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ANA	American Nursing Association
EC	Eastern Cape
DENOSA	Democratic Nursing Organisation of South Africa
GP	Gauteng Province
HCS	Healthcare service
HLA	Healthcare Leadership Alliance
ICN	International Council of Nurses
ILO	International Labour Organisation
KSAs	Key Service Agreements
KZN	KwaZulu-Natal
LRA	Labour Relations Act of 2002 as amended
NCHL	National Centre for Healthcare Leadership
NYSNA	New York State Nurses' Association
OSD	Occupation-specific Dispensation programme
RNs	Registered nurses
SANC	South African Nursing Council
SPSS	Statistical Package for Social Scientists
WC	Western Cape
WHO	World Health Organization

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1. INTRODUCTION

Within the parameters of the legislation in South Africa in line with the provisions of the Labour Relations Act (LRA) (South Africa 2002:s 65), all employees have a constitutional right to embark on a strike action. From 1980 onwards, the incidence of strike action in South Africa increased at a steady rate, owing mainly to the rise of unions representing employees. Initially, most of the strikes were illegal but due to revised labour legislation, increasingly more labour action was followed using official processes (Bendix 2007:242).

Though provisions of the LRA (South Africa 2002:s 65), allow for a right to strike, employees working within defined essential services, such as nurses, are excluded from using strike action as a means of industrial action. The healthcare strike action that rocked the South African public hospitals and clinics in 2007 and 2010 respectively, have highlighted the trend of professionals leaning towards their rights as employees to embark on strike actions, often also in solidarity with other categories of employees. These incidences placed into the spotlight the tension between rights, responsibilities, professional norms and values (De Carvelho 2011; Dhai, Etheredge, Vorster & Veriava 2011:58-59). It was also noted that strikes in which public healthcare workers participate are at odds with any acceptable professional norms, often accompanied by violence (Brand 2010).

The interest of the researcher to embark on this study was because of the potential and real impact of nurses going on strike. An understanding of the factors that result in nurses going on strike and how healthcare consumers experience this as well as the question of whether strike action has had the anticipated effect, will contribute towards finding a balance between the tension that could exist between professional imperatives and human rights of both nurses and healthcare consumers.

1.2. THE BACKGROUND TO THE RESEARCH PROBLEM

Many studies, nationally and internationally, have tried to explore various aspects of the tension and potential tension between what is regarded as professional ethical behaviour and growing human rights awareness. This is a dilemma within the public health discipline and of importance is the argument of ethics of practice against self-gain (Kunene 1995:74-77; Mabange 1998:37-39; Ngqiyaza 2007:1; Ngwenya 2009:147). A limitation of these studies is the transferability of the findings to a national South African context.

Exploring the views and factors driving nurses to get involved in strike action and its impact will assist healthcare providers and policymakers in managing the gaps and expectations between the employer and the employees in South Africa's public health sector towards a better management strategy of professional nurses, incorporating the standard of the World Health Organization (WHO) (2007:1-4).

During the periods of strike action in 2007 and 2010, media focus was more on the ethical aspects of the need to deliver essential healthcare services than on labour law and human rights issues. Muller and Coetzee (1990:30-40) in their study reported that unrealistic workloads and exploiting working conditions may be contributory factors to an untenable working environment for nurses.

A literature review on strike actions by nurses employed in public healthcare facilities within a South African context highlighted a need for an effective national management strategy to prevent or manage work-related challenges that result in increasingly unhappy nurses who then embark on and participate in strike action (Kunene 1995:157, 160-164; Kunene & Nzimande 1996:46; Mabange 1998:62-73).

In terms of the LRA (South Africa 2002:s 65) and within the overall legislative framework of South Africa, the nursing profession is classified as an essential service, which limits any category of nurse from participating in strike action.

Although the bases for excluding essential workers in terms of service delivery for the good of the population is understood, this limitation is in contradiction with constitutional and human rights (United Nations 1949; Crema 2005; Monkam 2010:15; Worugji & Archibong 2009:118; South Africa 1996). Many studies, nationally and internationally, have tried to explore some aspects of this dilemma within health disciplines and the importance of argumentation for or against individual human rights and self-gain as opposed to rights to access health care (De Carvelho 2011; Dhai et al. 2011:58-59; Brand 2010; Ketter 1997; Kangasniemi, Viitalähde & Porkka 2010:629).

The establishment of trade unions globally including South Africa; and the principle of freedom of association, resulted in increased numbers of professional health workers who prefer to affiliate with trade unions that represent a mixture of professional and non-professional workers, as opposed to a mainly professional organisation or trade union. For trade unions that work for the interests of a diverse group of people, often within a specific industry such as health, frequently revert to industrial actions such as strikes, in their negotiations. Members are often expected to actively participate in these actions, despite any other profession-specific rules or obligations.

With the advent of democratic government in 1994, nurses could belong to any professional association or union of their choice, and therefore started to engage in strike actions under the provision of Section 5 of the LRA 66 of 2002 as amended (South Africa 2002:s 65). However, under the provision of this law, nurses provide essential services and are therefore prohibited from abandoning their duties and engage in strike action (Searle, Human & Mogotlane 2009:221-227).

Although ethical codes form a key driver for nursing practice, Sasso, Stievano, Jurado and Rocco (2008:821) and Uys (1992:34) maintain that it is simplistic to expect professional nurses not to strike when they feel that their employer does not honour their employment contracts or when negotiating processes during bargaining discussions fail (Ogunbanjo & Knap van Bogaert 2009:307). It has

become a norm that industrial action is the key to having demands met (Kunene 1995:2).

In 2007, 2009 and 2010, strike actions including large numbers of professional nurses in public healthcare facilities, occurred in South Africa. These incidents impacted severely on service delivery in the public health sector. Vulnerable and ill people were largely deprived of effective and competent professional care (Urbach 2010; Van Wyk 2011; TNS Research Surveys 2007:67-69).

The limited scientific documentation on the factors which lead or contributed to nurses in public health care facilities choosing strike action despite professional norms and values in South Africa (Ngqiyaza 2007:1; Kunene 1995 74-77; Ngwenya 2009:147), and the researcher's opportunity for direct informal contact and interaction with nurses as a member of the community during these strike periods, although not a nurse herself, gave impetus to this study.

1.3. PROBLEM STATEMENT

Assess and ascertain the factors and processes embedded in the decision of nurses working in public healthcare facilities to participate in industrial action despite their ethical code of conduct, and describe proactive strategies to maintain a balance between human and professional rights of nurses, and the responsibilities of nurses within the legal framework of South Africa.

1.3.1 Sub-problem one

Assess and ascertain the factors embedded in the decision of nurses to participate in strike action despite their ethical code of conduct.

1.3.2 Sub-problem two

Describe proactive strategies to maintain a balance between the human and professional rights of nurses and their responsibilities within the legal framework of South Africa.

1.4. AIM OF THE STUDY

The primary aim of this study was to assess contributing factors for public healthcare nurses' participation in strike action and describe proactive strategies for balancing human and professional rights of nurses and their responsibilities within a legislative and professional framework in South Africa.

1.5. RESEARCH QUESTIONS

The following research questions guided the study:

- Why do nurses participate or don't participate in strike action?
- What is the value and impact of strikes as perceived by nurses who participated in strike action?
- What is the impact of strike action by nurses as perceived by healthcare consumers?
- What do nurse managers understand of the changing environment of nurse practice?
- What can be done to prevent strikes by nurses?

1.6. RESEARCH OBJECTIVES

The following objectives are stated in order to achieve the aim of the study and address the research questions:

- To explore the factors that result in nurses joining or not joining in strike action within the existing legislative framework of South Africa.
- To assess the value of strike action as perceived by nurses.
- To explore perceptions or views of healthcare consumers about nurses' participation in strike action.
- To explore nurse managers' understanding of the changing environment of nurse practice.
- To describe the strategies that can be used to prevent strikes.

1.7. SIGNIFICANCE OF THE STUDY

Findings of the study will assist nurse managers and policymakers to proactively address issues that contribute to nurses' involvement in strike action, thus prioritising the well-being of people in need of public healthcare serves.

1.8. DEFINITION OF TERMS

1.8.1. Strike action

Strike action is one form of industrial action provided for in Section 64 (1) of South Africa's LRA 66 of 2002 as amended. It is defined separately from other forms of industrial action given its relevance to the research problem being investigated in this study. There are two types of strikes that need to be explained within the context of this study. The two types include a legal protected strike and an illegal unprotected strike. A legal protected strike is a strike that complies with the provisions of the LRA 66 of 2002 as amended; and an illegal unprotected strike is one that does not comply with the provisions of the Act (South Africa 2002:s 66).

The legal protected strike is embarked upon after using statutory resolution procedures defined by the LRA in Section 64 (South Africa 2002:s 64). The illegal unprotected strike is embarked upon contrary to the provisions of the LRA (South

Africa 2002:s 65). For the purpose of this study, focus will be on the impact of strike action on public healthcare services and healthcare consumers.

1.8.2. Professional nurses

Professional nurses are all nurses registered under relevant sections of the previous and current Nursing Acts, namely Nursing Act, 69 of 1957 as amended (South Africa 1957), Nursing Amendment Act, 50 of 1972 (South Africa 1972), Nursing Act, 50 of 1978 (South Africa 1978), and Nursing Act, 33 of 2005 (South Africa 2005); (Searle et al. 2009:50).

In this study, the term refers to all registered nurses employed in any public healthcare facility.

1.8.3. Nurse manager

This is a trained registered nurse with the South African Nursing Council (SANC), with an additional qualification in management, who is employed in a managerial position in a healthcare facility.

1.8.4. Healthcare consumer

A healthcare consumer is any actual or potential recipient of health care, such as a patient in a hospital, a client in a community mental health centre, or a member of a prepaid health maintenance organisation (*Mosby's Medical Dictionary* 2009, sv "healthcare consumer").

For this study, a healthcare consumer is defined as a person or group of people across the lifespan that needs access to health care in public healthcare facilities.

1.8.5. Labour relations

This term refers to the formalised relations between employers and employees within the public health sector in South Africa. Formalised relations function within the labour legislation framework.

1.9. THEORETICAL FOUNDATIONS OF THE STUDY

The right to strike is a universally accepted principle enshrined in the 1948 Universal Declaration of Human Rights (United Nations 1949). This right is covered in the Constitution of the International Labour Organisation (ILO) (Crema 2005; Monkam 2010:15; Worugji & Archibong 2009:118). Although there is no direct reference in the ILO Convention to the right to strike, the supervisory bodies of the ILO have consistently affirmed that the right to strike is one of the essential and legitimate means by which workers and the trade unions may promote and defend their economic and social interests (Monkam 2010:15; Lee 2009). The ILO's supervisory bodies further reaffirm that a right to strike is an integral part of the free exercise of the rights guaranteed by the Convention (Monkam 2010:16; Worugji & Archibong 2009:123). While there is consensus that the right to strike is an indispensable instrument for the exercise of workers' economic and social rights, there is an ongoing debate about the need to strike a balance between the protection of these rights and the need to guarantee essential public services in order to safeguard citizens and their well-being (Crema 2005; Kangasniemi et al. 2010:629).

The ability of workers to form, join and run associations without undue interference, is critical to their ability to effectively defend their rights (Cruess & Cruess 2011:549). Healthcare professionals enjoy the same collective action rights as other employees (Worugji & Archibong 2009:118; Brand 2010; Burns & Goodnow 1996:26-27). Although the health sector provides an essential service, this fact only precludes its members from work stoppage in certain exceptional circumstances. In the light of the United Nations' jurisprudence on freedom of association focusing on the treatment of governmental organisations (NGOs) and political parties, the

interpretation of the core aspects of the right can also be applied to professional associations and trade unions (Brand 2010). The latter are also the subject of relevant ILO standards. Healthcare professionals such as nurses, have a legitimate right to defend both their professional status and their financial interests, and they must be well represented by unions of their choice in negotiations of such issues (Cruess & Cruess 2011:549; Briskin 2011:1; Hinarejos 2008:714; Ketter 1997:323). With very few exceptions, strikes or the threats of strikes in many countries deal with either healthcare professionals' remuneration or working conditions (Cruess & Cruess 2011:550; Bateman 2009:416; Briskin 2011:1; Ketter 1997:324; Muula & Phiri 2003:208; Beinin 2009:450; Lima 2009).

Strike action is a legally protected right of workers (Brand 2010; Goel & Karn 2011; Worugji & Archibong 2009:123; Monkam 2010), and is not embarked on without careful forethought. However, there are still nurses who are concerned that a strike action is ethically inappropriate (Cruess & Cruess 2011:550; Robertson 2012; Mawere 2010; Burns & Goodnow 1996:27; Kangasniemi et al. 2010:631). Most unions, including the Democratic Nursing Organisation of South Africa (DENOSA) that represents nurses in South Africa for collective bargaining, have written country-specific guidelines regarding strikes (DENOSA 2010; Ketter 1997:327; Beinin 2009:449). The issue of strike is difficult for any group of workers (Ketter 1997:328). The American Nurses Association (ANA) has held consistently for 50 years that nurses have a professional responsibility and an ethical duty to maintain employment conditions conducive to a high quality of nursing care (ANA 2011. Sometimes that means entering into a controlled strike action to achieve those conditions (Worugji & Archibong 2009:117; ANA 2011; DENOSA 2010; European Federation of Nurses Association 2011). In general, nurses who strike do so with the goal of attaining the ultimate good, both for patients and themselves (Mawere 2010; Dierckx de Casterlé, Izumi, Godfrey & Denhaerynck 2008:541).

In South Africa, the SANC is a regulatory body for the practice of nurses and the rights of patients, and therefore regulates that nurses who engage in a strike action in neglect of their patients' rights, may be subjected to disciplinary action (SANC

2011). Balancing ethics and a constitutional right to strike in a health discipline, has become a point of contestation (Mawere 2010; Briskin 2011:1; Fashoyin 2008:581).

Both the SANC and DENOSA emphasise that nurses will always have an ethical responsibility towards their patients, regardless of what legislation allows or does not allow (Garbers & Potgieter 2007:12). When strike action is contemplated, the rights of employees and employers usually feature prominently. However, in the health service the rights of the patient should not be neglected and should be taken into consideration as a matter of priority (Garbers & Potgieter 2007:12; Goel & Karn 2011).

However, literature indicates that nurses do participate in strike action and in large numbers in many countries, including the United Kingdom, Australia, Japan, Israel, Ireland and Portugal (Briskin 2011:1; Lima 2009; Gyamfi 2011:1; Sala & Usai 1997:332). In South Africa, there were two main waves of serious strikes in the health service in 2007 and 2010, which took a considerable long period and had an impact on the well-being of patients (TNS Research Surveys 2007:4; Stuart 2010:4; Van der Walt & Bekker 2011). Despite the historic resistance of nurses to unionise, because of their proportional large numbers and perceived low wages and poor working conditions, nurses are now more likely to be in unions like any other occupational group (Briskin 2011:2; Hinarejos 2008:714; Beinin 2009:449-450; Pera 2011:144).

It is reported in a number of studies that when nurses must decide whether or not to strike, they mostly consider the impact that their decision will have on every facet of their life, both professionally and personally (Ketter 1997:323; Robertson 2012; Burns & Goodnow 1996:27-28; Mawere 2010). Ultimately, nurses decide to strike to secure a safe and productive work environment, and also to provide for own basic needs (Motala 2009; Pera 2011:145; 146). Others believe that strikes by nurses may be morally justified, even mandatory, under certain conditions (Ketter 1997:324). In South Africa, most nurses belonging to unions partake in strike action, while those who did not get involved in strike action, sympathised with the

group in strike action as they worked with a heavy heart (TNS Research Surveys 2007:64; Ketter 1997:324). Other nurses, while not in favour of strike action, stayed away from work for fear of intimidation and the possibility of violence (Smith 2010; Parliamentary Monitoring Group 2010).

In exploring literature, two questions are raised. Firstly, could ethical values, norms and standards of professional nurses still be the utmost important factors to compel professional nurses not to partake in strike action to raise their challenges? Secondly, if nurses chose to strike, are they abandoning their commitment to preserve life? Both these questions raise a need for effective strategies that would proactively deal with issues around disillusionment with the structure and conditions of nursing, which include working conditions, nursing shortages, promotional opportunities and salaries, thus aiding in curbing the need to strike by nurses (Pera 2011:145).

1.10. THE RESEARCH DESIGN AND METHODOLOGY

1.10.1. Research paradigm

The study was conducted in three phases using both qualitative and quantitative approaches. A qualitative pilot phase was conducted to effectively inform the construction of a questionnaire for phase one and phase two of the study. Qualitative approaches contributed to an in-depth understanding of factors influencing the nurses' involvement or non-involvement in strike action, and captured and discovered meaning once the researcher became immersed in the data. Concepts were explored in the form of themes, motifs, generalisation and taxonomies. Qualitative approaches are particular and replication is very rare (Babbie 2010:75-76; Silverman 2010:275-286). Quantitative research is about asking people for their opinions in a structured way, so that the researcher can produce facts and statistics to address the research aim and objectives (Creswell 2009:3-4).

The phases of this study were informed by part of the literature review on two major strikes that took place in South Africa during 2007 and 2010 respectively. During these strikes, a large number of professional nurses participated in strike action, as informed by literature earlier. Therefore, the involvement by nurses in strike action as healthcare providers became a point of interest to the researcher as an environmental health practitioner but not a nurse by profession.

The study was limited to four target provinces namely, Eastern Cape (EC), KwaZulu-Natal (KZN), Western Cape (WC) and Gauteng (GP). These provinces were selected since they feature South Africa's metropolitan areas and experienced strike actions by nurses in the public health sector in 2007 and 2010. It was agreed with the study supervisor that these provinces would provide an acceptable national view on the focus of the study, given the budget limitations of the study.

A qualitative research approach was used for the **pilot phase** prior to the subsequent three main phases of this study. The pilot phase was conducted qualitatively to explore and ascertain factors identified through a literature review as contributing factors for nurses' involvement or non-involvement in strike action. This approach was used as a preliminary process towards constructing a questionnaire to assess and ascertain nurses' views on factors that influence their decision to strike or not to strike. This questionnaire was also designed to determine the perceived value of strike action amongst those who participated.

In **phase one**, the insight obtained from the explorative pilot phase was used to construct a questionnaire to assess and ascertain nurses' views on factors that influence their decision to strike. This questionnaire was also designed to determine the perceived value of strike action amongst those who participated. The quantitative approach allowed the researcher to get a larger sample using a self-administered questionnaire that was sent electronically or delivered to 80 nurses in the public health sector that were selected for the study.

In **phase two**, a quantitative approach was used. The questionnaire developed in phase one was used, with the adaptation of the respondent being a nurse manager. This has been applied to determine nurse managers' views on factors leading to nurses' strike action and to determine their understanding of the changing working environment of the nurse practice.

In **phase three,** an exploratory qualitative research approach was followed. A discussion guide was used to aid exploration of views on how healthcare consumers experienced the provision of health services while nurses were on strike. Four group discussions were held with ten participants in each of the four provinces selected for the study.

1.10.2. Research design

A descriptive, exploratory and analytic design was used. According to Creswell (2009:3-4) and Plano Clark & Creswell (2010:65-67), a descriptive design provides accuracy by describing what exists, the frequency with which it exists, ascribe new meaning to a phenomenon and put information into categories or themes. A descriptive design also provided for both qualitative and quantitative data. The phenomenon under study is presented both in narrative types of description and statistical analysis (Babbie & Mouton 2003:81; Saldaña 2011:71; Luttrell 2010:163; Mokoka 2007:150).

The study included a pilot phase followed by three main phases, as preluded in **section 1.10.1** and outlined below.

Pilot phase: Exploring factors that contribute to nurses' involvement in strike action

In the pilot phase, an exploratory process using in-depth interviews was followed amongst nurses who participated and those who did not participate in strike action during the strike actions that took place in South Africa in 2007 and 2010. This mainly assisted the researcher to determine what questions were required to

effectively explore the research objectives of the study. The output of the exploratory process was used as the basis for construction of a quantitative research instrument to assess and ascertain the factors and processes embedded in the decision of nurses' participation in strike action.

Phase one: Nurses' views on strikes

In phase one, the insight gained from the exploratory process of the pilot phase was used as the basis for construction of a quantitative research instrument to assess and ascertain the factors and processes embedded in the decision of nurses' participation in strike action. Nurses' views on the benefit of strike action as healthcare providers, were also assessed in phase one. The phase-one questionnaire was adapted to cater for the subsequent phase two of the study aimed at addressing set objectives.

Phase two: Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

The questionnaire constructed in phase one of the study was adapted to cater for nurse managers as respondents. The focus in phase two was to determine nurse managers' views on factors that contribute to nurses' participation in strike action and their understanding of the changing nurse practice.

Phase three: The views of healthcare consumers on nurses' participation in strike action

In phase three, community members that used public healthcare facilities during strike action in 2007 and 2010, were engaged with through group discussions. This was done to assess their views on the perceived impact that might have been caused by nurses' involvement in strike action and how that impacted on them in receiving the required public healthcare services.

1.11. STUDY POPULATION

Different study populations were used to explore the study aim and objectives. These population groups were drawn from the four target provinces (EC, KZN, WC, GP) in South Africa as indicated earlier, which this study was limited to due to budget limitation. The understanding of the researcher is that the spread of respondents or participants in these provinces would provide a fair understanding of areas explored to address the study objectives. The exploratory nature of the study would allow for limiting the study to these four provinces.

Pilot phase: Exploring factors that contribute to nurses' involvement in strike action

Registered nurses employed in public healthcare facilities in GP formed part of the participants for the pilot phase. GP was selected as the pilot province given its accessibility to the researcher, time and budgetary constraints. It was also one of the provinces to be included in the study for implementation of the three main phases of the study and experienced strike action in 2007 and 2010. The criteria for selection of participants in this phase was based on nurses' employment in public healthcare facilities and whether they participated or did not participate in strike actions in South Africa, either in 2007 or 2010.

The selected participants for the pilot phase did not form part of the main three phases of the study. Their contribution was limited to the pilot phase.

Phase one: Nurses' views on strikes

Registered nurses employed in public healthcare facilities in the target study provinces (EC, KZN, WC, and GP) formed part of the respondents for phase one. The criteria for selection was based on nurses' employed in public healthcare facilities and whether they participated or did not participate in strike actions in South Africa, either in 2007 or 2010.

Phase two: Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

Nurse managers working in public healthcare facilities in the four selected study provinces were included in phase two of this study. This allowed the research to explore the views of managers on strike action by nurses in public healthcare facilities and their understanding of the changing environment of nurse practice in South Africa.

Phase three: The views of healthcare consumers on nurses' participation in strike action

Healthcare consumers that needed or tried to access healthcare services during strike actions either in 2007 or 2010 were selected as study population for phase three. Their views and experiences were explored by means of focus groups.

1.12. SAMPLING

According to Trochim (2004), sampling is the process of selecting units (e.g. people, organisations) from a population of interest so that by studying the sample, the researcher may fairly generalise results back to the population from which they were chosen. In this study, a non-probability sampling was deemed relevant and the researcher used purposive and convenient sampling of professional nurses who are employed in public healthcare facilities and registered in the Nursing Council of South Africa's practice register (Creswell & Plano Clark 2011:173). The non-probability sampling approach is concerned with identifying cases that would enhance the researchers' understanding about the processes and interactions within the specific context of the study (Neuman 2003:211; Welman & Kruger 2001:61-62). It is important to note that the sample for this study was limited to the willingness of nurses who participated or did not participate in strike action to be included as part of the study, as the focus of the study objectives was perceived sensitive and could have rendered respondents prone to some form of intimidation.

The sampling for each phase of the study is outlined below.

Pilot phase: Exploring factors that contribute to nurses' involvement in strike action

The pilot phase focused on an exploratory process to derive at questions for the construction of a quantitative research instrument for phase one and adapted for phase two. Therefore, a sample of ten nurses employed in public healthcare facilities was selected for this phase, as it was not meant to be exhaustive but only indicative of areas to be focused on. An equal split of nurses who participated in strike action either in 2007 or 2010 working in public healthcare facilities was ensured to have a balanced view of opinions to address the study aim and objectives.

Phase one: Nurses' views on strikes

For effective and thorough exploration of the study objectives, 80 professional nurses who are conversant in English were selected from public healthcare facilities within the provinces selected for this study. The respondents were selected on the basis of them being employed in public healthcare facilities in South Africa and whether they participated or not in strike actions during 2007 and 2010. When selecting the sample, the researcher considered the respondents' affiliation or non-affiliation with DENOSA or some form of union group, as this could have a bearing on their level of involvement or non-involvement in strike action. The nurses were selected from accessible healthcare facility sites around EC, KZN, WC and GP. The limitation to only accessible healthcare facilities to the researcher was due to the perceived sensitivity around the objectives of this study.

The researcher ensured a fair spread of representation of nurses who participated in strike action and those who did not participate in strike action – both categories working in public healthcare facilities that were affected by strike actions.

Phase two: Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

The sample for phase two consisted of 12 nurse managers at accessible healthcare facility sites that were affected by strike action in the four provinces selected for the study. The twelve nurse managers were selected using a purposive and convenient sampling approach. The sample was spread across the four provinces. Firstly, this sample was meant to augment phase-one findings in terms of determining possible similarities in views of nurses and nurse managers regarding nurses' involvement in strike action; and secondly, to describe strategies that can be used to curb nurses' involvement in strike action. The sample size was therefore decided upon the need to get some indication on the latter-mentioned factors. This was also to allow for the budgetary limitations of the study, yet not compromising the depth of the study.

Phase three: The views of healthcare consumers on nurses' participation in strike action

In phase three, 40 participants were selected from communities which experienced strike actions by nurses in their public healthcare facilities. The healthcare consumers were selected on the basis of them having been at the public healthcare facilities or sought healthcare services from these facilities during the strikes in 2007 and 2010. This sample was spread across the four provinces selected for the study, and was decided upon noting that this phase was not meant to be representative of the whole population in South Africa. The sample was rather meant to provide depth and insight on public views about the perceived impact on healthcare consumers by strike actions in public healthcare facilities.

1.13. DATA COLLECTION

Burns and Grove (2002:49) describe data collection as the precise, systematic gathering of information relevant to the research purpose. In this study, the researcher paid attention to the use of relevant questions and methods of data collection to address the research objectives at each phase of the study.

The data-collection methods for each phase are outlined below.

Pilot phase: Exploring factors that contribute to nurses' involvement in strike action

The exploratory process of the pilot phase included the use of an in-depth interview guide for gathering qualitative insights to inform the quantitative instrument for phase one and phase two of this study. The in-depth interview guide was developed in English only and administered by the researcher. Given that the participants for this exploratory phase were registered nurses, the researcher assumed that all participants would be conversant in English as per the selection criteria referred to earlier.

Phase one: Nurses' views on strikes

A semi-structured quantitative research instrument was used for phase one and subsequent phase two to collect data that effectively addressed the objectives of the study. The research instrument was in English only, given that all respondents were qualified professionals able to understand the language. However, the researcher is also conversant in isiZulu, Sepedi (Northern Sotho) and Xhosa, given the language profile of the provinces selected for the study. Therefore, the researcher would have been able to converse in the preferred language, should a need arise.

The quantitative research instrument was constructed as a self-administered questionnaire to minimise any form of intimidation that the respondents may perceive when completing the questionnaire in the presence of the researcher, even though they would have given prior consent.

Phase two: Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

A semi-structured self-administered questionnaire in English only, developed during phase one, was adapted to cater for the nurse managers as respondents.

Phase three: The views of healthcare consumers on nurses' participation in strike action

In phase three, data was collected through the use of focus groups with 40 healthcare consumers in the four provinces selected for the study. A discussion guide was developed in English only and translated during discussions by the researcher. To collect the correct information during the discussions, the researcher was conversant and able to understand the languages used in the selected provinces. The languages used by the researcher during discussions for translation with healthcare consumers were mainly isiZulu, Sepedi (Northern Sotho) and Xhosa, given the language profile of provinces selected for the study. The participants were made to feel comfortable in an environment conducive to engage in discussions with focus groups by following guidelines outlined in detail in Chapter 3.

1.14. DATA ANALYSIS

According to Trochim (2006), data analysis involves three main steps, which include data preparation, description of the data and making inferences from the data.

Data collected from the four phases of the study were checked for accuracy, captured, cleaned and prepared before analysis.

Pilot phase: Exploring factors that contribute to nurses' involvement in strike action

Qualitative data from ten in-depth interviews collected during the exploratory process of the pilot phase was captured in a form of transcripts using the Microsoft Word 2010 computer programme. Data was colour-coded and themes determined in line with the objectives of the study. The identified themes were used to develop a semi-structured questionnaire to reach a bigger sample of 80 nurse professionals who worked in public healthcare facilities that were affected by strike action either in 2007 or 2010 (Saldaña 2013:8-9; Bernard 2011:429-434).

As the pilot phase was conducted to inform the questionnaire for phase one and phase two of this study, reporting on the findings derived at during this phase are limited to the methodology chapter of this study, as it was part of the methodological planning phase of the study.

Phase one: Nurses' views on strikes

The quantitative data from the self-completion questionnaires was checked for accuracy and captured. Descriptive statistics were used to describe the basic features of the data, using the IBM® SPSS® Statistics Version 21 (2013) computer software package (Jackson 2012:116-130).

A correlation analysis was valuable to check for influence of variables on each other and causal relationships between dependant and independent variables (O'Neil 2009:18-19; 28). In this study, the dependant variable is the involvement of nurses working in public healthcare facilities in strike action during 2007 and 2010, while independent variables are factors that contribute to nurses' involvement in strike action.

Phase two: Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

In phase two, quantitative data analysis approaches were used. Questionnaires were verified for accuracy and the data captured in the IBM® SPSS® Statistics Version 21 (2013) computer software package. Descriptive statistics were also

applied to understand the data, and inferential statics to determine any correlations between variables.

Phase three: The views of healthcare consumers on nurses' participation in strike action

This phase was mainly qualitative in nature; as a result, qualitative data analysis approaches were applied for analysis. The data was captured in a form of transcripts using the Microsoft Word 2010 computer programme. The researcher colour coded the data and determined themes in line with the objectives of the study (Saldaña 2013:8-9).

1.15. VALIDITY AND RELIABILITY

1.15.1. Quantitative data

- **Internal validity**

  The respondents selected to complete the self-administered questionnaire in phase one and phase two were not selected from the same section of the public healthcare facility. This limited any competition between respondents or form of intimidation when completing the questionnaire. Questionnaires were completed privately by all respondents (Laerd 2012).

- **External validity**

  The study was conducted in a variety of places, with different people and at different times. Therefore, the external validity (ability to generalise) will be stronger the more the study approach is replicated in different provinces (Trochim 2006).

  Though respondents were from different geographical areas, they would have all been exposed to the effect and impact of strike actions in the public health

sector at approximately the same period – whether by virtue of practice or manager expectations.

Respondents were assured of confidentiality to minimise the response dropout rates.

- **Quantitative data-gathering instrument**

Reliability

Cronbach's alpha was used to determine the internal consistency or average correlation of items in a survey instrument to gauge its reliability (Reynaldo & Santos 1999).

Validity

The semi-structured self-administered questionnaire for phase one and phase two were piloted amongst professional nurses and nurse managers working in public healthcare facilities, to assure that the construct of the research is effectively measured.

The researcher documented the procedures for checking and rechecking the instrument before finalisation and throughout the study. Another independent researcher assessed the instrument in line with pilot data gathered to double-check validity, and the process was documented.

1.15.2. Qualitative data

- **Credibility**

Leading questions in the discussion instrument of the exploratory process of the pilot phase and that of phase three of this study were avoided, as they might have compromised the true reflection of the participants' views. It was also important that the researcher develops a good rapport and a trust relationship

with the participants. It was important to inform nurse participants during the exploratory process of the pilot phase and healthcare consumers in phase three that the researcher is not a nurse by profession, but an environmental health practitioner and researcher. This was meant to enhance the possibility that participants respond more freely and for nurses without fear of being professionally judged. This enhanced the credibility of the data.

- **Dependability**

  The researcher documented the procedures for checking and rechecking the instrument before finalisation and throughout the study. Another independent researcher assessed the instrument in line with pilot data gathered to double-check validity and the process was documented. In order to address the dependability issue more directly, the researcher reported the processes within the study in detail, thereby enabling a future researcher to repeat the work, if necessary to gain the same results (Shenton 2004:71).

  Triangulation of data is important to validate themes coming out from the findings (Neuman 2003:179-185). The relevant literature was used in the discussion of findings, to triangulate information for control.

- **Confirmability**

  The researcher took steps to ensure as far as possible that the study findings are the result of the experiences and ideas of the participants, rather than her characteristics and preferences (Shenton 2004:72).

- **Transferability**

  Transferability of the instrument is based on the context to which the instrument was to be applied, and the researcher's professional decision.

The interview guide (Annexure D) for the pilot phase and the discussion guide (Annexure H) for phase three, were pre-tested amongst professional nurses working in public healthcare facilities and amongst healthcare consumers respectively, to assure that the construct of the research was effectively measured.

1.16. ETHICAL CONSIDERATIONS

According to Mokoka (2007:30), maintaining ethical standards implies whether the researcher shows the ability to conduct the research, maintains honesty in managing resources, acknowledges sources and supporters during the study and provides an accurate report of the findings.

Approval was obtained from the Research and Ethics Committee of the Department of Health Studies at the University of South Africa (Unisa). Consent letters to inform participants and respondents of the nature and purpose of the research were sent to each individual for scrutiny and signing. Ethical principles of confidentiality, protection from intimidation and the right to withdraw at any stage were emphasised.

The study might pose a risk of intimidation of nurses who chose to participate or not to participate in a strike. To cater for this risk, the researcher ensured that respondents from the healthcare facilities were not selected from the same section of the healthcare facility.

To ensure confidentiality, in-depth interviews were conducted at a time and place, and at a venue decided on by the interviewee. The candidates were provided a choice to withdraw at any stage of the interview should they feel uncomfortable or intimidated.

The research involved individuals and not any institutions. Individual informed consent was obtained in writing as indicated earlier.

The researcher is not a nurse by profession, but understands the health environment as well as the legislative framework in terms of her own professional background as an environmental health practitioner and her current work as a public opinion researcher in government. This made it easier for the researcher to minimise bias.

- **Summary of the steps followed to uphold ethical standards**
  - Approval was obtained from the Research and Ethics Committee of the Department of Health Studies, Unisa (Annexure A).
  - Permission to conduct the study was obtained from all nurses and nurse managers that participated in the pilot phase, phase one and phase two of the study (Annexure B).
  - Permission to conduct the study was also obtained from healthcare consumers that participated in phase three of the study (Annexure B).
  - Relevant information regarding details of the study and the expectations of the researcher were provided to all respondents and participants that participated in different phases of the study.

  - The researcher provided the respondents and participants with her contact details where she could be reached for any matters concerning the study or their participation.
  - Data collected and captured in electronic MS Word and SPSS (Statistical Package for Social Scientists) files are password-protected from unauthorised persons, to ensure confidentiality in the study. All discussion recordings are locked away by the researcher as backup material.
  - Respondents or participants of the research remain anonymous to ensure that responses are not linked to particular individuals. Their privacy was also respected.

- The researcher was guided by a promoter experienced in the field of nursing research, especially with the researcher not being a nurse. This ensured that ethical standards are maintained.

1.17. SCOPE AND LIMITATIONS OF THE STUDY

The study was limited to professional nurses and nurse managers within the public health sector and public members using public healthcare facilities in the four provinces selected for the study.

Ethical considerations were of importance for accessing information. Equally important, was the willingness of the professional nurses at the facilities to participate with consent in the study on matters related to the service and their participation in strike action.

1.18. STRUCTURE OF THE THESIS

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

Chapter 2: discusses the literature review conducted on nurses' involvement in strike action and the underlying factors that result in their participation in strike action. The chapter further discusses the theoretical framework of the study and potential models for proactive management strategies of strike action in public health facilities in South Africa.

Chapter 3: discusses the research design and methodology, including data collection, data-collection instruments, the pilot study, and ethical considerations.

Chapter 4: focuses on data analysis, interpretation of findings and literature control.

Chapter 5: discusses the limitations of the study, draw's conclusions and makes recommendations for nurse practice and further research.

1.19. CONCLUSION

This chapter gives context and an overview of the study. The background to the research problem and rationale, problem statement, research questions, aim and objectives and research methodology applied in the study are discussed. The theoretical foundations guiding the parameters of the study are outlined.

Terms that are important throughout the study were defined, based on their applicability to the study. Methodology and analysis approaches were discussed, including the ethical standards that have been adhered to in the study. The scope and limitations of the study were stated and informed by the aim and objectives of the study. The chapter further outlined the organisation of the thesis chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the literature reviewed around strike action as a form of collective bargaining and a means to an end. The main purpose is to locate, read, understand, interpret and form conclusions about published literature on the issue under study. According to Polit and Beck (2008:65,106), there are two main purposes for a literature review: to understand the state of current knowledge and to develop an argument that supports the need to conduct the study.

This chapter presents the summary and the conclusion derived from the literature reviewed under the following main areas: general views on strike action; the role of unions in strike actions; the involvement of professional registered nurses in strike action; the ethical code of nursing practice and its role in nurses involvement in strike action; the driving forces for strike action in essential services; the consequences and perceived benefits.

In the South African society, public-health issues are political issues because healthcare services (HCS) form the largest part of social services. The success of HCS is dependent on national and provincial legislative competency because HCS derive its finances directly from the government through nationally-collected general taxes and other revenues (Ngwenya 2009:37). As a result, HCS issues are often included in political debates, which sometimes do not promote objective, clarifying discourse.

2.2 UNDERSTANDING THE STRIKE ACTION

According to Hyman (1984:17), strike is defined as “a temporary stoppage of work by a group of employees in order to express a grievance or enforce a demand”. Garbers and Potgieter (2007:300) define strike action as “a concerted and temporary withholding of employees’ services from the employer for the purposes of extracting greater concessions in the employment relationship than the employer is willing to grant at the bargaining table”. Bendix (1996:521) explains strike action as “a temporary, collective withholding of labour, its objective being to stop production and thereby to oblige the employer to take cognisance of the demands of the employees”.

These definitions are to a greater degree in agreement with the definition of strike action according to Section 213 of the Labour Relations Act (South Africa 2002:s 213). This Act defines a strike action as “the partial or complete refusal to work, or the retardation or obstruction of work, by persons who are or have been employed by the same employer or by different employers, for the purpose of remedying a grievance or resolving a dispute in respect of any matter of mutual interest between employer and employee”. Every reference to ‘work’ in this definition includes overtime work, whether it is voluntary or compulsory (Garbers & Potgieter 2007:300).

Employers need to consider three important elements of the strike-action definition by Hyman (1984:17). Firstly, a strike is a temporary stoppage, which implies that the workers intend that at its conclusion they should return to the same jobs with the same employer, who himself should normally view a stoppage in the same terms. This is, however, in contrast with most employers’ perceptions that striking employees have breached their terms of contract or cancelled such contracts and therefore, may hire a completely new workforce. The understanding of this element in line with the employers’ perceptions depicts a need for employers to see strikers as committed workers demanding attention to issues which interfere with their achievement of work-related goals (Kunene 1995:15). Secondly, it is a stoppage of

work, and this in principle is distinct from such actions as an overtime ban or go-slow. Thirdly, it is a collective act undertaken by a group of employees. This implies that a single employee grievance has a potential of culminating to a collective grievance if not given the necessary attention by the employers.

Backer and Olivier (1996:39-40) further highlight that the definition as stated in Section 213 of the LRA (South Africa 2002:s 213), requires that three elements be satisfied before an industrial action constitutes a strike action. These entail the following:

- There must be a certain act or omission, such as the refusal to work overtime or work-to-rule. Noting that in the definition the words 'partial' 'complete' and 'retardation' apply not only to a full-blown strike, but also to a go-slow or work-to-rule.
- The employees must act collectively for a common cause.
- The conduct of the employees must be aimed at a particular purpose, such as remedying a grievance or the resolution of dispute concerning new wages or other conditions of service.

This clearly indicates that strike action need to have a purpose for it to occur and that the purpose should be for the benefit of a collective. For a better management of its occurrence, managers in the workplace need to be aware of and understand the key elements that constitute a strike action. The literature, therefore, indicates that strikes may be avoided if proper steps of collective bargaining are followed in good faith to solve grievances (Kunene 1995:16; Peel 1988:58).

2.3 OCCURANCES OF STRIKE ACTION AS PART OF THE COLLECTIVE BARGAINING PROCESS

Strikes are common worldwide (Cruess & Cruess 2011:549; Fashoyin 2008:578); Johnson 2008:102). For many years, strikes were believed to be the only method by which employees in a democratic state could express dissatisfaction with their

working environments through withdrawal of services, and achieve desired outcomes (Dhai et al. 2011:58; Ogunbanjo & Knap van Bogaert 2009:307). Common law had a long-standing dispute with industrial action, viewing it as a wrongful act and breach of contract of employment (Countouris & Freedland 2010:489-494). However, the right to strike is a universally accepted principle enshrined in the 1948 Universal Declaration of Human Rights (United Nations 1949). The right to strike also forms part of the declaration on fundamental principles and rights at work, developed by the International Labour Organisation (ILO) supervisory bodies (ILO 1998). According to Rycroft and Jordaan (1990:206), the right to strike is an essential element in collective bargaining because they believe that it is the threat of strikes which ensures that the employer bargains more fairly.

In the South African context, the Constitution of the Republic of South Africa (South Africa 1996:ss 17-18) and the LRA as amended (South Africa 2002:s 68) make provision for the employees in South Africa to have a right to strike. The right to strike, however, comes with conditions as regulated in Section 65 of the LRA as amended (South Africa 2002:s 65), which may render a strike action protected or unprotected. The consequences for employees differ depending on whether the strike is protected or unprotected (Garbers & Potgieter 2007:302).

Protected and unprotected public-service strike action has become a certainty in South Africa. However, in the public-health sector the reasons as well as the consequences generally and specifically on the involvement of professional nurses are often not extensively explored and documented (Urbach 2010).

2.4 STRIKE ACTION IN THE PUBLIC-HEALTH SECTOR

Regulations governing professional nurses' strikes in South Africa are drawn from Section 27 of the Constitution and Sections 70-74 of the Labour Relations Act No.66 of 2002 as amended (South Africa 1996:s 27; South Africa 2002:ss 70-74).

The nursing professionals being part of the essential services are, according to Sections 8 and 22-23 of the Constitution in the Bill of Rights (South Africa 1996:ss 8, 22-23), limited to enter protected strike actions in the absence of a minimum service-level agreement.

Strikes in essential services may be prohibited by the government in South Africa as regulated in the legislation. However, all members of the Republic are covered by the Constitution (South Africa 1996:s 23), which qualifies the right by all employees to collectively bargain for their rights as well as a right of association.

In 2007 and 2010, strike actions took place in South Africa, which included a large number of professional nurses by means of their associations with trade unions (Stuart 2010:6; Van Wyk 2011). This happened despite stipulations in the legislation prohibiting employees in the essential services, such as nurses, to participate in strike action (South Africa 2002:ss 68; 70-71).

Healthcare-worker strikes pose a difficult question, especially considering their ethical codes and professional beliefs (Dhai et al. 2011:58-59). The Florence Nightingale Pledge (Gretter 1893) binds nurses to act in the best interest of their patients and their profession, while Section 65 of the LRA (South Africa 2002:s 65) qualifies the general right to strike, stating that individuals who provide essential services such as healthcare (Garbers & Potgieter 2007:301), may not participate in protected or unprotected strike action (Fashoyin 2008:579). A contradiction is, however, observed when comparing the recommendations of the ILO (1998) and the provisions of Section 65 of the LRA of the Republic of South Africa (2002:s 65) on the right to affiliate to trade unions which, by their existence, are provided a right to use strike actions as one of their bargaining approaches. In the midst of all the regulations, the SANC (2011) exists as a regulated professional body guiding the work of healthcare workers in South Africa. This body stipulates that nurses are entitled to rights in line with the Constitution of the Republic of South Africa (South Africa 1996:ss 17-18) and the relevant labour legislation, provided that they exercise such rights without putting the life or health of patients at risk.

In South Africa, it has been argued that when nurses engage in strike action within the permissions of the legislative right, precautionary measures are put in place to ensure that the lives of patients are preserved and the necessary care required by patients is provided. However, experience and media reports have over time reported incidences of casualty cases not addressed at sites where professional-nurses' strikes occurred and in some instances, the lives of patients would also be threatened (Parliamentary Monitoring Group 2010).

Traditionally, the history of nursing has emphasised sacrifice and obligation to care, placing limits on the way that nurses could argue for improved conditions and status (Burns & Goodnow 1996:26). However, over the past decade the nursing profession needed change significantly, both in terms of its educational system and in the context in which nurses now work (Cruess & Cruess 2011:548; Dierckx de Casterlé et al. 2008:540). In an increasingly technological environment and the extended scope of work, lack of resources to perform work and the demand for service, nurses seem eager to consider industrial actions that other professions take (Robert & Tyssens 2008:502).

The act of strikes is difficult for any group of workers. Hence, it is mostly viewed as a last resort in the process of collective bargaining. The ANA (1985:14) for many years held a view that nurses have a professional responsibility and an ethical duty to maintain employment conditions conducive to a high quality of nursing care. Though, the literature indicates that the latter could not be achieved over the years, as gauged by the demands and changes in populations in different countries versus the allocated resources and non-conducive working conditions in most public-healthcare facilities nationally and internationally. It is thus argued that, as a last resort, nurses embark on strike action to achieve those conditions forming a critical element of their ethical code (International Nursing Council 2012:8; Ketter 1997:329).

2.5 TRADE UNIONS AND THEIR ROLE IN THE PUBLIC-HEALTH SECTOR

The existence of unions all over the world and in South Africa has seen more professional-health workers affiliating with these bodies, despite the fact that they are bounded by their affiliation to the nursing professional body for their practice (Searle et al. 2009:221; Van Rensburg & Van Rensburg 2013:2). The need to collectively bargain with their employer about conditions of service motivates nurses to affiliate with unions. The problem arises when agreements about conditions of service cannot be reached. Members of the trade unions then often resort to forms of industrial action to express their needs and demands (Searle et al. 2009:227).

Trade unions have become an important force in South Africa, with 1.3 million members in 2013 representing 69 per cent of the formal work force within the public sector (Bhorat, Naidoo and Yu 2014). However, a factor that public sector nurses have to consider as a matter of great urgency is the representation of nurses by shop stewards who are not nurses. Thus nurses must form a separate bargaining unit and shop stewards who are nurses should be appointed, so that knowledge and understanding of the work being undertaken and the ethics of the job are uppermost (Searle et al. 2009:221).

Nursing unions are formed with the intention to provide nurses a resource to deal with issues and problems that come with the profession. While supporters for nursing unions feel they give nurses more of a voice and more power in their profession, there are others who feel unions, although well-intentioned, just bring more complications to the workplace (Clark & Clark 2009:1-2).

Nursing unions work to help improve the pay and working conditions of nurses. The biggest cause of poor working conditions is a constant shortage of nurses, according to the New York State Nurses Association (NYSNA) (NYSNA 2013). A shortage of nurses means too many patients are assigned to one nurse, making the job difficult. When nurses become overworked, they are forced to put in overtime

and doing duties that aren't commonly associated with nursing, such as retrieving records and billing. With the power of a union behind them, nurses can negotiate for contracts that clearly define duties and hours. Unions also help nurses negotiate for pay scales and benefits that reflect the amount of work they put into the average day.

The nursing shortage is proving to be a serious public-health issue. Nurses who feel unappreciated, overworked, stressed and underpaid are expected to remain professional and deliver caring and competent care despite personal frustrations (Gordon 2002). Realistically this is difficult, even among the most professional of nurses.

Some nurses believe that one alternative to the current slide in morale is to join together as a collective voice to facilitate change within the health-care profession (Forman & Davis 2002). Although union membership in the private sector is declining (Cherry & Jacob 2002), in the public-health sector, participation in nursing unions is increasing. This is due to perception that it may lead to improved patient outcomes because of increased job satisfaction among nurses and increased safety measures designed to protect both nurses and patients (Grady 2002). In keeping with the legislation and aspirations of the majority of nurses that the time had come for nurses to bargain freely for their rights, South African nurses pursued a union organisation with both professional and union functions (Kunene 1995:25).

The frustrations on working conditions expressed by nurses in the public-health sector in South Africa are not only felt at a particular hospital or in a specific primary health-care facility. The frustrations are found to be nationwide given the studies conducted at the various provinces independently.

Leaving the profession or joining unions should not be the only alternative for thousands of South African public-health professional nurses who are discouraged

by the increased demands placed upon them by management and the public (Muller & Coetzee 1990:37-39).

Many nurses believe unionization would help elevate the profession and encourage more young people to consider nursing as a career. However, other nurses believe that the introduction of unions into an institution undermines the independent authority of the nurse and puts the patient at risk for substandard care (Brengman & Shields 2000; Muller 2001:38). Both sides make valid points and are related to the public's perception of nurses and the perception among nurses themselves. Although the United States' LRA was passed in 1935 to allow workers to collectively bargain against long working hours and unhealthy conditions, nurses were exempt from this protection and were not legally allowed to form a union until 1974 (Cherry & Jacob 2002; Forman & Davis 2002).

The nurse is an advocate for her patient, a caring and compassionate individual who puts the needs of others above her own. It's an accurate perception but also a double-edged sword when trying to balance the needs of the patient with that of the nurse. Nurses are also part of the South African public and within their constitutional right no right of the other is above the other. This notion clearly causes a dilemma in nursing practice.

Aware of the increasingly serious problems nurses are experiencing on the job, health-care unions stepped up their organizing efforts since the 1990s. Health-care professionals were slow to join unions, in part because many believed that union involvement was inappropriate and unprofessional. Nurses, in particular, have historically struggled with the conflict they see between union representation and their obligation to their patients. Nurses are socialized to be selfless caregivers and advocates for patients' well-being, and many perceive unions to be solely concerned with winning greater salaries and benefits for their members, regardless of the impact on the employer or patients (Clark & Clark 2009:5; Searle et al. 2009:214).

Searle et al. (2009:221) argues that nurses, especially in South Africa, cannot allow situations to develop where a person other than nurses determine their professional future. Allowing the situation to exist will prove disastrous as is perceived to be the case in other countries. This poses a challenge as in South Africa, there are unions in which nurses' form a larger part of the workers, and the negotiators and leaders are not nurses.

Given this concern, DENOSA was established in 1996 as a member of the International Council of Nurses (2012) to address the need of representation of nurses by nurses in South Africa. The development of this association is supported by the WHO because of the profession's goal of taking on the nation's healthcare responsibilities (Searle at al. 2009:213). DENOSA was formed through political consensus after the transition to democracy and was, therefore, mandated by its members to represent them and reunite the nursing profession in South Africa. The union has become the largest nurses trade union in the country with over 84 000 members (DENOSA 2010). This union has a dual focus on both trade union and professional development. The dual role has, however, proved to be a challenging one; when the need for industrial action arise this may conflict with the nurses' professional ethics.

2.6 SOUTH AFRICAN NURSING COUNCIL

The SANC is the body entrusted to set and maintain standards of nursing education and practice in the Republic of South Africa (SANC 2014a). It is an autonomous, financially independent, statutory body, currently operating under the South African Nursing Act (2005:ss 3-4).

The SANC is involved in the monitoring of nursing standards by:

- registering nurse practitioners, therefore permitting them to practice as nurses;
- accrediting new nursing education institutions and nursing education programmes;

- inspecting nursing education institutions and clinical facilities;
- constantly reviewing nursing education and training to be in line with the needs of the Republic of South Africa; and
- providing counselling and guidance to the nursing profession regarding the implementation of the nursing education and training policies (SANC 2014a).

Given the existence of the SANC, its main focus is on regulating professional development through educational standards and parameters of practice (SANC 2014a). This raises the question: If the nurses were not affiliated with unions to voice their occupational concerns, how does the existing professional body caters for the need? One may raise a further question: Is it not the absence of this aspect in the founding principles of the SANC that compels professional nurses' to affiliate with unions for dealing with challenges they experience as a result of their working conditions?

2.7 UNDERSTANDING THE NURSING PROFESSION WITHIN THE CODE OF PRACTICE

The International Code of Ethics for Nurses guide the practice of nursing internationally. This code was first adopted by the International Council of Nurses (ICN) in 1993. It has been revised and reaffirmed at various times (ICN 2012:1). This international code forms the basis of all ethical codes of practice in all countries for nurses. The Nursing Code of Ethics is a professional tradition that expresses the fundamental values and commitment. The Code of Ethics is a promise to society that registered nurses always do their best when caring for patients (ANA 2001).

The nursing profession in South Africa, such as any other professions, developed a code of ethics to which all professional nurses subscribe (Searle et al. 2009:267). This entail that the foremost important consideration of the profession is the patients' right to healthcare. It has often been experienced during strike actions in

South Africa that some healthcare facilities deny patients access to optimal healthcare, which impedes on the ethical code sworn by all practicing professional nurses.

Although the ethical code of practice is the key driver in the nursing discipline (Sasso et al. 2008:821), Uys (1992:34) maintains that it is simplistic to expect professional nurses not to strike when they feel that their employer/managers do not honour their work contracts with them. It has become a norm that industrial action is the key to having demands met (Kunene 1995:2). Therefore, nurses engage in strike actions as a last resort with the hope that their demands will also be met.

Within the interest of this study, the dichotomy between nursing ethics and strike actions is an aspect that needs to be addressed in the nursing profession in South Africa. Nurses often find themselves at a crossroad between two conflicting interests: union representation with a possibility of engaging in strike action, and the continuity of care that forms a core part of the nursing practice that is entrenched in the Nurses' Pledge (SANC 2014b). A strategy is necessary to deal with this situation in order to foster a balanced working relationship between the employer and the employees.

The ethical foundation of the nursing profession in South Africa is vested in the Nurses, Pledge. The pledge is derived from the Nightingale Pledge and has been in use since the institution of nurses' training in South Africa (SANC 2014b). This pledge signifies a verbal agreement between the nurse and the community. The question, however, arises as to whether this pledge reflects the dominant views of nurses in South Africa in terms of their expected contribution and working conditions (Dorse 2008:12; Muller 1997:14).

Searle et al. (2009:97) states that ethical codes for professions set the parameters of the responsibilities that nurses owe to their patients. Professional ethics are

moral dimensions of attitude and behaviour based on values, judgment, responsibility and accountability, which practitioners take into account when weighing up the consequences of their professional actions.

Considering the factors currently impacting on the nurses' professional practice in South Africa, the researcher poses the question whether it is still possible for nurses to adhere to their ethical code of practice by ensuring a continued patient care in a working environment with inadequate staffing, poor working conditions and unskilled staff support that inhibits the very nature of optimal nursing care? This could be the compelling factor that nurses resort to strike action in pursuit of attaining the ultimate goal of patients' benefit, nurses' benefit and ultimately that of society as a whole.

2.8 FACTORS INFLUENCING NURSES' INVOLVEMENT IN STRIKE ACTION

International studies reveal that the foremost reasons for strikes in the public-health sector are poor working conditions, followed by wage and other concerns (Beinin 2009:450; Briskin 2011:1; Burns & Goodnow 1996:26; Cruess & Cruess 2008:550; Gyamfi 2011:1; Ketter 1997:324). Some studies conducted, specifically in South Africa, reported similar findings (Bateman 2009:417; Dhai, et al. 2011:58; TNS Research Surveys 2007:2).

All these studies, scientific or non-scientific, point to issues of low wages, poor working conditions and the Occupation-specific Dispensation that allows for wage increases based on incremental linkages to experience, skill and good performance (Bateman 2009:418; Dhai et al. 2011:59; Sidley 2007:1240-1241; TNS Research Surveys 2007:62). In view of the findings, could these be the real drivers for South African professional nurses' involvement in strike action, despite the existence of the ethical code, standards and norms governing the practice?

It is, therefore, in the interest of this study to augment the available literature with a dual pursuit. Firstly, to ascertain the research to date and discover whether there are further underlying causes than what has already been discovered. Secondly, to derive at recommendations for a national management model for a more balanced proactive approach towards labour action in healthcare delivery. These attempts will be informed by the legislative framework in South Africa governing the practice of nursing.

The question as to whether employees should at all times be entitled to undertake strike action is much debated in industrial labour relations circles (Cruess & Cruess 2008:580,583; Hinarejos 2008:723; Lee 2009; Worugji & Archibong 2009:118). Certain theorists and practitioners are of the view that it should be outlawed because it disrupts normal labour relations, especially in the public-health sector (Goel & Karn 2011; Ketter 1997:323; Robertson 2012:344; Stuart 2010:4; Van Wyk 2011). Therefore, the motive for this study is to determine potential ways for avoiding the involvement of professional nurses in strike action as they fall within the parameters of essential services in South Africa. By law they are not allowed to engage in such act and the contrary has been common to date.

By contrast, people argue that strike action is an integral part of the labour relations process and a legitimate means of expressing conflict or exerting pressure (Bendix 1992:240). It may be argued whether the right to strike action should not be extended to professional nurses as well within the scope of the minimum service-level agreement. This could be a consideration. This study, however, argues that potential interventions could be put in place in line with the collective bargaining process, founded by mutual benefit to the professional nurses, management, unions and government.

In the light of the legislative framework, nurses are obliged by the Act not to participate in strike action. What does this say about their human rights within the context of the South African Constitution?

This raises a concern in South Africa, given the need for a balanced public-healthcare at all times. Understanding the underlying factors compelling the nurses to resort to unprotected strike action nationally and implementing ways to combat such actions, is of critical importance to sustain the profession and maintain its professional integrity.

The extent of the crises in the nursing profession and the health system, as well as the frustration of nurses who have even embarked on strike action, suggests that much more is needed to address issues of remuneration, retention of staff, management, support and career-development for nurses (Dudley 2007; Van der Westhuizen 2008:8).

2.9 IMPACT OF STRIKE ACTION ON PUBLIC-HEALTHCARE

Strikes are found to be generally undesirable and often have more unintended negative than positive consequences. According to Muller (2001), strikes are perceived to cause tensions amongst the professionals as often there are those who are not for strike action and respect their pledge. On the other side, those who do not engage in strike action are of the view that it lowers the professional standard and status of nursing to such an extent that communities lose confidence and trust in nurses.

Kunene (1995:153) highlights that some of the outcomes of strike action by nurses are patient-neglect and an increased number of deaths in hospitals that proves contrary to the ethical code and nurses pledge in South Africa. Less-mentioned consequences are also related to the nurse-patient relationship in providing total healthcare and patient-health deterioration due to delayed treatment.

During the strike action by nurses in 2010, reports received by the Department of Health suggested varying levels of disruptions among provinces and hospitals, with some provinces reporting major disruptions and interference with operations in

healthcare facilities (South Africa 2010). Other issues include negative experiences by some of the nursing staff after the strike action. According to Mabange and Muller (2000:27), these include stressed personnel; overwork due to compensation of nurses who embarked on strike action, manhandling and transport problems. To some extent those who upheld their ethical code commitment to the community were found to have mentally experienced a high degree of intimidation, fear and anxiety with threats of their houses being burnt.

Strike action is an undesirable resort to address grievances, especially in the public- health sector which demands attention of both unions and management to take responsibility for avoiding its occurrence (Rycroft & Jordaan 1990:206).

Nurse managers functioning within an environment of strike action are exposed to stress and other undesirable experiences (Mabange 1998:3). Kunene and Nzimande (1996:45) reports that nurse managers experience a lack of authority or direction on using authority during strike action. Failure by top-management to provide patient care result in evident consequences of strike action characterized by heavy workloads, threats, intimidation and insecurity on remaining nursing personnel.

Professional nurses within a strike environment have a definite conflict of interests. Therefore, this challenge raises a need for practice of principles of quality resource management related to personnel provision, utilisation, development and training, as well as personnel retention as prescribed by Muller (1996:282-283).

2.10 LEGISLATIVE FRAMEWORK GUIDING THE PRACTICE OF NURSING IN SOUTH AFRICA AND INVOLVEMENT IN STRIKE ACTION

The WHO viewpoint on nursing in support of the goal of “Health for all by the year 2000” is that nursing practice needs to be self-regulated and accountable (Geyer 1998:29). This implies that legislation which embodies unrealistic restrictions should

be re-examined and changes instituted. According to the WHO (1982:32), nursing care is complementary to all other types of care, but makes its own unique contribution to health services as a whole.

Nurses in the Republic of South Africa are accountable and do make a unique contribution to health services, but are experiencing legal and other restrictions which seriously impact on their ability to make a contribution to the vision of health for all.

In line with the Nursing Act (South Africa 1978), the nurse is the health professional that is available for twenty-four hours a day in most healthcare settings. Therefore, the nurse is ideally suited to coordinate the actions of the multi-professional health team, based on the health needs of patients. If the other members of the multi-professional team are not available, she often needs to have the skills and discretionary ability to either do what needs to be done herself or to refer. For the nurse to coordinate patient care in the absence of other members of the multi-professional team, necessitates moving into the grey areas of overlap of the practice to the nurse, medical practitioner and pharmacists (Bierman 1992:49).

This often challenging situation nurses find themselves in requires that they be properly skilled and provided necessary knowledge and expertise to be able to handle such responsibility (Kotzé 2010: [1]). This goes with a need to provide measures that legally and ethically enables the nurse to do so. Another important enabling factor is work-appreciation incentives for registered nurses that work across the disciplinary lines, thus also aiding the retention of registered nurses in the health discipline, especially in the public sector.

The healthcare and primary purpose of nursing is to provide the public with access to safe, competent basic healthcare. To do so the nurse should be empowered to practice her profession within legal and ethical boundaries in an enabling work environment (Geyer 1998:32). Should these necessities not be in place, it can be

argued that registered nurses are within their professional right to engage in strike action should their needs not be addressed in legislated processes such as the bargaining process. This process is seen in a negative light within the South African context as it is often not perceived as aiding the work needs of professional nurses. In essence, the strike action is often considered as an ultimate option. However, an alert management in the public-health system should not necessarily let the situation end in nurses resorting to strike action. There is a need for nurse managers to always strive towards adapting to the changing demands of the nursing profession and providing enabling measures that would create job satisfaction and retention within the work environment as stipulated in the South African Nursing Act of 1978. If strike action by hospital doctors and nurses is not effectively managed or discouraged all patients get affected regardless of the relief strategies employed during the strike action, rendering the health system not functioning optimally as intended (Eylert & Schinz [s.a.]).

While this is the case, strike action can also have a devastating effect even if it is a constitutional right in South Africa. A major concern with frequent strikes by health workers in the public-health sector is that it destabilizes the country's fragile health system and undermines the health-development efforts, therefore contributing to poor health outcomes in most developing countries. In 2007 and 2010 for instance, media reports indicate that the continuous strike actions embarked upon by the health workers contributed to the poor performance of the health-care delivery in the country (News24 2010; Smith 2010; Van Rensburg & Van Rensburg 2013:3). Therefore, even though strikes can sometimes serve as a catalyst of action and an effective tool for health workers to influence change in the health sector, the rampart strike actions pose a major challenge that undermines progress in the health sector (Ankomah [s.a.]).

2.11 THEORETICAL FRAMEWORK OF THE STUDY

The level of involvement by nurses employed in public healthcare facilities in strike action in the public-health sector is a reminder to nurse managers that human

behaviour in organisations is unpredictable because it stems from deep-seated needs and different value systems.

It becomes an important responsibility of nurse managers to be alert to employees' dissatisfaction, attend to complaints promptly and prevent them from escalating into serious grievances which, if not attended to, will end in strike action by nurses in public healthcare facilities (Kunene 1995:34).

Nurse managers should not use their own discretion or intuition, experience or tradition as a basis for making personnel-management decisions. Use of administration or management theories enables prediction, gives clues to possible outcomes of decisions made and implemented, and minimises chances of unexpected or undesirable responses or behaviours such as involvement in strike action. This is important because nursing work and management is performed in situations that are influenced by changes both in the external and internal environment.

The theoretical framework for this study is based on an integration of literature on factors influencing the involvement of public-sector nurses in strike action, and existing management models to be explored in detail to aid the researcher in determining strategies to curb strike action by nurses in the public-health sector.

2.11.1 The Health Leadership Alliance model on common competencies for all health managers

Today's healthcare executives and leaders must have management talent sophisticated enough to match the increased complexity of the healthcare environment. Executives are expected to demonstrate measurable outcomes and effectiveness and to practice evidence-based management. At the same time, academic and professional programmes are emphasizing the attainment of competencies related to workplace effectiveness. The shift to evidence-based

management has led to numerous efforts to define the competencies most appropriate for healthcare (Stefl 2008:360).

Drucker (2002:29-30) says that large healthcare institutions may be the most complex in human history and that even small healthcare organisations are barely manageable. Some time has passed since Drucker's observation, but the complexity of healthcare organisations, along with the demands on managers and leaders, has not diminished in any way (Stefl 2008:361). Today, executives in all healthcare settings must navigate a landscape influenced by complex social and political forces, including shrinking reimbursements, persistent shortages of health professionals, endless requirements to use performance and safety indicators, and prevailing calls for transparency (Stefl 2008:361). Further, managers and leaders are expected to do more with less.

Since 1999, the Society of Healthcare Strategy and Market Development and the American College of Healthcare Executives have been producing *Futurescan,* a compendium of healthcare trends and projections for the next five years. In *Futurescan 2008,* the publication's executive editor, Don Seymour, reflected on the past ten years in healthcare: “Society appears to be sending a clear, overarching message to the nation's hospitals: take care of more people who have growing expectations and more complex medical needs while providing increasingly sophisticated care with relatively fewer resources. In an environment of escalated public demand, it is only logical to question the competence of healthcare leaders and managers”.

As noted in Griffith (2007:11-12), the increased difficulty of running a healthcare organisation has led to the need for managers with more sophisticated capabilities. Questions are now being raised. Have mid- and senior-level managers been keeping pace with changing demands? Are healthcare academic programmes attracting sufficient numbers of students and adequately preparing them to operate effectively in this dynamic environment?

These concerns were the focus of the 2001 National Summit on the Future of Education and Practice in Health Management and Policy. Principally funded by the Robert Wood Johnson Foundation, this conference brought together practitioners, policymakers and educators to examine the effectiveness of healthcare administration and the role of academic preparation and continuing professional development in tackling the current and future challenges of healthcare delivery.

To meet the needs of healthcare administration, a number of university programmes have developed a set of competencies (Cherlin, Helfand, Elbel, Busch & Bradley 2006:354-355; Shewchuk, O'Connor & Fine 2005:34-35; 2006:369-371; White, Clement & Nayar 2006: 335), or competency models (Campbell, Lomperis, Gillespie & Arrington 2006:135) for their students (Stefl 2008:362).

In other words, academic programmes take steps to ensure that their competency models are tied with the realities and needs of the healthcare management practice. However, little evidence shows a link between actual performance and competency attainment (Bradley 2003:287-289), an area of inquiry that clearly needs more attention as competency models continue to develop (Stefl 2008:362).

Aside from this work in academia, the National Centre for Healthcare Leadership (NCHL) has expended considerable effort in creating a competency model that can be applied to professional development and to academic programmes (Calhoun, Vincent, Baker, Butler, Sinoris & Chen 2004: 419; NCHL 2005).

The Healthcare Leadership Alliance (HLA) is a consortium of major professional associations in the healthcare fields. Together, these associations represent more than 100 000 management professionals (Stefl 2008:362-363).

The extensive review of the credentialing and certification processes of the HLA members revealed a number of overlapping and complementary competencies. The Task Force determined that these Key Service Agreements (KSAs) are

clustered into five competency domains that were common among the membership of all six associations (Stefl 2008:363-364).

- **Communication and relationship management**

The ability to communicate clearly and concisely with internal and external customers, to establish and maintain relationships, and to facilitate constructive interactions with individuals and groups

- **Leadership**

The ability to inspire individual and organisational excellence, to create and attain a shared vision, and to successfully manage change to attain the organisation's strategic ends and successful performance

- **Professionalism**

The ability to align personal and organisational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement

- **Knowledge of the healthcare environment**

The demonstrated understanding of the healthcare system and the environment in which healthcare managers and providers function

- **Business knowledge and skills**

The ability to apply business principles, including systems thinking, to the healthcare environment; basic business principles include:

- financial management,
- human resource management,
- organisational dynamics and governance,
- strategic planning and marketing,

- information management,
- risk management, and
- quality improvement

In keeping with the current focus on outcomes and evidence-based management, these five domains were viewed as common competencies or competency domains. While ‘competency’ can be defined in a variety of ways, the HLA Task Force defined competencies as clusters that "transcend unique organizational settings and are applicable across the environment” (Stefl 2008:364). That is, the domains identified by the Task Force are generic and demonstrable.

The Task Force viewed these competency domains as interdependent (see Figure 2.1). Because leadership competencies are central to a healthcare executive's performance, the Leadership domain anchors the HLA model. All other domains draw from the Leadership area, but the other competencies also feed and inform leadership. The identification of these five domains sends a powerful message to the healthcare field: healthcare managers in a wide range of positions and settings share a common body of knowledge and a common lexicon.

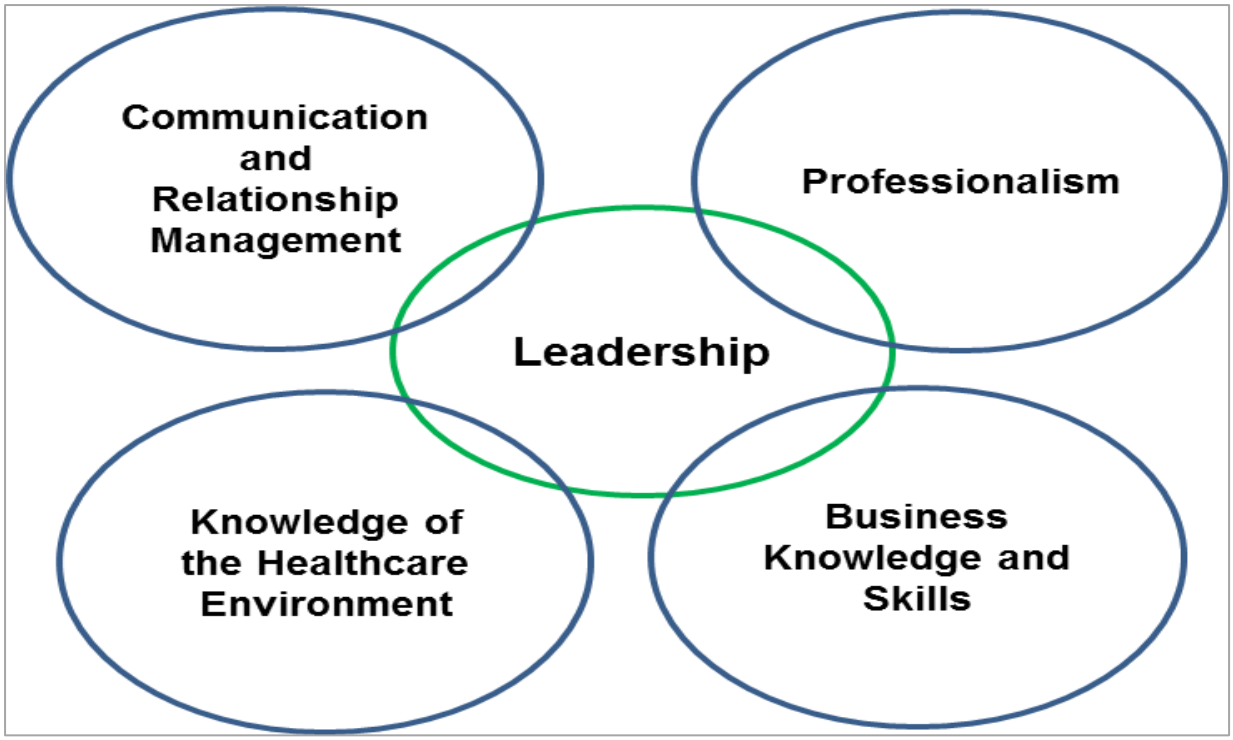

Figure 1.19: The Healthcare Leadership Alliance Competency Model

Source: ©2005. All Rights Reserved by Members of the HLA Competency Task Force: American College of Healthcare Facilities. American College of Physician Executives, American Organization of Nurse Executives, Healthcare Financial Management Association, Healthcare Information and Management Systems Society, and the certification body of the Medical Group Management Association—American College of Medical Practice Executives.

The HLA model highlights the importance of leadership as a core competence needed by nurse managers to deal with the changing environment and nurse behaviour. The leadership competence as the core necessity helps nurse managers to be able to cope with changing demands and the growing challenge of limited resources to provide optimal healthcare.

2.11.2 Understanding of organisational behaviour by nurse managers

Healthcare managers, just as managers in other industries, are responsible for ensuring the effective use of the material, financial, information and human resources of their organisations to deliver competent service to healthcare patients (McGinnis 2012:38). The manager's role requires a wide range of both technical and interpersonal skills. As seen with the HLA model, McGinnis (2012:38) supports

the notion that leadership, motivation, managing healthcare professionals, and teamwork in a demanding healthcare environment are some of the most important interpersonal skills of a manager. Understanding human behaviour at work is an important predictor of what a nurse manager can anticipate; therefore allowing earlier interventions that will curb the need of professional nurses to go on strike. Understanding the organisational behaviour aid the process to work with employees in a way that leads to beneficial outcomes for both the workforce and the organisation (Millett 1998:3).

Manager knowledge of organisational behaviour – that is how people act in an organisation – assist with the ability to work effectively with employees and colleagues across the organisation, supporting and influencing them to support and achieve organisational goals.

- **Understanding of individual behaviour and collective behaviour in the organisation**

Studying personal behaviour, helps managers to understand how perceptions, attitudes and personality influence work behaviour, motivation and other important work outcomes, such as satisfaction, commitment and learning (McGinnis 2012:38). Awareness of the interactions in the group of public-health employees within their work environment provides the nurse manager with necessary insight into the challenges of leadership, teamwork, communication, decision-making, power and conflict (McGinnis 2012:39).

2.11.3 Organisational behaviour theory

The organisational behaviour theory explains how the structure and power relationships of organisations work, and how they use systems for decision-making and control, how an organisations' culture affects behaviour, how organisations learn and how they adapt to changing competitive, economic, social and political conditions (McGinnis 2012:39). In the event of potential threats of strike in the public-healthcare sector, nurse managers need to be concerned with understanding

the behaviour that occurs under the conditions posed by organisational situations, and deal with such conditions appropriately as proactive action to minimise the possibility of a strike action.

McGinnis (2012:40) highlights the fact that while a specific organisation setting may create unique challenges or certain sets of problems, the behaviours of interest are similar to those of individuals, groups and often organisations in other settings or industries. Healthcare organisation behaviour does not create unique management issues so much, as certain issues are more prevalent in healthcare and occur along with other challenges (Shortell & Kaluzny 2000:5-8). Many of these challenges directly affect what is expected of healthcare workers and how they behave in healthcare organisations.

Extreme financial and policy changes on healthcare organisational setting may affect the way nurses do their work and how they behave, creating potential for their involvement in strike action. Increasing consumer demands for healthcare and perceived low salaries by nursing professionals requires that nurse managers have knowledge of organisational behaviour to have the ability to motivate employees to work as a team in a demanding industry of public healthcare.

To understand a resultant behaviour such as nurses' involvement in strike action, nurse managers need to understand the thoughts, assumptions and attributes of a situation that preceded the involvement of nurses in strike action and its impact.

Within the existence of organisational theory is the importance of the expectancy theory, especially in dealing with possibilities of nurses' potential involvement in strike action. To manage expectations, the nurse manager needs to use communication to create a shared, common focus of delivering competent healthcare service with limited resources (Shortell & Kaluzny 2000:224). The latter approach will assist in managing the expectations of the employees and managers in a demanding environment. It should also be noted that in the nursing profession,

there are different generations that have different expectations. Therefore, forming of work teams and allocation of work should be carefully considered to minimise any tensions (Duchscher & Cowin 2004:494).

2.11.4 Nurse managers as transformational leaders

In an era when nurse managers are both critical to and responsible for retention and performance, leadership style is critical to achieve both outcomes (Laschinger, Wilk, Cho & Greco 2009:636). According to McGuire and Kennerly (2006:179), the leadership skills and abilities of nurse managers have long been recognized as making a critical contribution to the smooth operation of inpatient units and the success of acute-care hospitals. Their leadership role is increasingly gaining attention in relation to their contributions to staff attitudes and relationships.

With an increased desire or developed need by registered nurses to get involved in strike action due to work-related dissatisfaction and other work-environment challenges, a transformational leadership style is the key in stabilizing the situation within the changing work environment. Nurse managers can be taught transformational leadership skills including establishing clear expectations, creating a shared vision and, ultimately, inspiring stronger organisational commitment (McGuire & Kennerly 2006:179).

Transformational leaders move beyond the management of transaction to motivate performance beyond expectations through the ability to influence attitudes (Scott, Mannion, Davies & Marshall 2003:115-116).

Organisations turn to the leader for solutions to workforce and other resource issues that will help the organisation achieve and maintain a competitive advantage. Nursing's current interests in organisational leadership are focused on recruiting, retaining and motivating staff and ensuring patient safety. The nurse leader's role is pivotal to achieve these outcomes and rebuild the trust and respect that staff must have in managers at all levels of the organisation (Laschinger &

Finegan 2005:6-8). Maintaining a positive work environment and building a team-effort are key to achieve patient safety through nurse employees who are satisfied with their job (Buykx, Humphreys, Wakerman & Pashen 2010:103; Mosadeghrad & Ferdosi 2013:121). Positive healthcare work environments must be in place to attract and retain staff (Walters 2005:18; 22-23). The current shortage of registered nurses at the bedside magnifies the importance of having strong, clear, supportive and inspirational leadership across the healthcare organisation.

Since transformational leadership characteristics can be taught and learned (McGuire & Kennerly 2006:185), organisations have a significant opportunity to develop the type of leaders who can positively interact with first-line employees. Nurse executives must be advocates for leadership education that emphasizes the four main components of transformational leadership to provide nurse managers with a solid foundation for professional growth and development.

By creating a shared vision for the nursing unit, staff nurses become committed to pursuing common goals and interests. Staff nurses will follow the leadership of nurse managers who can inspire and motivate them to perform beyond basic expectations and can engender a sense of team-spirit across the nursing unit on all shifts (Mosadeghrad & Ferdosi 2013:122; Thompson 2011:3).

Traditionally, the nurse manager's job responsibilities included directing, planning, coordinating and controlling the activities and personnel in one or more nursing units. Today's hospital environment, however, calls for managers who have the ability and desire to coach and mentor staff (Shiparski 2005:36-38). According to McGuire and Kennerly (2006:185), transformational leaders prefer to coach staff rather than control their behaviours. In doing so, they create a supportive climate where individual differences are recognized, two-way communication is promoted and effective listening skills are valued.

This study's findings validate that transformational nurse leaders promote a higher sense of commitment in their followers. To develop a committed nursing staff, nurse executives should develop, promote and hire individuals into nurse manager positions who demonstrate a balance of leadership characteristics which are more transformational than transactional. Employing charismatic nurse managers who have high ethical and moral character and integrity and exhibit risk-taking behaviours is an absolute plus at a time when corporate compliance, conflict of interest, and unethical business practices are scrutinized closely. Nurse executives who recruit and retain a committed workforce bring a competitive advantage to their organisations, foster a healthier work environment and gain a personal sense of accomplishment and success.

2.11.5 Kotter's change management model

Internationally, healthcare organisations go through rapid change as they strive to deal with the demands of their clients. South Africa is no exception. On daily basis, the healthcare managers need to deal with changes to implement quality-improvement initiatives and institute the occupation-specific dispensation (OSD) plan in line with the regulated agreement. Multiple other factors are evident in the healthcare workplace that, without proper change management, may lead to strike action. These include the ageing workforce, the impact of HIV/AIDS on patients and nursing staff, and the nursing shortage. These are challenges which affect nurse managers, as they have to continue their managerial functions of planning, organising, leading and controlling (Mokoka 2007:136).

To deal with this rapid change and help employees' transition to new ways of doing things, managers need an edge (Campbell 2008:23). This could be provided through the philosophy of John Kotter, one of the most widely-regarded thinkers in change management. Adopting Kotter's model of change, will assist managers to better deal with feelings of complacency, anger, false pride, pessimism, arrogance, cynicism, panic, exhaustion, insecurity and anxiety among employees (Kotter & Cohen 2002:180). These are all emotions that can undermine attempts at

promoting change in healthcare facilities and easily lead to undesired actions such as the strike action by nurses.

According to Campbell (2008:23), Kotter believes that organisational change can be managed using a dynamic, nonlinear eight-step approach. The steps in his model are outlined in Table 2.1 below.

Table 2.1: The 8-step process for leading change as adapted by Kotter International (Kotter 2012; Kotter International 2014)

Step1: Create a sense of urgency	Craft and use a significant opportunity as a means for exciting people to sign up to change their organisation
Step 2: Build a guiding coalition	Assemble a group with the power and energy to lead and support a collaborative change effort
Step 3: Form strategic vision and initiatives	Shape a vision to help steer the change effort and develop strategic initiatives to achieve that vision
Step 4: Enlist a volunteer army	Raise a large force of people who are ready, willing and urgent to drive change
Step 5: Enable action by removing barriers	Remove obstacles to change, change systems or structures that pose threats to the achievements of the vision
Step 6: Generate short-term wins	Consistently produce, track, evaluate and celebrate volumes of small and large accomplishments – and correlate them to results
Step 7: Sustain acceleration	Use increasing credibility to change systems, structures and policies that don't align with the

	vision; hire, promote and develop employees who can implement the vision; reinvigorate the process with new projects, themes and volunteers
Step 8: Institute change	Articulate the connections between the new behaviours and organisational success, and develop the means to ensure leadership development and succession

Kotter suggests that for change to be successful, 75 per cent of the healthcare-facility management needs to buy into the change. Instituting change without proper preparation may create an undesirable outcome (MindTools 2013). A nursing manager as a transformational leader needs to work hard to change the work ethics and behaviour leading to strike action in a public-healthcare facility. When nurse managers plan carefully and build the proper foundation implementing change can be much easier; this can improve the chances of success.

The theoretical framework chosen is considered to be appropriate to support the focus of this study and, most importantly, providing a possible framework within which nurse involvement in strike action and its management could be discussed, as well as adding to the field of evidence already gathered around nurse strikes and management strategies to prevent strike action.

2.12 CONCLUSIONS

The literature review showed commonalities from various authors regarding a significant problem that faces healthcare facilities: nurses' involvement in strike action and factors leading to it. Factors that are presumed to increase nurse involvement in strike action are related to conditions in the workplace and remuneration that lead to lack of job satisfaction and low levels of motivation.

The role of nurse managers, the government and union leaders is of utmost importance in the management of factors influencing nurses' involvement in strike action and, therefore, its impact. As a result, nurse managers need to constantly identify and manage factors that lead to job dissatisfaction that may awaken the nurses' urge to strike. The leadership style of managers is also of importance in promoting quality patient care and minimise strike actions in the public healthcare sector in South Africa.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter gives a detailed view on the research design chosen and its relevance to the current study. This chapter also includes the discussions on the study population and sample, research instruments, data collection and data analysis approach. The methodological approach was chosen with the aim to answer the research objectives. The research was conducted in three main phases preluded by a pilot phase using qualitative and quantitative methodologies, which is discussed in detail in this chapter.

3.2 RESEARCH PARADIGM

According to Taylor, Kermode and Roberts (2007:5), a paradigm is “a broad view or perspective of something”. Additionally, Weaver and Olson (2006:460) refer to a research paradigm as a pattern of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished”. Therefore, to clarify the researcher’s structure of inquiry and methodological choices, an exploration of the paradigm adopted for this study is discussed prior to the specific methodologies utilised in each of the phases of the study.

Qualitative and quantitative research approaches were applied in phases of this study, as needed for addressing the research aim and objectives. Qualitative and quantitative methods are used by researchers to collect data in social science. Qualitative methods include the researcher's experience through techniques such as focus groups, case studies, interviews and personal observations. On the other hand, quantitative methods include hard facts illustrated in surveys and polls, while

the advantage of qualitative research is to provide a richer, deeper understanding of a problem or question being observed (Smith 2008).

Therefore, to gain on the advantages of both methodologies and looking at the research aim and objectives, the researcher used both quantitative and qualitative research methods in different phases of this study. This was decided on in order to allow the researcher to make use of the most valuable features of each methodological approach (Kennedy 2009). Viewing the research problem through different paradigms enabled the researcher to develop a comprehensive knowledge base and an understanding of factors influencing nurses' involvement in strike action within the public-health sector. This approach also allowed for a detailed description of strategies to be implemented by nurse managers to curb nurses' strike action in public institutions (Singh 2014).

This approach allowed for methodological triangulation by using both qualitative and quantitative methods to collect and analyse data. Both methodologies assisted the researcher to understand the contributing factors for nurses' involvement in strike action and how to describe effective strategies for curbing strike action in the public-health sector (Smith 2008).

Employing the qualitative method allowed the researcher to:

- collect the primary data in a flexible, non-structured way that allowed emergence of new information and interpretations of factors influencing nurses' participation in strike action and describing proactive strategies for balancing human and professional rights of nurses and their responsibilities within a legislative and professional framework in South Africa
- interact with the research participants in their own language and environment conducive to the healthcare consumers
- understand the study phenomenon in detail

- obtain a more realistic and hands-on feel of the world that cannot be experienced in the numerical data and statistical analysis used in quantitative research

Implementing the quantitative method allowed the researcher to:

- state the research problem in very specific, definable and set terms
- specify clearly and precisely the independent and dependent variables
- follow the original set of research goals
- achieve high levels of reliability of the gathered data due to mass surveying
- test the research questions
- arrive at more objective conclusions by minimizing subjectivity of judgment

Due to budgetary constraints, this study was limited to four target provinces, namely EC, KZN, WC and GP. The provinces were selected since they feature the four major metropolitan areas in South Africa that had been affected by strike action both in 2007 and 2010. The selection of these provinces provided an acceptable national view on the study focus.

In the **pilot phase,** a qualitative exploratory approach was followed to explore factors identified through a literature review as contributing factors for nurses' involvement or non-involvement in strike action. This approach was used as a preliminary process to inform the researcher for effective construction of a questionnaire to assess and ascertain nurses' views on factors that influence their decision to strike or not to strike (Amora 2010).

In **phase one,** a questionnaire was constructed using insights from the pilot phase to quantitatively explore factors contributing to nurses' involvement in strike action. The questionnaire was also meant to determine the perceived value or non-value of strike action amongst nurses who participated. Using the quantitative approach in phase one allowed the researcher to reach a larger sample. A semi-structured self-

administered questionnaire was sent electronically or delivered to 80 public-health nurses that were selected for this study.

The participating nurses were selected on the basis of their level of involvement in strike action in 2007 and 2010. The quantitative approach in phase one was used by the researcher to quantify the problem and understand how prevalent it is by looking for projectable results to a larger population (Amora 2010).

In **phase two,** a quantitative approach was used. The questionnaire developed in phase one was adapted to the respondent being a nurse manager; the key concepts on factors contributing to public-health nurses' involvement in strike action remained the same. The quantitative approach was implemented in phase two to quantify objectively nurse managers' views on factors contributing to nurses' involvement or non-involvement in strike action and to determine their understanding of the changing working environment of nurse practice.

In **phase three,** an exploratory qualitative research approach was used to provide for an in-depth understanding of healthcare consumers' views on nurses' involvement in strike action. The purpose of phase three was not to generalise but to augment insight gained in phase one and phase two with the public viewpoint as recipients of healthcare services and being in some way affected by the problem addressed by this study.

3.3 RESEARCH DESIGN

A research design is the framework or plan for a study used as a guide in collecting and analysing data to address the central research questions (Creswell 2009:3; Polit & Beck 2008:49). In this study, a descriptive, exploratory and analytic design was followed, using both qualitative and quantitative approaches in subsequent phases of the study to meet the research objectives. According to Creswell (2009:3-4) and Plano Clark & Creswell (2010:65-67), a descriptive design provide accuracy

by describing what exists, the frequency with which it exists, ascribe new meaning to a phenomenon and put information into categories or themes. Descriptive research is also known to yield both qualitative and quantitative data, as was the case with this study (Mokoka 2007:150). The phenomenon under study could be described in ways varying from narrative types of description to a statistical analysis (Babbie & Mouton 2003:81; Luttrell 2010:163; Mokoka 2007; Saldaña 2011:71:150).

The advantages of the exploratory approach are rooted in literature sources (Jackson 2014). The exploratory nature of the study resulted from the fact that strike action in the public-health sector in South Africa has become a persistent phenomenon (Babbie 2013:90). The research design was therefore not meant to draw definite conclusions but to increase the researcher's understanding of the study problem. It helped the researcher to determine and understand the contributing factors for the involvement or non-involvement of nurses in public-healthcare facilities in strike action during 2007 and 2010.

The researcher aimed to uncover the factors that drive or influence the involvement of professional nurses in strike action while bonded to their ethical code of practice in South Africa. This was done with the purpose of describing proactive management strategies for nurse managers that would serve as a preventative measure for nurses' involvement in strike action. The experiences of a sample of nurses who participated and those who did not participate in strike action during 2007 or 2010 in South Africa were explored in the empirical research.

The exploratory part of the study in the pilot phase using a qualitative technique, helped the researcher to better understand the issues on strike action by nurses for effective construction of questions in a subsequent collection of data in phase one using a quantitative technique (Luttrell 2010:163; Saldaña 2011:71). A smaller sample of nurse managers from public-healthcare facilities that were affected by strikes in 2007 or 2010 was included in phase two. This was done to augment the findings of the study and understand nurse managers' views on factors contributing

to nurses' involvement in strike action and to determine their understanding of the changing working environment of nurse practice.

The questionnaire from phase one was slightly adapted for nurse managers as respondents. In phase three, the qualitative techniques allowed the researcher access to the perspectives of healthcare consumers who utilised the public-healthcare facilities during strike action in 2007 or 2010. This allowed the researcher to explore the area of interest from the perceptions of both the nurses and the healthcare consumers.

3.4 ORGANISATION OF THE STUDY PHASES

A phase approach was used in this study and the phases are outlined below.

The pilot phase was meant to explore through qualitative techniques factors that contributed to the involvement of nurses in strike action amongst nurses working in public-healthcare facilities in GP that either participated or did not participate in strike action during 2007 or 2010.

Phase one was a quantitative phase meant to further explore factors contributing to nurses' involvement in strike action during 2007 and 2010 from a bigger group of nurses across the four provinces selected for the study. It was also to determine the perceived value or non-value of nurses' participation in strike action.

Phase two was conducted using quantitative techniques to determine the factors contributing to nurses' involvement in strike action amongst nurse managers and to determine their understanding of the changing working environment of nurse practice. Only nurse managers working at the public-healthcare facilities that were affected by strike action in 2007 and 2010 were selected for this phase.

In phase three, the researcher used qualitative techniques to explore perceptions and views of healthcare consumers on nurses' involvement in strike action and the perceived impact thereof. Healthcare consumers that participated in phase three were mainly outpatients that sought services at public-healthcare facilities in the four selected provinces during 2007 and 2010.

In order to describe the variety of research activities undertaken during this study, the data collection activities and associated analysis methods are systematically discussed in detail under each phase of the study.

3.5 PILOT PHASE: QUALITATIVE APPROACH

In the **pilot phase,** a qualitative exploratory approach was followed to explore the factors contributing to nurses' involvement in strike action or non-involvement. An in-depth interview guide was developed and appointments made telephonically with ten nurse participants working in public-healthcare facilities. The in-depth interviews were conducted to provide insight to the subsequent development of a semi-structured questionnaire that was used as a self-administered questionnaire in both phase one and phase two.

3.5.1 Population and sampling

According to Creswell and Plano Clark (2011:172), to address a research question, the researcher engages in a sampling procedure that involves determining the location or site for the research, the participants who will provide data in the study and how they will be sampled, and the recruitment procedures for the participants. These steps in sampling apply to both qualitative and quantitative research.

In the pilot phase, the researcher purposefully selected professional nurses that could provide the necessary information. Purposeful sampling in qualitative research means that the researcher intentionally selects or recruits participants who

have experienced the central phenomenon or the key concept being explored in the study (Creswell & Plano Clark 2011:172).

Non-probability purposive convenience sampling was used for the benefit of time and cost to get representation of cases under investigation (Bowling 2011:206). The non-probability sampling approach is concerned with identifying cases that would enhance the researcher's understanding about the processes and interactions within the specific context of the study (Neuman 2003:211; Welman & Kruger 2001:61-62).

Gauteng was selected as the preferred province for the pilot phase because of its proximity and accessibility to the researcher. The decision was mainly driven by time and budgetary constraints.

- **Population**

The target population for the pilot phase was accessible nurses who reside in Gauteng that had or had not got involved in strike action but worked at any public-healthcare facility that was affected by strike action in 2007 and 2010. The nurses had to be registered in the SANC registry for nursing practice during the period of the study. The accessible population is defined as a population of participants available for a particular study or reasonably accessible to the researcher (Polit & Hungler (1999:209). According to Burns and Grove (2003:366), the sample in a study is obtained from the accessible population and findings are generalised first to the accessible population and then, more abstractly, to the target population.

- **Selection criteria of participants**

A purposive and convenience sampling approach was used to select professional nurses according to the following selection criteria (Bowling 2011:208; Creswell & Plano Clark 2011:173):

- All nurses selected should be working at any public-healthcare facility in Gauteng that was affected by strike action.
- The nurses should have been employed at such healthcare facilities during the strike periods in 2007 and 2010 and either participated or not participated in strike action in the same period.
- They should be conversant in English and reside in South Africa.
- Their names were supposed to be in the SANC registry for practicing professional nurses during the period of the study (Annexure C).

Purposive sampling required that one data-rich participant who met the criteria be identified first (McMillan & Schumacher 2006:320). The first participant was identified through a referral by the researcher's colleague who was a brother to the participant. Thereafter, nine participants were included on convenience basis. This means that successive participants were included by virtue of referral from participants themselves or colleagues of the researcher and family members of participants who were interacted with on a social basis (McMillan & Schumacher 2006:321). The ten participants thus identified fitted the criteria for inclusion. The researcher's standing as an outsider in the nursing discipline assisted in easily developing rapport and trust with the participants in absence of fear for victimisation.

3.5.2 Data collection

According to Burns and Grove (2002:49), data collection is the precise, systematic gathering of information relevant to the research purpose. Mokoka (2007:155) expresses that Brink (1999:148) identifies five questions that a researcher needs to ask when planning the data collection process. These questions pertain to the type of information needed to answer the research question, type of research instrument, who will collect the data, the setting and time frame for data collection.

The **pilot phase** included telephonic in-depth interviews conducted in September 2013 to determine whether similar themes as were observed in 2007 just after the strike action still remained (TNS Research Surveys 2007:1-4). This was done using

a discussion guide with participating nurses to explore the study objectives. This data collection method is an effective way of soliciting and documenting the respondents' own words and information about their own experiences and opinions or views (Babbie 2013:232; Saldaña 2011:32-33).

Based on the literature review, a set of pre-determined discussion points was formulated for participants who participated in strike action and those who did not participate in 2007 or 2010 (Annexure D). Areas of information required were essential to bring into view the professional nurses' potential causes of involvement in strike action in a public-health sector (Babbie 2013:230). This took into consideration the professional obligations of nurses and their rights as citizens of South Africa and functioning within the essential services as regulated by law in South Africa. Data collection for the pilot phase took place early in 2013.

3.5.3 Preparation of the interview guide (schedule) – (Annexure D)

Before conducting in-depth interviews with the participants, the researcher defined the information that was required to allow the interviews to proceed smoothly and naturally (Babbie 2013:346; De Vos et al. 2005:293).

The information that was required from professional nurses during the in-depth interviews was related to factors influencing nurses' involvement or non-involvement in strike action and a perspective on their work circumstances and environment in general. The interview guide comprised of seven main discussion points to allow for an interaction between the interviewer (the researcher in this study) and the participant (Babbie 2013:346). The questions were discussed with the researcher's supervisor and two researchers experienced in qualitative research methods.

- **Pre-testing the interview guide (schedule)**

The research instrument should be pre-tested before the actual collection of data. The validity of interview data relied on shared assumptions and understandings of

the discussion points. Pre-testing of discussion points included asking people to describe what they thought of when they listened to a question and about how they interpreted it. Respondents were informed that they were being interviewed for pre-testing the interview guide (Bowling 2009:301). In this study, most participants interviewed were willing to help and were honest enough to tell when the pointers for discussion were ambiguous and not easy to interpret.

In order to avoid pitfalls in the interview guide, the instrument was discussed with the study supervisor and other experienced researchers in qualitative research methods. The instrument was also pre-tested with four professional nurses in GP (due to close proximity) who also fulfilled the set participant criteria. These nurses were used solely to test the discussion guide prior the pilot phase of this study (Bernard 2013:237).

Pre-testing the interview guide helped the researcher to be more familiar with the areas of discussion and to come to grips with some practical aspects of the interviewing process. Pre-testing the interview guide entailed establishing the approximate time that would be required to conduct each interview, the necessary detail and clarity of the discussion points and even of the potential answers and necessary probes. The researcher had a pre-set time allocation for each interview but through the pilot study it was determined that the maximum required time for each interview was 35 to 40 minutes for a proper and informing discussion. Participants found the discussion points to be acceptable and relevant to them. Though one indicated a sense of discomfort when a discussion point related to the ethical code of practice and involvement in strike action was posed, it was within limits of tolerance.

- **Structure of the interview guide (schedule) – (Annexure D)**

The different sections focused on the following:

Section 1 – Perceptions of the nursing profession
Section 2 – Perceptions of the strike action

Section 3 – Perceptions of the public on the nurses' participation in strike action

3.5.4 The in-depth interviews

Consent was obtained prior to conducting the interviews with nurses who worked in public-health hospitals or clinics that experienced strike action in 2007 or 2010. Purposefully selected participants who were selected as described in section 3.5.1 were contacted and the purpose of this study explained to them before voluntarily agreeing to partake in the study. The participants were contacted prior the in-depth interviews for formal appointments. They were prepared for the in-depth interviews and suitable times were arranged. The participants were informed that the interview will take approximately 35 to 40 minutes. Appointments were confirmed a day before the in-depth interview. Before commencing with the interviews, the researcher explained the information required, the format and the process of the interview. The researcher reiterated to the participants that they could withdraw at any stage of the interview if they wanted to.

3.5.5 Position of the researcher

The researcher is an environmental health practitioner by profession. She is employed as a senior researcher at the Department of Communications and her main line function is research in public opinion on the implementation of government policies. She manages projects that apply either qualitative or quantitative research methodologies depending on the topic of interest to the government related to its policies.

The researcher never practiced as a professional nurse or qualified as such, though her undergraduate academic development involved aspects of health. In her current work environment, the researcher places emphasis on matters of national priority – and health is one of them.

Her position as a researcher allowed her extensive access to participants for the collection of qualitative data, presenting a none-bias interaction given the

occupation background of the researcher. This meant that she was an objective, authoritative, neutral observer. Therefore, no personal bias, values and assumptions are part of the reported findings. Open and honest relationships were developed between the researcher and the participants. The researcher was the agent of analysis and interpretation. Her position as an independent researcher outside the discipline of the nursing profession facilitated entry into the participants' world and encouraged effective participation with no pre-conceived ideas.

Identifying biases, personal values and interests regarding the research topic and process, and explaining how entrance was gained to the research site and how ethical issues were dealt with is crucial for the trustworthiness of the research findings. These were identified and acknowledged (Creswell 2009:184), such that the analysis and interpretation of the data is not adversely affected and not leading to invalid and unreliable conclusions.

To elicit relevant and honest views from the participants, the researcher allowed space for intuition by listening intently to what and how they responded to questions asked according to the interview schedule, and by using neutral probes when trying to elicit further information from respondents (Babbie & Mouton 2001:251).

The researcher understood her role in the interview process and allowed more time for the participants to state their views based on questions asked. The researcher created an atmosphere that was conducive for the interview by allowing the participants sufficient time to ponder their responses, avoiding the use of leading questions and at all times being sensitive to their reaction and feelings during the in-depth interview. It was also important to the researcher to show interest in the participants as well as in what they were saying when responding to questions.

During the in-depth interview, the researcher made provision for the participants to explain their views or responses where these seemed unclear. The in-depth interviews were recorded on audio tape and later transcribed verbatim for analysis.

3.5.6 Qualitative data analysis

Data was organised and analysed to elicit meaning (Polit & Beck 2010:463). This was an active and interactive process in which the researcher got immersed in the data. There are various methods available for qualitative data analysis. The researcher discovered patterns such as causal links among variables (Babbie 2013:411).

Data was transcribed verbatim into MS Word files, and the files were read for relationships and patterns. Similarities and differences were identified; words and phrases were grouped into clusters of similar ideas and concepts and highlighted in different colours. This aided in grouping similar concepts together and identifying the most commonly occurring concepts. The analysis of this phase was undertaken independently by the researcher and confirmed by a co-coder; the notes were compared to validate the concepts that occurred, and the findings interpreted (Creswell 2003:191; Saldaña 2011:90-97). The concepts that most commonly occurred during data analysis and interpretation of findings for the pilot phase were used to construct a questionnaire for phase one and phase two.

Audio-taped interviews were transcribed verbatim.

- Transcribed interviews were then read and re-read by the researcher and co-coder to identify patterns from the data.
- Themes were developed according to identified data patterns.
- Emerging data patterns were classified into major themes, firstly in the concrete language of the participant and then clustered into sub-themes, with their concrete meaning being transformed into the language of concept or science.

A conventional process of coding and thematic analysis was used in the study. Codes are a form of shorthand that a researcher repeatedly uses to identify conceptual re-occurrences and similarities in the patterns of the participants'

experiences (Birks & Mills 2011:95). Codes assist with understanding what is happening in the data and what the data means (Charmaz 2006:45).

3.5.7 Trustworthiness

The highly influential work of Lincoln and Guba (Babbie & Mouton 2001:276) reflects on an approach to clarify the notion of objectivity as it is manifested in qualitative research. For them, the key criterion or principle of good qualitative research is found in the notion of trustworthiness: neutrality of qualitative research findings or decisions. To account for trustworthiness of qualitative research, four notions of objectivity need to be considered. These are credibility, transferability, dependability and conformability (Creswell & Plano Clark 2011:211; Shenton 2004:64). These notions were applied in this study to ensure trustworthiness of the qualitative findings.

According to Babbie and Mouton (2003:277), the basic issue of trustworthiness lies in asking how researchers can persuade themselves and their audience that the findings of a study are worth taking account of or paying attention to. The authors draw a comparison between the four notions of trustworthiness in qualitative studies and the principles of objectivity in quantitative studies: internal validity, external validity, reliability and objectivity respectively. Just as a quantitative study cannot be considered valid unless it is reliable, a qualitative study cannot be transferable unless it is credible, and it cannot be deemed credible unless it is dependable.

In this study, the four notions of trustworthiness were applied as follows:

- **Credibility**

The credibility criteria involved establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since the purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes, the participants are the only ones who can legitimately judge the credibility of the results. The researcher's views, values and preconceptions were bracketed before analysing data and adhered to realist analysis of data.

The researcher documented the procedures for checking and rechecking the instrument before finalisation and throughout the study. To double-check validity, another independent researcher with extensive experience in qualitative research looked at the instrument in line with pilot data gathered. The process was documented. Potential for bias and distortion was checked using pilot data.

For validity of data in qualitative methodology, phrasing of discussion points is important. Leading discussion points were avoided that could have compromised the true reflection of the respondents' views. The researcher developed a good rapport with the respondents; this minimised the respondents saying what the researcher wants to hear. Discussions with all participants were recorded for reference and transcription. Triangulation of data is important to validate themes coming out from the findings (Neuman 2003:179-185). Therefore, data in this study was collected and described through data analysis in which elaborate discussions included different views and perceptions of participants, leading to an interpretation that describes different views, contexts and conditions. When data was examined, the research looked for patterns appearing across several observations that truly represent the different participants under study. This approach is called cross-case analysis, with a main focus on variable-oriented analysis.

- **Transferability**

Transferability refers to the extent to which the findings can be applied in other contexts or with other respondents (Babbie & Mouton 2001:277). Transferability of the instrument would be based on the context to which the instrument was applied and the researcher's professional decision. In this study, the researcher was not interested in generalisation when the qualitative approach was used. All observations were defined by the context in which they occur. The researcher therefore did not intend to claim that the knowledge gained from the observations' context will necessarily have a direct relevance for other contexts or for the same context in another time frame.

Transferability in this study was demonstrated by following two strategies described by Guba and Lincoln (1989:16). The two strategies are thick description and purposive sampling. These strategies were applied as follows:

- Selecting a purposive convenience sample of professional nurses in the public-health sector ensured that maximum information on factors influencing professional nurses' involvement in strike action was obtained in its context and as experienced by nurses.
- Providing sufficient descriptive data which is thick and dense. Firstly, this was achieved by the in-depth literature review on the nurses' strike action and related issues. Secondly, a descriptive, explanatory research design was implemented. This research design explored and described the factors which may determine the involvement of professional nurses in strike action and the perceived value of strike action (pilot phase & **phase one**); the perception of nurse managers (**phase two**); the perception of the general public being clients to the public-health sector (**phase three**). The aim and objectives of the study are also described in detail.
- Providing recommendations for intervention measures to effectively manage the factors contributing to the participation of South African public-sector nurses in strike action.

- **Dependability**

According to Shenton (2004:71), in order to address the dependability of the research more directly, the processes within the study should be reported in detail. This will enable a future researcher to repeat the work, if not necessarily to gain the same results. Thus, the research design of this study may be viewed as a "prototype model". In-depth coverage of the research design and all details of the research process will allow the reader to assess the extent to which proper research practices have been followed.

Dependability or consistency of the research study refers to the extent to which the outcomes of the study can be replicated. According to Guba and Lincoln (1989:22), replication in qualitative studies is equivalent to reliability in quantitative studies.

This is almost impossible to achieve because the research design is so flexible and the research findings are produced by constantly changing interactions between the researcher and respondents. Marshall and Rossman (2011:92-95) regard the changing conditions in the phenomenon and the design as being created by an increasingly refined understanding of the setting.

For the purposes of this study, dependability was demonstrated by:

- External control or audit, in that the supervisor followed the study from beginning to end. External control or audit involves having a researcher not involved in the research process examine both the process and product of the research study (Lincoln & Guba 1985:300; 317). The purpose is to evaluate the accuracy and whether or not the findings, interpretations and conclusions are supported by the data (Cohen & Crabtree 2006). External audits are conducted to foster the accuracy or validity of a research study (Golafshani 2003:601). External audits provide an opportunity for an outsider to challenge the process and findings of a research study. This can provide:
    - an opportunity to summarize preliminary findings
    - an opportunity to assess adequacy of data and preliminary results
    - important feedback that can lead to additional data gathering and the development of stronger and better articulated findings
    - triangulation through the use of different data collection approaches as discussed in section 3.4 of this chapter
    - an audit trail

The audit trail which the researcher maintained, entailed keeping all audio tapes used during data collection, data transcripts, interview schedules, notes about research procedures, and field notes until the final report has been approved by the institution in which this study was registered under.

- **Confirmability**

'Confirmability' or (neutrality) refers to data objectivity (Babbie & Mouton 2001:278) and deals with whether another researcher outside of the study could independently

confirm the findings (Wise 2011). In order to establish that findings can be confirmed by an inquiry audit, triangulation and keeping a journal are processes or strategies that the researcher could follow (Lincoln & Guba 1985:326).

Critics of qualitative research claim that qualitative research is inherently biased and subjective. Proponents of qualitative research believe that researcher subjectivity is the strength of qualitative research, as it allows the researcher to build rapport with and empathy for participants as the researcher immerses herself in the setting to gain an in-depth understanding of the participants' worldview (Wise 2011). The researcher's insights increase the likelihood that she will be able to describe the complex social system being studied. However, the researcher had to build in checks to control for bias in the interpretation of the study results. These checks included:

- Searching for negative or discrepant information.
- Checking and rechecking data and searching for rival hypotheses.
- Bracket researcher assumptions, personal values and beliefs.
- Conduct an audit of the data collection and analytic strategies.

Providing controls for bias in interpretation of data also strengthens confirmability (Marshall & Rossman 2011:39-41). Confirmability was pursued through:

- An audit trail of data transcripts, audio tapes, interview schedules and field notes.
- A description of data analysis methods.
- Checking and rechecking data collected from nurses who were respondents in the phase-one exploratory part.
- Following the guidance of previous researchers who are experienced in qualitative research, as well as the promoter's guidance.
- Familiarity of this researcher with qualitative research methods.

The researcher took steps to ensure as far as possible that the study findings are the result of the experiences and ideas of the participants, rather than of her characteristics and preferences (Shenton 2004:72).

The pilot phase for this study was conducted with the purpose to inform the main phases of this study. The researcher conducted this phase to effectively implement the three main phases of the study. Hence, it formed a planning phase which was only limited to the methodology chapter as it was meant to inform the main study instruments. To illustrate how the pilot phase informed the construction of the research instruments used for phase one (Annexure E) and phase two (Annexure F), the researcher took an informed decision to discuss the pilot-phase findings within the methodology chapter as part of the planning phase of the study. The findings of the pilot phase are therefore not reported on as conclusive results of this study but merely as informing instrument of the development process.

- **Presentation of the pilot-phase qualitative findings**

Analysis of data collected from nurses during in-depth interviews resulted in four main themes outlined below:

- General views on nursing as a profession.
- Nurses' affiliation with professional bodies and trade unions.
- Reasons for participation or non-participation in strike action.
- Management of future strikes in the public-health sector.

From these main themes, sub-themes emerged which were classified under each relevant theme. A summary of the themes and sub-themes is illustrated in Table 3.1.

Table 3.1: Themes and sub-themes from the exploratory data

Theme	Sub-theme
Theme 1 Views on nursing as a profession	i. Likes and dislikes of nursing as a profession ii. Provision of health services in the public-health sector iii. Interventions to improve nursing as a profession
Theme 2 Nurses' affiliations	i. Perceived advantages and disadvantages of nursing bodies and trade unions
Theme 3 Reasons for participation or non-participation in strike action	i. Push-and-pull factors to strike action ii. Impact of strike action on the nursing profession
Theme 4 Management of strike action within the public-health sector	i. Duration and management of strikes in 2007 and 2010 ii. Recommendation for future management of strikes

Theme 1: Views on nursing as a profession

i. Likes and dislikes of nursing as a profession

Participants indicated that they loved the nursing profession, as it gives them an opportunity to help other people and cure the sick. They recognised that nursing is a profession meant to save lives and making the sick feel better in their care. Most importantly, a few mentioned that they liked the profession because of their passion for it and opportunities presented by the standards of nursing in South Africa, compared to other countries.

"I like the profession because as nurses we are saving people's life and making them feel better. There is room for specialisation about what you want to focus on. There are international opportunities because of the standard of nursing in SA."

"I like to work with patients especially those in post-natal section. I like working with children and like dealing with patients who have cancer."

"Because I chose to do this job and it has been my passion for quite some time. I like working with people."

Positive feelings about the profession did not deter participants from mentioning some of the challenges that affect their passion for the profession negatively. Participants expressed their feelings about dissatisfaction with working conditions in public-healthcare facilities that relate to workload and the patient-nurse ratio. Others were concerned about the limited resources to perform their duties. These participants were of the view that lack of resources prevents them from providing quality healthcare as required by the profession.

"Most people are quitting nursing and there is just a lot of work and the nurse-to-patient ratio is just not according to standard."

"… hospitals and clinics are understaffed, government indicated not to have money to hire more nurses to deal with the nurse-patient ratio problem. If the government can employ more nurses, then they will do their work effectively."

"When I want to work you find out that there are no resources. That is so hurting and I hate that the most because it inconveniences us to provide proper nursing care."

Lower wages compared to the private sector were some of the reasons mentioned for not being happy with the nursing profession in South Africa. The participants were of the view that they also had higher qualifications that did not match the lower salaries provided to them. Other participants raised their concern about a lack of commitment and passion from the younger generation in the nursing profession. They reflected that in the olden days, the nursing profession used to be about passion, not so much about qualifications. It is said that the younger generation got into the profession for just gaining a salary. Further, they have to be reminded of all work they need to perform because they just studied theory and lacked practical experience.

"Salary is not according to one's qualifications while there is a lot of work to be done. Having high qualifications and being paid lower salaries."

"Young generation nurses are not committed to the profession. They just come because they did not have money to study what they wanted. The behaviour of young nurses is also not according to the ethical dress code of nurses. It affects the dignity of the profession."

When asked how they felt about their job satisfaction compared to a few years ago, most of the participants indicated a low job satisfaction which was mainly linked to things that they disliked about the profession. A few participants felt that their job satisfaction has increased compared to a few years ago. They said nowadays, workshops are conducted where nurses get to know and learn about new developments within the discipline of nursing, and the South African Nursing Council tries its best to align nursing with an outcome-based approach. All this intensifies the nurses' capabilities.

"The satisfaction has deteriorated. I doubt why I came back to work in the country. The OSD [Occupation Specific Dispensation] programme is also not being implemented effectively throughout the country."

"Now I am not satisfied as we are currently working more than 40 hours per week than it used to be."

"Because we are aligning ourselves with the outcome-based approach and the Nursing Council is trying to change to intensify nurses. These things improve my job satisfaction."

"My job satisfaction has increased because we have workshops and update ourselves as nurses on new developments within our discipline."

ii. Provision of health services in the public-health sector

A majority of participants were in consensus that the nurses are trying their best to offer healthcare to those who need it. Their concern is that they feel they do not provide the expected quality of healthcare services due to lack of resources, long working hours and overload of work, resulting in nurses experiencing fatigue and not responding professionally to patients. This feeling was shared by all participants regardless of their involvement / non-involvement in strike action.

"Resources are a problem. At times I can't perform my job the best way I should, this also demoralise the nurses."

"Nurses are trying their best but are limited by resources to perform their best. Sometimes the nurses at primary healthcare facilities tend to refer patients to hospitals unnecessary. Poor work ethics by some nurses, especially at primary healthcare facilities, overburden the public hospitals."

iii. Interventions to improve nursing as a profession

Findings indicated that if participants were to be in a management position, they would ensure that there is equipment, balance in terms of nurse-patient ratio as well

as good establishments in public-healthcare facilities. Participants further indicated that nurses need to do what they are employed for; not for laundry and catering for patients due to lack of personnel.

"I would correct the nurse-patient ratio – given the prescripts for attending to one patient – diet, dispensary and escorting of patients. Nurses are expected to do almost everything. Nurses need to stick to basic nursing care and not do other administrative work – stock ordering and other things. All sections in the healthcare facilities must do their own work, and don't overburden the nurses with non-healthcare chores."

"I would address the challenges raised by nurses that affect their performance, unlike the current management that just listens but do not act on nurses' concerns."

Similar views were presented by participants who participated in strike action and those who did not participate. However, the extent of emotional expression on contributing factors to nurses' involvement in strike action was stronger amongst those who participated compared to those who did not participate.

Theme 2: Nurses' affiliations

i. Perceived advantages and disadvantages of nursing bodies and trade unions

Generally, the participants feel that there is a need for the existence of unions and the SANC, as both these bodies serve different purposes that are equally important to the nurses. However, few mentioned that unions should be done away with, as they seem to have taken over everything and affect the effectiveness of the public-health system.

Participants understood the role of the Council as being to determine practice standards and seeing to it that patients are rightfully serviced by the nursing personnel. Others also recognised the role of the Council as being to compile standards for exam papers and determining the curriculum for nursing qualifications. However, there were some negative feelings from the participants about the function of the SANC. These included that the Council is there to punish the nurses by giving harsh punishments for misconduct of practice and that they necessarily look after the benefit of the patient than that of the nurses. The participants were of the view that the Council always considers the public's rights over their rights as nurses. Others felt that they are mainly paying the affiliation fee for being able to practice as professional nurses; other than that, they see no benefit of the Council to them.

"Helps with cases for misconduct – the union will provide a lawyer for me. The Council looks more to the satisfaction of the public than that of the nurses."

"The Council is just after the nurses. Just one mistake they take you off the roll. It was better if we were governed by government directly. The Council can suspend you for life."

Given this perception about the role of the Council, participants felt it was necessary to seek protection of their rights through affiliation with unions.

"Both are important, the Nursing Council is there to set standards but it is more for protection of the public. It is monitoring the nursing standards. Unions must be there because sometimes there may be something or charged with something, the union must be there for the protection of the nurses and look after the salaries of nurses. The unions must not be abused for self-benefit. Both organisations are important to me."

Few participants indicated that the best union to affiliate with is DENOSA, as it

understands the regulations which nurses need to abide by and always tries to assist nurses within legal parameters. The feeling was that other unions have regulations that contradict with those of the Nursing Council, especially when it comes to the abandonment of patients while fighting for nurses' rights.

"I think it is contradicting somehow. As nurses we are not supposed to totally neglect our patients. We must always be mindful of providing skeleton staff for patients. Some people have been threatened to participate in strike."

The findings indicate that the pull-factor for union affiliation is a need for recognition through wage negotiations, representation on cases of misconduct or dispute in the workplace as well as preservation of workers' rights for good and safe working conditions.

Theme 3: Reasons for participation or non-participation in strike action

i. Push-and-pull factors to strike action

As the basis of this study, participants were further engaged on reasons they thought led the nurses to engage in strike action. All participants regardless of their involvement or not in strike action indicated that the strike was bound to happen because the government and management do not listen and are not concerned about their well-being as indicated by low wages they provide to nurses.

"Money problem, cost of living is too high and nurses are working too hard and those seating in government offices get a lot of money while nurses are paid peanuts."

"Everybody wants to be satisfied concerning money, life is expensive and our salaries as health professionals cannot sustain us and provide for basic needs of our lives. The new nurses entering into the system have higher salaries that cause

unhappiness for the old nurses who earn lesser."

Most participants were of the view that wages that nurses get paid are very minimal compared to other government officials. It was difficult for the participants to understand why their profession is regarded as one of the essential services if the government doesn't show that by paying adequate wages that fit the responsibilities and workload of nurses. Another reason mentioned by participants was around the issue of working conditions that are not conducive for nurses to perform their duties.

"That the government say we are essential services, but essentials without money. It is difficult to act with unions and Council involved."

"The reason behind the strike, the government is not paying a living wage for nurses, yet they are doing hard and good job. Look at those in government offices they get a lot of money. I think 8.5 was a reasonable amount. Other industries are getting a higher percentage for their salaries. If someone is paid well they will do their job well. The nurses did not all go for strike, the managers were there as skeletons. The bad thing is that other nurses were intimidated if they wanted to come to work."

Participants were of the view that consideration of their wages is important. They mentioned that the cost of living is too high and they can't afford some of the basic necessities in life due to their low wages, yet a lot is expected from them. They mentioned that they are often expected to give their time and be friendly to patients and perform various other tasks that are not a direct responsibility of nursing personnel, and yet get paid minimal wages.

Other participants indicated that it was important for nurses to get involved in strike action, as it was perceived that the government will be shaken and make an appropriate offer quicker to avoid patients being left without being provided healthcare services.

“It is the only language the government understands. There was no consensus reached on time and our government just thought of itself.”

Amongst those who did not get involved in strike action, there was a view that even though money is important, it is ethically forbidden for nurses to get involved in strike action as that meant neglecting their patients. On the other side, from those who were involved the view was that the government should not blame the nurses for patient’ neglect; they should rather blame their negotiation processes that failed.

“It was to show that we are not happy with the money – but as we pledge we say nothing can separate us from the patients – in a way the nurses are not allowed to strike.”

All participants that did not directly get involved in strike action were generally motivated by the ethical code and commitment to saving lives and giving care to patients. On the other hand, some mentioned that they were caught in between choices to participate or not – reasons being that if they participated, they feared dismissal by the SANC, and intimidation if not striking. They however, indicated that they wanted to raise their concern about wages as well.

“I just wanted to help our people. It is my job commitment. The needs of the patients come first. Especially with us working in rural areas our patients do not have money to go for private care.”

“I thought twice. I was scared of dismissal from the Council. I wanted to strike for money but could not. We were also scared as we were not striking.”

Those who directly got involved in strike action had the following to say about their feelings and views while they were away from work:

“I did it at my own will. I believe if you want something you must fight for it if people

don't want to listen. Feelings during strike – I was worried but my worry was lessened by the skeleton staff put in place to take care of the patients."

"It showed what kind of government is in charge. It is government that thinks for itself and not about people who do their work. People were angry and we don't mind the loss of our salaries – as long as they have heard us and noticed our concerns."

"We were requested by our union representatives to please support the course."

"I am a key member of DENOSA and I am not a coward I wanted to support those who were striking."

"It is better if we are all on strike out there because when you are in the hospital you feel sorry and sad about the patients not being attended to. Skeleton staff was in place to save the lives of the patients that kept us content."

From this exploratory qualitative phase, the nurses indicated that they were not happy about their involvement in strike action and some were not proud of what happened, especially when they thought about patients. Though, they felt that their action was justified and that they did not act unjust, as skeleton staff was provided to look after the patients in most areas. Their only concern was that no one was supposed to be forced to partake in a strike action. Amongst those who participated, all participated in strike action out of their own will and some were requested for support by their union representatives but respondents assured that they were not pressurised into taking action.

ii. Impact of strike action on the nursing profession

The participants that were not involved in strike action felt that the strike compromised the value of the profession, as they need to take care of people's lives. Others felt that it is not worth being a nurse given the level of nurses'

involvement in strike action. Some participants expressed a need to leave the country or pursue a different career than nursing as a result of strikes within the health sector.

“It makes our profession lose value as we are responsible for the lives of the people.”

“I am bored and think of moving to another country or do something else other than nursing.”

Amongst those who participated, the feeling was that the strike action somehow affected the image of the profession and they were aware of the ethical code that binds them within the profession. However, their view was that as much as they did not want to abandon patients they were left with no options but to fight for their human rights with regard to satisfactory wages and working conditions. To some extent there were feelings of sadness: they mentioned letting patients down during their involvement in strike action.

“I was bored by all what was happening and I even felt of willingly going on pension. The way I see government responding to our challenges it makes me feel disheartened.”

“It is not right that the nurses must strike though there was a cause. Nurses are responsible for the lives of the people. The government must also be proactive and take people’s concerns seriously. The attitude of government towards those on strike was very wrong. I was not that worried as there was skeleton staff still looking after patients.”

“Nurses are actually not supposed to strike. We don’t strike because we think about the patients but the government does not think about the needs and working

conditions of nurses and recognise them by pay – these forces nurses to go on strike despite them recognising the code of practice."

Generally, the participants were aware of the ethical code that binds them within the profession, however concern over basic personal needs and good working conditions were believed by some as worth getting involved in strike action despite the existence of the professional code.

Theme 4: Management of strike action within the public-health sector

i. Duration and management of strikes in 2007 and 2010

The participants felt that negotiations took too long to be resolved due to misunderstanding between the negotiating parties. The feeling is that if the parties meant well negotiations should have been started earlier and agreements reached before strike action could be considered.

"Prolonged negotiations and misunderstanding between negotiating parties. The negotiations were very slow and there was a lot of power struggle that prevented concluding on consensus."

"The people, the structures above had differences and unwilling to reach consensus – more issue of power struggle."

Those who were engaged in strike action felt that there was some foul play between the government and the unions at the expense of the workers. They believed that those at the negotiating table were playing power struggles and fighting their political battles during the negotiations. With all considered the government was perceived more in the wrong and being unreasonable and prolonging the process towards a settlement.

“The political situation in the country also contributes a lot to the long period of strike, so many things have changed which cause these tensions and previously there were increments without negotiations involved.”

“I would say the political situation in the country had an influence on the prolonged strike action. These politicians are pushing their own agendas hence, no consensus were reached and the government always claiming not to have money.”

When exploring the strike management, respondents indicated that the strike action in 2010 was handled badly as it took too long to reach consensus. The feeling was that the negotiations could have commenced earlier and consensus reached to avoid strike action. There was a feeling that the government wanted to call the shots and did not aid the negotiation process, which made the process unnecessarily longer than what it was supposed to be.

Some of the perceived reasons for the strike action to take as long as three weeks in 2010 were power struggle between the unions and the government, and inconsideration of the government about its employees and the health of the people it serves. Participants were of the view that if the government cared for the people, consensus could have been reached quicker. The communication of the government during strike action in 2010 was felt to be very negative and instilling anger on those who were involved in strike action. Compared to how things were handled in 2007, participants indicated that the management and communication by the government in 2007 during the strike, was far better than it was in 2010. Though, those who were involved in strike action perceived communication by their respective unions as effective during the strike action in 2010.

ii. Recommendation for future management of strikes

Participants who were not involved in strike action were mainly in consensus that wage negotiations should be engaged on earlier and future plans be communicated to avoid unnecessary strike action.

“They should have reached an agreement and communicated future plans to avoid strikes in public sector in future.”

Those who participated in strike action felt that to avoid strike actions in future, wage negotiations should be done on time in line with the cost of living. They felt a need for the government to be considerate when it comes to the nursing profession and view it equal to other professions in terms of wage allocations. The participants were of the view that the Minister of Health should on a continuous basis engage with nurses – not management – to understand the work conditions that nurses are confronted with. This was perceived to be a solution in decreasing fatigue and workloads on nurses. When the Minister engages, he will see how much nurses improvise with limited resources in public-healthcare facilities.

“It is a bit difficult to say. The nurses tried to negotiate through their unions but government forced the hand of the nurses to strike. The government should just be considerate.”

“Appreciation of the work done by nurses in South Africa and the scope of work we do then there won’t be reasons for nurses to strike.”

“Minister to visit hospitals and frequently engage with nurses about their conditions of working plan with nurses as they are the ones providing healthcare and confronted with working condition challenges such as lack of standard resources.”

With the insights gained from the pilot phase, a quantitative questionnaire informed by key findings of this phase was constructed for phase one and adapted for phase two, mainly with pre-coded questions as informed by the qualitative findings reflected above. The insights were also used by the researcher for validation of findings in subsequent phases of the study. This will be reflected on in Chapter 4.

3.6 PHASE ONE: QUANTITATIVE APPROACH

The quantitative approach in phase one provided for a quantitative measurement of factors contributing to nurses' involvement in strike action, and enabled statistical analysis of behavioural trends, attitudes and perceptions.

3.6.1 Population and sampling

In phase one, a non-probability purposive and convenience sampling was used. The sample was drawn from a population of professional nurses working in healthcare facilities that were affected by strike action in 2007 and 2010. The nurses selected were professional nurses who are employed and registered in the South African Nursing Council's practice register (Bowling 2011:208; Creswell & Plano Clark 2011:173). Further, the selected respondents' affiliation or non-affiliation with DENOSA or some form of union group was determined.

With the budget limitations of this study in mind, the researcher and the study supervisor agreed on the sample of 80 respondents that were representative of the population of interest (Polit & Beck 2010:75). For the researcher, it is not always possible to study all members of the population of interest. A portion or subset of the population of interest was therefore selected (Babbie & Mouton 2003:100; De Vos et al. 2005:192). A non-probability sampling approach relying on purposive and convenience sampling was used in phase one based on the absence of a list of nurses who participated or did not participate in strike action either in 2007 or 2010 (Babbie 2013:128).

Four major provinces, namely EC, KZN, WC and GP were targeted for the study. These were selected on the basis that they include South Africa's four metropolitan areas and would – given the budget limitations – provide a better national view on the focus of the study (Polit and Beck 2004:28).

- **Population**

The target population for **phase one** was all accessible nurses working at public-healthcare facilities that were affected by strike action either in 2007 or 2010. The healthcare facilities were located in any of the four selected provinces, which were provinces that were affected by strike action in 2007 and 2010. The accessible population is defined as a population of subjects available for a particular study or reasonably accessible to the researcher (Polit & Hungler (1999:209). According to Burns and Grove (2003:366), the sample in a study is obtained from the accessible population, and findings are generalised first to the accessible population and then, more abstractly, to the target population.

- **Selection of respondents**

A non-probability purposive site sampling technique was used in the study (Creswell & Plano Clark 2011:173). The sample was selected from accessible public-healthcare facilities that were affected by strike action in 2007 and 2010 in KZN, GP, EC and WC and consisted of registered nurses who participated in strike action and some who did not participate in strike action. To realise the complete sample of 80 registered nurses in the four site provinces, a snow-ball sampling technique was applied in the sampling process.

This study was conducted in a situation where the researcher could not select the kinds of probability samples used in large-scale social surveys. There was no existing list of nurses who participated or not participated in strike action. Therefore, this situation called for a non-probability sampling approach. It was found appropriate for the researcher to select the sample on the basis of her understanding of the target population and its elements relevant to the study questions (Babbie & Mouton 2001:166).

The respondents were selected on the following criteria (Annexure C) (Bowling 2011:208):

- All nurses selected should be working at any public-healthcare facility in the four provinces (KZN, GP, EC and WC) selected for the study that were affected by strike action in 2007 and 2010.
- The nurses should have been employed at such healthcare facilities during the strike periods in 2007 and 2010 and either participated or not participated in strike action in the same period.
- They should be conversant in English and reside in South Africa.
- Their names were supposed to be in the SANC registry for practicing professional nurses during the period of the study.

The above criteria assisted in ensuring that the respondents know enough to respond on questions to address the research objectives.

A purposive and convenience sample selection approach for respondents was applied for this phase of the research due to the nature of respondents that were required (Bernard 2013:165). Nurses who participated in the pilot phase were also included as part of the phase-one sample of 80 registered nurses as per criteria outlined above. Given prior interaction with these nurses, referrals were provided for the respondents selected in GP. For the other three provinces, the researcher relied on colleagues and friends of colleagues who had nurse relatives or nurse friends that were either involved in strike action in 2007 or 2010 and working in public-healthcare facilities that were affected by strike action in the specified period (Burns & Grove 2009:42).

3.6.2 Data collection

The pilot phase assisted the researcher to identify the data needed to be collected in phase one and subsequent phases of this study. In addition to this, the data to be collected in phase one was informed by the study aim and objectives (Grove, Burns & Gray 2013:507). According to Burns and Grove (2009:43), data collection is the precise, systematic gathering of information relevant to the research purpose. This phase took place in October 2013, and involved collecting numerical data to address the research objectives and questions. A letter (Annexure B) explaining the

purpose of the research was sent to all respondents soon after identification and selection (Bernard 2013:244). In line with the data collection process described by Burns and Grove (2009:42), consent from respondents was obtained through receipt of signed consent forms prior data collection for this phase (Annexure B).

A constructed questionnaire for phase one (Annexure E) was e-mailed or hand delivered to all selected respondents (Babbie 2013:245). The completed questionnaires were returned to the researcher through e-mail on the agreed date. The questionnaires were returned in MS Word or PDF format. On receipt of the completed questionnaires by the researcher, the questionnaires were checked for completeness (Babbie 2013:245). Professional nurses were asked in a self-administered questionnaire to state or identify factors which influenced their involvement or non-involvement in a public-sector strike action and to give background information about their work environment or employment circumstances.

The researcher made some follow-up communication by electronic mail as a reminder for completed questionnaires to be routed back by e-mail from the respondents (Babbie 2013:243-247; Babbie & Mouton 2001:258-260).

3.6.3 Phase one: Quantitative research instrument (Annexure E)

The researcher developed the research instrument guided by the research questions, objectives, theoretical framework and the literature review as well as input from the supervisor and a statistician who later helped with data analysis. The research instrument addressed the objectives of the research study, which applied to registered professional nurses who were in practice during the period of the study and worked at public-healthcare facilities that were affected by strike action in 2007 and 2010. The quantitative research instrument (Annexure E) was used to obtain reasonably precise information on the area of interest to the researcher (Polit & Beck 2010:370). The research instrument was formulated in English only given that all respondents were qualified professionals and had to be conversant in English to participate in the study. Areas covered in the study questionnaire

focused on factors that contributed to nurses' involvement in strike action. Constructs were also reflective of items which could be described as needs for future management of nurses' involvement in strike action (Grove et al. 2013:200). Literature reviewed, referred to nurses' involvement in strike action. However, no such survey or study has been conducted in South Africa, especially pertaining to strike action in the public -health sector in general and not localised to one hospital or province.

The Likert scale of measurement was used for the measurement of degrees of viewpoints on the topic of the research (Polit & Beck 2010:346). The format was such that respondents were asked to strongly agree, agree, disagree, or strongly disagree, or perhaps strongly approve, approve and so forth as reflected in the study questionnaire (Annexure E) (Babbie 2013:231-232). Pre-coded, open-ended, close-ended and rating questions were constructed based on the pilot phase and the literature review. This meant inclusion of questions with pre-specified response alternatives and those that allowed participants to respond in their own way (Polit & Beck 2010:343). To avoid possible errors in data collected, the researcher ensured that questions are clear and that the language used could be understood by the respondents (Bernard 2013).

The self-administered questionnaire was opted for to benefit the researcher and the study as outlined below (Brink, Van der Walt & Van Rensburg 2012:153).

- It was a quick way of obtaining data from a large group representative of the population of interest.
- It was less expensive to distribute in terms of time and money.
- Respondents were given a greater sense of anonymity; thus likely to provide honest answers.
- The format of the questionnaire was standard for all participants and was not dependent on the mood of the interviewer.

The questionnaire was divided into seven sections

SECTION 1: BACKGROUND INFORMATION

Section one was designed to obtain background information of the respondents. Questions asked related to the employment sector, level of employment in the health sector, province currently working in as well as gender.

SECTION 2: INTRODUCTION AND WORK EXPERIENCE

Section two formally set the scene for the enquiry process. This section was focused on obtaining information on the kind of work that the respondents were doing, their satisfaction with working in the public-health sector, and labour relations. The respondents were reaffirmed that the information provided will not be linked to their names and that their names will be treated in the strictest confidence. The respondents were also reminded about the duration that the questionnaire will take to be completed.

SECTION 3: COMMITMENT TO JOB AND ORGANISATION

In section three, five questions focused on respondents' views about the organisation that they work for, i.e. whether it was ideal and appealing to work for. The other five were focused on eliciting their views about the kind of work they engage in on daily basis.

SECTION 4: TRADE UNIONS

Section four was included to obtain information about the nurses' association with labour unions and the role this play in their work within the public-health sector.

SECTION 5: THE STRIKE ACTION

Section five explored the reasons that could have led the nurses to get involved in strike action. This focused on understanding the contributing factors that could have

led to strike action within the public-health sector. Relations between the affiliates and union representatives were also explored in terms of their role during the strike action.

SECTION 6: SENTIMENT TOWARDS THE STRIKE

Section six focused on eliciting information on how respondents felt about the proceedings of the strike action. This leaned more towards understanding whether they thought things were managed accordingly; whether they were of the view that the strike action was indeed the right action to engage on; whether it served the purpose that it was meant for.

SECTION 7: DEMOGRAPHICS

Demographics as the most sensitive information required from the respondents, was put as the last section (seven) of the questionnaire to avoid unsettling the respondents at the beginning of the questionnaire.

- **Pre-testing the questionnaire (Annexure E)**

The researcher carefully designed the questionnaire (Annexure E) based on the literature review and the insights from the **pilot phase**.

According to Babbie and Mouton (2001:244), there is always possibility of questionnaire error that may occur due to terms of ambiguity of questions or some violation of questionnaire-design rules. They further state that the surest protection against questionnaire errors is to pre-test the questionnaire in full and/or in part.

For the purposes of this study, the research instrument or questionnaire (Annexure E) for phase one was pre-tested in full. Pre-testing was conducted to assist the researcher to identify problems that could have been encountered while collecting data (Grove et al. 2013:523).The instrument was pre-tested with five registered nurses in GP working at public-healthcare facilities that were affected by strike

action in 2007 and 2010. Five respondents were decided upon because there was no need for a representative sample for pre-testing the questionnaire, however, the smaller sample had to resemble the population of interest for the study (Babbie 2013:242; Babbie & Mouton 2001:244-246). These respondents were not included in the final sample of the study (Bernard 2013:237). The respondents used for pre-testing the questionnaire (Annexure E) were asked to comment and give their opinions on the instructions given, the content, level of comprehension, lack of ambiguity, and length of time required to complete the questionnaire**.** The questionnaire was also given to the study supervisor, a statistician and other colleagues in the field of public health for evaluation and comment prior finalisation and distribution to study respondents.

No changes were made to the questionnaire as the result of the pre-testing, except for minor grammar changes. Pre-testing also assisted with the indication of how long the self-administered questionnaire took to complete. As a result, 20 to 30 minutes were indicated in the questionnaire to alert the study respondents how long it would take them to self-complete the questionnaire.

- **Validity of the questionnaire**

Validity is the degree to which a questionnaire reflects reality or what it is meant to measure (Burns & Grove 2009; Peat, Mellis, Williams & Xuan 2001:108). It is important to measure validity for all newly-constructed questionnaires (Babbie & Mouton 2003:122). In order to determine the validity of the research instrument used in this study, content, face and construct validity were measured.

i. Content validity

Content validity refers to how much a measure covers the range of meanings included within a concept (Babbie 2013:192). The **phase-one** questionnaire was informed by the literature review presented in Chapter 2, the qualitative findings of the **pilot phase** and by professional colleagues including the study supervisor and the statistician. Pre-testing the questionnaire amongst the five professional nurses

in public-healthcare facilities and requesting them to critically review the questions and give comments while completing the questionnaire also assisted as measures to enhance the content validity of the study instrument (Bowling & Ebrahim 2005:132-133).

ii. Face validity

Face validity is based on the notion that a good measure should look like a good measure. It refers to whether the instrument looks as though it is measuring the appropriate concepts (Polit & Beck 2010:377). This procedure has a high degree of subjectivity as it is based on a subjective judgment that the instrument measures what it intends to measure in terms of the relevance and presentation of the questionnaire (Babbie 2013:191). In this study, immediately after the questionnaire design, the questionnaire was submitted to an expert statistician and the study supervisor as well as five practicing professional nurses to determine whether the questions were clear, understandable and in a logical order (Babbie & Mouton 2003:642; Polikandrioti, Goudevenos, Michalis, Nikolaou, Dilanas, Olympios, Votteas & Elisaf 2011:139).

iii. Construct validity

Construct validity refers to the degree to which a measure relates to other variables as should be expected within the system of theoretical relationships, validating not only the instrument, but also the theoretical framework (Polit & Beck 2008:750). It is the degree to which an instrument sets out to measure the construct that is being investigated and is based on the logical relationship among variables (Babbie 2013:192). Tests of construct validity can offer a weight of evidence that the study measure either does or does not tap the quality the researcher wants it to measure, without providing definitive proof (Polit & Beck 2010:379).

Firstly, the literature guided the researcher with respect to the development of the main and initial broad concepts. Secondly, the elements within the constructs were obtained from the nursing professionals that formed part of the pilot phase. Thirdly,

the constructs were re-visited and validated by the pilot process and consultation with the study supervisor and other students at a doctorate level, during the iterative process. The pilot process assured that the construct of the research is effectively measured.

- **Reliability**

Reliability is defined as the extent to which a questionnaire, test, observation or any measurement procedure produces the same results on repeated trials. It is the stability or consistency of responses over time that determines the reliability of the research instrument and the data obtained (Bernard 2013:46). Babbie 2013:188) refer to reliability as “a matter of whether a particular technique, applied repeatedly to the same object, would yield the same result each time”. Bowling (2005:132-133) and Polit and Beck (2010:386) concur with Babbie (2013:188) by referring to reliability as the ability of the instrument to yield similar results when repeating the same study using similar conditions, producing the same or similar results consistently.

In this study, the internal consistency or homogeneity was used for the assessment of reliability. Internal consistency concerns the extent to which all the instrument’s items are measuring the same thing (Polit & Beck 2010:386; Reynaldo & Santos 1999). The aim was to explore factors that influence nurses’ involvement or not in strike action and its impact. The reliability of each item in the research instrument was determined. This process was followed to determine whether the individual items are highly correlated with each other and Cronbach’s alpha was used to determine consistency or average correlation of items in the study questionnaire to gauge reliability. The study supervisor as an expert involved in teaching research, and some experienced individuals in the field of nursing management assessed the instrument and the homogeneity of the variables before they were used. Pre-testing the instrument further enhanced the reliability of the study questionnaire.

The researcher further ensured reliability by conducting the study in different provinces, with different people (who all have been exposed to the strike action and its impact in the public-health sector in approximately the same time period) and at different locations. The respondents were also not selected from the same section of the public-healthcare facility. This limited competition between respondents or some form of intimidation when completing the questionnaires. The questionnaire was completed privately by each respondent (Laerd 2012).

3.6.4 Quantitative data analysis

Quantitative data analysis involved descriptive and inferential statistical analyses to indicate proportions and relations between variables identified from the questionnaire (Burns & Grove 2009:461; O'Neil 2009:18-19). Descriptive statistics were also used to describe the basic features of the data in the study. This assisted to provide simple summaries about the sample and the measures (Jackson 2012:116-130). Quantitative data from the questionnaire for all four phases of the study was translated into numerical codes and captured by the researcher and validated by the statistician from the Human Sciences Research Council, using the IBM® SPSS® Statistics Version 21 package. Responses from open-ended questions were also coded, grouped into themes and categories and analysed. The analysis of findings in detail will be discussed in Chapter 4.

3.7 PHASE 2: QUANTITATIVE APPROACH

The quantitative approach in phase two provided for a quantitative measurement of views from nurse managers about perceived contributing factors for nurses' involvement in strike action during 2007 and 2010. This helped the researcher to further understand contributing factors and nurse managers' understanding of the changing work environment of the nurse practice. The researcher used this insight to describe strategies for future management of nurses' involvement in strike action reflected in the conceptual model provided in Chapter 5.

3.7.1 Population and sampling

In phase two, similar to phase one, a non-probability purposive and convenience sampling was used (Brink et al. 2012:139). The population of interest for phase two was all nurse managers that worked at public-healthcare facilities that were affected by strike action in 2007 or 2010. The nurse managers selected were professional nurses by profession and registered in the South African Nursing Council practice register (Bowling 2011:208; Creswell & Plano Clark 2011:173). Nurse managers were selected from the four provinces to which the study was limited to (Polit & Beck 2004:28).

- **Population**

The population of interest in phase one was all accessible nurse managers that worked at healthcare facilities that were affected by strike action in 2007 or 2010 and were managers at that time (Brink et al. 2012:131, 136). The healthcare facilities in which they managed at were located in any of the four selected provinces for the study on the basis of the criteria provided earlier. The accessible population is defined as a population of subjects available for a particular study or reasonably accessible to the researcher (Grove et al. 2013:351).

- **Selection of respondents**

The non-probability sampling was chosen, as it was difficult for the researcher to locate the entire population of nurse managers within the population of interest. Access to the respondents was also limited to their availability as well as willingness to be included in the study. The sample used in phase two was not meant for generalisation but to further gain insight on the area of interest to the study (Brink et al. 2012:139).

The following selection criteria were used for nurse managers that were included in the study (Grove et al. 2013:352-353):

- All nurse managers selected should be working at any public-healthcare facility in any of the four provinces (KZN, GP, EC and WC) selected for the study that were affected by strike action in 2007 and 2010.
- The nurse managers should have been employed as managers at such healthcare facilities during the strike periods in 2007 and 2010.
- They should be conversant in English and reside in South Africa.
- Their names were supposed to be in the SANC registry for practicing professional nurses during the period of the study.

A purposive and convenience sample selection approach for respondents was applied for this phase to select 12 nurse managers across the selected provinces (Bernard 2013:165). Twelve nurse managers were selected based on the criteria outlined above and the researcher relied on their accessibility and willingness to participate in the study. The researcher depended on personal contacts and nurse respondents for referral to nurse managers that fit the set criteria (Brink et al. 2012:139; Burns & Grove 2009:42).

3.7.2 Data collection

This phase involved collecting numerical data to address the research objectives and questions. Data collection took place in October 2013. A letter (Annexure B) explaining the purpose of the research was sent to all respondents soon after identification and selection (Bernard 2013:244). Prior data collection, consent to participate was obtained through receipt of signed consent forms from respondents (Annexure B) (Burns & Grove 2009:42).

For phase two, the phase-one questionnaire was adapted slightly to align to nurse managers as respondents. The questionnaire (Annexure F) was e-mailed or hand delivered to all selected nurse managers (Babbie 2013:245). The self-administered questionnaire ensured that all respondents get the same questions, thus limiting the interviewer bias or response effects (Bernard 2013:221). The completed questionnaires were returned to the researcher through e-mail in Ms Word or PDF

format on the agreed date. On receipt of completed questionnaires by the researcher, the questionnaires were checked for completeness (Babbie 2013:245).

The researcher made follow-up communication by electronic mail as a form of a reminder for completed questionnaires to be routed back by e-mail from the respondents (Babbie 2013:243-247; Babbie & Mouton 2001:258-260). This was done with the purpose of controlling the response rate; given the sample size (Babbie 2013:247). Two questionnaires returned with few questions uncompleted were followed up with respondents for clarity and completion. One respondent did not return the questionnaire even after repeated follow-up. As a result, a sample of eleven managers was achieved.

3.7.3 Phase-two: quantitative research instrument (Annexure F)

The questionnaire (Annexure F) for phase two was adapted from the phase-one questionnaire to align to nurse managers as respondents. The research instrument addressed the objectives of the research study, which applied to nurse managers' views on contributing factors to nurses' involvement in strike action and their understanding of the changing environment of nurse practice. The quantitative research instrument (Annexure F) was used to gain more insight and additional data to understand the area of interest to the study (Polit & Beck 2010:370). Thus, the construction, design and focus of the instrument in phase two were similar to that of phase one. The same reasons to phase one were applied in phase two for choosing the self-administered questionnaire approach. However, section four of phase one was not included for phase two as it was not of interest to the researcher for the purposes of the information that was required. Other questions that applied to personal involvement in strike action were also omitted for the phase-two instrument (Annexure F).

The questionnaire was divided into six sections

SECTION 1: BACKGROUND INFORMATION

Section one was designed to obtain background information of the respondents. Questions asked related to the employment sector, level of employment in the health sector, province currently working in as well as gender of the respondents.

SECTION 2: INTRODUCTION AND WORK EXPERIENCE

Section two formally set the scene for the enquiry process. This section was focused on obtaining information on the kind of work that the respondents were doing, their satisfaction with working in the public-health sector, and labour relations. Respondents at this stage were reaffirmed that the information provided will not be linked to their names and that their names will be treated in the strictest confidence. The respondents were also reminded about the duration that the questionnaire will take to be completed.

SECTION 3: COMMITMENT TO JOB AND ORGANISATION

In section three, five questions focused on respondents' views about the organisation that they work for; whether it was ideal and appealing to work for. The other five were focused on eliciting their views about the kind of work they engage in on daily basis.

SECTION 4: THE STRIKE ACTION

Section four explored the reasons that could have led the nurses to get involved in strike action. This focused on understanding the contributing factors leading to strike action within the public-health sector.

SECTION 5: SENTIMENT TOWARDS THE STRIKE

Section five focused on eliciting information on how respondents felt about the proceedings of the strike action. This leaned more towards understanding whether they thought things were managed accordingly; whether they were of the view that the strike action was indeed the right action to engage on; whether it served the purpose that it was meant for.

SECTION 6: DEMOGRAPHICS

Demographics as the most sensitive information required from the respondents, was put as the last section of the questionnaire to avoid unsettling the respondents at the beginning of the questionnaire.

- **Pre-testing the questionnaire (Annexure F)**

The instrument for phase two was not pre-tested because it was adapted from the phase-one questionnaire. The adaptation didn't include changing the questions or design of the questionnaire. Mainly similar issues were still explored, though with managers, to gain more understanding on the research area of interest.

- **Validity of the questionnaire**

Validation of the questionnaire in phase one (section 3.6.3.) was done with the adaptation of the questionnaire for phase two in mind.

3.7.4 Quantitative data analysis

The same approaches as in phase one (section 3.6.4) were applied for data analysis in phase two to understand the nurse managers' views.

3.8. PHASE 3: QUALITATIVE APPROACH

In **phase three,** an exploratory qualitative research approach was followed (Babbie 2013:90). This approach was used to satisfy the researcher's curiosity and desire for better understanding of the research problem (Babbie 2013:90). A discussion guide to aid exploration of views of how clients experienced the healthcare service while nurses were on strike was used (Krueger & Casey 2009:19). Four group discussions were held with ten participants in each of the four provinces selected for the study (Amora 2010). In this phase, the researcher relied on recall of events and lived experience by healthcare consumers during the time of strikes either in 2007 or 2010.

3.8.1. Population and sample

In phase three, purposive and convenience sampling was used to recruit participants (Bowling 2011:206). The participants were recruited on the basis of their interaction with any of the public-healthcare facilities that were affected by strike action in 2007 or 2010 (Creswell & Plano Clark 2011:172). The population for phase three was also limited to the provinces selected for this study (Creswell & Plano Clark 2011:172).

- **Population**

The target population for phase three was all available healthcare consumers who sought healthcare service during strike periods in 2007 or 2010 at healthcare facilities that were affected by the strike (Brink et al. 2012:131).

- **Selection criteria of participants**

Healthcare consumers were selected on the basis of the following criteria (Krueger & Casey 2009:21):

- Participants had to have a South African citizenship and reside in South Africa.

- Only participants who were 18 years and above were included for participation in phase three.
- Participants should have used a healthcare facility that was affected by strike action in 2007 or 2010, and tried to access service during the time of strikes.

Forty participants from communities which experienced strike actions by nurses in their public-healthcare facilities were selected (Bernard 2013:165). The healthcare consumers were selected across the four provinces selected for the study. The spread was ten participants per province. This allowed for four focus groups conducted across the four provinces that had participants with similar experiences though from different locations (Grove et al. 2013:267; Krueger & Casey 2009:21). The selection of the participants was however not easy for the researcher, as reliance for referrals was on community members, colleagues and friends within the social circles of the researcher (Grove et al. 2013:525; Krueger & Casey 2009:69). Contact had to me made for recruitment and explanation of the research to all participants. A recruitment questionnaire (Annexure G) was used to select the most appropriate participants (Bowling 2009:208; Krueger & Casey 2009:21).

3.8.2. Data collection

In phase three, data was collected through the use of focus groups with 40 healthcare consumers in the four provinces selected for the study. A discussion guide was developed in English only and translated during discussions by the researcher (Bernard 2013:236). To collect the correct information during the discussions, the researcher was conversant and able to understand the languages used in the selected provinces. The languages used by the researcher during discussions for translation with healthcare consumers were mainly isiZulu, Sepedi (Northern Sotho) and Xhosa given the language profile of the provinces selected for the study.

Data was collected from one focus group of ten participants per province that were exposed to similar experiences during 2007 and 2010 (Polit & Beck 2010:341). Ten participants were decided per group to ensure control of discussions and to afford

each participant an opportunity to share insights or views (Krueger & Casey 2009:67). Food was prepared at the venue where discussions took place as a form of incentive to the participants (Krueger & Casey 2009:79). The focus group discussions were recorded on audio tape and later transcribed verbatim (Grove et al. 2013:278). An atmosphere conducive to engage in discussions with focus groups was provided by (Grove et al. 2013:274):

- conducting the focus group discussions in a neutral comfortable environment where respondents were not intimidated, and at ease to engage in discussions
- allowing respondents sufficient time to ponder their responses
- avoiding leading discussion questions and at all times being sensitive towards respondents' reactions and feelings
- showing interest in respondents as well as in what they were saying

During discussions, the researcher allowed respondents to:

- paraphrase by rewording or expressing meaning, in other words, expressing their experience
- explain where responses seemed unclear to the researcher

3.8.3. Preparation of the discussion guide (Annexure H)

Before conducting focus groups with the participants, the researcher defined the information that was required to allow the discussions to proceed smoothly and naturally (Babbie 2013:346; De Vos et al. 2005:293).

The information that was required from healthcare consumers was related to their views about factors influencing nurses' involvement in strike action and how the strike affected them as well as how they perceived the management of strikes during 2007 and 2010. The discussion guide comprised of four main discussion points to allow for an interaction between the moderator (the researcher in this study) and the participant (Polit & Beck 2010:341). The questions were discussed with the researcher's supervisor and two researchers experienced in qualitative research methods.

- **Pre-testing the discussion guide**

The research instrument was pre-tested before focus groups were conducted for data collection (Bernard 2013:236). The validity of the discussion guide depended on shared assumptions and understandings of the discussion points. Three healthcare consumers from GP with the same characteristics as the participants that were to be included in the study, were interacted with simultaneously to describe what they thought of when they listened to a question and how they interpreted it. Participants were informed that they were called for a discussion to pre-test the discussion guide (Bowling 2009:301). The discussion guide was discussed with the study supervisor and other experienced researchers in qualitative research methods (Brink et al. 2012:158).

Pre-testing the discussion guide helped the researcher to be more familiar with the areas of discussion. Through pre-testing the researcher determined an approximate time that was required to conduct each focus group (Grove et al. 2013:274), the necessary detail and clarity of the discussion points and even the potential answers and necessary probes. It was therefore determined that focus groups would take approximately 45 to 60 minutes. Participants found the discussion points to be acceptable and relevant; as a result no changes were made in the pre-tested instrument.

- **Structure of the discussion guide (Annexure H)**

Section 1 – focused on healthcare consumers' perceptions of factors that contributed to nurses' involvement in strike action in 2007 or 2010. Focus was also on participants' views on how the strikes were managed at the time when it happened.

Section 2 – focused on views of participants on felt effect of the strikes.

3.8.4. The focus group discussions

Consent was obtained prior to conducting the discussions with selected healthcare consumers in each province. During the introductory contact with the participants, the researcher explained the purpose of the study prior finalising recruitment. Details of how, when and where the discussions were to take place were shared with the participants (Grove et al. 2013:275). To control attendance, follow-up calls were made as reminders prior the discussions. The participants were prepared for the discussions and suitable times were arranged. They were also informed that the discussions would take approximately 45 to 60 minutes. Before commencing with the discussions, the researcher explained the information required, the format and the process of the discussions. The researcher urged participants to openly give their views.

3.8.5. Qualitative data analysis

Data analysis for phase three was undertaken as reflected in section 3.5.6.

3.8.6. Trustworthiness

To account for trustworthiness of the qualitative research, four notions of objectivity were considered as outlined in section 3.5.7. These are credibility, transferability, dependability and conformability (Creswell & Plano Clark 2011:211; Shenton 2004:64).

3.9. TRIANGULATION

Triangulation refers to the use of multiple referents to draw conclusions about what constitutes the truth about a single phenomenon and to bring clarity to and understanding of that phenomenon (Brink et al. 2012:99); Polit & Beck 2010:497. Polit and Beck (2010:239) describe four types of triangulation: data triangulation, time triangulation, space triangulation and person triangulation. The researcher used triangulation to overcome the intrinsic bias that comes from a single-method

approach. Both qualitative and quantitative approaches were used to test the same phenomenon amongst different groups at different locations (Burns & Grove 2003:29). The different phases of the study were conducted at different times exploring the same phenomenon. Data collected through in-depth interviews, self-administered questionnaires and discussion guides were used to have an in-depth understanding of the research problem.

3.10. ETHICAL CONSIDERATIONS

Approval and ethical clearance were sought to ensure that the study maintained high ethical standards. A copy of the proposal was submitted and ethical clearance sought from the Health Studies Research and Ethics Committee of the College of Human Sciences, University of South Africa.

3.10.1. Ethical principles

Consent letters to inform participants and respondents of the nature and purpose of the research were sent to each individual for scrutiny and signing. Ethical principles of confidentiality, protection from intimidation and the right to withdraw at any stage were emphasised.

It was noted that the study might pose a risk of intimidation of nurses who chose to participate or not to participate in the strike. To cater for this risk, the researcher ensured that respondents or participants from the healthcare facilities are not selected from the same section of the healthcare facility.

In-depth interviews, self-administered questionnaires and discussions were completed or conducted at a time and place and at a venue decided on by the respondents and participants. All respondents or participants were provided a choice to withdraw at any stage of the study should they feel uncomfortable or intimidated.

The research involved individuals; not institutions. Individual informed consent was obtained in writing as indicated earlier.

The researcher is not a nurse by profession but understands the health environment as well as the legislative framework in terms of her own professional background and current working environment. This ensured that it is easier for the researcher to minimise bias.

3.11. CONCLUSION

The researcher experienced a number of advantages of applying both quantitative and qualitative methods in this research. Quantitative methods ensured high levels of reliability of gathered data. Qualitative research allowed for obtaining more in-depth information about how the nurses perceived contributing factors to their involvement in strike action and the perceived value of such involvement (Matveev 2002:59). Focus group discussions provided for a public view on the study phenomenon for a better understanding by the researcher.

This chapter provided detail on the study design. Information on the sample and study sites were provided to allow for future research endeavours as follow-up to this study. Researcher approaches to ensure validity of the research and findings were outlined in detail.

CHAPTER 4
INTERPRETATION OF FINDINGS AND LITERATURE CONTROL

4.1. INTRODUCTION

In this chapter, analyses of data and findings obtained from professional nurses, nurse managers and healthcare consumers on contributing factors to nurses' involvement in strike action are presented in line with the three main phases of the study. Findings also explore nurses' views on the value of involvement in strike action and the nurse managers' understanding of the changing environment of nurse practice.

The three main phases reported on are ❶nurses' views on strikes, ❷ nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice and ❸ the views of healthcare consumers on nurses' participation in strike action. The researcher also refers to the pilot-phase findings that were presented in Chapter 3 as part of the methodological process applied in this study. The pilot phase focused on assisting the researcher to better understand the research phenomenon prior developing research instruments for the study – by exploring factors that contributed to nurses' involvement in strike action during 2007 and 2010.

4.2. ANALYSIS OF DATA AND INTERPRETATION OF FINDINGS

Data is presented in the form of tables, graphs or verbatim quotes for each phase of the study and interpreted into study findings (Brink et al. 2012:177; Leedy & Ormrod 2010:289). The questions (Annexures E & F) that nurses and nurse managers responded to were grouped into constructs that measured certain topics. The constructs that were considered for inclusion into the analysis are outlined below:

Question 25: Reasons that nurses and nurse managers felt are contributing to strike action (the question statements below were considered).

1. Poor pay in the public sector
2. No recognition for the work they do
3. Lack of adequate benefits
4. The salary gap between workers and managers
5. To get the government to stop ignoring staff grievances
6. To show the government how much the country relies on workers in the public-health sector
7. To demonstrate anger at how the government treats public-sector workers
8. Poor working conditions
9. A power struggle between trade unions and the government
10. Lower levels of salaries in the public sector compared to the private sector
11. Frustration that issues raised in the October 2006 negotiations were still unresolved

Question 29 (Annexure E only): Personal reasons for involvement in strike action during 2007 or 2010 (the question statements below were considered).

1. You cannot survive on the pay you are getting
2. You were pressured to strike
3. You had to follow union orders
4. You were threatened or intimidated into participating
5. You wanted to show support for those who really need the money
6. Your employer advised you not to come to work
7. It gave you a nice break
8. You just went along with everyone else

Question 31 (Annexure E only): Reasons for union members not going on strike in 2007 or 2010 (the question statements below were considered).

1. You did not want to let the people you serve down
2. You could not afford to lose income by striking
3. The people you serve would suffer too much if you did not do your job
4. It is illegal for you to strike

5. You do not think strikes are the way to solve staff grievances
6. You did not want to fall behind in your work
7. Hardly anyone else in your department was going on strike
8. You did not agree with the trade unions' position
9. You were happy with the offer
10. Money is not a problem

Question 33: General sentiments towards strike action in 2007 or 2010 (the question statements below were considered).

1. The original request of an overall increase of 12,0% by the trade unions was fair
2. In general, the strike was conducted peacefully
3. Where violence occurred during the strike, it was justified
4. The strike gave foreign investors a negative impression of South Africa
5. The strike had a negative effect on the economy of the country
6. The strike had a negative effect on the image of the government as a fair employer
7. Ministers and top government officials are out of touch with the troubles of public-sector workers
8. The government was arrogant in its handling of the strike
9. The government could have stopped the strike sooner
10. The trade unions were responsible for prolonging the strike
11. The final settlement was fair
12. The government was hostile towards the striking public-sector workers
13. It was humiliating for public-sector workers to have to beg for a decent wage
14. The government does not deliver on its promises
15. It was important for public-sector workers to go on strike
16. Strike action does more bad for the country than good
17. Public-sector workers should just find other jobs in the private sector if they are unhappy
18. Most people only went on strike because the trade unions forced them to
19. Most public-sector workers had good reason to go on strike

20. Many public-sector workers don't deserve to be paid more because they are lazy
21. Important public-sector employees such as teachers, nurses and the police are underpaid
22. The government communicated effectively with the general public during the strike
23. The trade unions communicated effectively with the general public during the strike
24. The employer's original offer of an overall increase of 5,3% was fair
25. The media covered the strike fairly

Question 19: How nurses and nurse managers described their job (the question statements below were considered).

1. Your job makes a difference in society
2. Your job contributes to the country's future
3. Your job helps to improve the life of individual people
4. You have a secure job
5. You earn a good salary
6. You have good benefits
7. Your work is challenging
8. Your work is appreciated by the general public or people that you serve
9. You are overworked
10. You have opportunities for promotion
11. You are passionate about your job
12. Your job gives you status in the community

Question 20: How nurses and nurse managers described their employer – the government (the question statements below were considered).

1. Gives you recognition for your hard work
2. Empowers you to make your own decisions regarding how to do your job
3. Is understaffed
4. Well-resourced in terms of providing adequate equipment to do the job

5. Gives you fair remuneration for your experience and hard work
6. Have poor working conditions
7. Treats staff with dignity and respect
8. Provides the support you need to help you do your job well
9. Have safe working conditions
10. Competent people in senior positions
11. Pointless rules and regulations interfere with doing your job
12. Efficient in getting repairs done

To ensure that the questions selected for each construct were reliable, internal consistency (more specifically Cronbach's alpha) was utilised to calculate and interpret construct reliability. Construct reliability was deemed acceptable if alpha was 0.6 or higher (Burns & Grove 2009:377; Polit & Beck 2010:375; 379).

Table 4.1 shows that all the constructs met the criteria with a Cronbach's alpha greater than 0.6, besides one. This means that the questions that were selected for the individual construct explained the construct very well. The Cronbach's alpha for the last construct "How the employee describe their employer – which is the government" – has an alpha value lower than 0.6, which means that all the items included in the construct do not measure the construct. For purposes of analysis in this chapter, questions within the construct will be treated as individual variables.

Table 4.1: Respondents' gender and work status

Construct	Cronbach's alpha	Number of questions in a scale
Q25:Reasons that respondents generally felt are contributing to strike action in 2007 or 2010	0.604	8
Q29:Personal reasons for strike action in 2007 or 2010	0.813	11
Q31:Reasons for union members not going on strike	0.833	10

Construct	Cronbach's alpha	Number of questions in a scale
Q33:General sentiment towards strike action	0.824	8
Q19:How nurses and nurse managers described their job	0.884	10
Q9: How the nurses and nurse managers described their employer – which is the government	0.460	20

- **Chi-square analyses**

Bivariate analyses using the chi-square test for association was performed to determine if relationships exist between the dependent variable (nurses strike action) and each of the independent variables (variables within each of the constructs previously discussed) (Brink et al. 2012:191; Polit & Beck 2010:399).

The table provides the chi-square statistics as well as the level of significance for each of the independent variables considered (Annexure E & F). Statistical significance was tested at p-value < 0.05. For the purposes of the analyses, only the significant relationships are discussed in detail.

The general hypothesis test is as follows:

H0 (null) = There is no association (relationship) between the dependent and independent variables.

H1 (alternate) = There is an association (relationship) between the dependent and independent variables.

Variable numbers in questionnaire	Chi-sq value	p-value		Variable numbers in questionnaire	Chi-sq value	p-value
Q2(1)	0.167	0.92		Q31(1)	3.468	0.088
Q2(2)	2.48	0.289		Q31(2)		0.414
Q2(3)	1.554	0.46		Q31(3)	1.382	0.206
Q2(4)	2.35	0.309		Q31(4)	5.822	0.012
Q2(5)	0.847	0.566		Q31(5)	1.3	0.244
Q2(6)	1.904	0.386		Q31(6)	1.795	0.255
Q2(7)	0.544	0.762		Q31(7)	2.717	0.119
Q2(8)	0.504	0.777		Q31(8)	0.242	0.564
Q2(9)	3.124	0.21		Q31(9)	1.795	0.174
Q2(10)	0.721	0.697		Q31(10)	0.497	0.415
Q2(11)	0.116	0.943		Q33(1)	1.67	0.434
Q2(12)	0.342	0.843		Q33(2)	0.551	0.759
Q25(1)	5.945	0.05		Q33(3)	0.532	0.766
Q25(2)	8.999	0.011		Q33(4)	2.289	0.318
Q25(3)	3.206	0.201		Q33(5)	4.888	0.087
Q25(4)	0.674	0.714		Q33(6)	2.012	0.366
Q25(5)	3.621	0.164		Q33(7)	0.326	0.405
Q25(6)	4.182	0.124		Q33(8)	3.494	0.057
Q25(7)	4.345	0.114		Q33(9)	0.531	0.767
Q25(8)	5.611	0.06		Q33(10)	0.015	0.55
Q25(9)	1.425	0.483		Q33(11)	6.686	0.035
Q25(10)	3.81	0.149		Q33(12)	3.854	0.146
Q25(11)	3.074	0.215		Q33(13)	0.025	0.565
Q29(1)		0.000		Q33(14)	2.365	0.129
Q29(2)	12.73	0.001		Q33(15)	1.512	0.469
Q29(3)	39.259	0.000		Q33(16)	2.23	0.328
Q29(4)	17.449	0.000		Q33(17)	2	0.121
Q29(5)	39.259	0.000		Q33(18)	5.015	0.021
Q29(6)	6.118	0.036		Q33(19)	1.46	0.22
Q29(7)	8.625	0.011		Q33(20)	3.697	0.157
Q29(8)	22.435	0.000		Q33(21)	3.043	0.218
Q29(9)	1.988	0.337		Q33(22)	1.161	0.208
				Q33(23)	3.217	0.2
				Q33(24)	3.204	0.201
				Q33(25)	2.66	0.087

4.2.1. Phase-one: Nurses' views on strikes

In phase one, quantitative data was collected using a self-administered questionnaire. To adequately explore the research problem, and for instrument development, the questionnaire was informed by the literature review and qualitative insights from the pilot phase (as reflected in Chapter 3). The questionnaire consisted of seven sections reflected on in Chapter 3 (Annexure E). Data was captured and non-parametric statistics were applied using the software package IBM® SPSS® Statistics Version 21 (2013). The software was used for descriptive analysis of data, generating frequencies and determining correlation of variables in the dataset.

Non-parametric statistics were used because of the small sample size and the nature of the data collected (Polit & Beck 2010:412). Data collected in phase one from 80 professional nurse respondents that worked in public-healthcare facilities that were affected by strike action either in 2007 or 2010, was analysed for interpretation. The nurse respondents were selected from the four provinces (KZN, GP, EC and WC), as indicated in Chapter 3.

In **phase one,** analysis focused on differences or similarities of opinion or views that were observed between respondents that participated in strike action and those that did not. Views on the perceived value of involvement in strike action by those who participated were also explored. This exploration was meant to assist the researcher to understand the area of interest in order to ultimately derive at describing strategies that nurse managers could use to curb strike action by nurses in public institutions in South Africa.

- **Demographic and general information**

Demographic and work-related background information was sought in order to reflect on a profile of professional nurses who participated or did not participate in strikes during 2007 and 2010 in the selected four provinces of the study. These included information regarding the sector of employment, level of employment,

length of service, gender and affiliation with any union body of choice. To address the objectives of the study, information that related to the respondents' commitment to their work and organisation, views and sentiment towards the strike action and involvement therein, was also included. These components of the research instrument is presented and discussed.

Table 4.2: Respondents' gender and work status

Sample per province	Count	Female		Male		Work status
		count	%	count	%	Not at management level
Gauteng	20	17	27	3	19	[1]RNs
KwaZulu-Natal	20	16	25	4	25	RNs
Western Cape	20	15	23	5	31	RNs
Eastern Cape	20	16	25	4	25	RNs
Total	**80**	**64**	**100**	**16**	**100**	**RNs**

Table 4.2 indicates that out of 80 respondents that were included in **phase one**, 64 were females and 16 were males. Respondents were registered nurses practicing in public-healthcare facilities (these included public clinics and hospitals). The latest statistics by the South African Nursing Council (2013) show that although the number of male nurses has increased over the past 10 years, the gap in the number of male compared with female nurses is far from closing. Therefore, though the study followed a purposive and convenience sampling approach, the sample is reflective of the gender profile of the nursing profession in South Africa. However, the researcher did not directly explore the extent to which gender contributes to nurses' interest to get involved in strike action, with the understanding that the responsibilities of nursing care are not gender-specific.

Table 4.3 indicates that the years of service for the respondents varied from less than five years to five years [23 (29%)]; more than five years to 10 years [9 (11%)];

[1] *Registered Nurses*

and – the majority – above 10 years [48 (60%)]. The findings indicate a level of service stability amongst the respondents. This could be indicative of the level of commitment to their work as reflected by the years of service in the public-health sector. According to Kunene (1995:71), nursing personnel who have been in the service for a longer period are believed to display more commitment to attaining work goals (that is quality patient care in nursing services) in comparison with personnel who have been in the service for a shorter time.

Table 4.3: Years of service in the public-health sector

Years of service in a public-healthcare facility	Count	%
<5 yrs	23	29
5 yrs ≤ 10 yrs	9	11
> 10 yrs	48	60
Total	**80**	**100**

With further analysis of the data on who are more likely to strike by years of service, the findings in Figure 4.1 reflect that a higher proportion of nurses who have been in the service for less than five years, were more likely to go on strikes compared to those who have been in the service for more years. Table 4.3 indicate that the majority of nurses in the study sample had many years of nursing experience and therefore were assumed to have a clear understanding of the profession encompassing the ethical code of practice; though in Figure 4.1, a third of these nurses still opted to get involved in strikes. This factor demonstrates that the number of years in practice contributes to the level of commitment to work, however does not negate a need by nurses to get involved in strike action. No statistical significant difference was observed between the involvement in strike action of nurses who have been for less or more years *(less or equal to five years vs more than ten years: p=0.255)* in the nursing practice within the healthcare sector. This result in an observation that the number of years of service does not necessarily make a difference with regard to whether nurses will or will not be involved in strike action.

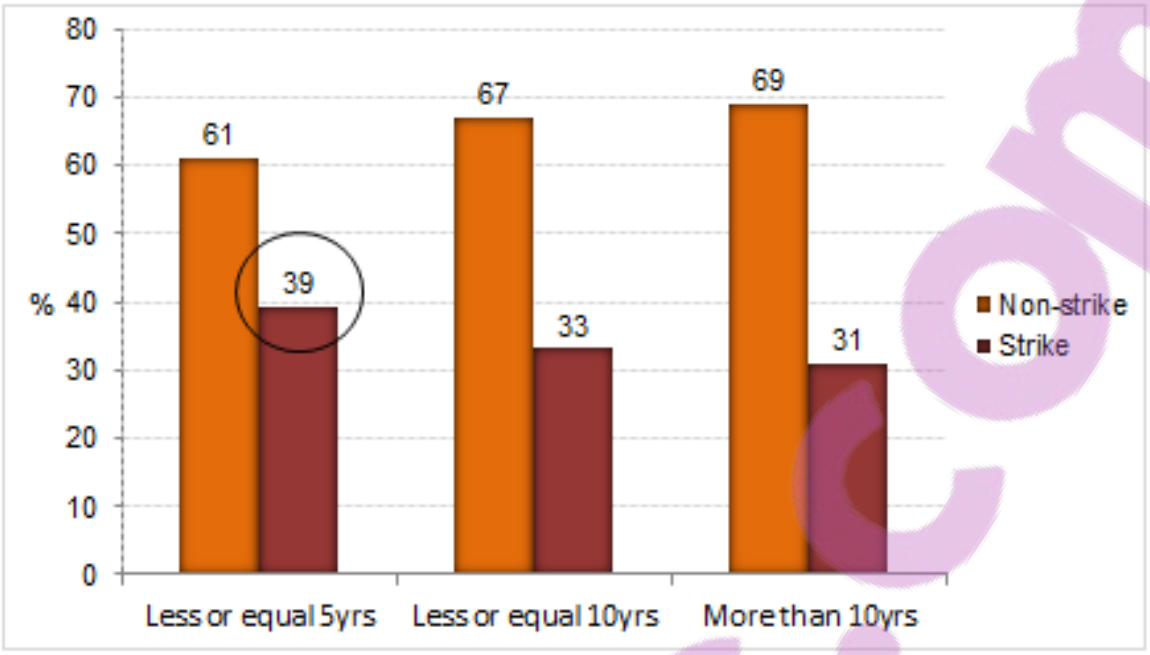

Figure 4.1: Involvement in strike action by years of service

Most respondents [26 (32%)] in Table 4.4 were within the age category of 36 – 45 years, followed by [23 (29%)] in the age category of 36 – 45 years and [18 (23%)] in the age category 46 – 55 years. Less respondents were observed in the age category of 18 – 25 years [9 (11%)], followed by the age category 56 – 65 years [4 (5%)].

Table 4.4: Age distribution and level of involvement in strikes

Age category in years	Count	%	Participation in strikes	%	Non-participation in strikes	%
18 – 25 yrs.	9	11	1	11	8	89
26 – 35 yrs.	23	29	10	43	13	57
36 – 45 yrs.	26	32	11	42	15	58
46 – 55 yrs.	18	23	4	22	14	78
56 – 65 yrs.	4	5	1	25	3	75
Total	**80**	**100**	**27**		**53**	

When comparing respondents' percentages by age, nurses who were more likely to participate in strikes were those within the age categories 26 – 35 years [10 (43%)] and 36 – 45 years [11 (42%)] *(p=0.034)* compared to those within the age categories 46 – 55 years [4 (22%)] and 56 – 65 years [1 (25%)]. The findings therefore indicate that the age of the respondents at the 95% confidence interval of the sample of those who participated in strike action, contributed to the decision to go on strike.

- **Participation in strike action and the role of union membership**

Healthcare-worker strikes pose a difficult question when considering the ethical code of practice and professional beliefs (Dhai et al. 2011:58-59). The Florence Nightingale Pledge (Gretter 1893) binds nurses to act in the best interest of their patients and their profession. On the other hand, section 65 of the LRA (South Africa 1995:65) qualifies the general right to strike, stating that individuals who provide essential services such as healthcare may not participate in protected or unprotected strike action (Fashoyin 2008:579; Garbers & Potgieter 2007:301). However, the South African Nursing Council ([s.a.]) as the regulatory professional body guiding the work of healthcare workers in South Africa, and the relevant labour legislation stipulate that nurses are entitled to rights in line with the Constitution of the Republic of South Africa (South Africa 1996:17-18), provided that they exercise such rights without putting the life or health of patients at risk.

Table 4.5: Strike participation

Participation in strikes	Frequency	%
NO	53	66
YES	27	34
TOTAL	**80**	**100**

The findings in Table 4.5 indicate that though strikes by nurses are common in South Africa, within the frame of this study, a smaller proportion of nurses [27 (34%)] who experienced strike action in their work environments directly got

involved in work stoppage. The majority of nurses in Table 4.6 that participated in strike action were found to have done that to a very limited extent in terms of time spent away from work. Amongst those who participated, the majority [11 (41%)] spent one to two days away from their work while just more than a third [9 (34%)] spent three to ten days away from work and seven (27%) spent twelve to thirty days away from work.

Table 4.6: Number of days spent on strike action

Participation in strikes	Number of Days	%
1-2 days	11	41
3-10 days	9	34
12-30 days	7	27

This indicates the difficulty that comes with the decision for nurses to get involved in strike action at the disadvantage of the healthcare consumers. The act of strikes is difficult for any group of workers; that is why it is viewed as a last resort in the process of collective bargaining, especially within the healthcare profession (International Council of Nurses 2012:8).

Table 4.7 indicates that almost all respondents [75 (94%)] were affiliated with some kind of union regardless of their involvement in strike action. About nine in ten [48 (94%)] respondents that did not directly get involved in strike action were affiliated with unions while five (9%) of this group did not affiliate with any union. All respondents [27 (100%)] that participated in strike action were affiliated with some union group.

Table 4.7: Union membership by participation / non-participation in strike action

			Participation in strike action		Total
			NO	YES	
Trade union member		Count	48	27	75
		Yes	91%	100%	94%
		Count	5	0	5
		No	9%	0%	6%
		Count	53	27	80
		Total	100%	100%	100%

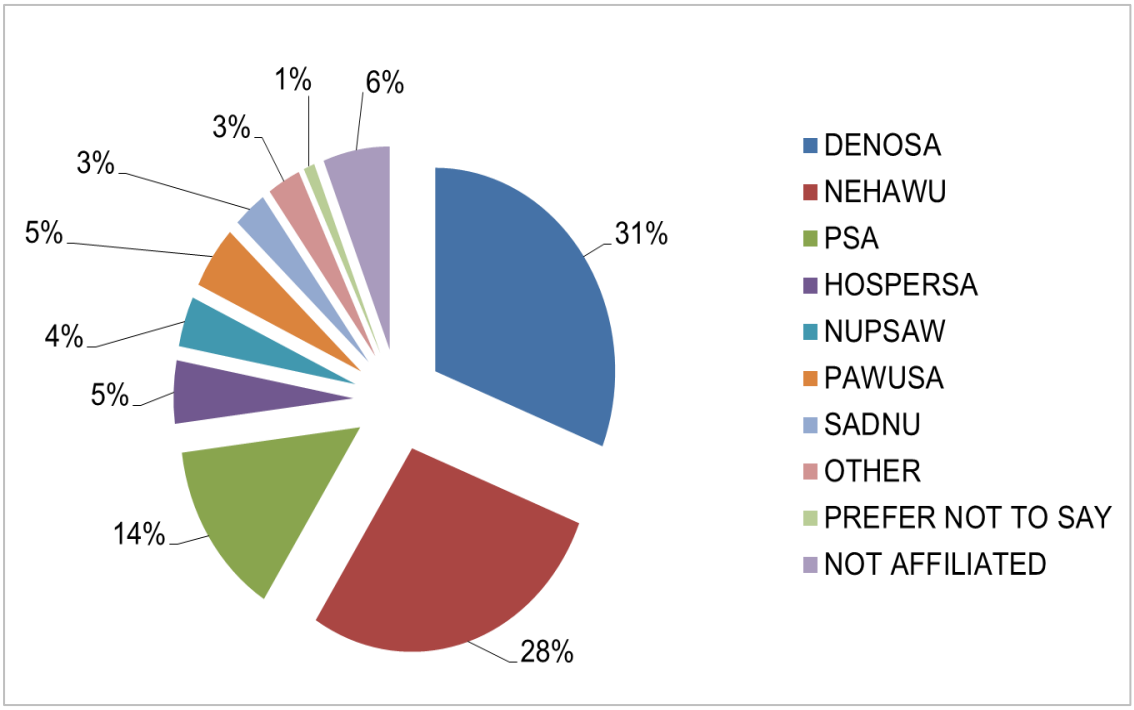

Figure 4.2: Union membership

Amongst the unions listed in the questionnaire, the three with most affiliation from nurses were DENOSA [25 (31%)], NEHAWU [22 (28%)] and PSA [11 (14%)].

Table 4.8: Type of union affiliation by participation or non-participation in strikes

Partici-pation in strikes	Type of union affiliation (%)										
	Not affilia-ted	DENOSA	HOSPERSA	NEHAWU	NUPSAW	PAWUSA	PSA	SADNU	Other	Prefer not to say	Total
Yes	-	19	-	48	15	-	15	-	3	-	**100**
No	9	38	8	17	-	8	13	4	2	1	**100**

Data analysis indicates that the percentage of members affiliated to DENOSA as their union of choice were significantly *(p=0.049)* more prone to refrain from engagement in strike action compared to those who affiliated with NEHAWU. These are the two main unions with a strong hold amongst the nurses. From the insights of the qualitative data collected during the instrument development stage, one respondent indicated that it would be better for nurses to affiliate with DENOSA as this union understands the processes within the profession as well as regulations that govern the profession. However, given the study sample, it is indicative that a fairly large proportion of nurses are affiliated with NEHAWU and as a result, would be most likely to be swayed to get involved in strike action to address their concerns. Managing union affiliation within the nursing profession thus becomes an important factor in healthcare planning and management.

In the questionnaire (Annexure E), respondents were provided with two questions with answers on a ten-point scale. The first question (q22) had a scale where one (1) meant they felt terrible not being a member of a union and ten (10) meant they felt it's ideal to be a member of a union. The second question (q23) had a scale where one (1) meant they felt terrible for being a member of a union and ten (10) meant they felt it's ideal not being a member of a union. Observation from the findings indicated that a majority [48 (60%)] of the respondents felt that it is ideal to be a member of a union. The question on how they felt about not being a member of a union [53 (66%)] indicated that they would feel terrible. These findings indicate a high level of dependence by nursing professionals on unions. This is related to the explorative qualitative data collected during the instrument-development stage

that indicated most nurses felt their rights were more preserved by their affiliation with unions as compared to the affiliation with the South African Nursing Association.

The findings are in line with the international trend that indicates that the existence of unions all over the world and in South Africa has seen more professional healthcare workers affiliating with these bodies despite the fact that they are bounded by their affiliation to the nursing professional body for their practice (Searle et al. 2009:221; Van Rensburg & Van Rensburg 2013:2).

Trade unions have become an important force in South Africa; professional nurses are within their large membership of about 3.1 million representing 25% of the formal workforce. This situation is found not unique to South Africa, as reported by Searle et al. (2009:221).

According to Clark and Clark (2009:1-2), nursing unions are formed with the intention to provide nurses a resource to deal with issues and problems that come with the profession. While supporters of nursing unions feel that unions give nurses more voice and more power in their profession, others feel unions; although well-intended, just bring more complications to the workplace.

- **Views on the nursing profession and participation in strike action**

To test whether respondents were aware of their role in the broader public-sector workforce, they were asked whether they considered their profession or job as part of the essential services within the public sector.

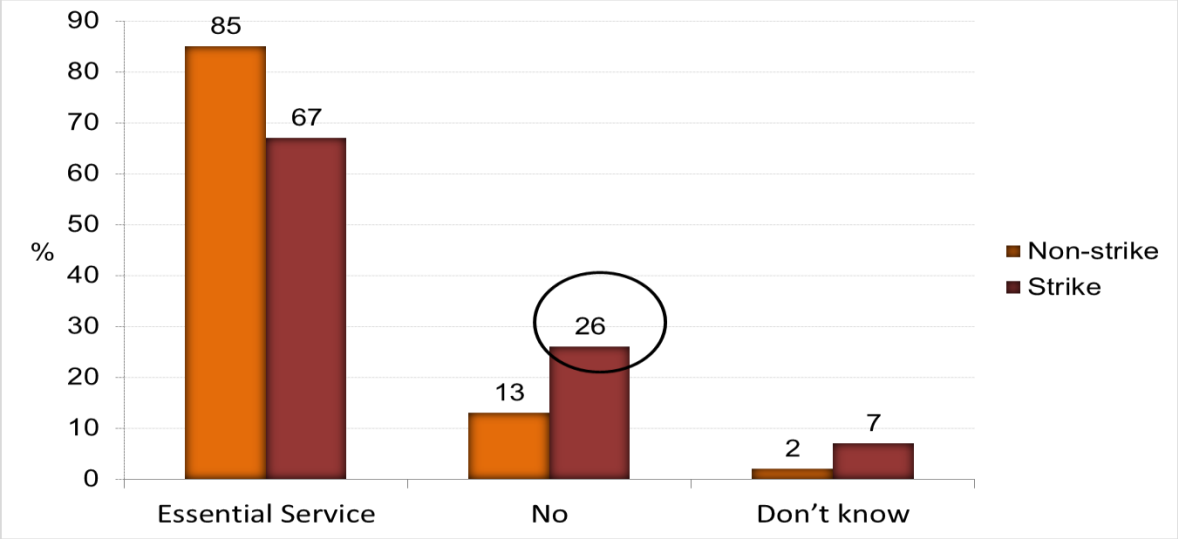

Figure 4.3: Percentage of respondents who perceive nursing services as part of the essential services, by their level of participation in strike action

When considering whether their job is within the essential services, Figure 4.3 shows that seven (26%) of respondents amongst those who participated in strike action said no, and only seven (13%) of those who did not participate in strike action were of the view that their work is not part of the essential services. It is observed that the percentage of those who did not acknowledge their job as part of the essential services is higher amongst those who participated in strike action. Although statistically no differences were observed in how nurses viewed their job as part of the essential services and their involvement in strike action, it is important for nurses to be reminded of and to acknowledge this fact, given the likelihood of large numbers who participated in strike action not considering the service as part of the essential services. No further exploration in the study was undertaken to determine the reasons why some of the nurses – even with the regulations in place – still perceived their work as not being part of the essential services.

However, a large proportion of the respondents, whether they participated or not participated in strikes, perceived their work as part of the essential services. Generally, of the nurses that perceived their work as part of the essential services, more than half [42 (67%)] indicated that in their opinion, nurses should not go on strike action.

Table 4.9: Indication by nurses whether essential services should strike or not

Is nursing part of essential services?	Should essential services strike? %							
	Yes		No		Don't know		Total	%
	count	%	count	%	count	%		
Yes	14	22%	42	67%	7	11%	**63**	**100**
No	7	50%	6	43%	1	7%	**14**	**100**
Don't know	2	67%	1	33%	-	-	**3**	**100**

The findings in Table 4.10 clearly indicate that a significantly *(p=0.072)* high percentage of nurses who viewed their work as part of essential services were not likely to participate in strikes as compared to the percentage of those who participated. Nurses' understanding of the role of nursing within the public service and its importance to human healthcare is one of the factors that could be used to harness passion and deter nurses from engaging in strikes. However, this factor will effectively compel nurses not to engage in strikes if addressed in conjunction with other contributing factors. Understanding the push-and-pull factors contributing to their involvement in strikes therefore becomes more important.

Table 4.10: Strike participation and views on whether essential services should strike or not

		Participation in strike action		*p*-value	Total
		NO	YES		
Is nursing part of essential services?	**Count**	45	18		63
	Yes	85%	67%	*P=0.072*	79%
	Count	7	7		14
	No	13%	26%	*P=0.267*	18%
	Count	1	2		3
	Don't know	2%	7%	*P=0.413*	3%
	Total	**100**	**100**		**100**

The ethical code of practice and the legislative framework are key drivers in the nursing discipline (Sasso et al. 2008:821). However, Kunene (1995:2) states that in

the context of South Africa, it has become a norm that industrial action is the key to having demands met; therefore, nurses engage in strikes as a last resort with the hope that their demands will be met.

- **Nurses' level of commitment to their job and their place of employment**

Employee commitment is an important element to consider because it is a reliable predictor of future behaviour and thus becomes a useful tool in developing strategies for the future – including managing disputes (TNS Research Surveys 2007:51; Vance 2006:5; Welsh 2013). To determine the respondents' level of commitment to their work and place of work as a critical aspect of their ethical code in their profession, questions 11 to 18 in the questionnaire **(Annexure E)** were used to develop an aggregate score of commitment to place of work, while questions 19 to 20 were used to develop an aggregate score for level of commitment to their own job. As a result of this analysis approach, four categories of commitment were arrived at for both the place of work and the own job. These included the following scale options:

4 = Very committed
3 = Committed
2 = Uncommitted
1 = Very uncommitted

It should be noted that for calculation of means, categorical variables were converted to numerical variables for the purposes of the analysis and interpretation. The scale was put in a reverse order for analysis.

Figure 4.4 indicates that nurses are more committed to their job compared to their place of work / employer. Encouragingly, and despite the challenges that the healthcare sector and its workers are often expressing, workers show a commendable level of commitment to their own work.

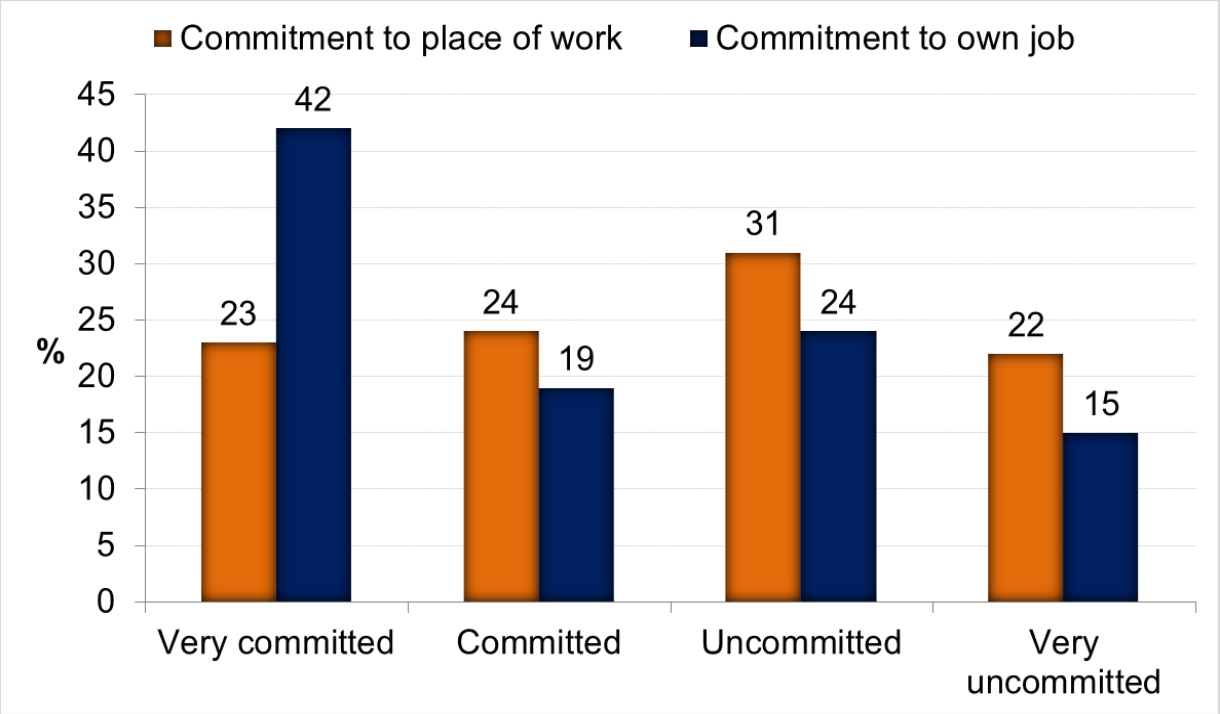

Figure 4.4: Level of commitment to place of employment and to own job

Low levels of commitment to the place of work / employer may be influenced by factors raised as concerns about the place of work. Robert and Tyssens (2008:502) indicate that in an increasingly technological environment and the extended scope of work, lack of resources to perform work and the demand for service, the nurses' level of commitment to their place of work / employer may be affected to the extent to which nurses become eager to consider industrial actions that other professionals take. The lower levels of commitment to the government or public sector as the employer suggest more of a breakdown in the relationship between the government and the nurses (TNS Research Surveys 2007:45) which, if not effectively managed, may result in more public-healthcare strikes.

According to Mosadeghrad & Ferdosi 2013:125, in line with other studies (Lumley, Coetzee, Tladinyane & Ferreira 2011:101; Al-Aameri 2000:533-534) there is a positive relationship between employee commitment and job satisfaction linked to fairness and care as well as concern for employees. Put simply, committed employees are believed to want to enjoy their work, feel they are appreciated and know they are making a contribution to their company's strategic objectives.

Additionally, employees who have trust in their leadership, and are trusted by their leadership, have a greater dedication and are ultimately more productive on the job.

In Table 4.11, analysis was conducted to determine the nurses' level of commitment to their job – amongst those who participated in strike action and those who did not. The results show that the p-value (χ^2 (1) =3.125; *p-value*= 0.373) is not statistically significant; thus there is no relationship between commitment and participation in strike action. However, interesting to note is that 53 of the 80 respondents did not take part in strike action and 49% of those said they were very committed to their work.

This indicated that the extent of commitment to own job makes a difference in deciding whether to strike or not. The more nurses are committed to their work, the more they are less likely to get involved in strikes.

Table 4.11: Commitment levels of nurses who participated in strikes and those who did not

		Participation in strike action						Chi-sq value	p-value
		No		Yes					
		count	%	count	%	Total	%		
Commitment to work	Very committed	26	49	8	30	34	43	3.125	0.373
	Committed	8	15	7	26	15	18		
	Uncommitted	12	23	7	26	19	24		
	Very uncommitted	7	13	5	17	12	15		
Total		53	100	27	100	80	100		

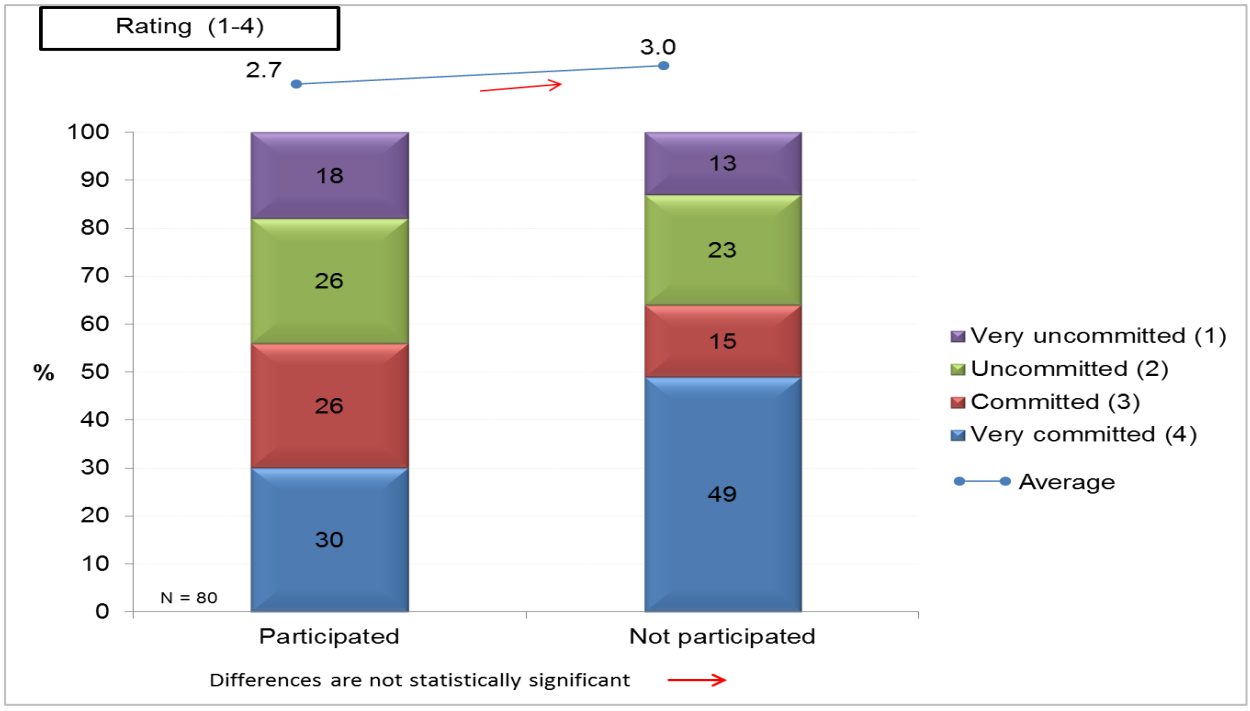

Figure 4.5 Participation in strikes and level of commitment to own job

Drivers of commitment amongst nurses

Strategies which motivate employees to become committed are valuable, as a workforce which is committed to both job and employer is more stable and more productive and promotes both the work and the employer in communication and interaction with others (Grant, Dutton & Rosso 2008:898).

The commitment measure was used to look specifically at what attributes of an employee's job most differentiates the uncommitted nurses from the committed. Mean values of commitment by strike participation were statistically compared on different attributes of nurses' job descriptors. The focus of discussion is limited to job attributes that significantly determine commitment by nurses.

Table 4.12 indicates that out of the 12 measured statements of job attributes, there are mainly three drivers of the level of commitment to their job. These include a sense of having a secure job, earning a good salary and having good benefits. According to these findings, nurses who felt that their job is secure, they earn a

good salary and have good benefits are most likely to have higher levels of commitment – thus minimising their likelihood to get involved in strikes.

Table 4.12: Nurses' job attributes contributing to level of commitment to their job

Twelve measured statements (Annexure E)	Mean value Participated in strikes	Mean value Did not participate	*p-value*
Q19(1).Scale - Your job makes a difference in society	2.9259	2.8846	.615
Q19(2).Scale - Your job contributes to the country's future	3.0000	2.9245	.250
Q19(3).Scale - Your job helps to improve the life of individual people	2.7778	2.9245	.179
Q19(4).Scale - You have a secure job	2.4800	2.7885	.052
Q19(5).Scale - You earn a good salary	1.5185	1.8800	.023
Q19(6).Scale - You have good benefits	2.1923	2.4808	.089
Q19(7).Scale - Your work is challenging	2.8148	2.8113	.978
Q19(8).Scale - Your work is appreciated by the general public or people that you serve	2.6296	2.6731	.783
Q19(9).Scale - You are overworked	2.5769	2.4615	.516
Q19(10).Scale - You have opportunities for promotion	2.1111	2.1154	.982
Q19(11).Scale - You are passionate about your job	2.8519	2.8846	.753
Q19(12).Scale - Your job gives you status in the community	2.7407	2.6863	.708

The findings mean that working towards managing the three factors is the most beneficial in building commitment. Conversely, should any of these areas falter, a decline in commitment would be expected and could potentially lead to more

involvement in strike action or initiation thereof.

Description of own work by nurses

Respondents were asked to describe how they viewed their own job. The analysis focused on the differences of views between nurses that participated in strikes and those who did not.

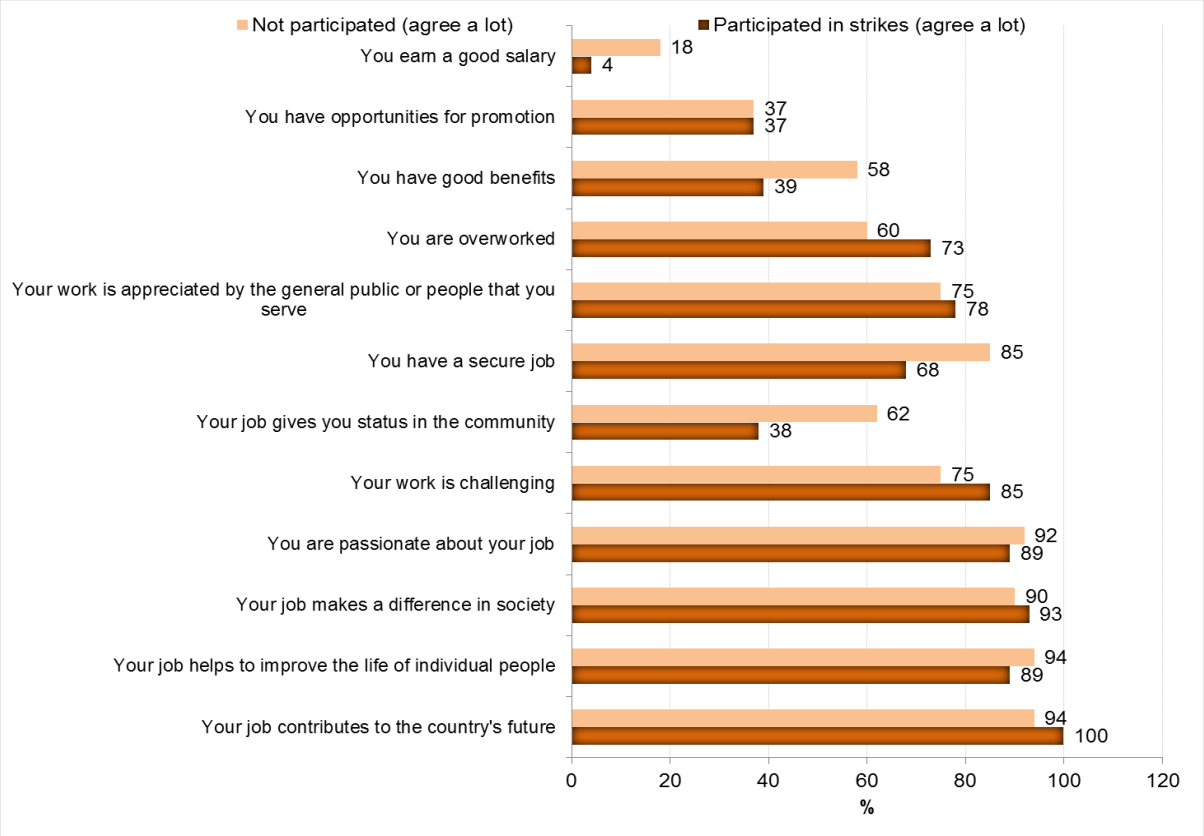

Figure 4.6: Nurses' description of own work

In Figure 4.6, overall differences of opinion are observed about attributes of own work between nurses that participated in strikes and those who did not. The nurses that participated in strikes were found to be less positive about the attributes of their own work compared to those who did not participate. Similarly to factors driving commitment, salary, job security and benefits remain the areas of concern, with a potential of leading nurses to strikes if they are not satisfied about them. Although those who participated in strikes indicated salary as an area of concern amongst the attributes of the nurses' job, it should be noted that it is not the only most

important driver of nurses' involvement in strikes. This is a finding evident in employee-commitment research worldwide (Mosadeghrad & Ferdosi 2013:121-123). However, since it is a tangible measure of the value that an employer places on the employee, it often stands in as 'proxy' for other areas of dissatisfaction such as being overworked and a feeling that their work doesn't give them status in community, and becomes a key sticking point in negotiations such as the strike actions under discussion.

Addressing salary alone will not in itself be sufficient to ensure a happy, committed and motivated workforce. The other fundamental drivers of the employer-employee relationship must also be addressed. This does not negate the fact that a fair living wage is still a basic requirement, and workers who feel they are not earning a good salary are more inclined to strike (European Foundation for the Improvement of Living and Working Conditions 2008:3; TNS Research Surveys 2007:82).

Nurses' description of their place of work / employer

The nurses' views about their employer were also explored to determine whether their views may have some influence in their involvement in strikes.

A statistical analysis using cross tabulations was conducted between the nurses' views about their employer and participation in strikes. The findings output in Figure 4.7 indicated a general similarity on how the two groups of nurses viewed their employer. The three areas highly rated positively between the two groups are: their employer treats staff with dignity and respect; their work environment is understaffed; competent people are appointed at senior management positions.

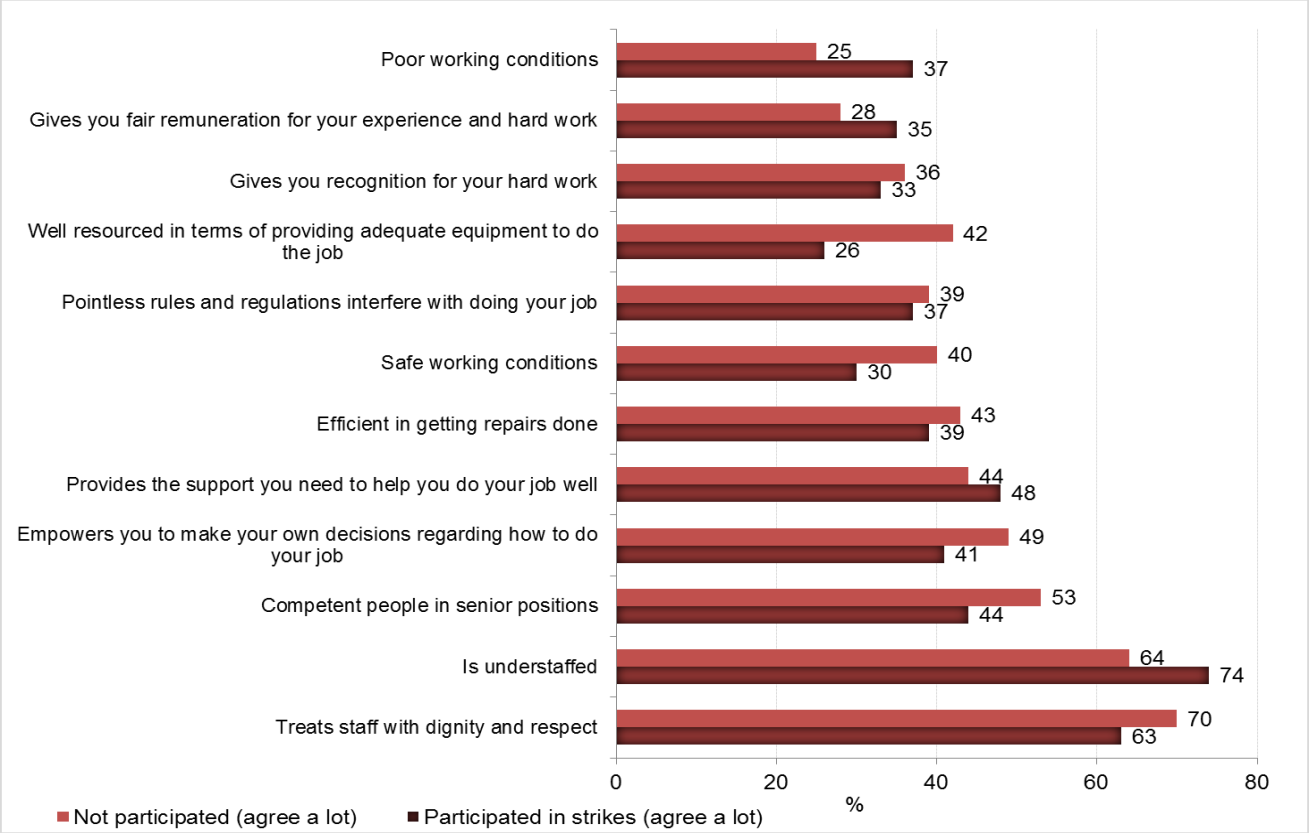

Figure 4.7: Nurses' description of aspects of own place of work / employer

No significant statistical differences in opinion about the employer were observed between nurses who participated in strikes and those who did not, although those who did not participate in strikes rated their employer slightly more positively compared to those who did. When statistically comparing response percentages between those who participated in strikes and those who did not, differences of opinion *(p=0,070)* were observed in rating their employer as well resources in terms of providing adequate equipment to do the job. Those who participated in strikes were most likely positive about this attribute of their employer.

Less than half of the nurses rated their employer as providing the support they need to help them do their job well, whether they participated or not participated in strikes. The issue of support is an important one, as it relates to dimensions of capacity, leadership, skills, safety and infrastructure. The qualitative data collected during the pilot phase highlighted that nurses often feel that the system is letting them down in different ways, to the extent that they cannot do their job (about which

they are passionate) properly.

In Table 4.13, nurses show gaps in areas relating to salary and remuneration as well as career growth and safe working conditions (including getting repairs done at the workplace). The government needs to focus on this because it is here where the strike action and the government's perceived 'inflexible' stance on key issues struck a sore point. Given the responsibility that the public-health sector has for the life of citizens, the perceived lack of resources for nurses to do their work is concerning.

- **Perceptions on reasons that led to strike action**

Respondents were asked to respond to a series of statements regarding the reasons in general that contributed to nurses' participation in strikes. This was to determine relationships between the series of statements that the nurses responded to and their level of involvement in strikes. Bivariate analysis using the chi-square test for associations was performed to determine if relationships existed between the variables.

Table 4.13 provides the chi-square statistics as well as the level of significance for each of the statements from the questionnaire. Statistical significance was tested at *p-value <0.05*. For purposes of the analysis, only the significant relationships are discussed in detail.

Table 4.13: General reasons for nurses' involvement in strike action

Variable (Annexures E)	Chi-square value	p-value
Q33(1).Poor pay in the public sector	5.945	0.05
Q33(2).No recognition for the work they do	8.999	0.011
Q33(3).Lack of adequate benefits	3.206	0.201
Q33(4).The salary gap between workers and managers	0.674	0.714
Q33(5).To get the government to stop ignoring staff grievances	3.621	0.164
Q33(6).To show the government how much the country relies on the public-sector workers	4.182	0.124
Q33(7).To demonstrate anger at how the government treats public-sector workers	4.345	0.114
Q33(8).Poor working conditions	5.611	0.06
Q33(9).A power struggle between the trade unions and the government	1.425	0.483
Q33(10).Lower levels of salaries in the public sector compared to the private sector	3.81	0.149
Q33(11).Frustration that issues raised in the October 2006 negotiations were still unresolved	3.074	0.215

After the analysis, only three of the statements showed relationship with the level of involvement in strikes. Tables 4.14 to 4.16 show that 27 nurses participated in strikes and that poor pay in the public sector, no recognition for work done and poor working conditions had a significant effect on the decision to take part in strikes.

Table 4.14 shows that a total of 27 nurses took part in the strike and 'agreed a lot' that one of the general reasons was poor pay received by employees in the public sector. There was a significant association between the dependent variable (participation in a strike) and the independent variable (poor pay in the public

sector). The null hypothesis is rejected with χ^2 (1) =5.945; *p*= 0.05 in favour of the alternate hypothesis.

Table 4.14: Association of strike participation and poor pay in the public sector

		Participation in strike action		Total	Chi-square value	*p-value*
		No	**Yes**			
Poor pay in the public sector	**A lot**	42	27	69	5.945	0.05
	A little	7	0	7		
	Not at all	3	0	3		
Total		52	27	79		

Table 4.15 looks at the association between the dependent variable (participation in a strike) and the independent variable that focuses on recognition for work done. At χ^2 (1) =8.999; *p*= 0.011 the null hypothesis is rejected in favour of the alternate; we conclude that the dependent and independent variables are associated.

Table 4.15: Association of strike participation and no recognition for work done

		Participation in strike action		Total	Chi-square value	*p-value*
		No	**Yes**			
No recognition for the work they do	**A lot**	31	25	56	8.999	0.011
	A little	16	2	18		
	Not at all	4	0	4		
Total		51	27	78		

Another reason that employees found to have an effect on the decision to take part in a strike is poor working conditions. Table 4.16 shows that the null hypothesis is rejected in favour of the alternate; we conclude that poor working conditions is associated with strike participation (χ^2 (1) =5.611; *p*= 0.05).

Table 4.16: Association of strike participation and poor working conditions

		Participation in strike action		Total	Chi-square value	*p-value*
		No	**Yes**			
Poor working conditions	**A lot**	29	22	51	5.611	0.05
	A little	18	3	21		
	Not at all	5	2	7		
Total		52	27	79		

Kunene (1995:112-113) also reflected on similar general reasons for strike participation amongst nurses and nurse mangers in his study conducted in the public-health sector in KwaZulu-Natal. Literature also reiterates similar associations, though highlighting that as much as remuneration is the most commonly stated cause of strikes worldwide, it often masks other deep-seated grievances.

The persistence of these factors as observed from the current research compared to other similar studies internationally and locally in South Africa, begins to highlight working conditions and remuneration as the main pull factors for the prevalence of nurses' involvement in strike action (Bateman 2009:416; Beinin 2009:450; Briskin 2011:1; Cruess & Cruess 2011:550; Hinarejos 2008:714; Kangasniemi et al. 2010:629; Ketter 1997:324; Kunene 1995:157, 160-164; Kunene & Nzimande 1996:46; Lima 2009; Mabange 1998:62-73; Muula & Phiri 2003:208).

Attending to these factors in an effective management approach with thought-through and research-informed strategies will assist in managing and minimising nurses' strikes in the public-health sector.

As discussed before in the drivers of commitment analysis, addressing working conditions, the need for support and recognition, and on-going issues in union–

government relations are important reasons which affect the decision to strike as well as the extent and severity of the strike action.

- **Nurses' personal reasons for involvement or non-involvement in strike action**

In Table 4.17, nurses who participated in strike action were asked to state their personal reasons for participating. Overall, the majority [24 (89%)] of nurses who participated in strike action were driven by concern over their remuneration, indicating that they cannot survive on the pay they are getting. About six in ten [16 (59%)] of nurses who participated indicated to have done that because they were following instructions from their unions. Union affiliations, especially other than DENOSA, present a point of conflict within the public-health sector. The reason is that most unions resort to strike action as a form of addressing concerns about their members' needs, and in most cases rules and regulations governing the nursing practice are overlooked. This finding confirms that nurses often find themselves at a crossroad between two conflicting interests: that of union representation with a possibility of engaging in strike action, and the continuity of care that forms a core part of the nursing practice that is entrenched in the Nurses' Pledge (SANC:2013).

The existence of unions in South Africa pose a challenge to the public-health sector as a larger number of nurses form part of their membership, and most comprise of negotiators and leaders that are not nurses. This leads to a situation where a person other than a nurse determines affiliated nurses' professional future and will prove disastrous as is perceived to be the case in other countries (Searle et al. 2009:221).

Table 4.17: Nurses' personal reasons for participation in strike action

Variable (annexure E)		Participated in the strike		Chi-sq value	p-value
		count	%		
Q29(1).You cannot survive on the pay you are getting	No	3	11	55.4	0.000
	Yes	24	89		
Q29(2).You were pressurised to strike	No	21	78	12.7	0.001
	Yes	6	22		
Q29(3).You had to follow union orders	No	11	41	39.3	0.000
	Yes	16	59		
Q29(4).You were threatened or intimidated into participating	No	19	70	17.4	0.000
	Yes	8	30		
Q29(5).You wanted to show support for those who really need the money	No	11	41	39.3	0.000
	Yes	16	59		
Q29(6).Your employer advised you not to come to work	No	24	89	6.1	0.036
	Yes	3	11		
Q29(7).It gave you a nice break	No	23	85	8.3	0.011
	Yes	4	15		
Q29(8).You just went along with everyone else	No	17	63	22.4	0.000
	Yes	10	37		

Some of the nurses that participated [16 (59%)] did that in support of their colleagues whom they felt needed the raise to survive. This reason points to a strong foundation of solidarity and concern for fellow workers.

A small proportion [8 (30)] of nurses that participated in strike action indicated that they did so because of intimidation or being threatened to participate. It is concerning that during the occurrence of strikes in South Africa, the rights of some members of the public-health force were violated at the expense of their own safety and that of the public. Though this happened to a lesser extent, its management may require a serious attention to ensure the rights of all nurses.

To understand why other nurses affiliated with unions didn't join the strike action, they were also asked for their personal reasons for not participating. Figure 4.8 below lists a number of reasons that were given by nurses that did not participate in strike action.

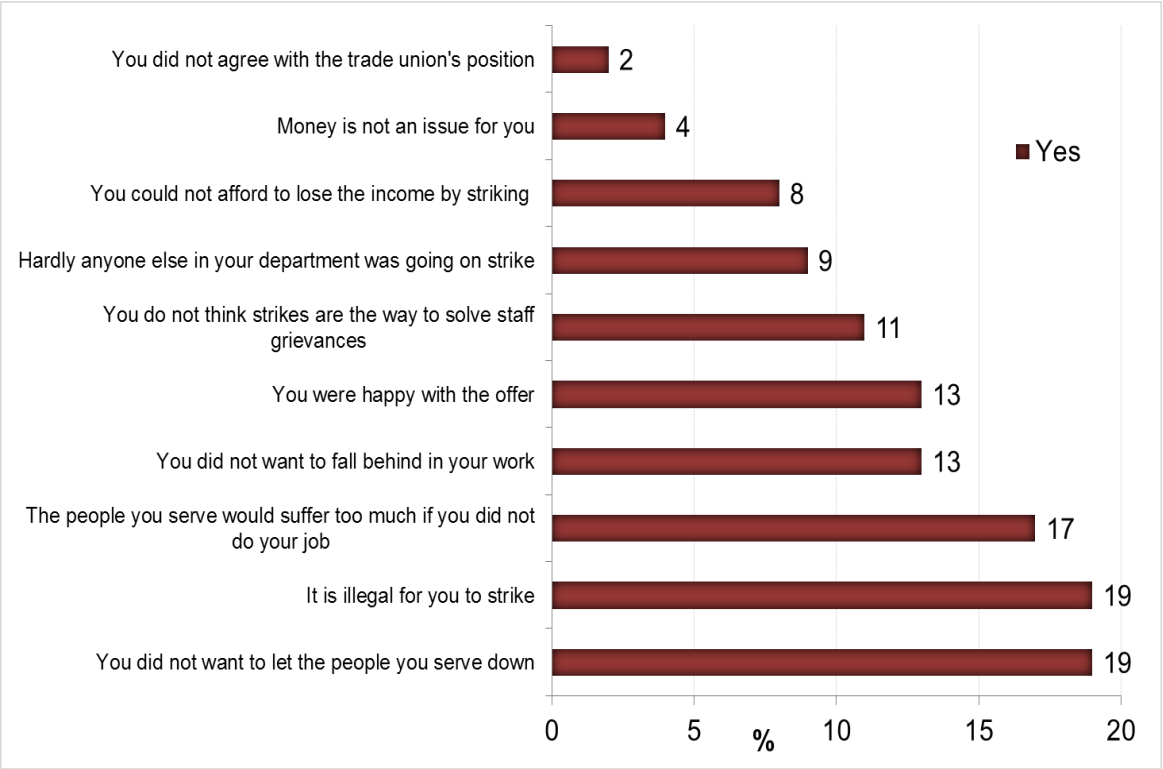

Figure 4.8: Nurses' personal reasons for not participating in strike action

Three reasons mentioned by most nurses that did not participate in the strike action related largely to issues of ethics and commitment to own work.

Workers who chose not to strike based their decision primarily on a sense of responsibility to those they serve [10 (19%)] with some indicating that they did not want the public to suffer [9 (17%)]. About two in ten [10 (19%)] felt that it is illegal for them to strike, and seven (13%) mentioned commitment to their job as they did not want to fall behind in their work. A small percentage [4 (8%)] was concerned about losing their income by striking.

Dissatisfaction with salary and remuneration was nevertheless evident even amongst non-striking workers with only seven (13%) stating that the offer was fair and two (4%) stating that money was not an issue. Though this has been the case, it is evident that their concern about the people they serve and the need to do their work became push factors for their non-involvement in strike action.

- **The outcome of strikes as perceived by nurses who participated in strike action**

Nurses who were involved in strike action were requested to indicate whether their decision to go on strike resulted in their concerns being addressed or not. As indicated in Figure 4.9, the majority of nurses that went on strike [n = 18 (67%)] were of the view that the strike action assisted a little in addressing their grievances. However, when positive responses (successful and less successful) were combined and compared to those who perceived strike action not having been successful, a significant difference was observed, indicating that those involved in strike action are most likely to be satisfied with the use of strikes to address their grievances.

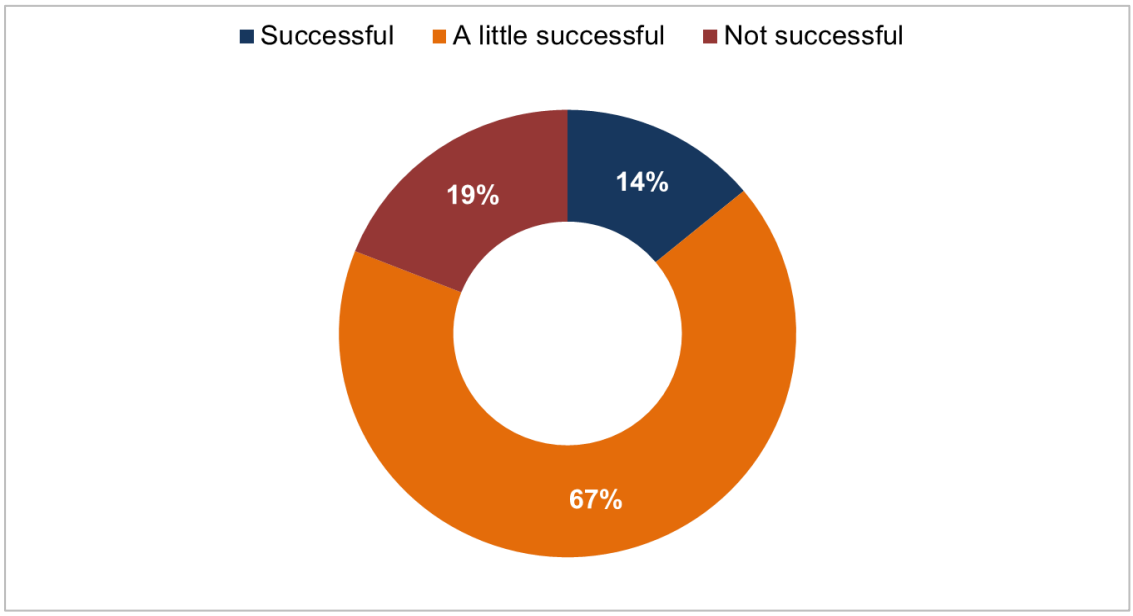

Figure 4.9: Rating of strike success by nurses who got involved in strike action

The findings indicate that given the view by nurses that strike action addressed their grievances to some extent; there is a potential threat of future strikes by public-health nurses if intervention measures are not put in place to address their grievances.

Managers should exercise new ways of leadership that would transform the mind-

set of nurses and leverage on the attribute of passion for their work and the ethical code that binds nurses to prioritise the health of patients. A transformational leadership approach using the adaptation of Kotter's model reflected on in Chapter two, would be ideal to address the situation with the aim of curbing nurses' involvement in strike action (Kotter 2012; McGuire & Kennerly 2006:185; Thompson 2011:3).

The on-going need for recognition of the valuable contribution of nurses should be expressed by increases in their salaries, according to findings of this study and other similar studies conducted in South Africa. A currently observed perception (not explored in this study) reflects lower wages for professional nurses than the average for other public-sector employees. This is one of the reasons, besides limited career prospects, that make nurses consider leaving the profession in search of better career prospects in other professions or ultimately engaging in strike action (Büscher Sivertsen & White 2009:10).

4.2.2. Nurse managers' views on strikes by nurses and their understanding of the changing environment of nurse practice

A self-administered questionnaire (Annexure F) was used for data collection in phase two. The research instrument was adapted from the phase-one questionnaire to accommodate nurse managers as respondents. The factors potentially leading to nurses' involvement in strikes were tested with nurse managers. Their understanding of the changing environment of nurse practice in relation to strike actions was explored.

Twelve nurse managers were selected by applying non-probability sampling using a purposive convenience sampling of registered nurse managers. Nurse managers were selected from the four provinces selected for the study, as reflected in Chapter 3. However, only eleven nurse managers completed questionnaires and sent them back by e-mail to the researcher for capturing and analysis.

Data was analysed using quantitative data-analysis approaches and the computer software package IBM® Statistics Version 21 (2013). Descriptive statistics were applied to understand data for interpretation and inferential statistics to determine correlations between variables. The focus for analysis in phase two was on the nurse managers' views of nurses' participation in strike action and the effects thereof.

- **Demographic and general information**

To assist in the evaluation of the responses, a few demographic variables were included in the questionnaire, such as the nurse managers' work status, age and gender.

Table 4.18: Nurse managers gender and work status

Sample per province	Count	Female		Male		Work status
		count	%	count	%	Senior management
Gauteng	4	2	50	2	29	[2]NMs
KwaZulu-Natal	3	1	25	2	29	NMs
Western Cape	2	0	0	2	28	NMs
Eastern Cape	2	1	25	1	14	NMs
Total	**11**	**4**	**100**	**7**	**100**	

The management profile in this study indicated a prominence of male managers [7 (64%)] in the public-healthcare facilities that were selected. Findings further depict that the majority of the managers were mostly within the age category of 46 to 55 years and highly qualified, as observed in Tables 4.19 and 4.20.

[2] *Nurse managers – salary level 13 -16*

Table 4.19: Nurse managers' age

Age category in years	Count	%
18 – 25 yrs	0	0
26 – 35 yrs	2	13
36 – 45 yrs	2	20
46 – 55 yrs	4	37
56 – 65 yrs	3	30
Total	**11**	**100**

Table 4.20: Nurse Managers' educational level

Education level	Count	%
Post grade 12	1	7
Postgraduate	2	14
Honours	1	13
Master's degree	6	57
Doctorate	1	9
Total	**11**	**100**

The demographic profile of nurse mangers indicates that the majority of the managers were older compared to the nurse employees and they all reported to have been in the service for more than ten years. This is indicative of their level of experience in implementing professional nursing practice policies and regulations at their level. The nurse managers' profile made it important to compare their views to that of nurse employees with regard to nurses' involvement in strike action. This was as such due to their age and level of experience in the profession of nursing.

- **Nurse managers' perceived reasons for nurses' involvement in strike action**

To assess whether managers had some understanding on why the staff opted for involvement in strike action amidst the regulations and policies of the nursing practice, a sample of nurse managers was asked to share views on their own understanding of what they thought contributed to the nurses' involvement in strike action.

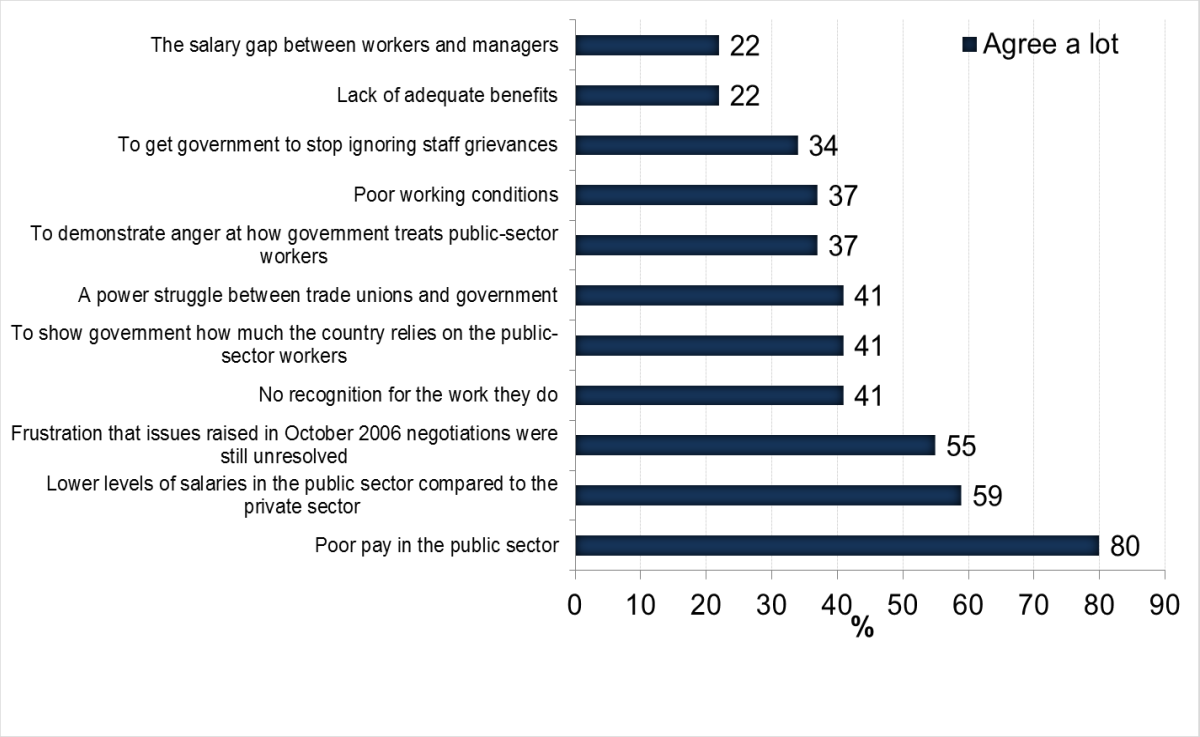

Figure 4.10: Nurse managers' perceived reasons for nurses' involvement in strike action

The three main reasons mentioned by nurse managers included poor pay in the public sector [9 (80%)]; lower levels of salaries in the public sector compared to the private sector [6 (59%)]; nurses were frustrated that issues raised in negotiations in October 2006 were still unresolved [6 (55%)]. These issues included an Occupational Specific Dispensation according to occupational level and years of experience. When these issues were not addressed as promised by the government, nurses lost trust in the government, Subsequent to the negotiations in 2006 was the biggest strike in 2007 in which a large number of nurses got involved.

Looking at the findings from the view of the nurse managers and the nurses' reasons for involvement in strike action, a similarity of issues associated with strike involvement is observed. The common thread in this study amongst all groups observed is the association of strike participation with low salaries that mostly drive the involvement in strike action. This finding reiterate the fact that as much as a concern on remuneration is not the only factor for nurses to get involved in strikes, it is the main proxy for all underlying concerns around working conditions and others (Motsosi & Rispel 2012:141). If these underlying issues are not effectively

managed, the wage problem gets exacerbated to a point of engagement in strikes by nurses.

4.2.3. The views of healthcare consumers on nurses' participation in strike action

This section reflects on **phase three** of the study that focused on determining the views of healthcare consumers on nurses' involvement in strike action. A qualitative research approach was used to better understand and explore the perception and views of how healthcare consumers experienced health service provision while nurses were on strike in 2007 and 2010.

A purposive and convenience sampling approach was used to recruit participants who matched the required criteria (Bowling 2009:208). Analysed data was collected through four focus groups with ten participants each across the selected provinces of the study, as indicated in Chapter 3. Each focus group consisted of ten participants that were 18 years and above.

A thematic data analysis approach was followed to determine themes from the four focus-group discussions (Bernard 2013:393). The discussions were audio-recorded and transcribed verbatim in English by the researcher. After transcription, the researcher read and reread the transcripts in detail to familiarise herself with the data (Polit & Beck 2010:464-465). This process was done before coding and searching for meanings and patterns in the data. Initial notes were recorded during this stage to aid the coding process (Brink et al. 2012:193). Colour-coding was done manually and confirmed with the external coder as a way of increasing the credibility of the findings. The study promoter was also consulted throughout the study process to increase credibility. The manner in which the discussion guide (Annexure H) was formulated prior the discussions and the objectives of the study aided for less fragmented discussions. This made the structuring of data into codes and themes less complicated for the researcher and the external coder.

- **Presentation of qualitative findings**

Analysis of data collected from public-healthcare consumers resulted in three main themes outlined below:

- General factors perceived to influence nurses' participation in strike action
- General reaction of healthcare consumers to strikes by nurses
- Management of strike action in the healthcare sector

From these main themes sub-themes emerged, which were classified under each relevant theme. A summary of the themes and sub-themes is illustrated in Table 4.21.

Table 4.21: Themes and sub-themes from the data

Theme	Sub-theme

Theme 1
General factors perceived to influence nurses' participation in strike action
	• Working conditions
	  - Hours of work
	  - Load of work
	• Remuneration

Theme 2 General reaction of healthcare consumers to strikes by nurses	• Healthcare consumers' access to healthcare services • Threat to well-being of healthcare consumers • Empathy towards nurses involved in strike action
Theme 3 Management of strike action in the healthcare sector	• Role of the government and the unions • Role of the nurses

Theme 1: General factors perceived to influence nurses' participation in strike action

According to studies conducted internationally and locally, the foremost reasons for strikes in the public-health sector are poor working conditions, followed by wage and other concerns (Beinin 2009:450; Briskin 2011:1; Burns & Goodnow 1996:26; Cruess & Cruess 2008:550; Gyamfi 2011:1; Ketter 1997:324). Some studies conducted – specifically in South Africa – had similar findings reported (Bateman 2009:417; Dhai et al. 2011:58; TNS Research Surveys 2007:2).

However, certain theorists and practitioners are of the view that regardless of the factors that may be, strike action should be outlawed because it disrupts normal labour relations especially in the public-health sector (Goel & Karn 2011; Ketter 1997:323; Robertson 2012:344; Stuart 2010:4; Van Wyk 2011).

Exploring these factors amongst the healthcare consumers highlighted the fact that the reasons for involvement by nurses in strike action are related to the nurse as individual and to the collective. The results are supported by relevant extracts of healthcare consumers when reflecting on nurses' working conditions and perceived low remuneration in relation to their work.

i. Working conditions and remuneration

The healthcare consumers perceived poor pay as the main reason for the nurses to get involved in strike action. Some of the reasons mentioned were perceived as salary gaps between public-sector nurses compared to those in the private sector, especially with reference to the load of work in the public sector.

"Increase for salary – as if when they don't strike, they won't get a raise."

"Money caused the nurses to go on strike. Nurses are unhappy because they work so hard and get a little money."

"I think it is money. Nurses are not happy because of the way they work and many patients – they have too many patients they have to assist in one day. They have a huge workload and get less salary compared to nurses in private hospitals."

According to the South African News Agency (2011), during the health summit in 2011 of nurses in South Africa, Health Minister Dr Aaron Motsoaledi re-committed himself to working hard in ensuring that the working conditions of nurses are improved in South Africa. In his presentation, he acknowledged that the public-health system has over the past number of years lost nurses to overseas countries due to poor working conditions and salaries. This aligned to perceptions that were discovered in the study reaffirming a need to focus on remuneration and working conditions to deter nurses from involvement in strike action. The report by Durning (2014) also affirmed that public-sector nurses were generally dissatisfied with their work while the private-sector nurses were generally satisfied. However, reflection was made that neither public-sector nor private-sector nurses were happy with their pay, though public-sector nurses were unhappy about their workload compared to their counterparts in the private sector.

Despite being faced with stressful and demanding working conditions, many nurses are passionate and committed to their profession, and to delivering quality patient care. However, the salary scale in nursing is not very high, especially in public institutions, and the struggle to stretch a limited salary is exacerbating an already difficult situation (George & Rhodes 2012: 6-7; Jolson 2011).

Theme 2: General reaction of healthcare consumers to strikes by nurses

In 2010 during strike action by nurses, reports received by the Department of Health (South Africa 2010) suggested varying levels of disruption in hospitals, with some provinces reporting major disruptions and interference with operations in healthcare facilities. To add to the insight of findings gathered through the preceding phases of this study, the researcher explored healthcare consumers'

views on how they experienced healthcare services during the period of strikes, determined any threat to well-being that could have been directed to healthcare consumers during strikes as well as how they felt about the situation. The following section provides findings on the three areas.

i. Healthcare consumers' access to healthcare services

The majority of concerns from the healthcare consumers focused on the lack of access to healthcare service followed by being inconvenienced, often quite badly. The major impact on healthcare was that many people could not access the care they needed from clinics and hospitals and they were, in fact, fearful of making use of public-healthcare facilities during the strike action by nurses.

"I was denied healthcare services during the strike. It was bad to see nurses involved in strike action and not being able to take care of patients' health."

"It was bad as the service was limited and poorer than usual. I had to wait for an hour for the ambulance."

"When in labour, I was afraid to go to hospital and stayed home and went later, maybe when they dispersed."

The findings highlight a need for nurse managers to strive towards adapting to the changing demands of the nursing profession and providing enabling measures that would create job satisfaction within the work environment as stipulated in the South African Nursing Act of 1978. If strike action by nurses is not effectively managed or discouraged, patients get affected regardless of the relief strategies employed during the strike action, rendering the health system not functioning optimally as intended (Eylert & Schinz [s.a.]).

ii. Threat to well-being of healthcare consumers

When healthcare consumers related their experiences during strikes by nurses, the discussions indicated that the impact of the strikes on daily life was widespread and profound. The comments from the focus groups on the impact of the strike sketch a harsh picture of the life-and-death situations many in the country faced with regard to health and hospital care at an individual level.

"I was discharged with a baby, and at the gate there were nurses on strike throwing stones. It was a scary experience."

"It was bad to see nurses involved in strike action and not being able to take care of patients' health."

"My child was critically ill at the time. I did not have money to take my child to a private doctor and the clinics were not working. I almost lost my baby."

"There were patients that were very ill and sent to hospital and quite a lot of them died without any medical attention. That upset me because those are our fellow human beings."

The health sector was one of the main sectors where the public was affected during strike periods by employees both in 2007 and 2010 (Schoeman 2012:8). In the light of healthcare services being key services and drivers of the population's perceptions regarding the government's overall performance (Government Communication and Information System 2013:17-18), the effect of the strike in this context was certainly compounded. Amongst the participants affected most by the strike action in the health- care sector were people without medical aid and relying on government healthcare services.

"I was worried as I was pregnant and the view on TV of pregnant women getting

kids in cars was scary. I could not afford private hospitals, and it was worrying."

The strike and the hardship that the public faced undermines the positive progress made in the public-healthcare sector by the government since 1994. The study by Kunene (1995:29-30) also highlights similar issues on how the healthcare consumers were affected during strike action in Kwa-Zulu Natal. This study indicates that during strike action by nurses, the outcome is often patient neglect and an increased number of deaths in hospitals that proves contrary to the ethical code and nurses pledge in South Africa. Other consequences relate to the nurse-patient relationship in providing total healthcare and patient health deterioration due to delayed treatment during strike action.

Strike action by nurses is an undesirable resort to address grievances, especially in the public-health sector which demands attention of both unions and management to take responsibility for avoiding its occurrence (Rycroft & Jordaan 1990:206).

iii. Empathy towards nurses involved in strike action

The general public was more empathetic towards the strikers, with the majority being sympathisers but anti-strike. Others amongst the participants were actual strike supporters given the reasons for nurses' involvement in strike action. Whilst the general public sympathised with the strikers' cause, they were not, as a rule, in favour of strike action as a means to remedy worker grievances.

"I support them as they need money."

"It affected the patients in a negative way but I also felt for the nurses who work so hard and do not get the salaries that they deserve."

In a study conducted by Gyamfi (2011:3), a similar view of empathy by healthcare consumers towards the nurses that got involved in strike action is observed. This

empathy was evident despite the negative impact that the strike had on their well-being. Other studies derive at similar conclusions, though caution is highlighted about the effect of media hype around mass mobilisation during strike action profiling nurses grievances (Dhai et al. 2011:58-60; Kowalchuk 2011:161; Ogunbanjo & Knapp van Bogaert 2009:307-308). Regardless of the media hype effect, academic research as with this study provides a platform to understand the true nature of participants' views and feelings.

Theme 3: Management of strike action in the healthcare sector

The advent of strike action in the public-health sector is a reminder to nurse managers that human behaviour in organisations is unpredictable because it stems from deep-seated needs and different value systems.

Nurse managers should not use their own discretion or intuition, experience or tradition as a basis for making personnel management decisions. Use of administration or management theories enables prediction, gives clues to possible outcomes of decisions made and implemented, and minimises chances of unexpected or undesirable responses or behaviours. This is important because nursing work and management is performed in situations that are influenced by changes both in the external and internal environment (Griffith 2007:11-12; Stefl 2008:361).

i. Role of the government and the unions

The public expressed a view that the government, being the employer of nurses and regarding them as part of the essential services, should compensate them accordingly given the amount of work they do in public clinics and hospitals. A majority of the participants mentioned that to avoid strikes in future, the employer should be in touch with the needs of the nurses or workers in general. These participants are of the view that the government should think about the health of the people when engaging in negotiations instead of power struggles between the

employer and the unions.

“Also the way they treated the nurses in the strike, if you watched the incidents on TV – how they tear-gassed old, old nurses who worked hard for this government. So they didn’t have respect.”

“The government should inform itself of the needs of the workers to avoid people going on strike.”

“Disagreements between the government and the unions during negotiations indicated that the government did not worry about the well-being of the public.”

“The government did not handle the strike action well because strikes took longer and patients suffered while others were fighting for their salaries.”

“We should avoid strikes and the government should put the life of people first. They should not have taken this long at the cost of people suffering.”

“Government took too long for negotiations and did not want to compromise.”

The occurrence of strike actions in the public-health sector should compel the government and nursing managers to use the opportunity for constructive feedback when revisiting and considering why strike actions occurred, as outlined in this study and other site-specific studies conducted to date (Beinin 2009:450; Briskin 2011:1; Burns & Goodnow 1996:26; Cruess & Cruess 2008:550; Gyamfi 2011:1; Ketter 1997:324; Robinson, McCann, Freeman & Beasley 2008:272-275). Furthermore, the occurrence of strike action in the public-health sector provides the government an opportunity and platform to review existing policies and promote the implementation of intervention strategies to prevent similar disputes from taking

place.

ii. Role of the nurses

Strike action by nurses within the public-health sector raises ethical and moral concerns (Kowalchuk 2011:162-163; Ogunbanjo & Knapp van Bogaert 2009:58). Contrary to this concern, some authors consider strike action in some instances to be necessary and ethically imperative (Kravitz, Shapiro, Linn & Sivarajan 1989:1229-1230; Ogunbanjo & Knapp van Bogaert 2009:58).

Although the findings earlier indicated that healthcare consumers were empathetic towards reasons that led to nurses' involvement in strike action, most were against the use of strikes by nurses to raise their grievances. Some healthcare consumers also raised a need for nurses to put in place contingency measures when they go on strike such that the well-being of healthcare consumers is not negatively affected.

"Nurses should discuss their problems with management, with the intention of avoiding unnecessary disagreements that often make them to go on strike, leaving us stranded."

"It was bad to see nurses involved in strike action and not being able to take care of patients' health. They need to fight for their rights through negotiations and discussions but not go out there to strike."

"I think at times, the nurses don't care as they just neglected their patients at the cost of participating in strike action. Yes, they have rights and they need to be paid better but if they are not there to help us, where must we go? We don't have money to go to private hospitals, they must think for the poor people that don't have money to go to private hospitals, and stay at their jobs while their problems are being discussed."

"They should make sure that there is skeleton staff to look after the patients while other nurses are on strike, this will prevent people from dying during strike actions by nurses."

According to Schoeman (2012:17), strike actions within the public-healthcare sector – regardless of the reasons, ethical and moral concerns – should not be taken likely as the nature of work is labour-intensive and there is little room for error. Therefore, management of strike actions within the public-health sector becomes a necessity to ensure adherence by nurses to their ethical code of conduct and to improve the health of all healthcare consumers.

4.3. CONCLUSION

This chapter and other relevant literature referred to in this study indicate that though there are different reasons for strike action in the public-health sector by area or by country, remuneration is undoubtedly the most mentioned reason. Pay can be assumed to be involved in many of the collective bargaining disputes which are prominent causes of industrial action as is evident within the South African context. It is important to note that salary per se is not the most important factor. However, it is a tangible measure of the value that the employer places on people and, in the absence of the other dimensions discussed in this chapter, becomes the focal point. However, addressing salary issues alone will not prevent strike action in the public-health sector.

Working conditions is also one of the common mentioned causes of strike action, especially amongst nurses internationally (European Foundation for the Improvement of Living and Working Conditions 2008:17; 20).

Unlike a "normal" strike at a production plant which involves only employers or their unions on the one side and trade unions on the other side, the findings in this chapter indicate that a strike in the public sector does not only concern the

economic and political interests of the public-sector employers. When strike action take place in the public-health sector, third parties such as the general public have to bear the consequences of such strikes.

Although freedom of association is guaranteed in South African law or is accepted as a constitutional right including the right to strike – when it comes to nurses, a constitutional right to strike is limited by the protection of essential services. However, it has been common that during the strike action by nurses in 2007 and 2010 other public-healthcare facilities did not provide for a minimum provision of service agreement prior to engaging in strike action, putting the health of consumers at risk.

The chapter further highlighted the importance of commitment in nurses' own work. It was observed that nurses would tend to be more committed to their work if they feel that they have a secure job, earn a good salary and have good benefits. Thus, the level of commitment of nurses who feel that the three issues mentioned are addressed increase, with a potential of minimising their likelihood to get involved in strikes.

The findings reflect a need for senior members of the government and the management to get closer to their workers by means of improved communication, opportunities for feedback and a better appreciation of the conditions that workers face in their work environment.

Overall, a considerable number of nurses and managers belong to a union, which makes it difficult at times for nurses to choose between their ethical code of conduct and following the demands of their unions. Unions with a strong hold amongst nurses are DENOSA and NEHAWU. A majority of unionised nurses tend to take part in strike action.

Feedback from the general public supports the frustration by nurses in the workforce, with the public indicating that public-sector salaries are perceived to be unfair and that important civil servants like nurses are underpaid. No doubt, this is due partly to the fact that the publicised issues were almost all around the percentage salary increase.

CHAPTER 5

OVERVIEW, THEORETICAL IMPLICATION, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 OVERVIEW

The study was set out for two reasons. The first reason was to assess and ascertain factors and processes embedded in the decision of nurses working in public-healthcare facilities to participate in industrial action despite their ethical code of conduct. The second reason was to describe proactive strategies to maintain a balance between the human and professional rights of nurses and the responsibilities of nurses within the legal framework of South Africa. The study identified factors contributing to public-healthcare nurses' involvement in strike action and proactive strategies for balancing the human and professional rights of nurses and their responsibilities within a legislative and professional framework in South Africa. The general theoretical literature on this subject – specifically in the context of South Africa – is inconclusive on vital questions on whether nurses should strike or not and how these could be handled within a legislative and professional framework for nurses in South Africa. The study sought to answer five questions:

- Why do nurses participate or don't participate in strike action?
- What is the value and impact of strikes as perceived by nurses who participated in strike action?
- What is the impact of strike action by nurses as perceived by healthcare consumers?
- What do nurse managers understand of the changing environment of nurse practice?
- What can be done to prevent strikes by nurses?

The following objectives were pursued to address the research questions:

- To explore the factors that result in nurses joining or not joining in strike action within the existing legislative framework of South Africa.
- To assess the value of strike action as perceived by nurses.
- To explore perceptions or views of healthcare consumers about nurses' participation in strike action.
- To explore nurse managers' understanding of the changing environment of nurse practice.
- To describe the strategies that can be used to prevent strikes.

5.2 EMPHIRICAL FINDINGS

The main empirical findings were summarized in Chapter 4. This section synthesizes the empirical findings to address the study's five research questions.

1. Why do nurses participate or don't participate in strike action?

a. Remuneration in the public-health sector is a proxy for underlying concerns: A majority of public-health nurses who got involved in strike action coupled a need for better remuneration to their working conditions in the main. Perceived lack of attention to their concerns with regard to remuneration and working conditions presents a potential recurrence of strikes within the public-health sector in South Africa.

b. Younger generation public-health nurses: The younger generation nurses in the study were more prone to engage in strike action, which could be attributed to a higher need to exercise their constitutional right as compared to the older generation.

c. Union affiliation: Almost all nurses in the study indicated a need for union affiliation to safeguard their needs. However, the affiliation to unions other than DENOSA comes with the added challenge for the need to strike to address concerns. This is presented by a lack of alignment of other unions to the regulatory framework of the nursing practice in South Africa.

2. What is the value and impact of strikes as perceived by nurses who participated in strike action?

a. Perceived added benefit of strike action: A majority of nurses who got involved in strike action were of the view that strikes assisted in getting their concerns heard, though the impact was felt as very minimal in terms of the management addressing their concerns.

3. What is the impact of strike action by nurses as perceived by healthcare consumers?

a. Public sympathy towards nurses involved in strike action: The public sympathise with nurses based on the level of remuneration they are believed to be getting compared to the perceived load of work the nurses have to deal with in the public-health sector. However, their sympathy is coupled with disapproval for nurses' engagement in strike action to raise their concerns.

b. Access to healthcare services: A number of consumers indicated that nurses' involvement in strike action compromise the well-being of healthcare consumers as access and quality of service are mostly affected during strike action.

4. What do nurse managers understand of the changing environment of nurse practice?

a. Remuneration: Similar to the nurses' views, nurse managers mainly attributed the involvement of nurses in strike action to low salary levels as compared to the private sector.

b. Implementation of the Occupation-Specific Dispensation (OSD): Given the developments within the public-health sector, nurse managers attributed the likelihood of nurses' involvement in strike action to unresolved areas of nurses' practice as were discussed in October 2006 which amongst others focused on the implementation of the OSD. The view from nurse managers was that perceived non-delivery of these issues which in the main revolve around structured remuneration was the main causes of the nurses' involvement in strike action. Given the understanding of the OSD, implementation and misunderstanding around

policy implementation may adversely affect the relationships between nurse managers and the nurses, leading to dissatisfaction (Motsosi & Rispel 2012). The latter may therefore result in nurses' involvement in strike action.

5. What can be done to prevent strikes by nurses?

a. DENOSA as union of choice: Given the need of the majority of public-health nurses' to belong to a union for their concerns to be addressed, it would be of value to promote the affiliation to DENOSA as a union of choice for nurses because of its alignment to the legal framework of nursing practice in South Africa.

b. Ethical code of practice: Reinforcement of the ethical code of practice especially amongst the younger generation of nurses will be of benefit to manage the likelihood of involvement in strike action.

c. Notion of nursing as an essential service: The understanding and buy-in by nurses to the fact that nursing is an essential service to the broader South African population will to a larger degree lessen the need to use strike action as a solution to addressing concerns.

d. Commitment to work: The three main drivers of commitment need to be satisfied, namely having a secured job, earning a good salary and having good benefits from work.

5.3 THEORETICAL IMPLICATION

The nursing professionals being part of the essential services in South Africa are according to sections 8 and 22-23 of the Bill of Rights, limited with regard to their level of involvement in strike action. However, within the South African context all members of the Republic of South Africa are covered by the Constitution (South Africa 1996:s23) which qualifies the right by all employees to collectively bargain for their rights as well as a right of association.

The nursing profession in South Africa developed a code of ethics to which all professional nurses subscribe (Searle et al. 2009:267). This entail that the foremost

important consideration of the profession is the right of healthcare consumers to healthcare. However, application/implementation of the code of ethics within the nursing practice present some ethical dilemmas such as a decision by nurses to get involved in strike action (South African Nursing Council 2013:8). Although according to Sasso et al. (2008:821), the ethical code of practice is the key driver in the nursing practice, Uys (1992:34) maintains that it is simplistic to expect professional nurses not to strike when they feel that their managers do not honour their work contracts with them.

The theoretical implication within the interest of this study therefore implies that the dichotomy between nursing ethics and involvement in strike actions needs to be addressed in the nursing profession in South Africa. In consideration of the literature, the theoretical framework guiding this study and the empirical findings derived at, the researcher developed a conceptual diagram (Figure 5.1) illustrating strategies aimed at curbing strike action by nurses in public-healthcare facilities. This conceptual diagram is mainly based on Kotter's model for transformational leadership as a proactive measure to respond to the need of a deterrent measure for nurses' involvement in strike action and instil the need for adherence to the professional code of ethics within the legislative framework. Figure 5.1 outlines possible courses of action or presents a preferred approach to an idea or thought (Mehta 2014).

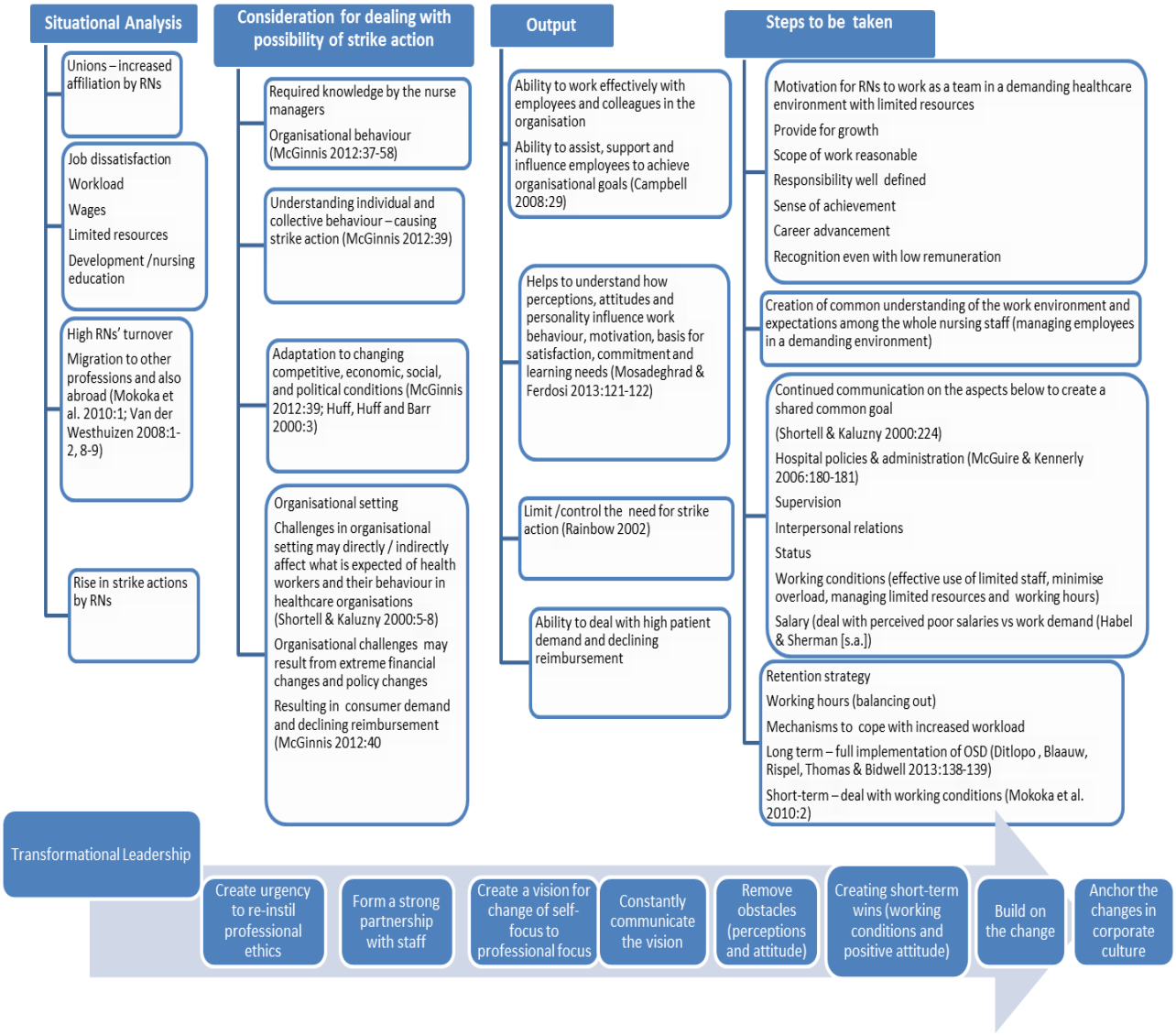

Figure 5.1: Strategies for curbing strike action by nurses in public institutions, South Africa

Figure 5.1 was developed as an aiding tool for nursing service managers to manage and change behaviour leading to strike action by nurses. It is based on the integration of models, theories from available literature and the empirical findings of this study. The common high prevalence of strike action in public-healthcare facilities in South Africa require remedial action that would bring back the dignity and expected work ethics from the nurses. The increasing population in South Africa has over time created a big demand for healthcare in the public sector. Some level of adaptation is required to deal with the growing need for quality healthcare in a demanding environment with minimum remuneration. This change is not limited to the nursing staff only; also in dire need are the clients' tolerance, management's

understanding of issues and dealing with emanating problems towards a common goal of quality healthcare.

5.4 RECOMMENDATION FOR FUTURE RESEARCH

The scale of this study explored the cause and effect of nurses' involvement in strike action. However, the root enshrined in the bargaining process needs to be explored by investigating the following for future research:

The effectiveness of the bargaining process within the public-health sector: How is this process aiding the nurses' responsibilities as outlined in their ethical code of practice in the event where they feel their needs are not met?

Drivers of nurses' adherence to the legislative framework of nursing practice in South Africa despite the challenging and changing work environment: This needs to focus on a common goal for nurses to keep their marching order despite the work circumstance.

5.5 LIMITATIONS OF THE STUDY

The study has offered an exploratory perspective on an important national concern in South Africa about causes for nurses' involvement in strike action amidst the existence of the legislative framework limiting this action. The study encountered the following limitations which need to be considered:

- The study was limited to professional nurses and managers within the public-health sector and public members using public-health facilities / hospitals in four provinces, looking at the urban-rural split.
- The study aimed to explore a national view of factors driving the involvement of nurses in strike action, and to derive at a national solution to assist healthcare providers and policy-makers. Due to time and budgetary

constraints, the research was conducted in the four provinces containing South Africa's metropolitan areas, with an urban and rural split as a proxy for a national representation of the target population given the nature of the study. These provinces included EC, WC, KZN and GP.

- Ethical considerations were of importance for accessing information. Equally important was the willingness of the professional nursing staff at the public-health facilities to participate with consent in the study on matters related to the healthcare service and their participation in strike action.
- The suggested strategies to curb strike action by nurses in public institutions in South Africa were derived at through a literature review and supported by the findings of this research. However, these strategies remain a proposal of great importance until its effectiveness within the public sector is scientifically explored.

5.6 CONCLUSIONS

In spite of what is often reported about nurses neglecting healthcare consumers as a result of engagement in strike action in South Africa, the sympathy for the perceived plight of the nurses indicated by healthcare consumers is an important factor to consider. The findings reflect that nurses felt "forced" to strike by the need to get their concerns addressed. This indicates flaws in the implementation of the bargaining process that if implemented in good faith, would address many of the concerns affecting nurses and their work without compromising the well-being of healthcare consumers.

The need for a much more open, frank and critical communication between managers and nurses as well as the unions and the government is paramount if strikes are to be avoided in the public-health sector. However, as outlined in Figure 5.1 this will be a demanding process. Nonetheless, by building on the expressed passion for the work that nurses do, and their recognition of the value of their work to the country, it is possible to build a new unity in the public-health sector towards a common purpose. But this can only be accomplished by building a culture of

mutual respect and dialogue that actively seeks to break down the ‘us-and-them’ divide which threatens a volatile condition if allowed to continue.

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ANNEXURE A

UNISA

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/193/2013

Date:	3 July 2013	Student No:	4105-156-4
Project Title:	An exploratory investigation of factors influencing nurses participation in strike action and its impact.		
Researcher:	Ntombi P Nala		
Degree:	D Litt et Phil	Code:	DIS890B
Supervisor:	Prof SP Human		
Qualification:	D Cur		
Joint Supervisor:	-		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

UNIVERSITEIT VAN SUID-AFRIKA PRETORIA UNIVERSITY OF SOUTH AFRICA

Prof L Goets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

3

[3]The title was changed after examination and accepted as *"Strategies for curbing strike action by nurses in Public institutions, South Africa"*

ANNEXURE B

Contact letter for nurses

Department of Health Studies
UNISA

Ref : Research Project in Health Studies

Enq : Prof SP Human
Tel : 012 429 6290
Fax : 012 429 6688
E-mail :
humansp@unisa.ac.za

Date: August 2013

Attention: Matron in charge / professional nurse in charge

Dear Sir / Madam

REQUEST FOR PROFESSIONAL NURSES PARTICIPATION IN AN INTERVIEW: AN EXPLORATORY INVESTIGATION ON FACTORS INFLUENCING NURSES PARTICIPATION IN STRIKE ACTION AND ITS IMPACT

The department of Health Studies at the University of South Africa (UNISA) request permission for Ms Nala to conduct interviews with professional nurses at your institution. Ms Nala is currently busy with data collection for her doctoral research project registered at the UNISA under the supervision of Prof SP Human within the department.

Her research project involves an engagement with professional nurses both in rural and urban areas on issues related to their work and their perceptions on the role and involvement of professional nurses in a strike action.

The process will involve the following steps:

1. Initial contact by Miss Nala (the researcher), to identify and select a respondent and set-up appointment and venue/number to call for in-depth interview.
2. Confirmation of the appointment date and venue/number to call by the researcher.
3. In-depth interview (40 minutes maximum)

Your cooperation and assistance will be greatly appreciated and will contribute towards the success of the project in striving towards promotion of effective provision of basic health services to all. Names of all respondents will be kept confidential during and after the completion of the research project.

Yours sincerely,

_____

Prof. SP Human
Department of Health Studies
Theo van Wijk Building 6-187
Muckleneuk Campus (UNISA)

Contact letter for healthcare consumers

Department of Health Studies
UNISA

Ref : Research Project in Health Studies
Enq : Prof SP Human
Tel : 012 429 6290
Fax : 012 429 6688
E-mail :
humansp@unisa.ac.za

Date: August 2013
Attention: Member of the community / nurse participants

Dear Sir / Madam

REQUEST FOR YOUR PARTICIPATICIPATION IN A FOCUS GROUP DISCUSSION ON AN EXPLORATORY INVESTIGATION ON FACTORS INFLUENCING NURSES PARTICIPATION IN STRIKE ACTION AND ITS IMPACT

The department of Health Studies at the University of South Africa (UNISA) request permission for Ms Nala to conduct focus group discussions with you as a public member using or having a potential to use a primary health care facility or public hospital. Ms Nala is currently busy with data collection for her doctoral research project registered at the UNISA under the supervision of Prof SP Human within the department.

Her research project involves an engagement with professional nurses and healthcare consumers both in rural and urban areas on issues related to nurses' work and perceptions on the role and involvement of professional nurses in a strike action.

The process will involve the following steps:

1. Initial contact by Miss Nala (the researcher), to set-up appointment and venue for in-depth interview or focus group discussion.
2. Confirmation of the appointment date and venue by the researcher.

3. In-depth interview (45 minutes maximum) / focus group discussion (1hr maximum)

Your cooperation and assistance will be greatly appreciated and will contribute towards the success of the project in striving towards promotion of effective provision of basic health services to all. Names of all respondents will be kept confidential during and after the completion of the research project.

Yours sincerely

_____

Prof. SP Human
Department of Health Studies
Theo van Wijk Building 6-187
Muckleneuk Campus (UNISA)

Consent form

STRATEGIES FOR CURBING STRIKE ACTION BY NURSES IN PUBLIC INSTITUTIONS, SOUTH AFRICA

I,……,ID number……,cell/telephone number……..,residing at (address) …… confirm that I understand the purpose of the research in which I will be a respondent/participant and therefore give consent to be contacted for a focus group discussion or an in-depth interview.

I understand that the information will be used in an anonymous form and that I, as an individual, will not be identifiable. I understand that everything possible will be put in place to prevent any form of victimisation, based on the information that I provide. I noted that I have the right to withdraw from the study at any stage.

I willingly and voluntarily participate in the study. I note that the researcher, whom I can contact if I have any query, is Ms NP Nala who provided her contact details should the need arise.

Signature: _____

Respondent/Participant

ANNEXURE C

Professional nurses recruitment form

Name:		Surname:	

1.	Did you participate in the strike that occurred in 2007 / 2010

Yes	1
No	2

2.	Which of the following best describe you? [select one]

Auxiliary nurse	1
Registered nurse	2

3.	Where do you work? _____ Name of hospital / clinic _____ Area of hospital / clinic _____

4.	Did the hospital / clinic you working at got affected by strike action in 2007 / 2010?

Yes	1
No	2

5.	Are you registered with the Nursing Council of South Africa?

Yes	1
No	2

6.	How many years have you been working as a nurse? _____

7.	Gender?

Male	1
Female	2

ANNEXURE D

NURSES INVOLVED IN STRIKE ACTION

In-depth interview guide

1. PERCEPTIONS TOWARDS NURSING PROFESSION

- This section seeks to establish respondents' thoughts, experience and feelings about their profession.
- It will further determine respondents views on ethical code and legalities within the discipline of nursing towards patients constitutional right of access to basic health services

Interviewer: *As an employee in the public sector, you have been selected to participate in this discussion. The main aim is to gain information on the 2007 & 2010 strikes and the reasons behind them. Answers to these questions will enable us to make suggestions to government on how to improve the work situation for people in the public sector and the bodies regulating the nursing practice.*

All this information that you give to us will be treated in the strictest of confidence. The results of these discussions will only be made available to the public health sector. No information given by any individual will be disclosed to anyone. We are, however, recording your answers to ensure that we have not missed out anything that you may have said.

1.1. Thoughts and feelings on nursing profession

Moderator: *Focusing on your present job, what are the positive and negative feelings you have with regards to your job.*

What are your thoughts and feelings towards the work that you do? Probe reasons

Probe:

- Aspects of the present job that they like the most, including reasons
- Aspects of the present job that they dislike the most, including reasons
- How would they consider their satisfaction towards their current job to have changed, if at all over the past few years? Probe reasons

1.2. Perceptions towards provision of basic health services

- How do you think the nurses are faring in delivering health services to the people? Probe reasons
- In what specific areas are nurses performing poorly in delivering services to the people? Probe reasons

- If you were responsible for the management of the public sector, what would you look at changing – probe reasons
    - What would you consider to be the most important thing that you would change? Probe
    - What would you consider to be the least important thing that you would change? Probe
- What are your views on nurses' affiliation with unions and the nursing council/association? Probe whether this allows them more rights and whether they see any contradiction in being affiliated to both concurrently? What are the benefits if any of each affiliation?

2. PERCEPTIONS ON THE STRIKE ACTION

- This section seeks to establish respondents' thoughts, experience and feelings about the nurses who participated in the strike action.
- It will further determine respondents views on ethical code and legalities within the discipline of nursing towards patients constitutional right of access to basic health services

2.1. Perceptions towards reasons behind the strikes

Interviewer: *Now I would like us to focus on the public sector strike which took place in 2007 and August 2010. In your opinion what do you think were the reasons behind the strike?*

- Allow spontaneous discussion

If not mentioned probe:

- Cost of living – inflation, etc
- Level of satisfaction with job. Are nurses in the public sector happy or unhappy?
- Political situation – give examples of how the political situation in the country could have influenced the strike

- What do you think is/was the most important reason for the nurses' participation if any in the strike action? Probe
- How did the strike make you feel about your profession? Probe
- Why did you participate in the strike action? Probe(perception, peer pressure, intimidation and fear, and level of knowledge and commitment to the profession-concern about the health of patients)
- Why do you think the strike lasted as long as it did? Probe
- While you were on strike what were your thoughts and feelings while striking? Probe

2.2. Perceptions towards settlement

Moderator: *Now I would like us to focus on getting back to work after the strike.*

- What sacrifices did you make by going on strike action? Probe examples like income loss and work back-log. Probe reasons
- How did you feel about the strike when it was over? Probe reasons
- How, if at all, the strike influences public health professionals' satisfaction with their job? Probe reasons

2.3. Perceptions on the way the strike was handled

Moderator: *Imagine you have the opportunity to write a postcard to the public health sector, about the way in which the strike was handled and resolved. Please tell me the message you would like to give.*

- What are your thoughts on the manner in which the strike was handled?
- How would you rate on a scale of 1 – 10, where 1 is extremely poorly handled and 10 is extremely well handled, the manner in which the strikes were handled? Probe **(Determine respondents average)**
- What, if anything do you think could have been done better in handling the strike both by authorities and participating nurses? Probe
- How did you get information on the strike action? Probe unions, television, radio, community, other
- How would you recommend to the Minister of Health that similar situations be prevented in future? Probe

2.4. How well the union handled the strike

- How well do you think the unions communicated during the strike action? Probe
- How would you rate the unions handling of the strike as a whole? Probe reasons

3. NURSES PERCEPTIONS ON PUBLIC'S VIEWS ON NURSES PARTICIPATION IN STRIKE ACTION

- This section will seek to establish respondents' thoughts and feelings while they were on strike
- This section will seek to gain perceptions on how the public may have felt and the impact the strike had on the country and public

How do you think the public feel/felt about the nurses' participation in a strike action?

What effect do you think the strike had on the country and public's use of services? Probe:

- Health services

Thanks!

NURSES NOT INVOLVED IN STRIKE ACTION

In-depth interview guide

1. PERCEPTIONS ON NURSING PROFESSION

- This section seeks to establish respondents' thoughts, experience and feelings about their profession.
- It will further determine respondents views on ethical code and legalities within the discipline of nursing towards patients constitutional right of access to basic health services

Interviewer: *As an employee in the public sector, you have been selected to participate in this discussion. The main aim is to gain information on the strike and the reasons behind it. Answers to these questions will enable us to make suggestions to government on how to improve the work situation for people in the public sector and the bodies regulating the nursing practice.*

All this information that you give to us will be treated in the strictest of confidence. The results of these discussions will only be made available to the public health sector. No information given by any individual will be disclosed to anyone. We are, however, recording your answers to ensure that we have not missed out anything that you may have said.

1.1. Thoughts and feelings on nursing profession

Moderator: *Focusing on your present job, what are the positive and negative feelings you have with regards to your job.*

What are your thoughts and feelings towards the work that you do? Probe reasons

Probe:

- Aspects of the present job that they like the most, including reasons
- Aspects of the present job that they dislike the most, including reasons
- How would they consider their satisfaction towards their current job to have changed, if at all over the past few years? Probe reasons

1.2. Perceptions on provision of basic health services

- How do you think the nurses are faring in delivering health services to the people? Probe reasons
- In what specific areas are nurses performing poorly in delivering services to the people? Probe reasons
- If you were responsible for the management of the public sector, what would you look at changing – probe reasons
    - What would you consider to be the most important thing that you would change? Probe

- What would you consider to be the least important thing that you would change? Probe

- What are your views on nurses' affiliation with unions and the nursing council/association? Probe whether this allows them more rights and whether they see any contradiction in being affiliated to both concurrently? What are the benefits if any of each affiliation?

2. PERCEPTIONS ON THE STRIKE ACTION

- This section seeks to establish respondents' thoughts, experience and feelings about the nurses who participated in the 2007 and 2010 strike action.
- It will further determine respondents views on ethical code and legalities within the discipline of nursing towards patients constitutional right of access to basic health services

2.1. Perceptions on reasons behind the strikes

Interviewer: *Now I would like us to focus on the public sector strike which took place since in 2007 and August 2010. In your opinion what do you think were the reasons behind the strike?*

- Allow spontaneous discussion

If not mentioned probe:

- Cost of living – inflation, etc
- Level of satisfaction with job. Are nurses in the public sector happy or unhappy?
- Political situation – give examples of how the political situation in the country could have influenced the strike

- What do you think is/was the most important reason for the nurses' participation if any in the strike action? Probe
- How did the strike make you feel about your profession? Probe
- Why did you come to work despite other nurses being involved in the strike action? Probe (perception, level of knowledge and commitment to the profession-concern about the health of patients)
- Why do you think the strike lasted as long as it did? Probe

2.2. Perceptions on settlement

Moderator: *Now I would like us to focus on getting back to work after the strike.*

- What sacrifices do you think people made by going on strike? Probe examples like income loss and work back-log. Probe reasons
- How do you think people felt about the strike / when it was over? Probe reasons
- How, if at all, this will influence public health professionals' satisfaction with their job? Probe reasons

2.3. Perceptions on the way the strike is/was handled

Moderator: *Imagine you have the opportunity to write a postcard to the public health sector, about the way in which the nurses handled the strike action towards wage increase. Please tell me the message you would like to give.*

- What are your thoughts on the manner in which the strike was handled?
- How would you rate on a scale of 1 – 10, where 1 is extremely poorly handled and 10 is extremely well handled, the manner in which the strike was handled? Probe **(Determine respondents average)**
- What, if anything do you think could have been done better by public health sector in handling the strike? Probe
- How did you get information on the strike? Probe unions, television, radio, community, other
- How would you recommend to the Minister of Health that similar situations be prevented in future? Probe

3. NURSES PERCEPTIONS ON PUBLIC'S VIEWS ON NURSES PARTICIPATION IN STRIKE ACTION

- This section seeks to gain perceptions on how the public feel/may have felt and the impact the strike had on the country and public

How do you think the public feel/felt about the nurses' participation in strike action?

What effect do you think the strike had on the country and public's use of services? Probe

- Health services

Thanks!

ANNEXURE E

Questionnaire on factors influencing nurses' participation in strike action

SECTION 1: BACKGROUND INFORMATION

1. MANAGER/EMPLOYEE

Manager (Employer)	-1
Employee	-2

---

2 Main Sub-sector

Hospital manager	-1
Ward supervisor	-2
Nursing sister	-3
Other	-4

---

3. PROVINCE

Eastern Cape	-1
Gauteng	-2
KZN	-3
Western Cape	-4

---

4. **SALARY BAND**

Skilled levels (3-5)	-1
Highly skilled production (6-8)	-2
Highly skilled supervision (9-12)	-3
Management level (13 – 16)	-4

---

5. **GENDER**

Male	-1
Female	-2

SECTION 2 : INTRODUCTION AND WORK INFORMATION

In this section you will be asked about the work that you do; your satisfaction with working in the public health sector and labour relations. Your answers will help us to make suggestions to government on how to improve the work situation of people like you in the public-health sector.

All the information that you provide will be treated in the strictest of confidence and your name will never be linked to the information that you give.

The interview should take about 20-30 minutes of your time.

6. Please provide your full name

Name: _____

_____

_

7. Can you confirm that you work for a public healthcare facility in **(FILL IN YOUR PROVINCE _____)**?

Yes -1
No -2

_____

_

8. How many years have you been working in the public health sector?

ESTIMATES ARE FINE. IF LESS THAN A YEAR RECORD AS 1
Options 1-60 years [ ]

_____

_

9. Would you describe your position as mainly…..?

SINGLE MENTION

Management	-1
Professional work such as nursing	-2
Professional support such as computer systems maintenance	-3
Administrative support such as financial administration	-4
Other (SPECIFY)	-5

_____

_

10. Is the work that you presently do regarded by government as an essential service? Essential services include nurses, doctors, police officers and correctional officers

Yes -1
No -2
Don't know -3

SECTION 3: COMMITMENT TO JOB AND ORGANISATION

11. Imagine your ideal organisation. Now think about **working for the public-health sector**. When you take into account everything that you look for in an organisation, how would you rate the public-health sector on a scale from '1' to '10' – where 1 means terrible and 10 means perfect?

SINGLE MENTION

Terrible -01

-02
-03
-04
-05
-06
-07
-08
-09
Perfect -10

12. When you think of all the different organisations you could work for, do you think the public-health sector is…… **(SEE LIST BELOW)?**

SINGLE MENTION

Better than most other organisations	-1
About the same as most other organisations	-2
Worse than most other organisations	-3

13. People can work for the public-health sector because it's just a way to make a living. Or people can work for the public-health sector because they really want to. Using a scale from 1 to 4 where 1 means it's something you really want to do; and 4 means it's just a way to make a living – how would you rate working for the public-health sector?

SINGLE MENTION

It's something I really want to do	-1
	-2
	-3
It's just a way to make a living	-4

14. Please indicate which of these three statements best describes your feelings about **working for the public-health sector?**

SINGLE MENTION

1. You can think of many good reasons for <u>continuing</u> to work in the public-health sector	-1
2. You can think of many good reasons to work somewhere else	-2
3. Both statements apply	-3

15. Now thinking about the **kind of work you do**. When you think about everything that you **look for in a job**, how would you rate the kind of work **you do** on a scale from '1' to '10' – where 1 means terrible and 10 means perfect?

SINGLE MENTION

Terrible -01
-02

-03
-04
-05
-06
-07
-08
-09
Perfect -10

16. Now think about other kinds of work you could do, do you think your work is……?

SINGLE MENTION

1. Better than most other types of work -1
2. The same as most other types of work -2
3. Worse than most other types of work -3

17. Still thinking about the actual work you do. Is the kind of work you do at the moment just a way to make a living – or is it something that you really want to do? Using a scale from 1 to 4 where 1 means the work you do is something you really want to do; and 4 means it is just a way to make a living – how would you rate the actual work you are doing at the moment?

SINGLE MENTION

Doing this kind of work is something you really want to do -1
-2
-3
Doing this kind of work is just a way to make a living -4

18. Please indicate which of these three statements best describes your feelings about the work you do?

SINGLE MENTION

You can think of many good reasons to continue doing the same kind of work -1
You can think of many good reasons to change to something else -2
Both statements apply -3

19. I am now going to read out a list of statements which could describe some people's jobs. Please could you tell me if it describes your job a lot, a little, or not at all.

SINGLE MENTION PER STATEMENT

1. Your job makes a difference in society
2. Your job contributes to the country's future
3. Your job helps to improve the lives of individual people
4. You have a secure job
5. You earn a good salary
6. You have good benefits
7. Your work is challenging
8. Your work is appreciated by the general public or people that you serve
9. You are overworked
10. You have opportunities for promotion
11. You are passionate about your job
12. Your job gives you status in the community

Answer options:

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

20. I am now going to read out a list of statements which people have used to describe the organisation that they work for. Please could you tell me if it describes your organisation or department a lot, a little, or not at all.

READ ONE STATEMENT AT A TIME
SINGLE MENTION PER STATEMENT

1. Gives you recognition for your hard work
2. Empowers you to make your own decisions regarding how to do your job
3. Is understaffed
4. Well-resourced in terms of providing adequate equipment to do the job
5. Gives you fair remuneration for your experience and hard work
6. Have poor working conditions
7. Treats staff with dignity and respect
8. Provides the support you need to help you do your job well
9. Have safe working conditions
10. Competent people in senior positions
11. Pointless rules and regulations interfere with doing your job
12. Efficient in getting repairs done

Answer options

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

SECTION 4: TRADE UNIONS

21. Are you a member of a trade union in the public sector?

Yes	-1
No	-2
Prefer not to say	-3

22. People feel differently about the alternatives of being a member of a trade union compared with not being a member of a trade union. Please rate how you feel about these alternatives using a 10 point scale where 10 means it is ideal and 1 means it is terrible. How do you rate…….

SINGLE MENTION PER CHOICE

1. Being a member of a trade union
2. **Not** being a member of a trade union

Terrible	-01
	-02
	-03
	-04
	-05
	-06
	-07
	-08
	-09
Ideal	-10

23. Thinking now about the decision of whether to be a member of a trade union or not, how important is that decision to you as a public health sector employee?

SINGLE MENTION

Extremely important	-1
Very important	-2
Moderately important	-3
Slightly important	-4
Not at all important	-5

24. **ANSWER IF TRADE UNION MEMBER (CODE -1 IN Q.18).**
You are now going to read a number of statements, which one statement best describes your feelings as a member of a trade union?

SINGLE MENTION

1. There are many good reasons to continue being a member of a trade union -1
2. There are many good reasons to stop being a member of a trade union -2

3. Both these statements apply -3

ANSWER IF NOT TRADE UNION MEMBER (CODE -2 IN Q.21).
You are now going to read a number of statements, which one statement best describes your feelings about **not** being a member of a trade union?

SINGLE MENTION

1. There are many good reasons not to be a member of a trade union -1
2. There are many good reasons to become a member of a trade union -2
3. Both statements apply -3

SECTION 5: THE STRIKE ACTION

25. Now focus on the previous public-health sector strikes, which took place in 2007 and 2010. People have mentioned various reasons for the strikes taking place. Do you think each of the following reasons contributed to the strikes a lot, a little or not at all?

READ ONE STATEMENT AT A TIME
MORE THAN ONE MENTION/ANSWER

1. Poor pay in the public sector
2. No recognition for the work they do
3. Lack of adequate benefits
4. The salary gap between workers and managers
5. To get government to stop ignoring staff grievances
6. To show government how much the country relies on the public-health sector workers
7. To demonstrate anger at how government treats public sector workers
8. Poor working conditions
9. A power struggle between trade unions and government
10. Lower levels of salaries in the public sector compared to the private sector
11. Frustration that issues raised in October 2006 negotiations were still unresolved

Answer options

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

26. Is there anything else not mentioned yet that contributed a lot to the strike?

WRITE IN YOUR OWN ANSWER

……

ANSWER IF MEMBER OF A TRADE UNION (CODE -1 IN Q.21).

27. Some people participated in the strike while others did not. Did you personally participate in the strike or go on a "go slow"? Remember everything you say will be kept confidential.

MORE THAN ONE MENTION/ANSWER

Participated in strike	-1
Went on a go-slow	-2
Did not participate	-3
Prefer not to say	-4

ANSWER IF PARTICIPATED IN STRIKE (CODE -1 IN Q.24 ELSE GO TO Q.28).

28. For how many days did you go on strike?

_____

ANSWER IF YOU WENT ON STRIKE (CODE -1 IN Q.24).

29. In addition to the reasons for the strike that you've just mentioned, did any of the following reasons <u>also</u> contribute to you <u>personally</u> participating in the strike? Please indicate your answers with 'yes' or 'no'.

READ ONE STATEMENTS AT A TIME
MORE THAN ONE MENTION/ANSWER

1. You cannot survive on the pay you are getting
2. You were pressurised to strike
3. You had to follow union orders
4. You were threatened or intimidated into participating
5. You wanted to show support for those who really need the money
6. Your employer advised you not to come to work
7. It gave you a nice break
8. You just went along with everyone else
9. Other (**SPECIFY**)

30. **ANSWER IF YOU WENT ON STRIKE (CODE -1 IN Q.24).**
During the strike, how well did the representative of the union to which you belong communicate with you to tell you about what was happening?

SINGLE MENTION

Communicated well	-1
Communicated a little, but not well	-2
Did not communicate	-3

ANSWER IF YOU DID NOT GO ON STRIKE (CODE -3 IN Q.27) BUT IS A MEMBER OF A TRADE UNION (CODE -1 IN Q21).

31. People had various reasons for not going on strike. Which of the following are the main reasons why you did not go on strike? Please indicate your answer with 'yes' or 'no'

READ ONE STATEMENTS AT A TIME.
MORE THAN ONE MENTION/ANSWER

1. You did not want to let the people you serve down
2. You could not afford to lose income by striking
3. The people you serve would suffer too much if you did not do your job
4. It is illegal for you to strike
5. You do not think strikes are the way to solve staff grievances
6. You did not want to fall behind in your work
7. Hardly anyone else in your department was going on strike
8. You did not agree with the trade unions' position
9. You were happy with the offer
10. Money is not an issue for you
11. Other (Specify)

_____

32. In your opinion, should **essential services** workers such as nurses and doctors go on strike?

Yes -1
No -2
Don't know -3

SECTION 6: SENTIMENT TOWARDS THE STRIKE

33. You are going to read a list of statements and opinions about the strike. Please indicate whether you agree or disagree with each statement.

READ ONE STATEMENT AT A TIME

1. The original request of an overall increase by the trade unions was fair
2. In general, the strike was conducted peacefully
3. Where violence occurred during the strike, it was justified
4. The strikes gave foreign investors a negative impression of South Africa
5. The strikes had a negative effect on the economy of the country
6. The strikes had a negative effect on the image of the government as a fair employer
7. Ministers and top government officials are out of touch with the troubles of public sector workers
8. The government was arrogant in its handling of the strike
9. The government could have stopped the strike sooner
10. The trade unions were responsible for prolonging the strike
11. The final settlement was fair

12. The government was hostile towards the striking public sector workers
13. It was humiliating for public sector workers to have to beg for a decent wage
14. The government does not deliver on its promises
15. It was important for public sector workers to go on strike
16. Strike action does more bad for the country than good
17. Public sector workers should just find other jobs in the private sector if they are unhappy
18. Most people only went on strike because the trade unions forced them to
19. Most public sector workers had good reason to go on strike
20. Many public sector workers don't deserve to be paid more because they are lazy
21. Important public sector employees such as teachers, nurses and the police are underpaid
22. The government communicated effectively with the general public during the strike
23. The trade unions communicated effectively with the general public during the strike
24. The employer's original offer of an overall increase was fair
25. The media covered the strike fairly

Answer options per statement

Agree	1
Disagree	2
Neither agree nor disagree	3
Don't know	4

34. To what extent do you think the strikers' were successful in having their grievances addressed?

SINGLE MENTION

Successful	-1
A little successful	-2
Not successful	-3
Don't know (DON'T READ OUT)	-4

35. Is there anything else that you would like to say about the strikes?

WRITE OWN WORDS

.....

.....

.....

SECTION 7: DEMOGRAPHICS

ANSWER IF MEMBER OF TRADE UNION (CODE -1 IN Q.21).

36. Which trade union do you belong to?

SINGLE MENTION

CTPA	-1
DENOSA	-2
HOSPERSA	-3
NAPTOSA SAOU	-4
NATO	-5
NEHAWU	-6
NPSWU	-7
NUPSAW	-8
PAWUSA	-9
PEU -10	
POPCRU	-11
PSA -12	
SADNU	-13
SADTU	-14
SAMA	-15
SAPU	-16
SASAWU	-17
UNIPSA	-18
Other (specify)	-19
Don't know	-20
Prefer not to say	-21

_____
_

37. This survey is almost complete and we just have a few questions we'd like to ask for classification purposes.

Into which of the following age brackets do you fall?

SINGLE MENTION

18 – 25 years	-1
26 – 35 years	-2
36 – 45 years	-3
46 – 55 years	-4
56 – 65 years	-5
66+ years	-6
Refused	-7

38. What language do you speak most often at home?

SINGLE MENTION

IsiZulu	-01
IsiXhosa	-02
Afrikaans	-03
Sepedi	-04
English	-05
Setswana	-06
Sesotho	-07
Xitsonga	-08
SiSwati	-09
Tshivenda	-10
IsiNdebele	-11
Other (SPECIFY)	-12

_____
_

39. What is the highest level of education you have achieved?

SINGLE MENTION.

None	-01
Some primary school (Gr. 1 – Gr. 6)	-02
Complete primary school (Gr. 7)	-03
Some secondary school (Gr. 8 – Gr. 11)	-04
Complete secondary school (Gr. 12)	-05
Certificate/diploma without completing Gr. 12	-06
Post Gr. 12 certificate/diploma/matric	-07
Bachelor's degree	-08
Post graduate certificate/diploma	-09
Honours degree	-10
Master's degree	-11
Doctorate	-12
Other (SPECIFY)	-13
Refused	-14

40. **RACE**
For statistical purposes, could you please tell me which of the following ethnic groups you belong to? Is it...?

SINGLE MENTION

Black African	-1
Coloured	-2
Indian/Asian	-3
White	-4

_____

RESPONDENT CONTACT DETAILS

D1. We may need to contact you again in the future for academic research purposes. Would you be willing to participate?

Yes -1
No -2

_____
_

ANNEXURE F

Questionnaire on managers' views about factors influencing nurses' participation in strike action

SECTION 1: BACKGROUND INFORMATION

1. MANAGER/EMPLOYEE

Manager (Employer) -1
Employee -2

---

2 Main Sub-sector

Hospital manager -1
Ward supervisor -2
Nursing sister -3
Other -4

---

3. PROVINCE

Eastern Cape -1
Gauteng -2
KZN -3
Western Cape -4

---

4. **SALARY BAND**

Skilled levels (3-5) -1
Highly skilled production (6-8) -2
Highly skilled supervision (9-12) -3
Management level (13 – 16) -4

---

5. **GENDER**

Male -1
Female -2

SECTION 2 : INTRODUCTION AND WORK INFORMATION

In this section you will be asked about the work that you do; your satisfaction with working in the public-health sector and labour relations. Your answers will help us to make suggestions to government on how to improve the work situation of people like you in the public-health sector.

All the information that you provide will be treated in the strictest of confidence and your name will never be linked to the information that you give.

The interview should take about 20-30 minutes of your time.

---

6. Please provide your full name

Name: _____

---

7. Can you confirm that you work for a public healthcare facility in **(FILL IN YOUR PROVINCE _____)**?

Yes -1
No -2

---

8. How many years have you been working in the public-health sector?

ESTIMATES ARE FINE. IF LESS THAN A YEAR RECORD AS 1
Options 1-60 [ ]

---

9. Would you describe your position as mainly…..?

SINGLE MENTION

Management	-1
Professional work such as nursing	-2
Professional support such as computer systems maintenance	-3
Administrative support such as financial administration	-4
Other (SPECIFY)	-5

---

10. Is the work that you presently do regarded by government as an essential service? Essential services include nurses, doctors, police officers and correctional officers

Yes -1
No -2
Don't know -3

SECTION 3: COMMITMENT TO JOB AND ORGANISATION

11. Imagine your ideal organisation. Now think about **working for the public-health sector**. When you take into account everything that you look for in an organisation, how would you rate the public health sector on a scale from '1' to '10' – where 1 means terrible and 10 means perfect?
SINGLE MENTION

Terrible -01

-02
-03
-04
-05
-06
-07
-08
-09
Perfect -10

12. When you think of all the different organisations you could work for, do you think the public health sector is…… **(SEE LIST BELOW)?**

SINGLE MENTION

Better than most other organisations	-1
About the same as most other organisations	-2
Worse than most other organisations	-3

13. People can work for the public health sector because it's just a way to make a living. Or people can work for the public-health sector because they really want to. Using a scale from 1 to 4 where 1 means it's something you really want to do; and 4 means it's just a way to make a living – how would you rate working for the public-health sector?

SINGLE MENTION

It's something I really want to do	-1
	-2
	-3
It's just a way to make a living	-4

14. Please indicate which of these three statements best describes your feelings about **working for the public-health sector?**

SINGLE MENTION

1. You can think of many good reasons for <u>continuing</u> to work in the public-health sector	-1
2. You can think of many good reasons to work somewhere else	-2
3. Both statements apply	-3

15. Now thinking about the **kind of work you do**. When you think about everything that you **look for in a job**, how would you rate the kind of work **you do** on a scale from '1' to '10' – where 1 means terrible and 10 means perfect?

SINGLE MENTION

Terrible	-01
	-02
	-03
	-04
	-05
	-06
	-07
	-08
	-09
Perfect	-10

16. Now think about other kinds of work you could do, do you think your work is……?

SINGLE MENTION

1. Better than most other types of work	-1
2. The same as most other types of work	-2
3. Worse than most other types of work	-3

17. Still thinking about the actual work you do. Is the kind of work you do at the moment just a way to make a living – or is it something that you really want to do? Using a scale from 1 to 4 where 1 means the work you do is something you really want to do; and 4 means it is just a way to make a living – how would you rate the actual work you are doing at the moment?

SINGLE MENTION

Doing this kind of work is something you really want to do	-1
	-2
	-3
Doing this kind of work is just a way to make a living	-4

18. Please indicate which of these three statements best describes your feelings about the work you do?

SINGLE MENTION

You can think of many good reasons to continue doing the same kind of work	-1
You can think of many good reasons to change to something else	-2
Both statements apply	-3

19. I am now going to read out a list of statements which could describe some people's jobs. Please could you tell me if it describes your job a lot, a little, or not at all.

SINGLE MENTION PER STATEMENT

1. Your job makes a difference in society
2. Your job contributes to the country's future
3. Your job helps to improve the life of individual people
4. You have a secure job
5. You earn a good salary
6. You have good benefits
7. Your work is challenging
8. Your work is appreciated by the general public or people that you serve
9. You are overworked
10. You have opportunities for promotion
11. You are passionate about your job
12. Your job gives you status in the community

Answer options:

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

20. I am now going to read out a list of statements which people have used to describe the organisation that they work for. Please could you tell me if it describes your organisation or department a lot, a little, or not at all.

READ ONE STATEMENTS AT A TIME
SINGLE MENTION PER STATEMENT

1. Gives you recognition for your hard work
2. Empowers you to make your own decisions regarding how to do your job
3. Is understaffed
4. Well-resourced in terms of providing adequate equipment to do the job
5. Gives you fair remuneration for your experience and hard work
6. Have poor working conditions
7. Treats staff with dignity and respect
8. Provides the support you need to help you do your job well
9. Have safe working conditions
10. Competent people in senior positions
11. Pointless rules and regulations interfere with doing your job
12. Efficient in getting repairs done

Answer options

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

SECTION 4: THE STRIKE ACTION

21. Now focus on the previous public-health sector strikes, which took place in 2007 and 2010. People have mentioned various reasons for the strikes taking place. Do you think each of the following reasons contributed to the strikes a lot, a little or not at all?

READ ONE STATEMENTS AT A TIME
MORE THAN ONE MENTION/ANSWER

1. Poor pay in the public sector
2. No recognition for the work they do
3. Lack of adequate benefits
4. The salary gap between workers and managers
5. To get government to stop ignoring staff grievances
6. To show government how much the country relies on the public-health sector workers
7. To demonstrate anger at how government treats public sector workers
8. Poor working conditions
9. A power struggle between trade unions and government
10. Lower levels of salaries in the public sector compared to the private sector
11. Frustration that issues raised in October 2006 negotiations were still unresolved

Answer options

A lot	-1
A little	-2
Not at all	-3
Don't know	-4

22. Is there anything else not mentioned yet that contributed a lot to the strike?

WRITE IN YOUR OWN ANSWER

……

_____
_

23 In your opinion, should **essential service** workers such as nurses and doctors go on strike?

Yes -1
No -2
Don't know -3

SECTION 5: SENTIMENT TOWARDS THE STRIKE

24. You are going to read a list of statements and opinions about the strike. Please indicate whether you agree or disagree with each statement.

READ ONE STATEMENT AT A TIME

1. The original request of an overall increase by the trade unions was fair
2. In general, the strike was conducted peacefully
3. Where violence occurred during the strike, it was justified
4. The strikes gave foreign investors a negative impression of South Africa
5. The strikes had a negative effect on the economy of the country
6. The strikes had a negative effect on the image of the government as a fair employer
7. Ministers and top government officials are out of touch with the troubles of public-sector workers
8. The government was arrogant in its handling of the strike
9. Government could have stopped the strike sooner
10. The trade unions were responsible for prolonging the strike
11. The final settlement was fair
12. Government was hostile towards the striking public sector workers
13. It was humiliating for public sector workers to have to beg for a decent wage
14. Government does not deliver on its promises
15. It was important for public sector workers to go on strike
16. Strike action does more bad for the country than good
17. Public sector workers should just find other jobs in the private sector if they are unhappy
18. Most people only went on strike because the trade unions forced them to
19. Most public sector workers had good reason to go on strike
20. Many public sector workers don't deserve to be paid more because they are lazy
21. Important public sector employees such as teachers, nurses and the police are underpaid by the public sector
22. The government communicated effectively with the general public during the strike
23. The trade unions communicated effectively with the general public during the strike
24. The employer's original offer of an overall increase was fair
25. The media covered the strike fairly

Answer options per statement

Agree	1
Disagree	2
Neither agree nor disagree	3
Don't know	4

25. To what extent do you think the strikers' were successful in having their grievances addressed?

SINGLE MENTION

Successful -1
A little successful -2
Not successful -3
Don't know (DON'T READ OUT) -4

26. Is there anything else that you would like to say about the strikes?

WRITE OWN WORDS

.....

.....

.....

SECTION 6: DEMOGRAPHICS

27. This questionnaire is almost complete and there are just few questions for classification purposes.

Into which of the following age brackets do you fall?

SINGLE MENTION

18 – 25 years -1
26 – 35 years -2
36 – 45 years -3
46 – 55 years -4
56 – 65 years -5
66+ years -6
Refused -7

28. What language do you speak most often at home?

SINGLE MENTION

IsiZulu	-01
IsiXhosa	-02
Afrikaans	-03
Sepedi	-04
English	-05
Setswana	-06
Sesotho	-07
Xitsonga	-08
SiSwati	-09
Tshivenda	-10
IsiNdebele	-11
Other (SPECIFY)	-12

_____
_

29. What is the highest level of education you have achieved?

SINGLE MENTION.

None	-01
Some primary school (Gr. 1 – Gr. 6)	-02
Complete primary school (Gr. 7)	-03
Some secondary school (Gr. 8 – Gr. 11)	-04
Complete secondary school (Gr. 12)	-05
Certificate/diploma without completing Gr. 12	-06
Post Gr. 12 certificate/diploma/matric	-07
Bachelor's degree	-08
Post graduate certificate/diploma	-09
Honours degree	-10
Master's degree	-11
Doctorate	-12
Other (SPECIFY)	-13
Refused	-14

_____
_

30. **RACE**
For statistical purposes, could you please tell me which of the following ethnic groups you belong to? Is it...?

SINGLE MENTION

Black African	-1
Coloured	-2
Indian/Asian	-3
White	-4

_____

RESPONDENT CONTACT DETAILS

D1. We may need to contact you again in the future for academic research purposes. Would you be willing to participate?

Yes -1
No -2

_____
_

ANNEXURE G

Healthcare consumers' recruitment form

Name:		Surname:	

1.	Are you a South African Citizen

Yes	1
No	2

2.	What is your age category?

15 – 17 yrs	1
18 – 24 yrs	2
25 – 34 yrs	3
35 + yrs	4

3.	Did you use or had to use a hospital / clinic that was affected by strike action in 2007 / 2010?

Yes	1
No	2

ANNEXURE H

Discussion guide for healthcare consumers

1. PERCEPTIONS ON THE RECENT STRIKE ACTION

- This section seeks to establish respondents' thoughts, experience and feelings about the nurses who participated in the current or recent strike action.

1.1. Perceptions on reasons behind the strike

Interviewer: *Now I would like us to focus on the recent public sector strike which took place since August 2010. In your opinion what do you think were the reasons behind the strikes?*

- Allow spontaneous discussion

If not mentioned probe:

- Cost of living – inflation, etc
- Level of satisfaction with job. Are nurses in the public sector happy or unhappy?
- Political situation – give examples of how the political situation in the country could have influenced the strike

- What do you think is/was the most important reason for the nurses' participation if any in the strike action? Probe
- How did the strike make you feel about your lack of or limited access to basic health services? Probe
- How did the strike make you feel about the nurses' participation in the strike action? Probe
- Why do you think the strike lasted as long as it did? Probe

1.2. Perceptions on settlement

Moderator: *Now I would like us to focus on getting back to work after the strike.*

- What sacrifices do you think nurses made by going on strike? Probe examples like income loss and work back-log. Probe reasons
- How do you feel about the nurses strike action now that it is over? Probe reasons

1.3. Perceptions on the way the strike was handled

Moderator: *Imagine you have the opportunity to write a postcard to the government, about the way in which the strike was handled and resolved. Please tell us the message you would like to give.*

- What are your thoughts on the manner in which the strike was handled?
- How would you rate on a scale of 1 – 10, where 1 is extremely poorly handled and 10 is extremely well handled, the manner in which the strike was handled? Probe **(Determine group average)**
- What, if anything do you think could have been done better in handling the strike? Probe
- How did you get information on the strike? Probe television, radio, community, other

- How would you recommend to the government that similar situations be prevented in future? Probe

2. PUBLIC'S PERCEPTION OF STRIKE

- This section will seek to gain perceptions on how the public may have felt and the impact the strike had on the country and public

How do/did you feel about the nurses strike action impact on patients' health?

What effect do you think the strike had on the country and public's use of services?
Probe:

- Health services

Thanks!