POSITIVE PSYCHOLOGICAL RESOURCES AND STRESSORS OF NURSES WORKING IN A NATIONAL HEALTH INSURANCE (NHI) PILOT SITE

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LANGUAGE EDITING CERTIFICATION

We, the undersigned, do solemnly declare that we have abided by the College of Humanity, University of KwaZulu-Natal policy on language editing. The thesis was professionally edited for proper English language, grammar, punctuation, spelling, and overall academic style. All original electronic forms of the text have been retained should they be required.

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I can do all things through Christ who strengthens me
Philippians 4:13

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ABSTRACT AND KEY TERMS

Introduction

The fragmentation of the South African Health Care system, the burden of disease and numerous unsuccessful policy initiatives have led to the consideration of the National Health Insurance scheme as a means of successfully bridging the gap between the two tiered health care system in South Africa and provide equitable and quality health care. Generally, public hospitals and clinics are not for profit and are mandated to treat citizens regardless of whether they are able to pay or not. This model of treatment for all while absorbing the majority of the costs of providing these services, have created an immense burden on health facilities. With the rising number of patients accessing primary health care facilities, it becomes imperative to ensure that adequate human resources exist. However, the decline in the number of health professionals being trained and employed in the public health sector remains a constant concern. It becomes imperative to consider how National Health Insurance system changes will impact on the increasingly limited primary health care workforce, and primary health care nurses in particular given they form the backbone of the system. Against this background, this study was designed to explore the experiences of nurses with a particular focus on Job Satisfaction, Job Strain, Wellbeing and Burnout.

Aim

The overall aim of the study was to understand and assess the wellbeing of nurses in the context of the Re-engineered primary health care and National Health Insurance systems.

Method

A sequential cross sectional mixed methods research design divided into two phases was employed. Phase one consisted of the quantitative segment aimed at investigating the relationship between Job Satisfaction, Job Strain, Psychological Capital, Burnout and Wellbeing among nurses in an National Health Insurance pilot site (Dr Kenneth Kaunda District Municipality) and a non-National Health Insurance pilot site (Bojanala Platinum District Municipality). The second phase, which was qualitative in nature, aimed to develop an understanding of the experiences and perceptions of nurses with regards to their Wellbeing, Job Satisfaction, Job Strain, Burnout, the Re-engineered primary health care system and the National Health Insurance through the use of a semi-structured interview schedule.

Results

In both districts, the quantitative data shows relatively high levels of positive psychological resources such as Psychological Capital in both sites. Job Control, General Health, Satisfaction with Life were found to be significantly higher for the National Health Insurance site than in the non-National Health Insurance pilot site. Significantly higher levels of Burnout and Job Strain were found in the non-National Health Insurance pilot site. Qualitative data indicates that nurses coped with their job stressors by relying on their faith and family support. Nurses from the National Health Insurance pilot site were positive and optimistic about the changes. However, they would have liked to have been consulted more on the changes that they were required to implement.

Conclusion

The data indicated that nurses in the NHI district reported greater Job Control as well as reported coping better with the demands of their job.

Key Terms: *Burnout; Communication skills; Decision latitude; Department of Health; General Health; Health care reform; Healthcare systems; Job Strain; Job Control; Job Satisfaction; Millennium Development Goals; National Health Insurance; Nursing; PC101; Positive organisational behaviour; Positive psychology, Primary health care; Psychological Capital; Psychological stressors; Re-engineering of primary health care; Skills discretion; South African organisational change; Sustainable Development Goals; Task sharing; Wellbeing.*

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GLOSSARY OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
APC	Adult Primary Care
ART	Anti-Retroviral Therapy
BP	Bojanala Platinum District Municipality
CHW	Community Health Workers
COBALT	Co-morbid Affective Disorders, AIDS&HIV, and Long Term Health
COPC	Community Oriented Primary Care
COR	Conservation of Resources Theory
CQI	Continuous Quality Improvement
DCST	District Clinical Specialist Team
DENOSA	Democratic Nursing Organisations of South Africa
DHS	District Health System
DMT	District Management Team
DoH	Department of Health
EAP	Employee Assistance Programme
EN	Enrolled Nurse
ENA	Enrolled Nursing Auxiliaries
GDP	Gross Domestic Product
GEMS	Government Employee Medical Aid Scheme
GHQ-12	General Health Questionnaire
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health Strategy 2012/13-2016/17

ICDM	Integrated Chronic Disease Management
ICSM	Integrated Clinical Services Management
IOL	Independent Online
IPA	Interpretive Phenomenological Analysis
ISHP	Integrated School Health Programme
JCQ	Job Content Questionnaire
JDC	Job Demand Control Model
KK	Dr Kenneth Kaunda District Municipality
LMIC	Low and Middle Income Countries
MBI	Maslach Burnout Inventory
MDG	Millennium Development Goals
NCD	Non-Communicable Diseases
NHI	National Health Insurance
NHS	National Health System
OD	Organisational Development
PC101	Primary Care 101
PDSA	Plan-Do-Study-Act
PHC	Primary Health Care
PMDS	Performance Management Development System
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse
POB	Positive Organisational Behaviour
PRIME	Programme for Improving Mental Health Care
PsyCap	Psychological Capital
RCT	Randomised Control Trial
RN	Registered Nurse

SANC	South African Nursing Council
SDG	Sustainable Development Goals
SRN	Specialist Registered Nurse
SWLS	Satisfaction with Life Scale
TB	Tuberculosis
UHC	Universal Health Care
UKZN	University of KwaZulu-Natal
USA/US	United States of America
WBOT	Ward-Based Outreach Teams
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1. Introduction: Overview of the South African Health Care System

> As a country we just have to go back to the basics of primary health care. We have to prevent diseases even before they occur. We have to act now (Motsoaledi, 2010).

Despite the Minister of Health's above statement, in terms of the South African health care system, health care in practice continues to be divided, long after the demise of the apartheid era. Indeed, this divide is one of the major contributing factors to the poor quality of care in the South African medical system (Mayosi & Benatar, 2014). The parallel private and public health system is a reflection of the socio-economic division among various groups—those who can afford private health care and those who cannot. The latest General Household Survey released by Statistics SA (2014) reports how even after the end of apartheid, access to health care in South Africa is still overly fragmented for black and white South Africans. This opinion is shared by the World Bank, who in 2012, still considered South Africa to be one of the most unequal societies in the world (Im et al. 2012).

Further disparities exist in terms of the total number of people served by the public health care system. According to Statistics SA, for the period of 2002-2014, 69.3% of South Africans preferred to first seek health care services from public facilities before making use of private facilities (2015a). Seemingly, the area of residence and socio-economic status determines accessibility and quality of health services received. In addition, South Africa's

history of colonialism, apartheid and institutionalised racism has resulted in the inherited fragmentation of health, wealth and education between the different race groups in South Africa. It is this history that has not only defined the current health and wellness landscape in the country, but has acknowledged the enormous disparities that exist between racial groups and communities, such as sanitation, access to clean water, education level to mention a few., which is largely due to the legacy of a segregation and inequality in the health care system (Sifunda, Reddy, Manyaapelo, James & Funani, 2011). Dookie and Singh (2012) concur that the imbalances in health care delivery in South Africa are largely due to its history and the concomitant changing patterns of disease, which has placed a massive strain on the public health service.

Cognisant of the fragmented health system, the Department of Health (DoH) established nine provincial departments of health with the commitment of building new clinics and improving existing infrastructures. Their commitment was further articulated in their list of priorities 2014-2019 to "ensure quality health care for all their citizens" (Department of Women, 2015, p. 22). The published health priorities sought to address the burden of disease, especially HIV and Tuberculosis (TB). However, the moot issue of providing comprehensive primary health care services to communities and emphasising a preventative rather than curative approach to care continues. Apparently, the priority afforded to combating the HIV pandemic has consumed much time, energy and resources.

1.1.1. *The Burden of Disease Landscape in South Africa*

South Africa is presently plagued by four health challenges: HIV&AIDS, TB, non-communicable diseases and injury and violence (Department of Health, 2015). HIV&AIDS and TB are evidently the largest contributors to the quadruple burden of disease experienced. According to Mayosi et al. (2009), South Africa has made significant strides in responding to the HIV and TB crisis by increasing funding from R 4.5 billion (2009-2010) to R 8.4 billion (2010-2011) for the expansion and up-scaling of preventative programmes and treatment integration. Despite this effort and the substantial progress achieved, all indicators for Millinium Development Goal (MDG) 6 were not realised, as is noted in Table 1.1. These goals essentially are interrelated, Goals 1 to 8 can be seen to all contribute towards achieving a healthy life for all which further concurs with the DoH's vision and mission as reiterated in the White Paper on National Health Insurance.

Table 1.1.

South Africa's Millennium Development Goals Progress

Millennium Development Goal	Status	Comments
Goal 1: Eradicate extreme poverty and hunger	Sufficient progress	Progress has been made in terms of three of the nine indicators; however, income inequality remains a challenge.
Goal 2: Achieve universal primary education	Sufficient progress	Progress has been made in terms of one of the three indicators especially in terms of securing the universal enrolment of all children of primary school going age and an increased pass rate of 76% in its National Senior Certificate in 2014. Progress related to the efficient use of resources is still a challenge and thus progress in terms of improving the quality of education has been slow.

Goal	Progress	Comment
Goal 3: Promote gender equality and empower women	Sufficient progress	Progress has been made in terms of five of the seven indicators, however women still bear a disproportionate burden of unemployment.
Goal 4: Reduce child mortality	Insufficient progress	Progress has not been made in terms of any of the relevant indicators, however has seen significantly reduced child mortality rates, increased access to essential health services, and reduced the prevalence of leading causes of child mortality and morbidity
Goal 5: Improve maternal health	Insufficient progress	Insufficient progress has been made with South Africa only meeting one of the MDG five indicator targets, which is antenatal coverage. However, South Africa has managed to reduce the maternal mortality rate after struggling for many years to contain the number of women who die in childbirth.
Goal 6: Combat HIV&AIDS, Malaria and other infectious diseases	Substantial progress	Progress has been made in terms of five of the nine indicators. Remarkably, South Africa has managed to reduce new infections in children, halt and reverse the spread of HIV and reduce the incidence of Malaria and TB-related deaths.
Goal 7: Ensure environment sustainability	Some progress	Only four of the MDG seven indicators have been reached, most notably the integration of the principles of sustainable development into the country's policies and programmes.
Goal 8: Develop a global partnership for development	Insufficient progress	South Africa has made some progress, in achieving macroeconomic stability and developing a framework to encourage the private sector roll-out of universal voice communications coverage but has failed to reach the desired levels of growth and has been unable to eliminate the fundamental constraints to inclusive economic development.

Note. Adapted from Statistics South Africa, 2015b, p. 20-21.

Although as Table 1.1 confirms, while improvements have been made in MDG 3 and MDG 6, South Africa continues to struggle to overcome the multi-drug resistant strain of TB. Furthermore, as Statistics SA (2013a) has confirmed, the leading cause of death in South Africa for three consecutive years was TB, followed by influenza and pneumonia. HIV&AIDS moved up from being the seventh leading cause of death in 2011 to the third leading cause of death in 2013. In North West Province, where the present study was situated, the leading cause of death was TB (8.7%), then influenza and pneumonia (7.0%) and finally,

other forms of heart disease (5.9%). While the MDGs have come to an end, the Sustainable Development Goals (SDG) will continue to engage with these more deliberately.

Apart from HIV&AIDS, Influenza and TB, a growing burden of NCDs such as hypertension and cardiovascular disease, diabetes, as well as increasing levels of injury and violence have become an added concern. As noted in Table 1.1., the inadequate progress in reducing the high maternal and child mortality rate speaks to the lack of necessary infrastructure to cope with such chronic diseases (Yerramilli, 2015; Levitt, Steyn, Dave & Bradshaw, 2011).

Logistically, the health care reform policies (i.e., the Re-Engineering of Primary Health Care, NHI, Integrated Chronic Disease Management and the Ideal Clinic) are based on the national burden of disease in South Africa. Across provinces however, dissimilarities exist on the disease profile as outlined in Table 1.2 for the leading causes of death in 2013. Tuberculosis in North West Province is noted as the number one cause of death, whereas HIV&AIDS does not feature in the top four causes of death. However, when one looks at the leading causes of death for the sub-districts of North West Province, it appears that in Bojanala Platinum District Municipality (BP), the second leading cause of death was influenza as well as in Dr Kenneth Kaunda District Municipality (KK), HIV&AIDS (Statistics SA, 2013a).

Table 1.2.

Leading Causes of Death According to Province

Province	1	2	3	4
Western Cape	Diabetes	Ischaemic Heart Disease	HIV	TB
Eastern Cape	TB	HIV	Other forms of heart disease	Cerebrovascular diseases
Northern Cape	HIV	TB	Cerebrovascular diseases	Hypertensive disease
Free State	TB	Influenza and Pneumonia	Cerebrovascular diseases	Other forms of heart disease
KwaZulu-Natal	TB	HIV	Cerebrovascular diseases	Diabetes
North West	TB	Influenza and Pneumonia	Other forms of heart disease	Hypertensive disease
Gauteng	TB	Influenza and Pneumonia	Other forms of heart disease	Diabetes
Mpumalanga	TB	Influenza and Pneumonia	Intestinal infectious diseases	Cerebrovascular diseases
Limpopo	Influenza and Pneumonia	TB	Intestinal infectious diseases	Diabetes

Note. Adapted from Statistics SA, 2013a.

To address these diverse health care needs, a phased implementation of the National Health Insurance (NHI) financing system was proposed to effectively reduce the burden of disease through the transformation of the Primary Health Care (PHC) system. Although proposed previously, the commitment by the DoH is to strengthen the current PHC system and translate policy into practice in order to reduce the burden of disease (Department of Health, 2015).

1.1.2. *National Health Insurance*

Statistics SA (2013b) reports that currently, only 18.4% of individuals in South Africa are members of a private medical aid scheme, with a progressive increase of 2.5% from 7.3 million to 9.3 million during the period 2002 to 2013. In addition, for the period 2004-2013, some 70.2% of the population reported accessing a public health institution if they or a family member required medical assistance, whereas 28.9% indicated that they would make use of private health care. Interestingly, some 687 694 government employees and their dependents are presently members of Government Employee Medical Aid Scheme (GEMS). On its website,[1] they affirm their commitment to NHI, but are silent on the impact NHI will have on their membership or whether GEMS will continue to exist after the promulgation of the proposed NHI.

The DoH proposes reinforcing and strengthening Primary Health Care (PHC) before fully introducing NHI. Unfortunately, the piloting of NHI has not successfully materialised as planned with the plethora of existing challenges that continue to prevail. Pilot sites, in particular, are confronted with a lack of medical equipment, staff and medicine shortages (Mkhwanazi & Nkozi, 2014).

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[1] See: https://www.gems.gov.za/default.aspx?eYKBZfmnxQQhqfXsNJG15Neg8VzCNLco/. Retrieved February 27, 2017.

1.2. Statement of Problem / Rationale

In an attempt to undo the historic injustices the disenfranchised suffered during the apartheid era, the then newly democratically-elected South African government has made rigorous efforts to redress the imbalances post-1994. One of the ways in which the government hoped to achieve a socially, political and economically just society was through proposing a NHI financing scheme. This had been done numerous times, by previous colonial governments, such as in 1928, 1935, and 1942. The justification for such a policy was to deal with the disparities that still existed in the health system following the demise of apartheid with a prime example being the two-tiered health system that still currently exists. However, the successful implementation and steady progression of these policies into practice have largely stagnated; according to Rispel and Moorman (2010), this has been due to "a lack of co-ordination of the various laws and policy initiatives" and the fact that "the process and timing of many policy initiatives appear to be flawed" which has often led to feelings of alienation among the stakeholders who are responsible for its implementation (p. 127). Based on their review of three policy initiatives (Health Sector Roadmap, Integrated Support Teams and the Advisory Committee on National Health Insurance), Rispel and Moorman (2010) make the following three recommendations:

i. The need for focus and prioritisation;
ii. Careful attention to process and actors when developing or implementing legislation or policies;
iii. Improved monitoring and evaluation to enhance accountability to the public and to achieve health outcome goals.

Given these recommendations, this study focuses on exploring what psychological resources nurses possess that can aid in embracing the change positively, as well as develop strategies that can reduce job strain and burnout. Due to the work environment and the many adversities that nurses face in their work, as well as the current challenges faced by the health care industry, it was evident that a study was needed to determine the potential impact the Re-Engineering of PHC and the NHI would have on nurses and their wellbeing in an effort to identify factors that could aid in the positive facilitation of the change initiative.

1.3. Research Aim and Objectives of the Study

The main aim of this present study is to understand and assess the wellbeing of nurses in the context of the re-engineered PHC and NHI systems and to understand how the NHI can potentially impact the wellbeing of nurses. In order to address the main aim, the specific objectives of this study are to:

i. Determine the similarities and differences in the levels of Psychological Capital, Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in the NHI pilot and non-NHI pilot sites.
ii. Investigate the relationship between Psychological Capital with Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in the NHI pilot and non-NHI pilot sites.
iii. Develop insight into the experiences of positive psychological resources and stressors of nurses working in a NHI pilot site, the knowledge they have regarding the re-

engineered PHC and NHI system, and how they understand their role within this new dispensation.

1.4. Research Questions

In line with the above mentioned objectives, this study sought to answer the following research questions presented below:

1.4.1. *Phase 1: Quantitative Study*

i. What is the relationship between Psychological Capital, Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in a NHI pilot and non-NHI pilot site?
ii. Is there a difference in the Psychological Capital, Job Satisfaction, Wellbeing, Job Strain and Burnout of nurses in a NHI pilot and non-NHI pilot site?

1.4.2. *Phase 2: Qualitative Study*

i. What are the roles and responsibilities of nurses in the Re-engineered PHC system and the NHI?
ii. What are the understanding of nurses in relation to Wellbeing, Job Satisfaction and Burnout?
iii. What are the perceptions of nurses in relation to the Re-engineered PHC system and the NHI?

1.5. Ethical Considerations

Ethical approval for this study was obtained from the Humanities and Social Science Research Ethics Committee of the University of KwaZulu-Natal, South Africa[2] and the North West Department of Health: Policy, Planning, Research, Monitoring and Evaluation.[3] Ethical principles of voluntary participation, informed consent, anonymity and confidentiality were adhered to throughout the study. Chapter 4 describes in detail the ethical procedures that were followed.

1.6. Outline of Chapters

Chapter One: The first chapter of this study provides an introduction to the research study by providing an overview of the research problem and the rationale for the study. The researcher also provides an understanding of the context in which the study took place. The research objectives will be highlighted as well as what the researcher hopes to achieve from the research study.

Chapter Two: In this chapter, a thorough background to the study is provided as it pertains to the study. This chapter discusses the current and past literature on the health sector in South Africa in terms of health care pre- and Post-Apartheid. This chapter also discusses the development of Primary Health Care (PHC) in South Africa

[2] See Appendix 1. Ethical Approval: University of KwaZulu-Natal.

[3] See Appendix 2. Ethical Approval: Department of Health, North West Province.

and the evolution of health care policies and financing. It concludes with a thorough discussion of the proposed NHI financing scheme and the profession of nursing within South Africa.

Chapter Three: This chapter provides a detailed review on the literature on Psychological Capital (PsyCap), Job Satisfaction, Wellbeing, Job Strain and Burnout. It commences with an overview of nursing in South Africa and their role within the PHC model. The chapter also highlights the role positive emotions play in fostering change capabilities within nurses and discusses the interrelationship between PsyCap, Job Satisfaction and Wellbeing. The chapter concludes with a discussion on Burnout and Job Strain.

Chapter Four: Chapter four provides a detailed description of the research methodology used for this study. The chapter describes in detail the operations performed by the researcher in terms of sampling, data collection and data analysis. It also offers a detailed discussion of the research design, as well as a description of the participants and the organisation that they were selected from, including, which instruments the researcher used and how they were constructed. In addition, this chapter provides the procedures followed by the researcher in obtaining ethical clearance as well as permission from the organisation. Finally, a discussion of the limitations of the research study is given, as well as a brief outline of the ethical considerations followed.

Chapter Five: This chapter presents the findings from the quantitative research results in terms of the descriptive and inferential statistics that were run to answer the quantitative research questions.

Chapter Six: This chapter presents the main themes and sub-themes that emerged from the qualitative data analysis.

Chapter Seven: By way of concluding this study, this chapter presents an integrated discussion of the findings from both phases of the research study. The chapter begins with a rehearsal of the research aims and objectives and proceeds to answer the main research questions. This chapter also provides the recommendations of the study as well as a summary of the main findings, limitations of the study and a final conclusion.

CHAPTER TWO

BACKGROUND TO THE STUDY

2.1. Introduction

In this chapter, a background to the study is provided by focusing on key components of the South African health care system and the concomitant initial challenges encountered in introducing a National Health Insurance (NHI) financing system.

The chapter commences with a discussion of the current disease burden in South Africa. Thereafter, a historical overview of the South African health care system is given. Moreover, the historical significance of the development of the Primary Health Care (PHC) system and the evolution of health care policies in South Africa will be explained in order to situate contextually the current study and its relevance. Thereafter, the evolution of health care financing since the end of apartheid will be explored. The establishment of a NHI financing system within the South African environment will be discussed, acknowledging the chronic disease burden in South Africa. Finally, nursing in South Africa will be briefly explored within the context of NHI in terms of task sharing.

2.2. Historical Overview

Widely documented prior to 1994, South African society was structured according to race, gender and age based hierarchies. These hierarchies determined social life, education and employment (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009) as well as the resources allocated to their health care and pensions. The deliberate fragmentation of health

services existed at an organisational level in order to facilitate service provision with respect to whites and those living in urban areas to access better quality public health services, while blacks and those living in rural areas were significantly worse off (Yach & Kistnasamy, 2007). Moreover, the organisational fragmentation was evident in how health responsibilities were divided during apartheid. The 1919 Health Act separated the health responsibilities by curative care overseen at a provincial level and preventative and promotive health being the sole responsibility of local authorities. Considering that hospitals were categorised according to race, and with the majority of hospitals situated in white areas, this led to a further breakdown of the health care system.

In 1944, the Gluckman Commission was established with an aim to redirect the health care system of South Africa and possibly unify the type of care provided at local and provincial levels (Union of South Africa, 1944). Their primary goal was to investigate and report upon the provision of an organised National Health Service for all and to advise what administrative, legislative and financial measures would be needed in order to provide South Africa with such a unitary Health Service (Phillips, 1993). Among the recommendations the Gluckman Commission made, was a National Health Service administrated by the Minister of Health. Furthermore, it proposed the establishment of Community Health Centres. If successful, this would have seen the development of health centres across the country which would deliver care with a focus on health promotion and the preservation of health based on the Pholela health model, as opposed to the preventative and curative approach that was the basis of health care services at that time. Additionally, the commission’s report advocated the integration and combination of health education and preventative care with curative medicine

and outlined the staff responsibilities in these centres through the use of auxiliary personnel (Phillips, 1993). Unfortunately, due to a change in government, the full vision of the Gluckman Commission was not realised and only Community Health Centres were implemented from their recommendations (Phillips, 1993).

The fragmentation continued with the establishment of a segregated medical school for black students in Durban during 1952. The state took over missionary hospitals which facilitated the creation of the Bantustan Health Services where each jurisdiction had its own health department and which ultimately resulted in 14 different health departments by the close of apartheid. During this period, *The Alma-Ata Declaration* had no effect on dismantling the fragmented health care system (Sifunda et al. 2011). The health care system primarily focused on the hospital sector, leaving a severely underdeveloped primary health care sector which became more entrenched in 1983 when the Tricameral Parliament further separated health services with separate White, Coloured and Indian departments.

The inherited fragmented health care system was a result from the racially segregated policies that dictated health care during this period (Coovadia et al. 2009; Foster, Freeman & Pillay, 1997). These segregationist policies touched on every aspect of social life, including where a person was allowed to live, the type of education that person received, access to health care, employment opportunities, as well as prohibiting marriage between "Europeans" and "non-Europeans" (Chokshi, Carter, Gupta, Martin & Allen, 1995).

Before the end of apartheid, these policies had legalised the forced relocation of Blacks to designated homelands which also resulted in disparities in determinants of health.

At the end of apartheid, the African National Congress (ANC) developed a national health plan for South Africa in an effort to create "a unitary, comprehensive, equitable and integrated national health system" (African National Congress, World Health Organisation, and UNICEF, 1994, p. 15). Their goal was universal health care (UHC) coverage for all South African citizens. According to Mayosi and Benatar (2014), such a goal can only be reached when the gap between public and private health care has been bridged and the disparities addressed between these two sectors.

2.2.1. ***The Health Care System in Post-Apartheid South Africa***

Since the end of the apartheid era, the health care system has undergone several policy reforms. According to Yach and Kistnasamy (2007), the initial hopes at the end of apartheid were to "provide a better life for all" by improving access to care within the social services sector (p. 2). Following the first democratic elections in April 1994, transforming the health care system into one unitary institution with the primary goal of creating a national health system that provided a better life for all and better access and care within the social services sector were among its stated goals (African National Congress, World Health Organisation, and UNICEF, 1994). However, four years later, residual legacies of the apartheid system still remained (Chapman & Rubenstein, 1998). Notable initiatives were programmes such as free health care for pregnant women and children and a massive programme aimed at building clinics to improve access to health services. In addition, the end of apartheid signalled the start of "the eradication of racially based services, the initiation of nutrition support in primary schools and a massive clinic building programme to improve access to health care services" (Yach & Kistnasamy, 2007, p. 2).

Between 1994 and 2008, South Africa was recognised as having a quadruple burden of disease, namely, poverty, violence and injury, non-communicable and communicable diseases (Coovadia et al. 2009). The White Paper on the Transformation of the Health System set the stage for a series of key policy initiatives including decentralising the management of the health service through the creation of a district health system. Additionally, access to primary health care for all citizens, health promotion and disease prevention were key priorities for the newly elected government in order to promote maternal, child and women's health while simultaneously fighting HIV&AIDS. Through the Integrated Nutrition Programme, it was the hope to develop and promote sustainable nutritional wellbeing programmes for the disadvantaged. Lastly, the aim was to rationalise health financing through budget reprioritisation and the creation of a National Health Information System to facilitate health planning and management (Department of Health, 1997).

Even though constitutionally, access to health care was an entrenched right, the weight of poverty, burden of disease and unemployment remained a challenge. Dookie and Singh (2012) attribute South Africa's inability to successfully meet its health needs to the imbalance in health care delivery, the absence of a curative-driven health system and an ineffective leadership that lacked the drive and commitment to preventative and promotive services (p. 2). Yach and Kistnasamy (2007) also add that where there is poverty and a struggle for food and jobs on a daily basis, health is not a priority for individuals or the community at large.

Although significant improvements in health services have been achieved since 1994, disparities still exist in the quality of care provided in public health facilities. Concerns by the

public regarding health services at public health facilities include cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock outs (Department of Health, 2011a, p. 9). In order to ameliorate these issues, the Primary Health Care (PHC) system has been overhauled in preparation for a National Health Insurance (NHI) financing scheme.

According to a 2011 report on the NHI Green Paper by the Helen Suzman Foundation, the goal of universal health care coverage is best described as a system where all citizens have access to quality health care when they need it, without risking financial ruin when accessing it. The report advanced that in South Africa the public health system provides health coverage to those who are unable or unwilling to pay for private health care, and the private sector covers those who are formally employed and have medical aid. The leading concern according to the Helen Suzman Foundation was therefore not the lack of coverage, but rather one of access and quality of health care.

The sustainability of such a noble, yet ambitious effort has been questioned by many, especially within the current economic climate in South Africa and globally. Econex has published a series of commentaries on the NHI, from cost analysis to the implications the burden of disease has on a proposed NHI.[4] The shared commentary is that unlike other countries who may have a single burden of disease, South Africa is faced with a quadruple burden of disease which has to be taken into account when developing a NHI. A NHI can

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[4] See: <http://econex.co.za/publications/>, [Retrieved February 5, 2017].

only work when the demand for health care does not exceed the ability to supply health care (Econex, 2009). The severe human resource crisis, depletion of medication stock and where South Africa already spends more of its Gross Domestic Product than is advocated by the World Health Organisation (WHO) on health are all issues of concern. Nevertheless, with the implementation NHI financing system, this number is set to progressively increase. Therefore, it is imperative that the feasibility of universal health care coverage be fully interrogated alongside the current health care budget.

2.3. Health and Health Care Spending in South Africa

During the shift from MDGs to SDGs, the WHO reports that although significant progress has been made in reducing poverty, improving education and increasing access to safe portable water, the world has seen a “turn around” of HIV, TB and malaria epidemics as well as on child mortality and maternal mortality rates despite the numbers falling short of the targeted goal set (WHO, 2015). According to the WHO, areas of concern in some countries include the lack of focus on strengthening health systems, a limited focus on health and disease programmes, and the emphasis on a “one-size-fits-all” development planning approach to health care.

South Africa confronts a quadruple burden of disease with the most prominent being the high rate of HIV infection. South Africa spends more per capita on health than any other African country, yet it has one of the highest child mortality rates and maternal mortality rates (Schaay, Sanders, Kruger, & Olver, 2011). Life expectancy in South Africa is 64.7 years for males and 71.0 years for females, with an overall life expectancy for the population

standing at 67.9 years of age (Statistic SA, 2014). This is far worse in contrast to countries that spend less per capita on health and which have not had an increase in the child mortality rate since the baseline for the MDGs were set. In addition, South Africa has some of the most progressive health care legislation and policies, yet has made insufficient overall progress in terms of the MDGs. Chopra et al. (2009) concurs that although a supportive policy and funding environment prevails, South Africa is facing a "paradox of apparent progress yet worsening health outcomes" (p. 2). Schneider, Barron & Fonn (2007) also refer to the gap between the promise of transformation and its practice in their chapter on 'The Promise and the Practice of Transformation in South Africa's Health System'. South Africa has enjoyed some success in implementing PHC, particularly accessing health care services, in comparison to pre-1994; however, numerous factors hamper its success, including the majority of the country's resources focussing on fighting the HIV-pandemic (Coovadia et al. 2009; Dookie and Singh, 2012). Another criticism offered is the failure to utilise the systems of care that have been developed to respond to HIV&AIDS to improve the health needs of patient groups that have similar needs for "patient-centred long-term care" (Levitt et al., 2011, p. 1692).

The NHI White Paper attributes the shortcomings on the inequitable distribution of health financing to the disparities that exist between policy and practice (Department of Health, 2015). This connection is worthy of interrogation. The White Paper cites the quadruple burden of disease which compromised the MDG goals regardless of the fact that the country spends 8.3% of its gross domestic product (GDP) on health (Department of Health, 2015). Indeed, South Africa spent approximately R 200bn on health service delivery

during 2009 alone. This figure is above what is recommended by the WHO and therefore ideally should improve health outcomes.

Based on the percentage of its GDP, it would seem that the challenge is not inadequate funding or the divide between private and public health care, but rather the mismanagement of funds, corruption, the lack of sufficient resources, and a growing burden of disease that is crippling the public health care system (Johnston & Spurrett, 2011). In an effort to address these challenges confronting the public health care system, a process of Re-Engineering the South African health care system was embarked upon in anticipation for the introduction of a NHI scheme.

2.4. The Current Divide between Private and Public Health Care

Among the challenges that the South African health care system faces, the worsening quadruple burden of disease and the shortage of key human resources are considered paramount. Previously, the image of health care services in public institutions was poor as many associated the public health care sector with poor management, poor quality of care, underfunding and a deteriorating infrastructure (Department of Health, 2015). Other concomitant challenges within a severely under-resourced environment were the ever-increasing number of patients and the associated multitudes of ailments they were presented with on a daily basis to public health facilities across the country.

South Africa's parallel private and public system has also seen health care professionals leaving the public sector in favour of the private sector or else exploring other options internationally (Pillay, 2009). The exodus of health care professionals which the

Minister of Health has mentioned in a previous address (Motsoaledi, 2013) has implications for the operationalisation of NHI.[5] Furthermore, the parallel private and public system operational in South Africa continues to separate socio-economic groups and ultimately contributes to the quadruple burden of disease (Pillay, 2009; Schaay et al.,, 2011). How the proposed NHI hopes to unite this fragmented system will be explored in this chapter on the section on NHI.

The public health sector affords services to the majority (80%) of the population by providing free basic health care for every citizen who cannot afford private medical aid or who is unemployed. This requires increasing access to clinics, in both townships and rural areas (Sifunda et al. 2011; Statistics SA, 2013b). Although access to health care may have improved, the low socio-economic status of the vast majority of South Africans continues to prevail. This is evident in the percentage of people who borrowed money in 2014 for health and medical purposes. The Global Findex Database reported that in 2014, 17.4% of people who lived in rural areas borrowed money for health care, where overall 17.24% of men and 18.02% of females borrowed money for such purposes (2014). The percentage of people who fell into the richest category (18.5%) and poorest category (16.4%) were quite similar. The above statistics seem to infer the uncertainty of South Africans to access public hospitals for major medical procedures and confirms the findings of the General Household Survey that 42.3% of South Africans preferred to use private health facilities (Statistics SA, 2013b). Furthermore, the perception of South Africans of public health facilities impacted on their

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[5] The human resource crisis in relation to a NHI scheme will be discussed further under the section on the NHI financing scheme.

decision whether to visit their nearest clinic or seek private medical help. Pillay (2009) attributes the poor quality of care being provided by the public sector to poor management, underfunding and the lack of human resources. He further postulates that the private sector, which services the minority (16%) attracts the majority of health care professionals in the country and offers better services to the population, resulting in a parallel health system that is unsustainable, destructive and unhelpful in reducing the quadruple[6] burden of disease that is facing South Africa (Pillay, 2009).

In order to address this reality, a recommitment to the principles of PHC as outlined in *The Declaration of Alma-Ata* (WHO, 1978) is imperative. Such a renewed determination would aim at ensuring primary health care services are more comprehensive and focused on preventative as opposed to the hospi-centric and curative approach that has long-dominated the South African health care environment (Sifunda et al., 2011; Dookie & Singh, 2012).

If the private and public divide continues to contest ever-shrinking resources, then strengthening the public health care system through a renewed commitment to PHC is an important, innovative and flexible strategy to achieve “Health for All” (Kautzky & Tollman, 2008).

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[6] The quadruple burden of disease refers to HIV&AIDS and TB; Maternal and Child Death; Non-communicable Diseases and Violence and Injuries.

2.5. Primary Health Care

2.5.1. *The Concept*

The objective of any health care system is to provide universal access to appropriate, efficient, effective and quality health services, in order to improve and promote people's health (Mogawa, 2012). The mechanism to attain this goal is Primary Health Care (PHC).

The goal of the WHO's to provide "Health for All" has largely been informed by *The Declaration of Alma-Ata* (WHO, 1978), which advocates that PHC is the main strategy to attain this goal (WHO, 2008b, 2008c). In 1978, the WHO defined PHC as "essential health care based on practical, scientifically sound methods, made universally acceptable to individuals and families, at a cost that they can afford." *The Declaration of Alma-Ata* (WHO, 1978) was the first international declaration that advocated primary health care as the main strategy for achieving the WHO's stated goal of "Health for All."

According to the WHO, the definition of PHC is as follows:

> Primary health care is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the

> first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service (WHO, 1978).

Primary health care (PHC) generally refers to health care that is based on “practical, scientifically sound and socially acceptable methods and technology” (WHO, 1978). Primary health care, according to Dookie and Singh (2012) is the first point of contact that a patient receives oriented towards preventing disease and allowing for “early diagnosis and treatment management” of illnesses, referral to more specialised care when needed, or providing continuity of care or health education directed at the individual or family (p. 2). Primary health care is thus a public health strategy aligned to the social model of health and the belief that when a community’s basic needs are met such as access to clean water and sanitation, health outcomes ultimately improve.

According to Dookie and Singh (2012), the definition and scope of primary care and primary health care has complicated the delivery of primary health care service delivery (p. 2). The interchangeable use of these two concepts, coupled with the multiplicity of interpretations, has created a situation of the differing models of PHC that presently exist, thereby hindering the successful implementation of a single best approach. A distinction between the two concepts effectively affords an appropriate understanding of the PHC approach in its entirety.

2.5.2. *Primary Health Care in South Africa*

Primary health care has been the fundamental pervasive theme in a democratic South Africa, as was evident in the National Health Plan since 1994. From the Pholela Health Centre model to the development of Community Oriented Primary Care (COPC), South Africa has been instrumental in the conceptualisation and development of the PHC approach. Indeed, since the inception of *The Declaration of Alma-Ata* (WHO, 1978), progress has been noted in promoting "the health of all the people in the world." Despite such progress, Mayer (2010) notes that many countries, including South Africa, have failed to provide and deliver health care that is "equitable, adequate, acceptable and appropriate" (p. 3). Sifunda et al. (2011) also suggest that South Africa was in "direct conflict with the PHC philosophy and *The Declaration of Alma-Ata*, given that its health care system was still largely biomedical in its approach to health care services (p. 89).

2.5.3. *A Critique of the Primary Health Care System*

If a NHI scheme is to become a reality, then the obstacles that have hampered the full integration of PHC up until now require urgent interrogation. The PHC system of South Africa has come a long way since the close of apartheid, however implementation has been slow. For Rispel and Moorman (2010), the country's failure to successfully implement policy changes within the health care system has been largely due to flawed processes, poor timing, and the alienation of many stakeholders, especially those who are responsible for its implementation. Becoming cognisant of these inherent challenges, the DoH recognised the importance of public engagement and the participation of key stakeholders responsible for its

implementation (e.g. nurses) who have been largely absent from discussions surrounding the implementation of a NHI scheme and the Re-Engineering of PHC.

2.6. The Re-Engineering of Primary Health Care

In its commitment to PHC principles, the DoH has had to revisit the basic tenets of health care to strengthen the existing practice which will ultimately accommodate the desired changes towards the implantation of a NHI scheme.

This evaluative concept was further informed in 2010 by the Brazilian model of improving performance and access to health care at a local level. Accordingly, the vision of Re-Engineering of Primary Health Care (PHC) was initiated. The task team, commissioned by the Minister of Health, led by Dr Yogan Pillay (DDG Strategic Programmes and Head of PHC sub-committee on the NHI Ministerial Advisory Committee) was commissioned to develop a strategy to Re-engineer PHC in South Africa (Pillay & Barron, 2011). Notably, PCH in Brazil improved their health outcomes by expanding the role of community agents working alongside health professionals in designated areas (Wadge et al., 2016). In order to suit their local context, a model was adopted to help manage and minimise the increase of disease burden and infection through early diagnosis and referrals before a person's health conditions deteriorated to the point of requiring specialised services.

Under a Re-engineered PHC system, children will receive routine care, within an Integrated School Health Programme (ISHP). The success of a NHI scheme is dependent on a strengthened PHC system. According to Schaay et al. (2011), the first step in strengthening

the health system is based on a Primary Health Care approach as defined by the WHO in 1978.

According to the NHI Green Paper, PHC services will be Re-engineered to focus mainly on community outreach services, as well as provide a more comprehensive community primary care package as noted in Figure 2.1 (Department of Health, 2011a). These services will focus primarily on health promotion and preventative care, while simultaneously ensuring that "quality curative and rehabilitative services" are provided (p. 24). Furthermore, the Re-Engineering process will require District Managers, Sub-District Managers and CEOs of hospitals to monitor and evaluate the performance of the services provided under the new Re-engineered PHC system.

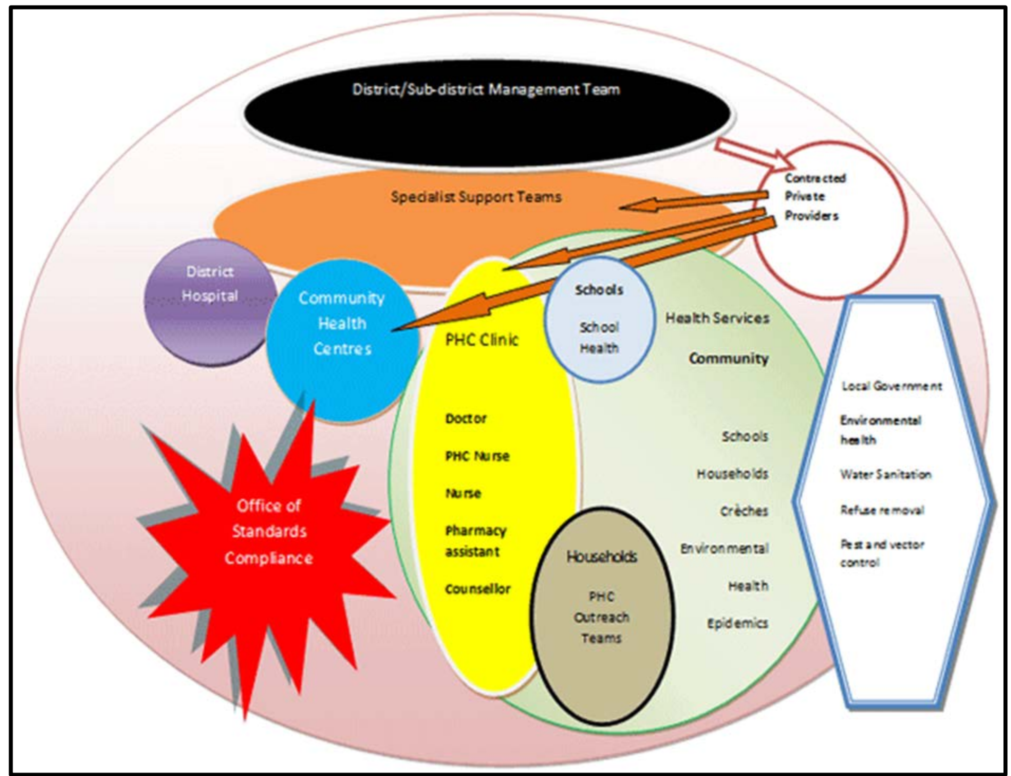

Figure 2.1. Proposed Primary Health Care Model. Adapted from Pillay and Barron, 2011.

The comprehensive services that the Re-engineered PHC system aims to deliver will follow four basic streams:

i. **District-Based Clinical Specialist Teams (DCST).** These teams will support the delivery of priority health care programmes at a district level in order to address the high levels of maternal and child mortality. These district teams will consist of a principal obstetrician and principal gynaecologist, a principal paediatrician, a

principal family physician, a principal anaesthetist, midwife and PHC professional nurse. This specialist team will afford comprehensive service within the PHC system (Department of Health, 2011a, p. 24-25). In addition, the team will provide a network of support for specialists working in primary care (Department of Health, 2011a). The NHI White Paper reports on the development and advancement of these teams. In particular, all 52 districts in South Africa have appointed DCSTs, with 90% of districts having at least three of the required seven team members. In addition, the decrease in institutional maternal and neonatal mortality rates in selected districts is attributed to the DCSTs (Department of Health, 2015, p. 34).

ii. **Integrated School Health Programme (ISHP).** This programme includes services such as health promotion and prevention and curative health services for school children. According to Brand South Africa (2012), child health programmes such as the Prevention of Mother-to-Child Transmission (PMTCT) programme has had a positive impact on the HIV prevalence rate among infants with a decrease being reported in numbers since the inception of the programme in 2006. Hence, within the Re-Engineering of PHC, further improvement on child health through services such as immunisation, regular deworming and growth monitoring will go a long way in promoting and protecting child health. While these services will be rendered by a School Nurse, due to the shortage of school health nurses, some provinces will be assisted by mobile health services (Pillay, 2012). The DoH has deployed 70 mobile school health services in the pilot districts which have identified over 200 000 learners who are inflicted by physical barriers (i.e. speech, hearing, eyesight and oral health) to learning (Department of Health, 2015, p. 33).

iii. **Municipal Ward-based Primary Health Care Agents (WBOTs).** Each ward will have either one or more PHC outreach teams, known as Ward Based Outreach Teams (WBOTs). The WBOTs will comprise of a professional nurse, environmental health and health promotion practitioner and Community Health Workers (CHWs), as noted in Figure 2.2. Their major function will be to promote good health and prevent ill-health through community interventions. Ideally, each team should be linked to a PHC facility through a professional nurse (Department of Health, 2011a).

iv. **Contracting Private Health Care Providers.** After the publication of the Green Paper on NHI and the subsequent piloting of the proposed PHC system, a fourth stream was added. Private health practitioners will be contracted to render health services in an effort to address the health needs of the population and to reduce the burden of disease (Department of Health, 2015).

These four streams differ from previous PHC strategies, as the focus of the current strategy is upon strengthening the DHS in order to promote the better implementation of basic systems. Moreover, the DMT will be given the responsibility of managing districts and being responsible for the health of the population. Furthermore, the way health services are conceptualised differs from the largely curative approach to a more preventative and promotive approach to health care (Asmall & Mahomed, 2013). The Re-engineered PHC approach emphasises community-based services as opposed to individual health care, taking health care services to the community to promote healthy living, assist in early identification

of individuals within families at high risk, and ultimately engaging the community in maintaining and improving their own health (Department of Health, 2010).

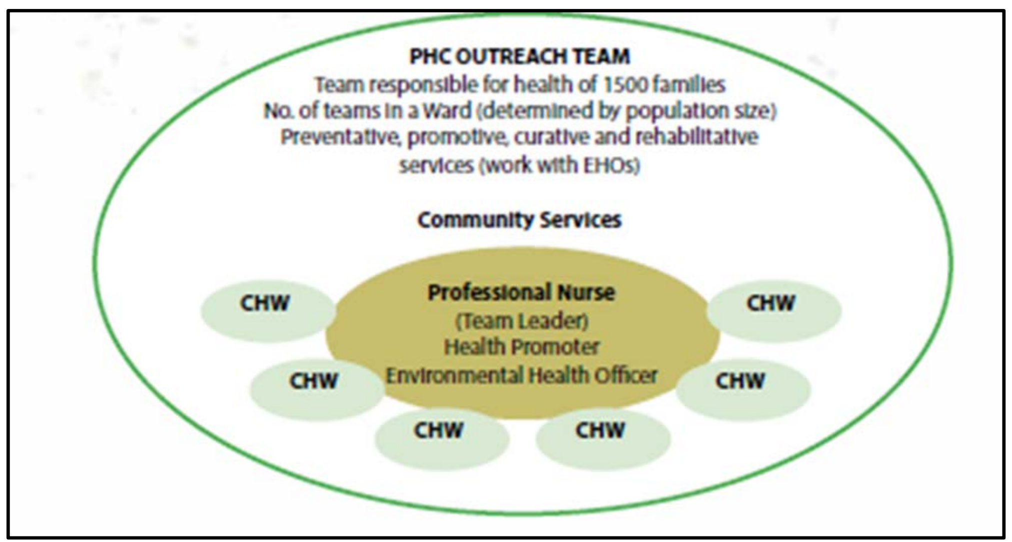

Figure 2.2. Primary Health Care Outreach Team. Adapted from Department of Health, 2011a.

In support of these four streams, an Integrated Chronic Disease Management (ICDM) (now referred to as the Integrated Clinical Services Management (ICSM)) model has been developed to assist in improving health outcomes for patients with chronic diseases in response to the growing burden of disease facing South Africa (Mahomed, Asmall & Freeman, 2014). Leveraging the HIV platform, the ICDM is an innovate model designed to improve the management of chronic conditions through a public health approach aimed at empowering patients to take responsibility for their own health (Mahomed et al. 2014).

Finally, the synergistic understanding between PHC, NHI and ICDM is that they all concentrate their efforts on decreasing the burden of disease by embracing a preventative ethos of care. This approach again asserts a PHC system with a focus on preventative care while ensuring quality curative and rehabilitative services (Department of Health, 2011a).

2.7. National Health Insurance

Based on the NHI White Paper, NHI is defined as:

> A health financing system that is designed to pool funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (Department of Health, 2015, p. 9).

The Re-engineered PHC system of how health facilities are run and the disease burden managed is a supportive framework to strengthen the health care system in preparation for the rollout of a NHI scheme. However, this journey toward universal health care commenced much earlier than 2010 as noted in Table 2.1.

As established earlier in this chapter, South Africa still remains one of the most unequal nations in the world in terms of wealth distribution. Despite spending more than most countries of their GDP on health, the high burden of disease and high rates of violence and injury and mortality continue to plague the country and reflect in South Africa's poor health outcomes (Im et al., 2012; van Rensburg, 2014; Stinson, 2015).

In an effort to increase access to health services and improve quality of care, while combating the quadruple burden of disease facing South Africa, the DoH has been focused on implementing an improved health system financing mechanism. The ideal of the proposed NHI is based on the idea of universal, compulsory and free health care for all. The central theme of the proposed NHI is that everyone will have access to health care services regardless of how much they contribute to the scheme (Econex, 2011; Johnston & Spurett, 2011). As described in the Green Paper on NHI, it is "intended to bring about reform that will improve service provision" (Department of Health, 2011a, p.4).

Table 2.1.

An Overview of Health Care Reform Strategies in South Africa

Year	Health Care Reform Strategies
1928	Commission of Old Age Pension and NHI
1941	Collie's Committee of Inquiry into NHI
1943	African Claims proposed equal treatment in the scheme of social security
1943-1945	Gluckman National Health Services Commission that proposed a NHI
1955	The Freedom Charter
1994	Ministers Committee on Health Care Financing
1995	Ministerial Committee of Inquiry into NHI
1997	Social Health Insurance Working Group
2002	Taylor's 2002 Committee of Inquiry into a Comprehensive Social Security System
2009-2014	Ministerial Advisory Committee on NHI
2015-Current	NHI White Paper published

Note. Adapted from the NHI White Paper, Department of Health, 2015.

With this “revolutionary” financing system, the DoH hopes to improve the functionality and management of the health system through stringent budgeting and expenditure monitoring (Brand South Africa, 2012). The long-awaited White Paper on the NHI was released on the 10 December 2015. It outlines that every citizen and permanent resident of South Africa will have access to quality health services based on their health needs and regardless of their socioeconomic status. It does recognise nevertheless that in order for this system to be operationalised, a massive reorganisation of the current parallel private and public health care system will be required.

Clearly, in response to the unsustainability of the current parallel private and public health system, the NHI was contemplated with the aim of ensuring that everyone has access to appropriate, efficient and quality health services regardless of socio-economic status or ability to contribute towards a medical aid scheme. As noted by van der Colff and Rothman (2009), in any country, a stable and productive health service is of vital importance and South Africa is no different. However, various factors need to be considered before implementing a NHI policy that has been successful in first world countries such as the United Kingdom, Switzerland and the United States of America.

2.7.1. *Rationale for National Health Insurance*

The rationale behind introducing a NHI financing scheme is to bridge the gap that exists between private and public by creating a single fund aimed at providing access to quality and affordable health care services for all South Africans irrespective of their socioeconomic status. Furthermore, the effectiveness and efficiency of the health system still

remains a challenge especially given the inequitable financing between public and private health care (Department of Health, 2015). The hope is that through a NHI scheme, the health system will become more responsive to health needs at a PHC level. This in turn will lead to improved patient satisfaction, enhanced quality of life and progressive health outcomes “across all socioeconomic groups” (Department of Health, 2015, p. 2).

A NHI scheme is not totally about health financing, but also about health transformation. As the Minister of Health has stated, the purpose of NHI is to not simply reduce the “catastrophic” health expenses incurred by ordinary citizens on a daily basis, but also to improve the quality of life for South Africans through universal health care (Motsoaledi, 2014).

The areas and operations that will be undertaken to strengthen the PHC system in order for a NHI scheme to work have been identified. Operation Phakisa, is one such initiative, consisting of an Ideal Clinic to improve the performance and quality of health services in PHC facilities (Department of Health, 2015).

2.7.1.1. *National Health Insurance Booklet 2011*

Articulating the concept into practice has been a contentious issue in South Africa. In response to this challenge, the DoH has published a booklet delineating the operationalisation of a NHI scheme. The prevailing ethos is that NHI will enable all citizens and permanent residents to have access to good health care by “sharing the money available for health care among all our people” (Department of Health, 2011b, p. 2). It stresses that an individual’s health benefits will not depend on how wealthy they are, but rather on how sick they are.

Through a NHI scheme, access to “hospitals, clinics, doctors, specialists, dentists, nurses and all other health workers will also be available much more equally” as noted below in Figure 2.3. The aim will be to, “create fairness in the sharing of health care finance and other resources,” provide access to free health care when required, and regulate the cost of health care in an effort to keep it reasonable and ultimately achieve a “healthier nation where people live longer and suffer less illness” (Department of Health, 2011b, p. 6).

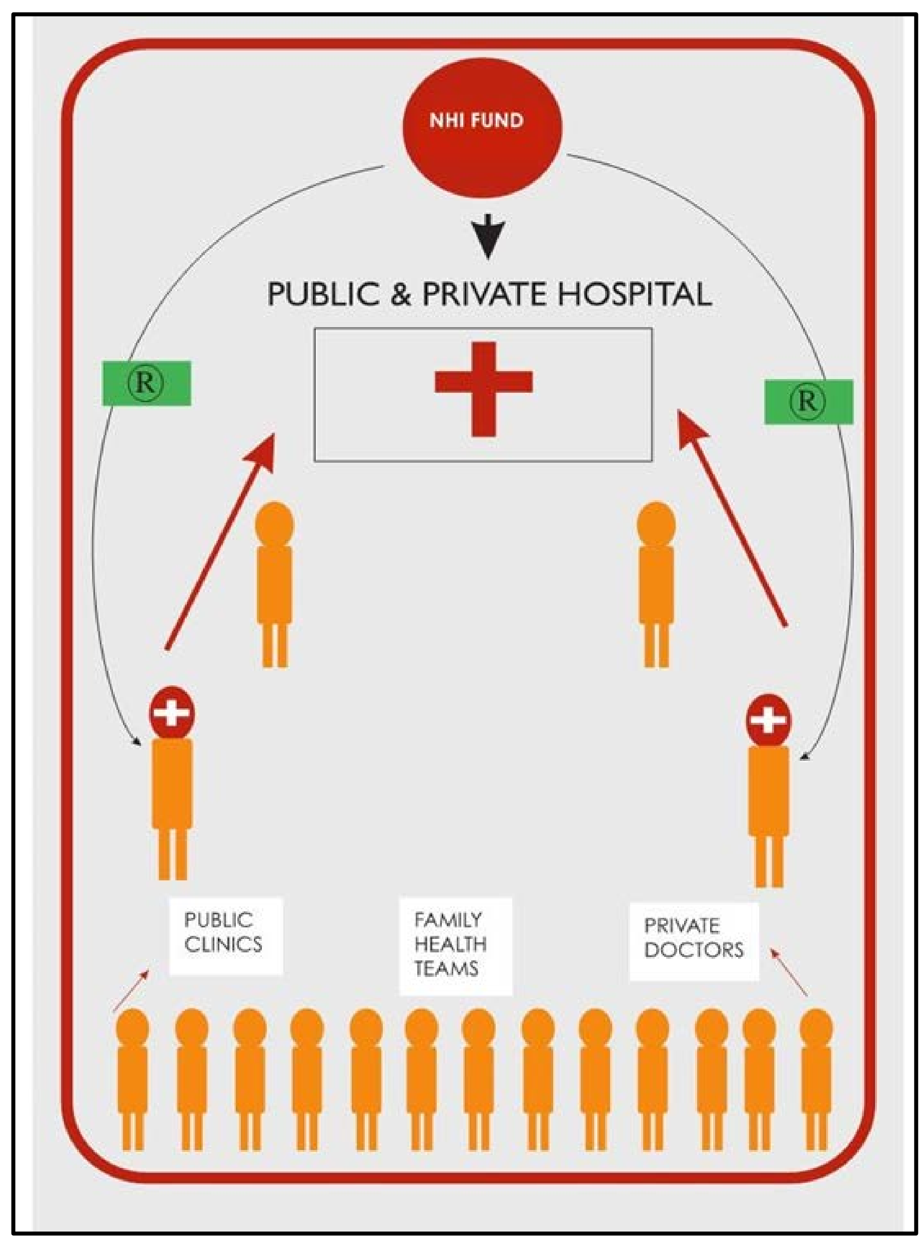

Figure 2.3. How will NHI Work? Adapted from the Department of Health, 2011b, p.7)

As depicted in Figure 2.3. NHI will provide finance for health care for all South Africans. However, NHI will not manage hospitals or clinics, but instead will rather enter into contracts with public and private hospitals. Specialist physicians and private hospitals will be contracted with the NHI to provide health services free of charge to every South

African. Health facilities will have to meet certain requirements before becoming a contracted partner of the proposed NHI. In order to benefit from the NHI, an individual will have to enter the health care system at a primary care level. This means that the first point of contact should be at a PHC clinic or General Practitioner's office. Patients will then be referred for specialist or hospital treatment if necessary. If however, a patient decides to avoid the primary care level and seek specialist help without the proper referral, the NHI will not pay for that patient to consult with a specialist (Department of Health, 2011b).

2.7.2. *Comprehensive Primary Health Care*

According to the NHI White Paper, all South Africans will have access to a "defined comprehensive package of health care services" (Department of Health, 2015, p.25) as outlined in Table 2.2. The comprehensive package of health services delivered will cover (but will not be limited to) the following:

Table 2:2.

Comprehensive PHC Services under National Health Insurance

	Comprehensive PHC Services under National Health Insurance
i	Preventive, community outreach and promotion services
ii	Reproductive health services
iii	Maternal health services
iv	Paediatric and child health services
v	HIV&AIDS and Tuberculosis services
vi	Health counselling and testing services
vii	Chronic disease management services
viii	Optometry services
ix	Speech and Hearing services
x	Mental health services including substance abuse
xi	Oral health services
xii	Emergency medical services
xiii	Prescription medicines
xiv	Rehabilitation care
xv	Palliative services
xvi	Diagnostic radiology and pathology services

Note. Adapted from Department of Health, 2015, p 26.

Hospitals will also be restructured within a NHI scheme. Currently, public hospitals are categorised as follows:

i. **District hospitals:** The smallest hospital facilities in the public hospital system, they provide general health services;

ii. **Regional hospitals:** These receive referrals from district hospitals and offer more specialised services;

iii. **Tertiary hospitals:** These offer more specialised services which are not available at regional hospitals;

iv. **Central hospitals:** These provide highly specialised services;

v. **Specialised hospitals:** These deliver services that require a high set of specialised skills and is delivered in sub specialities (Department of Health, 2015).

Within a NHI scheme, tertiary hospitals will provide specialist level services and should receive referrals from regional hospitals as opposed to the current practice where tertiary hospitals provide all levels of care, often resulting in poor quality of care and over-expenditure as specialist care is more expensive (Department of Health, 2015; Mohapi & Basu, 2012).

2.7.3. *Nursing within the National Health Insurance Scheme*

In order to ensure that a NHI scheme becomes a reality, nurses will have to take on roles more than they do currently, including becoming nurse practitioners. This will result in nurses taking on more responsibility for managing and providing health services within the NHI and a Re-engineered PHC system. In South Africa, nurses form the backbone of the PHC service, more often than not working in remote areas without the assistance of a doctor (Mayers, 2010). The literature reveals that not only are nurses highly dissatisfied with their current work environment, but they are also often faced with immense challenges. Accordingly, South Africa as a country is presently facing a crisis in retaining its their nursing professionals, as many are seeking better job opportunities abroad or choosing to leave the profession altogether (Pillay, 2009; Mokoka, Oosthuizen & Ehlers, 2010). Based on

the literature, nurses seek a place of work that looks after their interests and where they are given opportunities to grow and learn (Mafolo, 2003; ICN, 2003). It is important therefore to acknowledge the role they will play in the new NHI system and determine what impact this will have on their personal and professional wellbeing.

The Minister of Health in a speech given in 2013 prioritised the following areas in the National Strategic Plan for Nurse Education, Training and Practice to revitalise the nursing profession in South Africa, which has erstwhile been plagued by issues such as staff shortages, lack of resources, medication stock outs, and poor service (Mkhize, 2013). The plan aims to promote and maintain a high standard and quality of nursing through strong leadership at all levels of nursing and the provision of well-resourced practice environments for nurses and midwives in an effort to guide the production of sufficient numbers and appropriate categories of nurses (Khumalo, 2013). Furthermore, the need for teaching modules that promote an ethos of caring and which promote a culture of patient-centred care, should be compulsory at all levels of nursing and midwifery so as to address the issue of compassion or lack thereof in nurses working in public health facilities (Mkhize, 2013).

Presently in South Africa, there exist 136 854 nurses working in South Africa (SANC, 2016). The NHI policy does not clearly state how many nurses are needed to fulfil the goals of a NHI financing scheme, however an article published in 2013 by Independent Online (IOL) stated that South Africa needed an additional 44 780 nurses to service the population at that time. In the North West province where the present study was conducted, there are 9621 registered nurses for an estimated population of 3 706 962 (SANC, 2016). According to Klopper and Uys (2013), nurse training in South Africa presently has four categories:

i. Enrolled nursing auxiliaries (ENA) who train for one year;

ii. Enrolled Nurses (EN) who train for two years;

iii. Registered Nurses/Midwives (RN/M) who train for a total of four years;

iv. Specialist Registered Nurses/Midwives (SRN/M) who have one or two year's post-RN/M training.

In response to the changing needs, developments, priorities and expectations in health and health care, nursing education and training has being redesigned. New policies and cadres of health care professionals are being introduced under the new National Qualifications Framework (SANC, 2015). The White Paper on NHI has also introduced a PHC category for nurses to support the PHC system (p.6). In order to support such an initiative, the DoH has invested in expanding and building nursing colleges in an effort to train more nurses and combat the severe staff shortages.

The dominant Nursing Councils in South Africa are the South Africa Nursing Council (SANC) and the Democratic Nursing Organisation of South Africa (DENOSA). The DENOSA has pledged their support for the Minister of Health's vision of the proposed NHI scheme as released by their Head of Communications, Ms Asand Fongquo in a commentary published on March 28, 2012.[7] However, DENOSA raised considerable concerns related to the White Paper on NHI in their commentary paper. They called for clarity on a number of issues including that nurses should be included in the development of policy and not simply

[7] "NHI will fix our ailing health system: Denosa," <http://www.sabc.co.za/news/a/8022b5804aaddd9bbeb4feeddc7f75be/NHI-will-fix-our-ailing-health-system:-Denosa-20122803/>, [Retrieved 6 February 2017].

tasked with implementation. Furthermore, they stressed the importance of developing a balance between the rights of patients and that of nurses and that any training aimed at capacitating nurses needed to be collaboratively developed with the relevant regulatory bodies concerned (DENOSA, 2016).

2.7.4. *Primary Care 101 (PC101)*

In order to prepare both the health care system and the personnel for the proposed NHI scheme, all professional nurses will need to receive training in order for them to provide integrated services to the community. Primary Care 101, commonly known as PC101, and now referred to as Adult Primary Care (APC) is a symptom-based integrated clinical management guideline that aims to equip nurses and other clinicians to diagnose and manage common adult conditions at the primary care level (Folb et al. 2015). Based on the findings from the PC101 trial in 2011, it has since been adopted by the DoH as part of its Integrated Chronic Disease Management (ICDM) model and thereby forms part of the Re-Engineering of PHC strategy. Accordingly, it has been rolled out in all the NHI pilot districts.[8]

2.7.5. *Integrated Chronic Disease Management*

The Integrated Chronic Disease Management (ICDM) manual was developed in response to the renewed focus of the DoH on strengthening the management of chronic conditions at the PHC level. Accordingly, it targets the re-organisation and improved

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[8] See: http://knowledgetranslation.co.za/programmes/pc-101/, retrieved February 6, 2017.

functioning of clinical services in order to provide health care services using an integrated approach (Mahomed & Asmall, 2015). The ICDM is thus a "model of managed care that provides for the integrated prevention, treatment and care of chronic patients at PHC level to ensure a seamless transition to assisted self-management within the community" (Asmall & Mahomed, 2013, p. 13).

The ICDM interventions are focused at three levels: (i) the facility level, (ii) community level and (iii) the population level in an effort to achieve optimal clinical outcomes for patients suffering from chronic communicable and non-communicable diseases.

Within a NHI scheme, nurses will be required to provide more integrated health services as outlined in the NHI White Paper, ICDM and the revised PC101 manual. This in turn will increase their responsibilities which may contribute to their experiencing stress, job strain and burnout. In addition, the lack of sufficient human resources to meet the needs of the population, will inevitably place a level of strain on an already weak and overburdened health care system. In order to alleviate some of the pressures and burdens that health care facilities face, the WHO proposed that countries adopt a task sharing approach in order to address nurse shortages (WHO, 2008a).

2.7.6. *Task Sharing*

With the demand for health care rising and ever-changing disease patterns, coupled with the health worker shortage facing South Africa, meeting the health needs of the country requires the strengthening of the health care system. To address the critical shortage of health workers, the concept of task sharing has been proposed which involves capacitating lay

workers to deliver interventions under the supervision of supervised specialists and enabling mid-level professionals (nurses) to perform clinical tasks and procedures previously restricted to higher level professionals (doctors) such as ART-initiation (Lund et al., 2014; WHO, 2012).[9]

2.7.7. *Some Challenges to Achieving Universal Health Care Coverage for All*

The success or failure of a NHI scheme depends largely on important factors whereby cooperation from private health care practitioners and facilities will be instrumental in bringing the South African Government's vision of "Health for All" a reality. Since the piloting began in 2011, progress has been noted in areas such as building more clinics, developing a district health system and training more nurses and doctors. However, a key component—contracting private practitioners—is an area that has not broken much ground (Khan, 2015, 2016). Private medical practitioners educated in South Africa also leave the country to practice internationally. This incremental loss of skills impacts on retaining skills within the country. Another contentious area that has recently come under scrutiny is the educating of South African medical doctors in Cuba. A report by Erasmus, Pillay, Umraw and Saville (2016) raises concerns about this scheme, which could severely impede the objective of 800 to 1000 new doctors trained by 2018 to be employed within the NHI system.

The Minister of Health has often announced that eventually the Medical Schemes Act will be amended to ensure that Private medical aids will only be permissible to provide

[9] This concept will be discussed more fully in the chapter which follows.

complementary top-up coverage to the core NHI package. Many have argued that this is a direct violation of their Constitutional basic human rights, by inadvertently preventing them from choosing their own medical scheme and service provider.

Other political parties have advanced that a Government-backed universal health care scheme should not be implemented through an "elaborate, overcomplicated, convoluted and monumentally costly"' mechanism (Settas, 2016). Similarly, Settas (2016) is sceptical about the feasibility of raising funding for a NHI scheme in South Africa during what is a worsening financial situation, with growing debt financing costs and declining tax revenues. He questions the NHI projected expenditure as outlined in the White Paper and considers that the amount of R 256 billion is optimistic. Other interrelated challenges will be elaborated upon later in this study.

2.8. Chapter Summary

While the South African health care system has historically undergone many changes, the launching of a proposed NHI financing scheme and the Re-Engineering of PHC is proving to be one the most challenging issues faced by the National Government since the end of apartheid. Not only does a NHI scheme hope to bridge the gap between private and public health care, but it also aims to improve health outcomes for all citizens through a unified fund. Proponents of a NHI scheme have dubbed it a laudable policy, but even they

have their doubts about the financial sustainability of a NHI scheme in the current South African economic climate.

Given the high hopes of the DoH and the Government of South Africa for a healthier population, specific remedial processes need to be taken in order for the Re-Engineering process and NHI to work effectively. The burden of disease in the country, especially the high burden of chronic disease also poses a challenge for NHI. In terms of the current economic climate, South Africa is not in a position to afford a NHI scheme and measures should be taken to account for this. Furthermore, the current health workforce crisis is a challenge that can effectively derail the Re-Engineering of PHC as well as negatively impact the implementation and success of a NHI scheme. Policy documents and the introduction of new cadres of health workers will do nothing for the health system, if improvements to the current working conditions and health (physical and mental health) of current health workers such as professional nurses are not addressed.

The chapter which follows will look more in depth at the field of nursing in South Africa and how the role of nurses has changed in terms of Government health policy. The chapter will also explore how nurses are currently experiencing Burnout, Stress, and Job Strain and how this relates to their level of PsyCap, Wellbeing and Job Satisfaction.

CHAPTER THREE

A REVIEW ON PSYCHOLOGICAL RESOURCES AND STRESSORS EXPERIENCED BY THE NURSING PROFESSION

3.1. Introduction

National Health Insurance and the Re-engineered PHC system are both transformative change initiatives that require effective implementation and management. The previous chapter provided an overview of the DoH strategy for the successful roll out of a NHI financing scheme. However, an important aspect that has not received adequate attention is the role of the professional nurse beyond what is included in the policy documents. The additional responsibilities that come with the introduction of a NHI scheme have created a workforce that is potentially vulnerable to burnout and poor wellbeing. In an attempt to explore nurses' experience of NHI, this chapter will review current literature on Job Satisfaction, Job Strain, Burnout, Wellbeing and Psychological Capital (PsyCap) of professional nurses.

First, this chapter will provide an overview of nursing in South Africa pre-1994. Thereafter, the role of nurses within a Re-engineered PHC model will be discussed with particular focus on the symbiotic relationship between nurses and a NHI scheme. Second, the chapter will discuss the role positive emotions play within an organisation in the efforts to retain staff. The interrelationship between PsyCap, Job Satisfaction and Wellbeing will be explored towards developing a competent and ardent workforce that is capable of adapting to change. Finally, the chapter will conclude with a consolidated and synergic discussion on

Burnout and Job Strain with particular emphasis being placed on the role Decision Latitude and Skills Discretion can play in empowering nurses to embrace change.

The success of any health care organisation is dependent on the cadre of workers that constitute the biggest labour force of an organisation (Cummings & Worley, 2014). Organisationally, human resources is a broad concept which includes all cadres of a given workforce; however, for the purposes of this study, only nurses working in the public health sector will be delineated.

Nurses are undeniably the backbone of the PHC system in South Africa. They are the first point of contact for a patient seeking health care and are responsible for diagnosing, treating and referring patients. Accordingly, it is crucial to clearly define their role within the changing system. This sentiment was emphasised in the previous chapter on how a Re-engineered PHC system will collaboratively work in support of a NHI scheme. However, in order for nurses to be supportive of such changes, it is vital to acknowledge how this changed system inherently supports them within their current challenging work environment and yet exposes them to Burnout and Job Dissatisfaction.

Beyond understanding the occupational challenges the nursing profession is presently confronted with, it is essential to contextually understand the concomitant factors confronting the profession, including the current chronic shortage of nurses, high absenteeism rates and staff turnover. Despite a commitment to building more nursing colleges and creating a new cadre of nurses, the proposed NHI scheme is silent on its retention strategy to strengthen and support the existing workforce to ameliorate these challenges. Accordingly, this chapter will

investigate these important and mitigating factors as they impact on nurses' wellbeing within the NHI system.

3.2. Defining Nursing: An Overview of Nursing in South Africa

According to the Nursing Act (2005), nursing has been defined as:

> A caring profession which enables and supports the patient, ill or well, at all stages of life, to achieve and maintain health or where this is not possible, cares for the patient so that he lives in dignity until death (p.1).

This definition dictates an all-encompassing, caring and compassionate occupational ethos, all of which had serious implications for black South African nurses prior to 1994, but with the increase in the number of patients, job strain, workload and challenging work environments, have made this ethos difficult to maintain.

3.2.1. *Historical Context*

Pre-1994.

As with all professions and South African society as a whole, nursing has been inordinately shaped and conditioned by racial, class and gender discrimination. Before the Nursing Amendment Act of 1957, there was no distinction between nurses and midwives pertaining to race. The new Act introduced racial segregation into nursing by imposing passes on African nurses, instructing the SANC to maintain separate nursing registers for the different racial groups, different uniforms and badges to distinguish the different race groups,

and differential training (Marks, 1990; Van Der Merwe, 1999). With the 1957 Act, also came a shift in power from a body that was established on a "non-racial basis," to one which afforded white people greater control and power within the SANC (Marks, 1990, p. 1).

Racial segregation was further extended to how nurses worked and where they worked. Under the 1957 Act, it was considered a criminal offence for a nurse from another racial group to supervise a white nurse. This created an immediate challenge for these nurses to be promoted as they could never be in charge of their white counterparts (Carlowe, 2004). The racial divide in nursing severely impacted the provision of health care services. Black nurses were not allowed to treat white patients and were only allowed to provide low-skilled health care services, which meant being relegated to menial tasks such as tea making or cleaning bed pans (Carlowe, 2004; Marks, 1990; van Der Merwe, 1999).

As noted in a study by Carlowe in 2004, black nurses were not only forced to work in all black institutions and only with black patients, but were also prohibited from receiving the same training as their white counterparts. Accordingly, there was no possibility for upward mobility for black nursing staff even when they were more experienced and skilled than their white counterparts. They were not only kept from "scrubbing up" in the operating theatres but were rather called to scrub the floors (p. 14). This separatist mentality also had an impact on the development of health policies as was evident in the lack of support for the Community Oriented Primary Care (COPC) national health system as proposed by Dr Gluckman and his team in 1944. This proposal was based on the notion that the health of communities is determined by the social environment which is achieved through collaboration of the service user and service provider communities (Bam, Marcus, Hugo, &

Kinkel, 2013; Marks, 1994). Furthermore, it advocated for the integration of primary care with public health in order to ensure that the focus remained on health and not simply illness (Bam et al., 2013). The white National Party, in power since the watershed May 1948 General Election, strongly opposed a National Health Centre Programme and upon their ascendency into government removed from office all those who were supportive of the programme. Furthermore, the profession was vociferously opposed to the implementation of the Pholela/COPC approach as this seemingly threatened the preferential status of white nurses (Dookie & Singh, 2012).

Nursing Education and Training.

Due to the apartheid laws such as the Nursing Amendment Act of 1957, nurse education programmes prior to 1994 were dissimilar for white and black nurses. As a result, they contained many programmatic development flaws. The system according to Mekwa (2000) affected the personal development and career mobility of the nursing profession due to a failure to recognise the benefit of prior learning in terms of the cognitive development of the individual. The different learning programmes also existed in silos much like health care services at that time; this in turn lead to the duplication of learning content in some programmes that were relatively similar in scope.

During the late 1990s, education was reformed and restructured in an effort to abolish the racially-based system, reducing the number of institutions that existed as a result of apartheid and aligning nursing qualifications across all institutions (Breier, Wildschut, & Mgqolozana, 2009; Kautzky & Tollman, 2008). Unfortunately, the rationalisation of nursing

colleges led to an overall decrease in student numbers. This created an ageing nursing workforce, with over 77% of all nurses in South Africa in 2013 being over 40 years of age (Southall, 2016). Although the production of professional nurses (PNs), enrolled nurses (ENs) and enrolled nurse auxiliaries (ENAs) saw an increase in 2007, this did not translate into growth in the profession as the majority of professionals produced during this time were ENs and ENAs.

According to Dennill, King and Swanepoel, (1999), nursing education changed prior to 1994. In 1974, a WHO expert committee described the fundamental role that community nursing played in the provision of basic health care to communities and that through community nursing the health of communities would be improved. This directly tied in to the PHC approach that was discussed in the previous chapter. This philosophy produced radical changes in how health services were designed and how health workers were trained (Strasser, 1999), thereby calling for the integration of a comprehensive community health nursing component in to the four year basic diploma course. While acknowledging that even though the nurse of the 1990s was more knowledgeable as a result of the noticeable reforms in nursing education, Dennill (1999) remained sceptical on whether the professional nurse had the “necessary skills to fulfil the required role within the community and the clinic” (p. 5). This scepticism extended towards the “integration of the discipline” as she questioned the integrated discipline over the lack of a practice environment which enabled the nurse to prepare for her new role within the new health dispensation. Her scepticism at the time was largely due to nurses providing the bulk of health care services, yet still expected to act as the “handmaiden of the doctor” (p. 5).

According to Kautzky and Tollman (2008), the fragmentation of health services and the deregulation of the health sector proved damaging for the health care system during apartheid. By formally separating health services for Africans, health care provision in the ethnic-based departments of health resulted in inefficient and costly health care services due to differential spending. Furthermore, the shortage of trained health personnel and medical equipment to service these areas further perpetuated discrimination in health care access which directly impacted on health outcomes worsening.

Given all that has been done to overhaul the health care system, where does this leave nurses who are the backbone of the health care system in South Africa? The field of nursing has seen numerous changes since the end of apartheid, yet research shows that with all the changes, nursing is still one of the most stressful professions and has the highest rate of burnout and turnover of staff (van der Colff & Rothmann, 2009). The impact the introduction of the new policies and legislation had on nursing will be presented hereunder.

Post-1994.

The end of apartheid signalled a new beginning for all South Africans and for nurses who for many years had worked in racial segregated institutions due to the segregationist nursing policies (Breier et al. 2009). This era witnessed DENOSA aligning itself to the newly-elected ANC Government, thereby envisaging that their close affiliation would provide the necessary space to influence future policy-making efforts and increase their leverage in industrial relations (Southall, 2016, p. 145). According to Southall (2016), while nurses "shared in the benefits" of the progressive labour legislation passed by the ANC,

disparities still existed with regard to salaries and the performance of the sector, with DENOSA still struggling to make a significant impact in the health care sector (p. 145).

The newly-elected ANC Government declared that “Public health care will form an integral part of the country’s National Health Service, of which it will be the central focus while the PHC approach will guide the overall social and economic development of the community” (African National Congress,1994 p. 20). Under this new dispensation and in an effort to redress the disparities in health that had been caused by apartheid legislation, the ANC government proposed interventions aimed at eradicating the racially based services, introduced free health care for pregnant women and children, sought to provide nutrition support in primary schools and embarked on a major clinic building programme that it was hoped would ensure that people had easier access to health care services than before (Carlowe, 2004; Yach & Kistnasamy, 2007).

In response to the burgeoning HIV and TB epidemic, the ANC Government committed to increasing the budget for HIV programmes. This resulted in the expansion of antiretroviral therapy (ART), a scaling up of the prevention of mother-to-child transmission (PMTCT) programme and the integration of HIV and TB treatment programmes. This increased access to health care added to the workload of the clinic nurses, as did the new interventions proposed to address the HIV and TB crisis (Yach & Kistnasamy, 2007). This immediately inferred a change in the role of the clinic nurse from previously being no more than a tea lady to that of providing direct PHC services. This modification of these responsibilities were further compounded by the DoH not being fully cognisant of the disparity in the training that nurses received. Many were ill-prepared due to the lack of

uniformity in their basic education and training and limited exposure. As Southall (2016) notes, due to the "shortages of health professionals" nurses had to step-in and at times assume managerial and administrative roles (p. 150). The rise in patient numbers due to the high HIV infection rate and the associated TB epidemic also saw a major exodus of professional nurses from the public to the private sector (Yach & Kistnasamy, 2007).

The hope was that the end of apartheid would inject new life into the nursing profession through the various initiatives aimed at abolishing the discriminatory and divisive policies that plagued the profession under apartheid (Breier et al. 2009). Instead, by 2008, the profession was detrimentally affected by the soaring number of vacant nursing posts. Incrementally, with the severe staff shortages in the poorest provinces, nurses were becoming increasingly dissatisfied due to low salaries, poor working environments that were unsafe and often threatening to their safety (Carlowe, 2004).

This poor perception is shared by a group of young nurses who reported that nursing was a "low profession" and one student nurse stating that "My friends think all I do is bedpans" (Breier et al. 2009, p.114). In addition, these younger nurses were of the opinion that nursing was just a job and blame their lack of caring on pressure of work and low salaries (Southall, 2016).

3.2.2. *The Current Nursing Landscape in South Africa*

As discussed above, the nursing profession has been inundated with numerous complex challenges that cannot simply be fixed with a simple solution. From the above, it seems that the profession whose central purpose is to care for others, is itself in need of care

(Breier et al. 2009). The profession is plagued by increasing patient numbers, the migration of nurses, a growing chronic population, the burden of HIV&AIDS and TB, a lack of caring ethos, an ageing workforce and a poor public image (Breier et al. 2009; Meiring & van Wyk, 2013). Breier et al. (2009) also note that the nursing profession, once regarded as an "elite profession for women," is now often viewed as a lowly profession and is thus being "overshadowed" by more lucrative careers (p. 1). This perception directly impacts on the recruitment and retention of the youth into the profession, where the poor public image has demonstrably illustrated a direct link to the declining interest in the profession as a whole (Breier et al. 2009). According to Southall (2016), some of the factors that have significantly contributed towards a decline in the public perception of nursing and by extension, lowering the decline in recruitment, have been the proliferation of lower nursing categories and the perception that older nurses are more caring than younger nurses (p. 151). According to DENOSA, the declining interest in nursing is due to poor working conditions and the low salaries. However, they have yet to initiate industrial action to remedy and appropriately address the disparity in salary levels with those of other helping professionals. At times, where nurses have engaged in strike actions, DENOSA has chosen to follow the lead of the nurses as opposed to leading the charge (Meiring & van Wyk, 2013).

According to Rispel and Bruce (2015) the nursing crisis in South Africa has been characterised by the declining interest in the profession, staff shortages, a lack of caring ethos and an apparent disjuncture between nurses' needs and those of the communities they serve (p. 118). South Africa is not the only country afflicted with a severe shortage of health

professionals, this being confirmed in the literature by numerous studies that report similar challenges among other nation states (Dookie & Singh, 2012; Hull, 2010; Southall, 2016).

The declining interest in the profession is evident in the membership of DENOSA which has only managed to increase by 7 000 members between 1994 and 2012 (Singh, Nkala, Amuah, Mehta, & Ahmad, 2003). Furthermore, statistics obtained from SANC illustrate that the number of professional nurses graduating from nursing education institutes do not match the health service demands for nurses and midwives in geographical areas that require them most (SANC, 2016).

Other studies such as Blaauw, Ditlopo, and Rispel (2014) have shown that South Africa urgently needs to scale-up its nursing educational programmes so as to increase the output of more health professionals to address the patient and population demands for health care and to improve the public health sector performance overall (Southall, 2016). Furthermore, urgent attention should be attended to recruiting and retaining nurses and not only training them. This was endorsed by The Minister of Health, who in February 2014 added his concern regarding the migration of nurses which he conceded was not a uniquely South African phenomena, but a global problem. Partab (2015) proposes that addressing nurse migration requires a holistic approach by all stakeholders in addressing the factors that precipitate nurses' migration in an effort to develop sustainable plans that retains nursing numbers and their skills in the country.

3.2.3. *Migration*

The appeal of migration has been highlighted by Hull (2010) who reveals that for many the benefit of working abroad is undoubtedly financial. However, for some it also symbolises a higher status, due to the sense of achievement of attaining wealth and knowledge as a result of their employment overseas (p. 862). In her study, Hull (2010) uses the example of Bongile who migrated to the United Kingdom (UK) and upon her return for personal reasons, was viewed more positively not only by her peers, but also her community. This supports the view maintained by Breier et al. (2009) who admits that in more positive instances, professionals migrate in an effort to gain more experience and knowledge which they then bring back to their country of origin. However, for those nurses who choose to migrate, their reasons are simply that they want a better life and the ability to earn more money overseas than locally. Hull (2010), further reports that the status Bongile received as a direct result of her time in the UK, speaks to the greater issue of the higher value placed on education and training received outside of South Africa than by South Africans themselves. Southall (2016) also comments that while educational reform has taken place in South Africa since the end of apartheid, the inequality in education still remains systemic. Likewise, Spaull (2013) reports that South Africa has two different public school systems which impact greatly on the quality of education received. For Hull (2010), the appealing nature of migration lies in its ability to provide nurses with a "powerful tool" for acquiring cultural capital which in turn translates into an ability to build wealth for themselves, acquire knowledge and competencies which ultimately help them gain a higher professional status that is not dependent on the "traditional nursing hierarchy" (p. 863). These are pertinent and intricately

understood concerns that require interrogation when developing a retention strategy for the occupation to match the same opportunities as migration affords them. As Partab (2015) challenges, the failure to engage in the factors that precipitate nurse migration can potentially result in the value of the nursing profession being honoured internationally but not locally. Moreover, the investment of training a nurse has to pay dividends for the country, instead of that nurse migrating with her/his skills and offering it to a community that can afford to employ its own personnel.

With the proposed rollout of the NHI scheme, South Africa is on the precipice of a revolutionary health care financing policy; however, the human resource crisis will prove to be a huge challenge that potentially can hamper the efforts of the NHI and the re-engineered PHC system as nurses are integral to the new system. Unless South Africa can recruit more health professionals to work in rural areas, many of the programmes within the Re-engineered PHC model will be hard to implement.

3.3. The Nursing Profession within the Re-engineered Public Health Care Model

The current district based health system places emphasis on the importance of the clinic as the first point of contact between the patient and the health care system (Blaauw, Ditlopo, & Rispel, 2014). In this system, nursing staff provide the bulk of health care services. This is particularly the case in the rural areas, where there are no permanent doctors and the clinic is the only health facility in the area. Previously, the emphasis was more on hospitals and therefore the role of nurses was secondary to that of the doctor. Even though nurses were crucial to the health care system before the Re-Engineering of PHC took place,

this new shift in policy requires nurses to be at the forefront of every new initiative proposed by the DoH.

The current PHC system requires a nurse to be multi-skilled with the ability to not only diagnose and treat common ailments, but also recognise complex health problems, provide health promotion and counselling to patients, and follow-up with patients regarding their treatment and manage chronic conditions. With the increase in access to services and health care being free for all, the case load that nurses have to handle on a daily basis will have to be increased. With this, no provision has been made for handling the increased patient load and little to no support for services have been introduced to assist nurses with their workload (Geyer, 1999).

A clear example of how the role of a nurse has changed is provided in how the scope of practice for a nurse is defined in the South African Nursing Act of 2005. According to Nursing Act of 2005, the definition of the role of a nurse is:

> A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (p. 25).

Comprehensive services refers to a nurse providing more integrated services at the PHC level as outlined in various policies such as the ICDM, the NHI White Paper (2015) and the Re-Engineering Policy Discussion Document that were discussed in chapter2 of this study above.

Within the domain of the Re-engineered PHC, nurses are seen to have three key roles: (i) they are the leaders of the WBOT; (ii) they form part of the DCST and (iii) they head up the ISHP (Pillay & Barron, 2011). This is separate from their role as primary health care providers at the clinic level. How these roles will work, whether they are interchangeable, fixed or fluid has yet to be confirmed by either DENOSA, SANC or the NHI White Paper. One can only assume that a nurse who leads the WBOT would not be expected to work in the clinic itself, but be based in the community. However, based on the PHC narrative, the professional nurse who leads the WBOT is facility-based with the staff nurse (a cadre of health workers that do not presently exist) based in the community (see Figure 3.1). The ambiguity of the placement of the nurses who form part of these WBOTs, further adds to the stress and strain experienced by nurses in the system who are left to perform multiple roles with little guidance on what is expected of them within the new system.

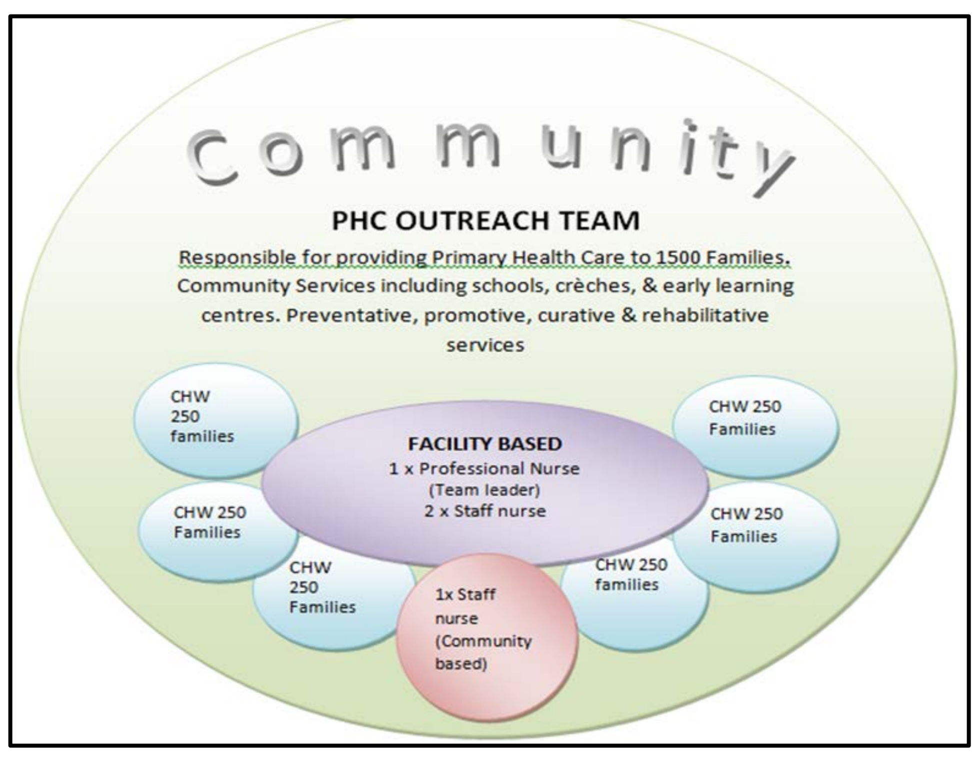

Figure 3.1. Public Health Care Outreach Team. Adapted from Rispel et al., 2010, p. 12.

Thus far, the creation of the WBOTs have not lead to professional nurses being taken out of the clinics to head up these teams, as the DoH has hired retired nurses to fill these posts. However, whether retired nurses will always lead these teams is yet to be confirmed.

The Human Resources for Health Strategy 2012⁄13-2016⁄17 defines the different cadres of health workers that need to be trained and recruited in order to implement the Re-engineered PHC system (Department of Health, 2012). In their report, the DoH is cognisant of the fact that currently South Africa does not have the required number of professional nurses, trained midwives or PHC trained nurses to fully implement all aspects of the Re-

engineered PHC system. The report recognises that a re-orientation of nurses towards the new scope of practice is thus required in conjunction with posts being redefined for the new PHC model (p. 67). However, the document does not elaborate further on the role of the professional nurse in the clinic setting, the WBOT setting or the ISHP setting. The report does however detail how the DCSTs will function and who will form part of this team.

According to the HRH document, the DCST will comprise of an Advanced Primary health Care Nurse, Advanced Midwife and Advanced Paediatric Nurse in addition to a Family Physician, Obstetrician and Gynaecologist, Paediatrician and Anaesthetist. Their primary role as discussed above, will be to strengthen the clinical governance of maternal, neonatal and child health services at hospitals, community and primary health care and at the home-based level in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital (Department of Health, 2015; Department of Health, 2012).

3.3.1. *Why Was It Necessary To Change?*

The PHC system of South Africa is nurse-driven, with nurses having to assume roles and functions that were previously undertaken by medical doctors. The role of a nurse has undergone immense transformation, from that of a supportive role to that of a main health care provider. Nurses have to contend with an ever-increasing population, as well as an

attendant increase in their daily workload as the scope of their practice is ever expanding to include even more duties (Mayers, 2010).

The changing disease profile in South Africa has also required nurses to adopt a broader role in all aspects of patient care. While nursing is seen as a dynamic field, constantly changing and seeking ways to better meet the needs to their patients, the current burden of disease facing South Africa has forced nurses in PHC settings to be the main and sometimes sole providers of health care services. Taking on additional tasks is nothing new to the nursing profession, as nurses for centuries have had to take on additional roles and responsibilities to meet the changing needs of their patients in settings where there were shortages of physicians (Willard, 2009). However, by placing a greater workload on a profession already characterised as overburdened with the influx of new and old patients can lead to the complete collapse of the health care system (Van Rensburg, 2014).

It is this transformation and increase in workload that has encouraged the WHO to advocate for the practice of "task shifting" in public health care facilities (WHO, 2008a). The first recommendation the WHO makes in its published guideline document is that countries should look at:

> Implementing and/or extending and strengthening a task shifting approach where access to HIV services, and to other health services, is constrained by health workforce shortages. Task shifting should be implemented alongside other efforts to increase the numbers of skilled health workers (WHO, 2008a, p. 3).

This recommendation is crucial in light of the challenges the South African Health System faces in terms of the burden of disease and attendant shortage of skilled health workers.

3.3.2. *Task Shifting vs. Task Sharing*

One of the challenges that face low and middle income countries (LMIC) in achieving better health outcomes is the shortage of health care workers. In an effort to help redress this shortage, the WHO (2008a) proposed that LMIC adopt a task shifting or sharing approach as a viable solution for improving health care coverage by using the current human resources more efficiently.

Task shifting has been defined as a process of delegation whereby tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications (WHO, 2008a). Task shifting is different from task sharing, as the latter involves the process of supervision and mentoring of non-specialist workers and emphasises the role of the supervisor as "sharing" the task of caring for the patient (Lund et al., 2014; Pillay & Barron, 2011; Rispel et al., 2010) Task sharing, as opposed to task shifting, is an ideal solution for addressing the many challenges that face state health care systems, including the high rate of NCDs that afflict the South African system as the latter has the potential risk of tasks being "dumped" on lower level health care workers.

3.4. The Effect of Organisational Change on Employees

According to Lavery and Patrick (2007), organisational change can contribute to stress- related outcomes for those impacted by the change. Within the proposed NHI scheme,

there is no cadre of health worker more impacted by the Re-Engineered PHC system than the professional nurse. It is thus important to be cognisant of the interrelationship between policy and the parties that are needed for policy to translate into practice and the psychological challenges that nurses face that could potentially hamper the successful roll out of the envisioned health care system.

Mash et al. (2008) provide some insight into organisational change within the health care setting. They suggest that organisational change within this setting typically focuses on issues of management and service provision. Furthermore, according to Capra (2003), the thought process behind change within the health care system is largely mechanistic in its perspective and as such the organisation is viewed as a machine. However, as Mash et al. (2008) contend, the machine is made up of people and therefore should be considered if change is to be effective and transformative.

Employee resistance to change is common in organisations that are undergoing substantial structural and organisational change. Learning how to effectively manage the change requires certain activities to be conducted at the organisational level. Cummings and Worley (2014), highlight the following activities: motivating for change, creating a vision, developing political support, managing the transition and sustaining momentum as being integral to effective change management (p. 180). Cummings and Worley (2014) further acknowledge that while the health care industry is dynamic and complex, significant opportunities exist for organisational development (OD). Accordingly, they suggest some OD practices that could potentially support the transformation of the health care industry (p. 686). Some of the practices they suggest include: developing strategic emotionally intelligent

leaders and teams, shifting organisational systems to a new paradigm, supporting aligned cultures, delivering comprehensive learning programmes and creating engaged employees (pp. 691-692).

The health care industry is not exempt from change and there are some important trends that drive such change. Some of these trends have been outlined in the NHI White Paper as the rationale for implementing a NHI, the biggest driving force being the structural problems that the current health care system is experiencing. Cummings and Worley (2014) share some of the trends driving change in the health care sector, such as “responding to health care reform, the need to improve quality and reduce costs, the rise of technology and the ageing workforce and changing demographics of patients” (pp. 687-689).

In South Africa, the NHI White Paper states that the structural problems experienced by the health system are due to the cost drivers in the public health sector and a costly private health sector. This is combatted by the poor quality of health services provided and the curative hospi-centric focus of the health system. The lack of human resources and unequal distribution of health professionals in rural and urban areas are further factors that add to the structural problems. According to the OD literature, change is an ongoing process that it is an inevitable feature of organisational life (Lukas et al. 2007; Lund et al. 2014; Mash et al. 2008). However, sustaining the change and having it become the norm requires effective management of the change and of the resistance employees might have towards such change.

3.4.1. *Positively Dealing with Resistance to Change*

Positively dealing with staff reluctance to change and getting employees motivated for change requires creating a workforce that is able to embrace change rather than resist it. That is where the concept of positive organisational behaviour (POB) comes into play. Luthans (2002b) defines POB as “the study and application of positively oriented human resource strengths and psychological capacities that can be measured, developed, and effectively managed for performance improvement in today's workplace” (p. 59).

Work makes up a substantial part of an individual’s life, where work has been cited as the biggest source of stress for many. It is no surprise therefore that workplace stress has become a growing concern for human resource (HR) managers (Cummings & Worley, 2014). Psychological resources are traits that not only enable an individual to embrace and adapt to change, but they also act as a buffer against developing burnout and stress-related disorders (Avey, Luthans, & Jensen, 2009; Tugade, Fredrickson & Barrett, 2004; Waddell, Cummings, & Worley, 2004).

Studies to date (e.g. see Aiken et al., 2002; Buitendach & Moola, 2011; van der Colff & Rothmann, 2014; Lavery & Patrick, 2007) have mainly focused on the Burnout and Psychological Capital of nurses in hospital settings as opposed to clinic settings. Researching positive emotions in the workplace, especially within the context of health care, is imperative if the present status quo which has had a negative effect on the health care system is to experience change. It is hoped that this will go long way to bridging this gap by focusing on nurses working in PHC clinics.

3.5. Positive Emotions in the Workplace

> "Positive psychology revisits the 'average person' with an interest in finding out what works, what is right, and what is improving" (Sheldon & King, 2001, p. 216).

The "broaden and build" theory of positive emotions suggests that positive emotions broaden an individual's awareness by encouraging exploratory thoughts and actions. In turn, awareness builds skills and resources (Compton, 2005). This theory is an exploration of the evolved function of positive emotions developed by Fredrickson circa 1998. It is a theory that describes the form and function of a subset of positive emotions. Fredrickson (1998, 2001) posits that positive emotions appear to broaden an individual's momentary thought-action repertoire and thereby build their enduring personal resources. According to Jackson, Firtko and Edenborough (2007), nurses face immense challenges in their workplace in relation to heavy workloads, safety concerns, and restructuring. Nevertheless, many nurses remain in the profession while others leave. They posit that this is due to the varying levels of resilience each person possesses. Against the background of high numbers of nurses leave the nursing profession and many remaining, resilience in the field of nursing has been well-researched (Cline, Reilly, & Moore, 2003). Tedeschi and Calhoun (2004, as cited in Jackson et al. 2007) go as far to state that of the nurses that remain behind, many thrive in the same surroundings that others found to be highly stressful. Study findings have shown that some nurses are

better able to cope with adversities in the workplace, due to some being more personally resilient than others.

The recently emerging positive organisational behaviour field recognises that much of the early history and research conducted on Job Satisfaction, Organisational Commitment, and Positive Affectivity are positively oriented (Luthans, Avolio, Avey, & Norman, 2007a). Indeed, the development of positive psychology in recent years has brought to light the importance of positive organisational behaviour and PsyCap (Shahnawaz & Hassan Jafri, 2009), and more recently how positive employees can have a positive impact on organisational change (Avey et al., 2009). Similarly, Fredrickson (2003) believes that positive emotions can transform organisations given that they broaden an individual's thought action repertoire, thereby creating more flexible, empathic and creative employees (p. 174). As a consequence, the relationship between positive emotions and the attitude of employees have been extensively researched, where studies reveal the differing drivers for positive organisational change. As example is that of Fredrickson's "broaden and build" theory which examined the role that positive emotions play in effecting positive organisational change (Avey, Wernsing, & Luthans, 2008; Cheung, Tang, & Tang, 2011; Fredrickson, 2003a; Fredrickson & Branigan, 2005). Research has also shown that positive emotions can lead to flourishing which is the experience of higher levels of functioning and wellbeing (Fredrickson, 2003b). This in turn results in better decision making (Fredrickson, 1998), thereby helping the employee cope with organisational change by broadening the options they perceive, maintaining an open approach to problem solving and supplying the energy for adjusting their behaviours to new work conditions (Chuang, 2007).

3.5.1. *Psychological Capital*

Luthans, Luthans & Luthans (2004) defines psychological capital (PsyCap) as a core psychological factor of positivity in general, and POB criteria meeting states in particular, that go beyond human and social capital to gain a competitive advantage through investment development of "who you are." According to Luthans & Jensen (2005), PsyCap is based on the positive psychological paradigm and includes psychological states based on positive organisational behaviour. Going beyond human capital and social capital, PsyCap involves investment and development for a return-yielding performance and improvement, resulting in competitive advantage. Luthans' research in the field of positive psychology led him to emphasise the positive motivational states of hope, confidence, optimism and resilience which made workers more productive. He found that these attributes can be embedded, developed, measured and trained to create sustainable, predictable, measureable increases over time which relates to profit at the end of the day for organisations (Robison, 2007). For Mortazavi, Yazdi, and Amini (2012), these four states of PsyCap improve performance, lead to higher productivity, better customer service and more employee retention.

Psychological capital (PsyCap) has been defined by Luthans, Norman, Avolio and Avey (2008) as an individual's psychological state of development and consists of having the four characteristics of, self-efficacyL, optimism, hope and resilience. According to Luthans, Youssef and Avolio (2007b), these four characteristics of PsyCap interact in such a way that hopeful people who possess the agency and pathways to achieve their goals are more motivated in life and are capable of overcoming their adversities which in turn makes them

more resilient. Likewise, confident people are able to transfer and apply their hope, optimism and resiliency to the specific tasks in their lives (p. 19).

3.5.1.1. *Hope*

According to Snyder (2000), hope is a multi-dimensional construct comprised of both an individual's determination to set forth and maintain effort toward achieving personal goals as well as the ability to find alternative ways to reach their goals. Snyder et al. (1991) define hope as a "positive emotional state based on interactively derived sense of successful (a) agency (goal directed energy) and (b) pathways (planning to meet goals)" (p. 287). Snyder et al. (1991) suggest that hope consists of three major conceptual foundations: agency, pathways and goals by hope being the aggregate if the agency and the pathways. Snyder (2000) postulates that it is the willpower and pathways thinking that generate hope.

Research conducted on the construct of hope has found a correlation between hope and performance. During an ongoing survey, Adams et al. (2002) found that organisations with respondents reporting higher levels of hope tended to be more successful than those with lower levels of hope. Similarly, Peterson and Luthans (2003) found fast food store managers' level of hope correlated with financial performance of their unit and employee retention and job performance.

3.5.1.2. *Optimism*

Optimism is similar to hope but different in its own way. For Seligman (1998, 2002,2004), an optimist is someone who makes internal, stable and global attributions

regarding positive events, while at the same time attribute external, unstable and specific reasons to negative events. Similarly, Carver and Scheier (2002) note that an optimist is a person who expects good things to happen to them, whereas pessimists are people who expect bad things to happen to them.

3.5.1.3. *Resilience*

Resilience is defined as an individual's ability, when faced with adversity, to rebound or bounce back from a setback or failure (Block & Kremen, 1996). It has been shown empirically, that positive emotions enhance resilience in the face of negative events (Tugade, Frederickson & Barret, 2004). This dynamic learning process of resilience which focuses on positive adaptation and developmental interventions serves to maximise assets or resources and minimise risk factors, thereby providing successful strategies for resilience-focused interventions (Masten & Reed, 2002).

3.5.1.4. *Self-efficacy*

Self-efficacy or the confidence to succeed, asks the question of the individual "do you believe in yourself? Self-efficacy provides the means for individual's to achieve their personal goals, their motivation being based on the belief that we will be successful. This construct refers to an individual's personal conviction about their own capacity to successfully execute a course of action that leads to a desired outcome (Bandura, 1997). The

probability that a person assigns to the likelihood of attaining their goal is referred to as the level of self-efficacy (Luthans et al. 2007).

Stajkovic and Luthans (1998) define self-efficacy as “one’s conviction (or confidence) about his or her abilities to mobilise the motivation, cognitive resources or courses of action needed to successfully execute a specific task within a given context” (p. 66). This construct of PsyCap is based on the work of Bandura’s social cognitive theory. For Bandura, sources of efficacy development include task mastery, vicarious learning or modelling, social persuasion and psychological/physiological arousal (Luthans et al., 2008).

3.5.2. *The Benefits of Psychological Capital*

Effectively managing stress is in the best interest of companies who hope to retain their workforce. As postulated in the beginning of this study, the impact of increased pressures at work can lead to stress and burnout (Avey et al., 2008). In a changing organisation such as the Department of Health, interventions need to be in place to help staff combat the negative effects of stress and burnout and thereby improve their own levels of psychological wellbeing. One such intervention that has been shown to have positive effects for the workforce is that of PsyCap. Numerous studies have been conducted that showcase the benefits of possessing high PsyCap. Indeed, research has shown the link between PsyCap and performance and extra role behaviours (e.g. see Wright, 2003; Luthans, 2002b). Similarly, Luthans et al. (2007a) presented findings in their research which provided psychometric support for a newly developed measure of PsyCap, as well as evidence which related PsyCap to job performance and satisfaction. Research has shown that the four

components of PsyCap have a positive relationship with performance, happiness, wellbeing and satisfaction of workers. Accordingly, the current study sought to investigate these relationships in a South African sample to see if previous findings hold true in the South African context (Legal & Meyer, 2009; Youssef & Luthans, 2007).

The "broaden and build" theory proposed by Fredrickson (1998, 2001), provides a framework for understanding how and why positive emotions help individuals cope better in the face of adversity. This framework synergises with the concept of PsyCap, which sees that individuals who possess certain traits or characteristics (hope, optimism, creativity and resilience), have increased performance rates and enjoy a higher satisfaction with life as opposed to others who score low on the PsyCap questionnaire. Similarly, positive emotions have been shown to contribute towards effectively managing organisational change (Baumeister, Gailliot, DeWall, & Oaten, 2006).

3.5.3. *Positive Emotions and Resilience among Nurses*

Positive emotions can undo lingering negative emotions because they put the negative emotions in a broader perspective. Accordingly, through the "broaden and build" theory, positive emotions can be used to help individual's cope with negative emotions (Fredrickson, 2001). The broadening effect of building positive emotions helps an individual to deal with whatever negative experience they are going through, whether that be a death, retrenchment or illness, and move forward and away from the negative emotions (Tugade & Fredrickson, 2004). As mentioned throughout this study, nursing is a highly stressful field, dogged by high staff turnover, absenteeism and burnout (Avey et al. 2009; Avey et al. 2008; Koen, van

Eeden, Wissing, & Koen, 2011b). According to Koen et al, (2011b), the stress of nursing and the experience of less than supportive work environments can leads to a sense of hopelessness and job dissatisfaction among nurses which results in them leaving the profession. Accordingly, they recommend developing interventions aimed at promoting positive emotions within nurses to assist them to deal with stress and burnout. In addition, these positive emotions help increase the probability of finding the good in future events. Within the changing health care system in South Africa, nurses face traumatic events on a daily basis and it is therefore imperative that they are able to "bounce back" from these setbacks and move forward.

Given the above, using this theory will provide valuable insights into how resilient nurses are and if there is a difference in the levels of resilience between nurses in the public and private sector. In this respect, Fredrickson (2003) carried out longitudinal studies to show that positive emotions play a role in the development of long term resources such as psychological resilience and flourishing.

3.5.4. *Positive Emotions and Happiness*

According to Cohn, Fredrickson, Brown, Mikels and Conway (2009), happiness is not only the result of success and high functionality, but it is often present before. Fredrickson (2003) is of the opinion that positive emotions build an individual's long lasting psychological, intellectual, physical and social resources, which in turn helps build up resources that increase an individual's overall wellbeing. This increased wellbeing leads to more positive emotions which in turn leads to higher resilience. This effectively creates an upward spiral,

whereby individuals can continually improve their own sense of wellbeing. Indeed, research has shown that people who are happy exhibit many positive, long-lasting traits such as better coping, a longer life and increased health (Fredrickson, 2003).

3.5.5. *Positive Emotions and Creativity*

Through conducting numerous studies, Fredrickson has found support for her theory. One of her randomised controlled lab studies saw participants randomly assigned to watch films that induce positive emotions and negative emotions. When the results were compared, participants who experienced positive emotions exhibited heightened levels of creativity, inventiveness and "big picture" perceptual focus (Klopper, Coetzee, Pretorius, & Bester, 2012; van der Colff & Rothmann, 2014). This is within the ambit of PsyCap which looks at developing the trait of creativity in individuals to help them create pathways that will overcome any obstacle they may face. This is why this theory is applicable to the work context as it helps people build enduring traits that can help them flourish at work and positively manage the changes taking place within the South African health care sector.

3.5.6. *The Importance of Psychological Capital*

When it comes to addressing some of the human issues organisations currently face, the concept of PsyCap is seen as an important subset (Shahnawaz & Hassan Jafri, 2009). Recent studies have shown an increase in recognising the positive value of managing human resources by developing the psychological resources of an individual (Mortazavi et al. 2012), These psychological resources have been linked by researchers such as Zhu, Han, Zeng and

Huang (2011), Friedman (2007) and Mortazavi et al. (2012) among others, to employee performance and positive organisational scholarship.

3.6. Job Satisfaction in the Context of Nursing

According to Asegid, Belachew and Yimam (2014), job satisfaction is related to the enjoyment, fulfilment and gratification that an employee derives from their work and is not only related to how much money or benefits an employee has as a result of their job. Human capital is considered to be the most vital asset for organisations today and especially for their organisational development (Khan, Nawaz, Aleem & Hamed, 2012). Getting the best out of human capital requires much skill by the organisation as well as its management. These skills are used to satisfy the needs of the workforce, where greater the levels of satisfaction among employees translate into higher returns for the organisation (Khan et al. 2012). Accordingly, job satisfaction remains one of the most extensively researched areas to date (Keung Fai, 1996).

South Africa has been facing a serious shortage of human resources within the public health care system for quite some time (Delobelle et al. 2011; Pillay, 2009). This shortage has been attributed to the migration of nurses to more developed countries, which offer incentives such as better living conditions, improved work conditions, better remuneration and improved career path options (Buchan, Sochalski, Parkin, & WHO, 2003; Dovlo, 2007). Migration does not only take place across borders, but also within the region itself, with nurses moving from public to private and from rural to urban areas in the hope of attaining better working conditions, better pay and a chance of an upward mobility career path.

The shortage of nurses in South Africa not only impacts access to health care but also the success of health reforms such as the Re-Engineering of PHC which is largely nurse-driven. Public Health Care nurses work in teams in areas that do not enjoy ready access to doctors or specialists. Their roles within the community are to provide health care services at a primary level and sometimes extends beyond diagnosis to curative measures. While there are many reasons nurses choose to leave their jobs, low job satisfaction is by far the most frequently cited reason given. In order for the Re-Engineering of PHC to work and the groundwork to be lain for the rollout of a NHI scheme which is dependent on nurses, it is imperative that studies be conducted, policies developed and implemented, so as to increase job satisfaction among nurses working within the public sector.

3.6.1. *Defining Job Satisfaction*

According to Spector (1997) and Locke (1976), job satisfaction has primarily been defined by two approaches: a global approach and a faceted approach. For the purpose of identifying specific areas for improvement, the latter approach seems to be favoured as it emphasised employees' attitudes towards individual aspects of their work (Coomber & Barriball, 2007).

International research conducted in the field of nursing with relation to job satisfaction among nurses has come to the conclusion that there is a growing dissatisfaction experienced by nurses around the world, including South Africa (Aiken et al. 2002; Hart, 2000; Pillay, 2009). The factors that they found to be the most important contributors to unhappiness included non-supportive environments and increased workloads (Sims, 2003;

Healy & McKay, 2000). However, one of the key contributors linked to job satisfaction in nursing was that of professional development and recognition (Nolan, Nolan & Grant, 1995; Lyon, 2003). These research results provide credibility that research in PsyCap and its development can lead to greater job satisfaction.

3.6.2. *The High Turnover in Nursing*

The literature reveals that job dissatisfaction has been the primary reason for the high turnover rate of nurses across the world (Delobelle, et al. 2011; Lambert, Hogan & Barton, 2001; Tzeng, 2002). In addition, it is the number one contributing factor to increased rates of absenteeism among nurses (Siu, 2002). This results in efficiency and effectiveness being impeded which in turn lowers the health care organisation’s capacity to provide good care and meet the needs of its patients (Shields & Ward, 2001; Tai, Barne & Robinson, 1998).

Research conducted by Pillay (2002), Borda and Norman (1997) and Cavanagh and Coffin (1992), found a decrease in morale among nurses. Low morale leads to increased turnover rates which not only affects the productivity level of an organisation, but also those nurses who remain behind. Similarly, Delobelle et al. (2011) found that nurses were dissatisfied with their pay and work conditions and that half of the nurses in the study had considered leaving the organisation in the past two years.

3.6.3. *The Relationship between Job Satisfaction and Organisational Outcomes*

Nursing research has shown that satisfaction in work life correlates positively with patient satisfaction and outcomes (Tseng, 2002; Leiter, Harvie & Frizzell, 1998). Demerouti,

Bekker, Nachreiner and Schaufeli (2000) found in their research that nurses who experienced dissatisfaction at work, seemed to distance themselves from their patients which ultimately resulted in poor quality of care. Buitendach and Moola (2011) conducted a study examining coping, occupational wellbeing and job satisfaction of nurses and found that job satisfaction was a good predictor of emotional exhaustion and cynicism which are components of burnout. Their research supports the fact that job satisfaction is regarded as one of the outcomes of burnout. Similarly, Baxter (2002) found that satisfaction at work for nurses had a strong influence on the quality of care they provided to their patients. Consequently, if the DoH hopes to achieve its motto of "a healthy life for all," they cannot ignore the dissatisfaction that currently exists within the PHC setting.

The dissatisfaction of employees has adverse effects of the efficiency of any organisation. Studying job satisfaction therefore remains one of the most important topics of enquiry in any organisation. The importance of job satisfaction can be realised by taking the recent strikes into consideration in South Africa (e.g. truck drivers, nurses, and teachers). The present research study therefore aims at exploring the current level of job satisfaction among nurses in South Africa with the hope of finding ways to help increase/improve job satisfaction overall.

3.7. How to Promote the Spirit of Collaboration in a Fractured Health Care System?

The question that the literature raises is how to foster collaboration within a system that is at breaking point? While the Re-Engineering of PHC calls for a more collaborative approach to care, it nevertheless fails to adequately look at how the system will empower and

equip nurses to foster this new approach to care. Providing collaborative and comprehensive care requires a shift from curative to a more holistic approach. This calls for a team approach in caring for the whole patient, as opposed to purely the physical and thus includes providing mental health care (Valentjin, Schepman, Opheij & Bruijnzeels, 2013).

Introducing NHI as a concept does not hold very much weight in the court of public opinion. Many claim that in order to achieve the dream of universal health care coverage, one needs a much stronger economy than South Africa currently enjoys (Setswe, Marindo, & Witthuhn, 2014).

What has been done thus far in terms of collaborative and inclusive care is evident by the many policies that the DoH has introduced since the end of apartheid. While the focus has shifted towards comprehensive health care at the community level, in terms of capacitating the workforce to be able to provide this type of care, a comprehensive training plan is required that acknowledges the emotional burden of the work that nurses already do.

3.8. The Emotional Burden of Care in Public Health Care Nursing

Nursing is seen as one of the most stressful and emotionally draining professions and is thus characterised by high staff turnover, burnout and absenteeism (Fredrickson, 1998, 2003). This is a testament to the emotional burden of care that accompanies "people work." Nursing viewed as "people work," means work that involves constant contact with others (Gray, 2009a). Additionally, nurses deal with human suffering on a daily basis and their job requires them to provide "genuine" levels of care to alleviate patients' distress rather than

simple task-oriented responses which can be stressful and emotionally draining (Msiska, Smith, Fawcett & Nyasulu, 2014).

Compassion is a core element in caring and providing care for others and the profession of nursing has to do with genuinely caring for the wellbeing of others (Msiska et al., 2014). Providing care on a daily basis and being compassionate and caring is a skill which both professional nurses and health care workers should possess.

Theodosius (2008) poses the question, “Do nurses still care?” In today’s inflexible, fast-paced and more accountable workplace where biomedical and clinical models dominate health care practice, is there room for emotional labour? (p. 2). The DoH is asking nurses to take on more responsibility and act as the ‘case manager’ for their patients. In practice, this means providing a more holistic and integrated approach to treating chronic conditions.

3.8.1. *Defining Emotional Labour*

The term “emotional labour” was first used by the sociologist Hochschild in 1983 and is defined as “management of feeling to create a publicly observable facial and bodily display” (Theodosius, 2008, p. 9). According to Theodosius, emotional labour involves the suppression of feelings in order to appear caring and make the patient feel like they are in a safe space. By integrating mental health into chronic care, cognisance needs to be taken of the additional emotional burden being placed on nurses. Nurses are inherently required to be compassionate when providing care, however this can be emotionally demanding on nurses (Kinman & Leggetter, 2016). Nurses dealing with the emotions of patients as well as their

own, are key features of a patient-centred care and thus nurses need to be adequately equipped with the tools to deal with such.

The motto of the health care system is “people first.” Accordingly, patients are seen to have more rights than nurses. From their visits to PHC facilities, Asmall and Mahomed (2013) note that nurses feel obligated to display certain emotions towards their patients even when they themselves are feeling overwhelmed; including, being afraid of patients complaining, which could result in charges being brought to the SANC or the DoH.

3.8.2. *The Relationship between Emotional Labour and Burnout*

Research studies have found a positive relationship between emotional labour and emotional exhaustion which is one of the three components of burnout (Kinman & Leggetter, 2016; Shankar & Kumar, 2014; Buitendach & Moola, 2011). Paley (2013) therefore challenges researchers to think of new ways in which compassion can be fostered among nurses. While emotions in health care tend to remain unspoken, new ways of dealing with emotions need to be developed. In particular, the emotions that make it hard for nurses to provide patient centred care, need to be effectively addressed if the success of the re-engineered PHC system and the NHI is to be achieved. If however the role of positive emotions in health care is not addressed and the status quo is simply maintained, then the high level of dissatisfaction among South Africa’s nursing workforce will continue unabated. Accordingly, the latter section of this chapter will present issues impacting on positive psychological resources, including burnout (emotional labour, stress, and work strain), the theoretical concept of job strain, and the lack of coping skills in South Africa’s nursing staff.

3.9. The Prevalence of Burnout and Job Strain in Primary Health Care Nursing

Burnout consists of a psychological syndrome of emotional exhaustion, and depersonalisation. It reduces personal accomplishment particularly in occupations where individuals work with other people. Burnout was originally referred to as a common work-related phenomena resulting from severe stress and was particularly evident in professionals such as teachers, nurses and social workers. According to van der Colff and Rothman (2014), the profession of nursing is "stressful and emotionally demanding" and it is these types of work demands that make nurses prone to burnout (p. 630).

3.9.1. *Defining Burnout*

Burnout has been defined as a "prolonged response to chronic emotional and interpersonal stressors on the job and is defined by three dimensions of exhaustion, depersonalisation and personal accomplishment" (Maslach, Schaufeli, & Leiter, 2001, p. 397). Traditionally, the three components of burnout have been characterised as:

i. Emotional exhaustion, such as lack of energy. Emotional exhaustion represents the basic individual stress dimension of burnout and refers to an individual feeling overextended, depleted and unable to give of themselves at a psychological level.
ii. De-personalisation, such as having negative attitudes towards patients, other colleagues, or the organisation as a whole. Depersonalisation represents the

interpersonal context dimension of burnout and refers to when an individual develops negative attitudes and feelings towards their work.

iii. Reduced personal accomplishment, such as the tendency of the employee to negatively evaluate themselves or reveal their lack of satisfaction with their own job performance. Personal accomplishment or the lack thereof, represents the self-evaluation dimension of burnout and refers to an individual feeling incompetent and non-productive at work (Noushad, 2008; Maslach & Jackson, 1981; Asmall & Mahomed, 2013).

According to the definition given by Maslach (1982), burnout is not limited to professions such as human services of health care, but is something that can occur in any profession. This is evident in a study conducted by Noushad (2008) on burnout among educators and students whereby he found that burnout was not only limited to those who do “people work” like educators and nurses but is also found in students.

Nurses working in complex environments, often face multiple stressors, which over time have the potential to lead to burnout. According to Gil-Monte (2009), burnout has become a public health problem that not only detrimental to the individual, but also to the organisation. Burnout has been shown to negatively impact organisations in terms of productivity and the quality of services provided (Schaufeli & Buunk, 2003).

Analysis of burnout in the human service profession has found that it is mainly related to the psychological and emotional demands of the relationship between caregivers and patients (Querios, Carlotto, Kaiseler, Dias & Pereira, 2013; Maslach & Jackson, 1984).

Although burnout has been extensively studied over the past 35 years, it still remains a huge problem in the workplace.

Due to economic trends (Querios et al., 2013), organisations are undergoing constant change, especially in the health sector. These changes require that employees either work additional hours or have multiple roles within an organisation, thereby adding to their workload and making them more prone to burnout (Querios et al., 2013). South Africa is no different, as the Re-Engineering of PHC and the introduction of the NHI pilot study has provided the health care sector with a large amount of change within a short period of time. It is thus imperative that understanding is acquired into the factors that lead to burnout, so as to design effective and efficient practical interventions that can help nurses to cope with the changing environment and thereby minimise the factors that lead to stress and burnout.

There are several factors that lead to the experience of burnout among health care professionals. Most notable are the concepts of stress, strain and emotional labour. These constructs will be discussed below.

3.9.2. *Stress and Strain in Nursing*

Studies conducted on job strain of professional nurses in South Africa, are invariably related to stress and burnout. Although stress, burnout and job strain are related, there is a slight difference between the constructs. Most notably, job strain is both a concept and a model, originally developed by Robert Karasek (Schnall, Landsbergis, & Baker; 1994). Job strain and stress have long been associated with each other with stress contributing to strain (Knapp, 1988).

The most common characteristics studied in relation to the health of an employee are job demands, job latitude and social support which are the key components of Karasek's job strain model. Karasek (1979) argues that work stress is not as a result "from a single aspect of the work environment, but from the joint effects of the demands of a work situation and the range of decision-making freedom available to the worker facing those demands" (p. 287).

The South African health care system has transformed in such a way that many services that were previously provided at a tertiary level, are now being provided at PHC facilities which are often poorly resourced, both in terms of human and material resources (van der Walt et al. n.d). Many of the services that were previously provided by doctors are now the responsibility of professional nurses (Mayers, 2010). These additional responsibilities have led to a change in the working environment and the characteristics that define their scope of practice.

3.9.3. *The Job Demand Control Model and Job Strain*

According to the job demand control (JDC) model, job strain is a result of the interaction between two main job dimensions, namely, work demands and decision latitude (control). Decision latitude consists of two elements, decision authority (this is when an employee is perceived to have influence over decisions affecting their work) and skill discretion. Therefore, job strain occurs when job demands are high and job decision latitude is low (Karasek, 1979, p. 287). To further understand job strain, not only a clear definition of stress must be developed, but also unpack what is meant by decision latitude. According to Schnall et al. (1994) decision latitude is an operationalisation of the concept of control and is

defined as a combination of job decision making authority and the opportunity to use and develop skills on the job. Historically, nurses did not possess the autonomy to make decisions regarding patients care and wellbeing. This has changed dramatically as the health care system now relies more on professional nurses to carry out tasks that were previously predominantly thought to be the role of the doctor.

In developing his job strain model, Karasek (1979), postulated the combination of high demands and low job decision making authority as being related to health problems (Bourbonnais & Mondor, 2001). Bourbonnais and Mondor (2001) further found job strain as having a relationship with psychological distress and burnout (Bourbonnais, Comeau, Vezina, & Dion; 1998), as well as with medication use (Bourbonnais, Brisson, Vezina & Moison, 1996).

In a country permeated with seemingly endless changes in its health care system, nurses bear the brunt of having to constantly deal with new policies and increased work load. The extent to how these changes affect the level of control and decision-making power nurses feel they have, is imperative in determining ways to help combat negative outcomes associated with high levels of job strain. Karasek and Theorell (1990) further suggest that health problems are associated with job strain resulting from the combination of high psychological demands and low decision latitude at work.

According to Bourbonnais, Comeau and Vezina (1999), certain environmental characteristics can contribute to the development of mental health problems. These include: job demands, job latitude and social support. These have been found either to contribute or

mediate the development of psychological disorders among nurses (Bourbonnais, Vinet, Meyer & Goldberg, 1992; Petterson, Arnetz & Arnetz, 1995; Fong, 1993). Within the context of the re-engineered PHC system, mental health services feature more prominently in the scope of work performed by professional nurses on a daily basis. Integrating mental health into chronic care is a challenge on its own and adds to the responsibilities of a workforce that is already on the brink of burnout. Accordingly, it remains a potential recipe for disaster.

Given the above, it further serves to strengthen the need for research to be conducted on the positive psychological resources professional nurses possess, which would enable them to better integrate mental health into chronic care, as well as provide more comprehensive primary health care services to the community.

3.9.4. *The Experience of Job Strain in Nursing*

Job strain occurs when an individual experiences a combination of high psychological demands and low decision making freedom over the tasks they perform and how they use their skills to perform these tasks (Karasek, 1979). Karasek (1979) goes on to define job demands as psychological stressors experienced in workers trying to accomplish the tasks given to them. Furthermore, psychological stressors are related to workers being asked to unexpectedly perform a task, perform work under time pressure, being interrupted while performing a task, or other “stressors of job-related personal conflict” (p. 291).”

Professional nurses in South Africa have the responsibility of diagnosing, treating and referring patients. They are the “gatekeepers” of the public health sector and expectations are high from both patients and the DoH (Mayers, 2010). Based on this definition, nurses are

faced with high demands given the expansion of their scope of practice. However, with this increase in job demands, it needs to be determined whether their level of autonomy in making decisions regarding their work has also increased. The increased demands from patients and employer combined with a lack of control in an individual's work contributes to high levels of stress being experienced. Increases in stress levels lead ultimately to job strain and burnout (Aiken et al. 2002; Daviaud & Chopra, 2008; Ross, Polsky & Sochalski, 2005).

Given the demands currently placed on professional nurses in a Re-engineered PHC, the profession is beset with stressed-out nurses who experience high levels of strain. As noted by Moorhead and Griffin (2008), stress is complex in nature and cannot purely be defined. In order for it to be understood, the process through which it develops must be examined. A definition that encompasses all that is known about stress, states that stress is caused by stimuli which can either be psychological or physical in nature. Accordingly, Moorhead and Griffin define stress as "a person's adaptive response to a stimulus that places excessive psychological or physical demands on him or her" (p. 180).

In the nursing profession, job strain has been cited as one of the contributing factors for nurses leaving the profession. The literature suggests that even when nurses enjoy the work that they do and the good relationships with their colleagues, the stress associated with the job and dissatisfaction with supervision contributes to them choosing to leave the profession (Delobelle et al., 2011).

The environment of nurses working within the public health care sector has been proven numerous times to be trying and stressful to staff. Not only do staff have to deal with

large numbers of patients on a daily basis, but the environments in which they work in are also severely understaffed and under-resourced. This leads to nurses experiencing more strain as a result of staff shortage and higher patient expectations.

In addition to the stress that nurses' experience in their working environments, two components have been identified that contribute to job strain: effort reward imbalance and high demand low control (De Jonge, Bosma, Peter & Siegrist, 2000). In the health care profession, nurses deal with many difficult life situations. Nevertheless, according to Bakker, Killmer, Siegrist and Schaufeli (2000), such work can still be quite rewarding. However, there are instances where the relationship between the caregiver and the patient is experienced as stressful, especially when in the case of nurses they are repeatedly confronted with difficult patients and situations and rewarded with little to no appreciation from the difficult and demanding patient (Bakker et al. 2000). They further posit that "disequilibrium" may develop which results in the nurses putting in more effort into the relations than they receive back from their patients. It is this disequilibrium that may "augment the risk of physical and mental health" and to be more specific nurses may therefore experience burnout and states of exhaustion (Bakker et al., 2000, p. 885). In the South African context, it seems that virtually on a daily basis, the public are more prone to complain about the poor quality of care that they receive at public institutions as opposed to praising the nurses who helped them (Pillay, 2009).

Another area of concern is the perception that an individual has little control of their work while constantly dealing with its high demands. It is thus posited, that this contributes to increasing an individual's risk of burnout and depression (Nauert, 2006). In the public

sector, there is very little chance for an individual to have autonomy in their working environment. Various studies have reported that nurses feel “left out” and not consulted enough” when asked about how empowered they feel in their environment. Accordingly, this study suggests that various types of job strain may contribute to burnout, the focal point being to assess the role job strain plays with regards to nurses’ levels of experienced wellbeing, burnout and job satisfaction.

3.9.5. *The Job Strain Model*

According to Karasek (1979) the combination of low decision latitude and high job demands leads to not only mental strain on the part of the individual, but also to job dissatisfaction. In the past, psychosocial effects of the work environment were approached from two differing traditions: job decision latitude and stressors on the job (Karasek, 1979). For Karesek (1979), these two mutually exclusive traditions ultimately led to a misinterpretation of what contributes to job strain. In Karasek’s (1979) view, earlier models of work and health were limiting in that they only considered the dimension of job demands. To counter this misinterpretation, he proposed that a more comprehensive model be developed that considered the working conditions employees face, rather than merely the nature of the job itself (Karasek, 1979). Karasek (1979) suggests that in order to best understand job strain, two important elements of the work environment should be taken into consideration: (1) the work demands placed on the worker and (2) the discretion permitted the worker in deciding how to meet these demands (p. 285). From this, the job strain model was developed.

The model developed by Karasek postulates that strain, be it mental or physical, is a result of the combined effects of the demands of the work environment and the range of decision-making freedoms the worker has in facing those demands and not from one single aspect of the work environment (1979). His dissatisfaction with earlier work and health models that purely focused on job demands, led him to develop his own model that included a psychosocial dimension, which included the level of perceived control an employee has over their work situation (Karasek & Theorell, 1990).

Among the influences that led Karasek to develop his job strain model included that of Seligman's theory of learned helplessness, theories of active and passive coping, and Sundbom's studies of psychological strain in challenging occupations. Together, they contributed to Karasek's idea of control and the importance of being able to make decisions at work (Theorell & Karasek, 1996). Karasek's proposition was that job strain was a result of the combination of high psychological demands such as having to work hard and fast with little freedom to make decision which affect a person's work such as the schedule they follow (Theorell & Karasek, 1996). This combination of high demands and low control increases the risk of disease. In contrast, when high demands are combined with high level of decision latitude, the stress can be positive and thus Karasek "proposed that the dimensions of demand and control might reflect different mechanisms of physiological activation" (Theorell & Karasek, 1996, p. 14).

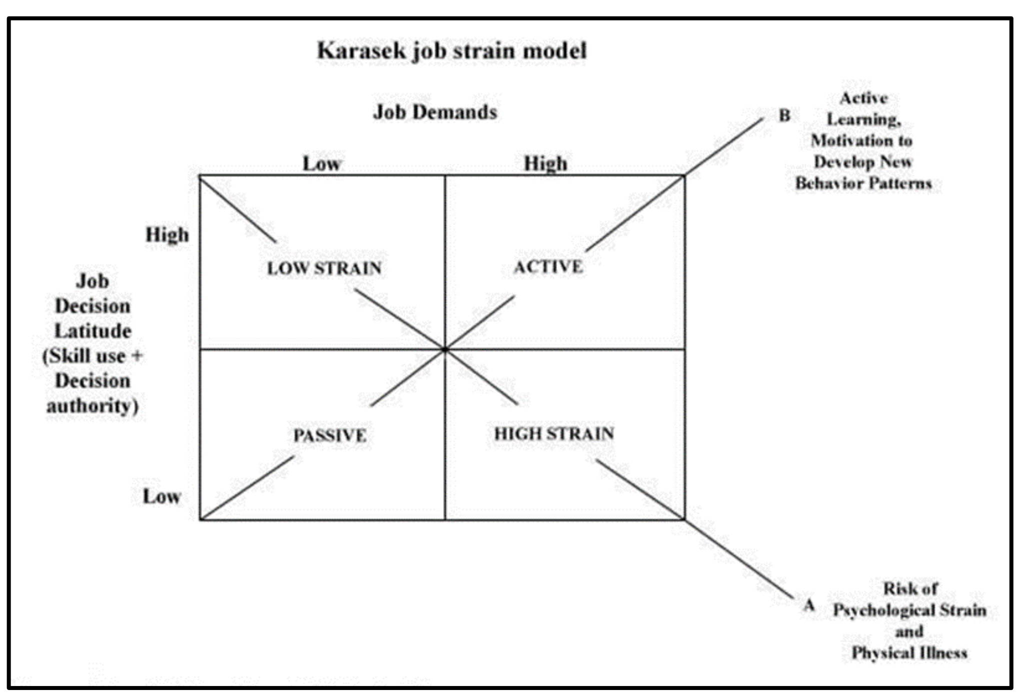

Figure 3.2. Karasek Job Strain Model. Adapted from Schnall, Landsbergis and Baker, (1994, p. 382).

Figure 3.2 is a physical representation of the job strain model as developed by Robert Karasek. According to the model "the combination of high demands and low decision latitude will lead to negative physical health outcomes such as hypertension and cardiovascular disease" (Schnall, Landsbergis & Baker, 1994). The model makes two predictions, Diagonal line A represents when job demands are high and decision latitude is low, the person will experience strain (Schnall et al., 1994)). Diagonal line B represents when job demands are high and job decision latitude is also high, the job is defined as "active" and it is hypothesised that it leads to development of new behaviour patterns. Karasek further states that working in either the active job category or the high strain job has the potential to modify an individual's psychological wellbeing as well as their coping styles (Karasek & Theorell, 1990).

In order for the change processes of both the proposed NHI scheme and the Re-Engineering of PHC not to add to the strain of nurses, research is needed to assess the current levels of strain that nurses face in terms of the level of job demands, decision latitude and skills discretion. Such research will lead to practical recommendations being made towards altering the process so that it can have a positive rather than negative effect on the overall wellbeing of nurses. A stimulating environment can create a positive feedback loop which in turn helps a person to learn and to cope in times of overload, in contrast to a high strain job, which can create a negative feed-back loop that not only arouses feelings of inadequacy and lack of control, but also further inhibits learning and impairs confidence and self-esteem (Karasek & Theorell, 1990).

Nursing is a highly demanding profession in South Africa, where PHC nurses simply perform tasks as outlined in the guidelines and protocols received from the DoH. On the surface, it is logical to assume that nurses have more job control/decision latitude over their work as they lead PHC facilities. However, as Karasek (1979) has shown, job control is understood in terms of when individuals have control over the tasks they are asked to perform and their behaviour during the workday. It also includes the ability of the individual to participate in and possess the authority to make decisions regarding how these skills are used, as well as the resources and time to complete their work (Petersen et al., 2015).

Irrespective of the fact that nurses may lead PHC facilities in South Africa, the decisions that they make on a daily basis and how they do their work are mandated/guided by National Guidelines, Protocols and Treatment Guidelines. Additionally, nursing is a compassionate profession and nurses are tasked with displaying the appropriate emotions

while consulting with a patient, even though they may not feel that way. Therefore, the current levels of decision latitude that nurses are experiencing as a result of them leading PHC facilities, are not at the desired depths as envisioned by Karasek in terms of his job strain module. The nursing profession is one where job demands are high and decision latitude is fairly low given that nurses are hesitant to make any decision regarding patient treatment plans without first consulting their guidelines or a doctor. This often results in mental strain which ultimately leads to depression and burnout (Karasek, 1979). In an environment beset with tension and stress, it is now more important than ever before to identify and develop positive emotions in the workplace.

3.10. How Does National Health Insurance Address Psychological Issues?

While calling for an increase in human resources for health, the NHI White paper fails to mention psychological issues such as burnout and absenteeism that have negatively affected the health care profession in South Africa. Successful change interventions depends on the capabilities of the employees to adapt and embrace the change. In such a process, positive emotions have been shown to have a positive effect on organisational change (van Deventer, 2015). Meanwhile, the nursing profession is experiencing mass resignation, high patient loads and a lack of resources. Apart from the economically challenges and the human resources shortage that South Africa is facing, the wellbeing of nurses is at an all-time low.

The governing bodies, while cognisant of the role burnout and emotional labour has played on the dissatisfaction and low levels of wellbeing experienced by nurses, have fallen short of implementing strategies to combat this scourge. It would therefore be advantageous

to the success of the NHI scheme to develop strategies to combat burnout among nurses working in PHC. In particular, in light of the “broaden and build” theory, these changes could be viewed as an opportunity to provide nurses with greater responsibility and therefore decision latitude, which in will have a positive impact on the level of job strain and burnout experienced. In addition, this could end up optimising the ability of nurses to embrace and effectively implement the changes in the new system.

Simply having a human resource strategy and contracting private providers will not fix the underlying emotional issues that are characteristic of the nursing profession. Burnout and emotional labour are two issues that afflict “people work” professions. It requires interventions aimed at building a resilient workforce.

3.11. Chapter Summary

The issues that were discussed in this chapter, have a direct link to successful change management. Nursing is a stressful profession that requires genuine caring and empathy on the part of the nurse. The work that nurses do impacts on their psychological wellbeing and physical health. The role that job control and specifically decision latitude plays on positive emotions cannot be overemphasised and therefore this study seeks to examine how it is incorporated within the new system (NHI). Furthermore, building on positive emotions and traits, and thereby addressing an important gap, will provide the means to help buffer employees against the negative effects of “people work” and as a means for achieving positive organisational change. It is thus important to consider the effect positive emotions such as hope and self-efficacy have on nurses, as well negative emotions such as burnout and

emotional labour. Failure to do so, could seriously hamper the efforts of DoH to retain the current nurses working in PHC.

The next chapter will focus on how these constructs were methodologically articulated.

CHAPTER FOUR

METHODOLOGY

4.1. Introduction

The overall aim of the present study is to understand and assess the wellbeing of nurses in the context of the Re-engineered PHC and the proposed NHI scheme. In order to achieve this overall aim, a sequential cross-sectional mixed methods research design divided into two phases was employed. The objectives of phase one was to investigate the relationship between Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing among nurses in both a NHI pilot site (Dr Kenneth Kaunda District = KK) and a non-NHI pilot site (Bojanala Platinum District = BP) and to explore whether there were any differences in the levels of positive psychological resources and stressors for nurses in the NHI pilot site and the non-NHI pilot site.

The second phase, which was qualitative in nature was conducted in the NHI pilot site (KK). This phase aimed to develop an understanding of the experiences and perceptions of nurses with regards to their Wellbeing, Job Satisfaction, Job strain, Burnout, the Re-engineered PHC system and the pilot rollout of NHI through the use of a semi-structured interview schedule. Each phase had corresponding research questions to help achieve the objectives of this study.

4.1.1. *Phase 1: Quantitative Study*

i. What is the relationship between Psychological Capital, Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in the NHI pilot and non-NHI pilot site?

ii. Is there a difference in the Psychological Capital, Job Satisfaction, Wellbeing, Job Strain and Burnout of nurses in the NHI pilot and non-NHI pilot site?

4.1.2. *Phase 2: Qualitative Study*

i. What are the perceptions of nurses in relation to the Re-engineered PHC system and the NHI?

ii. What are the understanding of nurses in relation to Wellbeing, Job Satisfaction and Burnout?

iii. What are the roles and responsibilities of nurses in the Re-engineered PHC system and the NHI?

This chapter provides the rationale for the research design employed in answering the research questions of the study. It also includes a description of the study site, the research design, a description of both phases of data collection, the sampling strategies and the appropriate analytical procedures employed. In order to ensure a distinct understanding of the research process employed, the two phases will be represented in two discrete sections with the relevant subsections. The chapter concludes with a discussion on the ethical considerations of the study.

4.2. Study Site

This study took place in the North West Province of South Africa. According to the Annual Performance Plan 2015/2016, the North West Province has four district municipalities; Bojanala Platinum, Dr. Ruth Segomotsi Mompati, Ngaka Modiri Molema and Dr. Kenneth Kaunda Districts. It is South Africa's fourth-smallest province with an estimated population size of 3.6 million in 2014.

Figure 4.1. Map of North West Province. Adapted from "North West Municipalities", 2017.

This study was conducted within the jurisdictions of the Dr. Kenneth Kaunda District Municipal area and Bojanala Platinum District Municipal area. The NHI intervention site comprised of 20 clinics in Dr Kenneth Kaunda District (KK) and the non-NHI control site

consisted of 20 clinics from the Bojanala Platinum District (BP) that were selected through a randomisation process.

4.2.1. *Dr Kenneth Kaunda District Municipal Area*

According to the Annual Performance Plan 2015/2016, the Dr Kenneth Kaunda District (KK) has a total population of 695 933 (Statistics SA, 2011), and covers a geographical area of 14,767 square kilometres. It has two peri-urban sub-districts, Matlosana and Tlokwe, and two rural sub-districts; Maquassi Hills and Ventersdorp. The majority of the population reside in Matlosana.

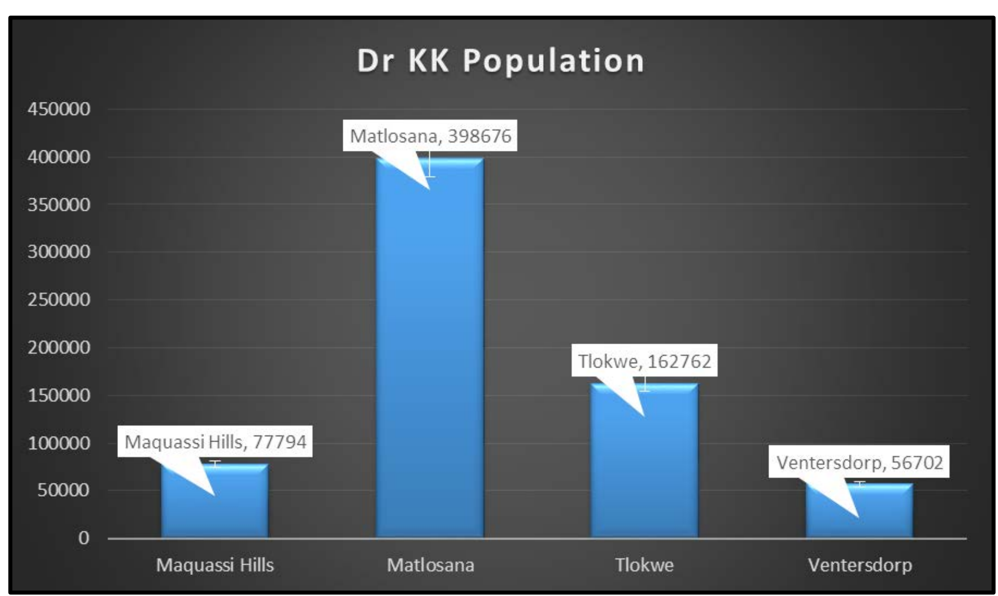

Figure 4.2. Population Distribution in Dr Kenneth Kaunda District and Sub-districts.

According to the "North West Municipalities" (2017), the main economic sectors are mining, trade and finance. The age demographics for the district are presented in Table 4.2.

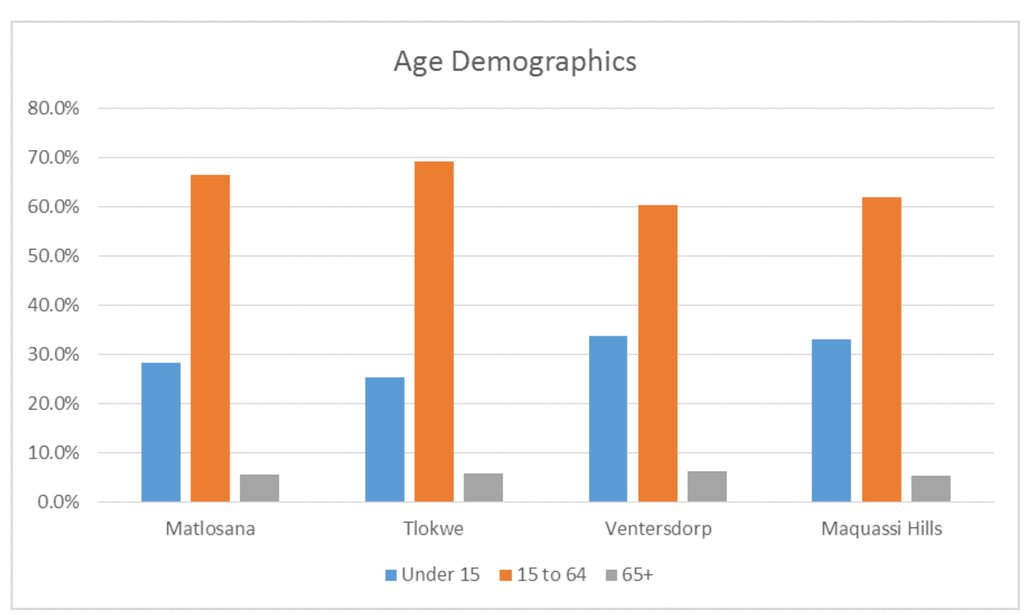

Figure 4.3. Age Demographics in Dr Kenneth Kaunda District and Sub-districts. Adapted from North West Kenneth Kaunda District Profile, 2013.

The majority of residents were aged between 15 to 64 years of age.

Sub-District	District Clinic	Community Health Centre	District Hospital	Mobile Service	Regional Hospital	Satellite Clinic	Specialised Psychiatric Hospital	Total
Maquassi Hills	6	2		4				
Matlosana	13	4		5	1			
Tlokwe	6	2	1	2			1	
Ventersdorp	2	1	1	3		6		
Total	27	9	2	15	1	6	1	62

Figure 4.4. Health Facilities in Dr Kenneth Kaunda District and Sub-districts. Adapted from North West Kenneth Kaunda District Profile, 2013.

From Figure 4.4 it is evident that health services were provided by 1 Regional and 3 District Hospitals; 9 Community Health Centres; 27 clinics; 6 satellite clinics and 2 mobile health service units. The two district hospitals as noted above are both situated in the rural area of the North West Province. In the urban areas, level 1 service was provided by the Regional Hospital (North West Kenneth Kaunda District Profile, 2013).

4.2.2. *Bojanala Platinum District Municipal Area*

Bojanala Health District is situated in the Eastern part of the North West Province and includes five sub-districts (Rustenburg, Kgetleng, Madibeng, Moses Kotane and Moretele). It has a total population of approximately 1.5 million (Bojanala Platinum Municipality, 2013/2014).

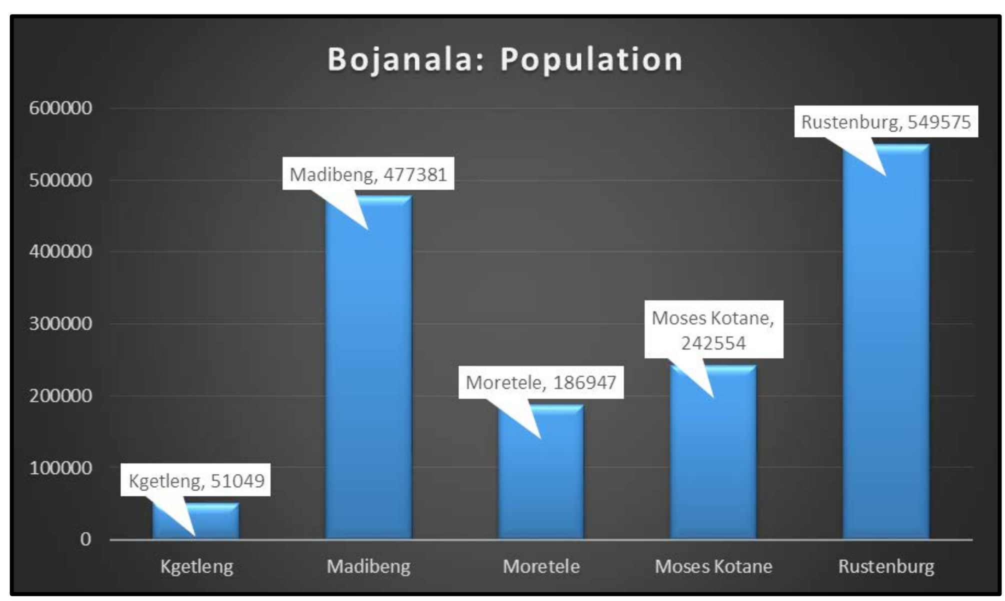

Figure 4.5. Population Distribution in Bojanala Platinum District. Adapted from Bojanala Platinum Municipality 2013/2014.

There are 119 fixed health facilities in the Bojanala district that consist of 1 Provincial Hospital and 4 District Hospitals, 8 Community Health Centres, 19 Clinics that are open 24 hours,, 15 Clinics that are open 12 hours and 77 clinics that are open 8 hours, 674 Mobile points and 16 Health points (Bojanala Platinum Municipality, 2013/2014).

Institution	Provincial Hospital	District Hospital	Health Centres	24 hour Clinics	12 hour Clinics	8 hour Clinics	Total
Kgetlengrivier		2		4		2	
Madibeng		1	2	17	2	5	
Moretele				17	1	2	
Moses Kotane		1	3	34	11	3	
Rustenburg	1		3	16	2	7	
Total	1	4	8	88	16	19	119

Figure 4.6. Health Facilities in Bojanala Platinum District and Sub-districts. Adapted from Bojanala Platinum Municipality, 2013/2014.

4.3. Sample Population

In this study, registered professional nurses working within both Dr. Kenneth Kaunda (NHI pilot site) and Bojanala Platinum (non-NHI pilot site) districts comprised the sample. They formed the sample frame since they were working intimately with the Re-Engineering of PHC. Given that Dr Kenneth Kaunda District was a NHI pilot site, they were one of the first districts to commence with the Re-Engineering of PHC as well as one of three sites where the ICDM was first piloted and implemented. Additionally, the Programme for Improving Mental Health Care (PRIME) had been working in the district for the previous three year period, piloting and implementing a mental health care plan. At the time of data collection, Bojanala Platinum District had not yet undergone any major system changes in light of the fact that the NHI scheme was only in its pilot phase for the first five years (2011-2016). Therefore data for this study was collected from both study sites during the period of

September 2014 to September 2015. The specific demographics of the participants will be elaborated upon in the two phases of the research process.

4.4. Research Method and Methodology

According to Babbie and Mouton (2006), "a research design is a plan of blueprint of how you intend conducting the research" (p. 74). Blaxter, Hughes and Tight (2006) distinguishes between the terms, method and methodology, as follows:

> The term *method* can be understood to relate principally to the tools of data collection or analysis: techniques such as questionnaires and interviews. *Methodology* has a more philosophical meaning, and usually refers to the approach or paradigm that underpins the research. (p. 58 Italics Original).

According to Royse (2011), the research design describes the process of data collection, how sampling will be accomplished, the research instruments, and how the research will be carried out. Research designs are normally categorised into three distinct paradigms: quantitative, qualitative and mixed methods. According to Bless, Higson-Smith and Sithole (2014), quantitative research "relies on measurement to compare and analyse different variables." Qualitative research on the other hand, "uses words or descriptions to record aspects of the world." Finally, mixed methods "uses both measurements and descriptions in a complementary fashion to deepen the researcher's understanding of the research topic" (p. 56).

For the purpose of this present study, a sequential mixed method design was employed to achieve the objectives of the study. More specifically, the study was explanatory in nature. The following sections describes the research process by outlining the two phases of this study with the corresponding methods and methodology.

4.5. Mixed Method Research Design

Mixed methods designs describe studies which use both quantitative and qualitative techniques. As a research design, it has its origins in 1959 with Campbell and Fiske who used multiple quantitative methods of data collection in their design of the multitrait-multimethod matrix used to measure a psychological trait (Gray, 2009b). The fact that they used multiple quantitative methods, does not detract from the important role their work played in encouraging the use of multiple methods.

For the purpose of this study, the definition by Johnson, Onwuegbuzie and Turner (2007) was found most appropriate. They define mixed methods as:

> A type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration (p. 123).

Hanson, Creswell, Clark, Petska, and Creswell (2005) maintain that mixed-method designs allow the researcher to generalise results from a sample to a population which

enables deeper understanding of the phenomena being studied. Accordingly, the use of mixed methods allowed for a deeper examination of the results from this study.

This method has not been without some critique. One area that seems to dominate the debate in the mixed method literature is its definition. A common misconception is that it is a mixing of research methods that are normally not compatible with each other (Morse, 2003). However, as Bulsara (2014) argues, the use of mixed methods enhances the validity of a study. Morse (2003) states that the goal of a social research project is to understand the complexity of human behaviour and experience, and as such the researcher is tasked to understand, describe and explain the reality of this complexity.

This study required a deeper examination of the experiences of PNs working in the NHI pilot site (KK). The goal of this study was not simply to describe and explain the complexities of the proposed NHI scheme, but to facilitate an understanding of these complexities and the potential effect it could have on the success of the Re-Engineering of PHC and NHI. Furthermore, Teddlie and Tashakkori, (2003) argue that mixed methods is superior to single approach designs due to the fact that it allows the research to answer questions that the other methodologies cannot. In addition, it provides stronger inferences as well as giving the researcher an opportunity to present a greater diversity of divergent views. Morse (2003) and Bulsara (2014) support this argument by stating that the combination of research methods enables the researcher to obtain a more complete picture of how people behave and experience events, promotes a deeper understanding of the phenomena and assists in the achievement of the research goals.

A mixed methods approach allowed for a more in-depth understanding of the phenomena that is the NHI and the Re-engineered PHC system. Limited information exists as to what impact NHI will have in terms of positive psychological resources of the PHC provider, other than the fact that it expands their scope of practice. It was therefore deemed important to determine whether the introduction of a NHI scheme has any impact on how nurses experience positive emotions at work and ultimately wellbeing in the NHI pilot site and compare this to the non-NHI pilot site in order to determine if there has been any change. Another advantage is that it offers compensation for weaknesses of one method with the strengths of the other. An example would be that in the case of the current study, the quantitative data added an objective measure of validity to the qualitative data. Similarly, the findings from the qualitative data were found useful in providing explanation for the quantitative findings. Lastly, mixed methods research adds to the credibility and validity of findings by corroborating both quantitative and qualitative findings and reduces bias normally associated with only using one type of methodology (Bryman, 2006; Johnson & Onwuegbuzie, 2004; Kelle, 2006).

4.5.1. *Types of Mixed Methods Designs*

In sequential designs, one method builds on the other, whereas in explanatory sequential designs, the researcher first collects the quantitative data, which then informs the qualitative data collection and analysis (Fetters, Curry & Creswell, 2013). According to Creswell (1994), sequential studies comprise of two-phase studies where the qualitative phase is first conducted, followed by the quantitative phase or vice versa. Moreover, this design calls for explanation or confirmation of the subject matter. The sequential mixed-method

design was most appropriate for the present study since it related directly to the type, purpose and focus of the research.

Symonds and Gorard (2008) and Bazeley (2004) highlight the four most commonly used research designs in health settings. They are convergent designs where the data is collected simultaneously and is used to address the study aims. Sequential designs on the other hand, comprise of one data set building on the results from the other. Embedded designs entail using quantitative and qualitative approaches in tandem and to embed one in the other in order to provide new insights or more refined thinking. They may be a variation of a convergent or sequential design. Lastly, multiphase designs, used frequently in the health sciences, stem from multiple projects conducted over time and linked together by a common purpose.

For the purposes of this study, a sequential approach was best suited therefore the explanatory mixed method design was used. Given that limited attention has been given to the potential impact NHI would have on the PHC provider in terms of their positive psychological resources, this approach was ideal to firstly measure Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing and secondly, to understand nurses' perceptions and experiences of NHI.

4.6. The Research Process

As stated above, an explanatory mixed methods design was carried out in two sequential phases. This study was layered on top of the PRIME/COBALT trials which consisted of a pair of pragmatic randomised control trials.

The first phase comprised of piloting a questionnaire in three clinics in the Orkney area. Upon analysis and feedback from participants, it was then decided to use a shorter version of the General Health Questionnaire (GHQ) and to use a longer version of the Job Content Questionnaire (JCQ). After the piloting phase, the questionnaire was amended and distributed to all the clinics from both cohorts. The questionnaire was amended and then distributed to the clinics that were to be used as part of the PRIME/COBALT trial in both KK (NHI pilot site) and BP (non-NHI pilot site.

For phase two, interviews were conducted with professional nurses and facility managers from three clinics in North West Province. This data provided possible explanations for the quantitative findings.

In line with the sequential explanatory design, data collection was performed in the following way:

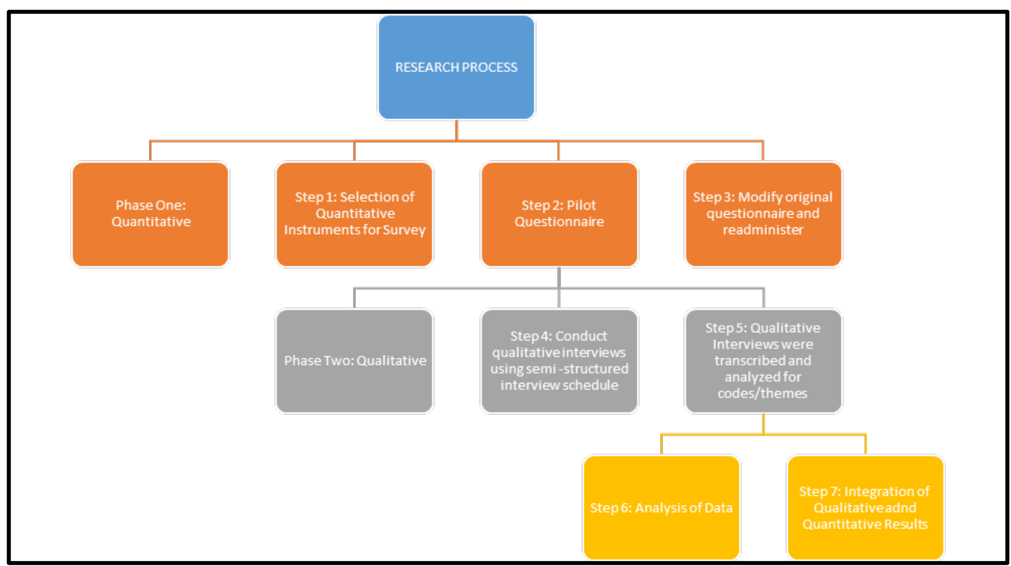

Figure 4.7. Schematic Representation of the Sequential Data Collection Process. Adapted from Ivankova, Creswell and Plano Clark. 2007.

PHASE ONE: THE QUANTITATIVE METHOD AND METHODOLOGY

4.6.1. *Introduction*

According to Neumann (2011), in quantitative studies, the reliance is on positivist principles and the emphasis is on measuring variables and testing hypotheses, which is what this study aimed to do.

The design proved to be appropriate, as the current study aimed to determine if there were significant relationships between Job Satisfaction, job Strain, PsyCap, Burn out and Wellbeing among nurses in the NHI pilot site (KK). The study also aimed to determine whether PsyCap is a predictor of wellbeing for both nurses in the NHI pilot site (KK) and

non-NHI pilot site (BP). Given the above context, the quantitative design was fitting as it explores relationships and allows for the researcher to infer with regards to prediction.

4.6.2. *Sampling Technique and Procedure*

Although clinics were randomised to one of two parallel groups, with equal numbers of clinics in either group for trial purposes, this study was conducted at all trial clinics irrespective of whether they were intervention or control for the trial. This was done given that all clinics in KK were part of the NHI pilot phase.

The researcher used non-probability sampling techniques at the clinic level to select participants for the first phase of this study. Purposive sampling is a non-probability technique of sampling and involves selecting participants based on a specific purpose rather than randomly selecting participants (Tedllie & Yu, 2007).

Mixed methods research sampling takes a different approach than that of quantitative and qualitative research methodology. Mixed method sampling involves the selection of units of analysis through both probability and purposive sampling strategies (Plano Clark & Creswell, 2008). According to Padgett (2008):

> As a general rule, qualitative researchers use purposive sampling—a deliberate process of selecting respondents based on their ability to provide the needed information… [It] is done for conceptual and theoretical reasons, not to represent a larger universe (p. 204).

For this reason, the characteristics that the population had to have in order to be selected for this study were that they had to be registered professional nurses working within the PHC setting and have undergone PC101 training.

Professional nurses from the largest 20 clinics in the Dr. Kenneth Kaunda (KK) and Bojanala Platinum (BP) districts were recruited from their place of work during the 12-month data collection period (September 2014-September 2016). The sample included professional nurses, facility managers, operational managers, as well as OTL's who formed part of the new PHC Ward Based Outreach Team (WBOT) for the NHI pilot site (KK) and only included professional nurses for the non-NHI pilot site (BP).

The sample population from the KK district was made up of the four sub-districts, Maquassi Hills, Matlosana, Potchefstroom and Ventersdorp. For the KK district, a sample size of 137 of 181 nurses who were informed of this study was obtained. The sample population from the BP district was made up of three sub-districts; Rustenburg, Madibeng and Moses Kotana. The sample of nurses who participated from BP consisted of 93 professional nurses (n = 93) from a sample of 168. This brought the total sample size for the quantitative phase to (n = 230).

4.6.3. *Sample Size Calculation*

Given that the research dealt with a special population (the nurses in the clinics), normal power calculation of sample size could not be employed to calculate sample size. According to Marlow and Boone (2011), the recommended sample size for a population of 200 is 132 and for a population of 150 it is 108 (p. 151). For the NHI pilot site (KK), this

recommendation was met. However, for the non-NHI pilot site (BP), the response rate was a lot lower. The data was elicited with help from the district PHC manager. The researcher knew that the BP clinics could potentially be problematic as some clinics and CHC's had closed down, hence the researcher and her assistant visited the next clinic upon recommendation from the cluster managers.

4.6.4. *Instruments for Data Collection*

For the quantitative part of this study, data was collected through the use of the following instruments as part of a booklet[10] which comprised of a consent sheet and biographical questionnaire and included but was not limited to the Psychological Capital Scale (PsyCap), Satisfaction with Life Scale (SWLS), General Health Questionnaire-12 item version (GHQ-12), Job Content Questionnaire (JCQ) and Maslach Burnout Inventory-Human Services Survey (MBI). The scales used in the quantitative survey have all been widely used in the context of employee wellbeing and especially within the context of nursing research.

4.6.5. *Reliability and Validity of Instruments*

4.6.5.1. *Satisfaction with Life Scale*

The Satisfaction with Life Scale (SWLS) was developed by Diener, Emmons, Larsen, and Griffin (1985) and is a short, 5-item instrument designed to measure global cognitive judgements of subjective wellbeing. The scale consists of 5 uni-directional attitude

[10] See Appendix 3. Quantitative Booklet.

expressions. For example, items such as, “I am satisfied with my life” and “If I could live my over, I would change almost nothing” are examples of these type of measurements.

Each expression was evaluated based on a 7-point Likert scale (1 – strongly disagree to 7 – strongly agree). The scale has been found to be reliable by Pavot and Diener (1993) for diverse populations with indicated by internal reliability of reported Cronbach alpha coefficients of between 0.79 and 0.89. A South African study conducted with 570 residents living in Soweto by Maluka and Grieve (2008) found the scale to be reliable with a reported Cronbach alpha coefficient of 0.77. Similarly, another South African study carried out by Westaway, Maritz and Golele in 2003 has shown very strong internal reliability, with a Cronbach alpha coefficient of 0.92. This study found the scale to be reliable with a reported Cronbach alpha coefficient of 0.866.

4.6.5.2. *The General Health Questionnaire-12*

The General Health Questionnaire-12 (GHQ-12) was developed as a screening tool by Goldberg (1978) to detect those likely to have or to be at risk of developing psychiatric disorders. It measures aspects of mental health and consists of four sub-scales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. The GHQ-12 (Goldberg & Hillier 1979) measures aspects of mental health by assessing symptoms and signs of non- pathological mental ill-being or lack of mental wellbeing. It consists of four sub-scales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression (Maslach et al. , 2001). The GHQ-2 has been found to be a reliable with a Cronbach alpha coefficient of 0.79 that was found for the population studied by Goldberg and

Hillier (1979). Other studies conducted on a sample of young people found the scale to be reliable with a Cronbach alpha coefficient of 0.87 (Maslach & Jackson, 1981). Furthermore, a study conducted by Koen, van Eeden and Wissing (2011a) on a sample of 312 South African nurses working in both private and public health facilities found the scale to be reliable with a reported Cronbach alpha of 0.84 which confirms that the GHQ-12 is a reliable measure. This study found the scale to be reliable with a reported Cronbach alpha coefficient of 0.829.

The items on the scale has four responses, ranging from "better than usual" to "much less than usual." For the purposes of this study, the Likert scale of 1-2-3-4 was used. The scores obtained in the GHQ were calculate by summing up all the scores in the 12 questions and deducting 11 from the total. Some examples of the items on the GHQ-12 scale are as follows:

i. The respondents have not been able to concentrate on what you are doing;
ii. The respondents have lost sleep due to worry;
iii. The respondents have been constantly under strain.

4.6.5.3. *Job Content Questionnaire*

The Job Content Questionnaire (JCQ) is a self-report questionnaire designed to measure social and psychological characteristics of job design, focusing on the psychological and social structure of the work situation—issues relevant to work demands, decision making opportunities and social interaction (Karasek, 1985). The JCQ has been widely used in research on different populations and validated. The construct, job strain is made up of two sub-scales: psychological demands and decision latitude (Karasek, 1985). In a study conducted on a group of nurses in Quebec, Bourbonnais and Mondor (2001) reported

Cronbach alpha coefficients for job decision latitude to be 0.72 and for psychological demands 0.79. The Cronbach alpha coefficients were found to be generally acceptable and the overall average alpha coefficients for women was 0.73 and men 0.74 (Nunnaly & Bernstein, 1994). Within the South African context, Johnston et al. (2013) found it to be reliable with reported Cronbach alpha coefficients of 0.76 for job demands and 0.80 for job control on a sample of employed South Africans from various industries and professions. The most common profession reported in their study was accountant and administrator. Furthermore, the JCQ has also been used in a study on a mining population in South Africa (Hodgskiss & Edwards, 2013) and was found to be reliable.

In order to demonstrate how the JCQ was used in this study, Figure 4.7 depicts the relationship between the constructs and the sub-scales.

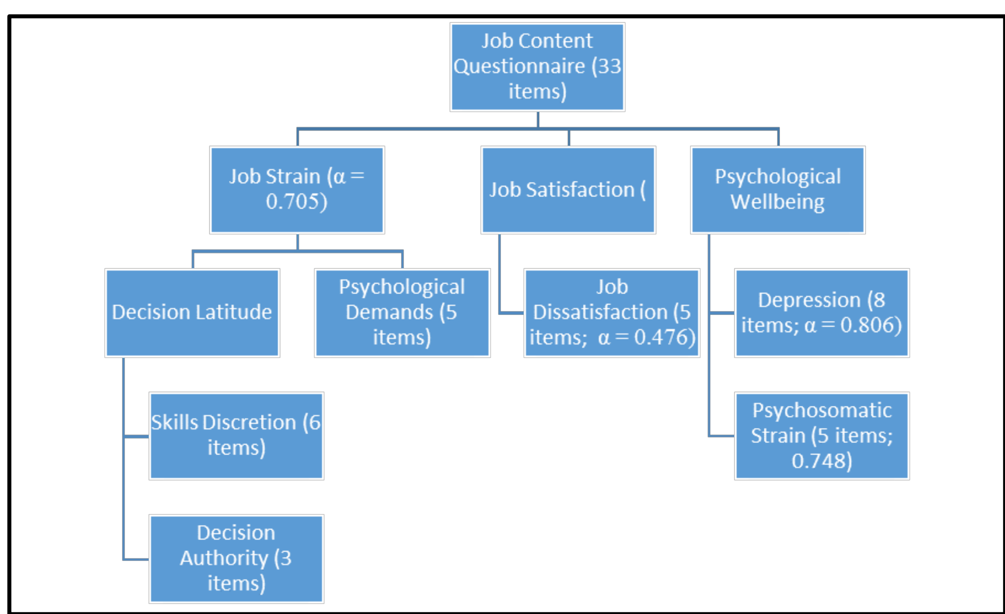

Figure 4.8. Schematic Representation of the Job Content Questionnaire

The questionnaire was divided into four different sections to measure the different sub-scales:

i. **Section I:** This section of the questionnaire measured skill discretion, decision authority, psychological workload and physical exertion. This section consisted of 15 questions rated on a 4-point Likert scale ranging from 1 = strongly disagree to 4 = strongly agree. Some examples of items included: “My job requires that I learn new things” and “I have a lot to say about what happens on my job.” The Cronbach alpha coefficient for this sub-scale in this this study was 0.705.

ii. **Section II:** This measured job satisfaction/dissatisfaction and consisted of 5 items. Examples of items on this section included: “How satisfied are you with your job” and “Is this job what you wanted when you applied for it.” The Cronbach alpha coefficient for this sub-scale in this study was 0.476.

iii. **Section III:** This section of the questionnaire measured physical / psychosomatic strain with 5 items rated on a 4-point Likert scale. Examples of items included: “How often do you become tired in a very short period of time” and “Do you have trouble with poor appetite.” The Cronbach alpha coefficient for this sub-scale in this study was 0.748.

iv. **Section IV:** This measured depression / life dissatisfaction with 8 items rated on a 7-point Likert scale. The items here required the respondent to rate their life in terms of whether they found their lives “Boring or interesting” and “Worthwhile or useless.” The Cronbach alpha coefficient for this sub-scale in this study was 0.806.

4.6.5.4. *Maslach Burnout Inventory—Human Services Survey*

The Maslach Burnout Inventory (MBI) is valuable tool for assessing burnout in human service, education, business and government professions. It was developed in 1981 by Maslach, Jackson, Schaufeli and Schwab (Ashtari, Farhady & Khodaee, 2009). The MBI consists of 22 items that measure professional burnout in human service, education, business and government professionals. It focuses on three areas, namely; emotional exhaustion, depersonalisation and personal accomplishment. Items such as: “I feel emotionally drained by my work” and “I feel frustrated by my work” are used to measure burnout while an item like: “I really don’t care about what happens to some of my patients/clients” is used to measure depersonalisation and lastly “I feel full of energy” is used to measure personal achievement. The questionnaire uses a response scale ranging from 0-6 with “Never” being indicated by a (0) and “Everyday” by (6). The MBI has been shown to have good internal consistency with

a level of alpha values ranging between 0.81 and 0.92 since its original validation in 1981 (Aguayo, Vargas, de la Fuente & Lozano, 2011).

The MBI-HSS has been used in South Africa on a sample of nurses by van der Colff and Rothmann (2009). Their study reported Cronbach alpha coefficients of 0.88 for emotional exhaustion, 0.75 for depersonalisation and 0.71 for personal accomplishment. This study found the scale to be reliable with a reported Cronbach alpha coefficient of 0.852.

4.6.5.5. *Psychological Capital Questionnaire-24*

The Psychological Capital Questionnaire was developed by Luthans et al. in 2007b and is a 24 item scale divided into four subscales, with 6 items in each subscale measuring the following four constructs of PsyCap: hope, resilience, optimism and self-efficacy. Items such as: "I feel confident helping to set target/goals in my work area" and "I feel confident presenting information to a group of colleagues" measure self-efficacy, whereas resilience is measured with an item such as: "I usually take stressful things at work in my stride." The PCQ has been found to have good internal consistency with a Cronbach alpha coefficient of 0.93 reported by Avey, Luthans, Smith and Palmer (2010). Similarly, Roberts, Scherer and Bowyer (2011) reported a Cronbach alpha coefficient value of .89 in their findings making the PCQ a reliable measure of the four constructs of psychological capital. Within the South African context, the PCQ-24 has been used in a study by Görgens-Ekermans and Herbert (2013), to investigate the internal validity, reliability and external validity pf the PCQ-24 on a South African sample. The South African sample was made up of employees at managerial and non-managerial levels at a construction company in the Western Cape. Cronbach alphas

for the sub-scales were reported as follows; hope: $\alpha = 0.81$; self-efficacy: $\alpha = 0.83$; resilience: $\alpha = 0.69$ and optimism: $\alpha = 0.67$.

Most of the scales used met the recommended 0.7 cut-off as suggested by Nunnally and Bernstein (1994). However, as reported in the literature, optimism and resilience have been shown to have less internal consistency compared to the other two sub-scales (Johnston et al. 2013). This study found the scale to be reliable with a reported Cronbach alpha coefficient of 0.872.

4.6.6. *Data Collection*

Data were collected through the use of a self-administered research survey. Participants were first informed of their rights and that their participation was completely voluntary. They were taken through the information and consent sheet which was in the booklet they received to complete.[11] The purpose of the study and the rationale for conducting research on the subject area was explained to all participants by the research team. To make the process easier for participants to understand what was required of them, they were taken through the questionnaire and provided with explanations for some of the questions which were identified during the piloting phase be problematic for the respondents to understand, given that their first language was not English.

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[11] See Appendix 3: Quantitative Booklet.

The survey was compiled of several scales that were written in English. However, in cases where participants were unclear of what a question asked of them, one of the members of the research team would use simpler terms to explain what was meant. The survey was administered in a group setting when possible and those who were unable to complete it during the time that the team was present at the facility, had the opportunity to take it home and have it collected at a later stage.

The participants were informed of the purpose of this study by either by the principal researcher or the research assistants. The requirements for participation in this study were also reiterated as the research was interested in only professional nurses. The survey took participants approximately 45 minutes to complete, however some of the older nurses took longer.

4.6.7. *Data Analysis*

The data analysis was conducted with the use of the Statistical Package for Social Sciences® (SPSS®) version 23.0. The data entry was done with the help of a research assistant who captured the questionnaires after the initial coding and re-coding of variables was done by the researcher. The data was entered into the SPSS® system by using numerical codes for all variables. First, descriptive analysis was conducted on the data to organise and summarise the data. This also allowed the identification of any data entry mistakes and their correction before continuing with further analysis of the data. The data was screened for errors by running frequency for all variables to ensure that all values fell within the possible values for each variable. Any errors found were noted and corrected. Two of the respondents

were found to be enrolled nurses and were deleted from the final data set. Pearson product-moment correlation coefficient (*r*) was used to examine the relationships between Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing for both the NHI pilot site (KK) and the non-NHI control site (BP). Cohen (1988) describes practically significant relationships as relationships that have a difference in means that are sufficiently large enough to be of practical value. A calculated difference is practically significant provided the actual difference it is estimating will affect a decision to be made. T-Test analysis was used to test for any differences between the NHI pilot site (KK) and the non-NHI pilot control site (BP) on Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing. Specifically, the t-tests conducted were used to determine whether PNs working in the NHI pilot site experienced higher or lower levels of Job Strain and Burnout when compared to PNs working in non-NHI pilot sites.

PHASE TWO: QUALITATIVE DESIGN AND METHODOLOGY

4.7.1. *Introduction*

According to Denzin and Lincoln (2000), the term "qualitative" implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measure. Furthermore, a qualitative design method offers more descriptive and rich data about people's lived experiences (King, 1998; Patton, 1990). According to Royse (2011), qualitative research designs have the following in common: the researcher is involved in the collection and analysis of the data and is characterised by a descriptive report of the findings (p. 261-262). For the purposes of this study, the definition provided by Blaxter et al.

(2006) was found to be the most appropriate, where they define qualitative research as a design that concerns itself with collecting and analysing information and explores the data in as much detail as possible in order to achieve "depth" rather than "breadth."

In addition to this study being qualitative, a cross-sectional research study design was used. According to Neumann (2011), "cross-sectional research can be exploratory, descriptive or explanatory, but is most consistent with a descriptive approach" (p. 44). Given that the context of the current study was to explore the relationship between the constructs, a cross-sectional design was best fitting to describe in as much detail, the knowledge and perceptions nurses had towards the Re-Engineering of PHC and the piloting of NHI.

4.7.2. *Interpretive Phenomenological Approach*

The researcher used an Interpretive Phenomenological Approach (IPA) in conducting the qualitative phase of this study. The approach was selected for the insight it would provide into the nursing world. Smith (2007) defines IPA as an approach to "psychological qualitative research" which has an idiographic focus. In this study, IPA offered insight into how a person may make sense of a phenomenon (NHI) in a given context (Re-engineered PHC system) as IPA aims to explore in detail how people make sense of their personal and social world (Smith & Osborn, 2007). Therefore, IPA was deemed to be the most logical approach to take in order to answer the research questions and achieve the objective of this study which was to

understand how nurses perceive and experienced the constructs in relation to the Re-Engineering PHC process and in light of the proposed NHI scheme.

According to Mackey (2005), researchers have found an interpretive approach to nursing research reveals more depth and diversity of the nursing knowledge than any other research approach. The IPA is a qualitative approach that sets out to examine how people make sense of their world (Avey et al. 2008). The theoretical roots of IPA lie in three key areas of philosophy, namely, “phenomenology, hermeneutics and ideography” (Smith et al. 2009, p. 11). The first principle of phenomenology was developed by Husserl (1927) as a basis for a “pragmatic system in philosophy” (p. 12). He saw it as involving careful examination of human experience, with the aim of finding ways to help people understand their own experience of a given phenomenon (Campbell & Fiske, 1959). The second theoretical underpinning of IPA stems from hermeneutics, which is a theory of interpretation. Lastly, according to Smith et al. (2009), idiography has also been found to be a major influence upon IPA.

Idiography has been defined as “being concerned with the particular (Sieber, 1973) and is characterised as the richly detailed and uniquely holistic representation of words and actions that attempt to describe a situation as experienced by its participants (Maykut & Morehouse, 1994). As Smith, Flowers and Larkin (2009, p. 3) have noted, “IPA is committed to the detailed examination of the particular case,” the research is focused on a particular situation, namely, a NHI pilot and how it impacts nurses-idiography being key to determining the impact the NHI may have. As Smith and Osborn (2007) state, it gives participants the opportunity to describe their individual experiences of a particular situation as well as

describe their experiences of the situation and the feelings and meanings they attach to it, making participants the experts and the researcher the curious party. Given the historical and theoretical underpinnings of IPA, it proves a useful approach when conducting research pertaining to nurses.

4.7.3. *Sampling Technique and Procedure*

Participants were selected for the second phase of the research using the same principles of sampling followed during phase one.

A total of (n = 8) professional nurses were purposively sampled in the second phase of the research study. This sample size more than met the recommended number of participants advocated by Smith et al. (2009), where they advise using between 3-6 participants. They further state that sample size is dependent on "the degree of commitment to the case study level of analysis and reporting; the richness of the individual cases; and the organisational constraints one is operating under" (p. 51).

Table 4.1.

Demographics of Participants from Phase 2

	P1	P2	P3	P4	P5	P6	P7	P8
Gender	Female	Female	Male	Female	Female	Female	Female	Female
Age	51-60	61+	20-30	41-50	51-60	20-30	31-40	51-60
Marital status	Married	Single	Single	Divorced	Single	Single	Married	Married
Race	Black	Black	Black	Black	Black	Black	Black	Black
No. of dependents	3+	1	0	2	2	1	2	0
Highest qualification	PHC	PHC	Dip. Nursing	Dip. Nursing	Dip. Gen. Nursing	Dip. Gen. Nursing	Dip. Nursing	Adv. Dip. Health Sciences
No. of years working in organisation	13	7	3	5	32	3	13	33
Position in organisation	NC	NC	PN	Acting OM	OM	PN	Snr PN	OTL

Notes. NC= Nursing Clinician, PN = Professional Nurse, OM = Operational Manager, OTL = Outreach Team Leader.

From Table 4.1., it is evident that the majority of the participants were female (n = 7), with the sample comprising of only 1 male nurse. Of all the participants interviewed, 2 were in a managerial or leadership positions; the 1 male participant was the facility trainer for PC101, whereas, 2 identified themselves as Nurse Clinicians due to having undergone PHC training, and finally, 1 identified herself as a Senior Nurse. The sample was spread out across all the different age groups

4.7.4. *Research Instrument*

According to Breakwell, Smith and Wright (2012), interviewing is not only an essential part of social research, but it requires “a systematic approach to data collection,

analysis and description" which allows for "meaningful, valid and reliable conclusions" (p. 369). Furthermore, interviewing as a research tool is flexible and therefore allows one to gather a wide range of information (Breakwell et al. (2012).

Marlow and Boone (2011, citing Kudushin and Kadushin (1997) define interviews as a conversation involving the exchange of ideas, attitudes and feelings. Much like a conversation, an interview has a purpose which is accepted by the participant. There are different types of interviews and depending on the nature and objectives of the study. The key difference between these different types of interviews, is the way in which they are conducted (Marlow & Boone, 2011; Breakwell et al. 2012; Smith et al. 2009).

The data collection process was conducted through the use of a semi-structured interview schedule.[12] The interview schedule was developed by using open-ended questions that were informed by the aims of the research as well as the constructs the researcher was hoping to measure during the quantitative phase of this study. The use of open-ended questions is encouraged by IPA as an open inductive approach to data collection and analysis in order to provide rich and detailed descriptions of the phenomenon being studied (Breakwell et al. 2012). The interview schedule included open-ended questions on Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing.

The questions were developed with the assistance of the researcher's supervisor who helped to ensure that the questions were related to the aims of the research study. According

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[12] See Appendix 5: Semi-structured Interview Schedule.

to Neuman (2006), the use of an interview schedule helps to increase the reliability of research as all of the participants are asked the same questions in the same order, thus showing consistency in how they make their observations. By using a semi-structured approach to the interviews, the researcher was able to clarify and paraphrase statements made by the participants to facilitate her understanding of their positions and responses.

The benefit of using a semi-structured interview schedule is that it allows participants to communicate their responses without placing it into predetermined categories (Marlow & Boone, 2011). Even though qualitative interviews are based on a set of topics that the researcher would like to discuss, this does not constrict the participants' answers into predetermined categories (Babbie, 2010).

A consent sheet was also developed which participants had to complete before commencing with the interview.[13] This allowed the researcher to capture the demographic information of the interviewees.

4.7.5. *Data Collection*

Before the initiation of the interview, the research participants were informed of their rights and that their participation was completely voluntary. They were taken through the information and consent sheet.[14] The researcher began by explaining the purpose of the study

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[13] See Appendix 4. Qualitative Consent Booklet.

[14] See Appendix 4. Qualitative Consent Booklet.

and the rationale for conducting research on the subject area. Each participant was then handed a letter of informed consent and a biographical sheet, which they were asked to fill in. Upon completion of the form, they were once again informed that they would remain completely anonymous, that their participation was voluntary and that they could withdraw from the study at any time. They were also reminded that their interview would be tape recorded. Any questions that they had were answered before the interview commenced.

The interviews took place at one clinic in the NHI pilot site (KK) and one clinic in the non-NHI pilot site (BP). Each interview was conducted using the semi-structured interview schedule that was developed with the help of the researcher's supervisor. The interviews lasted between 20-90 minutes depending on how willing a participant was to share. Each participant was compensated for their time with a small thank you gift after the completion of the interview.

All interviews were recorded using a voice recorder after permission was obtained from the participants. Throughout the interview process, participants were reassured that whatever they said during the interview would remain confidential and anonymous. The resultant data were transcribed verbatim.

4.7.6. *Data Analysis*

Given that the interest of this study was in exploring and understanding how nurses experience and perceive Job Satisfaction, Job Strain, PsyCap, Burnout and Wellbeing within the context of the Re-engineered PHC system, IPA was deemed to be valuable in unearthing these subjective meanings. As stated by Dey (1993), qualitative data analysis deals with

meaning and by using an IPA, it enabled the researcher to examine how nurses made sense of the changes within the health care system and how this influenced their perception of their Job Satisfaction and Wellbeing. Researchers using the IPA approach are interested in lived experiences that take on significance for the person concerned by unpacking their experience and the parts that make up this experience with emphasis on having the person reflect on the significance of the experience and engaging with these reflections (Smith et al. 2009). Nurses were asked questions that elicited this type of information from them regarding their experience of the Re-Engineering PHC process and its effect on their professional and personal life.

In line with the IPA approach, thematic analysis was used as it offered an accessible and theoretically flexible approach to analysing qualitative data through the search for themes and patterns in content (Braun & Clarke, 2006). Unlike other word-based analyses such as key-in-word-context or semantic network analysis, thematic analysis requires the researcher to be more involved and requires a higher degree of interpretation on the part of the researcher (Bernard & Ryan, 1998). Furthermore, thematic analysis goes beyond just counting words or phrases and focuses on identifying implicit and explicit ideas within the data and describing these ideas. These ideas are more commonly referred to as themes. A theme represents categories that were identified by the researcher in terms of how they relate to the research questions (Braun & Clarke, 2006). The argument has been made that from all the qualitative approaches to data analysis, thematic content analysis should be seen as the foundational method for qualitative analysis (Holloway & Todress, 2003). Hence, it is postulated by Braun and Clarke (2006) that it should be the first method of qualitative

analysis that students and researchers should learn because it provides core skills that will be useful for future use in conducting qualitative analysis.

Thematic content analysis is flexible and this was one of the major benefits the researcher drew from when she used this approach to analyse the data. Thematic analysis is a method for identifying, analysing and reporting themes within data which are then marked as codes. According to Boyatzis (1998), it minimally organises and describes research data set in rich detail. Given this description, in the context of the present study, thematic analysis provided the researcher with the flexibility of interpreting the data in such a way that highlighted the aims and objectives of this study.

Within the IPA approach, the researcher engages in an interpretive relationship with the transcript so as to be able to understand the context and complexities of the data (Smith & Osborn, 2007). The researcher creates names for the themes from the actual words of participants and groups them in such a manner that directly reflects the texts as a whole. Interpretation on the part of the researcher is kept to a minimum and the feelings and thoughts of the researcher make little difference in thematic content analysis (Anderson, 2004). According to Smith et al. (2009), the researcher need not follow a set of steps rigorously, but rather focus on following the guidelines of IPA. The steps of IPA and are outlined in Figure 4.8.

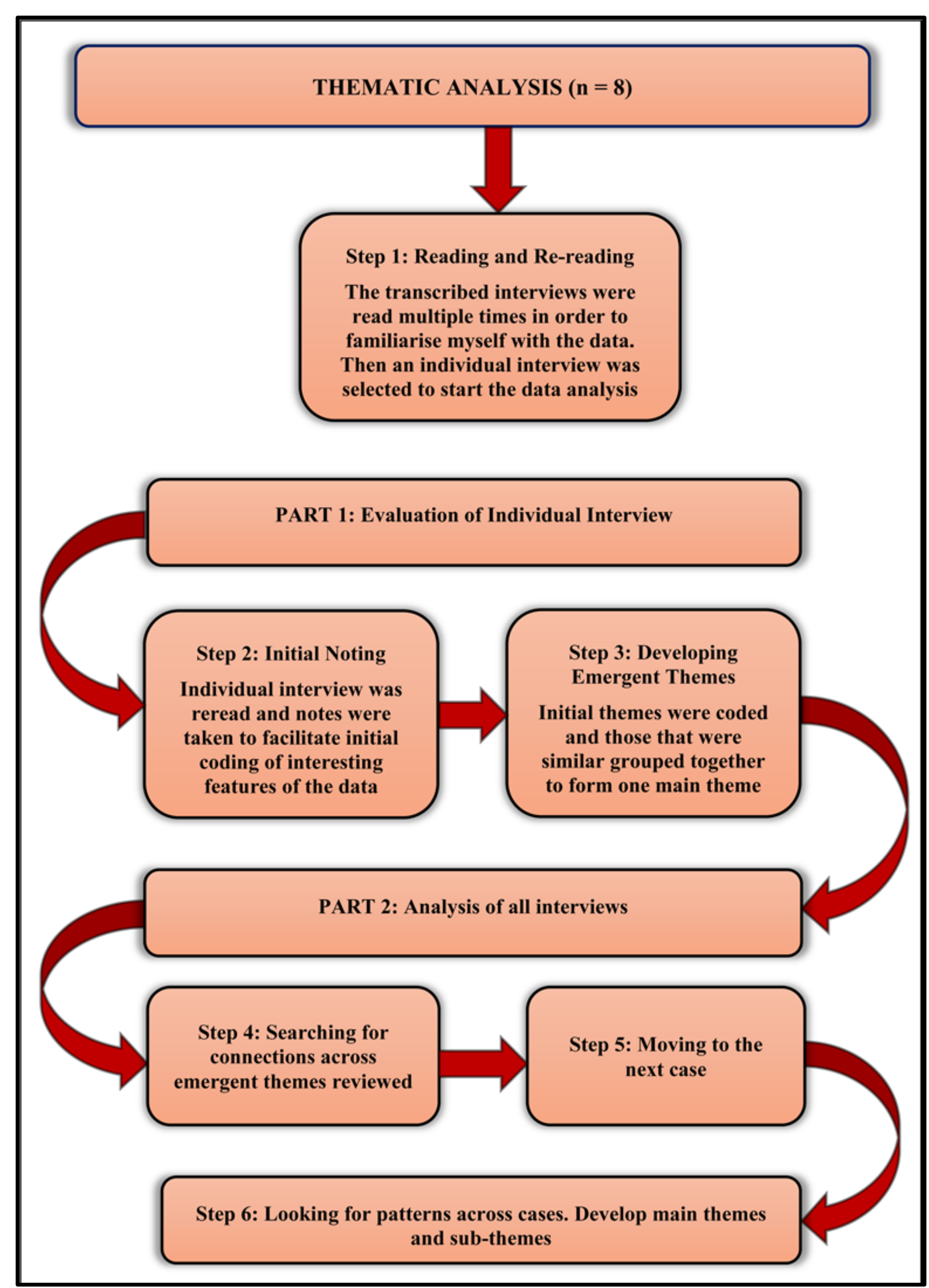

Figure 4.9. Schematic Representation of Thematic Analysis. Adapted from Smith et al. 2009.

In conjunction with the guidelines of the IPA, the researcher used the guidelines set out in Braun and Clarke (2006) for conducting the thematic analysis of the data. The first step in the data analysis process was the transcription of the interviews. Although the interviews were conducted in English, some of the participants unconsciously switched between their native tongue and English; consequently, independent parties were used to carry out the translation and transcription work. Through reading and re-reading the interview transcripts, the researcher became familiar with the data. Initial analyses of the interviews were done manually by reading and re-reading the transcribed interviews and highlighting key words and phrases. During this process, it was important to not impose the researcher's own interpretation on to the data. The initial coding of the first interview was guided by the broad areas that were discussed in the interview schedule. This initial coding was done by looking for patterns and potential themes. This process is supported by Braun and Clarke (2006) who advise that one "code for as many potential themes/patterns as possible" (p. 89). The interviews were also given to a group of postgraduate students to analyse as a means of confirming the codes and subsequent themes the researcher had identified. This process of triangulation of the data is supported by Marlow and Boone (2011) and Royse (2011) who state that triangulation can be used to validate the data through the use of "different people to collect and analyse the data" or through the use of multiple sources of information or use of different methods.

The next step following the coding process, was the search for themes. Braun and Clarke (2006) describe this part of the data process as the phase where the analysis is re-focused at a broader level of themes. Here, the researcher considered which codes were

related and could be grouped under one category. For example, the codes "helping people, improving lives, patient feedback" were all grouped into the sub-theme: Other People Matter. Connections and relationships were found between some of the themes, and these were then all placed into one main theme.

During the next step, the themes were first reviewed, after which using Patton's (1990) criteria for how themes should be broken down, the researcher proceeded to create main themes and sub-themes. During this process of reading all the extracts under each theme, it came to light that some of the themes did not form a coherent pattern and these themes were then reworked until the themes as adequately represented the coded data. However, it is important to note that coding is an ongoing process and therefore the themes that the researcher began with initially changed and were reworked as re-reading of the data set occurred numerous times.

The last few stages of the analysis process involved "defining and naming" the themes. Braun and Clarke (2006) explains this as the stage whereby the researcher can "identify the essence of what each theme is about" while remembering to keep it simple and not have complex themes that are too diverse (p. 92).

4.7.7. *Validity and Reliability of Qualitative Research*

The traditional criteria for validity and reliability have no bearing on qualitative research. There are alternative criteria upon which qualitative research is judged. According to Babbie and Mouton (2006), one approach in determining the validity and reliability of a qualitative study is that of trustworthiness. The following criteria fall under the concept of

trustworthiness: credibility, transferability, dependability and confirmability (Babbie & Mouton, 2006; Trochim, 2006). Regarding the issue of trustworthiness, this has to do with the relevance of the findings. The researcher must be convinced that the findings of her/his study is worth paying attention to. Babbie and Mouton state that "…a qualitative study cannot be called transferable unless it is credible and it cannot be deemed credible unless it is dependable" (2006, p. 277). The following paragraphs unpack how this study addressed transferability.

Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. The traditional quantitative view of reliability is based on the assumption of replicability or repeatability (Trochim, 2006). Guba and Lincoln (1984, cited in Babbie and Mouton, 2006) discuss strategies for transferability which include providing thick description of analysis and making use of purposive sampling in order to maximise the range of specific information that can be collected regarding the research context.

Credibility speaks to how true the results of the study are. According to Trochim (2006), the research participants are the only ones who can legitimately judge the credibility of the results. However, Babbie and Mouton (2006) provide alternatives to determining credibility of results. Accordingly, the researcher could make use of peer debriefing, triangulation, member checks, referential adequacy to name but a few. In this study, the researcher used member checking to ensure credibility, where the results of the qualitative interviews were discussed with participants during the Change Management Workshops which the researcher facilitated.

The idea of dependability, on the other hand, emphasises the need for the researcher to account for the ever-changing context within which research occurs. The researcher is responsible for describing the changes that occur in a setting and how these changes affected the way the researcher approached the study. Qualitative research tends to assume that each researcher brings a unique perspective to the study (Trochim, 2006). However, should a study be repeated with the same or similar participants within the same context, the findings should be similar (Babbie & Mouton, 2006). Dependability was achieved by interviewing nurses from two different districts using the same interview schedule in order to answer the research questions.

Lastly, confirmability refers to the degree to which the results could be confirmed or corroborated by others (Trochim, 2006). This involves determining whether the findings are a product of the focus of the research and not of the biases of the researcher (Babbie & Mouton, 2006. The researcher was able to confirm that the study findings related to the research questions and was supported by literature from prevalent studies.

4.7.8. *Ethical Protocols*

Ethical clearance was requested from the relevant authorities at the University of KwaZulu-Natal (UKZN) before commencing with this study. Provisional ethical clearance was obtained from the Humanities and Social Sciences Research Ethics Committee on the 23 October 2013. The researcher then proceeded to contact the relevant authority in the North West and sent her research proposal to the North West Department of Health: Policy, Planning, Research, Monitoring and Evaluation. Approval for the study was obtained on

February 14, 2014.[15] Thereafter, full approval from the HSSREC was received on February 24, 2014.[16]

After receiving ethical approval from both UKZN and NWDOH, data collection for this study commenced in April 2014. This study and the researcher were guided by the following ethical principles/guidelines as outlined in Royse (2011):

4.7.8.1. *Guideline 1: Research Participants Must Be Volunteers*

Participants were informed that they could withdraw from this study at any time and there would be no negative consequences for doing this. During the interviews, if a participant became overly stressed or emotional, the tape recording device was paused and the participant asked if they would like to stop there or continue with the interview. In

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[15] See Appendix 2. Ethical Approval: Department of Health, North West Province.

[16] See Appendix 1. Ethical Approval: University of KwaZulu-Natal.

addition, written informed consent was obtained from the participants in both phases of this study.[17]

4.7.8.2. *Guideline 2: Potential Research Subjects Should Be Given Sufficient Information about the Study to determine any Possible Risks or Discomforts as well as Benefits*

Before the interview was commenced, the research was explained to the participant and they were taken through the informed consent document. The researcher made sure to explain what the study was for and what the data would be used for. The participant was also given the chance to ask any questions and reminded of their right to withdraw from the study should they not wish to participate.

4.7.8.3. *Guideline 3: No Harm Shall Result as a Consequence of Participation in the Research*

This study did not have the potential to cause physical harm to the participants. Where any emotional harm was caused as a direct result of the study (e.g., participant started to cry

[17] See Appendix 3. Quantitative Booklet and Appendix 4. Qualitative Consent Booklet.

during interview), appropriate attention was given to this and the researcher proceeded to provide emotional support to the participant and stopped the recording.

4.7.8.4. *Guideline 4: Sensitive Information Will Be Protected*

To ensure that the participants remained anonymous and their privacy was protected, the researcher assigned code names to each participant. The researcher also explained who would have access to the data, how the data would be reported and stored, and that the participant would remain completely anonymous. At this stage, the participant was once again reminded that they could withdraw from the study should they want to.

4.7.8.5. *Storage of Research Data*

The recorded interviews were transferred onto a computer that was password protected. All audio files were also recorded on to compact discs (CDs) for the purpose of storage. As per UKZN procedures and protocols, these CDs will be kept safe in a locked cupboard at the School of Applied Human Sciences, along with the questionnaires. All research material will be destroyed after a period of five years by incineration.

4.8. Chapter Summary

In this chapter, the research method and methodology that was employed to conduct this study was described in detail. The demographic information of the research participants was presented, as well as a description of the study sites at which this study was conducted. The researcher made use of non-probability purposive sampling to select participants in both phases of the field research. Data were collected in two different stages and the qualitative

data was analysed using thematic analysis. Quantitative data was analysed using SPSS® 23.0. Lastly, the ethical guidelines that were adhered to during the study were briefly discussed.

The next chapters will contain the research findings from the analysis and discuss it in relation to the research objectives.

CHAPTER FIVE

QUANTITATIVE RESULTS

5.1. Introduction

The purpose of the quantitative phase of the study was to determine the relationship between PsyCap, Job Strain, Job Satisfaction, Burnout and Wellbeing for both the NHI pilot site (KK) and the non-NHI pilot site (BP). A questionnaire measuring these constructs was distributed to approximately 230 participants from clinics at both sites and the results from the analysis are presented in this chapter. The analysis conducted was to explicitly respond to the research questions of the study, namely:

i. What is the relationship between PsyCap, Job Strain, Job Satisfaction, Burnout and Wellbeing?
ii. Is there a difference in the levels of PsyCap, Wellbeing, Job Satisfaction, Burnout and Job Strain of nurses in the NHI and non-NHI pilot sites?

The chapter commences with a presentation of the demographic data for the combined sample from the NHI pilot site (KK) and non-NHI pilot site (BP). Thereafter, the results from the t-test will be presented which provides a comparison of the data collected for all the constructs from the two sites. Lastly, the correlation results from Pearson product-moment correlation for both sites will be presented discretely for all of the constructs.

5.2. Demographics of the Sample Population

The majority of the participants (85%) were female, possessed a diploma in nursing (n = 165) and were Black (n = 206). From the (n = 229) participants, the majority (n = 137) of the participants were from KK (NHI pilot site) and the minority (n = 92) from BP (non-NHI pilot site). A significantly large number of the participants (n = 137) were single, divorced or widowed, with only (n = 1) reporting being married/remarried. The full demographics of the sample population is presented in discrete sections in Table 5.1.

Table 5.1.
Demographic Profile of the Sample in Phase 1

Characteristics	Dr Kenneth Kaunda		Bojanala Platinum	
	N	%	N	%
Gender (n = 227)				
Male	20	14.6	14	15.6
Female	117	85.4	76	84.4
Age Groups (n = 226)				
20-40	58	43.3	36	39.1
41-60	48	35.8	46	50.0
61+	28	20.9	10	10.9
Marital Status (n = 228)				
Single*	83	60.6	54	59.3
Married*	54	39.4	37	40.7
Race (n = 228)				
Black	118	86.8	88	95.6
White	10	7.3	2	2.2
Coloured	6	4.4	2	2.2
Other	2	1.5	-	-
Qualification (n = 223)				
Diploma in Nursing	97	72.4	69	77.5
Bachelor's Degree in Nursing	30	22.4	17	19.1
Other (PHC Course)	7	5.2	3	3.4
Job Title (n = 222)				
Professional Nurse	123	91.8	81	92
Facility Manager	11	8.2	7	8
No. of Years in Profession (n = 227)				
≤ 5 years	45	33.1	32	34.8
6-15 years	36	26.5	22	23.9
15+ years	55	40.4	38	41.3

Note. N = 229; *single: includes divorced and widowed; married: includes remarried.

As depicted in Table 5.1., the majority of the participants (n = 213) indicated either possessing a diploma in nursing or a bachelor's degree in nursing. A small number (n = 10) indicated their highest qualification as having completed the PHC course under 'Other.' The sample was largely constituted by professional nurses (n = 204), with a minority (n = 18) of

the participants in managerial position at their health facility. A negligible number of the participants (n = 77) reported having been in the profession for less than five years.

5.3. Exploring the Differences in Levels of Psychological Capital, Job Satisfaction, Job Strain, Burnout and Wellbeing of the Two Sample Groups

An independent samples t-test was conducted to determine whether there was a statistically significant difference in the mean scores for the NHI pilot site (KK) and the non-NHI pilot site (BP), pertaining to their level of Job Satisfaction, Job Strain, Burnout and Wellbeing. The results for the different constructs are presented separately below.

5.3.1. *Psychological Capital*

An independent samples t-test was conducted to compare PsyCap for the NHI pilot site (KK) and non-NHI pilot site (BP) group. The results are presented in Table 5.2.

Table 5.2.
Results of t-test and Descriptive Statistics Comparing Levels of Psychological Capital in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	N	M	SD	n		t	df
Psychological Capital	106.71	14.86	113	106.62	16.09	72	-4.44, 4.63	0.40	183

Note. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

An insignificant difference in the scores for psychological capital for KK (M = 106.71, SD = 14.68) and BP (M = 106.62, SD = 16.09); t (183), .040, p = .968, was noted.

These results suggest that in terms of the overall construct of PsyCap, participants in both sample groups seemed to possess similar levels of PsyCap.

5.3.2. *Wellbeing*

An independent samples t-test was conducted to compare Wellbeing for the NHI pilot site (KK) and non-NHI pilot site (BP) as measured by the general health questionnaire and the satisfaction with life scale. Descriptive statistics and results from the t-test appear in Table 5.3.

Table 5.3.
Results of t-test and Descriptive Statistics Comparing Levels of Wellbeing in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	N	M	SD	n		t	df
General Health	11.9	6.94	132	20.04	7.00	84	-9.96, -6.13	-8.27**	214
Dissatisfaction with Life / Depression	23.81	9.85	136	19.32	3.27	87	2.33, 6.64	4.10*	221
Satisfaction with Life	19.75	6.05	131	19.42	6.26	89	-1.33, 1.99	.395	218

Note. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

As noted in chapter 4, a high score on the GHQ indicates low levels of Wellbeing, while a low score indicates high level of Wellbeing. A significant difference in the scores for general health for KK (M = 11.99, SD = 6.94) and BP (M = 20.04, SD = 7.00); t(214), -8.274, p = .000) and for Life Dissatisfaction/Depression for KK (M = 23.81, SD = 9.85) and BP (M =19.32, SD = 3.27); t (221), 4.104, p = .000) was noted at the .01 level of significance. The results therefore suggests that in terms of general health, participants from

KK (NHI pilot site) seem to be generally healthier than participants from BP (non-NHI pilot site).

An insignificant difference in the scores for satisfaction with life for KK (M = 19.75, SD = 6.05) and BP (M = 19.2, SD = 6.26); t (218), .395, p =.694) was noted. These results suggest that in terms of the construct Satisfaction with Life, participants in both sample groups seemed to possess similar levels of Life Satisfaction.

5.3.3. *Job Satisfaction*

The results from the independent t-test conducted to compare levels of Job Satisfaction as measured by the JCQ for the two groups are presented in Table 5.4.

Table 5.4.
Results of t-test and Descriptive Statistics Comparing Levels of Job Dissatisfaction in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	n	M	SD	n		t	df
Job Dissatisfaction	10.69	1.61	134	16.25	2.81	88	-6.21, -4.90	-16.83**	124.76

Note. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

A statistically significant difference was found in the scores of Job Dissatisfaction for KK (M = 10.69, SD = 1.61) and BP (M = 16.25, SD = 2.81); t (124.76) 16.83, p = .000. These results suggest that in terms of Job Satisfaction, the KK (NHI pilot site) group are less dissatisfied with their jobs than the BP (non-NHI pilot site) group.

5.3.4. *Burnout*

An independent samples t-test was conducted to compare levels of Burnout for the NHI pilot site (KK) and the non-NHI pilot site (BP). The results from the sub-scales are presented in Table 5.5.

Table 5.5.
Results of t-test and Descriptive Statistics Comparing Levels of Burnout in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	n	M	SD	n		t	df
Emotional Exhaustion	11.9	6.94	132	20.04	7.00	84	-9.96, -6.13	-2.223*	212

Note. Satterthwaite approximation employed due to unequal group variances. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

Results show a statistically significant difference in the scores for Emotional Exhaustion for KK (M = 23.73, SD = 11.91) and BP (M = 27.73, SD = 14.23); t(212), -2.223, p = .027) were noted. The results therefore suggest that in terms of Emotional Exhaustion, KK seem to experience lower levels of Emotional Exhaustion than BP.

An insignificant difference in the scores for Depersonalisation for KK (M = 7.74, SD = 5.74) and BP (M = 9.04, SD = 6.47); t(203), -1.488, p = .138) were noted. These results suggest that in terms of the construct Depersonalisation; participants in both sample groups seemed to possess similar levels of Depersonalisation.

An insignificant difference in the scores for Personal Accomplishment for KK (M = 32.11, SD = 9.54) and BP (M = 33.39, SD = 10.24); t(207), -.913, p = .362) were noted. These results suggest that in terms of the construct Personal Accomplishment, participants in both sample groups seemed to hold similar views regarding the level of Personal Accomplishment reached.

5.3.5. *Job Strain*

An independent samples t-test was conducted to compare levels of Job Strain for the NHI pilot site (KK) and non-NHI pilot site (BP). The results from the subscales are presented below.

Table 5.6.
Results of t-test and Descriptive Statistics Comparing Levels of Job Strain (Skills Discretion, Decision Latitude) in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	n	M	SD	n		t	df
Skills Discretion	20.18	2.66	136	13.04	4.36	85	6.10, 8.18	13.59**	123.60
Decision Latitude	28.93	3.18	134	20.01	5.45	84	7.62, 10.22	13.62**	118.90

Note. Satterthwaite approximation employed due to unequal group variances. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

A statistically significant difference in the scores for Skills Discretion and Decision Latitude were noted. KK (NHI pilot site) reported higher levels of Skills Discretion (M = 20.18, SD = 2.66) compared to (non-NHI pilot site) BP (M = 13.04, SD = 4.36) and for decision latitude (M = 28.93, SD = 3.18) compared to BP (M = 20.01, SD = 5.45) indicating

that they possess more skills and freedom in using the skills they have to carry out tasks at work.

Table 5.7.
Results of t-test and Descriptive Statistics Comparing Levels of Job Strain (Decision Authority, Psychological Job Demands) in Dr Kenneth Kaunda District and Bojanala Platinum District

	Group						95% CI for Mean Difference		
	KK			BP					
	M	SD	n	M	SD	n		t	df
Decision Authority	8.76	1.22	135	6.97	1.85	88	1.38, 2.19	8.70**	221
Psychological Job Demands	13.97	4.18	137	16.80	2.70	88	-3.81, -1.83	-5.62**	223

Note. * p < .05. ** p < .01 M = mean, SD = standard deviation; df = degrees of freedom.

The research results show a statistically significant difference in the scores for Decision Authority and Psychological Job Demands at the .05 level of significance. KK (NHI pilot site) reported feeling like they have more authority over the decisions they make at work (M = 8.76, SD = 1.22) compared to (non-NHI pilot site) BP (M = 6.97, SD = 1.85). Furthermore, KK reported experiencing lower Psychological Job Demands (M = 13.97, SD = 4.18) than the BP group (M = 16.80, SD = 2.70).

5.4. The Relationship between Psychological Capital (Hope, Efficacy, Resilience, Optimism), General Health, Burnout, Satisfaction with Life, and Job Satisfaction)

The results from the NHI pilot site (KK) will first be presented followed by the results for the non-NHI pilot site (BP).

In order to answer the first research question, Pearson product-moment correlation coefficient (*r*) was conducted to examine the relationship between PsyCap, Job Satisfaction as measured by the JCQ, Job Strain, Burnout and Wellbeing as measured by the SWLS and the GHQ-12. Table 5.8 and Table 5.9 present the results of the related analysis for the NHI pilot site (KK) and non-NHI pilot site (BP).

Table 5.8.

Correlation Matrix between Psychological Capital and Wellbeing (SWLS, GHQ-12), Job Strain, Job Satisfaction and Burnout (Emotional Exhaustion, Depersonalisation Personal Accomplishment) for Dr Kenneth Kaunda District

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Psycap	1													
2. Satisfaction w Life	.569**	1												
3. General Health	-.406**	-.319**	1											
4. Emotional Exhaustion	,062	,151	,044	1										
5. Depersonalisation	-,079	,113	,113	.626**	1									
6. Personal Accomplishment	,053	,111	-,004	,104	,009	1								
7. Skills Discretion	.409**	.308**	-,158	,108	,016	-,105	1							
8. Psych Demands	-,122	-,008	,149	,063	,124	,011	-,123	1						
9. Decision Authority	.221*	,149	-,070	-,006	-,009	-,084	.486**	-,085	1					
10. Life Dissatisfaction	-,183	-.267**	.229**	-,041	-,016	,038	,014	-,034	,105	1				
11. Psych Strain	-,101	-,100	.306**	,081	,166	-,066	-,103	.184*	-,037	,163	1			
12. Decision Latitude	.370**	.266**	-,133	,058	,000	-,107	.864**	-,122	.860**	,064	-,088	1		
13. Job Control	.249**	.222*	-,023	,085	,069	-,086	.676**	.504**	.696**	,033	,038	.796**	1	
14. Job Dissatisfaction	-.253**	-.210*	.370**	,102	,126	,117	-.252**	.295**	-,119	,067	.278**	-.221*	-,013	1

Note. *. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

Table 5.9.

Correlation Matrix between Psychological Capital and Wellbeing (SWLS, GHQ-12), Job Strain, Job Satisfaction and Burnout (Emotional Exhaustion, Depersonalisation Personal Accomplishment) for Bojanala Platinum District

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. PSYCAP	1													
2. Satisfaction w Life	.506**	1												
3. General Health	-,055	.366**	1											
4. Emotional Exhaustion	-.402**	-.220*	.322**	1										
5. Depersonalisation	-.311*	-.302**	,180	.590**	1									
6. Personal Accomplishment	,219	,148	,130	,227	,117	1								
7. Skills Discretion	,146	.228*	,029	-,132	-,078	.265*	1							
8. Psych Demands	-,086	-,101	,010	.362**	,164	,217	,100	1						
9. Decision Authority	-,070	,033	,111	,060	-,077	,034	-,108	,127	1					
10. Life Dissatisfaction	-.387**	-.315**	,048	.389**	.426**	-,183	-,133	,047	-,170	1				
11. Psych Strain	-.325**	-.277**	.257*	.511**	.411**	,115	-,022	,143	,109	.300**	1			
12. Decision Latitude	,085	,191	,089	-,074	-,124	,229	.750**	,193	.576**	-.217*	,065	1		
13. Job Control	,057	,133	,148	,222	,070	.343**	.529**	.785**	.377**	-,115	,085	.759**	1	
14. Job Dissatisfaction	-.396**	-.396**	,155	.609**	.488**	-,032	-,202	.328**	-,066	.289*	.489**	-.225*	,140	1

Note. *. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

Table 5.8 and Table 5.9 present the findings from the Pearson product-moment correlation analysis which was conducted to determine whether relationships exist between the different constructs. The tables depict all the possible relationship combinations for the constructs for the NHI pilot site (KK) and the non-NHI pilot site (BP). Only results that proved to be significant for one or both sites at either the 0.01 or 0.05 alpha level are reported on below.

5.4.1. Psychological Capital and Wellbeing

Wellbeing was measured using both the Satisfaction with Life Scale (SWLS) and the General Health Questionnaire-12 (GHQ-12) item version. From the results, it is evident that a significant negative relationship exists between PsyCap and Wellbeing as measured by the GHQ-12 for both KK ($r = -.406$, $p < .01$) and BP ($r = -.055$). However, for the non-NHI pilot site (BP) the results were not significant. This indicates that a high score on PsyCap correlates with a low score on the GHQ-2, which indicates lower levels of distress. This suggests that high PsyCap is correlated with lower levels of psychological distress. Also, a significant positive relationship between PsyCap and Satisfaction with Life for KK ($r = .569$, $p < .01$) and BP ($r = .506$, $p < .01$) was evident, suggesting that high levels of PsyCap correlates to being highly satisfied with life.

Regarding the relationship between PsyCap and Life Dissatisfaction as measured by the JCQ, a significant negative relationship was found for BP only between the two constructs ($r = -.387$, $p < .01$) implying that high levels of PsyCap correlates to a low score on

the Life Dissatisfaction sub-scale which means when a person possess high levels of PsyCap, they are less dissatisfied with their life.

5.4.2. Psychological Capital and Job Strain

The sub-scales of the Job Content Questionnaire (JCQ) which measures job strain was analysed in relation to PsyCap. As mentioned in Chapter 3 and 4 of this study, Job Strain is made up of the sub-scales Psychological Demands and Decision Latitude (Skills Discretion and Decision Authority). Here, it was found that a significant positive relationship existed between PsyCap and Skill Discretion ($r = .409$, $p < .01$) KK but not for BP ($r = -.070$), and Decision Latitude ($r = .370$, $p < .01$) for KK but not for BP ($r = .085$). Hence, it appears that high levels of PsyCap correlates to high levels of Decision Latitude and Skills Discretion for NHI pilot site (KK), suggesting the person is able to make decisions at work to combat the work demands. However, this was not found in BP (non-NHI pilot site). Psychological capital correlated negatively with Psychological Strain for BP ($r = -.325$, $p < .01$) suggesting that high levels of PsyCap correlate with low levels of Psychological Strain.

5.4.3. Psychological Capital and Burnout

Correlation analysis was also conducted on the sub-scales of the MBI in relation to PsyCap. The results demonstrate that PsyCap correlated negatively with Emotional Exhaustion ($r = -.402$, $p < .01$) and Depersonalisation ($r = -.311$, $p < .05$) for the non-NHI pilot site (BP), while showing no significant correlation with Emotional Exhaustion ($r = .062$) and Depersonalisation ($r = .079$) for NHI pilot site (KK). In terms of the significance of the findings, results for KK were insignificant for these relationships. However, based on the

results from BP, it could be interpreted that possessing high levels of PsyCap could result in a person scoring lower on the Depersonalisation sub-scale of the Burnout scale. Depersonalisation is when an individual becomes detached from their work and patients and develops a negative and cynical attitude towards patients. Accordingly, a nurse who scored high on this scale would be much disengaged from their work and treat their patients more "coldly" than someone who scored lower.

5.4.4. Psychological Capital and Job Satisfaction

To measure levels of Job Satisfaction, the Job Dissatisfaction scale of the JCQ was used. The results indicate that a statistically significant negative relationship exist between PsyCap and Job Dissatisfaction for KK ($r = -.253$, $p < .01$) and BP ($r = -.396$, $p < .01$). This suggests that high levels of PsyCap would result in a lower score on the Job Dissatisfaction scale indicating less Job Dissatisfaction.

5.4.5. Wellbeing (General Health and Satisfaction with Life) and Job Strain

The sub-scales of the Job Content Questionnaire (JCQ) which measures Job Strain were analysed in relation to General Health and Satisfaction with Life. A significant positive relationship was found between Satisfaction with Life and Decision Latitude for KK ($r = .2665$, $p < .01$) and Skills Discretion for KK ($r = .308$, $p < .01$) and BP ($r = .228$, $p < .05$). This suggests that having the greater power to make decisions at work and possessing the skills to do this leads to higher levels of Satisfaction with Life.

5.4.6. Wellbeing and Burnout

Results from the analysis conducted on Wellbeing and the sub-scales of Burnout, indicates that a significant positive relationship exists between general health and emotional exhaustion for BP (r = .322, .01). This seems to suggest that low levels of general health correlates with high levels of emotional exhaustion, indicating that when someone is physically unwell, they are unable to combat the negative effects of their job and become emotionally exhausted.

5.5. Chapter Summary

The results indicate that the NHI pilot site (KK) appears to be experiencing higher levels of Job Control (Decision Latitude, Skills discretion and Decision Authority), better general health, lower levels of Job Dissatisfaction and Emotional Exhaustion and similar levels of PsyCap and satisfaction with life compared to the non-NHI pilot site (BP). On the other hand, nurses in the non-NHI pilot site (BP), appear to experience high levels of Burnout, poor general health, higher levels of Job Dissatisfaction and low levels of Job Control and similar levels of PsyCap and Satisfaction with Life.

CHAPTER SIX

QUALITATIVE RESULTS

6.1. Introduction

The previous chapter presented the results from phase one of the study. This chapter presents the results from the qualitative phase of the research study.

As discussed in the first chapter, the study comprised of two phases with corresponding objectives. The objective of the qualitative phase was to develop an understanding of the experiences and perceptions of nurses with regards to:

i. Their wellbeing, job satisfaction and burnout.
ii. The re-engineered PHC system and the NHI.

As stated in chapter two, the Re-Engineering of PHC aims to strengthen the health care system in order for a NHI scheme to be implemented. A component of the Re-Engineering of PHC is the adaptation of the clinical set of guidelines used to diagnose and treat chronic illnesses, referred to as PC101.

Given the nature of IPA, the researcher was interested in obtaining an understanding as defined by Smith and Osborn (2007) of the meaning the participants attached to the changes occurring within the health care system in relation to their own wellbeing. Moreover, guided by the IPA, the research questions were broadly framed to allow an in-depth exploration of the participants understanding.

The pertinent themes that emanated from the eight (8) transcriptions from the interviews presented in this chapter are interconnected and inextricably linked to each other. All direct narratives of participants are indented and italicised. Further, to ensure that ethical guidelines of anonymity and confidentiality were maintained, participants are identifiable only by generic codes, i.e., P1, P2, P3.

Five major themes and sub-themes were identified and are schematically presented in Figure 5.1 to depict the interrelationship between the qualitative research questions and the identified themes.

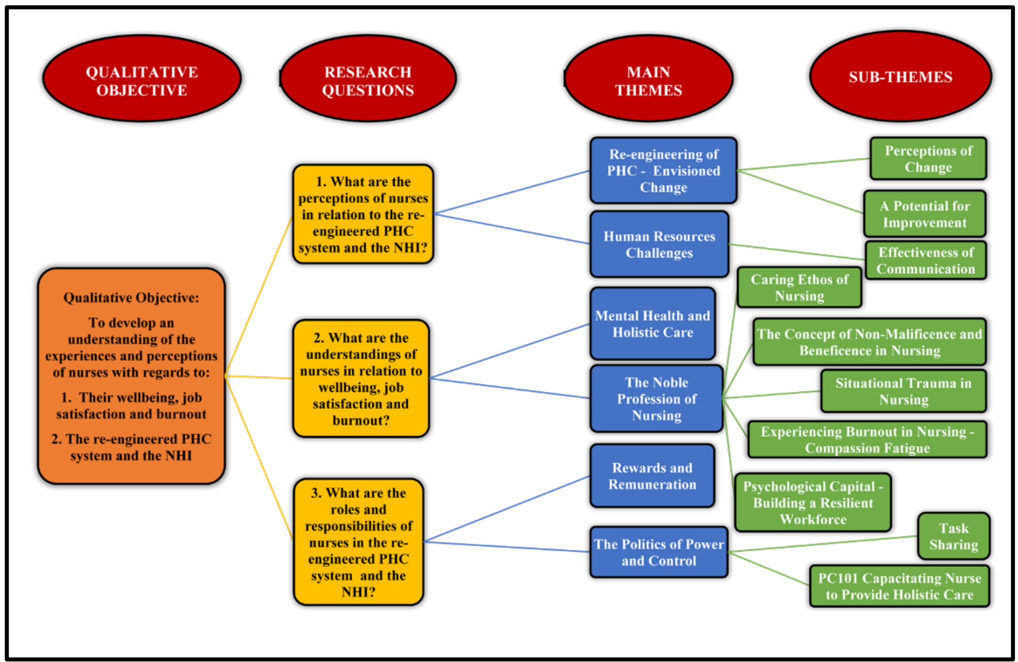

Figure 6.1. Schematic Representation of Qualitative Research Questions and Associated Themes

6.2. Themes

6.2.1. *The Re-Engineering of Public Health Care—Envisioned Change*

This theme related to the feelings and perceptions of the Re-Engineering of PHC, with specific emphasis on the integration of mental health into chronic care by nurses. As argued in chapter three, additional work demanded of an employee without consultation or providing them with the necessary skills would ultimately influence Job Strain and Burnout on an employee. As indicated in the preceding chapters, the introduction of the NHI pilot scheme and accompanying Re-Engineering of the PHC system in South Africa occurred without consultation of the workforce, to whom these changes affect the most. How the nurses in the

NHI pilot site (KK) experienced these changes is important to understand to inform interventions to promote nurse-preparedness of the changes and ultimately the successful implementation of the NHI scheme as it is rolled out to other districts.

6.2.1.1. *Perceptions of Change*

How change is perceived has an impact on the success of that change. In other words, employee values and assumptions influence the effectiveness of the intervention. Unpacking how the intervention is being perceived, understood and experienced by the employees is thus vital. Perception refers to the process through which an individual receives, organises and interprets information from their environment and by so-doing, influences their behaviour (Koen et al., 2011a; Montazeri et al. 2003). This significantly contributes to further understanding human behaviour.

The vast majority of the participants (n = 7) agreed that the changes that were occurring were essential to improving PHC services, although it was felt that the new system required them to be multi-skilled and provide additional services in the form of integration of mental health into chronic care.

The research participants (n = 4) shared some positive perceptions regarding the changes occurring, with specific emphasis on how integrating mental health has facilitated an improvement in their skills:

P1: *Initially we were not able to diagnose first of all depression, so we didn't know how to go about it. So since we have been taught on how to diagnose depression it has helped a lot.*

For Participant 1, the positive reaction was noted to change as the additional training contributed to increasing her skill set. Participant 2 however, shared her resistance when questioned about her PC101 training. She reported the lack of consultation on the additional allocation of tasks:

P2: *Some of the things (such as PC101) you cannot refuse them because, we have been hired to take care of the clients.*

Within the changing system, nurses are now expected to perform additional tasks without prior consultation or adequate remuneration. As cited above, Participant 2 felt that as a nurse, there was an obligation to comply with the requests from the DoH, irrespective of whether she agreed or understood them.

When questioned whether they felt the restructuring had improved the services they provide to the community, some of the research participants expressed a positive perception, especially what it potentially could mean for the health care system. One participant eloquently described it in the following terms:

P4: *At the moment I foresee beautiful things as I was saying to the manager, can you give me chance to restructure your clinic before you can take me out of your clinic, even if you don't give me that post, but give me a chance, so I can restructure.*

The above narrative speaks to the love this participant had for her job, to the point where she wanted to help the Re-Engineering of PHC.

Unlike Participant 2, who felt like she had no choice in the training and therefore no say in how things are changed, Participant 4 was very positive about the opportunities the changes would provide. Participant 4 further reported that for her, it was about leaving a legacy behind for the next person to improve upon:

> ***P4:*** *I said let's give other people a chance. 60 years I'm going home. I'll come and check maybe, I'll come and give my ideas. On how did I do it!*

According to some of the participants (n = 4), the integration as a result of the Re-Engineering of PHC and the introduction of ICDM in the NHI pilot site had aided in removing some of the stigma attached to mental illness:

> ***P5:*** *It is needed, because before the patients were isolated. Because they didn't mix with other patients, now they mix with other patients and they are happier because they are able to talk to everybody. The stigma is removed.*

The general consensus among the participants was that the Re-Engineering process was perceived as positive, particularly among the community health workers:

> ***P3:*** *So far we have community health workers, we having their team leader as a community based worker. I have seen it help a lot because they have to identify the follow up methods for patients that have defaulted for what so ever reason and they encourage them to come back to the clinics… so that we can assist. Also they assisted*

in identifying those who have medical problems and staying at home, so it has helped a lot as PC and PHC.

P6: *With the PC reengineering, we have started already and I have seen so much improvement because at least the community leaders manage to detect clients who need the medical attention and bring them there to the clinic.*

Even though in their responses, the research participants were optimistic about the changes, there was evidence of resentment on how some clinics were being favoured with receiving resources:

P1: *For instance, in our clinic we requested a park room; other clinics are building a park rooms, and we are still standing, so our problems have not been solved.*

P2: *I remember in 2010 we were asking for a park home, because our clinic is very small. [From] 2010 up to now we just received those promises, you know, "it will be done, it will be done." Last year they did the foundation. Since the foundation was laid nothing has taken place up to today. All of a sudden instead of us getting the park home, I don't know what happened, the park home at Kanana Clinic its ready, but we were the first ones to ask about the park home.*

Furthermore, the lack of knowledge of the changing system was noted by one participant:

P7: *If you ask me about N.H.I I know nothing about it. They just said the government wants us to you know, and we must be at the same standard.*

This lack of knowledge of the system extended beyond the health care worker and also to the health care service user who was ignorant of the services. Participant 8 reported that:

> ***P8:*** *As we are going around, we find that some of the people are not knowledgeable about how to take care of themselves, or some they don't even know, that there is a clinic available in... where they should go and attend.*

This is indicative of poor and ineffective communication. In addition, Participant 8 who was both a professional nurse and the leader of the WBOT, reported that the nurses who are commonly referred to as "Re-Engineering Nurse" (i.e., head of the Ward-based Outreach Teams), were not viewed as an integral part of the clinic team and were without leadership in the facility. These nurses who lead the WBOT feel isolated from the rest of the clinic staff, as they are sometimes 'forgotten' when training is scheduled at the facility level. Ambiguity still exists within this new system, especially with reporting structures and role overlap with health promotors:

> ***P8:*** *As a PHC re-engineered nurse in this facility they seem to not accept us as part of the team.*

The above participants were retired nurses who were contracted to assist as the PHC, Re-Engineering team. The ambiguity that exists in the roles between the outreach teams and the facility staff could be attributed to the dichotomy that exists in the way that these outreach teams are financed. Both these issues are discussed later in this study under a related theme.

Some participants were also concerned about fostering a team approach to care through the Re-Engineering PHC process. Moreover, the allocation of resources, specifically park homes to act as clinics incited anger.

6.2.1.2. *A Potential for Improvement*

One of the central aims of the Re-Engineering of PHC was to restructure and improve existing health care facilities in preparation for the rollout of the NHI financing scheme. However, according to the research participants, little infrastructural improvement and resources were noted at their respective facilities:

> ***P6:*** *The lack of resources especially when you want to trace the clients there wouldn't be transport provided or they will be using the bakkie for TB and other purposes.*

It seems that it is not only the staff at the clinics serve a dual purpose, but the resources also. Hence, using the clinic 'bakkie' for a TB campaign was mentioned by Participant 7:

> ***P7:*** *We are feeling demoralised, unhappy, we are sad we feel like leaving this sub-district and going to the private sector. At least there are resources there at clinics or hospitals.*

The above participant apparently believed that the resources in the private health sector were better than those in the public health sector. Furthermore, she noted that at times, they would have to wait for another nurse to have finished using a piece of equipment, in order to finish their examination of a patient:

__P7:__ There are no resources and equipment. We are struggling, so maybe clients come with an ear problem. There are no instruments or equipment to examine the patient with. You have to go to another room and wait for the sister who is maybe using that ENT set.

Two participants specifically cited the addition of park homes at two of the facilities as the only type of improvement that has happened at the PHC level since the piloting of NHI began:

__P4:__ They have already put up the homes and they are still busy with them but it shows that at least they are doing something because, the thing we are complaining. For us, the Re-Engineering was wonderful. We were short of consultation rooms, the structure was too small so because now they have put up the park homes.

__P6:__ With regard to NHI we have not yet started___. But we are busy so far… they have started with the building.

What was evident from all the participants, was the fact that numerous challenges still exist within the current health care system and these need to be addressed if the hope of NHI is to materialise.

6.2.2. *Human Resource Challenges*

One of the major challenges to a NHI and the success of the Re-Engineering of PHC is the human resource crisis presently being experienced in South Africa. A sizable vacuum has been created by nurses exiting the profession and their posts being made vacant or staff

are not replaced timeously in health facilities. This is in addition to the pervasive international migration of health care professionals impacting extensively on the national skills deficit which continues to exist as noted above in chapter 2. The research participants captured these concerns aptly and posed vexing questions about human resource management and the consequent impact on their essential service delivery:

> ***P4:*** *Because of shortage of staff, you will be saying "Sister whoever, can you do this for me?" But she has to do___, she will be doing a managerial job and then she has to do clinical job.*

The above response succinctly summarises how many of the nurses working in public health do two jobs while only being remunerated for one. There was a dual expectation from the nurses to perform both clinical and administrative tasks. According to one participant, some nurses were asked to volunteer to do extra duties without expecting to be remunerated or promoted. This self-initiation was an alternative to addressing unfilled posts and that of staff leaving the service:

> ***P5:*** *Another problem is that if for example staff leave, they are not replaced immediately, where does their salary go? Why are they taking our time? Now we have five, my colleague left, because she went to the municipality but she's never been replaced…Where did the money go? Why can't they appoint a permanent person immediately?*

> ***P6:*** *For example, for now there have been nurses who went away, so the department has not yet hired or advertised the post, you can feel for us.*

P7: *If you complain to the management they don't fill up posts. They wait for the financial year to end and it's going to take a lot of time because its procedure. They have to advertise, call people for interviews, short listing and so forth. Maybe the advertisement is in April but you find that those people are going to be hired in April but come to the clinics in June.*

P6: *We are overworked but there is nothing we can do for now, there is a shortage of staff, only two sisters. There are more tasks but fewer people. I am supposed to see 35 patients as per my guideline, seeing 70 patients is too exhausting. After 12, your mind is already tired.*

The four participants above succinctly highlighted the many questions staff at PHC facilities have with regard to staffing issues. This poses the question of how effective is the communication at both the facility and district level, when many of the staff feel that their legitimate queries are not resolved.

6.2.2.1. *Effectiveness of Communication*

Effective communication is a vital tool an OD practitioner utilises extensively during implementation of change interventions. It impacts on the effectiveness and sustainability of any change programme when members of the organisation have a distinct understanding of the desired change. Earlier, it was emphasised by Participant 7 that she possessed little knowledge about the major changes occurring within the health system. It became evident that although some (n = 2) participants expressed their support for the stipulated changes, a vast majority (n = 6) felt excluded during the process. They cited being undervalued and

ultimately powerless at the system failing them and the patients. This powerlessness was also illustrated by the narrative of Participant 2 previously, when she reported that she could not refuse PC101 training. Participant 1 indicated difficulties on procedural communication:

> ***P1:*** *Did you follow those patients? Did you find out what happened to those patients? That's what they say to us during presentations but they didn't tell us that earlier!"*

This respondent appeared to be frustrated at the system the DoH employed to rate a nurse's performance. According to the participant, they were never afforded training on filling in the performance management development system (PMDS) form:

> ***P7:*** *With those PMDS it's so unfair because you will work. Then when it comes to the presentation, they will introduce new thing that we were not aware of when writing those PMDS. They will only tell you during the presentation that you were supposed to do 1, 2, and 3.*

The PMDS system and the applicability of the form in light of the changes in the system is questionable in terms of its adaptability and how it engages with their present job environment. The current system still favours quantity over quality and this perpetuates the notion of pushing the queues and getting statistics:

> ***P4:*** *I am supposed to be on duty, and then I have to do 1, 2, and 3. It's month end, the statistics are due and we need to do that.*

Quantifications, as opposed to how well the nurse assisted the patient were reported by Participant 1 as an issue in staffing:

P1: *Because they are saying, we are not writing according to their expectation. If I score myself a three, I must write and motivate so they see everything from that. But we were not taught how to write, we were not taught. We just write the way we think we know. So it is demoralising the staff.*

This lack of clarity led to participants to report that they ended up feeling demoralised and unrecognised for the work that they did.

Failure to communicate in an effective manner, impacts on roles and responsibilities and ultimately buy-in's to the change programme. When communication and consultation does occur, the response is often delayed as emphasised by the participant below:

P1: *Although at times, they consult us late… but by the time we receive this notice letters it's very late.*

However, the following participant seemed to be less optimistic about her concerns about being heard within the facility. She felt that although they give their concerns, she reported that nothing was done about them:

P5: *We do give our concerns, but nurses are not supposed to strike, we just talk.*

On the other hand, Participant 4, who was a facility manager, did report that she was consulted when the process of Re-Engineering PHC began:

P4: *Yes, I was part of that, immediately when the Re-Engineering started. I was organising when it started, I was thinking that it will work for us because, we could*

arrange clients in the way it needs us to do. …maternal clients, chronic clients, so to me it was working wonderfully. So we continue doing that.

The above response clearly reveals that only those in formal positions of power were officially informed regarding the changes. Evidently, the managers in the facilities were predominantly occupied with meetings and other core responsibilities which relegated communicating to clinic staff a low priority:

> ***P4:*** *It's Monday, it's a meeting. We will be told what to do, so when we start and do that, then there is another meeting. You find that in a month you have attended so many meetings, and not yet implemented or planned for certain things and then you will be doing them running, not sitting.*

The above responses highlight how the participants who were in managerial positions felt more powerless about their daily tasks. More often than not, someone would reprioritise their day and this would leave them little time to communicate. Their narrative differed from the other participants who shared that they had some level of control over how their day progressed in terms of the tasks allocated to them:

> ***P6:*** *No, with regard to TB that I'm doing, I am entitled for the decisions but I also consult my management where I can.*

> ***P3:*** *I would say 80% control, because basically the daily planning of what I do is up to me… as far as the daily functioning of my job its solely up to me.*

This reaffirms that the managers in PHC facilities to some extent had some control and Decision Latitude; however, they had little time in their day to bring everyone under their charge up to date on DoH policy, as their day was already fully planned once they reached work.

6.2.3. *Mental Health and Holistic Health Care*

According to Participant 1, it would seem that the ICDM and integration had had a positive impact on how patients were treated:

> ***P1:*** *It hasn't affected us so much in a bad way, because they all come as chronic patients, we don't treat them separately, saying that these are depression patients or mental health patients so are treated differently from other patients. No, it hasn't made any difference because they are all treated as chronic patients.*

When probed about providing additional care, specifically to mental health patients under the auspice of the Re-engineered PHC system, many reported "*feeling overwhelmed*" while some responded positively. Other participants related to the mutual growth as they engaged in a counselling process:

> ***P1:*** *Yes, because when you are supposed to diagnose this patient you sort of counsel already.*

> ***P3:*** *I would say positively, because ,you get a chance to also assess yourself in a process of assessing others, and you would also in a way implement all sort of solutions that you would in a process of assessing others, give as advice to others. So,*

it has affected me positively, in a process of helping others... personally, because I am very passionate about mental health.

For these nurses, the additional training received on mental health as a component of the updated PC101 manual, assisted them in reflecting and engaging on their own emotional wellbeing. However, mental health still seems to occupy a lower status is the order of other health care priorities as articulated by Participant 3:

> ***P3:*** *I think it has helped a lot, because mental health for a quite a long time it has been treated as some side-line issue, or some issue that would not be taken seriously as far as health care is concerned.*

This participant's observation on the inclusion of mental health in the Re-Engineering of PHC, was shared by other participants who earlier declared that with the integration of mental health, the stigma of being mentally ill was gradually declining.

6.2.4. *The Noble Profession of Nursing*

The image of Florence Nightingale selflessly serving and assisting others is a dominant stereotype largely portrayed in contemporary society of the nursing profession. This theme emerged from the participants sharing their passion for their profession. Their responses communicated a lens of honour and self-sacrifice of assisting others. Several responses contributed to what constituted job satisfaction are indicated below.

6.2.4.1. *The Caring Ethos of Nursing*

Caring compassionately is the central tenant of nursing. This was reflected in the responses of the participants who reported that their job satisfaction emanated from making a difference in the lives of their patients. The following narratives highlight the caring ethos that guide these nurses to perform their duties to the best of their ability:

> ***P3:*** *I think helping people, making a difference in their lives. Saving a life, and when a life comes into this world in a safe and conducive environment physically.*

> ***P6:*** *When I see my clients being healthy and improving especially now since I'm doing TB.*

The above two responses emphasise how improved health outcomes are significant to nurses. A definitive synergy exists between their aim and the goal of Re-Engineering PHC, which eventually intends strengthening the health care system to advance healthy outcomes:

> ***P2:*** *I enjoy everything but, with the exception that we are understaffed especially where I am working, so at times we work under stressful conditions, because there are lots and lots of patients. The clinic is small and there is a large number of clients because at times when we knock off at seven we leave the clients, they become aggressive towards us.*

Although Participant 2 reported that while she appreciated her job, she also revealed experiencing aggression from patients who had been waiting in queues to be attended. Evidently, this unsafe work environment produced a fair degree of stress for her.

A patient's expression of gratitude was a salient statement shared by all nurses (n=8) that kept them motivated at work:

> ***P6:*** *The rewards is seeing the improvement with the clients and the clients being thankful for the job we did well, that's what keeps me here. It is more at the patient level that it is worthwhile, than on an organisational level.*

For Participant 6, there appeared to be certainly no organisational rewards or any consideration of PMDS as being fulfilling. This concept of caring for others was not confined to patients, but extended to colleagues, as reported by Participant 1, who expressed her dissatisfaction at the performance review one of her staff received from the review board:

> ***P1:*** *I nearly cried when I was representing one of the employees that day I said to my manager "I'm worried... I was not happy at all." What was I going to say to this nurse? Fortunately, it was a Sister who had resigned.*

For this participant, since the Sister had resigned she did not have to engage with her. This was a source of relief to the participant.

Participant 2 succinctly communicated the caring ethos of nursing when she noted that at times, the staff would remain after their shift to assist remaining staff with their patients:

> ***P2:*** *At times we even go an extra mile. Like we usually knock off at 04h00 and there are those who are going to knock off at 07h00 and sometimes you feel like the clients in the waiting room are so many and there are two Sisters remaining who are not*

going to finish the work. So some nurses therefore sacrifice and knock off at 17h00. At times we don't even take those hours, and then you just tell yourself that it's for the good of the client so you will get your reward somewhere one day no matter what.

The above narrative emphasises the sacrifice of the self for the greater good. Evidently for the participants, the most prominent contributing factor towards their job satisfaction, was the gratitude and acknowledgment of their patients.

6.2.4.2. *The Concept of Non-Maleficence and Beneficence in Nursing*

The ethics of care is an indelible component in the code of ethics of the nursing profession. Two vital concepts that emanated from this study were the concepts of non-maleficence and beneficence.

Participants were questioned about their role within the changing system and subsequent effects these changes had had on patient care. The participants collectively responded that the shortage of staff and lack of resources severely impacted on the type of care they provided. For particular participants, it was extremely challenging to ensure the safety of patients in terms of infection control at their facility:

P5: *For example TB, when I'm still busy injecting there will be emergencies coming in, I will have to stop maybe with the children and attend to the emergency first. So we need that the children must be in the room only, nobody else, so that we prevent infection.*

The above encounter of infection control cited by Participant 5 is pervasive in many clinics due to the lack of space and infrastructure as highlighted earlier in this chapter. This was elaborated upon also by Participant 1, who described the challenges of being understaffed and the times of having to work alone:

> ***P1:*** *Last year, I was the only person in the chronic room, seeing more than ninety [patients] per day and you know what you are doing there? There is no quality! You just give! Just give treatment and you do not even have time to update the files and I used to take the whole weeks files home for a weekend, and I never enjoyed my weekend.*

Clearly, for this participant, her commitment to her professional ethic is paramount despite the lack of human resources. Her concern of not rendering quality service due to large patient numbers and being the only person to assist, created an internal ethical dilemma for her. Moreover, her administrative work extended into the weekends which afforded her little time to appreciate her time off. Another participant eloquently communicated her thoughts on understaffing and its impact:

> ***P6:*** *Yes with regard to overloading of work. Sometimes we'll be only two [nursing] sisters in the clinic and we have to do all the programmes within the clinic, so it will be too much for us.*

Despite the above reported challenges the participants encountered within the constraining work environment, they continued to be cognisant of the ethical principles that govern their profession.

Yet another vital concern mentioned by participants during the interviews, was that of patient overflow. All of the participants reported how the patient numbers were steadily increasing with the new system and that the clinics were unable to manage such large patient numbers on a daily basis:

> ***P1:*** *Yes. Yes. Yes. When we have lot of patients, usually our clinic is always full. Like it is right now. Sometimes you know even though we are using appointment system but patients could not honour their appointment and you cannot chase those patients away you must just help them.*

> ***P2:*** *The clinic is small and there is a large number of clients because at times when we knock-off at seven we leave the clients, they become aggressive towards us.*

> ***P7:*** *Yes, more people are now coming to the clinic with this ICDM model, also all services are offered daily with no specific days allocated for certain services. So our numbers have increased. Our work is now simpler than before.*

While integration has benefitted patients, it has also caused an influx of patients because the scope of services has been expanded. However, there are inadequate resources to meet their emerging needs. Furthermore, what exacerbates the problem is that even though there is a system in place for patients who miss their appointment times, nurses nevertheless assist patients despite the closing times for the clinic, thus demonstrating their kindness and generosity:

> ***P1:*** *Maybe you were supposed to knock off at 16h00, you work until maybe 17h00, just to finish all these patients because they fight with you if they are not helped. If you close down the clinic they are not helped.*

Another area of concern that emanated from the interviews was the issue of safety. As much as nurses felt obligated to provide a service to their patients, they felt unsafe as other situational factors impacted on their working environment.

> ***P2:*** *I feel unsafe. There was another incident when I was working a 07h00 to 19h00 we were two professional nurses... I was left alone after the one nurse had to leave. On that day I had these young teenagers they were coming in the consulting room they were having beers bottles and they kicked the door and got into the consulting room. I said "Oh guys, can't you see that I'm having a client with me?" "No! No! We've also been here. We were here in the morning. It was so full and then we left at twelve-o-clock because we were hungry." "You must see us before you leave." "I've got drop sister you must give me the treatment now!" I said "But I'm still busy with the other client." Then they were complaining that they were here in the morning and then they left because the clinic was so full.*

Clearly, nurses are required to act ethically and in the best interest of their patients. Nevertheless, the general sentiment expressed among the participants interviewed was the constant challenge to uphold some of these ethical values within a constraining work environment.

6.2.5. *Experiencing Psychological Wellbeing at Work*

In chapter 3, the importance of emotions in the workplace and how this relates to experience of stress, burnout and depression was discussed. Experiencing positive emotions such as hope, optimistic and being resilient has been shown to have an impact on the level of wellbeing of a person. Healthcare professionals are at increasing risk of burnout and vicarious traumatisation due to their occupation. By focusing on factors that allow them to successfully overcome occupational stress, their general sense of wellbeing can be enhanced and thereby decrease the effect of burnout. Throughout the data collection process, it was evident that the research participants felt abandoned, let down and unsupported by the DoH in terms of their own personal wellbeing.

6.2.5.1. *Situational Trauma in Nursing*

As detailed earlier, nurses both ethically and according to their professional dictates should be caring and helpful; however, providing quality care with insufficient resources in communities that have high levels of poverty can be emotionally exhausting. In this regard, Participant I shared an experience of a riot that had occurred at the facility and how unsupportive management and sub-district personnel had been in dealing with the subsequent trauma. In the opinion of the respondent, management failed to support staff after the traumatic incident:

> ***P1:*** *And we were so traumatised by everything that happened there. When we had to leave the clinic we were escorted by the police… All those things are traumatising and when we went to the sub district, the psychologist was there, management was*

there. I personally told the psychologist that "I was hoping that we would be debriefed or helped immediately" but she said "No, we cannot do that, you must be booked, you must be done individually and it cannot happen immediately, it can happen maybe after three days." When you try to internalise everything that has happened. And to me I thought, let it just go then I don't need it. If I really need it I will just go to my own Doctor.

The above narrative reflects not only the trauma experienced by the participant in the riots, but also by the uncaring attitude of the psychologist. The interchangeable role experienced by this participant was evident as she was not extended the same courtesy of care that she normally extended towards her patients. The protocol procedures instituted by DoH appear in these circumstances to be non-functional with respect to the participant's specific needs. Supporting this notion, Participant 3 reported that there were no regular services available, except for the Employee Assistance Programme (EAP):

P3: *None, there is none unless outside the facility that you get EAP, basically but there are not available at a facility level... Because EAP they are more as a problem based solution, actually it not a thing that would be offered to you regularly.*

The perception of the EAP being punitive was shared by Participant 4 who stated that only employees who are problematic were referred to the EAP:

P4: *They were talking about EAP. It is there, but we don't take ourselves there, we are waiting for somebody. What we usually do, we take a person there if she is not doing her job.*

Participant 1 also reported that they would have benefited from counselling, but that this service was denied to them. Clearly, the participants viewed this as an essential service that should be offered to nursing staff in order to address occupational stress and burnout.

6.2.5.2. *Experiencing Burnout in Nursing—Compassion Fatigue*

Healthcare professionals are at increasing risk of burnout due to the nature of their work. By focusing on factors that allow them to successfully overcome adversity, wellbeing could increase, thereby reducing the effect of burnout (Avey et al.,2010; Koen et al., 2011a). The following narratives speak to how the participants had experienced burnout:

> ***P2:*** *We do have really this burn out syndrome, you find that at times now many people will be falling sick when they are supposed to come to work…but at times really this burn out syndrome makes you have those negative feelings and then you just decide that tomorrow you not going to work.*

> ***P3:*** *Physically you would be fatigued, that's the first thing that you would experience personally and emotionally you feel drained. Basically those are the two that I have experienced.*

The research participant were unmistakable in their belief that they had suffered from burnout syndrome. Hence, Participant 3 reported that she had experienced emotional exhaustion, while Participant 2 reported depersonalisation and the lack of personal accomplishment. Participant 7 went on to report:

P7: *We are burn out like now I've applied to the mining area. I feel it's too much because we are burnout, our problems are not being taken care off. So the only thing that I can do is to leave.*

Participant 7 emphasises an important factor that nurses are expected to be caring and compassionate. When however this is not reciprocated within the system that does not even acknowledge her needs, she felt neglected and alone. For her, the only choice to address burnout was to leave.

Experiencing positive emotions such as hope, optimistic and resilience has been shown to have an impact on the level of wellbeing. However, in the interviews conducted, positive emotions among the research participants were noticeably low. Indeed, one participant was clear that as a professional nurse, he ignored his wellbeing:

P6: *I would say we are avoiding our wellbeing, seriously, because, I would say for example, I would stay for a client until lunch, even forgetting I have to go to the loo, or lunch or breakfast or teatime. As for our health, we don't really consider our health that much.*

Some participants reported being unhappy and dissatisfied and had been considering their job options within the private health care system:

P1: *People are not happy. It's just that they cannot write it down.*

P2: *It makes us feel as though we not being recognised or taken care of.*

> ***P7:*** *We are feeling demoralised, unhappy, we are sad we feel like leaving this sub-district. Going to private, at least there are resources there at clinics or hospital.*

Yet, their unhappiness with the system did not translate into how they treated their patients:

> ***P3:*** *I believed that we go through things differently, but personally I always try to separate the two. I have never gone through situation where by I would cross the line or I will fail to separate the two. Because it would generally cloud my professional assessment and being a clinician in health ensures that I could not allow myself to do that.*

This participant communicated her inner conflict, that despite her stress, she was foremost a professional who had to adhere to clinical standards of practice.

6.2.5.3. *Psychological Capital—Building: a Resilient Workforce*

According to Koen et al. (2011b), interventions focused on building human resilience could promote health and wellbeing of nurses. They further advocate that research on resilience should be used to formulate guidelines to this effect. Studies conducted on the impact of PsyCap on employee wellbeing (Avey et al., 2009), reveal its role in reducing stress and employee turnover (Smith et al., 2009) and how positive employees can exert a positive influence on organisational change (Smith et al., 2009).

6.2.6. *Rewards and Remuneration*

When questioned about the rewards they receive, a vast majority of the research participants focused their comments on the Performance Management Development System. They shared their dissatisfaction with a system that tended to be more punitive than rewarding employees for their work. They cited examples of being unaware on how to use the system and specifically how *"to fill it in"* and that Management *"down scored employees"* who were not being recognised and acknowledged for their work. The only appreciation they received was from satisfied patients:

> ***P3:*** *I wouldn't say that there is not any reward that we get that would make us want to stay, except the fact you would see the kind of change you have had in individual clients life and you would disregard the negativity that you receive.*

The following excerpts highlight the participant's concerns about the Performance Management Development System (PMDS) at PHC facilities.

> ***P1:*** *Financial advice, we do get them from PMDS. But with PMDS you cannot—that is management of performance. Sometimes you do not get it because of the way the management does it… Sometimes you are down scored to a 2. This means you are not actually performing. It means interventions must be in place for you to perform to a normal level, so that is demoralising and demotivates people. It demoralises people because of the way they assess people or they reward people.*

P7: *No, there are no rewards even you know we have PMDS, but with those PMDS it's so unfair because you will work, there comes presentation, where they will introduce new thing that we were not aware when writing those PMDS, they will only tell you during the presentation that you were supposed to do 1,2,and 3..*

The above narratives clearly demonstrate the distinction between the caring nature of the nurse and the demands to be professional at all times with their patients. The contradictory nature of how they were expected to extend care to their patients was not the same care as communicated to them by the DoH. Also, the lack of acknowledgment—whether financial or otherwise—further contributed to their dissatisfaction within their work environments.

6.2.7. *The Politics of Power and Control*

What emerged very strongly from the narratives were the participants feeling demoralised by the system. The tone of despondency in the responses of the participants was very overt, thereby lending insight into the need to assess the positive psychological resources that the PHC nursing staff possess. When questioned about how much control they feel they have in their daily tasks, their responses varied from *"I have control"* to *"No control."* While this may seem to contradict the quantitative findings of this study, job control is not simply about making decisions concerning daily tasks, but also includes an individual being able to regulate their own behaviour and how they respond appropriately to situations. This seeming contradiction is further elaborated upon in chapter 7.

P1: *We do not have control at all. Your manager might be there, but she does not have control as well. She knows you. I am the supervisor of those people that I am*

going to represent them because I know them better. Now I read what these people have written, the panel will decide.

The above statement refers to how nurses are down-scored at their performance reviews and that even the manager had little impact over the panel's decisions. For Participant 3, she felt that although she was not in a managerial position, she was in control of her daily planning commitments:

P3: *I would say 80% control, because basically the daily planning of what I do.*

The despondency the participants felt in the lack of control they had in their daily duties and over how their work was evaluated was evident in all of the interviews. A major change that the Re-Engineering of PHC had brought about according to the participants interviewed was the additional administrative work they encountered which was not recognised by management:

P1: *I was to writing. Writing. Writing. And was I rewarded? No. Was I recognised? No.*

P6: *It makes me feel a little bit sad, because we are not recognising the type of jobs we do, but I keep on trying my level best that's all we can do.*

The majority of the participants (n = 6) emphasised that being acknowledged was a reward in itself; this being from patients and not management. Participant 5 communicated this thought succinctly:

P5: *Because there is a lot of writing, we need enough staff because we are writing for each patient I don't know how many papers I write. Because for other patients, for example, immunisation already have cards opened and secondly you have to attend to milestones, developmental milestones in screening, screening the patients also, whether they are going to get vitamins, then you write.*

In terms of the responses received, administrative work seemed to be overwhelming due to the clinics being severely understaffed, under resourced and experiencing an ever-increasing patient load:

P6: *Due to the lack of resources especially when you want to trace the clients there wouldn't be transport provided or there will be using their bakkie for TB, and other purposes.*

P7: *There are no resources and the equipment we are struggling, so maybe clients come with an ear problem. There are no instruments, equipment's you have to go to another room and wait for the Sister whose maybe using that ENT set.*

The lack of resources is reiterated here as it impacts on sharing equipment that needs to be negotiated with other departments within the facility.

6.2.8. *Task Sharing: The Introduction of Ward-Based Outreach Teams*

One of the ways in which the South African DoH has adopted the task sharing approach is by creating a Ward-Based Outreach Teams (WBOT) responsible for taking medical services to the community, thus alleviating the number of patients visiting health

care facilities. The majority of the research participants were positive about the role these teams have played, both in their health facilities and in the wider community. However, the lack of clearly defined roles and responsibilities did translate in some participants the feeling that this added more on to their daily workload.

One participant shared her scepticism she felt with respect to the WBOT. For her, little had changed. She noted that even though she was not the team leader, she had the additional task of deploying the community health workers (CHW) to trace patients:

> ***P3:*** *I am a focal point nurse… I am the one who advances the CHWs and tells them where to go. For instance, when tracing of defaulted patients… I would instruct the CHW's and their team leaders to go where the patients is and try to find them.*

The intention of introducing these teams was to outsource specialised tasks such as the tracing of defaulters and health promotion in the community. However, feelings of ambivalence on the part of the research participants regarding the benefit of these teams was clearly evident in the conducted interviews:

> ***P2:*** *In PHC reengineering, we are still seeing a lots of chronic clients. I don't know when it is going to happen that these Sisters [outreach tem leaders] they take the treatment to the community because it has not yet started now.*

> ***P5:*** *Especially the reengineering, because now clients who are staying at home are being referred to the clinic, especially the children who have been not recognised six years ago and the old ladies who are staying there at home, with social problems.*

Participant 5 went on to note other interrelated concerns of children and the elderly within the system that she felt had to be acknowledged.

6.2.8.1. *PC101: Capacitating the Nurse to Provide Holistic Care*

As discussed above and in chapter 2 of this study, PC101 refers to a set of clinical guidelines nurses use to diagnose and treat patients at a PHC level. For many of the participants (n = 5), the training of PC101 empowered them and provided the skills to better diagnose and treat their patients:

> ***P1:*** *It affected me positively because I was learning, I was going to use all those skills to diagnose my patients.*

For Participant 1, the additional training contributed to her becoming a better clinician:

> ***P6:*** *With regard to PC training 101, I think it is a good effort that national made because, I have used or utilised the guide lines, they broaden knowledge that a person has and the steps that I have to take for a client, so that one is a good effort.*

Similarly, Participant 6 viewed the training as positively contributing to him acquiring additional skills.

6.3. Chapter Summary

This chapter presented the main findings from the qualitative phase of the study. It explored the nurses' perceptions and understandings of the changes that occurred within the South African health care system and the differing roles they identified for themselves within

that changing system. From the research results, it was evident that the nurses interviewed possessed certain characteristics that sustained them, thereby enabling them to continue to work in the PHC system irrespective of the various interrelated challenges they encounter daily in their work environment. It was evident from the research interviews that the resilience the participants possessed afforded them the confidence to navigate around the challenging circumstances they operated within. The research results also indicated that many challenges continued to exist with regard to the changes occurring. These included a lack of human resources, the nonexistence of infrastructure and the shortage of medical equipment. Nevertheless, some participants were optimistic about specific changes, especially the integration of mental health into chronic care and ICDM.

The following chapter will present an integrated discussion of both the quantitative and qualitative findings as they pertain to the main research questions.

CHAPTER SEVEN

INTEGRATED DISCUSSION

7.1. Introduction

Chapter 5 and 6 of this study respectively, presented the qualitative and quantitative data as it relates to the overall aim of the study which was to assess and understand the psychological resources and stressors of nurses in the context of the Re-engineered PHC and the NHI systems. As identified above, the NHI pilot site was conducted in the Dr Kenneth Kaunda District (KK), North West Province, where there had been numerous training workshops and systems interventions as part of the piloting phase (ICDM, PC101, Re-Engineering) and the non-NHI pilot site was Bojanala Platinum District (BP), North West Province, which had not yet undergone any major system change at the time of data collection.

The three objectives of the study were as follows:

i. To determine the similarities and differences in the levels of PsyCap, Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in the NHI pilot and non-NHI pilot sites;
ii. To investigate the relationship between PysCap and Job Satisfaction, Wellbeing, Job Strain and Burnout for nurses in the NHI pilot and non-NHI pilot sites;
iii. To develop insight into the experiences of positive psychological resources and stressors of nurses working in an NHI pilot site, the knowledge they have regarding

the Re-engineered PHC and NHI system and how they understand their role within this new dispensation.

This chapter uses the findings from the correlational analysis between the constructs used to measure psychological resources and stressors, the qualitative findings and existing literature to elucidate the findings of the similarities and differences in the levels of psychological resources and stressors in the NHI pilot (KK) and non-NHI pilot site (BP).

OBJECTIVE 1: TO DETERMINE THE SIMILARITIES AND DIFFERENCES IN THE LEVELS OF PSYCHOLOGICAL CAPITAL, JOB SATISFACTION, WELLBEING, JOB STRAIN AND BURNOUT FOR NURSES IN THE NHI PILOT AND NON-NHI PILOT SITE

7.2. Similarities and Differences in the Levels of Psychological Resources and Stressors for Nurses in the NHI Pilot and Non-NHI Pilot Site

In terms of psychological resources and stressors, it was found that the NHI pilot site (KK) experienced better general health, more job control, less burnout and less job dissatisfaction than the non-NHI pilot site (BP). These results are elaborated upon in the proceeding sections.

7.2.1. Comparing Job Strain, Burnout and Job Dissatisfaction

Levels of Job Strain

As mentioned earlier in this study, the construct of Job Strain comprises of three different subscales, namely, Skills Discretion, Decision Latitude and Decision Authority. Skills and competencies have been found to relate to how much job control an employee experiences (Park, Jacob, Wagner, & Baiden, 2014). One way to assess this is to determine the levels of Skills Discretion, Decision Authority and Decision Latitude an employee reports as having within their current job. One of the objectives of this study was to determine whether there was a difference in the levels of psychological stressors experienced between the two sites given the difference in exposure to training and change in procedures received as a result of the piloting of the NHI financing scheme.

The t-test demonstrated that the NHI-pilot site (KK) reported significantly higher scores for Skills Discretion, Decision Latitude and Decision Authority than the non-NHI pilot site (BP). This result suggests that nurses from KK have more job control than nurses in BP. Nurses from the NHI pilot site (KK) offered that while they had more roles and responsibilities as a result of the changes taking place within the health care system, the majority of respondents felt the changes were essential towards improving the quality and type of care they provided to their patients. Accordingly, they felt competent to provide holistic care. As one participant eloquently related during the qualitative interviews, she now possessed the skill to diagnose depression since the introduction of the new training she had received as part of NHI and ICSM.

Concerning his development of the job strain quadrant, Karasek (1979) identified four different types of jobs: active, passive, high strain and low strain jobs. Nursing is typically characterised as a high strain job (high demands and low control). However, it is possible to move into the active job quadrant as noted in chapter 3, where a worker experiences high demands but also enjoys high levels of control over their work. The findings from this study supports this notion, as nurses from the NHI pilot site (KK) reported experiencing higher levels of control than nurses from the non-NHI pilot site (BP). Furthermore, when examining the data for skills discretion, which contributes a large component of the decision control scale, it was evident that nurses from the NHI pilot site (KK) scored significantly higher than nurses from the non-NHI pilot site (BP).

For the NHI pilot site (KK), nurses as a result of ICDM and PC101, had undergone training which provided them with the skills to provide integrated care to their patients. In addition, the NHI pilot site was better resourced in terms of staff and the access to NHI doctors which provided "informal" mentoring to the nursing staff. The NHI pilot site also had access to the WBOTs which the participants all agreed had helped to alleviate some of the queue pressure. The non-NHI pilot site (BP) has not yet undergone any training or development at the point of data collection. The conspicuous differences between the two sites, indicates that nurses in the NHI pilot site were more empowered and this also had an impact on other factors such as the experience of Burnout and Job Dissatisfaction.

Levels of Burnout

In their examination of the relationship between Job Control and Burnout, Park et al. (2014) determined that interventions to improve Job Control can reduce the negative aspects of burnout and enhance the positive. Linked to the above findings, it is not surprising that the t-tests revealed that there was statistically significant difference at the .05 level of significance between the NHI pilot site (KK) and the non-NHI pilot site (BP) in terms of the level of emotional exhaustion, with nurses from the non-NHI pilot site (BP) experiencing higher levels of emotional exhaustion. The research results therefore demonstrate that nurses from the non-NHI pilot site (BP) experienced more emotional exhaustion as a result of their job. This result is expected considering that the non-NHI pilot site (BP) reported lower levels of Skills Discretion, Decisions Latitude and Job Control, placing them in the high strain quadrant of Karasek's Job Strain model. These results were supported by a study conducted by van der Colff and Rothmann (2014), which found burnout among South African nurses to be higher than that of nurses in other countries. Furthermore, burnout among nurses has been found to be higher than any other health professional, as nursing requires providing compassionate care in environments where resources are limited and the exposure to traumatic events is greater. Working within an environment that exposes an individual to multiple stressors can lead to burnout and poor health (Khamisa, Oldenburg, Peltser & Ilic, 2015). The results from this study found that in the non-NHI pilot site (BP), higher levels of burnout were reported than the NHI pilot site (KK). In addition, poorer levels of general

health supports previous findings on the levels of burnout of nurses working in South African PHC facilities (Klopper et al., 2012; Van der Colff & Rothmann, 2014).

Burnout not only affects the individual, but also the organisation as low levels of Wellbeing and high levels of Burnout coupled with a lack of resources and staff have led to the health sector to experience high staff turnover rates (Delobelle et al., 2011). Given that South Africa has been facing a nursing crisis for some time, it would be prudent to consider the role that burnout and lack of job control has played in the decision of many nurses to leave the service. The Minister of Health has mentioned that if nurses are unhappy they should leave. Such an utterance invariably does not augur well for enlisting nurses' support within a changing health environment that is being implemented in South Africa. Van den Heuvel, Demerouti and Bakker (2014) cautions that organisations should focus their attention on the individual employee in terms of Burnout, Job Control and Job Satisfaction if they hope to have successful change initiatives.

Levels of Job Dissatisfaction

Job Satisfaction is key to combatting the experience of negative emotions at work such as Burnout and Stress. It is also key to motivating and retaining employees, and critical to improving health care systems functioning in low and middle income countries (Blaauw et al. 2013). When examining the results for Job Dissatisfaction, nurses from the NHI pilot site (KK) were less dissatisfied with their jobs than nurses from the non-NHI pilot site (BP). This meant that in terms of Job Satisfaction, it would appear that nurses from the NHI pilot site (KK) were experiencing greater job satisfaction that their counterparts in the non-NHI pilot

site (BP). These results link back to what was found in terms of Job Strain and Burnout for the two pilot sites, with nurses from the NHI pilot site (KK) experiencing greater Job Control and less Burnout than nurses from the non-NHI pilot site (BP). These results were supported by a study conducted by Laschinger, Finegan and Shamian (2001) which found that high levels of psychological empowerment had an effect on the experience of Job Strain and Job Satisfaction.

From the research results, it appears that the NHI scheme, with all its additional training and resources has in some small measure helped to improve the Job Satisfaction of nurses in the pilot site and has had a large impact on the experience of Job Control and Burnout.

7.2.2. *Comparing the Levels of Psychological Capital, General Health and Satisfaction with Life*

The importance of positive psychological resources and strengths have been highlighted in numerous studies to date in light of the impact it has on positive organisational outcomes such as Job Performance, Job Satisfaction and Wellbeing (Luthans et al., 2007a; Newman, Ucbasaran, Zhu, & Hirst, 2014; Tavakoli, 2010; Youssef & Luthans, 2007). In terms of PsyCap, nurses in both the NHI (KK) and non-NHI pilot site (BP) reported similar levels of PsyCap. Unlike traits that are fixed, people can be capacitated in the psychological constructs that make up PsyCap which can be beneficial to the person and the organisation alike. Both groups had relatively high scores in terms of PsyCap with KK reporting a slightly higher mean than BP. PsyCap encompasses hope, efficacy, resilience and optimism, with the

literature suggesting that these positive resources are universal (Luthans et al. 2007a; Newman et al. 2014).

Capacitation in or possessing PsyCap is however insufficient. Organisations need to provide a supportive environment whereby employees are able to express, develop and use these resources towards developing valuable routines and capabilities (Newman et al., 2014). This was evident with the results indicating that the two pilot sites had similar levels of PsyCap and Satisfaction with Life. Yet, differences were found in levels of Job Strain, Burnout and Job Satisfaction as was noted above. In terms of General Health, there were statistically significant differences in the scores between the two groups at the .01 level of significance. These results suggest that nurses from the NHI pilot site (KK) reported experiencing better general health than those nurses from the non-NHI pilot site (BP) even though the t-test further established that both groups seemed to possess similar levels of Satisfaction with Life, with no significant difference in their scores. However, the findings of this study are similar to a South African study conducted by Shelton and Renard (2015) where they found similarities in PsyCap among nurses in different work settings (public, private, NGO sector). Another study conducted by Delobelle et al. (2011) found that the majority of nurses reported that positive co-worker relationships and being happy with the content of their work contributed largely to their Life Satisfaction and Job Satisfaction score

A possible explanation for these similarities across settings could be that nursing provides the opportunity to make a contribution to helping others. This is supported by findings from the qualitative interviews which indicated that when considering what contributed to nurses experiencing Wellbeing or Satisfaction with Life, the data demonstrated

that it was witnessing their patients getting better and knowing that they had helped to achieve such made them feel virtuous and satisfied with their lives. In particular, Participant 6 reported that “helping clients” contributed to her Life Satisfaction. It is important however to be aware that Life Satisfaction refers only to how someone perceives their life experiences satisfy their physical and psychological wants and needs (Demerouti et al., 2000). The results could therefore indicate that in terms of their personal lives, nurses appear to be similarly satisfied.

Similarly to other studies, in both pilot sites a positive relationship was found to exist between PsyCap (positive resources such as hope, efficacy, resilience and optimism) and Satisfaction with Life (SWLS) and a negative relationship with General health as measured by the GHQ-12. These findings are similar to previous research (Avey et al., 2010; Cole, Daly, & Mak, 2009) where it was established that high levels of PsyCap were related to higher levels of Satisfaction with Life. The findings from this study supports this relationship as nurses from both pilot sites reported possessing similar levels of PsyCap. Accordingly, it could be expected that the two sites possessed similar levels of Satisfaction with Life.

Looking at the similarities and differences between the two pilot sites in terms of the correlations, it was found that in both groups, a practical and statistically significant positive relationship was found to exist between PsyCap and Satisfaction with Life. This indicates that possessing high levels of PsyCap was associated with higher Satisfaction with Life scores in both pilot sites. As explained in chapter 4, a practical relationship indicates that the results were not due to chance and that the results are applicable to the larger population.

Nursing has been characterised as a stressful profession to work in. Workplace stress has been found to be associated with certain psychological stressors, physical and mental health and job satisfaction (Khamisa et al., 2015). A study conducted by Avey et al. (2009) found that when employees possessed high levels of PsyCap, they were less likely to succumb to the negative stressors of their job and ultimately decide to vacate their jobs. Their study lends support to the notion that when an individual invests in PsyCap which is positively associated with Life Satisfaction, they also invest in resources that help mitigate negative experiences of doing "people work" and therefore limit subsequent staff turnover. The research results do indicate that positive emotions are essential in promoting and improving Life Satisfaction and should receive more adequate attention from the DoH as a viable intervention focus to combat staff turnover.

Nurses from the NHI pilot site (KK) reportedly experienced better general health than their counterparts in the non-NHI pilot site (BP). Yet, they still felt the system did not allow them to express their unhappiness or empower them to take an active role in improving their own Wellbeing. The first group (KK), having undergone significant organisational change before this study was conducted, still did not seem to report higher levels of Satisfaction with Life, nor PsyCap than their counterparts in BP. In addition, it was ascertained from the qualitative data that both groups reported feeling unsupported when considering their own emotional wellbeing.

OBJECTIVE 2: TO INVESTIGATE THE RELATIONSHIP BETWEEN PSYCHOLOGICAL CAPITAL WITH JOB SATISFACTION, WELLBEING, JOB STRAIN AND BURNOUT FOR NURSES IN THE NHI PILOT AND NON-NHI PILOT SITES

The results from the correlation analysis support the above findings in terms of the relationships that were found. This next section will present what was either practically and/or statistically significant. As mentioned in chapter 4 of this study, a practically significant relationship is indicative of the theoretical or applied significance of the result. Hence, it is a good way to assess whether the results are generalizable to the larger population.

7.3. The Relationship between Positive Psychological Resources and Psychological Stressors

As discussed in the above sections, nurses in the NHI pilot site (KK) experienced higher levels of Job Control, General Health and lower levels of Emotional Exhaustion and Job Dissatisfaction compared to the non-NHI pilot site (BP). The findings from the qualitative interviews suggest that these results are a product of the training they received as part of the changes, which had empowered them to do their jobs better, e.g., identify and diagnose depression in patients, as well as allowed them to practice a more team-based approach to care with the introduction of the WBOTs.

The Conservation of Resources (COR) theory outlines the importance of resources in coping with organisational change which can be perceived as quite stressful to the employee.

First, COR states that resources can enhance the ability of the employee to cope with stressful events by providing them with the mental and physical energy needed for utilising various coping behaviours and/or by protecting them against various dysfunctional psychological states. Second, resources can also act as a protective buffer against future loss and aid in the recovery from past losses (Hobfoll, 2001). The results from the correlation analysis indicated that for the NHI pilot site (KK) a positive practical and significant relationship between PsyCap, Life Satisfaction, Skills Discretion, Decision Authority and Decision Latitude existed which potentially explain why this pilot site reported experiencing lower levels of Emotional Exhaustion as was evident from the t-test results presented above.

7.3.1. *The Relationship between Psychological Capital and Job Strain and Burnout*

Job Strain is a result of the interaction between Job Demands and Decision Latitude. According to Karasek (1979), this provides a framework by which to understand the relationship between the psychosocial characteristics of the work environment and the health outcomes of employees. When an employee is experiencing high levels of Job Strain which is characterised as having high Job Demands and low Decision Latitude, studies have found that these employees were at a high risk of developing health problems such as cardiovascular disease (Habibi, Poorabdian, & Shakerian, 2015; Khamisa et al., 2015).

For the nurses from the NHI pilot (intervention) site (KK), a practical and statistically significant positive relationship was found between PsyCap and Skills Discretion, Decision Latitude and Decision Authority. For the nurses from the non-NHI pilot (control) site (BP), none of the findings were practically or statistically significant. When looking at the results

for PsyCap and Burnout, for the NHI pilot site (KK), none of the results were practically or statistically significant. For the non-NHI pilot site (BP), a practical and statistically significant negative relationship was found between PsyCap, Emotional Exhaustion and Depersonalisation. The results suggests that when an individual possesses high levels of PsyCap, they can in turn, experience lower levels of Emotional Exhaustion and Depersonalisation. Typically, this type of relationship would ultimately result in less Burnout. By focusing on building positive resources such as hope, resilience and optimism in nurses, it could be expected to help decrease levels of Burnout and Stress.

When looking at the relationships for both Job Strain and Burnout and how it correlates to PsyCap, it was evident from the data that high levels of PsyCap would result in a person experiencing less Job Strain (i.e. high Job Control) and thereby experience less Burnout. An individual would there need to score high on PsyCap, Skills Discretion, Decision Latitude and Decision Control in order to experience less Burnout. For the nurses from the NHI pilot site (KK) the above was found, where nurses reported lower levels of Emotional Exhaustion than those from the non-NHI pilot (control) site when looking at the results from the t-test analysis.

7.3.2. *The Relationship between Psychological Capital and Job Dissatisfaction*

In terms of the relationship between PsyCap and Job Dissatisfaction, it was found that for both sites (KK and BP), a practical and statistically significant negative relationship existed for PsyCap and Job Dissatisfaction. High levels of PsyCap were thus associated with lower Job Dissatisfaction, therefore indicating that nurses in the NHI pilot site (KK) were less

dissatisfied, experiencing higher levels of Job Satisfaction. This is supported by a study conducted in Nigeria by Olatunde and Odusanya (2015) which found job satisfaction to be positively correlated to PsyCap. As mentioned earlier, high levels of PsyCap were also related to Skills Discretion, Decision Authority and Decision Latitude. According to van der Colff and Rothmann (2014) the level of training a nurse receives, impacts the level of Burnout such a nurse will experience.

An overwhelming number of studies have concentrated on the relationship between Job Satisfaction and the turnover of nurses. The two are inextricably linked. Accordingly, where there is a lack or low levels of Job Satisfaction, higher staff turnover rates are experienced (Blaauw et al., 2013). The nursing profession has been beset by severe shortages, high turnover and absenteeism due to illness, all of which exacerbates the human resources situation (Delobelle et al., 2011). Therefore, the physical and emotional wellbeing of nurses cannot be overemphasised and is considered a contributory factor in their decision to leave the nursing profession.

As noted by COR, there are the two factors that can impede the ability to navigate around change: fatigue and anxiety. These two factors can undermine an individual's ability to control their stress and protect them against future resource loss. An integral component of the NHI scheme is to strengthen PHC. However, cognisance of the burden of care and its effect on the existing staff cannot be disregarded. As a consequence, the concept of Wellbeing in its entirety has to be considered in the contribution it makes towards holistic health care.

7.3.3. *The Relationship between Psychological Capital and Wellbeing (General Health and Life Satisfaction)*

In relation to PsyCap and the GHQ, a practical and statistically significant negative relationship between PsyCap and General Health was found for the NHI pilot site (KK). These results indicate that for the group of nurses from the NHI pilot site (KK), high levels of PsyCap translated into their scoring lower on the GHQ-12 which reflects better health. In regard to the non-NHI pilot site (BP), although there was a negative relationship, the relationship was neither statistically nor practically significant. This was despite there being similar levels of PsyCap in both sites, albeit the sample sizes were different which could potentially have affected the results reaching significance. As posited earlier in this chapter, the presence of PsyCap does not automatically translate into improved work outcomes. As stated by Newman et al. (2014), employees need to be able to develop and deploy these resources in order to achieve an effect. This is corroborated by Fredrickson (2013), whose study over a fifteen-year period found support for her theory on broadening and building positive emotions within an organisational context. Fredrickson believed that organisations should create environments that cultivate the experience of positive emotions at work in order for them to have an effect on personal and organisational goals. Accordingly, in the non-NHI pilot site (BP), possessing PsyCap was not associated with improved wellbeing in terms of General Health as their work environment was different to that of the NHI pilot site (KK).

The results from this study are important for encouraging a focus on the promotion of physical and mental health of PHC staff. The significant results indicate that when an worker has high levels of PsyCap, they would potentially also experience less Job Strain as a result

of possessing high levels of Skills Discretion, Decision Latitude and Decision Authority in their job. The "broaden and build" theory explains this relationship by stating that positive emotions can act as a driving force that motivates employees and organisations towards achieving optimal levels of functioning, which ultimately influences action (Fredrickson, 2003, 2013).

OBJECTIVE 3: TO DEVELOP INSIGHT INTO THE EXPERIENCES OF POSITIVE PSYCHOLOGICAL RESOURCES AND STRESSORS OF NURSES WORKING IN A NHI PILOT SITE, THE KNOWLEDGE THEY HAVE REGARDING THE RE-ENGINEERED PHC AND A NHI SYSTEM AND HOW THEY UNDERSTAND THEIR ROLE WITHIN THIS NEW DISPENSATION

The qualitative data from the NHI pilot site (KK), provided some further insight into how nurses were currently experiencing positive psychological resources and stressors within the changed system.

7.4. The Re-Engineering of Primary Health Care—Envisioned Change

Numerous studies to date have demonstrated the importance of positive psychological resources and PsyCap specifically in aiding the change process. Van den Heuvel et al, (2014) in particular emphasises the importance of psychological resources in aiding employees adapt to change and for the successful implementation of the change initiative, by focusing on clarifying the organisational identity of the employee within the proposed change.

Sufficient cognisance must be taken of the fact that nurses are affected by their daily interactions with patients. Nurses narrated that they were sometimes tasked with being the counsellor, pastor, nurse, psychologist and social worker for some of their patients. The multiplicity of these roles places them at a high risk for experiencing Burnout as noted by many of the published studies cited earlier in this work. As stated, Burnout potentially causes a nurse to disengage from patients, feel emotionally and physically exhausted, as well as feel highly unhappy with their career choice. The trauma experienced in PHC by nurses needs to be deliberately considered at the grass roots level before it becomes a much larger problem and has an impact on other areas of the new system. Some of the nurses who participated in this study, commented on how their traumatic experience of the riot that occurred in the NHI pilot site, (KK) during 2015 was not handled appropriately by senior management. In particular, one nurse felt her trauma was not adequately dealt with, where she received no psychological assistance and had no choice but to continue to work. She felt abandoned by a system that was supposed to support and promote the healing process, both physically and mentally.

7.5. Mental Health and Holistic Health Care

The perception that no-one really cares for the wellbeing of nurses was supported by the quantitative findings where nurses from the NHI pilot site (KK) did not differ from their counterparts in the non-NHI pilot site (BP) in terms of Life Satisfaction which is related to Wellbeing. Even though in terms of general health, nurses from the NHI pilot site (KK) reported experiencing better health and in the non-NHI pilot site (BP), during the qualitative interviews the participants reported that they would consult their own private doctors or

psychologists when faced with a traumatic event at work. The research participant who felt that her trauma was not dealt with at an organisational level, further stated that she felt so traumatised that she had to consult her own doctor in order to cope with what had taken place at her work. This indicates that in terms of the emotional burden of nursing, the participants felt that they were solely responsible for their own emotional wellbeing.

When asked about the EAP system that essentially should aid in providing some support for employees, the participants reported that they viewed the EAP to be more punitive than beneficial. Indeed, it was felt that someone would only be referred to the EAP if they were a problem employee and this could be used to negatively affect the performance review of a nurse. The research participants felt there were no supportive mechanisms in place to aid nurses in improving their own Wellbeing, nor to improve their performance in the workplace. According to Laschinger and Fida (2014) poor supervision and lack of support can result in poor physical and mental health outcomes. While the NHI White Paper has provided nurses with some form of informal supervision in the form of NHI doctors and the PC101 trainers, an official model of supervision and mentoring should be developed alongside, in order to provide nurses with the support they need.

A major component of being healthy, is to practice a healthy life style and adopt healthy ways of coping with stress. Nurses are integral in the PHC system and as indicated in this study through the quantitative findings, their own wellbeing easily becomes a low priority when compared to their patients. This was clearly evidenced by the results from the Life Satisfaction Scale where both sites (KK and BP) experienced similar levels of Life

Satisfaction. As mentioned by a few of the research participants, their patients came first as highlighted by the principle of *Batho Pele.*

The principle of *Batho Pele* has been defined as "putting other people first before considering your own needs," where the key message is "A better life for all South Africans by putting people first." It appears that this only applies to patients visiting PHC facilities based on the definition. Nurses are expected to place the needs of their patients above that of their own. The question therefore presents itself, who extends the same courtesy to them? If an individual is to apply this principle to all South Africans (nurses included), who then should assert the rights of nurses? In South Africa, there exists two nursing bodies (SANC and DENOSA), whose respective roles are to regulate the field of nursing and midwifery and unite the nursing profession through supporting and developing its members (Southall, 2016). It is therefore mandatory that these professional bodies consider their complaints so that nurses can feel supported and validated.

Rispel and Bruce (2015) suggest that one of the reasons for the crisis in South African nursing is the lack of a caring ethos and a disjuncture between the needs of the nurse and those of the communities they serve. This deduction was validated in this study as many of the nurses reported that their patients enjoyed all the rights, while they were left defenceless, even by an organisation such as DENOSA that was supposed to protect them. Realistically, South Africa is not processing enough health care professionals to meet the demands of the population, nor is there enough being done to retain the current workforce.

The next section will provide some insight into the potential implications of this study for health systems transformation in South Africa with specific emphasis in the implementation of the NHI financing scheme.

7.6. The Role of Organisational Identity

As discussed by van den Heuvel et al. (2014), one of the reasons that organisational change initiatives fail, is because employees may perceive the change as threatening their organisational identity. In relation to this present study, nurses may be more resistant to change since such change may impact on their role within in the health system. This is largely dependent on whether the work environment offers resources that facilitate and foster identification within the potential NHI system.

An empowered nurse is a nurse who is multi-skilled and is satisfied by the emotional, financial and physical support received from their employer. Such a nurse is willing and able to care for all the needs of all their patients and provide the much needed patient-centred care which PHC expects. Clear roles and responsibilities have not yet been drawn as some of the nurses reported that there was more administrative work within the new system. Nurses from the NHI pilot site (KK) reported that while they had more roles and responsibilities as a result of the changes taking place within the health care system, the majority felt that the changes were essential in improving the quality and type of care they provided to their patients. These findings were substantiated by the quantitative findings which revealed that nurses from the NHI pilot site (KK) had higher Skills Discretion, Decision Latitude and Decision Authority, when compared to nurses from the non-NHI pilot site (BP).

Nurses from the NHI pilot site (KK), were exposed to various programmes and training courses on the new guidelines relating to the Re-Engineering of PHC and the piloting of ICDM and NHI. Particularly in respect of knowledge resources, the nurses from the NHI pilot site (KK), were exposed to intensive training and evaluation during the change process, whereas nurses from the non-NHI pilot site (BP) did not receive the training or the resources afforded to the NHI pilot site (KK). This discrepancy in exposure to training and resources became evident in the data as it related to experience of Job Strain and Job Control.

7.7. Perceptions and Experience of Change

How employees experience change is necessary in identifying employees who may be less accepting of the changes. In turn, this may provide insight into how best to overcome resistance to change. According to resource theory, people tend to draw on both internal and external resources to protect themselves during stressful events (Gorgievski, Halbesleben, & Bakker, 2011). These resources are essential for employees, so that they can obtain, retain and protect what they value during the change process. During the data collection phase of this study, the research participants reported mostly positive views concerning the changes occurring as part of the NHI system. However, the majority of the participants were dissatisfied with how the change message was communicated to them. A research participant

reported how they were sometimes informed very late regarding changes in the system and yet were expected to immediately implement them.

7.7.1. *Communicating Effectively*

In terms of how NHI scheme and the Re-Engineering of PHC was introduced to the health facilities who participated in this study, the general consensus among all the research participants was that there exists a hierarchy in how information is disseminated within the DoH. A concomitant concern is the lack of being informed appropriately, Participant 7 proffered that she knew nothing about NHI and further shared her interpretation that government wanted nurses to be at the same standard as those at private health care facilities.

Within the South African PHC system, information is normally communicated in the following way: National department of Health disseminates the information to the provinces, which in turn have to inform the districts and various sub-districts of the new policies and procedures. Thereafter, the sub-district is responsible for informing all facility managers, who in turn have to go back and inform and educate their staff. These channels of communication do not always take place as noted by majority of the participants.

Within PHC, nurses play a pivotal role in facilitating NHI. Their core functions contribute to the sustainability of the health care system. Moreover, they work to ensure that policies and principles articulate themselves into practice within health care. In order to drive implementation, with minimum guidance and even fewer resources, they are often expected to shoulder the blame should a programme or policy fail. Nurses in this study reiterated feelings of being side-lined during the early stages of the development of the policy. Many

shared that they were only informed about the policy once it was approved and they had to implement it. Likewise, the majority of the research participants reported their lack of knowledge and understanding of how the new WBOT and the ICDM was to work. For many tasked with implementing the new duties, the information had simply not been communicated.

Cummings and Worley (2014) propose three major strategies to help organisations deal positively with resistance to change: (1) empathy and support, (2) communication and (3) participation and involvement (p. 183-184). Rispel et al. (2010) found in their review of Health Legislation and Policy that the "process and timing of many policy initiatives appear to be flawed," often slowing the progress of the initiative and alienating many of the stakeholders who are expected to implement these policies (p. 127). They further reported that while the proposed NHI system is to be welcomed and supported, they found that public participation had largely been absent. This criticism has been noted and rectified by a number of commentaries received to date from both public and private stakeholders in support of NHI. One essential area however that has limited literature available, relates to how nurses have been consulted and engaged during the process of development and the implementation of the NHI scheme.

Many agreed that there is value in the new way of work. However, factors such as being short staffed and a lack of the proper resources as highlighted by staff cannot be ignored. This will impact on change not being sustained and in time, regressing to older ways of working, simply because they are more familiar with them. The current study demonstrates

that nurses are optimistic regarding the changes occurring within the health care system; however, they are concerned of the long term impacts.

This uncertain phase potentially can lead to employees becoming resistant to the change as it may be construed as threatening their current role within the health care system. Accordingly, Cummings and Worley (2014) propose that in order for employees to support change, organisations need to create such dissatisfaction with the status quo that employees are motivated to try new work processes. In order to be supportive of a successful change initiative, organisations need to focus their attention on creating readiness for change and overcoming the resistance to change,

7.8. Organisational Inducements

Another important component for consideration during the change process is the role of organisational inducements in aiding the positive buy-in and uptake of the proposed change initiative. Based on research conducted by Shin, Taylor and Seo (2012) on the importance of resources for change, evidence suggested that organisational inducements and employee psychological resilience were positively related to two types of employee commitment to change. They believed that both these resources can be developed over time before organisational change takes place. This in turn could potentially affect employee's support for change, as well as assist in decreasing staff turnover during the change period.

Four practical implications emerged from their data:

i. Shin et al. (2012) emphasise the importance of being aware of employee commitment to and engagement in organisational change.

ii. According to Shin et al. (2012), organisations should consider providing inducements before initiating the change to enhance employee commitment to change. They define organisational inducements as including both intangible developmental components such as training, career development and open communication with management; and concrete materialistic components such as good health care and promotion opportunities (p. 730). Such inducements will augur well towards a commitment by employees with a change environment. Organisations should be prudent and proactive to adhere to those inducements which ultimately have deeper commitment ramifications towards an employee's attitude towards change.

iii. Shin et al. (2012) emphasise the important role of psychological resilience during training interventions. They postulate that resilience can be developed through training and support and therefore should be considered as an important criterion when developing or selecting training materials.

iv. According to Shin et al. (2012), employee commitment towards change can be enhanced by building employees positive affect and social exchange. In this study, these two inducements were mentioned. The majority of participants from both groups shared their frustration at the current PMDS system and the lack of training they received on how to complete the form. The research participants narrated their experiences about the PMDS system and how they would be informed after

submitting the document they had completed incorrectly, or as Participant 7 reported, sometimes introduce new things that the nurses were unaware of when completing the PMDS. The PMDS is supposed to reward nurses for the work that they do; however, the applicability of the form in light of the current changes requires an in-depth review of how it is aligned to the new principles that NHI, ICDM and the Re-Engineering of PHC are based upon. From the perspectives of the nurses, the current system rewards quantity over quality. If the ultimate goal of the new policies and procedures is to provide more patient-centred care as stipulated in the ICDM, should quality not be favoured above quantity?

When embarking on organisational change, it is essential for the organisation to focus on capacitating employees to embrace change and implement it. This is where positive emotions can assist. Participants from the NHI pilot site (KK) suggested that the change brought about more training which enhanced their skills and thereby enabled better service delivery to their clients. As suggested by Cummings and Worley (2014), a key component that assists organisations to succeed in change interventions, is in recognising the need for and acquiring new knowledge and skills that support the new desired behaviours as organisational change involves technical changes and changes in the social system that demands workforce preparedness. It would appear from both the quantitative and qualitative data that the NHI pilot rollout has done well to prepare the workforce for providing a more integrated care. As suggested by Weiner (2009), workforce preparedness for change involves the extent to which the change is valued and whether there is capacity to carry out the change. Furthermore, a key activity of effective change management, is providing resources for

change and developing new skills and competencies (Cummings & Worley, 2014, p. 180). This is stressed in the new National Strategic Plan for Nurse Education, Training and Practice, which is designed to revitalise the nursing profession in South Africa (Mkhize, 2013).

What has emerged from the research data is the disjuncture between policy and practice. It was evident that clinics were still understaffed and under-resourced to provide health services to the community even with the introduction of the WBOTs. The research participants shared their frustration at the high number of vacant posts currently existing within the PHC sector. The participants also conveyed their dissatisfaction when nurses who had resigned were not replaced immediately. In addition, they shared their disappointment in a health system that did not make a concerted effort towards retaining or replacing staff. The majority of the participants interviewed conveyed the thought that management was certainly aware of the shortage of staff and the impact this had had on the remaining staff, were nurses had to adopt multiple roles within the PHC system. Furthermore, one participant suggested investigating the reasons for nurses leaving the public sector for the private sector by conducting one-on-one interviews. Another participant suggested that exit interviews were no longer conducted properly and did not occur often.

This lack of commitment in addressing staff resignations is indicative of a much wider problem within the DoH, the received perception being that South Africa's nurses are lazy, mean and replaceable (Meiring & van Wyk, 2013). This negative and disreputable perception has only been intensified in the media, where the Minister of Health has even been recorded as saying that nurses had better "watch out" and not use their dissatisfaction with

their employer as a reason for behaving badly (Mahopo, 2016). He went on to state that "the last thing a patient expects when they get to a hospital is to meet a devil in white." His message on International Nurses Day 2016, was that with the introduction of the first-ever Health Ombudsman there would now be a "watchdog" against the poor treatment of patients (Mahopo, 2016). The statements made by the Minister of Health infers a punitive rather than facilitative mechanism which support the perception shared by the participants that their needs and wellbeing have not considered the priority they require by the DoH.

7.9. Recommendations

The recommendations outlined here are based on the principles of transformational change, whereby organisations hope to change the character of the organisations. It is clear that the NHI financing scheme and the Re-Engineering of PHC are change initiatives aimed at changing the way health care is provided and paid for in South Africa. According to Cummings and Worley (2015), transformational change is triggered by environmental and internal disruptions, is systematic and revolutionary, demands a new organising paradigm, is driven by senior executives and line management and involves significant learning. The recommendations below form part of a broad intervention aimed at preparing the workforce for change.

WORKFORCE PREPARDNESS FOR CHANGE

7.9.1. *Recommendation One: Organisational Readiness for Change*

Organisational readiness for systems change includes a shift in orientation from task-centred care to patient-centred integrated care. The research participants reported that they were asked to implement new ways of working without being fully informed of the reasons behind the change. One participant narrated, that while she could not refuse the additional training provided, she nevertheless harboured some resentment, resulting in her foregoing further training. This raises the issue of how prepared the organisation and the workforce really were for the Re-Engineering of PHC and the piloting of NHI.

Some of the issues that arose from this study were the lack of preparedness on the part of health facilities to integrate mental health into chronic care, the limited understanding of terms such as patient-centred care and wellbeing, and finally, the ambiguity of the nurses' role in the new system. In addition, facilities were ill-prepared for the WBOT and had limited knowledge about the tasks these teams would perform.

In light of the above, it is recommended that structured learning sessions with entire teams, oriented towards frontline managers are held in order to explain the integrated patient-centred continuous care approach and the systems changes that the new approach requires. Furthermore, these structured learning sessions must be geared to tackle resistance to change. Specifically, such sessions must focus on providing staff with the necessary information regarding the changes and the need for change, how their roles and responsibilities are expected to change, outline the plan for training and development of staff necessary to take

on their new roles and responsibilities, how the issue of turnover of staff will be addressed during the transformation, and how the performance system will be aligned with the Re-engineered system. The goal of these sessions will be to reassert the importance of task-sharing and a team-based approach to care under a NHI scheme, acknowledging the role each individual and the organisation plays in making NHI a success.

7.9.2. *Recommendation Two: Communication Skills*

Another major issue for the participants was how and when the change message was communicated to them. Many of the research participants shared their frustration at being excluded from the policy-making process and that they were only tasked with is implementation. Some felt that had they been consulted, they could have provided valuable insights into how to change certain procedures given that they work with the community and have practitioner knowledge of what needs to be changed.

The lack of effective communication mechanisms and styles were also identified as major barriers to having an informed and empowered staff. Indeed, many were unaware of what the NHI scheme entailed and how it would operate, once fully implemented.

Communication is vital in any change programme and by moving from acute-centred care to a more patient-centred approach requires clinicians to communicate in a different way. Cummings and Worley (2014) emphasise that uncertainty in an organisation can create panic and anxiety in its employees when they are given inadequate information regarding change. Accordingly, the provision of effective communication regarding change can help alleviate the anxiety and fear that employees may be feeling. In numerous recent studies,

effective communication has also been linked to better patient outcomes, thereby indicating that effective provider-patient communication is linked empirically to better outcomes of care, including patients' satisfaction, health status, recall of information, and adherence (Hall, Roter, & Katz, 1988; Ong, de Haes, Hoos, & Lammes, 1995; Stewart, 1995; Zolnierek & Dimatteo, 2009).

In light of the above, this study recommends communication training for both nurses and managers in order to benefit both the patient and the provider. In addition, it is recommended that clinical communication skills training be provided to enable the identification and incorporation of biomedical and patient perspectives into the problem identification and treatment plan, as well as patient empowerment to self-manage their conditions. Structured learning sessions in clinical communication skills, including preparing for a consultation, relationship building, and gathering holistic information on the problem from both a biomedical and patient perspective is imperative (Silverman & Draper, 2005), as well as incorporating brief motivational interviewing skills for patient self-management (VanBuskirk & Wetherell, 2014). Furthermore, PC101 training should be expanded to include intensive supervision and mentoring, thereby ensuring that the principles of a patient-centred care schedule is put into practice.

In addition to the above training regimens, an ethos of information sharing should be encouraged where staff should be given the space to share their comments and suggestions on the NHI. Monthly feedback meetings on staff performance should also be used as a safe space where any new information can be shared and comments welcomed by all staff. There should also be clear procedures and guidelines in place that inform staff on how their

comments and suggestions will be dealt with. A reasonable timeframe should also be provided as to when staff can expect feedback.

7.9.3. *Recommendation Three: Psychological Wellbeing, Burn-Out and Stress Management*

The results from this study showed a clear link between psychological resources, general health and emotional exhaustion. Based on these findings, it is evident that although nurses from the NHI pilot (intervention) site (KK) reported less Burnout and better General Health than those nurses at the non-NHI pilot (control) site (BP), this still does not mean that they were immune from the negative effects of their jobs. The qualitative data further revealed that nurses relegate their own emotional and physical health to a lower priority than that of their patients. Poor emotional and physical health has been indicated as some of the leading causes for high staff turnover, absenteeism and poor morale (Asegid et al., 2014; Laschinger & Fida, 2014; Mudaly & Nkosi, 2015). In order to combat the negative effects of change and "people work," it is thus recommend that learning sessions aimed at developing the emotional coping skills of care providers be included in order to enable nursing staff to better deal with Stress, Burnout and patient emotions. This is particularly important in the context of patient-centred care, where care providers are not automatically protected psychologically by the distance afforded in task-oriented care. Indeed, a patient-centred care regimen often demand that care providers engage in emotional labour (Petersen, 2000). With the investment of new resources in implementing the NHI scheme ultimately benefit the recipients of the service, the scheme cannot be realised or sustained without nurses, who are the backbone of the PHC system. How the NHI scheme will reflect the same level of care to

their staff needs to be clarified and expanded upon. This study therefore proposes the development of structured learning sessions on stress management, self-care and dealing with emotions in the provider-patient consultation.

7.9.3.1. *Implementation of Strategies for Debriefing Support and Referral Pathways for Counselling for Providers with Psychological Problems*

As proposed by Vesel, Waller, Dowden and Fotso (2015), structured learning sessions involve activities aimed at building positive psychological resources such as hope, efficacy, resilience and optimism. In terms of a Re-engineered PHC, such learning stratagems can provide new approaches for dealing with the emotional burden of "people work." As evidenced by the results from this study, by focusing on building the positive resources of nurses, a marked decrease in the negative experiences associated with "people work" such as Burnout, can be reliably expected.

7.9.4. *Recommendation Four: Leadership Training*

According to the tenets of transformational change, change is normally initiated by senior executives and line managers (Cummings & Worley, 2014). It is therefore vital that facility managers and PHC staff are prepared to lead the change in a ways that encourages the buy-in of staff. By acquiring new skill sets, this will enable staff to articulate a clear and credible vison of the new direction the organisation is heading in. In addition, staff will demonstrate personal excitement regarding the intended changes and be able to model the behaviour that is expected of others, communicate information that can assist staff make sense of the transformation, as well as engage with employees regarding the new

performance standards and hold them accountable to them (Cummings & Worley, 2014, pp. 531-532).

Based on the findings of this study, not all managers or leaders in PHC were aware of the changes that were taking place. In addition, those who were informed had little knowledge about the bigger picture, as well as how it would all eventually work. By developing leadership skills in facility managers, it can only strengthen the new model of health care. It is therefore recommend a teaching module based on developing leadership skills that focus less on the tasks to be accomplished and more on people and relationships be formed, using inspiration, motivation and emotional intelligence to achieve common goals (Cummings et al. 2010). Relational leadership is more enabling of operational flexibility, greater workforce decision latitude and greater responsiveness and engagement with the local population. Within the existing skills training platform, the PC101 curriculum should introduce a component on leadership development and problem solving. Structured learning sessions for facility and district managers in relational leadership styles will support greater care provider job satisfaction and empowerment, all of which are necessary in a patient-centred care regimen (Cummings et al. ,2010).

7.9.5. *Recommendation Five: Continuous Quality Improvement*

All participants in this study agreed that the changes that were taking place would improve the quality of care provided in PHC. However, many were unclear how this would be achieved remained. The changes taking place in the South African health care system have to do with changing the way care is provided and this means being able to measure whether

improvement has occurred. Managers therefore need to be trained to oversee the process of change and identify any stumbling blocks along the way.

Based on the findings of this study, it is recommend that a programme aimed at training managers in Quality Improvement be established. Quality Improvement skills are helpful in developing contextually-relevant interventions, as well as encouraging engagement, ownership and a sense of responsibility for the success of innovations by both care providers and service users (Davy et al., 2015). In addition, structured learning sessions in Continuous Quality Improvement (CQI), should be launched in order to identify bottlenecks and gaps in care using routine data. Working in multidisciplinary teams at the facility and district level will help to identify and tackle bottlenecks, implement planned actions, and continuously monitor the impact of the new systems in place using routine data following the Plan-Do-Study-Act (PDSA) quality improvement cycles (Higgins-Steele, Waller, Fotso & Vesel, 2015). Finally, rigorous quarterly monitoring and evaluation systems should be put in place to provide feedback on the progress of the piloting phase of NHI and the different interventions introduced. The findings should be shared with staff so as to allow for their engagement in developing potential solutions to any challenges encountered during the piloting phase.

7.10. Limitations

The study did not track NHI from its inception phase as the piloting began in 2011 and this study was conducted from 2012 onwards. Given that the study site was

predetermined by the DoH, the researcher did not have a choice as to where the study would be conducted. As a result, certain challenges resulted. These included:

i. Distance made it difficult to follow-up personally with nurses immediately after data collection as this had cost implications.
ii. Once follow-up was conducted, the high turnover rate was a challenge given that the nurses who had participated initially in the study had resigned.
iii. A methodological challenge as a result of the predetermined site was that the researcher was expected to use non-probability sampling as opposed to the recommended probability sampling technique advocated by quantitative theorists. This affected the sampling population and consequently provided the researcher with a confined pool of participants.
iv. Despite the researcher visiting the sites multiple times, the response rate was less than expected. Based however on sampling percentages advocated by Marlow and Boone (2011), the sample size was deemed adequate for the analyses which the researcher wanted to run.

7.11. Recommendations for Future Research

Based on the research presented here, the following areas for future research have been identified:

i. Expand the study to include all PHC staff as the NHI scheme promote a team-based approach to care. Accordingly, an examination of the impact this would have on the staff as a team should be investigated.

ii. Expand on the definition of psychological constructs by conducting research on constructs such as gratitude, joy and religious faith among health care staff.

iii. Develop more context-specific instruments for measuring those constructs that are resonate with the cultural and linguistic differences in the country irrespective of the fact that all instruments used for data collection in this study were found to be reliable and valid for use in South Africa. In addition, during data collection, the researcher should take participants through the questionnaire and explain any terminology that the respondent may not be acquainted with. An example would be, “Every cloud has a silver lining” which is a popular idiomatic expression in the English language and as such participants requested an explanation which the researcher provided.

iv. Replicate a similar study across provinces and/or in countries that have similar health burdens to ensure a more informed and successful NHI scheme which can provide other countries with a blueprint of how to achieve universal health care (UHC) as advocated by the World Health Organisation (WHO).

v. Expand the qualitative research component to include all members in an NHI team to better understand how the system changes impact on team members’ experiences of positive emotions and resources.

7.12. Final Conclusion

In this final chapter, the integrated results of the research study were presented and recommendations made in terms of the specific objectives of the study. The limitations of the

study were also tabled and acknowledged. Finally, recommendations for future research were offered.

The research results indicate that for the NHI pilot site (KK), the research participants reported higher levels of Skills Discretion, Decision Latitude and Job Control. These findings were supported by data from the non-NHI pilot site (BP), which demonstrated that the control site experienced lower levels of Skills Discretion, less Decision Latitude and ultimately lower Job Control. These results are encouraging for the introduction of NHI, as this new system has the potential to empower nurses to provide more holistic health care. One prominent aspect in this study was the resilience of the nurses. To stay in a profession beset with challenges requires inner strength and resilience and as postulated by Koen et al. (2011b), focusing on building human resilience can only further promote the health and wellbeing of nurses. Finally, the data supports the contention that positive emotions capacitate and support organisational change. Moreover, these are considered enabling mechanisms that facilitate sustainable change within the South African health care system.

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APPENDIX 1. ETHICAL APPROVAL UNIVERSITY OF KWAZULU-NATAL

24 February 2014

Ms Ruwayda C Petrus (211506565)
School of Applied Human Sciences
Howard College Campus

Protocol reference number: HSS/1074/013D
Project title: Positive psychological resources amongst nurses in National Health Insurance (NHI) pilot

Dear Ms Petrus,

Full Approval – Expedited

With regards to your response to our letter dated 23 October 2013, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....
Dr Shenuka Singh (Chair)

/ms

cc Supervisors: Professor JH Buitendach and Professor I Petersen
cc Academic Leader Research: Professor D McCracken
cc School Administrator: Ms Ausie Luthuli

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
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APPENDIX 2. ETHICAL APPROVAL: DEPARTMENT OF HEALTH, NORTH WEST PROVINCE

health
Department of Health
North West Province
REPUBLIC OF SOUTH AFRICA

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POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : **Ruwayda Petrus**

From : **Policy, Planning, Research, Monitoring & Evaluation**

Subject : **Approval Letter- Positive psychological resources amongst nurses in National Health Insurance (NHI) Pilot.**

Purpose

To inform the researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to arrange in advance with the chosen districts or health facilities, and issue this letter as proof that permission has been granted by the Provincial office.

Upon completion, the Department expects to receive the final report from the researcher.

Kindest regards

Director: PPRM&E
Mr L Moaisi.

14/02/2014
Date

DEPARTMENT OF HEALTH
PRIVATE BAG x2068
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SUPERINTENDENT GENERAL

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Healthy Living for All

APPENDIX 3. QUANTITATIVE BOOKLET

INSTRUCTIONS

Dear Research Participant, you are requested to answer the questionnaires in this booklet. You will also need to sign an indemnity form to show that you consent to this study. Please answer all the questions.

Your participation is much appreciated.

Dear Research Participant

I am a researcher working with the PRIME (Programme for Improving Mental Health Care) project at the University of KwaZulu Natal in Durban, South Africa. The Principal Investigator of this project is Professor Inge Petersen. Her details are listed below. The PRIME-SA project is funded by the Department of International Development (DFID) in the United Kingdom and the current study is jointly funded by PRIME and the National Research Foundation.

The current study is interested in the psychological capital, job strain, job satisfaction, burnout and wellbeing of nurses working in the North West.

What is the purpose of the study?

The overall aim of the research is to understand the wellbeing of nurses in the context of the re-engineered PHC system and the NHI. The aims of the research are approached from a mixed methodology with corresponding objectives. **The first objective** is researched from a qualitative perspective. The aim is to develop an understanding of the experiences and perceptions of nurses with regards to their wellbeing, job satisfaction, job strain and burnout, as well as their perception and understanding of the re-engineered PHC system and the NHI. **Secondly, the researcher aims to** determine the relationship between Psychological Capital, Job Satisfaction, Burnout, Job Strain and Wellbeing amongst nurses quantitatively through the use of this baseline questionnaire in an attempt to evaluate their response to the changes happening in the healthcare system. In addition, the baseline questionnaire also attempts to measure levels of stress and wellbeing of nurses who have undergone PC101+ training and clinical communication skills training.

Who are we asking to participate?

All registered professional nurses working in Primary Health Care facilities in the North West are eligible to participate. The study will be conducted during April 2016 – April 2017. We would like to recruit approximately 200 nurses working within Primary Health care facilities.

What will it mean if you participate in this study?

If you agree to participate in the study, you will receive a booklet made up of several questionnaires that we would like you to answer. These questionnaires focus on assessing your

level of wellbeing as well as how you experience job strain and burnout in your current vocation. It will also assess level of stress you experience and the resources you employ to cope with stress and burnout. For your participation in both the Clinical Communications Skills Workshop and the Baseline Questionnaire, you will receive a small thank you gift. In order for you to receive your gift, you need to complete the baseline questionnaire, and the Clinical Communication Skills training. Your participation is likely to help generate knowledge and greater understanding on the wellbeing, job satisfaction and burnout of nurses in South Africa with relation to their psychological capital and job strain. Your knowledge will be used to help researchers develop programs and interventions focused on fulfilling the current wellbeing needs of nurses in South Africa.

Will my information remain confidential?

Yes. Should you agree to take part in the study, all your records will be seen by the study researchers only. Information and results of the study that are shared with other researchers will not contain any identifiable (personal) information such as names or contact details. Every effort will be made to keep your information confidential.

The possibility also exists that, despite the absence of identifying data, the clinic could be identified as one of the research sites due to a process of deduction from the public information about the PRIME project. This does not mean that you yourself will be identified but that the aggregate data from the study may be linked back to your clinic.

Do I have to participate in this study?

Your participation will be voluntary and your identity will be protected throughout the research. Anonymity will be ensured by omitting any identifying characteristic, such as your name, or department.

How will we report this research?

We will report our results and other aspects of the study in scholarly journals, conferences and to the Department of Health via policy briefs and other reporting structures.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/1074/013D) and the North West Department of Health.

In the event of any problems or concerns/questions you may contact:

For questions related to the study	For your rights as a research participant
Researcher: Ruwayda Petrus Tel: 27 31 260 2261 Email: petrus@ukzn.ac.za **Research Supervisors:** Professor Inge Petersen Tel: 27 31 260 7970 Email: Peterseni@ukzn.ac.za Professor Joey Buitendach Tel: 27 31 260 2407 Email: Buitendach@ukzn.ac.za	**RESEARCH OFFICE** Miss Phumelele Ximba KwaZulu-Natal, SOUTH AFRICA Tel: 27 31 360 3587 Email: ximba@ukzn.ac.za

I………………………. (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT……………….... DATE………………

Consent form for participation in the study titled: "Positive Psychological Resources amongst nurses in the NHI: Pilot."

Please complete this form after you have been through the information sheet and understand what your participation in this study entails.

Thank you for considering taking part in this study. If you have any questions arising from the information sheet, please ask before you decide whether to take part. You will be given a copy of the information sheet and consent form.

I, (write your full name here), ______________________________ have been informed about the study.

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without any negative consequences.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions or concerns or queries related to the study or my rights as a research participant, I understand that I may contact:

For questions related to the study	For your rights as a research participant
Researcher: Ruwayda Petrus Tel: 27 31 260 2261 Email: petrus@ukzn.ac.za **Research Supervisors:** Professor Inge Petersen Tel: 27 31 260 7970 Email: Peterseni@ukzn.ac.za Professor Joey Buitendach Tel: 27 31 260 2407 Email: Buitendach@ukzn.ac.za	**RESEARCH OFFICE** Miss Phumelele Ximba KwaZulu-Natal, SOUTH AFRICA Tel: 27 31 360 3587 Email: ximba@ukzn.ac.za

______________________ ______________________

Signature of Participant Date

______________________ ______________________

Signature of Witness Date

(Where applicable)

______________________ ______________________

Signature of Translator Date

(Where applicable)

BIOGRAPHICAL DATA SHEET

INSTRUCTIONS: (Please answer the following questions by circling the applicable box and do not make any marks in the shaded boxes)

Gender:

Male	1	Female	2

Age Group:

20 - 30	31 40	41 - 50	51 - 60	61+
1	2	3	4	5

Marital Status:

Single	Married	Divorced	Widow	Remarried
1	2	3	4	5

Race:

Black	White	Coloured	Indian	Other
1	2	3	4	5

Number of Dependents (This refers to everyone who is dependent on you including children):

None	1	2	3	3+
1	2	3	4	5

Highest Qualification Obtained:

Matric	Diploma in Nursing	Bachelor’s Degree in Nursing	Other
1	2	3	4

Please indicate your position in the Clinic:

Nursing Assistant	Enrolled Nurse	Professional Nurse	Facility Manager
1	2	3	4

Number of years in the profession:

Less than 1 year	2-5 years	6-10 years	11-15 years	15+
1	2	3	4	5

POSITIVE PSYCHOLOGICAL RESOURCES

Positive Psychology is the scientific study of the strengths and virtues that enable individuals and communities to thrive. Positive psychological resources are based on positive organizational behaviour and include psychological states that go beyond human and social capital and focus more on "who you are." The following questionnaire assesses your levels of hope, efficacy, resilience and optimism.

PSYCHOLOGICAL CAPITAL QUESTIONNAIRE

Instruction: Below are statements that describe how you may think about yourself right now. Use the following scale to indicate your level of agreement or disagreement with each statement. (1=strongly disagree, 2=disagree, 3=somewhat disagree, 4=somewhat agree, 5=agree, 6= strongly agree)

		Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**
1.	I feel confident analysing a long-term problem to find a solution.	1	2	3	4	5	6
2.	I feel confident representing my work area in meetings with management.	1	2	3	4	5	6
3.	I feel confident contributing to discussions about the company's strategy.	1	2	3	4	5	6
4.	I feel confident helping to set targets/goals in my work area.	1	2	3	4	5	6

5.	I feel confident contacting people outside the company (e.g. suppliers, customers) to discuss problems.	1	2	3	4	5	6
6.	I feel confident presenting information to a groups of colleagues.	1	2	3	4	5	6
7.	If I should find myself in a jam, I could think of ways to get out of it.	1	2	3	4	5	6
8.	At the present time, I am energetically pursuing my goals.	1	2	3	4	5	6
9.	There are lots of ways around any problem that I am facing now.	1	2	3	4	5	6
10.	Right now, I see myself as being pretty successful.	1	2	3	4	5	
11.	I can think of many ways to reach my current goals.	1	2	3	4	5	6
12.	At this time, I am meeting the goals that I have set for myself.	1	2	3	4	5	6
13.	When I have a setback at work, I have trouble recovering from it, moving on.	1	2	3	4	5	6

14.	I usually manage difficulties one way or another at work.	1	2	3	4	5	6
15.	I can be "on my own," so to speak, at work if I have to.	1	2	3	4	5	6
16.	I usually take stressful things at work in stride.	1	2	3	4	5	6
17.	I can get through difficult times at work because I've experienced difficulty before.	1	2	3	4	5	6
18.	I feel I can handle many things at a time at this job.	1	2	3	4	5	6
19.	When things are uncertain for me at work, I usually expect the best.	1	2	3	4	5	6
20.	If something can go wrong for me work-wise, it will.	1	2	3	4	5	6
21.	I always look on the bright side of things regarding my job.	1	2	3	4	5	6
22.	I'm optimistic about what will happen to me in the future as it pertains to work.	1	2	3	4	5	6

23.	In this job, things never work out the way I want them to.	1	2	3	4	5	6
24.	I approach this job as if ‘every cloud has a silver lining.”	1	2	3	4	5	6

HEALTH AND WELLBEING

Employee wellbeing has been shown to be crucial to the success of an organizations. It affects the performance of individuals and teams and by improving employee wellbeing, organisations can create significant and sustainable business benefits. Please take the time to answer the short questionnaire which will help us to help you.

SATISFACTION WITH LIFE SCALE (SWLS)

Instructions: The purpose of this survey is to assess how you view your satisfaction with life. The following are statements of the satisfaction that you may agree or disagree with. It is expected of you to indicate your agreement with each of the statements by crossing out (x) the appropriate number next to each statement, using the criteria.

		Slightly Disagree	**Disagree**	**Strongly Disagree**	**Neither Disagree, nor Agree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1.	In most ways, my life is close to ideal.	0	1	2	3	4	5	6
2.	The conditions of my life are excellent.	0	1	2	3	4	5	6
3.	I am satisfied with my life.	0	1	2	3	4	5	6

4.	So far, I have gotten the most important things that I want.	0	1	2	3	4	5	6
5.	If I could have my life over, I would almost change nothing.	0	1	2	3	4	5	6

GENERAL HEALTH QUESTIONNAIRE (12)

We would like to know if you have had any health complains, and how your health has been in general, over the past few weeks. Please answer ALL the questions simply by circling the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Have you recently:	1	2	3	4
1. Been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5. Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual

6. Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. Been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9. Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Lee so than usual	Much less than usual

BURNOUT

Employees working in the healthcare profession have been reported as exhibiting high levels of burnout as a result of their jobs. Burnout consists of three components-emotional exhaustion, cynicism and personal efficacy. Given the physical demands of your profession, we would like to assess the level of burnout experienced by you. Please answer all the questions.

MBI HUMAN SERVICES SURVEY

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. There are 22 questions on this page. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, make a X under the column labelled 0.

If you have had this feeling, indicate how often you feel it by marking an X under columns labelled 1 - 6 that best describes how frequently you feel that way.

Statement	Never	A few times a year	Once a month or less	A few times a month	Once a week	A few times a week	Every day
1. I feel emotionally drained from my work.	0	1	2	3	4	5	6
2. I feel used up at the end of the workday.	0	1	2	3	4	5	6
3. I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4	5	6
4. I can easily understand how my recipients feel about things.	0	1	2	3	4	5	6
5. I feel I treat some recipients as if they were impersonal objects.	0	1	2	3	4	5	6
6. Working with people all day is really a strain for me.	0	1	2	3	4	5	6
7. I deal very effectively with the problems of my recipients.	0	1	2	3	4	5	6
8. I feel burned out from my work.	0	1	2	3	4	5	6
9. I feel I'm positively influencing other people's lives through my work.	0	1	2	3	4	5	6

10. I've become more callous toward people since I took this job.	0	1	2	3	4	5	6
11. I worry that this job is hardening me emotionally.	0	1	2	3	4	5	6
12. I feel very energetic.	0	1	2	3	4	5	6
13. I feel frustrated by my job.	0	1	2	3	4	5	6
14. I feel I'm working too hard on my job.	0	1	2	3	4	5	6
15. I don't really care what happens to some recipients.	0	1	2	3	4	5	6
16. Working with people directly puts too much stress on me.	0	1	2	3	4	5	6
17. I can easily create a relaxed atmosphere with my recipients.	0	1	2	3	4	5	6
18. I feel exhilarated after working closely with my recipients.	0	1	2	3	4	5	6
19. I have accomplished many worthwhile things in this job.	0	1	2	3	4	5	6
20. I feel like I'm at the end of my rope.	0	1	2	3	4	5	6
21. In my work, I deal with emotional problems very calmly.	0	1	2	3	4	5	6

22. I feel recipients blame me for some of their problems.	0	1	2	3	4	5	6

STRESS

In addition to burnout, stress is a major contributor to nurses leaving the profession. We would like to know the level of stress you experience in your job.

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by crossing out (x) *how often* you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

	Never	**Almost Never**	**Sometimes**	**Fairly Often**	**Very Often**
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and “stressed”?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

JOB STRAIN AND JOB SATISFACTION

People in the helping profession experience high levels of job strain when they have little to no control over their daily activities. Job strain has been defined as occurring when the demands placed on the worker is high and their decision latitude is low. Please answer the following questionnaire which helps to determine the levels of job strain and job satisfaction you experience in your current role.

Job Content Questionnaire

Instructions: The following questionnaire assesses the level of job strain you experience in your daily duties. There are 24 questions on this page. Please read each statement carefully and indicate whether you agree or disagree with a statement by crossing out (x) the appropriate number.

Section One: Skill Discretion, Decision Authority, Psychological Workload and Physical Exertion

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1. My job requires that I learn new things.	1	2	3	4
2. My job involves a lot of repetitive work.	1	2	3	4
3. My job requires me to be creative.	1	2	3	4
4. My job allows me to make a lot of decisions on my own.	1	2	3	4
5. My job requires a high level of skill	1	2	3	4
6. On my job, I am given a lot of freedom to decide how I do my work.	1	2	3	4
7. I get to do a variety of things on my job.	1	2	3	4

8. I have a lot to say about what happens on my job.	1	2	3	4
9. I have an opportunity to develop my own special abilities.	1	2	3	4
10. My job requires working very fast.	1	2	3	4
11. My job requires working very hard.	1	2	3	4
12. My job requires lots of physical effort.	1	2	3	4
13. I am not asked to do an excessive amount of work.	1	2	3	4
14. I have enough time to get the job done.	1	2	3	4
15. I am free from conflicting demands others make.	1	2	3	4

Section Two: Job Satisfaction/Dissatisfaction

16. How satisfied are you with your job?

Not at All	Not Too	Somewhat	Very
1	2	3	4

17. Would you advise a friend to take this job?

Advise Against	Have Doubts About It	Strongly Recommend
1	2	3

18. Would you take this job again?

Take without hesitation	Have second thoughts	Definitely not
1	2	3

19. How likely is it that you will find a new job in the next year?

Very likely	Somewhat	Not at all
1	2	3

20. Is this job like what you wanted when you applied for it?

Very much	Somewhat like	Not very much like
1	2	3

Section Three: Physical/Psychosomatic Strain

During the past 12 months, have you experienced the following?

21. How often do you become tired in a very short period of time?

Often	Sometimes	Rarely	Never
1	2	3	4

22. Do you have trouble with sweaty hands which feel damp and clammy?

Often	Sometimes	Rarely	Never
1	2	3	4

23. Do you have trouble with feeling nervous, fidgety or tense?

Often	Sometimes	Rarely	Never
1	2	3	4

24. Do you have trouble with poor appetite?

Often	Sometimes	Rarely	Never
1	2	3	4

25. Do you have trouble staying asleep?

Often	Sometimes	Rarely	Never
1	2	3	4

Section Four: Depression/Life Dissatisfaction

Please mark which of the words best describe your life. If your life is somewhere in between, please mark the correct box.

26. Is your life:

Boring						Interesting
1	2	3	4	5	6	7

27. Is your life:

Enjoyable						Miserable
1	2	3	4	5	6	7

28. Is your life:

Worthwhile						Useless
1	2	3	4	5	6	7

29. Is your life:

Friendly						Lonely
1	2	3	4	5	6	7

30. Is your life:

Full						Empty
1	2	3	4	5	6	7

31. Is your life:

Hopeful						Discouraging
1	2	3	4	5	6	7

32. Is your life:

Rewarding						Disappointing
1	2	3	4	5	6	7

33. Your life:

Brings out the best in you						Doesn't give you much chance
1	2	3	4	5	6	7

ATTITUDES TOWARDS MENTAL HEALTH

Mental Illness: Clinicians Attitudes Scale

Instructions: The following questionnaire measures your attitudes towards mental illness. For each of the sixteen questions, please respond by ticking one box only. Mental illness here refers to conditions for which an individual would be seen by a psychiatrist. Please tick the box which most accurately represents your position on the statement.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1. I just learn about mental health when I have to, and would not bother reading additional material on it.	1	2	3	4	5	6
2. People with a severe mental illness can never recover enough to have a good quality of life.	1	2	3	4	5	6
3. Working in the mental health field is just as respectable as other fields of health and social care.	1	2	3	4	5	6
4. If I had a mental illness, I would never admit this to my friends because I would fear being treated differently.	1	2	3	4	5	6
5. People with a severe mental illness are dangerous more often than not.	1	2	3	4	5	6
6. Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.	1	2	3	4	5	6
7. If I had a mental illness I would never admit this to my colleagues for fear of being treated differently.	1	2	3	4	5	6
8. Being a health/social care professional in the area of mental health is not like being a real health/social care professional.	1	2	3	4	5	6

9. If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.	1	2	3	4	5	6
10. I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.	1	2	3	4	5	6
11. It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.	1	2	3	4	5	6
12. The public does not need to be protected from people with a severe mental illness.	1	2	3	4	5	6
13. If a person with a mental illness complained of physical symptoms (Such as chest pain) I would attribute it to their mental illness.	1	2	3	4	5	6
14. General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.	1	2	3	4	5	6

15. I would use the term ‘crazy’, ‘nutter’, ‘mad etc., to describe to colleagues people with a mental illness who I have seen in my work.	1	2	3	4	5	6
16. If a colleague told me they had a mental illness, I would still want to work with them.	1	2	3	4	5	6

APPENDIX 4. QUALITATIVE CONSENT BOOKLET

Dear Research Participant

The purpose of this document is to notify you that you have been selected to participate in a research study and to attain informed consent if you decide to partake.

The current study is interested in the psychological capital, job strain, job satisfaction, burnout and wellbeing of nurses working with the North West, with special emphasis on clinics where the NHI is currently being piloted.

You are being invited to participate in this research because of your experience as a nurse. There will be no direct benefit to you if you participate in this research, but your participation is likely to help generate knowledge and greater understanding on the wellbeing, job satisfaction and burnout of nurses in South Africa with relation to their psychological capital and job strain. Your participation will be voluntary and your identity will be protected throughout the research. Anonymity will be ensured by omitting any identifying characteristic, such as your name, or department. Data collected will not be shared with anybody outside the research team and will only be used by PRIME and the Department of Health. If you have any queries please feel free to contact me (Ruwayda Petrus 211506565@ukzn.ac.za or my supervisor Professor Joey Buitendach at 031 260 24 07/ Buitendach@ukzn.ac.za) or Prof Inge Petersen (Peterseni@ukzn.ac.za).

If you wish to obtain information on your rights as a participant, please contact Ms Phumelele Ximba, Research Office, UKZN, on 031 360 3587.

I………………………. (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire. I consent to my interview being tape recorded for the purpose of the study.

SIGNATURE OF PARTICIPANT………………..... DATE………………

Please answer the following biographical data sheet.

INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes)

Gender

Male	Female

Age Group

20 - 30	31 - 40	41 - 50	51 - 60	61+

Marital Status

Single	Married	Divorced	Widow	Remarried

Race

Black	White	Coloured	Indian	Other

Number of Dependents

None	1	2	3	3+

Highest qualification obtained:

____

Number of years working for the organisation:

____

Please indicate your position in the organisation:

____

Please indicate the type of organisation:

____

How long have you worked for this organisation?

____

What previous positions have you held with the organisation?

____

____

What is your job title? ____

How long have you held your current position? _________________________________

Briefly describe your work responsibilities (as you would on a resume):

____

____

____

____

APPENDIX 5. SEMI-STRUCTURED INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

Objective: To develop an understanding of the experiences and perceptions of nurses with regards to their wellbeing, job satisfaction, job strain and burnout, as well as their perception and understanding of the re-engineered PHC system and the NHI.

Research Questions:

What are the perceptions of nurses in relation to the re-engineered PHC system and the NHI?

What are the understanding of nurses in relation to wellbeing, job satisfaction, job strain and burnout?

What are the roles and responsibilities of nurses in the re-engineered PHC system and the NHI? *(This question looks at whether what the policy papers say the new roles of nurses are, is actually what is being done by nurses or have their roles expanded beyond this scope thus increasing job strain)*

To start off with the researcher will give a brief background to the study and reasons for conducting the study before proceeding to handing out consent forms and a biographical questionnaire for participants to complete.

QUESTIONS ON JOB SATISFACTION

1. What is it that you enjoy the most about your job right now? If you had to pinpoint one thing that makes your job enjoyable, what would that be?
2. How satisfied are you with your job currently?

QUESTIONS ON JOB STRAIN (EFFORT-REWARD IMBALANCE AND HIGH DEMANDS/LOW CONTROL) **AND BURNOUT**

3. We know that your job requires a lot of effort, what kind of rewards do you get out of it that makes you stay?
4. Do you think these rewards make it worth the effort?
5. How much control do you feel you have over your daily activities in your job?
6. If you were consulted more about decisions made that affect the work that you do, do you think you would be happier at work?
7. Do you feel sufficient attention is given to what you have to say regarding daily clinical activities that you perform or your work environment?
8. Has any suggestion you have made at work to your supervisor, been taken into consideration and implemented?
    a. How did this make you feel?
9. Do you sometimes feel the job is too much for you?
10. How does your job affect you personally?
11. What do you understand by burnout? (Burnout has been used to explain a state of mental weariness amongst human service professionals. It has been described as a specific kind of occupational stress reaction as a result of demanding and emotionally charged relationships between caregivers and their recipients. More commonly it has been defined as a syndrome of feelings of emotional exhaustion (energy depletion of emotional resources), depersonalization (cynical attitudes towards patients) and reduced personal accomplishment. Given the above statement, how burnt out do you currently feel in your job? Why?
12. What could be done to help you with burn-out?

QUESTIONS ON EMPLOYEE WELLBEING AND EMOTIONAL LABOUR

13. When we are helping people especially with mental health being integrated into your job description, it is sometimes difficult to put personal issues aside when having to be there for someone else. Have you ever experienced something like that?
    a. How do you deal with such a situation?

    b. How can PRIME (Programme for including mental health in re-engineering of PHC and the NHI by recommending training of nurses and doctors to identify and manage mental disorders) assist the Department of Health to develop a something to help you cope better?

14. In order for people to experience positive emotions and experience good feelings, it has been said that they need to experience a sense of individual vitality as well as undertake activities that are meaningful and make us feel competent and in control of making decision which affect us. In addition the role of supportive relationships and a sense of connection with others are very important to the aspect of wellbeing. In your current profession, how have you experienced wellbeing?
15. How can employee wellbeing be improved within the organization?

QUESTIONS ON NATIONAL HEALTH INSURANCE AND RE-ENGINEERED PRIMARY HEALTH CARE SYSTEM

16. Your clinic is part of the NHI pilot sites and has undergone a lot of restructuring–
    a. How has the restructuring happened in your clinic?
    b. Do you think that this has improved the services provided to the community?
    c. How has your current role changed within the restructured PHC system and the NHI?
17. With mental health care also being introduced as part of chronic care, how has this affected you personally?
    a. Has it increased your burden/ workload?
    b. How has it helped the patients?
18. With all of the restructuring that has happened, how has it impacted on you personally?
    a. How has it affected your mood
    b. How has it affected your physical health?
    c. How has it impacted your relationship with your family?
19. What services/interventions would be helpful to help you cope better?