PERCEPTIONS ON THE IMPACT OF NURSES' STRIKES ON NURSES, THE NURSING PROFESSION AND ON QUALITY OF HEALTH CARE IN KWAZULU-NATAL PROVINCE

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Perceptions on the impact of nurses' strikes on nurses, the nursing profession and on quality of health care in KwaZulu-Natal Province

By

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Date of Submission	:	January 1999

DEDICATION

This work is dedicated to the following:

* My colleagues in the nursing profession who provide and manage patient / client care in nursing services.

* The communities who provide the challenging, dynamic environment within which the nursing profession is practised.

* My present and past Nursing Administration / Management students who inspire me to continuously think critically and seek more knowledge about my profession.

* My children S'busiso, Gugulethu, Fikile, Dumisani.

* My late parents Philemon and Nessie Biyela for instilling in me the love of education.

* My late husband Obed Artwell Kunene whose life and example provided me with endless challenges for progress in education.

DECLARATION

I hereby declare that this research on

"Perceptions on the impact of nurses' strikes on nurses, the nursing profession and on quality of health care in KwaZulu-Natal Province" is my own investigation. All sources that I have used or quoted have been acknowledged by means of complete references.

Signed: P.J. Kunene

P.J. KUNENE

DURBAN

January 1999

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ABSTRACT

The aim of this study was to pursue an exploratory, descriptive case study to investigate perceptions on the impact of nurses' strikes on nurses, the nursing profession and on the quality of health care. Other aspects of the strike phenomenon that were investigated included the issues of job satisfaction, causes of the strikes, activities and feelings in relation to the strikes and suggestions for the future in regard to nurses' strikes.

A purposive sample was selected from a population consisting of nurses, nursing management, officials of the Provincial Health Department, chairpersons of two nursing representative organisations and community members as consumers of health care. For the purpose of the investigation semi-structured interviews were utilised.

The study revealed that perceptions on nurses' strikes were not typical of any particular group. Similarities and differences were noted within and between groups. It was found that job dissatisfaction remains prevalent among nurses in spite of acknowledged attempts at addressing job dissatisfiers. Negative feelings and views about nurses' strikes persist, mainly because of the adverse impact on consumers of health care. It was evident that management and employers face greater challenges in prevention of strikes. Increased awareness of employee rights have led to legislation through labour laws, for example the Labour Relations Act (66 of 1995) as amended.

Based on the perceptions and suggestions of the participants, a model entitled *The Integrative-Developmental-Adaptive (IDA) Strike Model* was constructed. It emphasises the need for coordinated training and development programmes to facilitate an integrative approach and continuous adaptation by all health-care stakeholders to the various factors that precipitate or trigger strike action. This model is applicable before, during and after strikes.

ABSTRAK

Hierdie studie was daarop gerig om 'n verkennende, beskrywende gevalle studie ondersoek te doen van die persepsies rakende die invloed wat die verpleegster stakings op verpleegsters, die verpleegkunde professie en die kwaliteit van gesondheidssorg het. Ander aspekte van die stakings verskynsel wat die ondersoek insluit in die kwessie van werksbevrediging, oorsake van stakings, aktiwiteite en gevoelens in verband met die stakings, asook oorstelle vir die toekoms rakende stakings deur verpleegsters.

Die steekproefmetode wat gebruik is was doelgerig en het dus op 'n onewekansige wyse respondente gekies vanuit 'n populasie bestaande uit verpleegsters, bestuurs personeel in verpleging, beamptes van die Provinsiale Gesondheidsdepartement, voorsitters van twee verteenwoordigende organisasies vir verpleegsters en lede van die publiek as gebruikers van die gesondheidsdiens. Vir die doel van dié ondersoek is gebruik gemaak van semi-gestruktureerde onderhoude.

Uit die bevindinge van die ondersoek het dit geblyk dat die persepsies van stakings deur verpleegsters nie tipies van enige van die groepe was nie. Ooreenkomste en verskille is aangeteken in die groepe asook tussen die groepe. Dit is bevind dat ontevredenheid met hulle werksomstandighede algemeen onder verpleegsters voorkom ten spyte van erkende pogings om die oorsake van onbevredigende werksomstandighede aan te spreek. Negatiewe gevoelens en sienings rakende stakings deur verpleegsters duur voort, hoofsaaklik omdat dit 'n ongunstige uitwerking op gebruikmakers van die gesondheidsdienste het. Dit het duidelik geblyk dat bestuur en werkgewers nog groot uitdagings in die gesig staar wat betref die voorkoming van stakingsaksies. Die toenemende bewustheid van werknemers se regte het daartoe gelei dat wetgewing deur arbeids wette, byvoorbeeld die gewysigde wetgewing van die Wet op Arbeidsverhoudings, Wet Nr 66 van 1995, opgestel is.

Gebaseer op die perspsies en voorstelle van die respondente, is 'n model, getiteld *The integrative development-adaptive strike model* geskep. Dit beklemtoon die behoefte aan gekoördineerde opleidings en ontwikkelings programme om die opleiding van 'n geïntegreerde gesondheidsdiens te bevorder en voortdurende aanpassing by die verskeidenheid faktore wat stakingsaksies voorafgaan of aan die gang sit, moontlik te maak. Die model kan aangewend word voor, tydens of na stakings.

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CHAPTER 1

OUTLINE OF THE STUDY

1 INTRODUCTION

The subject of this study is nurses' strikes which occurred at different times in 1994 in two hospitals of KwaZulu-Natal Province in South Africa. The two hospitals were not the only ones affected by nurses' strikes since the strikes were scattered in several hospitals in the various provinces. They escalated from province to province to become nationwide. The nurses' strikes were part of widespread strikes and other forms of labour unrest which were experienced in South Africa in the 1990s, inclusive of both the pre- and post-1994 government election periods.

This investigation is aimed at determining perceptions of nurses, nurse managers, provincial health department policy-makers, organised labour as nurses' representatives and consumers of health care about nurses' strikes and their impact on health care delivery as well as on labour relations in the health care system.

Nurses' strikes were a common occurrence in the historically Black hospitals. This fact was considered in the selection of the two research hospitals. Public health institutions were more affected by nurses' strikes than private health institutions. The primary aim of public health services is provision of equitable health care to all citizens of the country with no profit-making motive. On the other hand in private health services, the profit-making motive takes precedence over service provision. Therefore occurrence of strikes in public health services has implications for those consumers who are dependent on them mainly because of their inability to afford private health care.

The two hospitals were selected because they are the largest public hospitals in the province of KwaZulu-Natal. As such these hospitals employ large numbers of nursing personnel and cater for a wide local patient / client population. They are referral hospitals which provide advanced therapeutic facilities for patients transferred from the smaller, less complex and minimally equipped hospitals in the province. The fact that the strikes within the province did not occur at the same time in the various hospitals meant that patients could be transferred to non-striking hospitals for continuation of treatment and care.

1.2 BACKGROUND TO THE PROBLEM

The strikes which are the subject of this study were not purely nurses' strikes. Other categories of health care personnel were involved, for example general assistants, clerical staff and some paramedical staff. However, it was noted that the word that went round generally was "Nurses at hospital X are on strike". The strikes were not generally referred to as hospital strikes. More focus was placed on strikes and other forms of labour unrest or industrial action by nurses than by any other category of health care personnel. There are two main reasons for this.

(i) Nurses' strikes were forbidden by nursing legislation, namely the Nursing Act (50 of 1978) as amended, Section 40.2 which stipulated that:

> "40.2 (a) No person shall instigate a strike or go-slow strike by persons registered or enrolled in terms of this Act or incite such persons to take part in or to continue such a strike or go-slow strike or in the continuation of such a strike or go-slow strike."

This "no strike" clause was later deleted in 1992 through the Nursing Amendment Act (21 of 1992). In honouring its responsibility for protection of the health of the citizens of South Africa, the South African Nursing

Council took a stand that nurses who neglected patients by leaving them unattended during strikes would face the Professional Conduct enforcement procedures which entail disciplinary measures.

(ii) (a) Nurses comprise the largest group of health care personnel. The total number of nurses on the registers and rolls of the South African Nursing Council in 1997 was 192 993 including student and pupil nurses. Of these, 36 935 were in the province of KwaZulu-Natal. (South African Nursing Council Statistics 1998:1, 7). Table 1.1 shows the number of nurses in comparison with other categories of health care personnel in KwaZulu-Natal public health hospitals only.

Table 1.1: Statistics - Some categories of health care personnel in KwaZulu-Natal Public Health hospitals in 1997

	No. of Posts	**%**
Total No. of Posts	59 154	100
Nurses	28 673	48,5
General Workers, Cleaners and Messengers	6 644	11,2
Clerical staff (Administrative)	3 535	6,0
Medical Officers	1 541	2,6
Other	18 761	31,7

(Source: KwaZulu-Natal Department of Health Staff Establishments (Summary of Posts) 1997)

Table 1.1 shows that nurses alone comprise 48,5% of the total staff establishment of health care personnel of KwaZulu-Natal public health hospitals. The categories reflected in this table are only those with highest numbers. This explains why some categories with a small number of members of the health care team, for

example pharmacists, radiographers and others do not appear on this table even though they work closely with the nurses.

(ii) (b) Nurses spend the longest time with patients, rendering bedside nursing care on a 24-hour basis.

For reasons cited in (ii)(a) and (ii)(b) above, nurses' roles in patient care are vital and highly visible, therefore withdrawal of nurses' services leads to significant disruption to patient care.

Besides the actual strikes, any form of industrial action by nurses such as go-slow, picketing, attendance of numerous meetings for strike planning, interferes with effective, timeous implementation of well-planned, objective-directed patient / client care activities.

Van Tonder (1992:29) issues a reminder that patients and their families are exposed to numerous risks if nurses strike. She cites the following as examples:

- delays in diagnosis and institution of treatment
- anxiety and aggravation of illness caused by moving patients from a health service affected by strikes to one where there are no strikes.
- cancellations or delays in booked surgery.
- failure to attend promptly to emergencies.

A previous study by Kunene (1995:163) revealed that both nurses and nurse managers were concerned about lowered standards of nursing care during strikes as patients were left unattended regardless of their degree of illness and dependency. The 'caring ethos' was thus neglected. Adequacy of plans for effective strike handling is questionable when one considers the service disruption that occurs during strikes. Kunene (1995:168), Nel and Van Rooyen (1993:208),

Reese (1991:34-36), Botha (1986:3) and others, recommend a strategy of planning well in advance for handling a strike instead of waiting until it occurs. This should be done in the same way that other emergencies or disasters are planned for. Botha (1986) goes further to state that proper planning may take away the sting of a strike if employees see the organisation functioning effectively in spite of them being on strike.

1.3 STATEMENT OF THE PROBLEM

Before the 1990s, nurses' strikes were a rare phenomenon in South Africa. Nurses were originally socialized into a system where patients' and management's rights were given more attention than nurses' rights. Nurses were not empowered and lacked assertiveness to stand up for their rights. Dominant management was allowed to go on unchallenged. Any challenge to authority was regarded as a form of insubordination. However nurses' dissatisfaction with salaries and conditions of service were expressed in other ways, for example low productivity, high rates of absenteeism and staff turnover.

In the 1990s, in line with the general overt expression of revolt against any form of oppression or domination by government, employers or management, nurses took it upon themselves to tackle new and long-standing grievances, for example salary dissatisfaction. They were prepared to use whatever means feasible to exert pressure, including strike action.

History was made in 1985 when 1 800 hospital workers, including 900 student nurses, went on strike at Chris Hani Baragwanath Hospital (previously known as Baragwanath Hospital). It was the first time that nurses had challenged the state on such a massive scale, claiming that their decision to strike was taken because the state had ignored their complaints for several months. The main complaint from workers was that they had last received their increment in 1983. The student

nurses emphasised poor working conditions, low standard of catering, imposition of a curfew and unfair dismissals. In a swift reaction by authorities, the strikers were all dismissed, though they were later reinstated amidst serious tensions (*The Star*, November 19 1985) (*City Press*, November 17 1985) (*The Citizen*, November 15 1985) and others. Though this acted as a deterrent to strike activity by nurses, it did not mean an end to strikes, hence their appearance in various provinces in the beginning of the 1990s.

The beginning of the 1990s was marked by radical socio-political changes in South Africa as a preamble to and an integral part of change from the previous apartheid government to a democratic, all-inclusive government. Whereas Black nurses, like all Black South Africans, had until 27 April 1994, not had voting power and therefore no say in the running of the country, this changed when all South Africans went to the polls to vote for a government of their choice. This immediately led to increased expectations in regard to power and freedom among the previously disadvantaged groups in society. This was a result of hopes raised through promises made during election campaigns. These expectations were also experienced by employees at the workplace, including nurses in health services.

In the struggle for power, nurses saw management and employing authorities as failing to rise to their expectations timeously in regard to power sharing and need satisfaction. Escalation of nurses' strikes from institution to institution, province to province, might be seen as a sign of impatience with employers and management who were seen to be insensitive to nurses' needs.

The present government of South Africa subscribes to a philosophy of democracy. Employees, including nurses, challenge employers and management to subscribe to the same philosophy which advocates participative, integrative decision-making and respect of employees' rights. An autocratic management style of the past is no longer acceptable, hence the practice of resorting to strike action when

management is perceived to be sticking to this style of management which stifles communication or freedom of expression and creativity.

The scenario just described lends itself to conflicts which may be intrapersonal, interpersonal and intergroup in nature. The latter two types of conflicts are more marked in large, complex hospitals which feature impersonal relationships as can be observed in the two hospitals under study. Conflict is inevitable where people interact, though not all conflict is bad. Nurse leaders in health care settings should be able to distinguish between both constructive and destructive conflict. The overall internal organisational climate and human relations are important determinants of the outcome of any conflict (Grohar-Murray & Di Groce 1992:78-79).

Frequent monitoring of environmental factors that determine the internal organizational climate is necessary if strikes are to be prevented, for example monitoring of employer policies, management styles and level of commitment to goals of the organisation. Conflict is usually associated with perceived unequal distribution of power, status and resources. These perceptions may be real or may be inaccurate perceptions of reality (Grohar-Murray & Di Groce, 1992:81). In the historically Black health institutions providing services for Blacks only, these perceptions prevailed and created conflicts in the superior-subordinate relationships.

1.4 MOTIVATION FOR THE STUDY

When the long-awaited democratic government came into power in South Africa in 1994 there was hope for peace and tranquillity in the country generally and in the public service in particular. The researcher observed that on the contrary political and labour unrest continued in the midst of the confusion brought about by the radical socio-political and economic changes in the immediate pre- and post-

election period. Tensions heightened in labour relationships as employers, including the state or, in the context of this study, provincial health authorities were forced to speedily review their personnel policies, especially those that were based on racially discriminatory laws. Employees, acutely aware of their rights, showed no more preparedness to tolerate any policies regarded as unjust and undemocratic.

Strikes became a common occurrence in 1994, both within and outside the nursing profession. When no immediate amicable solutions for perceived problems could be found, nurses' strikes escalated to health services which had not been involved in strikes previously. An example is that in KwaZulu-Natal nurses' strikes featured prominently in large hospitals like King Edward VIII Hospital, Edendale Hospital, Prince Mshiyeni Memorial Hospital and Ngwelezane Hospital in 1994, but in 1995 strikes were also observed in hospitals like Clairwood Hospital, Madadeni Hospital, Benedictine Hospital, Emmaus Hospital, Umzimkulu Hospital and others which had not been involved in strikes before.

Fears that nurses' strikes would continue to occur were based on the following perceptions:

* The main source of dissatisfaction, namely salary structures, was addressed by the National Health Department but most nurses were still disgruntled and stated that their needs had not been satisfied in line with the rate of inflation and cost of living.

* Nurses have used the strike weapon to fight for their rights and for the satisfaction of their needs. Though total satisfaction was not achieved, the government, through the public service and Health Departments, showed preparedness to negotiate and compromise to meet some of the nurses' demands. This set a precedence whereby, if nurses remain dissatisfied, more

pressure in the form of strikes might be applied on power structures in order to have further demands met.

Since strikes by nurses continue to occur, it is important to investigate what impact they have on individual nurses, the nursing profession in general and on quality of health care.

1.5 OBJECTIVES OF THE STUDY

The study is intended to achieve the following objectives:

5.1 To describe perceptions of nurses and organised labour as nurses' representatives, consumers of health care, nurse managers and health policy-makers as employers of nurses about nurses' strikes.

5.2 To describe activities that took place before, during and after nurses' strikes.

5.3 To elicit participants' perceptions of their feelings before, during and after nurses' strikes.

5.4 To investigate participants' perceptions about the impact of nurses' strikes.

5.5 To develop a model that can be adopted to minimise the occurrence of nurses' strikes and their adverse effects.

1.6 ASSUMPTION

Participants in this study have different roles, levels of responsibility, accountability and expectations in the health care system. These are determined

by the levels at which they operate as providers or consumers of health care. Administration and management of public health services is a responsibility of the state, delegated to provincial health authorities who are the employers and health policy-makers in the provinces. Implementation of the health policies occurs at institutional or operational levels as a responsibility of management, the overall aim being provision of quality health care and a contented workforce.

Nurses at non-managerial levels rank low in status and reward structures, for example salaries. They are at the receiving end of employer and management policies. The policies have implications for job satisfaction and therefore a potential for leading to strikes if considered unacceptable. Consumers of health care are an important component of the health care system, hence the need to look into their perceptions about actions and behaviour of nurses as health care providers.

In this context the study is based on the assumption that:

positions and levels of responsibility of different stakeholders within the health care system predispose to variability in specific modes of perceptions about nurses' strikes and their impact.

1.7 SIGNIFICANCE OF THE STUDY

The study is significant in that it creates an awareness among nurses and management about positive, constructive ways of managing conflict and engaging in collective activity. Managers and policy-makers are alerted to policies, procedures and management approaches required to democratise health services and involve nurses through participative management. The study also contributes to identification of strategies to prevent nurses' strikes, manage or handle them effectively to minimise adverse effects on provision of quality health care and thus maintain public relations.

The study provides an educational tool for maintenance of healthy labour relations in the health sector. For nurse representative organisations it highlights co-operative ways of bargaining collectively with employers to generate acceptable labour contracts and resolve personnel problems. For consumers of health care the study creates an awareness of problems experienced by nurses, leading to nurses' strikes, as well as roles that communities can play in assisting to minimise disruption of health care services due to nurses' strikes.

1.8 RESEARCH METHODOLOGY

An exploratory descriptive case study design was selected for this study. An in-depth investigation of two hospitals which were affected by the strikes was done. Semi-structured interviews were used to collect data. The sample comprised both health care providers and consumers.

1.9 DEFINITION OF TERMS

To explore and describe the variables of interest in this study, key terms pertaining to the sample and study variables will be defined conceptually and operationally.

1.9.1 **Perception** refers to insight, comprehension or making a distinction based on understanding and good judgement. It refers to description of an event as it makes sense or is understood by the person perceiving it. Operationally the term refers to description of subjective meanings that participants attach to the strike event under study.

1.9.2 Participants, in the context of this study, is used to refer to the different health care stakeholders participating as subjects in this study. These include the following:

1.9.2.1 Nurses are health care providers who give direct clinical nursing care, having undergone a prescribed period of training in a recognised educational institution and licensed to practise nursing for gain by the professional regulatory body, the South African Nursing Council. Operationally the term refers to professional nurses, enrolled nurses and enrolled nursing auxiliaries (also referred to as clinical nurses in this study) employed at the two hospitals under study at the time of the strikes.

1.9.2.2 Nurse managers are professional nurses appointed to supervisory and managerial positions. The study was undertaken during a transitional phase. The nurse managers' titles changed between the phase of data collection for the study and preparation of the report. In the context of this study two groups of nurse managers are identified. Firstly there are Nursing Service Managers (now Assistant Directors) or Chief Professional Nurses who are referred to as 'area managers' or 'sectional matrons' in the two hospitals under study. They supervise several nursing units within a department, for example medical, surgical or other departments. For purposes of this study the concept "area managers" will be used. Secondly the term refers to the nurse managers in charge of the two hospitals under study. They were previously entitled Chief Nursing Service Managers. According to the 1997 dispensation, the title has been changed to Deputy Director Nursing Services. For purposes of this study they will be referred to as Nurse Manager A and Nurse manager B.

1.9.2.3 Health policy-makers are government officials appointed to top positions in the provincial department of health. Operationally this refers to the Director of Nursing Services representing the Nursing Directorate at Head Office which is the structure that plans, organises, supervises, directs and controls all nursing services in KwaZulu-Natal province.

1.9.2.4 Organised labour refers to formally structured organisations that provide employee representation through collective bargaining in labour relations matters. Operationally it refers to nurse representative organisations in the form of professional organisations and unions. The two are not mutually exclusive, hence, for example in South Africa the nurses' organisation, the Democratic Nurses Organisation of South Africa (DENOSA) has both a professional and union leg. In recent times, general unions catering for all workers in the health care industry show more concern for professional development in addition to socio-economic development of their professional members.

1.9.2.5 Consumers of health care refers to community members for whom health services are provided. They are patients in hospitals or clients in other health care settings. In this research the term refers to:

* Ex-patients: people who were in-patients in a hospital during a nurses' strike.

* Community members — who have not had direct experience as in-patients during a nurses' strike but experience them indirectly as people who live in the community served by a health service affected by strikes.

1.9.3 **Impact** is used figuratively in this research to refer to a dramatic effect of an event. The impact of nurses' strikes is described as it is perceived by participants in the study.

1.9.4 **Strikes** are defined conceptually as a form of protest whereby a concerted temporary, partial or complete work stoppage, a retardation or obstruction of work is undertaken by employees for the purpose of applying pressure

on management to remedy a grievance or resolve a labour dispute. Striking employees do not intend to withhold their labour permanently but merely intend to oblige the employer or management to negotiate, or where negotiations are already in place, to oblige him to adopt a different stance to meet employee demands (Bendix 1996:521). Strikes are the most extreme type of industrial action or labour unrest. In health services it is more pronounced since there is a danger of patients who need care being left unattended.

1.10 CONCLUSION

This chapter outlined the orientation to the study, giving an indication of the core problem under investigation and the objectives to be achieved. The next chapter gives attention to the concept and the broad field of labour relations as it applies to the field under investigation.

CHAPTER 2

THE LABOUR RELATIONSHIP: A CRITICAL ISSUE IN STRIKE ACTIVITY

2.1 INTRODUCTION

This chapter surveys the broad field of labour relations and reviews, in particular, the views of some authors on strike-related issues. The discussion includes the context within which nursing activities take place, and nursing issues with a potential for dissatisfaction and possibility of strikes. It also addresses activities and procedures aimed at strike prevention, for example good employment policies and management practices, organising nurses through unions or professional associations with collective bargaining powers, good working relationships between labour and management as well as legislation controlling the labour relations system in South Africa. A broader perspective is provided by discussing collective bargaining and strike activity in other countries which had no-strike clauses initially but, as in South Africa, experienced nurses' strikes even before these clauses were rescinded.

2.2 ANALYSIS OF THE LABOUR RELATIONSHIP

2.2.1 The Concept Labour Relations

The main issue in strike prevention is maintenance of healthy labour relations. Labour relations are described as those practices and procedures affecting daily work lives, for example discipline, grievance handling, fair labour practices and communication between employers /management and their personnel, as well as communication among personnel. The primary basis of the employer-employee relationship is the service contract which both parties enter into.

Bendix (1996:2-3) agrees with Bezuidenhout, Barbers and Potgieter (1998:4) and Brewis and Necker (1995:20) that industrial relations (also called labour relations) are all aspects of the relationship which exists between workers / employees and their employers. The concept also refers to rules governing the employment situation and the way these rules are made, changed and administered. Bendix (1996) further describes Industrial Relations as a field of study which emphasises "... institutionalisation of conflict through collective representation, collective bargaining, joint consultation and legislative constraints". She explains this relationship as one marked with a negativism which results mainly from the involuntary and impersonal nature of the relationship into which both employers or managers representing them and employees enter, not because of any personal interest or liking for one another but for purposes of getting the work done and to fulfil personal economic needs respectively.

In the labour relationship both employers and employees have rights which entitle them to mutual respect. Whilst a balance between employer and employee rights is advocated, Levy (1992:4) gives a reminder that the working relationship is never an equal and amicable one because the two parties do not face each other as equal partners in the bargaining relationship. The employer has an advantage over the employee because he is in a stronger economic position and can therefore determine the course of the relationship. He usually takes his power for granted. The state provides legislation which acts as a powerful protection aid in the employment relationship. Because of the inequality of the relationship, workers have to fight for their rights, and the fights are usually long and expensive. By the time the law steps in, regardless of who wins, it may be too late to save the co-operative atmosphere which should exist at the workplace.

A labour relations-related issue which has important implications for ethical nursing practice and nursing management is 'rights' versus 'responsibility'. Kyriacos (1996:40) warns that nowadays there is too much talk about rights and

too little attention is placed on the balancing factor, that is, responsibility. The researcher concurs with this view and emphasises that every right should be balanced with a responsibility. Current debate is that general unions with a nurse membership emphasise nurses' rights irrespective of consequences of nurses' actions on patient care. Professional associations hold the view that this brings nursing into disrepute with society. Nurses earn respect by maintaining high standards of performance and conduct. It is their moral responsibility to present a professional image to society that engenders trust and respect (Poggenpoel & Muller, 1996:10).

Kemp (1992:10-13) observes that an authoritative approach continues to be the main style of management all over the world because of the authority and power which accompany supervisory and management positions. Many organisations, including many public health services in South Africa, still prefer strong, forceful managers or supervisors and are still based on strict hierarchical structures. In these types of organisations management's word is final. If employees are consulted, most of their suggestions, constructive criticism or saying "no" to unreasonable demands may be taken as insubordination.

In support of Kemp's view, Lawlor (1995:1-8) agrees that in the past, management had the prerogative of making unilateral decisions, but now times are changing internationally, as well as in South Africa. Participative processes that give more autonomy to workers in decision-making and control of their own functions are being introduced. Lawlor further observes that unions are hesitant to endorse this participative approach in the belief that, in many cases it is introduced without consultation with them and implemented with the intention of decreasing union support. It is considered as a management perspective to increase productivity while undermining the bargaining power of the union.

Scholtz (1991:138-140) recommends utilisation of labour relations managers to manage consistency of labour relations through joint consultation. Depending on

management style, one of the following three styles of consultation may be used, namely:

(1) Pseudo-consultation whereby management uses consultation structures to communicate predetermined decisions to employees or their representatives with no intention to allow participation in decision-making. It is often used to prevent unionisation of employees.

(2) Classical approach allows joint consultation to exist alongside collective bargaining structures to explore issues of common interest in management-employee relations. However management is not obliged to change its stance and the result of the consultation is not expressed as a binding and enforceable formal agreement.

(3) Integrative consultation is used to enlarge areas of joint decision-making between management and employees or their representatives in matters of common interest by using mutually explored problem-solving methods.

In modern organisations where democracy and transparency are emphasised, integrative consultation is recommended because it means that decisions are jointly owned thus leading to equalisation of employer / employee relationship.

Paterson, McCornish and Aitken (1997:89) hold the view that abuse of power and bullying have become more common at the workplace over the last decade. The perpetrator of the bullying is usually stronger than the victim who is usually not in a position to stop the bullying and may be reluctant to report it for fear of further victimisation. Based on observations of what happens in contemporary South African health services, the researcher supports Paterson *et al*'s (1997) view that managers are not always the villains when it comes to bullying. Instead they may be at a greater risk of being bullied than other categories of workers. Employees can be described as bullying when they constantly challenge managers'

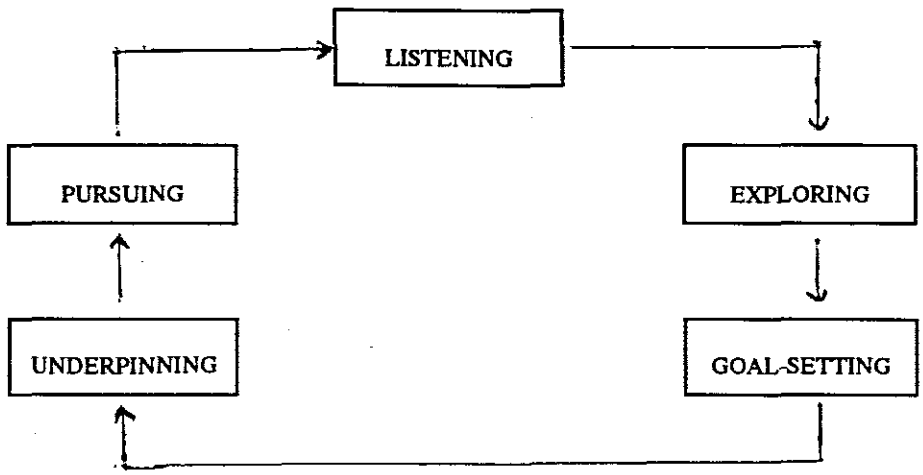
decision-making and control prerogatives, refuse to take directives or instruction, and lay emphasis on protection of their rights to an almost total neglect of obligations that they have to honour at the workplace.

Closely related to Paterson *et al's* views is Davidhizar and Vance's (1997:18-19) warning for managers to beware of people who are whiners, that is, people who are negative about everything and complain about things that others take for granted. The authors describe it as a sign of powerlessness, or an inner anger of having been cheated of some privilege. Managers should react calmly to the whiners, investigate each of their complaints before they influence others in the organisation, then use effective problem-solving methods. In this way grievances which involve groups of personnel and require handling through tedious grievance procedures, sometimes necessitating collective action, may be avoided.

De la Bodeyere (1989:1-8) states that managers are in business to solve problems which are a constant feature of their work. Ability to solve problems is an important measure of a manager's worth. According to this author, people in helping professions, for example social workers, counsellors, nurses etc., are poor in problem-solving in spite of several years of training in this. The researcher argues that problem-solving is an integral part of practice of these professions. It is intertwined with quality of the service rendered. Skills and expertise are acquired through constant involvement in diverse problem-solving situations. From this, managers should learn a lesson that problem-solving is not an academic discipline which can be acquired through academic study of relevant subjects only. These are important, but the knowledge should be put to practice in order to acquire the skill. A person who has practised problem-solving would be a better guide than one who has become an expert through reading books, hence the importance of nurse managers and nurse representatives to be experienced nurses who can relate better to nurses' problems because they have experienced them.

The researcher agrees with De la Bedoyere (1989) that problems show up easily in small enterprises and can lead to disastrous results if no immediate action is taken. On the contrary single problems may have little effect on the success of a large enterprise and managers may get away with poor problem-solving skills. However the cumulative effect of these can have even more disastrous effects. This warning is worth noting because the hospitals under study are large hospitals and occurrence of strikes is assumed to result from a cumulative effect of unresolved problems. De la Bodeyere suggests use of the LEGUP MODEL for problem-solving, as illustrated in Figure 2.1

Figure 2.1: The LEGUP Model of Problem-solving



(Source: Adapted from De la Bodeyere, 1989)

This is a five-step problem-solving process comprises Listening, Exploring, Goal-setting, Underpinning and Pursuing. When faced with a problem, the problem-solver must first **listen**, then **explore** for more information on the problem, its cause and possible underlying problems. **Goal-setting** should be carefully thought-out so that the goals set are realistic, worthwhile, concrete and observable. **Underpinning** is a strategy used to support the person faced with the problem, for example additional training, in order to facilitate goal achievement. **Pursuing** is follow-up done to discover if goals set for problem-solving are achieved.

According to De la Bodeyere,critics of using a particular model for problem-solving view it as artificial and inhuman because people cannot be reduced to a formula. They also regard it as a manipulative approach whereby managers engineer relationships with subordinates by using techniques to their advantage. The researcher, supported by Bezuidenhout *et al* (1998:261) disagrees with the views of these critics because of the importance of scientific, participative systematic problem-solving approaches to prevent haphazard decision-making.

To facilitate problem-solving, progressive employers and management have well-structured and publicised disciplinary and grievance procedures in place. Poor attention to these procedures is perceived as a problem area and is usually quoted among causes of dissatisfaction that predispose to strikes. It is important that these procedures are negotiated with employees and/or their representatives to ensure understandability and acceptability. Scholtz (1991:129) recommends that the line managers should practise flexibility in their implementation of established labour relations strategies in order to successfully deal with the volatile unpredictable nature of the work relationships and to allow for innovative designs and procedures. Total adherence to established policies and procedures in handling labour relations issues may give rise to conflict. Scholtz (1991:147) further advises that employee attitude surveys and continuous labour relations surveys should be done to provide valuable information on causes of dissatisfaction which may manifest in conflict. This helps management to address issues before they become problems.

2.2.2 Conflict Management: A critical issue in labour relations

Grohar-Murray & Di Groce (1992:80-81) agree with Meredeen (1988:287) that conflict is inevitable where people interact and stress the importance of developing effective strategies for conflict management. In Grohar-Murray's & Di Groce's view, when conflict exists, the outcome is dependent on four critical factors,

namely the issue, power base of participation, co-operation between participants, and communication. These factors are worth considering in regard to causation, prevention and management of nurses' strikes and will therefore be explained briefly.

(1) **The issue:** It may be critical or non-critical. Issues may be kept in manageable proportions or can escalate as a result of courses of action taken. Using this analogy, it can be assumed that issues that nurses considered as critical, for example salary dissatisfaction, were not treated as such by management and therefore escalated into strikes.

(2) **Power base of participation:** The power base should be equal enough for negotiation to take place, if not, attempts should be made to equalise it relative to the issues causing conflict. Two types of power that may be used are:

- Directive power which shapes others for the purpose of advancing the interest of the power wielder, for example refusal or delay in reviewing salaries to employees' satisfaction is an economic benefit to the employing authority and may be used as a negative force by those in power (employers) to coerce the ones with less power (employees).

- Synergic power incorporates group values and cherishes goals and wishes of other people. It is an essential element in balancing control through compromises in competitive environments. This has relevance in health care organisations where nursing is practised. Bureaucratic goals of the employer and management dominate, thus putting personal and professional values of employees at risk. The nurses' strikes of 1994 occurred at a time when there was outright rejection of any practices perceived as domination of the powerless by those in power positions. Synergic power is an essential element in balancing power in this situation.

(3) **Co-operation between participants:** It occurs when each party considers the other's point of view as important in order to make compromises which are of mutual benefit. Using the example of salary dissatisfaction, in a co-operative environment employees should consider that the employer / management is charged with responsibility of providing maximum, high quality service with minimum cost, while the employer should consider that employees need fair compensation for services rendered so as to be able to satisfy personal needs.

(4) **Communication:** It should be spontaneous with no hidden agendas. It should also allow for free flow and sharing of information in order to achieve quick resolution of conflicts and thus prevent escalation of issues which could lead to strikes. Free flow of information remains a problem in hierarchically-structured health services in South Africa where emphasis is on vertical rather than horizontal lines of communication.

Kemp (1992:1-6) emphasises a need for managers to use their interactive skills to integrate each individual employee into the organisation rather than lay emphasis on the collective side of labour relations. If the latter happens, management tends to have an arms-length relationship with individual employees and develops good relationships with trade union representatives who bargain for the collective. In this way inherent conflicts of individual employees may be neglected if they are not shared or articulated by the collective.

2.3 LEGISLATION THAT CONTROLS LABOUR RELATIONS

Labour law is the instrument through which the state regulates the employment environment to ensure harmonious relations between employer / employer organisations and employees / employee representatives so as to prevent conflict which, if unchecked, may lead to strikes. Nurses as an employee category

function under control of the existing labour law as well as policies and staff codes of their employing authority.

2.3.1 The Labour Relations Act

The newly-elected government of 1994 in South Africa started working on a new Labour Bill which culminated in the Labour Relations Act (66 of 1995) (LRA). It was promulgated to be in line with the political, social and economic changes which took place in association with the democratic principles of the new government. The purpose of this Act is to "advance economic development, social justice, labour peace and democratisation of the workplace ... '(LRA, 1995:1). Some of the objectives of the Act are to:

* regulate the fundamental rights;

* provide a framework within which employees and their trade unions, employers and employer organisations can bargain collectively to determine wages, terms and conditions of employment and other matters of mutual interest;

* formulate industrial policy.

The Labour Relations Act (66 of 1995) as amended confers employees' right to freedom of association whereby any employee can participate in forming or joining a trade union of her choice and participate in its lawful activities. This is coupled with the right of freedom from victimisation which stipulates that "no employee may be prejudiced because of his previous or existing membership of a union." It is balanced with the employer's right to participate in forming or joining an employer organisation of his choice and participate in its lawful activities (LRA, 1995:3, 5). This important right of freedom of association was not open to nurses

before the 1990s in South Africa. All practising nurses had to be members of existing nursing associations or organisations and unionism among nurses was not allowed. Currently nurses are free to join any union or other organisation of their choice, hence the concern of management about nurses' involvement in strikes which are perceived to be a weapon that is frequently used by unions.

In support of a need for worker associations, Fantasia (1988:10-11) explained the rationale for their existence as a need to create new bonds and links among the workers so that they come out of the isolation and loneliness imposed on them in the employment situation. Employees create solidarity through association. The author highlights that association activities are neither revolutionary nor designed to overthrow the social order, instead they are transformative. Managers need to be aware of this assurance. Using a sociologist's perspective, Fantasia (1988) explains employee solidarity as a means by which they usurp power of the dominant or powerful groups, hence the negative attitude of management towards worker associations. The researcher is of the opinion that if the integrative consultation approach described by Scholtz (1991) is adopted, there will be no concern about employees usurping the power of management.

Other provisions of the Labour Relations Act (66 of 1995) as amended include:

Collective bargaining: One of the important responsibilities of employee associations is collective bargaining, hence their involvement in negotiations for their members in the Bargaining Chamber during and after strikes. This section of the Act specifies organisational rights which give sufficiently representative unions rights of access to the workplace in order to recruit or communicate with members and hold meetings with them outside of working hours. An employee who is an office-bearer of a representative trade union is entitled to take reasonable leave with pay during working hours for the purpose of performing functions of that office. According to Section 14.4 of the Act this representative has a right

to perform specific functions, for example, to assist and represent the employee in grievance and disciplinary proceedings at his request and to monitor the employer's compliance with the workplace-related provisions of the Act, or any law regulating terms and conditions of employment and any collective agreement. A challenge for nurse managers is to seek knowledge of how to handle these previously unfamiliar responsibilities so as to be able to protect their management prerogative when these agreements are drawn and implemented, and also to protect managers from transgressing the law, for example by wrongfully denying or allowing trade union access to the workplace. The Act also provides for establishment of Bargaining Councils by registered trade unions and registered employer organisations.

Strikes and lockouts: Section 64 of the Act confers on every employee a right to strike and on every employer recourse to lock-out on condition that procedures required by the Act have been complied with, including giving 48 hours' notice of the commencement of the strike or lockout in writing to the employer. According to Section 65 of the Act there are some limitations to strike and lock-out, for example, if bound by a collective agreement that prohibits these or requires the dispute to be referred to arbitration and if a person is engaged in an essential service or maintenance service. An Essential Services Committee is provided for in the Act, charged with responsibility of investigating whether or not the whole or only part of a service is an essential service.

Debate exists on what constitutes an essential service. In a statement issued by the Director-General for Health on 31 January 1997 it was made clear that all components of a health service are interrelated, form a chain and cannot be broken into isolated services which can be assessed individually. The Democratic Nursing Organisation of South Africa (DENOSA) which represents 78% of South African nurses, made recommendations which endorse the Director-General's statement but further highlighted that there are 3 classes of services in a hospital situation, namely:

- critically essential, where services may not be stopped, for example, intensive care units.

- services that may become essential over time, for example, medical and surgical services for acute and chronic conditions.

- support services that are essential to enable health care delivery to be possible and if withdrawn, health care is seriously hampered, for example, dietary and linen services.

Previously all nursing services in the public sector were considered to be essential and in private sector as non-essential. Currently the trend is to designate only certain areas as essential, for example, intensive care units, frail care units in old age institutions, care of the mentally retarded and the disabled. DENOSA took it upon itself to draw up a document on minimum services to be provided through skeleton staff in these essential areas. The dilemma arose when unions emphasised that industrial action and the right to strike must not be weakened by this agreement. They insisted that striking in these areas strengthens industrial action and forces management or the employer to reach a desired settlement quickly.

Remuneration and dismissal issues in strikes: A provision of the Act which has aggravated conflicts in strike situations is that an employer is not obliged to remunerate an employee for services not rendered during a protected strike or lock-out. However if remuneration includes payment in kind, for example food and accommodation and employee requests that it be continued, the employer must not refuse but at the end of the strike may recover the monetary value of the payment in kind through civil proceedings instituted by the labour court. An employer may not dismiss an employee for participating in a protected strike, but this does not preclude an employer from dismissing an employee for a reason related to his conduct during a strike (LRA, 1995:77). Disagreements around this

issue of remuneration or lack of it as well as perceived unfair dismissals featured prominently in the 1994-1995 nurses' strikes.

Workplace forums: These must be established in any workplace in which an employer employs more than 100 employees. Their functions are to enhance efficiency at the workplace and to promote the interests of all employees in the workplace whether or not they are trade union members. They are entitled to be consulted by the employer and to participate in joint decision-making on matters specified in the Act. To maintain transparency and effective communication there must be regular meetings between the workplace forum and the employer and between members of the workplace forum and the employees. In the two hospitals under study employees are in thousands, therefore workplace forums form an important link between management and the vast numbers of personnel. In some hospitals, including the two under study, nurses have opted for nurses' forums which comprise nurses only, because of the belief that nurses' problems are so unique that they can only be understood by people who are nurses.

Dispute settlement: A new structure referred to as the Commission for Conciliation, Mediation and Arbitration (CCMA) has been established under the Labour Relations Act (66 of 1995). It is appointed to settle any dispute referred to it in terms of this Labour Relations Act. It has power to accredit and subsidise Bargaining Councils and private agencies as mediators and arbitrators. It functions independently of government and employers.

An area of concern is inadequate knowledge of provisions of the Labour Relations Act and its implications for labour relations in the health care system with particular reference to nursing practice and nursing management. To support the concern about this lack of knowledge, Mills (1989:19) states that employees are the ones who recognise the importance of studying labour-management relations while managers often state that they are too busy with other management problems

to have time to think about labour relations. In an effort to address this concern, the professional organisation and its media, the unions, employers and management, have all accepted the challenge of providing education and training opportunities for their members in this regard. Nurse managers are expected to take a lead in striving for understanding of the labour legislation in order to be able to guide their personnel.

2.3.2 The Public Service Staff Code

Public health services are controlled through a Public Service Staff Code (PSSC) which caters for all categories of staff, including nurses. It is formulated to be in harmony with the existing Labour Relations Act. It stipulates rules that govern all personnel issues, for example salary determination including all allowances and fringe benefits, recruitment, selection and placement of staff, leave arrangements, training, promotions, terminations, disciplinary codes, grievance procedures. It serves to ensure consistency throughout the public service. On this point, the PSSC is frequently criticised of bringing about too much centralised control and thus unable to address needs and concerns peculiar to particular employee groups and institutions.

The 1994 Public Service Staff Code dealt comprehensively with labour relations in the following sections:

- general policy statement which afford departments an opportunity to deal with labour relations in an autonomous manner

- line management and staff function responsibility in labour relations

- leave / time-off arrangements and payment of expenses of personnel engaged in labour relations

- internal communication between the management of departments or institutions and their staff members

- labour relations training policy

- dealing with individual and collective conflict, such as full-scale strikes, whether legal or illegal. Contingency plans for strikes are outlined in detail in this section.

A document related to the Public Service Staff Code was the Public Administrative Standard (PAS) (1994) which existed to facilitate personnel administration in departments. It dealt comprehensively with elements of the service dispensation and personnel practices affecting a particular occupation or post class, for example nurses as an occupational class and the various categories of post classes within the nursing occupational class. In this way centrality of control through the Public Service Code was minimised.

A weakness worth noting as a predisposing factor for nurses' strikes was lack of knowledge of the PSSC and the PAS by staff, including some nurse managers at middle and first management levels. They only got to know about it when a particular provision had been transgressed. This poses a challenge for employers and top management to devise strategies of making policy documents known widely in their institutions and departments.

2.3.3 Professional Regulation of Nursing in South Africa

In addition to control of nurses as employees, their professional conduct is controlled nationally through an existing Nursing Act which is administered through the statutory nursing regulatory body, the South African Nursing Council. As mentioned in chapter one Section 40 of the Nursing Act (50 of 1978) as

amended, outlawed striking by nurses. In spite of this legislation nurses got involved in strikes when they felt that their rights were extremely violated. Such actions resulted in nurses who were involved in strikes having to face disciplinary action by the then South African Nursing Council. This was resented by the majority of nurses who saw it as further victimisation by what they perceived as an unacceptable body established under an oppressive, non-democratic government. Benade (1996:44) describes appearing before the Council as the worst nightmare for nurses. To address this negative image, the transformed South African Interim Nursing Council which existed from August 1995 to March 1998 adopted a positive stance to investigating misconduct by nurses through a committee that is no longer referred to as a disciplinary committee but is now called a 'Professional Conduct' committee.

When pressure for the South African Nursing Council to transform radically and threats of strikes continued, a resolution was taken at its meeting in Kimberley in 1991 to recommend to parliament deletion of the "no-strike" clause. This resolution was approved and the "no-strike" clause was deleted in 1992 by Nursing Amendment Act (No 21 of 1992). It was however explicitly stated that nurses who got involved in strikes would continue to face 'disciplinary action', not for striking *per se* but for neglect of patients during strikes (Kotze 1991:7). This led to an assumption that there would have been no need for discipline if disruption to effective patient care did not occur during nurses' strikes. Today's nurses insist that their rights and needs are as important as the patients' rights, and even challenge phrases in the nurses' pledge where they are expected to say "... the total health of my patient will be my first consideration". This demonstrates the importance of balancing rights and responsibilities in nursing.

2.4 ORGANISING NURSES FOR COLLECTIVE BARGAINING

Bezuidenhout *et al* (1998:320) defines collective bargaining as a process of negotiation through which an employee representative organisation such as a labour

union seeks to restrict management's right to act in a unilateral manner, for example, in decisions on working conditions. Collective bargaining is preferred by employees whenever they perceive that their economic power would be greater through collective action than through individual bargaining with employers". To support this, Bendix (1996:248) states that collective bargaining arises because employees have identified interests and goals which are divergent from those of their employers and a need to seek power in their collectivity. Its main purpose is to prevent either party from using coercive means to achieve its own ends. Two main issues of collective bargaining in health care settings are patient care issues and personnel issues.

Internationally arguments exist on whether it is professional associations or general unions who should rightfully represent nurses. Literature shows that there has been no significant change over the years in arguments on whether or not nurses should be organised for collective bargaining. To reinforce this concern Rotkovich (1980:16) argues that there is loss of professionalism when nurses are organised in collective bargaining units. She maintains that it diminishes the nurses' self-image, negatively affects the nurses' image before the public, and ultimately causes a deterioration in the nurses' professional practice. In her view, representation through a professional association whose main concern is quality of service conflicts with representation by a labour union whose main concern is socio-economic conditions for its members, for example salaries, fringe benefits, working conditions and job security. She however acknowledges that when nurses have reached the bottom of their endurance they will accept unionisation. In the researcher's opinion, supported by Searle (1995:364-368) professional associations and unions are not mutually exclusive since both play an important role in collective bargaining for their members.

The divergent views expressed by Rotkovich (1980) still prevail within and outside the nursing profession in South Africa in the 1990s. She further maintains that

once there is enough consensus among nurses to seek collective bargaining, the representative organisation best suited to be the bargaining agent should be chosen, based on the following criteria:

- has sufficient skills, funds and other resources to succeed in negotiations

- is willing to fight for the whole range of nursing goals, including those that are labelled as professional and socio-economic issues. In this context, there is merit in nurses preferring representation by organisations which have both a professional and union leg such as the present Democratic Nursing Organisation of South Africa (DENOSA)

To illustrate opposition to unionism in nursing, Albright, Coutunier and Jones (1993:81) refer to a vice-president of a human resources department of St Joseph Medical centre in Illinois in the United States of America who was so opposed to unionism that he said "You'll see a union in this hospital when pigs fly". This was interpreted as an assumption that unionism in the hospital was an impossibility because seeing pigs fly is an unquestionable impossibility. The expression was used when nurses in this hospital were organising to have representation to address issues of poor staffing ratios, outdated equipment, lack of respect and non-existent communication between staff and management. Their main concern was improvement of patient care.

2.4.1 Organising Nurses in South Africa

2.4.1.1 Professional organisation of nurses in South Africa

In South Africa there is wide diversification of representative organisations for health workers generally and nurses in particular. A survey was conducted by Rispel and Burns (1991) on nurses' opinions of which organisations would best

represent them. It revealed that because of ignorance of alternative organisations nurses preferred to be represented by the then existing South African Nursing Association in spite of perceptions that it had not performed satisfactorily to represent nurses in the past. It must be noted that Rispel and Burns' survey was conducted prior to the dissolution of the South African Nursing Association and the establishment of the Democratic Nurses Organisation of South Africa. A report by Forrest in the SA Labour Bulletin (1996:58) highlighted that about 60% of workers in the health sector, including nurses, were unorganised. Unorganised nurses expressed general hostility to all official worker organisations when they realised that their grievances had not been satisfactorily addressed.

Historically nurses in South Africa had to be members of their respective nursing associations or organisations according to whether they were practising in the then Republic of South Africa or independent states and homelands which existed before the 1994 government elections. Through a long and tedious process nurses fought for transformation and re-unification of nursing organisations / associations so that all nurses of South Africa could be represented by one professional body. These efforts were also directed at the professional regulatory bodies, that is the South African Nursing Council and all other Nursing Councils of the homelands, for example Transkei, Ciskei, Venda and Bophuthatswana which had formed their own, according to the homelands policy of the National Party government. In this way nursing was in line with the general trend which intensified in South Africa in the mid-1980s to challenge legitimacy of all apartheid-based organisations and legislation.

Among many nursing organisations which came into existence in the early 1990s was a group of nurses called the Concerned Nurses of South Africa (CONSA). These nurses came under strong influence of the National, Education, Health and Allied Workers Union (NEHAWU) which was gaining popularity among nurses who were disillusioned with the South African Nursing Association and the other

nursing organisations of that time. Their stated objective was achievement of equality, non-discrimination and inclusiveness for all nurses of South Africa, regardless of race, nursing category, political or union affiliation. They were against policies which opposed unionism in nursing, more so those of the South African Nursing Association which was said not to be representative of all nurses. However they clearly articulated the fact that they wanted to retain control of their own organisation as a nursing organisation though they were willing to work together with well-established and experienced trade unions. At that stage unionism had not been given the blessing of the authorities in nursing. Another issue that was strongly revolted against, was the disciplinary action to be instituted against nurses who were involved in strike action after the "no-strike" clause had been deleted. CONSA members demanded that those disciplinary cases be dropped, arguing that in their opinion the South African Nursing Council had no authority to discipline nurses, They demanded total dismantling of that Council, claiming it was so unacceptable that there was no way that it could be meaningfully transformed. The same applied to the South African Nursing Association.

Many forums were established to plan for change until an interim body called the Transitional Nurses Committee (TNC) was established in 1994. Its purpose was to organise for formation of a new integrated, democratic organisation for all South African nurses. In 1995 a new unified nurses' body came into existence when the Democratic Nursing Organisation of South Africa (DENOSA) constitution was accepted. Membership of DENOSA is voluntary, in line with the principle of freedom of association. The multiple nursing organisations dissolved one by one until, in 1996 October, the South African Nursing Association unified with the other organisations and the new "big", all-inclusive organisation was then formed. The President of South Africa, Dr Nelson Mandela and the National Minister of Health, Dr Nkosazane Dlamini-Zuma attended the launch of this organisation. This was history for the South African nursing profession. In line

with transformation of the professional organisation a temporary regulatory body for nursing was formed in August 1995 with the enactment of the Nursing Amendment Act (5 of 1995). This body was called the South African interim Nursing Council. It lasted until March 1998 when the new democratically elected South African Nursing Council came into being with the enactment of the Nursing Amendment Act (19 of 1997).

DENOSA serves its members both as a professional organisation and a union. It has an Industrial Relations Department which is run by nurses who hold formal qualifications in labour relations. The researcher agrees with Mngomezulu (1998:27) that nurses can understand implications of problems in their profession better than anyone else, hence the rationale of having nurses in management of the union wing of the organisation.

The fact that DENOSA plays a vital role in labour relations for nurses is indicated in the following selected clauses of its Constitution.

Clause 3: Character of the organisation

It is voluntary, autonomous, non-sexist, non-racial, dynamic, pro-active, transparent and continually in touch with the communities it serves, democratic and has both a professional and union wing.

Clause 4: Aims and objectives

It safeguards and promotes the dignity, rights and socio-economic status of nurses, and aims to achieve progress in areas of socio-economic welfare, education, political influence, health care delivery, ethical thinking. It safeguards the historical heritage of the profession. In this way the professional, personal and occupational aspects are catered for. It negotiates on behalf of its members on

labour relations issues by means of collective bargaining. Nurses can feel that they have a representative nursing organisation with collective bargaining power to be able to represent them holistically on both professional and socio-economic issues, for example it has represented nurses in the Bargaining Chamber during salary increase and other socio-economic negotiations. On the professional side, it has represented nurses in parliament during Termination of Pregnancy Bill debates to present the nurses' viewpoint. It can realistically be assumed that the dramatic increase in membership of DENOSA nationally to 70 000 (seventy thousand) members in 1997 in spite of its voluntary membership is influenced by its dual representativeness.

Clause 5: Membership

It is open to all registered and enrolled nurses and midwives, including students and pupil nurses.

Clause 7: Workplace representative committees

In line with the Labour Relations Act (66 of 1995) on workplace forums, DENOSA rules that workplace representative committees should be elected in each workplace in which at least 10 members of DENOSA are employed. The number of representatives varies according to the number of members in each workplace. They should be empowered through regular training in all relevant areas of their functions. They should assist and represent their members in grievance procedures at their request. (Revised DENOSA Constitution: 1997)

In line with its responsibility for the welfare of its members, In August 1997 DENOSA commissioned a team of researchers to conduct a survey of the profile of nurses in South Africa. The survey covered, among others:

- the sociological profile of the nurses as individuals, family or community members.

- nurses' employment and workplace issues, including job satisfaction or constraints at the workplace.

- organisational affiliation to detect which organisations were most favoured by the nurses and why.

(Sitas, Burns, Webber, Phillips, Jarvis and Isaacs, 1998). This report is available to interested members through DENOSA offices. Relevant aspects will be referred to in this report.

2.4.1.2 Unionism among nurses in South Africa

Many unions have nurses in their membership, some of whom take dual membership whilst being members of DENOSA. These include the National Education Health and Allied Workers Union (NEHAWU), Hospital Personnel Association of South Africa (HOSPERSA) and South African Health and Public Service Workers Union (SAHPSWU), National Workers Union (NWU) previously a staff association, South African Democratic Nurses' Union (SADNU) and others. As their names indicate, these organisations represent nurses and other categories of health workers who are not nurses. They subscribe to the 'health worker concept' whereby it is advocated that all health workers have similar needs which can be articulated by the same representative organisation. They also assume that all health workers can display the same militancy in expressing their dissatisfaction at the workplace. According to Forrest (1996:59-63) some unions issued a warning that nurses are weakening themselves by isolating themselves under the so-called "oppressive" professional organisations. This creates conflicts and controversy for some nurses who believe that they are a unique profession with unique needs and responsibilities. Forrest (1996) further warns that organisers of

unions need an approach which shows nurses as professionals that it is in their best interest to unify with other health workers, including unskilled workers. She nevertheless highlights that nurses feel they have a strong power base because of their large numbers and do not need to rely on the strength of unskilled workers. In view of the freedom of association stipulated in the current Labour Relations Act (66 of 1995) as amended, the researcher is of the opinion that while nurses are free to make their own decisions they should ensure that professionalism is never sacrificed and that patients are never harmed by their actions.

In the early 1980s the Congress of South African Trade Unions (COSATU) got involved in helping to organise nurses into its member unions. According to Forrest (1996) about 10% of nurses are affiliated to COSATU. A COSATU affiliate which gained popularity among nurses and was considered by management in different institutions to be at the centre of the 1994-1995 nurses' strike wave is NEHAWU which came into being in 1975 initially as a representative of non-professional employees. Only selected clauses of the NEHAWU constitution are reflected here to provide a comparison with the current nurses' professional organisation (DENOSA):

(1) **Preamble:** Committed to formation of a strong, democratic organisation controlled by its members, as well as a united, democratic South Africa free from oppression and economic exploitation. It is based on the belief that unorganised and divided workers cannot meaningfully improve their working conditions, wages, standard of living nor protect themselves from insecurities of life. Members commit themselves to comradeship and solidarity of all workers irrespective of colour, nationality, race, sex, religion or creed. They declare that long-term interests of workers are alike. The motto shall be the universal slogan of the working class solidary " ... an injury to one is an injury to all".

(6) **Membership**

It shall be open to all workers covered by the scope of the constitution.

(8) **Aims and objectives**

To recruit and unite into a single union all workers in order to share their economic welfare. It is also to improve the wages, salaries, terms and conditions of employment through collective bargaining, to protect the job security of membership, to advance their employment prospects, to serve the interest of employees in their individual and collective capacities.

(10-15) **Shop stewards Council**

These shall exist at National, provincial and branch levels. Institutional shop stewards committees are elected at every institution where the union has a minimum of 50 members. Functions of the committee are to conduct affairs of the union at institutional level, receive and attend to complaints affecting members concerning their employment and, if necessary report these to the Branch Executive Council, to report any counter revolution of statute or improper employment practice to the Branch Executive Council and to defend the individual and collective interests of members in the institution.

(16) **Representation on Industrial Councils and Conciliation Boards**

This is provided for in the union constitution.
(NEHAWU Constitution:1995).

To facilitate healthy labour relations, member education by representative organisations is done to facilitate compliance with their constitutions. Management

should be made aware of provisions of each relevant constitution to enable it to deal correctly and effectively with member issues. Management's prerogative to provide effective service should be protected at all times.

According to Forrest (1996:60-61), nurses employed in the public sector fall under the Public Services Bargaining Chamber (PSBC) which takes for granted that unions and/or associations in the public sector cover all employees and that government representatives represent employees across the board. The researcher shares the general feeling that bargaining by the PSBC is over-centralised, since it includes all levels of staff in the health sector for example doctors, nurses, all levels of management, general workers and others. This makes it difficult for people on the ground to negotiate locally on their own specific issues according to the uniqueness of their situation. Furthermore provinces have minimal financial control to be able to negotiate around working conditions at their level. The same concern was raised in relation to the Public Service Staff Code PSSC) and the Personnel Administration Standard (PAS)

Many nurses employed by local government are organised by the South African Municipal Workers Union (SAMWU) which showed nurses that it was able to represent their interest, by taking up issues like restructuring salary scales and grading systems. As an example, during the strikes of 1995 one of the grievances was that in hospitals served by both provincial nurses and municipal nurses, municipal nurses earned higher salaries than their provincial counterparts, as illustrated in the comparisons of 1993-1994 mid-point salaries in Table 2.1.

Table 2.1 Comparison of mid-point salaries of nurses in Public Service and in Municipal Service in 1993/94 in South Africa

Nursing Category	Public Service	Municipal Service	Discrep-ancy (%)
Senior Nursing Service Manager	R63 848	R97 472	52,7
Nursing Service Manager	57 443	76 764	33,6
Chief Professional Nurse	48 420	67 236	38,9
Senior Professional Nurse	39 977	47 302	18,3
Professional nurse	30 273	46 736	54,4
Enrolled nurse	20 859	29 400	40,9
Enrolled nursing auxiliary	13 890	25 467	83,3

(Source: Health Systems Trust News, 1995:23)

In addition to discrepancies reflected in table 2.1 it should be noted that wages or salaries in municipalities differ according to the local government structure involved and are usually higher in major cities than in smaller towns (Smith, 1995:5).

2.4.2 Organising nurses in the United States of America

Parallels exist between South Africa and the United States of America on development of nurse-representative organisations and its implications for collective bargaining in nursing. In the United States of America the American Nurses Association (ANA) was established in 1896. Similar to DENOSA, it serves as a strong professional association for nurses and a strong union for the nursing profession. It represents nurses in collective bargaining because of the belief that the quality of work-life is intertwined with the implementation of quality nursing practice, therefore representing nurses enhances provision of quality nursing care. In the United States of America nurses have a legal right to collective bargaining which proves to be one of the most effective ways to protect patients from inadequate and unsafe care and ensure that nurses have good benefits and satisfactory working conditions.

In a pamphlet of Basic Facts and Considerations published by the ANA (undated) it is stated that employee interest in collective bargaining has always been met with fierce resistance from employers. In the health sector opponents argue that it creates an internal struggle which detracts from a hospital's mission to provide high quality patient care. However, in the same pamphlet there is evidence that when collective bargaining is used effectively it actually facilitates delivery of the best care and services. The researcher supports the idea that collective bargaining for nurses by a professional nurses' organisation which is in touch with the nurses' professional and socio-economic issues should be encouraged. For this reason DENOSA got involved in collective bargaining for nurses' salaries and conditions of service in the Bargaining Chamber.

The original purpose of the American Nurses Association was to promote and honour the financial and other interests of the nursing profession. Through ANA's establishment of standards of nursing practice and nursing education, nursing achieved recognition as a profession.

The ANA recommended that organised nurses should assume responsibility for advancing the social and economic security of nurses rather than leaving it to organisations outside the profession.

Such arguments have been heard in the new South African nursing profession.

In 1952 the ANA adopted a no-strike policy similar to that provided for in South Africa through the Nursing Act (50 of 1978) as amended. Zimmerman (1991:9) an ex-president of the ANA described adoption of the no-strike clause as a carrot dangled to the employer in the hope that if it was put in writing that nurses would not strike, employers in hospitals would deal fairly with them. Zimmerman further expresses a view that employers indeed did not take nurses seriously because nurses are women, subservient to male dominance, timid, apathetic and

too 'angelic' to take collective action. Zimmerman (1988:7) believes that if the collective bargaining battles of nurses converged with the labour movement and the women's movement they would make greater gains. Similarly DENOSA, at its National Board meeting held in November 1998, decided to join the National Women's Coalition League to strengthen its position in the National Economic, Development and Labour Council (NEDLAC).

Elliot (1996:21) in the United States of America states that in spite of the no-strike policy nurses used a variety of means to demand recognition by their employers, including mass resignations which eventually gave way to strikes. It became evident that ANA could not enforce the no-strike policy at national level. In 1968 ANA's Commission on Economic and General Welfare recommended that ANA should rescind it and allow the State Nurses Associations (SNAs), the actual bargaining agents for nurses, to determine their own policies regarding strikes. The SNAs are the professional organisations and unions for nurses in each state of the United States of America. Elliot (1996) quotes Schutte (1968) who states that "anyone who knows nurses, knows that few will use the strike weapon easily, and that if they do, they will use it responsibly, with adequate notice and plans to provide emergency care". The present study will investigate if the strikers acted responsibly, for example, if adequate notice and plans to continue nursing care were provided. Elliot further states that nurses, like other workers, felt that the threat of a strike gave them more leverage at the bargaining table. Similar to South Africa, opponents of the rescission of the "no-strike" clause feared that it would increase strikes but, on the contrary, reports showed that economic activity was stimulated without increasing the number of strikes by nurses in the United States of America after rescission of the "no-strike" clause.

The ANA has 53 constituents, the State Nurses Associations (SNAs) representing the different states of America. The SNAs are certified by the National Labour Relations Board (NLRB) to act as collective bargaining representatives of the local

bargaining units. The ANA does not represent nurses directly for collective bargaining purposes but performs supportive, training and consultative functions on labour relations matters. It also provides a communication network with state nurses associations regarding labour relations issues (Flanagan, 1993:4).

State Nurses Associations are described as trendsetters in collective bargaining for nurses and have secured outstanding contracts for their members, for example:

- quality patient care through creation of professional practice and patient care committees, regulation of use of temporary staff and other types of health care reform.

- getting employers to designate non-nursing functions which nurses will no longer perform.

- securing SNA health and safety committees for workers.

- job security, economic gains and fringe benefits.

Local bargaining units operate under the State Nurses Associations. A local bargaining unit is an organisation of registered nurses employed in an institution or agency. Its overriding value is in its collective strength based on the premise that the influence of a unified group far exceeds that of a single individual. Strength of a local bargaining unit hinges on the degree of involvement of its membership, with members having a sense of ownership and commitment. Flanagan (1993) recommends an 'organising model' approach to local bargaining unit administration whereby members take an active part, communication is active, information is shared in a democratic and decentralised structure. The role of local unit leaders is to educate, develop, communicate and activate members. Leaders rely heavily on members' skills and abilities. In this model leaders must

be committed to internal organising and focus on identifying workplace concerns of bargaining unit members. They should involve members in working to resolve these issues, and keep members informed of the SNA bargaining unit's efforts to resolve their issues.

The purpose of a local bargaining unit is to give registered nurses an effective voice in determining the terms and conditions of their employment which impact on the quality of their work-life and ability to provide safe patient care. This approach is in direct contrast to the current South African approach which the researcher strongly supports, whereby all categories of nurses have equal representation in the professional organisation.

An example of the State Nurses Association (SNA) relationship with a local bargaining unit will be given by describing the Illinois Nurses Association's (INA) contract with the University of Illinois at Chicago Hospital (UIH) which was successfully negotiated in 1995 and represents the ±850 INA/UIH registered nurses. The contract protects patients, for example it stopped UIHs "Operations Improvement" programme which was a restructuring plan which replaced registered nurses with lesser trained, unlicensed personnel, thus sacrificing patient care and restructuring professional nurses out of their jobs. Key provisions of the contract include guaranteed nursing positions, appropriate delegation of nurses, future INA registered nurses involvement in budget settings, salary increases and stricter lay-off criteria (Towne, 1995:2). All labour issues are regulated according to provisions of this agreement which is administered jointly by hospital management and INA union representatives.

During an exchange visitor programme, the researcher had an opportunity to observe negotiations between the two parties for grievance handling. She noted that this is done amicably, facilitated by openness and equal treatment of the aggrieved nurse and her supervisor, perhaps due to the fact that all members are

aware of procedures to be followed as well as their rights and obligations as laid out in the agreement. Each member is given a copy of the agreement. Regular labour-management meetings are held to keep each other apprised of personnel and patient care issues rather than wait until there are problems. Joint staffing statements are made by registered nurses concerned about the staffing position in their units and presented to the Professional Patient Care Committee which includes both management and INA union representatives. In this way inadequate staffing is dealt with to prevent unsafe nursing care. According to hospital management, there is a general feeling that strikes are not likely to occur in such a positive working environment even if the 'no-strike policy' did not exist in the agreement. In summary, the INA/UIH contract contains articles on wages, benefits, work rules and conditions, maintaining and filling bargaining unit positions, discipline and grievance procedure, labour-management conferences, seniority issues, professional standards and performance, in-house (flexi-team) registry and scheduling programme, and dues deduction. In South Africa the National Board of DENOSA represents nurses nationally and internationally while the Provincial Board consults and liaises with workplace representatives or directly with its members locally and provincially, as is the case with the SNAs just described. The researcher is of the opinion that more emphasis on publicised collective agreements between management of South African health services and nurse representative organisations would facilitate labour relations management, as the INA/UIH contract described.

2.4.3 Organising Nurses in Canada

In Canada there is a national professional association for nurses, namely the Canadian Nurses Association which looks after nursing professional matters. Similar to the United States of America, each province has its own nurses association. There are also nurses unions which are independent and separate from the professional body. The role and function of the union is to create a good

working environment which will enhance high quality care. This further confirms that the roles of professional associations and unions are not mutually exclusive (Geyer 1997:10-13). Geyer further observes that Canadian nurses are proud to be nurses and more concerned with the quality of care delivered than the take home pay. There is more lobbying with politicians for nurses' issues.

Hibberd (1992:21-25) states that collective bargaining is widely endorsed by Canadian nurses, but having to withdraw services to achieve socio-economic goals remains a controversial issue even though it has done much to advance the socio-economic goals and status of nurses. At the heart of every strike is a power struggle between employees and employers. Labour disputes in the health field occupy a central place in the political arena because of the role government plays in funding health care and in protecting public interest. Unions may capitalise on this by timing strikes to coincide with important national or provincial events in order to pressure government and health care agency employers to settle the dispute expediently to prevent negative political fallout. This strategy may however have a negative impact where the political event may undermine the power of a striking union by diverting public attention. The timing of the 1994-1995 strike wave in South Africa shows a correlation with this strategy as this was a politically turbulent period during the pre and post-government elections of 1994.

While unionism was not allowed for South African nurses before the 1990s, Hibberd (1992:21) reports that in 1992 ±75% of Canadian nurses were unionised compared to about 20% in the United States of America. Centralising bargaining has given nurses significant power to secure improvements in terms of conditions of employment. Hibberd (1992) maintains that economic and non-economic gains could not have been achieved without the nurses' willingness to resort to strikes or threats of strikes. She believes that the *threat of a strike* can be a very effective bargaining tool. It strengthens the power and credibility of union negotiators who

can then return to the bargaining table well-armed for a final showdown. It can resolve an impasse without the cost and anguish of an all-out strike. Whilst the researcher supports this viewpoint, she sees it as a dangerous challenge if management has not developed strategies of preventing the *threat of a strike* from becoming an actual strike.

Grand (1971) in Hibberd and Norris (1991:43-53) states that nurses who subscribe to professional collectivism stress responsibility for high quality patient care and its dependence on satisfactory working conditions and job satisfaction. To them a strike is not a strike against patients but a way for nurses to gain benefits that will result in more and better care for patients. However those nurses reject 'Nightingalism', that is, a belief that the service ideal takes priority over self-interest and they believe that the employer does not have the interest of the employee at heart. These authors argue that to withdraw services in order to bring about a future good is not sufficient reason to ignore immediate, life-saving duties. They maintain that improving conditions so that future lives can be saved while losing a patient's life here and now is not justifiable. In support of this, the researcher acknowledges this as a dilemma that those taking the decision to strike to improve patient care conditions in future would have to grapple with.

Nurses bargained without much power under the self-imposed ban on strikes by 'no-strike' clauses. In return for "no-strike" agreements in Canada, policemen and firemen enjoyed large salary increases, but not nurses. This angered nurses. It led to frustration and disillusionment which resulted in rescinding of the 'no-strike' clauses for nurses in Canada (Hibberd and Norris, 1991).

The South African Nurses Code of Ethics and the Canadian Nurses Association Code of Ethics both state unequivocally that even when a nurse is working under conditions which violate justice, withdrawal of services as a way of resolving such injustices is unethical. Therefore nurses must determine within their unions and

associations how their duty to ensure safety of all patients will be fulfilled in the event of a strike.

As in South Africa, the Canadian and other governments have restricted the right to strike in essential services and substituted it with mandatory post-impasse procedures, for example arbitration. Even though a hospital strike can be tolerated for a while, the magnitude of the threat to public health and safety is likely to increase in direct proportion to the duration of the strike. In Quebec and British Columbia nurses have a legal right to strike provided certain designated essential services are maintained. Unions and employers are sometimes required to agree on the type and extent of services to be designated as essential. The Essential Services committee in South Africa performs this function. This issue becomes as difficult to agree upon as the bargaining issues themselves and may require a third party to impose an arbitration decision. In Canada union leaders and individual members can be liable to heavy fines for engaging in illegal strikes, but it is not clear whether a nurse would be disciplined by a licensing body for unprofessional conduct in other countries.

2.5 CONCLUSION

This chapter has provided a comprehensive discussion of aspects of the labour relations system which have implications for nurses, with particular reference to maintenance of healthy labour relations and prevention of nurses' strikes. The section is provided to enlighten the reader about the diversity of factors which have an impact on labour relations as well as mechanisms that exist to regulate the control of employer / employee relationships. It emphasised that these should be regulated for the benefit of all stakeholders in the health care environment. Strikes invariably impact negatively on the work environment. The next chapter discusses the strike phenomenon.

CHAPTER 3

NURSES' STRIKES AND THEIR IMPACT

3.1 INTRODUCTION

Controversy surrounding nurses' strikes arises out of concern for their implications for life, health and wellbeing of consumers of health care. In the preceding chapter maintenance of healthy labour relations and its implications for strike prevention was discussed. In this chapter strikes and strike management activities are analyzed to detect their role in minimising disruption of patient / client care services during nurses' strikes. In this regard the discussion includes description of contingency plans that have been utilised to manage patient care in strike-torn health services. The impact of strikes on individual nurses, the nursing profession and on the quality of health care is the main focus of this research and is therefore analyzed to provide a theoretical base for the findings of this research.

3.2 HISTORICAL BACKGROUND AND ANALYSIS OF STRIKE ACTION, WITH PARTICULAR REFERENCE TO NURSING

There are different types of strikes and these will be described according to Bendix's (1996:522, 526, 533) classification, which includes:

- **Legal versus illegal strikes:** Those strikes which occur after use of the official dispute settlement machinery in accordance with the limitations of government legislation are legal, whilst those that do not follow legislated procedures and regulations are illegal strikes. Legal strikes are protected while illegal strikes are unprotected by labour legislation, currently the Labour Relations Act (66 of 1995) as amended.

- **Procedural versus spontaneous strikes:** Where employer and union provisions for strikes exist, strikes which are authorised by the union are procedural. If employees embark on a strike without deferring to their union, it is referred to as a spontaneous or wildcat strike.

Strikes arise from labour disputes. Meredeen (1988:3) describes a labour or industrial dispute as a short-term episode of disruptive conflict between two or more collective interest groups in the employment relationship. In theory each side purports to be acting rationally in pursuit of its legitimate objective, for example, by controlling salary increases the employer acts in pursuit of its objective of providing maximum service within financial constraints whilst employees, by making demands for more pay, are acting in pursuit of the objective of protecting their own right of need satisfaction. In practice, however, each party seeks to achieve all or most of its objectives by preventing the other party from achieving its own objective. Meredeen (1988:12) further emphasises that the timing and circumstances of a labour dispute must be distinguished from its underlying cause because root causes are usually more complex than the first impressions which are immediately visible.

Kunene (1995:14) cites White (1985) who states that the right to strike is the most widely discussed and emotionally-charged issue internationally. Labour unions argue that there can be no true bargaining without the strike. From their perspective no law can prevent a truly determined union from conducting a justifiable strike. The central question is "... What is a justifiable strike when patient care responsibilities must be performed?" Attempts to answer this question result in the controversies discussed in preceding paragraphs. Germishuizen (1994:630) described striking by nurses as unethical and irresponsible behaviour which he hoped would come to an end in the new spirit of peace and reconciliation prevalent in South Africa.

In analysing the right to strike Nisan, in Jennings and Western (1997:289-290) presented the 'Moral Balance Model' in which he assumes that people calculate a kind of moral balance for themselves based on morally significant actions within a given time. After weighing morally relevant omissions and commissions, they take final decisions based on personal moral standards below which they cannot descend. These decisions are based on benefits and harm to others, and gains or losses for the self. This model is relevant in consideration of strikes by nurses since the nurses' focus is on the patient's good, but for the final decision the nurse as decision-maker considers risks and benefits for herself. She may allow a degree of deviation from what is considered an ideal solution. Because she is aware of the discrepancy between her actions and the ideal, she resolves to reduce the discrepancy in future decisions.

Casey (1995:3) in Great Britain, points out the myth of believing that nurses are weak and powerless. She states that nurses' collective power is so great that they are loathe to use it, hence their consistently voting to retain the no-strike vote. Their pact of not striking is with the public and not with government or management. Opinion polls show that once nurses are assured that patients are safe and cared-for, they would consider taking industrial action to boost their bargaining power. In consideration of the importance of assuring patient safety before undertaking any strike, this research investigates what arrangements were made to assure patient safety before the nurses went on strike.

Stephens (1992:8) advises that, because nursing service is irreplaceable, nurses may resort to token one-day strike or mass casual leave to press their demands. He warns that public sympathy maybe lost and their course weakened if a nurses' strike is prolonged. It is to be noted that the strikes being investigated were of one month and two months' duration respectively, which is contrary to Stephens' view.

3.3 STRIKE MANAGEMENT, WITH PARTICULAR REFERENCE TO NURSES' STRIKES

An important challenge posed by strikes to management is strike management or proper handling of the strike to ensure minimum service disruption and prevention of harm to providers and consumers of the service. This issue becomes even more important when discussing nurses' strikes because of patient care responsibilities. Nel and Van Rooyen (1993:207) observed that longer strikes have greater effects on strikers in that union funds may run out and the strikers may be forced to return to work even though their demands have not been met. The proposal made by Haines (1987:48) that unions or professional organisations should establish a strike fund to be distributed to members experiencing financial difficulties whilst involved in an approved strike has merit. In patient-care situations further concern is that longer strikes involving large numbers of personnel may have a greater impact on patients in need of care, hence the concern about the impact of the strikes which are the subject of this study.

Reese (1991:34-36) agrees with Nel and Van Rooyen (1993:208) that management must be seen to be prepared for the worst in a threat of strike and must demonstrate eagerness to avoid unnecessary conflict. Both authors agree that an important part of strike handling or strike management is provision of a contingency plan to counter a strike. Basic principles of such a plan should include the following:

- selection of a strike action team which includes top administrators or human resource managers, finance managers, labour relations manager. Departmental heads should be represented in the team. This team should be notified immediately on notification of a strike.

- operation centre for the strike team should be allocated and provided with internal and external telephone links.

- employing authority should be informed immediately.

- well-trained security personnel should be available and a standby security team arranged in case the institution's security team joins the strike. Protection of staff and anybody within the institution should be given priority.

- closure of non-key areas which will not be operative during the strike to protect those departments and equipment.

- reschedule and retrain staff who will not be affected by the strike, for example those who do not belong to the striking union, to prepare them for unfamiliar duties. Rehearse with these staff members so that they know exactly what to do and can remain calm. Strikers should never get the impression that the organisation is panicking.

- keep employees and the public informed to avoid untrue rumours. This should be a responsibility of a public relations manager. Staff should be instructed to refrain from disseminating any information nor passing any opinion.

- as soon as the exact nature of the problem is known, start negotiating with employee representatives immediately and aim at minimising the strike period.

- arrange for police standby in case of trouble, otherwise police must remain completely out of sight.

3.4 NURSES' STRIKES IN SOUTH AFRICA IN THE 1990s

Nurses' strikes need to be looked at in the social, economic, political and environmental context within which they occurred as this may account for their escalating beyond localised, institutionally contained entities to provincial and national events.

3.4.1 Nurses' strikes in South Africa in the pre-election period

In line with the general political climate prevailing in the country in the immediate pre-election period, nurses were involved in political activity and conflicts were openly expressed. Nurses employed in the then KwaZulu Homeland Government-controlled hospitals expressed concern about the issue of Inkatha Freedom Party, the ruling party in that government, refusing to go for the 1994 government elections. This raised concern about the future of these hospitals, for example regarding control, availability of resources and security of pensions. Strike action was designed to force the KwaZulu Homeland Government to allow its employees to go and vote during elections.

An analysis of strikes in the Durban and Pietermaritzburg area between 1993 and 1994 indicates that the main reasons for nurses' strikes were a combination of political issues mainly in KwaZulu hospitals and personnel issues in Natal Provincial hospitals for example salaries, working conditions, disciplinary measures and failure to address long-standing grievances. The latter were also demanding that Government should settle disputes in KwaZulu hospitals immediately because of the ripple effect of further over-burdening the already short-staffed and overworked personnel when some hospitals were closed. Union issues were also identified and the unions planned strikes to coincide with National and Provincial events to put pressure on government to settle disputes promptly as was the case in the immediate pre-election period. Strike action was not marked in the previously White and Indian hospitals, and that was attributed to their better conditions in comparison to the previously Black hospitals (Shabalala, 1994:34-39).

Kunene (1995:119-126) found that the nurses' strikes of 1993 and 1994 had numerous adverse effects on patients, the community, the employing authority, management, nursing personnel and the nursing profession which culminated in its politicisation and spoiled reputation. Nurse managers were found to be lacking in

the ability to handle striking nurses. Alternative plans for patient care were ineffective in maintenance of quality health care.

3.4.2 Nurses' strikes in South Africa in the post-election period

In the years 1994-1995, the strike wave in South Africa was a sign of disillusionment with the newly-elected, democratic government. The newly appointed health authorities tried to convey to striking nurses that they understood the difficult conditions under which nurses worked. However they needed time to implement plans which would address nurses' issues whilst also having to deal with demands for salary increases by other public sector employees. Nurses felt they had waited long enough and were sceptical of promises and plans of the health department, especially because they were told that there was not enough money that year and they were guaranteed an increase in the next year. Another issue that nurses felt strongly about was unsatisfactory working conditions.

Mtshelwane, in Ribton-Turner (1995:32-33, 70) supports Strachan's views when he says that, in spite of the political and power changes following the 1994 government elections, strikes were a pointer that tensions at the workplace were not gong to be wished away simply because there was a new government in place. Workers demanded that changes occurring in the political sphere extend to the workplace. The entrenched "spirit of struggle" led to conflict and strikes in many employment sectors, not only in the health sector. When considering that nurses' strikes occurred in health services staffed mainly by Black nurses, Mtshelwane's idea that the communal work ethic, with a bonding of collective unity and a common agenda typical of African culture, appears to have merit.

Butler (1995:21) observes that, after encouraging militancy among nurses in the past, the new South African government found itself on the receiving end of public sector strikes. Butler (1995:18) quotes Gwagwa who states that the nurses' tactics

were nothing new and should have been no surprise because "... less than five years ago similar action might have been praised by anti-apartheid groups for unifying against an oppressive regime". The National Minister of Health emphasised that nurses' strikes should be in accordance with legal provisions. In expressing her concern for quality health care, she warned that striking should not lead to a situation where nurses neglect patients in pursuit of salaries. She further stated that trade unionism in nursing is a good instrument for collective bargaining, but protection of nurses' rights should not lose sight of protection of patients' rights (*Nursing news*, 1994) in Pera and Van Tonder (1996:187-188).

When strikes occurred in health services in the provinces, provincial governments were under obligation to intervene and to co-ordinate services, to ensure safety of personnel and consumers of the service, hence the interventions by the provincial Ministry of Health and the Nursing Directorate. Provincial Health officials had to act according to recommendations of the National Health Department. For example, In KwaZulu-Natal the Premier appointed the Mall, Hardman and Mthiyane Commission of Enquiry in 1994 to investigate and report on allegations of corruption, favouritism, discrimination, victimisation and intimidation during strikes in several health care institutions. Specific terms of references of the Commission varied according to need but were mainly to investigate:

- listed grievances that had been forwarded to the KwaZulu-Natal Provincial Administration

- allegations of corruption at managerial levels

- alleged irregularities in personnel departments

- any other allegations in various provincial hospitals, and

- to report to the Executive Council of the Province at the earliest opportunity to enable appropriate action to be taken.

Evidence led and recommendations of the Commission had an influence on decisions taken later to address strike demands (Mall, Hardman and Mthiyane, 1995:1-3).

Heunis and Pelser (1997:41-46) addressed the question of whether nurses in South Africa should strike or not. The authors maintain that the new Labour Relations Act (66 of 1995) allows for a wider range of protected industrial action. They quote Nyembe (1992) who states that the right to strike should be without fear of dismissal. This statement is in line with the International Labour organisation provisions. Contrary to this, ultimatums of dismissals were issued to striking nurses in South Africa in 1994. Conflict arises because the public sector provides essential services and citizens should not be denied access to services because of disputes between civil servants and the state.

The International Council of Nurses, to which South Africa was re-admitted in June 1997, has not taken a stand on whether nurses have got a right to strike or not, but it has emphasised encouragement of machinery for negotiations between employers and nurses or their representatives. In a nurses' strike in South Africa at the beginning of the 1990s placards exclaiming "To hell with Florence Nightingale", and nurses shouting "...we don't need an organisation, we need money" were interpreted as an indicator that nurses' strikes would continue to be a problem which cannot be wished away if nurses' needs are not satisfied (Uys, 1992) in Heunis and Pelser (1997:46).

According to Forrest (1996:58) difficulties in handling the strikes were due to the fact that report-backs were problematic since about 60% of workers in the health sector were unorganised. The state did little to ensure that the striking workers

were kept informed about negotiations and final settlements. Amongst the 40% organised health workers, problems were created by the fact that they belonged to different unions thus making report-back difficult. In some health care services even senior managerial officers were unaware of final settlements and therefore could not effectively answer queries of their personnel.

An issue to be kept in mind with regard to nurses' strikes is the threat of disciplinary action for patient neglect in spite of the "no-strike" clause having been deleted in 1992. Germishuizen (1994:630) the then registrar of the South African Nursing Council (SANC), explained that the SANC experienced great difficulty in instituting disciplinary action (now called professional conduct procedures) against striking nurses, firstly because employing authorities showed great reluctance to report such cases to SANC. Secondly, even when such reports were made, it was almost impossible to find witnesses who would be willing to testify in an open inquiry for fear of retribution. He noted, however, that many of the nurses participated in strikes or stay-away action unwillingly because of intimidation. It has been reported that some nurses have had their houses burnt down for daring to go to work during a strike. Joyce *(pseudonym),* in Sheriffs (1995:70) confirms this when she states that, having lost her son in violence, she joined a strike reluctantly after being told to 'swallow her house and take it with her', otherwise she would find it in ashes. She, like other nurses, considered seeking refuge at the nurses' home but thought of her children. She went to her nurse manager for advice but was merely told to use her discretion, she then decided to join the strike. This is evidence of the high degree of insecurity that those who oppose strikes are subjected to.

Mittner (1995) reports on a two-week illegal strike which was opposed by NEHAWU, HOSPERSA and SANA at Baragwanath hospital. Nurses spontaneously initiated action in protest against a massive patient overload caused by opening of hospitals to all races and provision of free health services to

pregnant women and children under six, coupled with a switch of funding from tertiary to primary health care.

Butler (1995:21) reports that many wildcat strikes involving thousands of nurses flared up in 1995. For example, in Baragwanath which is the largest hospital in the southern hemisphere, 1 700 nurses walked out for seven days leaving 2 000 patients in the care of doctors and army medical personnel. In the Eastern Cape Province 30 public hospitals were involved in unofficial walkouts, 7 000 nurses were sacked and told to re-apply for their jobs after defying government ultimatums to return to work. Strikes spread to other provinces including KwaZulu-Natal where, amongst other issues, it is reported that 20 nurses were arrested in one Durban hospital for violent behaviour.

Strachan (1995:2) and Forrest (1995:56-57) share the view that the main issue that led to strikes was salary dissatisfaction, made worse by discrepancies in salaries of health workers of comparable training, seniority and responsibility, as outlined in table 2.1 (page 42). Forrest (1995:58) explains reasons for escalation of the strikes as the fact that when provincial nurses opened their pay packets after having stated their dissatisfaction, they still had a lower package compared to their municipal counterparts. The nurses' anger was based on the notion that nurses in provincial health care settings perceived themselves to be working under more difficult conditions compared to their municipal counterparts. Reports state that nurses were angry to find that, after calling for a 25% to 33% pay rise, they were awarded only 5%. Salary dissatisfaction was a long-term grievance which nurses hoped would get priority attention in that period of redress of all injustices of the previous government. The mistrust previously created by unfulfilled promises made nurses more sceptical of promises that their salaries would be given attention gradually along with other priority issues (Butler 1995:21).

Shabalala (1995:48) reports on a survey conducted by the Portfolio Committee on Health to elicit a general overview of the background and specific nature of the

strike action affecting the nursing profession in 1995. Results of the survey showed that:

- the number of hospitals affected by the strike action differed from province to province. The highest rate of unrest was in Eastern Cape followed by Gauteng. The lowest rate of unrest was in Western Cape. In KwaZulu-Natal most big hospitals (over 500 beds) were affected by strikes.

- the most favoured form of industrial action was one-day work stoppages and other forms included pickets and marches.

- the Eastern Cape reported 90-100% stay-away by nurses at all institutions while the Western Cape reported a 30% stay-away. No statistics were provided from other provinces, including KwaZulu-Natal which is the province under study.

- the nurses' strikes largely affected Black urban and rural communities from lower or middle socio-economic class.

- a wide range of different forms of response to the strikes were taken by the health department, for example, ultimatums to striking nurses, negotiations with nursing forums, various emergency measures where strikes continued for more than one day, e.g. relocation of patients, closure of general wards, use of volunteers. All provincial departments were in contact with the National Department of health on a daily basis because the Minister of Health established a hotline and a help desk in the department.

- in regard to the main grievances, core demands were consistent across the country though in some provinces additional demands arose. Core demands were as follows:

- 2 to 100% increase in salary

- parity of salaries between provincial and local authorities

- increase in professional and night-duty allowances

- improvement in conditions of service

- a human resource development policy to ensure career pathing and professional status

- filling of vacant posts to ease workloads

- direct representation of nurses in the Central Bargaining Chamber

- consultation regarding the transformation of health services and programmes which have an impact on workload, e.g. free health services for pregnant women and children under 6 years of age.

Additional demands included free medical services to nurses and a danger allowance. Two provinces added important points which they felt needed consideration, namely:

- there was no evaluation undertaken on the way the strikes were handled at national and provincial level.

- not all provinces carried out decisions taken at national telephone conferences and meetings, e.g. giving warnings to nurses, "no work no pay" rule.

- there was no feedback on the outcome of the Bargaining Chamber negotiations.

3.5 ANALYSIS OF NURSES' STRIKES IN THE UNITED STATES OF AMERICA - selected examples

More studies on strike activity by nurses have been undertaken in the United States of America (USA) than in South Africa. Most USA studies look at the ethics of striking, consequences of striking for hospitals and patients, media reaction to strikes, which is not surprising considering the impact that the media has in shaping people's views and opinions in that country. Studies and research articles published indicate that strikes by nurses are on the decrease in the USA in the 1990s compared to the 1980s. As an example whole issues of Supervisor Nurse, which is the journal of nursing leadership and management, and the Nursing Administration Quarterly published in 1980 and 1982 respectively dealt solely with collective bargaining and strikes by nurses.

Kravitz, Leake and Zawacki (1992:645-659) describe striking as the most organised and public declaration of job dissatisfaction resorted to by nurses. These authors refer to previous research which revealed that nursing ideology negatively correlated with strikes and reported that strike participants were more likely than non-participants to have militant attitudes. They were also most likely to be non-American Nurses Association affiliates. The latter is in line with a general assumption in South Africa that non-professional organisations affiliates are more prone to striking.

Kravitz *et al.* (1992) presented a case study of registered nurses shortly after a 4-day strike in a 2000 bed hospital and trauma centre employing 1500 registered nurses. It was found that by announcing the strike well in advance the nurses were able to minimise lost income by scheduling their days off on the strike days. Participants in the strike were classified into four categories, namely, activists, followers, would-be participants who did not participate but wanted to, and committed non-strikers who would never strike under any circumstances. Greater

participation was associated with political liberalism, activism, endorsement of unionism, perception that others favoured the strike and that it was normally justified. Older nurses were no less likely to strike than younger nurses, contrary to popular belief. Research questions addressed were nurses' views of cause of strike, strike-related actions of participants and non-participants, nurses' perceptions of consequences of the strike on the hospital, plans for the future, demographic, professional and attitudinal factors associated with various levels of participation in the strike. These variables are investigated in the present study.

Similar to the South African nurses' strikes, Kravitz *et al* (1992) found that there was no single issue that appeared to provoke the strike. Respondents referred to heavy workloads, difficulty in providing good care, low salaries, patient overcrowding, and poor working conditions with particular reference to uncaring attitudes and practices of management whereby nurses were expected to do non-nursing work of a clerical and technical nature.

Consequences of the strike were fewer and less serious than expected. Though clinics were closed, surgeries cancelled, patients transferred or discharged earlier, only a minority of nurses thought that overall quality of care declined during the strike, probably because of prior negotiation, its short duration, its partial nature, the strained working conditions that existed before, and prompt curtailment of non-essential surgery. The researchers predicted that a survey of patients might have provided a different perspective of the impact of the strike. They noted previous studies which indicated that patient satisfaction does not necessarily decline during health workers' strikes. In the present study patients and other consumers of health care are given a chance to state their perceptions on the impact of nurses' strikes.

Similar to the South African nursing philosophy, in the study by Kravitz *et al.* (1992) it was emphasised that nurses are unlike factory workers, therefore they

must consider the moral implications of their actions for the people they serve. It is however acknowledged that strikes may call attention to important patient care problems or grievances that have the potential for causing harm to patients through failure to provide them with the care they expect and deserve. Kravitz *et al's* findings also revealed that the strike negatively affected nurses' perceptions of their working environment. A high percentage reported an intent to leave the hospital thus creating a problem in maintaining adequate staff in future. Some of the nurses indicated a wish to leave hospital nursing altogether.

Sigal, Diamont, Bacalu, Arad and Levi (1989:409-411) conducted a study on the effects of a nurses' strike on the functioning of chronic patients in a psychiatric hospital. Findings showed that, contrary to expectations, patients' level of functioning improved during the strike compared to before and after. Patients showed more responsibility toward property and other patients, showed increased initiative and functioned more independently. This superior functioning reflects an ability to express ego powers during a crisis situation. It shows that if patients are given a message that they can be counted on, they adjust and live up to those expectations. This supports the concept of self-fulfilling prophecy. The superior functioning could also be explained in terms of systems theory which contends that every system needs to maintain a balance. To achieve this, roles are assigned according to capabilities of each member. According to findings of Sigal *et al* (1989), this research, when staff were not available for their normal roles during the strikes, patients mustered strengths that were not previously expressed in order to help the system maintain equilibrium.

Baird (1988:696) conducted a study on a strike by nurses in an oncology unit whereby nurses on picket lines told patients to go back because there would be no one to give them chemotherapy. Her findings show similarities to the South african situation. She reports that one patient who came to start his first cycle of chemotherapy was nearly hit with a picket sign flung deliberately in his direction.

She observed that when nurses strike unintended incidents occur. Nurses have no intention of involving patients in their strike activities but when tensions mount and tempers flare it adds to patients' existing burdens and is incongruent with the caring ethos of the profession. Nurses consider implications of the strike on personal and professional levels but undertake it to make it a success through a united front. All nurses in the study did not see the strike as the right thing to do, but explained that at times it seems the only thing to do. The author comments on the negative image of the profession when nurses were hauled into police vans for untoward behaviour and when the media flashed angry faces and screaming picketers. Some lessons learnt from the strike were also highlighted in regard to the period before, during and after the strike and can be applied in the South African situation:

(i) Before the strike

Pre-planning is done to assure that patient care will not be compromised. Nurses from management seek re-orientation to specific aspects of direct care, for example chemotherapy administration in oncology units. Nurses who plan to go on strike have shown unwillingness to share this knowledge because it would facilitate continuity of care and therefore weaken their strike. Pre-planning by management should include medical staff and other departments, and should also ensure enough basic supplies in case deliveries are prevented.

(ii) During the strike

The striking nurses felt that things were out of control and went further than they had anticipated when they saw admissions curtailed, early discharges, and transfer of long-term oncology patients who were in a difficult time of their life to facilities where they were not known. The financial impact on striking nurses varied but one nurse reported that several years after one strike she had never recouped the savings that she used during the strike.

(iii) After the strike

Difficulty is experienced when coming to work together after a strike. Animosity may exist between strikers and non-strikers for years after the strike. Not all nurses may be returned to work immediately and it may not be according to seniority. This leads to further tensions. Strikes put all nursing activities on hold while pre-occupied with pre-strike planning. Careful pre-planning and planning of post-strike activities always seem insufficient. If the strike had lasted longer, hostility would have been heightened (Baird, 1988).

3.6 ANALYSIS OF NURSES' STRIKES IN CANADA - selected examples

Localised and province-wide nurses' strikes occurred in Canada particularly in the 1980s, the main reason being concern for staff shortages and unsatisfactory patient care conditions. Detailed planning for strikes decreased their negative impact. For example in a study by Stabler, Stuart, Powell, Stuart and Guenter (1984:205-210) it is noted that, as a result of a brief nurses' strike in the preceding 5-year period, a comprehensive contingency plan to deal with increased demands for patient care imposed by strikes in other hospitals in the region was drawn. The plan included appointment of a co-ordinating committee for response to the strike, chaired by the assistant executive director of the hospital. To cope with a rapid influx of severely ill patients, the plan included cancellation of elective surgery, permitting only emergency admissions, appointing a medical member of staff to review appropriateness of all admissions, to increase the medical and nursing staff in emergency and intensive units through re-assigning staff from non-emergency departments in the hospital or from other hospitals or through temporary recruitment of staff not currently employed. Additional beds were to be added in intensive care units. A communication centre was set up in the emergency department to communicate with other hospitals, ambulance services and admitting officers. The researcher maintains that this type of coordinated strike plans would

be relevant in South Africa since nurses' strike have also been noted to spread in several hospitals in the province.

Hibberd and Norris (1991:43-54) reports on a study of perceptions of nurses who worked in a hospital which was the only tertiary care centre to remain in full operation in the province of Alberta during an illegal 19-day strike by members of United Nurses of Alberta in 1988 which affected 98 hospitals. Focus of the study was on nurses' perceptions of a strike by colleagues in another union and on strikes by nurses in general. Findings revealed that the hospital received many transfers, an increase in trauma and life-threatening cases, a 35% rise in maternity cases, the workload rose significantly and the hospital was under severe strain. The influx of seriously ill patients was like a disaster situation and required regular rapid organisational responses. Nurses contended with extraordinary workloads throughout the strike period. Major priority was providing safe care in spite of the constant influx of critically ill patients, uncertainty and disruptions in normal work groups and unfamiliar technologies. Nurses worked long hours under constant pressure, fatigue and frustration. When the strike continued with no apparent end in sight, nurses at the non-strike-hit hospital considered a way to end their ordeal, for example, to launch their own strike. They wondered what they would do if their own union called a strike. They emphasised that patients needed their service in order to survive but also felt that they had a responsibility to pursue their economic interests.

In describing the strike as a dilemma, Hibberd and Norris (1991) state that there was a profound ambivalence or mixed feelings about strikes as a bargaining strategy. The nurses were torn between conflicting duties, beliefs, attitudes and fears and suggested that an alternative to the strike weapon should be found as a solution to their dilemma. It was mainly a 'crisis of conscience'. One or two nurses specifically said that they were disappointed because their decision to take up employment in that hospital was influenced by the fact that no strike had ever occurred before.

Arguments against strikes were patient care concerns in view of the severity of their illness and their dependency on nurses. Some nurses expressed a belief that patients who came to their unit would have died if they (the nurses) were not there. The researcher supports this theme of 'idealism' which made the nurses feel that they should not resort to activities which might punish and cause hardships to the people they serve. Further arguments against the strike included economic reasons because nurses did not get paid for days when they were not working. A nurse who had previously been involved in an earlier strike expressed opposition because in the previous strike she had been very uncomfortable and felt it was a humiliating experience. The more militant nurses went to the extent of saying that if they called their own strike the existing strike throughout the province would come to an end because the government would either capitulate to nurses' demands or get the nurses to go back to work.

Among those who argued in favour of strikes, one expressed a feeling that the right to strike should not be taken away from nurses because it is the final ammunition they have in bargaining. These nurses felt that they had an obligation to prevent erosion of their economic status, they were fighting a 'woman' and a 'nursing' thing. An important reason for joining the strike was a need to support the majority decision because of peer pressure and fear of possible retaliation, coupled with solidarity based on the fact that nurses rank competent and supportive colleagues as an important ingredient of a quality work environment. The nurses were also disillusioned and frustrated that they bargained with little power under the self-imposed 'no-strike' bans.

McSwain (1991:17) reported on the largest and longest strike in Canadian history since 1919. This was the Manitoba strike of 1991 which lasted 32 days, similar to the strikes under study which were of four to six weeks' duration. The author states that nurses' discontent with lack of professional recognition and their desire for more control over their own practice can lead to strikes. Nurses found themselves doing non-nursing duties and whatever had to be done because if they

refused, patients would suffer and see the nurses as cruel. According to this author, referring to nurses as professionals is seen as rhetoric because nurses have low status, little voice in decision-making and minimal power. Nurses have become increasingly subject to managerial control and face many problems. Management targets nursing labour as a means to contain costs and improve efficiency. Staffing based on patient classification systems which do not consider indirect care activities result in intensification of workloads which leads to decline in patient care. Management keeps telling nurses to prioritise and not try to do everything but nurses feel that there is nothing which is not a priority. This situation is very similar to the South African one where nurses have found themselves doing general assistants' work, porters' or messenger's work, clerical, pharmacy, medical or physiotherapists' work, 'for the sake of the patient'

In the Manitoba strike of 1991 wages, job security, working conditions including working hours and benefits were hot issues. Working conditions are an underlying concern because of their impact on patient care. The main accomplishment of the Manitoba strike was commitment to establishing a Nursing Advisory Council (NAC) which would increase the decision-making power and influence of clinical nurses.

Gains and losses of the Manitoba strike were further described by Cummings & Leverington (1992:19-25). Gains were listed as follows:

- new friendships as nurses bonded together with those normally not their usual co-workers. The sheltered environment strengthened cohesiveness.

- more time to nurture families and reflect on their lives, careers and the profession of nursing.

- Leadership qualities were cultivated in those who organised and operated the strike headquarters. They had to co-ordinate essential services and picket lines, interact daily with disgruntled hospital management, and be a link to the bargaining table.

- Striking nurses learned many things which they had not known. They had been relatively uninvolved union members for many years and remained ignorant of the strike process and workings of a union including lobbying, ratification and binding arbitration. The first-hand knowledge gained would remain with them for life.

- The public learned more about nurses and nursing. Nurses demonstrated to the public the value they placed on making responsible decisions about patients' lives. The public learned that nurses are the only health care professionals who care for the whole patient (holistic care) and were not merely physicians' handmaidens. That the strike occurred during a bitterly cold month proved the nurses' determination. The public responded by giving moral and material support.

- The nursing management also gained a new awareness of nurses' roles, for example most people who came in to care for the remaining patients were surprised by the myriad of duties expected of nurses. As a result management reassessed nurses' workloads, especially non-nursing duties.

- Exercises and abundant fresh air made the nurses healthier.

Losses experienced were described as follows:

- most devastating was the guilt they felt because of declining quality of patient care. Only minimal care was provided to critically ill patients only. They felt

guilty when outpatients arrived at emergency doors but could not be attended while the nurses were on picket lines. Another source of guilt was when long-term patients were denied the basic care and personal contact they usually got. The guilt led to personal doubts about the correctness of their action in following the direction of their union leaders to strike when they did and for as long as they did. They expressed doubt if it was for the right reasons. They started to question union information and the carefully prepared statements that aggravated matters to the point where even-tempered personalities became very militant.

- they felt they were stripped of their individual power and their future was dependent on the union leaders. They felt they had lost all control.

- as the strike went on support seemed to diminish and barriers of misunderstanding grew between former peers, friends or family. Strained personal finances were a practical outcome as strike pay was not enough to cover personal and family costs and commitments.

- there was unhappiness over unresolved issues. After the 32-day strike only a slight pay increase was obtained but it remained far behind counterparts in other provinces. Recruitment, retention and nursing shortage as well as unsafe working conditions remained unsolved.

Cummings' & Leverington's (1992) findings just described underline the importance of strike evaluation since any strike has implications for future strike activity.

Hibberd (1992:26-29) did an analysis of six province-wide hospital nurses' strikes that took place in Canada in the period between 1988 and 1991. Alberta and Saskatchewan had strikes in 1988, British Columbia and Quebec in 1989,

Manitoba and Saskatchewan in 1991. The bargaining process is centralised in five of these provinces and this is primarily responsible for the broad scope of institutions hit by strikes. When strikes are so broad-based, remaining hospitals and health agencies throughout the health system feel the impact of such disputes, whether or not their workers are on strike. Patients are transferred between hospitals and other agencies to obtain necessary services, physician referral and treatment are altered if not curtailed. This was the case when the 1994-1995 nurses' strikes became province-wide and nation-wide in South Africa.

Hibberd (1992) notes that despite legal requirements to designate essential services, the province-wide strikes in Canada significantly disrupted hospital services. Before the strikes nurses refused to work overtime and take on non-nursing duties. In Quebec alone, 2 100 hospital beds had to be closed. This revealed the extent to which effective operation of the provinces' health system relies on the goodwill of the nurses. Even when nurses work to rule the efficiency of the hospital can be seriously undermined.

A characteristic of nurses' labour disputes is the complexity of economic and non-economic demands. In these province-wide strikes economic issues were central. Nurses wanted their salaries to reflect the value of their service to the health system and to be compensated at least equally to employees carrying similar responsibilities. Similar to the South African situation, salaries are almost the most contentious issue in nurses' strikes in Canada. Nurses were demanding 85% of the salaries of physicians, dieticians and social workers. Management justified the discrepancy in salaries between nurses and these groups on the reason that nurses were generally not prepared at university level whilst these other health professionals were. It has always been an uphill struggle internationally to convince administrators, who are usually male, that nurses, who are usually female, should be adequately compensated for their jobs. This attitude has contributed to nurses' propensity to take strike action. Many of the reasons for

strikes were as outlined in the Manitoba strike reported in preceding paragraphs and have parallels with the South African experience.

Nurses were disappointed that cumbersome structures of province-wide negotiations could not, and did not address small group or individual concerns, hence in Manitoba, three of the nurses' local bargaining units continued to strike beyond the 32 days because they felt that their local issues were not adequately addressed. Similarly, concern over failure of centralised bargaining to address individual or institutional issues, for example in the Central Bargaining Chamber, is not unheard of in South Africa.

According to Hibberd (1992) recommendation of union negotiations to take strike action is probably the most important decision in union affairs. Failure to deliver a ratifiable agreement is most likely to be followed by a change in union leadership. Union members have a responsibility to question if their leaders have released comprehensive and accurate information for them to make informed decisions.

Nurses have said that they prefer not to withdraw their service because of the dilemma of having to choose between loyalty to patients and loyalty to peers. However the experience of walking a picket line increases feelings of solidarity and has a radicalizing effect, especially if the strike is seen as successful.

Media coverage is important for each party to communicate to its own and to the opposing constituent, as well as to solicit and gauge public support, for example, Hibberd (1992) noted that employers, in an attempt to undermine union solidarity, make sure that the press hears about nurses crossing picket lines. Union leaders in each of the strikes claimed to have received public support, including donations of food and money as well as support from other labour organisations. Systematic surveys of public opinion on whether nurses should strike revealed an even balance of responses for and against.

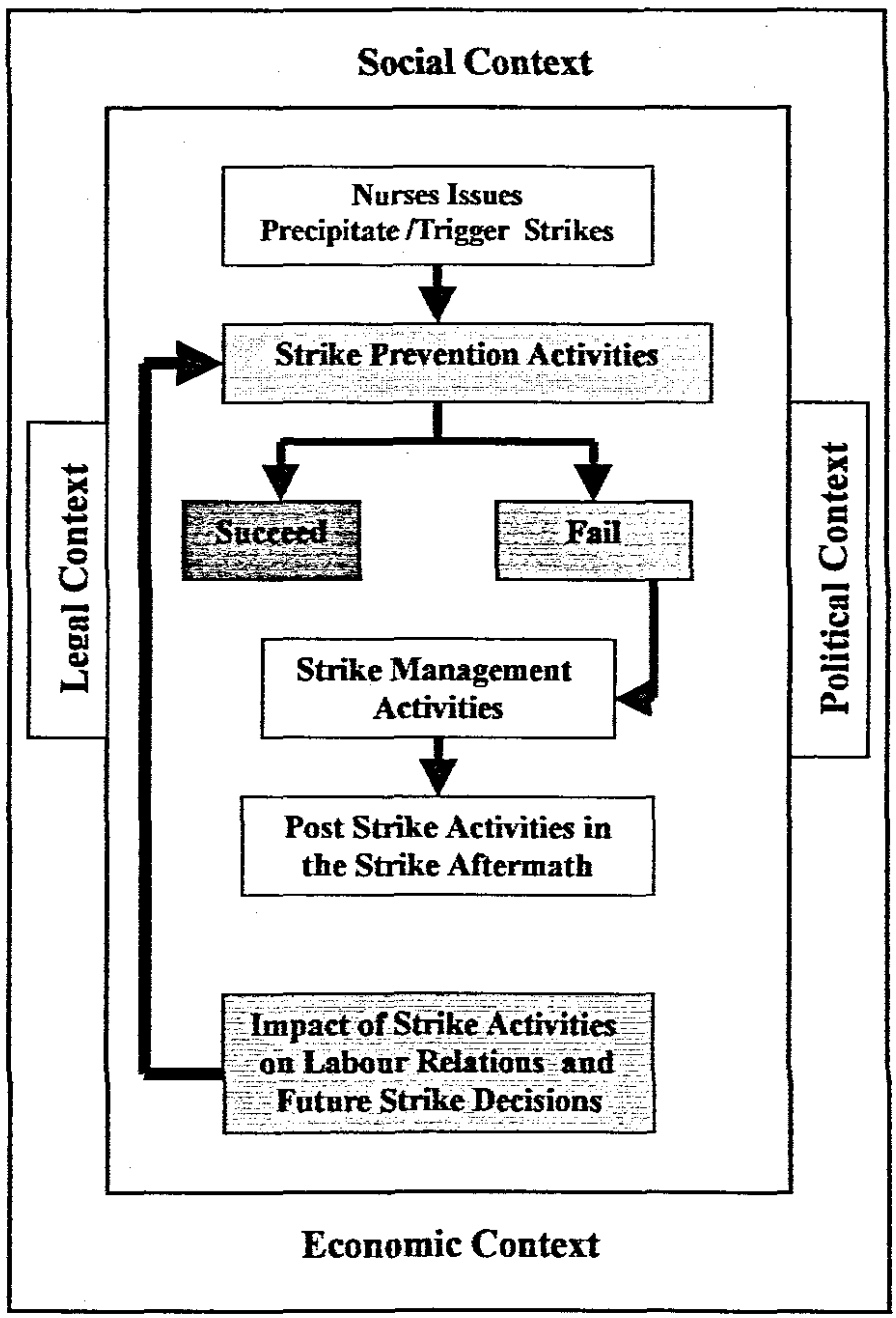
Hibberd (1992) identified a controversial question raised by unionised nurses on why their professional associations do not give them more support during strikes activities. In his view, professional associations are unequivocal in supporting collective bargaining but are usually silent on the question of withdrawal of service. The Order of Quebec Nurses made public statements in support of striking nurses. In this context DENOSA, whilst not opposing the nurses' right to strike, has committed itself to protection of patients during strikes.

Similar to South Africa, Hibberd (1992) notes that announcements that someone has died as a result of a hospital strike are common but difficult to substantiate. There is an increasing interest in measuring the impact of strikes by hospital workers on health outcomes. According to these authors the argument that strikes by nurses place health and safety of the people they are committed to serve in jeopardy is not supported by objective evidence. However a former president of the Canadian Nurses Association advised that nurses need to think of other alternatives to strikes and strikes should be a last resort. It is only effective for a limited time. Alternatives referred to include mediation, arbitration, final offer selection, locked-in bargaining where parties establish a mutually imposed deadline for reaching a settlement with or without recourse to arbitration.

3.7 CONCEPTUAL FRAMEWORK

From the literature reviewed the researcher produced a conceptual framework illustrated in Figure 3.1, through which strike behaviour and action can be explained.

FIGURE 3.1.
CONCEPTUAL FRAMEWORK FOR THE DESCRIPTION AND ANALYSIS OF NURSES STRIKE ACTIVITY



The conceptual framework presented in Figure 3.1 illustrates the context within which nurses function and within which nurses' strike activities occur. The context has four major domains, namely social, political, legal and economic domains. Each will be described briefly.

* SOCIAL DOMAIN

- the social domain includes the cultural and ethical contexts;

* POLITICAL DOMAIN

- the political domain describes the political environment within which nurses practise their functions. This environment shapes the practice of nursing and health care delivery e.g. the violence and political uprisings surrounding the 1994 government elections period characterised the health care system.

* LEGAL DOMAIN

- the legal domain includes labour legislation and policies that govern the labour relationship in the country, as well as the political environment within which nurses operate;

* ECONOMIC DOMAIN

- the economic domain and its implications for resources that facilitate or inhibit provision of quality health care, bearing in mind that distribution of resources is closely linked to the political system. These factors are external predisposing factors for nurses' strikes.

They influence internal factors, for example personnel policies which in turn determine labour relations in health care services, particularly in public health services where the state is the employer directly responsible for formulation of personnel and patient care policies.

These personal policies can predispose nurses to strike activity if formulated or implemented in a manner which leads to dissatisfaction.

Precipitating factors for nurses' strikes exist in health care organisations where nurses' issues and management factors are in constant interaction and form a foundation for labour relations. A single issue may easily serve as a trigger for strikes where there are long-standing grievances in the institution, for example in one of the hospitals under study salary dissatisfaction was a long-term grievance but a strike was triggered by the fact that nurses had been promised an increase, which never came. Instead of a pay increase there was a small deduction in their salaries.

In contexts where the right to strike exists, as is provided for in the South African Labour Relations Act (66 of 1995) as amended, strike prevention activities are spelt out, but they may succeed or fail. When strikes cannot be prevented, strikes occur and require expert strike handling and management procedures aimed at minimising disruption to the service. This is of particular importance in nurses' strikes because they have a direct impact on people's lives and well-being as well as on labour relations. Post-strike activities to restore order and facilitate quality health care delivery in the aftermath of nurses' strikes are very important since they have implications for future strike decisions and/or strike management.

3.6 CONCLUSION

Literature indicates that nurses' strikes are an international problem. Differences exist only in magnitude or patterns of their occurrence in relation to frequency, duration, numbers and categories of nurses involved, as well as their impact on nurses and health care. It has been demonstrated that where comprehensive contingency plans are put in place well in advance, the negative impact of strikes is minimised. Strikes by nurses remain a controversial issue. There is usually a

balance between arguments for and against them. Patient care needs and ethical responsibilities are at the centre of the controversy. It therefore needs critical thinking to make strike decisions and expert leadership to organise and manage nurses' strikes. Including findings of studies on strikes in other countries in this discussion gives a broader perspective of lessons which can be learnt and considered in making strike-related decisions.

From the literature reviewed, a conceptual framework has been developed. To further increase the basis for understanding of strikes and related issues two theories selected for their relevance in this study are discussed in the next chapter.

CHAPTER 4

THEORETICAL FRAMEWORK FOR THE STUDY

4.1 INTRODUCTION

Two theories that have been identified as having complementary value for use as a basis for this study are Silverman's Social Action Theory (1981), and the Systems-Development-Stress Model by Chrisman and Riehl-Sisca (1989). Social action is a result of interaction of actors in an organisation or a society. In this study it is nurses, nurse managers, health policy-makers and nurses' representatives who are seen to be in constant interaction in the labour relations system in health care organisations. The type of interaction has a potential of producing stress to which nurses as individuals or as a collective should continually adapt. This in turn has a potential for strike action which has an impact on nurses and other categories of health care providers, the nursing profession and on the quality of health care.

4.2 SOCIAL ACTION THEORY

This classical theory was described by Silverman (1981) in an attempt to form an ideal-typical action theory based on the works of earlier theorists, including Parsons (1951), Weber (1964), Schultz (1964), Berger (1966), Cohen (1968), and others. The theory still has relevance in discussion of current issues in the labour relationship.

In this theory action is defined as all human behaviour to which an individual attaches a subjective meaning. The action becomes social when the actor's subjective meaning takes into account and is oriented towards the behaviour of others. 'Others' may be individuals or groups known or unknown to the actor.

In this way social action theory differs from the psychological approach which explains human action as a result of intrapersonal needs of individuals (Scholtz, 1991:24-25). In the present study participants describe the subjective meanings they attach to labour relations practices in their institutions and to the impact of nurses' strikes on them as persons or as members of the nursing profession, as well as on 'others', that is other members of the health team, consumers of health care, employers and management. Each participant describes his or her perceptions according to the specific interpretation and subjective meanings that he or she attaches to the experiences or events.

According to Scholtz (1991:25), the assumption of the social action approach is that there is a hypothetical actor who has a purpose of wishing to bring about some future state of affairs and therefore manipulates certain means or conditions to attain that purpose. Strike action is undertaken because employees wish to meet some needs through making demands to the employer or management. If they feels that those needs are not satisfied they may resort to manipulation of the authority through strike action. Actors in the organisation may differ in their involvement in the action and the way in which they respond to the behaviour of others, hence the decision of some nurses to strike while others decide not to strike.

Silverman (1981:126) presents dialectical views of action as a frame of reference. Some view action or behaviour as a reflection of the organisational structure and its problems while others argue that an organisation is the outcome of people who are motivated to attempt to solve their own problems. To support the former view nurses' strikes are a form of protest undertaken to address unresolved problems in the organisation. The second argument also has some validity in that strategies adopted to solve problems in the organisation create precedences and patterns that shape present and future behaviours or actions.

Social action derives from meanings which people assign to situations and actions of others, then they react in terms of their own interpretations of those situations and actions. This is why people may react differently to the same stimulus, for example nurses in any institution are exposed to the same conditions of service but their interpretations may differ. As a result they may react differently and take completely different courses of action, hence decisions to strike or not to strike. Furthermore a person may perceive social action in a way which distorts meaning to those involved as actors due to the fact that a person is unable to experience the experience of another. It is therefore not possible to predict how people will react to specific given situations. This underlines the importance of investigating subjective meanings that the actors themselves attach to their actions. Each action will have a certain meaning to the person who carries it out and to those at whom it is directed, hence the rationale for inclusion of nurses as the strike actors and their employers or managers to whom strike action is directed as well as consumers of health care as people on the receiving end of the service rendered.

Silverman (1981:130) further expresses the view that action is a product of a system of expectations arising out of past experiences and a definition of perceptions of the probable reactions to one's act. The actor becomes aware of alternative courses of action and chooses the one perceived as likely to produce the most satisfactory outcome. For this study one can hypothesise that nurses resort to strike action when it is perceived to be the only action which will lead to obtaining the desired concessions.

The discussion of social action has so far centred around meanings. Using Durkheim's propositions, in Silverman, (1981:130), one can explain that meanings are given to people by past and present society, therefore people are constrained by social facts which determine their actions and consciousness. Society and, for purposes of this research, organisations, motivate their members to conform to social or organisational roles and expectations through the process of socialisation.

In this way too much deviance from expected behaviour is prevented. This study will reveal if strike action by nurses is regarded as too much deviance which must be prevented. Society and organisations constrain the actors, however when they act, they do what commonsense suggests they do.

According to Social Action Theory, society is described as both a *prison* and a *puppet theatre*: a prison because it is external to the person and constrains him through impersonal social factors; a puppet theatre because, through the process of socialisation it gives people social roles and determines how they will respond in future. Society is a stage where people are manipulated while they think that they are doing what any reasonable person would expect them to do. The social world is experienced as an unquestioned reality in which people will go on acting as they have always done because it is right. In Parson's action frame of reference, workers perform according to need-disposition and role expectations, just like actors on stage perform according to scripts already written (Silverman, 1981:132, 140). These arguments can be applied to employers / managers and nurses alike. Employers / management may stick to their autocratic, instructive approaches because they have always managed organisations that way and succeeded to get personnel to conform. Nurses, on the other hand, use established communication and negotiation structures to avoid industrial action because it has always been right to avoid the latter at all costs. The occurrence of strikes can be interpreted to mean that what has been considered right over time needs to be reviewed because it may no longer be valid.

In his theory, Silverman (1981:136-137) points out that, though social norms are internalised, a person can act in a certain way and feel guilty about offending his conscience only retrospectively. People generally seek approval but are more concerned with approval of certain individuals than that of others. This holds true of nurses and strike action. There is a degree of guilt that nurses feel after involvement in strikes if they become aware of any negative impact. In deciding

whether to strike or not nurses are more concerned about approval of their colleagues than that of their employers or management.

Action in organisations is linked with aspects of the organisational structure, for example nature of authority, level of rewards, promotion opportunities. When expectations are high, as happened particularly among Black nurses in South Africa around the 1994 government elections, satisfaction becomes low. Low levels of satisfaction have a high potentiality for strike action as a way of applying pressure for need satisfaction. Orientations or social meanings differ because actors bring different expectations to the organisation. These differences derive from the various historical experiences inside and outside the organisation, for example status held (a breadwinner will be more concerned with salary dispensations than non-breadwinners), history of unemployment (a person with such history will be more tolerant towards policies and practices regarded as unjust), paternalistic management (will respond unquestioningly to orders). These will have an impact on the actors' involvement in the organisation and the way in which they respond to the behaviour of others.

To further explain action in organisations, Silverman (1981:175-178) mentions *attachment* to the role system of the organisation. When one joins an organisation voluntarily, for example through employment, he becomes involved in its roles which contain certain expectations about his behaviour and characteristics. It is assumed that this person has chosen to meet the dominant set of expectations within the organisation, otherwise he would not join. Attachment and compliance with the dominant system of expectations may be for different purposes, for example for one it may be a sincere expression of the person's view of himself while for another it may create role distance, that is, a gulf between his performance and his true self-conception. Weber (1964) in Silverman (1981:137) shares this view when he states that, even though social relations are based on shared values, the meanings involved may not be shared. Weber makes an

example that is relevant for this research, about a shop steward and manager who come together not because of shared values but because their different ends may be served by the same means. In negotiation the two parties work together, but the shop steward hopes to gain better concessions for the employee while management is in it to protect the employer by not acceding to demands that are perceived as unreasonable.

Attachment can further be explained by making reference to Barnard's Acceptance theory of authority. According to this approach acceptance of authority is dependent on it being in the *acceptance zone*, also called the *indifference zone*, anything outside this zone is unacceptable. This presupposes that a person gives consent or exercises free will in deciding whether or not to comply with dominant authority. When orders of the authority fall outside the acceptance zone the person may wish to leave the organisation or may resort to strike action in an attempt to force the authority to operate within his acceptance zone (Tosi, 1984:60-61).

Differential attachment arises from factors both within and external to the organisation, for example people's background, the extent to which they compete for scarce resources and the extent to which they see the probability that their interest will be furthered by attainment of organisational goals. In undertaking a study of nurses' strikes, one operates from the premise that the striking nurses had concluded that there was an intolerable discrepancy between furthering of their interests and attainment of organisational goals.

Social action theory makes reference to ideal-type actors who pursue certain ends by choosing appropriate means based on subjective meanings attached to the situation. To understand an act, one must find typical motives of typical actors to be able to explain the act as a typical one arising out of a typical situation. Nurses are typical actors whose typical motives are achievement of personal and organisational goals, of which quality patient care is the primary organisational

goal. Strike action is a typical action arising from a situation where need or goal achievement has been grossly thwarted.

Action may take one of two forms, namely *strategy* and *tactics*. Strategy on one hand is an act taken regularly because it is likely to produce a favourable response from other actors. A tactic, on the other hand is a particular course of action pursued in a specific situation, designed to attain a single end. For purposes of this research nurses' strikes can be described as 'a tactic' pursued to address a specific issue of dissatisfaction. Strategies and tactics once perceived as successful may become rituals which are used even when they no longer deliver the goods or when they have become harmful to the desired ends. Likewise, if management continues to use the strategy of ignoring nurses' complaints because it was done in the past and nurses were submissive enough to accept it, it may become harmful to the organisation when nurses decide that it is no longer tolerable. They may then devise tactics which may be harmful to management but at the same time affect patients for whom the service is intended.

Some strategies are defensive in nature when they are used to resist perceived threats, for example policies that prohibit nurses' strikes may be described as defensive. Other strategies are aggressive in nature in that they involve initiation of certain courses of action designed to change the situation and relative position of some actors. Nurses' representative organisations are usually involved in aggressive strategies that continuously challenge policies of the employer or management to strengthen the power position of their members and satisfy their desire to have more control in the labour relations system.

The value of social action theory for labour relations management is indicated in the following explanations:

- The actor's interpretation of a given situation is influenced by previous

experiences, present motives, purposes and expectations. In the context of the present study it is the employees' unfulfilled expectations by the employer and management which lead to job dissatisfaction with a potential for strike action.

- Acceptance of a dialectical relationship between the individual and society and between the deterministic and voluntaristic nature of social action. Actors in labour relations have certain obligations and a degree of freedom in their interpretation of their roles, therefore they must accept responsibility both as individuals and as a collective. It is in this context that the reciprocal relationship of mutual responsibilities and obligations as well as protection of one another's rights between employer / management and nurses is emphasised.

- Social action explains reasons for differences in various groups and individuals' response to the same reality. It depends on the subjective meaning attributed to a particular situation, past experiences and the expected behaviour and motives of others. This serves to explain the different reactions of staff to the same conditions of service and to other factors in the work environment. Some staff members opt for strike action while others opt for discussions and negotiations to continue while they are fully engaged in their duties. This analogy has relevance for the assumption on which this study is based, that is whether variability of perception is determined by positions, levels of responsibility or differs if strikes are experienced as health care providers or consumers.

- The importance of the influence of previous experience in social action underlines the need for a long-term approach to labour relations management. This is important for maintaining consistency and stability in the organisation (Scholtz, 1991:25).

4.3 THE SYSTEMS-DEVELOPMENTAL-STRESS MODEL

This model was developed by Chrisman and Riehl-Sisca, in the 1980s out of their concern to improve comprehensiveness and flexibility of nursing models in addition to their suitability to nursing practice. The model was specifically designed for application to psychiatric nursing but the authors maintain that it is flexible enough and has universal applicability in all nursing situations (Riehl-Sisca, 1989:279). In this research the model is modified for application to nursing management with specific reference to human resources management.

4.3.1 The Systems-Developmental Aspect of the Model

The model emphasises both structure and process. Structure refers to the systems development and it provides the broad philosophical base of assumptions, values and ethical principles of nursing. Process refers to stress and the act of analysing human problems within the structure. Using this model in this research is based on the premise that assumptions, values and ethical principles of nursing have implications for nurses' decisions to strike or not to strike. The underlying assumption that patients suffer if nurses strike, coupled with the belief and value that it is unethical for nurses to strike and neglect their ethical obligation to provide continuous nursing care may be a deterrent to strike action by nurses.

An important element emphasised under structure in this model is *change*. From birth through death people exist in a framework of change, passing through different developmental stages. As such at any point in a person's life he/she is seen as a unit of interlocking biological, interpersonal and intrapersonal systems. These systems are also open to the environment and therefore subject to change and development (open systems). This principle can be applied to the life of an organisation. Organisations are dynamic and exist in a framework of change. The change occurs as a result of interlocking factors in the internal and external

environments. It is the way that people accept and adapt to change that determines the health or integrity of an organisation which in turn facilitates its development.

According to Riehl-Sisca (1989:280), assumptions on which the model is based are summarised as follows:

- "Human beings are viewed as a set of dynamic systems interacting within an environment and along a developmental continuum.
- Development includes biological, interpersonal and intrapersonal change. These perspectives interrelate with one another and influence health.
- An individual moves along the continuum by a gradual mediation from one developmental stage to another. Information and effects are stored, incorporated into the present, and projected into the future...
- Change is inherent to life. The systems attempt to maintain stability within change.
- People's situations can be described as the interface between the human system and time-environment."

In the context of this research these assumptions can be related to the dynamic state of organisations which results from the inherent changes and its developmental needs. As personnel and their managers interact within the context of a changing environment, they are continually trying to maintain stability and a healthy working environment.

In patient care, the rationale for use of the systems model is that it provides an organised way of analysing the interdependent aspects of the condition of a patient.

In the context of this study this is comparable to the interdependent aspects of human resource or personnel functioning.

Nurses' strikes are a form of interaction between nurses and their representatives reacting to the actions of management or employers. That is part of the interpersonal system, influenced by the self-image, self-esteem needs and emotional patterns which are part of the intrapersonal system.

4.3.2 The Stress Process

In this model the stress process is discussed as it relates to the clinical situation, where it is described as a comprehensive way of identifying patient problems. It is also described as universal in its relevance and applicability to clinical nursing. In human resources management, the stress process is described as a way of identifying personnel problems. The stress process and its components are illustrated in figures 4.1 and 4.2 respectively.

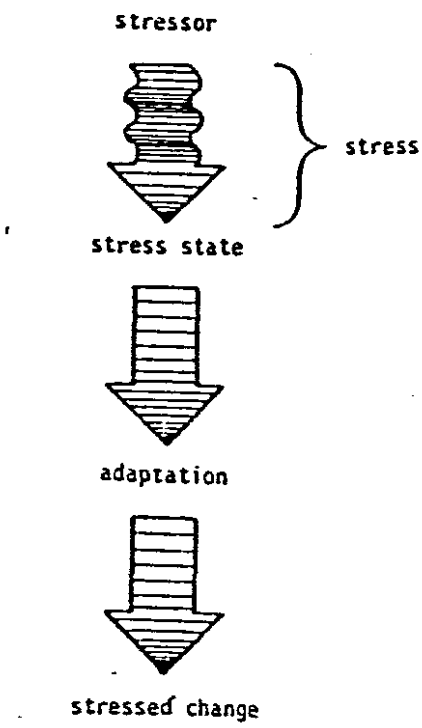


Figure 4.1: The stress process

(Source: Riehl-Sisca, 1989:282)

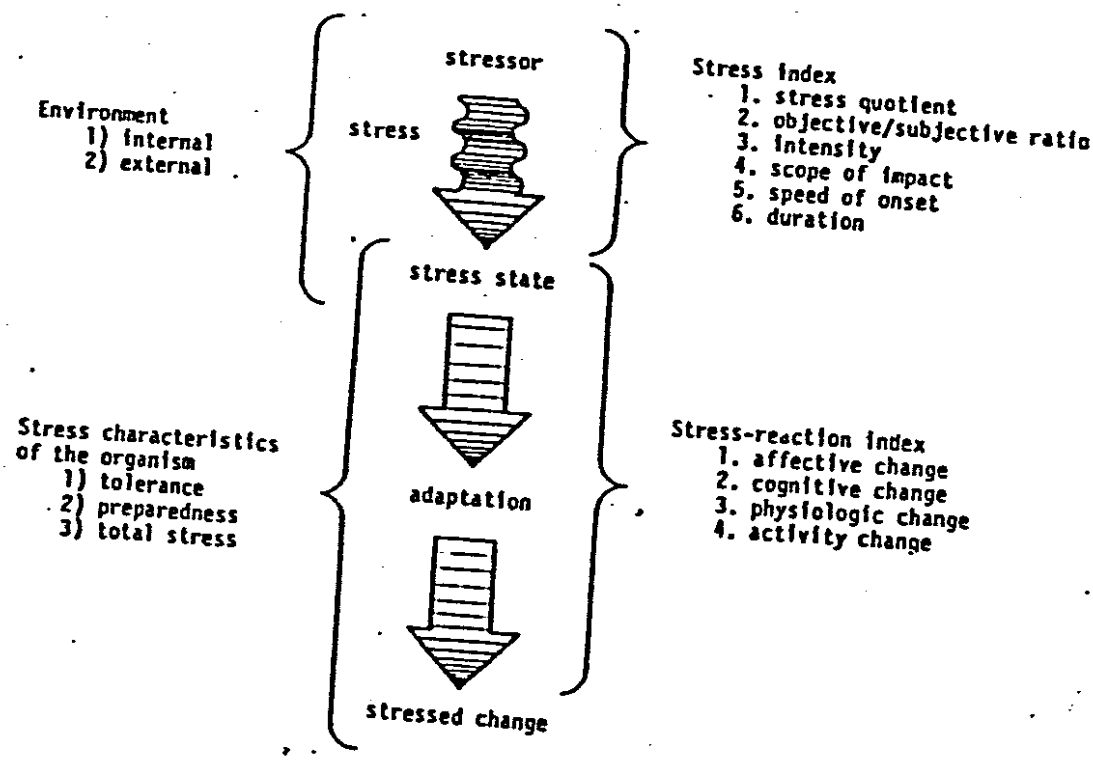


Figure 4.2: Components of the stress process

(Source: Riehl-Sisca, 1989:283)

To understand the stress process, the following concepts are explained:

Stressor

The agent that precipitates or provokes the stress state. Though not a cause of the stress, a stressor acts as a catalyst for it, for example low salary.

Stress

The force that produces the stress state, for example, low salary is not a cause of the stress state but it is a stressor which works on the mind of the employee to produce the stress of dissatisfaction. Stress is the source of adaptation. Management or employer may adapt by planning to reduce, eliminate or resolve the stress through manipulation of the stressor, for instance through increasing the salary.

Stress state

It refers to the impact of the stress and describes the disturbance or turmoil that occurs within the person as a result of the stress. It includes the psychological stress state which manifests itself in different kinds of emotionally-charged behaviours such as anger, depression, anxiety as is seen in cases where nurses express gross dissatisfaction and threaten to go on strike or get involved in actual strikes.

Adaptation

Adaptation is the key element in the stress process. It is a mechanism which guides and directs the change that results from the stress state. Adaptation to the stress state may be positive or negative. In positive adaptation mechanisms are put in place to assist or enable the person to cope with the stress in a way which culminates in a sense of well-being and satisfaction. Negative adaptation means that the individual is unable to cope with the stress state. It results in failure to interact with the environment and resorting to changed behaviours, such as strikes which occur as a result of failure to adapt to the stress of gross dissatisfaction in the work environment or result of failure of employer or management to put into place mechanisms that bring a sense of satisfaction. In this context parallels can

be drawn between this model and Roy's adaptation model described in George (1995:254-256). In Roy's model reference is made to the person as an adaptive system constantly using coping skills to adapt to stimuli in his/her internal and external environments in order to maintain stability. Roy also makes reference to effective or ineffective responses which correlates with the positive and negative adaptation described in Riehl-Sisca's model.

Stressed change

This refers to change in the person brought about by the introduction of stress and by adaptation to it. The subjective and objective impact of stressed change itself is a stressor because it is a deviation from normal expected behaviour. The change may be desirable or undesirable, and may be an advantage or disadvantage. It may increase or decrease the functioning of the person, depending on his or her integrity, the nature and severity of the stress and the mode of adaptation to it. Nurses' strikes represent stressed change in nurses as a collective, occurring as a result of negative adaptation to the stress of dissatisfaction with issues or unfavourable factors in the work environment. Nurses' strikes are a deviation from normal expected behaviour of nurses in the health care delivery system and they can be looked at as a stressor which provokes further stress to which an individual or the group as a collective must adapt.

4.4 LINKING THE THEORETICAL AND CONCEPTUAL FRAMEWORK OF THE STUDY

The conceptual framework presents nurses' issues that precipitate or trigger nurses' strikes. According to Social Action theory, the nurses' strikes are regarded as a form of social action through which nurses respond or react to the behaviours of others, namely their employers and management. These responses and reactions are influenced by the social, legal, political and economic contexts. Actions and

behaviours of striking nurses have an impact on others. These 'others', for example consumers of health care, attach their own interpretations and meanings to nurses' strike actions, hence the importance of including them in this study. In Silverman's Social Action theory, emphasis is laid on interpretation and meanings attached to actions and events by the actors and those who are affected by them, hence the rationale for basing this study on perceptions of the participants.

The Systems-Developmental-Stress Model is used to explain an organisation as a system which exists within a framework of change. As explained in Social Action theory, personnel in organisations are continually interacting with one another. In the working environment they are confronted by various stressors and this requires continuous adaptation to the stress states. Positive adaptation results in desired stress change which facilitates growth and development, integrity and stability in the organisation and job satisfaction. These are the key to strike prevention. Negative adaptation results in undesirable stressed change in which personnel may resort to strike action if they feel grossly dissatisfied in their work environment. As indicated in the conceptual framework, the impact of any strike has implications for the labour relationship and strike decisions or strike management in the future.

4.5 CONCLUSION

This chapter has dealt with the theories used as a framework for the study because of their applicability for the industrial relations system *per se* and strikes in particular. The two previous chapters dealt extensively with theoretical aspects underpinning the study. The next chapter discusses the research methodology used for data collection to illuminate the pertinent aspects of the study.

CHAPTER 5

THE RESEARCH METHODOLOGY

5.1 INTRODUCTION

In this chapter a description of the research methods and procedures used in this study is given. The description includes the research design used and the rationale for its use. The target population, sample and sampling method as well as the research instrument and its administration are also described.

5.2 THE RESEARCH DESIGN

An exploratory, descriptive case study was done. This research design is appropriate when the researcher wants to gain new insights and increase knowledge about a phenomenon or topic which has not been rigorously researched (Burns & Grove, 1987:11). In this study, the literature review presented in chapter three shows that more studies on nurses' strikes have been done in other countries than in South Africa, hence the rationale for use of this research design.

Polit & Hungler (1995:12) demonstrate the value of combining the exploratory and descriptive approach in order to extend the comprehensiveness of the investigation into a phenomenon by answering a wider array of questions, including:

- Exploration - looking into the nature of the phenomenon, what is going on, what factors are related to it.

- Description - investigating how prevalent is the phenomenon, its characteristics, the process by which it is experienced.

This study attempts to answer all these questions in order to contribute to the comprehensiveness and depth of knowledge on nurses' strikes.

The case study method was selected because the researcher was interested in obtaining a wealth of information on the problem of nurses' strikes. Burns & Grove (1987:250) agree that a case study is a good source of information. It can generate new hypothesis for testing in future. It involves in-depth investigation of a single subject, a limited number of cases, a group or an institution. Likewise, in this study, the number of participants was limited and two institutions were studied in depth.

Intensive probing in case studies provides an opportunity to gain intimate knowledge of the subjects' thoughts, feelings, intentions, actions, experiences and the situational context or environmental factors relevant to the problem under study. In this study investigation of these variables was based on perceptions described by the participants. Probing led to insights into elements which were not initially built into the study. Because of the exploratory nature of the study, those elements were incorporated into the study (Burns & Grove, 1987:250) (Polit & Hungler, 1995:200-201) (Uys &Basson, 1995:49-50).

Gummerson (1991:86-97), supported by Yin (1989:19) maintains that a case study is not just a retrospective study. It adds two important sources of evidence, namely direct observation and systematic interviewing. Case studies are a reflection of the view that history is always present in current events. Furthermore, history is created from the current reality. This view has relevance for this study wherein participants reflected on their past experiences of nurses' strikes. They were also able to map out a way forward based on past and present events within the social, political, legal and economic contexts. These contexts are highlighted in the conceptual framework of this study in chapter 3.

Yin (1989:22) states that a case study tries to illuminate why a decision or sets of decisions were taken, how they were implemented, with what results. In this study the researcher investigates why the decisions to strike were taken, activities and feelings before, during and after the strikes, the result or impact of the nurses' strikes.

Gummerson (1991:76-77) highlights the ability of case studies to provide an holistic view of a phenomenon through study of the different aspects in relation to one another. In this study it was possible to provide an holistic view because the impact of nurses' strikes was not studied in isolation. Numerous variables that have direct or indirect implications for providers and consumers of health care in relation to strikes were included, for example job satisfaction, communication, rewards and incentives.

5.3 DATA COLLECTION

5.3.1 Area of study

The study took place in the province of KwaZulu-Natal which is one of the nine provinces delineated in South Africa after the 1994 government elections. In the middle of 1995 the total population of this province was estimated at 8 713 100 and this formed 21,2% of the whole South African population of 41 244 500 (Regional Surveys of the World 1998:963). Population density in the province was 92,3 per sq km and 38,2% of the population was classified as urban (*Health review*, 1995), in Van der Merwe (1996:157).

The study was limited to two large, urban, academic hospitals in KwaZulu-Natal Province, to be referred to as Hospital A and Hospital B respectively in this report. These hospitals were purposively chosen because they were both involved in major strikes during 1994. They are in the two major cities in KwaZulu-Natal.

They previously belonged to two different health authorities, that is Natal Provincial Administration and KwaZulu Homeland Government respectively. Currently there has been amalgamation of all health services in the province under one employing authority, namely KwaZulu-Natal Provincial Health Department. This occurred when the fourteen previous health departments in South Africa were amalgamated into one national health department. KwaZulu-Natal health department is currently divided into eight (8) health regions. Hospital A is in Health Region F and Hospital B is in Health Region B (See Annexure 1, page 284) for a map of KwaZulu Natal Health Regions.

Hospital A is a 1 913-bed hospital presently regulated to limit the number of in-patients to 1 600 due to down-sizing or planned reduction in number of beds. It is situated approximately seven (7) kilometres from the centre of the city. For supervisory and management purposes, the nursing department is divided into three (3) areas as they are called in this institution, namely:

- Area 1 : Obstetrics, gynaecology, paediatrics and their out-patients departments.

- Area 2 : Medical, surgical and orthopaedic wards and their out-patients departments, casualty, intensive care units, respiratory unit, renal unit.

- Area 3 Operating theatres, comprising four (4) theatres.

Each area is supervised by a Nursing Service Manager or Chief Professional Nurse referred to as Area Manager. An 'area' comprises a number of departments, sub-areas or zones, each of which is supervised by a Nurse Supervisor (previously known as a zonal matron). The category of nurse at this level is a Chief Professional Nurse or, in a few instances, a Senior Professional Nurse acting in that position.

Hospital B is a 1 400 hospital now down-sized to ± 1 020 beds, situated approximately 10 kilometres from the centre of the city. For supervisory and managerial purposes the nursing department is divided into sections, each with a number of nursing units or departments, supervised by Chief Professional Nurses referred to as Sectional matrons in this hospital. For purposes of data analysis in this research, they will be grouped together with Area Managers from Hospital A.

Statistics obtained from the nursing management offices in November 1997 in the two hospitals showed that the total nursing manpower for Hospitals A and B are as presented in table 5.1.

TABLE 5.1 NUMBER OF NURSING PERSONNEL IN HOSPITALS A AND B

	HOSPITAL A	HOSPITAL B
Chief Nursing Service Manager (now Deputy Director)	1	1
Senior and Nursing Service Managers (now Assistant Directors)	5	2
Chief Professional nurses	21	41
Senior Professional nurses	86	130
Professional nurses	807	481
Senior Enrolled nurses	45	88
Enrolled nurses	1 003	462
Nursing Auxiliaries	350	333
Student / Pupil nurses	480	263
TOTAL	2 798	1 711

5.3.2 Population

The target population for this study includes participants who experienced nurses' strikes from different perspectives because of their positions and job responsibilities as providers of health care. It also includes those who experienced nurses' strikes directly or indirectly as consumers of health care. The various categories of participants were defined in chapter 1 under definitions (refer pages 11-12 of this report).

5.3.3 Sample and sampling method

The sample comprised the Director of Nursing Services, chairpersons of organised labour, the Deputy Directors of Nursing Services in charge of the hospitals under study (then entitled Chief Nursing Services Managers).

For the other nurse participants, purposive sampling was done, followed by random sampling. In the purposive sampling method participants are consciously selected based on certain criteria or characteristics that they possess in relation to the phenomenon under study or if they are judged to have a wealth of knowledge on the phenomenon, the so-called 'key informants'. Polit and Hungler (1996:235) agree that a researcher's knowledge can be used to hand-pick those to be included in the study. Van der Merwe (1996:53) warns that this type of sample selection requires careful monitoring by an experienced researcher to strengthen its logical and scientific basis. For purposes of this research, sample and sampling method was discussed, agreed upon and supervised by a research expert.

Random sampling means that all subjects have an equal chance of being selected. Randomisation of purposive samples serves to increase credibility of results by reducing suspicion of why certain cases were selected over others. Randomisation here is only for credibility and not for statistical generalisation. In addition the

researcher used disproportionate stratified sampling. Homogeneous strata of the various categories were identified. 'Disproportionate' indicates strata of unequal size in keeping with differences in numbers in the categories of participants in the population.

Purposive sampling was based on defined criteria for inclusion. These criteria were that:

- all nurses and area managers participating in this study had at least three years' experience as a nurse in any hospital, or had at least one year's experience in the position held and were not officially on any kind of leave at the time of the strike under study.

- should have remained in full-time employment in the hospital for at least one year after the strike under study. However preference was given to those who were still employed in the same hospital at the time of data collection because they would be more in touch with the current situation.

For ex-patients the criteria was that:

- the person was an adult over 18 years old at the time of the nurses' strike, had been hospitalised for at least 24 hours before the strike commenced, was mentally alert and not under sedation during the strike

In this study the principle that small samples are justifiable in case study research was followed. The number of subjects was limited, but the number of variables investigated was large to enhance the depth of the study (Morse (1989) (Patton 1990) Polit & Hungler (1995).

The sample size in this study was sixty-two (n=62). It comprised the following categories as presented in table 5.2:

TABLE 5.2: DESCRIPTION OF THE SAMPLE

Nursing Directorate - Head Office	1
Organised labour (Democratic Nursing Organisation of South Africa (DENOSA) and National Education, Health and Allied Workers Union (NEHAWU)	2
Deputy and Assistant Director Nursing Services-in-charge of the hospitals	2
Area Managers (including Sectional matrons)	6 (3 in each hospital)
Senior Professional nurses in charge of nursing units	6 (3 in each hospital)
Professional nurses	12 (6 in each hospital)
Enrolled nurses	12 (6 in each hospital)
Enrolled nursing auxiliaries	6 (3 in each hospital)
Ex-patients	3
Focus groups (2 groups)	12 (6 in each group)
TOTAL (n)	**62**

Before data collection a meeting was held in each hospital to complement and further clarify contents of the letter written to seek permission. The method of data collection was explained verbally. Assistance requested was specified. It included sample selection, explaining and clarification of any misconceptions to nurses in the units, arranging time for them to be interviewed on duty time and providing space and privacy for interviews to be conducted.

Selection of Area managers in hospital A was guided by the fact that the hospital is divided into three areas as described in 5.3.1 (page 99). Area managers for Areas 2 and 3 were included. Area 1 manager was not included because she went on leave soon after commencement of the strike. The person who relieved her did

not fit into the criteria for inclusion because she had not held the position for at least three months at the time of the strike. The Area manager who was in charge of night duty was recommended as a key informant, so she was invited to participate. Her inclusion was considered important in that it would bring in a perspective of management of nursing care on night duty during a strike. In hospital B it was found that only four of the Sectional Matrons were in those positions at the time of the strike and, because one of the four was on leave, the remaining three who had been officially on duty throughout the strike were included in the sample.

For all the categories of clinical nurses a purposive stratified random sample of senior professional and professional nurses, enrolled nurses and enrolled nursing auxiliaries were selected by assigning numbers to different categories of nurses appearing in the change list. Every 20th name was selected until the predetermined number of those who fitted the criteria for inclusion was obtained. Only those who expressed a willingness to participate were included in the sample.

Of the names picked, the following pattern of unwillingness to participate emerged, as presented in table 5.3.

Table 5.3 NURSES UNWILLING TO PARTICIPATE IN THE STUDY

Nursing Category	Hospital A	Hospital B
Senior professional nurses in charge	1	2
Professional nurses	2	1
Enrolled nurses	3	4
Enrolled nursing auxiliaries	2	2
Total number unwilling to participate	**7**	**9**

Reasons given for unwillingness to participate included:

- not convinced of anonymity in a face-to-face interview

- not convinced that information would not be used against her in spite of assurance of confidentiality (fear of victimisation)

- suffered too much in the strike, does not want to think about it, let alone talk about it.

- questions like "why pick on this hospital?" were raised and fear of being discredited in Head Office and in the public was expressed.

- questions like "why pick on me?" ... not convinced that selection was objective; suspicion that the researcher was 'put on' to her for a reason.

- too busy at the time, for example in hospital A data collection coincided with the deadline for writing of personal profiles which was very important for staff to be considered for salary increases, as one put it "This is my bread and butter, I have to do it now, try others."

An additional sampling strategy used was a typical case method. Patton (1990:173) describes this as an approach used to provide a profile of 'typical' cases who have unique experiences or information regarding the topic of study. These are selected with the help of key informants who can identify what is typical about the cases selected. There must be consensus about what is typical. During meetings with the managers and during some interviews certain typical cases were mentioned and these included:

- employee representatives (shop stewards) or worker / nurses' forum members

- union activists or nurses active in professional organisation affairs

- those who suffered overt harm during the strike, physically or socially.

Of those identified and approached through this method there was no resistance to participation. Two who expressed enthusiasm made the following comments:

- *"It is time the world knows about us and our strikes from us. We are sick and tired of this nonsense of being labelled as irresponsible"*

- *"So now you want to hear from us? You are tired of taking what management tells you. O.K. You will get it. We are not like them. We have nothing to hide. After all they don't care for us".*

Selection of patients was done by making use of admission and discharge registers of adult wards in one of the hospitals to identify patients who were in the ward and not due for discharge when the strike commenced. Permission was obtained to retrieve these registers from registry to get their full particulars such as addresses and telephone numbers.

In addition, two focus groups were interviewed. Each focus group represented the communities served by the hospitals under study, referred to as Focus Group 1 and Focus Group 2 respectively. In each focus group there were six participants. They were requested to select fictitious names that they would feel comfortable with during the interview. The focus groups are described in table 5.4.

Table 5.4 DESCRIPTION OF THE FOCUS GROUPS

FOCUS GROUP I			FOCUS GROUP II			Age Range
Fictitious Name	Sex	Age	Fictitious Name	Sex	Age	
Sue	F	22	Pat	F	21	21 - 30 = 9
Dan	M	23	Gugu	F	23	31 - 40 = 1
Lucy	F	25	Dudu	F	25	41 - 50 = 1
Kay	F	29	Siza	M	25	51 - 60 = 0
Sally	F	32	Nomsa	F	29	61 - 70= 1
Mary	F	61	Jenny	F	42	

The researcher refrained from asking further personal particulars to prevent bias and class consciousness among the participants. Participants who initially showed a reluctance to be interviewed gave reasons that they had no knowledge of what nurses do besides what they see when they come to hospital or clinic. They expressed fear that nurses might victimise them if they said bad things about them and the service they provide. After assurance that the idea was to get whatever information they could share regardless of how much it was, and that all information would be treated confidentially and anonymously, they participated willingly.

5.3.4 Ethical considerations

Ethical assumptions described by Munhall (1994:11) were considered in this research. Munhall states that individuals should be taken as they are and no effort made to change them. The researcher should only concentrate on attempting to discover and understand the experience. She should not predetermine reality through her own assumptions and language but should allow the subjects to be the authors of their experiences.

The researcher requested permission to conduct the study from the KwaZulu-Natal Provincial Department of Health (Refer Annexure 2 page 290). An agreement in principle to conduct the study in the hospitals was obtained. This was followed by directly approaching Medical Superintendents of the hospitals selected for the study as well as for the pilot project. Except for the delays, there was no problem in obtaining permission in any of the hospitals. Further arrangements were made through direct communication with the nursing management of each hospital.

Informed consent was obtained from participants without difficult inducement after the thorough explanation that the researcher went through before commencing the interview. It was made clear that participation was completely voluntary and those who expressed unwillingness were thanked and assured of no ill feelings since it was their right to refuse.

Anonymity and confidentiality were emphasised. This became even more critical because some participants expressed a view that they were not comfortable with having a face-to-face discussion. Others had no problem with that. One who had no problem went to the extent of saying "You can use my name if you like so that they can come and ask me if they have any queries. They will get what they want." It was explained that it could not be done for purposes of the research, instead she was encouraged to use the available channels of communication to present what she felt strongly about.

Permission was also obtained to conduct interviews with participants representing the nursing directorate and organised labour respectively.

5.3.5 The Research Instrument

In this study semi-structured interviews were used to collect data from the participants (Refer annexure 3 page 294). They were preferred because they allow the person to describe feelings, thoughts, intentions, opinions and behaviours that

took place at some previous point in time while allowing the interviewer to guide the discussion and probe further to elicit meanings attached to those experiences. It is also possible to focus on specific areas of interest and ensure that all those areas and questions are answered (Burnard & Morrison 1994:77). This tallies with the characteristics of case study research as described on page 97.

In line with Patton's (1990:290-293) guide to content of the interview, questions addressed description of experiences, activities or behaviours involved in or observed. These are closely related to sensory questions where a description of what was seen, heard or touched was given. Opinion or value questions were asked which addressed what participants thought of the phenomenon under study, including their intentions, desires or values. These variables are considered important because they have implications for decision-making. To make such questions clear to participants, they were preceded by "What would you like to see happen ..." or "What do you suggest should be done." Feelings questions were included and these are important to elicit emotional responses of people to their experiences, for example 'anxious, happy, proud, embarrassed.' Questions here clearly asked participants to describe their feelings as an emotional experience. During the interview there was confusion which the researcher had to clear regarding opinion and feeling questions. Knowledge questions were also included, and these merely elicited what participants knew to be the facts of the case, for example, asking what representative organisations nurses were affiliated to. Background or demographic data was included to identify characteristics of the person interviewed as this might have implications for interpretation of responses.

5.3.5.1 Description of the interview guide

This was a newly formulated instrument. Though different interview guides were formulated for the different categories of participants, the researcher endeavoured to follow an almost similar pattern of questioning with only minor variations to

allow for easy organisation of data and cross tabulation. Intensive consultation with the research expert and reference to literature marked the process of formulating the interview guide until agreement was reached on an acceptable one. For all categories of health care providers the interview guides contained the following sections:

Introduction:

This was used to focus the participant to the strike that was to be discussed. In initial meetings with top management in the hospitals and after review of some records, consensus was reached about the major strike to be discussed in each hospital. For Head Office executives and nurses' representatives the discussion was not focused on a particular nurses' strike even though they were free to make reference to a particular strike for specific significant points.

Section A: Demographic Data

This was included to provide a profile of the research participants as this might have implications for their decisions, opinions, actions or behaviours in regard to strikes.

Section B: Context

This section dealt with perceptions about the working environment, becoming aware of strikes, feelings and actions related to becoming aware of a strike.

Section C: Nurses' issues and strike prevention

In this section participants were asked about organisations to which nurses were affiliated in consideration of the influence they might have on nurses' decisions on

strikes, as well as issues causing the nurses' strikes and how demands made during strikes were met. On issues that caused the nurses' strikes, a system of rank ordering or listing in order of priority was used. This was done to determine how much importance was attached to each issue in comparison to the others. Smith, Thorpe & Lowe (1991:119-120) support this type of open question but warn of the complexity of ranking long lists. They suggest that the number of items should be restricted to not more than six. In this study the items were limited to three.

Section D: Strike management

In this section the researcher sought information on activities that took place during the strike, with particular reference to patient care activities, how each person was involved in the strike, how they felt during the strike and opinions on how nurses felt about the way that the strike was handled.

Section E: Impact of nurses' strikes

In this section participants were asked to describe their perceptions of the impact of nurses' strikes on them, the nursing profession, quality of health care and on other members of the health team. It also included a question on how the nurses' strike might have been influenced by the other members of the health team.

Section F: Post-strike activities

This section sought information on participants' feelings after the strike(s) as well as activities which took place when the strike ended and when nurses returned to work. As a way forward participants were asked to give suggestions of what they thought should be done in future to prevent nurses' strikes, manage them when they occur and evaluate their implications.

Interview guides for consumers of health care contained three sections only, namely:

Section A: Demographic Data

This included sex and age of participants as well as admission particulars for those who were patients in the hospital during a nurses' strike.

Section B: Context

This section only addressed views of the consumers of health care about whether nurses are happy or unhappy in their work environment. Relevance of this information lies in its potential for influencing reactions of the consumers of health care towards nurses' strikes.

Section C: Strike activities

For this section consumers of health care who were patients in a hospital were to describe their specific experiences of nurses' strikes whilst the community members were to describe how they had experienced nurses' strikes either as a family member, a relative, a neighbour or close friend of a person affected by a nurses' strike situation as a provider or consumer of health care. Those who did not have any of these experiences were included to get a general picture of awareness of the community in general on strike activities by nurses.

5.3.6 **Preliminary or Pilot Interviews**

Permission was obtained to conduct pilot interviews in an urban hospital which was not part of the main study but was known to have been involved in another strike by nurses at a different time. The aim of the pilot study was to pre-test the

interview guide as it was a newly formulated instrument. Three clinical nurses who fitted criteria for inclusion and were willing to participate were interviewed. Rationale for using clinical nurses only for the pilot study was the fact that this category formed the largest portion of the total sample. This activity served to test the interview guide for understandability and answerability, ability to get relevant responses, to observe the participants' reactions to questions, for example whether they were regarded as sensitive or not, and the length of time it took to complete the interview. This also enabled the researcher to practise the skill of in-depth interviewing by using the semi-structured interview and probing questions.

In the pilot study, time taken for each interview ranged between 30 and 45 minutes. The variation was ascribed to the variations in pace of answering questions and the amount of probing aroused by each respondent's answers. Two of the respondents noted that the interview was long. They would have been happier if it was shorter, but when asked for suggestions of what could be changed or omitted they felt that all items were relevant and should not be omitted. For this reason the instrument was administered as designed except for minor grammatical and semantic changes which were suggested to improve understandability and answerability. A few changes were also made to the sequence of questions when it became clear that participants were giving information early on aspects asked much later in the interview guide or responses to certain questions made it reasonable to follow with particular questions.

5.3.7 Conducting the Interviews

5.3.7.1 The participants

Each interview was a unique experience for the researcher because the participants exhibited different characteristics and approaches to responding to the interviews ranging from confidence, clarity and loudness of voice, assertiveness, ease of understanding, speedy answering, friendly disposition, enthusiasm and

comprehensive story-telling type of answers, to shyness, soft voice, slowness to answer, short answers with no elaboration, aggressiveness and defensiveness. It was not possible to group these characteristics according to the categories of participants as there was no set pattern typical of any category. These were handled as personality differences which needed to be taken into consideration when dealing with each interviewee.

5.3.7.2 The setting for the interviews

The settings in which the interviews took place were characterised by privacy since in most cases the researcher was offered sole use of a manager's office with minimal or no interruption. Whilst most participants were comfortable with this arrangement, two of the clinical nurses in the professional nurse and enrolled nurse categories respectively expressed uneasiness because they did not utilise that office under normal circumstances. They only came there for special incidences, and as one put it, *"We only come here when things are bad, usually to be reprimanded if you have done something wrong or if you have a grievance."* They were reassured that this was not the case and then they relaxed. In other instances the duty room was used and staff were made aware of what was going on and requested not to come in while the interview was on unless absolutely necessary. Problems were experienced in this set-up because the duty room is used as a nurses' work station in some nursing units. It was used only where there was no alternative space.

5.3.7.3 Initiating the interviews

The researcher started by establishing rapport with each interviewee. This was done by reading together a letter explaining why the person had been invited to participate, assuring anonymity and confidentiality, freedom to participate voluntarily and to recall and answer questions as comprehensively as possible

according to own experience, bearing in mind that there are no right and wrong answers (see Annexure 3, page 294). Participants were also informed that all information would be part of the study, but no information would be linked to a particular participant.

5.3.7.4 Interviewing and transcribing the interviews

All interviews were audiotaped and guidelines according to Patton (1990:248-253) for tape-recording and transcribing interviews were followed. Before taking out the tape recorder permission of the interviewee to be audiotaped was sought. It was explained that the purpose of recording the interview was to ensure that nothing said would be missed or misrepresented and to minimise the need for extensive note-taking, thus saving time so as to get done with the interview within the shortest possible time. Interviewees were also told that the tape recorder could be switched off whenever they felt they did not want something recorded. Permission to take minimal notes was also sought.

After the initial introductory remarks and answer to the first question the recording was stopped and played back to enable participant to hear his voice, after which it would be easy to request him to speak louder, closer to the tape recorder or speak more clearly if necessary. At midpoint and end of the interview a short playback was done to ensure that the tape recorder was still functioning. If several consecutive interviews had to be done, a period of thirty to forty-five minutes was allowed to give the researcher time to play the recording, compare with the notes. If there were unclear areas or ambiguities the researcher would communicate with the participant immediately either telephonically or face-to-face if possible, to ask for clarification. Some participants who had time to spare were allowed to sit and listen to their own recordings, in fact some requested it.

The next step was transcription of the interviews. This was done as soon after the interview as possible. A typist was trained in transcribing according to needs of

this research and worked together with the researcher to transcribe interviews verbatim on a word processor, check and agree with the researcher for accuracy of transcript. In spite of being very expensive and time-consuming, full transcriptions are recommended as a way of ensuring that one does not lose relevant data for analysis and also allow for independent analysis in later replications (Patton, 1990:349). Identification of participants in the transcripts was done though a code reflecting the institution, the category and number allocated to participant, for example APN 1 = Hospital A, Professional nurse number 1, BPN 1 = Hospital B, Professional nurse number 1.

5.4 ESTABLISHING THE VALUE AND LOGIC OF THE STUDY

Since the sample size was small, the researcher utilised strategies recommended by various authors to ensure trustworthiness of the findings (Burns & Groves, 1987), (Gmeiner & Poggenpoel, 1996), (Morse, 1989), Munhall, 1994), (Patton, 1990), (Polit & Hungler, 1995). A variety of criteria were used. These include:

5.4.1 Credibility

Credibility of the researcher is considered very important. This is determined by the experience, training, perspectives and biases that she brings into the field and the effect this might have on research participants. In this research the aspect of credibility was ensured through close supervision by a research expert. Credibility is also enhanced by empathic neutrality whereby the researcher does not go into the field to prove a particular perspective or theory, for example in this research the researcher looked for the impact of nurses' strikes from a point of neutrality rather than from a pre-determined perspective. The aim was to understand the position, feelings, experiences and world view of others from their own point of view.

Credibility of data was further ensured through triangulation, a process of using different data collection techniques and research strategies. Data was collected from a sample which consisted of both the consumers and providers of health care. Further than that, in the provider category the employing authority, management as well as the direct health care givers were represented. Investigator triangulation was done through working closely with the research supervisor.

5.4.2 Transferability

Transferability refers to the possibility of the data to be applicable, generalisable or transferable to other settings or groups. As previously stated, small sample sizes usually pose a problem of generalisation. Polit and Hungler (1995:364) highlights the need to provide comprehensive descriptive data in the report to facilitate generalisability. This was feasible in this research because verbatim transcriptions of interview data was done and used as a basis for data analysis. According to Brink (1996:107) transferability is comparable to external validity and reliability.

5.4.3 Dependability

This criterion is accomplished in two ways, namely stepwise replication whereby two teams of people deal with data sources independently and also by conducting an inquiry audit whereby the data is scrutinised by an external reviewer. This latter approach was adopted in this research. Achieving dependability and credibility also serves to ensure validity whereby the researcher and the external reviewer agree that the instrument tests what it is supposed to test and reliability that ensures that the data can yield similar results if replicated over time or in a different setting.

5.4.4 Confirmability

Confirmability refers to objectivity and neutrality of the data. Inquiry audit was used to assess both dependability and confirmability.

5.4.5 Methodological rigor

Burns (1988) in Munhall (1994:186-188) highlights that rigor in research is important in order to give direction to practice and further research. In this research rigor was maintained through the following:

- **Descriptive vividness:** the researcher clearly described the site, participants and her decisions in order to inspire the reader to experience the event.

- **Methodological congruence:** the researcher described the methodological approach which was used. Methodological congruence was achieved through rigor in documentation of procedures and ethical aspects.

- **Theoretical connectedness:** theoretical schema from the study is clearly expressed through literature review, conceptual and theoretical framework, ensuring that it is logically consistent and reflective of the data, and compatible with the knowledge base of nursing.

5.5 CONCLUSION

A comprehensive description of the methodology followed to collect data in this study has been given in order to enhance its credibility. Background information on exploratory descriptive case study research was given to assist the reader to understand the rationale for using the processes described for both data collection and data analysis. The next chapter presents data analysis and interpretation of findings.

CHAPTER 6

DATA ANALYSIS AND INTERPRETATION OF FINDINGS: HEALTH CARE PROVIDERS

6.1 INTRODUCTION

In this study both quantitative and qualitative data analysis was done. For quantitative analysis, interview data of all nursing personnel, including their supervisors who are referred to as area managers in this study, was organised, coded and sub-coded through a computer. In this chapter the quantified data is presented in the form of tables and graphs. In line with the stated assumption of this study, cross tabulation is done on each item to note if there are any significant variations in perceptions of the different categories of participants. For purposes of analysis Senior Professional Nurses (SPN) and Professional Nurses (PN) are grouped together as Professional Nurses, Enrolled Nurses (EN) and Enrolled Nursing Auxiliaries (ENA) are grouped together as Enrolled Nurses, Nursing Service Managers, (now Assistant Directors) and Chief Professional nurses in charge of 'areas' or 'sections' are grouped together as area managers (AM). The concept "total sample" in this chapter is used to refer to the quantified data obtained from the participants described above (n-42).

Interview data from singular subjects representing a particular category was not quantified. Only narrative descriptions are given. In the context of this research it represents the qualitative data analysis. Participants in this group comprise the Deputy Directors or nurse managers in charge of the two hospitals, who will be referred to as nurse manager A and B respectively, chairpersons of the selected organised labour, Head of the nursing directorate and participants who represent the consumers of health care. This approach is supported by Polit and Hungler (1994:519) who agree that data can be analyzed both quantitatively and qualitatively.

In the present study data analysis begins as case analysis whereby each interview is analyzed individually. This is followed by cross-case analysis whereby a presentation of perceptions of the various categories of participants is done. A brief description of how the tables and graphs of the quantitative data analysis are presented is given below for clarification.

6.1.1 Tables

Tables are comprised of four (4) main columns as follows:

Column 1 : Total sample (n=42)
Percentage in this column means % of total sample.

Column 2 : Area managers (n=6)
Percentage in this column means % of six (6) area managers.

Column 3 : Professional nurses (n=18)
Percentage in this column means % of eighteen (18) professional nurses.

Column 4 : Enrolled nurses (n=18)
Percentage in this column means % of eighteen (18) enrolled nurses

6.1.2 Graphs

Graphs are presented as three (3) columns representing area managers (AM), Senior professional nurses and professional nurses (SPN / PN) as well as enrolled nurses and nursing auxiliaries (EN / ENA). Similar to the tables, percentage in the graphs refers to % of that particular category. The total sample does not appear in the graphs but may be mentioned in the discussion of the graph.

The researcher has considered guidelines by Miles and Huberman (1984), in Patton (1990:372), that a researcher should make sense of massive volumes of data by reducing it, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. This was done in the present study.

Qualitative analysis of interview data of the consumers of health care is provided in a separate chapter. Comparison of their responses with those of the health care providers should assist to determine if there are significant similarities and differences in perceptions of providers and consumers of health care.

Analysis, interpretation and discussion of findings is done per item. It is presented in two chapters, namely:

Chapter 6 : Data Analysis - health care providers (or health care givers)

Chapter 7 : Data analysis - health care consumers.

6.2 DATA ANALYSIS AND INTERPRETATION OF FINDINGS

ITEM 1 PERCEPTIONS OF NURSES ABOUT THEIR WORK ENVIRONMENT AND JOB SATISFACTION

In this item nurses were asked to describe how they perceived their work environment in relation to their job satisfaction. The area managers were asked to give their perceptions of how the nurses under their supervision perceived these variables.

TABLE 6.1 PERCEPTIONS OF NURSES ABOUT THEIR WORK ENVIRONMENT AND JOB SATISFACTION

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
There is lack of job satisfaction among nurses	36	85	6	100	14	78	16	89
Reason for lack of job satisfaction								
Staff shortages / high nurse-patient ratios	25	60	6	100	12	67	7	39
Overwork / long hours of work	23	55	5	83	7	39	11	61
Low salaries	13	31	2	33	6	33	5	28
Over-control of overtime by authorities	7	17	0	0	5	28	2	11
Lack of upward mobility	4	10	0	0	4	22	0	0
Poor communication	3	7	0	0	1	6	2	11

(Respondents could give more than one response)

Key: SPN/PN : Profession nurses
EN/ENA : Enrolled nurses

Table 6.1 reflects that the majority of total sample, 85% (36) perceive lack of job satisfaction among nurses. Various reasons were given for job dissatisfaction. All area managers identified staff shortages and related high nurse-patient ratios. 83% (5) of them further identified overwork and long hours of work which are a consequence of staff shortages. These concerns are in line with the overall responsibility that area managers have as supervisors, to ensure that quality patient care is rendered in their departments in spite of staff shortages.

The perceptions of the area managers are similar to those of the majority, 67% (12) of the professional nurses who also expressed concern about staff shortages whilst the majority of enrolled nurses, 71% (11) expressed concern about overwork. It is noted that, in addition to their clinical roles, the professional nurses are responsible for organising and co-ordinating all patient care activities in nursing units utilising the available staff, therefore staff shortages have a direct impact on their functions. The enrolled nursing categories are involved in direct patient care activities, hence their primary concern about overwork. These findings correlate with those of Shabhalala (1994).

On the issue of salaries, responses to this item are contrary to the general assumption that the main reason for strikes is employee dissatisfaction about salaries. Low salaries were mentioned as reasons for dissatisfaction by only 33% (2) of the area managers, 33% (6) professional and 28% (5) enrolled nurses. This may be interpreted to indicate that salary dissatisfaction was no longer an important issue at the time of data collection for this study since salary progression was in place following representations made by organised labour at the Bargaining Chamber during and following the 1994 and 1995 nurses' strike wave, as reflected in table 6.2 for 1996 to 1998 salary notches. Contrary to this finding, a recent study by Erasmus (1998:52) revealed that low salaries were ranked highest as a barrier to career prospects in the workplace. This could be interpreted as an indication that nurses in that study perceived the salary progression as inadequate to meet their expectations.

TABLE 6.2 (a) SALARY RANGE FOR NURSES IN KWAZULU-NATAL PUBLIC HEALTH SERVICES - 1996 AND 1997

1996						1997		
LEGS	LEVELS	CATEGORIES	SALARY NOTCHES IN RANDS			SALARY NOTCHES IN RANDS		
1	1	ENA-Std 8	17 100	17 697	18 294	19 002	19 290	19 941
2	2	SENA - Std 8	20 079	20 943	21 807	21 888	22 842	23 784
3	3	ENA - Std 10	23 526	24 615	25 704	25 659	26 832	28 020
1	4	EN - Std 10	27 882	28 905	29 920	30 396	31 509	32 625
2	5	SEN - Std 10	32 980	34 296	35 604	35 958	37 386	38 814
1	6	PN	40 836	43 344	45 052	44 514	47 241	49 783
2	7	SPN	50 868	53 487	56 106	55 449	58 302	61 155
3	8	CPN	63 963	67 509	71 055	69 381	73 248	77 094
1	9	AD	78 141	86 853	89 757	84 423	87 561	90 696
2	10	DD	98 463	102 702	106 941	106 377	110 958	115 539
3	11	D	115 413	123 468	131 523	124 692	133 392	142 098

KEY

ENA : Enrolled Nursing Auxiliary
SENA : Senior Enrolled Nursing Auxiliary
EN : Enrolled Nurse
SEN : Senior Enrolled Nurse
PN : Professional Nurse
SPN : Senior Professional Nurse
CPN : Chief Professional Nurse
AD : Assistant Director
DD : *Deputy Director*
D : Director - Nursing Services

(Source: KwaZulu-Natal Provincial Administration Records 1998)

Table 6.2 (b) **Public Service salary scales for nurses with effect from 1 July 1998**

1.	ENROLLEDNURSESAUXILIARIES	LEG 1	LEVEL 2	23 740 24 386 25 392
		LEG 2	LEVEL 3	27 445 28 646 29 914
	SENIOR NURSING AUXILIARIES	LEG 1	LEVEL 4	32 512 33 639 34 830
		LEG 2	LEVEL 5	38 461 39 913 41 438
2.	ENROLLED NURSES	LEG 1	LEVEL 4	32 512 33 639 34 830
		LEG 2	LEVEL 5	38 461 39 913 41 438
	SENIOR ENROLLED NURSE	LEG 1	LEVEL 6	47 612 50 441 53 362
3.1	PROFESSIONAL NURSE	LEG 1	LEVEL 6	47 612 50 441 53 362
	SENIOR PROFESSIONAL NURSE	LEG 2	LEVEL 7	59 308 62 243 65 289
	CHIEF PROFESSIONAL NURSE	LEG 3	LEVEL 8	74 210 78 200 82 306
3.2	ASSISTANT DIRECTOR	LEG 1	LEVEL 9	89 455 92 780 96 101 99 430 102 752
		LEG 2	LEVEL 10	111 653 116 462 121 270
3.3	DEPUTY DIRECTOR	LEG 1	LEVEL 11	130 877 140 008 149 146
		LEG 2	LEVEL 12	158 278 167 173 176 122

(Source: Democratic Nursing Organisation of South Africa (DENOSA) records - 1998)

Tables 6.2 (a) and 6.2 (b) show salary notches according to the job gradings introduced in 1996 in the public service. When one compares these figures with the 1994 mid-point salaries appearing in Table 2.1 (page 42), the improvement in salary becomes evident. In table 6.2 (b), the overlapping of notches between different categories is clearly demonstrated, for example Senior Nursing Auxiliary Leg 1, Level 4 overlaps with Enrolled Nurse Leg 1, Level 2, Senior Enrolled Nurse Leg 1, Level 6 overlaps with Professional Nurse, Leg 1, Level 6. The overlapping has also been highlighted as a source of dissatisfaction.

These perceptions of nurses' lack of job dissatisfaction have some correlation with findings of Sital, *et al.* (1998:46) in the DENOSA National Survey of South African nurses. When asked about the constraints and most significant difficulties in the workplace nurses in that survey identified, in rank order from highest to lowest, staff-related problems, working conditions, institutional problems, remuneration, work / technical problems, patients, being downtrodden as nurses, heavy workloads and bad communication.

Parallels can be drawn with studies from other countries to support that these factors of job dissatisfaction are not unique to South Africa. Morris (1998:1128) in the United Kingdom identified staff shortages and inflexible working arrangements which she interpreted as "... a notion that nurses have no personal life or are married to their work." In South Africa this concern exists especially among the younger nurses. Ketter (1997:323-325) and Ponte, Fay, Doyle, Person, Zizzin and Barret (1998:35-40) in the United States of America identified poor training and career opportunities, fear of change, poor conditions of service, workplace health and safety concerns, perceived reduction in benefits and perceptions that inequities in salaries between nurses and senior executives is unjust because nurses work harder.

In the qualitative data analysis, there were shared perceptions among the nurse managers in charge and organised labour that nurses were dissatisfied about low

salaries. According to nurse manager A *"nurses are disgruntled because they work very hard but are not remunerated to their satisfaction. ... there is a tendency to increase salaries for general assistants, porters and other categories. Very little is done to increase nurses' salaries."* Nurse manager B responded *"Salary" was number one ... nurses were also querying the amount of money that was paid for night duty ... it did not tally with the amount of work done."*

Both nurse managers A and B highlighted staff shortages, overwork and delayed or unfair promotions as dissatisfiers. To support the concern of staff shortage, it was reported in Mall *et al.* (1995:23, 41) that Hospital A had ±2 000 beds, attended 1 680 patients daily and delivered 4 000 babies annually but had a staff complement of 2 019 nurses and 700 doctors. In comparison, a similar specialist, academic 1 400-bed hospital had a staff complement of 7 200 nurses and 1 240 doctors. These comparisons reveal disparities in terms of resources which could also be a factor causing dissatisfaction.

Similarly, both representatives of organised labour highlighted the salary issue as number one. DENOSA representative added that nurses were not happy because of *"inadequate equipment for the quality of patient care that they are supposed to render, then there is no incentive even when they sacrifice ... even the bit of the so-called incentive that they had, that is overtime, has been taken away from them."*

NEHAWU representative further related nurses' job dissatisfaction to working conditions which were still very low. He pinpointed that *"there are staff shortages, the harsh treatment that nurses endure in their profession by the authorities and even by the community."* He also highlighted that nurses were concerned about lack of advancement through training. A specific example made was dissatisfaction with unfair selection of enrolled nurses to bridging courses. The majority of nurse members in this organisation are enrolled categories of nurses, hence the emphasis on enrolled nurses bridging courses. Nurses were also

conscious of disrespect towards them by the community and their tendency to criticise them for all shortfalls in health care delivery, for example shortage of medicines.

Perceptions expressed by the Director of Nursing Services on nurses' job satisfaction were in contrast to those expressed by the other participants as she said *"... nurses have job satisfaction. Nursing has status, it is a career and there is permanency ... nurses have protection ... the turnover is not so much. There are people with 35 or 40 years experience. So there is job satisfaction if they can stick to one profession throughout their lifetime"*. It is the researcher's opinion that empirical evidence is needed to prove that relative permanency in nursing posts is an outcome of job satisfaction. Many extraneous variables could influence nurses to remain in nursing in spite of job dissatisfaction, for example their specialised educational preparation for nursing, commitment to the profession and the service motive, unavailability of other jobs where they could fit. Damane's (1992:118-119) research highlights the view that relative permanence of nurses in their jobs could be related to the fact that nurses, especially the older nurses, are usually satisfied with less because they have developed commitment to the organisation. They are usually in senior positions and they have limited opportunities of alternative employment. Looking at the younger nurses, Bester, Richter and Boshoff (1997:99) found correlation between their job satisfaction and career orientation as well as occupational concept. In the present study there was no evidence that age had any influence on levels of job satisfaction.

ITEM 2 COMMUNICATION STRUCTURES USED BY NURSES TO KEEP AUTHORITIES INFORMED OF THEIR PERCEPTIONS ABOUT THEIR WORK ENVIRONMENT

This question attempted to elicit responses in relation to the communication structures that facilitate communication between nurses and the authorities. It must be borne in mind that only 6% (1) professional nurses and 11% (2) enrolled

nurses mentioned poor communication as one of the causes of job dissatisfaction in item one (1). Responses of nurses and their area managers on this item are presented in table 6.3.

TABLE 6.3 COMMUNICATION STRUCTURES TO KEEP AUTHORITIES INFORMED OF NURSES' PERCEPTIONS ABOUT THEIR WORK ENVIRONMENT

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Continuous communication through formal channels of communication	32	76	3	50	13	72	16	90
Staff meetings	28	67	4	67	14	78	10	56
Observation and direct communication during ward rounds	8	19	4	67	3	17	1	6
Nurses forum	3	7	0	0	1	6	2	11

(Respondents could give more than one answer)

Table 6.3 indicates that the majority of participants in all categories, 76% (32) communicate continuously with authorities through formal channels of communication. 67% (28) of the total sample referred to the use of monthly meetings with nursing management. These meetings were used to discuss policies, nurses' grievances or any other general nursing issue as well as to give feedback or solutions to problems. Whereas nurses' forums were established as an attempt to facilitate communication links between employees and management without going through the multi-level formal communication channels typical of most health care organisations in South Africa, only 6% (1) professional nurses and

11% (2) enrolled nurses mentioned them. The Labour Relations Act (66 of 1995) as amended provides for the establishment of these forums to normalise workplace relationships.

In this item both nurse managers A and B, chairpersons of organised labour and the Director of Nursing Services were asked to indicate how they were kept informed of nurses' perceptions about their work environment. Nurse manager A stated that it was the workplace forums comprising nurses and other workers which kept her informed about this. She added that she maintains direct telephonic communication with organised labour.

Nurse manager B highlighted that she holds meetings and discussion groups with different categories of nurses. She also makes note of the grapevine. She stated that personnel from Head Office also came to address nurses' grievances which had been reported to them previously. Delays in feedback on grievances forwarded is a potential source of job dissatisfaction.

DENOSA representative made reference to meetings with the members. She highlighted the difficulty that most members expected the employer to allow them to attend meetings during on-duty time and to assist them with transport. She also stated that she holds informal discussions with institutional representatives or shop stewards.

NEHAWU representative stated that his organisation receives reports on nurses' issues through nurses' forums. He stated *"As we have nurses, social workers, paramedics as members of our union, we do have a nurses forum which is coordinated at institutional level."* When asked about their nurse membership he explained that their database does not divide the membership except to note that nationally they have 160 000+ members and in the KwaZulu-Natal Province alone

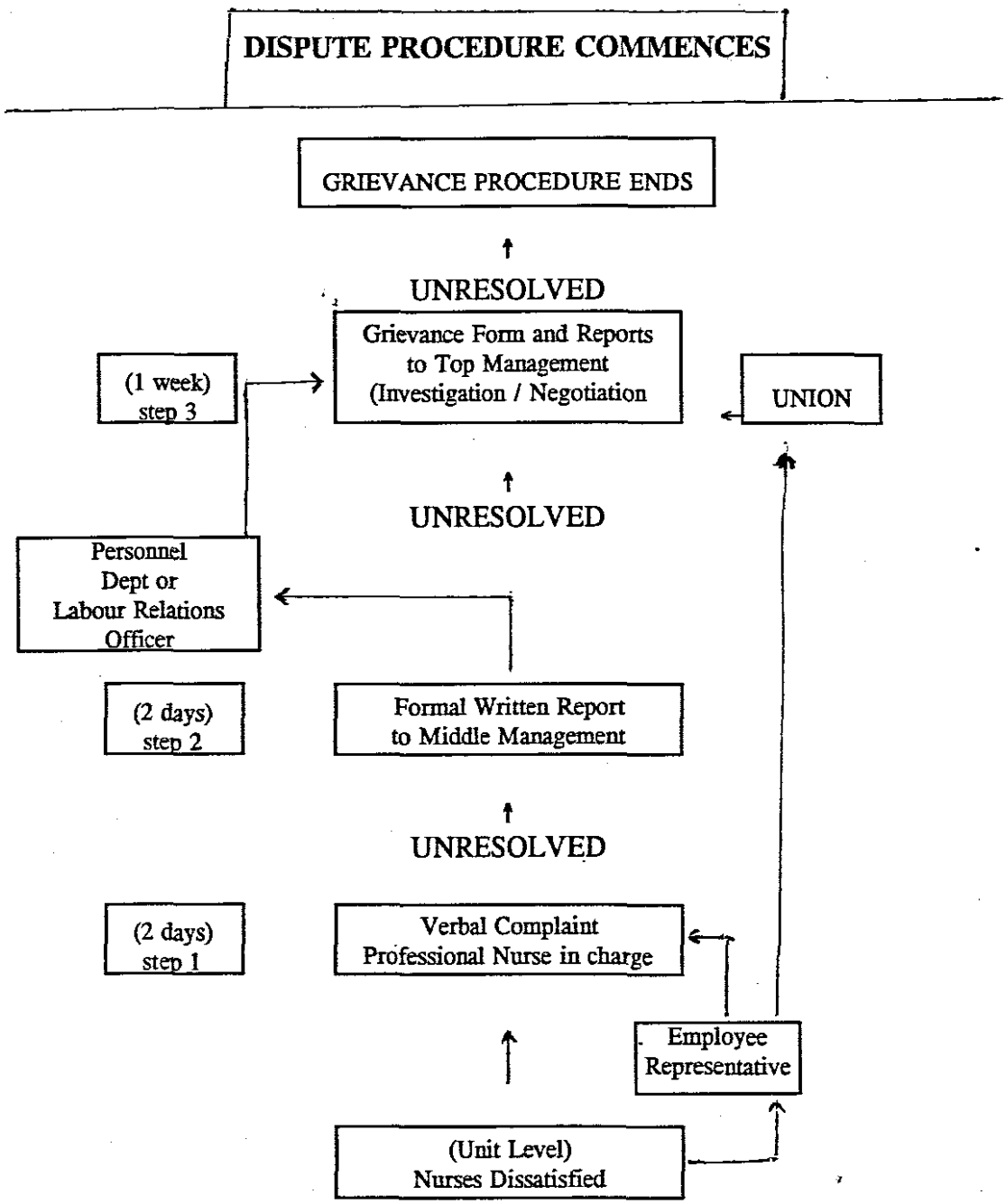
they command a membership of 19 707. It should be noted that NEHAWU is a general National Education, Health and Allied Workers Unions and is not particularly a nurses' union. The institutional NEHAWU coordinators meet with members and inform them about policies of the organisation. They also keep the organisation informed of the nurses' grievances.

The Director of Nursing Services stated that she holds monthly departmental meetings with nurse managers who are Deputy Directors in the eight health regions of KwaZulu-Natal Province wherein she is informed as to what is happening in their institutions. She also allows direct telephone communication with them so that they do not wait for the monthly meetings if they want some intervention. They also make written submissions to keep her informed of any incidents, for example threatening or actual strikes.

From these findings it is clear that various communication structures are used between the nurses or their representative organisations and management or employers. However effectiveness of these structures remains doubtful since it is not clear how feedback is obtained or if personnel policies, plans and procedures are continuously communicated to the stakeholders. For this reason the LEGUP model of De la Bodeyere (1989) described in chapter two (2) of this report has relevance for improved communication. The model suggests that managers and employers should **listen** to the nurses' problems, **explore** to get more information and possible causes so as to be able to set realistic and worthwhile **goals for problem-solving.** In **pursuing** the goals, problem-solving can be facilitated through **underpinning** which may include further training.

To illustrate delays in dealing with grievances and providing feedback to personnel an example of a grievance procedure is presented in figure 6.1.

FIGURE 6.1 GRIEVANCE PROCEDURE IN THE PUBLIC HEALTH SERVICE - APPLICABLE IN A NURSING DEPARTMENT



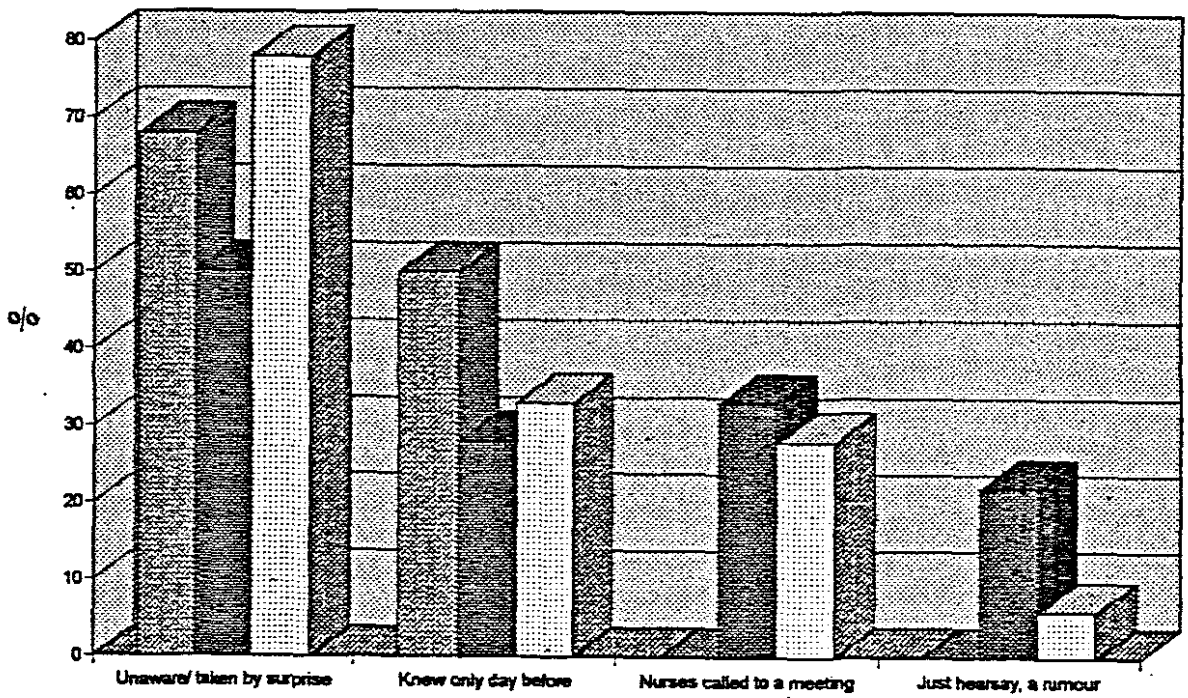
(Source: Modified from: Bendix 1996:351) and Bezuidenhout *et al.* (1998:156)

According to figure 6.1 it is evident that it would take one to two weeks for a grievance to reach top management. Presumably it would take about another week for the aggrieved nurse to get feedback or get her problem solved.

ITEM 3 HOW PARTICIPANTS BECAME AWARE OF THREATENING STRIKES

In this item an attempt was made to establish how the various stakeholders of health care became aware of threatening strikes, whether they had any pre-warnings or the strikes were only noted when they occurred. Responses to this item are presented in figure 6.2.

FIGURE 6.2: BECOMING AWARE OF STRIKES



Key: ⊠ Area Managers ▣ Professional Nurse ⊡ Enrolled Nurses

Figure 6.2 shows that the majority of participants, 64% (27) of total sample were not aware of threatening strikes. They were taken by surprise, for example, they came to work in the morning or evening and only then became aware that there was a strike. This applied to all categories as it was indicated by 67% (4) area managers, 50% (9) professional nurses and 78% (14) enrolled nurses. 50% (3) area managers, 28% (5) professional nurses and 33% (6) enrolled nurses knew about the strike only the day before it commenced. Area managers did not indicate awareness of nurses having been called for meetings, though 33% (6) professional nurses and 28% (5) enrolled nurses were aware of this. Area managers were also not aware of any rumours about pending strikes which a few in the other categories were aware of. According to these findings, it is clear that the requirement of the Labour Relations Act (66 of 1995) as amended, that a 48-hour notice of strike should be given, was not complied with (LRA, 66 of 1995: Section 64 (1) (b)).

Qualitative analysis of data from interviews of nurse managers in charge of both hospitals under study revealed that they had no pre-warning about the strikes. This appeared to be a contradiction for both of them. Nurse manager A stated that she was seconded from another hospital to take chargeship when there was a threatening strike by students who were revolting against authority. The reason given was that she was an experienced nurse educator and college Principal, therefore she might be able to handle the students. Another reason was that she was Black, since there was also rebellion against a White nurse manager being in charge of a Black institution. The latter finding was confirmed in the evidence given to the Mall *et al.* Commission of Enquiry 1995:12-13) where filling of senior posts by non-Blacks in Black institutions was mentioned as one of the grievances. The reasons cited by nurse manager A should have served as a warning of the possibility of a strike.

Nurse manager B stated that she was aware that *"many meetings were held during a strike by general assistants who later intimidated nurses to stop work because they were also affected by the same issues that general assistants were complaining about, that is promotions, salaries and allowances."* Referring to the nurses' involvement in the strike she emphasised that *"there was no warning at all because, as management, we were still trying to manage the general assistants' strikes with NEHAWU which was the union representing them"*. In the researcher's view, the fact that there was already a strike by general assistants should have been a warning that it might escalate to involve other categories of workers. Silverman's Social Action Theory proposes that 'others' may react according to the meanings they attach to the collective action of actors in an organisation.

According to the 'systems' part of Riehl-Sisca's Systems-Development-Stress model, malfunctioning of one subsystem produces a stress state on the other subsystems and negative adaptation may occur, hence the nurses action of joining the strike.

Both chairpersons of organised labour reported that they, like the other participants, had no formal warnings. DENOSA representative said she picked up vibes from the grapevine or formally through reports from DENOSA board members who worked in the institutions concerned. In addition, she stated that at times she senses issues which may cause a strike. Quoting the salary grading system, she said *"Those are issues that you analyze and realise that at one stage they may cause an eruption of some sort... — you immediately try to sensitise the employer that, 'Please attend to this issue because if you don't, there's going to be fire'. Most unfortunately they usually turn a deaf ear."* She further remarked that it is not only the membership at grassroots levels which needs to be taught but also management. The researcher supports the notion that management should be seen to be sensitive to personnel needs and problems since that has been mentioned as a source of dissatisfaction.

According to NEHAWU representative, most nurses' strikes were unprocedural and unprotected. He related this to the fact that nurses harbour dissatisfaction for a long time and then explode unexpectedly. In responding to whether he was aware or not that there was going to be a strike, the NEHAWU representative expressed an opinion that *"nurses just organise themselves. Nurses have gone on strike not understanding that we now have a bargaining chamber."* In analysing this viewpoint, it is clear that NEHAWU representative did not expect the nurses to go on strike.

According to the Labour Relations Act (66 of 1995) as amended, the strikes just described are unprotected, illegal, unprocedural or wild cat strikes. It therefore poses a challenge for nurses to be educated on how to ensure that they only get involved in legal strikes. In this regard, DENOSA takes responsibility to educate its members through workshops and its official publication, the DENOSA Nursing News in a series of articles entitled "Labour Talk". Extensive training has been started on the new Labour Relations Act (66 of 1995) as amended and on all issues related to strikes. DENOSA has taken a strong stand that industrial action will be the last resort. If, for any reason strikes have to happen, patients will never be left unattended. DENOSA, being a professional organisation, has a responsibility to protect its members against any unethical behaviour. The South African Nursing council, like DENOSA, publicly states that patients should never be left unattended.

Similarly the NEHAWU representative highlighted that they have a training department which trains their members and shop stewards, for example, on provisions of the Labour Relations Act (66 of 1995) as amended, and correct procedures to follow for legal industrial action. More dissemination of information within the organisation is done through a journal and newsletter. These efforts by both organisations correspond with the 'Underpinning' described in the LEGUP

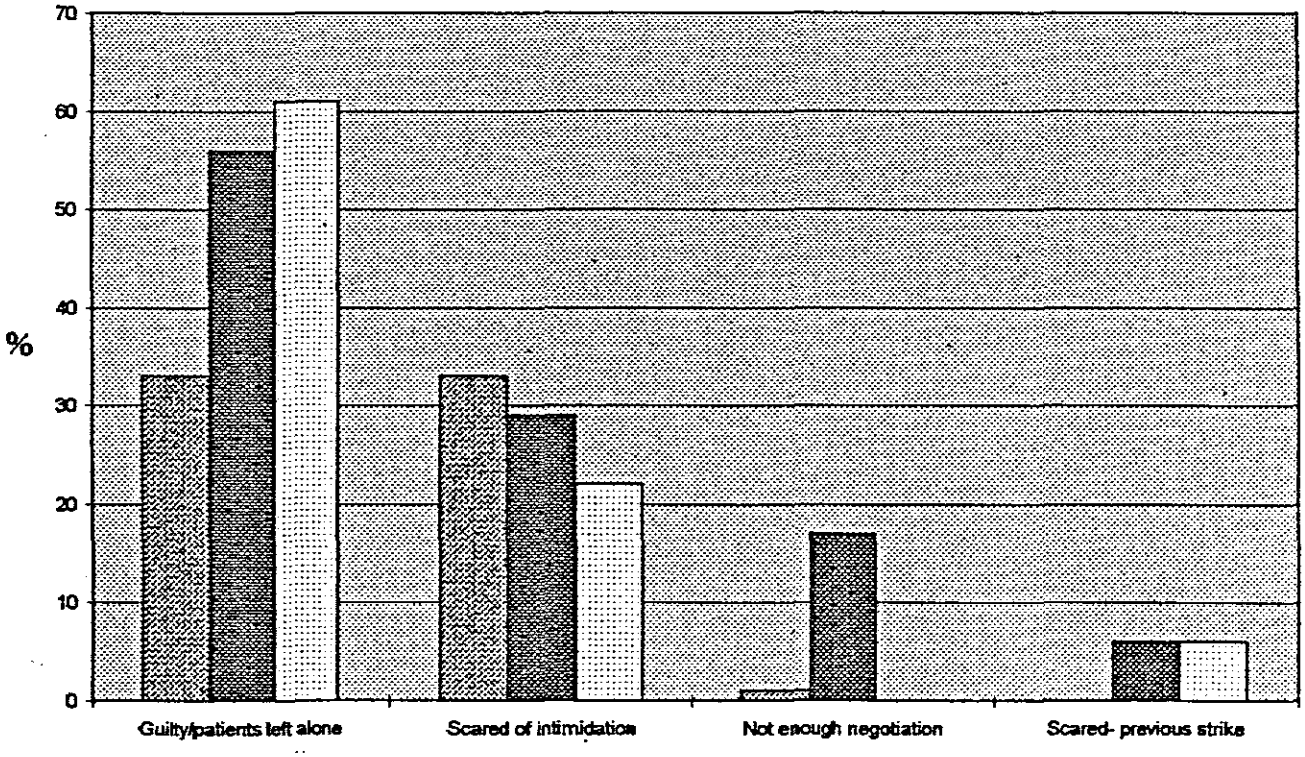
model of De La Bodeyere (1989) as the need for additional training to facilitate problem-solving. Both organisations work with the workers college which assists with training on labour relations issues.

According to the Director Nursing Services, the nursing directorate becomes aware of strikes through organised labour which has direct communication with them for example, after answering a telephone during the interview she explained *"The telephone I have just answered is from a secretary of a labour union who is telling me about a problem in one area. So he is warning us to solve the problem before a strike occurs."* She also made reference to the Provincial Health Chamber where nurses are represented. One staff member of the nursing directorate always sits in meetings of the Chamber. She further explained that there is a Labour Relations Department with its own directorate and fully-fledged staff at Head Office level. Sometimes representatives of organised labour phone directly to this department which in turn informs the nursing directorate in order to get the professional perspective and to give direction on strikes. Considering the lack of awareness of the other participants about threatening strikes, it is possible that by the time they are informed at Head Office level, it is too late to avert the strike.

ITEM 4 FEELINGS ABOUT THREATENING OR COMMENCING STRIKES

In this item participants were asked to express how they felt when they became aware that there was an imminent strike or when they came on duty to find that nurses were on strike. Feelings expressed are presented in figure 6.3.

FIGURE 6.3: PRE-STRIKE FEELINGS



Key: ⊠ Area Managers ⊠ Professional Nurse ⊡ Enrolled Nurses

According to figure 6.3, guilt feelings were expressed by participants in all categories, comprising 33% (2) area managers, 56% (10) professional nurses and 61% (11) enrolled nurses. The main reason given for this was the thought that patients would be left unattended during the strike. These findings are in line with the South African Nurses' Code of Ethics and the Nurses' Pledge which state *"My patient will be my first consideration"*, therefore according to this pledge, abandoning patients at any time is in contrast to what the nurses have pledged. In a previous study by Kunene (1995:185), guilt feelings were also expressed, for which numerous reasons were given, including patient suffering and premature

deaths, violation of ethics, perception that no problems are solved through strikes, poor image in the community and unknown outcome re salary for days not worked.

Another feeling expressed by 33% (2) area managers, 29% (5) professional and 22% (4) enrolled nurses was that they were scared of intimidation. In support of these findings, many incidents of intimidation directed at all levels of management and non-striking workers in Hospital A were mentioned in the evidence to the Mall *et al* Commission (1995:133-142). Some examples include the following:

- the medical superintendent stated that workers from various departments were forcefully removed from their duties to join the strike. Extra security had to be brought in to protect staff who were deeply committed to care for their patients. He further stated that at times he was not able to enter his office because striking workers had taken occupation of it.

- nurses in an Intensive Care Unit were forced by a crowd to leave critically ill patients who were all on support systems. The crowd left reluctantly when one of them who was a nurse asked them to leave. The Intensive Care Unit nurses were then able to continue caring for patients. A week later strange men came to the same unit, ordered the nurses out and they left. When management intervened by confronting the intimidators, the nurses returned to work but refused to write statements and to identify them for fear of further intimidation.

- nurses were ordered out of an operation theatre in the middle of an operation and doctors had to complete it without the nurses.

- those who opposed the strike were openly told they would be beaten up and/or killed.

These incidents are suggestive of a negative impact on the quality of patient care. Kunene (1995:84) found that fear and intimidation by strikers were cited as the main reasons for unwilling participation in strikes. It is therefore evident that intimidation continues to be a typical feature of nurses' strikes. This practice inhibits continuation of nursing as an essential service. Whilst the need for nurses to fight for their rights is acknowledged, intimidation during strikes is strongly condemned because it violates the patients' rights to be cared for as well as the rights of personnel who are ethically committed to continuity of patient care whilst fighting for their rights.

Contrary to the negative feelings just described, 18% (3) professional nurses and 22% (4) enrolled nurses indicated that they were happy about the strikes because their problems would be solved. Whereas nurses did not like to leave patients unattended, they were disillusioned by the fact that it was only after strike action that they could hope to have their problems solved. None of the area managers indicated a feeling of happiness and this can be related to their high degree of accountability for accomplishment of the primary goals of management or employer, that is, quality patient care.

When asked to describe their pre-strike feelings, both nurse managers in charge of the hospitals expressed an uncomfortable experience which made them feel **frustrated and disillusioned.** Nurse manager A stated *"There were days when it was very distressing because it was very difficult to see nurses abandoning patients and singing towards the front office."* She expressed surprise that nurses could be influenced by a charismatic student nurse making false, unfounded statements that nurses should fight for a R500 incentive which was due to them since nurses in other provinces had got it. She noted *"it was very amazing that nurses listened to a student. It was a male student. They hero-worshipped him like ... anyone of the charismatic leaders."* This nurse manager maintained that she tried to be calm,

having benefited from a strike-handling course that she had attended. This underlines the importance of involving management in training programmes so that they gain more knowledge and expertise on labour relations and strike issues.

Nurse manager B expressed the thought that nurses would act professionally in spite of their grievances. Some of the grievances had been reported to Head Office. She followed up on them to hasten attention and possible solution. This delay in attention to grievances was illustrated in Figure 6.1.

Feelings of unhappiness were expressed by both representatives of organised labour. DENOSA representative stated *"The feeling ... is that one has got to do something. Secondly you ask yourself 'how many of these people are my members?', especially in a hospital where there are two organisations that are pulling the membership apart. That is DENOSA and NEHAWU ... The feeling that one gets, the feeling that becomes very strong is the feeling that 'What is happening to nursing? Is nursing going down?' — the main thing that one should look at is 'What is this going to do to me and for me?' ... when you look at your plan of action you have to consider that even though the members are right, one has got to look at how much of the action that they decided on is going to affect nursing."* This is in line with the stand taken by DENOSA that patients will never be left unattended if strikes occur.

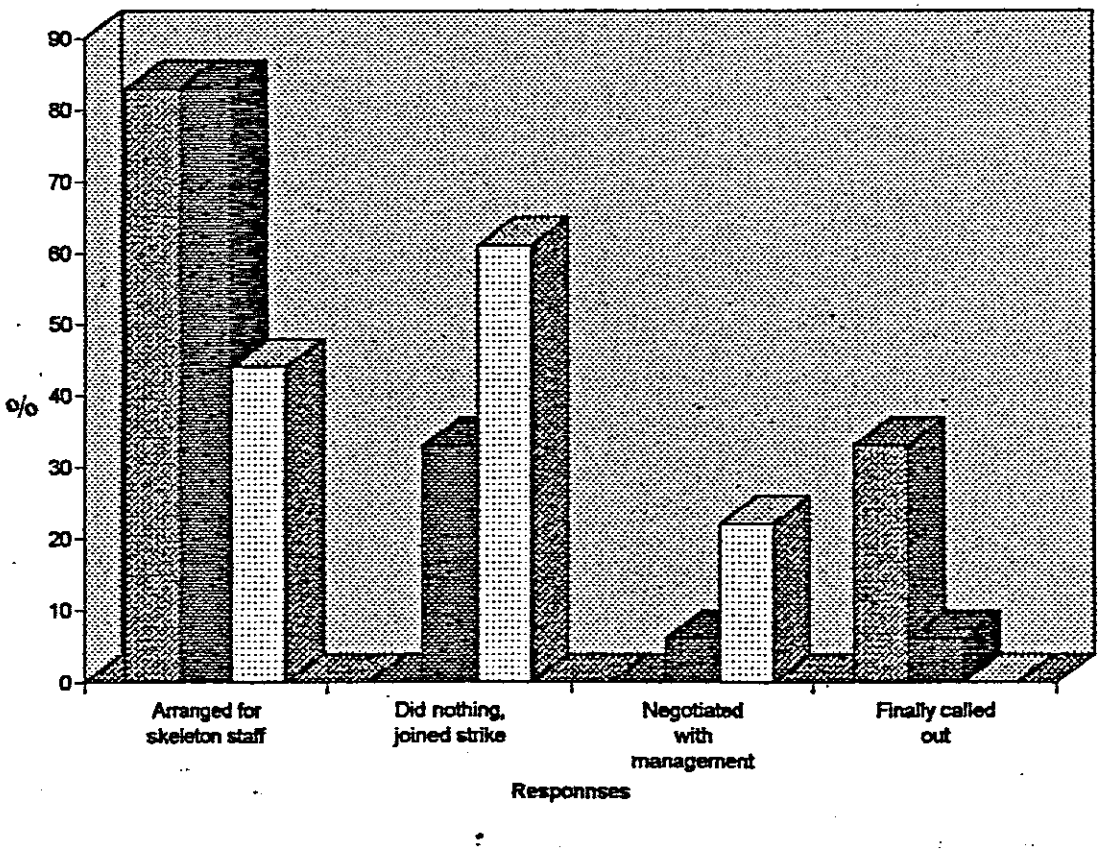
Similarly NEHAWU representative explained *"I am not for strikes ... I become very tense, I gear myself to ensure that my members benefit from the strike ... I become very emotionally involved in the strike. Anyway you don't have to show them that you are tense so they do not lose hope."* This finding is contrary to the popular belief that unions 'enjoy' using the strike weapon as a demonstration of their power.

The Director of Nursing Services expressed concern that the strikes would compromise health care delivery and lead to patients suffering, thus working against the philosophy that the patient is a nurse's first priority. She stated that she was saddened by the breakdown in communication that sometimes occurs in spite of their efforts to maintain open communication with institutional management and organised labour. She also expressed sadness about failure to negotiate and to use available Labour Relations and Human Resources Departments. She informed the researcher that there are workshops on effective communication. These workshops are targeted for all levels of management and workers. The researcher supports this strategy which is in line with the "Underpinning" stage of De la Bodeyere's LEGUP model described in chapter two of this report. The question to be asked is whether they are known and utilised effectively since they were not mentioned by the other participants.

ITEM 5 ACTIONS TAKEN WHEN AWARE OF STRIKES, INCLUDING PLANS FOR CONTINUITY OF PATIENT CARE

Many authors, including Botha (1986), Baird (1988), Reese (1991), Nel & Van Rooyen (1993), Kunene (1995), and Bezuidenhout *et al* (1998) agree that effective strike handling requires adequate planning to minimise disruption of services and injury or discomfort to providers or consumers of the service. This is of crucial importance in health care services where patients' lives are at stake. Strike plans are also aimed at minimising damage or destruction to property and interpersonal relationships as well as shortening the duration of the strike. Plans and actions in relation to the strikes under study are presented in figure 6.4.

FIGURE 6.4: PLANS FOR CONTINUITY OF PATIENT CARE



Key: ▣ Area Managers ▣ Professional Nurse ▣ Enrolled Nurses.

According to figure 6.4, 67% (28) of total sample, comprising 83% (5) area managers, 83% (15) professional and 44% (8) enrolled nurses indicated that arrangements for skeleton staff were made. These findings indicate a greater awareness of this arrangement among professional nurses and area managers since all except one participant in these categories respectively were aware of it. This is in line with their higher levels of accountability for quality patient care in comparison with the enrolled nursing categories where only 44% indicated such awareness. Among those who indicated that they did nothing but joined the strike, there were more enrolled nurses, 61% (11) than professional nurses, 33% (6).

Nurse Manager A stated that she found it very difficult to plan because all nurses were involved in the strike except senior staff who were the only ones available to continue nursing care. Nurse manager B stated that in her hospital there were meetings of all senior management, sectional nurse supervisors (matrons) and senior doctors to plan for patient discharges or transfers back to patients' original hospitals since her hospital is mainly a referral hospital. She stated that initially they managed to render basic nursing care since the strike started as a go-slow strike. Later they were physically prevented from continuing to provide care, therefore they got involved in discharge and transfer of patients before being forced to go and sit outside. These findings demonstrate concern among the health care providers about minimising disruption of patient care which is in line with the views of several authors including Baird (1988), Kunene (1995), Bezuidenhout *et al* (1998) and others. These authors agree that contingency plans are an essential requirements of successful strike handling. The findings indicate failure to plan for continuity of patient care. This can be related to lack of pre-warnings about the strikes and is indicative of an adverse impact on quality of health care.

DENOSA representative stated that they move in and get hold of their institutional representatives once they became aware of a strike. They would then find out from them if their members are involved and if they want DENOSA to intervene at that stage. She emphasised that they start their discussions with their members. They avoid starting their discussions with management because their members might doubt their loyalty if that happens.

Similarly, NEHAWU representative stated that in his organisation they talk to those people planning or involved in the strike, get their grievances, find out what they think would be the solution, then start the necessary negotiations. They conscientise their members about provisions of the Labour Relations Act, for example, they are told that they cannot strike while negotiations are in progress.

The Director of Nursing Services emphasised that it is very rare to find a strike occurring with no prior warning. This statement was not in line with responses to item 3 where the majority of participants indicated that they had no pre-warning about the strikes. They were mostly taken by surprise. She maintained that the hospital nurse managers in charge inform her immediately about threatening strikes, whether they materialise or not. Her department investigates how many nurses will be available during a strike. They can then decide how many patients can be cared for or how many wards will have to be shut down. In this regard the researcher reiterates her opinion that whatever information is given to the nursing directorate on threatening nurses' strikes may be too late to prevent actual strikes, or facilitate adequate plans to minimise disruption of services.

ITEM 6 DESCRIPTION OF THE MOOD PREVAILING JUST BEFORE OR AT COMMENCEMENT OF NURSES' STRIKES

In this item a description of the atmosphere or mood which prevailed just before or at commencement of the strikes was sought. This was based on the assumption that strikes do not erupt without any noticeable change in mood, behaviour or actions that would give an indication or suspicion of an imminent strike. Responses to this item are presented in table 6.4.

TABLE 6.4: MOOD PREVAILING BEFORE AND AT COMMENCEMENT OF STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Abnormal mood, wild, excited	27	64	3	50	13	72	11	61
Concerned about strike implications	3	7	0	0	3	17	0	0
Things appeared normal	15	36	3	50	5	39	7	56

(Respondents could give more than one response)

According to table 6.4 participants were divided in their perceptions of the mood that prevailed before and at commencement of the strike. The majority, 64% (27) of the total sample indicated that the mood was not normal. These comprised 50% (3) of the area managers, 72% (13) professional nurses and 61% (11) enrolled nurses. They noted that people were wild, excited, moving in and out in an unusual manner. From this finding it can be deduced that there was no open communication to explicitly express to other nurses or management the intention to go on strike.

36% (15) of the total sample stated that everything seemed normal before the strike. It is significant that 50% (3) area managers were not aware of any change of mood whilst the majority of professional nurses, 72% (13) and enrolled nurses, 61% (11) were aware, indicating a gap in communication between the nurses and their supervisors. The idea is not to inform nurse managers so that they can be taken by surprise and prevented from planning for the strike. Strikers believe that greater service disruption puts more pressure on management to negotiate and reach a settlement. This view is shared by Baird (1988:696) who relates the unwillingness to share strike decisions with management to the perception that it will weaken the strike.

On this issue, nurse manager A said *"it was as if people thought, the environment and the time was ripe for them to make representations to the powers that be ... so the general mood was as if they were saying '... we want change and we want it now.'* Describing the general behaviour of people she stated *"They felt authorities were responsible for their issues not being addressed, saying that people in authority are usually satisfied and are not doing much to address their issues."* When asked whom she meant by the 'powers that be', she explained that it did not mean only local management but also political structures and community members. She noted that people were emphasising *"We are going to a new government ... it must realise that we have been under these grossly deficient conditions and it is time they did something about them to put a stop to the stress that people have been operating under"*. This response is in line with the earlier observation that high expectations of instant eradication of perceived injustices of the past government had implications for strike activity.

Nurse manager B agreed with the participants who thought things were normal. She said *"We were not suspecting anything. We thought things were normal. That is why when I heard the shouting and singing I was just puzzled. It was very strange."* Again, this response contradicts the fact that there was already a strike by General Assistants. It is thus expected that the mood was not normal, so the 'shouting and singing' should not have been puzzling.

DENOSA representative stated *"In most cases you first sense, then you play it by ear, then you even see certain people's attitudes"*. She indicated she could sense a strike brewing when she was told that students held a 4-hour meeting with no prior permission as was usual practice. Thereafter songs were heard and she intervened by telling them that, even though they were right, they had started on a wrong footing. The students were advised to call off the strike and strategise.

When asked about the mood which prevails in a health service before a strike, NEHAWU representative made reference to tensions caused by divisions between

members of different organisations and those who are 'for' strikes versus those who are 'against' it. This finding is supported by Forrest (1996:58) who highlights multiple organisations in institutions as one of the constraints in strike decisions and strike handling.

NEHAWU representative also recalled that there was name-calling in the spirit of confrontation. The strikers were forcing everyone to join the strike. Non-strikers were called "*amagundane*" (mice) which "would be eaten by "cats" (the strikers). This is common jargon used during strikes generally to intimidate others to join. To support this Kunene (1995:84) found that one of the main reasons for unwilling participation in strikes was fear and intimidation by the strikers.

The Director of Nursing Services described the strike situation as life-threatening. She took these as real threats, not merely intimidation and agitation as she emphasised, *"They threaten to kill. They go about with coffins, written the name of the supervisor saying 'We are going to kill you'. They go about with tyres, burning tyres written the supervisor's name. All these are real threats. Therefore it does not just bring about intimidation ... people become scared, afraid and they flee from the workplace ... It is fear for life."* The researcher agrees that such inflammatory expressions instil a lot of fear and would lead to an altered mood at the workplace. This situation is not conducive to stability and a healthy environment suggested in Riehl-Sieca's Systems-Developmental-Stress Model.

ITEM 7 NURSES' AFFILIATION TO REPRESENTATIVE ORGANISATIONS (ORGANISED LABOUR)

In line with other anti-oppression campaigns of the beginning of the 1990s, mandatory membership of the existing professional associations for example South African Nursing Association (SANA), was withdrawn. Nurses were allowed to

form or join any organisation of their choice, hence the appearance of organisations like Concerned Nurses of South Africa (CONSA) in 1992.
CONSA played a significant role in mobilising nurses nationally against what it referred to as apartheid-based organisations, namely South African Nursing Association (SANA) and South African Nursing Council (SANC).

In this item, the researcher sought to establish which organisations nurses were affiliated to at that time when strikes occurred. This would be closely aligned with the next item which sought to discover if the nurses' strikes were organised or influenced by any organisation. It was also deemed important to establish if nurses had stuck to the organisations they were affiliated to at the time of strikes or if they had changed, and if so, establish if there were specific reasons why they had changed. Responses to this item are presented in table 6.5.

TABLE 6.5 NURSES' AFFILIATION TO REPRESENTATIVE ORGANISATIONS

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
NEHAWU	38	91	5	83	17	95	16	89
DENOSA	41	98	6	100	18	100	17	95
Don't know of any organisation	2	5	1	17	0	0	1	6

(Respondents could give more than one response)

Table 6.5 indicates that the leading representative organisations at the time of the strikes in 1994 were NEHAWU, a general union, as well as KNO and SANA, the nurses' organisations which were later dissolved in 1995 and 1996 respectively,

to form DENOSA which has both a professional and union leg. 98% (41) of total sample identified professional organisations (SANA, KNO, later DENOSA) respectively. 91% (38) identified NEHAWU. Membership of SANA or KNO was dependent on where the person was employed at the time. Since one of the hospitals was under control of the now defunct Natal Provincial Administration (NPA) nurses there belonged to SANA. The other hospital was under the now defunct KwaZulu Government (KZG), and nurses there belonged to KNO. During data collection, it was made clear that some nurses had withdrawn their NEHAWU membership after the strikes because they were not happy with the way NEHAWU handled the strike and they could not cope with payment of fees.

According to Nurse manager A, SANA membership was compulsory in her institution. She stated that there was mistrust in this organisation since nurses were against its emphasis on "patients as the nurses' first consideration" while no attention was given to the nurses' personal needs. It was also non-representative of all nurses, particularly the Black nurses. She mentioned that some nurses formed and/or joined the Concerned Nurses of South Africa (CONSA) which got involved in organising national and provincial workshops to lay a foundation for transformation of the nursing profession to address the perceived injustices of the previous apartheid-based professional bodies, SANA and SANC. She highlighted that when DENOSA was formed in 1995 nurses expressed a perception that it was useful only for professional issues, hence the dual membership whereby DENOSA members also joined another union which, in their opinion, would cater for their socio-economic and other employment issues.

In reference to general unions, nurse manager A highlighted that some nurses belonged to the National Workers Union (NWU), previously known as the Hospital Staff Association. She also mentioned NEHAWU which, in her perception, had few nurse members. In this regard she confirmed the nurses'

perception that many nurses who joined NEHAWU for protection during strikes could not cope with payment of fees and therefore dropped out. To support this, the NEHAWU constitution (1997) Clause 6.2.1 stipulates a subscription fee of not more than 1% of basic salary. This means that, for example, a member earning R4 000 a month would subscribe up to R40 a month, totalling R480 a year. This amount is higher than what is charged by professional organisations, for example DENOSA fees of R15 a month amount to R180 a year. Stating that some nurses were members of Hospital Personnel Staff Association (HOSPERSA), she explained that though it is mainly a WHITES union, it is preferred because of its loan facilities. She also noted that a few nurses belonged to the South African Democratic Nurses Union (SADNU) which was a newly-formed nurses union. According to these findings, it is clear that the membership was split among several organisations and this could have created problems of lack of consensus in decision-making on labour relations issues. These general unions are still operative in this hospital.

Nurse manager B stated that nurses in her institution belonged to KwaZulu Nurses Organisation (KNO) at the time of the strike. It was the professional organisation for nurses employed in KwaZulu Government-controlled health services. KNO was said to have been very active during the strike. For example the KNO president and other representatives were involved in negotiations with management for salary increases for nurses. Subsequently a 'rank promotion' system was introduced for nurses. She was also aware that NEHAWU was active in her institution. It was initially for general assistants but got some nurse members through canvassing during the strike. According to this nurse manager, only a few aggressive nurses joined NEHAWU. These included a few nurse managers and some senior nurse educators who later pressurised nurses to join. She also noted that when DENOSA was formed, many previously KNO nurses became DENOSA members.

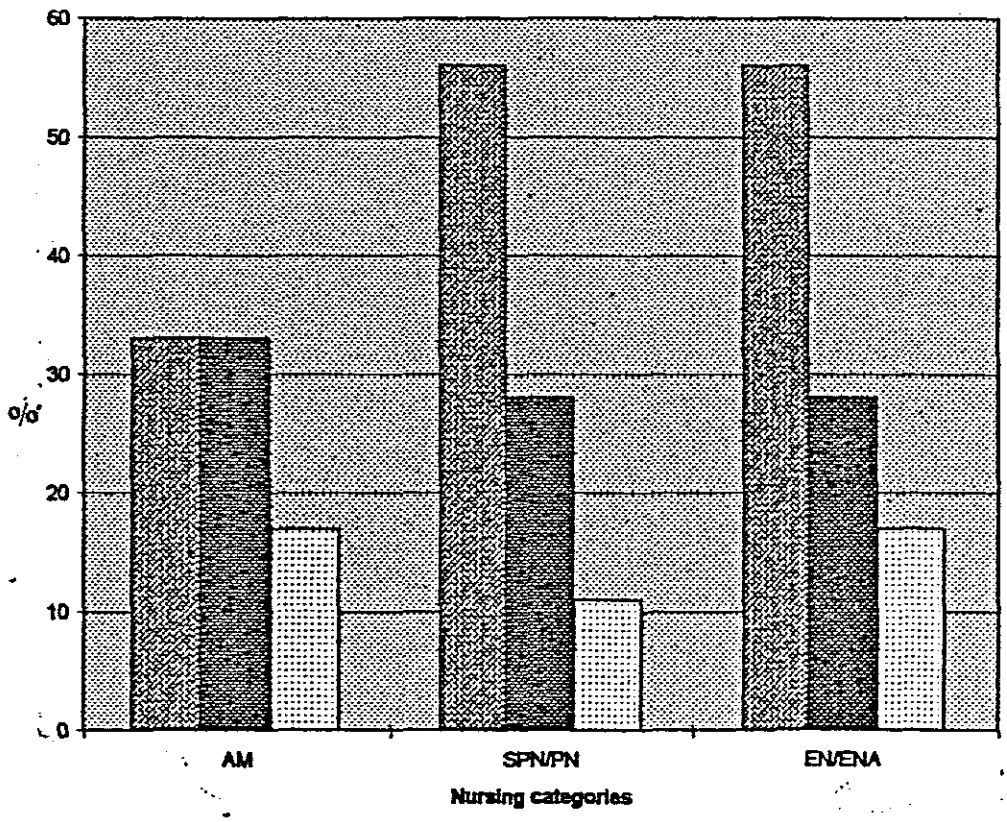
In the national survey of South African nurses done for DENOSA (Sitas *et al*, 1998:49-55)) it was found that the majority of nurses in South Africa, 90,2% were affiliated to a labour and/or a professional association. Out of the 1 000 nurses interviewed for this survey, 60,7% were DENOSA members; 5,8% had dual membership of DENOSA and another organisation; 17,9% were members of general unions 15,5% were not affiliated to any organisation. Professional nurses were found to be most likely members of DENOSA whilst sub-professional categories were more inclined to be members of other organisations (Sital, *et al*, 49-51).

The nurses' representatives and the Director of Nursing Services were not asked this item. It was limited only to the participants employed in the two hospitals under study.

ITEM 8 ESTABLISHING WHICH ORGANISATION INFLUENCED NURSES TO STRIKE

It is a general assumption and a requirement of labour legislation, e.g. the Labour Relations Act (66 of 1995) as amended that where employees are unionised, strikes will be called by the union after a strike ballot receives a majority vote in favour of the strike. In this study it was noted in item 3, as confirmed by NEHAWU representative, that most nurses' strikes were unprocedural and unprotected, meaning that they were not union-initiated. In this item participants were asked to state which organisation, if any, influenced the nurses to strike. Their responses are presented in figure 6.5.

FIGURE 6.5 ORGANISATION(S) THAT INFLUENCED NURSES TO STRIKE



Key: NEHAWU officials / Shop Stewards Not sure who influenced

Spontaneous, not Union

According to Figure 6.5, 52% (22) of total sample referred to NEHAWU as having influenced the strike, whilst 14% (6) stated that the strike was spontaneous with no union influence. This perception of the majority of participants is in contrast to the perception expressed by NEHAWU representative that the strikes were spontaneous and not called by any union. In view of the NEHAWU-supported general assistants strike reported in Hospital B, the assumption that NEHAWU could have influenced the nurses' strike is not unfounded.

In terms of the Public Service Act (105 of 1994) which was operational in 1994, these strikes were illegal because they did not comply with the stipulated 10 days' notice of strikes in the public service. Both hospitals under study were public health sector services. 29% (12) of the total sample indicated that they were not sure who influenced the strikes. This lack of awareness may be indicative of a lack of open communication in the hospitals concerned. In addition to the illegality of spontaneous strikes, the researcher strongly agrees with the DENOSA standpoint that patients should never be left without any nursing care in cases of strikes. The minimum 48-hour notice stipulated in the current Labour Relations Act (66 of 1995) as amended should be adhered to, to facilitate plans for continuity of patient care.

Both nurse managers A and B shared the perception that it was NEHAWU who influenced the strikes, yet again in contradiction to the NEHAWU representative expressing unawareness of the strikes. In the report of the Mall *et al* (1995:49) Commission it was confirmed that no worker organisation accepted responsibility for initiating the strike. However management was on record in this commission as saying that NEHAWU played a double role in the conflict and was suspected of supporting the strike.

The nurse representatives and nursing directorate were not asked this item since it was meant only for the hospital-based participants who experienced the strikes directly.

ITEM 9 ESTABLISHING WHAT ISSUES WERE CONSIDERED AS CAUSES OF THE STRIKES

As outlined in the conceptual model of this study the researcher assumes that issues referred to as causes of job dissatisfaction in item 1 are precipitating factors

for strikes in any employment setting, including nursing services. This item was included to establish what issues actually triggered the strike action, to determine whether it was new issues or long-term issues which had either been bottled up as indicated by NEHAWU representative (item 3) or were grievances which had been reported to employers or management but had not been attended to, as indicated by nurse manager B in item 4. According to Barnards Acceptance Theory of Authority described in Silverman's Social Action Theory, the issues that cause the strike are outside the acceptance or indifference zone. When 'strategy' used regularly fails to produce positive responses or effective adaptation the actors (nurses in this study) develop 'tactics' to deal with the specific undesirable action, hence this strike action undertaken.

TABLE 6.6 PERCEPTIONS ON WHAT ISSUES CAUSED THE STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Low salaries, unfulfilled promises	29	69	4	67	14	78	11	61
Medical Superintendent not wanted in one hospital	12	29	3	50	2	11	7	31
Dissatisfaction with staff office personnel and wrong staff recruiting system	12	29	3	50	6	33	3	17
Long hours of night duty, not paid for	12	29	3	50	5	28	4	22
Factors related to the government elections	14	33	0	0	7	31	7	31
Numerous unsolved problems	4	10	0	0	2	11	2	11

(Respondents could give more than one response)

Table 6.6 shows that low salaries and unfulfilled promises for salary increases were identified as causes of the strikes by the majority, 69% (29) of total sample comprising 67% (4) area managers, 78% (14) professional and 61% (11) enrolled nurses. This emphasis on low salaries is not in line with responses to item 1 where low salaries were not identified as a major cause of dissatisfaction. This may further support the assumption that, while salary dissatisfaction was a critical issue at the time of the strikes in question, it was no longer an issue at the time of data collection for this study since some salary progression had occurred, as reflected in table 6.2.

Other issues mentioned as causes of the strikes included removal of an unwanted medical superintendent from the hospital, long hours of unpaid night duty and dissatisfaction with staff office personnel and their use of wrong recruitment systems as causes of the strikes. In reference to the staff office issue, examples of several grievances highlighted to the Mall *et al* Commission (1998:100-110), include:

- concern that inadequate attention was paid to confidentiality in handling staff personal files.

- dissatisfaction with poor dissemination of information on conditions of service, legislation, staff codes, guidelines, procedures and circulars. To address this shortfall, there was a proposal that a Resource Centre be established where such documentation would be readily available for workers to scrutinise, with someone who could guide and interpret it for workers being available at specific agreed-upon times.

- dissatisfaction on the issue of circulars, whereby some staff members were privileged to see circulars long before the others, to their advantage particularly in regard to favouritism in promotions.

These are all communication problems which prevailed at the time. 19% (8) of the participants expressed concern about uncertainty in regard to factors related to the government elections, for example they demanded to be assured that they could use their right to vote and that their pensions would remain safe if there was a change of government. In both these issues, it was the hospital controlled by the then KwaZulu Government which was affected, hence the strike could be described as having political undertones.

According to nurse manager A, the first issue was unfair labour practice and discrimination. She stated *"... there was a feeling that promotions were unfairly done. The strikers were quoting the case of Indians occupying senior posts in the clerical division"*. Asked if this was a nursing issue, she replied ...*"it might not have been a direct nursing issue but it was a workers' issue"*. To support this, Fantasia (1988:10-11) supported by Forrest (1996:59) share the view that employees create solidarity and bonds with one another to prevent the isolation of the employment situation. Forrest advised that nurses should strengthen their collective bargaining power by aligning themselves with other employee groups. This poses a challenge for nurses not to lose sight of their professionalism and ethical responsibilities for patient care when that happens.

Another issue mentioned by Nurse Manager A was *"unhealthy conditions for patient care and ineffective ways of addressing patients' problems*. In this regard there is correlation with many overseas countries for example the United States of America and Canada where patient care issues, for example quality patient care and staffing ratios are the main issues of collective bargaining in health. To support these, inadequate facilities and resources were important causes of dissatisfaction in the previously disadvantaged, historically Black health care services in South Africa.

Nurse manager A also highlighted that *"nurses ... were complaining of ineffective management in addressing personnel issues."* She made the example that *"... nurses felt some personnel were being unfairly remunerated when they got the merit allowance. They said that everybody is working hard. How can you select somebody and say she is working hard? When people are working together it is hard to tell whose input was more important than the others."* In the Mall *et al* (1995:144) Commission report, the perception that merit awards were given to people who were favourites of the administration was expressed, quoting the R5 000 merit awards given to three nurses. The researcher sees this as a result of inadequate communication, hence personnel did not understand the criteria and procedure for merit awards. It may be explained as a form of pseudo-consultation which Scholtz (1991:139) describes as a strategy where management simply communicates predetermined decisions to employees.

Nurse Manager B shared the perception of the other nurse participants when she said *"One of the hot issues was political. Nurses were demanding to be freed from KwaZulu Government control so that they could go for elections."* Furthermore she noted that nurses resented that KwaZulu Government did not allow unions to operate in institutions under its jurisdiction. Another demand mentioned was that staff wanted to have all management removed, everybody in charge. Actually the medical superintendent had to leave because he was threatened. They also demanded to have the hospital closed so that it would open under new management. From these findings it can be deduced that there were political undertones in both institutions.

According to DENOSA representative *"Salaries are always number one ... even now one is not sure that we will not end up with strikes because of the salaries."* She also highlighted student dissatisfaction with implementation of certain policies, for example the policy of termination of students who had failed was not uniformly

implemented within and between institutions. Another issue noted was that students were not registered timeously with the South African Nursing Council even in spite of having paid their registration fees on time. The third issue mentioned was dissatisfaction with conditions of service. There were discrepancies between institutions and yet management expected the same quality of patient care. The researcher agrees that inequity was a typical feature of the social system and service provision before 1994. Equity became one of the priorities in the vision, mission, goals and objectives of the democratic government of 1994 in response to the implied and explicitly expressed expectations of the previously disadvantages citizens of South Africa.

Similar to his response to issues causing job dissatisfaction, the NEHAWU representative emphasised *"I will still put demands for opportunities for learning as number one"*, again making reference to the Enrolled Nurses Bridging course issue. To support this finding it is common knowledge that nurses in both hospitals were aggrieved that the number of places for the Bridging Course were limited. Only ten, later fifteen, could be taken on the course at any one time, resulting in long waiting lists. They were unhappy that some places in the course were reserved for outsiders. Furthermore, they alleged that they did not know the criteria used for selection. The explanation that taking more would aggravate the staff shortage, and thus necessitate creation of more posts, as well as require more space for accommodation in lecture rooms and more teaching staff was not acceptable to the enrolled nurses.

As a second issue, NEHAWU representative highlighted *"... the national programmes which get everyone involved in the strike. For instance it happened this year (1997) when the government failed to meet promises made last year (1996) in regard to salaries. So every member of NEHAWU on July 2 had to go on strike."* In this regard, he stated that a skeleton staff of NEHAWU members

was provided while other joined the national strike. It must be noted that it is only NEHAWU members who would be involved in such national NEHAWU strike, therefore non-NEHAWU members would continue to work. It is important to monitor the presence of the skeleton staff of the striking organisation.

As a third issue NEHAWU representative mentioned that nurses expressed frustration with management, though no specific issue was quoted. He explained that, as an organisation they were aware of these issues before the strike because they were always in touch with their members. However whilst they were involved in debates in the Bargaining Chambers, their members went on strike.

The Director of Nursing Services stated *"There was a strike because nurses refused to pay their licensing fees ... You see they reject the South African Nursing Council as an apartheid structure. They said they are not only professionals but they are workers too so they don't want to pay their licensing fees."* This refusal to pay the South African Nursing Council fees was a widespread issue in the country advocated by NEHAWU. It was in direct defiance of the Nursing Act (50 of 1978) as amended, wherein annual renewal registration is mandatory for all practising nurses in South Africa.

The Director of Nursing Services also made reference to the nurses' dissatisfaction with their salary packages. She said that they were unhappy with the coupling of ranks for example the rank of Senior Professional Nurses coupled with that of Chief Professional Nurses. In this practice people were given the same status, but they had different levels of responsibility whilst earning the same salary. Another issue mentioned was the students' demand to be allowed to sit for examinations without fulfilling academic requirements, for example, even if the compulsory tests were failed or not written.

Variability of responses to this item on causes of nurses' strikes makes it clear that there is no consensus within and between the various categories of nurses, the institutional and provincial Director as well as the nurses' representatives on the specific issues that caused the strikes in the two hospitals under study. To illustrate this, variation in perceptions on causes of strikes and their rank order is presented in table 6.7.

TABLE 6.7: RANK ORDER OF ISSUES PERCEIVED AS CAUSES OF THE NURSES' STRIKES BY THE PARTICIPANTS

RANK ORDERED ISSUES	NURSE MANAGER A	NURSE MANAGER 2	DENOSA	NEHAWU	DIRECTOR NURSING SERVICES
Issue No. 1	Unfair Labour Practice / discrimination	Political: Government Election-related	Low salaries	Demand for learning opportunities	Refusal to pay South African Nursing Council annual fees
Issue No. 2	Unhealthy patient care conditions	Prohibition of Union activity	Student dissatisfaction	Obligation to National NEHAWU strikes	Salary dissatisfaction
Issue No. 3	Management ineffectiveness in addressing personnel issues	Demand for complete change of management	Inequity	Frustration with management-	Students' refusal to comply with tests / examination requirements

ITEM 10 PERCEPTIONS ON WHETHER DEMANDS MADE DURING THE STRIKES WERE MET

Inclusion of this item was based on the premise that perceptions on outcomes of a strike have implications for future decisions on strikes. If nurses are convinced that the work situation improves in response to strike action, employers and management are challenged to address nurses' issues of contention before they become grievances which might end in strikes. According to the Systems-Developmental-Stress model, strikes may be used as a form of adaptation to a perceived stress change. According to the Social Action Theory people as individuals attach their own subjective meanings to the actions of others. When there is collective action, these meanings are shared, though individual differences persist.

TABLE 6.8 PERCEPTIONS ON MEETING OF DEMANDS

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
DEMANDS NOT MET No salary increments given	29	69	4	67	12	67	13	72
Only general assistants gained from the strike	7	7	0	0	4	22	3	17
Management took too long to address grievance	7	17	0	0	4	22	3	17
DEMANDS MET All demands were met	5	12	2	33	3	17	0	0
Medical Superintendent left	10	24	2	33	2	11	6	33
People were promoted	7	17	0	0	4	22	3	17
Assured that pensions were safe	6	14	0	0	3	17	3	17
Got paid for night duty	6	14	5	83	0	0	1	6
Moonlighting / overtime allowed	5	12	0	0	2	11	3	17
Elections uncertainties cleared	5	12	0	0	2	11	3	17
Grievance committee formed	5	12	2	33	3	17	0	0
Changes in staff office personnel and recruitment system	2	5	1	17	1	6	0	0

(Could give more than one response)

According to table 6.8, the majority 69% (29) of total sample shared a perception that demands were not met. When asked why they had this perception, only three reasons were given. 67% (4) area managers, 67% (12) professional and 72% (13) enrolled nurses expressed concern that no increments were received. In view of the salary progression reflected in table 6.3 of this report, the perception of no increment is questionable except if interpreted to mean that there is still dissatisfaction with improvements in salary.

Further on the issue of salaries, only 11% (2) professional nurses echoed nurse manager A's perception which she expressed in item 1 that only general assistants benefited from the strike by getting salary increases. Although this could be in line with the government principle of giving higher salary increases to those on lowest salary scales in order to narrow the gap between the highest and lowest paid, nurses interpreted it as an injustice when considering their professional status. Professional nurses in South Africa handle more responsibility to meet health care demands, especially with the shortage of doctors for effectiveness of the Primary Health Care System.

Another reason given by 22% (4) professional and 17% (3) enrolled nurses for the perception that demands were not met was that management took too long to address demands.

It was 12% (5) of the total sample who stated that all demands were met while other participants in varying proportions identified only specific demands which were met, for example, that the nurses got paid for night duty, eligible nurses were rank promoted and the Medical Superintendent was transferred to another hospital.

When asked to describe their perceptions of how nurses felt about whether their demands were met or not, nurse manager A acknowledged that some were met, saying *"... they were met partly. For example there was a reduction of the bed state ... from 1913 beds we were to admit not more than 1 600 patients. There were no more floor beds"*. She maintained that nurses could then be more productive and give better quality care. She also highlighted that nurses forums were formed thus management became more aware of problems in the institutions, and was more prepared to give a listening ear and communicate effectively.

On the merit award issue she said *"Instead of the merit system we now use the personal profiles. These are supposed to enable people with outstanding*

performances and incidences to benefit by getting increment before their actual time". She gave the example that if one's personal profile is outstanding, increment may be given after a year instead of three years. It must be noted though that the system of personal profiling was not well accepted by the majority of nurses who alleged that they were not involved in decision-making for its introduction, not given adequate training and guidance in its use and it was time-consuming.

Nurse manager B's responses indicated a perception that some demands were met. She stated that nurses were happy that they were able to join elections, the Medical Superintendent was transferred immediately and NEHAWU was allowed to operate through shop stewards comprising general assistants and nurses. In reference to working with unions, she expressed an opinion that they tended to make more demands on management prerogatives, for example, they demanded access to staff confidential files, post structure, to check documents to see if more staff had been requested and to be involved in staff selection. She expressed unhappiness with long, boring, unproductive meetings which were called by the unions and all management had to attend. This underlines the need for intensive training and guidance on how to work cooperatively and respect one another's prerogatives as needed. If the parties enter into collective agreements as stipulated in Section 23 of the Labour Relations Act (66 of 1995 as amended) this can be spelt out thus minimising conflict.

On the salary issue, nurse manager B indicated that "... *It was not addressed. The Department said they were still trying to amalgamate the services, so it was not possible to address the salary issue there and then".* However to state that the salary issue was not addressed at all is controversial in view of the salary progression and rank promotion already described.

In regard to the demand for closure of the hospital, nurse manager B stated that it happened and patients had to be transferred to other hospitals. She explained

"in fact that is one of the things which always breaks my heart when I think of what happened to those patients. She explained that patients were packed in ambulances, no time to find out how many beds each hospital had. Some patients were newly-operated upon. It was alleged that some were refused in the hospitals because of their political affiliation. This degree of suffering and inconvenience to patients and their relatives can be related to lack of strike notification resulting in haphazard management of patient care or patient transfers during strikes.

Both representatives of organised labour were of the opinion that generally the demands were not adequately met, even though they were aware that something was happening. DENOSA representative noted that for most issues, the common explanations were that "the issue is receiving attention", for example the salary issue. On the students' registration issue, she stated that students were registered and those who wanted to join DENOSA were encouraged to do so voluntarily. As stated in DENOSA constitution-clause 3, membership is voluntary and freedom of association is observed as stipulated in the Labour Relations Act (66 of 1995) as amended, chapter 2.

NEHAWU representative emphasised on the issue of the South African Nursing Council (SANC), stating *"Some of our cries in nursing have been the non-democratic SANC. We have always called for its transformation ... Something is happening, for instance as there are elections all nurses regardless of affiliation are part of the process. To support this finding the South African Nursing Council which was elected in 1998 according to Nursing Amendment Act (19 of 1997), is an all inclusive regulatory body comprising all categories of nurses including students, representatives of other health disciplines and the community."*

According to the Director for Nursing Services, nurses who had boycotted paying SANC fees started paying South African Nursing Council fees when reminded about their professional status and after explanations that they would not be

allowed to continue practising nursing if these were not paid, since it was mandatory. She also highlighted that consultations and meetings were held, salary structures were undergoing change and the staff were kept informed of proceedings.

ITEM 11 NURSES' PERCEPTIONS ON HOW STRIKES WERE HANDLED

Both employees or their representatives and management have a responsibility to ensure that a strike comes to an end as soon as possible with minimum disruption of services. This item sought to establish perceptions of nurses on how the strikes were handled.

TABLE 6.9 NURSES' PERCEPTIONS ON HOW THE STRIKES WERE HANDLED

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Frustrated, saw no end to strike	22	52	1	17	11	61	10	56
Felt humiliated since no benefit	15	36	2	33	6	33	7	39
Dissatisfied that strike was not handled well	9	21	2	33	2	11	5	28
ANC smoothed situation	2	5	1	17	1	6	0	0

(Respondents could give more than one response)

Table 6.9 shows that half of total sample, 53% (22) expressed frustration because they saw no end to strike, the majority here being 61% (11) professional nurses and 56% (10) enrolled nurses. Feeling humiliated that there were no benefits was

highlighted by more of the enrolled nurses, 39% (7) followed by 33% (2) area managers and 33% professional nurses. None of these participants expressed positive perceptions about the handling of the strikes.

Nurse manager A maintained that there was no real handling of the strike because it was spontaneous. She noted that some nurses did not want to be involved in the strike because they felt it was bad. According to nurse manager B nurses were divided on the issue of strike handling. She said *"Some were happy not to be working"*. It was not clear whether this was a fact or an assumption. She highlighted that everybody, including matrons, had to go and listen to union officials addressing them. She further reported that the College of Nursing had to close because of intimidation, initially from the general assistants, later from the nurses. She mentioned that a crisis committee was formed to deal with the crisis immediately.

DENOSA representative stated: *"I have not come across one who said she gained anything from the strikes. In the first strike some nurses were suspended by the South African Nursing Council, in the second strike they did not gain anything."* She added *"In my opinion, the community has become negative towards nurses and stopped allowing them to go to work during stay-aways" This could be due to the community thinking that nursing people might not be so important to the nurses anymore. The researcher shares the concern of DENOSA representative about lack of protection of nurses during stay-aways."*

According to NEHAWU representative, there was a general feeling among nurses that the strikes were not handled well. The tone and language used were not good. Expectations were not met, nurses' esteem and status were not recognised. Further, he explained that some nurses vowed that they would no longer be involved in "toyi-toying" because they were professionals. This is in line with the responsibility that nurses have to preserve life and alleviate suffering or pain by being 'available' to patients in need of care. It is the nurses' ethical commitment.

The Director Nursing Services differed from the other participants when she expressed the view that nurses were appreciative of the open consultative approach after the strikes. She emphasised that the nursing directorate at Head Office was supportive, approachable, understanding and physically available. She stated that there were less strikes at the time of data collection for this study. In her opinion, this was because Head Office personnel would go immediately to health services where strikes were threatening. While the researcher agrees that nurses' strikes are on the decrease, she argues that there are many extraneous variables to which this may be attributed.

ITEM 12 ESTABLISHING WHAT NURSING CARE ACTIVITIES CONTINUED DURING THE STRIKES

Nursing care remains a primary concern during strikes hence the need for strike notification to enable pre-planning in order to ensure that care can be continued while the strike is on. As previously stated this is regulated in Section 64(1)(b) of the Labour Relations Act (66 of 1995) as amended. In this item, participants were asked to list those nursing activities that could be performed during the strikes. Responses appear in Table 6.9.

TABLE 6.10 NURSING CARE ACTIVITIES DURING STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Patients discharged or transferred	32	76	6	100	12	67	14	79
Skeleton staff - professional nurses, matrons, doctors	15	36	3	50	10	56	2	11
Soldiers protecting staff	5	12	0	0	3	17	2	11
South African Red Cross support	3	7	3	50	0	0	0	0

According to Table 6.10 discharge and transfer of patients was identified by the majority, 76% (32) of total sample, comprising 100% (6) area managers, 67% (12) professional and 79% (14) enrolled nurses. 50% (3) area managers, 56% (10) professional and 11% (2) enrolled nurses agreed that some nursing care continued, rendered by doctors, matrons, professional nurses in charge and skeleton staff. These findings underline the need for pre-planning for continuation of services during a strike and formation of well-organised strike management teams. However, from these responses it is not clear what specific nursing activities were continued and if that nursing care was effective. Some participants added that soldiers were brought in to protect the skeleton staff. This tallies with the high degree of intimidation already described and gives rise to concerns about 'work ethic'. It was only area managers, 50% (3) who acknowledged that the South African Red Cross Society volunteers assisted with cleaning and one of them who was a former nurse assisted with patient care activities.

Nurse manager A observed that nursing care was given intermittently during the strike. She said *"some 'good nurses' gave good patient care while 'bad ones' were influencing others to stop rendering care"*. In her opinion, patients were generally neglected. According to nurse manager B, no nursing care activities

continued after the first 24 hours. The crisis committee was disrupting patient care and management meetings. She noted that there were threats that houses of people who continued to work would be burned down. There were urgent meetings with doctors to plan for discharge or transfer of patients. These responses are indicative of the difficulty experienced when strikes are accompanied with intimidation, threats and violence which shows a total lack of consideration for patients as consumers of the service.

In line with the nurse managers' views, DENOSA representative expressed her awareness that patients were fetched by their families or transferred to other hospitals because nurses were completely removed from patients during the strike(s).

NEHAWU representative stated that they provided their own skeleton staff from their members. They discussed their plans with management and offered their services. He added that his organisation was involved in making contingency plans. He highlighted that discharge and/or transfer of patients, though very costly, helped to focus limited resources so that patient care was not compromised. It is noted that this involvement of NEHAWU in planning patient care activities was not mentioned by any of the other participants, particularly the nurse managers who took the ultimate responsibility for patient care plans.

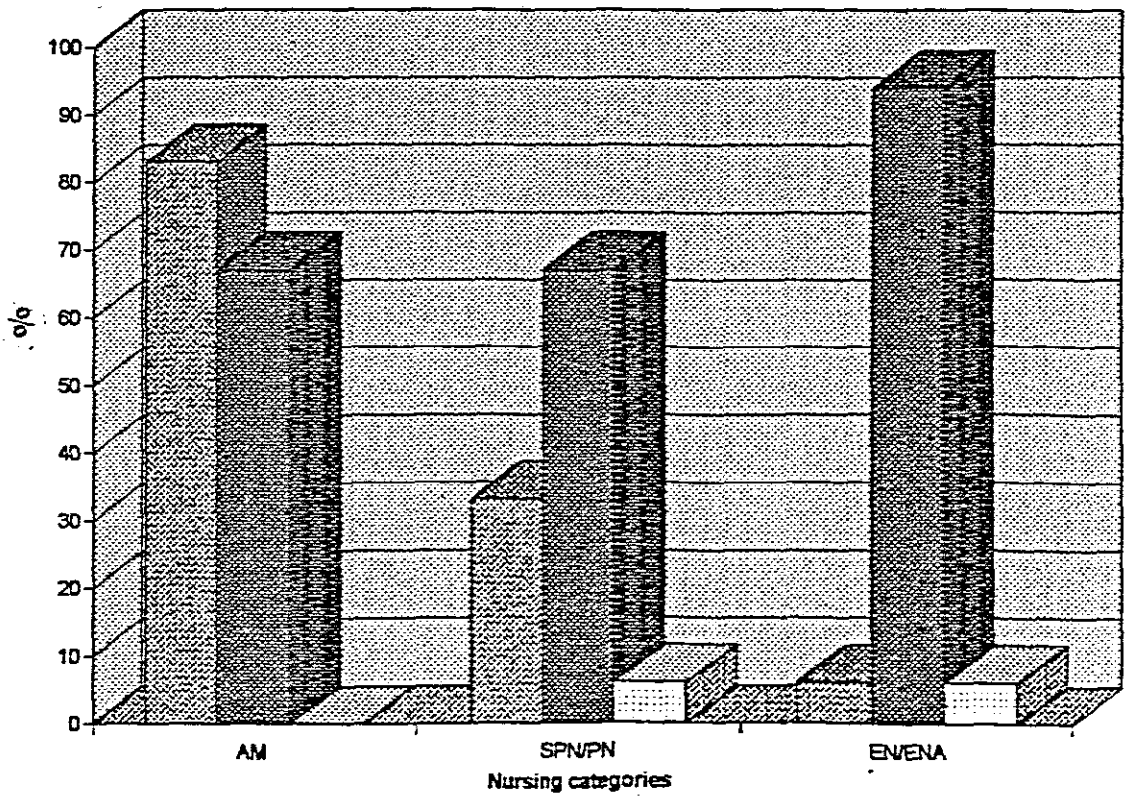
The Director of Nursing Services highlighted that health care and nursing service are essential services. For this reason all attempts are made to continue providing care. She agreed with the NEHAWU representative that organised labour makes arrangements that some continue providing care while others sit in. She added *"strikes had to be official according to conditions laid down by the Labour Relations Department and magistrate of the area through negotiations with organised labour."* In view of the nurse managers' responses, it is clear that these arrangements were ineffective and nursing care was disrupted, thus quality care suffered. In the study by Kravitz *et al* (1992) it was clear that there were few

adverse consequences because the strike was announced well in advance (Refer chapter 3).

ITEM 13 OTHER STRIKE INTERVENTION ACTIVITIES

In this item participants were asked to state any other specific strike intervention activities that they were involved in besides the patient care activities described in item 12. In seeking this information, it was deemed important to detect what actions might have facilitated control and ending of the strike or what might have contributed to its escalation.

FIGURE 6.6 OTHER STRIKE INTERVENTION ACTIVITIES THAT PARTICIPANTS WERE INVOLVED IN



Key: ▨ Control/part of skeleton staff. ▩ Sat outside doing nothing

▨ Member of nurses' forum

Figure 6.6 shows that all 95% (17) enrolled nurses except one, sat outside doing nothing. This applied also to 67% (4) area managers and 67% (12) professional nurses. This supports the need for discharge and transfer of patients as expressed in the preceding item. 83% (5) area managers and 33% (6) professional nurses indicated that they formed part of skeleton staff until they were forced to leave. They were also involved in control activities. This is in keeping with their level of responsibility for managerial and supervisory functions.

Nurse manager A described her main involvement as attendance of meetings with nurses' forum, organised labour and Head Office officials. Nurse manager B stated that while she was forced and intimidated to stop work, she did her best to persuade community members to urge striking nurses to return to work. In the researcher's opinion it is an extreme form of intimidation to force top management to stop work and sit with the strikers. In pursuance of her accountability for service provision, this manager stated that she compiled reports daily on the progress of the strike. The researcher agrees that this is an important foundation for later evaluation of the strike. She also expressed concern that some hospital property was stolen as there was vandalism.

DENOSA representative reiterated that in her organisation they would move in to the health service or any setting with a nurses' strike, assess the situation and assist as needed by their membership. This is in line with their dual responsibility to protect their members as well as patients and thus help to preserve the image of the profession.

NEHAWU representative indicated that his organisation would go to the strike scene to mark attendance registers. His organisation used the strike to run workshops for their members. They also invited specific people to address their members. He maintained that his organisation was actively involved in articulating the strike situation to the community. In this regard, the importance of giving the community a balanced report from all the stakeholders cannot be overemphasised.

He observed that the spirit of the strike continued in the form of talks, singing and dancing.

The Director of Nursing Services expressed her main involvement during strikes as visiting the hospital, to be visible and to have discussions with management.

ITEM 14 ESTABLISHING WHAT SUPPORT WAS OBTAINED DURING STRIKE INTERVENTION

This item was based on the premise that a strike is a crisis situation, therefore those involved in it or affected by it may need support to enable them to cope. Support may be obtained from various sources, for example, families, communities or their representatives, colleagues — both strikers and non strikers, management, employing authority, politicians or government, unions — both nursing and general unions, and any other. Responses to this item are presented in table 6.11.

TABLE 6.11 SUPPORT OBTAINED DURING STRIKE(S)

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
No response	30	71	0	0	12	67	18	100
Management involved in negotiations	6	14	4	67	2	11	0	0
Medical Superintendent called in soldiers	6	14	3	50	3	17	0	0
SA Red Cross support-giving nursing care	3	7	2	33	1	6	0	0
Union present to give support	2	5	1	17	1	6	0	0

(Respondents could give more than one response)

According to table 6.11, it is evident that none of the enrolled nurses responded to this item, indicating that they were not aware of any support worth noting.

67% (4) area managers and 11% (2) professional nurses acknowledged that management assisted in negotiations. 33% (2) area managers and 11% (2) professional nurses stated that the Medical Superintendent called in soldiers to protect non-strikers and enforce a lockout. In view of the intimidation reported earlier in this report, this was an important form of support and security.

50% (3) area managers and 17% (3) professional nurses observed that Head Office personnel were not visible. This is contrary to evidence given to the Mall *et al* (1995:138) Commission where it was pointed out that authorities who came to negotiate with the strikers, including the Provincial Minister of Health and other KwaZulu-Natal members of parliament, NEHAWU and COSATU leaders, were defied and treated rudely.

It is noted that union presence and support was mentioned by only one participant each in the area managers and professional nurses category. This is contradictory to NEHAWU representative's statement that they were at the strike scene supporting their membership.

Nurse manager A acknowledged that Head Office officially gave support during the strike, for example, at times the Natal Provincial Administration (NPA) Director of Nursing would come to the hospital and spend the night negotiating and trying to resolve the issue. Generally this finding indicates that there was minimal support that strikers got from the employing authority while management got most of the support.

Nurse manager B also acknowledged Head Office support though she stated that Head Office officials could not come physically to her hospital because it was

unsafe and too dangerous. She mentioned that, nevertheless, contact with Head Office personnel was maintained per phone. She further indicated that support was obtained from the Hospital Christian Fellowship who were very active. They conducted morning prayers at the strike scene and tried to calm the people. She also mentioned that the religious bodies were praying for the hospital. She highlighted that her family gave support since they were worried that people in charge were always targeted in cases of strikes.

The nurse representatives and the Director of Nursing Services were not asked this item as it was deemed not to be directly applicable to them.

ITEM 15 CONSULTATION WITH CONSUMERS OF HEALTH CARE IN REGARD TO THEIR VIEWS ON NURSES' STRIKES

In addition to their own perceptions of the impact of nurses' strikes, nurses need to be in constant consultation or communication with the community so as to be in touch with their views on nurses' strikes. It is the consumers of health care who are directly affected by withdrawal of nursing care when strikes occur, therefore their views are important and should be considered in strike decisions. Responses to this item are presented in table 6.12.

TABLE 6.12 CONSULTATION WITH HEALTH CARE CONSUMERS ON NURSES' STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
No response	30	71	0	0	12	67	18	100
Lost public support and respect	11	26	5	83	6	33	0	0
No formal consultation, heard remarks	6	14	3	50	3	17	0	0
Communication boards formed	2	5	1	17	1	6	0	0
Communication through media	2	5	1	17	1	6	0	0

(Respondents could give more than one response)

Table 6.12 shows that all enrolled nurses 100% (18), and 67% (12) professional nurses gave no response to this item. This finding signifies a major lack of awareness of communication with consumers of health care on how they view nurses' strikes. 50% (3) area managers and 17% (3) professional nurses stated explicitly that there was no formal communication in this regard. They only heard remarks in the public transport about how the public views nurses' strikes. They further stated that the public was informed about nurses' strikes through the media.

To support the preceding finding and a previous statement on newspaper publicity on hospital care, Nurse manager A confirmed that radio and television were sources of information on nurses' strikes. This finding is significant because the media is an important instrument in shaping society's views on day-to-day issues. Therefore if nurses' strikes are portrayed negatively in the media, community views tend to be negative, and vice-versa. This underlines the importance of openness of communication between health care providers and consumers as well the importance of health authorities and organised labour taking responsibility to disseminate accurate official reports on strikes.

Nurse manager B reported that there was a six-month old hospital board which consisted of community representatives. She was aware that it was informed, about the strike situation in her hospital. In this way the community was kept informed. She also highlighted that the Medical Superintendent was involved in writing newspaper articles daily to keep the public informed.

DENOSA representative noted that there was not much communication and, on reflection about the salary issue she said *"... it has dawned on my mind that we should look at having some meetings, ... perhaps we should involve the community, because on of the things that nurses are bitter about is that they are overworked."* She went further to quote the example of *"... introduction of the free health services. Nurses are very bitter about this because in the first place they were never consulted. Secondly the community has never been educated on how this has got to be used, for example clients go from one clinic to another collecting treatment for one problem without counting the costs."* In support of this finding, it is evident that expectations of the community are not met if the free health services are crippled by lack of resources, for example medications. The need for intensive education to prevent abuse of the free health services by the consumers is strongly supported.

NEHAWU representative stated that his organisation accepted it as its responsibility to inform the community in advance about hospital strikes. This is done though radio announcements or distribution of pamphlets in taxis or to various organisations through which they can reach many people. The aim is to reach everyone, especially in their area of jurisdiction.

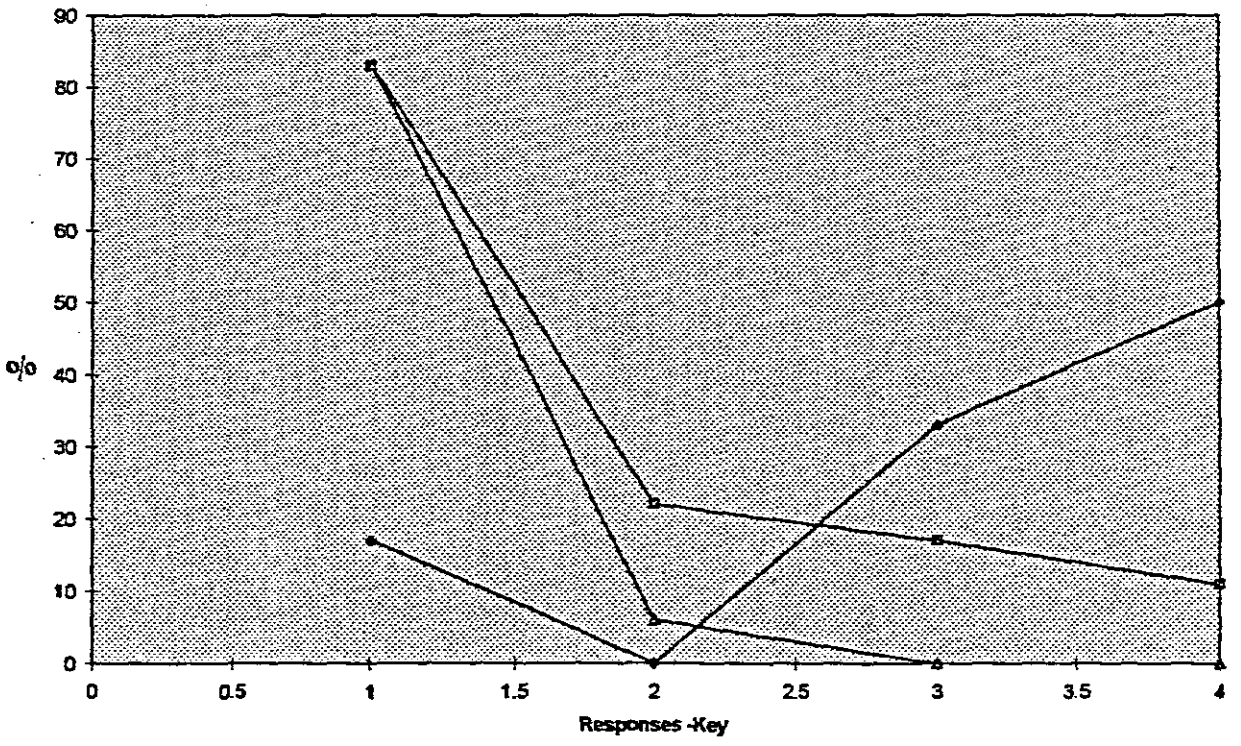
The Director of Nursing services stated that there was community participation in health care issues, adding *"The committees, hospital management committees also co-opt community members. ... they are representing the community. Therefore our policies are 'people-driven' because the community is there"*. This is in line

with requirements of the National Health Department based on the government principles of the Reconstruction and Development Programme.

ITEM 16 DESCRIPTION OF FEELINGS DURING THE STRIKES

A description of pre-strike feelings was given in item 4. Inclusion of the item to establish feelings during strikes was based on the premise that as the strike progresses, the manner in which it is handled may be approved or disapproved, thus there may be changes in feelings. It was noted that pre-strike feelings were predominantly guilt and frustration. According to the Social Action Theory people are sometimes forced to act against the internalised social norms but they feel guilty retrospectively. Figure 6.8 presents the participants' feelings during the strikes.

FIGURE 6.7: FEELINGS DURING THE NURSES' STRIKES



Key: Area Managers Professional Nurse Enrolled Nurses

1 = Depressed and panicky

2 = Worried that they would not be paid

3 = Tired of sitting; wanted strike to end

4 = Scared because non-strikers were intimidated

Feelings presented in figure 6.7 suggest that nurses were negative about the strikes since the majority, 74% (31) of total sample, comprising 83% (15) of professional nurses and enrolled nurses respectively with only 17% (1) area manager stated that they were depressed and panicky. These were similar to the pre-strike feelings expressed in item 4.

A smaller percentage of 33% (2) area managers and 17% (3) professional nurses indicated that they were tired of sitting and doing nothing. None of the enrolled nurses expressed this concern. This may be related to the different levels of responsibility between the professional and enrolled nursing categories. The Social Action Theory supports the fact that people exposed to the same reality may react differently based on the subjective meanings attributed to that situation.

Though reports circulated in the media about strikers not getting paid or threatened with 'no pay', it was only a minority, 22% (4) professional, 6% (1) enrolled nurse and none of the area managers who expressed worry and concern that they might not be paid for time not worked. This fear was not unfounded because the 'no work no pay' practice was later legalised through inclusion of Section 67.3 of the Labour Relations Act (66 of 1995) as amended, which stipulates that "... an employer is not obliged to remunerate an employee for services that the employee does not render during a protected strike or a protected lockout...". If loss of earnings happens, striking employees might experience financial difficulties. The researcher supports establishment of Strike Funds by organised labour to assist strikers who are not getting part or all of their salaries. An example described by Haines (1987) is the New South Wales Nurses' Association Strike Fund established in 1986 to assist nurse members involved in approved industrial action. Guidelines for distribution of this fund were given by Haines for example

- given to members experiencing financial hardship, as determined by its Executive committee,

- given to meet basic living costs, for example food and rent. For food, distribution of food vouchers is preferred to cash payments.

Nurse manager A expressed her feelings, saying *"I was disgusted and unimpressed to see the way nurses were behaving"*. This feeling may have been aggravated by

some incidents reported in Mall *et al* (1995:140), for example her office and the Medical Superintendent's offices were occupied by noisy, 'toyi-toying' strikers, including nurses. When asked why this was done, one of the strike leaders explained to the Commission that workers felt management was not doing enough to get administrators from Head Office to the hospital. In the workers' opinions, management was free and happy in their offices while people were roasting in the sun. Therefore occupation of offices was aimed at forcing them to do something.

This nurse manager further explained that, in her concern about the nurses' behaviour, she introduced a bioethical course to keep her staff up-do-date with ethical implications of their behaviour and actions. Case studies were done on how to handle strikes. The aim of these was to identify ethical issues and to facilitate ethical improvements in patient care.

Nurse manager B expressed fear of the unknown since she did not know how long the strike would take, so there was quite a lot of frustration. She expressed a feeling that the authority of people in charge was challenged especially when some nurses openly made statements like

"...nurses are now free to do as they want"

"... those who want to go for training should just go straight to college and not worry about Matric certificates"

"... nurses who want to change from one ward to another or from night duty to day duty and vice-versa should just change. It is their right."

Nurse manager B stated what concerned her most was that the other nurses were laughing, shouting and clapping hands in typical mob spirit to show their approval as all this was said. In view of the statements just quoted, it is deduced that it was difficult for management to maintain a healthy hospital environment.

DENOSA representative stated that the strike was very distressing to her and she felt helpless. She explained that the 1994 strikes occurred during a transition

period in the nursing profession. Membership of organisations was not clear especially because some nurses had decided to stop paying annual subscriptions. Therefore as nurse representatives they were not sure whom they were representing. It was also difficult because organisers of the strike were not known, though people were physically removed from their work situation. She reaffirmed that in her opinion the strike was politically motivated.

NEHAWU representative repeated that though personally he was not for strikes, as a leader he had to identify with the strike, feel that he is engaged in it and strive to get the best settlement for the members. He said *"NEHAWU members are advised to constantly review the strike and check if it is still necessary"*. This may be interpreted as an indication of a desire for the strike to end. The union needs to get a mandate from its members to end a strike. He stressed that in his organisation they do not want to be defeated and they take care not to wait until management has applied its tactics to deal with the strike. He stated that they are always proactive so as to ensure that members do not lose faith in them.

The Director of Nursing Services expressed her feelings during strikes as fear, then anger, hostility, aggression and uncertainty. These feelings are in line with her responsibility for the overall quality of nursing care in the province.

ITEM 17 IMPACT OF THE NURSES' STRIKE(S) ON THE NURSES AND ON THE NURSING PROFESSION

This item sought to establish perceptions of the research participants on what impact the strikes had on nurses as individuals, taking into consideration the physical, social and psychological impact. It also sought to establish perceptions on the impact of strikes on the nursing profession, considering nurses as a collective, with various categories and diverse responsibilities.

TABLE 6.13 PERCEPTIONS ON THE IMPACT OF NURSES' STRIKES ON NURSES AND ON THE NURSING PROFESSION

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Lost public support and respect as a nurse	39	93	6	100	17	94	16	80
Not myself, unhappy, unhealthy	32	76	5	83	13	72	14	76
Aware of public concern about strike implication	31	74	5	83	14	79	12	67
Fear of retrenchment and no earnings	8	19	0	0	6	33	2	11
No specific social impact	7	17	1	17	2	11	4	22
Happy with relief of tensions	4	10	0	0	0	0	4	22
Forced to be away from families, merely sitting	2	5	0	0	0	0	2	11

According to table 6.13, the majority of total sample, 93% (39) shared the perception that the nursing profession lost public support and respect because of the strikes. This indicates that nurses are concerned about how the public views them. In addition the majority, 83% (5) area managers, 79% (14) professional and 67% (12) enrolled nurses indicated their awareness that the public was concerned about strike implications. As indicated in item 15, this concern was heard mostly as remarks in public transport and in the media. This confirms the challenge for formalisation of systems of communication and consultation with the community on nursing issues and problems. 83% (5) area managers, 72% (13) professional and 78% (14) enrolled nurses stated that they were not themselves, they were unhappy and their physical health was affected. Those with chronic illnesses like hypertension and diabetes reported acute exacerbation of their conditions which they attributed to stress and irregular meals.

Fear of retrenchment and loss of earnings was expressed by 33% (6) professional and 11% (2) enrolled nurses but none of the area managers. This lack of fear among area managers may be interpreted to mean that, though they were prevented from continuing with patient care activities, they were convinced that they had not participated in any unethical behaviour.

Positive perceptions on the impact of strikes on nurses was expressed by enrolled nurses only, a minority of 22% (4) who stated they were happy because the strike served as a relief of tensions. This could possibly relate to tensions experienced before and during the strike as the hospital changed to become a strange or unfamiliar environment.

Interviews with the nurse managers in charge of the hospitals revealed that they did not suffer physically, but the strikes had an impact on them emotionally and psychologically. Nurse manager A explained that she was emotionally disturbed by ill-treatment and neglect of patients, as well as of other staff members, for example some staff members had their houses burnt for having refused to participate in the strikes. The expressed emotional disturbance is in line with the responsibility that nurse managers have for the welfare of patients and staff. On a positive note on the impact of the strikes on the nursing profession, this nurse manager noted that there was increased awareness of the Labour Relations Act as a mechanism to address labour issues.

Compared to Nurse Manager A, Nurse manger B expressed more negative, destructive effects on her as a person. She suffered emotional trauma and stress. She felt destroyed, helpless and useless in that she could not help patients and she was in charge but could not do a thing to manage the situation. She explained that she was too depressed and her family was worried about her daily, thinking that she might break down because of the depression. What was worse in her opinion was that nothing had changed since the strike, nurses were still dissatisfied.

Status-wise, nurse manager B said *"You know, even when you addressed a meeting you felt that you have been weakened. I was no more myself. I knew myself as a very firm person ... but all that had changed. I could see myself changing as subordinates came into my office. I would just expect that the person is coming to say something silly. Maybe someone has not been on duty for the whole month with no report. When you call her she just asks you 'why did you call me? Is this money coming from your pocket?'"* Describing the impact of the strike on her socially she said she was embarrassed when people started feeling sorry for her even in social gatherings where they would say "... Oh, shame matron, we wonder what is happening now at the hospital". She felt she was a sorry sight. Considering her position and status, it is evident that her concern for her image was not unfounded.

With regard to the impact on the nursing profession, nurse manager B made reference to low morale, lack of discipline, unreasonable demands. For example, students challenged nursing college rules of promotion and termination, demanded unprocedural extension of training and demanded to see their examination scripts. It is confirmed in the report of Mthiyane Commission of Inquiry (1997:56-57) that numerous long-term disputes existed in the College of Nursing.

The representatives of organised labour and nursing directorate were asked about their perceptions on the impact of strikes on hospital management.

DENOSA representative expressed the opinion that the strike had no effect on management otherwise they would have been more careful. To substantiate her opinion she said *"I think they tell themselves it is one of those things. It is even worse now that they have got this policy of 'no work, no pay'. They tell themselves, 'Let them go on strike. We will deduct their pay at the end of the month'"*. This may be seen by nurses as a further sign of insensitivity. She also highlighted that there were numerous unfounded allegations which, in her analysis

as a representative, were due to inadequate communication. This further underlines the need to re-visit communication structures and procedures.

NEHAWU representative stated that some managers did not come back after strikes. They chose to resign or request transfers. He explained that after strikes Commissions of Enquiry are appointed to investigate and some managers feel dejected if found to have been wrong or to have messed things up. Other managers become hostile to personnel who went on strike.

The Director of Nursing Services quoted fear and intimidation as the effects of strikes on management. She stated that as a result *"They demand more security, demand protection, demand place for squatting, demand more police, they even demand that Security guards should be armed"*. In view of the high level of intimidation described, it is imperative that steps should be taken to protect management, personnel and consumers of the service.

ITEM 18 IMPACT OF THE NURSES' STRIKES ON QUALITY OF HEALTH CARE

Primary concern over nurses' strikes is the possible negative impact on the quality of patient care. In this regard, it is important to avoid a biased view based on general assumptions and include an item in which those who have been involved in nurses' strikes, directly or indirectly, and those who were affected by them can describe how they perceived the impact on quality of health care. Literature has shown that when nurses strike, their concern about improvement of their work conditions is due to their desire for improvement in quality of the care rendered to patients or clients. They therefore take cognisance of the possible short-term adverse effects of the strikes but consider long-term gains in patient-care conditions (McSwain, 1991) (Kravitz *et al*, 1992) (Casey, 1995).

TABLE 6.14 PERCEPTIONS ON THE IMPACT OF STRIKES ON QUALITY OF HEALTH CARE

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Poor quality, patients neglected	41	98	6	100	18	100	17	94
Nurses unruly, refused instructions	3	7	0	0	2	11	1	6

(Respondents could give more than one response)

According to table 6.14, participants were unanimous in the perception that quality patient care was adversely affected because patients were neglected while nurses were not working. In item 12 it was evident that even those who wanted to continue rendering patient care were prevented, to the extent that they were physically removed out of nursing units.

Nurse manager A firstly pointed out long-term positive effects of the strike, namely that the bed state was reduced and no patients were nursed on floor beds. This was a relief to nurses who saw it as inconvenient and dehumanising to be indecently exposed while caring for patients under beds. She agreed that quality care during the strike was "zero" and nurses' attitudes towards patients changed. Nurses became sluggish for as long as they felt their needs were not met. She mentioned that it took a long time for nurses to regain positive attitudes towards patients.

Nurse manager B also stated that standards of care dropped to "zero". The environment was filthy, for example, rubbish bins were emptied in the wards. Obviously no quality patient care can be provided in such a non-therapeutic

environment. She expressed concern that neighbours informed her that a family member who was asthmatic with cardiac problems died probably because she had to go to another hospital to wait in the queue because the hospital where she used to come and get prompt attention was closed. The researcher's view is that any death occurring during a strike needs to be investigated. It might or might not be as a result of the strike. According to Van Tonder (1992:31) even a single death that can be linked to nurses' strike action is unacceptable.

DENOSA representative supported the notion that sporadic strikes in the province had a "terrible" impact on quality of nursing care. She quoted an example of a maternity case who went to three hospitals which could not attend to her because of the strikes. When she eventually got attention in the fourth hospital, there were serious complications.

NEHAWU representative shared the view that services to patients and to the community were severely affected. He emphasised that in his opinion strikes are never a solution and they compromise patient care whether they occur in a single or a number of institutions. During the period of the strikes in question several institutions were affected.

The Director of Nursing Services supported the view that quality of patient care was lowered and compromised because the number of nurses was decreased therefore nurse-patient ratios were high. This poses a challenge for more effort to be put into making plans for continued patient care during nurses' strikes and devising systems for effective implementation of those plans.

According to the responses to this item, it is evident that the only positive impact was reduction of the bed state with no more floor beds in hospital A, otherwise all participants identified a negative impact on the quality of care.

ITEM 19 IMPACT OF NURSES' STRIKES ON OTHER MEMBERS OF THE HEALTH TEAM AND THE INFLUENCE OF OTHER MEMBERS OF THE HEALTH TEAM ON THE NURSES' STRIKES

Considering that quality of health care is a product of the continued efforts of the multidisciplinary health team executing their interdependent roles it was deemed important to include this item. In the study by Baird (1988) it was found that physicians were concerned about disruption of patient care whilst also in sympathy with the nurses' problems. Responses to this item are presented in table 6.15.

TABLE 6.15 THE NURSES' STRIKES: IMPACT ON OTHER MEMBERS OF THE HEALTH TEAM AND HOW THE OTHER HEALTH TEAM MEMBERS INFLUENCED THE NURSES' STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
General assistants enjoyed the strike and forced nurses to join	37	88	6	100	16	89	15	83
Doctors unhappy, overworked, some had to work in other hospitals	32	76	2	33	13	72	17	94
The team was stretched, matrons and doctors did all the work	7	18	4	67	3	17	0	0
Doctors divided, some for, others against	2	5	2	11	0	0	0	0
Improved relations, togetherness in the struggle	2	5	0	0	1	6	1	6
No-one wanted the strike, all wanted it to end	4	10	0	0	1	6	3	17

(Respondents could give more than one response)

Table 6.15 shows that the majority, 88% (37) participants comprising all area managers, 100% (6), 89% (16) professional and 83% (15) enrolled nurses expressed a perception that general assistants enjoyed and joined the strikes, or in some cases initiated the strikes and intimidated the nurses, forcing them to join. It has been noted that the general assistants were NEHAWU members. Report of the Mall *et al* Commission of Inquiry (1995:133-142) confirmed widespread intimidation during strikes.

While 11% (2) professional nurses stated that doctors were divided for and against the nurses' strikes, the majority, 76% (32) of total sample, comprising 33% (2) area managers, 72% (13) professional and 94% (17) enrolled nurses shared the view that doctors were unhappy because they were overworked and had to work in other hospitals. 67% (4) area managers and 17% (3) professional nurses acknowledged that the team was stretched, matrons and doctors had to do all the work and it was taking a toll on them. According to the Systems-Developmental-Stress Model, if nurses' functions are disrupted then the functioning of the whole system is not in equilibrium and this leads to a stress state that further calls for adaptive strategies.

On this issue, nurse manager A said *"To be honest with you, some doctors were encouraging nurses to strike because they felt that conditions for patients were appalling and needed improvement"*. She emphasised that everybody was in the same predicament because they also had grievances. However she noted that some doctors actually remained behind and nursed patients, specifically two doctors whom she saw caring for patients and doing the best they could when everybody had left the ward. This further underlines the interdependence of the various disciplines or groups in the multi-disciplinary health team.

In particular reference to nurses influenced by other health team members, she stated with conviction *"Nurses were actually influenced by general assistants but*

when the general assistants had their salaries increased more than that of nurses, then the nurses felt they could not assist the general assistants who had substantial advancement in their salaries". She quoted incidents where some general assistants earned the same salary or more than some enrolled nursing auxiliaries then - *"the general assistants would laugh at this whole thing and say 'Just look at them! They say they are educated but we are using them and they are earning less than us'. That made the nurses very uncomfortable".*

Nurse manager B shared the perception that *"Doctors were badly affected. Some were fed up because of their own conditions of service. They were also complaining about their salaries and allowances. The territorial allowance was stopped or grossly reduced. All White doctors were getting a territorial allowance. They were getting this allowance for working in Black institutions."* She also highlighted that doctors were affected by lack of discipline to the extent that even their prescriptions were not carried out, thus impacting on the quality of patient care.

On influencing nurses to strike, nurse manager B also said *"... General assistants were the very people who were intimidating nurses. Some clerical staff were involved. Some were in the crisis committee and were very influential".* This poses a further challenge to organised labour to maintain discipline among their members during strikes.

DENOSA representative also noted that doctors were doing everything, they found themselves providing care which would otherwise be given by the nurses. She indicated that predominantly nurses were influenced and she could not remember a single strike which was purely a nurses' strike. Nurses are drawn in on the belief that *"... by pulling nurses in, it would have more effect on management:* Forrest (1996:60) supports this viewpoint. This belief is probably based on the premise that, because nurses take responsibility for direct patient care,

management would succumb to demands faster if nurses stop working. She further noted that professional nurses, except for a few, were not very active on strike matters, it was more the enrolled categories who were involved.

NEHAWU representative also shared the view that nurses' strikes have a negative impact because *"nurses are the engine of the health care team ... they nurse the patient totally. Also in some administrative situations the bulk of the work is done by a nurse ... the doctors will try to stretch themselves, but most definitely it is true that nobody can do it better than the nurse"*. To support this, the researcher confirms that the core of nursing is CARING, the nurse is next to the patient for 24 hours a day and is the coordinator of activities of the health care team to ensure holistic care.

On influencing nurses to strike, the NEHAWU representative said *"That is what I call a myth that has been created. People have said nurses are 'angels'. They say 'people have just spoiled the nurses by influencing them to go on strikes'. But the fact of the matter is that when nurses go on strike they soberly decide to go on strike ... They go on strike knowing what it is that they want to achieve by going on strike:"*. With this remark, it was clear that the NEHAWU representative was strongly opposed to the perception of the other participants that nurses were influenced, for example, by general assistants. In the researcher's opinion, this could be associated with the fact that most general assistants in the institutions under study were members of NEHAWU:.

The Director of Nursing Services agreed with the organised labour representatives that *"nurses are the core of the health team; 50% of health care workers are nurses"*. She quoted that out of ±60 000 health care workers in KwaZulu-Natal, ±33 000 are nurses. She explained that the whole health care system is nurse-driven. Therefore if nurses are disillusioned and burnt out or disorganised, the whole health care system is disorganised. On influencing nurses to strike she

agreed with NEHAWU representative when she said it is a mere coincidence that nurses work with other health team members but *"no-one can influence the nurses to strike when the fact is that when nurses strike they strike because of problems that are related to their own profession"*. In the researcher's opinion, if this represents the views of the employing authority, it reinforces the challenge on them to address nurses' issues timeously to prevent strikes.

ITEM 20 VIEWS ON NURSES' STRIKES

For purposes of this research, the views of the nurses and institutional managers were not asked. It was the representatives of organised labour and nursing directorate as employer representative who were asked about their views on nurses' strikes and whether or not their views were influenced by experiencing the strikes in the positions they currently held.

Expressing her views, DENOSA representative showed concern about management's failure to follow correct channels as a cause of strikes because *"... higher management has got this in their minds that nurses are committed people. They will never abandon their work, therefore management can do anything ...* This finding correlates with Heunis and Pelser's findings (1997:41-46) that in one South African nurses' strikes placards reading "to hell with Florence Nightingale" were seen. Since 'CARING' as a foundation of nursing was laid by Florence Nightingale, placards denouncing her can be interpreted to be denouncing the commitment to caring.

DENOSA representative further stated *"The police had the same problem with salaries and when they started doing something they got something, meaning that they embarked on strike action and their salaries improved"*. She continued *"teachers did it and got something. But what is happening to the nurses, because it is maintained that we are committed, we never stop working ...Nurses are*

exploited for their commitment". In this view it is implied that nurses compare themselves with other professionals in the public service and expect the same attention to their needs by employer and management. She concluded by explaining *"I have got quite ambivalent, but ... I feel that if people who are in higher positions, if they do things correctly, strikes can be averted, because I cannot imagine any strike that was unwarranted".* In analysing this response, the researcher notes that, according to the DENOSA representative there is justification for strikes if management does not take steps to prevent them. However, the researcher reiterates that patients must never be left unattended. Illegal strikes must be avoided at all costs as it compromises patient care.

According to the NEHAWU representative, *"Strikes are not a solution. Actually I would not expect that when we have the established Bargaining Chambers, coupled with the Labour Relations Act and the Public Service Act, and all these guide personnel in the public service, I wonder why we are led to a situation where we need to go on strike".* This view emphasised the need for educating personnel on labour relations issues, as mentioned in items 3 and 4. It also brings a different dimension to the generally-held view that unionists are in favour of strikes.

When asked if his views on strikes had been influenced in any way by being a unionist he agreed, saying *"It is true that before one was engaged as a unionist I had different views about strikes and problems that we have. Some of the things I just expected or I viewed them as normal when they were not. Interacting with other people and reflecting on my experiences I learned that some of them are not normal".* He made examples of unfair dismissals which he now understands according to the Labour Relations Act (66 of 1995) as amended.

Repeating his opposition to 'professionalism' entrenched through 'nursing ethos', he said *"I do not subscribe to that, much as they are a good basis to nurture nurses, I have seen that somehow it shapes nurses to be dependent".* It was

explained in item 7 that this was not the case in contemporary nursing. This stand about "professionalism" in nursing is a source of concern because it reduces nursing to an :occupation" which requires no ethical code, no ethical responsibility, no professional code of conduct. If all these were done away with, patient safety and need satisfaction could never be guaranteed. The profession of nursing will be challenged to restore professionalism if the expressed viewpoint is a union philosophy to which members of the organisation are socialised. He explained that as a unionist he had learned to be assertive, to analyze situations critically and respond to them assertively without compromising his christian values. To him, defending people's right was a christian duty. The researcher argues that denying patients' right to care is not a 'Christian' duty.

Expressing her opposition to strikes, the Director of Nursing Services emphatically stated *"I don't feel we should get to the level of striking. To me, I view a strike as a complete breakdown of communication and negotiation skills. We as professionals, we ought to be knowing the various forms of negotiation, of compromising, of letting go ... because of our basic professional philosophy that we are committed to health care delivery".*

Referring to her position, she admitted *"Before I came into this position I used to be threatened about organised labour ... I used to view them as people who are hostile. It is only after the various strikes that I am capable of talking to a union leader ... I know that now if I can orientate them to our philosophy, then we will understand each other. So organised labour, now I know that we need them. They understand our policies ... the standpoint of the department. They are the ones who will cascade it or disseminate it to their constituencies ... So this I did not have before I came here but now I know that the sooner they come, the sooner we consult and settle problems, the lesser the strikes".* She further explained that they, as the nursing directorate, advise management to communicate with the shop stewards to negotiate so that when they understand they will relay proper

information to the personnel. She noted that relations between management and shop stewards have improved. In the Provincial Health Portfolio Chamber management sits and discusses issues with organised labour. This cooperative stance between organised labour, management or employees is strongly supported.

ITEM 21 FEELINGS AFTER THE STRIKES

Since strikes are a departure from regular routine and assumed to be an undesirable occurrence, it is important to establish how the various categories of health care stakeholders felt after strikes, whether they were directly involved or not. In applying the Social Action Theory, it is at this stage that the 'actors', including those involved as strikers or others directly or indirectly affected by the strike, are able to analyze the past strike phenomenon, analyze their consciences retrospectively and seek approval or justification for their actions.

TABLE 6.16 POST-STRIKE FEELINGS

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
Positive feelings	f	%	f	%	f	%	f	%
Relieved, happy to return to work	25	60	3	50	11	61	11	61
Relieved, communication lines opened	5	11	1	17	1	6	3	17
Learnt lessons to use channels for change	4	10	0	0	4	22	0	0
Mixed feeling about the strike	4	10	3	50	1	6	0	0
<u>Negative feelings</u> Worried about possibility of another strike	12	29	0	0	3	17	9	50

(Respondents could give more than one response)

Unlike the feelings before and during the strikes, table 6.16 reflects more positive than negative feelings. The majority, 60% (25) were relieved that the strike had ended and were happy to return to work. These comprised 50% (3) area managers, 61% (11) professional and 61% (11) enrolled nurses. In addition:

* a few participants expressed relief that lessons had been learnt about use of correct channels for change and

* relief that communication lines were established between nurses and the authorities.

Negative feelings were described as:

* worry about the possibility of another strike. These were expressed by 17% (3) professional nurses, 50% (9) enrolled nurses and none of the area managers. This may be related either to greater dissatisfaction among the enrolled categories about meeting of demands or a higher vulnerability to strike action compared to professional nursing categories.

* very few stated that they were worried about loss of salaries and jobs.

The mixed feelings expressed by 50% (9) area managers were explained as a reflection that they too were experiencing problems in the work environment but because of their commitment to ethical behaviour and protection of patients, they did not approve of strike action.

Both nurse managers in charge expressed relief and happiness that the strikes had come to an end. Nurse manager A stated that she was very unhappy that strikes had happened at all. She wondered what had happened or what had gone wrong and said she could not rest until she found answers. She stated that she was committed to work for prevention of further strikes.

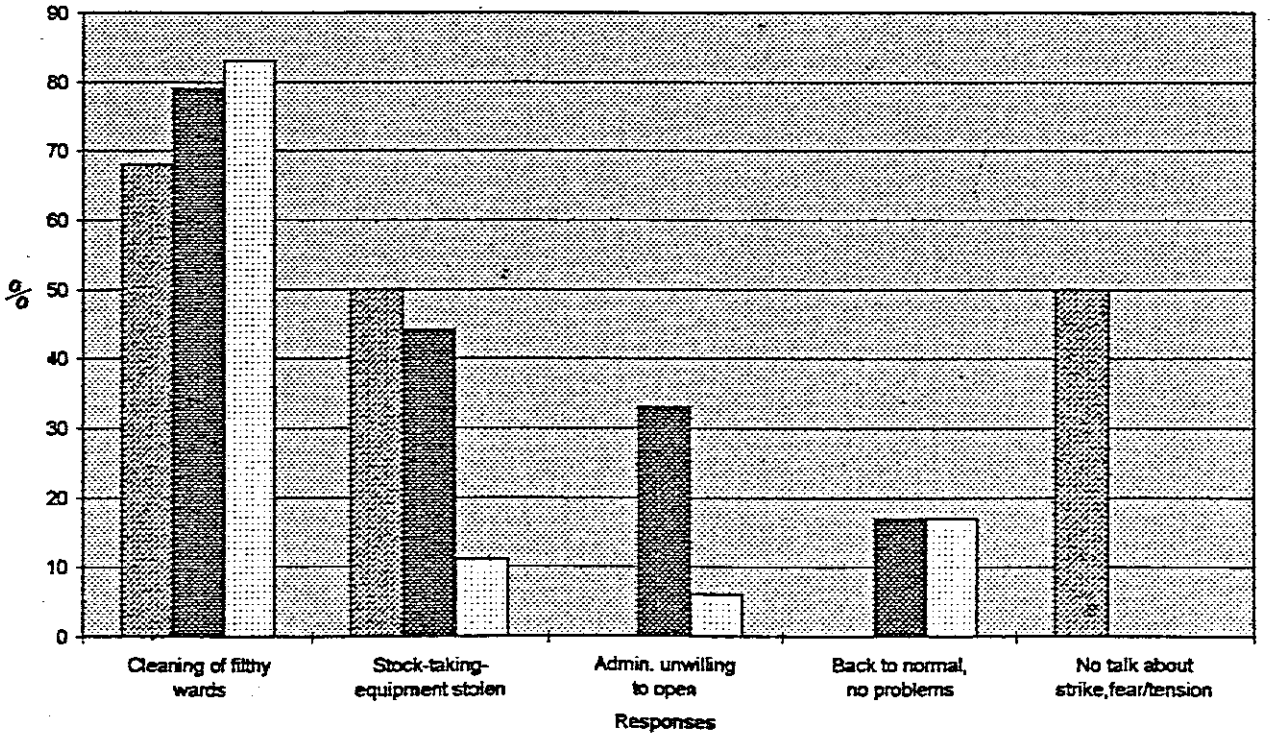
Nurse manager B stated that she felt they should start afresh to teach nurses, have vigorous workshops on nursing standards, nursing care plans and record-keeping. She observed that nurses were not keen on this because they were still bitter that their demands were not met in spite of strike action. There is similarity between the positive and negative feelings expressed by participants in this study and the gains and losses experienced in the Manitoba strikes that were described by Cummings & Leverington (1992:19-25) (Refer pages 71 to 73 of this report).

This item was not included in the interviews with the representatives of organised labour and the Director of Nursing Services since it was covered in the item to depict their views on nursing strikes.

ITEM 22 ESTABLISHING WHAT ACTIVITIES PARTICIPANTS WERE INVOLVED IN IMMEDIATELY AFTER THE STRIKES

This item was included to establish how easy or how difficult it was to return to normal activities after the strikes. It was based on the premise that any unpleasant experiences of the strike aftermath will influence strike decisions in future and vice-versa. Responses to this item are presented in figure 6.8

FIGURE 6.8: IMMEDIATE POST-STRIKE ACTIVITIES



Key: ⊠ Area Managers ⊠ Professional Nurse ⊡ Enrolled Nurses

Figure 6.8 indicates that the majority, 68% (4) area managers, 79% (14) professional and 83% (15) enrolled nurses were involved in cleaning the filth in the wards. It was highlighted that in some instances management had to hire

specialist companies at extra cost in order to cope with the extra cleaning load. 50% (3) area managers, 44% (8) professional and 11% (2) enrolled nurses mentioned stocktaking as an important activity since some equipment was stolen during the strikes. 33% (6) professional and only 6% (1) enrolled nurses highlighted that Administration was hitting back and not willing to re-open the hospital when workers wanted to return to work. 33% (6) of the professional and enrolled nurses respectively stated that return to normal was easy and non-problematic.

Nurse manager A highlighted the main involvement as the cleaning of wards, replacement of missing stock and re-establishing relations and morale. Nurse manager B also identified cleaning the hospital, further explaining that nurses were quite aggressive, demanding to know why the hospital was not cleaned. Eventually a private cleaning company was hired at great cost. Difficulties experienced on return to work after a strike were also identified by Baird (1988:696) as reflected in chapter 3 of this report.

This item was not included in the interviews of nurse representatives and Director Nursing Services since they were not interviewed as part of the organisations' workforce.

ITEM 23 IDENTIFYING STRATEGIES THAT CAN BE ADOPTED FOR PREVENTION OF NURSES' STRIKES IN FUTURE

When comparing benefits and adverse effects of nurses' strikes as expressed in previous items, it is clear that strikes are an undesirable occurrence. Inclusion of this item therefore has merit in that it is part of the process of consultation with the stakeholders, giving them a platform to indicate how they think nurses' strikes can be prevented. This will increase commitment to success of the strategies identified by them rather than those imposed by the employer or management. The same applies to strike management and strike evaluation.

TABLE 6.17 STRATEGIES SUGGESTED FOR STRIKE PREVENTION

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Flatten hierarchies	31	74	0	0	14	79	17	93
Stick to job descriptions	17	41	3	50	9	50	5	28
Formation of discussion groups, nurses forums	5	12	1	17	3	17	1	6
Formation of a strike committee	2	5	1	17	1	6	0	0
Strikers taken to court, or issue warnings	2	5	1	17	0	0	1	6
Lessons should be learnt, no more strikes	4	10	2	33	2	11	0	0

(Respondents could give more than one response)

According to Table 6.17, a need to flatten hierarchies was suggested by the majority of professional nurses, 79% (14) enrolled nurses, 94% (17), and none of the area managers. This finding indicates that personnel at lower levels of the hierarchy are more concerned that pyramidal structures with emphasis on authority prevent effective communication. The suggestion to form discussion groups and nurses' forums is in line with the need to flatten hierarchies in order to hasten open communication.

A need to stick to job description was mentioned by 50% (3) area managers, 50% (9) professional and 28% (5) enrolled nurses. In support of this suggestion, conflicts arose as a result of nurses, especially in the enrolled categories, being forced to do non-nursing duties even though the nurses themselves were affected by overwork due to staff shortages. Conflict arose on the issue of damp dusting which created arguments between nurses and the general assistants, the one group stating that it is a function of the other because some job descriptions did not come

out clearly on whose responsibility this was. This is an indication of a weakness in the job descriptions at the time when the strikes in question occurred, hence the arguments between nurses and general assistants on role clarification. Presently the KwaZulu-Natal Department of Health is involved in restructuring job descriptions for the various post structures in public health care settings. It is hoped that this will improve role clarification.

Nurse manager A expressed a hope to be proactive. She pledged *"We are the ones who must identify and diagnose the problem. Then by allowing them* (the nurses' forum and general workers' forums) *to come on a monthly basis we are able to discuss issues as they come, in as normal and humanitarian way as possible. We should not wait for crisis management"*. She further stated *"We have to educate some of our managers who are still very negative to unions. They do not want to have anything to do with them. We try to make them understand that they can work together positively and in fact that is according to legislation"*. The legislation just referred to is the Labour Relations Act (66 of 1995) as amended, in which Chapter 2 makes provisions for freedom of association and protection from discrimination or victimisation on grounds of union activity. The negative attitude of management towards unions and the need to educate managers about them was also identified by the DENOSA representative.

To illustrate that these negative attitudes are not typical of South African managers only, Wilson, Hamilton and Murphy (1990:433) in the United States of America expressed the notion that "management typically questions whether high professional standards can be maintained in a unionised health care setting, whereas the union maintains that unionisation is consistent with high professional standards. These authors further maintain that "the manager's long-term behaviour has a great deal to do with whether the department is a fertile ground for union organising activity" Where employees are reasonably contented, the urge to unionise will be less. In accordance with the Labour Relations Act (66 of 1995)

as amended, managers cannot discriminate, victimise, threaten nor interrogate employees on the basis of union activities or sympathies.

Nurse manager B's perception was that *"nurses should utilise DENOSA because it is a democratic organisation. It looks after nurses' professional issues. I think it is significant that DENOSA has a union leg because nurses feel their problems can be effectively addressed"*. She highlighted that the interdisciplinary nature of hospital strikes indicate the move towards all employees maintaining a united front at the workplace, hence nurses increasingly joining general unions.

DENOSA representative reiterated her previous statement that management should do things correctly, then strikes would be averted. This reaffirms her strong belief that management can play an important role in prevention of strikes.

NEHAWU representative mentioned that they have the nurses forum which deals with nurses issues only, further explaining *"We are aware that nurses do not want to be a mob and just take action because everyone is dong it. We respect that"*. He reiterated that nurses need education and training that can make them to be independent. In view of his earlier statement of nurses' lack of independence as a result of professionalism, it is important to continue with programmes that develop assertiveness skills in nurses and to emphasise that one of the ethical principles of the profession is "Autonomy" which emphasises use of one's own discretion and independent decision-making.

The Director of Nursing Services emphasised that *"... all registered labour unions must be known by the hospital or nursing management. She must know that this is a shop steward for this particular union ... Then when there is a problem ... the nurse manager should know the shop steward for that union. The sooner she knows them and talks with them, the lesser there will be problems"*. This further emphasised the need for education of managers, as suggested by Nurse Manager

A and the DENOSA representative. The Director of Nursing Services further highlighted a need for policies, for example in regard to meetings, so that communication is maintained.

ITEM 24 STRATEGIES FOR MANAGEMENT OF NURSES' STRIKES NOW AND IN THE FUTURE

It is important that lessons learnt from handling and managing present strikes should be considered when faced with strikes in future. Strengths and weaknesses should be identified and considered as a basis for future planning accordingly.

TABLE 6.18 STRATEGIES SUGGESTED FOR EFFECTIVE MANAGEMENT OF NURSES' STRIKES

	TOTAL		AREA MANAGERS		SPN/PN		EN/ENA	
	42		6		18		18	
	f	%	f	%	f	%	f	%
Forum: for fast communication	30	72	5	83	12	67	13	72
Plan for continuity of patient care	12	29	4	67	4	22	4	22
Nurse manager to be accessible to staff	2	5	0	0	1	6	1	6
Call an independent third party	2	5	0	0	2	11	0	0
Involve the community	2	5	0	0	2	11	0	0

(Respondents could give more than one response)

According to table 6.18 the main strategy suggested by the majority, 83% (5) area managers, 67% (12) professional and 72% (13) enrolled nurses was formation of nurses' forums to facilitate fast communication as well as to teach nurses what to

do before embarking on strikes. This suggestion is in line with establishment of workplace forums as stipulated in chapter 5 of the Labour Relations Act (66 of 1995). The need to set up plans for continuity of patient care during strikes and to call volunteers to assist was identified by 67% (4) area managers and 22% (4) each of professional and enrolled nurses.

Nurse manager A stated that there are guidelines provided by Head Office authorities from time to time on what to do in the event of a strike. There are also in-service educational programmes on strike issues and procedures. Nurse manager B expressed doubt about adequacy of communication at grass-roots level. During the strike she discovered that even those who had joined NEHAWU did so because of ignorance, did not know conditions of service. All they knew was that they had rights to go on strike but did not know clearly what to do and what not to do. There was total neglect of responsibility and much emphasis on rejection of "oppressive discipline". She emphasised a need for 'discussing' rather than 'demanding' and a need for more communication between the nurses and management. She was of the opinion that it would help that strikes in essential services are not allowed by law.

DENOSA representative highlighted that they are in the process of formulating guidelines and policy on management of nurses' strikes. It is done by their National Industrial Relations Committee in consultation with the membership. This was important because the current Labour Relations Act (66 of 1995) allows all workers to strike, but as an essential service there must be clarity on how to go about it. The Essential Services Committee was charged with responsibility to delineate essential and non-essential services in a health care facility and define minimum services required, for example, to plan skeleton staff. She made reference to the policy of "no work, no pay" as creating problems whereby it would be only those who formed skeleton staff who would be remunerated whereas it was a formalised arrangement that some will go out to strike and others will

remain at work. This is an important dilemma to consider. The "no work no pay" policy created further conflicts between strikers and non-strikers, with the strikers reminding that everybody will benefit if the strike is successful.

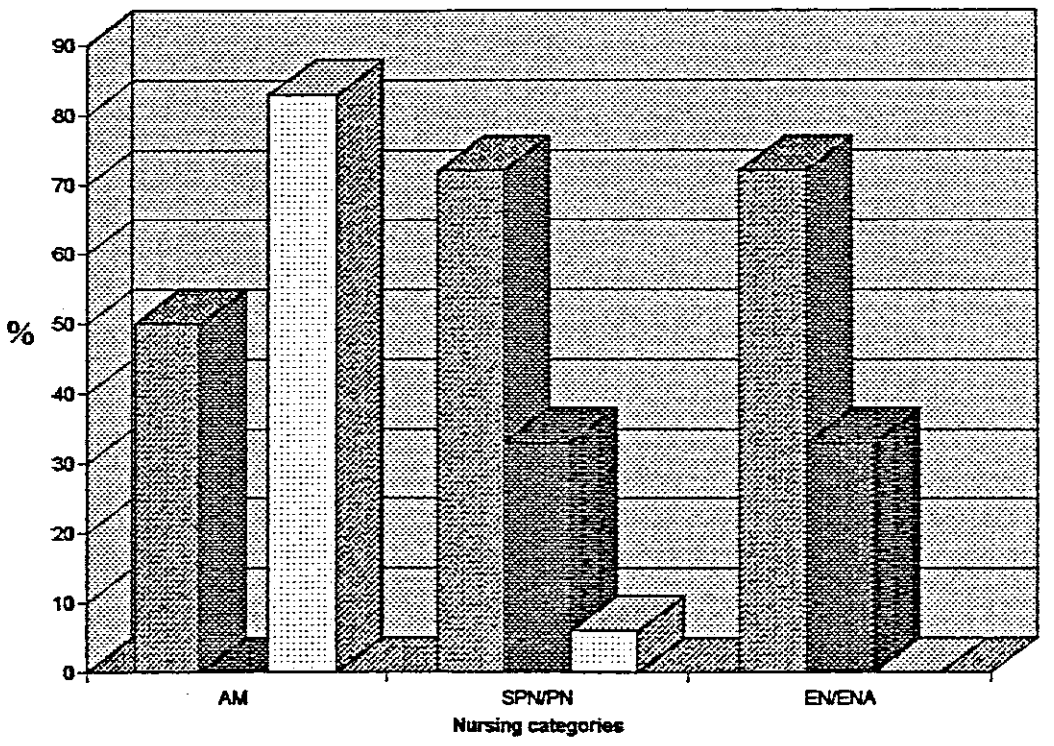
NEHAWU representative stated that there is no direct prescription on what to do and what not to do. He emphasised that the objective of a strike is to put more pressure and get the problem resolved in the quickest way. He acknowledged that management is more important in strike situations because if they do not accede to demands, the strike is prolonged. He emphasised the need for skeleton staff to continue providing care.

The Director of Nursing Services stated that strikes are a form of disaster and are therefore managed according to the main disaster plan. Plans are made to cope with reduced staff, for example shutting down some units and co-opting services from the army and South African Red Cross. This finding is supported by Kunene (1995), Botha (1986) and others.

ITEM 25 STRATEGIES FOR EVALUATION OF NURSES' STRIKES

Since strikes have been described as an irregular occurrence in any employment setting, an area of particular concern in health care settings, it is important to have evaluation systems well defined and agreed upon to determine the impact of the strikes on both providers and consumers of health care.

FIGURE 6.9: STRATEGIES FOR EVALUATION OF NURSES' STRIKES



Key: Not done Consult Community on effects

Professional Nurse in charge evaluates with other staff

Figure 6.9 reflects the predominant opinion that there was no effective evaluation of the strikes, as indicated by 50% (3) area managers, 72% (13) professional and 72% (13) enrolled nurses. However 83% (5) of the area managers and 6% (1) professional nurse indicated that evaluation was done by the professional nurses in charge in the nursing units with unit personnel. Equal numbers of professional and enrolled nurses, 33% (6) respectively suggested that there should be consultation with communities to assess effects of strikes on their health status.

Nurse manager A stated that evaluation of strikes is done by Head Office officials through its Labour Relations department. Officials of this department go to

institutions during and after strikes to compile reports. Some of these reports were made available to the researcher and have been referred to in this study.

Nurse manager B indicated that evaluation of the strike was done by management, including the Medical Superintendent and all Heads of Departments, not only the nursing departments. There were meetings with all staff and a report was compiled. Lack of awareness among the nurses about evaluation of the strikes raises questions about inclusivity of all stakeholders in the evaluation process and questions about the effectiveness in dissemination of findings of the evaluation activity.

DENOSA representative indicated that there are no formalised plans for evaluating nurses' strikes but DENOSA was in the process of formulating them. This move is regarded as important to give a clearer direction of how the organisation can represent its members on strike issues in future, based on lessons learnt from previous strikes.

NEHAWU representative acknowledged that as a union they did not do any follow-up on any strike. Expressing appreciation for the question he said *"In fact I am glad you asked because already I see the need to do it. it is important"*. He made reference to newspaper reports about strikes as well as Commissions which meet to evaluate strikes and issue reports to both unions and management or employers, hence the Commission reports quoted in this study. Again the effectiveness of dissemination of such reports to staff remains questionable.

On the issue of strike evaluation, the Director of Nursing Service repeated *"use of the disaster plan is important for post-evaluation of what were the implications. It is all in the disaster plan. It includes the pre-disaster plan for before ..., during ... and the post-disaster plan of the institutions.* This approach is supported by Botha (1986) Reese (1991) Nel and Van Rooyen (1993) Kunene 1995) and others.

ITEM 26 AVAILABILITY OF COORDINATED STRIKE PLANS THROUGHOUT THE INSTITUTION OR THE PROVINCE

As stated in chapter one of this study, the strikes were not localised in one institution. They occurred in several institutions, spread from province to province and became nationwide. This endorses the importance of having strike plans which are coordinated institutionally, provincially and nationally to ensure orderliness and consistency.

In response to this item, all participants except one area manager indicated lack of awareness of any plans. 34% (2) area managers stated that they did what they thought was right at the time. This demonstrates a haphazard approach to strike management which could be a danger if strikes occur in future. It was only 17% (1) of the area managers who expressed awareness that senior people were called to meetings and strike plans were discussed. This is yet another weakness in communication especially because area managers have supervisory responsibility.

According to nurse manager A, there are well-coordinated plans and guidelines from the Provincial Health Department. In her opinion, her institution functions as a coordinated unit and reports of any strike activity are submitted to Head Office.

Nurse manager B maintained that there is co-ordination because there is an ombudsman for the KwaZulu-Natal province who addresses staff in hospitals on different personnel and strike issues and on how to negotiate.

DENOSA representative pointed out that they are still working on strike plans at provincial level and co-ordinating them with the National Board of DENOSA. No details of these plans were given. However the membership was assisted to resolve problems with management through constant negotiations at work places. Negotiations at the Bargaining Chamber are continued as well.

To emphasise coordination of their activities, NEHAWU representative pointed to a calendar on the wall, saying *"We conduct our activities according to that calendar but it has to be flexible to be adjusted according to circumstances that arise in the course of the year. Most of the time we try to stick to the plan. We attend a lot of meetings and we sit in national Bargaining Chamber negotiations.*

The Director of Nursing Services indicated that in her department they are talking about educational and safety programmes which will fall under occupational safety and security of the health care workers in the province. To confirm their plans for coordination, she mentioned that they have created a post of a Chief Professional nurse to co-ordinate these programmes provincially.

ITEM 27 ADDITIONAL INFORMATION ON ANY STRIKE-RELATED OR LABOUR RELATIONS ISSUE

Seeing that one cannot exhaust ideas, views or perceptions in spite of the open-endedness of semi-structured interviews, participants were given an opportunity to add anything that came to their minds on the topic under study.

67% (28) of total sample indicated that they had nothing to add because, in their opinions, the topic had been dealt with very comprehensively. 33% (14) added the following comments;

- some expressed a hope that there would be no further strikes while others felt that strikes 'are here to stay'. This emphasised the importance of discussions with management who should contribute to strike prevention.

- in-service educational sessions on labour relations issues are needed and should include general assistants.

- discussions with key personnel in unions is important.

- problems that arise should be addressed personally, in a proactive rather than a reactive manner.

- sadness that the public is now negative towards nurses.

- in-service education on transformation: there was a suggestion to swop leaders of one race group to work in institutions of predominantly other race groups in the name of transformation.

- some indications that the strikes helped and some improvements were noticed.

Nurse manager A emphasised that strikes are not a good experience, work ethic suffers and mistrust exists between management and workers. More effort should be put in efforts to increase knowledge and understanding of labour relations issues and procedures so that nurses can make informed decisions. In the researchers' opinion, supported by the previous responses, this applies equally to nurse managers. She stated that the support of workers is important and freezing of posts should be stopped. This is supported as a strategy to minimise staff shortages and overwork expressed as a cause of job dissatisfaction.

Nurse manager B expressed worry about the management authority being challenged and the emphasis that is now laid on rights but not on responsibility. In her opinion, nurses should negotiate rather than strike. The researcher shares the concern about failure to balance rights with responsibility because it means that inevitably protection of one's right would be at the expense of honouring one's responsibility to another.

DENOSA representative simply said *"All I can add is that flexibility of management is very important"*. This further endorses her previous opinions that strikes will be minimised if management does things right.

NEHAWU representative made reference to the concern of NEHAWU about transformation in the Public Health Sector. He cited the example that the service

should be representative of the community it serves, saying *"It is abnormal to find an institution serving mostly Black people in a particular township being managed by Whites or Indians who live away from that community"*. To support this finding it was brought up in evidence to the Mall *et al* Commission that one of the grievances was the filling of senior posts in the hospitals previously segregated for Black patients with people of other races, thus inhibiting the upward mobility of the Blacks serving the hospital (Mall *et al* 1995:12). He also suggested that facilities should be well balanced to prevent preferential utilisation where people will refuse to go to a particular health facility because of its historically negative background. In this regard the researcher is of the opinion that the present policy of equity addresses the need to balance the health services and attempt to bring them to the same level, for example in regard to resources.

He also pointed out that some supervisors choose morning assembly in nursing units as a platform to inform nurses that DENOSA is the only organisation for nurses. He described that as unfair use of opportunities to influence nurses through wrong information. He added that some problems arose when some nurses who were NEHAWU formed the group called Concerned Nurses of South Africa (CONSA) and then crossed the line to become DENOSA leaders. He did not specify the problems. He highlighted that some nurses join DENOSA for professional issues and NEHAWU for other issues. He then stated that DENOSA needs to strengthen its union structure and identified a need for national unity among representative organisations.

When asked for further comments, the Director of Nursing Services said *"I'll be interested in your research report because, as you know that strikes will compromise health care, so I would like to hear about your recommendations, which recommendations will also help us to implement strategies for minimising or stopping strikes in our province."*

6.3 CONCLUSION

In this chapter findings on perceptions of the health care providers on the various dimensions of the labour relations issue and the strike phenomenon were described. The next chapter discusses findings on perceptions of the consumers of health care. Comparisons are made where applicable.

CHAPTER 7

DATA ANALYSIS AND INTERPRETATION OF FINDINGS: HEALTH CARE CONSUMERS

7.1 INTRODUCTION

This chapter provides qualitative data analysis of interview data of health care consumers. As reflected in chapter five, the consumers are represented by two focus groups comprising a sample from communities served by the two hospitals under study as well as three ex-patients hereto referred as ex-patient 1, 2 and 3 respectively who were hospitalised during the strike in question. It should be noted that the ex-patients were directly affected by the nurses' strike while participants in the focus groups experienced the strike(s) indirectly.

ITEM 1 PERCEPTIONS ABOUT NURSES' JOB SATISFACTION IN THEIR WORK ENVIRONMENT

According to the three ex-patients, nurses were not happy in their work environment. The reason given was low salaries which, nurses felt, did not match the heavy workloads and long hours of work, and did not compare well with salaries of other professionals of their status, thus did not allow nurses to maintain the standard of life they wanted.

In addition, ex-patient 1 referred to problems related to long-term patients and said *"At times the nurses' salaries do not match their needs. So now at the end the patients become violent. When nurses report this to the superiors no-one takes notice of that. So now they are not happy at all. I think you cannot treat people well if you are not happy. So that creates a conflict between the nurses and the patients. Another thing about the superiors, the nurses sometimes raise their complaints but we hear that no-one takes care of their complaints".*

In spite of the unfavourable conditions mentioned, ex-patient 2 explained *"... Generally I can say nurses appear to be happy and they like their work. They seem to be devoted to their work.*

Participants in the focus groups were divided in their perceptions of whether nurses were happy or not in their work environment. Only one participant had no reservations about saying nurses appeared happy about their work while two stated that nurses were divided on this, some nurses were happy while others were unhappy. They further observed that it varied from time to time whether nurses were happy or not.

Three participants in the focus groups expressed the perception shared by the ex-patients that nurses are unhappy in their work environment. The main reason given for unhappiness and dissatisfaction was low salaries, staff shortages and overwork in a very demanding job. **Pat**, the youngest participant (21 years old) was opposed to the idea of nurses having too much work and said *"To me that is not true because when you come to the hospital you see them talking, laughing and not even hurrying to attend to you."* Expression of this perception highlights the importance of projection of a "caring" attitude to patients / clients at all times.

In analysis of responses to this item, shared perceptions that nurses were generally not happy in their work environment were evident between the providers and consumers of health care.

ITEM 2 DESCRIPTION OF THE CONSUMERS' DIRECT AND INDIRECT EXPERIENCES OF NURSES' STRIKES

The period of direct experience of the nurses' strikes among the ex-patients ranged between two to seven days. Two of them stated they had no idea of what was happening. Describing her suspicion of something unusual happening, ex-patient

3 explained *"We did not know at all. We thought things were just normal but we saw that nurses were not coming to give us tablets as usual. They appeared to be fewer than normal, but we could notice that they seemed to be absorbed in something".*

When asked about care given to patients at that time ex-patient 1 explained *"On the first day of the strike nurse managers came to the wards and helped the patients. On the second day of the strike the doctors came and told us that we would be transferred to other hospitals because there would be no-one to take care of us, especially those who were helpless, they were the first ones to be taken to other hospitals ... Those who were not seriously ill were discharged even though they were not yet due for discharge".*

She explained that though there was no pre-warning about strikes, they noticed departure from routine, for example nurses did not come to pray together with patients in the morning as they usually did. Only one or no nurse would be seen in the ward for a long time. During the night they saw only one nurse instead of the usual four. People from the kitchen would come with food and leave it in the ward. Patients who were not helpless would dish for themselves and assist the other patients. This finding confirms the perception expressed by the health care providers that this was not purely a nurses' strike. General assistants were also involved and were therefore not available to serve meals.

Ex-patient 2 also stated that he and other patients were still quite ill when discharged and taken away by relatives. He noticed that some patients were taken off traction and transferred to other hospitals.

Describing the scenario during the strike, ex-patient 3 said *"Oh, there was chaos. Oh, I can't really describe it because it was too surprising. What we observed was that there are two sides to nurses. There were those who wanted to nurse, for*

example to change linen, give tablets and so on, but they were prevented from doing that by other nurses, so they would come to the ward secretly." She observed that two young patients who were not so ill took over basic nursing care activities like assisting other patients with elimination, changing of linen, and feeding.

In relation to her own care and treatment, ex-patient 3 stated that she was on intravenous infusion, supposed to be given medication through that line every six hours. She observed that up to 10 hours would pass with no-one coming to give the medication. She was eventually discharged prior to completion of her planned one-week therapy: She stated *"We envied those who were leaving even though they were still ill".*

Emphasising that the strike resulted in negative attitudes towards that hospital, she explained that when she got ill a year later, she totally refused to go to that hospital and opted for another one. In referring to the 'other' hospital she explained, *"I was treated very well but I was not relaxed at all because I had seen that nurses just leave you alone if they want to. So I was worried to think of what would happen if those nurses decided to go on strike."* She added *"How can you know because they don't even tell you what they are planning. In fact even when they talk about these things they just talk as if you are deaf".* Such utterances indicate a serious communication gap between nurses as providers of health care and patients as consumers of the service, hence she added *"You get worried because you don't quite understand what they are planning but you suspect something is going to happen."*

Participants in the focus groups expressed diverse experiences of nurses' strikes. In focus group 1 **Dan** indicated he had a vague idea of nurses who were seen marching and heard making a noise but had no further details. He also got information about this from the media. **Lucy** knew of a strike which happened

soon after the 1994 elections in the hospital where her sister was admitted. They were told to take her home though she was still ill. She expressed appreciation that they were given medicines, so her sister got better.

Mary, a retired hospital clerk experienced two hospital strikes by nurses and other workers in 1990 and 1994. She chose to describe the 1990 strike because it was her first experience. She had no pre-warning, was taken by surprise when word went round that they should stop working because there was a strike. She was so shocked and frightened that she went to a doctor and was given two weeks' leave.

Sally was aware of a strike against nurse educators who were alleged to be taking their relatives for training and ignoring those who had applied and met the criteria for admission. The latter then came together to demand that they be taken and to make sure that those who had been taken irregularly did not continue with training. Considering the definition of strikes as 'a temporary stoppage of work by employees', the protest described by Sally may not be classified as a strike since it was non-employees who were disrupting the College activities.

In focus group 2 **Nomsa** and **Siza** had no idea about any nurses' strike while **Gugu** and **Pat** were aware of the 1994 strike where the hospital was eventually closed, but they had no further details on it. **Dudu** explained *"It was bad because when I came to the hospital there was rubbish all over. The workers had thrown it all over the ground so that their superiors could see that they were angry. People who came to the hospital were angry because they had come to a dirty hospital and yet they had nothing to do with what was happening in the hospital".*

Jenny, wiping tears from her eyes, said *"It was on May 2 1994. It was a Monday. I remember it like it was yesterday".* Noticing that she continued to be upset, the researcher commented that she did not have to talk about it if it made her very unhappy. To this she replied *"yes, of course I do want to talk about it*

so that the others can know what happens here." She proceeded to explain that on that day she brought her 16-year old daughter, her only child, to hospital with an asthmatic attack.

She explained that her daughter used to get instant treatment at the hospital, including nebulisation, whenever she had the attack. On that day, she found the hospital closed and had to proceed to another hospital where her daughter was admitted and died on 04 May 1994. Asked what she thought had caused her daughter's death she said *"I believe it was the delay ... well, I don't know, maybe it was her day to die. You know that asthma needs immediate attention. So she did not get immediate attention."* Again wiping tears and shaking her head she said *"Oh no! ... she was so bad she was in a coma"*. She then smiled and said *"yes, of course. I think somebody should know these things. May be they can do something about it."* This emphasises the need for evaluation of the impact of strikes to become aware of how the various stakeholders were affected physically, socially or psychologically. For example if these highly emotive experiences come to light during or immediately after the strike more efforts will be applied to end the strike within the shortest period possible. It may also be possible to interact with consumers who were adversely affected, like Jenny, so that the necessary healing processes can be initiated.

After Jenny's story there was a moment of silence, then the other participants in the group shared more experiences about nurses' strikes. **Gugu** remembered that her pregnant friend who was in labour was told to go to another hospital because nurses were on strike. Her friend was worried that she might lose her baby, fortunately she got a live baby. This incident reminded **Siza** of a young pregnant girl who was not so fortunate. She came to hospital and found it closed due to a strike. When she arrived in another hospital it was found that she had a difficult labour because of an impacted shoulder. It was too late to save her baby so she had a still-birth and was also sick for some time.

Dudu shared that her brother who worked in the hospital mortuary was involved in a strike for salaries. He used to come home very tired and said it was due to standing most of the day doing nothing. He was very disturbed when he went back to work at the end of the strike to find serious disorganisation, for example some corpses were not even labelled. He eventually left the hospital because he was no longer happy to work there. This is another demonstration of the adverse effects of strikes on personnel in the organisation.

The experiences described by the consumers of health care confirm the perceptions expressed by the various categories of health care providers who stated that the community was negative towards nurses' strikes, felt that nurses were no longer committed to caring for patients and thus needed no sympathy nor protection from the community.

ITEM 3 DESCRIPTION OF FEELINGS ON BECOMING AWARE OF THE NURSES' STRIKES

All three ex-patients expressed negative feelings about nurses' strikes mainly due to fear of the unknown. Ex-patient 1 stated *"I was frightened because during that time I was seriously ill ... the only thing that came to my mind was that I am going to die or perhaps I am going to become worse because no-one was giving us the treatment, no-one was taking care of us. Other patients who were next to my bed were unable to help themselves and I was also depressed by the situation".*

Ex-patient 2 indicated that he was too sick to worry about many things. He was very relieved when his wife said she would be happy to take him home to continue care and treatment. He expressed worry about what would happen to those patients who were completely helpless, paralysed and dependent on nurses for everything.

Ex-patient 3 stated that she and other patients were very shocked since she had been in hospital before but had never seen nurses on strike.

Awareness of the negative feelings expressed by those who were directly affected as hospitalised patients during a nurses' strike is important to challenge the health care providers to review their commitment to protection of patients as well as to improve pre-warning of patients about impending strikes. If patients become aware of what plans are in place for continuity of their care, it can be presumed that the level of fear and anxiety would be reduced.

In focus group 1, **Lucy** expressed concern about the safety of her sister who was hospitalised since she knew that there is a lot of fighting during strikes. On the issue of perceived unfair admission for training, **Sally** explained *"I was happy, very happy because I was one of those who thought I could also come and do nursing if we can force them to take us. Unfortunately I had not applied before but my friend told me people just come even though they had not applied. They say they applied and join those who demand to come in."* She stated that she was afraid to come. Later she heard the protest was over so they did not get in.

In focus group 2, it was **Jenny** who expressed strong feelings about the strike, saying *"I felt embarrassed. Exactly! I felt embarrassed because they did not take my child. There was no admission for my child. They used to admit her when she came with an attack"* She emphatically added later *"personally I just got fed up with* X hospital, *I just got fed up. I just had enough of them. Truly,* X hospital! *My child would be alive today. I don't even want to see them,. I would rather die at home. Honestly! I can rather die at home than go to die at* X hospital. *My heart was sore deep inside."* On a more positive note, when asked about her previous experiences in this hospital she said *"I never used to notice anything because I usually came as an emergency. They used to attend to my daughter very well, very quickly. That is why I feel so much pain ... my child died ... I nearly*

went mad". She added that she had never gone to that hospital again because she did not normally use it for herself. Expressions of negative feelings of this magnitude indicate that strikes have serious implications for the image of the hospital and of nurses in the communities they serve. It should be borne in mind that rebuilding a damaged image is a very difficult exercise.

ITEM 4 VIEWS ON NURSES' STRIKES

All three ex-patients shared the view that nurses should not strike and gave a variety of reasons for this, though some justification for strikes was identified as the discussion proceeded.

Ex-patient 1 verbalised that she thought *"Nurses are not supposed to strike because of the patient"*. Adding an opposing view she stated *"On the other hand I can say they are supposed to strike because they are fighting for their rights. They have seen that if they do not involve themselves in a strike nothing will happen. To show that they really want that thing ..,. maybe they ought to strike. But I have a problem because the patient suffers. That is why I say it is difficult. I am really not sure what is right ..."* She further explained that she could not think of an alternative to strike since she had heard that nurses do hold meetings, tell their superiors their needs but no-one cares about their needs.

Ex-patient 2 emphasised that *"There is no justification for that kind of action by nurses ... at any time. I think the work they do is too delicate. Lives may be lost if they strike. It doesn't look nice."* He suggested that nurses should know what structures they should use to get their complaints attended to. Similar to ex-patient 1,, he justified nurses strikes by saying *"Nurses are people too. They have their needs. As I said they complain about their salaries, it means it worries them and somebody must listen to them ... I am afraid they will continue to go on strike if their needs are not met, whether we say it is right or wrong."*

Ex-patient 3 did not express any justification as she emphasised *"... I believe they have their organisations and those who are in charge to whom they can voice their grievances in their meetings ... The work should go on. I feel strongly they should not strike."* She further emphasised *"If all nurses go on strike one cannot even see that it is a hospital. It becomes very untidy. There is a lot of dissatisfaction even among those who are patients. Whereas one went to hospital to be cared for, it does not happen. You don't feel you will come out well because people become aggressive when they are on strike, which does not put nurses in good light. It really does not befit them."*

In focus group 1, **Dan** supported the idea of nurses' strikes because they should fight for their rights like other employees. However he shared the view expressed by ex-patients 1 and 2 that *"What is bad is that when nurses go on strike you hear people saying they went to hospital or clinic and found no nurse ... So it means that nurses don't care about people. They don't make means to help people even if they are on strike..."* According to **Dan's** view, strikes by nurses are not wrong if plans to continue with patient care are provided and this is in line with warnings of the previous South African Nursing Council that nurses would continue to be disciplined if there is any evidence of patient neglect during strikes (Kotze, 1991) in Kunene (1995:23).

Four of the participants in this group were against nurses' strikes for several reasons. **Kay** felt it is not right because people struggle to get money. At times they have to borrow money to come to clinic, only to find that there are no nurses. **Sue** expressed the opinion that nurses are influenced by what they see on television because before they never used to strike.

Supporting her opposition to strikes, **Mary** emphasised that there is freedom of speech now, so authorities and workers should sit and discuss, continue discussion and giving reports on how things are progressing. She warned *"If it is one person*

person who is allowed to dictate, then there will continue to be problems. I think they must continue seriously to talk about this money issue. Nurses are complaining bitterly about money. It is not only the nurses. I complained about money until I retired. I heard that now some people have their salaries decreased and nobody tells them why that is happening". She emphasised that if there is going to be any change, no matter how minor, it should be discussed with all concerned, no matter how low they are in the hierarchy.

Kay's opinion was that *"Nurses should learn to speak for themselves and put their things right. Maybe why they strike is because people say the government 'hears' you when you strike. It gives you what you want because they want your vote. So if nurses do that, they must think of what happens to us when we are sick".* Pointing out a specific issue she said *"it is a problem when you are pregnant. You can't go to another clinic. They chase you away and say you must go back to your clinic. If you tell them there are no nurses there or you say nurses are not working they say it is not their business."*

In focus group 2, five participants were against nurses' strikes except **Siza** who asked *"Are nurses not people like all of us?* Like **Dan** in focus group 1, he said *"They are justified in striking if they do not get what they want". You see that everybody is striking and things happen. So what about the nurses? How will they get what they want?"*

Nomsa, who had stated she had no knowledge of nurses' strike said *"It is not right for nurses to strike. You heard the stories that they told us, it is wrong. I think they should plead with their superiors to give them what they want."* It is noted that in previous responses the consumers expressed the perception that superiors do not attend to nurses' needs.

Jenny was emphatic in her statement *"Nurses should never strike. That is all I can say. You heard what I just told you? I think it is not right. Nurses should*

not strike because we have nothing to do with their salaries. Yes, we have nothing to do with that. We are less concerned."

Pat also expressed a strong feeling that nurses should not strike, adding *"They said they wanted to be nurses because they want to help people but now they keep on demanding money".* She asked *"Why do nurses need more money?"* Repeating her previous statement on nurses' perceived hard work she said *"I don't think they work so hard. We come here, they make us wait for hours, they just ignore you. They are not busy. Sometimes they go for tea and we are told to wait because the nurse is still having tea. Why can't they attend to us and then have their tea? Even when they are not on strike they do not do their work well. They do not treat patients well. Sometimes they do not even attend emergencies, like patients who are bleeding. People may die because of that."*

When asked if she had observed these nurses' behaviours, **Pat** replied *"Some of it I have seen. But don't think people do not talk outside. People see things and talk. Sometimes when nurses do things they think that you don't see, you don't hear",* a comment in line with ex-patient 3's perception that nurses think patients are deaf when they plan their strikes. **Pat** laughed and explained *"Just now you will think I do not like nurses. No, it is not that. It is just really the things that they do I do not like."*

Commenting on what nurses should do instead of striking **Pat** said *"There is freedom now. I think they should talk to their government. It is the government which should look after them, give them money or whatever they want".* Referring to patient suffering she asked *"If they strike, where is the government? Does it suffer? Nurses must think twice before they go on strike."*

Further emphasis on nurses not justified to strike was laid by **Dudu** who made the exception that *"It is only nurses working in labour ward who may strike because*

they work so hard. I have seen them. I feel sorry for them." She expressed a hope that they would not decide to go and leave nobody to look after patients, then added *"I hope you understand me well. I am not saying they should strike. I am only saying they may strike because of the hard work they do.*

Gugu suggested that nurses should tell their superiors that *"if they don't listen something is going to happen, even if they know they will not go on strike."*

The responses to this item invariably point to the undesirability of nurses' strikes and are in line with views of the health care providers. To support this, Bezuidenhout *et al* (1998:27-28) emphasise that "the public sees striking nurses as people who are completely immoral, who try to further their own interests at the cost of the patients in their care".

ITEM 5 PERCEPTIONS OF WHAT THE DEPARTMENT OF HEALTH CAN DO TO MEET DEMANDS THAT CAN LEAD TO NURSES' STRIKES

In the previous item, it became evident that the government was expected to satisfy nurses' needs, particularly salaries, in order to prevent strikes. This perception was further confirmed in this item, for example, ex-patient 1 stated explicitly that *"once nurses have stated their demands to the department, they must take action on those demands. There should be feedback, ... empathy ... I think strikes will go on if the government does not take serious steps to meet nurses' demands."*

Ex-patient 2 suggested an increase in salary to make nurses happy in their work and to train more nurses so that they are not overworked. Further emphasising responsibility of the Department, ex-patient 3 stated *"nurses' strikes will not stop ... if the Department of Health does not work closely with their workers... all departments of health in the provinces should work closely with the hospitals. They*

should actually go to the hospitals, not only lay down policy. They should meet with the administrators in the hospitals to hear people's grievances ... should work on them because they are a great source of dissatisfaction." When asked if she thought it was enough to meet administrators only her response was: *"I think so because administrators will have spoken to the workers so they will be able to inform the officials from the department about the issues and what is happening ... They should leave their offices, go round from hospital to hospital and get first-hand information instead of hearsay. In that way workers will not feel uncared for, they will believe that their grievances are attended to and will show more tolerance".* To demonstrate "caring" for nurses, in chapter 6 (item 2) the Director of Nursing Services highlighted that they have direct communication and regular meetings with institutional managers. She also mentioned that the Labour Relations officials, the Provincial Ministerial Health Officials and the nursing directorate leave Head Office and go to institutions which have threatening or actual strikes (Chapter 6, item 11).

In the focus groups responsibilities of government and the Department of Health were dealt with comprehensively in the preceding item. Only two participants gave further views on this aspect. **Siza** reiterated views previously expressed, saying *"The Department should give nurses more money and may be there will be no more trouble. No one can work on an empty stomach".*

Pat who had previously suggested that nurses should talk to their government now expressed a different view *"How can the government stop the strikes when there is corruption by the very nurses. They say they want more money. They say they are overworked. What will happen now? The government will employ more people, then they will get less money because there will be more people to be paid."* This was interpreted as a significant dilemma because increasing salaries and numbers of personnel has budget implications which currently pose constraints in the whole health care system influenced by the depressed economic climate in

the country. Further corruption identified by **Pat** applied to nursing schools or colleges as she explained *"They bring their relatives who do not even qualify for nursing. They become nurses, they do not have any calling for nursing. They only want money and a job. There is this corruption which the government does not know about. So, what can the government do?* Allegations of this nature are a cause of concern because they are an indication of mistrust between the service providers and consumers, whether founded or unfounded.

ITEM 6 VIEWS ON THE ROLE THAT COMMUNITIES CAN PLAY IN PREVENTION OF NURSES' STRIKES

Since participants in this category were consumers of health care and therefore representing the communities served, it was important to detect what they perceived their roles to be in the prevention, management and evaluation of nurses' strikes. This is in line with the government's principle of providing services that are "people-driven", hence the importance of continuous communication, consultation and participation between consumers and providers of the service.

In spite of seeing the community role in this as very difficult, ex-patient 1 highlighted that *"nurses themselves are the community ... they have relatives, children and husbands who do not like these things which happen and causes nurses' strikes. They support the nurses ... should work with them when they present their problems ... whoever is responsible for accepting the list of grievances should listen and attend to them".* She further suggested that *"Communities should form committees which will also attend to issues in the hospital".* In part one of this chapter, both nurse managers in charge indicated awareness of the existence of such committees even though they were relatively new with roles not clearly defined.

The two other ex-patients agreed that communities have a role to play. Ex-patient 2 suggested that *"Communities can play a role because nurses are serving the*

community. So the nurses should know that the community cares about them. Imagine that the government gave people free health services. I don't know whether they ran short of money or what. Now we hear that most of the time there are no medicines in clinics. People get angry and fight with the nurses. I think in the community there should be structures that communicate with the government about problems in the hospitals or clinics." He made the example of schools where there are school governing bodies who work with the teachers to protect the schools and the teachers. He added *"if nurses see that the community is with them they will be more committed and try their best to avoid strikes. The community must go out of their way to protect the hospitals ... Look at what happened in clinics here. They used to open throughout the day and night but all that stopped because nurses were no longer safe from the very communities they serve ... In the end it is the community that suffers and nurses are most likely to continue to strike if they don't feel that the community is with them.*

Ex-patient 3 suggested that *"communities can get in touch with the hospital through the Councillors"*. She explained that if people feel they don't get the care they need in hospitals, *"Councillors can faithfully go and meet with the health authorities before nurses embark on strike action. Perhaps nurses do things that are unjust to patients because they themselves have things that cause them dissatisfaction. Such involvement can help prevent a strike before it occurs.*

In focus group 1, **Mary** said *"quite honestly there is nothing that can be done by the community because even the nurses who are dissatisfied are the community. The very people who suffer when nurses are on strike are the community itself.* According to **Sue**, *"the community should show that they care for the nurses and the clinic ... The nurses will inform them if they want to do anything, like strikes."* There was general consensus among this group and the ex-patients on the need for community involvement in hospital or clinic matters.

In focus group 2, **Jenny** and **Gugu** shared the view that the community can do nothing. **Pat** repeated the issue of free health services but no medicines. Protecting the nurses she said *"Why did the government do that if it cannot bring the medicines? Now the nurses are suffering. The patients must please stop scolding the nurses if they do not get medicines. They know where the government is. They must just go straight to them and tell them their complaints. Some people go from one clinic to another, wasting government money. That must stop."*

Further protection of the nurses came from **Siza** who asked *"Are nurses different from teachers? Teachers go on strike every day. Our children suffer but the teachers say we must not worry. Things will be all right in future. Even with the nurses, I think they want things to be all right in future."* In applying the Moral Balance Model (Jennings & Western 1997:289-290) described in chapter 3 of this report, nurses, like teachers, consider gains and losses of strike action with the aim of improving the quality of service they provide. To support this, Benn-Rohloff (1997:341) holds the view that a successful nurses' strike will help patients in the end because better service conditions will lead to job satisfaction, thus making nursing more attractive, resulting in a better qualified, more motivated staff.

According to these responses, participants are divided in their perceptions of what communities can do in relation to nurses' strikes. Some see absolutely no role while others believe that if the community maintains constant contact with the hospital, the authorities will become aware that nurses are supported and protected by community members.

ITEM 7 VIEWS ON THE ROLE THAT COMMUNITIES CAN PLAY IN MANAGEMENT OF NURSES' STRIKES

There was consensus among the ex-patients that communities should work together with the hospital during strikes. Ex-patient 1 stated that *"Communities should*

show solidarity with the nurses so that even the superiors can see that the community does not like what is happening." Referring to previous strikes she recalled *"... It was very good to see the community, even the Councillors coming forward, actually forwarding the nurses' memorandum of grievances. Authorities could become aware that the community can see what is happening, is in solidarity with the nurses. The authorities can do something and can be influenced to meet the nurses' demands just because they have become aware that the community sympathises with the nurses."*

Ex-patient 2 suggested that governing bodies should be involved in issues discussed in the hospital and *"during a strike they can come in and see what help is needed. I think they can even influence the authorities to attend to the needs of nurses. The community can also talk to the nurses and tell them how much they suffer and that may influence nurses to stop the strike and go back to the structures."*

Ex-patient 3 praised the community for its participation. She said *"One good thing that we noticed was that relatives who lived nearby came to look after their sick ones whilst arrangements were being made to transfer or discharge them ... community members can volunteer to help because there are always those patients who are helpless. Male or female members of the community may help, for example to clean wards, serve food for patients, change them and so on".*

When asked about the issue of strikers' unhappiness with those who came to help during strikes, her response was *"I think if somebody can explain to the striking nurses that those people are not being employed, they are just there because nurses are not working at that particular time. I think nurses will understand because they are not being deliberately destructive. I do not think that there should be any quarrelling between the two, that is the strikers and the volunteers who come to help."* This is an important issue to note because many strikes are marked by conflicts between strikers and scab labour (those who come to help during a

strike). Strikers assume that if work continues, it weakens their strike. However if vulnerability of patients' lives is considered, use of volunteers to continue providing care has merit.

In focus group 1 only two responded to this item. **Mary** recalled that *"During strikes in the hospital the community was fully involved, helping the workers"*. She continued *"They heard what the workers were complaining about. They were convinced that the nurses were not treated well. So they decided to support them ... I heard that some community leaders went to talk to the authorities. We don't know what they were discussing but we know that they were trying to show that the community is concerned about the situation in the hospital."*

Lucy supported Mary's perception of community support and specified *"I actually heard that Councillors from the different sections went to the hospital during the strike. They talked to the workers and established their complaints ... They initiated discussions with the authorities, telling them that they, as Councillors had a responsibility to see that the community does not suffer. They wanted to work with the hospital to try and sort out worker problems. There was even a march that was organised. We heard that Councillors were in the forefront of that march when letters of grievances were taken to the authorities. They said they wanted to make it clear to the authorities that they were concerned about what the hospital workers were not happy about because it was affecting the service."*

Lucy's emphasis on the role of Councillors supports the views of ex-patient 3 on their role in prevention of nurses' strikes when the latter stated *"We voted for them because we trusted that we could talk to them about issues that concern us. They can report these issues to the Mayor, then the Mayor can report to appropriate persons.* Ex-patient 1 also highlighted visibility of Councillors in showing solidarity with nurses during strikes. **Lucy** further explained that Councillors were requested to ask the workers to return to work while waiting for feedback and from what she heard, Councillors were together with the workers to get feedback.

In focus group 2, **Siza**, **Jenny** and **Gugu** maintained that they did not know what communities could do. **Siza** explained *"I think it is the hospital which should know what to do, but we must support the nurses because they are helping us."* **Gugu** supported **Siza** by saying *"The community can help if somebody asks them and tells them what to do."*

Responses of focus group 2 on this item demonstrate a wider gap in communication, consultation and participation between the hospital and the community served. They differ from views of focus group 1 where the role of the community was supported, for example, the supportive role played by Councillors during the strikes was commended.

ITEM 8 VIEWS ON THE ROLE THAT COMMUNITIES CAN PLAY IN EVALUATING NURSES' STRIKES

In view of the implications of nurses' strikes for health care provision, it is important to detect if community members see any role they can play in evaluating the aftermath of the strike. Lessons learnt from previous and present strikes influence decisions and strategies for prevention, management or handling of future strikes. They also influence the consumers about strikes in future.

According to ex-patient 1, continued contact between the hospital and the community is important, as she explained in reference to the strike she experienced *"...I think that because the community was there, especially the leaders in the community, like the Councillors, they put it clearly that they are going to maintain contact with the hospital authorities on an ongoing basis. They will always be in touch and in the know of what is happening, what the workers' complaints are. Then they can bring the complaints of the communities about the service rendered."* She indicated she was not sure if that was happening but thought it could be good.

Ex-patient 2 opposed the above view when he said *"I don't see what role the community can play because it is the responsibility of the hospital to see that it provides a good service to the community."* In this view, it is clear that the joint responsibility of the health service and the community for quality service delivery is not supported.

Ex-patient 3 supported ex-patient 1, saying *"... I think the community can play a big role. Neighbours can come together and talk about problems instead of 'toyi-toying'. In this way they can set an example to other nearby communities."* She quoted the example that fighting in some residential communities stopped when people started talking.

There was not much input on this item from the focus groups. In focus group 1 **Dan** mentioned the media which tells them if there is a strike in a particular hospital. **Kay** heard from a neighbour that there are committees for the clinics, adding *"She said she is in that committee. She even said we must contact her if we have a problem with the clinic."* **Lucy** repeated her emphasis on importance of the role of community leaders, especially the Councillors, maintaining constant contact and acting as middle-man between workers, authorities and communities.

In focus group 2, it was only **Pat** who suggested *"I think the community should be informed about strikes and what happened during strikes. No secrets."*

It is noted that there is no clarity on the issue of evaluation of nurses' strikes and this was also observed in the responses of the various categories of health care providers.

ITEM 9 ADDITIONAL COMMENTS ON NURSES' STRIKES OR ANY OTHER RELATED ISSUE

Two of the ex-patients did not contribute to this item. Ex-patient 2, appearing to have an after-thought on prevention of nurses' strikes, said *"There is something I am thinking of now as something which can help to prevent strikes. Why is it that in hospitals which treat Black patients mostly and have a predominantly Black staff, the people in high positions are not Black People?*

Ex-patient 2 continued to explain that if this issue is not attended to *"... Then nurses do not feel they own these services. They just see themselves as workers and do not worry if they leave the service even if it is for minor reasons. If you feel a thing is yours you persevere even if there are problems. So what I am suggesting is that they look at what is happening in industry. The people who did not have opportunities before are now being considered for better positions. They are even trained to fit into those positions. Nurses are also people who like to be in better positions. I do feel if these things are considered it can make a difference."*

This concern was raised in evidence to the Mall *et al* Commission 1996:11-16) where workers were opposed to appointment of outsiders of other races to senior management positions. In its final recommendation, the Commission supported affirmative action principles to bring the previously disadvantaged Blacks to parity with other races. NEHAWU representative also shared this concern.

Some participants in focus group 1 made comments on the quality of health care. **Dan** said *"Oh! it is much worse than before... Before we used to get everything that we needed but now they just tell us there are no medicines. The standards have gone down. Treatment is not good."*

Mary explained the reason for this by saying *"... The difference is caused by the fact that before you used to pay when you came to the clinic. Now you don't pay. Everything is free. So things get used up."* Referring to abuse of the free health services she issued a warning *"So it is up to us. The government is trying to help but we destroy and waste our own things if we do that. We must learn to be responsible. A person must take only what she needs even if she is not paying for it ... The nurses get a supply, they know how long it is supposed to last. It doesn't last because people are abusing it."*

Mary explained the practice whereby people watch the medicine delivery van coming to clinic then tell others. The next day the clinic is full. She wondered *"Do you think they all got sick suddenly just because medicines came to the clinic? No. I think we must teach one another."* When **Dan** asked why nurses give out medicines which are not needed **Sue** answered *"Do you think nurses can refuse to give the medicines? They are also afraid that you will blame them and say the government is giving you medicines but the nurses are refusing. If I were a nurse I would also give everything you want and then if there is nothing I am free."*

These debates by health care consumers demonstrate the community's sensitivity to the nurses' plight of inadequate resources to deliver expected quality of health care as promised by the government. The fact that nurses are usually the ones criticised for these weaknesses in the health care system supports the visibility of nurses which was highlighted in chapter 1 of this study.

In focus group 2, there were no additional comments.

7.3 CONCLUSION

In this chapter perceptions of consumers of health care on nurses' strikes have been analyzed, and some comparisons with those of the health care providers were

made. Many responses have been quoted verbatim in an attempt to capture and share with the reader the "lived experience" as it was described by the participants. Conclusions made from these findings will be presented in the next chapter together with the recommendations.

CHAPTER 8

SUMMARY, LIMITATIONS, DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

This study investigated the impact of nurses' strikes on nurses, the nursing profession and on quality of health care. The extensive literature search provided a broad theoretical base of national and international perspectives on the issue of labour relations and collective bargaining in nursing as well as on the problem of nurses' strikes. It also underlined the importance of investigating the strike phenomenon in its entirety rather than look at the 'impact of strikes' as an isolated phenomenon. The theories selected as a framework for this study address this need as follows:

* In Social Action Theory, Silverman highlights that the **actor** (striker in this context) has a purpose of wishing to bring about a desired future state of affairs (having demands met). Acting within a particular context, he therefore manipulates certain means or conditions (adopts tactics, eg withdrawal of labour) to attain that purpose. The researcher is of the opinion that a study which only looks at the outcome of manipulation of the conditions (impact or strike aftermath) without looking at the structure (context and causes of the strike) and processes involved (strike activity) would not give a balanced picture of the strike phenomenon as reflected in the conceptual framework of this study.

* The Systems-Developmental-Stress Model by Chrisman and Riehl-Sieca takes the researcher through **structure** which comprises the broad philosophical base of assumptions, values and ethical principles of nursing, to **process** which

explains the stress state experienced by nurses as a result of problems within the structure. To achieve and maintain desired change requires continuous adaptation by all stakeholders in the health care system.

8.2 SUMMARY

An exploratory descriptive case study was undertaken in two purposively selected hospitals in the province of KwaZulu-Natal. Through semi-structured interviews participants were able to share their experiences of nurses' strikes by describing the subjective meanings that they attached to the strike experience. The data was subjected to both quantitative and qualitative analysis.

In line with the present government's principle of inclusiveness, freedom of expression and transparency, the sample included stakeholders representative of both the health care providers and consumers. However it was not possible to confirm the assumption on which this study was based, namely:

> *"Positions and levels of responsibility of different stakeholders within the health care system predispose to variability in specific modes of perceptions about nurses' strikes and their impact".*

Though there were similarities and variations in perceptions of the various health care stakeholders on the major issues in relation to strikes, there was no specific pattern typical of any particular group.

No hypothesis was stated but an assumption and objectives were used to guide the study. Conclusions drawn from the findings therefore relate to the assumption and take into account the question of whether the objectives were achieved or not. Objectives of the study were:

* to determine perceptions of nurses, and organised labour as nurses' representatives, consumers of health care, nurse managers and health policy-makers as employers of nurses about nurses' strikes.

* to describe activities that take place before, during and after nurses' strikes.

* to elicit participants' perceptions of their feelings before, during and after strikes.

* to investigate participants' perceptions about the impact of strikes.

* to develop a model that can be adopted to minimise the occurrence of nurses' strikes and their adverse effects.

8.3 LIMITATIONS OF THE STUDY

The limitations in the study divide into conceptual and methodological issues. First, the latter is discussed.

8.3.1 - Although there were numerous strikes of different magnitude and impact in the province, only two became the focus of this study. For this reason the findings capture experiences of the particular strikes and these may not necessarily be typical of others (Dane, 1991:113-114). Nevertheless, the magnitude of the strikes under study was an important consideration taken into account. Patton (1990:489) argues that extrapolations can be made, meaning that findings can be applicable to similar, though not identical conditions if data was obtained from information-rich samples.

8.3.2 - Despite prior planning, an important limitation was that logistic problems prevented participation of the political and administrative top executives of the Provincial Health Department as initially intended. The rationale for their

inclusion was to get input of the ultimate health policy-makers in the province since these have implications for labour relations and therefore strikes. However participation was established at nursing directorate provincial level. This contact did help as the study is on nursing issues.

8.3.3 - Delays in the preparatory processes for this study, including delays in obtaining permission from the various stakeholders resulted in the data collection process being stretched over long periods. This caused unnecessary lapses in the process.

8.3.4 - Some participants attempted to hi-jack the interview sessions to inform the researcher on their personal views, not necessarily directly pertinent to the investigation. The period during which the strike occurred was turbulent. The sensitivity of the material and participants in the study was of utmost importance to the researcher.

8.3.5 - Conceptually the study focuses on nurses' strikes, the activity part of it and the impact on the different stakeholders involved. The concept strike is dealt with in terms of legality and/or illegality according to the labour Relations Act (66 of 1995) as amended. These aspects and other definitional characteristics were not singled out for precision due to the paucity of sources that would have informed the researcher most adequately at a deeper theoretical level.

8.4 DISCUSSION OF FINDINGS AND CONCLUSIONS

Individual objectives are used as a foundation for discussion of findings in the succeeding section.

8.4.1 Objective One

* **To describe perceptions of nurses, and organised labour as nurses' representatives, consumers of health care, nurse managers and health policy-makers as employers of nurses about nurses' strikes**

Several aspects were investigated to achieve this objective.

8.4.1.1 Perceptions on work Environment and Job Satisfaction

Comparison of perceptions of the various categories of participants revealed that all except the employer category, as represented by the nursing directorate, shared the view that nurses were unhappy in their work environment and lacked job satisfaction (Chapter 6, item 1:122-124). Expression of lack of job satisfaction places a challenge on the Department of Health to set in motion and evaluate effectiveness of processes established to achieve its stated objective of maintaining a "contented quality workforce" through creation of 'a caring ethos'. The culture of caring must transcend through both the providers and consumers of health care (White Paper for Transformation of the Health System, 1997:64-65). The view of the Director of Nursing Services that nurses are happy is superseded by all other participants in the study.

In spite of shared perceptions about what caused job dissatisfaction, there were differences among the various participants in the rank order of importance, for example picking the first two variables, the following variations were identified:

* **Nurses and their area managers:**
  (1) staff shortage, overwork and long hours of work
  (2) low salaries

* **Nurse managers A and B:**
  (1)low salaries
  (2) unfair promotions and merit allowances

* **DENOSA representative**
  (1) low salaries
  (2) inadequate equipment to enable nurses to render quality patient care

* **NEHAWU representative**
  (1) high expectations of salary increases
  (2) lack of advancement through training

These differences in importance of job dissatisfiers underline the proposition of the Social Action Theory that people exposed to similar experiences give their own interpretations which make them react differently, for example some are more concerned with personal needs and goals than organisational needs and goals, that is quality health care in the context of this study. This can further be explained as a product of "attachment" which, according to this theory, determines the extent to which employees would be prepared to comply with the dominant system of management in the organisation.

There were shared perceptions between the health care consumers and the health care providers that low salaries and overwork were responsible for nurses' job dissatisfaction. However it was found that the consumers laid more emphasis on nurses' unhappiness about conflicts and criticisms from the communities at the nurses' failure to deliver the expected service. It is therefore concluded that nurses are placed at an unfair disadvantage in the forefront of health care delivery and take criticism for all weaknesses in the health care system, for example unavailability of doctors and medicines; as one consumer asked *"why don't the nurses give us what the government has provided?"* From this finding it is clear

that the government has a responsibility to protect the nurses by using its principle of 'transparency' to keep consumers informed of budgetary and resource constraints. It is also expected to review its policies on health care delivery, for example free health services to consider resource availability and, as suggested by **Mary** in focus group 1, to educate the community on how to use them.

8.4.1.2 Correlation between factors causing job dissatisfaction and causes of strikes

In chapter 6, numerous reasons given for job dissatisfaction in item 1 were repeated as causes of strikes in item 9 (155-162), though in a different order of priority. As explained in the conceptual and theoretical frameworks of this study these long-term job dissatisfiers were precipitating factors for strike action to which the nurses were continually using "strategies" to 'adapt' in order to prevent the 'stress state', or as NEHAWU representative put it, *"they were the dissatisfiers that nurses had harboured for a long time"*. As nurse manager A put it "maybe the time was ripe" that 'adding a little oil to the fire' would trigger "tactics" to put an end to the dissatisfaction, for example through strike action. Applying Barnard's acceptance theory of authority, as in Tosi (1984:60-61), the conclusion is drawn that strikes occurred because factors of job dissatisfaction fell outside the acceptance zone.

In addition participants indicated that the strikes had overt political connotations since they occurred during the period marked by rapid socio-political changes and political conflicts surrounding the 1994 government elections. Promises made during election campaigns were believed to have heightened expectations of immediate removal of any previous government and employer policies perceived as unjust and undemocratic. To address this situation, the newly elected government showed expediency when it promulgated the new Labour Relations Act (66 of 1995) aimed at protection of employees and employers against unfair labour practices.

8.4.1.3 Ineffectiveness of communication

The investigation revealed perceptions of rigid, ineffective communication structures which created gaps and distance between nurses and management or employers, resulting in poor attention to grievances. Nurses and their representatives (organised labour) blamed management for failure to attend promptly to grievances or to give them feedback. The nurse managers in charge, particularly nurse manager B, shared the perception that it was the employer at Head Office level who did not attend promptly to grievances reported to them (chapter 6, item 2:128-133). The health care consumers blamed both management and the employer (the Provincial Department of Health) for failure to attend to nurses' needs (chapter 7, item 1:216-217).

To support this finding, the researcher observes that the grievance procedure in the public service is long and tedious, taking days to reach top management and employer while going through the various levels of communication. It takes even longer to provide feedback on proposed solutions especially because some problems are beyond control of the immediate management. To support this, Figure 6.1 (page 132) provides an example of the grievance procedure followed in a public service setting and therefore applicable in the nursing departments of the two hospitals under study.

It should be noted that legal recognition of employee representatives at functional levels occurred with establishment of workplace forums through the Labour Relations Act (66 of 1995) as amended. To date their cohesiveness with management remains questionable. The situation of worker or nurses forums was worse in 1994 because they were new in most institutions, neither legalised nor clearly defined and management had problems working with them in consultation or negotiation activities.

The importance of effectiveness of organisational communication was endorsed by the International Labour Organisation (ILO) Recommendation 129 of 1967) when it stated that a climate of mutual understanding and confidence in organisations is promoted by rapid dissemination and exchange of complete, objective information. ILO stressed the importance of consultation with employees before establishment of communication structures, however the role of employee representatives and freedom of association was emphasised (Bendix 1996:334-336). To apply the ILO recommendation of consultation with employees effectively, it is important to avoid pseudo-consultation whereby management communicates predetermined decisions to employees (Scholtz 1991:139).

8.4.1.4 **Organisational Affiliation**

Though various organisational affiliations were mentioned in chapter 6 (item 7:148-152), the highest membership identified was that of professional associations. This might be influenced by the previous prescription of compulsory membership. According to Sitas *et al* (1998:38), the high membership of DENOSA which was 70% of the total nursing population in the country at the time of the DENOSA survey, is related to the image they hold of themselves as 'professionals' rather than 'workers', hence they described themselves as "professionally-trained, viewed with esteem, ... hard-working nurses".

In respect of general unions, NEHAWU was said to be commanding the highest membership. On organisations influencing or initiating the strike(s), it was only the nurse managers in charge (A and B) who stated with conviction that organisations were involved whilst the representatives of organised labour maintained that they were also taken by surprise. In the nurse categories, dissatisfaction was clearly expressed over unions not allowed to operate freely in health services, especially the then KwaZulu Homeland Government controlled ones. To them one of the main post-strike achievements was freedom of

association, legalised through the Labour Relations Act (66 of 1995) as amended (Chapter 2). Persistent conflict or strained relationships still exist between some managers and unions. To this the said Act stipulates that "No person may prejudice an employee ... for participation in the lawful activities of a trade union ..." (Section 5 (2)(c)(iii).

8.4.1.5 Views on nurses' strikes

Though some divisions were noted in chapter 6 (item 20:195-198) on views about nurses' strikes, general opposition to strikes was overwhelming. The nurse representatives acknowledged that in spite of opposition to strikes nurses would strike to fight for their rights while the Director of Nursing Services explicitly expressed the view that there was no need for strikes as she kept referring to open communication between Head Office officials and the health care organisations management and organised labour. Among the health care consumers, (chapter 7, item 4:224-228) views were distinctly divided since some maintained that the type of nurses' work is such that they should not strike at any time whilst others expressed the opinion that nurses may strike with no limitations like any other worker. Only two health care consumers appeared to condone the view of nurses' striking to fight for their rights on condition that they show care for the consumers, warn them beforehand, keep them informed of what is happening and make sure somebody is available to provide care. Jenny's experience of losing her daughter allegedly due to unavailability of emergency treatment endorses this need.

In the study by Kunene (1995:119-126) the nurses and nurse managers endorsed the undesirability of strikes because of the major adverse consequences as compared to very few benefits. In view of the expressed opposition to strikes, their occurrence may be explained as an indicator that the strike driving forces of perceived violation of rights and failure to meet personal needs became stronger than the strike inhibiting forces of the desire to preserve the professional image described in Sitas *et al* (1998:38).

8.4.2 **Objective Two**

* **To describe activities that took place before, during and after strikes/**

8.4.2.1 Before Strikes

Since there was agreement that there was no pre-warning of strikes, as indicated in chapter 6 (item 3:133-137), it is concluded that this caused the difficulty in planning for continuity of patient care or for solving the nurses' problems. It was only the Director of Nursing Services who maintained that, as Head Office officials, they were always warned of strikes through the open lines of communication. The researcher is of the opinion that since there was no prior notification, institutional management or organised labour could only inform them when the strike was commencing, because the strikes in question were described as wildcat strikes, as confirmed by Butler (1995:21).

According to perceptions of management, though change of mood and departure from routine was noted, as confirmed by the ex-patients, it was difficult to take appropriate actions due to high levels of tension and lack of visible strike leadership (chapter 6, items 5 and 6:142-148). To counteract this, intensive education is needed to create awareness and compliance with legal strike procedures which include a specific notification period according to the Labour Relations Act (66 of 1995) as amended, to enable pre-planning that involves all stakeholders.

8.4.2.2 During strikes

What came out as the main concern of most participants, inclusive of both health care givers and consumers, was failure to render effective patient care which resulted in extensive suffering of patients and their significant others as well as a

tarnished image of the nursing profession (chapter 6, item 18:188-189), chapter 7, item 2:21-222). In accordance with the Social Action Theory it can be concluded that actions and behaviours of 'social actors' as striking nurses have an impact on 'others', including the consumers of health care who in turn attach their own meanings to these actions and their outcomes, hence the negative image of striking nurses in the community. It is for this reason that emphasis is placed on the importance of pre-planning for strikes (Kunene, 1995) Bezuidenhout *et al* (1998).

Participants acknowledged the commitment of doctors and nursing management to provide whatever care possible, however the chaos and disorganisation did little to reduce patient suffering. The example of patients who could not be traced due to chaotic discharge and transfer procedures signifies the suffering. Forrest (1996:58-60) further attributed the chaos and difficulty to handle the 1994-1995 strikes to the fact that a large percentage of the workers were not part of organised labour and those who were organised belonged to different unions.

8.4.2.3 After the strike

According to chapter 6 (item 22:201-202) the main challenge faced by nurses and nurse managers was to try and return swiftly to orderliness and normality after the strike, for example replacing stolen equipment, cleaning the filthy environment which even required hiring cleaning contractors at great cost. The nurse managers in charge highlighted that they faced further accusation of failing to restore orderliness by the very personnel who were involved in the strike and had therefore contributed to the disorderly work environment. It should be emphasised here that all stakeholders have responsibilities in achievement of organisational goals which should not be lost sight of in pursuance of own goals (Kyriacos, 1996:40).

Concern was also expressed over management's refusal to end the lockout when they wanted to come back to work. This concern endorses Bendix's (1996:521) view that "Employees engaged in strike action do not intend permanently to withhold their labour from the employer but merely to oblige him into negotiation or, where negotiations are already in place or deadlock has been reached, to persuade him to adopt a different stance regarding the demands of his employees". It is again emphasised that intensive education of both employees and management on legal lockout and strike action is important.

8.4.3 Objective Three

* **To elicit participants' perceptions of their feelings before, during and after strikes**

8.4.3.1 Before strikes

Predominant feelings described in chapter 6 (item 4:137-142) were mistrust, sadness and guilt feelings out of concern for imminent patient neglect. The views expressed by Erasmus (1998:50) that nurses are nurturers who "still publicly identify their desire to help, serve and care for people" could explain these feelings. Those nurses who had experienced strikes previously related most of their concern to the unpleasant experiences of the past which included disciplinary action by the then South African Nursing Council. As indicated in Social Action Theory, actions and reactions to others' actions are influenced by past experiences. Tensions were also identified, resulting from lack of communication as described in preceding items. Similarly, tensions were also marked in the strikes reported in other countries for example Baird (1988) in the United States of America and Hibberd and Norris (1991) in Canada.

8.4.3.2 During strikes

Generally participants expressed depression and panic about the situation as reflected in chapter 6, item 16:180-184). This can be understood against the background of lack of strike notification resulting in chaos since there were no pre-plans for continuation of patient care and for strike handling. Another cause of worry identified was the threat of 'no work no pay' and fear of victimisation. The ex-patients expressed shock at seeing two sides to nurses, and fear of the unknown since they did not get the care they expected. In the focus groups marked depression and anger was expressed, in line with their indirect strike experiences.

The conclusion drawn is that the negative feelings experienced before the strikes persisted during the strikes. This poses a further challenge of having to deal with such feelings whilst actively involved in strike handling. This is important to facilitate positive adaptation to the stress state described in the Systems Development Stress model of Chrisman and Riehl-Sisca.

8.4.3.3 After strikes

Mixed feelings were described in chapter 6 (item 21:198-200) as some shared that they were happy the strike was over and they could go back to work. There were few expressions of a sense of relief that lines of communication had been established and lessons on how to channel change were learnt. Predominant feelings described were hostility, mistrust and destroyed long-term relationships, hence the post-strike period was difficult as they tried to rebuild the relationships. These findings are supported by Baird (1988) in the United States of America who confirmed that it is difficult to come to work together after a strike and animosity may exist between strikers and non-strikers for years. In the researcher's opinion the issue of rebuilding harmonious relationships in the strike aftermath poses further challenges for management, personnel and consumers of the service to work interactively in the rebuilding process in the strike aftermath.

8.4.4 Objective Four

*** To investigate participants' perceptions about the impact of nurses' strikes**

8.4.4.1 Impact on Nurses

According to chapter 6 (item 17:184-188), the physical aspect, the impact highlighted was that most got tired of sitting, those with chronic diseases, for example hypertension, diabetes, reported exacerbation of symptoms due to stress, others were manhandled as they were physically removed from nursing units. On the social aspect there was consensus that the image of nurses was tarnished, the strikers were embarrassed when passers-by pointed fingers at them as they sat not working, and when the public passed remarks in public transport. This finding is in line with lack of consultation or communication between the health care organisations and the community, as expressed by the majority of participants. The few who mentioned existence of Hospital Boards made it clear that these were relatively new and their roles were not yet clearly defined. The emotional states described in the preceding section on feelings indicate that the strikes impacted adversely on the nurses.

8.4.4.2 Impact on the Nursing Profession

Both health care providers (chapter 6 item 17:184-188) and consumers (chapter 7, item 4:224-228) emphasised the destroyed image, lost respect, trust and dignity and lowered status of the nursing profession generally. As explained in chapter one (page 1), the strikes in question were not the only ones but many more were experienced in various institutions, provinces and were on a national scale. Health care consumers made it clear that they were sceptical about nurses openly pledging that 'patients are their first priority', then not making sure to arrange for patients to be cared for while nurses are involved in pursuing their strikes. Nurses, on the

other hand, made it clear that it is the very clause of 'patients as first priority' which has led to nurses' rights being downtrodden. In view of these conflicting expectations between the health care stakeholders the researcher concludes that the potential for dissatisfaction and/or strikes will continue to exist unless common ground is reached on what to expect of one another.

8.4.4.3 Impact on the quality of health care

In line with the finding discussed in chapter 6 (item 18:188-190) that patient care activities could not continue during the strikes, all participants expressed a perception that quality of patient care suffered during the strike. Both nurse managers A and B made the statement "Quality patient care was 'ZERO'". This denotes their serious concern as officials who are ultimately accountable for the quality of health care throughout the organisation. The minimal care available even before total stoppage of work or closure of the hospital(s) was rated very low. This reaffirms that nurses are the backbone of health services (the 'engine', according to NEHAWU representative). Moreover, the core of nursing is "CARING". Though it was highlighted that doctors stretched themselves to provide care, two factors made it ineffective:

(1) Their numbers: Too few doctors compared to nurses.
(2) The art of "CARING": Not their main area of expertise. Their primary area of expertise is "CURING" though change to a more Primary Health Care focused Health Care System emphasises preventive and promotive care aspects by all health care personnel.

According to chapter 7 (item 3:222-224) Health care consumers openly expressed disappointment that nurses could not care for them. The findings revealed explicit hatred between those who suffered tangible losses during the strike, for example, Jenny in focus group 2 who lost her daughter. The researcher draws a conclusion

that there is inadequate communication and interaction between health care providers and consumers before, during and after strikes. This creates lack of awareness of nurses' strikes and their impact on the quality of health care expected by the consumers. The consumers were unanimous in emphasising that they are the ones who suffer during nurses' strikes, not the employer or government. This is further supported by Tabak and Wagner (1997:283-287) who emphasise that even a successful strike entails distress and most of the pain is borne by the public. These authors maintain that in spite of the empathy the public may feel for nurses, there is a negative reaction related to nurses' failure to meet their ethical and moral obligations to provide care. The authors also stress the obligation to inform patients, colleagues and public officials of nurses' intention to strike.

8.4.5 Participants' suggestions for a way forward

The researcher's recommendations will incorporate the way forward as suggested by the participants in chapter 6 (items 23, 24, 25, 27:202-210; 212-214) and chapter 7 (items 5, 6, 7, 8, 9:228-238). This will culminate in achievement of OBJECTIVE FIVE which was stated as follows:

* **To develop a model that can be adopted to minimise adverse effects of nurses' strikes**

The participants' suggestions for a way forward are summarised in the succeeding section.

8.4.5.1 Strategies for prevention of strikes

Participants suggested:

* Clear job descriptions and role clarification

* Flatten hierarchies — to facilitate communication
* Educate management
  - to identify problems / respond promptly
  - give feedback
  - work cooperatively with employee representatives (workplace forums / nurses, forums / unions)
* Nurses, not to "bottle up"; to utilise representatives, to exercise their own rights
* Employer (Department of Health) to be in constant touch with health care organisations
  - Be sensitive to nurses' needs
    . workloads
    . salaries
* Communities as stakeholders to be actively involved in the health care system
  - show concern for nurses' welfare; protect the health care system
  - not to 'fight' with nurses for weaknesses in the health care system
  - community representatives to be involved
    . councillors
  - to serve in Hospital or Clinic Boards or Committees

8.4.5.2 Strategies for strike management / strike handling

Participants suggested:

* Publicised plans for continuity of service
* Visible strike leadership: Control of strikers / negotiation
* Management to work with nurses' forums
* Management to provide strike guidelines
* In-service education on how to handle strikes
* Head Office guidelines: coordinated and consistent — physical presence and support

* Union guidelines; skeleton staff
* Strike plans part of disaster plans
* communities to give visible support to striking nurses to increase pressure on management so as to facilitate dispute settlement.

8.4.5.3 Strategies for evaluation of nurses' strikes

Participants suggested:

* Post-strike evaluation to be done at all levels: functional and management levels, open to all stakeholders.

* Management to call meetings of all staff, adopt a positive approach; encourage input from all employees regardless of category.
  - to compile reports, disseminate information, not to be hidden in managers' offices.

* Reports of Commissions of Inquiry publicised.

* Head Office — to go to institutions for first-hand evaluation of strikes and compilation of reports. To maintain contact and monitor the strike aftermath for:
  - prevention of further strikes
  - implementation of changes and new policies

* Organised labour to put in place evaluation systems and contact with members.

* Communities to demand to know results of the strikes; to be given a chance to report how it affected them; to be assured of attention to their care needs in future strikes.

8.5 RECOMMENDATIONS

In terms of the findings and conclusions of this study the researcher makes the following recommendations:

* Open communication and an interactive, consultative approach involving all health care stakeholders should be adopted in dealing with nurses' issues to facilitate job satisfaction among nurses and thus prevent or minimise the occurrence of nurses' strikes. It is important to keep the community informed. Nurses need to feel as equally supported, protected and cared for as their patients / clients. In this context the 'caring ethos' proposed by the National Health Department in the White Paper for the Transformation of the Health System in South Africa (1997:64-65) should be a guiding principle. The rights of health care personnel should be defined and respected. Employers and management should design procedures that facilitate the 'culture of caring' throughout the organisations under their jurisdiction. These should be closely monitored and evaluated systematically.

* The fact that predominant pre-, during and after-strikes feelings expressed were guilt for patient neglect reinforces that nurses' commitment to patient / client care exists in spite of their involvement in strikes. For this reason the researcher recommends that strikes should be taken as a crisis situation for which counselling and emotional support services are required to promote the psychological well-being of both striking and non-striking nurses as well as management. In addition personnel and patient care policies should be reviewed to balance satisfaction of nurses' personal needs with satisfaction of patient / client care needs and achievement of organisational goals in order to eliminate the need for strikes.

* There should be well-coordinated training and development programmes for all health care stakeholders on strike prevention and strike management procedures in line with existing labour and professional legislation.

* There should be long-term integrated contingency strike plans that are inclusive of all health care stakeholders, for example:

  - nurses and other multidisciplinary health team members for continuity of patient care.

  - the pool of volunteers available to support the strike contingency plans.

  - intersectorally-collaborated plans including transport, catering services, security or police service to handle intimidators and thus protect skeleton staff and volunteers.

These can be adjusted to suit conditions prevailing with each strike.

* Institutionally there should be a well-defined, publicised, accepted strike team that includes management, Heads of departments, human resources and/or labour relations managers, financial managers and organised labour.

* The employer, management and organised labour should work jointly to devise strike handling strategies that will prevent patient neglect, damage to property, harm to non-strikers and other members of the multidisciplinary health team.

* There should be adequate coordination of strike plans at local, provincial and national levels, to facilitate consistency and effectiveness in strike handling in the country.

* Stricter control of intimidators during strikes is needed to eliminate interference with continuation of service provision. Policy should be explicit on punitive measures that may be taken against them, in line with requirements of the Labour Relations Act (66 of 1995) as amended.

* Systematic evaluation of strikes should be done to objectively identify benefits and losses to the nurses, the nursing profession, management, employers, organised labour, health care consumers. It is important to eliminate stereotypes that exist about strikes as only having a negative impact with no positive gains. International literature consulted for this study indicated that when post-strike evaluation is done, gains and losses are identified, for example in the Manitoba strikes in Canada studied by Cummings & Leverington (1992), and the positive impact of a strike in a psychiatric hospital studied by Sigal *et al* 1989) (see chapter 3 of this report).

* Lessons learnt from each strike should be used to guide management and handling of future strikes. Each strike should be handled better than the previous one to minimise its magnitude, duration and adverse effects.

* When staff have been made aware of, or have given evidence to Commissions of Inquiry on strikes, it is important that they are informed of findings and recommendations as well as implementation of those recommendations.

* Results of strike evaluation should be used as a foundation for training and development programmes on labour relations and strike issues.

* Physical and psychological healing processes should be planned and implemented in accordance with any harm or damage revealed through strike evaluation results, for example counselling services are essential.

8.5.1 Recommendations for further research

* This study should form a basis for similar studies in other health care services in KwaZulu-Natal and in other provinces.

* Since the study revealed that these were not purely nurses' strikes, it is important to study health services strikes generally, not limited to nurses.

* In view of the government's emphasis on Primary Health care whereby effectiveness of health care programmes in the community is a priority, research should not be limited to hospital settings. It should be inclusive of all health care settings, institutional and non-institutional.

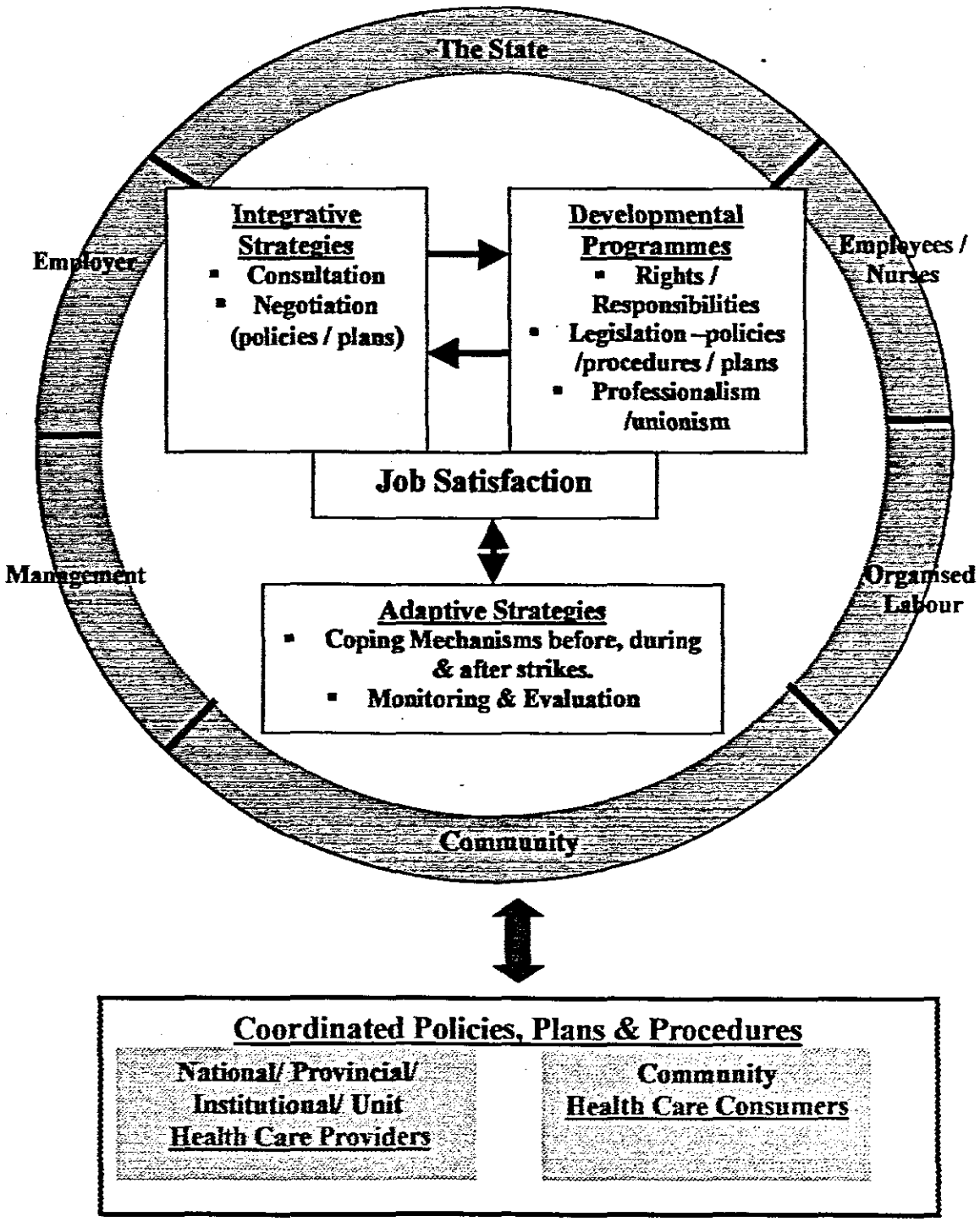
* Inclusion of health care policy-makers in studies of strikes in health care organisations remains a priority.

8.6 PRESENTATION OF THE PROPOSED MODEL

As stated earlier, in undertaking this study, the researcher set out to develop a model that could be used as a guide to minimise the occurrence of nurses' strikes and/or, in the event of their unavoidable occurrence, to minimise their adverse effects on all health care stakeholders, be they providers or consumers of health care (**OBJECTIVE FIVE**). The proposed model is applicable before, during and after nurses' strikes.

The model presented in figure 8.1 is intended to highlight different factors which need consideration in prevention, management and evaluation of nurses' strikes as well as portray relationships between these factors. Since this is a proposed model at this stage, the researcher intends to present it to the nursing and nursing management community as well as to experts in model development. Through its utilisation and evaluation, the model will be refined to ensure its appropriateness and possible adaptation to different health care settings. The researcher believes that this proposed model will make an impact within the health care system to prevent or minimise further occurrence of nurses' strikes.

Figure 8.1.
GRAPHIC REPRESENTATION OF INTEGRATIVE-DEVELOPMENTAL-ADAPTIVE STRIKE MODEL.



On the basis of findings of this research and the recommendations made, a model entitled the "Integrative-Developmental-Adaptive (IDA) Strike Model" has been constructed. To support this approach to model development, Fawcett (1995:3) explains that models evolve from empirical observations and intuitive insights of researchers. They may be inductively developed from generalisations about specific observations or findings. They may also be deductively developed when specific observations or situations are taken as examples of other, more general events. Both the inductive and deductive elements were considered in the development of the proposed model.

Models used in nursing management / administration provide a systematic structure for observations or thinking about management settings. The following comparison can be made between elements of models of nursing and those of nursing management:

Nursing	Nursing Management
Person	nursing personnel
Environment	the clinical milieu
Health	wellness or illness of personnel functional state of the organisation
Nursing system	management policies and strategies

These elements of nursing management are addressed in this study.

In constructing the Model, the philosophical underpinnings of the two theories selected for the study, namely Social Action Theory and Systems-Developmental-Stress Model, were considered. In line with the Social Action Theory used as the foundation for this study, the "Integrative" part of the Model presents the labour relationship as an integrative process of continuous interaction among various stakeholders. In this process actions of individuals or groups of 'actors' are perceived or interpreted by those experiencing them or affected by them according to their own "subjective meanings".

The reciprocal interaction world view which Fawcett (1995:5-6) describes as a "synthesis of elements from the organismic, simultaneity, totality, change, persistence and interactive - integrative world view, was considered in the development of this model. The metaphor for this view is the holistic interacting human being. In management situations, organisations may be seen as holistic, interactive and integrative entities. Each part of the organisation has meaning only within the context of the whole organisation - interacting with the environment in a reciprocal manner. Both are involved in continuous change whilst also aiming at stability. The Systems-Developmental-stress model used as the theoretical framework for this study correlates positively with Fawcetts' (1995) world view.

In constructing this model, the researcher emphasises continuous communication and consultation between health care stakeholders at all levels, both as providers and consumers of health care. This is important to eliminate any unilateral decision-making by health authorities which was identified by various participants as a source of job dissatisfaction.

Personnel policies should be negotiated and reviewed integratively since they have a direct impact on job satisfaction. They should be acceptable to personnel (nurses, in the context of this study). Through these policies, it should be possible to ensure protection of nurses' rights and need satisfaction whilst ensuring similar protection of rights of other health care stakeholders for example:

- protection of employers / management's right to manage the service for provision of maximum quality health care.

- protection of consumers' right to receive quality health care at all times. They have a right to know what policies exist to guide and control personnel.

It is important to monitor the labour relationship continuously to ensure that any issue with a potential of inhibiting a healthy labour relationship is given prompt attention. For example grievance procedures exist, but it was evident from findings of this research that dissatisfaction exists about poor handling of grievances in spite of existence of grievance procedures. This was also identified as one of the causes of strikes. Some questions to ask are "How much awareness is there among personnel (nurses in this context) about grievance procedures?" "How acceptable are they?" "How much input do personnel have in their formulation?" "Are there monitoring systems in place to detect their effectiveness?" Answers to these questions are important determinants of the success of the grievance procedure.

To emphasise a holistic, integrative and consultative approach, the researcher warns against the practice of excluding health care consumers in the consultative processes as if they are mere passive recipients of a pre-designed health care system. After all that goes against the call of the government of the day for all services to be "people-driven". Input of the consumers is critical since they are the ones who are directly affected by the quality of the service rendered. It is also important to conscientise the community about the context within which nurses provide nursing care so as to enhance cooperation and tolerance when nurses are unable to live up to expectations in service provision due to factors beyond their control, for example shortage of resources.

For successful negotiation to take place, the researcher concurs with Grohar-Murray and Di Groce's (1992:81) emphasis on equalisation of the power base of negotiators as well as a need for use of synergic power that accommodates values, goals and wishes of all health care stakeholders.

The researcher also warns against "pseudo-consultation" which Scholtz (1991:139) describes as inappropriate use of the term 'consultation' whilst involved in

communicating pre-determined decisions. An example frequently mentioned by both provider and consumer participants in this study was lack of consultation before implementation of the "free health services:" policy, thus nurses found themselves at the receiving end of criticism for inadequacy of resources for health care.

In recommending integrative strategies the researcher builds on the Labour Relations Act (66 of 1995) as amended (Sections 84, 85, 86) which prescribes joint consultation and decision-making between employer) / management and employees or their representatives in workplace forums or as union officials. Adoption of these integrative approaches means putting an end to the "top-down" policy-making and planning procedures which were also identified as a source of job dissatisfaction.

The integrative strategies just described are crucial for maintenance of healthy labour relations in which job satisfaction prevails and strikes can be prevented. These strategies should also be adopted when strikes occur to facilitate effective strike handling and management, for example integrative contingency planning enhances commitment to the plan for continuity of service during strikes. After strikes integrative strategies are important, for example to facilitate shared views on the impact of the strikes and to influence future strike decisions.

In line with the Chrisman and Riehl-Sisca's Systems-Developmental-Stress Model, the Developmental-Adaptive part of the constructed strike model presented in figure 8.1 takes cognisance of the health care system as a subsystem of the wider social system. It is therefore in a constant state of development and change. New systems, procedures and policies are introduced to ensure that the health care system is well integrated into the politico-socio-legal and economic contexts within which it operates. The latter were explained in the conceptual model of this study.

To maintain stability and integrity in the health care system positive adaptive strategies are necessary to cope with crises and stress in the changing work environment. To facilitate this, training and development programmes are needed to stamp out ignorance on labour relations policies and procedures, as was highlighted by the various participants in this study. The researcher emphasises a need for well-coordinated training and development programmes in which all health care stakeholders are involved. This will enhance cooperation and common understanding of labour relations policies and procedures. It will in turn lead to more cohesiveness and shared expectations in respect of behaviours and actions of the various 'actors' in different situations that have an impact on the labour relationship.

Since findings of this research highlighted lack of emphasis on responsibility, the training and development programmes should emphasise the issue of balancing rights with responsibility. Whilst all health care stakeholders have rights to be protected, they also have responsibilities to honour, for example

- management's right to manage should be balanced with its responsibility for personnel welfare

- employee's right to fair working conditions should be balanced with responsibility for quality service provision

- whilst unions publicly advocate for employees' rights to acceptable socio-economic status, they need to publicly take a stand on emphasising employee responsibility to provide a service according to contractual agreement. In the context of this study the issue of professionalism and ethical conduct would be an important part of the training programmes.

To facilitate legality of all industrial action, including strikes, a critical analysis of the labour and professional legislation should be a focus of the training programmes. A high level of awareness of policy matters should be created, for example a need to educate communities about utilisation of free health services was identified in this study.

All health care stakeholders should be trained on adaptive strategies that they should adopt during strikes in order to minimise their adverse impact. Roles of each group should be well identified, followed by clear guidelines, for example involvement of communities in nurses' strike intervention was agreed upon by the consumers of health care but proper guidelines are needed to prevent further disruption of the service through poorly organised community involvement.

To facilitate positive adaptation after strikes all health care stakeholders should work collaboratively to expedite return to normal in the strike aftermath and to evaluate the impact of the strike(s) in relation to successes and failures. Resolutions taken should be implemented and resultant change sustained. Accurate and complete strike records that clearly reflect frequency, duration, magnitude and patterns of nurses' strikes should be kept and disseminated to facilitate effective planning and coordination and to keep stakeholders conscientised about the problem of nurses' strikes.

Success of the Integrative-Developmental-Adaptive strategies suggested in this strike model depend on coordination of all policies, plans and procedures at national, provincial, institutional, unit and community levels.

It is hoped that as this proposed model is used, it will be possible to have it modified and refined by the clinicians and scholars in the fields of management and labour relations in the health care system.

8.7 CONCLUSION

In this study diverse aspects of the phenomenon of nurses' strikes have been investigated since these have implications for the impact on various stakeholders. Nurses' strikes pose many ethical dilemmas for patient care and professionalism and will continue to be one of the challenges for health care stakeholders nationally as they move into the 21st century. Lessons learnt in the 20th century will form a foundation for dealing with the problem of nurses strikes in the 21st century. While the 1994-1995 strike wave might be seen to be decreasing, the study has highlighted the relationship between increase in incidence of labour unrest and radical socio-political changes. In view of the coming government elections in June 1999,the labour relationship will need to be stabilised and monitored very closely.

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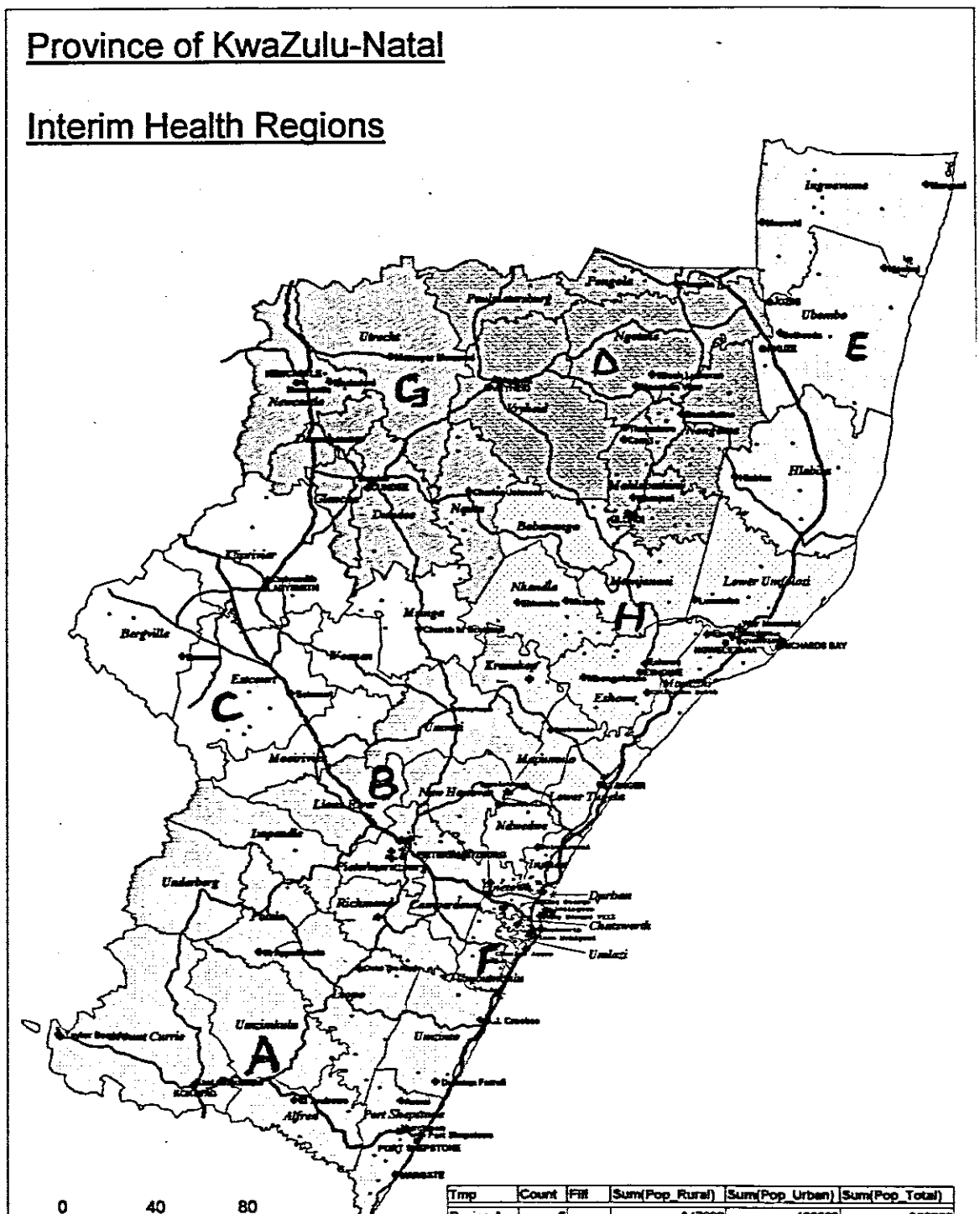
ANNEXURE 1

MAP OF THE HEALTH REGIONS OF KWAZULU-NATAL



Tmp	Count	Fill	Sum(Pop_Rural)	Sum(Pop_Urban)	Sum(Pop_Total)
Region A	6		847609	120683	968292
Region H	8		998093	168673	1166766
Region C	6		585107	148821	733928
Region B	10		862404	434898	1297302
Region G	6		415105	316465	731570
Region E	3		478557	8587	487144
Region F	7		744903	1958723	2703626
Region D	6		553915	63085	617000
—	0		0	0	0

ANNEXURE 2

COPIES OF LETTERS GRANTING PERMISSION FOR RESEARCH

2.1 The Department of Health: Request for permission to undertake research in the selected hospital.

2.2 Acceptance letter: Department of Health.

2.3 Director of Nursing Services (permission telephonically).

2.4 Medical Superintendents of the study hospitals (Permission telephonically).

2.5 Senior Nursing Services Manager (Assistant Director): Pilot study hospital.

2.6 Acceptance letter.

2.7 Introductory letter to participants: Health care providers.

2.8 Introductory letter to participants: Health care consumers (ex-patients)

ANNEXURE 2.1

12 April 1997

ATTENTION: PROFESSOR R. GREEN-THOMPSON

Superintendent General
KwaZulu-Natal Department of Health
Private Bag X9051
PIETERMARITZBURG
3200

Dear Professor Green-Thompson

REQUEST TO CONDUCT RESEARCH IN SELECTED HOSPITALS IN KWAZULU-NATAL TO FULFIL REQUIREMENTS OF A D.LITT *et* PHIL IN NURSING: UNIVERSITY OF ZULULAND. STUDENT NUMBER: 881825

TOPIC OF RESEARCH:

The Impact of Nurses' Strikes on Nurses, the Nursing Profession and on Quality of Health Care

I hereby request permission to collect data in selected hospitals for the above research. The topic has been chosen out of concern for persistence of strikes in health / nursing services. The period earmarked for data collection is June to August 1997.

I enclose a proposal which gives details of the proposed study and methodology (Annexure 1). A copy of the research report will be forwarded to your department.

Hoping that my request will be considered favourably.

Sincerely

P.J. KUNENE (Mrs)
SENIOR LECTURER: NURSING SCIENCE DEPARTMENT
DURBAN-UMLAZI CAMPUS

ANNEXURE 2.2

PROVINCE OF
KWAZULU-NATAL
DEPARTMENT OF HEALTH

ISIFUNDAZWE
SAKWAZULU-NATALI
UMYANGO WEZEMPILO

NATALIA
330 LONGMARKET ST
PIETERMARITZBURG

PROVINSIE
KWAZULU-NATAL
DEPARTEMENT VAN GESONDHEID

Private Bag : X9051
Isikhwama Seposi : Pietermaritzburg
Privaatsak : 3200

TEL. 0331-952111
FAX 0331-426744

06 May 1997

Mrs P J Kunene
Private Bag x10
ISIPINGO
4110

Dear MrsKunene

RESEARCH PROJECT: "THE IMPACT OF NURSES STRIKES ON NURSING; THE NURSING PROFESSION AND THE QUALITY OF HEALTH CARE".

Dr P Emerson, Director, has supported your request to undertake the above research provided that:

(I) You approach the Hospital Management;

(ii) The Department of Health is acknowledged in the research;

(iii) The confidentiality of the interviewees is maintained; and

(iv) A copy of the thesis is forwarded to this Department.

Yours faithfully.

Dr L L Nkonzo-Mtembu
DIRECTOR: NURSING SERVICES

LLNM/nas

ANNEXURE 2.3

28 October 1997

Dr. L.L. Nkonzo-Mthembu
Director: Nursing Services
KwaZulu-Natal Department of Health
Private Bag X9051
PIETERMARITZBURG
3200

Dear Dr. Nkonzo-Mthembu

REQUEST FOR PERMISSION TO COLLECT DATA FOR DOCTORAL RESEARCH PROPOSAL.

TOPIC: ***A STUDY ON THE IMPACT OF NURSES' STRIKES ON NURSES, THE NURSING PROFESSION AND ON QUALITY OF HEALTH CARE.***

STUDENT NO: ***881825***

I hereby request you to kindly allow me to have an interview with you for purposes of collecting data for the above research project. Part of my data collection involves having interviews with top policy makers of the Provincial health department which includes the MEC for health, Superintendent General and Director Nursing Services.

I enclose a shortened version of the research proposal which outlines the problem under investigation, sample to be selected and the method of data collection. The scheduled interview guide has been forwarded to your office for your attention.

Hoping that my request will be considered favourably. Please accept my apology for the break in communication which has occurred in this regard.

Sincerely

MRS P.J. KUNENE
SENIOR LECTURER: NURSING SCIENCE DEPT.

ANNEXURE 2.4

13 May 1997

The Chief Medical Superintendent

Dear Sir

PERMISSION TO COLLECT DATA FOR RESEARCH PROJECT FOR D.LITT et PHIL IN NURSING: UNIVERSITY OF ZULULAND - STUDENT NO: 881825

TOPIC: THE IMPACT OF NURSES' STRIKES ON NURSING, THE NURSING PROFESSION AND ON QUALITY OF HEALTH CARE

I hereby request permission to collect data from your institution for the above research project. The research is a requirement for my Doctorial studies. The topic has been chosen out of concern for continued occurrence of nurses' strikes in health services.

I enclose a shortened version of the proposal which gives details of the intended study. I have obtained permission from the Provincial Department of Health to conduct the research. The period earmarked for data collection is June to August 1997

On completion of the study I shall forward a copy of the research report to your institution.

Hoping that my request will be considered favourably.

Yours sincerely

MRS. P.J. KUNENE
SENIOR LECTURER: NURSING SCIENCE DEPT.
DURBAN-UMLAZI CAMPUS

ANNEXURE 2.5

19 May 1997

ATTENTION:
Senior Nursing Service Manager
. . . . . .
. . . .

Dear . . .

REQUEST FOR PERMISSION TO CONDUCT A PILOT STUDY IN YOUR HOSPITAL AS PREPARATORY WORK FOR A DOCTORIAL RESEARCH PROJECT

I hereby request to be allowed to conduct interviews on 3 to 5 members of your staff as a pilot study, the main aim being to test the interview guide before conducting the major study in other hospitals. Each interview will take ± 30 minutes. The findings of the pilot project are for my own guidance and will not be reported in the major study.

I am currently registered as a D.Litt et Phil student in the Nursing Science Department of the University of Zululand: Durban-Umlazi Campus. The title of my research is "The Impact of Nurses' Strikes on Nurses, the Nursing Profession and on Quality of Health Care". I have enclosed a brief outline of the proposed research for your information (See Annexure I).

I have obtained permission from the Provincial Department of Health to collect data from hospitals (See Annexure 2). I would like to proceed with the pilot study as soon as possible because data collection is scheduled for June to August 1997.

Hoping that my request will be granted and thanking you for your past support and co-operation.

Yours sincerely

MRS P.J. KUNENE
SENIOR LECTURER
NURSING SCIENCE DEPARTMENT

ANNEXURE 2.6

NATAL PROVINCIAL ADMINISTRATION

KWAZULU-NATAL PROVINSIALE ADMINISTRASIE

UKUPHATWA KWESINDAZWE SAKWAZULU-NATAL

. . . HOSPITAL

Ikheli Leposi	P\Bag X 04	Fax	(031)	Ikheli Lomgwaqo	J Higginson
Postal Address:	MOBENI	Fax Number:	421993	Street Address:	Highway
Posadres:	4060	Faksnommer		Straatadres	MOBENI

Imibuzo	Acting Chief	Ucingo	(031)	Inkomba	
Enquiries:	Nursing Service	Telephone	422221	Reference	
Navme	Manager	Telefoon	Ext.2177	Verwysing	

26 May 1997

Attention: Mrs P.J. Kunene
Senior Lecturer Nursing Science Department
University of Zululand
Umlazi Extramural Division
Private Bag X 10
ISIPINGO
4110

Mrs Kunene

Permission has been granted to conduct your Doctorial Research Project.
Do inform us of the date of your visit.

Yours sincerely

H. Ceele

ACTING CHIEF NURSING SERVICE MANAGER

ANNEXURE 2.7

University of Zululand:
Universiteit van Zululand:

UMLAZI EXTRAMURAL DIVISION
BUITEMUURSE AFDELING

Private Bag X10
Privaatsak
ISIPINGO 4110
031 9075055
6-28081 SA
FAX: 9073011

18 August 1997

Dear Participant

RESEARCH TOPIC: THE IMPACT OF NURSES' STRIKES ON NURSES, THE NURSING PROFESSION AND ON QUALITY OF PATIENT CARE

Thank you for your willingness to participate in this research. You have been selected because of the important role you play in provision of patient care and because of your experience with nurses' strikes.

Please feel free to answer as comprehensively as you can and give your honest views and opinions. There are no right or wrong answers. Your name will not be used in any part of the report or any future reference.

Sincerely

P.J. KUNENE (MRS)
RESEARCHER

ANNEXURE 2.8

18 August 1997

Dear Participant

You have been invited to participate in this research on nurses' strikes because of the importance we place on hearing your views on nurses' strikes and description of your experiences as a patient during a nurses' strike.

You are assured of anonymity. Your name will not appear anywhere in this report and will not be used for any future reference. Feel free to recall and answer as comprehensively as you can, giving your honest views and opinions.

Thank you for participating in this research.

Sincerely.

MRS P.J. KUNENE
RESEARCHER

ANNEXURE 3

INTERVIEW GUIDES FOR:

3.1 Director of Nursing Services

3.2 Chief Nursing Service Managers (Deputy Directors)

3.3 Area Managers

3.4 Clinical Nurses in Nursing Units

3.5 NEHAWU or DENOSA representative

3.6 Consumers of Health Care: Ex-patients

3.7 Consumers of Health Care: Focus groups

ANNEXURE 3.1

INTERVIEW GUIDE FOR DIRECTOR OF NURSING SERVICES: KWAZULU-NATAL DEPARTMENT OF HEALTH

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group 21-30 ☐
   31-40 ☐
   41-50 ☐
   51-60 ☐

3. Title / Position ☐

4. Number of years in that position ☐

B CONTEXT

5. What is your opinion about job satisfaction among nurses in the province of KwaZulu-Natal?

   _____

   _____

6. What communication structures exist to keep you informed of perceptions of nurses about their work environment?

   _____

   _____

7. **Nurses in various health services in KwaZulu-Natal have been involved in strike action at different times between 1994 and 1996**
   How did you become aware that there might be strikes by nurses in hospitals?

   _____

   _____

8. How did the warnings you have just described assist you in planning for continuity of health care delivery in the event of strikes?

_____

_____

9. How can you describe the general mood which prevailed in health services at that time?

_____

_____

10. How did you feel when you became aware of pending strikes?

_____

_____

C NURSES' ISSUES AND STRIKE PREVENTION

11. Can you list **NOT MORE THAN THREE (3)** issues that were mentioned as causes of the strikes? List in order of priority, starting with the most pressing issue.

_____

_____

12. Were you aware of these issues before they were mentioned during strikes?
Yes ☐ No ☐

13. If yes, what actions were taken to address these issues before the strike occurred?

_____

_____

14. In your opinion, why was it not possible to prevent the strikes?

_____

_____

15. In your opinion, have the demands made by nurses and their representatives during the strike been met?

Yes ☐ No ☐

16. If yes, describe how they have been met.

_____

_____

17. If no, what prevented handling those issues or meeting those demands?

_____

_____

18. In your opinion, how do nurses feel about the way the strikes were handled?

_____

_____

D STRIKE MANAGEMENT

19. Describe the strike-related activities that you engaged in during the strike as part of your patient care and personnel policy-making responsibilities.

_____

_____

20. Describe how patient care activities continued during the strikes.

_____

_____

21. Describe your feelings during a nursing strike in a health service.

_____

_____

E IMPACT OF NURSES' STRIKES

22. **As Director of Nursing Services for KwaZulu-Natal Department of Health people in the province look up to you for quality health care**
How did the strikes by nurses affect or impinge on quality of health care within the province?

_____

_____

23. How did the strikes affect hospital management?

_____

_____

24. **Nurses form part of the health care team.**
What impact do you think the nurses' strikes had on other members of the health team?

_____

_____

25. In your opinion what influence did other members of the health team have on the nurses' strikes?

_____

_____

26. What implications to health care have been identified by consumers of health care in relation to nurses' strikes?

_____

_____

27. **The democratic government of South Africa is committed to consultation and working with people at grassroots level in its provision of services.**
How does your department consult with consumers of health care in regard to their views on nurses' strikes?

_____

_____

28. What are your views on nurses' strikes?

_____

_____

29. How have your views been influenced by your experience of the strikes discussed?

_____

_____

F POST STRIKE ACTIVITIES

30. As a way forward, what strategies have been devised in your Provincial Health Department for dealing with strikes by nurses in regard to:

30.1 Prevention

_____

_____

30.2 Managing nurses' strikes

_____

_____

30.3 Evaluating strike implications?

_____

_____

31. How are these plans coordinated with plans of the National Department of Health?

_____

_____

32. Any other comments on nurses strikes?

_____

ANNEXURE 3.2

INTERVIEW GUIDE FOR CHIEF NURSING SERVICE MANAGER (DEPUTY DIRECTOR)

INTRODUCTION

This discussion is about a major ... day nurses' strike which took place in your hospital in the year 199... You are requested to recall as much as possible your experiences in relation to that strike.

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group
   - 21-30 ☐
   - 31-40 ☐
   - 41-50 ☐
   - 51-60 ☐
   - 61-70 ☐

3. Length of service in this hospital (years) ☐

4. Present title / Position ☐

5. Period of experience in that position (years) ☐

B CONTEXT

6. What is your opinion about job satisfaction among nurses in your institution?

_____

_____

7. How are you kept informed of perceptions of nurses about their work environment?

_____

_____

8. How did you become aware that there might be a strike by nurses in your institution?

_____

_____

9. How did you feel when you became aware of a threatening strike?

_____

_____

10. When you became aware of the pending strike, what plans did you make for continuity of patient care during the strike?

_____

_____

11. How can you describe the general mood which prevailed in your institution at that time?

_____

_____

C NURSES' ISSUES AND STRIKE PREVENTION

12. What representative organisations are nurses in your institutions affiliated to?

_____

_____

13. How does this affiliation influence the nurses' decision to strike or not to strike?

_____

_____

14. Can you list **NOT MORE THAN THREE (3)** issues that were mentioned as causes of the strike? List in order of priority, starting with the most pressing issue.

_____

_____

15. In your opinion have these issues or demands of nurses and their representatives been met?

_____

_____

Yes ☐ No ☐

16. If yes, describe how they have been met.

_____

_____

17. If no, what reasons were given for not meeting them?

_____

_____

D STRIKE MANAGEMENT

18. In your opinion how do nurses feel about the way the strike was handled?

_____

_____

19. **As a nurse manager in charge, provision of quality nursing care in your institution is your responsibility.**
Did nursing care continue during the strike?

Yes ☐ No ☐

20. If yes, how did it continue?

_____

_____

21. If no, what happened to the patients / clients?

_____

_____

22. How does your department consult with consumers of health care in regard to their views on nurses' strikes?

_____

_____

23. What implications to health care have been identified by consumers of health care in relation to nurses' strikes?

_____

_____

24. Describe what specific interventions / activities were involved in your intervention in the strike.

_____

_____

25. Did you get support in regard to your intervention in the strike?

Yes ☐ No ☐

26. If yes, describe what kind of support you got.

_____

_____

27. Describe your feelings during the strike.

_____

_____

E IMPACT OF THE STRIKE

28. What was the impact of the strike?

28.1 On you as a person

(i) Physically

_____

_____

(ii) Socially

_____

_____

(iii) Emotionally

_____

_____

28.2 On the nursing profession

_____

_____

28.3 On quality of health care

_____

_____

29. **Nurses form part of the health care team.**
What impact do you think the nurses' strike had on other members of the health team?

_____

_____

30. In your opinion what influence did other members of the health team have on the nurses' strike?

_____

_____

F POST STRIKE ACTIVITIES

31. As a way forward what strategies have been devised in your institution for dealing with future nurses' strikes in terms of:

31.1 Prevention:

_____

_____

31.2 Managing nurses' strikes

_____

_____

31.3 Evaluating strike implications

_____

_____

32. How are these plans coordinated with overall Regional or Provincial Health Department plans?

_____

_____

33. Any other comments on nurses' strikes?

_____

_____

_____

_____

_____

ANNEXURE 3.3

INTERVIEW GUIDE FOR NURSING SERVICE MANAGER OR CHIEF PROFESSIONAL NURSE IN CHARGE OF DEPARTMENTS (AREA MANAGER)

INTRODUCTION

This discussion is about a major ... day nurses' strike which took place in your hospital in the year 199... You are requested to recall as much as possible your experiences in relation to that strike.

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group 21-30 ☐
   31-40 ☐
   41-50 ☐
   51-60 ☐
   61-70 ☐

3. Length of service in this hospital (years) ☐

4. Present title / Position ☐

5. Period of experience in that position (years) ☐

B CONTEXT

6. What is your opinion about job satisfaction among nurses in your institution?

   _____

   _____

7. How are you kept informed of perceptions of nurses about their work environment?

   _____

   _____

8. How did you become aware that there might be a strike by nurses in your institution?

_____

_____

9. How did you feel when you became aware of a threatening strike?

_____

_____

10. When you became aware of the pending strike, what plans did you make for continuity of patient care during the strike?

_____

_____

11. How can you describe the general mood which prevailed in your institution at that time?

_____

_____

C NURSES' ISSUES AND STRIKE PREVENTION

12. What representative organisations are nurses in your organisations affiliated to?

_____

_____

13. How does this affiliation influence the nurses' decision to strike or not to strike?

_____

_____

14. Can you list **NOT MORE THAN THREE (3)** issues that were mentioned as causes of the strike? List in order of priority, starting with the most pressing issue.

_____

_____

15. In your opinion have these issues or demands from nurses and their representatives been met?

_____

_____

Yes ☐ No ☐

16. If yes, describe how they have been met.

_____

_____

17. If no, what reasons were given for not meeting them?

_____

_____

D STRIKE MANAGEMENT

18. In your opinion how do nurses feel about the way the strike was handled?

_____

_____

19. **As a nurse manager in charge of a department, provision of quality nursing care in your department is your responsibility.**
Did nursing care continue during the strike?
Yes ☐ No ☐

20. If yes, how did it continue?

_____

_____

21. If no, what happened to the patients / clients?

_____

_____

22. How does your department consult with consumers of health care in regard to their views on nurses' strikes?

_____

_____

23. What implications to health care have been identified by consumers of health care in relation to nurses' strikes?

_____

_____

24. Describe what specific interventions / activities were involved in your intervention in the strike.

_____

_____

25. Did you get support in regard to your intervention in the strike?
Yes ☐ No ☐

26. If yes, describe what kind of support you got.

_____

_____

27. Describe your feelings during the strike.

_____

_____

E IMPACT OF THE STRIKE

28. What was the impact of the strike?
28.1 On you as a person
(i) Physically

_____

_____

(ii) Socially

_____

_____

(iii) Emotionally

_____

_____

28.2 On the nursing profession

_____

_____

28.3 On quality of health care

_____

_____

29. **Nurses form part of the health care team.**
What impact do you think the nurses' strike had on other members of the health team?

_____

_____

30. In your opinion what influence did other members of the health team have on the nurses' strike?

_____

_____

F POST STRIKE ACTIVITIES

31. As a way forward what strategies have been devised in your department for dealing with future nurses' strikes in terms of:

31.1 Prevention:

_____

_____

31.2 Managing nurses' strikes

_____

_____

31.3 Evaluating strike implications

_____

_____

32. How are these plans coordinated with overall institutional plans?

33. Any other comments on nurses' strikes?

ANNEXURE 3.4

INTERVIEW GUIDE FOR CLINICAL NURSES IN NURSING UNITS

INTRODUCTION

This discussion is about a major ... day nurses' strike which took place in your hospital in the year 199... You are requested to recall as much as possible your experiences in relation to that strike.

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group 16-25 ☐
   26-35 ☐
   36-45 ☐
   46-55 ☐
   56-65 ☐

3. Length of service in this hospital (years) ☐

4. Present title / Position ☐

5. Period of experience in that position (years) ☐

B CONTEXT

6. What is your opinion about job satisfaction among nurses in your institution?

   _____

   _____

7. How do you keep your supervisors / managers / employer informed of your perceptions about your work environment?

   _____

   _____

8. How did you become aware that there might be a strike by nurses in your institution?

_____

_____

9. How did you feel when you became aware of a threatening strike?

_____

_____

10. What did you do when you became aware of this pending strike?

_____

_____

11. How can you describe the general mood which prevailed in health services at that time?

_____

_____

C NURSES' ISSUES AND STRIKE PREVENTION

12. What representative organisations are nurses in your organisations affiliated to?

_____

_____

13. How did this affiliation influence the nurses' decision to strike or not to strike?

_____

_____

14. Can you list **NOT MORE THAN THREE (3)** issues that were mentioned as causes of the strike? List in order of priority, starting with the most pressing issue.

_____

_____

15. In your opinion have these issues or demands by nurses and their representatives been met?

_____

_____

Yes ☐ No ☐

16. If yes, describe how they have been met.

_____

_____

17. If no, what reasons were given for not meeting them?

_____

_____

D STRIKE MANAGEMENT

18. How do you feel about the appropriateness of the way that the nurses' strike was handled?

_____

_____

19. Did nursing care activities continue during the strikes?

Yes ☐ No ☐

20. If yes, how did they continue?

_____

_____

21. If no, what happened to patients / clients?

_____

_____

22. How did you personally become involved in the strike?

_____

_____

23. Describe your feelings during the strike.

_____

_____

E IMPACT OF THE NURSES' STRIKE

24. What can you say about the impact of the strike?

24.1 On you as a person.

(i) Physically

_____

_____

(ii) Socially

_____

_____

(iii) Emotionally

_____

_____

24.2 On the profession of nursing

_____

_____

24.3 On the quality of patient care

_____

_____

25. **Nurses form part of the health care team.**
What impact do you think the nurses' strike had on other members of the health team?

_____

_____

26. In your opinion what influence did other members of the health team have on the nurses' strike?

_____

_____

F POST STRIKE ACTIVITIES

27. What do you think should be done in future about nurses' strikes in terms of:

27.1 Prevention

_____

_____

27.2 Management of nurses' strikes

_____

_____

27.3 Evaluating implications of nurses' strikes.

_____

_____

27.4 Any additional comments on nurses' strikes?

_____

_____

_____

_____

_____

ANNEXURE 3.5

INTERVIEW GUIDE FOR KWAZULU-NATAL PROVINCIAL NEHAWU / DENOSA REPRESENTATIVE

(Tick appropriate organisation)

INTRODUCTION

This discussion is about nurses' strikes that occurred in health care organisations where you have membership as organised labour. You are not restricted to a particular strike but you are free to discuss any strike(s) which occurred between 1994 and 1996 which, according to your opinion(s) was / were a major strike(s).

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group
   - 21-30 ☐
   - 31-40 ☐
   - 41-50 ☐
   - 51-60 ☐
   - 61-70 ☐

3. Title / Position in DENOSA / NEHAWU ☐

4. Number of years in that position (years) ☐

B CONTEXT

5. What is your opinion about job satisfaction among nurses in the province of KwaZulu-Natal?

_____

_____

6. What communication structures exist to keep you informed of perceptions of nurses about their work environment?

_____

_____

Nurses in various health service in KwaZulu-Natal have been involved in strike action at different times between 1994 and 1996.

7. How did you become aware that there might be strikes by nurses in hospitals?

_____

_____

8. What steps did you take as a nurses' representative organisation when you became aware of strikes?

_____

_____

9. How can you describe the general mood which prevailed in health services at that time?

_____

_____

10. How did you feel when you became aware of pending strikes?

_____

_____

C NURSES' ISSUES AND STRIKE PREVENTION

11. Can you list NOT MORE THAN THREE (3) issues that were mentioned frequently as causes of the strikes? List in order of priority, starting with the most pressing issue.

_____

_____

12. Were you aware of these issues before they were mentioned during strikes?

_____

_____

Yes ☐ No ☐

13. If yes, what actions were taken to address these issues before the strike occurred?

_____

_____

14. In your opinion, why was it not possible to prevent the strikes?

_____

_____

15. In your opinion have the demands made by nurses and their representatives during strikes been met?

_____

_____

Yes ☐ No ☐

16. If yes, describe how they have been met.

_____

_____

17. If no, what prevented handling those issues or meeting those demands?

_____

_____

D STRIKE MANAGEMENT

18. In your opinion how do nurses feel about the way the strikes were handled?

_____

_____

19. Describe the strike-related activities that you engaged in during the strike as part of your responsibilities as a nurses' representative.

_____

_____

20. Describe how patient care activities continued during the strikes.

_____

_____

21. Describe your feelings during a nurses' strike in a health service.

_____

_____

E IMPACT OF NURSES' STRIKES

22. How did the strikes by nurses affect or impinge on quality of health care within the province?

_____

_____

23. How did the strike affect hospital management?

_____

_____

24. **Nurses from part of the health care team.**
What impact do you think nurses' strikes had on other members of the health team?

_____

_____

25. In your opinion what influence did other members of the health team have on the nurses' strikes?

_____

_____

26. What implications to health care have been identified by consumers of health care in regard to nurses' strikes?

_____

_____

27. How does your organisation consult with consumers of health care in regard to their views on nurses' strikes?

_____

_____

28. What are your views on nurses' strikes?

_____

_____

29. How have your views been influenced by your experience of the strikes discussed?

_____

_____

30. As a way forward, what strategies have been devised in your organisation for dealing with strikes by nurses in regard to:

F POST STRIKE ACTIVITIES

30.1 Prevention

_____

_____

30.2 Managing nurses' strikes

_____

_____

_____

_____

30.3 Evaluating strike implications?

31. How are these plans coordinated with plans of your organisation nationally?

32. Any other comments on nurses' strikes?

ANNEXURE 3.6

INTERVIEW GUIDE FOR CONSUMERS OF HEALTH CARE, THAT IS PATIENTS WHO WERE HOSPITALISED DURING A NURSES' STRIKE

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group 21-30 ☐
   31-40 ☐
   41-50 ☐
   51-60 ☐
   61-70 ☐

3. Type of ward (e.g. Medical, Surgical, etc.) _____

4. Period of hsopitalisation before commencement of strike. _____

5. Condition for which you were hospitalised _____

B CONTEXT

6. In your opinion are nurses happy in their work environment?

   Yes ☐ No ☐ Unsure ☐

7. What do you think makes them happy?

   _____

   _____

8. What do you think makes them unhappy?

   _____

   _____

C STRIKE ACTIVITIES

You were a patient at _____ Hospital in Ward _____ when nurses were on strike.

9. Did you know beforehand there would be a nurses' strike?
   Yes ☐ No ☐

10. If yes, how did you get to know?

_____

_____

11. Describe how you felt as a patient during the strike.

_____

_____

12. Can you recall what happened in relation to nursing care in the ward at that time?

_____

_____

13. Describe your observations in respect of continuity of your own nursing care during the strike.

_____

_____

14. Is there any specific effect or outcome of your condition or treatment that you can associate with the strike in any way?

_____

_____

15. In your opinion are nurses justified to embark on strike action?

   Yes ☐ No ☐

16. What is your reason for the opinion you have just expressed?

_____

_____

17. If you think nurses' strikes are not justified, what do you suggest nurses should do if their demands are not met?

18. What suggestions can you offer for ways in which authorities in the Department of Health can address issues or meet demands that lead to nurses' strikes?

19. What role do you think communities should play in future with regard to nurses' strikes in terms of:

19.1 Prevention

19.2 Management of nurses' strikes.

19.3 Evaluating the impact of nurses' strikes.

20. Any other comments on nurses' strikes?

ANNEXURE 3.7

FOCUS GROUP INTERVIEW GUIDE FOR COMMUNITY MEMBERS AS CONSUMERS OF HEALTH CARE

A DEMOGRAPHIC DATA

1. Sex Male ☐ Female ☐

2. Age Group 21-30 ☐
   31-40 ☐
   41-50 ☐
   51-60 ☐
   61-70 ☐

B CONTEXT

3. In your opinion are nurses happy in their work environment?

   Yes ☐ No ☐ Unsure ☐

4. What do you think makes them happy?

   _____

   _____

5. What do you think makes them unhappy?

   _____

   _____

C STRIKE ACTIVITIES

Describe any experience that you have had on nurses' strikes.
If you ever had a family member, relative, neighbour or close friend who was hospitalised in any hospital during a nurses' strike in that hospital, describe that experience according to this guide:

6. Did you know beforehand there would be (was) a strike?

   Yes ☐ No ☐

7. If yes, how did you get to know?

_____

_____

8. How did you feel when you became aware that there would be (was) a strike?

_____

_____

9. What did you do when you became aware of the strike?

_____

_____

10. Tell us what happened to your ---------- during the strike

_____

_____

11. Is there anything else that you can say about what happened during the strike generally?

_____

_____

12. Is there any specific effect or outcome of the condition or treatment of your ---------- that you can associate with the strike in any way?

_____

_____

13. In your opinion are nurses justified to embark on strike action?

Yes ☐ No ☐

14. What is your reason for the opinion you have just expressed?

_____

_____

15. If you think nurses should not strike, what do you suggest they should do if their demands are not met?

_____

_____

16. What suggestions can you offer for ways in which authorities in hospitals or in the department of health can address issues or demands that lead to nurses' strikes?

_____

_____

17.1 What role do you think communities should play in future in regard to nurses' strikes in terms of:

17.1 Prevention

_____

_____

17.2 Management of nurses' strikes.

_____

_____

17.3 Evaluating the impact of nurses' strikes

_____

_____

18. Any other comments on nurses' strikes?

_____

_____

_____

_____

_____