46.2%) found poor leadership in nursing 'extremely important' for migration from the PHS; 17 (32.7%) considered it 'important'; eight (15.4%) considered it 'fairly important', and only three (5.8%) considered it 'unimportant'. This finding would appear to indicate strained relationships between RNs and the nursing leadership as one of the reasons for migration. This supports and emphasises the finding that some nurse managers still display bullying attitudes towards RNs (see figure 5.16).

5.6.1.39 Poor working conditions lead to nurse migration

Figure 5.19 RH respondents' perception of poor working conditions (n= 52)
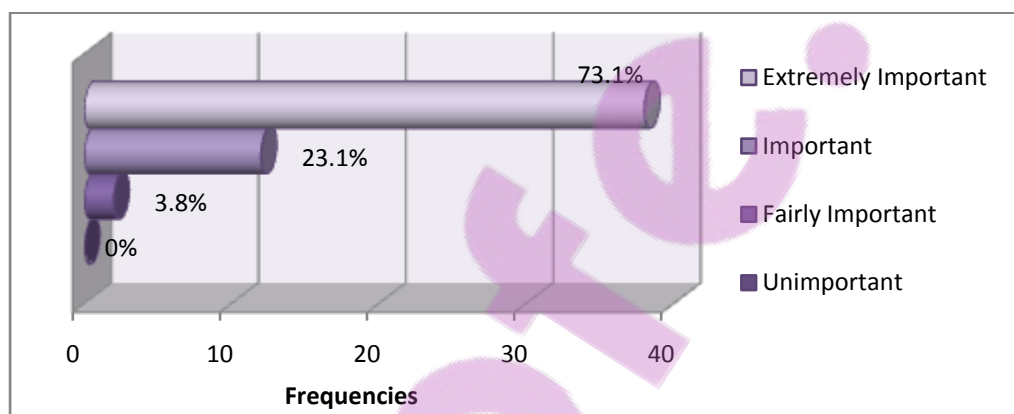
Of the respondents, 38 (73.1%) indicated poor working conditions an 'extremely important' reason for migration; 12 (23.1%) indicated 'important'; two (3.8%) indicated 'fairly important', and none indicated 'unimportant'. This finding emphasised the importance of good working conditions.

5.6.1.40 RNs migrate for "different" experience

Figure 5.20 RH respondents' perception of migration for "different" experience (n= 53)
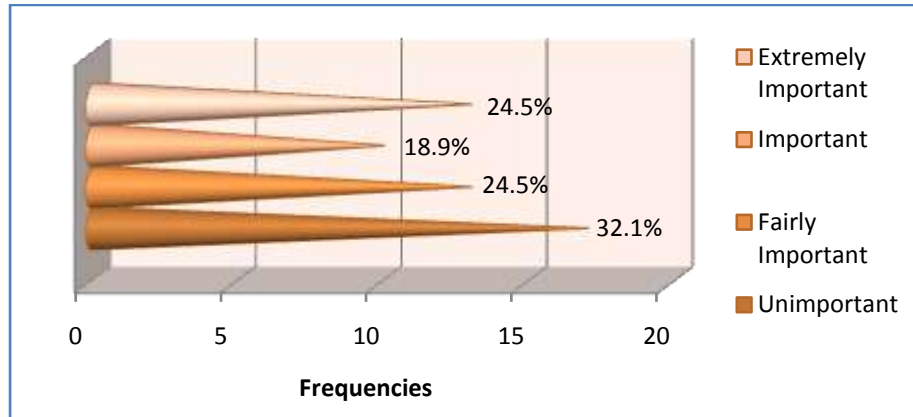
Of the respondents, 13 (24.5%) indicated acquiring "different" experience an 'extremely important' reason for migration; 10 (18.9%) indicated 'important'; 13 (24.5%) indicated 'fairly important', and 17 (32.1%) indicated 'unimportant'. This could therefore indicate the respondents' commitment to the profession and South African society by placing service delivery above pursuing "different" experience.

SECTION G: Nurses and strike actions

5.6.1.41 RNs prefer strikes to solve nurses' problems

The respondents were asked to indicate their experience with strike actions in the PHS (see figure 5.21).

Figure 5.21 RH respondents' perception of strikes to solve nurses' problems (n= 54)
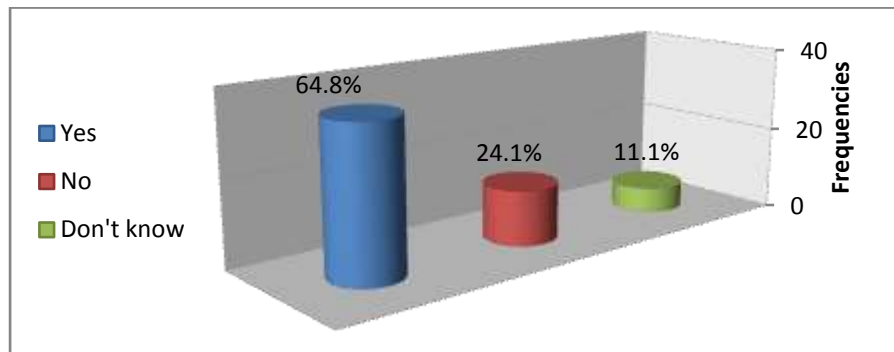
Of the respondents, 35 (64.8%) agreed and 13 (24.1%) disagreed that RNs preferred strikes to solve nurses' problems, and six (11.1%) did not know. The data could imply that the majority who agreed were drawing on experience of industrial actions that had yielded positive results in salary increases. Nevertheless, it should be borne in mind that not only salaries but also other work-related problems, such as staff shortages and lack of equipment, need to be addressed in the PHS.

5.6.1.42 RNs and unions share same values regarding patient care

This question sought the respondents' perceptions of shared values between the unions and the RNs regarding patient care (see figure 5.22).

Figure 5.22 RH respondents' perceptions of unions' and nurses' shared values (n= 53)
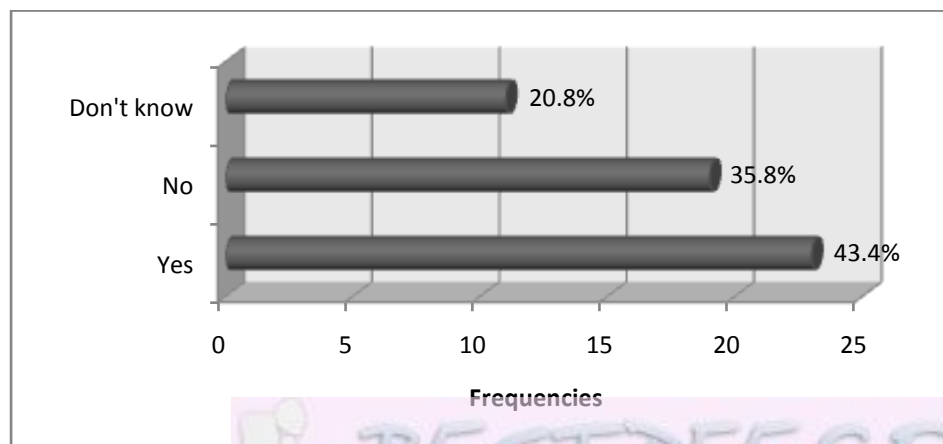
Of the respondents, 23 (43.4%) agreed and 19 (35.8%) disagreed that unions and nurses shared similar values, while 11 (20.8%) did not know. The slight difference between those who agreed and those who disagreed could imply that despite their view that unions and nurses shared values, they were not entirely convinced.

5.6.1.43 RNs support division between unions and professional associations

The respondents were asked to indicate their experience of the division between unions and professional associations within the PHS (see figure 5.23).

Figure 5.23 RH respondents' perception of division between unions and professional associations (n= 52)
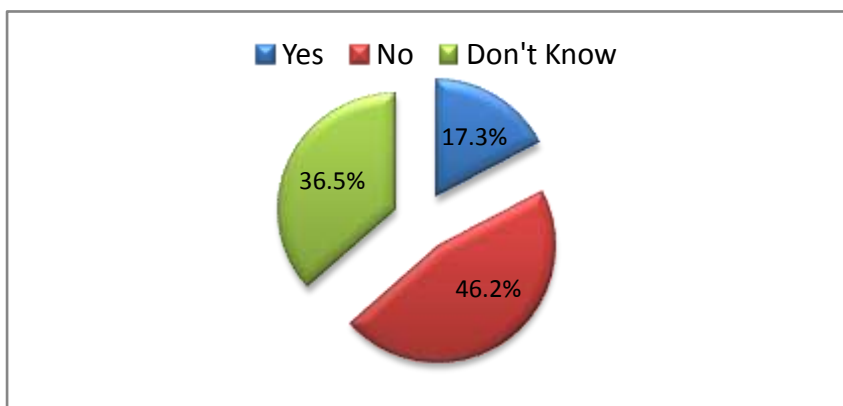
Of the respondents, nine (17.3%) agreed while 24 (46.2%) disagreed that RNs supported the division between unions and professional bodies, and 19 (36.5%) did not know. This finding contrasted with figure 5.21, where the majority indicated that nurses preferred strikes to solve their problems.

SECTION H: Nurses and politics

This section investigated political astuteness among nurses, particularly with regard to the changing political climate in the country and around the globe.

5.6.1.44 Poor nurse representation in government contributes to migration

Figure 5.24 RH respondents' perception of poor nurse representation in government (n=53)
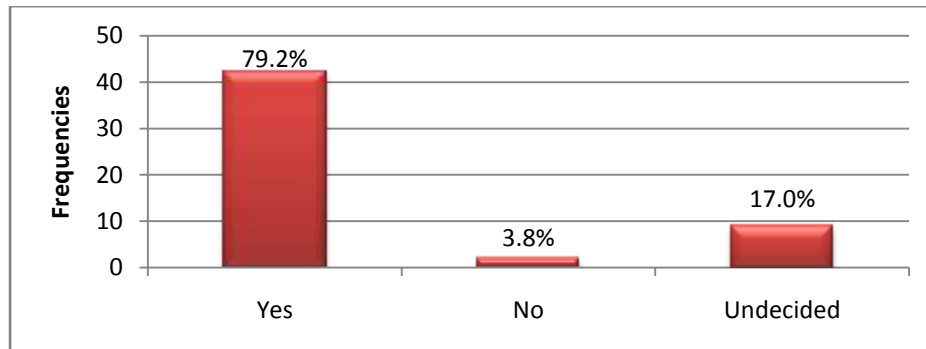
Of the respondents, 42 (79.2%) agreed that poor nurse representation in government contributed to migration, while two (3.8%) disagreed and nine (17.0%) were not sure. This data could suggest that the respondents were not satisfied with the current representation at government level or felt that their views were not represented, or that feedback did not filter through as expected.

5.6.1.45 RNs vote for parties that add value to nursing

Figure 5.25 RH respondents' perception of nurses' voting for parties that add value (n=52)
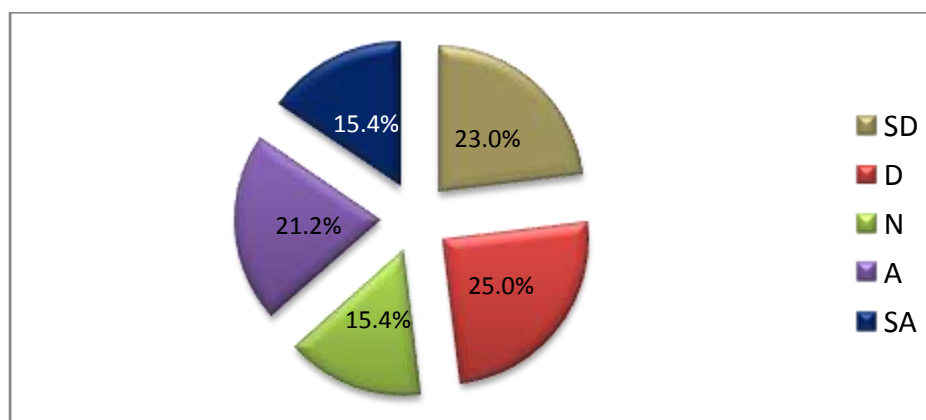
Of the respondents, 48.0% (23.0% + 25.0%) strongly disagreed/disagreed and 36.6% (21.2% + 15.4%) agreed/strongly agreed that RNs voted for parties that add value to nursing, while 15.4% did not know. The findings appear to indicate that the majority of the respondents did not think that RNs voted for parties that added value to nursing practice. This is a critical issue for the nursing profession because nurses need to be well informed about political parties and their agendas. The findings also support the notion that the nursing curriculum should include political science.

5.6.1.46 Nurses' issues are entertained in political debate

Figure 5.26 RH respondents' perception that nurses' issues are considered in political debates (n=50)
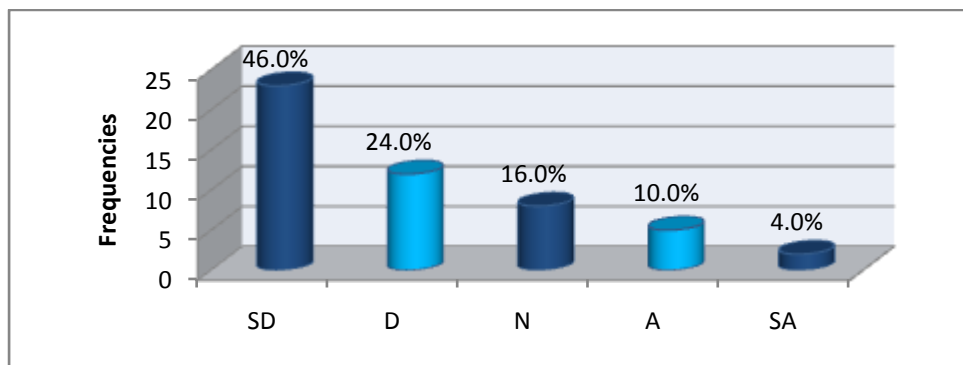
Of the respondents, 70.0% (46.0% + 24.0%) strongly disagreed/disagreed while only 14.0% (10.0% + 4.0%) agreed/strongly agreed that nurses' issues were entertained in political debates, and 16.0% did not know. This finding could be attributed to poor representation of nurses in government (see figure 5.24). Furthermore, this response could signal a need for better/more representation by nurses because they understand nurses' issues better.

5.6.1.47 RNs nurses can become policy analysts in South Africa

Figure 5.27 RH respondents' perception of RNs as policy analysts (n=52)
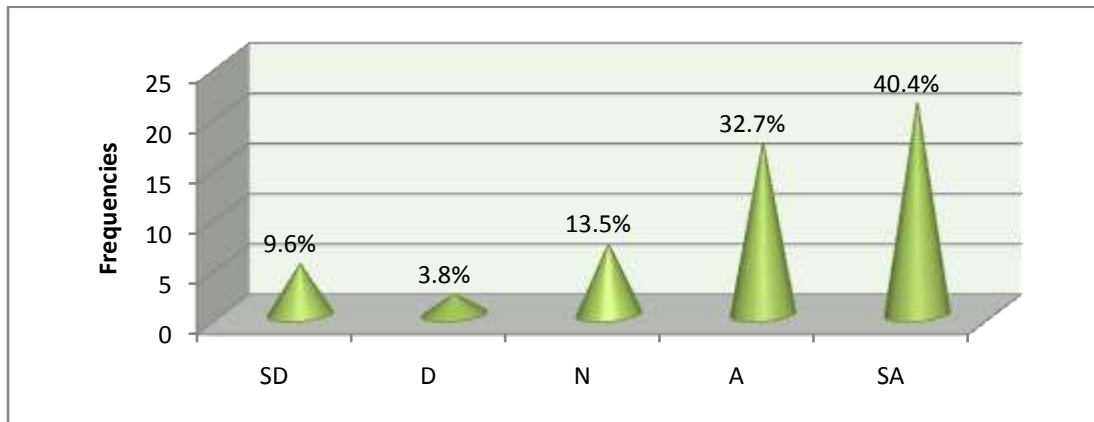
Of the respondents, 73.1% (40.4% + 32.7%) strongly agreed/agreed while 13.4% (9.6% + 3.8%) strongly disagreed/disagreed that RNs could become policy analysts in the RSA and 13.5% were undecided. This finding revealed a positive attitude towards RN involvement in political issues.

5.6.1.48 RNs know how policies are made in government

Figure 5.28 RH respondents' perception of policy making at government level (n=52)
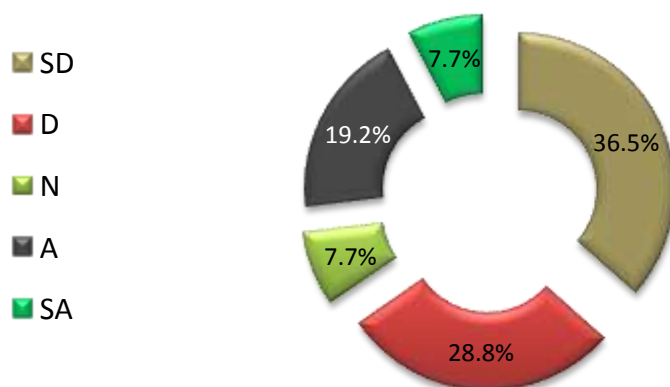
Of the respondents, 65.3% (36.5% + 28.8%) strongly disagreed/disagreed while 26.9% (19.2% + 7.7%) agreed/strongly agreed that RNs knew how policies were made at government level, and 7.7% did not know. This finding

would further imply that the lack of inclusion of political science in the nursing curriculum is largely responsible for a deficiency in political astuteness among RNs.

5.6.1.49 RNs can influence policy making

Figure 5.29 RH respondents' perception of RNs' influence on policy making (n=53)
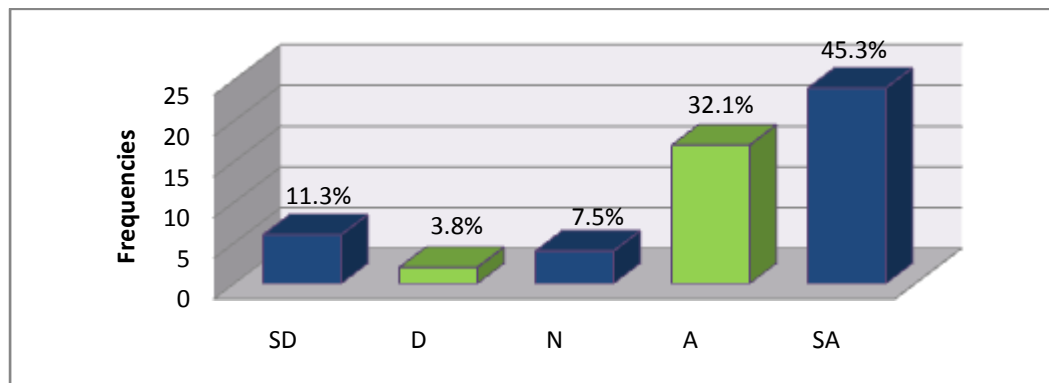
The RNs agreed by their majority, 77.4% (45.3% + 32.1%) strongly agreed/agreed that nurses can influence policy making processes in the country. It would seem that RNs are convinced that they can influence the politics of this country, meaning that the only problem could be lack of information on how to begin and how to get involved. This situation calls for mechanisms to be put in place which could facilitate information processes among RNs in all public hospitals. The combined total of those who disagreed was very insignificant (15.1%). Four (7.5%) of the RNs were not sure if nurses could influence policy-making processes or not.

5.6.2 Qualitative data analysis for the regional hospital

There were also written narratives that were provided by some of the respondents in questionnaire items. These are presented in chapter 6.

5.7 ACADEMIC HOSPITAL (AH)

This hospital is a level three health care institution located in Tshwane Metropolitan area. It offers highly specialized services such as Magnetic Resonance Image (MRI) scanner, 64-sliced Computed Tomography (CT) scanners, totally digital radiology, In vitro fertilization (IVF), picture archiving communication system (PACS) and other sophisticated procedures and services (Marais 2007). Because it is affiliated with medical universities, it offers practical training for students in the nursing profession, medical field and other medical related disciplines such as physiotherapy, occupational therapy, radiology, social work, pharmacology, and dietetics. It also caters for patients referred from level two and adjacent level one hospitals, and referrals from African States (DOH 2002:3-4; Ndaki, 2004).

At the time of the study, the AH had 601 RNs and 900 beds. The number of beds is indicative of the size of the hospital. Over the past five years, 363 RNs had resigned from this hospital for different reasons. Most of the units in this hospital were well equipped with modern equipment and computers. Because of the size of the hospital, 165 RNs who were on day shift were targeted for the study. However, only 68 completed questionnaires were returned, resulting in 41.2% response rate. This was considered a reasonable response rate in respect of the logistics of public health institutions such as staff shortages, day and night shifts as well as different kinds of leaves for RNs.

In the data analysis, the total number of respondents varied from item to item because some respondents did not answer all the questions.

5.7.1 Quantitative data analysis for Academic Hospital (AH)

(NB: In the tables and figures, AH indicates data for Academic Hospital.)

SECTION A: Demographic information

5.7.1.1 Age distribution

The respondents were asked to indicate their age (see table 5.1).

Table 5.1 AH respondents' ages (n=67)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	11	7	20	20	8	1	0
Percentage	16.4%	10.4%	29.9%	29.9%	11.9%	1.5%	0.0%

Of the respondents, 11 (16.4%) were between 18 and 25 years old; seven (10.4%) were between 26 and 33; 20 (29.9%) were between 34 and 41; 20 (29.9%) were between 42 and 49; eight (11.9%) were between 50 and 57; one (1.5%) was between 58 and 65, and one did not indicate age. The data found that most of the respondents were between 34 and 49 years old. This is the age range that is vulnerable to migration, unless nursing and health care issues are given appropriate and urgent attention.

5.7.1.2 Race

The respondents were asked to indicate their race (see table 5.2).

Table 5.2 AH respondents' race (n=68)

Race	Black	Coloured	Asian	White	Other (Please specify)
Frequency	42	11	0	15	0
Percentage	61.8%	16.2%	0.0%	22.1%	0.0%

Of the respondents, 42 (61.8%) were Black; 11(16.2%) were Coloured, and 15 (22.1%) respondents were White. There were no Asians or other races.

5.7.1.3 Gender

Of the respondents, 65 (98.5%) were females and one (1.5%) was male (see table 5.3). Even though more male RNs were on the hospital record, they were not available for this study because of leave, days off and work-related obligations.

Table 5.3 AH respondents' gender (n=66)

Gender	Frequency	Percentage
Male	1	1.5
Female	65	98.5

5.7.1.4 Marital status

Of the respondents, 32 (49.2%) were married; 28 (43.1%) were single; four (6.2%) were divorced, and one (1.5%) was widowed (see table 5.4). Three respondents did not indicate marital status.

Table 5.4 AH respondents' marital status (n=65)

Marital status	Married	Single	Divorced	Widowed
Frequency	32	28	4	1
Percentage	49.2%	43.1%	6.2%	1.5%

Since there were more married RNs in table 5.4, it is assumed that there could be more discontent among RNs, particularly if their schedules interfered with their family obligations. This could imply that in their multiple roles as RNs, mothers, wives, students and members of society, they still need time to be with their families, attend to their studies and fulfil their other roles and commitments. Financial obligations apply to all categories of RNs since all need adequate salaries to care for their families.

5.7.1.5 Number of dependants

Of the respondents, 17 (25.4%) had no dependants; 48 (71.6%) had between 1 and 3 dependants, and two (3.0%) had more than three dependants (see table 5.5). One respondent did not answer this question.

Table 5.5 AH respondents' number of dependants (n=67)

Dependants	None	1 – 3	> 3
Frequency	17	48	2
Percentage	25.4%	71.6%	3.0%

Table 5.5 shows that the majority of the respondents had between 1 and 3 dependants, a potential area of discontent especially if they worked compulsory night shifts, which would require a helper. This item was included to determine the respondents' financial responsibilities and family commitments that require working conditions and salaries adequate to meet their needs.

5.7.1.6 Residential area

Of the respondents, 35 (52.2%) lived in the city suburbs; 30 (44.8%) in townships, and two (3.0%) came from a village (see table 5.6). None came from informal settlements (see table 5.6).

Table 5.6 AH respondents' residential area (n=67)

Residence	City/Town	Township	Village	Informal settlement
Frequency	35	30	2	0
Percentage	52.2%	44.8%	3.0%	0.0%

The study surmised that the respondents' residential area could also aggravate discontent in terms of financial cost of accommodation, particularly RNs who came from rural areas and other provinces.

5.7.1.7 Type of health care service

All the respondents worked in selected PHs (see table 5.7).

Table 5.7 AH respondents' public health service (n=68)

Hospital	Academic hospital	Regional hospital	District hospitals	Private hospitals
Frequency	68	0	0	0
Percentage	100.0%	0.0%	0.0%	0.0%

5.7.1.8 Positions held

Of the respondents, 26 (39.4%) were CPNs; 14 (21.2%) were SPNs, and 26 (39.4%) were PNs (see table 5.8). Two respondents did not indicate their positions.

Table 5.8 AH respondents' positions held (n=66)

Positions	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	26	14	26
Percentage	39.4%	21.2%	39.4%

Since the study used a purposive sample, the respondents did not represent a conclusive picture of the spread of positions held in their hospitals. A random sample would have enabled a selection of equal proportions of respondents from different ranks, particularly if the majority had previous PHS employment history (see chapter 4, section 4.8.1).

5.7.1.9 Years of experience since registration

Of the respondents, 20 (31.3%) had between one and five years' nursing experience since registration with the SANC; 11 (17.2%) had between 6 and 10 years; 23 (36.0%) had between 11 and 20 years; nine (14.1%) had between 21 and 30 years, and only one (1.6%) had between 31 and 40 years'

experience (see table 5.9). No one had over 40 years' service since registration. Four respondents did not indicate their years of experience.

Table 5.9 AH respondents' years of experience (n=64)

Experience	1-5	6-10	11-20	21-30	31-40	41-50	51-60
Frequency	20	11	23	9	1	0	0
Percentage	31.3%	17.2%	36.0%	14.1%	1.6%	0.0%	0.0%

Years of experience were critical in this study as they need to be recognized when special awards, opportunities and other incentives are given to public servants or this could become an area of discontent.

5.7.1.10 Qualifications

Of the respondents, 12 (19.7%) had a Basic Nursing Diploma (BND); 17 (27.9%) had a post-BND; 19 (31.1%) had a basic four-year nursing degree; nine (14.8%) had a BA Cur degree, and four (6.6%) had doctoral degrees in nursing (see table 5.10). Seven of the respondents did not provide information on this aspect.

Table 5.10 AH respondents' qualifications (n= 61)

Qualification	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hons	M	D
Frequency	12	17	19	9	0	0	4
Percentage	19.7%	27.9%	31.1%	14.8%	0.0%	0.0%	6.6%

Higher qualifications in nursing are a result of dedicated hard work, commitment to the nursing profession, and an immeasurable contribution to excellence in delivery of care. Therefore, this would require recognition of qualifications, proper placements, and remuneration commensurate to their worth. Without these considerations, academic advancement could be retarded in the future for lack of recognition and rewards.

SECTION B: Transformation of PHS

5.7.1.11 PHS transformation successful

Of the respondents, 31 (50.8%) disagreed and 28 (46.0%) agreed that transformation in HCS was successful, while 3.2% were not sure (see figure 5.1).

Figure 5.1 AH respondents' perception of PHS transformation (n=61)
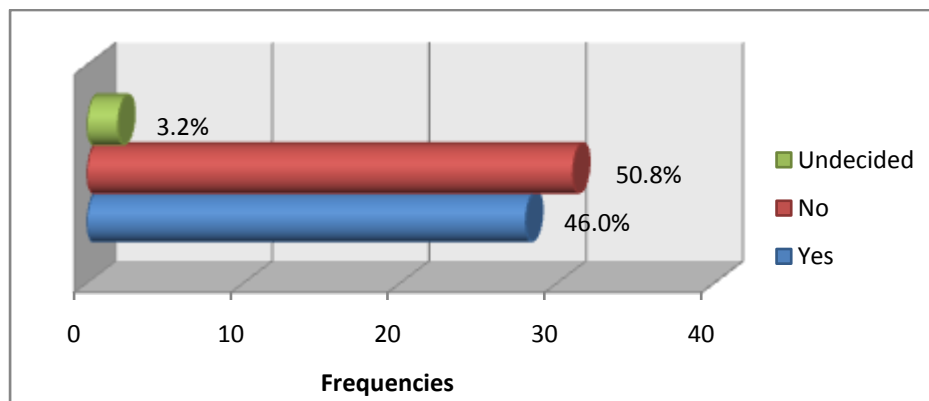
The results appeared to indicate that transformation had not evolved as the respondents had expected, even though benefits had been derived from transformational initiatives. Some areas had not improved, while transformation had brought more responsibilities, less incentives and inequitable advantages for health care providers. According to respondents, free PHC services and improved patients' rights had placed an additional burden on staff.

5.7.1.12 Promotions are allocated fairly in the PHS

Of the respondents, 15 (23.1%) agreed that promotions were fair while 40 (61.5%) disagreed, and ten (15.4%) did not know (see figure 5.2). This could imply unfair practices, possibly due to favouritism or deliberate exclusion by NSMs.

Figure 5.2 AH respondents' perception of promotions (n=65)
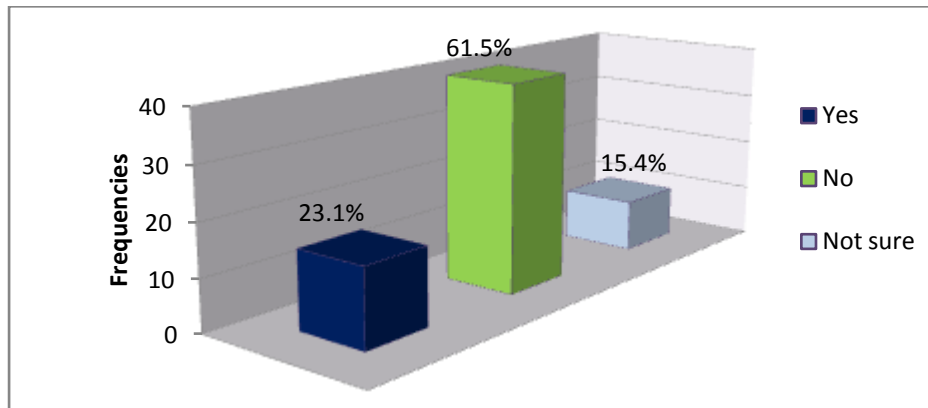
The new OSD salary structure with grade promotions and pay progression, and different salary scales attached to qualifications was intended to improve the situation. This system also seems to have caused discontent, however, because it appears to favour those with specialty qualifications. It should be noted that the OSD did not consider RNs with higher academic qualifications, which is a serious area for discontent particularly after investing so much in their studies.

5.7.1.13 Young South Africans are attracted to nursing

This question was included to assess RNs' perceptions of the efficacy of recruitment efforts in an attempt to combat shortage of staff in the PHS.
Of the respondents, 44 (68.8%) disagreed while 15 (23.4%) agreed that young people of South Africa were still attracted to nursing, and five (7.8%) were not sure (see figure 5.3).

Figure 5.3 AH respondents' perception of youth attracted to nursing (n=64)
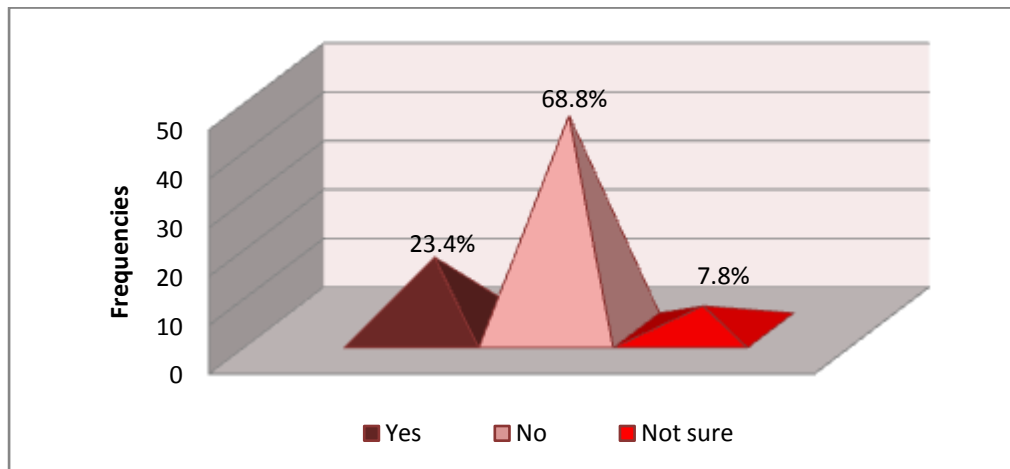
According to respondents, discontent among RNs could be associated with a poor public image of nursing.

5.7.1.14 A national workforce forum investigates nurses' issues

Of the respondents, 14 (21.5%) agreed while 28 (43.1%) disagreed and 23 (35.4%) did not know that a nursing forum existed to investigate nurses' issues (see figure 5.4).

Figure 5.4 AH respondents' knowledge of national nursing forum (n=65)
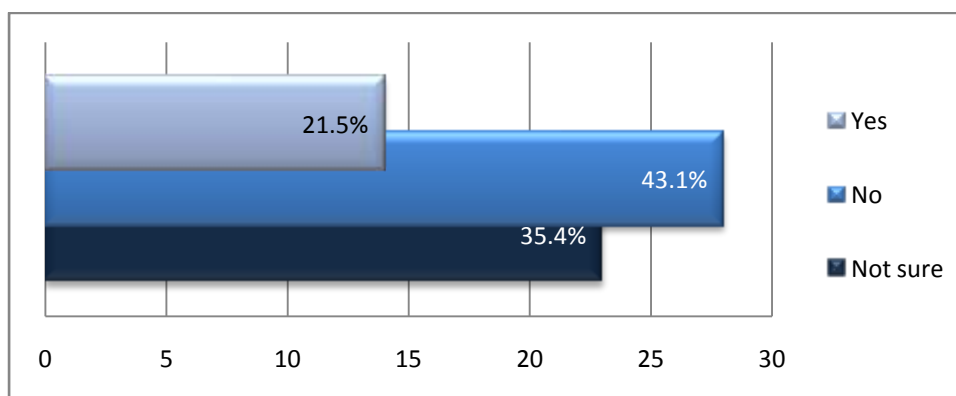
From figure 5.4 it could be deduced that some of the respondents possibly joined unions to address their issues, particularly if they felt that they did not want to join professional associations.

5.7.1.15 Employing body communicates with nurses

Of the respondents, 27 (42.2%) indicated that the government never communicated with nurses; 34 (53.1%) indicated occasional communication; three (4.7%) indicated frequent communication. None indicated that government always communicated with nurses (see figure 5.5).

Figure 5.5 AH respondents' perception of communication with nurses (n=64)
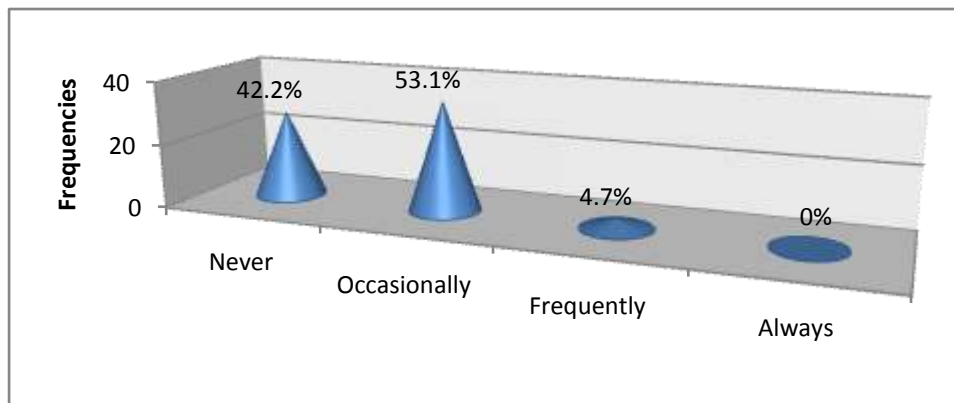
Given the numerous issues government has to deal with, the researcher considered the response acceptable as occasional communication should be sufficient for important issues to be communicated to employees at operational level. It would be an indictment against government if all communication were left to unions.

5.7.1.16 The Occupational Specific Dispensation (OSD) is a perfect solution for discontent

Of the respondents, 45 (67.2%) disagreed and only 15 (22.4%) agreed that the OSD was a perfect solution, while seven (10.4%) did not know (see figure 5.6).

Figure 5.6 AH respondents' perception of the OSD as solution (n=67)
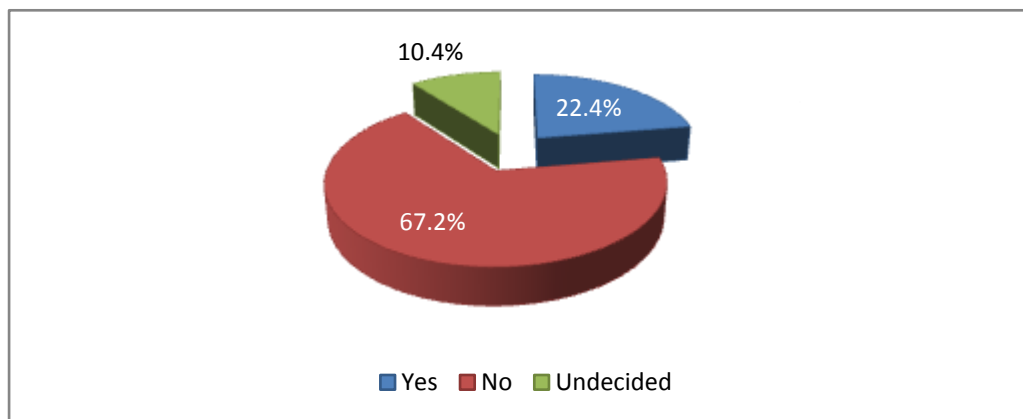
The majority disagreement of the AH respondents could emanate from the fact that the OSD did not appear to have met their expectations, since not all nurses benefited. The criterion used might also not have been explained or understood clearly and precisely to them, hence the dissatisfaction. The few respondents who agreed could have been among those who benefited from the new salary structure probably because they satisfied the requirements.

5.7.1.17 All stakeholders agree on the OSD

Of the respondents, 47 (71.2%) disagreed and only four (6.1%) agreed that there was stakeholder consensus on the OSD, while 15 (22.7%) did not know (see figure 5.7).

Figure 5.7 AH respondents' perception of stake holder consensus on the OSD (n=66)
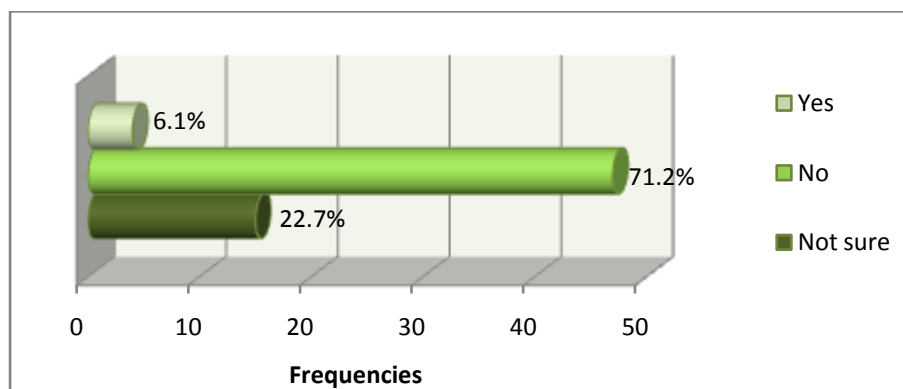
This result concurred with the finding that 67.2% disagreed that the OSD was the perfect solution (see figure 5.6). Since the AH was a large establishment, the data indicated that there was no consensus regarding the implementation of the OSD, thereby creating the impression of no prior soliciting of input from the respondents. The 22.7% who were not sure on consensus also implied a lack of information regarding the OSD. Moreover, this result did not seem to support the finding that 53.1% of the respondents agreed that there was occasional communication between government and the nurses in PHS (see figure 5.5). It can therefore be surmised that this part of important information was not included in the occasional communication from government.

5.7.1.18 Overseas exchange programme a success

Of the respondents, 25 (46.3%) disagreed and 19 (35.2%) agreed that the overseas exchange programme was a success (see figure 5.8).

Figure 5.8 AH respondents' perception of overseas exchange programme success (n= 54)
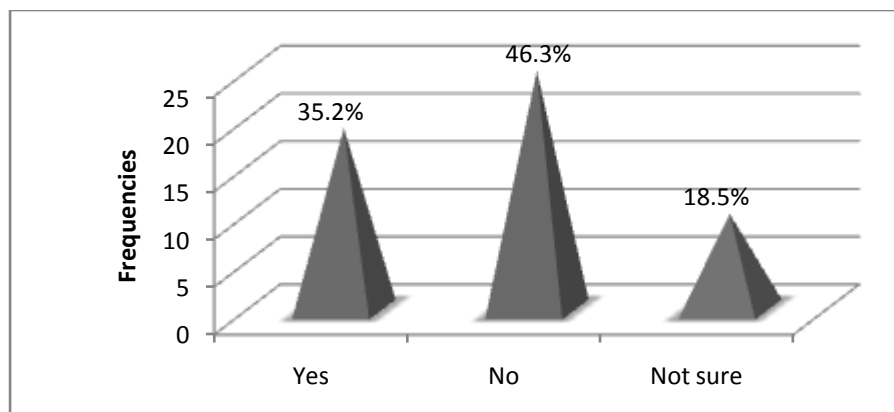
The insignificant difference in these responses would imply that involvement in the programme was neither bad nor good. Since this AH had an opportunity to participate in the programme, the respondents' views can be endorsed as legitimate because they were based on experiential information and insight. This could mean that the majority of the respondents felt that this programme could advance their careers. However, the responses of those who disagreed could be linked to possible unfulfilled expectations at the host hospitals

overseas, or difficulty in complying with the conditions attached to such contracts.

5.7.1.19 Discontent among registered nurses is an observable reality

Of the respondents, 77.4% (25.8% + 51.6%) agreed/strongly agreed, only 9.6% (4.8% + 4.8%) strongly disagreed/disagreed that discontent of RNs was an observable reality, while eight (13.0%) did not know (see table 5.11).

Table 5.11 AH respondents' observation of discontent among RNs (n=62)

Responses	SD	D	N	A	SA
Frequency	3	3	8	16	32
Percentage	4.8%	4.8%	13.0%	25.8%	51.6%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The respondents who agreed could have been referring to visible acts of discontent such as involvement in strike actions and migration from the PHS. This could also indicate the evident division of nurses between unions and professional associations.

5.7.1.20 Low morale associated with low salaries in public hospitals

Of the respondents, 75.9% (56.9% + 19.0%) strongly agreed/agreed and 12.1% (5.2% + 6.9%) strongly disagreed/disagreed that low morale was associated with low salaries, while seven (12.1%) did not know (see figure 5.9).

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Figure 5.9 AH respondents' perception of low morale associated with low salaries (n=58)
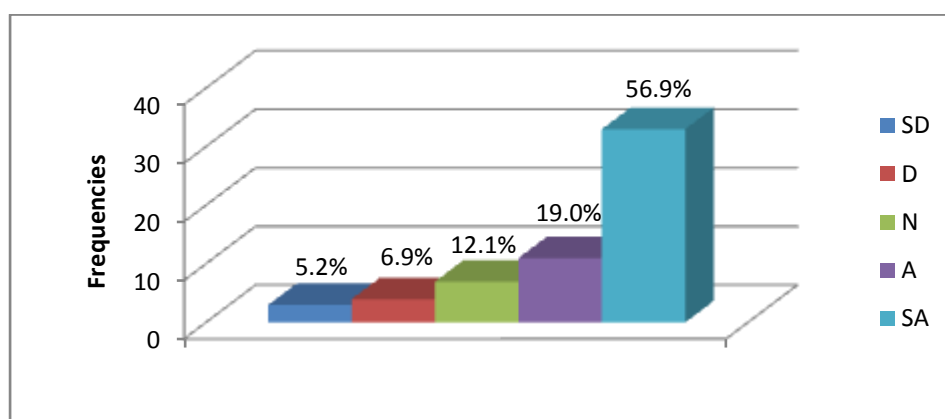
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This result could indicate that those respondents contemplating migrating endured the conditions in a state of low morale until they could leave. Those who disagreed, however, may also have considered reasons other than low salaries.

5.7.1.21 RNs contribute to change in hospitals

Of the respondents, 46.1% (30.2% + 15.9%) agreed/strongly agreed and 27.0% (11.1% + 15.9%) strongly disagreed/ disagreed that RNs contributed to change in hospitals, while 17 (27.0%) were not sure (see table 5.12).

Table 5.12 AH respondents' perception of RNs contribution to change in hospitals (n=63)

Responses	SD	D	N	A	SA
Frequency	7	10	17	19	10
Percentage	11.1%	15.9%	27.0%	30.2%	15.9%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From table 5.12 it would seem that the respondents were given an opportunity to make their own contributions to change in the AH. This would imply a sharing of information between hospital management and nurses in this hospital.

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5.7.1.22 RNs are sponsored for conferences

Of the respondents, 62.0% (42.9% + 19.1%) strongly disagreed/disagreed and only 12.7% agreed that they were sponsored to attend conferences, while 25.4% did not know (see figure 5.10).

Figure 5.10 AH respondents' perception of sponsorship for conferences (n=63)
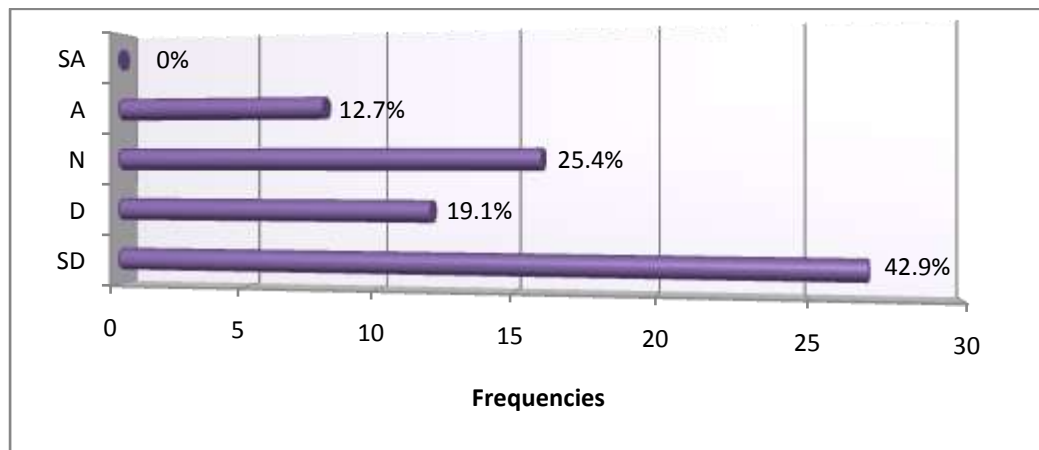
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This data seemed to suggest that despite possible interest among RNs to stimulate their profession by attending conferences, the NSMs appear to show no interest. As a cadre that has connections with the corporate world, NSMs could be expected to find ways of funding nurses' events. Such effort eventually translates into the welfare of nurses as government employees. In addition, government contributions could also play a significant role in making this venture a reality.

5.7.1.23 RNs are financed to do research

Of the respondents, 73.0% (39.7% + 33.3%) strongly disagreed/disagreed and 13.8% (4.8% + 9.0%) agreed/strongly agreed that nurses were financed to do research, while 12 (19.1%) did not know (see table 5.11)

Figure 5.11 AH respondents' perception of financing for research (n=63)
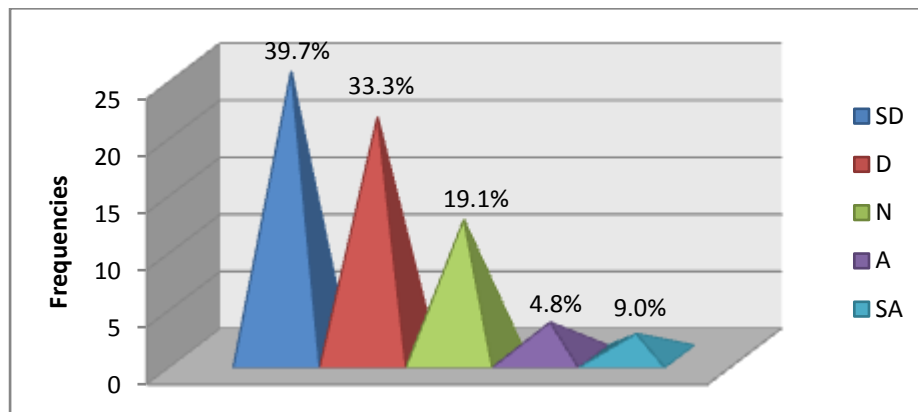
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Research is vitally important in order to solve problems and to add to the theory base in the nursing profession. The data appeared to indicate that the respondents were not consulted on or financed to undertake research on identified areas, including health and organizational problems. Furthermore, there are many research institutions that could assist RNs in this regard without necessarily directly involving government.

5.7.1.24 Opportunities exist for RNs' career development

Of the respondents, 47.7% (35.0% + 12.7%) agreed/strongly agreed and 27.0% (12.7% + 14.3%) strongly disagreed/disagreed that opportunities for career development existed, while 16 (25.4%) were undecided (see table 5.13).

Table 5.13 AH respondents' perception of opportunities for career development (n=63)

Responses	SD	D	N	A	SA
Frequency	8	9	16	22	8
Percentage	12.7%	14.3%	25.4%	35.0%	12.7%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Although this did not appear to be the case in this AH, these results indicate a potentially significant cause for discontent among RNs, which could trigger

decisions to look for better alternatives. The reason for this is that if issues of staff shortages are not settled in a timely manner in the PHS, NSMs could find it difficult to allocate study opportunities. It should also be borne in mind that career pathing and pay progression initiatives in the OSD for nurses have made provision for RNs to advance to higher salary scales without necessarily occupying senior positions.

5.7.1.25 RNs agree with their extended role as medical assistants

Of the respondents, 47.7% (11.1% + 36.5%) strongly agreed/agreed and 27.0% (11.1% + 15.9%) strongly disagreed/disagreed with their extended role as medical assistants, while 25.4% were undecided (see figure 5.12).

Figure 5.12 AH respondents' perception of extended role as medical assistants (n=63)
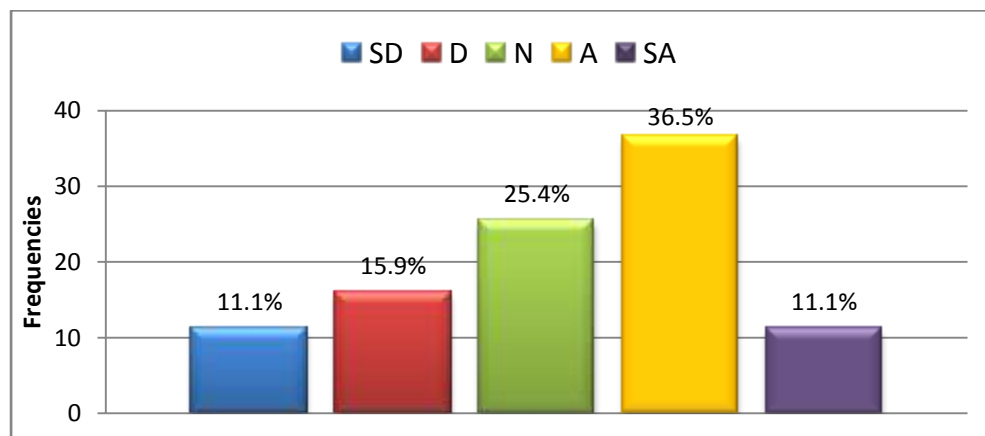
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From the data it would appear that most of the respondents were familiar with PHC services and felt comfortable advancing their careers by accepting a possible extended one-year course to qualify as medical assistants. RNs with specialty in PHC have added value because of numerous benefits attached to PHC services, which include the availability of rural allowances, PHC qualifications, and pay progression that in other instances can be higher than that of nurse managers in the general mainstream.

SECTION C: Workplace violence in the PHS

5.7.1.26 Security system for nurses in the workplace is satisfactory

Of the respondents, 47 (72.3%) disagreed and 12 (18.5%) agreed that security at the hospital for nurses was satisfactory, while six (9.2%) were not sure (see figure 5.13).

Figure 5.13 AH respondents' perception of security system for nurses (n=65)
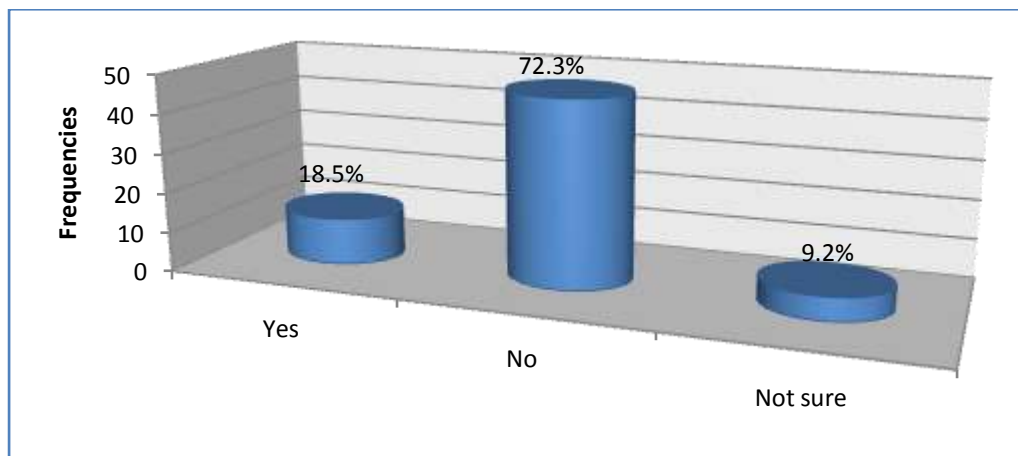
These results were of concern, indicating that security for nurses in the PHS could require investigation or reinforcement. Hospitals are an open system made vulnerable by frequent movement of visitors and supply deliveries. Consequently, car parks as well as main and ward entrances are areas requiring constant monitoring to ensure the safety of nurses and their possessions.

5.7.1.27 Patients are safe in hospital under the current security system

The findings revealed that the respondents were equally divided on this issue, with 27 (41.5%) agreeing and 27 (41.5%) disagreeing that patients were safe under the current security system. Only 11 (17.0%) respondents were not sure about patients' safety (see figure 5.14).

Figure 5.14 AH respondents' perception of patients' safety in hospital (n=65)
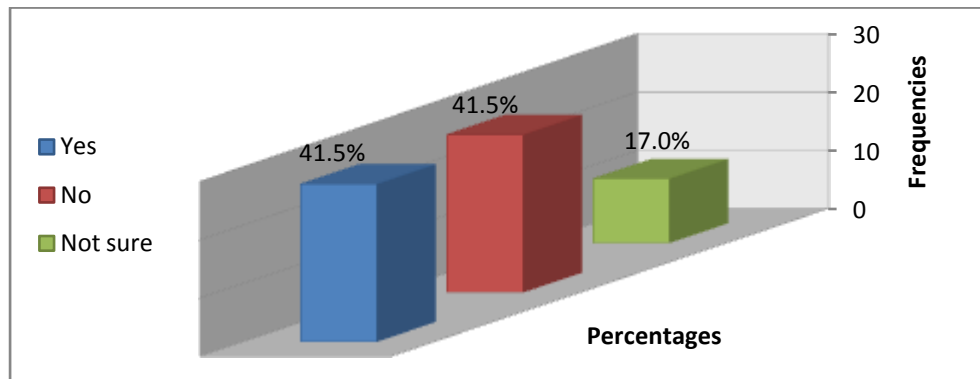
The data could indicate that there are security measures, but not adequate enough to ensure the safety of patients. It should be taken into consideration that even though security measures might be in place, the safety of patients remains an ethical responsibility for RNs. It would be an indictment against hospital authorities if patients or nurses were hurt in wards where they are expected to be safe, if safety measures were not adequate.

SECTION D: Stress

5.7.1.28 Stress is intolerable among RNs in the PHS (n= 63)

Of the respondents, 48 (76.1%) agreed and eight (12.7%) disagreed that stress had reached intolerable levels among RNs, while seven (11.1%) did not know and five did not respond to this question (see figure 5.15).

Figure 5.15 AH respondents' perception of stress level (n=63)
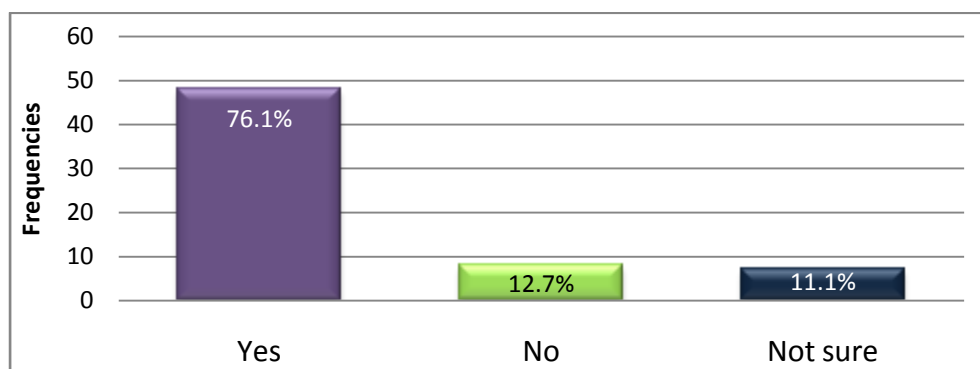
This item was included in the item in order to establish the reasons for the recent magnitude of migration of RNs from the PHS. It was assumed that if stress could not be tolerated in the workplace, employees would seek other avenues that would best serve their needs without undue stress. The majority finding that stress was intolerable could be due to factors arising from salary issues, strike actions involving nurses, staff shortages, and exhaustion.

5.7.1.29 Have you personally used your vacation for resting?

Of the respondents, 32 (49.2%) used their vacation to rest and 31 (47.7%) did not (see figure 5.16).

Figure 5.16 AH respondents' use of vacation to rest (n=65)
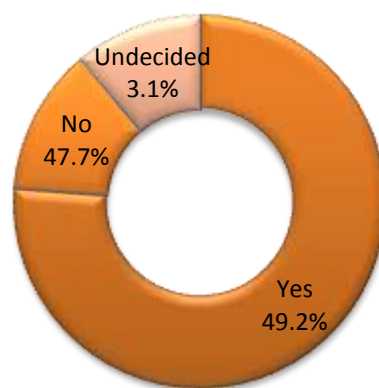
The data could imply that those who did not rest worked overtime to augment their salary. Since nursing duties are extremely tiring, it could be assumed that some RNs would consider well paying jobs that enabled them to use their holidays to rest.

5.7.1.30 RNs experience physical signs of exhaustion

Of the respondents, 28 (43.8%) indicated that they often experienced physical signs of exhaustion; 27 (42.2%) always did; nine (14.1%) occasionally did, and none never experienced physical signs of exhaustion (see figure 5.17).

Figure 5.17 AH respondents' experience of physical signs of exhaustion (n=64)
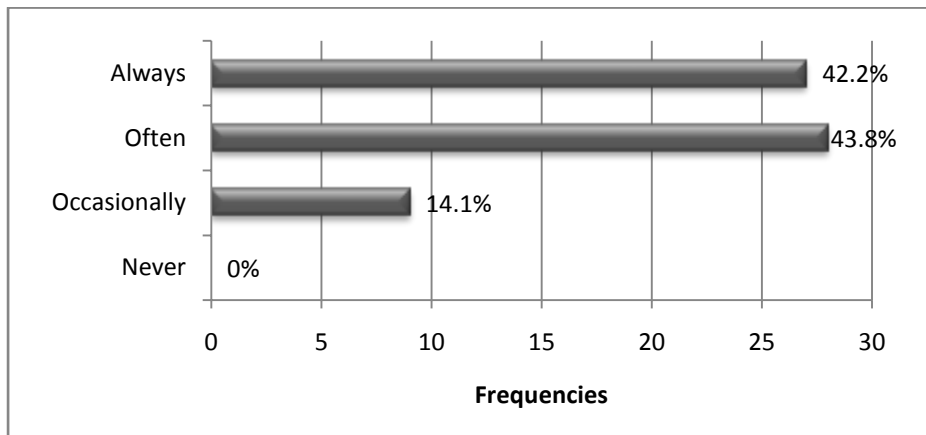
Since most of the respondents indicated the experience of physical exhaustion, it could be the result of lifting heavy patients; lack of rest on their days off and holidays, as well as mental and emotional exhaustion from mounting pressure of work and lack of staff.

5.7.1.31 Do you have intentions to leave the PHS for other institutions?

Of the respondents, 32 (49.2%) did and 18 (27.7%) did not intend leaving the PHS, while 15 (23.1%) did not know (see figure 5.18).

These results could indicate the level of commitment of those who would not leave, as well as a degree of despondency on the part of those who felt they could not endure any more.

Figure 5.18 AH respondents' intentions to leave (n=65)
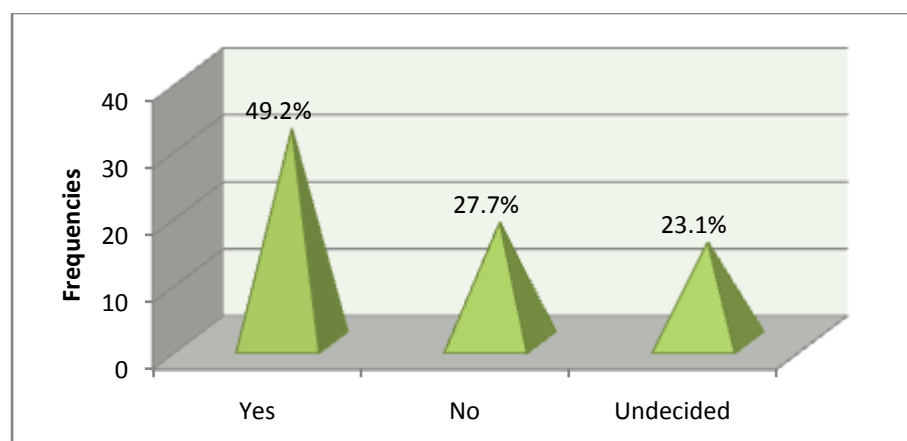
5.7.1.32 NSMs still display bullying attitudes

Of the respondents, 76.9% (43.0% + 33.9%) agreed/strongly agreed and 10.7% (7.7% + 3.0%) strongly disagreed/disagreed that some NSMs still displayed bullying attitudes towards RNs, while 12.3% did not know (see figure 5.19).

Figure 5.19 AH respondents' perception of NSMs' bullying attitudes (n=65)
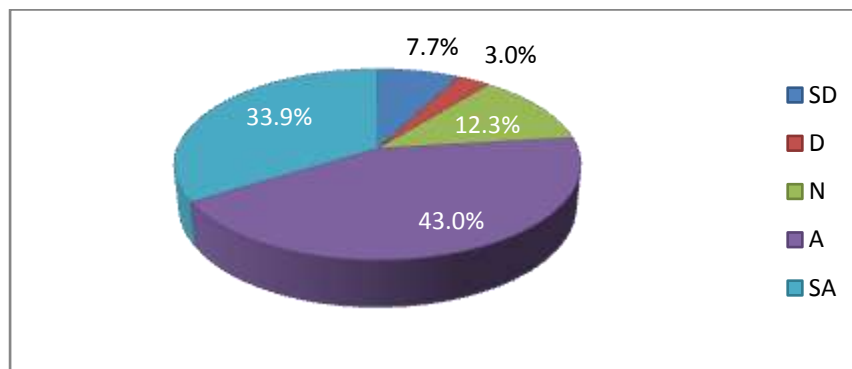
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding could reveal seemingly strained relationships between some of the respondents and their NSMs. In addition, it could also highlight why some nurses prefer unions, which could be a way of seeking to punish or threaten their NSMs with bodies that seem stronger than them. This would also emphasise the need for RNs and NSMs to pursue mutual relationships to accomplish their goals and create a health environment that promotes healing.

5.7.1.33 RNs acknowledged for outstanding contributions

Of the respondents, 60.6% (19.7% + 40.9%) strongly disagreed/disagreed and 21.2% (10.6% + 10.6%) strongly agreed/agreed that RNs were acknowledged for outstanding contributions in the units, while 12 (18.2%) were undecided (see table 5.14).

Table 5.14 AH respondents' perception of acknowledgement for outstanding contributions (n=66)

Responses	SD	D	N	A	SA
Frequency	13	27	12	7	7
Percentage	19.7%	40.9%	18.2%	10.6%	10.6%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

In large hospitals, it is easy for nurses to overextend themselves without NSMs noting of it, which then deprives them of encouragement. For acknowledgement to materialise requires frequent visibility of NSMs at the production level and feedback of acknowledgement from top management through memos, letters and physical forms of assistance to help ease the pressure. These efforts affirm nurses and inform them that management is with them and acknowledges their contributions.

5.7.1.34 NSMs give feedback on problems reported

Of the respondents, 48.5% (36.4% + 12.1%) agreed/strongly agreed and 21.2% (13.6% + 7.6%) strongly disagreed/disagreed that hospital management gave feedback on problems reported, while 20 (30.3%) were undecided (see table 5.15).

Table 5.15 AH respondents' perception of feedback on reported problems (n=66)

Responses	SD	D	N	A	SA
Frequency	9	5	20	24	8
Percentage	13.6%	7.6%	30.3%	36.4%	12.1%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This was an encouraging finding indicating a good working relationship between NSMs and the respondents at the AH. It should be noted that some problems and issues in wards require intervention by management. Failure to have them addressed at that level, with the level of expertise, resources and

authority vested in them, could result in undue stress, unnecessary delays and frustration.

5.7.1.35 RNs are acknowledged for their sacrifices

Of the respondents, 71.2% (50.0% + 21.2%) strongly disagreed/disagreed and 15.1% (10.6% + 4.5%) agreed/strongly agreed that RNs were acknowledged for their sacrifices in the units (see table 5.16).

Table 5.16 AH respondents' perception of acknowledgement for sacrifices (n=66)

Responses	SD	D	N	A	SA
Frequency	27	14	15	7	3
Percentage	50.0%	21.2%	22.7%	10.6%	4.5%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This finding could imply that some of the respondents worked beyond the call of duty, and sacrificed their vacations, tea or lunch breaks to make up for staff shortages without receiving commensurate acknowledgement.

5.7.1.36 NSMs discuss problems with RNs

Of the respondents, 36 (55.4%) disagreed and 22 (33.8%) agreed that hospital management discuss problems with RNs while seven (10.8%) were undecided (see figure 5.20).

Figure 5.20 AH respondents' perception of joint discussion of problems (n=65)
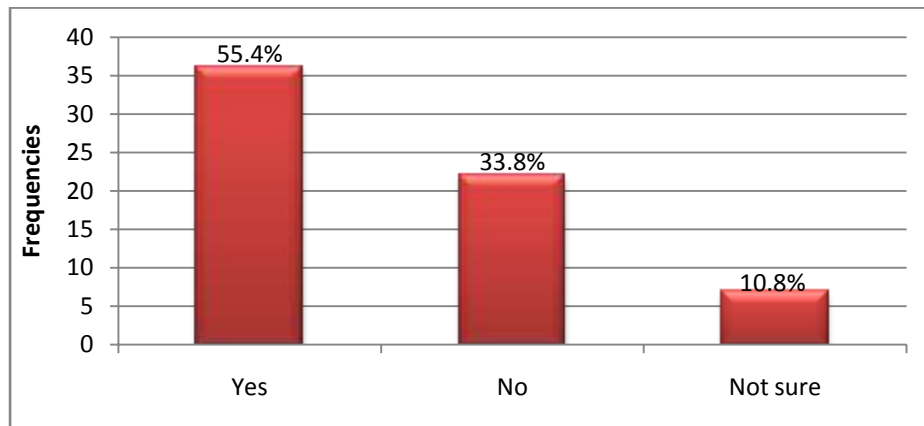
From the data, the respondents and their NSMs appear to have a positive and stable relationship. When RNs are offered opportunities to participate in problem resolution and decision-making, it could encourage them to participate more and strive for excellence in performance.

SECTION F: RNs and migration

This section intended to elicit the RNs' perception of nurse migration from the PHS.

5.7.1.37 Nurse migration is due to inadequate salaries

Of the respondents, 40 (61.5%) rated inadequate salaries extremely important for migration; 22 (33.9%) rated them important; two (3.1%) rated them fairly important, and only one (1.5%) rated them unimportant for migration (see figure 5.21).

Figure 5.21 AH respondents' perception of inadequate salaries and migration (n=65)
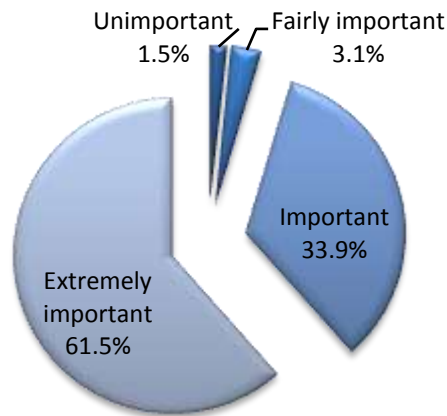
This result suggested that salaries were a major issue for the respondents, emphasizing the need for adequate and equitable salaries to meet their financial obligations.

5.7.1.38 Poor leadership in nursing contributes to nurse migration

The respondents were asked to rate poor leadership as a reason for migration.

Figure 5.22 AH respondents' perception of poor leadership and migration (n=64)
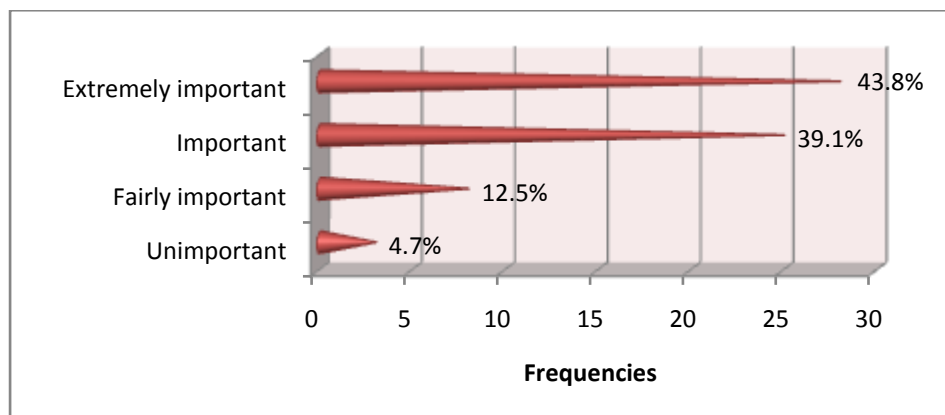
Of the respondents, 28 (43.8%) regarded poor leadership as extremely important in migration; 25 (39.1%) considered it important; eight (12.5%)

considered it fairly important, and only three (4.7%) considered it unimportant for nurse migration (see figure 5.22) above. This finding implied that the majority of the respondents viewed the kind of leadership in place as essential in order to retain staff.

5.7.1.39 Poor working conditions lead to nurse migration

Of the respondents, 37 (56.9%) found poor working conditions extremely important for nurse migration; 26 (40.0%) found them important; two (3.1%) found them fairly important, and none found poor working conditions unimportant for nurse migration from the PHS (see figure 5.23). Poor working conditions include inadequate salaries, lack of equipment, poor facilities, and shortage of staff, among others.

Figure 5.23 AH respondents' perception of poor working conditions and migration (n=65)
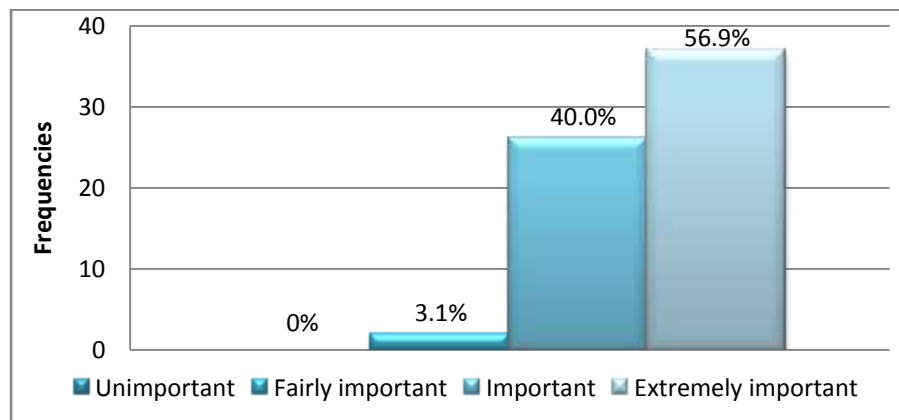
It should be noted that as an AH, this hospital carried the weight of referrals from different hospitals. Consequently, nursing staff should be the most crucial commodity this hospital endeavoured to retain. Moreover, in a level three health care service, adequate and modern equipment is indispensable.

5.7.1.40 RNs migrate for "different" experience

Of the respondents, 16 (25.0%) indicated acquiring "different" experience an extremely important reason for migration; 16 (25.0%) found it important; 14 (21.9%) found it fairly important, and 18 (28.1%) found it unimportant for migration (see figure 5.24).

Figure 5.24 AH respondents' perception of migration for "different" experience (n=64)
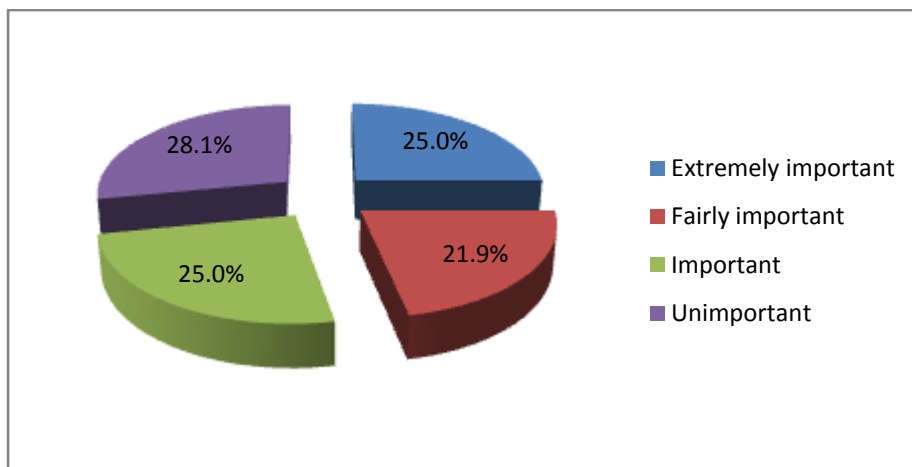
The above results could indicate that the respondents generally did not consider leaving the PHS to acquire "different" experience a solid reason to move.

SECTION G: Nurses and strike actions

5.7.1.41 RNs prefer strikes to solve nurses' problems

Of the respondents, 42 (66.7%) agreed and 13 (20.6%) disagreed that nurses' preferred strikes to solve nurses' problems, while eight (12.7%) did not know (see figure 5.25).

Figure 5.25 AH respondents' perception of strikes to solve nurses' problems (n=63)
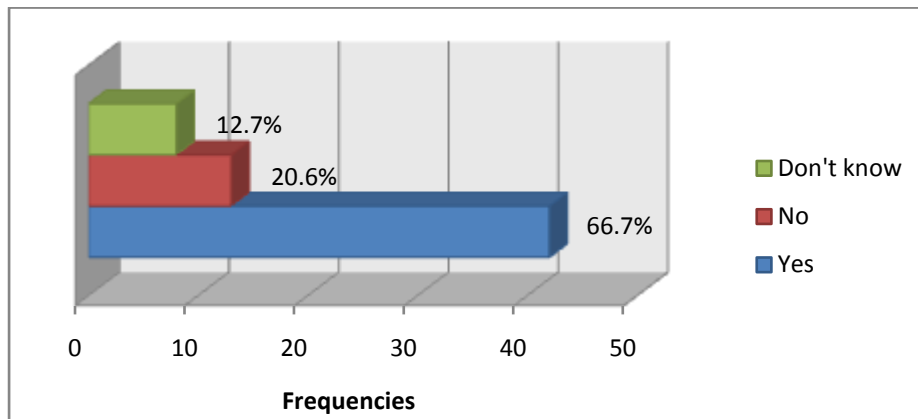
This result seemed to suggest that RNs resorted to strike actions as a last resort to solve their problems because they had lost trust in the NSMs.

5.7.1.42 RNs and unions share same values regarding patient care

Of the respondents, 31 (50.0%) disagreed and 21 (33.9%) agreed that RNs and unions shared the same values, while ten (16.1%) did not know (see figure 5.26).

Figure 5.26 AH respondents' perceptions of unions' and nurses' values (n=62)
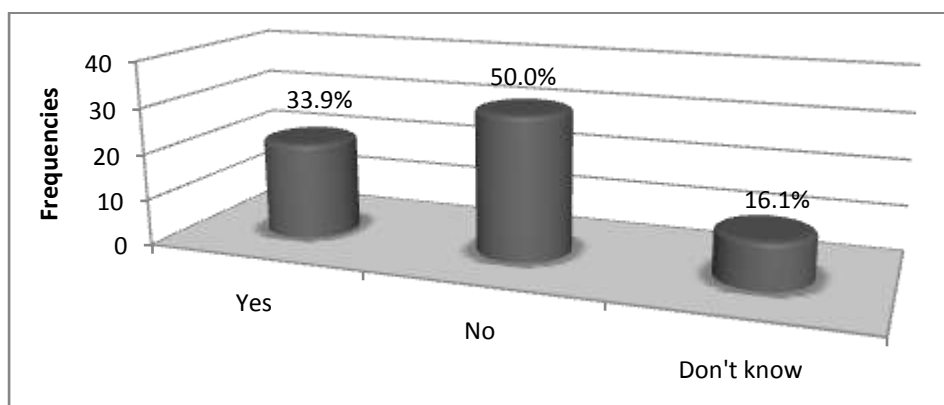
From the preceding data it was concluded that most of the respondents seemed to hold the nursing profession in high regard since they did not equate its values to those of unions. This would appear to indicate it is highly

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probable that those who belonged to unions had done so for the purpose of collective bargaining only, since salary issues had been raised on several occasions.

5.7.1.43 RNs support division between unions and professional associations

Of the respondents, 15 (24.2%) agreed and 27 (43.5%) disagreed that RNs supported the division of unions and professional associations, while 20 (32.3%) did not know (see figure 5.27).

Figure 5.27 AH respondents' perception of division between unions and professional associations (n=62)
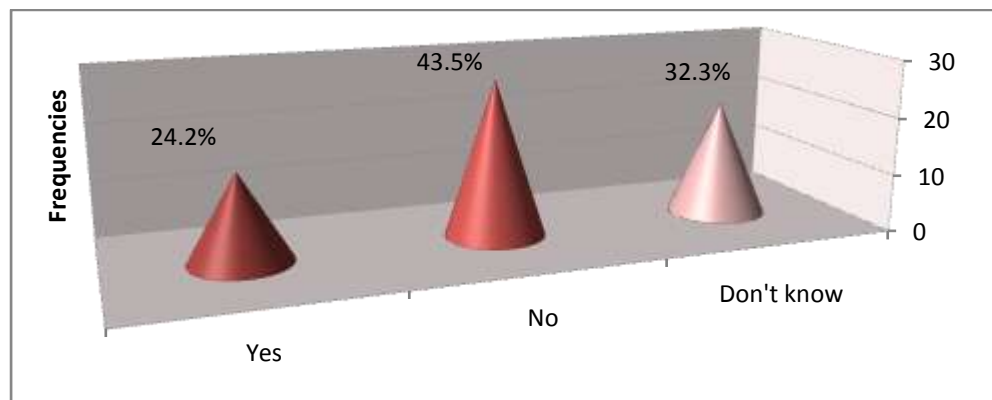
The results could be attributed to the benefits RNs had reaped from affiliating with unions in the past. It should be borne in mind that some of these respondents could have been union members as well, who did not support this kind of division. As a result, the study assumed that the respondents still believed in the nursing profession.

5.7.1.44 Poor nurse representation in government contributes to migration

Of the respondents, 55 (81.5%) agreed and only four (6.2%) disagreed that poor nurse representation in government could be responsible for nurse migration from the PHS, while eight (12.3%) were not sure (see figure 5.28).

Figure 5.28 AH respondents' perception of poor nurse representation in government and migration (n=67)
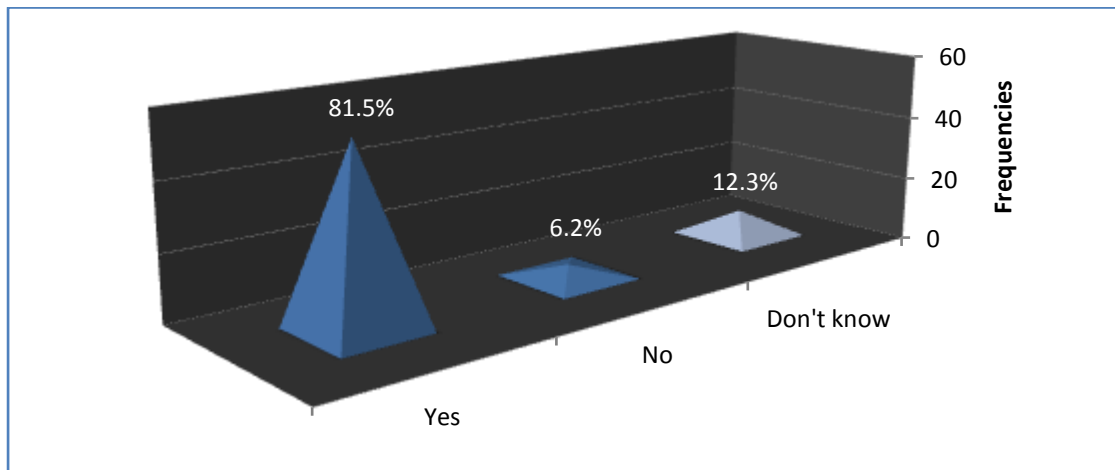
The above data appeared to suggest that the respondents believe that nurses could be represented by nurses at government level to have their views and concerns addressed as opposed to unions, and that this could significantly reduce discontent, strike actions and nurse migration.

5.7.1.45 RNs vote for parties that add value to nursing (n=59)

Of the respondents, 47.4% (20.3% + 27.1%) strongly agreed/agreed and 32.2% (18.6% + 13.6%) strongly disagreed/disagreed that RNs voted for parties that add value to nursing, while 12 (20.3%) did not know (see figure 5.29).

Figure 5.29 AH respondents' perception of voting for parties that add value
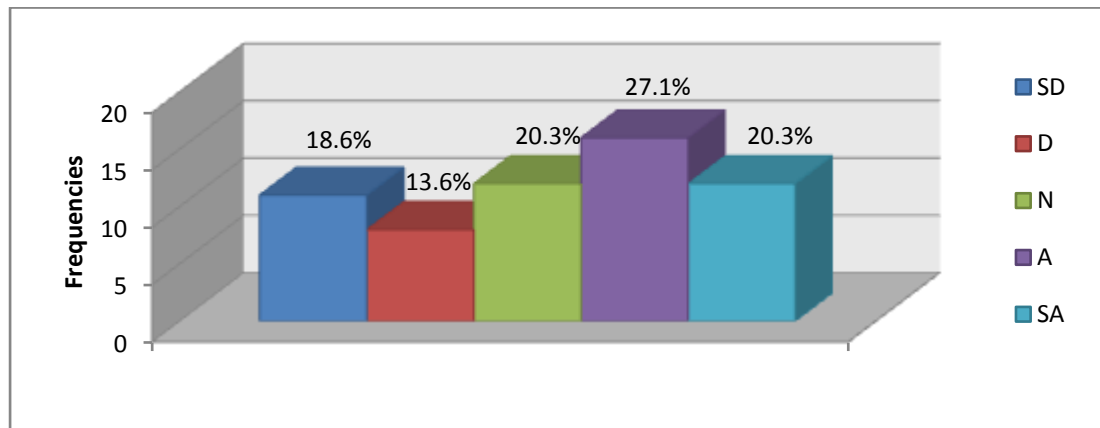
The data implied that the respondents were conversant with the importance of voting for parties that had nursing and health issues high on their political agenda. This was an encouraging finding that the respondents seemed determined to find ways to advance the interest of nursing and health care delivery. However, the number of those who did not indicate their position created the impression that some nurses either did not vote, or voted without prior consideration of the impact of their votes on health care delivery and the nursing profession.

5.7.1.46 Nurses' issues are entertained in political debates (n=58)

Of the respondents, 60.3% (29.3% + 31.0%) strongly disagreed/disagreed and 15.5% (13.8% + 1.7%) agreed/strongly agreed that nurses' issues were entertained in political debates, while 14 (24.1%) did not know (see table 5.17).

Table 5.17 AH respondents' perception of nurses' issues in political debates (n= 58)

Responses	SD	D	N	A	SA
Frequency	17	18	14	8	1
Percentage	29.3%	31.0%	24.1%	13.8%	1.7%

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Data suggest that nurses' issues cannot be effectively considered in political debates unless nurses have their own representatives when important decisions are made. The majority finding, however, seemed to indicate that the respondents were aware of the need for political astuteness and not leaving nursing decisions to politicians without authentic nursing representation that informed their decisions. The significant number of respondents who did not know could imply that they lacked political insight and were not interested in whether nursing issues had a hearing in political arenas or not.

5.7.1.47 RNs can become policy analysts in South Africa

Of the respondents, 51.6% (38.7% + 12.9%) strongly agreed/agreed and 33.9% (27.4% + 6.5%) disagreed/strongly disagreed that RNs could become policy analysts if given the right preparation, while nine (14.5%) were not sure (see figure 5.30) below.

Figure 5.30 AH respondents' perception of RNs as policy analysts (n= 62)
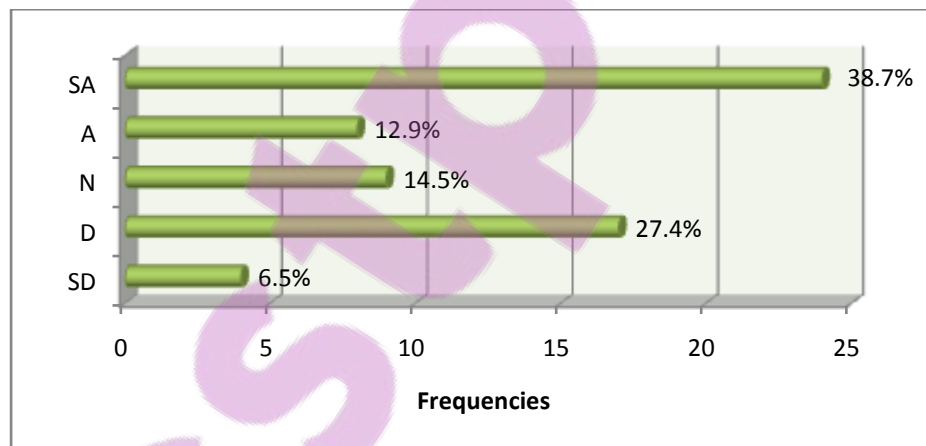
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The preceding data indicated a possible willingness among the respondents to broaden their horizons and seek opportunities that could enable them to advocate for nursing in the political arena.

5.7.1.48 RNs know how policies are made in government

Of the respondents, 53.3% (23.3% + 30.0%) strongly disagreed/disagreed and 28.4% (21.7% + 6.7%) agreed/strongly agreed that RNs were familiar with policy formulation procedures at government level, while 18.3% did not know (see figure 5.31).

Figure 5.31 AH respondents' perception of nurses' knowledge of policy-making at government level (n=60)
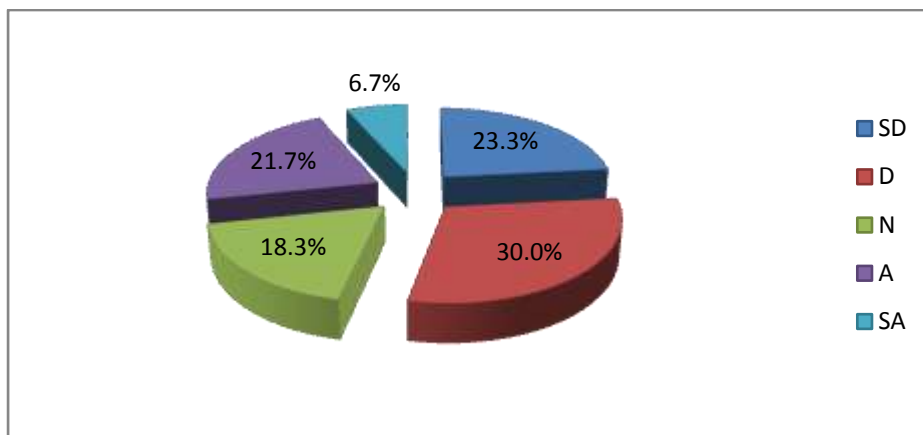
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The findings therefore suggested that the respondents were not well informed about political activities, including how policies that affect them and their HCS are formulated. This factor could be ascribed to the nursing curriculum that does not include political science as a subject to familiarize nurses with political activities. It could also be influenced by socialization of nursing practice prior to democracy where nurses were not allowed to participate in politics.

5.7.1.49 RNs can influence policy making

Figure 5.32 AH respondents' perception of nurses' influence on policy making (n=60)
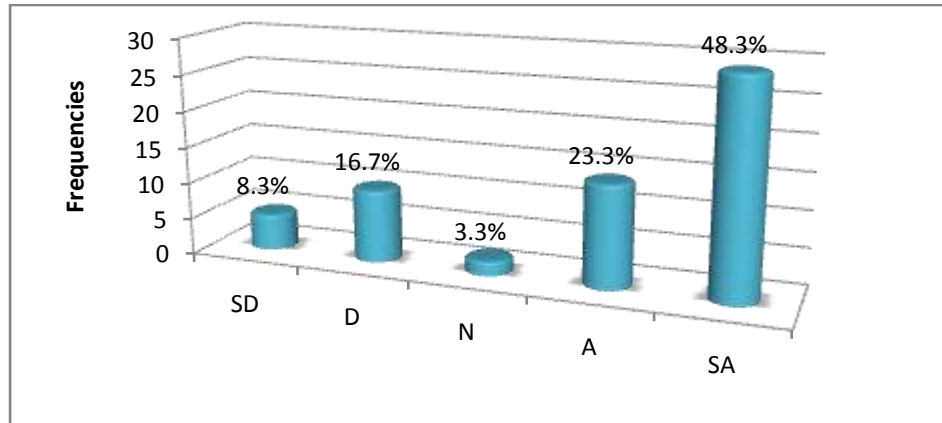
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Of the respondents, 71.6% (48.3% + 23.3%) strongly agreed/agreed and 25.0% (8.3% + 16.7%) strongly disagreed/disagreed that nurses could influence policy making, while 3.3% did not know (see figure 5.32). From the data the majority of the respondents indicated confidence that, given appropriate education and opportunity, RNs could influence policy-making which could imply that they were ready for change.

5.7.2 Qualitative data analysis for the academic hospital

Most of the respondents provided written narratives to questions of their choice, which are discussed in chapter 6.

5.8 PRIVATE HOSPITALS (PHs)

The study also involved two private hospitals (PHs) in Tshwane Metropolitan area, to explore discontent among RNs in the PHS using a purposive sample. One hospital was a 'for profit' provider and the other was a non-profit private hospital. Both hospitals offer the latest and best in medical technology, qualified and competent nursing staff, and some of the best medical professionals in the country. Apart from general cases, these hospitals have ultra-modern cardiovascular units with catheterization laboratories, adult and paediatric intensive/high care units equipped with the best and latest monitors, ventilators and equipment, as well as specialized theatres that accommodate any type of cardio-thoracic or vascular procedures. In the context of this study, these could be tantalizers for the siphoning of highly skilled nursing personnel from the PHS.

The same questionnaire used for the PHS respondents was distributed to the PH respondents to elicit information from their previous experience in the PHS. It should be emphasised that this study was not investigating private hospitals per se, but RNs in retrospect. In order to eliminate 'recall' and any other bias, nurses who had resigned from the PHS more than five years before were intentionally excluded from this study (see chapter 4, section 4.7.1).

The data from these two hospitals were combined and classified under "private hospitals" (PHs) because it was not the intention of this study to investigate them individually. Sixty questionnaires were distributed between the two hospitals and yielded a return of 24 completed questionnaires, which reflected a 40.0% response rate. This was considered a reasonable response because not all the RNs employed in these hospitals had PHS employment background. The total number of respondents varied from item to item because some respondents did not answer all the questions.

5.8.1 QUANTITATIVE DATA ANALYSIS FOR PRIVATE HOSPITALS (PHs)

(NB: In the tables and figures, PHs indicates data for Private Hospitals.)

SECTION A: Demographic information

5.8.1.1 Age distribution

Of the respondents, three (12.5%) were between 26 and 33 years old; eight (33.3%) were between 34 and 41; eight (33.3%) were between 42 and 49; four (16.7%) were between 50 and 57, and only one (4.2%) was between 58 and 65 (see table 5.1). None were older than 65 or younger than 26 years old.

Table 5.1 PH respondents' ages (n=24)

Age	18-25	26-33	34-41	42-49	50-57	58-65	65-72
Frequency	0	3	8	8	4	1	0
Percentage	0.0%	12.5%	33.3%	33.3%	16.7%	4.2%	0.0%

5.8.1.2 Race

Of the respondents, six (26.1%) were Black; five (21.7%) were Coloured, and 12 (52.2%) were White, and one did not indicate race (see table 5.2).

Table 5.2 PH respondents' race (n=23)

Race	Black	Coloured	Asian	White	Other (Please specify)
Frequency	6	5	0	12	0
Percentage	26.1%	21.7%	0.0%	52.2%	0.0%

5.8.1.3 Gender

Of the respondents, 23 (95.8%) were females and one did not indicate gender (see table 5.3).

Table 5.3 PH respondents' gender (n=23)

Gender	Frequency	Percentage
Male	0	0
Female	23	95.8

5.8.1.4 Marital status

Of the respondents, seven (30.4%) were single; 12 (52.2%) were married, three (13.0%) were divorced; one (4.3%) was widowed, and one did not indicate marital status (see table 5.4).

Table 5.4 PH respondents' marital status (n=23)

Marital status	Single	Married	Divorced	Widowed
Frequency	7	12	3	1
Percentage	30.4%	52.2%	13.0%	4.3%

5.8.1.5 Number of dependants

Of the respondents, eight (34.8%) had no dependants, 14 (60.9%) had between one and three dependants, and one (4.3%) had more than three dependants (see table 5.5).

Table 5.5 PH respondents' number of dependants (n=23)

Dependants	None	1 – 3	> 3
Frequency	8	14	1
Percentage	34.8%	60.9%	4.3%

As a general principle, the more dependants the RNs have, the more financial burden they could be experiencing. Most of the respondents therefore, had between one to three dependants, which could have been one of the reasons why they left the PHS, particularly if there were higher salaries and other benefits.

5.8.1.6 Residential area

Of the respondents, 20 (87.0%) lived in the city suburbs; one (4.3%) lived in a township; two (8.7%) came from informal settlements, and none came from a village (see table 5.6).

Table 5.6 PH respondents' residential area (n=23)

Residence	City/Town	Township	Village	Informal settlement
Frequency	20	1	0	2
Percentage	87.0%	4.3%	0.0%	8.7%

These private hospitals (PHs) were located in the city centre, which could possibly have explained the respondents' residence. The study wished to determine the respondents' residential area since this could affect the cost of living and affordability, which could also be a cause of discontent. Most of the PH respondents lived in the city suburbs, which might also have contributed to their decision to migrate from the PHS.

5.8.1.7 Type of health care service

All the respondents (100.0%) worked for PHs (see table 5.7).

Table 5.7 PH respondents' type of health service (n=24)

Health care service	Academic hospital	Regional hospital	District hospital	Private hospital
Frequency	0	0	0	24
Percentage	0.0%	0.0%	0.0%	100.0%

5.8.1.8 Positions

Of the respondents, three (13.0%) were CPNs; seven (30.4%) were SPNs, and 13 (56.5%) were PNs (see table 5.8).

Table 5.8 PH respondents' positions held (n=23)

Positions	Chief professional nurse	Senior professional nurse	Professional nurse
Frequency	3	7	13
Percentage	13.0%	30.4%	56.5%

Since this study used a purposive sample, the results do not accurately reflect the different ranks of RNs in these PHS (see chapter 4, section 4.8.2).

5.8.1.9 Years of experience since registration

Of the respondents, one (4.3%) had between one and five years' nursing experience since registration with the SANC; two (8.7%) had between six and 10 years; ten (43.5%) had between 11 and 20 years; five (21.7%) had between 21 and 30 years, and five (21.7%) had between 31 and 40 years' experience (see table 5.9). None had over 40 years' experience since registration, and one respondent did not indicate years of experience.

Table 5.9 PH respondents' years of experience (n=23)

Experience	1-5	6-10	11-20	21-30	31-40	41-50	51-60
Frequency	1	2	10	5	5	0	0
Percentage	4.3%	8.7%	43.5%	21.7%	21.7%	0.0%	0.0%

5.8.1.10 Qualifications

Of the respondents, eight (34.8%) had a Basic Nursing Diploma (BND); three (13.0%) had a post-BND qualification; seven (30.4%) had a basic four-year nursing degree; two (8.7%) had a BA Cur degree, and three (13.0%) had an Honours degree (see table 5.10).

Table 5.10 PH respondents' qualifications (n=23)

Qualifications	BND	Post-BND	Basic 4-year nursing degree	BA Cur	Hons	M	D
Frequency	8	3	7	2	3	0	0
Percentage	34.8%	13.0%	30.4%	8.7%	13.0%	0.0%	0.0%

SECTION B: Transformation of PHS

5.8.1.11 PHS transformation successful

Of the respondents, 86.4% disagreed and only 4.5% agreed that transformation of HCS in the PHS had been successful (see figure 5.1).

Figure 5.1 PH respondents' perception of PHS transformation (n=22)
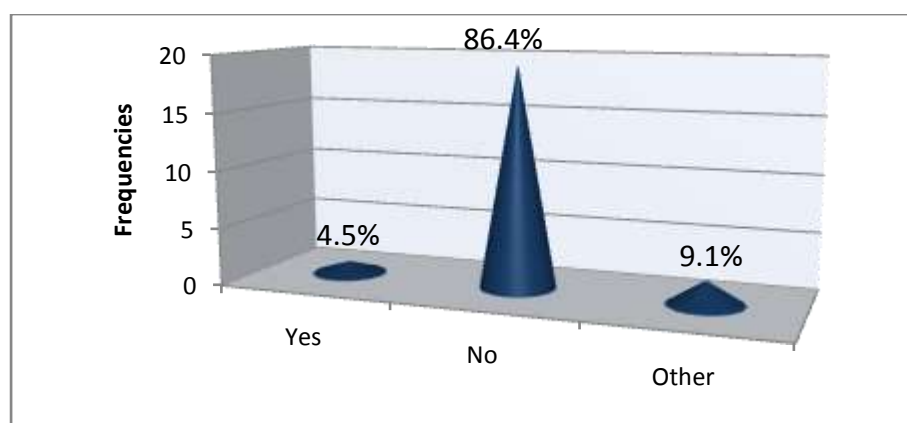
The data indicated the PH respondents' discontent with the PHS and could also have explained the move from the PHS and the reason for strike actions. This finding did not mean that no changes had occurred, but simply indicated that much had still to be accomplished for HCS to function according to policy. Important transformational achievements included the discontinuance of delivery of care in a discriminatory manner, elimination of bureaucratic practices in hospital management, and strengthening of the PHC services. Since many changes occurred during the restructuring of HCS, progress could have been hampered by the unexpected migration of RNs, resulting in a lack of capacity to drive the objectives of the National Health Plan and the *Batho Pele* transformational initiatives.

5.8.1.12 Promotions are allocated fairly in the PHS

Figure 5.2 PH respondents' perception of promotions (n= 22)
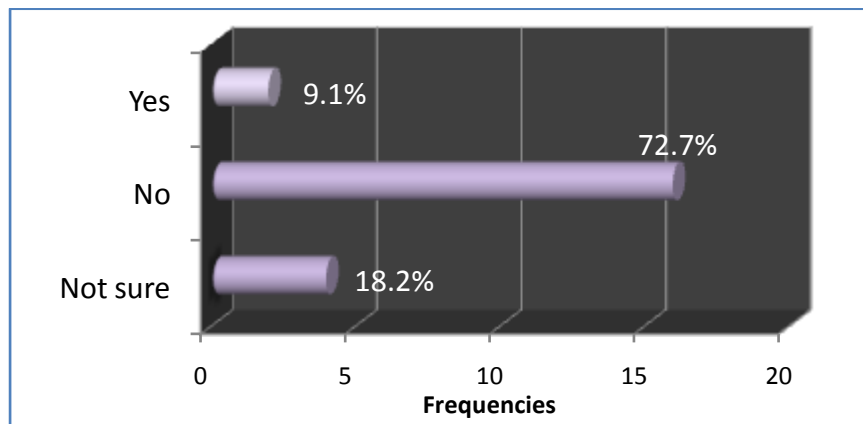
Of the respondents, 16 (72.7%) disagreed and only two (9.1%) agreed that promotions were allocated fairly in the PHS, and four (18.2%) did not know. Since these respondents had a previous history of PHS employment, this could have been one of the reasons why they left the PHS employ. It should be borne in mind that the OSD with its changes of grade and pay progression whereby RNs could move to higher salary scales without necessarily occupying the relevant posts was implemented during the early stages of this study. The PH respondents had therefore already migrated.

5.8.1.13 Young South Africans are attracted to nursing

Figure 5.3 PH respondents' perception of youth attracted to nursing (n= 23)
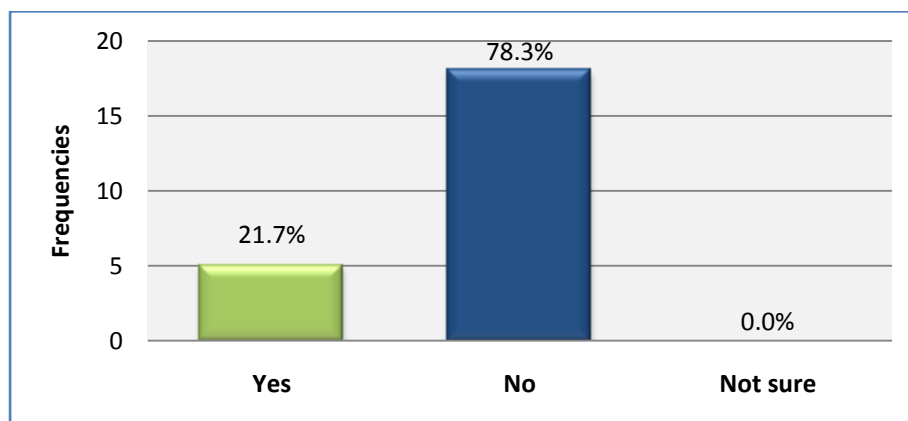
Of the respondents, 18 (78.3%) disagreed and five (21.7%) agreed that the youth were still attracted to nursing (see figure 5.3). This data would imply a reduction in the intake of nursing students possibly influenced by several factors, such as more opportunities in other professions; limited bursaries and entrepreneurships for those who wish to establish themselves in small and medium businesses, as well as how nursing is portrayed in public.

5.8.1.14 A national workforce forum investigates nurses' issues

Of the respondents, 14 (60.9%) disagreed and five (21.7%) agreed that there was a nursing forum to address nursing issues, while four (17.4%) were not sure (see figure 5.4). The respondents who agreed could possibly have been referring to professional associations, which do not represent all nurses since some had joined unions. The data seemed to suggest the respondents' perception of a lack of an authentic nursing forum to investigate and address nurses' concerns in a professional manner. This, in turn, could be because task teams appointed to investigate HCS problems largely function on an ad hoc basis.

Figure 5.4 PH respondents' perception of a national nursing forum (n= 23)
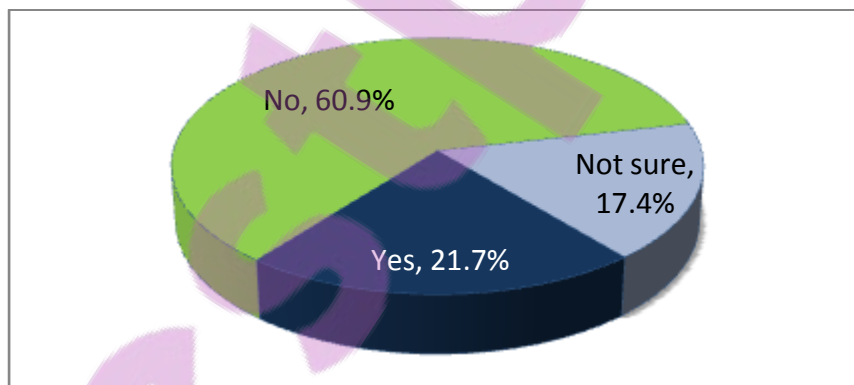
5.8.1.15 Employing body communicates with nurses

Of the respondents, 11 (50.0%) indicated that government never communicated with nurses; nine (40.9%) indicated occasionally; two (4.5%) indicated frequently, and two (4.5%) indicated always (see figure 5.5).

Figure 5.5 PH respondents' perception of communication with nurses (n=22)
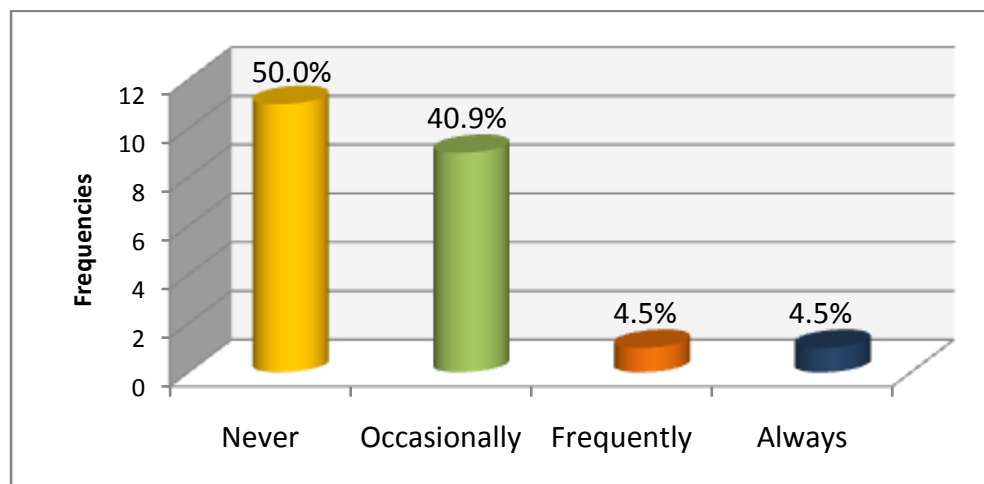
From figure 5.5 it appeared that though not regularly, the provincial department nevertheless communicated matters pertaining to HCS to nurses. This was an encouraging result because of unionization of HCS where communication could easily be relegated to unions, while not all nurses were union members. On the other hand, the majority (50.0%) indicated that government 'never' communicates with nurses in the PHS.

5.8.1.16 The Occupational Specific Dispensation (OSD) is a perfect solution for discontent

Of the respondents, only one (4.5%) agreed and 15 (68.2%) disagreed that the OSD was a perfect solution for nurses, while six (27.3%) were undecided (see figure 5.6).

Figure 5.6 PH respondents' perception of the OSD as solution (n=22)
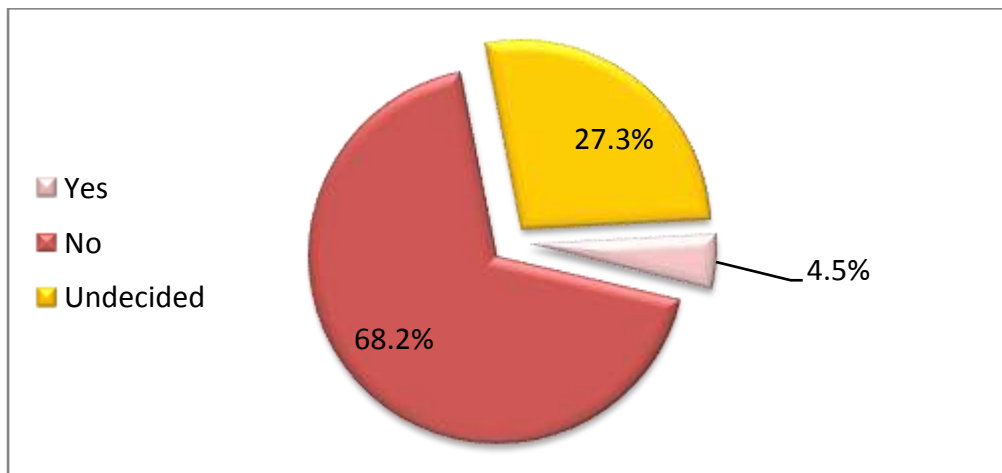
This finding could imply that the PH respondents had heard that the implementation of the OSD did not benefit all nurses, particularly those without specialty qualifications; hence it was not considered a perfect solution. Furthermore, since this study has repeatedly found that salary issues are very important to nurses, it can safely be concluded that the PH respondents had an interest in the outcome of the OSD. From this data, it would seem that all nurses were alert to the process of the implementation of the OSD so that they could seize lucrative opportunities that emerged, particularly as the OSD was a recruiting and retention strategy, to woo back professionals with specialty qualifications, hence their salaries were higher than those without specialties who had not left the PHS (DPSA 2007).

5.8.1.17 All stakeholders agree on the OSD

Of the respondents, 52.2% disagreed and 43.5% agreed that there was stakeholder consensus on the OSD, while 4.3% did not know (see figure 5.7).

Figure 5.7 PH respondents' perception of stakeholder consensus on OSD (n=23)
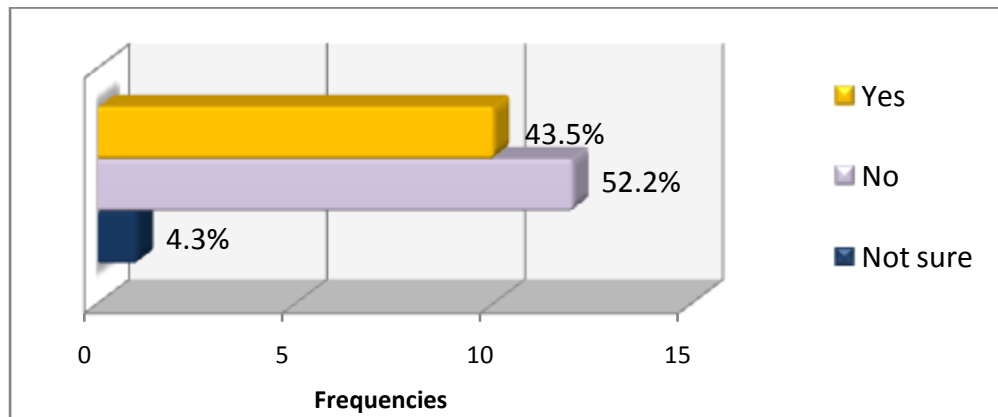
From figure 5.7 it would appear that there is still confusion regarding consensus on the appropriateness of the implementation of the OSD. Lack of consensus results because vital information is not disseminated as intended or because the people who will be directly affected by the decisions taken on their behalf are not consulted.

5.8.1.18 Overseas exchange programme a success

Of the respondents, 17 (73.9%) disagreed and four (17.4%) agreed that the overseas exchange programme was successful, while two (8.7%) did not know (see figure 5.8).

Figure 5.8 PH respondents' perception of overseas exchange programme success (n= 23)
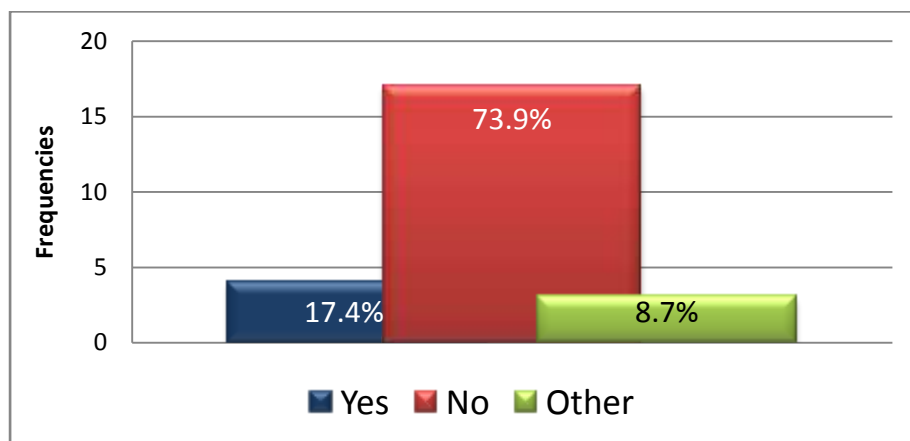
This finding could indicate that the PH respondents had heard varying reports from colleagues in the PHS about the overseas exchange programme. The PH respondents' perceptions would then have been formed on these reports.

(NB: In the following table, figure and discussion, the 'strongly disagree' and 'disagree' percentages, and the 'strongly agree' and 'agree' percentages have been combined respectively. Only the totals are presented.)

Table 5.11 PH respondents' perception of PHS transformation (n=24)

Statement	Disagree	%	Agree	%	Undecided	%
Discontent among RNs an observable reality	2	8.3	22	91.7	0	0.0
Low morale and low salaries	2	8.3	22	91.7	0	0.0
RNs contribute ideas to change	8	33.3	11	45.8	5	20.8
RNs sponsored to attend conferences	20	83.3	1	4.2	3	12.5
RNs are financed to do research	20	87.0	0	0.0	3	13.0
Opportunities exist for RNs' career development	14	63.6	5	22.7	3	13.6
RNs agree with their extended role as medical assistants	5	20.8	13	54.2	6	25.0

Figure 5.9 PH respondents' perception of PHS transformation
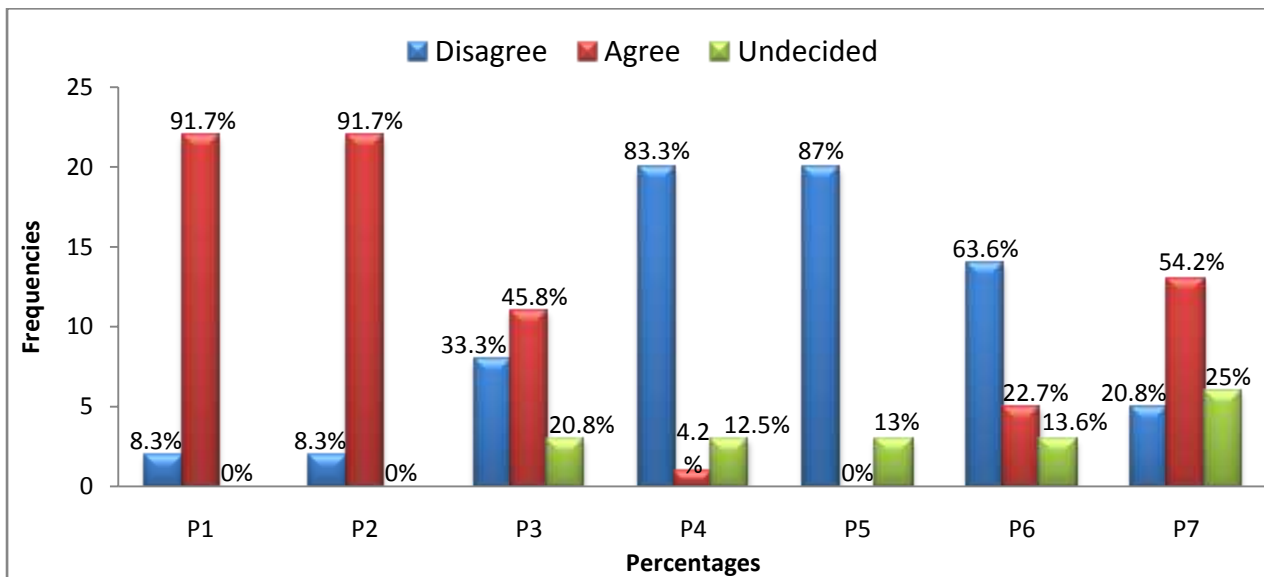
(NB: P1 to P7 in figure 5.9 indicate categories listed below)

P1	Discontent among RNs an observable reality	P5	RNs are financed to do research
P2	Low morale and low salaries	P6	Opportunities exist for RNs' career development
P3	RNs contribute ideas to change	P7	RNs agree with their extended role as medical assistants
P4	RNs sponsored to attend conferences		

5.8.1.19 Discontent among RNs is an observable reality (n=24)

Of the respondents, 22 (91.7%) strongly agreed/agreed and only two (8.3%) disagreed that discontent was observable among RNs in the PHS. For discontent to be observable in the PHS means there are overt signs that point to the existence of discontent, such as when RNs migrate in unprecedented numbers from the PHS, take part in strike actions, and join unions. Observable actions would manifest when they sought better opportunities elsewhere in order to satisfy their needs.

5.8.1.20 Low morale associated with low salaries (n=24)

Of the respondents, 22 (91.7%) agreed and only two (8.3%) disagreed that low morale among RNs was associated with low salaries, which apparently

accounted for many who left the PHS to areas where they would be better remunerated. This data could imply further future loss of skilled staff if insufficient salaries and salary disparities were not addressed.

5.8.1.21 RNs contribute to change in hospitals (n=24)

Of the respondents, 11 (45.8%) agreed and eight (33.3%) disagreed that RNs contributed to change in hospitals, and five (20.8%) were undecided. This could indicate that ideas were solicited from RNs on occasion, but not always.

5.8.1.22 RNs sponsored for conferences (n=24)

Of the respondents, 20 (83.3%) disagreed and only one (4.2%) agreed that RNs were sponsored to attend conferences. This finding could indicate that in the PH respondents' view, the PHS did not attach great value to conferences and their social networking opportunities to exchange ideas and compare how other provinces or countries solve their problems.

5.8.1.23 RNs financed to do research (n=23)

Of the respondents, 20 (87.0%) disagreed and none agreed that RNs were financed to do research, while three (13.0%) did not know. This finding suggested that the respondents did not know of RNs in the PHS receiving financial support to conduct research on problems identified, which could further be perceived as undermining their potential and scientific knowledge.

5.8.1.24 Opportunities exist for RNs' career development (n=22)

Of the respondents, 14 (63.6%) disagreed and five (22.7%) agreed that there were career development opportunities for nurses in the PHS, while three (13.6%) were undecided. This factor could be linked to a shortage of staff where at times it would be difficult for the PHS to release staff for study leave,

which could constitute discontent when their professional advancement is impeded.

5.8.1.25 RNs agree with their extended role as medical assistants (n=24)

Of the respondents, 13 (54.2%) agreed and five (20.8%) disagreed that RNs agreed with their extended role as medical assistants, while six (25.0%) were undecided. That most respondents agreed with the item, it could indicate how familiar RNs are with PHC services, particularly that the preparation of medical assistants is primarily geared toward alleviating shortage of doctors in district hospitals and clinics.

SECTION C: Workplace violence in the public health sector

5.8.1.26 Security system for nurses in the workplace is satisfactory

Figure 5.10 PH respondents' perception of security system for nurses (n=24)
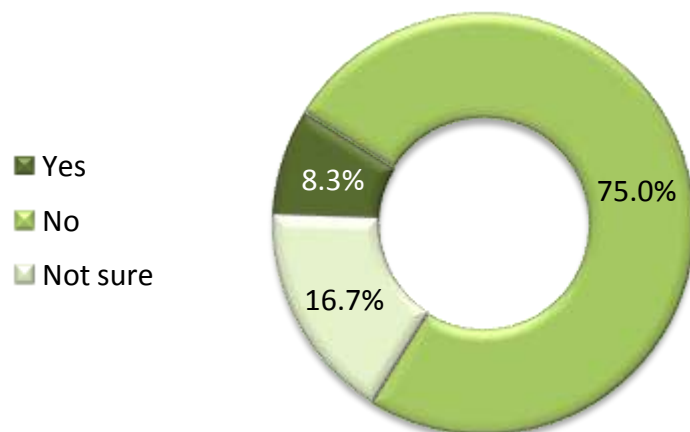
Of the respondents, two (8.3%) agreed and 18 (75.0%) disagreed that security at the hospital was satisfactory, while four (16.7%) did not know. Staff security therefore appeared to require urgent attention, which could have influenced the departure of the PH RNs from the PHS.

5.8.1.27 Patients are safe in hospital under the current security system

Figure 5.11 PH respondents' perception of patients' safety in hospital (n=24)
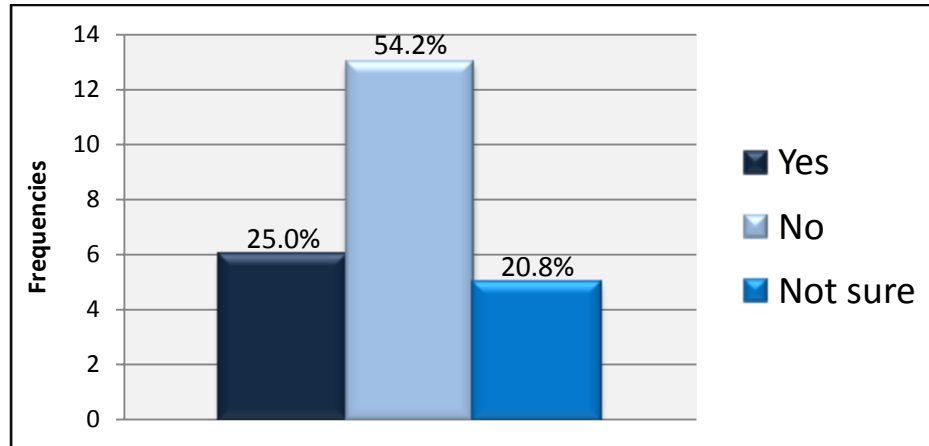
Of the respondents, six (25.0%) agreed and 13 (54.2%) disagreed that patients were safe in hospital under the current security system, while five (20.8%) were not sure. This question was included because RNs follow a holistic approach in the care of the sick; consequently the safety of the patients is one of their ethical and legal responsibilities. The data indicated that most of the PH respondents did not feel that patients were safe in hospital under the current security. This could mean that the hospital security system still required reinforcement.

SECTION D: Stress

5.8.1.28 Stress is intolerable among RNs in the PHS

Of the respondents, 22 (91.7%) agreed and none disagreed that RNs in the PHS were extremely stressed, while two (8.3%) did not know (see figure 5.12).

Figure 5.12 PH respondents' perception of PHS stress (n=24)
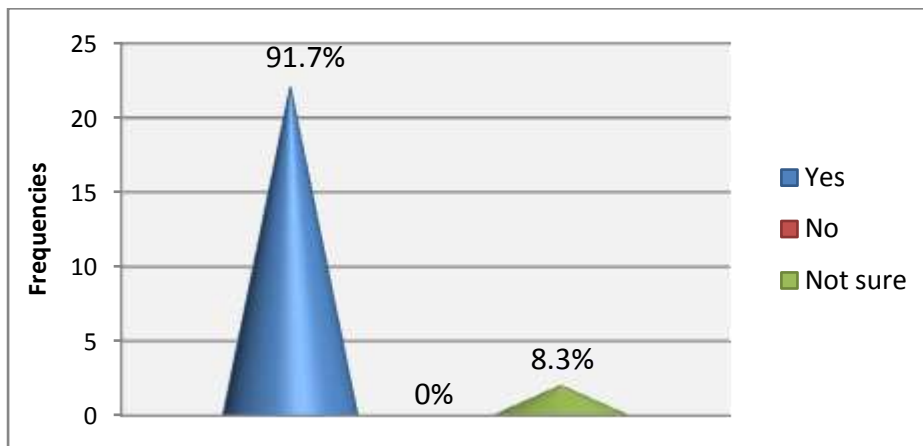
From the data it appears that the respondents' perceptions were based on their own experience and subsequent migration from the PHS as well as the recent strike actions involving PHS nurses.

5.8.1.29 Have you personally used your vacation to rest?

Of the respondents, 14 (58.3%) had used their vacation to rest while under government employment and nine (37.5%) did not (see figure 5.13). This finding was encouraging because RNs need time to rest during their days off to de-stress, rest and relax. The respondents who did not use their vacation for resting perhaps worked part-time to augment their salaries.

Figure 5.13 PH respondents' use of vacation to rest (n= 24)
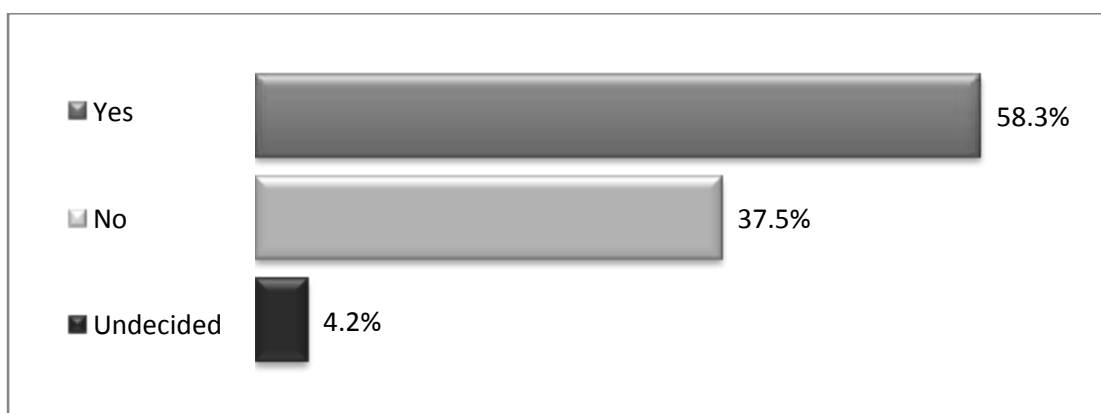
5.8.1.30 RNs' experience of physical signs of exhaustion

Of the respondents, 18 (75.0%) often, five (20.8%) always, and only one (4.2%) occasionally experienced signs of physical exhaustion. This finding emphasised that nursing is physically, mentally and emotionally exhausting.

Figure 5.14 PH respondents' experience of physical signs of exhaustion (n=24)
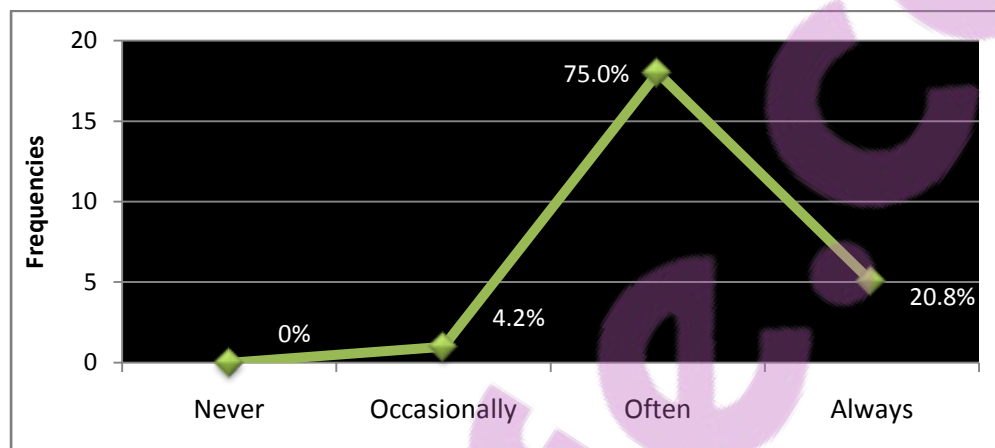
5.8.1.31 Did you have intentions of leaving the PHS for other institutions?

Figure 5.15 PH respondents' intention to leave the PHS (n=24)
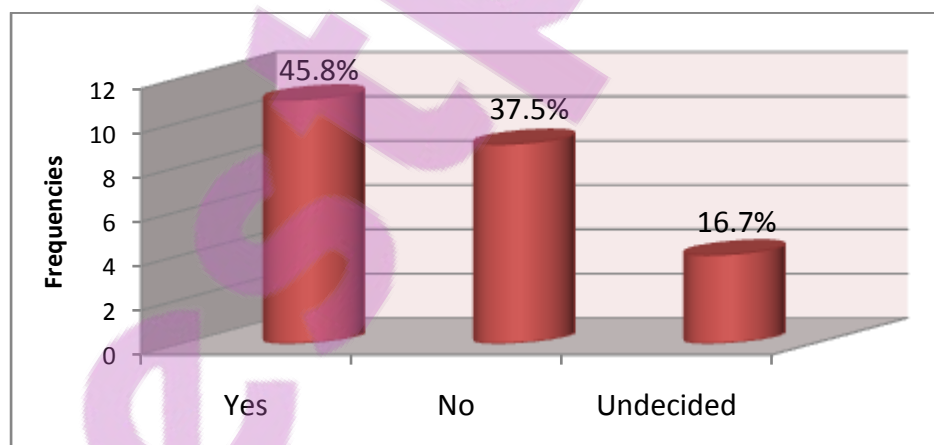
All the respondents had left the PHS for private hospitals. The difference between the respondents who agreed to intentions to leave the PHS (n=11; 45.8%) and those who disagreed (n=9; 37.5%) suggested that most of them

had prior intentions to leave while the latter had possibly left the PHS due to mounting pressure when changes did not unfold as expected. The four (16.7%) who did not know would suggest that they had probably moved when the opportunity arose (perhaps without prior intention to do so).

SECTION E: Management and leadership problems

(NB: In the following table, figure and discussions, the 'strongly disagree' and 'disagree' percentages; the 'strongly agree' and 'agree' percentages have been combined respectively. Only the totals are presented.)

Table 5.12 PH respondents' perception of management and leadership problems

Statement	Disagree	%	Agree	%	Undecided	%
Nurse managers' bullying attitudes	1	4.2	20	83.4	3	12.5
Outstanding contributions acknowledged	9	37.5	13	54.2	2	8.3
Nurse managers give feedback on problems reported	16	66.7	5	20.9	3	12.5
Registered nurses are acknowledged for sacrifices	19	79.2	3	12.5	2	8.3
Hospital management discuss problems with RNs	16	66.7	5	20.8	3	12.5

Figure 5.16 PH respondents' perception of management and leadership problems
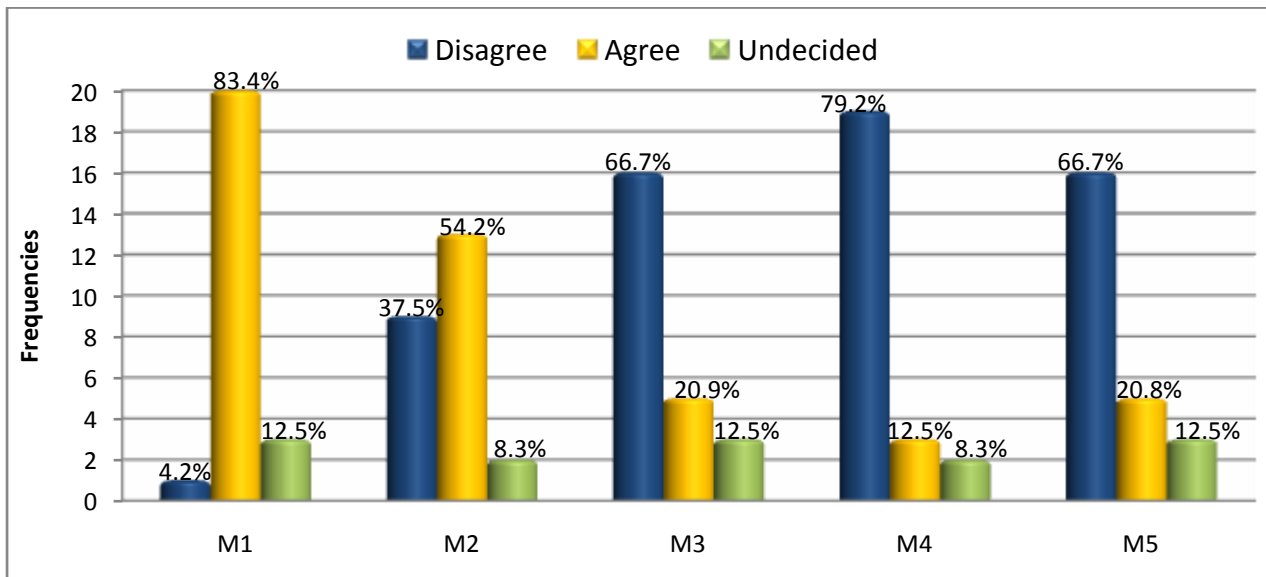
(NB: M1 to M5 in figure 5.16 PH indicate categories listed below)

M1	Nurse managers' bullying attitudes	M4	Registered nurses are acknowledged for sacrifices
M2	Outstanding contributions acknowledged	M5	Hospital management discuss problems with RNs
M3	Nurse managers give feedback on problems reported		

5.8.1.32 NSMs still display bullying attitudes (n=24)

Of the respondents, 20 (83.4%) agreed and one (4.2%) disagreed that some NSMs still displayed bullying attitudes towards RNs, and three (12.5%) were undecided. Some of the PH respondents had possibly left the PHS because of strained relationships with NSMs. This could also explain why many RNs had apparently lost confidence in their nursing leaders and joined unions, not only for the purpose of collective bargaining, but as an indirect way of dealing with unwarranted attitudes from NSMs.

5.8.1.33 RNs acknowledged for outstanding contributions (n=24)

Of the respondents, 13 (54.2%) agreed while nine (37.5%) disagreed that RNs were acknowledged for outstanding contributions and two (8.3%) were undecided. This was a positive finding indicating good relationships the RNs had with NSMs in the PHS. Furthermore, the finding indicated that outstanding contributions were generally acknowledged as well as notable visibility of nursing leaders at the operational level.

5.8.1.34 NSMs give feedback on problems reported (n=24)

Of the respondents, 16 (66.7%) disagreed and only five (20.9%) agreed that hospital management gave feedback, while three (12.5%) did not know. This data suggested that nurse managers did not readily provide feedback on problems reported, which could be discouraging to those who look to them for effective leadership. This response could also refer to problems beyond the scope of RNs, where only nursing leaders could exercise their authority to have such problems resolved.

5.8.1.35 RNs acknowledged for their sacrifices (n=24)

Of the respondents, 19 (79.2%) disagreed that RNs were acknowledged for the sacrifices they made while only three (12.5%) agreed and two (8.3%) were undecided. The data created the impression that the nurses were not generally acknowledged for sacrifices made. This could be due to nursing managers being too preoccupied to make meaningful and supportive ward rounds, or that during rounds their focus was mainly on finding mistakes rather than acknowledging how RNs over-extended themselves. Sacrifices include forfeiture of tea and lunch breaks and responding to assist with heavy workloads, even though overtime was paid.

5.8.1.36 Hospital management discuss problems with RNs (n=24)

Of the respondents, 16 (66.7%) disagreed and five (20.8%) agreed that NSMs discussed problems with RNs, while three (12.5%) did not know. This could perhaps also indicate that at meetings RNs were not given the opportunity to influence decisions, but were presented with conclusions and decisions. This situation could be exacerbated by too many meetings and workshops attended by hospital management outside their hospitals, which left them with no time for their staff and in-house problems.

SECTION F: Registered nurses and migration

5.8.1.37 Nurse migration is due to inadequate salaries

Of the respondents, 22 (91.7%) indicated inadequate salaries an extremely important reason for migration from the PHS; one (4.2%) found them fairly important, and one (4.2%) found them unimportant (see figure 5.17). This data seemed to indicate why most of the respondents had left the PHS.

Figure 5.17 PH respondents' perception of inadequate salaries and migration (n= 24)

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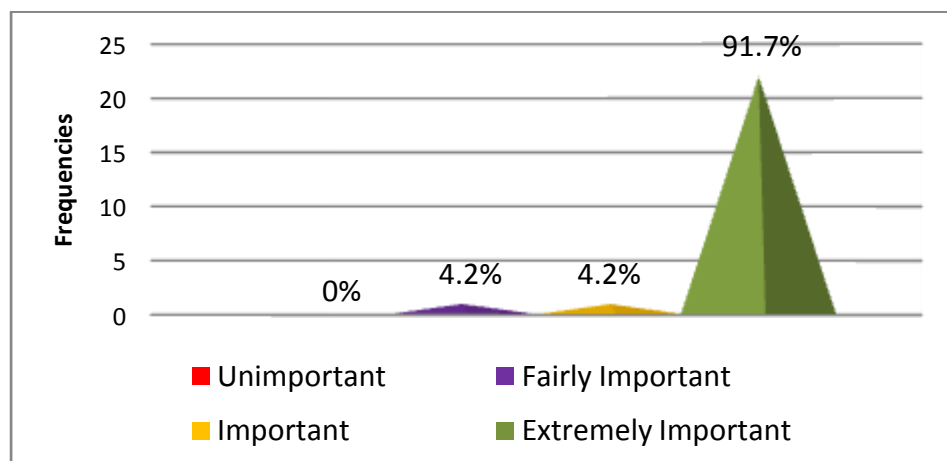
5.8.1.38 Poor leadership in nursing contributes to nurse migration

Of the respondents, 14 (58.3%) found poor leadership in nursing an 'important' reason for nurse migration from the PHS; six (25.0%) found it 'fairly important', while only four (16.7%) found poor leadership in nursing 'extremely important' in migration (see figure 5.18).

Figure 5.18 PH respondents' perception of poor leadership and migration (n= 24)
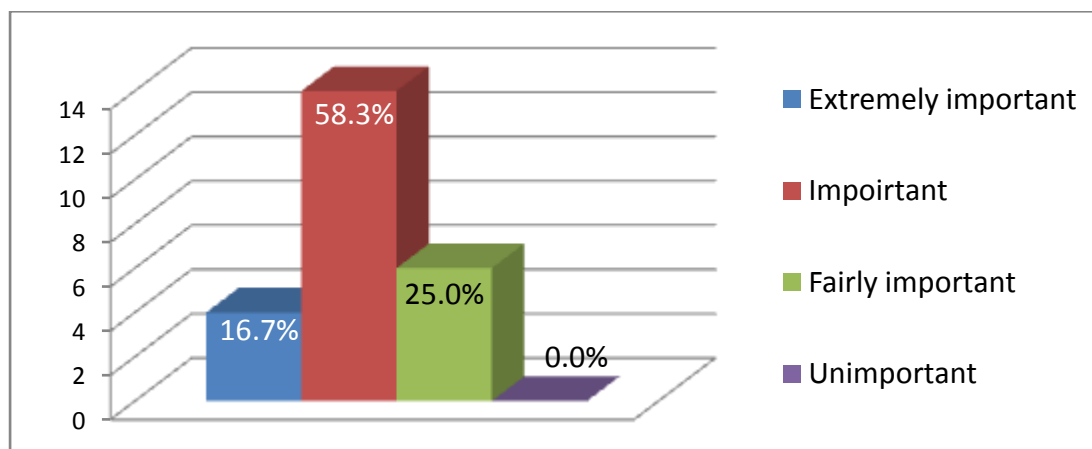
The data indicated that the respondents considered poor leadership an important reason for nurse migration from the PHS. This supported the finding that most of the respondents disagreed that NSMs gave feedback on problems reported (see figure 5.16).

5.8.1.39 Poor working conditions lead to nurse migration

Of the respondents, 13 (54.2%) indicated that poor working conditions in the PHS were extremely important for migration; seven (29.2%) found them important; three (12.5%) found them fairly important, and only one (4.2%) found them unimportant for migration (see figure 5.19).

Figure 5.19 PH respondents' perception of poor working conditions and migration (n= 24)
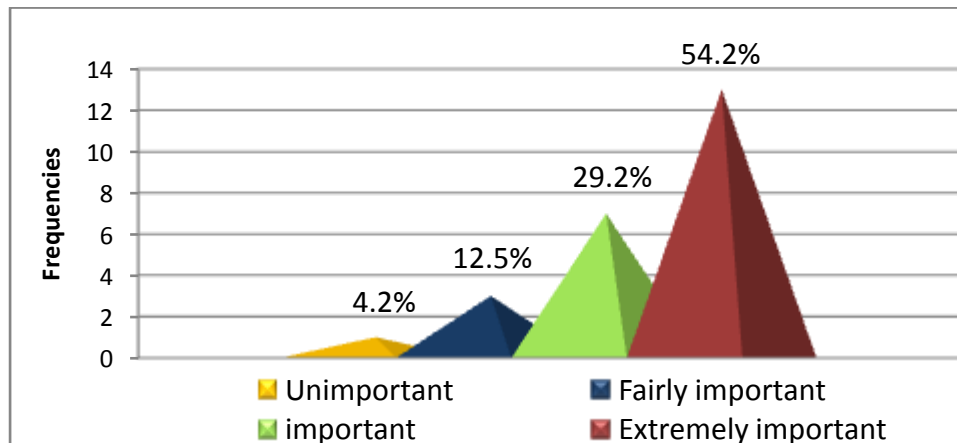
Poor working conditions include long working hours, lack of equipment, and shortage of staff.

5.8.1.40 RNs migrate for "different" experience

Of the respondents, six (25.0%) indicated the desire for "different" experience an extremely important reason for migration; three (12.5%) found it important; seven (29.2%) found it fairly important, and eight (33.3%) found it unimportant for nurse migration (see figure 5.20).

Figure 5.20 PH respondents' perception of migration for "different" experience (n= 24)
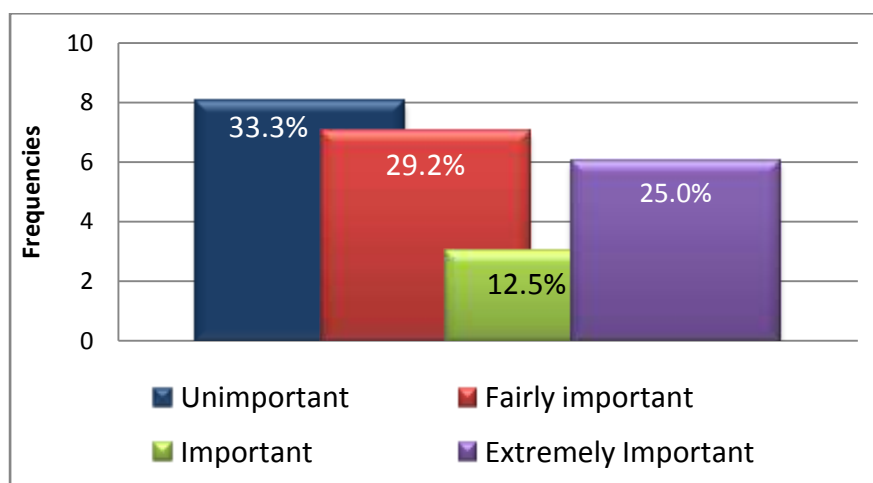
The data indicated that the respondents had not left the PHS for "different" experience. This concurred with the findings that inadequate salaries, poor leadership in nursing and poor working conditions caused nurse migration from the PHS (see figures 5.17, 5.18 and 5.19).

SECTION F: Nurses and strike actions

5.8.1.41 RNs prefer strikes to solve nurses' problems

Of the respondents, 20 (87.5%) agreed and three (12.5%) disagreed that RNs preferred strikes to solve nurses' problems, not to deliberately disrupt work, but to achieve change and better salaries through collective bargaining by unions (see figure 5.21). This supported the finding that confidence appeared to have shifted from nursing management to unions (see figure 5.18).

Figure 5.21 PH respondents' perception of strikes to solve nurses' problems (n= 23)
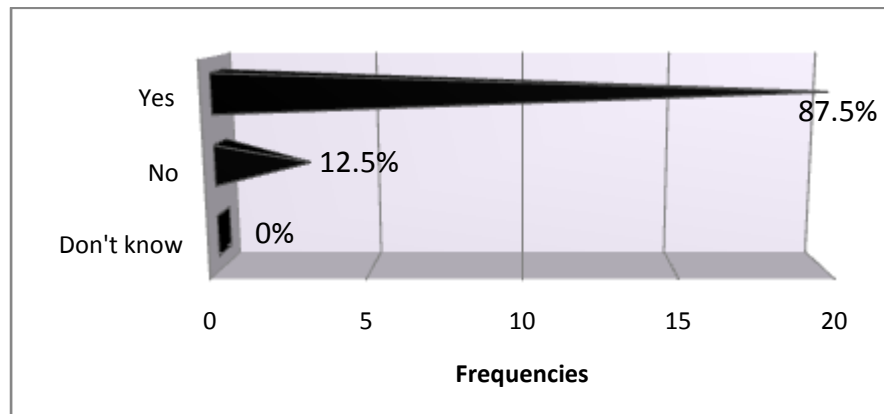
5.8.1.42 RNs and unions share similar values regarding patient care

Of the respondents, 15 (66.7%) disagreed and three (12.5%) agreed that unions shared similar values with RNs regarding patient care issues, while five (20.8%) were undecided (see figure 5.22).

Figure 5.22 PH respondents' perception of unions' and nurses' values (n= 23)
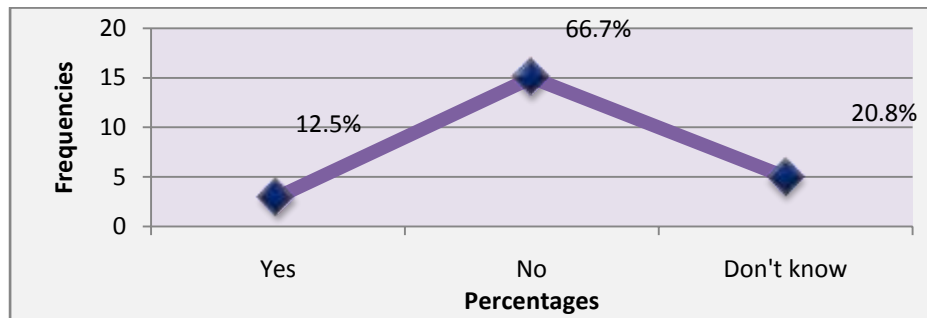
This contradicted the finding in figure 5.21 where 87.5% of the respondents indicated that RNs preferred strikes to solve problems. This data appeared to reflect a dilemma because strikes were initiated and led by unions, yet interests differ, hence although some of the goals are achieved, other areas suffered through dereliction of duty.

5.8.1.43 RNs support division between unions and professional associations

Of the respondents, nine (37.5%) agreed and eight (33.3%) disagreed that RNs supported the division between unions and professional associations, while seven (29.2%) did not know (see figure 5.23). The narrow differences between those who agreed and disagreed and also those who did not know indicated that the respondents were largely divided on the matter.

Figure 5.23 PH respondents' perception of division between unions and professional associations (n= 24)
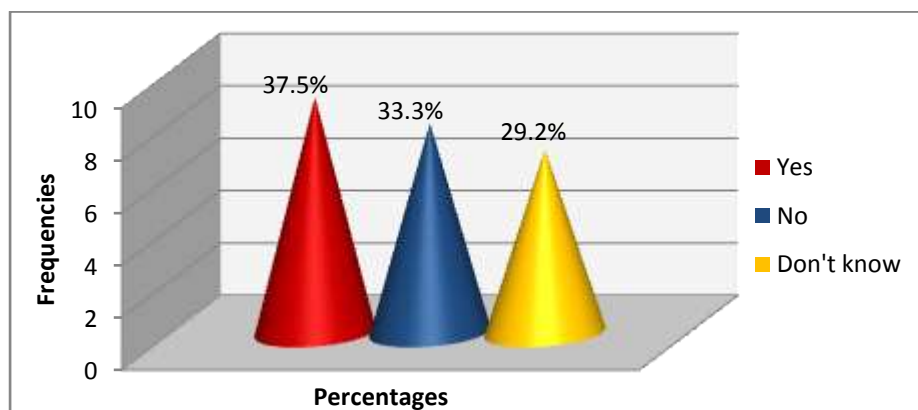
SECTION H: Nurses and politics

5.8.1.44 Poor nurse representation in government contributes to migration (n=24)

Of the respondents, 18 (75.0%) agreed and two (8.3%) disagreed that poor nurse representation in government was a cause of migration from the PHS while four (16.7%) did not know (see figure 5.24).

Figure 5.24 PH respondents' perception of poor nurse representation in government
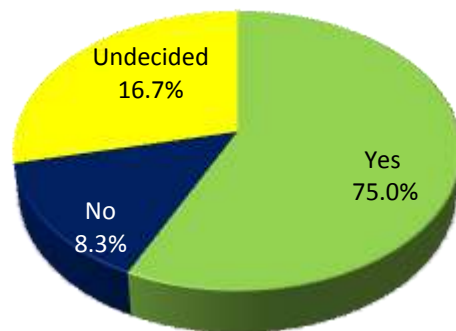
This finding seemed to imply a need for nurses to be united as a profession and be represented by nurses in government and bargaining chambers. There could also be a feeling that unions were not able to represent all nursing and health care issues, hence this group left the PHS.

5.8.1.45 RNs vote for parties that add value to nursing

Of the respondents, 56.5% (26.1 + 30.4%) strongly disagreed/disagreed and 34.7% (13.0% + 21.7%) agreed/strongly agreed that nurses voted for parties that added value to nursing practice, and two (8.7%) were undecided (see figure 5.25). This could mean that most nurses cast their votes without serious consideration of the impact of their votes on the practice of nursing and health care delivery. If so, this is a matter of concern requiring serious attention.

Figure 5.25 PH respondents' perception of voting for parties that add value (n= 23)
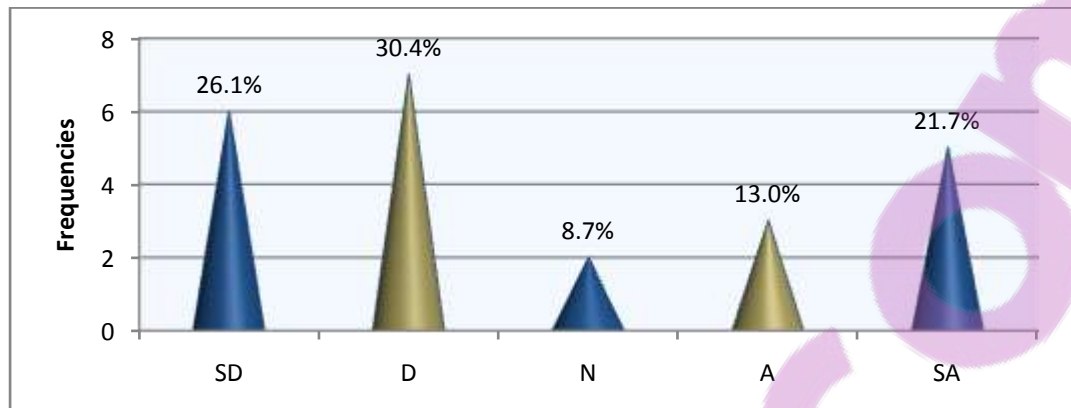
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

5.8.1.46 Nurses' issues are entertained in political debates

Of the respondents, 73.9% (47.8% + 26.1%) strongly disagreed/disagreed and 17.4% (0% + 17.4%) strongly agreed/agreed that nurses' issues were entertained in political debates, and 8.7% did not know (see figure 5.26).

Figure 5.26 PH respondents' perception of nurses' issues considered in political debates (n= 23)
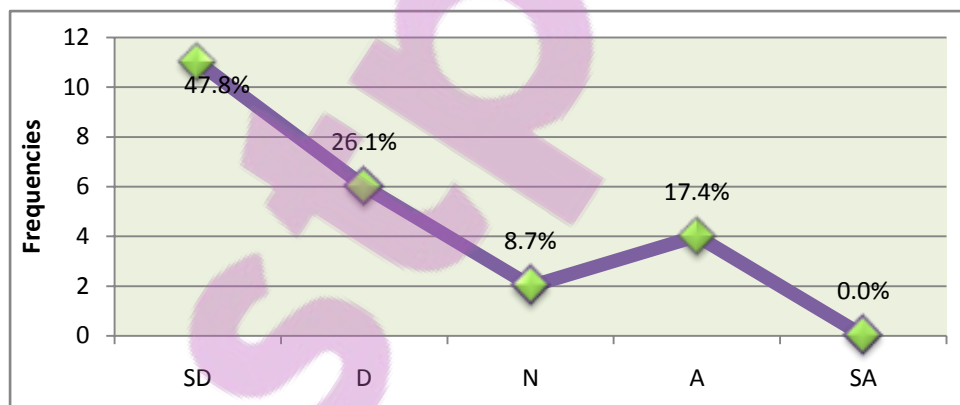
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

This response would appear to reflect the respondents' experience of struggling with issues of salaries and problems surrounding delivery of health care without achieving the desired results. This could be one of the reasons

why some joined unions to expedite negotiation through the power of collective bargaining.

5.8.1.47 RNs can become policy analysts in South Africa

Of the respondents, 60.8% (30.4% + 30.4%) strongly agreed/agreed and 30.4% (17.4% + 13.0%) strongly disagreed/disagreed that nurses could become policy analysts in the RSA if given the right educational preparation, while two (8.7%) did not know (see figure 5.27).

Figure 5.27 PH respondents' perception of RNs as policy analysts (n= 23)
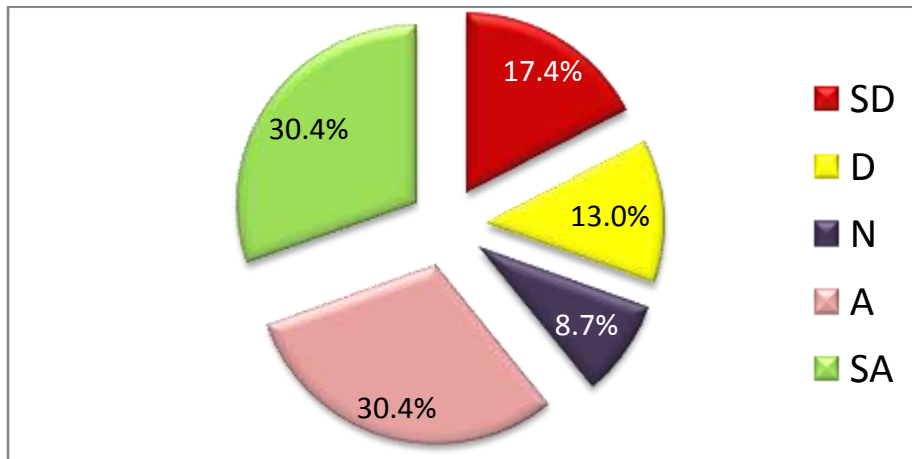
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

From this data, it was deduced that RNs could be successful as policy analysts in the RSA.

5.8.1.48 RNs know how policies are made in government

Of the respondents, 52.2% (26.1% + 26.1%) strongly disagreed/disagreed and 30.4% (8.7% + 21.7%) agreed/strongly agreed that nurses knew how policies were made at government level, while four (17.4%) were undecided (see figure 5.28). This finding suggested that RNs were not familiar with the political processes of the country. This then would support the need to include

political science in the nursing curriculum, and to bridge the gap for those who qualified under the previous curriculum.

Figure 5.28 PH respondents' perception of nurses' knowledge of policy-making at government level (n= 23)
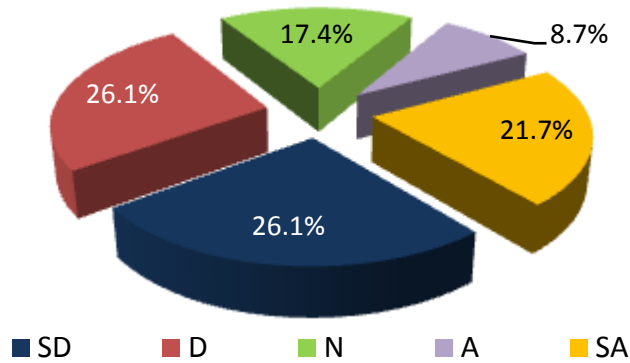
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

5.8.1.49 RNs can influence policy making

Of the respondents, 69.5% (30.4% + 39.1%) agreed/strongly agreed and 21.7% (13.0% + 8.7%) strongly disagreed/disagreed that, given the opportunity, nurses could influence policy making in the country, while 8.7% did not know (see figure 5.29).

Figure 5.29 PH respondents' perception of nurses' influence on policy making (n= 23)
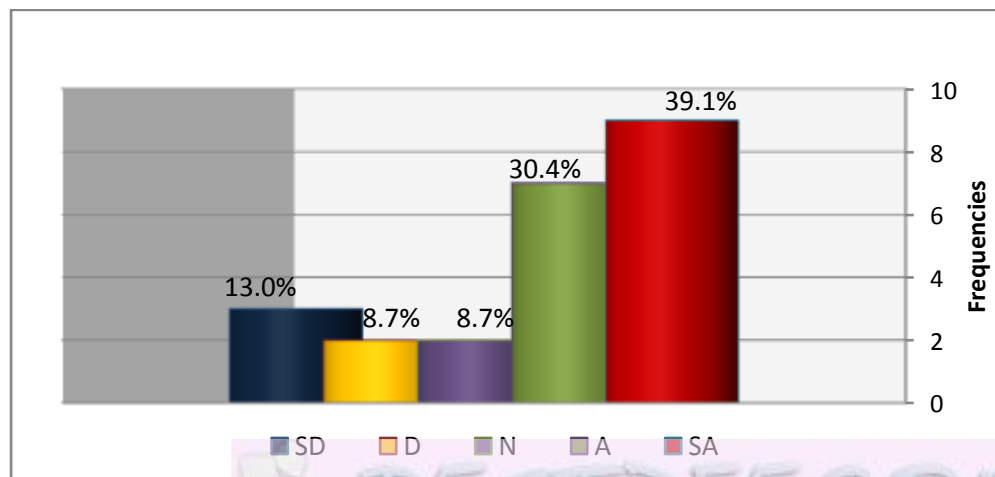
Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

The results indicated that most of the respondents believed that RNs could change politics to effectively promote nursing and health service delivery by using their influence, negotiating skills and collective power. This political awareness poses a challenge to nursing leaders to find ways of encouraging and supporting nurses to rise to public office appointments and active participation in political arenas in order to represent nursing issues before decision-makers.

5.8.2 Qualitative data analysis for the PHS

Some of the respondents gave written narratives in response to questions of their choice, which are discussed in chapter 6.

5.9 COMPARISON OF RESEARCH FINDINGS

The researcher compared all the respondents' perceptions expressed in the quantitative data as well as their experiences relating to discontent among RNs in the PHS in order to identify differences. This section presents the data in percentages to ensure that the scales use standardised or commensurate measures because the composition of each hospital varied, resulting in concomitant variation in samples, hence responses from different hospitals differed in sizes and weight with each item. Therefore, a detailed analysis as shown in the tables and figures revealed the relative importance of discontent in each hospital. The target sample of each hospital was in proportion to the entire sector's importance in the health system.

It should be noted that in all different levels of care represented in this study; there were budgetary restrictions between levels of care, which could have influenced the reasons why the degree of discontent in groups varied. Also, there is a difference between academic, regional and district hospitals. Consequently, the respondents' perceptions could be based on the conditions surrounding each individual hospital, because some levels of care had equipment lacking in others, consistent with the regional distributions and disparities in the allocation of scarce resources. It was therefore expected that one hospital would emphasise a component considered highly important, while another would highlight a different area of need or frustration.

It should also be taken into consideration that the PH respondents' perceptions were in retrospect, therefore should not be construed as comparisons between the public and private health sectors. In addition, when comparing the data from different HCS, the *average percentages of the district cluster* was used to compare with the regional, academic and private hospitals, because they bore the same characteristics.

5.9.1 Comparison of responses from the district cluster (DC), regional (RH), academic (AH) and private (PHs) hospitals

(NB: In the table and figure that follow, HC indicates data for Hospital Comparisons).

SECTION A: Demographic information

5.9.1.1 Age distribution

The data revealed that with the exception of one respondent, the respondents' ages in all the hospitals did not go over 64 years.

Table 5.1 HC of respondents' ages (n=209)

Hospital	Frequency	Percentage						
		18-25	26-33	34-41	42-49	50-57	58-64	65-72
District	65	8.6	26.3	30.6	24.3	9.1	1.2	0.0
Regional	53	5.7	15.1	15.1	17.0	39.6	5.7	1.9
Academic	67	16.4	10.4	29.9	29.9	11.9	1.5	0.0
Private	24	0.0	12.5	33.3	33.3	16.7	4.2	0.0
Average	52.3	7.7	16.1	27.2	26.1	19.3	3.2	0.5

Figure 5.1 HC of respondents' ages
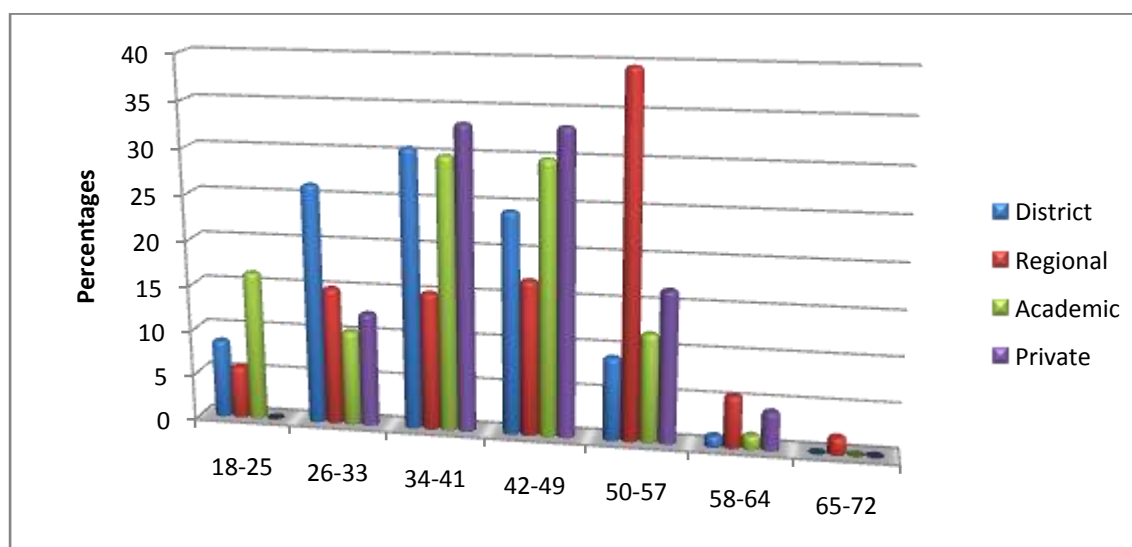
The regional hospital was spread from 65 to 72 years. Modal groups for district and academic ages were 34 to 41 years each, but district hospitals had a lower frequency than the private hospitals. Private hospitals had a modal group at 42 to 49 years and regional ones had a modal group of 50 to 57 years. There were 35 missing values in this item.

5.9.1.2 Race

The data indicated a majority of Black respondents and no Asian or "Other" respondents.

Table 5.2 HC of respondents' race (n=210)

Hospital	Frequency	Percentage				
		Black	Coloured	Asian	White	Other
District	66	89.2	2.1	0.0	2.0	0.0
Regional	53	98.1	1.9	0.0	0.0	0.0
Academic	68	61.8	16.2	0.0	22.1	0.0
Private	23	26.1	21.7	0.0	52.2	0.0
Average	52.5	68.8	10.5	0.0	19.1	0.0

Figure 5.2 HC of respondents' race
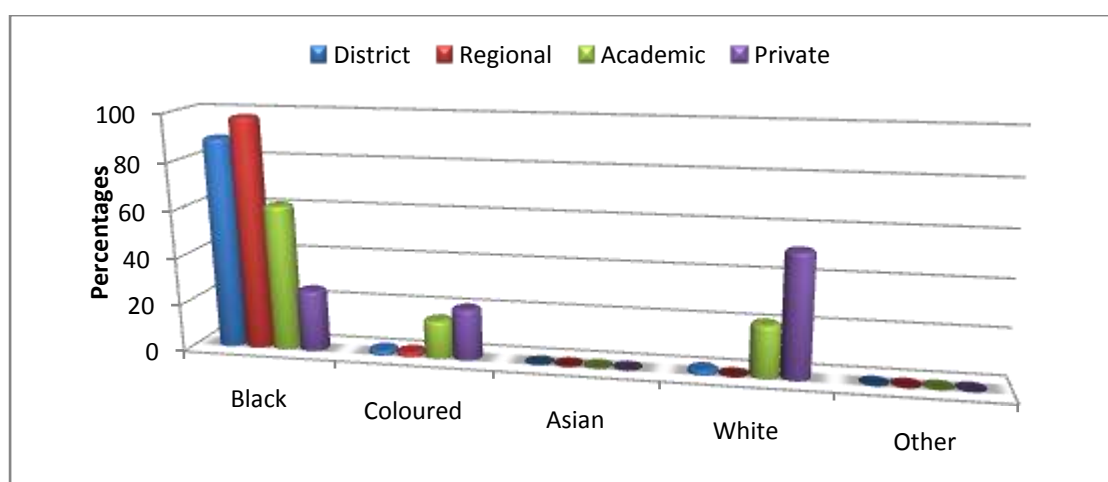
Black respondents dominated in all the hospitals, but were found mostly in the RH (98.1%), followed by the DHs (89.2%), then the AH (61.8%). The PHs had the least Black respondents (26.1%). There were no White respondents in the

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RH while more Whites were in the PHs. This could have been due to the areas in which these hospitals were located. The Coloured and White respondents were found mainly in the PHs (21.7%), followed by the AH (16.2%). There were 34 missing values in this item.

5.9.1.3 Gender

The data revealed more female than male respondents.

Table 5.3 HC of respondents' gender (n=206)

Hospital	Frequency	Percentage	
		Male	**Female**
District	64	6.4	93.6
Regional	53	5.7	94.3
Academic	66	1.5	98.5
Private	23	0.0	95.8
Average	51.5	3.4	95.6

Figure 5.3 HC of respondents' gender
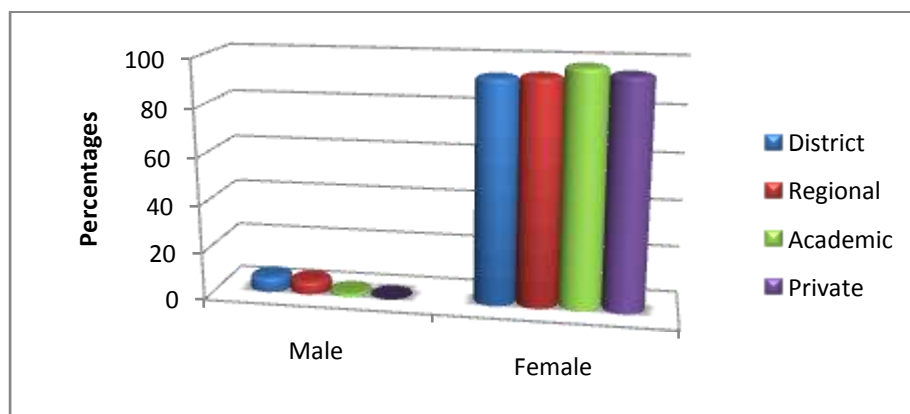
The female respondents outnumbered the males in all the hospitals, and there were no male respondents in the PHs. There were 38 missing frequencies in this item.

5.9.1.4 Marital status

The majority of the respondents were found to be married.

Table 5.4 HC of respondents' marital status (n=207)

Hospital	Frequency	Percentage			
		Single	Married	Divorced	Widowed
District	65	41.9	49.1	6.4	2.6
Regional	54	35.2	48.1	5.6	11.1
Academic	65	43.1	49.2	6.2	1.5
Private	23	30.4	52.2	13.0	4.3
Average	51.8	37.7	49.7	7.8	4.9

Figure 5.4 HC of respondents' marital status
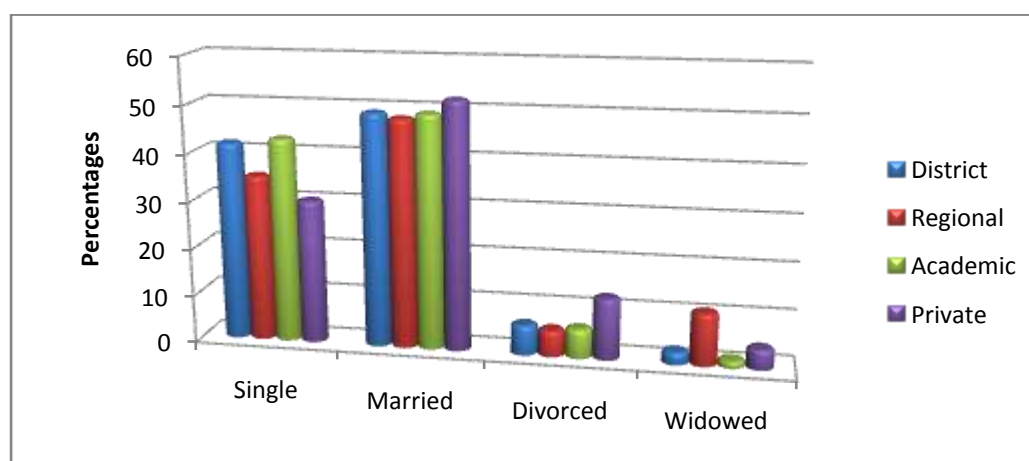
In all the hospitals, the majority of the respondents were married, followed by single and divorced respondents. The widowed respondents were found mainly in the RH. There were 37 missing values.

5.9.1.5 Number of dependants

The data revealed a majority of respondents with one to three dependants in all the hospitals.

Table 5.5 HC of respondents' number of dependants (n=209)

Hospital	Frequency	Percentage		
		None	**1 – 3**	**> 3**
District	65	21.7	75.0	3.4
Regional	54	11.1	72.2	16.7
Academic	67	25.4	71.6	3.0
Private	23	34.8	60.9	4.3
Average	52.3	23.3	69.9	6.9

Figure 5.5 HC of respondents' number of dependants
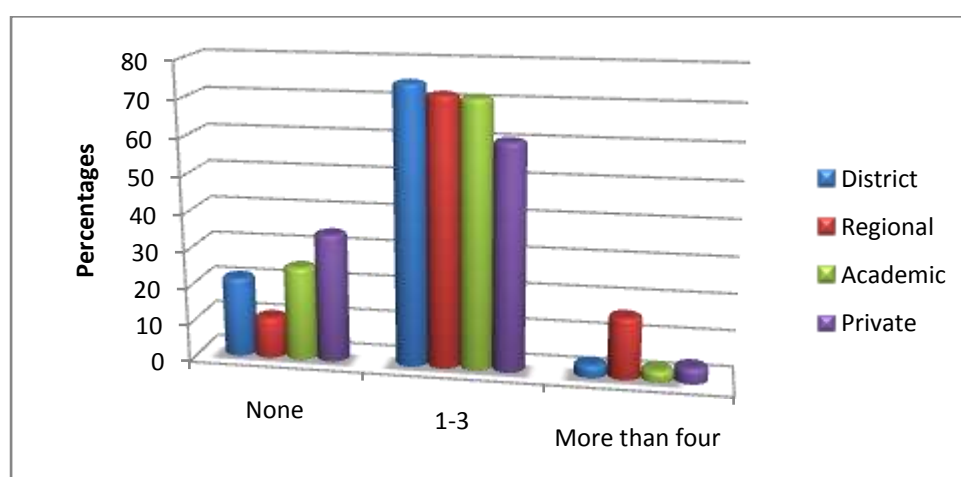
Most of the respondents in all the hospitals had between one and three dependants. The DHs had 75.0%, followed by the RH with 72.2%, the AH with 71.6%, and finally the PHs with 60.9%. The RH had more respondents with four or more dependants than the other hospitals. There were 35 missing values.

5.9.1.6 Residential area

The data revealed that most of the respondents resided in the city/town and townships.

Table 5.6 HC of respondents' residential area (n=210)

Hospital	Frequency	Percentage			
		City/Town	Township	Village	Informal settlement
District	66	49.0	46.2	3.5	1.0
Regional	54	31.5	68.5	0.0	0.0
Academic	67	52.2	44.8	3.0	0.0
Private	23	87.0	4.3	0.0	8.7
Average	52.5	54.9	41	1.6	2.4

Figure 5.6 HC of respondents' residential area
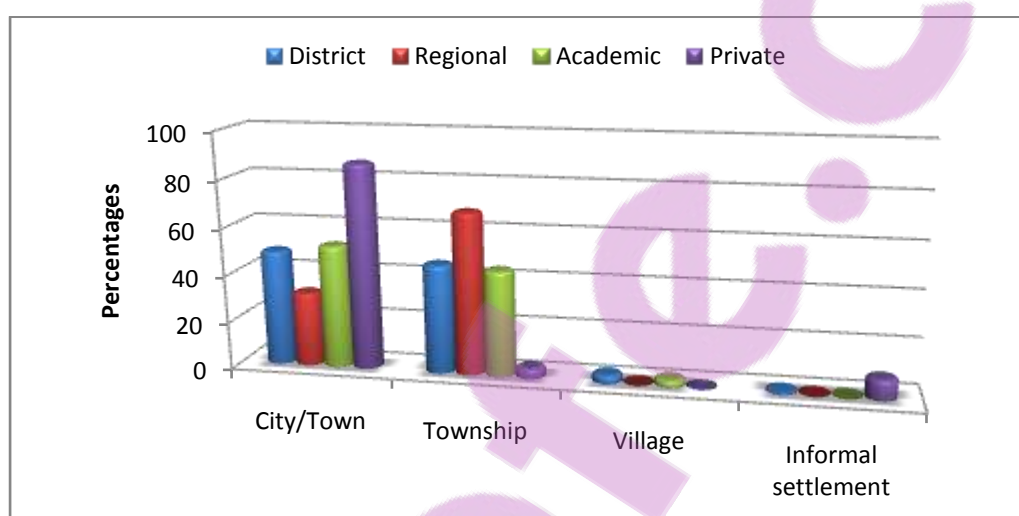
Of the respondents who lived in the city, 87.0% were from the PHs; 52.2% from the AH; 49.0% from the DHs, and 31.5% from the RH. This factor could have been influenced by the fact that the PHs and AH were located in town. Of the respondents residing in townships, 46.2% were from the DHs; 68.5% from the RH; 44.8% from the AH, and 4.3% from the PHs. Only 3.5% of DHs and 3.0% of AH respondents lived in villages. Only 1.0% of DHs and 8.7% of PH respondents lived in informal settlements. There were 34 missing values. This data was significant in identifying the respondents' degree of financial responsibility in terms of the cost of accommodation, while the high cost of general commodities is virtually the same for everyone.

5.9.1.7 Type of health care service (HCS)

The respondents had purposely been selected to cover the public and the private health care services.

Table 5.7 HC of respondents' type of HCS

Hospital	Frequency	Percentage
District	98	100
Regional	54	100
Academic	68	100
Private	24	100

Figure 5.7 HC of respondents' type of HCS
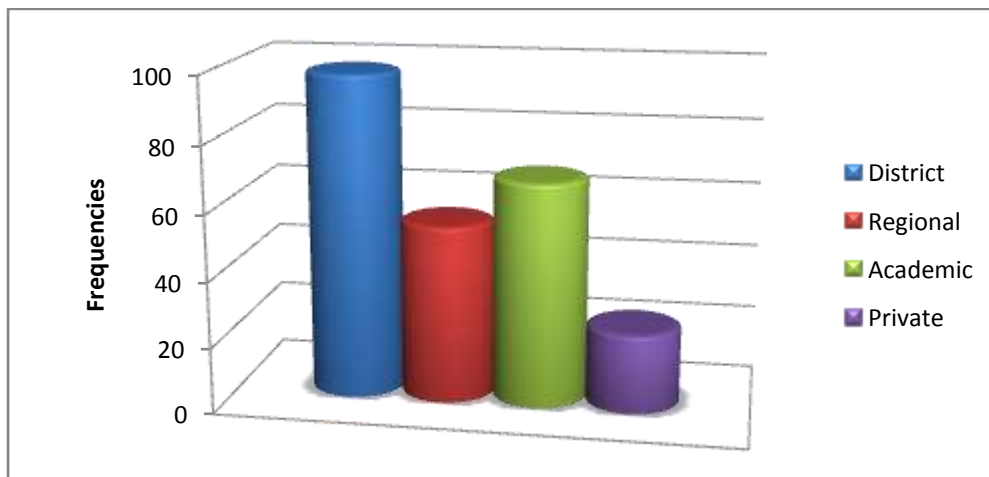
The number of respondents for each hospital varied. Of the respondents, 98 were from the DC; 68 were from AH; 54 were from RH, and 24 were from PHs.

5.9.1.8 Positions

The respondents' positions (ranks) were also compared.

Table 5.8 HC of respondents' positions held (n=207)

Hospital	Frequency	Percentage		
		CPNs	**SPNs**	**PNs**
District	64	24.5	24.2	51.3
Regional	54	53.7	11.1	35.2
Academic	66	39.4	21.2	39.4
Private	23.0	13.0	30.4	56.5
Average	51.75	32.7	21.7	45.6

Key: CPN = Chief professional nurses; SPNs = Senior professional nurses; PNs = Professional nurses

Figure 5.8 HC of respondents' positions held
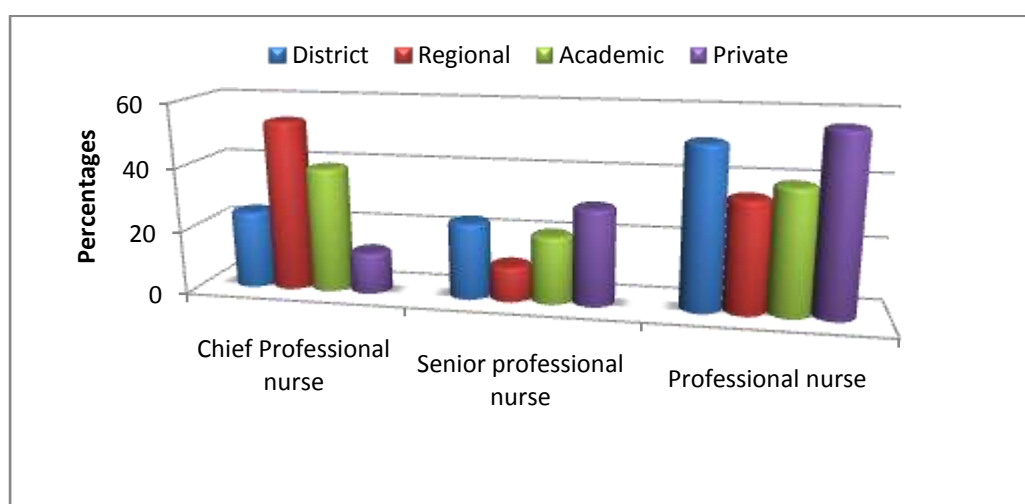
The data indicated that most CPNs were found in the RH (53.7%), followed by the AH (39.4%), the DHs (24.5%), and finally the PHs (13.0%). The low PH percentage could have been influenced by the number of promotions controlled by hospital policies. Most SPNs were found in the PHs (30.4%), followed by the DHs (24.2%), then the AH (21.2, and lastly the RH (11.1%). Most of the PNs were found in the PHs (56.5%), followed by the DHs (51.3%), the AH (39.4%), and finally the RH (35.2%). There were 37 missing values.

5.9.1.9 Years of experience since registration

The respondents' years of service since SANC registration were also compared.

Table 5.9 HC of respondents' years of experience (n=205)

Hospital	Frequency	Percentage						
		1-5	6-10	11-20	21-30	31-40	41-50	51-60
District	65	37.1	23.9	29.5	6.7	2.7	0.0	0.0
Regional	53	18.9	9.4	34.0	24.5	11.3	1.9	0.0
Academic	64	31.3	17.2	36.0	14.1	1.6	0.0	0.0
Private	23	4.3	8.7	43.5	21.7	21.7	0.0	0.0
Average	51.3	22.9	14.8	35.8	16.8	9.3	0.5	0.0

Figure 5.9 HC of respondents' years of experience
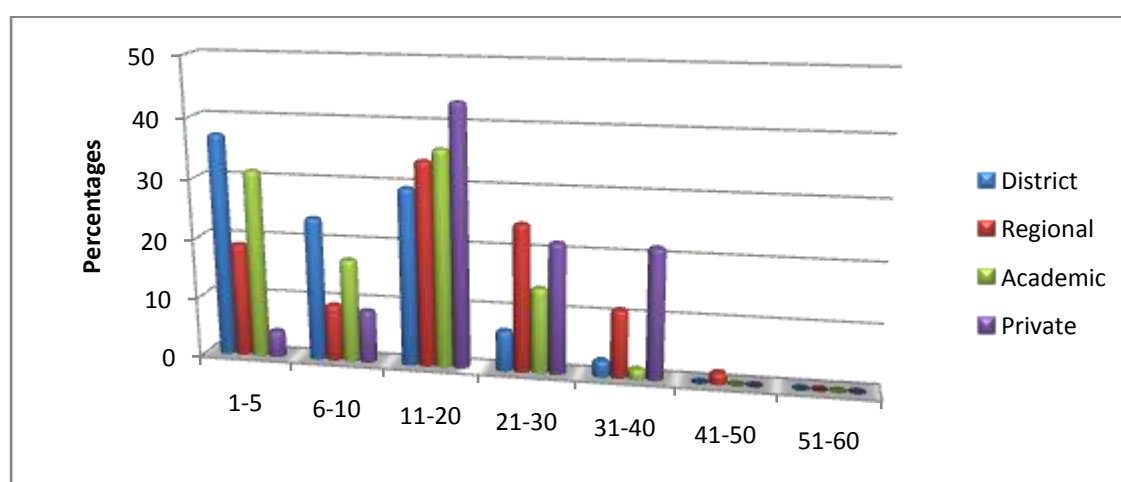
The data revealed that the RH was the only hospital that had respondents with between 41 and 50 years' experience. These respondents had been recalled to help compensate for the shortage of staff. The DHs (37.1%) and AH (31.3%) had the most respondents with 1 to 5 years' experience. The DHs (23.9%) and AH (17.2%) also had the most with 6 to 10 years' experience. The PHs (43.5%) had the most respondents with 11 to 20 years' experience, followed by the AH (36.0%), the RH (34.0%), and the DHs (29.5%). The RH (24.5%) had the most respondents' with 21 to 30 years' experience, followed by the PHs (21.7%), the AH (14.1%), and the DHs (6.7%). The PHs (21.7%) had the most respondents with 31 to 40 years' experience, followed by the RH (11.3%), the DHs (2.7%), and the AH (1.6%). There were 39 missing values.

5.9.1.10 Qualifications

The respondents' qualifications were also compared.

Table 5.10 HC of respondents' qualifications (n=200)

Hospital	Frequency	Percentage						
		BND	Post-BND	Basic 4-year nursing degree	BA Cur	Honours	M	D
District	63	41.7	23.6	18.9	14.3	1.6	0.0	0.0
Regional	53	34.0	43.4	5.7	17.0	0.0	0.0	0.0
Academic	61	19.7	27.9	31.1	14.8	0.0	0.0	6.6
Private	23	34.8	13.0	30.4	8.7	13.0	0.0	0.0
Average	50.0	32.6	27	21.5	13.7	3.7	0.0	1.7

Figure 5.10 HC of respondents' qualifications
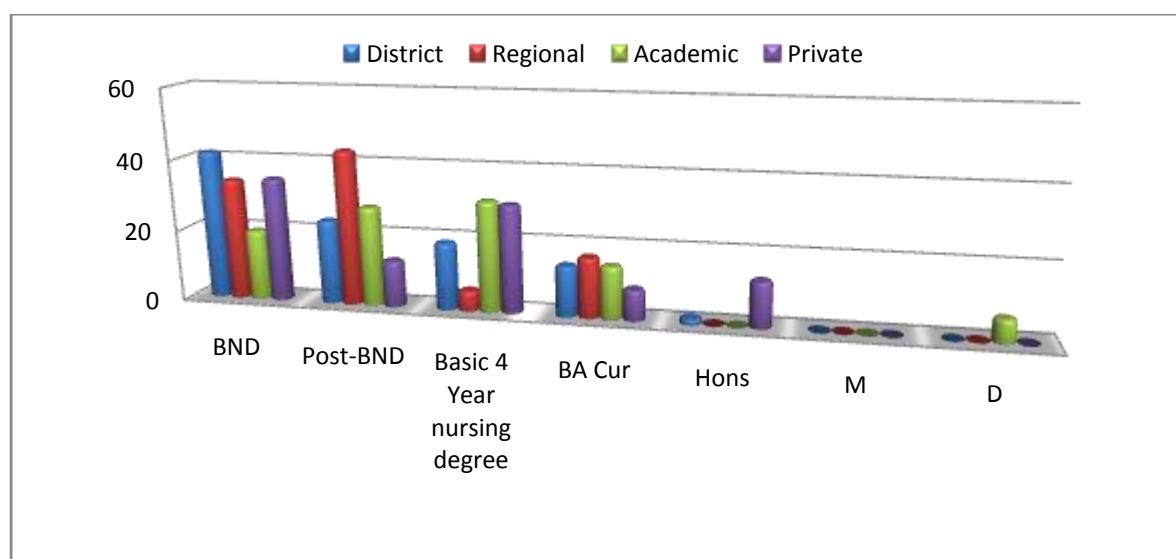
The data revealed that the DHs (41.7%) had most respondents with a BND, followed by the PHs (34.8), the RH (34.0%), and the AH (19.7%). The RH (43.4%) had the most respondents with a Post-BND, followed by the AH (27.9%), the DHs (23.6%), and the PHs (13.0%). The AH (31.1%) had the most respondents with a Basic 4-year degree, followed by the PHs (30.4%), the DHs (18.9%), and the RH (5.7%). The RH (17.0%) had the most respondents with a BA Cur, followed by the AH (14.8%), the DHs (14.3%),

and the PHs (8.7%). Only the PHs (13.0%) and the DHs (1.6%) had respondents with Honours degrees in nursing. No respondents had Master's degrees. Only the AH (6.6%) had respondents with a doctoral degree. The data indicated a lack of post-graduate qualifications in nursing. There were 44 missing values.

SECTION B: Transformation of the PHS

5.9.1.11 PHS transformation has been successful

The study examined and compared the respondents' perceptions of PHS transformation.

Table 5.11 HC of respondents' perception of PH transformation (n=189)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	61	29.2	67.9	2.9
Regional	45	24.4	64.4	11.1
Academic	61	46.0	50.8	3.2
Private	22	4.5	86.4	9.1
Average	47.3	26.0	67.4	6.6

Figure 5.11 HC of respondents' perception of PH transformation
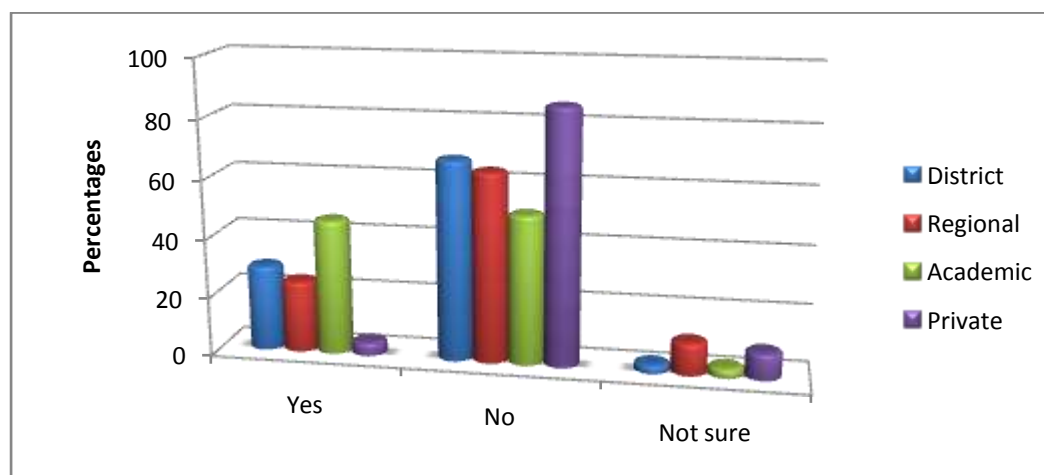
The data revealed that the majority of the respondents in all the hospitals disagreed that PHS transformational initiatives were successful. The PHs (86.4%) had the most respondents who disagreed, followed by the DHs (67.9%), then the RH (64.4%), and lastly the AH (50.8%). The AH (46.0%) had the most respondents who agreed that PHS transformation had been successful, followed by the DHs (29.2%), the RH (24.4%), and the PHs (4.5%). There were 55 missing values.

5.9.1.12 Promotions are allocated fairly in the PH

The respondents were asked whether promotions were allocated equitably in the PHS, and their responses compared.

Table 5.12 HC of respondents' perception of PH promotions (n= 204)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	66	14.3	65.3	20.4
Regional	51	2.0	72.5	25.5
Academic	65	23.1	61.5	15.4
Private	22	9.1	72.7	18.2
Average	51.0	12.1	68	19.9

Figure 5.12 HC of respondents' perception of PH promotions
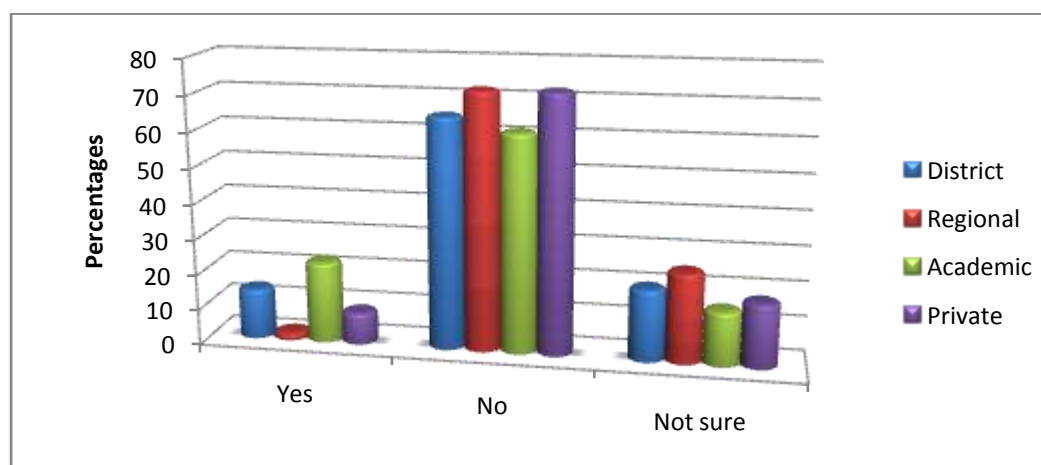
The data revealed that most of the respondents from all the hospitals disagreed that promotions in the PHS were allocated fairly. The PHs (72.7%) and the RH (72.5%) had the most respondents who disagreed that promotions were allocated fairly in the PHS, followed by the DHs (65.3%) and the AH (61.5%). The AH (23.1%) had the most respondents who agreed that promotions were fair, followed by the DHs (14.3%), the PHs (9.1%), and the RH (2.0%). More DHs, RH and PH respondents were not sure than those who agreed. There were 40 missing values.

5.9.1.13 Young South Africans are attracted to nursing

The respondents' perceptions of youth being attracted to nursing were compared.

Table 5.13 HC of respondents' perception of youth attracted to nursing (n=202)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	65	38.7	49.6	11.7
Regional	50	20.0	62.0	18.0
Academic	64	23.4	68.8	7.8
Private	23	21.7	78.3	0.0
Average	50.5	26.0	64.7	9.4

Figure 5.13 HC of respondents' perception of youth attracted to nursing
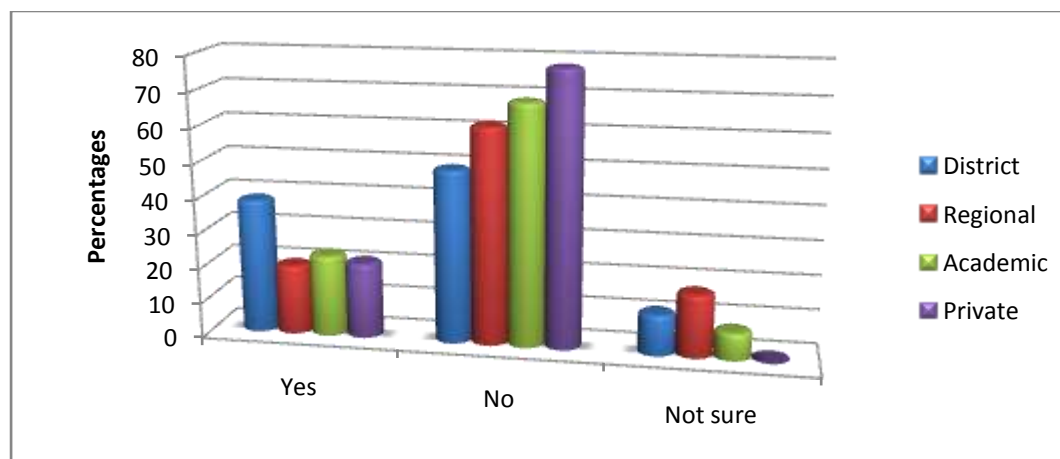
The data revealed that the majority of the respondents disagreed that the youth were attracted to the nursing profession. The PHs (78.3%) had the most respondents who disagreed, followed by the AH (68.8%), the RH (62.0%), and the DHs (49.6%). The DHs (38.7%) had the most respondents who agreed that youth were still attracted to nursing, followed by the AH (23.4%), the PHs (21.7%), and the RH (20.0%).

The findings created the impression that the PH respondents had lost confidence in the ability of the nursing profession to attract young people. At the same time, the AH and RH respondents could have been influenced by daily observation in their interaction with young nursing students who are mostly placed in these HCS for clinical experience. There were 42 missing values.

5.9.1.14 A national workforce forum investigates nurses' issues

The respondents' perception of the existence of a national forum to investigate nurses' concerns was compared.

Table 5.14 HC of respondents' perception of national nursing forum (n=201)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	63	19.1	39.0	41.9
Regional	50	16.0	36.0	48.0
Academic	65	21.5	43.1	35.4
Private	23	21.7	60.9	17.4
Average	50.3	19.6	44.8	35.7

Figure 5.14 HC of respondents' perception of national nursing forum
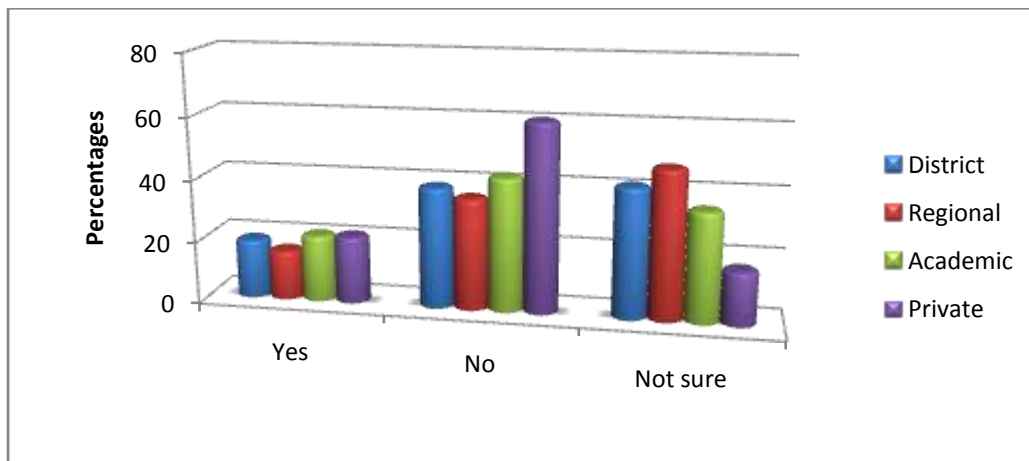
The data revealed that the PHs (60.9%) had the most respondents who disagreed that a national nursing forum existed, followed by the AH (43.1%), then the DHs (39.0%), and lastly the RH (36.0%). The PHs (21.7%) had the most respondents who agreed that a national nursing forum existed, followed by the AH (21.5%), the DHs (19.1%), and the RH (16.0%). Furthermore, the RH, DHs and AH had more respondents who did not know than those who agreed. There were 43 missing values.

The finding could imply that the proliferation of unions with their popularity and impact has mystified other options available for nurses, where their issues and problems could be addressed in a professional manner. It was assumed in this study that the respondents were aware of the existing professional association.

5.9.1.15 Employing body communicates with nurses

The respondents' perception of official communication with nurses was compared.

Table 5.15 HC of respondents' perception of communication with nurses (n=199)

Hospital	Frequency	Percentage			
		Never	**Occasionally**	**Frequently**	**Always**
District	61	48.8	44.8	3.9	2.6
Regional	52	41.0	46.2	0.0	2.0
Academic	64	42.2	53.1	4.7	0.0
Private	22	50.0	40.9	4.5	4.5
Average	49.8	45.5	46.3	3.3	2.3

Figure 5.15 HC of respondents' perception of communication with nurses
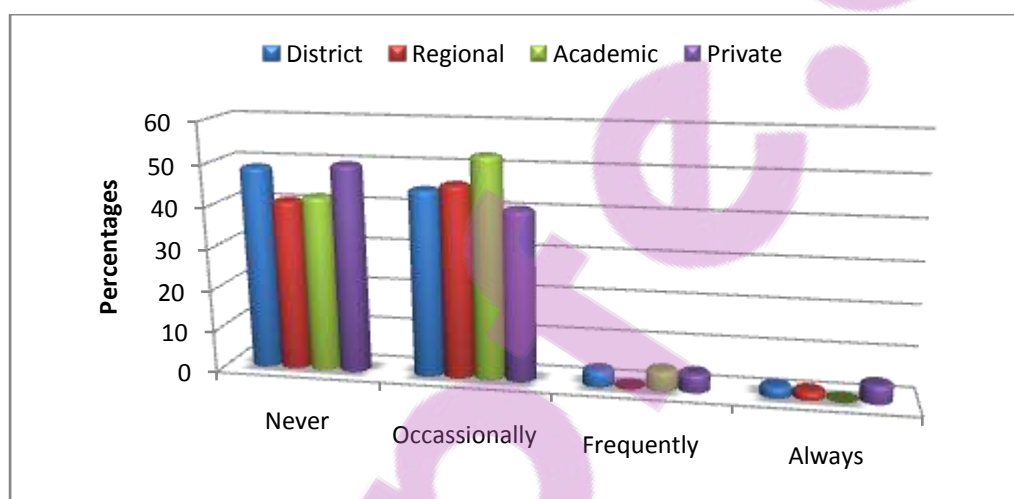
The data revealed that percentages were generally higher in the "never" column, with a gradual decline towards the "always" column. The PHs (50.0%) had the most respondents in the "never" column, followed by the DHs (48.8%), the AH (42.2%), and the RH (41.0%). This suggested a serious communication gap between government and nurses.

The AH (53.1%) had the most respondents in the "occasionally" column, followed by the RH (46.2%) and the DHs (44.8%). According to these respondents, there is some communication though possibly not effective. Moreover, the high percentages in this column seemed to signify minimal communication between provincial government and nurses.

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The AH (4.7%) and the PHs (4.5%) had the most respondents in the "frequently" column, followed by the DHs (3.9%). There were no responses from the RH. According to these results, there seemed to be no regular communication between government and nurses, particularly at the production level.

The PHs (4.5%) had the most respondents in the "always", followed by the DHs (2.6%) and the RH (2.0%). There were no responses from the AH in this column. There were 45 missing values.

5.9.1.16 The Occupational Specific Dispensation (OSD) is a perfect solution for discontent

The comparison of the data showed that most of the respondents in all the hospitals disagreed that the OSD was a perfect solution for discontent among RNs in the PHS.

Table 5.16 HC of respondents' perception of the OSD as solution (n=203)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	64	23.2	50.5	26.3
Regional	50	18.0	62.0	20.0
Academic	67	22.4	67.2	10.4
Private	22	4.5	68.2	27.3
Average	50.8	17.0	62.0	21

Figure 5.16 HC of respondents' perception of the OSD as solution
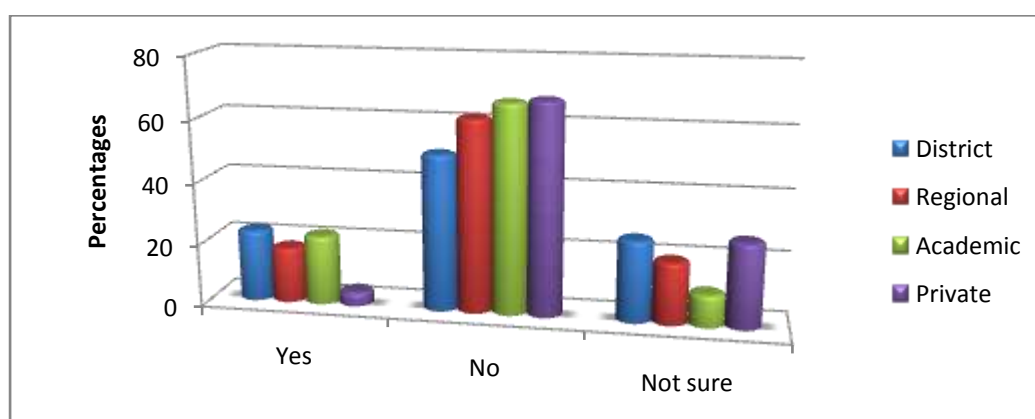
The data indicated that the PHs (68.2%) had the most respondents who disagreed that the OSD was a perfect solution, followed by the AH (67.2%), the RH (62.0%), and the DHs (50.5%). The response from the PHs could have been influenced by their interest in the outcome of the OSD for nurses for the purpose of comparing the new package with that of the PHs.

The DHs (23.2%) had the most respondents who agreed that the OSD was a perfect solution for discontent, followed by the AH (22.4%), the RH (18.0%), and lastly the PHs (4.5%). The DHS, RH and PHs had more respondents who were not sure than ones who agreed. There were 41 missing values.

5.9.1.17 Stakeholders agree on the Occupational Specific Dispensation

The comparison of the data indicated that most of the respondents from all the hospitals disagreed that there was consensus on the OSD.

Table 5.17 HC of respondents' perception of consensus on the OSD (n=204)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	64	12.9	54.5	32.5
Regional	51	13.7	54.9	31.4
Academic	66	6.1	71.2	22.7
Private	23	4.3	43.5	52.2
Average	51.0	9.3	56.0	34.7

Figure 5.17 HC of respondents' perception of consensus on the OSD
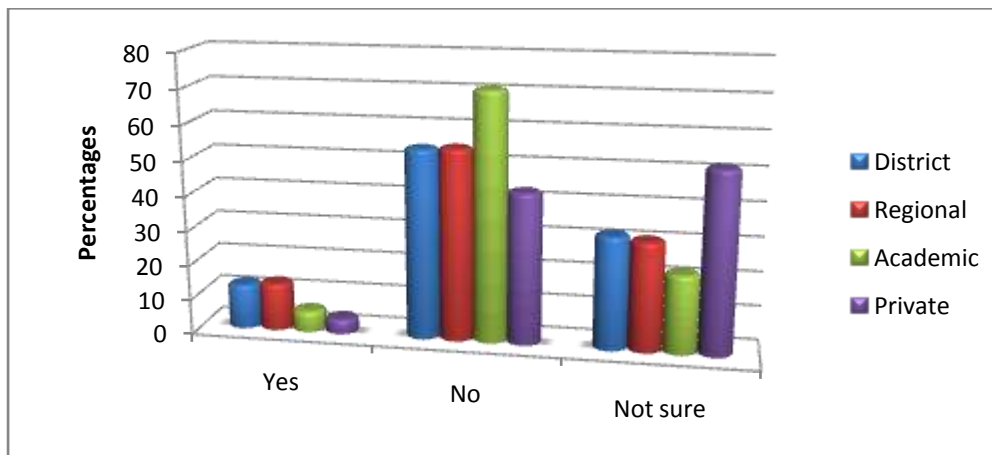
The AH (71.2%) had the most respondents who disagreed, followed by the RH (54.9%), the DHs (54.5%), and the PHs (43.5%). The RH (13.7%) had the most respondents who agreed that there was consensus among stakeholders, followed by the DHs (12.9%), the AH (6.1%), and the PHs (4.3%). There were 40 missing values.

A significantly higher number of respondents in all the hospitals were not sure compared to those who agreed. This finding could be indicative of despondency, confusion, frustration or ignorance among RNs in the PHs because of possible lack of information regarding the OSD.

5.9.1.18 Overseas exchange programme a success

The comparison of the data indicated that the majority of the respondents in all the hospitals did not perceive the overseas exchange programme to have been a successful venture.

Table 5.18 HC of respondents' perception of overseas exchange programme (n=179)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	57	38.6	49.4	11.9
Regional	45	28.9	55.6	15.6
Academic	54	35.2	46.3	18.5
Private	23	17.4	73.9	8.7
Average	44.8	30.0	56.3	13.7

Figure 5.18 HC of respondents' perception of overseas exchange programme
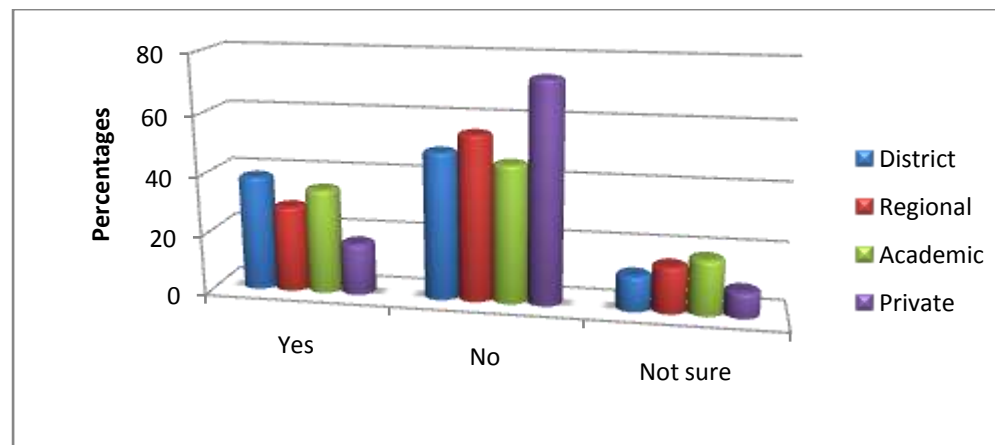
The PHs (73.9%) had the most respondents who disagreed that the overseas exchange programme was successful, followed by the RH (55.6%), the DHs (49.4%), and the AH (46.3%). The DHs (38.6%) had the most respondents who agreed that the programme was a success, followed by the AH (35.2%), the RH (28.9%), and the PHs (17.4%). There were 65 missing values.

The AH had been expected to take the lead in confirming or disproving the success of the programme as it was only implemented in academic hospitals, according to information released by the DOH during the study. Consequently, it was assumed that the DHs, PHs and RH respondents had either perceived the possible positive outcomes of such a programme, or had based their perceptions on what they had heard from AH colleagues.

5.9.1.19 Discontent among RNs is an observable reality

(NB: In the discussions that follow, the total 'strongly agree' and 'disagree' scores were combined. Similarly, the 'strongly agree' and 'agree' scores were also combined. Only the totals are presented.)

The data revealed that the majority of respondents in all the hospitals agreed that discontent was an observable reality among RNs.

Table 5.19 HC of respondents' perception of discontent among RNs (n=200)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	62	7.3	7.7	6.7	36.3	41.7
Regional	52	5.8	3.8	5.8	23.1	61.5
Academic	62	4.8	4.8	13.0	25.8	51.6
Private	24	8.3	0.0	0.0	37.5	54.2
Average	50.0	6.6	4.1	6.4	30.7	52.3

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.19 HC of respondents' perception of discontent among RNs
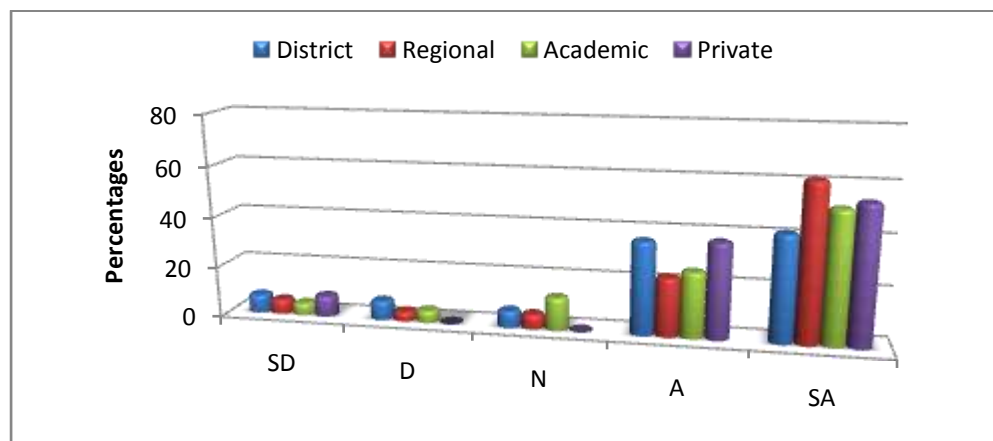
The PHs (91.7%) had the most respondents who agreed that discontent was observable among RNs, followed by the RH (84.6%), the DHs (78.0%), and the AH (77.4%). Far fewer respondents disagreed with the statement. The DHs (15.0%) had the most respondents who disagreed that discontent was observable among RNs, followed by the RH and AH (9.6%, respectively), and

the private hospital RNs coming last with (8.3%). There were 44 missing values.

5.9.1.20 Low morale associated with low salaries in PHS

The data revealed that the majority of the respondents in all the hospitals agreed that low morale was associated with low salaries in the PHS.

Table 5.20 HC of respondents' perception of low morale and low salaries (n=195)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	2.9	5.0	7.3	38.2	46.6
Regional	50	1.9	0.0	7.7	25.0	65.4
Academic	58	5.2	6.9	12.1	19.0	56.9
Private	24	8.3	0.0	0.0	12.5	79.2
Average	48.8	4.6	3	6.8	23.7	62.0

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.20 HC of respondents' perception of low morale and low salaries
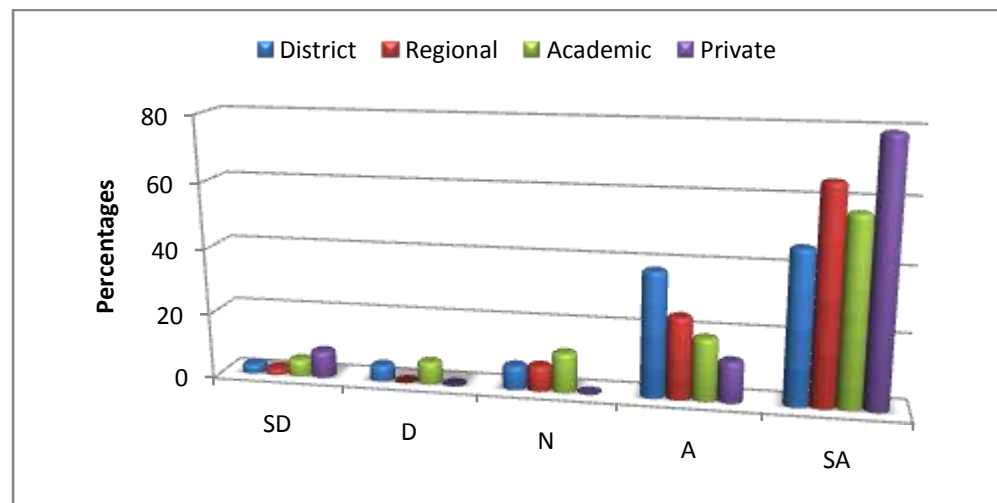
The PHs (91.7%) had the most respondents who agreed that low morale was associated with low salaries in the PHS, followed by the RH (90.4%), the DHs

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(84.8%), the AH (75.9%). The AH (12.1%) had the most respondents who disagreed, followed by the PHs (8.3%), the DHs (7.9%) and the RH (1.9%). The data therefore indicated a general feeling among the respondents that low salaries in nursing are a serious cause of low morale. There were 49 missing values.

5.9.1.21 RNs contribute to change in hospitals

The data indicated that with the exception of the PHs, most of the respondents agreed that RNs contributed to change in hospitals.

Table 5.21 HC of respondents' perception of RNs' contribution to change in hospitals (n=202)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	14.5	15.5	19.8	40.7	9.5
Regional	52	23.1	17.3	15.4	25.0	19.3
Academic	63	11.1	15.9	27.0	30.2	15.9
Private	24	62.5	20.8	12.5	4.2	0.0
Average	50.5	27.8	17.4	18.7	25.0	11.2

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.21 HC of respondents' perception of RNs' contribution to change in hospitals

418
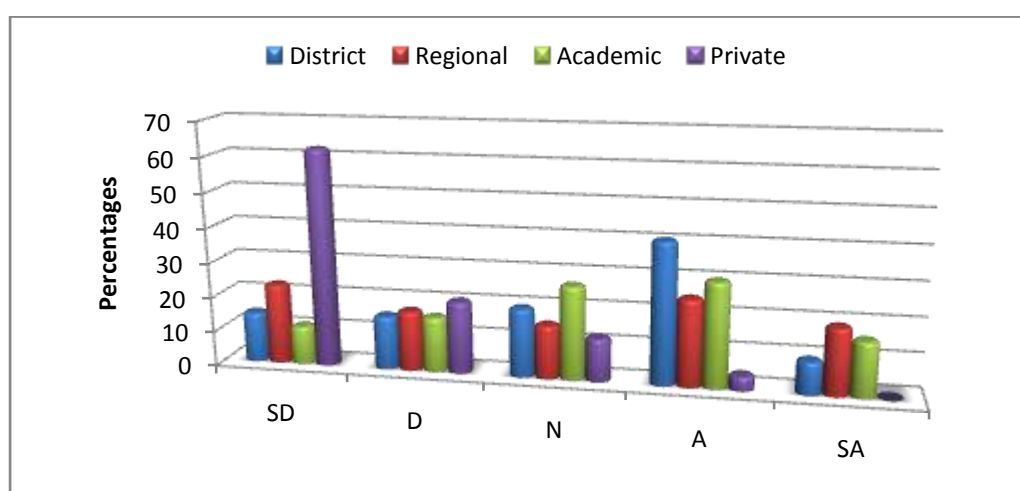
The DHs (50.2%) had the most respondents who agreed that RNs contributed to change in hospitals, followed by the AH (46.1%), and the RH (44.3%). The PHs (83.3%) had the most respondents who disagreed that RNs contributed to change in hospitals, followed by the RH (40.4%), the DHs (30.0%) and the AH (27.0%). There were 42 missing values.

5.9.1.22 RNs are sponsored for conferences

The data revealed that the majority of respondents in all the hospitals disagreed that nurses were sponsored for conferences.

Table 5.22 HC of respondents' perception of sponsorship for conferences (n=200)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	32.6	32.6	19.5	9.1	6.2
Regional	50	62.0	18.0	10.0	10.0	0.0
Academic	63	42.9	19.1	25.4	12.7	0.0
Private	24	62.5	20.8	12.5	4.2	0.0
Average	50.0	50.0	22.6	16.9	9	1.6

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.22 HC of respondents' perception of sponsorship for conferences

419
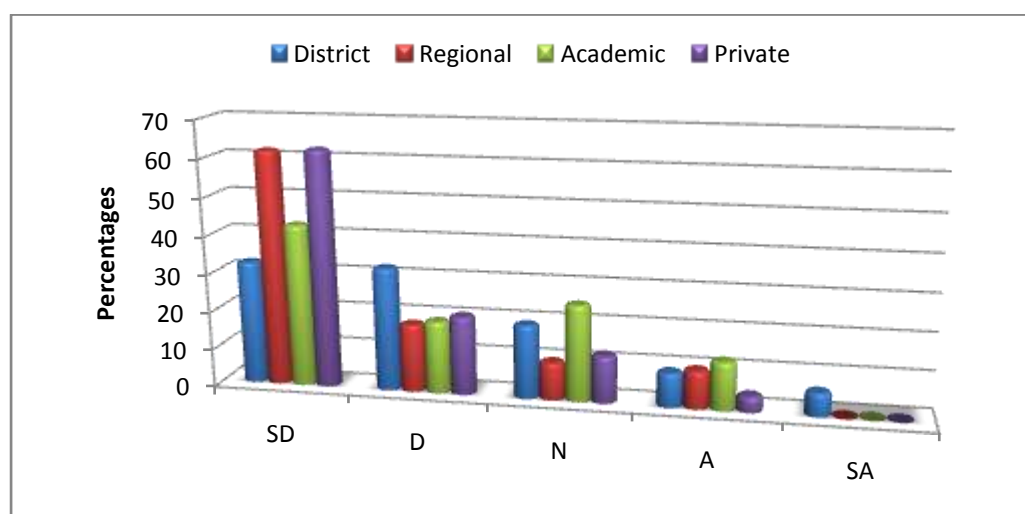
The PHs (83.3%) and the RH (80.0%) had the most respondents who disagreed that RNs were sponsored for conferences, followed by the DHs (65.2%), and the AH (62.0%). The DHs (15.3%) had the most respondents who agreed, followed by the AH (12.7%), the RH (10.0%) and the PHs (4.2%). The data seemed to imply insufficient efforts to support and expose RNs to conferences for personal and professional growth. There were 44 missing values.

5.9.1.23 RNs are financed to do research

The data revealed that most respondents disagreed that nurses were financed to do research.

Table 5.23 HC of respondents' perception of finances for research (n=199)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	31.8	32.9	15.1	17.6	2.5
Regional	50	48.0	22.0	20.0	8.0	2.0
Academic	63	39.7	33.3	19.1	4.8	9.0
Private	23	56.5	30.4	13.0	0.0	0.0
Average	49.8	44.0	29.7	16.8	7.6	3.4

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.23 HC of respondents' perception of finances for research
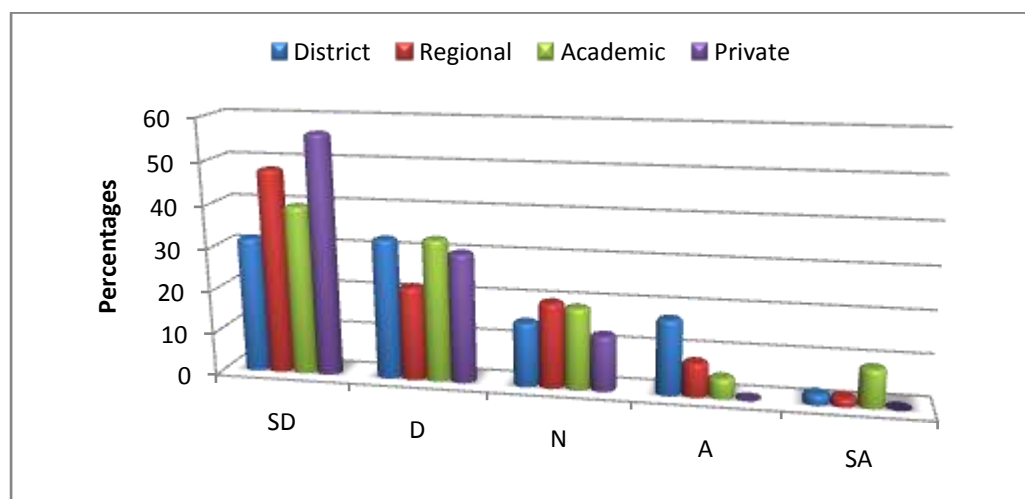
The PHs (86.9%) had the most respondents who disagreed that RNs were financed to do research, followed by the AH (73.0%) and the RH (70.0%), and the DHs (64.7%).

The DHs (20.1%) had the most respondents who agreed that nurses were financed to do research, followed by the AH (13.8%) and the RH (10.0%). No PH respondents agreed. There were 45 missing values.

5.9.1.24 Opportunities exist for RNs' career development

The data indicated that most of the respondents in all the hospitals disagreed that there were opportunities for PH RNs' career development.

Table 5.24 HC of respondents' perception of PHS opportunities for career development (n=200)

Hospital	Frequency	Percentage				
		SD	**D**	**N**	**A**	**SA**
District	64	21.1	24.8	12.3	32.0	10.0
Regional	51	31.4	25.5	21.6	15.7	5.9
Academic	63	12.7	14.3	25.4	35.0	12.7
Private	22	54.5	9.1	13.6	18.2	4.5
Average	50.0	29.9	18.4	18.2	25.2	8.3

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.24 HC of respondents' perception of PHS opportunities for career development

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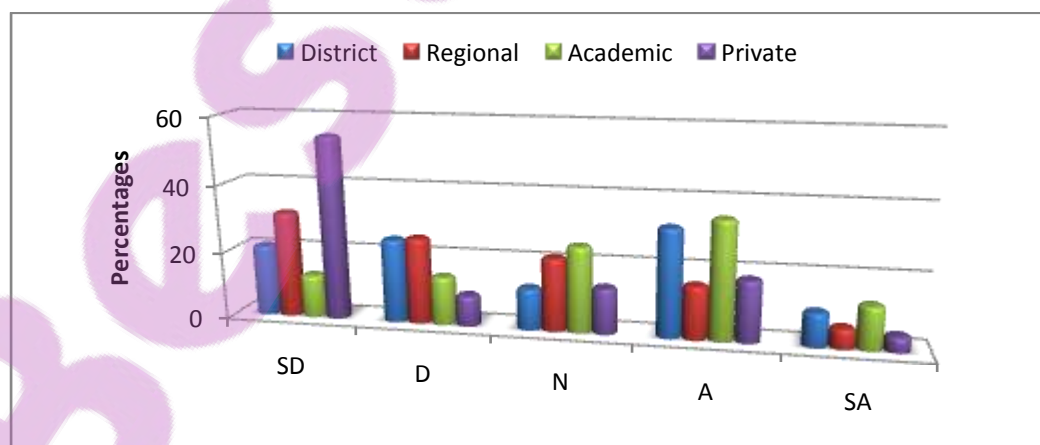
The PHs (63.6%) had the most respondents who disagreed that there were PHS opportunities for RNs' career development, followed by the RH (56.9%), the DHs (45.9%), and the AH (27.0%). However, the AH (47.7%) had the most respondents who agreed that there were PHS opportunities for RNs' career development, followed by the DHs (42.0%), the PHs (22.7%), and the RH (21.6%). There were 44 missing values.

5.9.1.25 RNs agree with their extended role as medical assistants

The data revealed that most of the respondents agreed with their extended role as medical assistants.

Table 5.25 HC of respondents' perception of extended role as medical assistants (n=200)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	5.0	13.8	22.4	41.0	17.9
Regional	50	16.0	12.0	38.0	18.0	16.0
Academic	63	11.1	15.9	25.4	36.5	11.1
Private	24	0.0	20.8	25.0	25.0	29.2
Average	50.0	8.0	15.6	27.7	30.1	18.6

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.25 HC of respondents' perception of extended role as medical assistants
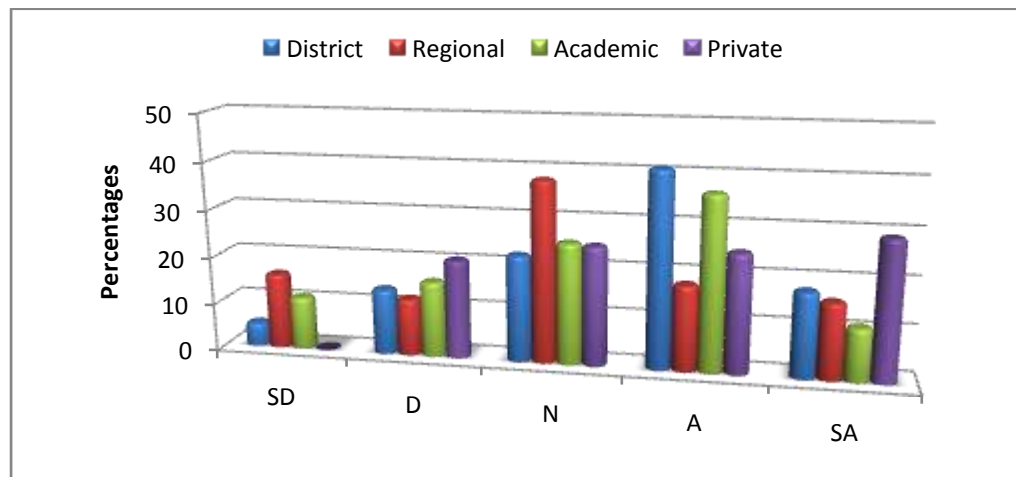
The DHs (58.9%) had the most respondents who agreed with their role as medical assistants, followed by the PHs (54.2%), the AH (47.6%), and finally the RH (34.0%) on this item with the most neutral respondents at (38.0%). The RH (28.0%) had the most respondents who disagreed, followed by the AH (27.0%), the PHs (20.8%), and the DHs (18.8%). What could influence this factor is that the DHs are level one HCS which serve as referrals for PHC services. As a result, they could be comfortable with a more independent role in contrast to more stringent procedures found in higher levels of care. There were 44 missing values.

SECTION C: Workplace violence in the PHS

5.9.1.26 Security system for nurses in the workplace is satisfactory

The data indicated general disagreement among the respondents that their workplace security was satisfactory.

Table 5.26 HC of respondents' perception of workplace security for nurses (n=208)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	65	16.5	78.0	5.4
Regional	54	13.0	77.8	9.3
Academic	65	18.5	72.3	9.2
Private	24	8.3	75.0	16.7
Average	52.0	14.1	75.8	10.2

Figure 5.26 HC of respondents' perception of workplace security for nurses
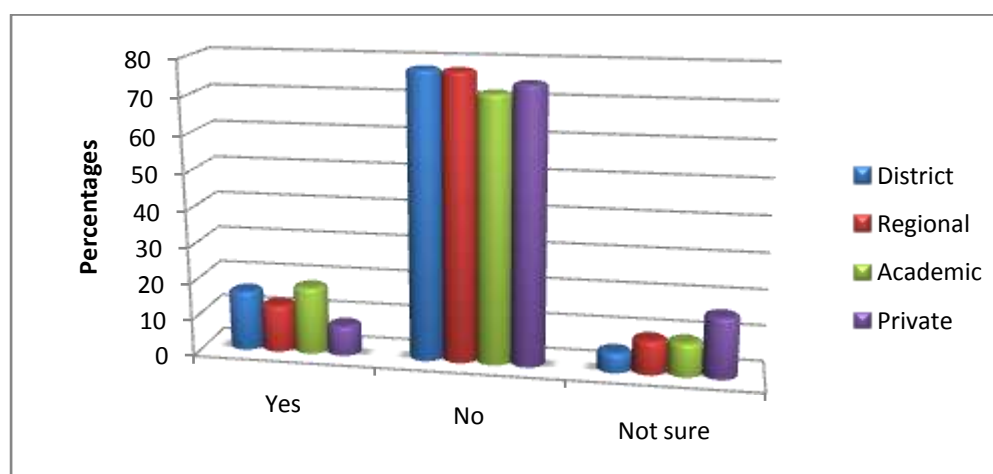
The DHs (78.0%) had the most respondents who disagreed that security for nurses was satisfactory, followed by the RH (77.8%), the PHs (75.0%), and the AH (72.3%). The AH (18.5%) had the most respondents who agreed the security was satisfactory, followed by the DHs (16.5%), the RH (13.0%), and the PHs (8.3%). The data from all the hospitals thus implied that security for nurses was a serious issue, requiring urgent attention. There were 36 missing values.

5.9.1.27 Patients are safe in hospital under the current security system

The data revealed the respondents' general perception that patient safety in the hospital was not completely satisfactory.

Table 5.27 HC of respondents' perception of patients' safety in hospital (n=206)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	64	31.2	48.2	20.6
Regional	53	32.1	45.3	22.6
Academic	65	41.5	41.5	17.0
Private	24	25.0	54.2	20.8
Average	51.5	32.5	47.3	20.3

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Figure 5.27 HC of respondents' perception of patients' safety in hospital
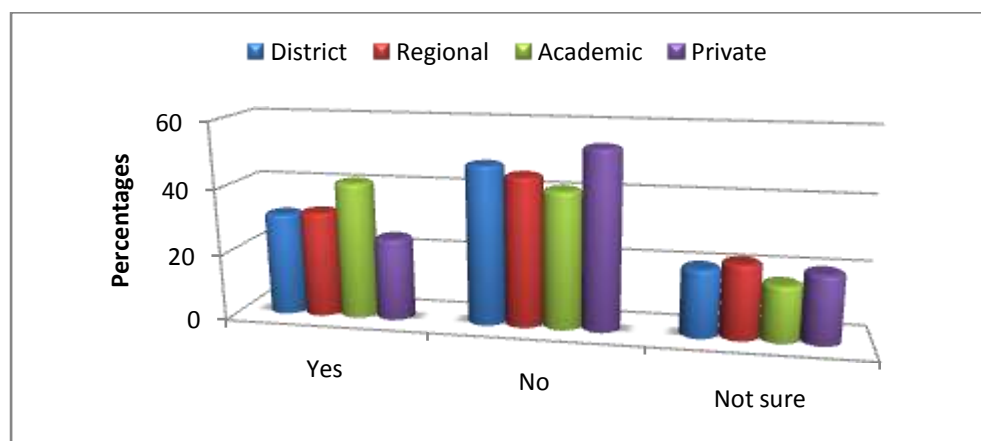
The PHs (54.2%) had the most respondents who disagreed that security for patients was adequate, followed by the DHs (48.2%), and the RH (45.3%), and the AH (41.5%). The AH (41.5%) had the most respondents who agreed that security for patients was satisfactory, followed by the RH (32.1%), the DHs (31.2%), and the PHs (25.0%). There were 38 missing values.

SECTION D: Stress

5.9.1.28 Stress is intolerable among RNs

The data indicated that the majority of the respondents agreed that stress was intolerable among RNs.

Table 5.28 HC of respondents' perception of stress (n=199)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	62	73.0	13.0	14.0
Regional	50	81.5	7.4	11.1
Academic	63	76.2	12.7	11.1
Private	24	91.7	0.0	8.3
Average	49.8	80.6	8.3	11.1

Figure 5.28 HC of respondents' perception of stress
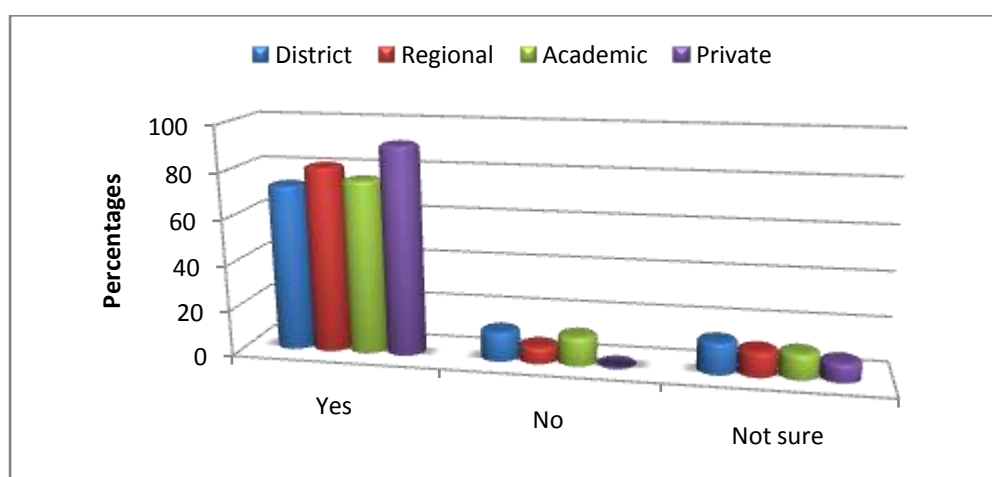
The PHs (91.7%) had the most respondents who agreed that stress had reached intolerable levels, followed by the RH (81.5%), the AH (76.2%), and the DHS (73.0%). The DHs (13.0%) had the most respondents who disagreed that stress had reached intolerable levels, followed by the AH (12.7%), and the RH (7.4%). There were 45 missing values.

5.9.1.29 Have you personally used your vacation for resting?

The data indicated that most of the respondents agreed that they used their vacation to rest.

Table 5.29 HC of respondents' use of vacation for rest (n=208)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	65	47.4	39.8	12.8
Regional	54	44.4	46.3	9.3
Academic	65	49.2	47.7	3.1
Private	24	58.3	37.5	4.2
Average	52.0	49.8	42.8	7.4

Figure 5.29 HC of respondents' use of vacation for rest
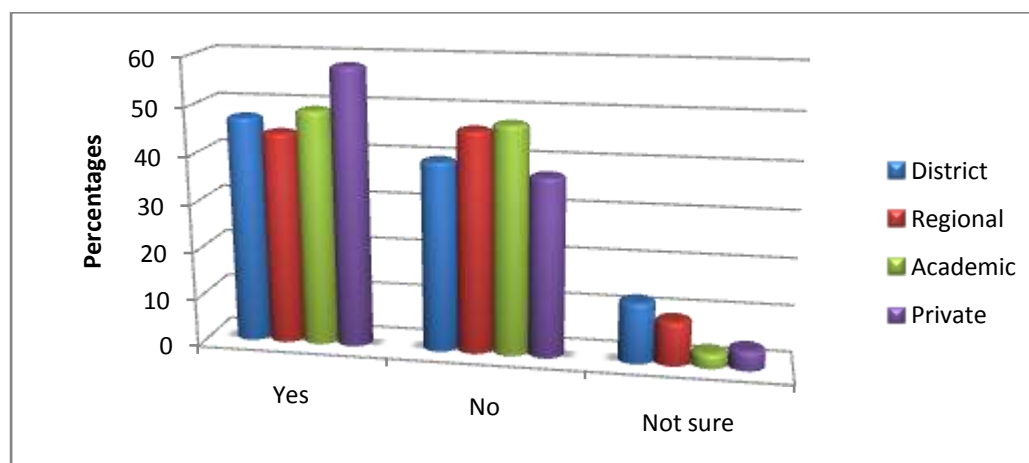
The PHs (58.3%) had the most respondents who used their vacation for rest, followed by the AH (49.2%), the DHs (47.4%), vacation and the RH (44.4%). However, the AH (47.3%) had the most respondents who did not rest in their vacation, followed by the RH (46.3%), the DHs (39.8%), and the PHs (37.5%). There were 36 missing values.

5.9.1.30 Nurses experience physical signs of exhaustion

The data found that the majority of all the respondents experienced physical signs of exhaustion.

Table 5.30 HC of respondents' perception of physical signs of exhaustion (n=206)

Hospital	Frequency	Percentage			
		Never	**Occasionally**	**Often**	**Always**
District	66	1.4	9.3	31.1	58.2
Regional	52	0.0	5.8	21.2	73.1
Academic	64	0.0	14.1	43.8	42.2
Private	24	0.0	4.2	75.0	20.8
Average	51.5	1.4	10.6	32.8	64.1

Figure 5.30 HC of respondents' perception of physical signs of exhaustion
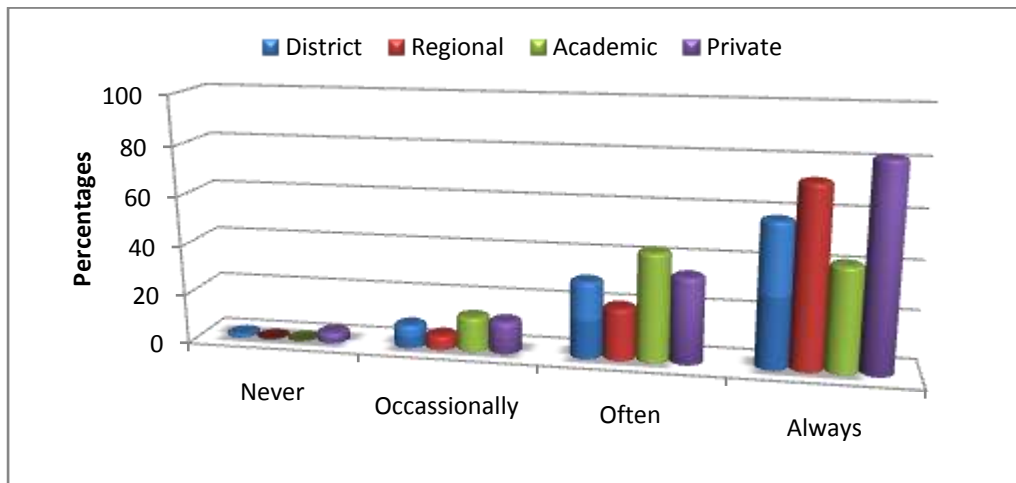
The RNs were asked if they ever experienced physical exhaustion in the workplace. The RH (73.1%) had the most respondents who "always" experienced physical exhaustion, the DHs (58.2%), the AH (42.2%), and the PHs (20.8%). The PHs (75.0%) had the most respondents who "often" did, followed by the AH (43.8%), the DHs (31.1%), and the RH (21.1%). Very few respondents "occasionally" or "never" experienced physical exhaustion. There were 38 missing values. Many respondents provided written narratives in response to questions, which are discussed in chapter 6.

5.9.1.31 Do you have intentions to leave the PHS for other institutions?

The data revealed that most the respondents in the PHS (DHs, RH and AH) did intend leaving the PHS, while the PHs respondents had intended and migrated.

Table 5.31 HC of respondents' intentions to leave (n=207)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	65	40.9	31.8	27.3
Regional	53	47.2	13.2	39.6
Academic	65	49.2	27.7	23.1
Private	24	45.8	37.5	16.7
Average	51.8	45.8	27.6	26.7

Figure 5.31 HC of respondents' intentions to leave
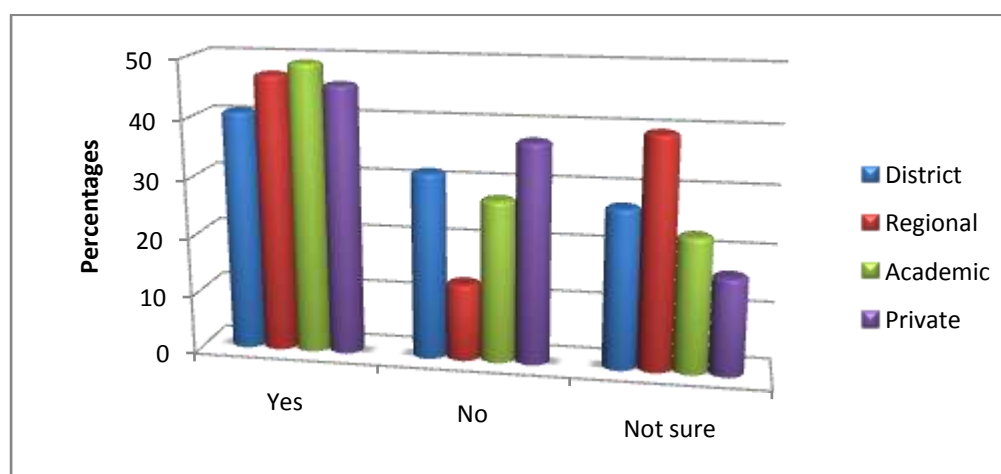
The AH (49.2%) had the most respondents who intended leaving the PHS, followed by the RH (47.2%), and the DHs (40.9%). Of the PH respondents, 45.8% indicated that they had intended leaving before subsequently doing so. The DHs (31.8%) had the most respondents who did not intend leaving, followed by the AH (27.7%), and the RH (131.2%). The (37.5%) of PH respondents who had no intention to leave, could possibly indicate that they had left when the opportunity arose, or perhaps they had misunderstood the question to mean leaving the private hospitals.

SECTION E: Management and leadership problems

5.9.1.32 Some NSMs still display bullying attitudes

The data indicated that most of the respondents agreed that some NSMs still displayed bullying attitudes.

Table 5.32 HC of respondents' perception of NSMs' bullying attitudes (n=208)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	65	14.3	11.5	7.4	25.7	40.5
Regional	54	16.7	3.7	3.7	33.3	42.6
Academic	65	11.1	4.4	17.8	62.2	4.5
Private	24	0.0	4.2	12.5	29.2	54.2
Average	52.0	10.5	6.0	10.3	37.6	35.5

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.32 HC of respondents' perception of NSMs' bullying attitudes
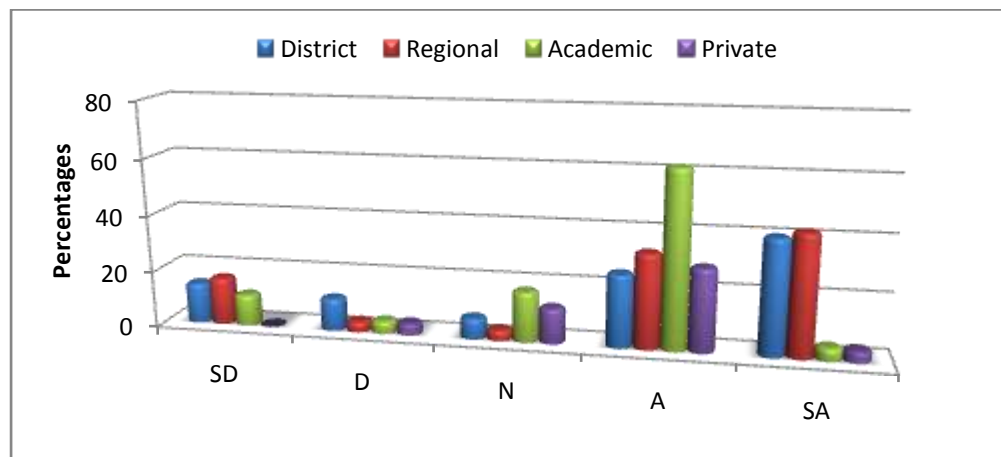
The PHs (83.4%) had the most respondents who agreed that some NSMs still displayed bullying attitudes towards RNs, followed by the RH (75.9%), the AH (66.7%), and the DHs (66.2%). The DHs (25.8%) had the most respondents who disagreed that NSMs still displayed bullying attitudes, followed by the RH (20.4%), the AH (15.5%), and the PHs (4.2%). The high percentages of PH

respondents who agreed suggested that some NSMs still struggled with old bureaucratic practices. There were 36 missing values.

5.9.1.33 RNs acknowledged for outstanding contributions

The data indicated that most of the respondents disagreed that RNs were acknowledged for outstanding contributions.

Table 5.33 HC of respondents' perception of RNs acknowledged for outstanding contributions (n=204)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	61	24.5	30.4	22.1	12.1	10.9
Regional	53	35.8	18.9	22.6	13.2	9.4
Academic	66	19.7	40.9	18.2	10.6	10.6
Private	24	8.3	29.2	8.3	50.0	4.2
Average	51.0	22.1	29.6	17.8	21.5	8.8

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.33 HC of respondents' perception of RNs acknowledged for outstanding contributions
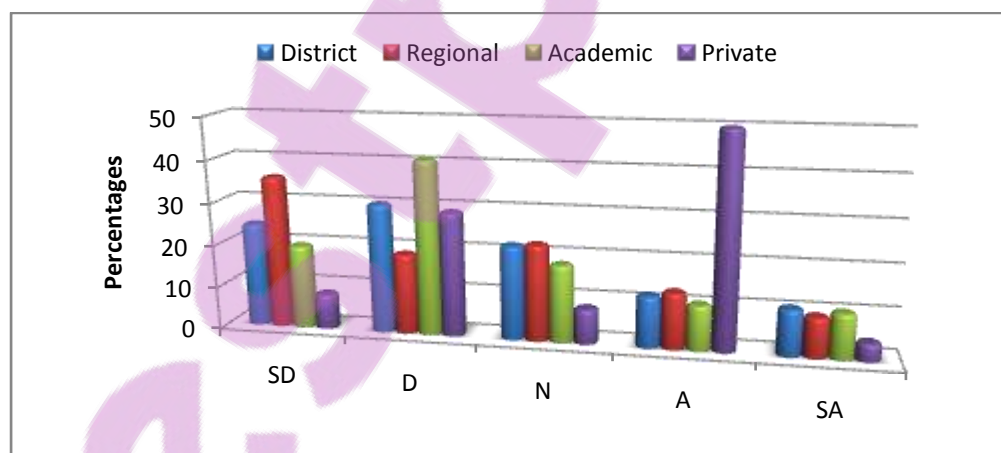
The AH (60.6%) had the most respondents who disagreed that RNs were acknowledged for outstanding contributions, followed by the DHs (54.9%), the RH (54.7%), and the PHs (37.5%). The PHs (54.2%) had the most

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respondents who agreed that RNs were acknowledged for outstanding contributions, followed by the RH (22.6%), and the AH (21.2%). More PH respondents disagreed than agreed. There were 40 missing values.

5.9.1.34 NSMs give feedback on problems reported

The data revealed that most of the respondents disagreed that NSMs gave feedback on problems reported.

Table 5.34 HC of respondents' perception of feedback on reported problems (n=204)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	64	25.8	12.7	29.7	26.7	5.1
Regional	50	20.0	12.0	24.0	34.0	10.0
Academic	66	13.6	7.6	30.3	36.4	12.1
Private	24	37.5	29.2	12.5	16.7	4.2
Average	51.0	24.2	15.4	24.1	28.5	7.9

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.34 HC of respondents' perception of feedback on reported problems
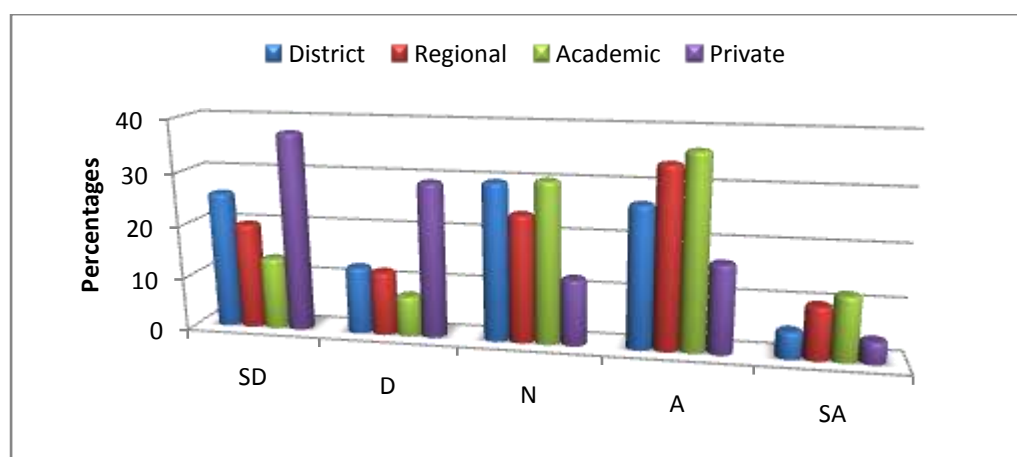
The PHs (39.6%) had the most respondents who disagreed that NSMs gave feedback on problems reported, followed by the DHs (38.5%), the RH

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(32.0%), and the AH (21.2%). In contrast, the AH (48.5%) had the most respondents who agreed, followed by the RH (44.0%), the PHs (36.4%), and the DHs (31.8%). This factor could have been influenced by the fact that there were more supervisors in the RH and AH to assist with problems in units, thus expediting the feedback process, than in the DHs. There were 40 missing values.

5.9.1.35 RNs acknowledged for sacrifices

The data revealed that most respondents in all the hospitals disagreed that RNs were acknowledged for sacrifices made.

Table 5.35 HC of respondents' perception of RNs acknowledged for sacrifices (n=201)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	61	40.7	23.0	16.1	12.1	8.3
Regional	50	38.0	36.0	12.0	4.0	10.0
Academic	66	50.0	21.2	22.7	10.6	4.5
Private	24	50.0	29.2	8.3	0.0	12.5
Average	50.3	44.7	27.4	14.8	6.7	8.8

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.35 HC of respondents' perception of RNs acknowledged for sacrifices
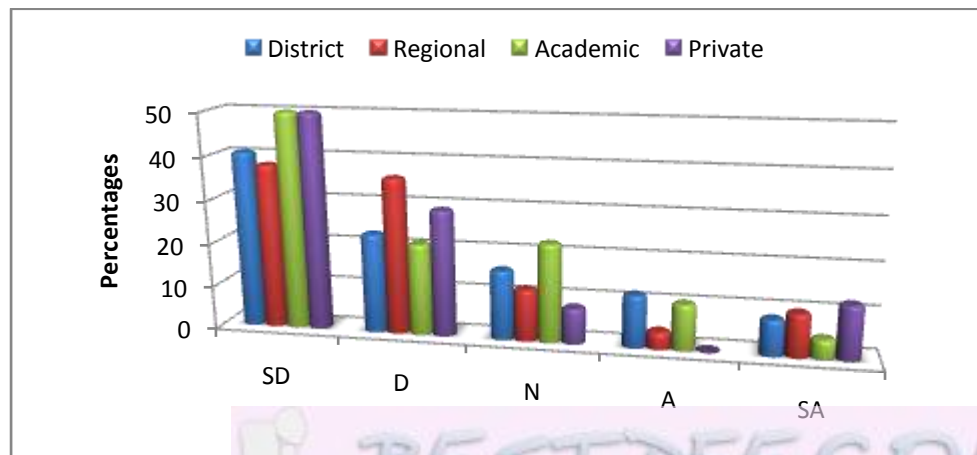
The PHs (79.2%) had the most respondents who disagreed that RNs were acknowledged for sacrifices, followed by the RH (74.0%), the AH (71.2%), and the DH (63.7%). The DHs (20.4%) had the most respondents who agreed, followed by the AH (15.1%), the RH (14.0%), and the PHs (12.5%).

5.9.1.36 Hospital management discuss problems with RNs

The data revealed close differences in the number of respondents who disagreed and those who agreed.

Table 5.36 HC of respondents' perception of joint discussion of problems (n=206)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	63	38.0	37.0	25.1
Regional	54	37.0	37.0	25.9
Academic	65	36.9	40.9	22.7
Private	24	20.8	66.7	12.5
Average	51.5	33.2	45.4	21.6

Figure 5.36 HC of respondents' perception of joint discussion of problems
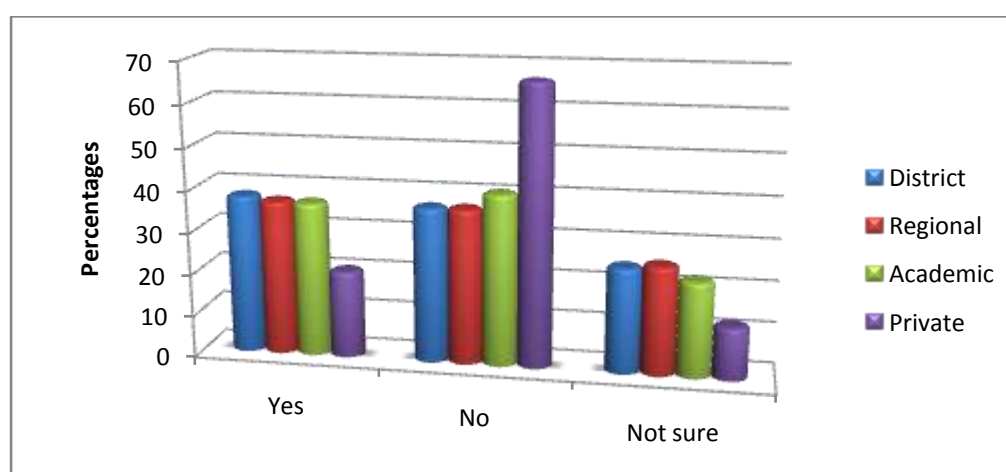
The AH (40.9) had most of the respondents who disagreed that NSMs discussed problems with RNs, followed by the DHs (37.0%), the RH (37.0%),

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and PHs (20.8%). The PHs (66.7%) had the most respondents who agreed, followed by the DHs (38.9%), the RH (37.0%), and the AH (36.9%). Since data indicated a similar pattern for all public hospitals, this could be a sign of no consistency in management. There were 38 missing values.

SECTION F: RNs and migration

5.9.1.37 Nurse migration is due to inadequate salaries

The data revealed that most respondents rated inadequate salaries an important reason for migration.

Table 5.37 HC of respondents' perception of inadequate salaries and migration (n=209)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
District	66	1.4	3.5	24.6	70.4
Regional	54	0.0	9.3	27.8	63.0
Academic	65	1.5	3.1	33.9	61.5
Private	24	0.0	4.2	4.2	91.7
Average	52.3	0.7	5.0	22.6	71.7

Figure 5.37 HC of respondents' perception of inadequate salaries and migration
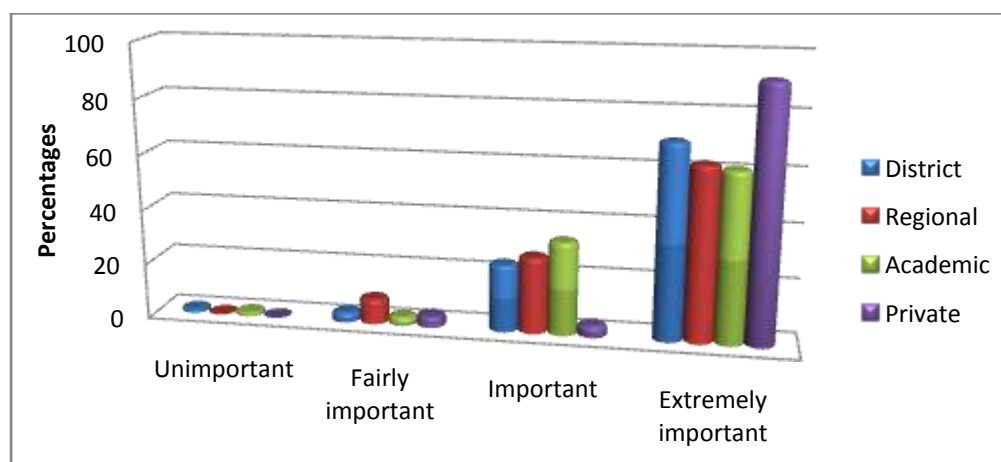
The AH had 1.5% of the respondents who regarded inadequate salaries "unimportant" for migration, followed by the DHs with 1.4% while the RH and PHs had no respondents. There were no responses for the regional and the private hospitals. In the context of these few responses, this means that insufficient salaries are not important for nurse migration from the PHS, as there could be other reasons for nurse migration.

In the "fairly important" column, the RH (9.3%) had the most respondents, followed by the PHs (4.2%), the DHs (3.5%), and the AH (3.1%). These low percentages indicate that insufficient salaries could slightly influence nurse migration from the PHS.

In the "important" column, the AH (33.9%) had the most respondents, followed by the RH (27.8%), the DHs (24.6%), and the PHs (13.0%). These respondents perceived inadequate salaries an important 'push factor' for migration.

In the "extremely important" column, the PHs (91.7%) had the most respondents, followed by the DHs (70.4%), the RH (63.0%), and the AH (61.5%) in this response column. There were 35 missing values.

The findings generally imply that inadequate salaries have a serious bearing on nurse migration from the PHS.

5.9.1.38 Poor leadership in nursing contributes to nurse migration

The respondents were asked about the importance of poor leadership as a reason for migration.

Table 5.38 HC of respondents' perception of poor leadership and migration (n=203)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
District	62	6.9	10.3	47.8	35.0
Regional	52	5.8	15.4	32.7	46.2
Academic	65	4.7	12.5	39.1	43.8
Private	24	0.0	25.0	58.3	16.7
Average	50.8	4.3	15.8	44.5	35.4

Figure 5.38 HC of respondents' perception of poor leadership and migration
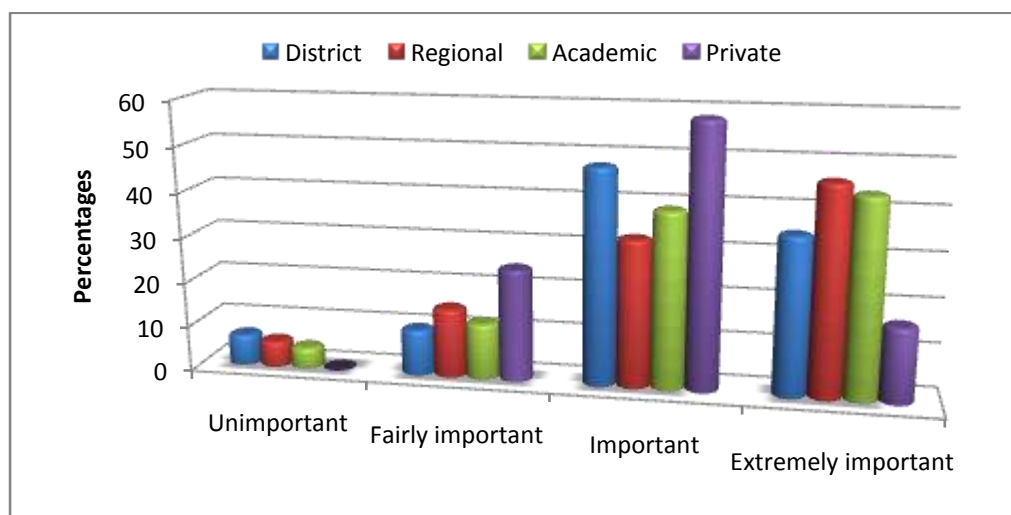
The findings were generally low in the "unimportant" column, gradually increasing to the "extremely important" column. In the "unimportant" column, the DHs (6.9%) had the most respondents, followed by the RH (5.8%), and the AH (4.7%).

In the "fairly important" column, the PHs (25.0%) had the most respondents, followed by the RH (15.4%), the AH (12.5%), and the DHs (10.3%). These respondents considered poor leadership in nursing partly responsible for nurse migration from the PHS.

In the "important" column, the PHs (58.3%) had the most respondents, followed by the DHs (47.2%), the RH (43.5%), and the AH (39.1%).

In the "extremely important" column, the RH (46.2%) had the most respondents, followed by the AH (43.8%), the DHs (35.0%), and the PHs (16.7%).

This result supported the district cluster findings that the majority of the respondents indicated that some NSMs displayed bullying attitudes, and disagreed that RNs were acknowledged for sacrifices they made (see figures 5.32 and 5.35). There were 41 missing values.

5.9.1.39 Poor working conditions lead to nurse migration

The data indicated that the respondents perceived poor working conditions an important cause of migration.

Table 5.39 HC of respondents' perception of poor working conditions (n=206)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
District	65	1.4	7.0	38.8	52.6
Regional	52	0	3.8	23.1	73.1
Academic	65	0	3.1	40.0	56.9
Private	24	4.2	12.5	29.2	54.2
Average	51.5	1.4	6.6	32.8	59.2

Figure 5.39 HC of respondents' perception of poor working conditions
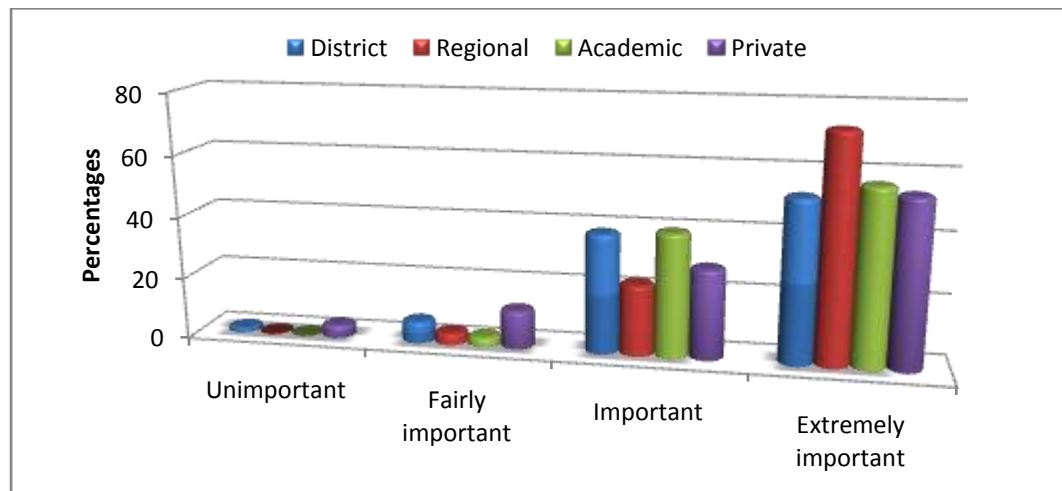
In the "unimportant" column, the PHs (4.2%) had the most respondents, followed by the DHs (1.4%). There were no responses from the RH and the AH.

In the "fairly important" column, the PHs (12.5%) had the most respondents, followed by the DHs (7.0%), the RH (3.8%), and the AH (3.1%).

In the "important" column, the AH (40.0%) had the most respondents, followed by the DHs (38.8%), the PHs (29.2%), and the RH (23.1%).

In the "extremely important" column, the RH (73.1%) had the most respondents, followed by the AH (56.9%), the PHs (54.2%), and the DHs (52.6%). This data further suggest that working conditions are crucial in determining the length of stay in the place of employment.

5.9.1.40 RNs migrate for "different" experience

The data indicated that the respondents did not perceive acquiring "different" experience an important cause for migration.

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Table 5.40 HC of respondents' perception of migration for "different" experience (n=204)

Hospital	Frequency	Percentage			
		Unimportant	Fairly important	Important	Extremely important
District	63	32.1	34.7	18.6	14.6
Regional	53	32.1	24.5	18.9	24.5
Academic	64	28.1	21.9	25.0	25.0
Private	24	33.3	29.2	12.5	25.0
Average	51.0	31.4	27.6	18.8	22.3

Figure 5.40 HC of respondents' perception of migration for "different" experience
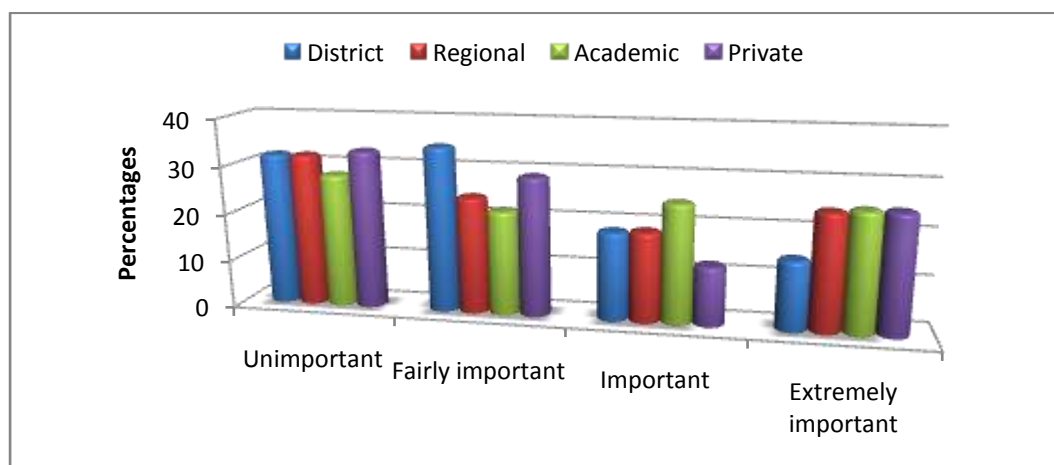
In the "unimportant" column, the PHs (33.3%) had the most respondents, followed by the DHs and the RH with 32.1% each, and the AH with 28.1%.

In the "fairly important" column, the DHs (34.7%) had the most respondents, followed by the PHs (29.2%), the RH (24.5%), and the AH (21.9%). These respondents considered migration for "different" experience contributing to some extent to nurse migration.

In the "important" column, the AH (25.0%) had the most respondents, followed by the RH (18.9%), the DHs (18.6%), and the PHs (12.5%).

In the "extremely important" column, the AH (25.0%) and the PHs (25.0%) had the most respondents, followed by the RH (24.5%), and DHs (14.6%). Most of the respondents therefore considered migrating for "different" experience not as important as inadequate salaries (see table and figure 5.37). There were 40 missing values.

SECTION G: Nurses and strike actions

5.9.1.41 RNs prefer strikes to solve nurses' problems

The data indicated that many respondents agreed that nurses preferred strikes to solve nurses' problems.

Table 5.41 HC of respondents' perception of strikes to solve nurses' problems (n=204)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	64	77.2	18.6	4.2
Regional	54	64.8	24.1	11.1
Academic	63	66.7	20.6	12.7
Private	23	87.5	12.5	0.0
Average	51.0	74.0	19.0	7.0

Figure 5.41 HC of respondents' perceptions of strikes to solve nurses' problems
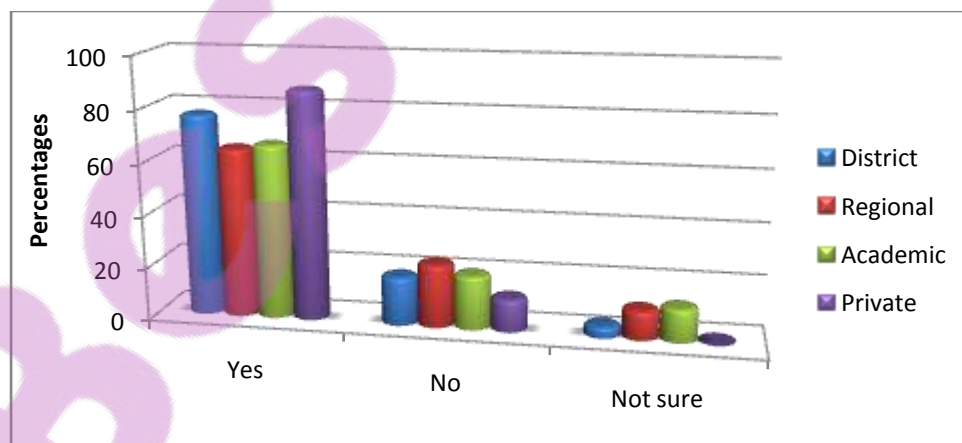
The PHs (87.5%) had the most respondents who agreed, followed by the DHs (77.2%), the AH (66.7%), and the RH (64.8%). The RH (24.1%) had the most respondents who disagreed, followed by the AH (20.6%), the DHs (18.6%), and the PHs (12.5%). There were 40 missing values.

5.9.1.42 RNs and unions share similar values regarding patient care

The data compared the respondents' perception of unions' and nurses' values.

Table 5.42 HC of respondents' perception of unions' and nurses' values (n=199)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	61	41.5	33.5	25.0
Regional	53	43.4	35.8	20.8
Academic	62	33.9	50.0	16.1
Private	23	12.5	66.7	20.8
Average	49.8	32.8	46.5	20.7

Figure 5.42 HC of respondents' perception of unions' and nurses' values
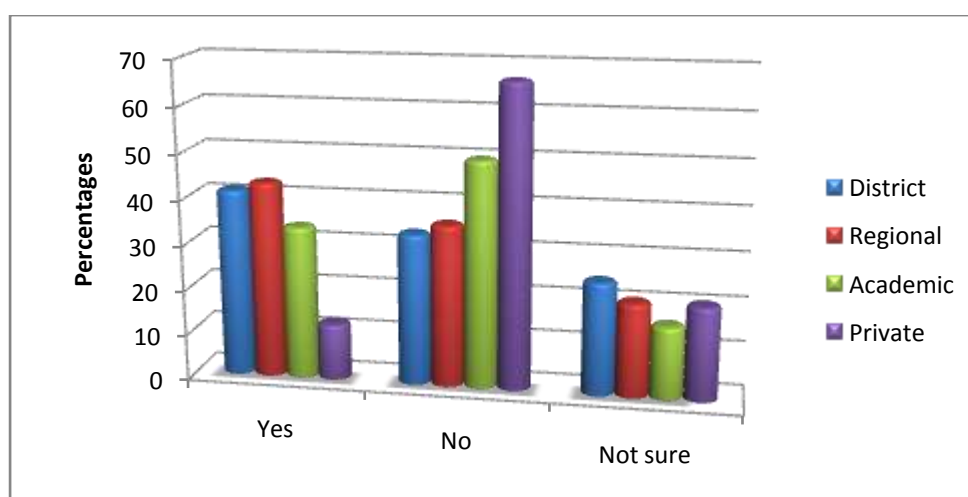
The RH (43.4%) had the most respondents who agreed that unions and nurses shared similar values, followed by the DHs (41.5%), the AH (33.9%),

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and the PHs (32.8%). The AH (50.0%) had most of the respondents who disagreed that RNs shared the same values with unions, followed by the PHs (46.5%), the RH (35.8%), and the DHs (33.5%). These divisions in opinions revealed that the respondents could be cognizant of the status carried by their profession and able to draw distinctions between these dichotomous organizations. However, RNs appear to be driven by circumstances that require them to engage in more aggressive means to be heard by government even though they do not share same values with unions regarding patient care issues. There were 45 missing values.

5.9.1.43 RNs support division between unions and professional associations

The data indicated that most respondents did not agree with the division between unions and professional associations.

Table 5.43 HC of respondents' perception of division between unions and professional associations (n=198)

Hospital	Frequency	Percentage		
		Yes	No	Not sure
District	60	26.1	39.9	34.1
Regional	52	17.3	46.2	36.5
Academic	62	24.2	43.5	32.3
Private	24	37.5	33.3	29.2
Average	49.5	26.3	40.7	33.0

Figure 5.43 HC of respondents' perception of division between unions and professional associations
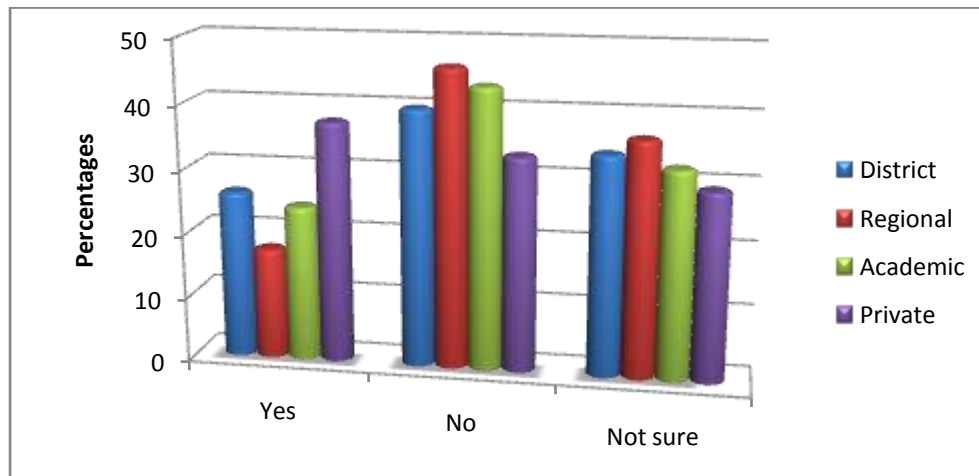
The RH (46.2%) had the most respondents who disagreed, followed by the AH (43.5%), the DHs (39.9%), and the PHs (33.3%). The PHs (37.5%) had the most respondents who agreed and supported the division, followed by the DHs (26.1%), the AH (24.2%), and the RH (17.3%). Research findings indicate that the PH RNs were not in favour of the division. The PH respondents were the least in this category. There were 46 missing values.

SECTION H: Nurses and politics

5.9.1.44 Poor nurse representation in government contributes to migration

The data indicated that most of the respondents agreed that poor nurse representation in government contributed to migration.

Table 5.44 HC of respondents' perception of poor nurse representation in government (n=203)

Hospital	Frequency	Percentage		
		Yes	**No**	**Not sure**
District	61	78.6	15.7	5.7
Regional	53	79.2	3.8	17.0
Academic	65	81.5	6.2	12.3
Private	24	75.0	8.3	16.7
Average	50.8	78.6	8.5	12.9

Figure 5.44 HC of respondents' perception of poor nurse representation in government
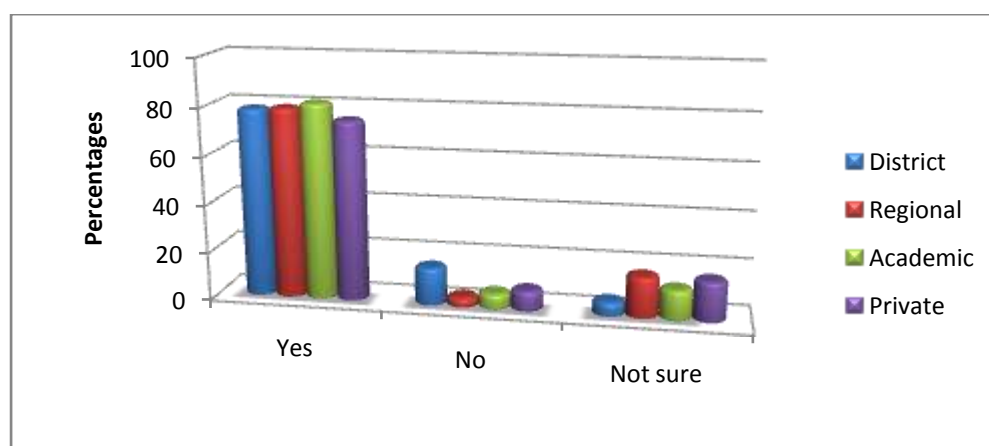
The AH (81.5%) had the most respondents who agreed that poor representation with government was a contributory factor to nurse migration, followed by the RH (79.2%), the DHs (78.6%), and the PHs (75.0%). The DHs (15.7%) had the most respondents who disagreed, followed by the PHs (8.3%), the AH (6.2%), and the RH (3.8%). This finding seemed to suggest that the respondents were convinced that it is critical for nurses to be represented by nurses at government level. This result supported the finding that most respondents disagreed on regular communication with nurses (see table and figure 5.15). There were 41 missing values.

5.9.1.45 RNs vote for parties that add value to nursing

The data indicated that most respondents disagreed that nurses voted for parties that added value to nursing.

Table 5.45 HC of respondents' perception of voting for parties that add value (n=197)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	25.7	24.4	20.8	15.4	13.8
Regional	52	23.1	25.0	15.4	21.2	15.4
Academic	59	18.6	13.6	20.3	27.1	20.3
Private	23	26.1	30.4	8.7	13.0	21.7
Average	49.3	23.4	23.4	16.3	19.2	17.8

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.45 HC of respondents' perception of voting for parties that add value
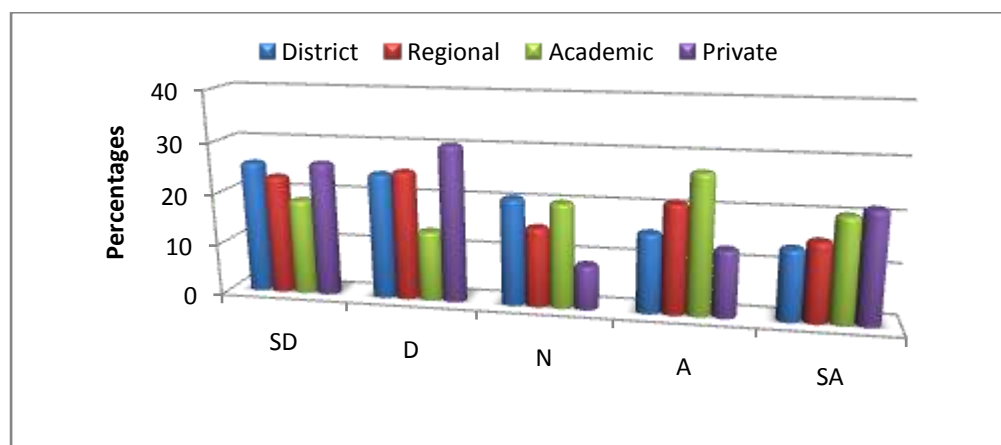
The PHs (56.2%) had the most respondents who disagreed that nurses voted for parties that added value to nursing, followed by the DHs (50.1%), the RH (48.1%), and the AH (32.2%). The AH (47.4%) had the most respondents who agreed, followed by the RH (36.6%), the PHs (34.7%), and the DHs (29.2%). The data seemed to imply that some of the respondents made informed decisions in their votes while others could have voted as a matter of principle. There were 47 missing values.

5.9.1.46 Nurses' issues are entertained in political debates

The data indicated that most of the respondents disagreed that nurses' issues were considered in political debates.

Table 5.46 HC of respondents' perception of nurses' issues in political debates (n=194)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	63	30.8	29.3	22.7	12.3	5.0
Regional	50	46.0	24.0	16.0	10.0	4.0
Academic	58	29.3	31.0	24.1	13.8	1.7
Private	23	47.8	26.0	8.3	17.3	0.0
Average	48.5	38.5	27.6	17.8	13.6	2.7

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.46 HC of respondents' perception of nurses' issues in political debates
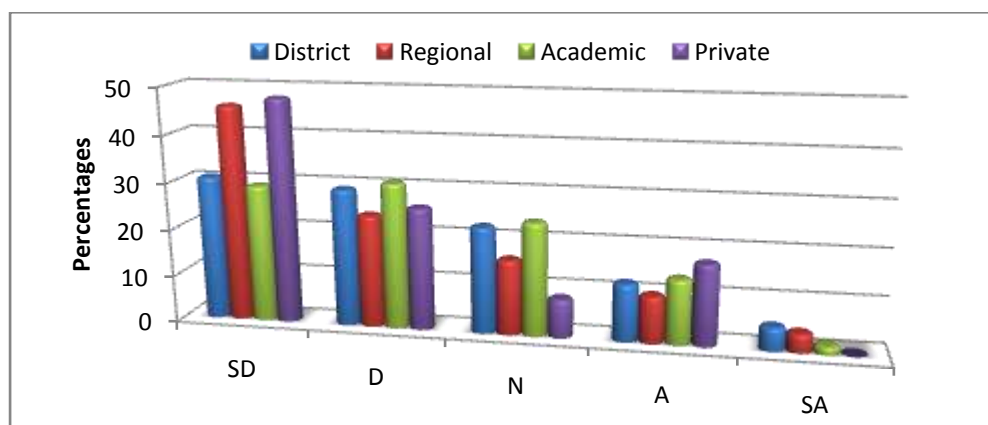
The PHs (73.8%) had the most respondents who disagreed that nurses' issues received attention in political debates, followed by the RH (70.0%), the AH (60.3%), and the DHs (60.1%). The DHs (17.3%) and the PHs (17.3%) had the most respondents who agreed, followed by the AH (15.5%) and the RH (14.0%). There were 50 missing values.

5.9.1.47 RNs can become policy analysts in South Africa

The data indicated that most of the respondents agreed that RNs could become policy analysts.

Table 5.47 HC of respondents' perception of RNs as policy analysts (n=199)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	62	9.7	6.7	11.3	44.2	28.1
Regional	52	9.6	3.8	13.5	32.7	40.4
Academic	62	6.5	27.4	14.5	12.9	38.7
Private	23	17.4	13.0	8.7	30.4	30.4
Average	49.8	10.8	12.6	12.0	30.1	34.4

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.47 HC of respondents' perception of RNs as policy analysts
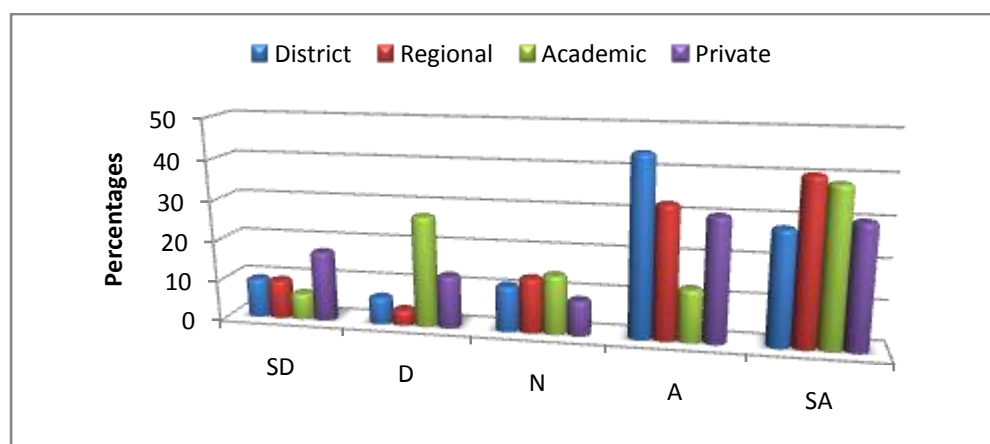
The RH (73.1%) had the most respondents who agreed, followed by the DHs (72.3%), the PHs (60.8%), and the AH (51.6%). Data suggest a need for political astuteness among RNs. The AH (34.2 %) had the most respondents who disagreed, followed by the PHs (23.4%), the DHs (16.4%), and the RH (13.4%). There were 45 missing values on this aspect.

5.9.1.48 RNs know how policies are made in government

The data revealed that most of the respondents disagreed that nurses knew how policies were made at government level.

Table 5.48 HC of respondents' perception of policy-making at government level (n=191)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	64	30.4	21.5	24.6	20.6	2.8
Regional	44	36.5	28.8	7.7	19.2	7.7
Academic	60	23.3	30.0	18.3	21.7	6.7
Private	23	26.1	26.1	17.4	8.7	21.7
Average	47.8	29.1	26.6	17.0	17.6	9.7

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.48 HC of respondents' perception of policy-making at government level
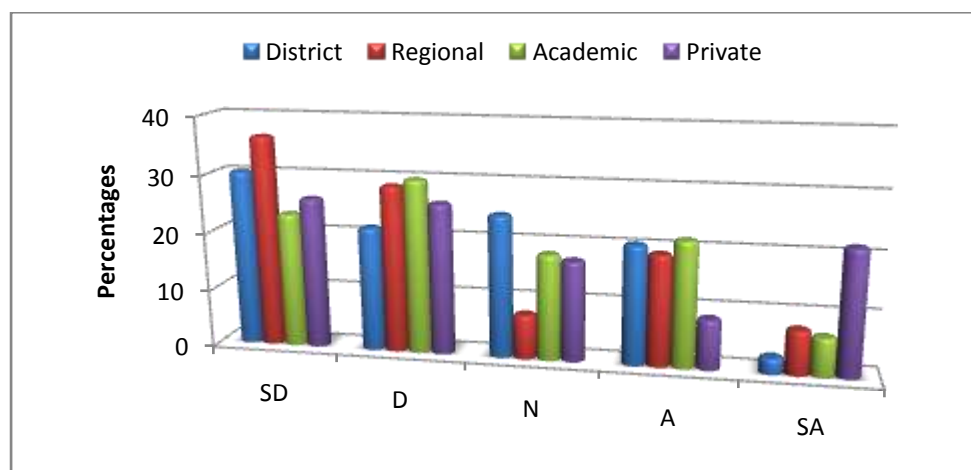
The RH (65.3%) had the most respondents who disagreed, followed by the AH (53.3%), the PHs (52.2%) and the DHs (51.9%). The PHs (30.4%) had the most respondents who agreed, followed by the AH (28.4%), the RH (26.9%), and the DHs (23.4%). There were 53 missing values.

5.9.1.49 RNs can influence policy making processes

The data indicated that most of the respondents agreed that nurses could influence policy-making.

Table 5.49 HC of respondents' perception of nurses' influence on policy-making (n=198)

Hospital	Frequency	Percentage				
		SD	D	N	A	SA
District	62	4.2	9.3	11.3	35.8	39.4
Regional	53	11.3	3.8	7.5	32.1	45.3
Academic	60	8.3	16.7	3.3	23.3	48.3
Private	23	13.0	8.7	8.7	30.4	39.1
Average	49.5	9.2	9.6	7.7	30.4	43.0

Key: SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree

Figure 5.49 HC of respondents' perception of nurses' influence on policy-making
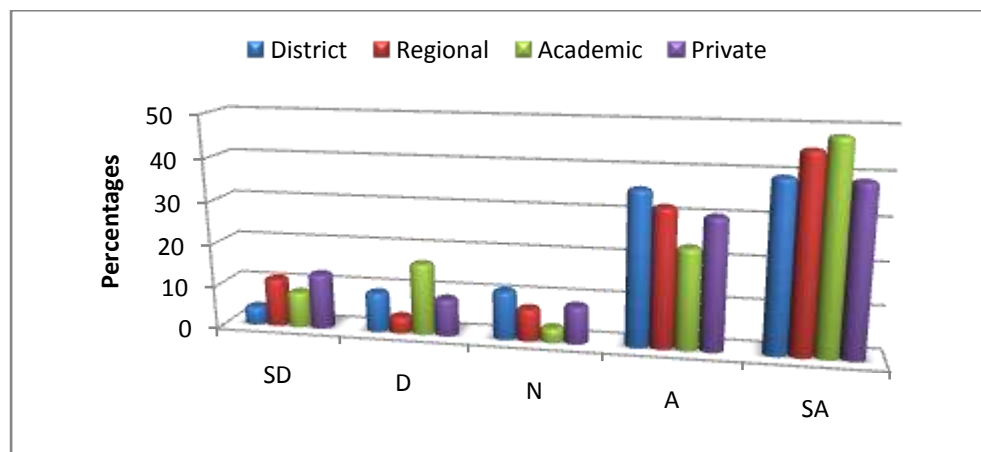
The RH (77.4%) had the most respondents who agreed that given the opportunity, nurses could influence policy making, followed by the DHs (75.2%), the AH (71.6%), and the PHs (69.5%). The AH (25.0%) had the most respondents who disagreed, followed by the PHs (21.7%), the RH (15.1%), and the DHs (13.5%). There were 46 missing values.

5.9.2 Comparison of qualitative data of all hospitals involved in the study

Some of the RNs responded with written narratives to questions of their choice, which are discussed in chapter 6.

5.10 INDIVIDUAL AND FOCUS GROUP INTERVIEWS

The methodological considerations engaged in this study provided unanticipated responses. After the quantitative data analysis was completed, the transcriptions were read and re-read by the researcher, assistant researcher and the statistician. The researchers and the statistician analyzed data separately, then cross-checked each other's categories, themes and interpretations of written statements. After reaching consensus, submissions were made to the promoter for further scrutiny. Thereafter, it was discovered that the respondents had provided so much detail in written narratives of the open-ended questions that it was decided to curtail individual and focus interviews for the main study because of data saturation. This situation was confirmed by similarities found with regard to information obtained from three individual and one focus group comprising three RNs in the pilot project (see chapter 4, section 4.10.2). The pilot study data was captured with field notes and a tape recorder permitted by respondents.

According to Polit and Beck (2008:70-71), data saturation is achieved when "themes and categories in the data become repetitive and redundant, such that no new information can be gleaned by further data collection". Consequently, the researcher should be alert to repetitions, other than proceeding with the predetermined sampling of a specific number of respondents.

Streubert and Carpenter (2003:25) cite the example of Beck's (2000) study with nursing students, where interviews continued until a repetition of salient points or themes was reached. Upon recognition of this pattern (repetition), it

was concluded that additional respondents only served to confirm the findings rather than generate new information. As a result, the point of repeatedly emerging themes was declared "saturation of data."

Morse (1989) (cited in Streubert & Carpenter 2003:25) argues that a new set of respondents could provide different perspectives on the same subject at a different time. In other words, saturation of data is concerned only with the group involved. In concert with this view, interviews were going to be conducted from the same population in the hospitals in this study, within the same period of the study. Polit and Beck (2008:357) emphasise that, if respondents are very good in articulating their experiences, saturation can be achieved with a small sample.

After consultation with the promoter and the statistician, it was safely concluded that data saturation had been reached. Consequently, the scheduled interviews were curtailed because it was assumed that both individual and focus group interviews for the main study would not yield a different result.

5.11 CONCLUSION

This chapter discussed the data analysis and interpretation, presenting the results in tables, bar charts and percentages. The data for the different hospitals were presented and discussed individually. Data for the district cluster (DC) was compared, followed by a comparison of findings between the DC, the regional, academic and private hospitals. Chapter 6 presents a literature control to consolidate other research findings on discontent among RNs in the PHS. Also, chapter 6 discusses the findings and makes recommendations for practice and further research.

CHAPTER 6

FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Chapter 5 discussed the data analysis and interpretation and results. Comparisons of responses for the district cluster and of the different hospitals were also presented and analysed. This chapter discusses and synthesizes the main findings in chapter 5, in line with the research questions investigated.

This study set out to investigate and explore discontent among registered nurses (RNs) in the public health sector (PHS) in Tshwane Metropolitan area. To achieve the purpose, the study wished to answer the following questions:

- What do RNs perceive as the source or cause of discontent among RNs in the PHS?
- How do RNs perceive the effects of discontent on their personal and professional lives in the PHS?
- What are the factors contributing to discontent among RNs in the PHS?
- How can RNs be supported so that they become more confident, efficient and effective in public health service delivery?

The discussion will focus mainly on respondents' narrative statements extracted from open-ended questions, in conjunction with statistical figures provided in chapter 5 in order to establish consistency and provide a defensible and scientifically proven argument. The reason for this approach is that method triangulation was used for data collection. In Morse's (1997:230) view, the results produced by one method are validated by data from another method. The written narratives thus prove or disprove the quantitative data. Brink (1998:337) supports this approach and method, adding that qualitative designs seek to discover knowledge or uncover new insights, meanings and understandings. Therefore, qualitative data analysis provided vital information

that assisted in determining any consistency with the quantitative data. Lastly, the findings of these two methods complemented each other thereby enhancing the authenticity, validity and trustworthiness of a study of this magnitude (Morse 1997:230).

With regard to written narratives, Polit and Hungler (1999:574) emphasise that without including sufficient supporting statements directly from information provided by respondents, the richness of the narrative material could be compromised. Therefore, concise narratives extracted from sections 'B' to 'H' of the questionnaire are presented verbatim. This process was convenient for the respondents and the investigator as it reflected the precise responses. A further advantage from this process was that the cost-effective instrumentation used to generate supplementary data benefited the researcher and assured the respondents that their descriptions and meanings would be captured in their "own words". This was a gainful process whereby the "etic" descriptions enhanced the organization and reduction of relevant data for analysis (Polit & Hungler 1999:576).

Even though some of the responses are presented in discussion form, most of the responses are presented verbatim in order to enhance validity and trustworthiness, as indicated before. For this reason, the researcher included sufficient supporting statements directly from the respondents' information so as not to compromise the richness of the narrative material. However, caution was exercised not to unduly compress qualitative data; as the very essence of preserving the truthfulness of narrations might be lost in the process (Polit and Hungler 1999:574).

The data generated from all the health care services (HCS) are discussed collectively because of the similarities in emerging themes and categories (Patton 1990:376).

After supplementary information from all the respondents was analysed, related concepts were grouped together into clusters. The level of detail, specificity and abstraction differed from hospital to hospital (Polit & Beck

2008:510; 515). It should be noted that this study did not only seek commonalities in written narratives, but natural variations as well to provide a broader perspective of discontent among RNs in the PHS.

Cognizance should be taken that the respondents did not comment on all the open-ended questions. Consequently, this chapter will only deal with comments on items selected by respondents. The researcher's own emphasis will be bracketed throughout. Furthermore, the Coloured and White respondents were predominantly Afrikaans speaking, and one questionnaire was completed in Afrikaans and had to be interpreted and included in discussions.

For confidentiality, the following codes have been used to indicate the hospitals referred to: DHA: District Hospital A; DHB: District Hospital B; DHC: District hospital C; RH: Regional Hospital; AH: Academic Hospital; and PHs: Private Hospitals.

The average percentages for all HCS investigated will be used as opposed to individual scores for each hospital (see section 5.9). This chapter also draws from original data in other research findings to contextualise the results within comparable national and international situations. In other instances, conceptual references are used to form a solid foundation for recommendations. Finally, the researcher discusses the limitations of the study and makes recommendations for further research.

6.2   DISCUSSION AND SYNTHESIS OF THE MAIN FINDINGS

Apart from the demographic information, the questionnaire addressed *transformation of health care services (HCS), management and leadership problems, workplace violence, stress, registered nurses and international migration, nurses and strike actions,* as well as *nurses and politics,* in relation to discontent among RNs in the PHS.

6.2.1 Public health transformation

6.2.1.1 The success of PHS transformation

With regard to the success of transformation initiatives in the PHS, new health policies appear to be very advanced and much progress to have been made in policy implementation in many areas such as discontinuance of delivery of care in a discriminatory manner, reprioritization of resources and budgets by reducing the delivery of sophisticated curative health care and focus resources on primary health care (PHC), free health care for pregnant women and young children, transformation of statutory bodies (Councils) that regulate registered health professionals, establishment of more training schools to increase diversity of skills for health professionals, and much improved patients' rights (ANC 1994, Sarkin 2000:288; Stack & Hlela 2002:5-6). However, serious problems with the implementation of some of the new policies were also noted, such as access to free health care services which did not compare well with the staff available.

In the quantitative data analysis, the respondents in all the hospitals who negated the success of transformational initiatives outnumbered those who agreed with an average of 67.4% against 26.0%. It also became evident that the leading ones were the respondents in private hospitals, which could be one of the reasons why they left the PHS (see chapter 5, table and figure 5.HC11). Based on the foregoing data, extrapolations can be made for RNs who took employment in overseas countries since they were together at work more than they were with their families. In their study on factors that may influence South African nurses' decisions to emigrate, Oosthuizen and Ehlers (2007:20) found that most of the respondents had resolved to migrate to foreign countries because nursing in the Republic of South Africa (RSA) had become a "torment".

In this study, the respondents stated that there were still unfulfilled promises in the PHS, and hospital management did not know how to implement

transformational initiatives. This information could imply that the Department of Health (DOH) had lacked strategies for the implementation of new policies. In restructuring HCS, the planning process should have been geared towards soliciting and incorporating ideas from health care providers who could have advised the implementation in a more practical manner. Moreover, management should have been given policies to implement with guidelines and deadlines for different phases of the implementation process. This process should have included regular feedback mechanisms which would have informed the DOH about areas in which the services struggled. Such a process is further strengthened by periodical follow-up to monitor progress and to assess if policies are implemented as intended. This could have minimised problems of uncertainty, disillusionment, confusion and discontent among RNs. Daft (1999:159) points out that open communication is usually a major obstacle and is a crucial element in institutions to enhance and facilitate operations, and also to assist managers to convey the vision, values and information that provides a bigger picture about the organization's goals and future.

In the United Kingdom (UK), Howarth, Holland and Grant (2006:144) revealed that, because nurses were considered ill-equipped to meet challenges of integrated service provision, it was necessary to reinforce partnerships between higher education institutions and health and social care organizations to ensure a well-prepared workforce to manage continuous change in delivery of care.

6.2.1.2 Conditions of service

The study found that an average of 59.2% of the respondents rated conditions of service 'extremely important' and 32.8% as 'important' in nurse migration from the PHS. At the same time, only 6.6% considered conditions of service 'fairly important' and 1.4% considered them 'unimportant' as a reason for migration (see table and figure 5.39).

These responses appear to indicate that conditions of service are an important determinant of the length of stay for health care providers in their

organizations. These include the state of the health service facility, remuneration, incentives, management styles and other factors that make the working environment conducive to service delivery and the welfare of health providers.

Amongst other issues raised by the respondents, long working hours were a notable concern for RNs in all levels of care, as indicated by the following responses:

> *"Uniform allowance inadequate, housing and working hours too long e.g. 12 hours shift too long"* [AH]
> *We are overworked and work long hours with minimum rest and when you come to work you are not condusive* [DHA]
> *Due to shortage, nurses have to work long hours* [DHB]
> *Long hours, no upward mobility, underpayed* [DHC]
> *Salary poor; hour is too long* [PH]
> *Long working hours and the renumeration is unsatisfactory* [RH]

Spelling mistakes from the preceding statements also attest to the frustration emanating from fatigue, pressure of work and long working hours. Furthermore, section 11(2) of the Basic Conditions of Employment Act, 75 of 1997 states that, in agreement with section 11(1) an employer may not require or permit an employee to work: (a) for more than 45 hours in a week; (b) more than ten hours overtime in any week; and (c) on more than five days in a week. Also, subject to the provisions of Section 13, the "Minister, on grounds of safety, may prescribe by regulation the maximum permitted hours of work, including overtime, that any category of employee may work…" (South Africa 1997a).

In the respondents' views, this was exacerbated by the increased workload due to the proliferation of HIV patients and shortage of staff, particularly as public hospitals were experiencing unprecedented migration of staff from the PHS since the promulgation of the new Constitution of the RSA, which allowed freedom of movement. The respondents expressed concern that

hospitals were overcrowded with declining standards of care. In their investigation into the management of public hospitals, von Holdt and Murphy (2005:12; 18) found that nurses were blamed for things not done, yet there was no capacity and material resources to accomplish tasks. The budgets for HCS did not match expenditures on PHC service delivery and related expansions of HCS, making compliance with the *Batho Pele* White Paper and the *Patients' Rights Charter* very difficult for health providers, as attested below:

> *"It is always stated that we are negligent. No consideration of conditions we work under. (poor)"* [RH]
> *"Representatives* [for nurses] *don't emphasise the importance of increment and increasing staff"* [DHC]
> *"Nurses are expected to be silent even when they work under stressful conditions such as short staffing, unsecured environment."* [DHA]

This finding was also confirmed by John, Lubbe and Serfontein's (2007:48) finding that existing budget allocation was not adequate to address procurement of medicines in the Potchefstroom Health district. In addition, the Minister of Health (MOH) acknowledged this dysfunctional state of HCS, pointing out that she and her advisers had already established that twenty health districts were "in a bad way" and it was daunting (Cullinan & Thom 2008:3) (also see appendix F). The commission of inquiry into hospital practices also reported intense frustration in five hospitals investigated in Gauteng province due to inability to provide quality care because of severe budgetary restrictions, inappropriate facilities, lack of equipment and lack of incentives (Rantho 1999:12).

In the light of the above, it can be surmised that it appears impossible for facilities in this state to meet the requirements of the South African Nursing Council (SANC) for providing a safe environment for patients, quality care by nurses and a suitable clinical area for students. Also, it seems unlikely that nurses would enjoy their work, given all the skills they possess, when

government does not provide sufficient material, financial and human resources. The negative outcome is that HCS could end up with nurses who are tired, frustrated and barely making it in the face of protracted struggles with authorities to put HCS in a state conducive for healing and working.

In accordance with the Nurses Rights policy, nurses have the right to a safe working environment which is compatible with efficient patient care, and equipped with at least the minimum physical, material and personnel requirements in order to provide safe nursing (SANC 2008).

6.2.1.3 Poor leadership in nursing

Some of the respondents attributed the apparent failure of transformation initiatives to poor leadership in nursing. An average of 35.4% considered poor leadership 'extremely important' for nurse migration from the PHS and 44.5% rated poor leadership as 'important'. Only 15.8% considered poor leadership a 'fairly important' reason for migration and 4.3% considered it 'unimportant' (see table and figure 5.38).

The respondents considered lack of knowledge in the nursing leadership, racial discrimination, nepotism and lack of transparency as some of the hindrances to successful transformation and as causing the state of discontent among RNs in the PHS. The respondents expected NSMs and not unions to take the lead in addressing staffing issues, recognition of professional achievements, severe budget cuts, lack of equipment, and disparities in salary adjustments, as well as overcrowding of patients in units and out-patient departments. In this regard, respondents stated:

➢   *"We experience more pressure from management"* [RH]
➢   *"If there is a problem you will be classified under the useless people"* [RH]
➢   *"Only care about what wrong have we done not on the good side we do everyday. The bad is due to us being overworked with less equipment to offer proper nursing care"* [RH]

- ➢ *"Management take complaints from patients and not from staff complaints"* [RH]
- ➢ *"Managers do not support R/N in wards. Do not solve nurses' problems that we encounter in wards"* [RH]
- ➢ *"Top management only lookout for themselves"* [AH]
- ➢ *"Nurses concerns and needs are never taken into consideration"* [RH]
- ➢ *" Lot of favouritism by seniors, very biased and racial"* [DHA]
- ➢ *"It depends on the individual NSMs, some are good but some are just problematic"* [RH]

From the foregoing, rapport between nursing management and RNs would appear to have been severely compromised. Based on these concerns, the following important questions surfaced: "What are leaders at different levels in the public health services doing to address these problems?" (Dolamo 2008:40); "Do leaders in the public service live the vision…? What role do they play, if at all, in developing a vision and commitment to it by staff? (Mokgoro 2003:7); "What type of South Africa do we want?" (Mbeki 2004); "If our children should live to see the next century…what change will they see? What progress will we have made?" (Obama 2008b).

To these rhetorical questions, Webster (2008) adds that attending workshops and conferences on how to navigate in current uncertain times was the goal of every leader. Daft (1999:159) emphasises that the "most important lesson you should add to your leadership play book is to recognize that to effect change, it all starts with you. Leaders need to lead by example; upholding and enacting the vision and values before they expect results from followers."

The study also noted the difficult position surrounding NSMs in HCS who are expected to successfully lead diverse groups which are led by various unions and professional associations, according to the provisions of the Constitution of the RSA. It would also appear that prior thought was not given to how HCS would balance authority between leadership in HCS and labour organizations in terms of dissemination of information, control of union members, as well as

how and who should handle issues of health care delivery arising from the operational areas (see section 6.2.5).

6.2.1.4 Appointment of more nurses in chief executive officer (CEO) positions

A source of great frustration for the respondents was the apparent appointment of other professionals and officials in leadership positions of HCS where the nurses form the largest cadre of the work force, such as radiographers in CEO positions, doctors with no experience in the South African health system, and other public office positions such as Premiers. Some of the respondents indicated that most of the decisions taken by these leaders could not address the core of the problems faced by nurses because in most instances they lacked insight into the deeper aspects of nursing and health care delivery. To these respondents, leadership in HCS was not about having management skills in any field, but an understanding of the dynamics of health care delivery, insight, and a broad perspective of the implications of the delay or denial for essential commodities for health care delivery. Most importantly, their lack of insight into patient acuity levels and staffing needs could aggravate the accomplishment of vital tasks that could be an indictment against health organizations if not performed. Similarly, Mashaba (1995: 16) also notes that many of the internal conflicts which caused discontent among black nurses in the era of missionary and settler's hospitals emanated from poor communication and lack of consultation with nurses because white matrons could not comprehend black nurses' problems. According to the respondents in this study:

➢ *"People who make decisions for nurses have no idea what is going on in the profession"* [RH]

➢ [Nurses] *"Not well represented, their rights are not met only the right of the patient is NB, where there are long queues at the pharmacy out patient the nurse is to be blamed. The patient swears at the nurses..."* [DHA]

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➤ *"Nurses will represent nurses well as they understand and know all the logistics"* [RH]

Hosken (2008:2) reports that, when asked about her lack of health care credentials, the MOH said, "You do not have to be a health professional to know what the problems are" (see appendix F). The respondents disagreed with the idea of personnel with lack of experience and relevant qualifications lead HCS and nurses' issues, as follows:

➤ *"People who are controlling or deciding for nurses, are not nurses and they don't understand nurses problems eg salary, poor working conditions, lack of equipment, shortage of nurses and long working hours"* [DHA]

➤ *"Maybe people who are representing nurses, they have no experience about the work of the nurses"* [RH]

➤ *"Because transformation are done by people who don't know anything about public health service"* [AH]

It is clear from the respondents that the question of leadership in health service delivery has raised serious questions among RNs in the PHS.

Dolamo (2008:41) points out that when leaders read "newspapers, listen to the radio and television news about bad service provision, the majority of them think what is needed is a new strategy, when the root problem is the leadership". Consequently, it is critical to examine the differences existing in the curricula for nurses and doctors, in comparison to other professionals' educational preparation with regard to leading HCS, as delineated below:

• *Nurses*: The following modules[4] form part of the curriculum for BA(Cur), depending on the course, type of curriculum chosen by students and the level of study: Planning and organising in Health Services management, Leading and control in Health Services management, Comprehensive PHC,

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[4] Nursing curriculum for 2009– University of South Africa

Health and the environment, Human Resource Management in Health services, Labour Relations in Health services Management, Financial Management in Health services, Leadership in Health services Management, Contemporary issues in Health Services Management, Basic Epidemiology in Health care, Business Management, Public Administration, Critical Reasoning and Organizational Communication (Unisa 2009:58-65).

After acquiring these qualifications, nurse graduates can proceed to Honours, Masters and PhD degrees in the subject of their choice.

- *Medical doctors*: In addition to the MBCHB qualification and registration as a physician with the Health Professions Council of South Africa (HPCSA), their four- to five-year Master of Medicine (MMed) degree in Community Health equips them with the following skills: Health legislation, Health Policy and Health systems management, Learning in Public Health, Project and Financial management in public sector, Epidemiology and demography, as well as Social and Behavioural Sciences among others. These skills are essential for effective management of HCS and understanding of the dynamics and aetiology of disease patterns in society (University of Pretoria 2008:46-51).

- *Other professions*: The Bachelor degree programmes are taken in line with specialisation in a particular field of study, for example: Dietetics, Dentistry, Radiography, Occupational and Physiotherapy. The Honours, Masters' and PhD "may only be taken in a field of study in which the foregoing degrees or equivalent qualification has been obtained", as well as registration with the HPCSA (University of Pretoria 2008:95-123).

Since HCS is a complex system, an educational preparation of this nature does not appear sufficient to handle the enormity and magnanimity of the dynamics of a prototype health care service. Moji (2006:6) points out that managers who have power, position and no principles to guide the process, may find it difficult to implement transformational policies they have been charged with, just as managers who have position and principles of

democratisation without power, cannot be successful in fulfilling organisational goals.

Recommendations

In this regard, the study makes the following recommendations:

- Since nurses form the largest cadre in HCS, more CEO, Executive Director, Member of the Executive Committee (MEC) for Health, Premiers, Director General, Deputy Minister and Minister of Health positions should be open to more nurses with high academic qualifications and practical experience in the clinical area. Doctors with postgraduate qualifications also appear to be suitable for the job, because together with the right leadership in nursing, they could craft solutions for HCS as they know the system and the problems. It is also critical that these doctors have sufficient hospital or ward experience in the RSA.

- Because it is the SANC's prerogative to safeguard the public from medico-legal hazards by practising nurses, and for the accreditation of clinical facilities for students' practica, the SANC should consider the plight of nurses who are expected to provide quality care without the necessary equipment, staff, and visible nursing and governmental leadership as indicated by respondents in this study. Secondly, the SANC should make recommendations to government on the right/relevant leadership in HCS. This recommendation is consistent with the document released by the Department of Public Service and Administration (DPSA) (2007:6), which states that the SANC provides general support, networking, liaison, customer care and negotiations. In addition, the SANC is expected to make recommendations, advise, provide information in the form of reports and letters, and assist in the decision-making process (DPSA 2007:6).

- Academic staff has a role to play ensuring that facilities for the placement of students meet the requirements of the SANC by advocating for and consulting with relevant authorities.

- As the main role players and advocates of policies, nursing leaders need to take up leadership of HCS as opposed to relegating this responsibility to unions. Good rapport with nurses at all levels should be established by mending broken and trust relationships and improving communication systems.

- Since salaries are foremost in this and previous studies, nurses' salaries should therefore superlatively reflect that value in all remuneration packages (not only specialty, rural or scarce skills) without external pressure from unions, strike actions and nurse migration.

- The long hours of service for nurses should be reviewed with the aim of allowing nurses to work reasonable hours, within the prescribed legislation in the Basic Conditions of Employment Act, 75 of 1997.

- Renovations of State hospital buildings should be considered, in terms of increasing the annual health budget, in order to make the work environment a conducive, attractive and safe place for all. Because of the long lifespan and long process in construction of buildings, the planning of facilities should cater for the present and future requirements to avoid waste of resources. Decisions must be precise as to what is required, that is, upgrading, downgrading, maintaining or closing down the facility as the situation warrants.

- Because government took a decision to provide affordable and free HCS, the DOH and the Department of State Expenditure need to decide how much government is able to afford for these services, so that they do not disadvantage funding of hospitals. District, regional and academic hospitals need PHC services to survive the workload, much as PHC services need these levels of care to function effectively and efficiently.

- In order to avert waste of resources and minimize constraints on health systems reform, the recommendations of the Commission of Inquiry into Hospital Care Practices, and the Research Report on Enhancing Policy Implementation: lessons from the health sector and others should be revisited in view of implementation (Rantho 1999:14-29; von Holdt & Murphy 2006:4; 26-28).

6.2.2 Young South Africans attracted to nursing

The quantitative data showed that 64.7% of the respondents disagreed and only 26.0% agreed that the youth were still attracted to the nursing profession (see table and figure 5.13). From this, the study concluded that the public image of nursing had suffered a lot of disrepute, probably due to circumstantial evidence of strike actions involving nurses in the PHS, the unfavourable working environment in most of the public hospitals, the pride of nursing that has been severely dented by alleged careless remarks seemingly made by some of the government officials in the media as alluded to by some of the respondents, and the chronic poor salaries that emphasise 'specialty' qualifications for better remuneration, which seem to have caused division and dissension among nurses. Grobler (2007:21) maintains that the image of nursing was sabotaged by the media and the public, and nursing no longer appealed to the public, because of apparent disciplinary measures against nurses by the SANC.

Regarding young nurse graduates' expectations in the USA, Smith, Hood, Waldman & Smith (2005:529) found that, with the exception of salaries, nurses' satisfaction was not related to how the practice environment conformed to their expectation. Smith et al (2005:525) consequently concluded that nursing had difficulty attracting youth due primarily to inadequate pay, though staff shortages and job stress also contributed to the intolerable practice context responsible for driving nurses out of the profession, thus undermining efforts to attract new recruits.

The respondents (26.0%) who agreed that young people were still registering for nursing courses, pointed out that they joined nursing because they came from poor families and therefore could study while getting a stipend; otherwise they found nursing de-motivating and devalued by government and society, although a scientific profession. These results concurred with Du Plooy's (2007:55; 59) finding that young people just enrolled in nursing courses to get started with finances in order to study for what they really

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desired. On the other hand, Stack and Hlela (2002:41) found that top black students were no longer attracted to nursing due to overwork.

Tshabalala-Msimang (2007) emphasises that it is a challenge to come up with creative measures suitable to attract young people with great potential to the nursing profession, or even make the health science professions an attractive choice for gifted young people leaving high school, because of the proliferation and competitive nature of career choices in this era. This reinforced the DOH's (2006) efforts to develop recruiting strategies that would motivate students in pre-higher education, notwithstanding young people's inclination to experience life abroad.

Recommendations

In order to attract young South Africans to the nursing profession, the image of nursing needs to portray the right professional image in some of the following ways:

- Nurses should be given the liberty to restore professionalism, pride and confidence in the nursing profession as a special caring service for humanity in all HCS without interference from government and unions.
- Improvement of health facilities, indiscriminate salaries, and acceptable conditions of service are some of the areas that need urgent attention in public hospitals. The younger generation is thought to take pride in identifying with appealing, modern facilities. Hard work does not seem to be a problem with nurses, as long as they are properly staffed and have appropriate tools to work with.
- Nurses have to engage the media more meaningfully by show-casing hospital and community projects in which nurses are involved. This includes media coverage of local and international conferences, Nurses' Day, World AIDS Day, Nurses' Day of Prayer and other special days to commemorate the heroes of nursing, and important events that enhance the image of nursing in society.

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- Hospital open days, preceptor and mentorship practices, including giving matriculation (Grade 12) students an opportunity to wear the uniform while observing nursing in action firsthand, could serve as a source of attraction for young South Africans.

- Modern equipment would be as exciting for young graduates as it is for experienced nurses and doctors, making life at work easier and enjoyable.

6.2.3 A National Workforce Forum to investigate nurses' issues

The data suggested general ignorance among the respondents concerning the existence of a nursing forum. Significantly, 44.8% of the respondents did not know there was a forum and 35.7% were not sure what a workforce forum was (see table and figure 5.14). Those who agreed (19.6%) cited the Democratic Nurses Organization of South Africa (DENOSA) as the only work force forum they knew. It could be that the proliferation of unions, their popularity and impact has overshadowed other options for nurses to pursue to have their issues and problems addressed in a professional manner, or, apart from DENOSA, there is no other professional structure that investigates or attend to nurses issues. Lack of information and solidarity in the nursing profession seems to hamper creative and innovative ideas among nurses on the formation of unified, purposive groups under one body where nurses' issues could be addressed.

Most of the respondents expressed a state of despair among RNs in the PHS because in spite of their complaints, seemingly nothing had been done. The SANC was regarded as antagonistic to the nurses and fostering a role that showed high commitment to the protection of the public against practising nurses, irrespective of the poor conditions nurses had to endure. According to respondents, nurses still struggled with unresolved issues, hence some subscribed to unions only for salary negotiations while others believed that professional associations served them better.

Recommendations

It is recommended that the role of task teams be reviewed, since they attend only to hospital problems in different provinces on an ad hoc basis. Nurses' issues also need to be investigated by nurses because unions do not seem to have been able to handle them in the past. In addition, hosting special issues forums could substantially reduce the level of discontent among the nursing staff.

6.2.4   Employing body communicates with nurses

6.2.4.1 Poor communication

This question wished to determine whether there was any communication between the employing body and the nurses at the production level, particularly given the changes in policies affecting various areas of health care delivery and the nurses. The quantitative data analysis indicated that 45.5% of the responses fell in the 'never', and 46.3% in the 'occasionally' column, leaving the 'frequently' and the 'always' columns with insignificant numbers (see table and figure 5.15).

This suggested a serious omission by the provincial government in providing nurses with vital information, particularly at the operational level. The study assumed that such communication could have been relegated to unions to communicate concluded matters between unions and government to nurses.

In the written narratives, respondents indicated that they felt dejected and let down by government in that they had longstanding unattended problems. Of note also, was the role played by hospital management as the overseers of these health institutions with government. The respondents seem to suggest that RNs are in a perpetual struggle by themselves, without support or feedback on what government intends doing to assist in resolving salary issues and the provision of necessary requirements to help nurses and doctors fulfil their duties.

According to the respondents:

> *"How can I study my B. Cur + honours and be perceived as someone they can get from the streets. We go on strike, they still can't swallow their pride to recognise their mistakes + weak points. Instead they threaten us on dismissal. They are arrogant, bully, heartless, self-centred, non-thinkers, with no goals regarding SA."* [DHC]

> *"We are expected to deliver quality patient care with not enough staff, no support from our NSM, no equipments to be used to observe patient e.g Baumanometers, pulse oxymeter suctions mobile, haemoglucometers, etc"* [RH]

> *"Nobody cares about nurses, we mainly do our work and non-nursing duties. We wheel patients to other disciplines for investigation e.g. scan or transfer to other wards. Porters are very reluctant"* [AH]

> *"Nurses have been exploited for years even today"* [DHB]

The MOH is on record as saying that it "is extraordinary that people continue to work in hospitals where there is so much dysfunction", and that there was no reason why the dysfunctional health system could not turn around within five years (Cullinan & Thom 2008:3) (see appendix F). One of government's priorities is to look at the interest of the community by providing resources for effective service delivery. Because of limited resources, nurses find it difficult to practise nursing the way they should (Zuma 2007:43). The employer provides the resources while the nurses bring the skills.

6.2.4.2 Increased workload

Frustration with the increased workload was also among issues raised by the respondents as they felt that government did not communicate to encourage them and to indicate how government intended to solve the problem. This made most of the respondents to think that their efforts were not appreciated and government just wanted to see work completed, irrespective of what was required to accomplish the desired outcomes. In this regard, the Italian nurses

also expressed dissatisfaction over being regarded as 'machines', inundated with patient care issues, thus, increasing the likelihood of mistakes (Cortese 2007: 308).

In this study, most of the deficiencies in health care delivery were attributed to poor working conditions, such as lack of equipment, unrealistic staffing ratios, and exhaustion. According to the respondents:

➢ *"Uitputtende werksure. Meeste van die tyd op jou bene. Kry somtyds nie kans om te gaan eet nie. Vat helfte van die tyd van etenstyd weg, 15 minute"* (Long working hours. Most of the time on your feet. Sometimes there is no chance to go for lunch. We take short lunch, approximately 15 minutes) [PH]

➢ *"I work in the most busy children's ward, work very hard to keep up with the workload every single duty day. I can't at times do my allocated duties, am always with the patients instead of in the office. Every day tired when I arrive home."* [AH]

➢ *"Incredibly painful back, where it is some nights impossible to fall asleep. Exhaustion causing immunity to weaken and getting infected with conditions in the ward. Or, getting flu much more regularly. Ending up in hospital. Not eating and drinking enough or some days not at all, due to workload."* [AH]

➢ *"There is a shortage of staff. All the wards are full. Not enough money, work with stress always. We need money to live and to be happy"* [RH]

➢ *"While at home when you are from work, just find yourself sleeping while trying to watch TV"* [DHB]

➢ *"We are working for invisible people and do not get their salaries. I alone do three people's duties in a daily period"* [DHC]

This indicated the severity of discontent that has deteriorated into anger and resentment among nurses in the PHS. Mokgoro (2003) points out that officials in large bureaucracies are often preoccupied with their own interest and needs as opposed to the people they should be serving.

At the same time, however, government had taken steps to address some of the burning issues. Firstly, more nursing colleges were opened in order to increase the number of graduating nurses to resolve staff shortages. Secondly, the SANC introduced short courses as an attempt to replace the skills shortages within the PHS. These were later curtailed when they failed to achieve their intended purpose. Finally, the OSD was introduced as a strategy to recruit and retain specialty skills. These issues are discussed later.

6.2.4.3 The South African Nursing Council (SANC)

The respondents noted their perception of the SANC in written narratives, referring to the Council as a body that governs nurses with much authority and not without blame with regard to nurses' struggles in HCS, particularly regarding standards required for safe patient care and accompaniment of students. This referred to the lack of equipment and shortage of staff, and the respondents' view that when HCS are in serious trouble, the SANC should assist by advising government until the crisis was over. The respondents were opposed to the role of the SANC of only assuming the offensive against nurses and never showing support on issues where they could make a difference by suggesting ways that could make HCS a better place to work in. It should be noted that the respondents were aware of the role of the SANC towards nurses, HCS and the public as stipulated in the Nursing Act, 33 of 2005. Furthermore, the DPSA (2007:6) states that the SANC can make recommendations to government on the right/relevant leadership in HCS by providing general support, networking, liaison, customer care and negotiations. The SANC is also expected to make recommendations, advise, and provide information in the form of reports, letters and assist in decision-making process (DPSA 2007:6). The respondents seemed to be aware of this document as they appeared to be calling for the SANC to also intervene:

> ➢ *"As die SANC nie tot ons redding kan kom nie, het ons geen ander uitweg as om na die Unions te gaan – kom voor hulle kry meer alles reg* (If the SANC does not come to our rescue, we have no choice but

> to go to the unions – because they seem to manage to get things right.)*" [PH]

- ➤ *"Only care about what wrong have we done not on the good side we do every day. The bad is due to us being overworked with less equipment to offer proper nursing care"* [RH].
- ➤ *"Payments are delayed by SANC registrations which put strain on nurses financially"* [DHC]
- ➤ *"SANC only protects the public and they don't care about the nurses"* [DHA]

From these statements, the respondents appear to feel alienated by the SANC, whose primary focus is the protection of the public from ill-practice by nurses, which makes the SANC their enemy by definition. Seemingly, some nurses chose union affiliation to have nurses' and nursing issues solved. This, according to respondents, should have been the SANC's prerogative in conjunction with hospital management in order to protect communities by ensuring availability of resources in line with the Council's mission and vision.

Secondly, the respondents indicated that the SANC was not prompt to register newly qualified nurses as they seemed to be subjected to long waiting periods before they could begin to practise as RNs, thus exerting more financial pressure on young graduates. Therefore, as the pressure of work mounted in the face of severe staff shortages, anger and frustration also appeared to take a toll on the remaining nurses.

Thirdly, the data suggested a rift between RNs and the SANC, almost similar to the one that existed in the apartheid era. This could indicate that the respondents saw no proactive move by the SANC to assist nurses with some of the struggles and issues, particularly in negotiating with government because many government officials seem not to be conversant with the needs, the urgency, delays or denials of certain commodities required for health care delivery.

Fourthly, the respondents appeared to expect the SANC to intervene regarding discriminatory salaries related to the OSD by clarifying the confusion regarding the 'Specialty' offer in the new OSD salary structure. This could have been achieved by providing clear and documented delineations of the 'one-year post-basic' qualifications required in order to qualify for the OSD as a specialty qualification. Government Notice R48 and R212 of the SANC, which were followed by the DOH, the DPSA, the bargaining councils and possibly other parties involved in bargaining, were found not to have included all the listed post-basic courses (DPSA 2007:5; Government Notice R48 and R212; SANC 2007b:4).

Lastly, the respondents were concerned about frequent mistakes committed by nurses on duty, which exposed them to disciplinary hearings by the SANC. Moreover, the respondents pointed out that the prosecuting authority appeared to be oblivious of unpleasant circumstances surrounding these incidents, such as lack of capacity and fatigue due to excessive workload. According to the respondents, in other instances the disciplinary hearings did not consider the time lapses between the alleged offence and the hearing date, as some implicated RNs could not remember the incident when summoned to the inquiry. A case in point was cited by one respondent, where the RN working in maternity was called to an inquiry involving a baby admitted (10 years after delivery). According to this respondent, even though the records were kept up to that time, she could not remember the finer details surrounding that incident because of the appalling numbers of patients they dealt with, which apparently was surprising to the disciplinary committee (SANC), and frustrating to the registered nurse. According to the respondents:

➢ *"Frequent mistakes due to exhausted nurses. Mostly due to increased workload and shortage of staff. Sometimes because they have to work more (moonlight) to earn needed extra cash"* [RH]

➢ *"Registered Nurses work harder under difficult situations. Nobody appreciates the best that they offer, especially the community. Even our council. WHERE ARE THE NURSES RIGHTS!"* [RH]

➢ *"They [RNs] are overworked and burned out. The ratio of patient to nurse does not allow nurses to render quality nursing care to PT. All that is done is just <u>ROUTINE</u> and go off"* [DHA]

➢ *"There is a shortage in the public service. Where I work, one registered nurse has to manage paeds, psych, gynae and medical conditions"* [DHB]

➢ *"Nurse-patient ratio equals RN 1:38 and mostly, no reliever"* [RH]

➢ *"It is always stated that we are negligent. No consideration of conditions we work under. (poor)"* [RH]

The nurse-patient ratios provided by respondents are consistent with the nurse-patient ratios of 1:120 (general wards) in Malawi, 1:50 for maternity and paediatrics, 1:26 for neonatal and 1:51 for gynaecological patients, which similarly, does not accommodate safe patient care (Gerein, Green & Pearson 2006: 45) (see section 6.2.17 for effects of exhaustion on RNs and more comments.)

The endurance and sacrificial services provided by these nurses was also acknowledged by the MOH when she paid tribute to all health care providers for giving up "their time, livelihoods and families" to take care of the sick and afflicted (Cullinan & Thom 2008:3) (see appendix F). With regard to the nurses' rights referred to by respondents, the SANC acknowledges that nurses have rights too (SANC 2008).

Recommendations

From the findings, the study makes the following recommendations:

• The Honourable President of the RSA should be requested to allow 'change' by possibly appointing a 'Registered Nurse' for the 'Minister of

Health' portfolio in order to put the nursing profession and public health services back in a position of recognition, importance and excellent service, as suggested by the respondents. A 'Medical Doctor' would also appear to be a suitable candidate for this portfolio on account of their curriculum and experience with South African HCS.

- More RNs and medical doctors should be considered for appointments in CEO, MEC for Health, Deputy Minister positions, based on their qualifications, practical experience with HCS, nursing and medical expertise, and not merely by virtue of possessing management skills in any field, since this does not appear to benefit the uniqueness of HCS.

- To reinforce the roles of CEOs and NSMs, additional strong management teams with skills to deal with human resource, financial, Information Technology (IT) and engineering matters should be considered for effective management of hospitals.

- Active recruitment and acceleration of the registration process for RNs from other countries is highly recommended.

- While inspections of hospitals by the SANC are indispensable, they should also be geared towards making recommendations to government to increase the health budget, and improve health facilities, provision of equipment and medical supplies.

- It is highly recommended that the SANC provide the South African nurses, the DOH and the DPSA with a Regulation containing a list of 'Post-basic' courses to make up for accredited post-basic qualifications that are visibly missing in R48 and R212, since the DOH and DPSA rely on these Regulations to guide the allocation of the OSD.

- The SANC should assist in putting the PHS back into the desired position of quality service delivery by expediting the process of registrations of newly qualified nurses. Furthermore, nurses should be given the liberty to research the necessity, feasibility, operation and costs of putting up branches of the SANC in all provinces to avoid over-centralization of the Council's activities.

- Nursing leaders should be ready to speak out and use clinical and patient-based arguments to defend the budget allocations for the DOH,

regardless of any statutory laws already in place, because laws and regulations can be repealed to suit changes in the health care system.

- A national hospital plan should be designed, which would spell out the pace and stages of introducing certain developments in upgrading public hospitals. This would help determine where provincial departments are under- or over-spending their budgets with new expansions. Existing research reports and new study findings could be useful in guiding such plans and processes.

- Structures and communication channels between provincial departments and HCS need to be reviewed and improved to facilitate dissemination of information and efficiency in the delivery of care, to ensure that employees receive information from the DOH as intended.

- Task teams should continue to be used to investigate nurses' issues, where countrywide RNs' views should also be solicited, categorised, examined and prioritised for presentation to the DOH, and feedback provided by all provincial departments.

- Members of the strategic planning team should be appointed from the pool of experienced members of the multidisciplinary team in HCS, since they will be able to craft solutions because they know the system and what the problems are (Stack & Hlela 2002:37; Swanburg 1996: 419). Nurses and doctors should be in the majority because nurses form the largest cadre of employees in HCS and together with doctors are in the health environment 24 hours. Their input can be relied on to form the basis for feasible, effective and realistic policies.

6.2.5 The Occupational Specific Dispensation is a perfect solution for discontent

6.2.5.1 Demeaning salaries for nurses

This item was intended to elicit the respondents' perception of the purpose and adequacy of the OSD[5]. Whereas it was expected that most of the respondents be content with the OSD, the quantitative analysis revealed that 62.0% did not regard the OSD as a perfect solution to deal with the level of nurse migration believed to have been induced by poor salaries in the PHS. Only 17.0% agreed and 21.0% were not sure. The respondents reported that the OSD had not met their expectations, especially as the cost of living was too high for the low salaries they earned. Their hopes appeared to be shattered by the manner in which the OSD was allocated. The 17.0% of respondents who agreed that the OSD was the solution could have been among those whom the OSD favoured (see table and figure 5.16).

One of the concerns raised by respondents was what they called "unfair distribution of the OSD"; where those who did not benefit from the new salary structure said their salaries were still too inadequate for them to even qualify for a bond to buy a house. According to the respondents:

➢ *"Other nurses still get low salaries and do not qualify to get bonds for houses, ie professional nurses"* [DHC]

➢ *"I am not satisfied because I got less than thousand rand with 15 yrs experience."* [RH]

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[5] The OSD (for nurses) is an agreement (PHSDSBC Resolution 3 of 2007) signed in 2007 between government and five health sector unions: the Democratic Nursing Organisation of South Africa (DENOSA), the National Health and Allied Workers Union (NEHAWU), the Public Servants Association (PSA), the Health and Other Service Personnel Trade Union of South Africa (HOSPERSA), and the National Union of Public Service and Allied Workers (NUPSAW) for the implementation of the new salary scales to attract and to retain employees, as a result of the (PSCBC Resolution 1 of 2007.

➤ *It is better to never even use the word SATISFACTION at all* [regarding the OSD] [DHC]

➤ *"Academic success of nurses not rewarded or recognized"* [AH]

➤ *"Newly qualified earns like those with long service"* [AH]

The responses indicated that some of the respondents were still desperate for salaries commensurate with their qualifications and years of experience. The reason for this is that the OSD seemed to have excluded RNs with high academic qualifications and long years of experience on the basis of not having specialty qualifications. Consequently, the respondents appeared to have been disillusioned by these irregularities and disparities where some felt betrayed that they took time and effort to study courses that would not be recognised and reimbursed by the OSD, thus leaving them with inadequate salaries. Du Plooy (2007:53) found that nurses shared rooms in rented flats (which they dreaded), because their poor salaries could not cover accommodation costs and other necessities. Issues of salaries were also top on the list in Selebi and Minnaar (2007:56). They found that salaries were a burning issue among nurses, especially with regard to the type of work.

6.2.5.2 Lack of involvement of nurses in occupational specific dispensation decisions

The findings revealed that the respondents appeared to be ill-informed about the OSD in general. It would seem that no initiatives were taken by the DOH, unions, or hospital management to elicit the reaction of the nurses to the proposed method (OSD) and to explain reasons for the selection of categories that would benefit and why government decided to settle for this strategy. The *Batho Pele* White Paper emphasises that finding the right person to speak to in a national or provincial department, particularly someone who can give friendly advice, can be very trying, leaving the citizen feeling helpless, frustrated and uncertain (South Africa 1997c:14).

According to the respondents:

> *"Nurses were not involved throughout or informed, we were just told about that decision. IT IS UNFAIR"* [RH]
> *"I know nurses were not asked for their input"* [RH]
> *"It was wrongly implemented. No explanation was given"* [RH]
> *"Nurses are not involved in issues concerning the OSD"* [RH]
> *"It* [OSD] *was done by top stakeholders only"* [AH]
> *"Differences have been identified among hospitals. Implementation not understood"* [RH]
> *"Information is for top management"* [DHB]
> *"People in high positions are still not open about a lot of things, especially money issues"* [AH]
> *"Management go to meetings without mandate"* [AH]

The data would suggest that the respondents were merely informed about concluded matters on issues that directly concerned them, particularly important matters such as salaries. Even when problems were encountered, it appeared that there were no explanations given to nurses who seem to have been left in an apparent state of confusion regarding the new salary structure and why certain personnel benefited.

In Italy Cortese (2007:308) found insufficient communication was also evident in delays with dissemination of information and reluctance to listen to information from the 'bottom'.

It should be noted, however, that according to the 1955 Freedom Charter in the RSA, workers are free to elect their officers and to make wage agreements with their employers, among other things. In contrast, decisions appear to have been made for nurses, thus, creating an informational gap between government and nurses at the production level, yet both the Freedom Charter and the Constitution of the RSA make provision for the right of all citizens to speak out, organize and have meetings, not only with unions, but professional associations as well. Nurses also have the freedom to form a unified front that will represent them at the bargaining table, government level

and policy makers to negotiate their nursing and health care needs. Moreover, the 1997 *Batho Pele* White Paper indicates that the Constitution, through the Bill of Rights, afforded citizens certain rights, including access to information held by the State, which they may need at any point in time (South Africa 1997c:10).

Based on the provision of this law, this study argues that if nurses were united under one body, they could have their own professional representation to government and the bargaining councils, other than relying on unions. This could minimize discontent, nurse migration, and ignorance and confusion among nurses in the PHS. Professionalism, expertise in management of HCS, and representation to government are necessary to demystify and provide proper perspectives on issues surrounding HCS and the nursing fraternity to ensure that salaries are negotiated as intended and that excellence in delivery of care is attained.

6.2.5.3 Specialty offer

The respondents indicated that the OSD not only caused dissatisfaction among RNs, but also friction, division and dissension because of the 'specialty offer' that was made available for certain qualifications only. Some of the respondents were concerned that the maternity ward, especially as it includes labour and delivery units, was not classified under specialty wards. Some respondents maintained that surgical wards that have 'high care' beds and cardio thoracic units should have been classified as specialty wards. According to the respondents:

➢ *"Most nurses (senior managers) don't exactly know which dept are special units"* [RH]

➢ *"It was not fairly allocated because they call some units specialty, but cardio thoracic not specialty"* [AH]

➢ *"Chirurgic wards got none – all categories* [of patients] *+ high care pts are nursed there"* [AH]

>   *"All categories* [of nurses] *are doing their best but only one category is rewarded … whereas all categories are doing special duties"* [AH]

>   *"Others feel that they are being exploited. Each category* [of nurses] *works according to scope of practice and way over"* [RH]
>   *"Salaries were improved but others are not happy, e.g. nurses with no speciality, because patients are the same if they are not well. They need to be nursed to be well" "*[RH]

The respondents' confusion and misunderstanding would not have existed had there been a policy document to settle disputes from the SANC that clearly delineates specialty courses, particularly because Government Notices R48 and R212 were followed by the DOH and the DPSA in the distribution of the OSD, and were found to be devoid of most of the specialty qualifications designated by the SANC.

Secondly, the data seem to suggest no prior consultation with RNs and no feedback sessions specifically regarding the criteria used to classify 'specialty' qualifications and why long service for some was not considered by the OSD. These disparities find common ground in the ICN's (2007) position statement regarding equal pay for work of equal value, where recommendations were made that there should be no discrimination between occupations or professions with the same level of responsibility, work experience, skill requirement and hardships among others. In the light of this information, the OSD seems to be in stark contrast to this recommendation.

The pay progression and grading of posts within the OSD structure also needed to be brought to the attention of the nurses, so that all workers had a common understanding of their definition, meaning and purpose prior to implementation. The respondents further appear to indicate no prior research on the concept 'Specialty' qualification and the OSD, as follows:

>   *"There is a lot of misunderstanding and confusion"* [AH]
>   *"There is a misunderstanding between the labour relations …"* [AH]

➢ *"We were told that it is going to be like flat conclusion"* [salary increase a flat rate] [AH]

➢ *"Not all stakeholders* [agreed] *because when gathered for any problem they do not come to resolution, that causes further dissatisfaction …"* [AH]

➢ *"Every province does whatever suits them. There are no national and standard policies"* [regarding the implementation of the OSD] [DHA].

These views reveal serious problems with representation of nurses on the provincial government, the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) and the Public Service Co-ordinating Bargaining Council (PSCBC). From the respondents' comments, it appears that there was discord among labour organizations, with misinformation such as equal pay for all nurses (flat rate). This confusion was to be expected because unions are not conversant with nursing issues and nomenclature. As a result, these comments suggest that nurses find themselves in a serious predicament where they do not know what to do with their problems. Mantashe (1995:82) emphasises this struggle among nurses and that nurses were "highly fragmented, frustrated and trapped in a 'cycle of action' that has been damaging to their professional status". While also advocating for the unification of nurses, Mantashe (1995:82) recommends a representative leadership that can "hear their issues and negotiate a path forward". The 1997 *Batho Pele* White Paper also noted that complex regulations and lack of information were usually hindrances for citizens to access information (South Africa 1997c:14).

The ICN (2007) advocates for nurses to be protected from false information, the withholding of relevant information, misleading claims and exploitation pertaining to job descriptions, benefits or allocations of specific offers. Accordingly, access to truthful employment-related information should be guaranteed, as well as the concept of informed consent to all parties involved in employment issues and negotiations. However, this study found that nurses

were trapped in information that was inconsistent with the official OSD document with regard to a purported general increase for all nurses.

6.2.5.4 Recruiting and retention strategy

The respondents appeared to be perplexed to discover that the OSD worked to the advantage of returning RNs to the PHS, evidenced by their disapproval of the OSD being used as a recruiting and retention strategy. The feeling portrayed in the preceding data is similar to the 'Scarce Skills' allowance implemented with effect from 1 July 2003, and accessed by other registered health professionals and a small segment of RNs (oncology, critical care and operating theatre technique), in terms of the Public Health and Welfare Sectoral Bargaining Council (PHWSBC) Agreement No. 1 of 2004 and Resolution No. 2 of 2004 (PHWSBC 2004a; PHWSBC 2004b). The respondents' responses appeared to indicate that nurses seemed not to have been aware of these agreements. Therefore, with the introduction of the recruiting and retention strategy, it seems that nurses were not given the opportunity to examine the deal to agree or disagree with the new strategy since it would impact their salaries as important members of HCS. In their exasperation, the only way out appeared to be resignation from their posts, which actually seemed to defeat the purpose of the OSD to attract and retain employees (DPSA 2007:1). The respondents seemed to imply that, whereas the State was losing skilled professionals to private and overseas recruitment, it would now have to grapple with the loss of RNs in the 'Generalist' stream, those with high academic qualifications, and others who did not benefit from the new salary structure. According to the respondents:

➢ *"A lot of RNs not covered will leave the public sector, so it is not retention strategy"* [RH].

➢ *"Doctors and other health care workers get preference. Nurses issues are discussed at a higher level mostly by managers and they do not have nurses' interests at heart..."* [PH]

The OSD strategy, then, appears to have aggravated a problem it was intended to solve. Oulton (2006:91) points out that in a positive work environment, employees' wellbeing and retention of staff are at the core of every business corporations for increased productivity. So, "Why do we ignore it in health care? Instead we reach out for ineffective solutions, when the principles of trust, respect, fair remunerations, safety in the workplace, recognition, opportunities for growth and teamwork are what is required for retention of staff." Oulton believes that recruitment of nurses or students to a dysfunctional health or nursing system is neither ethical nor cost effective, as the main focus should be to achieve a self-sustainable national nursing working force which ascertains a stable core of health providers (ICN 2007).

6.2.5.5 Conflicting ideas

There appeared to be conflicting ideologies and interests from stakeholders; the national government, the DOH, professional associations and different unions that seemed to be speaking in different directions. Nurses who were union members appeared to have some relayed information, while others were not informed. According to the respondents:

➢ *"Nehawu suggested R 160,000 entry level for all General Nurses/Professional Nurse"* [DHC]
➢ *"Who agreed upon it?* [OSD]*"* [DHC]
➢ *"Unions agreed"* [RH]
➢ *"Institutions still don't know how to implement it and no follow-up is done to check what the hospitals are doing. I think other nurse were not represented fairly"* [RH]
➢ *"No agreement, people are complaining"* [RH]

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> *"PN's* [Professional nurses] *with long service gained nothing"* [AH]

These discrepancies in the allocation of the OSD and conflicting ideas suggest a disorderly health care system, where instructions apparently emerge from all directions and the nurses at the production levels bear the brunt. What compounded the problem appeared to be lack of follow up, presumably by the DOH, to make sure that information was disseminated as intended. Also, the process of implementation of the OSD was apparently not monitored, leaving many questions unanswered among nurses, in contrast to the DPSA (2007:15) statement that the Department of National Health would follow through with this responsibility, to assist provincial departments with the implementation of the OSD.

6.2.5.6 Rural allowance

The rural allowance was a strategy meant to woo and recompense health professionals who work in rural areas (DOH 2006). Here, too, it would appear that sufficient information regarding the definition of this concept was lacking. According to the DOH (2006), there is no official definition for "rural" in the RSA. In the past, Statistics South Africa (Stats SA) designated areas according to municipalities, that is, cities, towns and their townships as urban and the remaining areas "rural". Presently, all municipalities comprise one or more towns, which include areas that are to some extent "rural", with the exception of Metropolitan municipalities. In the context of this description and this study, Tshwane Metropolitan area does not have 'rural' areas. However, it does have PHC services. Accordingly, if a 'rural' allowance were to be paid to RNs in other rural areas which offer PHC services within the RSA, in the respondents' understanding, RNs in Tshwane Metropolitan area should also qualify for it since they also offer PHC services.

According to a respondent:

> *"Not all nurses are satisfied. For example, why rural area specialty – we as nurses are doing the same important work. Why can't we all get the allowance? Who is not important in their field of work?"* [DHA]

In the respondents' view, rural areas are predominantly PHC services, which together with district hospitals are level one HCS. Thus, according to the respondents, this justifies equal consideration for the rural allowance, unless other reasons are provided.

6.2.5.7 Disparities in the allocation of the OSD

The data indicated that respondents felt that there were disparities in the implementation of the OSD in general. The respondents cited an example of newly qualified RNs from the 4-year course earning the same salary with RNs who had twenty years' experience in nursing. Other examples were different salary packages for RNs in different levels of care, and RNs working in same units with different remuneration. According to the respondents, discrepancies were also observed in the amount allocated to individual RNs:

> *"OSD issue – Academic hosp. got OSD of >R30.000 especially those whom we qualified same time with, but with us at district only got R2000"* [DHB]
> *"Because we didn't have same salaries, and even the professional nurses that had their diplomas after others are getting more money. I think we should have been placed on the same scale, because after all we are all working in the same departments, there isn't any place where nurses are just seated doing nothing. So it should be reversed."* [RH]
> *"Newly qualified sister (with psychiatry 4-year course) earn the same salary with the RN with 20 yrs' service."* [RH]
> *"Because those who resigned earlier are rated high"* [DHB]

> *"Others only received R200"* [RH]
> *"A person with Degree/Masters can't be applying same skills knowledge same as general nurse = exploitation"* [DHC].

This clearly indicated that the respondents wished to know who, how, where, why and what happened about the OSD. The following table contrasts RNs with specialty qualifications and RNs with no specialty. Thereafter, an attempt will be made to delineate the legality, purpose and identified inconsistencies with the OSD. This could help answer questions, concerns and misunderstandings surrounding the implementation of the OSD.

Table 6.1 A comparative analysis of RNs with 'specialty' and without 'specialty' qualifications

RNs with specialty on 30/06/2007	RNs with NO specialty on 30/06/2007
1. OSD specialty paid	OSD specialty not paid
2. Long service (experience) recognised and remunerated according to OSD	Long service (experience) working in a particular specialty area not recognised by the OSD
3. Rural allowance paid (if in rural area)	Rural allowance paid (if in rural area)
4. Dual career path: Progress to higher levels with salaries equal to/or higher than that of managers in general nursing without moving into post	Translate as a once-off provision to the lowest salary scale attached to production post (entry level) in that specialty
5. Career pathing by means of grade progression for RNs who choose to remain at production levels, than move into supervisory posts	No grade progression to higher salary scale attached to post in that clinical specialty without first obtaining the required qualification
6. (3%) pay progression every two years without moving to supervisory post in that specialty	3% pay progression every two years in the 'General' nursing stream
7. An employee with speciality qualifications (according to R48 and R212) working in a non-specialised unit forfeits specialty benefits	In the absence of post-basic qualifications but working in specialty units due to staff shortages, a salary structure applicable to the General Nursing stream will be paid for replacement of that specialty

8. Request for transfer by specialty nurse to General Nursing: A lower scale attached to the post with reduction in the relevant notch applies	Request for transfer by registered nurse without specialty to General Nursing: A General Nursing stream salary structure is applicable
9. Employer initiated transfer to General Nursing: A lower scale attached to the post with retention of salary notch will be paid	Employer initiated transfer to General Nursing: a General Nursing stream salary structure is applicable
10. RNs on study leave (training ranks): Non-OSD employment and remuneration framework apply	RNs on study leave (training ranks): Non-OSD employment and remuneration framework apply
11. Facility managers in small clinics shall translate to operational managers nursing (PHC)	Managing without PHC specialty shall translate as a once-off provision to the appropriate salary scale attached to the related management level
12. Facility managers (Assistant Directors) in large community Health Centres (CHCs) and sub-district managers shall translate to Assistant Manager Nursing (PHC)	Managing without PHC specialty shall translate as a once-off provision to the appropriate salary scale at management level in that specialty
13. All employees from outside public hospitals shall comply with requirements for OSD (returnees and internal nursing employees)	All employees from outside without the required specialty, qualify for entry level scale only (returnees and internal nursing employees)
10. Newly qualified (4 year course) with relevant specialty qualifies for OSD specialty benefits	RNs with 20 years service experience without the required specialty in that specialty area do not qualify for specialty benefits
11. Diploma in clinical assessment, diagnosis, Treatment and Care translates to PHC	OSD for specialty not applicable without first obtaining required qualification (PHC).

(Information extracted from Department of Public Service and Administration document: 'Implementation of the Occupational Dispensation (OSD) for the occupations Professional Nurse, Staff Nurse and Nursing Assistant in the public service, 2007 (File: 18/2/P)), and Personnel circular minute No. 8 of 2008 (2008b), addendum 2 (Implementation of the Occupational Dispensation for Nurses: Guidelines for translation to PHC Stream).

6.2.5.8 Legality of the OSD

According to (PHSDSBC Resolution 3 of 2007), an agreement was reached in the PHSDSBC for the implementation of the OSD, which in the context of this study, included the occupations Professional Nurse, Staff Nurse and Assistant Nurse with effect from 01 July 2007. This was determined by the relevant authority at 'National Government' level and applies to all employees who are covered by the scope of the OSD, both at provincial and national levels.

It is not within the remit of this study to provide a broad analysis of the entire OSD package, as that has been covered by DOH and DPSA documents. This study will therefore only reflect briefly on some of the DOH and DPSA documents regarding the implementation of the OSD for the occupations Professional Nurse, Staff Nurse and Nursing Assistant in the public service, and examine the gaps between only the areas highlighted by the respondents and the OSD policy relative to identified issues.

6.2.5.9 Purpose of the OSD for nurses

According to the DPSA (2007:1), the OSD came into being following an identified need to adjust the remuneration policy, processes and systems in organizations to continuous changing circumstances, including the South African public service. Consequently, it was found that the existing remuneration framework in the RSA was failing to attract and retain sufficient skills crucial to improve public service delivery. RNs, among others, continued to exit the PHS in unprecedented numbers. Given this challenge, government policies regarding remuneration of public servants were subjected to change, after an agreement with organised labour was reached. A new salary structure (OSD) was subsequently introduced to attract and retain employees, with effect from 1 July 2007, in agreement with the sectoral councils of the Public Service Co-ordinating Bargaining Council (PSCBC) (PSCBC Resolution 1 of 2007).

6.2.5.10 Identified inconsistencies between the OSD for nurses and respondents' views

(a) Remuneration structure

The respondents seemed not to be aware of this section of the OSD. This includes the definition of scope or description of each occupation and the concomitant salary structure with 3% increments between notches to facilitate progression of RNs at the production level, without them necessarily moving into supervisory posts in General Nursing and in Specialty Nursing (DPSA 2007:3).

(b) Pay progression system

The respondents did not mention this aspect in their responses. The pay progression allows for a 3% increment every two years according to qualifying criteria (DPSA 2007:3). The commencement of the first biennial (two-yearly) pay progression cycle for translated incumbents was 1 April 2007 to 31 March 2009, which puts the next pay progression on 1 July 2009, thus nullifying the previous annual pay progression (yearly basis) (DPSA 2007:15).

(c) Unequal distribution of the OSD

The respondents appeared to indicate that nurses were expecting a general increase for all. It should be emphasised that this expectation is not unreasonable as it could be founded on the information provided by unions to nurses, as attested by a respondent:

"We were told that it is going to be like flat conclusion" [flat rate] [AH]

In addition, Tshabalala-Msimang (2007) pointed out that through engagement with other state institutions, an additional amount of R1, 4 billion was allocated for the improvement of salaries for nurses through the Occupation Specific Dispensation (OSD) signed with the health sector unions. This

seemed to suggest a general increase for all nurses. However, the DPSA (2007:3) stated that the implementation of "OSD does not entail a general salary increase for employees in these occupations or that all nursing employees will gain the same financial benefit with implementation of the respective OSD". The reason for this was that the new salary structure would use post and grade promotions, hence the discrepancy against non-'Specialty' nurses.

(d) Specialty offer

The DPSA (2007:5) clearly stated that the allocation of the OSD for RNs was based on possession of the prescribed post-basic clinical nursing qualifications accredited by the SANC and listed in Government Notices R48 and R212. These RNs were also required to be "permanently appointed in a post in such a specialty unit or primary health care clinic" and should have been performing these duties satisfactorily in specialty units on 30 June 2007. This seems to suggest that if RNs with specialty qualifications were allocated in areas other than specialty units, they would not qualify for the specialty offer. However, this study identified the following problems:

- If the one-year post basic Midwifery is considered 'Specialty', as indicated in R. 212, then the purpose of the OSD is defeated because almost all RNs have the one-year Midwifery as a post-basic qualification.
- If the 4-year course qualifications (Community, Psychiatry and Midwifery) are considered basic course qualifications, this suggests that they will have to repeat one or all courses comprising the 4-year course in order to convert them to one-year post-basic qualifications, in order to qualify for the OSD, and the purpose of the 4 year course is also defeated. In other words, nursing could find itself regressing instead of progressing.
- What further compounds this problem is that most of the RNs with post-basic qualifications (Community, Psychiatry, Midwifery) are not working in the designated areas, possibly due to over-supply of these qualifications. They are therefore found mostly in general wards and other specialty

areas (other than their qualifications) and will, by definition, not qualify for the OSD.

- According to the respondents, High Care in Surgical wards, Cardio thoracic units, Gynae and other units, which were traditionally considered 'Specialty' units, were excluded from the OSD. These were found not listed in Regulation R. 212 and R. 48, and the respondents wished to know which regulation covers these areas.

- Non-remuneration of experience and skills in the general stream: Long service (experience) working in a particular specialty area was not recognised by the OSD.

These factors seem to have contributed immensely on discontentment among RNs in the PHS. Therefore, based on the written narratives, it is clear that the respondents did not fully comprehend that the allocation of the OSD was not based on units in which RNs were working, as much as on the 'Specialty' qualification possessed by RNs, recognized by SANC, and RNs actively practising those specialty skills in related specialty units. That is why RNs working in specialty units, without the required specialty qualification, were not considered for the OSD. The DPSA (2007:19) states that the "inclusion of other specialties for this purpose is subject to the relevant one-year post-basic qualification being registered with the SANC in the relevant specialty". Consequently, if it is not a post-basic qualification according to the SANC's classification of post-basic courses, it should not be considered a 'Speciality' (Regulation R212 1993).

As a recruiting and retention strategy, the current classification of specialty could pose the following setbacks:

- While this policy is a mechanism used to motivate RNs to acquire specialised qualifications, most RNs could be tempted to specialize in only the SANC and OSD recognised 'Specialties' because of the financial incentives attached to them, without necessarily having the passion or natural talent for them.

- Hospitals could be further short-staffed as more RNs with certain "Specialties' leave "General Nursing' to position themselves in their specialty areas, resulting in overload of skills in those areas.

- Posts in 'Specialty' areas could possibly not be able to accommodate specializing RNs, thus, many could be placed in 'General' wards, where the 'transfer' and 'vacant' posts conditions apply, thereby further disadvantaging them. This means that some RNs with the same 'Specialty' qualifications could be reimbursed by virtue of being positioned in 'Specialty' units while others with similar 'Specialty' qualifications would not be compensated because they are located in 'General' wards (see section 6.2.5.10 'K'; 'L'). This could also affect the RNs in management positions who could be tempted to return to the production level since whatever 'Specialty' they possess can only be paid when they are in relevant specialty areas at the production level.

- Finally, the academic progression through postgraduate studies could be extinct in the future, because of lack of recognition for these valuable qualifications by the OSD.

Following the preceding discourse, it is clear from the new OSD salary structure that RNs at the production level with 'Specialty' qualifications have the opportunity to earn salaries that are "equal to/or higher than those of managers in general nursing without necessarily moving into management/supervisory posts" (DPSA 2007:3). Furthermore, it is clear that their salaries are also equal to or higher than those of RNs with high academic qualifications (Honours, Masters and PhD), hence according to the respondents:

➢ *"A person with Degree/Masters can't be applying same skills knowledge same as general nurse = exploitation"* [DHC]

➢ *"As from next year, I believe my brain can fairly serve me better to do what will build me better. How can I do four-year B.Cur degree + honours and earn R106* [R106 000] *per annum, with my matric certificate? Nursing is useless for a living"* [DHC]

These disparities have the potential to cause tension; discord and dissension within the nursing fraternity, further dividing the already divided profession (see section 6.2.19).

(e) Long service

Most of the respondents indicated that their years of experience were not considered in OSD. In their perception, the impression portrayed by the OSD is that the 'General Nurses' do not appear to be valuable to HCS, as focus has drastically shifted to 'Specialty' qualifications.

With regard to these concerns, the DPSA (2007:5) stated that RNs already occupying permanent production posts in specialty units or PHC clinics without the required post-basic qualifications on 30 June 2007 (long service) shall be translated as a 'once-off provision' to the lowest grade or salary scale attached to those posts. Moreover, these RNs "shall not progress by means of grade progression to the higher grade (salary scale) attached to the post in the clinical specialty without first obtaining the required post-basic clinical nursing qualification in the speciality" (DPSA 2007:5; 16). However, these RNs will still be eligible for the DPSA Incentive Policy Framework pay progression in the lower production grade (DPSA 2007:16). This, then, makes the salaries for RNs with specialty qualifications equal to/or higher than those of RNs with long service, hence according to the respondents:

➢ *"A sister [registered nurse] with 20 years at a general hospital earns the same as a sister (4yr course) at a psychiatry hospital who has only 1 year's service"* [RH]

The preceding comment by the respondent is clearly illustrated in the DPSA policy which further specified that RNs already managing specialty units and PHC services without post-basic qualifications in those specialties on 30 June 2007, "be translated as a **once-off provision** to the appropriate salary scale

attached to the corresponding management level" (DPSA 2007:5), while a 4-year course RN with one year service is advantaged by their qualification in psychiatric nursing (see section 6.2.5.10 [d]).

(f) Appointees from outside the PHS

The respondents were concerned about new appointees who were remunerated higher than those who had been loyal to the organization. According to DPSA (2007:3), all appointees "from outside the PHS or the promotion of internal nursing employees to RNs' posts in 'Specialty' nursing, PHC and unit managers in 'Specialty' areas will have to comply with the required qualifications. This will enable appointment of employees from outside the public service to be given a salary recognition that allows them higher notches/levels at unit level, based on their specialty, as an attempt to attract and retain RNs with 'Specialties'" (DPSA 2007:3). This clause addresses the following respondent's comment:

➢ *"Those who left the sector and came back, their scale is higher than those who have been honest with the sector"* [AH]

From the data, the OSD strategy seems to have good intentions and unpleasant elements, hence some RNs embraced it while some were dissatisfied.

(g) Consolidation of Scarce skills allowance

It would seem that respondents did not understand or consent to the classification of 'Scarce Skills' when it was introduced in 2004 because there were questions on what criteria were used for this classification. The Scarce Skill allowance, which was already being paid to other health professionals and RNs working in the specialties Intensive Care Unit (ICU), Oncology and Operating Theatre, in terms of PHWSBC Resolution 1 of 2004, was consolidated in the new OSD salary structure (DPSA 2007:3). The

incongruence of information between decision-makers and nurses suggests that vital information did not filter through to nurses at the production levels as intended. This would then suggest that the problem is not with the nurses and neither is it with the decision-makers but in between (representatives), where a lot of information is either distorted or lost, resulting in confusion and ignorance as stated by the respondents.

(h) Rural allowance

Although Resolution 2 of 2004 was passed at the PHWSBC, many of the respondents still appear to be uninformed about its origin, purpose and who qualifies for it, as evidenced in their responses. This also could signify serious communication breakdown between the employer and the employees. In the meantime, according to OSD policy, the Rural allowances will continue to be paid together with the new OSD structure to RNs working in those identified areas until the allowance is re-negotiated in the PHCDSBC (DPSA 2007:17).

(i) OSD for RNs and Staff Nurses on training

The respondents were discontent because those who were furthering their studies were seemingly not considered for the OSD. To them, it seemed that they forfeited their years of experience for services provided while in their previous ranks. However, the OSD does not provide for training ranks or grades (DPSA 2007:17). These students and pupil nurses would still be remunerated in terms of the current non-OSD employment and remuneration frameworks. These concerns were about the gap between services rendered and the commencement of their training. It seems convincing that these RNs were found deserving of study leave awards after competency assessments and interviews. Therefore, it is arguable that they were recognised for their loyalty and faithful service, which should have earned them credits with the allocation of the OSD, particularly since they were still under the employer's contract or employment when the OSD was implemented.

(j) Appointment of SNs to RNs' posts

According to the promotion rules for RNs, staff nurses and assistant nurses; employees who satisfy the SANC requirements to register as RNs must gain at least one (1) notch when appointed to RNs' post (General Nurse), or promoted to a higher grade, or promoted to a higher post. Similar conditions apply to nursing assistants appointed to staff nurses' posts (DPSA 2007:7). It should be noted that this section of the OSD addresses the period after registration as a registered nurse or staff nurse with the SANC.

(k) Vacant posts

The respondents expressed resentment and frustration that others in the same units with equal years of experience were earning significantly higher than they were. To clarify that disparity, the DPSA (2007:16) requires that when vacant posts in 'Specialty' areas cannot be filled, such posts be advertised on the salary structure applicable to the 'General Nursing stream'. These RNs, then, should not be compensated with a 'Specialty' salary by virtue of working in Specialty areas to cover staff shortages. The respondents held that the new pay system worked against the generalist nurses because, per definition, they were performing similar duties with specialising nurses in the same units without corresponding remuneration. This was a potential source of resistance, dissension, poor production, division, tension and shifting of responsibilities among RNs in those units.

(l) Request transfer to General Nursing post

This aspect is similar to the preceding one and is also covered by the DPSA (2007:16) statement that RNs with 'Specialty Nursing', who request a transfer to a General Nursing post, will have to accept a reduction in their notch and a lower scale attached to that post. If the employer initiates such a transfer, a lower grade attached to that post will be awarded, while they retain their salary notch. According to respondents, this grading did not consider patient

acuity levels in 'General' wards, which in most instances were equally or more hectic than 'Specialty' units, particularly if the transfer were arranged by the employer to cover staff shortages.

(m) Scarcity of study leaves

Some of the respondents indicated that the allocation of the OSD appeared not to have considered the shortage of staff and other logistics that hindered most RNs from taking study leave. According to respondents, these sacrifices were made by RNs in conjunction with NSMs in HCS to sustain health care delivery while government was working on strategies to recruit and retain skilled staff.

(n) Increased workload

Due to the shortage of staff, most of the respondents engaged in part-time studies indicated that exhaustion prevented them from completing their studies. Most of them felt that the additional qualifications could have assisted them to qualify for grade and post promotions. Their sacrifices thus appeared to have placed them in a disadvantaged position. Some respondents indicated being recalled from vacation and off-days to cover staff shortages, which interrupted their study programmes.

(o) Honours, Masters and Doctoral qualifications

Some respondents with academic qualifications were dissatisfied over a lack of consideration for these qualifications since the OSD document did not appear to elucidate specific positions about these degrees at the production levels. The main focus appeared to be on the "one-year" post-basic qualification accredited by SANC in R. 48 and R. 212. However, provision has been made for the post and salary structure for Clinical Nurse Specialists career stream in PHSDSBC Resolution 3 of 2007 to be implemented

immediately upon promulgation of the required Regulations (DPSA 2007:20). This should hopefully benefit RNs with (advanced) academic qualifications.

The foregoing inconsistencies clearly point to a serious information gap between the OSD policy and the employees' level of knowledge, as the respondents' remarks stand in stark contrast to the policy. Whereas section (14) of the DPSA (2007:15) states that the National Department of Health will "assist departments with implementation of the OSD through regular provincial visits", and "on a continuous basis monitor the implementation of the OSD", the respondents do not appear to be clear about the OSD, the conditions and terms applicable. As stated by the former President of the RSA, Nelson Mandela, citing Nehru (1976:520): "There is no easy walk to freedom anywhere, and many of us will have to pass through the valley of the shadow of death again and again before we reach the mountain top of our desires".

Recommendations

In regard to the above matters, the study makes the following recommendations:

- The OSD should be taken back to the bargaining councils to ensure that it includes experience in specialty units, long service and academic achievements because these are accredited by the SANC. Awarding a certain group of nurses does not solve staffing problems in the PHS, but could produce a dissatisfied, unproductive and divided nursing workforce. It is further recommended that the salary redress be preceded by research and sufficient consultation with nurses at the production level to solicit their ideas, so that the redistribution is based on consensus and understanding.
- Nurses need to be unified under one nursing organization that accommodates all the nurses in the RSA, where they can be briefed on proposed changes, ask questions, examine policies that affect them, and

agree or disagree based on proper understanding of the policy before it takes effect. Representation could be appointed from that forum to government and other decision-makers, to present nurses' concerns, requests and suggestions regarding change of policy.

- Nurses should be encouraged to venture into the political arena and not rely on mechanisms that do not fully represent their interests due to lack of deeper insight into and experience with nursing and health care issues.

- RNs who are on study leave should be considered for OSD because they have valuable experience and long service that requires equal consideration.

- The National Department of Health needs to follow through with assistance to departments regarding the implementation of the OSD through regular provincial visits and monitoring of the implementation of the OSD on a continuous basis as stated in (DPSA 2007:15).

- Recruitment and retention of skilled staff is not only about special salaries for certain skills. Accordingly, open communication between the DOH and nurses; adequate salaries for all nurses; improvement of conditions of public hospitals; tuition reimbursement; involvement in decision making, and ensuring that all employees are taken care of, are valuable strategies that should be employed by government.

6.2.5.11 Short courses

(a) Listed short courses

Further misunderstandings seem to emanate from the following short courses for RNs that were approved by the SANC and promulgated in Government Notice R. 238 of 13 February 1981, Government Notice R. 237 of 13 February 1981 and Government Notice R. 670 of 31 March 1983:

- Renal Nursing and Stoma Care Nursing
- Occupational health nursing and
- Spinal Injury.

The above Regulations for short courses were later repealed under Government Notices R. 1746, R. 1747 and R. 1748 in August of 1984 when the Council resolved that "it would no longer regulate short courses that were less than one academic year" (SANC 1984). However, according to Circular 30/84 (SANC 1984), these short courses could still be instituted only if needed, under the following conditions:

- Identified need at provincial or national level
- The SANC would consider these qualifications only for statistical purposes. This means that these qualifications do not "entitle the person to register to practice in a particular capacity or a registration certificate", because they have no status.
- Educational institutions would conduct their own examinations, and
- These institutions would provide certificates at the end of the courses.

Subsequently, as a response to a need identified by the national and/or the regional health departments in recent years, to curb skills shortages, which seemed to have been activated by excessive nurse migration from the PHS, educational institutions were allowed to present these short courses (SANC 2007b:1-2). The intention was to empower incumbents with needed skills to function under supervision of qualified RNs in those particular areas.

(b) Challenges encountered with Short Courses

- There was a drastic shift from the original intent of addressing a provincial or national need to personal and institutional interests.
- Quality assurance standards for the SANC to monitor these short courses were lacking.
- There was lack of compliance with the prescribed SANC guidelines by providers in that the short courses they produced caused confusion with the listed courses.
- There was a duplication of regulated advanced qualifications.

- The Nursing Act 50 of 1978 and the Nursing Act 33 of 2005 did not make provision for the registration of the short courses.

- The short courses on the SANC database were not registered with the National Qualifications' Framework (NQF).

- Of utmost importance was that there was no regulation for these short courses (SANC 2007b:1-2).

As a result, the SANC took a resolution to discontinue the listing of short courses, because none of the listed courses on the SANC database were accredited and quality assured. Nevertheless, nursing education institutions were allowed to continue conducting these short courses, examinations and certification as skills programmes or in-service education programmes only. Furthermore, short courses that fell within the scope of the SANC as an Education and Training Quality Assurance Body (ETQA), and complied with the requirements of the NQF for registration, would still be accredited by the SANC (2007b:2).

The foregoing underscores the discontent and frustration among many RNs who were involved in short courses that were not accredited by the SANC, because these short courses do not qualify them for the OSD, which could be the reason why the previous nursing rule discontinued them in 1984 (SANC 1984:1).

In general, the findings revealed possible lack of consultation with RNs to solicit their views on how government planned to distribute the OSDs, the SANC Regulations that would be followed to guide the process as well as the accreditation restrictions surrounding short courses. Sarkin (2000:288) argues that in an attempt to ensure cost-effectiveness in the delivery of care, legislation is often "pushed through without adequate consultation and negotiation, which leads to resentment from the affected parties". Roussel, Swanburg and Swanburg (2006:191) maintain that it "is better to retain nurses than to recruit them", because costs are contained, staff morale is high and there is high quality care.

Finally, the respondents' perceptions suggest that nurses' issues have not been handled in an appropriate manner by all parties that have a stake in nursing issues, particularly if they have to take courses that are not accredited by the SANC and are excluded from the OSD benefits.

Recommendations

- It is highly recommended that the SANC provides nurses, the DOH and the DPSA with a comprehensive list of post-basic courses, to augment additional courses listed in Regulation R. 212, which guides the allocation of the OSDs.

- It is advisable not to implement short courses in the future to address shortage of skills because they limit the independent function of nurses, there is no regulation for them and are therefore not recognized by the SANC for registration. Most importantly, they are encapsulated in a seemingly risky policy that seems to create a conundrum by aggravating the problem it was intending to solve.

- Consideration should be given to opening new nursing colleges to keep up with the demand of RNs within the country, in contrast to relying on mechanisms and tentative measures such as the OSDs, short courses and wooing RNs into medical assistant programmes to resolve long term problems.

6.2.6 Successful overseas exchange programme (OEP)

The World Health Organization (WHO) describes the OEP as a conscious strategy followed by China, Cuba, India and Ghana to send personnel to other countries on short-term remunerated contracts in order to acquire new skills, prevent 'brain drain' and foster cooperation between governments (Chanda 2002:160-161).

Most of respondents (56.3%) did not perceive the OEP as successful in the RSA; while some (30.0%) thought it was, and others (13.7%) were not sure

(see table and figure 5.18). The study had expected the academic hospital to lead in pronouncing it a success because the OEP was only implemented in some academic hospitals in Gauteng province, according to the DOH.

However, most of the respondents who were not sure came from the academic hospital. This would appear to imply poor dissemination of information on the OEP and its outcome.

According to the Gauteng DOH (2002), the purpose of the programme was to allow nurses to improve or broaden their professional skills by providing them with placement opportunities in London hospitals for two years, while their posts were preserved for them in the country. Their salaries and all other benefits, inclusive of medical aid schemes for their families, would be frozen in the meantime, as their salaries would be paid by the receiving hospitals. The contract required that at the end of the programme the RNs return to their hospitals to implement acquired knowledge and skills. Furthermore, the incumbents would be required to work for a "period equivalent to his/her absence on unpaid leave for the department plus an additional year, in an area of clinical specialty specified by the department" (Gauteng DOH 2002). Also, the departure or discharge from the department was subject to penalties that would withhold any financial remuneration due to them by the department, including any pensions accrued. Wilful termination of the contract would make nurses liable to repay immediately to the department a lump sum of money equivalent to the salary for the period owed with prescribed interests (Gauteng DOH 2002).

The researcher had the opportunity to discuss the course and outcome of the OEP with NSMs of the academic hospitals. One of these hospitals was involved in the study. Among other things, it became evident that the programme did not yield the desired results as most of the RNs who were involved did not complete the contracts signed with government; some returned to their hospitals because they disliked the programme, and others indicated that their placements and assignments at the host hospitals did not match the goals of the programme.

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Recommendations

Based on these findings, the researcher recommends the following:

- People who survey, plan and arrange such programmes for nurses should mainly comprise nurses and doctors if objective and progressive programmes are to be underpinned, because they have broader understanding and insight into the implications, success or demise of the programmes prior to implementation.
- This kind of programme might not be necessary because many RNs who had already left the country would come back with newly acquired skills once the PHS had been improved. Alternatively, to ensure the success of the programme would require total review of the terms and conditions of the contract to reflect the value attached to nursing and the personal needs of the RNs in the RSA by possibly not freezing some of their benefits, which are crucial, if not indispensable to their families.

6.2.7 Discontent among RNs is an observable reality

The quantitative data revealed that of the respondents, 83.0% found discontent among RNs in the PHS an observable reality while 10.7% did not (see table and figure 5.19). Respondents pointed out that discontent was evidenced by the enormous loss of skilled RNs to areas with better remuneration packages, good facilities and other service benefits. Also, some argued in written narratives that nursing was regarded as an essential service, yet their needs were not given appropriate attention until crisis started in the workplace. For that reason, some felt that nurses were oppressed in their own country because strikes were prohibited for public servants engaged in essential services. The following statements provide evidence of the frustrations expressed by RNs in the PHS as an indication of observable discontent:

- ➤ *"This is observable when looking at the absenteeism profile. Nurses get ill too often or have personal problems. Some complain of back pain and feet"* [RH]
- ➤ *"Because they sacrifice to work while understaffed and are not remunerated for that"* [DHC]
- ➤ *"We are overworked and work long hours with minimum rest and when you come to work you are not conducive"* [DHC]
- ➤ *"There are other reasons for dissatisfaction apart from financial compensation (salaries), e.g. no friendly work environment. Overworked, understaffed (lack of experienced staff to teach others – e.g. resuscitation, etc), stressed and irritable fellow employees taking their frustration out on others. Belittling and demeaning others"* [AH]
- ➤ *"RNs are the centre of a multidisciplinary team. If one member of a team is dragging, an RN has to see to it that clients are satisfied at the end of the day regardless, how? Responsible for everything that goes wrong; when good is done, no-one pats you on the back."* [RH]

These findings reflect the visible effects of a stressed nursing workforce, indicating substantial discontent. This observable state of discontent could exacerbate the response to the international demand for health personnel; hence, losing them would mean losing the opportunity for skills transfer to future generations (Stack & Hlela 2002:38; 41). The evidence shows further that having 'contented' nurses would significantly boost the nursing profession. Contented nurses become better carers and practitioners. Also, it could encourage a positive spiral that result in the appropriate policy milieu. Neglect of this aspect appears to aggravate nurse migration from the PHS, which has an impact on the health and prospects of all South Africans. Swanburg (1996: 472; 475) adds by stating that people want to hear their managers telling them that they are valued in order to be successful in today's unstable work environment. Italian nurses also reported similar shortcomings in their workplace where the absence of coordinators during difficult moments was a common factor, or supervisors were not interested in problem-solving (Cortese 2007:308). Managers should therefore be visible

and openly encouraging concerted effort towards the fulfilment of the vision, gathering information, and assuring workers that management cared about them.

6.2.8 Low morale associated with low salaries in PHS

The quantitative data also revealed that low morale among RNs in the PHS was associated with low salaries, as indicated by 85.7% of the respondents, while only 4.9% disagreed (see table and figure 5.20). The respondents who linked low salaries to low morale also cited lack of incentives for additional qualifications (e.g., Honours, Masters, PhD), and the high cost of living. According to the respondents:

➢ *"I think low salaries are actually what contribute most; and we thought that OSD was going to change things, but it has worsened things because of a huge different salary scale, amongst us as professionals especially doing the same work e.g., caring for the sick."* [RH]

➢ *"We are not motivated. Even if you can try to update yourself by doing special courses, you will not get any remuneration from that"* [RH].

Apart from low salaries, other reasons advanced by respondents for low morale included increased workload, staff-patient ratios, lack of equipment and lack of support from management. According to the respondents:

➢ *"It's not only low salaries, also patient ratio to nurse is too high. No support from management"* [DHB]

➢ *"RNs are overworked, thus they have low morale. Even if RNs are sacrificing, they are not acknowledged"* [DHA]

➢ *"Not all just salary. They want to work when they want to and not when asked to! The increase in salary made no change regarding the standard of nursing care or the loyalty of staff. Still passive."* [DHA]

It can be deduced from the preceding statements that low morale has already taken toll of RNs in the PHS, especially when they are apathetic towards their work. Du Plooy (2007:83) found that where low morale seemed to emanate not only from poor salaries, but that good performance was not acknowledged, whereas when mistakes were made, a nurse became "the talk of the town".

In an effort to find solutions for low morale in the workplace, James, Kotze and van Rooyen (2006:10) point out that replacement of staff who resigned, buying of equipment to facilitate quality care, and visible and measurable support from hospital management were some of the measures that could bring hope, courage and stability in the workplace. However, budgetary constraints and lack of finances for the creation of new posts appeared to be some of the impediments to such progress in the PHS. Swanburg (1996: 438) maintains that "nursing leaders can also act as buffers or advocates for nurses", by protecting nurses from external and internal health system factors such as the health care organizations, unions, government, the community, other departments and agencies. Moreover, nurses who enjoy such support have high morale as they tend to be confident and more productive in their work.

6.2.9 RNs contribute to change in hospitals

This item intended to elicit if RNs were involved in decisions pertaining to their institutions. The quantitative data analysis revealed that of the respondents 45.2% disagreed and only 36.2% agreed (see table and figure 5.33). The respondents stated that management did not practise management by objectives, but imposed unilateral decisions for implementation without consolidating RNs' views. This, according to respondents, was responsible for the drastic decline in health care delivery in the PHS:

> ➤ *"They believe they are on top, no need to discuss with employees, they just decide on everything without the people they are leading"* [DHC]

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> ➤ *"At meetings usually nurse managers give instructions. Whenever problems arise they discuss among themselves then give instructions on what to do in meeting"* [PH]
> ➤ *"They discuss among themselves and tell you what they have decided; they don't want RN's opinions"* [DHC]
> ➤ *"No one pays attention to the nurse's cry"* [AH]
> ➤ *"We hardly have meetings in our hospital with NSM"* [RH]

The respondents' remarks indicate that they have ideas that could make a difference if they were only given the chance and their ideas incorporated in improving HCS. This could be achieved by creating an environment where their talents and academic achievements gained recognition and were utilized to benefit the services. The data further revealed that employees, who were excluded from planning for improvement, became de-motivated and discontent, hence the tendency to look for alternative jobs.

James et al (2006:7) found that RNs in the RSA were disillusioned by disintegrating relationships between them and nurse managers, and the consequent lack of support, guidance and acknowledgement of their contributions. These results are consistent with Cortese's (2007:308) findings where lack of acknowledgement for work completed emerged as a central theme among Italian nurses, including insufficient positive feedback and compliments that would stimulate intrinsic motivation and assure nurses that their commitment was appreciated.

Daft (1999:159) cites the example of a company that involved its employees in decision-making processes. In that company, sufficient transparency from management was ensured, which led to open forums where employees were allowed to ask questions, share information and congratulate one another. Throughout this process, efforts were made to circulate information to all divisions of the company, thus increasing staff morale and efficiency, and retention of skilled professionals.

Unlike the preceding example, the recruiting and retention strategy alluded to by the respondents appeared to have divided nurses by benefiting only RNs with specialty qualifications as opposed to the entire nursing workforce.

6.2.10   RNs and migration

It should be noted that the hospitals involved in the study could not provide up-to-date statistics of changing patterns in hospital staffing since 1994, with specific reference to the number of RNs who had resigned their posts from the PHS as these could not be obtained from existing data systems. What compounded this problem was that people leave employment for different reasons therefore it might not necessarily have been discontent that motivated resignations. Some may have been attracted by the opportunity to acquire "different" experience and new skills or to change citizenship. Hence the information provided for each hospital in chapter 5 only covered a five-year period.

Regarding acquiring "different" experience as a reason for the migration of RNs from the PHS, 31.4% of the respondents considered it 'unimportant'; 27.6% considered it 'fairly important'; 18.8% considered it 'important' and 22.3% considered it 'extremely important' (see table and figure 5.40). These findings would imply that RNs were not seeking fun or thrills by migrating from the PHS. Rather, their decision to leave their families and children to work overseas appeared to be out of desperation for better salaries. According to a respondent:

➢   *"Die main rede hoekom nurses oorsee gaan, is oor geld. – om meer geld te gaan verdien"* (The main reason why nurses go overseas is over money – to earn more money) [PH].

Recommendation

Regarding the foregoing questionnaire items (sections 6.2.7-6.2.10), the study recommends the following:

- Health institutions should assess and provide accurate statistics for nurse migration from the RSA by conducting exit interviews without intimidating leavers, to establish reasons for resignations. Short questionnaires at international airport check-in points in the RSA, which are collected and submitted to the Department of Foreign Affairs, are another form of monitoring that could be refined to monitor nurses going abroad so that problems could be identified.

- Nursing managers should make every effort to present patient care and nurses' needs before policy makers for consideration when budgets are allocated.

- Management should attempt to reduce the number and length of meetings to devote more time to their employees in individual hospitals because many answers to questions are found 'on the floor'.

- Critical thinking skills to make good professional judgments and assertiveness to challenge unworkable strategies should be encouraged among RNs as opposed to doing work because it's routine or policy driven.

- Where possible, policies should reflect the views and aspirations of employees since they are the implementers thereof.

- Government should provide modern equipment to save time, improve quality of care and enhance nurses' enthusiasm for their work. Cost centres should be held accountable for their safe keeping and any damages that result from carelessness should be compensated from the budget of the cost centre.

- NSMs should make efforts to solicit RNs' ideas in meetings, and to exercise patience and kindness towards RNs, even under pressure.

- New employees should be made comfortable with a facilitator assigned for orientation, providing support by occasional visits to the units to find out

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how new members are settling in. Everything should be done to ensure that the experience of the new job matches their expectations to some degree.

- Providing resources such as rewarding additional qualifications and special achievements, study leave opportunities and hosting special issues forums could substantially reduce the level of discontent among RNs.

6.2.11 RNs are sponsored to attend conferences

The quantitative data analysis revealed that the majority of the respondents (72.6%) disagreed that nurses were sponsored to attend conferences (see table and figure 5.22). Based on these findings, it can be surmised that there are insufficient efforts in the PHS to expose RNs to conferences for personal and professional growth. There are many national and international conferences in which RNs could participate as a break away from routine patient care. This crucial exercise could arouse both external and intrinsic motivation for RNs to participate meaningfully through presentation of papers, and exchange of ideas with other health professionals to enhance their professional development. The International Council of Nurses (ICN), Sigma Theta Tau Lamda Honour of Society, Renal Care Society and the Pan African Congress are examples of organizations that host national and international conferences that could benefit nurses.

6.2.12 RNs are financed to do research

The majority of the respondents (73.7%) indicated that there was no financial support for RNs to conduct research (see table and figure 5.23). Support to research problems and envisaged projects for health institutions could assist RNs to assess the needs and identify factors to be considered when planning. The prediction of probable outcomes and prevention or control of the occurrence of undesirable outcomes of such programmes cannot be overemphasised. Besides making a meaningful contribution to the scientific

body of knowledge, nursing research improves the depth and breadth of the RNs' practice of nursing (Loiselle, Profetto-McGrath, Polit & Beck 2007:5).

Failure to provide financial support for research in the clinical area would exacerbate the discontent of RNs who were constrained by lack of financial means from research. Furthermore, presenting papers at health, academic and other forums would enhance their self-worth and morale as well as encourage furthering their studies.

Stack and Hlela (2002:30) maintain that lack of scientific data could hinder efforts for effective planning for hospital restructuring since hospital data lacks credibility for decision making in many instances. Nurses and doctors are capable of conducting meaningful research because they have provided accurate statistics and projections for the number of patients with particular patterns of diseases and their prognosis, assisted with plans for required services, provided numbers of patients and clients using health facilities, referrals and defaulters as well as patient/staff ratios based on patient acuity levels. Loiselle et al (2007:5) emphasise that some practices that "are based on tradition rather than on research are simply not the best way to do things". This view is consistent with Fitzsimmons, McCane and Armstrong's (2006:751) findings in Northern Ireland where only two of the seven health and care providers they studied had systems in place for forward planning based on research results. Fitzsimmons et al consequently emphasise that effective planning should be preceded by research capacity building. Therefore, with research findings, the chances of interventions producing desired outcomes would be enhanced.

Recommendations

Based on the findings (sections 6.2.11-6.2.12), the study makes the following recommendations:

- Health organizations should develop creative means to generate finances to sponsor RNs to attend national and international conferences, and conduct research. Companies that provide hospitals with medical equipment, hospital contractors, pharmaceuticals and banks could be approached to provide financial assistance for conferences and research projects.

- Nurses could launch fundraising events such as "Miss Health Care Beauty Pageant", musical choristers, and traditional dances in community halls, which would simultaneously serve as marketing strategies for the nursing profession.

- Hosting national and international nurses' conferences is a means to create the need for sponsorship from companies and large organizations. These events also generate revenue to further the interest of such projects, depending on the objective of these programmes.

- Feedback, oral presentations and spearheading trials or implementation of new projects within organizations should be made mandatory for RNs who were sponsored to attend conferences where research presentations were made. This would enable dissemination of information and motivation for other RNs.

- All health care institutions should have controlled internet facilities for RNs to access research results, announcements and on-line feedback on various conferences, as well as health care-related information.

- Hospitals should liaise with academic institutions for presentation of scientific papers on research done by nurses so as to encourage ongoing research in HCS. Nurses should also research problems identified in their health institutions after acquiring their degrees, and motivate others to do likewise.

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6.2.13 Opportunities exist for RNs' career development

According to the ICN (2007), career development assists nurses to advance their careers and also benefits communities with advanced skills to respond to social, scientific, technological, political and economic changes to meet identified health needs.

The findings revealed that of the respondents, 48.3% maintained that career developments for nurses were not readily available, and should be considered as something of the past, while 33.5% believed that though there were some career development opportunities, only a small number of RNs were able to access them because of favouritism, shortage of staff, and management's reluctance to release RNs for study purposes (see table and figure 5.24). According to the respondents:

➢ *"Career development in nursing is <u>ZERO</u>. Nurses are only seen as working forces to do the daily routine, not to develop their skills and build up their competency"* [DHA]

➢ *"To have more/higher qualifications than your manager becomes a threat with resultant creation of barriers to development"* [DHC]

These findings would indicate that career developments in the PHS have drastically declined, which could leave the PHS devastated if unresolved. Consistent with this finding, the level of burnout among nurses in Turkey was high because of lack of personal accomplishments (Alimoglu & Donmez 2004:553). In the RSA, career paths were either poorly defined or non-existent in the PHS (Stack & Hlela 2002:40). Lack of clearly defined pathways for nurses and midwives in the area of research was also evident across all twenty health and care providers in Northern Ireland. Moreover, very few organizations offered positions to Masters and Doctoral candidates (Fitzsimons et al 2006:751).

According to Snow (2008:12-13), the UK took a bold step when Prime Minister Gordon Brown announced the institution of protection systems for nurse training budgets and provided opportunities for career development for nurses that were on par with those of the doctors. This could have been an attempt to ease the burden of some nurses who were paying their own tuition and used their annual leave to advance their studies because of lack of support from their employers (Snow 2008:12). Pauline and Seamus (2007:626) found that 99% of nurses cited promotions to a higher position and extension of clinical roles as the main motivation for engaging in further study. However, Neuhauser (2002:473) advocates an internal environment that allows nurses to move through career pathing from one specialty to another, if they so wish. Career pathing is a strategy used by organizations to enable employees to attain personal career goals by encouraging competency through a reward system (ICN 2007).

In the RSA, the OSD for RNs, staff nurses and nursing assistants provides for career pathing in the PHS by means of grade progression at production level, and dual career paths.

6.2.13.1 Career pathing by means of grade progression at production level

This is not an automatic salary increase, but a periodic remuneration system which is based on above-average performance, qualifications and experience to facilitate progression at production level without RNs necessarily moving to supervisory or specialty post for salary increase (DPSA 2007:3). This appears to be a good strategy that endeavours to motivate RNs for better performance.

6.2.13.2 Dual career paths

RNs will progress to higher levels when entering specialised fields, with salaries equal to or higher than those of managers in general nursing without moving into management or supervisory positions (DPSA 2007:3).

Recommendations

The study recommends that nurses who aspire to advance themselves in professional development should not be harnessed by staff shortages, since denying them the opportunity would only exacerbate the problem as they could choose to resign their posts.

6.2.14   Workplace violence in the PHS

- **Security system for nurses in the workplace is satisfactory**

The study found that the majority of the respondents (75.8%) rated security measures for nurses as 'non-existent'; some (8.3%) rated the security minimal and inefficient, and others (16.7%) were not sure how to rate the present security (see table and figure 5.26). In written narratives, some respondents revealed that their personal belongings were stolen since no lockers were provided and nurses' cars were vandalised while they were on duty. A common factor reported by the respondents was that there were no cameras and no security in hospitals' main entrances and butler doors were mostly found in psychiatric wards. The respondents expressed the desire to have butler doors in psychiatric wards reinforced with security presence because of violent patients and few male nurses.

During field work, the researcher observed that the security personnel stationed at hospital gates were mainly focused on vehicles entering or leaving the hospital premises while pedestrians walked in and out freely. As a confirmation, some of the respondents indicated that security at main gate served mainly to safeguard hospital property and there was no consistency in the control of visitors and visiting times. Consequently, nurses' cell phones were stolen and there were arguments between nurses and visitors when nurses tried to implement hospital policy regarding visiting times. Noting that today's nurses were faced with one of the most complex and dangerous occupational hazards in HCS, McPhaul and Lipscomb (2004:8) found that the

common sources of exposure were related to taking care of violent patients, staff shortages, emergency rooms, psychiatric wards, unrestricted movement of the public and lack of "strong violent prevention programs and protective regulations". According to the respondents in this study:

➢ *"I have encountered visitors with a hand gun twice in this hospital already"* [AH]

➢ *"No gun device meganismes is op die premises op grondvloer. Besoekers kan die hospitaal besoek met vuurwapens sonder dat sekuriteit dit weet, en ons en pasiënte bedreig"* (There are no gun detectors on the premises and on ground floor. Visitors can come to the hospital with weapons, without security knowing, and threaten nurses and patients.) [PH]

➢ *"Daar is geen kontrole by enige ingang van sale nie. Sekuriteit het slegs sekere tye wat hulle kom rondtes doen, maar nie deur die hele saal nie"* (There is no control on all ward entrances. Security has specific times for doing rounds, but not through the whole ward.) [PH]

➢ *"Security personnel are lax, leave their posts unattended while loitering around."* [PH]

➢ *"We are not at all safe in the workplace – no security system … for people from outside. Hawkers come in anytime but visiting parents encounter problems …"* [AH]

➢ *"There are a lot of security risks in hospitals. No security, no alarm system. Anybody can gain in and out access in the hospital without control"* [DHA]

➢ *"Every nurse takes responsibility of his or her safety"* [RH]

➢ *"Outsiders come in at any time. Stopping and telling them they are not allowed or saying it is not yet visiting hour creates misunderstanding."* [AH]

➢ *"Nurses are bitten and robbed within the premises"* [DHC]

➢ *"Doors are not locking properly, security guards have no guns and sometimes during nights there is nobody on security"* [DHB]

> *"I have not seen any means of security for nurses in my institution"* [RH]

> *"There is no safety measure in public hospitals"* [RH]

> *"Community shout to security and nurses are not safe"* [DHB]

> *"Because when visitors come to the hospital they are not escorted"* [DHC]

> *"Security personnel don't know how to control visitors even when it's not visiting hours"* [AH]

> *"Verbal and physical abuse toward nurses +++"* [by patients] [DHA]

These comments revealed a nursing workforce that feels insecure in the working environment. There seem to be a necessity to bring these concerns to the attention of government urgently, before negative incidents multiply. Oosthuizen and Ehlers (2007:16) found that, like all citizens of the country, nurses were exposed to acts of violence and crime in their personal capacity and as health care providers in the workplace. However, some of the respondents seemed to suggest that some risk factors in the PHS could be minimized, such as redesigning assignments and tasks for RNs in public hospitals judiciously, as a safety measure. According to the respondents:

> *"Going to night supervisor's office at midnight for statistics instead of doing it telephonically"* [exposes RNs to danger] [RH]

> *"We have to go for report at 3 am. They refuse telephonic report"* [AH]

> *"Nurses run errands during the night without being accompanied by security. Patients usually attack staff or harass them with minimal intervention from management."* [PH]

> *"Especially during the night when we have to walk through the corridors, there are no security guards"* [RH]

These statements appeared to indicate that there are no precautionary measures to safeguard RNs from danger. Sending RNs on errands on night duty appeared to be a blanket problem in all the hospitals, which appeared too risky. It also suggested that staff coverage in the units was compromised

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while RNs run night errands, given the skeleton staff they worked with as indicated by some of the respondents. The ICN (2007) emphasises a safe work environment, stating that nurses should be protected from violence, occupational injuries and health hazards through mechanisms that ensure effective prevention, monitoring and reporting of real and potential incidences. This requires that protocols for withdrawal of services from life-threatening situations for nurses be implemented (see appendix F).

Recommendations

The researcher makes the following recommendations:

- Hospital management should review the communication system between night supervisors and RNs in the wards as a matter of urgency, and withdraw nurses from fulfilling the role of messengers which exposes them to danger in dark corridors. Porters or male messengers would be ideal for these errands on night duty, because male RNs are equally necessary for ward coverage and are often few, if any.
- Security at the main gates, the main ward entrances and emergency units, like casualty, should be reinforced. Security should also be required to patrol the staff parking areas, since visitors use the same parking areas in some hospitals. However, it would be better if all hospitals could provide secure parking exclusively for staff members.
- The government should consider outsourcing security services in all State hospitals to replace hospital-employed security. This could assist with control, monitoring and disciplining of members of the security agencies concerned.
- The security agency contracted should be liable to pay the hospital for any damages occurring as a result of carelessness on the part of security officials when the terms and conditions agreed upon have been breached.
- Any inefficiency with the security system should immediately be reported to the relevant hospital authority who, in turn, would take the matter up with the contracted company.

- Firearms should not be allowed in HCS, excluding policemen and security on duty. Devices for scanning firearms should be installed at all hospital main entrances.

- Visiting times should be strictly enforced and adhered to. In cases of unforeseen circumstances or emergency, security should alert the sister in charge of the unit in question.

- Alarm systems or buzzers would be ideal for all wards to alert security in corridors of any problems arising from the units. Modern buzzers for hospitals should be installed with a red flickering light and a controlled 'buzz' which indicates the unit in need of help.

- Security gates under security control in some of the hospital units could be ideal, depending on the results of further research and needs assessment mandatory prior to installation of any expensive devices. Good lighting systems in corridors at night cannot be overemphasised.

- Policies and training sessions for staff on proper management of violent patients and crisis situations are a necessary commodity in HCS. Also, The International Labor Organization (ILO), the WHO, the ICN and the Public Services International (PSI)'s joint programme on workplace violence in the public health sector, prepared by Richards (2003:6-25) is highly recommended.

- The ILO designed a similar code of practice in workplace violence in services sectors designed to develop practical responses in the workplace and provide guidance in developing national laws and policies that would minimize or eliminate workplace violence (ILO 2003).

- Lastly, after the murder of a State employee in the USA in 1993, the Californian Occupational Safety and Health Administration (OSHA) provided guidelines for workplace violence prevention programme outlined in McPhaul and Lipscomb (2004:8).

6.2.15   Stress is intolerable among RNs in the PHS

• **Stress levels among RNs**

The findings revealed that all the respondents indicated that stress had reached intolerable limits among RNs in their hospitals. Most of the respondents (80.6%) cited overwork with shortage of staff as the main reason for the intolerable levels of stress (see table and figure 5.28). Staff-patient ratios in all the units were of serious concern for the majority of the respondents, evidenced by the absenteeism, resignations and sickness among nurses. According to the respondents:

➢ *"R/Ns are de-motivated, burnt out, have lost interest in their profession. Lots of RNs are leaving the profession"* [DHA]
➢ *"Werkslading kan somtyds hectic raak, en jy voel jy kom nie by alles uit nie"* (Workload is sometimes quite hectic, and you find it hard to cope or manage everything.) [PH]

The preceding remarks concur with Rantho's (1999:11) finding that professional and support staff generally exhibited uncaring attitudes, which were attributed to high levels of stress related to conditions of service in particular. This concurs with Ruggiero's (2005:261) finding in the USA where there was a positive and significant correlation between job satisfaction and the number of weekends off per month.

The respondents' descriptions depict hospitals as extremely stressful environments to work in on account of constant interaction with the sick, thus, portraying nursing as a very stressful occupation. Rees (1997:35) points out, however, that some of the causes of stress were striving for excellence in the public health sector against budget constraints, and the drive for cost-effectiveness and organizational restructuring.

According to Booyens (2000:146), restructuring of HCS is one of the factors exacerbating stress in the workplace. Employees may find that there is no clarity or adequate information regarding what is expected of them. This could be accompanied by feelings of lack of support from management to implement change within the organization. The unprecedented enormity of resignations during reform initiatives therefore has stress-related consequences. Frequent changes in instructions, policies and procedures, especially where staff is deficient, also exacerbate stress for workers.

In Zondagh's (2005:38) view, failure to retain nurses and successful recruitment usually manifested in highly stressed nurses and low standards of care. Nieman and Bennett (2002:265) emphasise that it "does not make sense to spend time, money and human resources on appointing the right people to the right positions only to lose them because they are not looked after properly". Empowered employees attain their personal goals by accomplishing the objectives of the organization. In addition, satisfied employees are less stressed, keep their jobs, are loyal and productive, and always strive for excellence as they take ownership of their respective organizations.

However, there are 'non-financial' strategies that can be used to attract and retain skilled nurses to the PHS. Besides improving salaries and conditions of public hospitals, the care of all employees is also required. Appropriate use of their skills and talents and providing them with necessary tools to accomplish institutional goals could enhance job satisfaction and prevent excessive stress. This view is consistent with reports on the success of the Zuid-Afrikaans Hospital Cardiovascular Unit in the RSA, which was attributed to permanent staff that was well taken care of, and provided with the latest equipment, as a way of putting patients first (Du Plooy 2006: 5) (also see Appendix F), in line with the 1996 Batho Pele White Paper requirements.

6.2.16 Used vacation for rest

The respondents were asked if they ever used their vacation for rest. The findings indicated that 49.8% used their vacation to rest and relax, while 42.8% did not (see table and figure 5.29). According to the respondents, their vacation was used as follows:

- *Worked overtime* (65.8%) – Most of the RNs worked overtime in private hospitals and sometimes in their own establishments, to augment what they called 'peanut' salaries.
- *Household chores* (22.0%) – These respondents used their vacation for doing household chores because they did not have money for holiday trips.
- *Re-called from vacation* (5.1%) – This group said they were called back from vacation to assist with the workload because staff on duty could not cope.
- *Worked due to shortage of staff* (4.1%) – These respondents played a 'Good Samaritan' role by volunteering to make up for shortage of staff on their days off (eventually counted as overtime).
- *Part-time studies* (1.0%) – Some of the RNs were involved in part-time studies through Unisa and other educational institutions to upgrade their professional status, thus, vacation was the only time at their disposal to catch up with their studies.
- *Looking for another job* (1.0%) – This group used their vacation to search for new jobs in private hospitals, private laboratories, case management positions and fact-finding missions with international recruiting agencies for overseas employment.
- *Caught infection and stayed in bed* (1.0%) – Some of the respondents said they could not even attend to their family obligations because they were sick. This was attributed to exhaustion from strenuous work, exacerbated by overtime work, and infection acquired from work due to lowered resistance, since they frequently missed their lunch and tea breaks.

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6.2.17   RNs experience physical signs of exhaustion

The results revealed that of the respondents, 64.1% reported that they 'always' experienced physical signs of exhaustion because of overload of work, coupled with severe staff shortages in the PHS, while 32.8% 'often' felt physical signs of exhaustion (see table and figure 5.30). This data seemed to suggest that the respondents were exhausted from overextending themselves. This, then, had had adverse effects on their health status; coupled with the fact that most of them used their days off to work voluntary and mandatory overtime.

The respondents further alluded to the added responsibility of having to deal with an increased number of patients due to HIV/AIDS epidemic. The sudden increase in the number of patients, incompatible staffing ratios, financial constraints and increased exposure of the health personnel to additional health risks were some of the concerns raised.

More importantly, respondents seemed to be disillusioned by the outcome of free medical services without additional budget, staff, medication and equipment, and equal increase in salaries. Cognizance should be taken that free medical care has its roots in the *Freedom Charter* adopted at the Congress of the People in 1995. While the respondents acknowledged these privileges, the main concern was about the necessary capacity and tools to accomplish the tasks. According to the respondents:

> ➢   *"Nurses stand from the morning till the end of the day and due to burnout, they end up losing their temper easily"* [RH]
> ➢   *"We work very hard, at the end of the work I feel very exhausted, impatient and just want to sleep. A nurse will not have time to see his/her children* [when they get home] *due to heavy workload"* [DHA]
> ➢   *"We age early. divorce, unmarried, children out of hand"* [DHC]
> ➢   *"These days, people are very ill, because of this pandemic disease, so we experience very high exhaustion on a daily basis because of the high number of people per day."* [RH]

➢ *"We are always short staffed. You sacrifice your tea and lunchtime for the sake of the patients."* [RH]

➢ *"Movement slow. Conserve energy by sitting after procedures"* [AH]

➢ *"Nurses experience physical signs of exhaustion because of overwork. There is a shortage of staff in institutions, nurses work hard and become exhausted"* [DHA]

➢ *"When one is working night duty, which runs for 7 days, usually on the last night one feels the exhaustion"* [DHA]

The above statements find strong support from the MOH who found it "extraordinary that people continue to work in hospitals where there is so much dysfunction" (Cullinan & Thom 2008:3) (see appendix F). However, in their written narratives, respondents indicated that on very few occasions they used brief moments after procedures to sit down in order to preserve their energy. In contrast, in their attempt to establish whether burnout among nurses was a result of poor daylight exposure, Alimoglu and Donmez (2004:553) found that apart from sleeping disorders, there was no correlation between burnout and working night shifts among Turkish nurses.

According to Booyens (2000:146), the multiple roles of nurses played a significant part in their lives, with particular reference to married nurses. Conflict arises where there is a shift from the professional context at work to the role of a mother and spouse at home. Added to this is the strain of working cumbersome and exhausting shifts, which is further compounded by the fact that an individual's biorhythm takes long to adjust to changes in sleeping patterns. These factors in some cases led to divorce and confrontations with in-laws and husbands (Du Plooy 2007:34).

The increased workload due to the escalating numbers of patients and staff infected with HIV/AIDS emerged clearly throughout this study. Tackling this issue from the perspective of shortage of staff, this study wishes to emphasise that the time has come for strategies, informed plans and standardized approach to deal with HIV/AIDS effectively on a national level, be put in place. Since much research has been done on this subject, this will

require that nurses, doctors, academics, researchers and other groups consolidate efforts to revamp the entire policy on HIV/AIDS, and work together with government to reduce or combat the epidemic. This study also noted that nurses are also victims of this condition, as indicated by respondents.

The respondents cited long hours of work, eleven to twelve hours for seven days for day staff, and seven nights in a row for night staff, as very strenuous and with psychological and physical effects on nurses, as well as disturbances in their sleeping patterns. Consequently, some respondents had problems with their children who were too young to understand how exhausted they were, even to supervise homework.

According to the respondents:

➢ [Nurses] *"Limping movement, depressive signs, irritability, rudeness"* [AH]

➢ [Nurses] *"Swollen legs, orthopaedic movements; backache, arthritis"* [AH]

➢ [Nurses] *"Back trouble, lethargy"* [PH]

➢ *"Most of the time at the end of a shift RNs experience painful feet, mental exhaustion, lower backache"* [AH]

➢ [Nurses] *"Eyes red – feet and movement slow. Conserve energy by sitting after procedures"* [AH]

➢ *"I have developed serious heart problems, Dysrythmia and pulmonary embolisms!"* [PH]

➢ *"Shortage results = fatigue = stress = psychosocial illness"* [DHC]

➢ *"The morale is low. Increased shortage of nurses. Workload has increased. Backache and stress are common illnesses. Increased absenteeism."* [RH]

➢ [Nurses] *"Knees are always hot and painful, and back."* [RH]

Given these experiences, it seems unlikely that quality nursing care is possible with exhausted, burnt out and sick nurses who are aware that they

are not as productive as they should be under the given circumstances. At the same time, the respondents referred to government with severe budget cuts, the SANC with disciplinary hearings, management with uncaring attitudes, and the community with all the rights afforded them through legislation, as adding more pressure on nurses who are already exasperated and barely able to cope. According to the respondents:

- *"They work overtime for extra money – then take sick leave during normal hours. Passive at work"* [DHA]
- *"Because there is no appraisal for work well done, but only mistakes are taken into consideration. Nurses work under-staffed and they just pass the time"* [DHC]
- *"There is a lot of shortage which prohibits us from doing our proper nursing"* [RH]
- *"Extreme shortage of staff that affects nurses physically, mentally and emotionally, and on top of that one cannot take decisions on issues that affect you directly in the workplace"* [AH]

It was evident from the foregoing comments that the respondents had a sincere regard for their patients and seemed to care for the public more than the SANC and the provincial department, because they still arrived for duty in spite of the difficult situations they faced.

The results of this study supported Zondagh's (2004:39) finding that nurses with the highest numbers of patients reported emotional exhaustion, discontent, and were twice as likely to develop burnout. In addition, Koekemoer and Mostert (2006:87) in the RSA, and Piko (2006:315) in Hungary found that financial remuneration rated high among other causes of emotional exhaustion, and the number of years of employment in the health sector was a significant predictor of psychosomatic symptoms.

In order to resolve this dilemma, Carroll (2006:309) contends that nurses should break away from the hassle and bustle of busy wards because there

are limits to what the body can take. Furthermore, ignoring this simple principle could lead to burnout, which is not being tired, but being "completely drained of the capacity to care and to be objective about patient challenges nurses face". To add to this, Erlen (2004:290) considers it an ethical dilemma when it comes to caring for the 'patients' and 'self', yet it is not logical to continue caring for the others when caring is not reciprocated.

Addressing women's health, Makhubela-Nkondo (2001:viii) highlights the importance of considering the effects of workload, stress, nutrition, socio-economic status and numerous other factors on women since it is generally accepted that they are important determinants of disease.

Recommendations

In the light of the findings (sections 6.2.15-6.2.17), the study recommends the following:

- The number of meetings for NSMs should be reduced significantly to enable NSMs to spend more time planning for their organizations, identifying problems and being there when needed. Individual departments and hospitals should be given guidelines and projects to work on, with circulating facilitators from the DOH to assist where necessary.
- Nurses should not overstretch for the sake of covering for staff shortages. Carrol (2006:309) advocates that workers only consider leaving their organizations on condition that the organization is constantly understaffed, with perpetual high stress levels.
- The SANC should require substantial research to establish firsthand the appalling conditions under which nurses work.
- The SANC should create sufficient capacity for training young nurses in order to match increasing public health demands of the country.
- In order to fully protect the public from low standards of nursing, the SANC should assist, advise, negotiate and support HCS to secure a safe health environment with sufficient staff and equipment. This recommendation is

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consistent with the DPSA (2007:6) statement that the SANC provide general support, networking, liaison, customer care, negotiations, advice and make recommendations to assist in decision-making processes.

- Strategic thinking and planning should include nurses' opinions on issues pertaining to restructuring of HCS and other health-related matters.

6.2.18   Intentions to leave the PHS

Of the respondents, 45.8% contemplated to leave the PHS due to discontent; 27.6% indicated that they would stay in the PHS, while 26.7% were not sure (see table and figure 5.31). From this data, it can be assumed that there is a lot of tension and confusion in public hospitals, with seemingly no explanation given, particularly with the allocation of the OSD. There were also similarities in the respondents' reasons for intentions to leave the PHS, which were based on problems already identified, such as shortage of staff, long working hours, and lack of involvement of nurses in important decisions. Some of the aspirations that surfaced in this section were better opportunities, recognition, and personal, professional and organizational growth. According to the respondents:

➢ *"As from next year, I believe my brain can fairly serve me better to do what will build me better. How can I do a 4-yearr B.Cur Degree + honours and earn R106 per annum* [R106 000]*, with my matric certificate? Nursing is useless for a living"* [DHC]

➢ [In pursuit of] *"A better organized and ordered working environment, e.g. medicine in stock, meals arriving, files not falling apart, file papers in stock"* [AH]

➢ *"Busy studying further, would like to work in the industries for better salaries and working hours"* [DHA]

➢ *"Have left PHS; understaffing (severe), equipment (insufficient, inadequate) working environment undesirable"* [PH]

➢ *"Due to overwork load, community disrespect for nurses, poor communication. No respect for employees from management"* [PH]

➢ *"Because nobody appreciate one's input"* [RH]

➢ *"To get my morale high, because I don't enjoy this hospital"* [DHA]

➢ *"Stress, shortness of staff, struggling to get hold of doctors"* [AH]

In 2001, nurses in New Zealand also reported similar feelings of dissatisfaction with their current jobs and were intending to leave within one year for better places (Finlayson, Aiken & Nakarada-Kordic 2007:21).

According to one respondent who was undecided:

➢ *"Undecided, because I love my profession. But circumstances beyond my control will push me to do it. It is just a matter of time."* [DHA]

The implications of the findings would suggest that if nurses were content with their salaries, not overworked, and were made to feel valued by government, hospital management and society, they would stay in their current employment. Carrol (2006:309) supports intentions of workers to leave their organizations only on condition that the organizations were constantly understaffed, with perpetual high stress levels. In London, Barron, West and Reeves (2007:50) found that all estimates were higher for intentions to leave the current employment and not the nursing profession per se. Oosthuizen and Ehlers (2007:14) revealed that the overwhelming majority (95.5%) of the respondents in their study were motivated to consider emigration for financial reasons. In contrast to all the preceding results, Smith et al (2005: 527) found a high level of organizational commitment among respondents in the USA through loyalty and intentions to maintain their employment contracts.

Given the findings of the current study and results of other studies, it is concluded that among all major factors that influence decisions to leave, poor salaries seem to be foremost, followed by conditions of service, as also noted by Roussel et al (2006:192). This situation therefore suggests that without dramatic changes in the PHS, the health sector would continue to lose skilled personnel to areas that pay well and provide resources for RNs to apply their

skills, as also noted by the MOH that "no one wants to work in an unhappy environment" (Cullinan & Thom 2008:3) (see appendix F).

Recommendations

The study makes the following recommendations:

- Leavers should be profiled to determine the average age, marital status, qualifications, years of experience and other essential clues that could assist in addressing areas of deficiency in order to retain competent nurses (Roussel et al 2006:191).
- Nurse managers should take advantage of research as a crucial tool to identify areas that lead to discontent among nurses in order to rectify them.
- Exit interviews by an independent body should be intensified in order to provide an accurate report of the rationale behind resignations.
- Nurses should espouse the fact that even though they are committed caregivers, they are not 'supermen.' Therefore, it is necessary that they call hospital management if they cannot cope with the workload due to shortage of staff and that they use their days off for resting.

6.2.19   Nurses and strike actions

6.2.19.1   RNs prefer strikes to solve nurses' problems

The respondents indicated that government was not informed about the conditions under which they worked and the problems they faced in the daily execution of their tasks.   Most of the respondents (74.0%) indicated that nurses preferred strike actions to solve nurses' problems (see table and figure 5.HC41). According to the respondents:

➢   *"It* [strike action] *gets the government's attention, they do very little. At the end of the day not a lot changed"* [AH]

- *"There is only oppression in our country for RNs in our country. Not allowed to go on strike when things are not well"* [AH]
- *"Nurses are expected to be silent even when they work under stressful conditions such as short staffing, unsecured environment"* [DHA]

These results are consistent with Brown, Greaney, Kelly-Fitzgibbon & McCarthy's (2006: 203) findings in Ireland, where strikes by nurses was presented as unavoidable since there was no other option at nurses' disposal to push for better salaries. Secondly, apart from financial gain, it was also seen as a united effort to evoke public support. Lastly, it was an attempt to present nursing as a strong profession in contrast to "a perceived governmental representation of nursing as weak, unprofessional and lesser educated than equivalent groups".

At the same time, the genuineness and faithfulness of stewardship among the respondents was evident in the responses provided by those (19.0%) who were opposed to aggressive resolves such as strikes and migration from the PHS. These respondents unanimously opted for negotiations with government as indicated below:

- *"*[No to strikes] *negotiations, negotiations, negotiations"* [RH]
- *"Let government pay attention to our request, let the person at government level be a nurse because she/he will be knowing what is happening"* [RH]
- *"Negotiations and taking matters seriously by government before they get out of hand"* [RH]
- *"Managers should not cover up shortages and stop giving the impressions that nurses can cope"* [RH]
- *"Nurses to participate at government level e.g.*[to negotiate] *pay"* [RH]
- *"Demand of employees should be taken into consideration in respect to daily rising inflation rates"* [RH]

The preceding remarks indicated how critical contentment was in the nursing profession. Inner contentment triggers all the positive values in a nurse; hence most organizations invest intensively in the workforce to promote productivity and excellence in delivery. Content nurses are also more receptive to patients' needs, and likely to make more compassionate practitioners. The reluctance to protest was also clear in Brown et al's (2006: 204) study where Irish nurses saw strike as a government and union strategy enforced through policy that left nurses with no choice but to comply with, thus, leaving them with the ambivalence of being nurse and striker.

6.2.19.2 RNs and unions share similar values regarding patient care

The majority of the respondents (46.5%) disagreed that RNs and unions shared similar values (see table and figure 5.42).

These divisions in opinions revealed that the respondents could be cognizant of the status carried by their profession and had been able to draw distinctions between these dichotomous organizations. However, RNs appear to be driven by circumstances that require them to engage more aggressive means such as union-led protests in order to be heard by government, even though they did not share same values with unions regarding patient care. According to the respondents:

➢ *"Unions don't care about patients' care"* [DHA]
➢ *"Unions have not improved working conditions, only the salaries. Working conditions still remain the same, if not worse"* [AH]
➢ *"Unions want to please the nurses and not patient care"* [DHA]
➢ *"As die SANC nie tot ons redding kan kom nie, het ons geen ander uitweg as om na die Unions te gaan – kom voor hulle kry meer reg"* (If the SANC does not come to our rescue, we have no choice but to go to the unions – because they get most things right.)*"* [PH]

The respondents appeared to expect the SANC to assist nurses with problems encountered in HCS, while the SANC's role in nursing issues is to

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protect the public by making sure that health providers were certificated by the SANC to practise nursing in the RSA. Unions and professional associations exist mainly for the welfare of workers.

It can therefore be concluded that the sharing of nurses' concerns and moral vision with trade unions need to be reviewed in terms of competing values and moral preferences espoused by the two parties.

Recommendations

In regard to the preceding remarks, the study recommends the following:

- Serious consideration for a unified nursing organization that accommodates all the nurses in the RSA, where they can be briefed on proposed changes, ask questions, examine policies that affect them, and agree or disagree based on comprehension of the policy prior to implementation. One of the roles of this forum would be to represent nurses to government and other decision-makers, to present nurses' concerns, requests and suggestions regarding change of policy.
- Nurses should be encouraged to venture into the political arena and not rely on mechanisms that do not fully represent their interests due to lack of deeper insight into and experience with nursing and health care issues.
- National and provincial departments of health need to follow through with assistance to departments regarding the implementation of the transformation initiatives on a continuous basis, through regular visits, observation and monitoring of different phases of implementation.
- Open communication between the DOH and nurses; adequate salaries for all nurses; improvement of conditions of public hospitals; tuition reimbursement, and involvement in decision-making processes cannot be overemphasised.
- Proper utilization of acquired knowledge, skills and talents, and providing RNs with the necessary tools to accomplish institutional goals would enhance job satisfaction among all categories of nurses.

6.2.20   Nurses and politics

Mason, Leavitt and Chaffee (2007:121) describe politics as "a process of influencing the allocation of scarce resources – figuratively, influencing who gets a slice of the pie, how big it is, and whether they get ice cream too". From this description, it can be deduced that influence is only achieved through active involvement and effective communication. The role played by nurses in communicating with patients and various stakeholders in HCS is one of the powerful assets at their disposal that can be used to promote public health by becoming involved in shaping health and social policy.

This section was included in the questionnaire to elicit the extent to which nurses were involved or positioned to influence political decisions to favour the course of health care delivery and the nursing profession in the RSA.

6.2.20.1   Poor nurse representation in government contributes to migration

Apart from union affiliation, there seemed to be a serious deficit of information regarding available channels of communication between nurses and government. This question was used to establish whether there was a link between lack of nurse representation and nurse migration from the PHS.

Most of the respondents (78.6%) stated that there was no authentic representation for the nurses in government (see table and figure 5.44). With some of the nurses affiliated to unions and professional associations, the study had expected that the respondents would disagree with the above statement and rather indicate that unions and professional associations represented nurses. As a resolve for this apparent gap, the respondents indicated different strategies and views that they felt RNs could pursue:

➢ *"Change your job or institution. It's not everywhere so bad"* [PH]

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➢ *"An international migration is so important and helpful, because you learn many things and there are special resources that are used there"* [RH]

➢ *"Better educational opportunities and more experience in advanced medical technology"* [RH]

➢ [Some RNs] *"still remain in this disorganised field which we all want to quit from"* [DHC]

➢ *"We can still study and occupy senior positions within PHS"* [DHC]

According to Neuhauser (2002:470), HCS have embarked on many strategies to recruit nurses but failed to retain them. This author adds that a compelling work environment has the potential to reduce turnover rates because people tend to stick to organizations they like. Therefore, organizations need to build a culture that inspires employees to take pride in their work. This factor was evident in the following respondents' comments:

➢ *"People at government level do not know the conditions in which nurses are working and the problems that nurses encounter"* [DHA]

➢ *"They do not interact with nurses themselves, only with the organisations"* [DHA]

These statements suggest that the respondents were concerned about the quality of representation with government. Ehlers (2000:77) found that the fragmentation of the nursing profession between unions and professional associations in the RSA was responsible for failure of the nursing profession to form a united front that would influence political decisions that impact nursing and health care delivery.

Mason and Leavitt (1998:485) found that nurses in the USA had taken note of how clinical practice was increasingly influenced by decisions made by legislators and policy-makers who had no knowledge about patient care issues and the practice of nursing. As a result, nurses were using their professional organizations to engage politicians by writing letters (e-mails or

facsimiles) that spell out their concerns and requests, and inviting them to the workplace and nurses' events to brief them about nursing issues after the keynote speech had been delivered.

The ICN (2006:2) emphasises that educators could also take advantage of their negotiation power to advocate for improvement in remuneration and working conditions in the clinical area through dialogue with government officials and policy makers. The reason for this is that the development and retention of adequate skilled personnel has become the most critical political issue facing many African countries.

6.2.20.2 RNs vote for parties that add value to nursing

The data indicated that of the respondents, 46.8% did not agree that RNs voted for parties that add value to the practice of nursing, while 37.0% agreed, and 16.3% did not know (see table and figure 5.45). From these findings it seemed reasonable to assume that RNs did not have sufficient information and enthusiasm regarding the question of voting for parties that add value to the practice of nursing.

Byrd, Costello, Shelton, Thomas and Petrarca (2004:501) maintain that it is important for nurses to know legislators and identify their interest and commitment towards health-related legislation. This, they believe, will position nurses to make intelligent voting. In order to put the nursing profession in the spotlight of politics, the USA positioned nursing students by teaching them the principles of organizing and encouraging them to telephone, e-mail and write letters to legislators concerning issues that pertain to nursing, so that after they take office they can bring nurses' issues to the table. This exercise was seen as crucial to the preparation of students to be able to influence public policy.

6.2.20.3 RNs know how policies are made in government

Of the respondents, 52.2% indicated that nurses had no knowledge about the question of policy formulation at government level; 30.4% indicated that nurses were familiar with policy formulation, and 17.4% did not know (see table and figure 5.48).

Not only should nurses be expected to know the process of policy making, but also to be familiar with legislative jurisdiction so that issues are taken up with the relevant authority. Mason and Leavitt (1998:482) found that most voters were familiar with the names of presidents, but were not conversant with their State representatives or key members of staff appointed to research and draft policy proposals. In the USA, the nursing curriculum is structured in such a way that nursing students are afforded an opportunity to experience the political process in action in the State House, where the nursing profession is welcome and applauded by legislative leaders for their participation in political processes.

6.2.20.4 RNs can influence policy making

The majority of the respondents (73.4%) indicated that nurses had the potential to influence policy making at provincial and national levels (see table and figure 5.49).

Ehlers (2000:79) postulates that nurses could influence policy making processes through their collective experience and cumulative knowledge as patient advocates and experts in their field of work. The time has never been as ripe as it is today for nurses to help shape health policy in the RSA. As the largest cadre in HCS and experts in health care delivery, nurses can advise policy-makers on the requirements and costs of quality care delivery. This also emerged clearly in Forsyth and McKenzie's (2006:209) study on contemporary nurses' discontent conducted in Australia, where recommendations were made that a wider and more extensive nursing involvement in the international policy arena and the global politicization of nurses be considered to alleviate the current shortage of nurses. In keeping with this view, Cohen, Mason, Kovner, Leavitt, Pulcini and Sochalski

(1996:260) advocate that the influence of nurses be extended to other policy arenas because of their active participation. This would appear to indicate that nurses elsewhere could also take up positions in political debates about public policy in health care issues for the benefit of the nursing profession and their communities instead of relying on unions. To do so, however, would require an understanding of how to lead both in the clinical and political spheres by developing their political leadership skills.

Stack and Hlela (2002:24) refer to the 1997 meeting of clinicians from different departments under the injunction of the DOH (RSA), to formulate proposals for facility and service planning in public hospitals. The purpose was to establish suitable requirements and locations for launching new service ways of public service delivery within the framework of restructuring and rationalization of hospitals. According Stack and Hlela (2002:24), the proposals that were submitted were subsequently considered unaffordable and therefore not feasible, resulting in the province implementing unilateral decisions in an attempt to contain costs. As a result, most clinicians had lost confidence in the provincial leadership, which was described as lacking hospital perspective, and therefore most health providers opted to leave the PHS. National policy making was therefore not sufficiently informed by implementers, which could have largely accounted for its lack of success.

Recommendations

Based on the findings, the study makes the following recommendations:

- The nursing curriculum should be revamped to include Political Science as an additional course for nursing students in order to equip them with political skills.
- Nursing students should have the liberty to participate in Parliamentary sessions to gain practical experience in understanding the political process that leads to policy formulation, policy change, drafting of legislation and the course of political debates.

- Nurses should use websites to familiarize themselves with different political parties and know their leadership and proposed policies for the country.

- Nurses should interact with policy-makers through telephone calls to their offices, e-mails and letters, and formal visits to their offices to make requests for nursing concerns and ask questions in order to get nursing back on the country's agenda for planned reforms.

- Nurses should organize themselves and in unison invite specifically the President of the RSA, where they can submit their proposal to the President for the appointment of nurses in public offices which include the portfolio of Minister of Health, Deputy Minister, MEC for health and other high ranking positions. This is exemplified by the significant impact in politics made by Mrs Albertina Sisulu, Mrs Adelaide Tambo and the late President Samora Machel of Mozambique, who emerged from the nursing profession. This would require the drafting of a meticulous and reasonable proposal, which spells out the significance and reasons for such a request.

6.3   AUTHENTICITY OF COLLECTED DATA

In order to confirm the trustworthiness of the results, the researcher noted the need for ensuring issues of validity, reliability, credibility, dependability and transferability of the research findings throughout the course of the investigation (Polit & Beck 2008:705-751; Lincoln & Guba 1985:317). To enhance this process, an attempt was also made to link the background information outlined in chapter 1 and the literature review in chapter 2, which provided the context of discontent among RNs in the PHS, to the quantitative (questionnaire-based) and qualitative (written narratives) findings of the study.

6.4   CONCLUSIONS DRAWN ON FINDINGS

The researcher drew the following conclusions from the findings:

- *Government policies:* Most of the South African health policies are very advanced and among the best in the world, but seem to have encountered problems with implementation. Interference for implementers (RNs) seems to emerge from many instructions, conflicting ideologies and opinions from hospital management, different unions, professional associations, the provincial DOH, the SANC and patients. This pointed to too many groups discussing nurses' issues with government, and making decisions for nurses without involving nurses, thereby leaving nurses disillusioned, including those who are not members of trade unions.

  Furthermore, some of the decisions and resolutions agreed upon between the government and bargaining councils appear to work against some of the nurses, further dividing them and failing to accomplish the intended purpose because nurses' input does not appear to be solicited. This means that the problem is not with the nurses and neither is it with the decision-makers (government level), but in between, where much information is either distorted or lost, resulting in confusion and ignorance of crucial clauses entailed in the OSD and other policies.

- *Nursing exits:* Nurses who left the PHS seemed to have acted within their constitutional rights, because without adequate financial, material and human resources, it is impossible to provide quality care and to function efficiently. The golden rule is that government provides resources and workers bring skills.
- *OSD:* The OSD strategy does not appear to have been a good recruiting and retention strategy to address staff shortages and nurses' salaries in the PHS. Instead, it appears to have caused confusion, disparity and division among nurses who were committed to one cause within the PHS. Consequently, some of the RNs with long service in the indispensable

'Generalist Nursing' stream of nursing would apparently retire frustrated and poor, after serving the government and the South African society faithfully.

- *Provincial government:* The provincial government seems to have problems communicating with employees in HCS because the constitution has made provision for employees to join unions or professional associations of their choice, which represent them to government. This could possibly have caused government to rely on these organizations to convey information to employees, which does not seem to work, because the respondents indicated a lack of crucial information that affected them and their work milieu.

- *Follow-up by the DOH:* The nursing fraternity appears to be severely fragmented between unions and professional associations, which possibly makes it extremely difficult for government to monitor the dissemination of information as intended, or whether unions representing nurses are really operating under the 'informed' mandate of their members.

- *Workshops by the DOH:* No workshops appear to have been conducted by the DOH prior to the implementation of the OSD in the PHS. The respondents reported that the media was their chief source of information, which raised questions about the content of mandates given to their representatives for negotiations with relevant bargaining councils.

- *Legal access to government:* The study found no active communication between nurses and government. The respondents' perception was that everyone except nurses appeared to have had access to government about nurses; for example, unions and professional associations to the PHSDSBC; provincial governments to national government; NSMs and hospital CEOs to the provincial government, the South African Qualifications Accreditation (SAQA), the media, the SANC, and patients.

- *Postgraduate qualifications:* The OSD gave no consideration or recognition to RNs with Honours, Masters and PhD qualifications at production level. Because of this discrimination, the academic side of nursing (Honours, Masters, and PhD) could drastically decline or be extinct in the future, which should be avoided at all cost.

- *Hospital management:* NSMs and CEOs appeared to be experiencing problems leading the diverse groups of nurses who operate under the leadership of different unions, making it difficult to bond together in decisions, in order to craft the way forward with united nursing aspirations and needs.

- *General salary increase:* In contrast to the respondents' expectation (based on undocumented information they were given), the OSD did not entail a general salary increase for all employees in nursing occupations, nor that all nursing employees would gain the same financial benefit with implementation of the respective OSD (DPSA 2007:3).

- *Poor leadership in nursing:* There appeared to be leadership problems in the PHS because most of the appointed officials in hospitals and government positions were not nurses or doctors, and thus lacked understanding, experience and insight into practical experiences (on the ground) of the very essence of nursing and public health care delivery. Expertise in these particular areas seem to be key to their success, order and excellence in delivery of care.

- *Research:* Implementation of some decisions and programmes did not appear to have been preceded by research, both at national (the OSD) and provincial levels (the OEP). As a result, there seem to be lack of data to support implementation efforts where pitfalls could have been predicted to avoid failure of these projects.

- *Available skills in the PHS:* The provincial government did not appear to be taking advantage of the wealth of competent, committed and highly skilled health care professionals within the country when planning changes within the PHS.

- *The SANC:* The respondents perceive the SANC to be an enemy of nurses and a friend of the public.

- *Nurses in politics:* Nurses appeared not to be involved in the general politics of the country, and most did not know how policies were made at provincial and national levels. As a result, they seemed to rely on unions to represent them to government, even though according to the constitution they have the right to belong or not to belong. Also, the

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nursing curriculum in the RSA does not include Political Science as a subject, which appears to be a serious deficit in these times of political awareness and unionization of HCS.

- *Safety and security issues:* Hospitals are no longer safe for nurses and their patients due to increased criminal activity and poor surveillance.

- *Poor working conditions:* The HCS appear not to be suitable for expected quality care and for providing appropriate practical area for nursing students because wards are poorly equipped, RNs were overworked, tired, and sick and most were apparently frustrated with the outcome of the OSD and conditions of public hospitals.

- *Time for change:* 'Change', in the spirit of the words spoken by the 'then' Senator and Democratic party candidate elect for 2008, Barack Obama during his campaign for Presidential elections in the United States of America, also echoing the 'then' President of the RSA, Thabo Mbeki's words, "Business unusual" in his State of the Nation address on 8 February 2008, seems to be what is required to resuscitate the nursing profession and the entire health care system in the RSA (Mbeki 2008; Obama 2008a).

6.5   LIMITATIONS OF THE STUDY

The researcher identified the following limitations in the study:

- Because of the enormity of this study, it was the advice of the statistician that the Pearson's correlation coefficient measures be excluded in this study. This quantitative aspect of the study could have assisted with comparisons of the mean values relating to differences in, and the degree of discontent among RNs in terms of age, race, qualifications, marital relations, residential areas and type of health care service.

- Since the nursing profession primarily comprises females, very few male nurses in all establishments were able to participate in this study. This limitation is detrimental in that it deprived this study of the richness that could have been achieved by comparing the female and male nurses'

perspectives with regard to perceptions and themes that emerged during the study.

- The researcher had planned to use a simple random sampling technique with all its advantages. However, due to different shifts and shortage of staff that hindered this choice of method, a convenient and a purposive sample were used to advance the objectives of this study.

- The salary scale for RNs in private hospitals could not be obtained for reasons beyond the researcher's control. This would have been helpful in comparing private and public health sector salaries to further determine if salaries take pre-eminence over conditions of service.

- The study focused on RNs, which automatically limited the ability to generate or generalize study findings to other categories of nursing.

6.6   AREAS FOR FURTHER RESEARCH

The researcher recommends the following areas for further research:

- This study's main target was the RNs in the PHS. The inclusion of enrolled nurses (ENs) in the pilot study became instrumental in revealing that this category of nurses also experience discontent in one way or another. Therefore, it is highly recommended that an independent study investigating discontent among ENs in the RSA be conducted. By capturing their views and opinions on this subject, new strategies could be developed to make the workplace and the nursing profession a better place for them.

- Another category of crucial importance in both the public and private health sectors in the RSA is the enrolled nursing assistant (ENAs). Even though they are the lowest category in the nursing profession, their valuable contribution in the workplace cannot be overlooked. As the researcher interacted with various categories of nurses in hospitals, it became apparent that a study that exclusively targets the ENAs was an absolute necessity.

- An independent study should capture the views of the RNs who took employment overseas. This group is considered to be rich information sources as they could provide reasons that led to the decisions to leave the PHS.

- The nurses who migrated to the private health sector can provide valuable information regarding the 'pull factors' in private hospitals, in order of importance.

- A study among matriculants and/or community members to establish the status of nursing in public opinion, with the aim of finding ways of attracting the right brand of students to the nursing profession.

6.7   CONCLUSION

This study set out to explore discontent among registered nurses in the public health sector in Tshwane Metropolitan Area. The major findings on the perception of RNs regarding current circumstances surrounding them, the conditions under which they work, causes and contributory circumstances to discontent among RNs in the PHS, as well as recommendations for identified problems were presented. This chapter concluded with conclusions, limitations of the study and topics for further research.

While this field research was valuable in exploring the intricacies of discontent among RNs in the PHS, Douglas (1976) in (Miles & Huberman 1994: 265) points out that it can also be "considered as an act of betrayal, no matter how well intentioned or well – integrated the researcher. You make the private public and leave the locals to take the consequences." The above data was therefore precisely presented with views from respondents, and not the researcher's ideas.

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