

**A MODEL FOR THE INTEGRATION OF
PROVINCIAL AND LOCAL AUTHORITY NURSES
RENDERING PRIMARY HEALTH CARE SERVICES
IN A DISTRICT**

by

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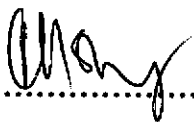
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I declare that "**A MODEL FOR THE INTEGRATION OF PROVINCIAL AND LOCAL AUTHORITY NURSES RENDERING PRIMARY HEALTH CARE SERVICES IN A DISTRICT**" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. This work has not been submitted before for any other degree at any other university.


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Summary

Prior to 1994, the South African Health Department was characterised by a fragmented health care system, which was largely curative and hospital based, with services planned and managed without community involvement and participation.

The government, through the establishment of a district health system, integrated the health services with the aim of overcoming the fragmentation, and providing integrated comprehensive health care services that are equitable, accessible, efficient and effective. The integration of health services in Gauteng, meant the devolution of primary health care services from the provincial health department to the local authority health department, because the local authority services are nearer and accountable to the community. The process of integration of health services also meant the closing down of provincial clinics and transferring of provincial authority nurses to the local authority clinics. The transfer process impacted negatively on staff morale and on the resources available for health care delivery to the communities.

It is against this background that the researcher decided to investigate the integration process. The researcher then conducted focus group interviews with the local authority nurses, provincial authority nurses and the district management team as these nurses's immediate supervisors. The results revealed that the local and provincial authority nurses were integrated without proper consultation and as a result integration was rejected. The following themes emerged from the results as negative perceptions and obstacles towards integration: lack of consultation, disparities in conditions of service and resistance to change. Positive perceptions also emerged from the results as strategies to improve the integration, and these strategies were used to develop guidelines to operationalise the model.

It is envisaged that the proposed model will serve as a theoretical framework for nurse managers from both spheres of government, local and provincial to improve the integration of nurses through proper consultation, and involvement of nurses in the process affecting them.

It is further envisaged that the model will serve as guideline to introduce changes within the district health system with more understanding and acceptance by nurses affected.

Health care managers will find the model useful to overcome disparities in conditions of service among nurses and, in turn this may boost the moral of nurses and lead to successful integration of provincial and local authority nurses.

KEY WORDS

Acceptance, assurance, change, consultation, disparities in conditions of service, district, integration, management of resistance to change, primary health care, proper consultation, resistance to change, uniform conditions of service.

*This study is dedicated to my husband,
Raymond and my children
Oratile, Makabongwe and Phumelela*

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Chapter 1

Overview and rationale of the research

1.1 INTRODUCTION

The aim of this study is to develop a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district that will promote equity and quality comprehensive health care, improve relations between provincial and local authority nurses and boost morale at the same time.

While there is much information available on the integration of health services, little has been documented about the integration of the nurses rendering those services. This has resulted in a lack of guidelines on the integration of the personnel who render services.

The integration of health services has had a major impact and multiple implications for both the health system and its personnel. Local health care departments are reorganising, restructuring and redesigning systems and structures in response to the White Paper on the Transformation of the Health System to improve health services for all (South Africa (Republic)1997).

The integration of provincial and local authority nurses in South Africa came about as a result of the integration of health services as a strategy towards the development of a district health system.

The integration of health services has two components: a structural component and a functional one. Functional integration involves the actual integration of both provincial and local authority health services delivery in the districts, and most importantly transfer or secondment of provincial authority nurses to local authority clinics. Structural integration involves the integration of structures such as governance and management (South Africa (Republic) 1995). This study will focus on functional integration, with specific attention to the integration of nurses rendering primary health care services in the districts.

The establishment of a district health system was initiated by the National Health Department with the aim of overcoming fragmentation, and providing integrated comprehensive health care services that are equitable, accessible, efficient and effective. This is expected to be achieved through the devolution of primary health care services to local government, where community participation and involvement will be enhanced (South Africa (Republic) 1999:3-5).

The district health system based on the primary health care approach, is a self-contained segment of the national health system. It comprises a well-defined population, living within a clearly delineated administrative and geographical area, either urban or rural. It includes all institutions and individuals that provide health care in the district as contemplated in the White Paper on the District Health Care System (South Africa (Republic) 1999:35).

In terms of the national health system, the district health system should be able to:

- overcome fragmentation
- promote equity
- provide comprehensive services
- be economically efficient
- provide services of the highest quality
- allow access to all
- be accountable to the local communities served
- allow for full community participation
- decentralise appropriate powers and functions
- be based on a developmental and intersectional philosophy
- be sustainable

The district health care system is used as a vehicle through which comprehensive integrated primary health care services will be delivered. A properly functioning health district will bring health care managers and communities together to ensure the sustained improvement of the health status of the population through the provision of equitable, efficient, high quality, acceptable, appropriate and affordable health care.

The challenges of effecting the devolution of primary health care services from provincial to local authorities, and the proposed way of addressing them, have a profound impact on the morale of nurses rendering such services.

The advantages of a district health system include the premise that both local accountability and community participation contribute substantially to the delivery of effective health services. The integration process will ensure full participation by the users or beneficiaries of the health system, by ensuring that staff and services in a district are accountable to the communities they serve (South Africa (Republic) 2001b).

In response to the changes in the health care sector, the provincial and local government health services are rapidly merging to form an integrated health system that can provide effective, efficient, affordable and accessible health care to a larger number of people.

Inherent in these changes is the impact on the practice of nurses, who statistically form the largest proportion of the health care providers.

1.2 BACKGROUND TO THE STUDY

1.2.1 Impact of integration on nurses

The White Paper on the Transformation of Health Services published in 1997 was followed by a range of other policies and procedural documents, which expanded on the process of change involved in integration. The scope and significance of the changes brought about by integration should not be under-estimated as they affect the day-to-day functioning of both the local authority and the provincial authority nurses.

It was a new challenge for local authority nurses and managers and provincial authority nurses and their managers to have to collaborate so closely, sharing information and resources, and undertaking joint planning and development.

Local authority nurses and provincial authority nurses will be required to share more information, and work more closely than ever before on quality improvement programmes such as audits and the implementation of the Batho Pele Principles.

Integration also brings about changes in the professional roles and relationships of both local authority nurses and provincial authority nurses, with the aim of enabling them to work in partnership with the client or community. Provincial authority nurses and local authority nurses from individual authorities are now part of a larger organisation at district health authority level under the national health system.

Local authority nurses and provincial authority nurses can contribute to service changes and development by working on subcommittees of the district health system. Local authority nurses and provincial authority nurses' knowledge and needs will change their career options and expand their professional competencies and they will be expected to support the increasing complexities of patient care.

1.2.2 Integration as a change process within a system

When change is initiated in one subsystem that affects the other subsystems, patterned behaviours no longer work adequately and tension rises in other subsystems. In addition, more energy is lost from the whole system during such a period. With regard to this study, it has been experienced that tension exists between local authority nurses and provincial authority nurses, as provincial authority nurses are being allocated to work in local authority clinics.

Prior to the changes brought about by the integration process, nurses functioned in roles within organisations, and these roles were relatively fixed or patterned. With a specific role, there are certain responsibilities and also certain freedoms and privileges. This structure of roles within the district health system, which makes up a subsystem of the nursing unit, helps the local authority nurses and provincial authority nurses to maintain

the equilibrium of the system. This "safe" and familiar working environment is threatening to the personnel during an integration period.

1.2.3 Effective utilisation of resources

In response to the pending changes in health care reform, the Gauteng Health Department, with services along the continuum, is engaged in reorganising health services to form an integrated system that can provide efficient health care services to a large population at an affordable cost. Inherent in these changes is the better management of services by knowledgeable nurse managers, improved information technology and increased focus on costs per month per enrollee. These changes will invariably create jobs, improve care processes, stimulate new working environments and require new approaches to management and effective and efficient cost management.

Nurses are expected to take the lead and manage the integration process and ensure that changes are understood and accepted by those affected, and that these changes impact positively on health care delivery for the benefit of both the recipient and the providers.

The local authority health personnel rendering primary health care services to the communities are, because of the integration process, being faced with limited resources and limitless demands for health care from the public. During transitional changes, nurse managers need to foresee that, in order for nurses to take up the challenges of the massive changes occurring in the health services as well as in the profession, there will be a need for substantial investment in the existing staff. This will have to include investment in training, innovation and innovative thinking action research, as well as more effective coordination between all levels of staff and policy-makers if the potential of the profession is to be realised.

1.2.4 Integration as a tool for effective and affordable health care delivery

Because there is little literature available on the integration of nurses, reference will also be made largely to the integration of services, in which staff play a part.

A study conducted by Strachan (1999b) found that the integration of health services has proved to ensure the quantitative distribution of material and human resources, and most importantly the effective utilisation of human resources.

According to Clarke (1999:3), integration of health services improves efficiency in administration and delivery of services, two systems in health services that have proved to be costly in terms of human and financial resources.

Clarke (1999:3) also found that where services are provided by two health authorities, these services are duplicated which results in a waste of resources, and more expensive for the community.

Waltson, Kimberley and Burns (1996:84) confirm that integration ensures more efficient care, reduced duplication of services, economies of scale, reduced administrative costs, greater coordination of services, and increased market influence. In turn, society also anticipates lower costs and higher quality care.

Waltson et al (1996:84) further advocate that administrative integration will improve marketplace efficiency by reducing excessive capacity, eliminating unnecessary care, and concentrating responsibility for a continuum of care.

Blancett and Flarey (1995:88) are of the opinion that integration of horizontal and vertical processes eliminates duplication, leads to fewer delays in service delivery, lower overhead costs, and better response to customers and enhance worker empowerment.

In addition, Blackie (1998:22) confirms that the integration of health services proved to control costs, unite organisational structures and ensure effective and efficient health care services to the population.

1.2.4.1 Limiting fragmentation and duplication

The changes within the health department are intended to lead to a primary health care approach in which health care is rendered by a primary health care team that will encourage a climate of shared roles and skills, flexibility, more innovation and the use of

scarce resources to greater advantage than where a fragmented team with rigid role boundaries exists.

According to the ANC National Health Plan for South Africa (ANC 1994a:59) the aim of reorganising health services in South Africa was to improve health services for all. This was achieved by adopting a primary health care approach and bringing the services in line with international thinking and practices. Crucial to effective primary health care is the strengthening of community services, rendered by provincial nurses and local authority nurses through the integration of health services in the district.

Primary health care services should be rendered by an integrated team who have the appropriate skills to deal with common conditions and who are able to execute a prompt and appropriate referral system to the next level of care. The team should include community health nurses, midwives, doctors, primary health care nurses, enrolled nurses, auxiliary nurses, an oral hygienist, clerical and support staff and rehabilitation personnel (South Africa (Republic)1997:55).

Although the primary health care team is a complex team, consisting of different professionals, this study's emphasis will be on the role of nurses in the primary health care team or context.

According to Twinn, Roberts and Andrews (1996:482), in order for the primary health care team to achieve efficient, effective and affordable health care services, the team needs to have a vision and be tenacious about new plans and flexible enough to deviate from them when necessary. They should also have a common wish to share success.

Historically it is important to note that the legacy of Apartheid policies in South Africa had created a fragmented health system with racially based services, which resulted in inequitable access to health care and disparities in conditions of service for health personnel. The term "fragmented" not only describes the fact of racial segregation but also the existence of a confusing multiplicity of authorities and structures responsible for the management and delivery of health care (De Beer 1988:1). The fragmented nature of the health care system has had serious consequences for the capacity of the system to deliver good health care to the people. In addition, fragmentation has been shown to lead

to an irrational and inefficient organisational structure, and to a wasteful utilisation of human and material resources. Most importantly, the services were planned and managed without community involvement and participation (Harrison 2000:8). Fragmentation of health care services inhibited the health personnel from coordinating the implementation of policies related to health care and the development of strategies for dealing with major public health problems.

Another implication of fragmented health services relates to the fact that the emphasis of services were curative and hospital based, management was largely centralised and top down while community participation was limited. Because of the emphasis on curative services, hospital health personnel were overloaded with patients who could have been treated at clinic level (ANC 1994a:7).

Other effects of fragmented health services are limited human and material resources at both provincial and local authority level, as well as demotivated nurses, and lastly the perception on the part of the public that health care in the public sector is inferior to that available in the private sector (South Africa (Republic) 2001a:11)

One of the legacies of fragmented health services has been the creation of discrepancies between conditions of service and salaries of nurses with similar qualifications and experience employed by different authorities, local or provincial (South Africa (Republic) 2001a:18).

The process whereby South Africa acquired a fragmented health service is the key to understanding the nature of health care in this country. It reveals how health care was distorted by political structures of the past, how fragmentation of health services took place over three periods, namely the periods of Tripartite Health Care, Homeland Health Care and Tricameral Health Care (De Beer 1988:79).

◆ **The need for the integration of health services in South Africa**

Tripartite Health Care was the first source of fragmentation. Under this system the three tiers of government, namely local authorities, provincial authorities and the state or

national department, were all responsible for different aspects of health care.

(1) National Health Department

Health personnel employed by the National Health Department, as the first tier of government, were responsible for the following services:

- Coordination of state health services with those provided by provincial and local authorities and provision to supply any additional services needed to establish a comprehensive health service for the population of the Republic.
- Promotion of a safe and healthy environment.
- Establishment of a national laboratory service.
- Promotion of family planning.
- Promotion and undertaking of research.
- Provision of medico-legal services.

(2) Provincial Health Department

Provincial health departments fell under the second tier of government and health personnel were responsible for the following services:

- Provision of hospital facilities and services.
- Provision of ambulance services.
- Provision of facilities for the treatment of acute mental illness.
- Provision of outpatient services.
- Provision and maintenance of maternity services.
- Provision of personal (curative) health services, sometimes in conjunction with local authorities.
- Coordination of state and local authorities to provide comprehensive health services for the province.

(3) Local authorities

Local authorities formed the third tier of government and were independent of national and provincial health departments and health personnel. They were responsible for the following services:

- Maintenance of district in a clean and hygienic state.
- Prevention of nuisances, offensive conditions and so on.
- Prevention of pollution of water intended for consumption.
- Rendering services for the following:
 - (a) prevention of communicable diseases
 - (b) promotion of health
 - (c) rehabilitation
 - (d) coordination with other authorities

This tripartite division of functions reflects the colonial history in which health services resulted from a process of ad hoc development rather than of conscious planning (De Beer 1988:79).

The excessive fragmentation of services led to a miscalculation of resources and to wasteful duplication of services, as was reported by Browne Commission of Inquiry in 1986 (De Beer 1988:79).

◆ Homeland health care system

Homeland health services were established to encourage ethnicity and to foster a black tribal identity rather than a national identity. In Lebowa, for example, a hospital was handed over to Gazankulu homeland health personnel. This led to the withdrawal of nursing and administrative staff because they were Sotho/Pedi speaking and refused to work under Gazankulu authorities, who were Tsonga speaking (De Beer 1988:2).

The homeland health services reinforced the dependence of homelands on central government, but the adverse publicity focused on the homeland and away from the South

African Government. In Kangwane, where services were very poor, the local population blamed the homeland authorities for poor health services and high rates of disease, rather than the South African state (Pretoria) which was really responsible (De Beer 1988:194).

During this era, 1960 and 1970, the policies of racial segregation and domination were modernised and rationalised through Grand Apartheid and the emergence of the homeland policy.

The positive consequence for health care delivery in this era has been the avoidance of the pitfalls of the tripartite system. Within a district all the services were rendered by a single authority under the Department of Health, there was no fragmentation.

◆ **Tricameral health care services**

In this era, health services were divided into own affairs and general affairs. Own affairs services (Whites, Coloureds and Indians) health personnel rendered hospital and preventive and promotive services and White, Coloured and Indian nurses were employed to render such services. Hospital services were the responsibility of the Province, and preventive and promotive services were the responsibility of the local authority nurses for the particular racial groups.

"General Affairs" meant health services for Africans, which were characterised by lower budgets, lack of resources and limitless demands for health care (De Beer 1988:1). During this period Black nurses were employed to render services with a limited budget, poor infrastructure and inferior salary packages and conditions of services.

See figure 1.1 which shows the structure of health services prior to 1994.

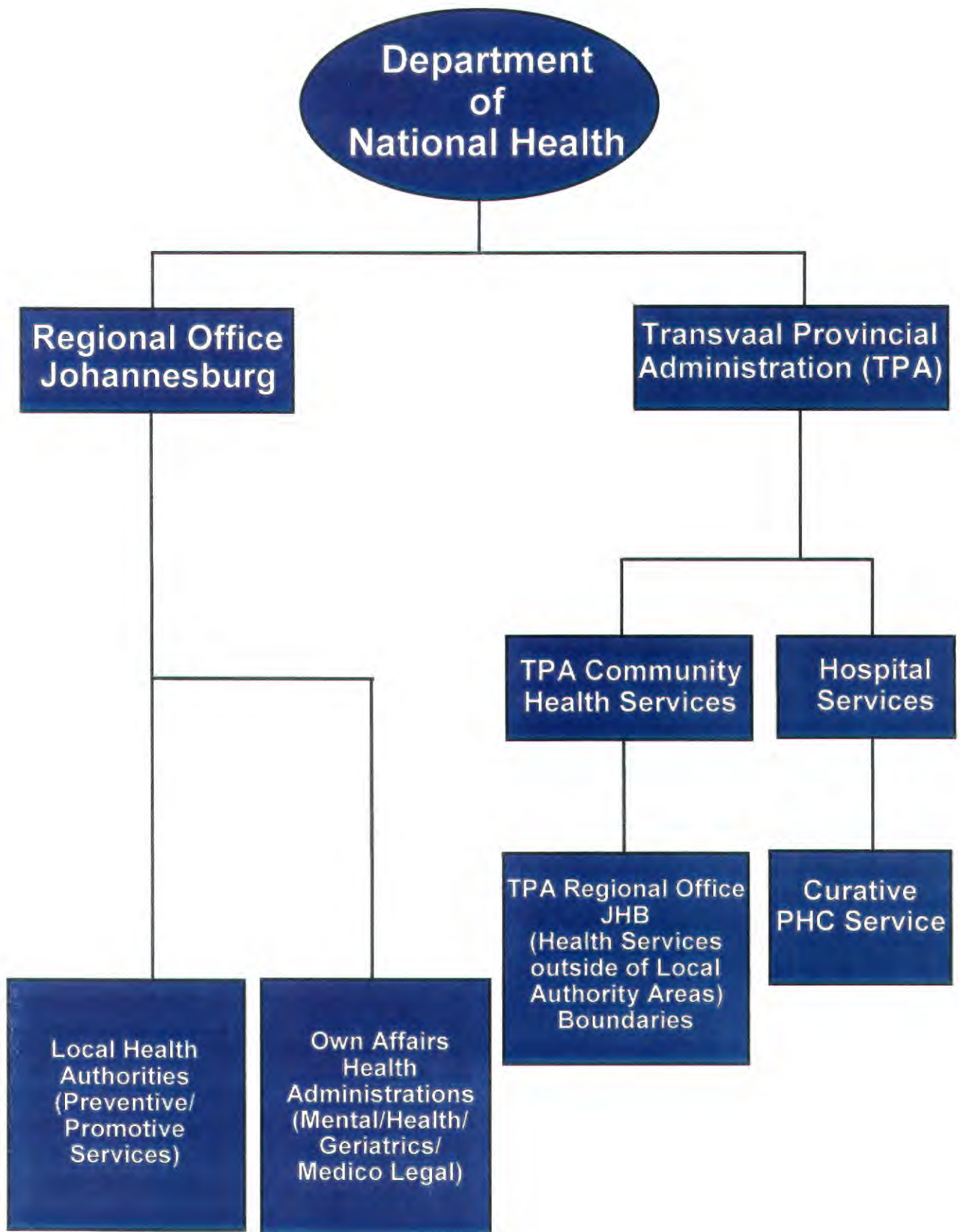


Figure 1.1
The structure of health services in Gauteng
(formerly Transvaal) prior to 1994
 (South Africa (Republic) 1997)

◆ Health care services post 1994

The government committed itself to transforming the health sector in order to unify the fragmented health services at all levels into a comprehensive and integrated national health system, where provincial and local authority nurses will be employed by one authority, with the same salary packages and uniform conditions of services for the same qualifications and experience. The aim of the government was to reduce disparities and inequalities in health service delivery and to increase access to improved and integrated services. These services were to be based on the primary health care approach as outlined at Alma Ata 1978 and the Reconstruction and Development Programmes (ANC1994b:48-49) in which the government created a framework for readdressing the imbalances, and rectifying the fragmented and inequitable health services in the country.

The Gauteng government implemented the devolution of functions for the provision of primary health care services from the provinces to local authorities. The implementation constitutes the core for integrating health services and bringing health care managers and communities together to ensure the sustained improvement in the health status of the population through the provision of equitable, efficient, high quality, acceptable, appropriate and affordable health care (South Africa (Republic) 2001a:3).

The rationale of devolving primary health care functions from provincial health departments to local authorities is that the local authorities have clear and legally recognised geographical boundaries over which they exercise authority and within which they are accountable to the public they serve (South Africa (Republic) 2001a:4).

The Government of National Unity stood up to the challenge of transforming the health services and accepted the Alma Ata Declaration as a point of departure in readdressing the inequalities and fragmented health services. The government committed itself to transforming the health sector in order to unify the fragmented health services and integrate health personnel at all levels into a comprehensive and integrated national health system (South Africa (Republic) 2001a:3).

With the constitution of the country encouraging the delivery of services to the tier of government (local authorities) nearest to the people, the integration of primary health care services in the province which led to the integration of provincial and local authority health personnel rendering primary health care services in a district has created challenges for the health managers of both provincial and local authorities. The researcher employed as a local authority manager, experienced a need for clear guidelines to facilitate a smooth and acceptable integration process.

Owing to the fragmentation of health services, one found that health personnel from different institutions, that is in provincial, local authority, non-governmental organisations and the private sector, were providing health services in the same district. There was little coordination, and duplication occurred, as well as a non-comprehensive type of health care delivery. At the end of the day, this was not appropriate for the needs of the community (own experience).

In 1995, the Gauteng Department of Health addressed these problems by developing the structural transformation plan (STP). The STP ensured the rationalisation of hospital services and the reallocation of health resources towards the primary health care infrastructure. However, these resources were then allocated to the provincial health department, with very little going to local authorities, which are formally accountable to their communities for relevant action (South Africa 2001a:11).

The Gauteng government made the decision to move forward and devolve responsibility for health services to local government. This move was characterised by the closure of provincial clinics and the transfer of provincial nurses to local authority clinics, and by the formation of district management teams. The district management team is made up of local authority health managers and provincial health managers with the main purpose of driving the process of integration of primary health care services. However, this move went on without any increase in subsidy allocation for the provision of primary health care services to local authorities.

Such changes have had to occur in the face of limited and diminished resources and rapid population growth, especially in the area under study, owing to migration and a weakened

economy (payment for services) or poor revenue collection from the public by the local authorities (Springs Town Council 1999:2).

The transfer of provincial authority nurses to local authority clinics and the closure of the provincial authority clinic impacted negatively not only on staff morale but also on the resources available for health care delivery to the communities. The resources initially allocated for provincial health facilities were not transferred to local authorities together with the personnel, hence local authorities are faced with limited resources but limitless demands for health care from the public (Springs Town Council 1999:3).

Limited resources and personal expectations of the provincial health personnel transferred to local authority clinics affect communication and lead to strained relationships between provincial and local authority health personnel (District Management Team 2001:2).

The impact of local authorities' inability to meet the community's health needs impairs relations among personnel (local authorities and provincial nurses), some being so badly affected that they decided to quit the services, leading to an excessive staff turnover. Gillies (1989:327) confirms that excessive staff turnover leads to overburdening of and poor interpersonal relationships among the remaining staff, with the result that a deterioration in patient care is experienced.

It is clear that if the working environment is not sufficiently conducive to efficiency, productivity targets are often not realised, and in this case, health care delivery is poor. Nurses who are overworked become easily frustrated, emotionally drained and tend to treat patients as objects (Gillies 1989:397).

According to Wright (1992:26), health personnel can only adopt a positive attitude to patients and their colleagues if the working conditions are conducive to this.

The District Management Team (2001:1-2) states that local and provincial health authority managers are continuously locked up in meetings to consider ways of striking a balance between the growing health needs on the part of the communities, the limited or scattered resources and the frustrated, burnt-out health personnel. Since there were no proper

guidelines on the integration of local authority nurses and provincial authority nurses rendering primary health care services in the district of Springs, this so-called integration has resulted in strained relations and a drop in morale among the two groups of nurses referred to. This resulted in a situation where service delivery in the district was compromised. It is therefore with this in mind that a need was felt for an investigation aimed at developing a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

1.3 RESEARCH PROBLEM

Although the need for the integration of health services previously offered by both provincial and local authorities is acknowledged, the integration process in the case of a local authority in the Gauteng Province, resulted in feelings of insecurity of personnel, reduced available resources and unmet health needs of the community.

On the basis of the problem statement outlined above, the following research questions that need to be addressed were formulated:

- What are the perceptions of local authority health nurses about the integration process?
- What are the perceptions of the provincial authority nurses about the integration process?
- What are the perceptions of the district management team about the integration process?
- What strategies can be implemented to facilitate a smooth and acceptable integration process?

1.4 PURPOSE AND OBJECTIVES

1.4.1 Purpose of the study

The general purpose of the study was to develop a model for the integration of provincial

and local authority nurses rendering primary health care services into an integrated health district system.

1.4.2 Objectives of the study

The objectives of the study were

- to explore and describe the perceptions of local authority nurses about the integration process
- to explore and describe the perceptions of provincial nurses about the integration process
- to explore and describe the perceptions of the district management team about the integration process
- to explore and describe the strategies followed by local authority nurses, provincial authority nurses and the district management team during the integration process

In addition to the above-mentioned objectives, the researcher aimed to develop guidelines to operate a model for the integration of provincial and local authority nurses rendering primary health care services in a district.

1.5 CENTRAL THEORETICAL STATEMENT

The exploration and description of perceptions of local authority nurses, and provincial health nurses about their integration, and the strategies of local authority nurses, and the district management team regarding the integration of provincial and local authority nurses rendering primary health care services in a district, will provide the basis for the development of a model for the integration of provincial and local authority nurses rendering primary health care services in a district. The operationalisation of this model will enable the health managers to effectively utilise resources and improve morale and strained relations among the health personnel, and ultimately improve mentor primary health care services.

1.6 APPLICATION OF ROY'S MODEL OF NURSING TO THIS STUDY

This research will be based on the Roy Adaptation Model (Fawcett 1984:145; George 1990:259). See figure 1.2.

Roy's model is a system model that focuses on the outcome of reaction to stimuli, that leads to change in the internal and external environment. The concepts in the Roy's model are person, goal, health and environment.

A person in this study, refers to local authority nurses and provincial authority nurses, district management team and the community nurse as the chief nurse responsible for improving the integration process. For the purpose of clarity, both the local authority nurse and provincial authority nurse are community nurses as they render primary health care services to a community within a district, but in this context a community nurse (chief nurse) is used as an authority to assist local authority nurses and provincial authority nurses to adapt to the changing environment of integration.

Local authority nurses and provincial authority nurses as adaptive systems, employ their coping mechanism to adapt to changes brought by their integration. Local authority nurses and provincial authority nurses's external and internal environments are stimulated by the changes that integration introduces. The behaviour in the model is portrayed by local authority nurses and provincial authority nurses's behaviour or reaction to the proposed changes.

The community nurse as adaptive system will employ the four adaptive modes of physiological, self-concepts, role function, and interdependence to assist local authority nurses and provincial authority nurses to adapt to the changing environment. Critical to the model is the description of the environment as all conditions, circumstances, and influences that surround and affect the development and behaviour of a person.

In this study, the community nurse need to stimulate, motivate local authority nurses and provincial authority nurses to develop new skills to be competent to function in the new environment. In addition, the community nurses will influence local authority nurses and provincial authority nurses's visual motivation and ability to solve their problems and to find new ways to deal with the challenges of their integration.

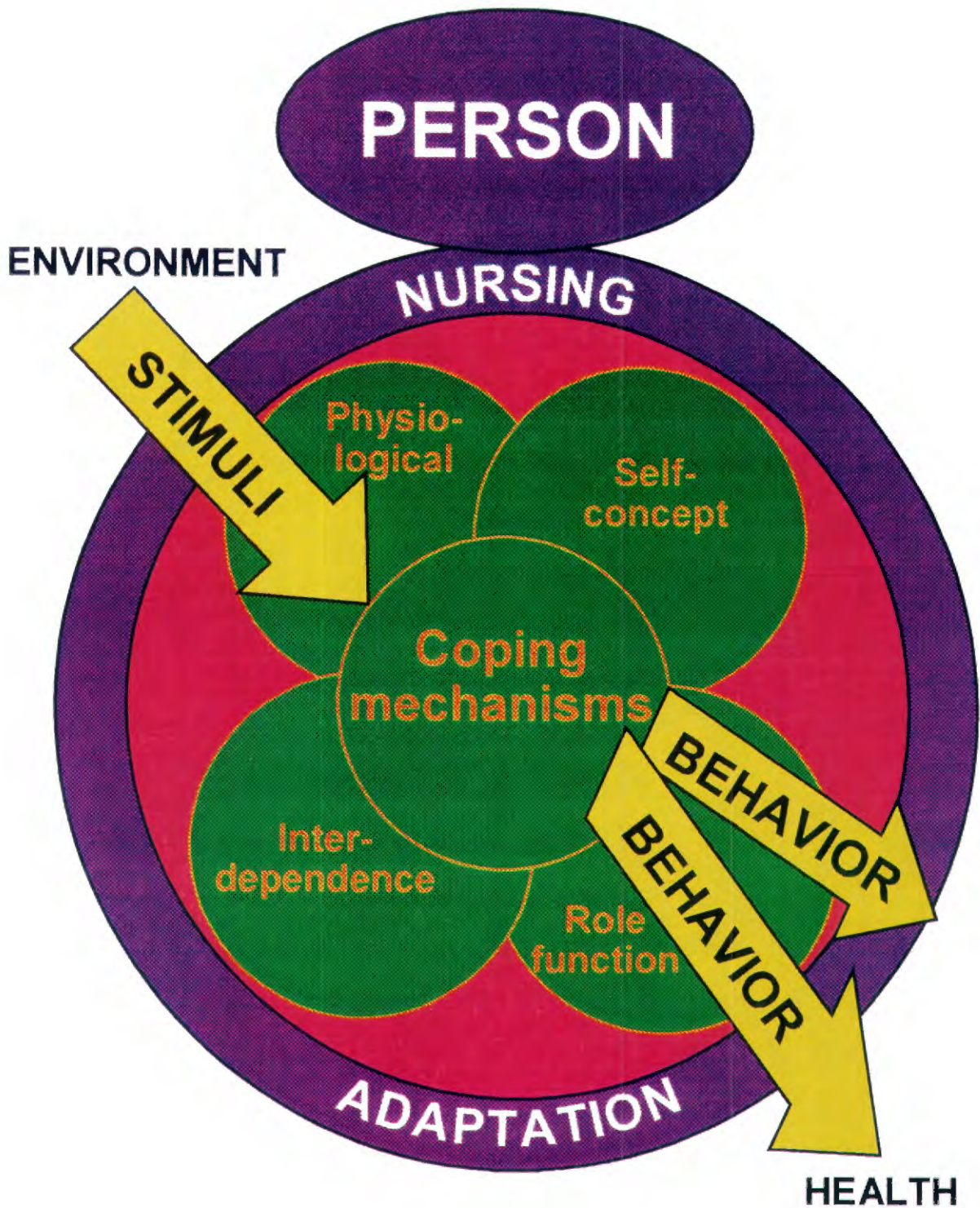


Figure 1.2
Roy's adaptive system
 (Fawcett 1984:145; George 1990:259)

Roy defined health, as "a state and a process of being and becoming an integrated and whole person" (Andrews 1991:19). Health status, reflects the adaptation process of four integrated, adaptive modes: physiologic, self-concepts, role function and interdependence. The "health" of local authority nurses and provincial authority nurses depends on their ability to strive and achieve their maximum potential of adapting to changes introduced by the integration process.

The researcher chose this theory as a point of departure because it is a system theory focusing on organisation and the integration of parts and elements. The study deals with integration, which in this case involves the integration of human beings, namely local authority nurses and provincial authority nurses.

This model also reflects how human beings manage to adapt to change. As integration of local authority nurses and provincial authority nurses involves change, this model will assist the researchers in gaining more knowledge of how to effect relevant changes.

Based on the theoretical framework the following assumptions will be discussed:

- meta-theoretical
- theoretical
- methodological

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions are philosophical in origin and are merely value convictions and are not testable (Botes 1991:12). The meta-theoretical assumption of this study is based on Roy's Adaptation Model of Nursing.

Certain terms used in Roy's model and this study are defined below (Fawcett 1984:251).

◆ Person

In this study, a person refers to the local authority nurses and provincial authority nurses

as well as to managers, who are all biopsychosocial beings, in constant interaction with a changing environment. The person has a great potential of self-actualisation and is an active participant in his or her own destiny (Fawcett 1984:250).

◆ **Health**

Health is a state and the process of becoming integrated into a whole. A person, as an adaptive system and a being who is constantly growing and developing in a changing environment, has the potential to become integrated or whole (Riehl & Roy 1980:11). Health is also described within the context of adaptation. Adaptation therefore refers to a process of responding positively to environmental changes (Fawcett 1984:254).

◆ **Environment**

Environment refers to all the conditions, circumstances and influences surrounding and affecting the development of an organism or group of organisms.

Roy referred to internal and external environments as sources of inputs into adaptive systems (Fawcett 1984:253). In this study, the term "environment" encompasses the changing working environment of the nurses employed by local authorities, provincial authorities and district health system.

◆ **Nursing**

Nursing is defined as a science and a practice discipline. In either situation, it is the body of knowledge used to positively affect a person's health status (Riehl-Sisca 1989:117).

In this study the practice discipline will positively affect local authority and provincial authority nurses' mental health status to be able to adopt to changes introduced by the integration process.

1.6.2 Theoretical assumptions

Theoretical assumptions are testable and offer an epistemic pronouncement about the research field (Botes 1991:12). With regard to this study, these assumptions will be based on Roy's Adaptation Model of Nursing (Fawcett 1984:247-279)

1.6.2.1 Theoretical statements

The theoretical statements as stated in Roy's Adaptation Model will be utilised in this study:

- The person is a biopsychosocial being in constant interaction with a changing environment.
- To cope with a changing world the person uses both innate and acquired mechanisms, which are biologic, psychological and social in origin.
- Health and illness are inevitable dimensions of a person's life.
- The person is conceptualised as having four modes of adaptation: physiological adaptation strategies, self-concept, role function, and interdependence relations.

1.6.2.2 Theoretical definitions

◆ District

A district is defined as a territory demarcated for special administrative processes.

◆ District management team

A team of local authority middle managers and provincial middle managers involved in the integration of services.

◆ **Model**

A model is a conceptual framework that classifies phenomena in terms of building and organising the relationship between the phenomenon and variables. A model illustrates relationships between the main element of the process (Botes 1991:3).

◆ **Primary health care**

WHO(1985:16) defines Primary health care as an essential form of health care made universally accessible to individuals and families in communities by means acceptable to them, with their full participation and at a cost that the community and the country can afford to maintain at every stage of development, in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the control function and 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 in bringing health care as close as possible to where people live and work (World Health Organization 1985:16).

◆ **Local authority nurse**

For the purpose of this study a local authority nurse is defined as a nurse registered with the South African Nursing Council and employed by a local authority.

◆ **Provincial authority nurse**

For the purpose of this study a provincial authority nurse is defined as a nurse registered with the South African Nursing Council and employed by a provincial authority.

◆ **Community nurse**

For the purpose of this study a community nurse is a professional nurse who is registered with the South African Nursing Council to render health care services in the community/primary health care setting (cross reference – page 18).

◆ **Integration**

Integration is defined as the process or result of the unification of parts to form a whole or process of bringing or coming into equal participation in an institution (Pearsall 1999:735).

◆ **Involvement**

Involvement of local authority nurses and provincial authority nurses in the integration process refers to them as being part of the process as they affected by the integration process.

◆ **Local accountability**

In this research the local accountability refers to the services rendered in local authority clinics by nurses who have close contact with the community they serve.

1.6.3 Methodological assumptions

The assumption is that scientific practice in primary health care must arise from a functional approach. Proponents of the functional approach believe that knowledge should not be generated through research for the sake of knowledge only, but should be applied in practice to improve the practice of nursing (Botes 1991:19). In this study knowledge will be generated and applied in primary health care services, in which a model for the integration of provincial and local authority nurses rendering primary health care services in a district will be developed and then operationalised to improve the primary health care services and improve the morale and relations of nurses.

1.6.4 Assumptions of the researcher

The assumptions for this researcher emanate from the paradigmatic perspective on which this study is based (Roy's Adaptation Model) and consequently the researcher proposes the following:

- The person is in interaction with a changing environment.
- The individual as an adaptive system interacts with the internal and external environment. The person, as someone having the potential for self-actualisation and as an active participant in his own destiny, will promote the integration of local authority nurses and provincial authority nurses rendering primary health care in a district.
- Guidelines describing the integration of local authority nurses and provincial authority nurses rendering primary health care in a district will enable community nurses in future to integrate local authority nurses and provincial authority nurses and in turn improve primary health care in the district.

1.7 RESEARCH METHODOLOGY

A qualitative, explorative, descriptive and contextual design will be followed to achieve the overall purpose of this study. According to Chinn and Kramer (1995:143), the qualitative research is designed to discover and describe relationships without imposing preconceived notions of what these phenomena mean. The purpose of this study is to explore the relatively unknown perceptions in the internal and external environments of local authority and provincial authority nurses rendering primary health care services in a district, and the operationalisation of the model to improve the quality of primary health care services in a district.

To identify concepts of the model, fieldwork was carried out using an inductive approach. The results of data gathered from focus group interviews will be utilised to design a model.

The research took place in two phases. In phase I, the exploration of the integration process through focus group interviews.

In phase II, a model will be designed based on the findings of the focus group interviews.

A brief summary of the research methodology is outlined in table 1.1.

All the abovementioned aspects will be discussed in detail in chapter 2.

The following aspects form the basis of the determinants for the research design:

- context of research
- research purpose
- attributes of the field of research
- sampling
- data gathering
- data analysis

1.7.1 Research context

The research study is contextual in nature; it focuses on the perceptions of local authority and provincial authority nurses and the district management team in a specific district in Gauteng Province.

1.7.2 Research purpose

The purpose of the research study was to explore and describe the perceptions of local authority nurses, provincial authority nurses and the district management team about the integration of local authority nurses and provincial authority nurses rendering primary health care in the district, and their suggested strategies to improve integration.

Based on the findings of their responses, a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services was generated.

1.7.3 Attributes of the field of research

The determinants provide a framework for the research decisions that are taken; they are specific for each and every study and are used to justify research decisions which can be evaluated within their own framework (Botes 1991:3). This is a logical relationship

between the research decisions and the determinants of research.

1.7.4 Sampling

According to Patton (1990:169), the logic and power of purposeful sampling lies in selecting information for study in depth.

In qualitative research, sampling size is subject to peer review, consensual validation and judgment. What is crucial is that the sampling procedures and decisions should be fully described, explained and justified so that information users and peer reviewers have the appropriate context for judging the sample (Patton 1990:186).

Streubert and Carpenter (1995:24) emphasise that in qualitative research, the concern of the researcher is to develop a rich or dense description of the culture or phenomenon so that results can be transferred and not generalised.

A purposive sampling method will be utilised in this study as it is based on the judgment of the researcher in composing the sample of elements that contain the most characteristic, representative or typical attributes of the population (De Vos 1998:198).

In this study the research chose, provincial and local authority nurses and the district management team, as the three are affected by the integration process.

Burns and Grove (1993:246) describe purposive sampling as a process of conscious selection by the researcher of certain subjects or elements to include in the study. For the purposes of this study, the target population will be all the local authority managers and local authority nurses employed at First Avenue Clinic, Kwa-Thema, White City, Payneville, Bakerton and Thembelisha Clinic, and registered with the South African Nursing Council as registered/community nurses, rendering primary health care in the Springs district.

◆ **Criteria for inclusion**

The criteria for inclusion in the sample were the following:

(1) Provincial and local authority nurses

- Nurses should be registered with the South African Nursing Council as nurses and should be employed by either the Gauteng Provincial Health Department or the local authority health department rendering primary health care services in the a specific district in Gauteng Province.
- Informed consent to participate in the study had to be given by participants.
- Participants must be senior nurses involved in the integration of local authority nurses and provincial authority nurses rendering primary health care services in a specific district in Gauteng Province.
- Participants must be able to speak, read and write English.

(2) District management team

- Members of the district management team must be designated managers, involved in the integration process of health services, and must be employed by either the provincial health department or the local authority health department.
- Members of the district health team must give informed consent to participate in the study.
- They must be in a managerial position.
- They must be able to speak, read and write English.

The sample size will depend on the saturation of data, when no new themes or essences emerge from participants and there is repetition and confirmation of previously collected data (Streubert & Carpenter 1995:24).

1.7.5 Data gathering

In qualitative research the data collection method depends entirely on the purpose

question, skills and resources available to the researcher (Morse 1994:223).

Streubert and Carpenter (1995:24) highlight the fact that data collection and sampling size will be determined by the saturation of data. Saturation refers to the repetition of discovered information and confirmation of previously collected data (Streubert & Carpenter 1995:24). However, Morse (1989) in Streubert and Carpenter (1995:24) warns that saturation of data may be a myth, the argument being that new data may be revealed when another group is interviewed at another point in time.

In this study, data will be gathered by means of focus group interviews. De Vos (1998:314) describes focus group interviews as a purposive discussion of a specific topic or related topics taking place between eight to ten people with a very distinctive set of characteristics and common interests. The group interaction will consist of verbal and nonverbal communication and an interplay of perceptions and opinions that will stimulate the discussion without changing or modifying the ideas of participants. The data gathering method will be discussed in more detail in chapter 2.

1.7.6 Data analysis

Streubert and Carpenter (1995:24) indicate that data analysis is a "hands on" process. They are of the opinion that the researcher should become deeply immersed in, and fully committed to, understanding what the data reveal. The process requires a significant degree of dedication to reading, intuiting, analysing, synthesising and reporting (Streubert & Carpenter 1995:24).

According to Marshall and Ross (1989:112), qualitative data analysis is a search for general statements about relationships among categories of data.

Streubert and Carpenter also point out that data analysis in qualitative research begins when data collection. During observation or interviews, records are kept and are constantly being reviewed to discover additional questions which need to be asked or to offer descriptions of what is found.

Tesch (1990) (in Cresswell 1994:153-155) indicates that qualitative data analysis allows flexibility, and states that there are no hard rules on how it should be done. De Vos (1998:337) emphasises that there no right or wrong approach to data analysis in qualitative research, but that there are only general guidelines that researchers can adhere to for analysing their data.

In this study, data will be analysed by using qualitative analysis techniques as described by Tesch (1990) (in Cresswell 1994:153-155). These steps engage the researcher in a systematic process of analysing textual data.

Table 1.1: Summary of the research method

PHASES	STEPS	METHODS	TRUSTWORTHINESS	REASONING STRATEGY
Phase 1: Explorative phase	Step 1: Exploration of the integration process	<ul style="list-style-type: none"> • Designing an interview guide • Preparation of the field • Sampling • Pretest • Data gathering 	<ul style="list-style-type: none"> • Topic will be clearly defined • Questions will be clearly stated • Long-term relationship has been established with the institution where focus group interviews were conducted • Purposeful sampling will be done to ensure full coverage of insight of the integration process • Pretest will be done to validate the questionnaires • Data gathering will be done with three focus groups to ensure triangulation 	Inductive

PHASES	STEPS	METHODS	TRUSTWORTHINESS	REASONING STRATEGY
	<p>Step 2:</p> <p>Presentation and analysis of data</p>	<ul style="list-style-type: none"> • Identification and description of concepts • Data analysis (Tech's method) • Literature control 	<ul style="list-style-type: none"> • Engagement of independent coder to limit bias • A protocol for coding will be between the researcher and the independent coder • Consensus discussions between the independent coder and the researcher when differences in coding have been identified • Results from the three focus group discussions will be compared with available literature • Researcher is an experienced qualitative researcher with good interpersonal skills to conduct the focus group interviews • Ethical standards will be adhered to. 	Inductive

PHASES	STEPS	METHODS	TRUSTWORTHINESS	REASONING STRATEGY
Phase 2: De-signing phase	<ul style="list-style-type: none"> ▪ Description of the model 	Description of: <ul style="list-style-type: none"> ▪ Implementation of strategies for the integration process ▪ Process of the implementation of the model ▪ Conclusion, limitations and recommendations 	Description and suggestions based on research findings and literature study	Deductive

1.7.7 Measures of trustworthiness

According to Streubert and Carpenter (1995:24), rigor in qualitative research is demonstrated through the researcher's attention to, and confirmation in, information discovery.

Guba is of the opinion that in qualitative research, researchers need alternative models that ensure rigor without sacrificing the relevancy of qualitative research. Guba further proposes a model for assessing the trustworthiness of qualitative data (Guba 1981:215-216).

Trustworthiness in this research will be ensured by applying Lincoln and Guba's model. The four criteria for ensuring trustworthiness are truth-value, applicability, consistency and neutrality. Truth-value will be ensured by using the strategies of credibility and applicability. Consistency will be ensured by using the strategies of dependability, transferability, neutrality and confirmability (Lincoln & Guba 1985:290).

(1) Credibility will be ensured by looking at the activities that increase the probability that credible findings that will be produced ensures truth-value: prolonged engagement and (Lincoln & Guba 1985:30).

- Prolonged engagement is the investment of sufficient time to achieve certain purposes, testing for misinformation introduced by distortion of the self or of the respondents and building trust. Lincoln and Guba (1985:32) believe that prolonged engagement also requires the investigator to be involved with the location long enough to avoid the distortion that might otherwise creep into data. The researcher as an experienced manager who has been at the local authority health department for four years will help detect distortions. The information given by the participants during focus group interviews and the literature control may result in a credible finding.
- Triangulation in this study will be applied in order to gain multiple information from different sources (Lincoln & Guba 1985:305). Information will be

verified by using interview transcripts, Tesch's method of data analysis, an independent coder and by means of the data gathering method, which will involve focus groups targeted at three different levels. namely: provincial authority nurses, local authority nurses and members of the district management team.

- (2) **Transferability.** Transferability refers to the degree to which findings can be applied to other contexts and settings within groups. Lincoln and Guba (1985:290) suggest that a more appropriate perspective against which the applicability of qualitative data is assessed would be transferability. In this study, the research will provide thick description of findings so that these findings can be transferred to another similar context or situation, and still preserve the particularised meanings and interpretations.
- (3) **Dependability.** Dependability determines whether the findings would be consistent if the enquiry were replicated with the same subject or context. Variability can be expected in qualitative research due to the fact that the instruments assessed are the researcher and the participants, both of whom vary greatly within the research project. As the researcher emphasises the uniqueness of the human situation it is variation, rather than identity replication, that is sought (Field & Morse 1985:15). Because variability can be expected in qualitative research, consistency is defined in terms of dependability, meaning variability that can be ascribed to identified sources.
- (4) **Confirmability.** In this research consensus in discussions between the researcher and the independent coder had to be reached in the form of a confirmability audit. Literature was also used as control measures during the designing of the model.

A summary of the above is presented in table 1.2.

Table 1.2: Strategies of trustworthiness

STRATEGY	CRITERIA	APPLICATION
Credibility	<p>Prolonged engagement</p> <p>Triangulation</p>	<p>Researcher was a manager in the local authority health department for four years. Focus group interviews with three different groups.</p> <p>Different data sources utilised participants, literature, Tesch's method of data analysis. Independent coder to analyse data. Data gathering method: focus group interviews from the three groups ie local authority nurses, provincial nurses and district health team.</p> <p>Transcriptions of interviews are readily available to be examined critically at any stage. Independent expert was involved in the analysis of data at the request of the researcher.</p>
Transferability	Authority of researcher	Thick description of data. Focus groups with three different groups.
Dependability	<p>Dense description</p> <p>Dense description of research method, theory generation and guideline for use in practice Triangulation</p>	<p>Complete description of methodology. Purposeful sampling.</p> <p>All steps of data collection analysis and interpretation described. Focus group interviews. Tesch's method of data analysis.</p>
Confirmability	Confirmability audit	<p>Consensus in discussion between researcher and independent coder have to be reached.</p> <p>Independent coder. Tesch's method of data analysis.</p> <p>Literature control.</p>

1.7.8 Ethical considerations

According to Streubert and Carpenter (1995:30), qualitative researchers are required to abide by ethical principles in all professions; to safeguard the rights of the public, they should conduct their studies with the highest ethical standards.

Protection of human subjects is essential in the conduct of research. If human subjects are not protected, unique ethical problems would result, jeopardising the study or ending up with lawsuits against the researcher.

Ethical measures will be adhered to by using the standards set by the Democratic Nurses Organisation of South Africa (DENOSA) (1998) and reference is also made to the Statements of Ethics by the American Anthropological Association (Glesne & Peshkin 1992:118). Ethical consideration will be discussed in detail in chapter 2.

1.8 LAYOUT OF CHAPTERS

- CHAPTER 1: Overview and rationale of the research
- CHAPTER 2: The research methodology
- CHAPTER 3: Presentation and analysis of data
- CHAPTER 4: Designing a model for the integration process
- CHAPTER 5: Conclusions, limitations and recommendations

1.9 SUMMARY

The South African health care system is undergoing rapid changes that affect human and financial resources to such an extent that health care delivery is affected negatively.

The changes are meant to improve health care services by integrating provincial and local authority nurses rendering primary health care services in a district so that resources are now directed to one tier of government (local government) that is nearer and is accountable to people regarding management and administration. But the changes introduced seem to impact negatively on staff morale and on material resources.

Nonetheless, since the integration of provincial and local authority nurses rendering primary health care services in a district is an ongoing process which cannot be reversed, it is the only vehicle that can achieve better health for all and better conditions of employment for nurses, what one can do is to find ways and means of integrating primary health care services without impacting negatively on staff morale and resources allocated for health care delivery. It is with this in mind that the researcher will explore and describe in the next chapter the methods to be used to achieve the research objectives.

Chapter 2

Research methodology

2.1 INTRODUCTION

The overview and rationale of this study were outlined in chapter 1.

The overall purpose of the study was to develop a model for the integration of provincial and local authority nurses rendering primary health care services in a district, so as to improve primary health care services and achieve health for all in the district.

This research was conducted in two phases. Phase 1 explored the integration process through the focus group interviews and the steps followed are explained in detail in this chapter. Phase 2 outlined the designing process of the model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in the district.

According to Reinharz as cited in (Swanson-Kauffman & Schonwald 1988:101), qualitative research consists of three challenges, and all researchers need to be committed to meeting these challenges and be willing to operate within such a methodology. These challenges are:

- Understanding the substantive problem under study.

- Allowing personal change to occur, especially on the part of the researcher.
- Creating innovative methodological strategies to capture the unique features of each research project.

2.2 RESEARCH DESIGN

The research design of the study is qualitative, explorative, descriptive and contextual in nature, with an inductive approach which is aimed at understanding integration of health services and a deductive approach in the description of designing a model for implementing an integration process.

2.2.1 Qualitative research

"Qualitative research" refers to an approach in which procedures are not strictly formalised, where the scope is more likely to be undefined, and a more philosophical mode of operation is adopted (Mouton & Marais 1991:155-156).

According to Burns and Grove (1993:26-61), qualitative research is a systematic, subjective approach used to describe experiences and to give meaning to such experiences.

A qualitative approach was followed for the description of perceptions of local authority nurses, provincial authority nurses and the district management team on the integration of primary health care services in the district.

2.2.2 Exploratory process

According to Woods and Catanzaro (1988:50), explore means scrutinising unknown regions for the purpose of discovery, while Mouton (1996:102-103) is of the opinion that the purpose of exploration is to explore a relatively unknown territory to gain new insight into the phenomena. This method guides the researcher towards not allowing pre-conceived ideas to influence the study but instead gaining insight into the perceptions of

local authority nurses, provincial nurses and the district health team about the integration of provincial and local authority nurses rendering primary health care services in a district.

2.2.3 Descriptive research method

The descriptive research method refers to describing that which exists as accurately as possible (Mouton 1996:102). Parse, Coyne and Smith (1985:90) are of the opinion that the descriptive research method is a model which yields findings based on conversations and observation.

In this study, this method will enable the researcher to

- describe the perceptions of local authority nurses about the Integration of provincial and local authority nurses rendering primary health care services in a district, and strategies to improve integration
- describe the perceptions of provincial authority nurses about the integration of provincial and local authority nurses who render primary health care services in a district primary, health care services and strategies to improve integration
- describe the perceptions and strategies of the district management team on integration of provincial and local authority nurses rendering primary health care services in a district
- describe the guidelines for the operationalisation of the model

2.2.4 Contextual

The contextual approach describes the uniqueness, differences and distinguishing characteristics. The research is only valid within a certain time space and value context (Botes 1991:7). This research will focus on the perceptions of local authority nurses, provincial nurses and those of the district health team of Springs in Gauteng, and therefore refers to nurses employed by local authorities and the province rendering

primary health care services, from 1996 to 2000. The research refers to specific people, a specific time and specific area and is bound to a unique context. Furthermore the results cannot be generalised but can be transferred.

2.2.5 Model

Chin and Kramer (1995:216) describe a model as a "symbolic representation of perceptual phenomena in words, numbers, letters, or generic forms. Models may provide a sense of understanding as to how theoretic relationships develop and are useful to illustrate various forms of theoretic relationships. Models can be presented as part of a theory or can be constructed to show links between theories".

According to George (1990:5), models are "representations of interaction amongst and between the concepts showing patterns". This means that a model is a pictorial representation of a proposition.

(George 1990:5) further explains the relationship between the concepts that in essence a conceptual model can be described as an analogy that determines how the world is viewed and what aspects of the world are to be taken into account. Conceptual models provide a specific frame of reference for members of the discipline to be able to interpret what they have observed.

2.3 REASONING STRATEGIES

In this research, a number of reasoning strategies will be used to generate a model for the integration of provincial and local authority health personnel rendering primary health care services in a district, namely:

- analysis
- synthesis
- induction
- deduction

Some research and reasoning strategies are applicable only to specific steps and are used simultaneously in other steps of theory generation. Analysis, synthesis, induction and deduction will be utilised to generate a model in this study.

2.3.1 Analysis

Analysis refers to clarification, refinement of concepts, and statement of theories. The existing whole is broken into parts and then each part, as well as the relationship between the parts, is examined to gain a better and clearer understanding (Walker & Avant 1995:28).

In this study, analysis is used during the exploration and description of concepts relevant to the model, as well as during interviews.

2.3.2 Synthesis

Synthesis is used to combine isolated pieces of data, that have not yet been theoretically combined to form a concept, into a pattern or relationship (Bloom 1956:206; Walker & Avant 1995:28-29). In this study synthesis will be used to define, analyse, categorise and position the concepts drawn from the perceptions of local authority health personnel, provincial health personnel and the district health team about the integration of provincial and local authority health personnel rendering primary health care services in a district according to identified relations to form a statement.

2.3.3 Induction

Induction refers to the collection of information to reach a conclusion. It can be used effectively to seek regularities, similarities, patterns and tendencies as a guide, although it is limited, because it is not possible to observe all the instances of a specific event (Bandman & Bandman 1988:257-266).

Induction will be used during discussions of results from the three focus groups, that is provincial nurses and local authority nurses and the district management team (the details

of this will be discussed in chapter 3) to seek similarities regarding the perceptions of the three focus groups about the integration of provincial and local authority nurses rendering primary health care services in a district.

2.3.4 Deduction

In deductive logic, two or more premises as a relational statement are used to draw a conclusion. In deductive processes, an abstract theoretical relationship is used to derive specific questions or hypothesis (Chinn & Kramer 1995:213).

A deductive argument, which is probably valid, is one that, if the premises are true, the conclusion is likewise true. Deduction is based on conclusions that can be drawn concerning a phenomenon when one can say that the conclusions are probably correct (Bandman & Bandman 1988:184-187).

In this study, deductive reasoning will be used to draw guidelines for the operationalisation of the model for the integration of provincial and local authority nurses rendering primary health care services in a district.

2.4 PHASE 1: EXPLORATION OF THE INTEGRATION PROCESS

Phase 1 will be conducted in two steps.

2.4.1 Step 1: Exploration of the integration process

Step 1 will address the following:

- designing an interview guide
- preparation of the field
- sampling
- pretest
- data gathering

2.4.1.1 Designing an interview guide

The design of the interview guide is a vital task because it establishes the agenda for the focus group interview and provides the structure within which the members will interact. (De Vos 1998:318).

The concepts to be investigated need to be clearly defined, questions must be ranked from the more general to the more specific, and the questions of greatest significance must be placed at the beginning, with those of lesser significance being included towards the end (De Vos 1998:319).

The researcher clearly defined the topic(s) to be discussed, namely "the integration of provincial and local authority nurses rendering primary health care services in a district". The questions asked were:

- (1) How do you perceive your integration with local authority nurses and what strategies can be implemented to improve the integration?
- (2) How do you perceive your integration with provincial authority nurses and what strategies can be implemented to improve the integration?
- (3) How do you perceive the integration between local authority nurses and provincial authority nurses and what strategies can be implemented to improve integration of local authority nurses and provincial authority nurses?

2.4.1.2 Preparation of the field

The research will be conducted at the local authority clinics in a specific town in Gauteng where local authority nurses and provincial nurses and the district management team are working.

To ensure effective data collection, a relationship must be created between the institution at which that data will be collected and the researcher (De Vos 1998:316). At the time of

collecting data, the researcher was an employee of the local authority health department in the same town, and had a relationship with local authority nurses. In addition, she was known by provincial authority nurses after the integration of provincial authority nurses and local authority nurses and as a manager the researcher reports to the chief executive officer of the specific local authority.

2.4.1.3 Sampling

A purposive sampling method was utilised in this study as it is based on the judgment of the researcher in composing her sample of elements that contain the most characteristic, representative or typical attributes of the population (De Vos 1998:198). Burns and Grove (1993:246) describe purposive sampling as a process of conscious selection by the researcher of certain subjects or elements to be included in the study.

For the purpose of this study, the target population was all the local authority nurses and provincial nurses, who were registered as nurses/community nurses and who were providing primary health care in a specific district in the East Rand region of Gauteng. These nurses were employed by either the provincial health authority or the local authority as registered nurses with at least three years of experience in the district and were part of the integration process.

At the time of the study, the total number of registered nurses employed by the local authority was 49, and the number employed by the province was 28. Among this population there were other categories, including of one social worker and environmental officers who were all part of the district management team and therefore had been included in that particular focus group.

The study population was then divided into subgroups of managers and a functional group of nurses rendering primary health care. The management group consisted of one social worker, three environmental officers and four nurses, and the functional group consisted of 16 registered nurses rendering primary health care services in the district clinics.

Since the sampling method was purposive, the researcher chose from these two lists, all the local authority managers, and all the provincial authority managers who are members of the district management team in the specific town.

Criteria for inclusion in the sample were the following:

◆ **Local authority nurses and provincial authority nurses**

- All nurses included in the study were nurses registered, with the South African Nursing Council as professional nurses, and employed by either the provincial health department, or the local authority health department as senior nurses and who were part of the integration process in a specific district, in Gauteng Province.
- All participants gave informed consent to participate in the study and were available for the study (consent form included as annexure A).
- All participants had at least three years' experience in the district.
- They were able to speak English.
- They were willing to participate in the focus group discussions.

◆ **District management team**

District management team members were managers

- with at least five years' experience in management positions
- involved in the integration process of health services
- who attended monthly meetings with the political structure where policies were communicated
- who were either employed by the provincial health department or local authority health department, in the district under study
- who had given informed consent to participate in the study
- who were willing to participate in the focus group interviews
- who were able to speak English

2.4.1.4 Pretest

A pretest was conducted to determine whether the research question elicits the information that is being sought. The following questions were asked:

- What is your perceptions about the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district?
- What strategies can be implemented to improve the integration of local authority nurses and provincial authority nurses in the district?

Both questions were answered satisfactorily during the pretest hence the questions were kept as planned for the main study.

One provincial nurse and one local authority nurse were interviewed for pretest purposes. They were not included in the actual research.

2.4.1.5 Data gathering

Data was gathered by means of focus group interviews in which the three groups of provincial authority nurses, local authority nurses and the district management team were interviewed.

De Vos (1998:314) describes a focus group interview as a purposive discussion of a specific topic or related topics taking place between eight to ten people with a very distinctive set of characteristics and a common interest.

Verbal and nonverbal communication and an interplay of perceptions and opinions that stimulated the discussion without changing or modifying the ideas of participants were allowed and observed during focus group interviews.

The focus group interview method was chosen because it enabled the researcher to facilitate the natural, spontaneous discussion of events or experiences by local authority

nurses, provincial authority nurses and the district management team.

The three focus group interviews were conducted separately, over a period of three weeks. The first group interviewed was made up of provincial authority nurses, who were interviewed during the second week of January 2001. The interview lasted for 35 minutes and was stopped when data saturation point was reached. The local authority nurses were then interviewed on the following Monday, at 14:00 to 14:38, at which time the researcher observed that there was a repetition of information that had already been given by the nurses employed by the provincial health authority.

The district management team, consisting of one social worker, three environmental officers and four nurses from the province and the local authority, were interviewed on the Tuesday of the following week. The interview lasted from 14:10 to 14:50. Saturation of data was experienced during this focus group.

The three groups were each asked open-ended questions, namely:

- (1) How do you perceive your integration with local authority nurses and what strategies can be implemented to improve this integration?
- (2) How do you perceive your integration with provincial authority nurses and what strategies can be implemented to improve this integration?
- (3) How do you perceive the integration between local authority nurses and provincial authority nurses and what strategies can be implemented to improve this integration?

All the three focus group interviews were conducted in a quiet area, and a tape recorder was used to capture the information.

◆ The process of focus group interviewing

The researcher conducted the interviews in series to control and observe matters like

dominancy by other participants which might threaten the validity of the research findings. The most important steps in focus group interviews are discussed on the basis of the following phase:

◆ **Selection and recruitment of participants**

In this study local authority nurses, provincial authority nurses and the district management team were selected, as they have rich information and in-depth experience about their integration at the district level.

◆ **The size of the focus group**

De Vos (1998:317) maintains that a focus group should ideally be less than ten, so that each participant gets an opportunity to share his or her perceptions.

In this study, eight local authority nurses, who complied with the criteria discussed in chapter 2, were selected to participate.

Eight provincial authority nurses, who complied with the criteria discussed in chapter 1, were selected to participate.

Four local authority managers and four provincial authority managers who are members of the district management team were involved in the process of integrating health services were selected.

◆ **Selecting the interview location**

The interview location should be easy to find, close to the homes or workplaces of the participants, and located in well-travelled areas that are perceived to be attractive (De Vos 1998:318).

In this study, the interview location was at the offices in the specific district in Gauteng Province where provincial and local authority nurses are rendering primary health care

services. The office space belong to the local authority clinic, and was found to be suitably tranquil. Comfortable chairs were arranged in such a way as to enhance face-to-face discussions.

2.4.2 Step 2: Presentation and analysis of data

Data from the three focus group discussions will be discussed under the following headings:

- description of concepts/definitions
- data analysis
- literature control
- role of researcher
- ethical rigour

2.4.2.1 Description of concepts/definitions

Following concept identification, conceptual meaning was created by considering all sources of experience related to the concept.

Classification of concepts was ensured by using the survey list of Dickoff, James and Wiedenbach (1968:434-450). Identification concepts were structured within the parameters of person, environment and health as described in Roy's Adaptation Model of Nursing (Fawcett 1987:251-255).

In this study, the survey list of Dickoff et al (1968:434-452) was applied, using the agent recipient procedure, context and terminus to classify concept.

After the classification of concepts the researcher went on to define the term "concept" using Wandelt and Stewart's (1975:34) and Wilson's (1989:114) combined methods by identifying the characteristics of concepts from:

- (i) Dictionary definitions, which provided synonyms and antonyms and conveyed

commonly, accepted ways in which words are used.

- (ii) Subject literature definitions, which provided a source of definition that sometimes extends beyond the limits of common language usage.

These definitions conveyed meanings that pertain to the domain of the discipline from which the subject comes.

- (iii) Model cases/related cases which involved presenting an object or instances of experience, or constructing a scenario that illustrates the experience.

In constructing a model case, one describes or present an instance of an experience so that "if this is not X, the nothing is" in other words, a representation of the concept to the best of one's present understanding.

In this study a model case was formulated to refine the characteristics of identified concepts from the data collected

Copi's (1986:157-161) five criteria for defining concepts were applied. Copi's rules are said to define by genus and difference and are applicable to the defining of concepts. They are as follows:

Rule 1: A definition should state the essential attributes of the species

This rule means that a definition should state the conventional connotation of the term being defined. Copi (1986:158) warns that the conventional connotation of a term need not be an intrinsic characteristic of the things denoted by it, but might well have to do with the origin of those things, the relations they have to other things, or the uses to which they are put.

Rule 2: A definition must not be circular

This rule forbids the use of antonyms as well as synonyms of the terms being defined. According to Copi (1986:158), if a definition is circular, it will fail in its purpose of reporting

the meaning of the terms being defined.

Rule 3: A definition is neither too broad nor too narrow

This rule asserts that the definitions should denote neither more nor fewer things than are being defined (Copi 1986:158).

Rule 4: A definition must not be expressed in ambiguous, obscure or figurative language

If the definition is ambiguous, the definition fails to perform its function of saying what the term means.

The use of obscure terms relative to the group who are to read the definition defeats the definition's purpose, that of clarifying the meaning. A definition that uses figurative or metaphorical language may give some feeling for the use of the terms being defined, but it cannot succeed in giving a clear explanation of what the definition means.

Rule 5: A definition should not be negative where it can be affirmative

The reason for this rule is that a definition is supposed to explain what a term means rather than what it does not mean, since for the vast majority of terms, there are far too many things that they do not mean for any negative definition possibly to cover.

Following concept identification, definition and classification (see table 2.2), the meaning created will be structured and contextualised (Chinn & Kramer 1995:111-122). The concepts will no longer be seen in isolation but in relation and will represent a higher level of complexity. The structure of theory gives overall form to the conceptual relations within it. Relationship statements will be formulated to provide links among and between concepts. Tentative identifications of relations will be made. The nature of the character of relations will be addressed. Relationships within a theory that create meaning and impact on understanding often link multiple concepts in a loose structure (Chinn & Kramer 1995:111-123).

For qualitative research, as was used in this study, theoretical relations will be generated by moving from observation to inferences. In order to generate theoretical relationship statements, the results of studying the phenomenon of perceptions of local authority health personnel and provincial health personnel, and the district health team, about the integration of provincial and local authority health personnel rendering primary health care services in a district will be used.

2.4.2.2 Data analysis

Data was analysed according to Tesch's steps (in Cresswell 1994:154-155). These steps engage the researcher in a systematic process of analysing data and were carried out as follows:

- The researcher got a sense of the whole, read through all of the transcriptions carefully, and jotted down some ideas as they came to mind.
- The researcher then took the interview documents – went through them, and wrote thoughts in the margin.
- After repeating this process with all documents, the researcher made a list of all topics and clustered them together into similar categories. These categories were tabled as major topics, unique topics and leftovers.
- The researcher then went back to her data and allocated codes to the topics which were indicated next to the appropriate segments of the text. The researcher tried out the preliminary organising scheme to see whether new categories and codes emerged.
- The researcher consequently identified the most descriptive way to illustrate the topics and turned them into categories. All the categories were then grouped according to related topics and lines were drawn between categories to show interrelationships.

- A final decision on the abbreviation for each category was then determined and listed in alphabetical order.

After completing the above process, similar themes were grouped together and categorised.

A protocol was designed (see annexure D) and given to an independent coder who has a doctoral degree in nursing with a request to analyse the transcribed data. This independent expert was someone with experience and knowledge of qualitative research methods. The researcher subsequently met with the independent coder and they compared and agreed on their analyses. Although they did not have similar categories at first, they later held consensus discussions on categories, and these categories were used to describe the perceptions of all the three focus groups.

2.4.2.3 Literature control

The results of the research were discussed on the basis of relevant theories and results of completed studies related to the subject of this study. The literature review was done at this stage to verify the trustworthiness of the study.

Themes that emerged from the results were discussed in the light of relevant literature and information obtained from similar studies.

2.4.2.4 Role of the researcher

Paterson (1994:301) states that the role and relationship dilemmas that arise during qualitative research make this type of research particularly vulnerable in that the interpretation and reporting of the research findings can be challenged. The behaviour and the response of the researcher and the research participants to one another during the process of data collection are very important, as they can affect the validity of data if the following are not taken care of by the researcher:

- emotional valence

- distribution of power
- importance to the integration
- goal of interaction
- the effect of cultural criteria

◆ **Emotional valence**

Emotional valence is representative of the feeling or tone that exists between the researcher and the participant during data collection in research. This is usually determined by the level of trust established between these parties. The trust of the participants may determine the nature of the data that they are willing to share with the researcher. At the outset of the research, when the researcher is a stranger, the informants may share only that information which it is prudent to expose to those who are unknown and yet not trusted. In this research process, a certain degree of trust was established between the researcher and the participants.

An important issue in the emotional valence between the researcher and the informants is that of *overidentification* of the researcher with the participants. Although overidentification can be cognitive (eg adopting the informants' point of view on an issue), it generally refers to the researcher's empathy with the informants. It is a matter of concern that a researcher who identifies too much with the informants' viewpoint, or empathises too strongly with their situation, will be unable to analyse data critically. Without critical analysis, the researcher is at risk of misinterpreting, or prematurely analysing, data. This in turn impairs the credibility of data. However, Connors as cited in (Paterson 1994:304) is of the opinion that qualitative researchers should avoid overidentification, stating that the feelings of the researcher contribute data to qualitative research.

In this study, the relationship was reciprocal, and there was collaborative dialogue with the participants.

◆ **Power differential**

Subjects in qualitative research have more power in the researcher/subject relationship

than is the case in quantitative research (Chenitz & Swanson 1986:159). However, this is still a crucial ethical aspect to be dealt with in qualitative research. In this study an attempt at equalising the power differential was made by obtaining informed consent from the respondents as discussed above. This also helped in establishing rapport with participants.

According to Paterson (1994:305), the distribution of power in qualitative research refers to the perceptions of either the researcher or the informants that the one has more or less status or authority than the other. Participants who perceive that they are subordinate to or have less power than the researcher may wish to please the researcher or to gain the researcher's approval. This may naturally alter their usual response and behaviour accordingly. It is especially research that is based on brief interactions with participants that is prone to collecting data skewed by this effect.

Another important issue regarding the power differential is the participants' perception of the researcher as either an insider or an outsider. However, both these positions have both advantages and disadvantages.

◆ **Goal of interaction**

At times, because of factors beyond the researcher's control, the participants may not perceive the goal of the research to be as stated in the written description of the study. In qualitative research there may be confusion between research goals and therapeutic goals. Several authors described occasions during data collection when informants begin to view the qualitative researcher as a counsellor rather than a researcher (Paterson 1994:306). The development of a psychotherapeutic relationship between the researcher and the informant may result in the aim of the research being compromised by the informant's need for comfort and guidance (Paterson 1994:306). Naturally this has to be guarded against, but it is doubtful whether the therapeutic potential of the qualitative interview can be fully kept in check.

In this study, the tendency of local authority nurses to expect sympathy and support from the researcher was taken into account when analysing the research data.

◆ **Importance of the interaction**

The interaction between the researcher and the participants may influence how they react to one another. A tired or discouraged researcher may ignore some of the information given by the participants, regarding that information as being obvious or not important.

This naturally distorts data and has ethical implications (Paterson 1994:307). Informants may negate their contribution to the field of study because they believe that what they know is uninteresting or apparent to everyone. They may thus omit details or may fail to mention experiences they perceive as meaningless and unimportant (Paterson 1994:306). For this reason the researcher, during the present research, made a point of reassuring informants that nothing is unimportant in what they have to tell and also that there is no right and no wrong in what they have to contribute.

◆ **The effects of cultural criteria**

Cultural criteria refer to the standards, norms, and "shoulds" of behaviour, which are directed towards the persons involved in the research. Because normative criteria are often reflections of an individual's personal values, contravention of normative criteria generally evokes emotional responses. Consequently, research incidents entailing normative criteria frequently also entail emotional valence. Thus, trust and rapport are enhanced in qualitative research when the researcher is sensitive to the cultural and social norms of the participants (Paterson 1994:307).

In this study, the researcher was sensitive to the cultural and social norms of the local authority nurses, provincial authority nurses and the district management team and the data was therefore not affected by such pitfalls.

The researcher's credentials are vital for ensuring interviewees that they are dealing with a *bona fide* interviewer.

According to De Vos (1998:302), the researcher should be honest, and be able to convince the participants of the sincerity of her intention to collect data in an objective

manner.

◆ **The development of friendships**

Neuman (1982:12-13), Glesne and Peshkin (1992:117) are concerned that should the researcher befriend some of the informants, information might be acquired in the context of friendship rather than in the context of the research.

The dilemma is whether the researcher should handle such information as research information; whether it should be treated in the same way as all other information; or whether it should be excluded from the research on the grounds of it having been revealed to the researcher in confidence. During the focus group interviews with local authority nurses, provincial authority nurses and the district management team this never happened. Although the researcher tried to equalise the power differential, this never got to the point where the researcher was befriending the participants. Further, the researcher's age and academic status and the formal arrangements during focus group interviews did not really allow for *friendships* to be established. However, the above factors did not drive a wedge between the researcher and the participants.

In this study the researcher and participants developed an intellectual relationship when the two parties reached an agreement on the objectives of the research and the way in which they should be achieved. The researcher as a Deputy Director at the Local Authority Health Department already has a relationship with local authority nurses, and as provincial authority nurses were seconded to local authority clinics, the researcher developed a relationship with provincial authority nurses through integration. The researcher and the local authority nurses, provincial nurses and the district health team agreed on the general purpose of the study of developing a model for the integration of provincial and local authority health personnel rendering primary health care services in a district and also on ways of developing this model.

◆ **Use of communication technique**

The researcher made use of communication strategies such as probing, paraphrasing,

reflecting, clarifying minimal responses and summarising, so that participants are encouraged to freely ventilate their opinions or perceptions.

◆ **Probing**

Probing is a powerful technique used to elicit additional information when participants make vague comments (De Vos 1998:322). The researcher continuously probed to obtain additional information from local authority nurses and provincial authority nurses, who made vague statements.

◆ **Paraphrasing**

Paraphrasing is method of restating the interviewee's basic message in similar, but usually fewer, words. This is used by the person conducting the interview to test her understanding of what the interviewee has said (Bernstein & Bernstein 1980:16-19). The researcher often used this technique on local authority nurses, provincial authority nurses and the district management team to ensure that she had captured what had been said by the participants.

◆ **Reflecting**

Reflecting refers to conveying to the sender his expressed thought and related feelings (Perko & Kreigh, 1988:247). The researcher often reflected what the participants were saying to ensure that what she had captured as a researcher was what the participant had actually expressed as a thought or feeling.

◆ **Clarifying**

Clarifying means attempting to find the intended meaning of the communicated message (Perko & Kreigh 1988:247). The researcher frequently asked for clarity on responses made by some participants.

◆ **Minimal responding**

This refers to when the interviewer adopts a less active role and allows more time for interviewees to talk (Stuart & Sundeen 1991:122). In this study the researcher made an opening remark about what their perceptions are about their integration and then listened carefully to the discussions and statements. Probing, paraphrasing, reflecting and clarifying were used only when necessary and usually during times of silence within the focus group discussions.

◆ **Summarising**

De Vos (1998:324) points out that summarising is necessary, as it will help the interviewer to tie up the main points and verify the information with the participants. The summary is usually made when saturation of information has been achieved, after which comments from the participants are invited, and then the researcher thanks the group for participating. The summary also serves to verify the proceedings.

2.4.2.5 Ethical rigour

The researcher has ensured ethical rigour by adhering to the ethical standards set by the Democratic Nurses Association of South Africa (DENOSA 1998). The Statements of Ethics by the American Anthropological Association (Glesne & Peshkin 1992:111) were also adhered to as an additional method to protect participants in the study.

In this study the following measures were adhered to:

◆ **Informed consent**

Chenitz and Swanson are of the opinion that information elicited during a research interview is private, therefore informed consent needs to be given to ensure that respondents are protected from exploitation and disclosure of identify, which might be damaging.

A written consent was obtained from the chief executive officer in charge of the local authority health department in the district of Springs and the director in charge of the provincial health department (see annexures A and C).

Written consent from local authority nurses, provincial authority nurses and the district management team was obtained and conveyed the following information:

- title of the research study
- objectives of the research
- research method
- the type of participation that will be expected from the participants

◆ **Respondents' rights**

The right of interviewees to terminate their participation without fear of being penalised or victimised was ensured. However, during the development of the relationship phase, the researcher asked respondents if they thought they would be able to complete the study in order to decrease the number of respondents withdrawing early.

Potential benefits of participating in the research study were explained to the participants.

The researcher offered to answer any pertinent questions that might be raised by the council authorities and the prospective respondents.

◆ **Privacy**

Privacy means that a person can behave and think without interference or the possibility of private behaviour or thoughts being used to embarrass or demean that person later (DENOSA 1998:2-3).

Glesne and Peshkins (1992:118) state that the right to privacy entails projecting the informant's confidence. In this research study, privacy was ensured in that the researcher avoided collecting more information (especially of a private nature) from local authority

nurses, provincial authority nurses and the district management team than is absolutely necessary to reach the objectives of the research study.

◆ **Anonymity and confidentiality**

Anonymity means that the subject's identity cannot be linked, even by the researcher, to his or her individual responses (Burns & Grove 1993:99). In this research study, respondents, namely local authority nurses, provincial authority nurses and members of the district management team, were requested not to indicate any identifying data (for example, name or surname) during the interviews. The participants of all the three groups were referred to as P1, 2, 3, 4, 5, 6, 7 and 8.

Confidentiality, on the other hand, refers to the management of private data in research so that subjects' identities are not linked with their response (Burns & Grove 1993:764). The researcher ensured that no unauthorised person gained access to raw data. Confidentiality to the respondents both in person and in writing was ensured.

The researcher also made it a point not to reveal the identities of participants when reporting or publishing the research findings.

◆ **The right to refuse to participate or to withdraw from participation**

In this study, during the processing of recruiting participants, and of obtaining informed consent, the researcher clearly stated that participants could withdraw from the study at any time without fear of intimidation.

2.5 PHASE 2: DESIGNING A MODEL

The structure emerges from the relations among concepts. The relationship of and between main concepts must be clear. Individual concepts were structured in forms such that they create greater clarity, as suggested by Chinn and Kramer (1995:112-122).

Assumptions were identified on which the model is based. Assumptions are the accepted "truths" that are fundamental to theoretical reasoning (Chinn & Kramer 1995:112-122). Assumptions from Roy's Adaptation Model of Nursing and personal assumptions by the researcher were integrated in the model.

In this study a visual model was constructed, based on Roy's Adaptation Model of Nursing and applied to the integration process, that showed the relation of the concepts to each other. Once a visual model has been designed and relationship statements have been formulated, the context of the model was described.

The goal and boundaries of the model was identified. Based on and derived from the model, specific relational statements were made.

◆ **Clarity**

Clarity refers to how well the model can be understood and how consistently the ideas are conceptualised (Chinn & Kramer 1995:127). The question of clarity addresses the clarity and consistency of presentation, which may be both semantic and structural. Semantic clarity and consistency primarily refer to the understandability of theoretic meaning as it relates to concepts. Structural clarity and consistency reflect the understandability of connections between concepts within the model.

◆ **Semantic clarity**

Semantic clarity is determined mainly by the definitions of concept in the model, since these help to establish empirical meaning for concepts within the model. Therefore, if concepts are not defined or are incompletely defined, the empirical indicators for the idea are less clear; whereas if concepts are clearly defined, identification of empirical indicators is relatively easy. Clarity may be obscured by borrowing terms from other disciplines; by using general language terms that carry broad general meanings; when words are used that have no common meaning; when words are invented or coined by the researcher to represent some idea; when words with similar meaning are used to represent the central concepts of a model and when excessive narrative is included. On the other hand,

economy of words, important definitions and wise use of examples and diagrams lend clarity. However, absolute semantic clarity can never be achieved, nor is it necessarily desirable, because the limitation of language make it impossible for theoretic meaning to be perceived uniformly by all readers, no matter how clearly the researcher represents it (Chinn & Kramer 1995:128-129).

◆ **Semantic consistency**

Semantic consistency means that the concepts of the model are used in ways that are consistent with their definition. When key words are not explicitly defined, their implied meanings may be inconsistent from one usage to the next. In reflecting on consistency, one can examine one's descriptions of each component of model and consider whether there are consistencies and inconsistencies within, as well as between, the descriptive elements of the model.

The consistent use of basic assumptions is important in achieving consistency. The model's purpose definitions of concepts and their relationships as well as examples and diagrams need to be consistent with the stated assumptions of the model. The purpose of the model must be consistent with all other components. Definitions must be examined for consistency with each other and in relation to assumptions. It is important to note that some semantic inconsistencies with model are more common early in the development and leave room for new possibilities for further development. However, inconsistencies at the basic root of model, as between assumptions and goals, have implications that will affect the entire model (Chinn & Kramer 1995:129-130).

◆ **Structural clarity**

Structural clarity refers to how understandable the connections and reasoning within model are, and is closely linked to semantic clarity. The core of structural clarity is in the descriptive elements of structure and relationships. With structural clarity, concepts are interconnected and organised into a coherent whole. Structural clarity is enhanced if all major relationships are included within a single structure. It is obscured or lost if there are gaps so that relationships are not contained within a coherent structure or when major

concepts do not fit into the structure (Chinn & Kramer 1995:130).

◆ **Structural consistency**

Structural consistency relates to the use of different structural forms within a model. Whatever the structure, consistency throughout the model with respect to the structure serves as a conceptual "map" that enhances clarity. If the structure of the model is reflected in the relationships as the model develops, a high level of consistency is achieved (Chinn & Kramer 1995:130-131).

◆ **Simplicity**

The question of simplicity addressed the number of structural components and relationships within model. Simplicity, as opposed to complexity, implies that the number of elements within each category, particularly concepts, and their interrelationships, are fewer. The desirability of simplicity or complexity varies with the stage of model development. For example, in grounded model, there may be considerable complexity as the model begins to emerge, but as it develops relationships and concepts are coalesced, and the model becomes simpler. Whatever the approach to model development, some concepts created early in the process may eventually be deleted or changed. Theories reflect varying degrees of simplicity; some situations suggest the need for a relatively simple and broad model that can be used as a general guide for practice, while others suggest the need for a model that is relatively complex, and therefore enhances understanding of extremely complex practice situations (Chinn & Kramer 1995:131-134).

◆ **Generality**

Generality addresses the scope of experience covered by the model; it is reflected by the scope of concepts and purposes within the model. A model containing broad concepts will encompass more ideas in fewer words than one containing very narrow concepts. Whether or not generality is viewed as desirable depends on the purpose of the model. A general model organises many ideas and is quite useful for generating ideas or hypotheses. Nursing theories that address broad concepts like individual, society, health

and environment have a high degree of generality and are useful for organising ideas about universal health behaviours. On the other hand, theories that address a specific human experience like pain are less general and, because of their relative specificity, are useful for guiding practice in a clinical setting (Chinn & Kramer 1995:131-132).

◆ **Accessibility**

Accessibility refers to the extent to which empirical indicators can be identified for concepts within the model, and to how attainable the projected outcomes of the model are. Concepts can be made empirically accessible by generating and testing relationships, by deliberative application of a model and by clarifying conceptual meaning. Only selected dimensions of highly abstract concepts may be empirically accessible. Therefore, if the concepts of a model do not reflect empirical dimensions or if the dimensions are very obscure, there may be ideas that cannot be explored or understood empirically. Increasing the complexity within theories often increases empirical accessibility because as subconceptual categories are classified, empirical indicators become more precise. Empirical accessibility of concepts contained within a model is basic to testing theoretic relationships and deliberative application of model. Empiric accessibility varies according to what the model is developed to do: model that provides a conceptual perceptive of clinical practice may not need much empiric accessibility, whereas if a model is to be used to guide research, empiric accessibility is important (Chinn & Kramer 1995:133-134).

◆ **Importance**

Importance refers to the extent to which the model leads to valued nursing goals in practice, research and education; in other words, the model's practical value. A model is important if it is forward looking, useful and valuable for creating a future. The central question for addressing importance is: "Does the model create a reality that is important to nursing?" If a model contains concepts, definitions, purposes and assumptions that are grounded in practice, it will have practical value for enhancing model-based research. If it has limited empiric accessibility, it may not have practical value for research, but it can stimulate ideas and spark political action that can improve practice.

On the other hand, importance will be minimal if the underlying assumptions are unsound, as well as if these assumptions have extremely broad purposes which may be essentially unattainable (Chinn & Kramer 1995:134).

During this step, theoretical relations are generated (Chinn & Kramer 1995:134). Relationship statements may be descriptive, explanatory or predictive. General description means that the statement projects something of what the something is or features of its character. Explanation suggests how or why and prediction projects circumstances that create or alter a phenomenon.

These statements are only in relation to design a model and not to empiric validations (Chinn & Kramer 1995:134).

2.5.1 Process of implementation of the model

A deductive approach was utilised and guidelines which are dynamic in nature were developed for operationalising the model in practice in this study. For the purposes of this study, only guidelines for application in the practical setting and based on research findings were given. The study did not engage in measuring the results of the application.

2.6 SUMMARY

In this chapter, qualitative, explorative, descriptive and contextual research design specific to the integration process of provincial and local authority nurses rendering primary health care services in a specific district, with an aim of developing a model for the integration of local authority nurses and provincial authority nurses rendering primary health care in the district was discussed. Data were gathered through focus group interviews. Three groups – local authority nurses, provincial authority nurses and the district management team – were interviewed separately.

The following chapter will deal with the presentation and analysis of data of the results of focus group interviews from the local authority nurses, provincial nurses and from the district health team. The results will be categorised and then coded by the independent coder, and then combined with literature to validate the context.

Chapter 3

Presentation and analysis of data

3.1 INTRODUCTION

The previous chapter dealt with the research methodology. In this chapter results will be presented and discussed according to the identified patterns of interaction between the local authority nurses and provincial nurses rendering primary health care services in a district.

The results will be discussed in three sections. The first section will focus on discussing results of focus group discussions conducted with provincial authority nurses regarding their perceptions about the integration of local authority nurses and provincial authority nurses, and strategies for improving integration. The second section will focus on the results of discussions with local authority nurses regarding their perceptions about the integration of local authority nurses and provincial authority nurses rendering primary health care in the district and also the strategies for improving the integration of local authority nurses and provincial authority nurses. Subsequently the third section will focus on the results of the focus group discussions with the district management team regarding the perceptions about the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district, as well as strategies to improve the integration of local authority nurses and provincial authority nurses.

The literature control was integrated and compared with the results of the three focus group discussions as a further measure of the trustworthiness of the findings since, according to Woods and Catanzaro (1988:136) control of literature confirms the reliability of the findings. Examples of transcribed focus group discussions with one of the three groups (provincial authority nurses) are included as annexure B.

Permission was obtained from the chief executive officer of the Springs Town Council (see annexure C), the regional director: provincial health department, as well as from provincial authority nurses, local authority nurses and members of the district management team (see annexure A).

The three focus group discussions were all conducted in English, audio taped and subsequently transcribed *verbatim* and then analysed using Tesch's steps (in Cresswell 1994:154-155). This method was discussed in detail in chapter 2.

The focus group discussions of local authority nurses, provincial authority nurses and the district management team respectively were based on the initial research questions:

"How do you perceive the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district?"

In addition, what strategies can be implemented to improve the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district?

The two research questions were put to the three focus groups separately.

The protocol was designed (see annexure D) for the independent coder who is a doctoral graduate with extensive knowledge and experience of the qualitative research method. The protocol served as a guide for the independent coder to analyse the transcribed material from the focus group discussions according to Tesch's steps (in Cresswell 1994:154-155).

Following a consensus meeting with the independent coder, the description by provincial authority nurses, local authority nurses and the district management team of perceptions about the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district were grouped together as negative perceptions, and the strategies to improve integration grouped together as positive perceptions.

3.2 DISCUSSIONS OF DATA

The researcher kept field notes as a supplement to the focus group interviews, by means of jotting down thoughts generated, observations made, and methodological attributes so as to create a deeper understanding of what happened during the focus group discussions.

◆ Observational notes

Observational notes are descriptions of events experienced through watching and listening while conducting focus groups. They contain the who, what, where and how of a situation, as well as a little interpretation (Wilson 1989:434).

◆ Theoretical notes

Theoretical notes are purposeful attempts to derive meaning from the observational notes. Here, the researcher interprets, infers and hypothesises in order to ultimately build an analytic scheme (Wilson 1988:485) (see table 3.1).

Table 3.1: Observation and theoretical notes

The following notes were taken during the focus group sessions:

OBSERVATIONAL NOTES	THEORETICAL NOTES
<p>Provincial authority nurses had lack of trust in researcher as a director of local authority nurses, and would simply say their views had been covered when asked to respond. One asked the following question twice:</p> <p>"Are you sure that your recommendation will help us get some benefits of local authority nurses"</p>	<p>Provincial authority nurses who perceived researchers as unreliable people, who suck information from them to get their qualifications and forget about their problems, expressed concern.</p>
<p>Some of the provincial authority nurses did not want to talk; they were quiet, although their faces showed interest in speaking, they were scared. Some would raise their hands, and when the researcher indicated they should speak, they would say "I am covered by the previous speaker".</p>	<p>Initially, the groups did not trust the researcher, because the researcher is employed by the local authority as a Deputy Director. Although the researcher is not directly involved with them, they thought their views would be known by local authority nurses. After the researcher had explained that she was part of policy-making, and that their contribution would assist in policy development for proper integration, they started opening up and participating.</p>
<p>Provincial authority nurses were worried about the information they gave and whether it would be discussed with local authority nurses as local authority nurses were also to be interviewed "(Err... can we find out, are you going to ask the same questions and are you going to tell local authority nurses what we are discussing?)"</p>	<p>Though the ethical rigour was discussed and written consent obtained, the participants were worried that their information might further destroy their relationship with local authority nurses</p> <p>"(The researcher further explained and reassured participants that she would abide by the ethical standards to keep their information confidential.)"</p> <p>The researcher may be seen as being in favour of local authority nurses, and there may be fear of further destruction of their (provincial authority nurses') relationship with local authority nurses.</p>

◆ **Methodological notes**

Methodological notes are notes about the researcher's own reactions, reflection and experiences during the focus group interviews (Wilson 1988:435).

The researcher has well-developed interpersonal skills and clinical experience in interpersonal work, and ensured that the groups stay focused and that the researcher does

not distort the data. The following methodological tactics were followed:

- Avoided asking leading questions, which may seem to create an impression that a specific answer is sought.
- Paraphrased certain statements to ensure meaning is not lost.
- Encouraged involvement of all respondents in the focus group by casting eyes around the group.
- Probed to ensure the depth of the view is shared by the group in the focus group (Johnson 1999:161-194).

◆ **Personal notes**

Personal notes are notes about the researcher's own reactions, reflections and experiences (Wilson 1989:435).

The following personal notes were recorded in the course of focus group interviews:

- The researcher as a local authority official, though not directly involved, experienced frustration and a sense of being affected when some of the provincial authority nurses remarked that local authority nurses are bullying and autocratic like some of their managers. She did, however, remain neutral and objective.
- The researcher was continually guarding against being subjectively absorbed by responses of local authority nurses who happened to be in her employment.

The three focus group discussions were conducted separately with the three groups.

◆ **Perceptions of the integration process by provincial authority nurses**

Provincial authority nurses expressed dissatisfaction about the way integration was introduced to them. They indicated that they were not consulted, they were just called into a meeting that lasted a few minutes and told that their clinic would be closed down and that they would be allocated to local authority clinics as part of the integration process.

The provincial authority nurses also indicated that they were not prepared psychologically for the changes and as such they were burnt out, and some were resigning.

◆ **Perceptions of the integration process by local authority nurses**

Local authority nurses expressed unhappiness about the integration process indicating that they were not properly consulted, they were just told in a meeting that lasted for 15 minutes that they will be integrated with provincial authority nurses and they will be sharing offices with them.

Local authority nurses also indicated that though the integration process is not a bad process, sharing office space with provincial authority nurses, whom they perceive as "lazy, dogging and non-committed" was unacceptable.

Local authority nurses always referred to provincial authority nurses as a burden to work with as "they are always not on duty, indicating that they are always on leave". Local authority nurses also expressed a concern that provincial authority nurses are "resisting to change" because provincial authority nurses want the status quo to remain of "being non-accountable".

◆ **Perception of the integration process by the district management team**

District management team as a supervisory leg of both local authority nurses and provincial authority nurses also expressed lack of information about the integration process of which rendered them "useless as supervisors" and did not enable them to inform local authority nurses and provincial authority nurses properly about the integration process. They indicated that the integration process was "not properly introduced to them", as supervisors, and neither to local authority nurses nor to provincial authority nurses. This culminated "uncertainty and rejection of the process" by both local authority nurses and provincial authority nurses.

The district management team indicated that there were "no proper guidelines" to guide them to implement the integration process and they, as supervisors, can understand why

local authority nurses and provincial authority nurses are frustrated about the integration process.

The district management team also expressed concern on the different conditions of services of nurses doing the same job that exist within the two tiers of health authorities, and indicated that this also "created un-cooperativeness" among the nurses.

The district management team recommended that the nurses be "fully consulted on the integration process", "mechanism be implemented to manage the resistance to change among nurses" and "uniform conditions of service be implemented" for all the nurses with the same qualifications and performing the same duties.

3.3 ANALYSIS OF RESPONSES BY PROVINCIAL AUTHORITY NURSES

In analysing the data gathered from focus group discussions with the provincial authority nurses, the findings indicated the existence of both negative and positive perceptions about their integration with local authority nurses. A number of themes emerged from the data, such as:

- emotional support
- budgetary issues
- new structures
- team building workshops
- empowering strategies

The researcher, however, identified three themes which emerged continuously from all three focus group discussions and which will therefore be focused on in the following in-depth discussions:

3.3.1 Negative perceptions expressed by provincial authority nurses

Provincial authority nurses expressed the following as negative perceptions:

3.3.1.1 Theme 1: Lack of consultation

Negative perceptions about the integration process were clear among the provincial authority nurses who indicated that they "had not been consulted", they were "just called in to a meeting that lasted a few minutes" and in which they were told that their clinic would be closed down. They also indicated that they were not "prepared psychologically" for the integration nor "supported by the district health team".

It became evident that the provincial authority nursing staff felt that they had not been treated fairly by the authorities, who introduced changes without negotiating with them or informing them, to enable them to understand the changes that integration brings with it and to prepare themselves mentally. They expressed their concern as outlined below:

Err ... can I come in, there firstly we were not properly consulted, we were just told that in a weeks time our clinic will be closed down, and we will be transferred to local authority clinics, mm ... we were shocked and we raised lot of concerns to our supervisors who also did not get full information on the whole process, and she promised that she will call the director to explain to us. Unfortunately, we were transferred before we could see the director. Nonetheless, the director met with us, three weeks later. In that meeting, we were very furious and emotional about the process and the way we are treated by the local authority nurses. He actually informed us that integration process is a national instruction, and its above his scope, but he will arrange a meeting with local authority managers to discuss our interpersonal issues with local authority nurses.

Yes ... You know what we read about the integration process in District Health System Bill, but the actual consultation with us and our unions was not done, and I want to assure you that, we are not opposed to the integration process, but what we are saying is we want clarity on a lot of issues, like our benefits, salaries and organograms.

3.3.1.2 Theme 2: Disparities in conditions of service experienced by provincial nurses

All the provincial nurses described their conditions of services as being "inferior to those of local authority nurses". A variety of benefits including travelling allowances and working hours were used to describe the disparities between the provincial health

department and the local authority health department.

They added in their argument about disparities that they "do not understand why they receive lesser benefits" than the local authority nurses received as they are "as well qualified" as the local authority nurses and also "more experienced than the local authority nurses". The following excerpts form the transcripts of the discussions by this group support this theme:

Our conditions of service are so inferior to those of local authority nurses, it hurts, they all drive beautiful cars and wear colourful smart uniforms.

... They get all the benefits in the world, as if they are better qualified than us, and some of them boast about such benefits and make us feel really odd and humiliated.

Let me say ... we as provincial nurses our salaries are very low as compared to those of local authority nurses who have the same qualification and experience or sometimes lesser qualification, to be honest with you, this actually frustrates us to an extent that one has actually lost interest in working, like some of our two colleagues, have resigned.

Mmm ... I personally think that integration is not a bad idea because we stand to benefit from the process, like travelling allowance, uniform allowance and better salaries from local authority, it is the manner in which the process was conducted that is negative and bad.

No let me explain, how some of us think, yes, we will maybe benefit, but the way it was introduced it makes us suspicious of the good intentions. The general perception here is, we perceive it negative because we believe that any change without consultation is criminal in a sense that it means that authorities have hidden agendas, and at the end we as employees we will lose out.

Err if you think of going to work, it is a nightmare, because you do not know what will happen next, and the other thing we are treated like junior nurses, local authority nurses are in charge of clinics, programs and everything, we feel worthless, useless, unwanted and resented.

3.3.1.3 Theme 3: Resistance to change

Provincial authority nurses raised concerns that local authority nurses are "anti-integration". One of the participants differed with the others, stating that "they should not

blame local authority nurses for their behaviour, as they would feel the same if they were in the same situation". Local authority nurses were perceived as being "resistant to change" because they "are enjoying all the benefits in the world".

Provincial authority nurses remarked that local authority nurses do not want to integrate, for the simple reason that they "still want to hang on to power" as illustrated by the following quotations!

I think local authority nurses do not want change, they definitely do not want to integrate with us, you know, they want to continue to enjoy all the benefits in the world, they forget that we also want to drive beautiful cars.

Yes ... local authority nurses want to maintain the status quo.

My observation with the whole process is local authority nurses always say negative things about working with us and they think we are fools we cannot see that they don't want to integrate.

It really make us mad, when local authority nurses delay the integration process by being negative toward change as if they will be responsible to buy cars and uniform for us when we integrate, or I don't know, maybe their benefits will be reduced?

Let me put it clearly: local authority nurses are resisting change because they want to cling to power, enjoy benefits alone, I think they are self centred they don't realise that change is imminent, and it is a national directive that services need to be integrated.

Mnh ... they behave like tribal chiefs.

Local authority nurses resent us as if we have come to steal something from them or as if we smell, I don't know.

Err ... Can I say something ... people we should not put all the blame on them, I think they resist change because they have fear of the unknown, I personally don't think they do it deliberately, for example imagine you are working alone in your posh office and all of a sudden you must share your office with someone else, it is frightening and frustrating, and it is even worse if you don't know what will happen to your position and benefits.

And I think we will all react the way they react, I know for a fact that most of local authority nurses are willing to integrate with us, it is just that they are still confused about the changes. They will be alright with time!

3.4 RESPONSE BY LOCAL AUTHORITY NURSES

In analysing the data gathered from focus group discussions with the local authority nurses, the findings indicated the existence of both negative and positive perceptions about their integration with provincial authority nurses.

3.4.1 Negative perceptions expressed by local authority nurses

Negative perceptions were discussed under the following headings:

3.4.1.1 Theme 1: Lack of consultation

Local authority nurses supported integration with provincial nurses, but it affected them negatively as they "were not properly consulted" and were not allowed to air their views on whether or not they agree with the process of integration with provincial nurses. Another issue of concern was the effect of rapid integration with provincial nurses "without any legislation or guidelines to guide the whole process". This is illustrated by the following remarks:

I ... can say that this whole process actually frustrated all of us, we were not consulted, we were called in a meeting and we were told that since there are these Integration processes all over in the few weeks to come, we will work with provincial nurses in our clinics, well we did not have a serious problem because we were short staffed, and therefore we thought integrating with provincial authority nurses would relieve pressure.

Mm... what really make us sick is, no proper arrangements were made, all of a sudden we must share office equipment', you know such things ..., we must change our office hours to accommodate Province ...

3.4.1.2 Theme 2: Disparities in conditions of service

Local authority nurses widely described disparities in conditions of services between them and provincial nurses.

They indicated that some of their benefits "are inferior to those of provincial nurses", in matters such as the number of days allowed for vacation leave. They only receive a "few days' leave" compared to the conditions of employment in the province and this "creates a problem because they are overworked and receive few days to rest", hence they have burnout syndrome.

Local authority nurses find themselves faced with situations where they are made redundant as they "do not get study leave and study loans like provincial authority nurses", to allow them to upgrade themselves, and this puts them in a disadvantaged position for promotional opportunities in comparison with provincial nurses.

Another issue of concern is the "way provincial nurses are promoted" while the local government promotional system is not conducive to their competing with provincial nurses, and at the end of the day this will benefit provincial nurses in the competition for senior posts.

The following excerpts from the focus group interview support this theme:

Provincial nurses are always on leave, we are made to understand that they have \pm 100 days a year because they have accumulated those days, while we only get 26 days per annum and we are always on duty. We feel that we are overworked and receive less leave days.

Err ... oh ... maybe what they are saying it is not true because I think they get 30 days, but because there is no control, they just go on leave without signing leave forms.

Yah, it is true, they get 30 days, and the days accumulate other days.

Hmm ... one other thing is they get study leave, and Province pays for their studies, while we only get five days special leave and we pay for ourselves.

Err ... you know their study leave ranges from one to three years depending on the course hence they are always not on duty studying and we are fools we remain doing the work, while they capacitate themselves for better positions, I tell you this is not fair.

And again they do all the short courses and courses that are not relevant to the type of job they are doing, they just do this to be away from work and be multiskilled against us.

Err ... and its so true, and let me tell you, all of them are promoted to the post of chief professional nurses in preparation of our integration with them, so that they are our bosses, I feel this is not fair for us.

3.4.1.3 Theme 3: Resistance to change

Resistant to change was identified as a common theme among both the local authority nurses and the provincial authority nurses. Local authority nurses perceived provincial authority nurses as "being negative towards integration" and "showing their belief in the old fragmented system by being disruptive and negative".

The following quotes from the local authority nurses focus group support the theme of resistance to change:

Err... You know provincial nurses are unaccountable, they come on duty as and when they like, they don't want to report to our facility head, you know they are disruptive, and we feel they must get out of clinics because they do not want to change.

I think ... They don't want to integrate they still want to work in their old clinics, where they were not accountable, dodging, taking leave without leave forms and now they are expected to account for eight hours, it is very difficult for them.

"E ... you know, we used to see their patients from their clinics before their clinics were closed down, and their patients would tell you that all the nurses are half day so the clinic is closed.

Local authority nurses often spoke of provincial authority nurses' negative attitudes towards change, which they believe will bring better benefits for both local authority nurses and provincial authority nurses and the community they serve.

Local authority nurses reported that provincial authority nurses are "disruptive and uncooperative about change", and at the same time, although provincial authority nurses "pretend" to be in favour of integration, they "behave in a manner that suggests that they are against it". This is supported by the following quotes from the local authority nurses' focus group discussions:

You know ... it is so funny, provincial authority nurses pretend to be supporting integration but their behaviour tells us something different ... by the mere fact that they are disruptive and uncooperative, it is clear that they are anti-change so they must stop fooling us.

Yes ... they must stop playing games with us, yes! It is clear they don't want integration so let them get out of our clinics, we will integrate with other people who are ready for change.

3.5 RESPONSES BY THE DISTRICT MANAGEMENT TEAM

In analysing the data gathered from focus group discussions with the district management team, the following findings evolved about the three main themes under discussion:

3.5.1 Theme 1: Lack of consultation

The district health team indicated that nurses were "not properly consulted as managers", as they themselves "did not have enough information about the integration process to communicate to their subordinates".

They indicated that during the transfer of provincial nurses into local authority clinics there were "no proper or written guidelines for the transfer and integration process". They were called in for meetings to explain to the nurses about the integration, but "they did not have full information" to do so effectively.

The team members felt that they were "locked in a situation where the nurses were blaming them for not consulting and informing them about the integration process", for which they did not have any written guidelines. At the same time, the district management team were calling meetings with the National Health Department for more clarity on the issue. The only information given to them was with regard to the integration of services,

but nothing was provided to them regarding the integration of human resources. As a result the district management team "did not have answers to the problems encountered by local authority nurses and provincial authority nurses working together in the district".

The district management team expressed their concerns as follows:

Err ... man, you know it is a pity that the integration of local authority nurses and provincial authority nurses in this district was introduced prematurely, and we as managers, we are expected to do miracles to make these nurses understand, while we ourselves we having nothing to tell or show the nurses, there is absolutely nothing.

E ... if I may put it clearly it is true there are no written guidelines to say, how do we implement the integration of these nurses and it is such a problem to us that the nurses think that we are dictators, we cannot consult or communicate.

Err ... can you tell me how do you consult without information, you know it was going to be stupid of us to run workshops with nurses without having the actual information.

I must say that, the only information we have it is only about the integration of services, but the integration of Human Resources was never addressed.

Err ... I must say that we are also victims of these changes, you know, I miss my old job, I knew where I was, I was respected by my subordinates, now they think I am a crook, I am hiding information from them.

3.5.2 Theme 2: Resistance to change

The district management team, being part of the integration process, are "struggling with their own ambivalence", while trying to give a high profile guidance and support to local authority nurses and provincial authority nurses, who need to be inspired to put their energy behind all the changes and also adapt to changes involving the integration process.

The district management team expressed the opinion that local authority nurses and provincial authority nurses "were resisting change because they did not understand the integration".

The majority of members from the district management team indicated that they understood why these nurses resisted change and rejected the integration, although concerns were raised about compromising patient care because of the negative feeling.

You know, just imagine accepting something you do not know, something that can alter your conditions of service or your position, I fully understand the nurse's uncertainty and their resistance to accept the integration.

Ja ... I think these nurses have a valid point to resist change, I know that their behaviour affects services delivery, but they are human beings, they must react you know...

But ... a ... people, we know that our mandate as nurses is service delivery, I believe that what ever we do, should not compromise patient care though I understand that poor nurses are undergoing change with lot of question marks or uncertainty but I think their behaviour to resist change will delay the process and actually affect service delivery negatively.

3.5.3 Theme 3: Disparities in conditions of service

The district management team perceived the disparities in the conditions of local authority and provincial nurses' service as "unfair and a source of disharmony among the poor nurses" and expressed this as follows:

Well this is a more serious and chronic problem facing us, which demoralises and demotivates those who receive inferior benefits. I must say that this is very much unfair in a sense that how nurses are fighting amongst one another because of decisions taken ages go by higher authorities.

Yes ... there is, firstly the local authority nurses get better benefits than provincial nurses, hence we have nominated a task team to investigate the matter, so that we can recommend to the MEC's committee and then action can be taken from there, to actually bridge the gap.

I think, this is the worst discrimination one has ever seen in ages, nurses with same qualifications and experience, doing the same job, but getting different salaries and conditions of service and I must say that this affects the nurses so much that they have a drop in morale and they are unproductive.

Negative perceptions expressed by local authority nurses, provincial authority nurses and the district management team are summarised in table 3.2.

Table 3.2: Negative perceptions expressed by provincial authority nurses, local authority nurses and the district management team

PROVINCIAL AUTHORITY NURSES	LOCAL AUTHORITY NURSES	DISTRICT MANAGEMENT TEAM
THEME 1: LACK OF CONSULTATION		
No information Not consulted Slotted in Demotivated Frustrated Desperate Insecurity Confused Burnt out	Not consulted Not informed Just told Meeting lasted for 15 minutes Insecurity Anxiety Irritable Overworked Desperate	Nurses not properly consulted No information No guidelines
THEME 2: DISPARITIES IN CONDITIONS OF SERVICE		
No travelling allowance Low salaries Less uniform allowance	No promotional opportunities No study loans Short leave No overtime payment	Different salaries and benefits Local authority nurses get better benefits than provincial authority nurses
THEME 3: RESISTANCE TO CHANGE		
Negative attitude Local authority nurses anti-integration Maintain the status quo Delay integration Local authority nurses want to cling to power Local authority nurses behave like tribal chiefs Fear of unknown Uncertain	Provincial authority nurses have negative attitude towards change Provincial authority nurses uncooperative and disruptive towards change Provincial authority nurses pretend Provincial authority nurses anti-change	Uncertainty among nurses Uncooperative towards changes

3.6 STRATEGIES SUGGESTED BY LOCAL AUTHORITY NURSES, PROVINCIAL AUTHORITY NURSES AND THE DISTRICT MANAGEMENT TEAM FOR SUCCESSFUL INTEGRATION – POSITIVE PERCEPTIONS

Provincial authority nurses, local authority nurses and the district management team are of the opinion that lack of consultation between the employer and the nurses has led to

uncertainty and negative perceptions about the whole integration process and they suggest that "proper consultation with them by both the provincial and the local authority will stimulate a positive response and better understanding of the process of change". In the quest for ensuring integration of provincial nurses with local authority nurses, the three groups suggested that the authorities should create uniform conditions of employment and "remove all the disparities" so that nurses from both employing authorities should be able to treat one another "with dignity as they would be at the same level with equal benefits".

Regarding control of management of the clinic, the local authority nurses, provincial authority nurses and the district management team suggested "joint management as an interim structure", and later a "new structure to accommodate both groups", so that "no-one should feel that they had been left out or slotted in after the change". The following excerpts from the focus group reflect this theme:

Er ... you see, firstly the higher authorities should have discussions with the us and get our inputs about the change, not the way it was done, maybe we can get a positive response and secondly we should be fully informed about the change and the way forward should come from us.

Yes ... the harm is already done but since the integration process is a national issue, we need to continue with the process. What we need to do now, is to go back to the negotiation table with the employer and our unions so that a clear understanding of the process is achieved, and they should get suggestions from us, what needs to be done according to the legislation under the district health system bill.

Mmm ...

Er ... I would like to support the previous speaker, if management reassures us, I think that can build our confidence and we will be able to tolerate one another and work together well in the clinic. I mean there are changes and we need to adapt.

But what is important also, is to actually bridge the gap between different conditions of employment and benefits, because this has created animosity amongst us as, a.

... you see, the problem is, we were transferred into local authority clinics, and we found local authority nurses in charge of clinics and that cannot be changed until we have a joint organogram, but none the less we proposed that they should have joint management and

that provincial nurses should deputise local authority nurses in charge/-managers already in charge of facilities, ok.

Er... let me add by saying that these nurses need to be reassured because it is a fact, changes are painful for everybody. It is even worse when people were not properly consulted and they do not know exactly what is happening around us.

I think this is a long process and a budget can only be compiled after a full investigation and after the matter has been finalised and any way, we still have time for the next financial year to include those difference in the next budget.

Er ... just to add on that, a new organogram should be developed to accommodate everybody, and senior posts should be created so that both local authority and provincial nurses have equal opportunities to compete for the post.

Er ... there is fortunately restructuring at local government level, all the local authorities in the East Rand will be disestablished, and all the employees will be employed by the New East Rand Metro and a new structure will be formed, and this will accommodate provincial nurses seconded into our clinics.

3.7 DIFFERENT VIEWS AROUND IDENTIFIED THEMES

It was mentioned earlier that themes other than the three main themes, also evolved from the focus group discussions. Interesting differences of opinion and similarities in the three groups are now presented.

Occasional differences of opinion on what constituted inferior benefits were raised. An example of this was where local authority nurses cited leave days, study leave and loans, while provincial authority nurses indicated travelling allowance and uniform allowance and these differences were endorsed by the district management team.

Local authority nurses perceive their integration as a process that has "brought misery to them instead of relief", as they are "short-staffed and overworked".

Though provincial authority nurses perceive integration negatively owing to the "personal problems they encounter with local authority nurses", they still believe that "integration will

bring positive changes", such as that they will receive the same benefits as local authority nurses, for example, "a car allowance, colourful uniforms and other benefits".

Some local authority nurses perceive themselves as "responsible and accountable", and therefore they will "continue to see their patients because they understand their role and commitment to the community they serve".

Although local authority nurses expressed concern that their conditions of employment are inferior to those of provincial authority nurses, with regards to aspects such as leave, study leave and loans, they still want "to retain their benefits after changes".

Some provincial authority nurses perceived local authority nurses as "dominant, rude and boastful about their benefits", which make them feel "depressed and hopeless". On the other hand they are expected to "deliver or work hard". Others feel that it is "not of their own making that they get better benefits".

Some local authority nurses perceived provincial authority nurses as "lazy, irresponsible and unaccountable" and feel that therefore "provincial authority nurses should vacate their clinics as they do not see any difference in terms of workload relief". Others feel that if relations between them and provincial authority nurses improve, the workload will decrease as they will be working well together.

3.8 SIMILAR VIEWS AROUND IDENTIFIED THEMES

It was interesting to note that provincial authority nurses share the sentiments of local authority nurses in that they are also "not opposed to the changes brought about by integration", but they "have a problem with the way it was done". They alluded to the fact that they were not consulted and that posed a lot of problems because they were "not mentally ready to integrate", and they "did not have the information on how they were supposed to integrate".

It is interesting to note that neither provincial authority nurses nor local authority nurses are opposed to integration but the manner in which it was done made them perceive

integration negatively because "they were not properly consulted". This concern is endorsed by the views of the district management team, which felt that they "themselves did not have the information to consult and inform the poor nurses about the integration".

Local authority nurses and provincial authority nurses reported that although they "have personal problems in working together with limited resources", there are positive things that integration is bringing about.

Local authority nurses and provincial authority nurses perceived integration as a change process that will unify the two spheres of government and also improve health care service delivery in their district. This sentiment is shared by the district management team, which felt that "integration is the only vehicle that can unify the two tiers and streamline resources for better utilisation and improve service delivery".

Local authority nurses and provincial authority nurses reported that they see integration "as a great challenge to all of them because it is like any process of change".

While the integration of local authority nurses and provincial authority nurses is rewarding for both local authority nurses and provincial authority nurses, in the sense that it rationalises resources, providing one-stop service to the community, as well as uniform conditions of service, "it is not without its challenges". One such challenge came from the initial stage of the integration process, in which they are expected to share offices, synchronise working hours, and still get different remuneration packages and conditions of service.

Both local authority nurses and provincial authority nurses suggested that "the authorities should have organised a team-building workshop to forge relationships among themselves to prepare them for integration". The district management team supported this by stating that, if they had all the information about integration before they transferred provincial authority nurses into local authority nurses' clinics, they would have started by consulting, and workshopping the nurses about the coming changes of integration. They believed that a team-building workshop could have made a difference in terms of relations and mental preparedness for the integration.

It is clear from the findings that there was a high degree of uniformity between the views of provincial authority nurses, local authority nurses and the district management team regarding the workload, understaffing and the fact that the nurses are overworked.

The uniformity and consistency of the listed attributes, together with the largely negative perceptions, augur badly for service delivery when such nurses are required to work together in collaborative settings where issues of life and death are at stake.

An issue which emerges strongly from the three focus groups, is that it is important for the authorities to create uniform conditions of service and benefits.

The negative perceptions of local authority nurses regarding provincial authority nurses, and the negative perceptions of provincial authority nurses regarding local authority nurses, literally indicate a covert power struggle and resistance to change among the two groups. The result of a power struggle is that it goes underground, bringing about almost inexpressible confusion. While the possibility of its resolution lies in the ability of the two groups to develop a framework of ideas shared among themselves, it is, however, important for authorities to realise that it is not all that easy, and it needs their undivided support.

3.9 COMPARING RESULTS WITH LITERATURE FINDINGS

Results from the three focus groups were combined with literature to ensure validity of the study.

3.9.1 Lack of consultation

The lack of consultation by authorities of both the local authority and the provincial authority makes it almost impossible for provincial authority nurses and local authority nurses to come to terms with change of integration or acceptance of one another.

Lack of consultation came out as a common theme among the three focus groups (local authority nurses, provincial authority nurses and the district management team); there was

a general feeling of being overlooked, undermined and belittled by both authorities. Logic dictates that a lack of consultation breeds negative perceptions about a process. However, good the intentions may be, the mere fact that the people affected have not been consulted means that they will be negative and resent the process or proposal (Kirkman 1996:380). According to Gillies (1994:587), change without consultation leads to a drop in morale and productivity.

Nurses from both the local authority and the provincial authority feel insecure and uncertain about their future as they were not fully informed about the process, and this in turn affects their morale and productivity. Carrel, Elbert, Hatfield, Marx, Grobber and Van der Schyf (1998:208) confirm that anxiety and insecurity are the greatest causes of labour turnover among employees during change, especially uninvolved employees.

The local authority nurses and the provincial authority nurses indicated that they are confused and frustrated as a result of lack of information and consultation about integration as expressed by:

"We are confused, we don't know whether we are coming or going, we are being pushed around."

Machine (1998:47-48) found that lack of consultation during change led to distraction, disloyalty and withdrawal from any form of commitment to the goals and values of the organisation since the people affected may experience high anxiety as to their own job performance or even deeply rooted anger arising from any insensitivity shown regarding the integration process.

Strachan (1999b:7-8) confirms that the integration of health services failed dismally, mainly because staff were not part of the process, there was no consultation with staff.

Bromfield (1999:5) supports Strachan's conclusion that the integration of services/staff is not just something that management is trying to do, but staff should be involved in the process, otherwise that integration is bound to fail.

Jost (2000:33) reported that organisations that have never engaged their employees on transitional/change issues more often experience a downward spiral that includes a decrease in patient satisfaction, poor community relations, and poor employee morale.

The focus group discussions of local authority nurses, provincial authority nurses and the district management team revealed that some nurses have resigned as a result of the frustration of not knowing what is happening around them. This is supported by Jost (2000:34), who says that if change or transition is a worthwhile investment, early detection of problems and initial involvement of people affected should be the starting point so that the people affected own the process and this will prevent adverse effects of staff turnover as a result of frustration.

Geddes, Salyer and Mark (1999:40-48) revealed in her study that nurses who are not involved in decision-making during transition have a high level of emotional exhaustion (burnout). George, Burke and Rodgers (1997:53-61) further indicate that individuals and groups behave negatively because of their differing perceptions of the reasons for change, coupled with lack of consultation and empowerment of the people affected.

Kooi, White and Smith (1998:18) recommend that the employer should identify several nursing negative reactions commonly associated with lack of consultation during mergers (integration) so as to prevent a negative reaction towards the envisaged change.

George et al (1997:53-61) in their study (staff integration after hospital acquisition) reported that management literature and transition theory suggest that changes in ownership (whether from merger acquisitions or affiliations) create transitional periods of high cognitive dissonance in the life of the organisation, and employee unrest owing to change and fear which are often caused by job insecurity and poor consultation.

Goodstein (1991:5-17) is of the opinion that any change in the organisation without proper consultation with employees, that causes distrust and fear, leads to either disregard of or resistance to interaction, or may cause covert sabotage.

3.9.2 Resistance to change

Local authority nurses and provincial authority nurses identified resistance to change as one of the obstacles to their integration.

Though each group pointed a finger at the other, as being resistant to change, it became clear that resistance to change as a negative reaction to power relations and the fear of loss of a power base emerged as a theme that needs to be given attention, so that mechanisms can be put in place to facilitate integration.

Greenberg and Baron (1997:560-561) confirm that individuals and groups may believe that change will threaten future resource allocation, and therefore change may be perceived as a threat.

From the findings of the three focus groups, namely local authority nurses, provincial authority nurses and the district management team it became apparent that both local authority nurses and provincial authority nurses resist change because they were not informed about integration and they were unsure and uncertain of what will happen to their status and benefits.

Swanepoel et al (2000:5-6) confirms the theme that employees may resist change because they are concerned about how it will affect their work and their lives.

Booten, Hayman and Naylor (1988:108) are of the opinion that if the Director communicates her expectations more specifically, share information with the nurses from the outset, and actively enlist their help in planning for and securing the intended benefits of change, these nurses will feel comfortable with the changes introduced.

Carrel, Jennings and Hearin (1997:317) indicate that uncertainty about the cause and effects of change may affect their work and lives and therefore they resist change.

Greenberg and Baron (1997:560-561) came to a similar conclusion that fear of the unknown, may influence the attitudes of employees negatively towards change; they may

feel manipulated and wonder about the real intention behind the change.

Greenberg and Baron (1997:560-561) further indicate that employees may be unwilling to give up their existing benefits, habits, and way of doing things, as change requires new ways of doing tasks, and therefore these may become a source of resistance.

Robbins (1997:195) points out that failure of management to consult and involve those affected by change, mistrust and misconception about change may develop, and employees may therefore resist change.

Coch and French's (1984:512-532) study revealed that employees are unwilling to cope with the complexity of doing new tasks or doing things differently and as a result they may resist change.

Greenberg and Baron (1997:560-561) further confirm the theme that employees may be unwilling to give up quality of work, percentage and power and they may therefore resist change.

According to Swanepoel et al (2000:5-6), redistribution of decision-making authority can threaten power relations, and as a result employees may resist change because they fear the loss of their power base.

The findings have shown that local authority nurses and provincial authority nurses resist change because they are worried about how it will affect their work and their way of living. Even if they have some appreciable dissatisfaction with their present conditions of work, they may still worry that things will be worse after the integration process. The situation became even worse as they are not fully informed nor involved about the change process. This is confirmed by Robinson, who says that employees may resist change as a result of misinformation and poor communication about change (Robbinson 1990:395).

The local authority nurses, provincial authority nurses and district management team focus group discussions revealed that the local authority nurses and the provincial authority nurses were not consulted nor involved in the integration process, and as a result they

developed fear of the unknown and therefore rejected integration by showing resistance to change.

Their reaction of resistance to change is echoed by Robinson (1990:395), who stated that employees who are not involved in the decision making process regarding change that affects, tend to be very anxious, fearful and stressed out and as a result they may resist change.

Booyens (1995:469) supports the theme that employees may resist change as a result of misunderstanding, lack of knowledge and uncertainty about the goals of the change process.

Hayes (1985:111-119) concurs with Booyens that employees may resist change for reasons like misconception and inaccurate beliefs concerning the change process, as a result of a lack of information from management. He further advocates that these employees will be highly stressed as a result of uncertainty (Hayes 1985:111-119).

Threats to existing power relationships and expertise became evident in the finding that senior local authority provincial authority nurses fear the loss of their power base as a result of the integration process.

You see, some of us are Senior Community Nurses, some Regional Nurses, some of us are Chief Community Nurses, and we were not just given these senior posts, we were grilled, in interviews, and anyway we are qualified to be in these posts, so we feel that this integration will give us a problem. How do we combine our organization with that of Provincial Authority Nurses, because I know for a fact that Provincial Authority Nurses are not exposed to our type of screening for senior positions, they are simply promoted on rank, no interview, no qualifications needed nothing.

It is clear that changes in the redistribution of decision-making authority can threaten long-established power relationships within any institution. This is confirmed by Greenberg and Baron (1997:560-561), who state that apart from fear of loss of their power base, individuals within the organisation develop certain specialised expertise, therefore change will destabilise them and they may therefore resist change.

Jost (2000:1) in her study on the transfer of general nurses from a setting where they were familiar and competent practitioners to the ICU where they returned to novice level, said that this influenced their self-esteem and morale, and that they therefore requested to be transferred back to their old units.

Hellriegel et al (1983:540) are of the opinion that employees resist change from uncertainty, insecurity and lack of involvement and participate on. Employees often resist change because they have fear of the unknown, which can be corrected through consultation and involvement.

Hellriegel et al (1983:450) further supports the contention that employees become anxious, fearful and frustrated as a result of lack of involvement, and poorly defined objectives of change.

Lemone, Lillis and Taylor (1993:373) confirms that nurses will resist change because of lack of understanding as they were not involved. Lemone et al (1993:373) are of the opinion that nurses who are not involved in the change process affecting them tend to be confused and lack understanding of the whole process, and as a result may resist change.

The result revealed that local authority nurses and provincial authority nurses were not involved in the integration process. Provincial authority nurses were slotted into local authority nurses' clinics, and so forth, and they developed a distrust and suspicion of the intention of management about the integration process, because they did not fully understand the purpose of introducing these changes.

Mm ... Yes of course, it was an instruction, we were all tense, anxious and everything, because we did not get answers to our questions. To be blunt, we were slotted into local authority nurses clinics', like you would slot in your goats into a kraal.

Smit and Cronjé (1999:386) confirm that employees will resist change from lack of trust and misunderstanding of the envisaged change.

Smit and Cronjé (1999:386) further argue that change may be resisted because employees have different assessments of and perceptions about the change.

Marriner (1979:9-14) argues that lack of involvement and knowledge about change leads to stress and uncertainty over change and as a result nurses may resist change.

Ward and Moran (1984:30-33) indicate that lack of knowledge creates misunderstanding and misconceptions about the proposed change, and as a result those affected experience extreme uncertainty about their future and in this situation they will resist change.

Kozier and Erb (1988:455) concur with Iyer and Camp that employees may resist change as a result of inaccurate perceptions of change, incomplete or inaccurate information and lack of involvement of the people affected by the change.

Blackie (1998:214) is of the opinion that people may resist change because they feel inconvenienced, and working conditions become more difficult, and resources may be insufficient for the new order.

Balogum and Hailye (1999:97) indicate that change itself brings about uncertainty and fear, and it becomes even worse if employees are not fully informed or involved in the process.

3.9.3 Disparities in conditions of service

The three groups, local authority nurses, provincial authority nurses and the district management team, have clearly identified disparities in conditions of service for professionals with the same qualifications and experience, doing the same job, as one of the obstacles to integration. They indicated that this poses a problem, that there is unhappiness and mistrust among them and they believe that as a result of that there is a lack of commitment to patient care.

The adverse effects of integration with different conditions of service between local authority nurses and provincial authority nurses brought about uncertainty and rejection

of the integration process. This is supported by Asia (2000:4) in his report on integration in the Western Cape. He said that the difference in conditions of service and salaries of provincial and local authority staff in the Western Cape has created uncertainty and tension among staff.

3.9.4 Proper consultation

The complexity of integration of provincial authority nurses and local authority nurses without proper consultation places a great burden on communication skills. Provincial authority nurses from the three groups emphasised how important it was, therefore, for team building workgroups to take place around real examples that are capable of generating a new and genuine understanding of their concerns, stresses, anxiety, doubts and ultimately general solutions to those uncertainties.

Local authority nurses and provincial authority nurses have both suggested that proper consultation was the way forward to their integration. They strongly suggest that authorities should go back to the negotiating table and start the process from the beginning, as this will help to ease tensions, stress and uncertainty among them, so that they can understand the integration better.

Indeed workshops could be valuable because they provide the opportunity for reflecting on the issues and difficulties of collaborative work in the primary health care services. Pietrone and Pietrone (1996:153) confirm that workshopping on communication was felt to be essential in bridging the inevitable gaps between the viewpoints of individuals regarding the uncertainty brought by changes.

Provincial authority nurses stated that working together made more sense of their difficult and sometimes unrewarding work, and produced better outcomes, like understanding their differences and putting those differences aside for the sake of the community they serve.

Uncertainty about their future as local authority nurses and provincial authority nurses was not the only impediment to integration. It was pointed out that mistaken perceptions concerning the roles, knowledge and professional skills of others often hindered the extent

to which integration could be thought about constructively. This was particularly found to be so in local authority nurses and provincial authority nurses in senior management position. In addition, it was stated that communication between local authority nurses and provincial authority nurses and the management team was often difficult as a result of different agendas. This is confirmed by Reason (1996:237-271) in his study on power and conflict in multidisciplinary collaboration. Reason further advocates that a communication strategy on the transfer of provincial staff to local government should be developed as a matter of urgency, to respond to the growing anxiety and erosion of morale among health workers regarding the uncertainty that they perceive about their future employment prospects.

Makan and Asia (1996:8) in their study on the integration of provincial staff with local authority staff in the Western Cape Health Services suggested that health workers need to be consulted and informed about how their work will be affected and what will happen to their personal benefits.

Furthermore, Makan and Asia (1996:8) assert that the staff employed in these health systems need to be kept up to date regarding any changes in service delivery and they should be given the opportunity to choose whether to be transferred or not.

According to Bezuidenhout, Garber and Potgieter (1998:137), the legal framework requires that the employee be consulted when a transfer is contemplated, but the transfer itself cannot be considered an unfair labour practice, unless it is accompanied by employer conduct falling within the scope of the definition of unfair labour practices.

According to section 84 (1) of the LRA, employees are entitled to be consulted by the employer about proposals relating to restructuring or any type of changes in their work (Carrel et al 1998:470).

Across the focus group there was a strong suggestion that authorities need to consult with them, so that they as employees understand and accept change or make choice whether to integrate or not. This is confirmed by Flarey and Blance (1995:76), who suggest that management should ensure that they communicate with employees and make them

understand how change will occur so that fears are allayed and trust and confidence are built among employees.

Flarey et al (1995:6) further recommended that during change, management should provide staff with the assurance and motivation necessary to understand and accept changes.

The findings of the local authority nurses, provincial authority nurses and district management team focus groups, revealed that information about the integration process is a critical element. It is thought that if the local authority nurses and provincial authority nurses are involved and understand the need for change, their behaviour will change and they will therefore accept the changes that come with integration. The quality and amount of information exchanged between local authority nurses, provincial authority nurses and the district management team are critical to the success of the integration process for only information will convince them (local authority nurses and provincial authority nurses) of the need to integrate.

Swanson and Nies (1997:104-414) emphasise that change can only be effective if the people affected are consulted and involved in planning and problem solving at all levels of the change process. Swanson and Nies (1997:141) further indicate that for change to be long-lasting the process needs to be slowly introduced and eventually owned by those affected by it and therefore in turn there won't be any resistance. If there is resistance, the slow process of change can deal with it.

Twinn, Roberts and Andrews (1996:492) concur with Swanson and Nies that management needs to consult staff affected by change, ensure that they understand the process and that they are skilled enough to manage the uncomfortable process of change. Twinn et al (1996:492) further confirm that managers need to communicate clear goals, agree on key issues with people affected by change and also involve them in their vision for the future so that they can accept change as their own process.

Armentrout (2000:38-46) is of the opinion that for change to be accepted the managers need to consult, involve, and get the people affected into the act and this will not only

avoid bruising of egos and resistance but can raise their levels of self-esteem as well.

Participation and involvement of local authority nurses and provincial authority nurses in the process was heavily emphasised in the discussion with the three focus groups, where it was stressed that employees need to be involved in the planning process of change, they must design the strategy that will be implemented so that the change process becomes their own process, and as a result commitment and acceptance of change will be achieved.

Krass (2000:268) confirms that commitment to change will be achieved only by explanation and consultation with those affected by change, and by striking of balance between continued uncertainty as a result of an extended period of change and the resentment that too speedy a move to uniformity may arouse.

It became apparent from the result that how and what local authority nurses and provincial authority nurses think about the change process affects their actions. The more they are involved in the planning and implementation of the process, the greater the chances of success.

Stickland (1998:135) confirms that for a process of change to be effective there should be consultation and interaction between those involved and affected by change. There was a perception by the local authority nurses and provincial authority nurses that integration was introduced abruptly and prematurely, to such an extent that this left the nurses more confused, frustrated and insecure.

A suggestion was made that integration should be done gradually so that the nurses can understand and own it. Haffer (1986:8-12) supports the concern that change should be made gradually, allowing nurses time to absorb the changes from a cognitive perspective.

Eden and Spender (1998:47-48) confirm the contention that mental preparedness towards change needs to be ensured so as to accommodate change, the reason being that people had a deep emotional commitment to the previous system.

A similar study was conducted by Magwaza (1999:1-7) (integration of reproductive health services) where she reported that people affected by integration need to be consulted in the decision-making to make transition more acceptable. Magwaza stressed that managers should be accessible and supportive, and inform the subordinates about transition issues that affect them (Magwaza 1999:1-7).

Burke (2001:169-172) is of the opinion that involvement of staff in activities around changes has considerable merit in terms of accepting those changes.

Hellriegel, Slocum and Woodman (1983:541) recommend that employees should be consulted and informed about the goals of change so that they fully understand and they should participate in the process, if change is to be successful. Hellriegel et al (1983:541) further recommend that for change to be accepted by employees, consultation and communication on defined goals of change, objectives and how change will impact on the employees should be ensured.

The respondents also recommended that the authorities should organise workshops and negotiations so that those affected by change fully understand and are able to make choices. Their recommendation is echoed by Azevedo (1999:8), that for integration of personnel to be successful, endless workshops and negotiations on how integration will affect staff, and what it would mean for staff's condition of service should be held.

Azevedo (1999:8) further states that change is a very difficult process, and management needs to nurture it, by consulting and involving staff, so that the intended integration of staff can be successful.

From the findings of the focus group discussion with the members of the district management team, it became clear that the district management team members as managers did not have full information about integration, hence they recommended that managers should be informed about change before they introduce the change process to their subordinates. The district management team indicated that it was difficult for them to answer questions and queries posed by local authority nurses and provincial authority nurses, as they were in the dark.

Twinn et al (1996:480) confirm the findings that nurse leaders in the community nursing setting need to first understand and accept change, take nurses with them, build commitment and be seen to lead if they want to achieve long-lasting change.

Facilitation and support were emphasised by the local authority nurses and provincial authority nurses, who felt that management needs to give emotional support, instil trust, and facilitate a training session for employees so that fears and insecurity are minimised and therefore employees will be reassured and will easily accept change. Twinn et al (1996:481) state that nurse managers need to demonstrate visionary leadership to give a clear direction and support to their employees, so as to build trust and assurance in those affected by change.

Kanter (2001:413-425) argues that people who are empowered with information and resources are in a position to develop trust and commitment to the organisation, and are able to adapt to changes.

Locke (2000:380) confirms that management should support employees during change, as these affected employees will need support to develop the necessary skills and attitudes to adapt to the changes introduced.

The nurses recommended that the authorities empower them, so that they understand the process of change itself, so that it would be easy for them to co-operate with any proposal introduced. Their suggestion is supported by Kanter (2001:413-425), who argues that people who are empowered with information and resources are in a position to develop trust and commitment to the organization, and are able to adapt to change.

According to Barry and Walker (2000:77-89), empowered employees with knowledge of their organisation tend to develop emotional attachment to, identification with, and involvement in that organisation, and therefore change or transition or restructuring in that organisation may not affect them negatively.

From the discussion of the findings, it is evident that the three focus groups, namely local authority nurses, provincial authority nurses and the district management team, were

calling on higher authorities to involve them in the planning and implementation stages of change, to make them comfortable with the change.

Weick (2001:396) supports the findings that for an organisation to survive during restructuring, that particular organisation should be having a shared vision with its employees, and as a result these employees should feel they are fully involved in the process, so that there will be commitment and support from employees to effect changes within the organisation.

Weick (2001:396) further confirms that employees who participate in the envisaged process of change become more informed about dealing with the issues that are presented with by the change process, and will therefore accept change.

McRae (1996:6-11) in his research on restructuring of a hospital in ... recommended that when possible the affected parties should be involved in the decision-making process, and when they cannot be involved they should be kept accurately and fully informed so that changes do not come as a surprise to them, but as a process they own.

Kooi et al (1998:10-20) are of the opinion that sustained behavioural change can be enhanced by engaging all staff in the change process. There was a general perception that if higher authorities had given the necessary information, the local authority nurses and provincial authority nurses would be assured, and in turn be confident about the changes.

Bendix (1997:595) confirms the contention that during change, employees need to be given all the relevant information, to understand the objectives, and to receive the necessary assurance regarding their own job security. Bendix (1997:596) further advocates that management needs to communicate with employees about change, through numerous workshops sensitisation sessions and interactions.

The results revealed that all three groups stressed the importance of negotiations between them and the authorities (employer) before any change can be effected so that everybody affected by such change is brought on board and therefore acceptance of change can be

achieved.

Bezuidenhout et al (1998:137) confirm the assertion that, should the employer propose change to the employee, he should follow the route of negotiation, that is, he should present his proposal and enter into negotiations with the employee before he can effect any changes. Bezuidenhout et al (1998:138) further confirm that the employer is expected to provide reasonable and objective reasons for the proposed change, and the employee should be given an opportunity to consider and respond to the proposal.

Marchand (1995:41-48) found that by involving the target population in the initial phase of change, they become more amenable and committed to the desired change. Marchand further states that if the target population is involved and fully informed about the process, they will come out with solutions to the whole process (Marchand 1995:41-48).

Gannon (1982:494) confirms that if members are involved in defining and solving problems associated with the envisaged change they will own that process.

The findings of the focus group discussions revealed that local authority nurses and provincial authority nurses suffer insecurity and lack of assurance as a result of a lack of information about integration as a change process, and that local authority nurses and provincial authority nurses recommended that the employer should reassure and support them.

Rosengren, Engstrom and Axelsson (1999:289-298) recommend that leaders should instil faith in employees by consulting them and encouraging their participation so that all doubts and anxieties about change are dealt with, and successful change can in turn be achieved.

Ingersol, Kirch, Merk and Lightfoot (2000:11) further confirm the contention that for successful organisational change, the employees concerned need to feel empowered to influence the change, and that management needs to create a platform for employees to participate in the process.

Both local authority nurses and provincial authority nurses accused management of being unfair, autocratic and suspected management of having a hidden agenda about the integration process, hence the two groups suggested that for them to be cooperative and committed towards changes, they need commitment from the employer, which the employer should demonstrate by fully consulting with them.

Krass (2000:268) echoes the sentiments of local authority nurses and provincial authority nurses that commitment and cooperation during change can only be gained by explanation and consultation, with the emphasis on long-term prospects.

Kooi et al (1998:10-20) further suggest that management needs to understand the acquired (transferred) staff's actual perceptions of their experience to be able to plan strategies collaboratively to minimise perceived threats. Kooi et al (1998:10-20) recommended that employees need to be incorporated into the decision making process to maximise cooperation and minimise the confusion and uncertainty that could be caused by lack of communication and misattribution of cause.

Negotiation, agreement and the building of trust in local authority nurses and provincial authority nurses came out strongly from the three focus groups, suggesting that management needs to establish trust between them and employees by negotiating, and that then uncertainty will diminish in turn.

Difonzo and Bordia (1998:293-303) support the suggestion that effective consultation through communication tends to reduce uncertainty through collective planning and proactively establish and maintain trust between employees and the employer.

Holland (1998:410-417) recommends that a successful change can only be achieved when the people concerned understand the need for change and have a shared purpose to effect the change.

Dixon and Mark (1999:30-33) concur that negotiation, collaboration and communication with employees during mergers can effect a successful change.

From the discussion with provincial authority nurses, it became evident that their transfer from their clinic to local authority clinics, where they were well established, competent and happy, influenced their self-esteem and confidence.

3.9.5 Uniform conditions of service

Both local authority nurses and provincial authority nurses unanimously suggest that the authorities should provide uniform conditions of employment across the board for personnel doing the same job, with the same qualifications and experience, and this is strongly supported by the district management team, who indicated that budgetary arrangement should be made to accommodate the new salaries and benefits.

The White Paper on District Health for Gauteng confirms that salaries and benefits of personnel with comparable training, seniority and responsibility employed by province and the local authorities should be the same. The local authority nurses, provincial authority nurses and district management team emphasised in no uncertain terms that the authorities need to ensure equal benefits for equal qualifications. They believe that if local authority nurses and provincial authority nurses get uniform conditions of service, their integration would be successful. These recommendations is supported by Bamform (1999:14) that for integration of staff in East Vaal to be successful, provincial and local authority nurses should receive the same salaries and conditions of service. He recommended that the authorities should increase or improve provincial nurses' salaries and conditions of services to match those of local authority nurses.

Makan and Asia (1996:11) in their draft report recommended that the national department of health should play an active role in facilitating workshops and guidelines to clarify parity and also make funds available to address the disparity between local authority nurses and provincial authority nurses' conditions of employment.

Munro and Makan (1999:40) further confirm confirm this assertion by recommending that an in-depth investigation at the provincial level on the salary parity issue and the financial implications be done as a matter of urgency.

Rank promotion of provincial staff should be undertaken to bridge the gap of salary parity between local authority nurses and provincial authority nurses. The national department of health should investigate the actual financial effect of rank promotion and its impact on salary parity, provide a legislative framework on funding parameters where local government is a governance option and investigate incentive mechanisms to attract personnel to remote rural and under-served areas as part of the parity process (Munro & Maken 1999:45)

IGOLI Transitional Human Resources and Labour Relations Employee Brochure recommended that employees who perform similar work should receive a salary within the range for that particular grade. Akasia (2000:8) indicated that the National Health Department, and the Public Service and Administration should set standards and policies to streamline salaries and conditions of service so that local authority and provincial staff have uniform salaries and conditions of service.

Swanepoel et al (2000:759) further support the thesis that for employers to achieve smoother change, it best that the subordinates are fully informed about the envisaged change, and participate in it before it is finally introduced.

The results revealed that both local authority nurses and provincial authority nurses were faced with new tasks, that required new skills to function in the primary health care services. Both groups suggested that they need to be empowered so that they are competent to work in the new environment of change.

Carrel et al (1998:208) confirm that employees need to be inducted so that they all the skills and abilities needed for the new environment, which in turn promotes security, confidence and a sense of belonging in the organisation.

Kelly (1992:228) asserts that nurse leaders should have courtesy, belief in people, and the ability to deal with complexity, ambiguity and uncertainty experienced by her subordinates, during transformation, so that her employees understand the change process.

Management should have the necessary leadership and interpersonal skills to spearhead the change process. Management should

- have a means, ie role, project, resources or influence to promote change
- have knowledge of the institution and health care system, its history and its influential characters, ie policies (Kelly 1992:229)

Flarey (1995:4) argues that the communication strategy will highlight the internal realities and forces impacting negatively on the primary health care services, and in turn mechanisms can be put in place to facilitate an integrated primary health care service.

Drake (1993:72-74) emphasises that management should facilitate change in such a manner that local authority nurses and provincial authority nurses as individuals are able to meet the demands of change.

Drake (1993:72-74) further proposed the following steps as strategies to overcome resistance to change:

- dynamic communication with all role players
- empowerment through participation of all the relevant role players
- leadership development
- resource management

3.9.6 Suggestions for the management of resistance to change

Local authority nurses and provincial authority nurses all realised that resistance to change had become an obstacle that hindered their integration; in this they were supported by the district management team, who indicated that if they had had all the information about integration they would have informed the nurses and there would have been no reason for nurses to resist change as they would be fully informed, and could therefore have suggested ways of dealing with it.

They suggested that the authorities should negotiate with them and their unions, involve them, and get solutions from them, instead of the authorities providing their own solutions, and the authorities should also give them some reassurance. This is confirmed by the following quotation:

I think if the authorities negotiated first with us, and gave our opinions, and gave us choices to choose to be transferred, or integrate with local authority nurses, it was going to be easy for us, personally I wouldn't agree to integrate, this is definitely frustrating.

According to some of the provincial authority nurses, they feel that if the negotiation with unions had been done before integrating, they would not have agreed to integrate with local authority nurses. They feel it is a "mental torture to be slotted into local authority nurses' clinics without any concern being shown for them".

Management's resistance to change seems to play a very important part in the acceptance of changes for the successful integration of local authority nurses and provincial authority nurses. The suggestion emerged from the three focus group discussions that the authorities need to involve and negotiate with local authority nurses and provincial authority nurses so that they are fully informed about the process. The findings are supported by Carnall (1995:355-411), who suggests that resistance to change can only be managed through five clusters of attributes:

- ability to define goals
- ability to manage role relationships
- ability to communicate effectively and negotiate with key players
- "managing up" by being skilled at the art of organisational politics

Urden and Rogers (2000:161-162) are of the opinion that successful change during a merger can only be achieved through communication, clarifying everything, maintaining a sense of humour, being innovative, focusing on outcomes and openly celebrating the successes.

Coch and French (1984:78) advocate that resistance to change can be eliminated by having those involved participate in the design of the change.

Leavitt (1964:97) came to a similar conclusion, suggesting that in order to avoid resistance to change, managers should take into account the social effects of change, by giving support and rewards.

Beer, Eisenfet and Spector (1990:158-167) were of the opinion that resistance to change can be reduced by mobilising commitment to change through joint diagnosis of business problems and helping employees to develop a shared diagnosis of what can be done.

Kotter and Schlesinger (1969:7) proposed that educating and communicating with employees about the change process will help reduce resistance to change.

Beer et al (1990:158-167) pointed out that management needs to negotiate with employees, and obtain agreement from them before initiating any change, so that the said change is accepted.

Greenberg and Baron (1997:560-561) recommended that management should ensure that employees are capacitated and developed to deal with new challenges that change brings about.

For any change to be successful, communication and participation with those affected by the change need to be ensured. This sentiment is echoed by Robbinson (1990: 35), who says that for managers to deal successfully with resistance to change, the following tactics need to be followed:

- education and communication
- participation
- facilitation and support
- negotiation
- manipulation and cooptation
- coercion

Lemone et al (1993:373) echo Robbins's sentiments and proposes the following guidelines for nurse managers to overcome resistance to change:

- list the advantages of the proposed change
- relate the proposed change to the existing beliefs and values of the person or group
- provide opportunities for open communication and feedback
- indicate clearly how the change will be evaluated
- introduce change gradually – involve everyone affected in the design and implementation of the process
- provide incentives for commitment to change

From the discussion of results it became apparent that management is encountering resistance to change from both local authority nurses and provincial authority nurses, and it is therefore incumbent upon management to determine the actual causes of resistance, and then remain flexible enough to overcome the resistance in an appropriate manner.

Nadler (1983:22) and Kotter (1996:63) point out that in order for managers to bring about effective change, they must have knowledge and formal authority to put change into practice.

According to Kotter (1996:63), the importance of communicating the vision and strategies down to employees cannot be overemphasised; these strategies will assist employees to understand and accept the envisaged change.

Warren (1992:74) points out that it is crucial to accomplish employee understanding and acceptance of the visionary strategies when bringing about changes.

Strebel (1996:86-92) is of the opinion that it is essential for management not only to communicate its vision and strategy to employees at all levels, but to communicate how the changes will impact on their job description and relationships with their colleagues.

Hart and McMillan (1996:4-12) support Strebel's remarks by emphasising that for the mission to be aligned with the organisation, it must be communicated with the employees

in such a way that they see in it a role for themselves that is aligned with their personal ambition.

Lynn (1993:79) suggests that the communication process should be directed towards changing the mindset of employees, causing them to accept and adapt to change positively.

Rosenthal and Noling (1998:63-69) recommend that management should involve and allow participation of those affected by change and their union representatives in any envisaged change before implementing it, so that workers do not resist the said change.

Helvie (1991:157) suggests three methods of dealing with resistance to change:

- (a) *Compliance*, which refers to a change in behaviour as a result of hoping to gain a reward or incentive.
- (b) *Identification*: clients change as a result of understanding the process and identifying with the change agent.
- (c) *Internalisation*: client is involved and the idea of change is consistent with his values.

Verstal (1995:191) emphasises that management should give out information, manage the process and should attend to sensitive issues, so that the subordinates affected by change are informed, are assured and are fully involved in the process, and this will enhance a positive attitude.

A correctly managed programme of change through consultation and involvement of local authority nurses and provincial authority nurses as people affected by change can enhance understanding and acceptance of change, as suggested in the results of the three focus group discussions.

Lundy and Cowling (2000:356-357) support this thesis and recommend the following steps towards a desired change:

- Commitment and training of senior managers
- Ensuring the involvement of all staff
- Improvement of communication between management and staff
- Provision of education and training for all staff
- Introduction of performance appraisals
- Introduction of performance-related rewards for those employees who show commitment towards accepting change
- Continual feedback, reassessment and consequent refinement of change programme

Tinkhan, Voorhies and McCarthy (1984:136) are of the opinion that careful preparation for change, maintenance of open channels of communication and provision for a reward system for people furthering change will contribute long-lasting change.

Strickland (1998:140) suggests that management should keep staff informed of developments and ensure that they (staff) have an opportunity to react to the design option of change, so that staff can internalise the process.

Iyer and Camp (1991:133) confirm the thesis that managers need to create a vision and align the staff around that vision, ensure team building and consensus building, and involve those affected in the decision-making process to ensure successful change. Iyer and Camp (1991:133) further recommend the following steps for managers to implement during change:

- (1) Managers should support change.
- (2) Person effected by change should participate in the local authority nursing phase and be kept informed.
- (3) Change should occur gradually.

Iyer and Camp (1991:134) suggests four steps in effecting successful change in a nursing institution for nurse managers:

- (1) Avoid impossible promises.
- (2) Accept the necessity of negative feelings.
- (3) Devote enough resources.
- (4) Remember the old while introducing the new.

The three groups suggest that the management of both the local authority and the provincial authority needs to give accurate information, allowing local authority nurses and provincial authority nurses to understand the reasons and goals for the proposed change. Communication coupled with education will definitely dispel fears of the unknown and in turn employees will accept the changes.

Iyer and Camp (1991:135) support the suggestion that the following methods will help nurse managers to implement effective changes in their institutions:

- (1) Define the process of change.
- (2) Brainstorm possible solutions with those affected.
- (3) Develop a joint operational plan.
- (4) Ensure communication and active participation of those affected.

Twinn, Roberts and Andrews (1996:982) are of the opinion that the management team that leading people during change should do the following:

- (1) Be able to tolerate uncertainty and manage conflict.
- (2) Have a high level of personal security.
- (3) Have a capacity to see both the detail and the "wide angle" picture or strategic view at the same time.
- (4) Have good communication skills.
- (5) Have a wish to share success.
- (6) Have a clear and open motivation for the changes.
- (7) Be visionary.

Gerber, Nel and Van Dyk (1998:215) are of the opinion that advanced communication of a pending change allows workers time to evaluate it and prepare for it. They are then more likely to cooperate in the proposed change.

Strickland (1998:45) supports the other scholars in the literature in their contention that resistance to change can be managed through unfreezing of the current state, moving to the new state, and finally refreezing of the new state.

Pendlebury, Grouand and Meston (1998:224) confirm that consultation through communication of reasons and vision for change and active participation of those effected can overcome emotional barriers and can, in turn, promote acceptance of change.

According to Kotter and Schlesinger (1969:10) and Beer, Eisenfet and Spector (1990), it is important to managers to negotiate with potential resisters to change, and even obtain written letters of undertaking from them.

Swanepoel (1998:560) further supports Kotter et al in their view that managers need to develop a vision of how to mobilise commitment to change and to reach agreement with resisters so that the change process becomes a shared responsibility between management and employees.

George, Burke and Rodgers (1997:53-61) also recommended that by engaging all staff in the change process, the motivation for positive and behavioural change can be enhanced, and therefore employees will be ready for any change introduced.

Robbinson (1990:35) is of the opinion that during change employees' fear and uncertainty are high, and therefore recommends that management should arrange counselling and therapy, and new skills training in order to assist employees to adjust to changes. Robbinson (1990: 35) further confirms that management can offer support through positive incentives, or offer financial incentives for those who accept transfer and those who are cooperative about change.

Nadler (1983:23), and Kotter (1996:63) point out that in order for agents (managers) to bring about change, they must have the formal authority, position and legitimate power base to put transformation into practice.

Torrington (1974:57) is of the opinion that participative methods, such as discussions and group meetings, have been shown to facilitate change. Torrington (1974:57) further advocates that the whole process of implementing change is related to the replacement of key personnel either by an actual change role incumbent, or by a change in the attitudes and role relationships of the person.

It became apparent that the district management team was not familiar with the integration process either, hence they suggested that they need to have more information and the capacity to deal with change, and be able to inform local authority nurses and provincial authority nurses about the integration process.

Hawkins and Winter (1997:18) confirm that change agents need the right skills, in order to understand the change process itself and be able to create a strategy for a successful change process.

According to Vestal (1995:192), nurse management needs to be a change agent before they can even try to persuade subordinates to change. The following steps are proposed:

Step I

Nurse managers need to have control over their attitudes and the way they manage change. They must choose to be pioneers, explorers, positive enthusiastic players who can focus on removing obstacles and moving forward.

Step II

Assume ownership of the change process, and should take personal responsibility for moving forward.

Step III

Protect their political capital by choosing an issue they can challenge.

Step IV

Management should try to keep their sense of humour, and should not take change so seriously that they are mired in stress.

Step V

Management stay focused on inventing a new future rather than trying to fit in with the past. They should focus on what is coming and anticipate how they can acquire the knowledge and skills to succeed in the new environment (Vestal 1995:192).

Hart and McMillan (1996:4-12) suggest that managers as change implementers should help to shape, enable, orchestrate and facilitate successful change through negotiating and bargaining with employees' trade unions.

According to Gillies (1994:457), resistance can be prevented by giving those affected by change detailed information about the cause, purpose, method, design and schedule for the process well in advance, before any initiation. Gillies (1994:457) further recommends that since change is inevitable and painful, "the nurse manager should control the change process so that alterations occur at the right time at the right speed in the right direction, and as smoothly as possible to achieve the desired results with minimal disruption of workers lives and sensitivity".

Stanhope and Lancaster (1992:139) believe that change should occur in a three-step process: unfreezing, moving and refreezing. The nurse leader should promote the unfreezing process or the willingness of employees to give up their old ways and consider alternatives. This involves identifying forces for and against change (Bernard & Walsh 1990:143).

Step VI

This step in the change process is referred to as moving, that is implementing the change. This involves three strategies, namely empirical – rational, normative – re-educative, and power–coercive.

The empirical–rational strategy, "provides knowledge that the change will improve the situation".

The normative-reeducative strategy enhances increase in knowledge to include change in values and attitudes.

The power–coercive strategy implements change with power, with involvement and participation of staff members (Stanhope & Lancaster 1992:140).

Stoner and Wankel (1986:235) confirmed that for change to be permanent, and successful, it needs to be a three-stage process. Unfreezing the old behaviours, changing to a new level of behaviour and refreezing or locking the new level of behaviour.

Hellriegel and Woodman (1983:538) found that action research was the only method of managing resistance to change. They argue that if employees are fully involved in the change process, employees are given a chance to come up with strategies to implement change in the organisation and that management has identified the need for change and this has been widely communicated and shared with employees to implement and support a change that they have planned.

Lippitt, Watson and Westley (1958: 15-21) added that change should be a process, not an action; it should be a seven-phase model:

- the development of a need for change
- establishment of a change relationship
- diagnosis of the client system and problem
- the examination of alternative routes and goals

- the transformation of intentions into actual effort
- the generalisation and sterilisation of change
- achieving a terminal relationship

Swanepoel (2000:763) elaborates on this formula by indicating that if change takes place in phases or stages, success may be achieved as employees affected would have been ready for it, after all the phases.

Robbins (1997:525) pointed out that the managers should focus on employees' skills, attitudes, perceptions and expectation to influence their acceptance of change within the organisation.

Local authority nurses and provincial authority nurses accused management of introducing integration prematurely and abruptly, and further recommended that integration should be introduced slowly, with more information so that people are able to make informed choices.

The recommendation is supported by Booyens (1995:470-471) that management needs to give employees a chance to understand, change their attitudes towards change, internalise and accept change as it is not done abruptly – these employees are mentally ready to go through the change process.

It became apparent from the focus groups' results that local authority nurses and provincial authority nurses did not have the necessary information about what was happening around them, integration was not explained to them, there was no document they could refer to. This included the district management team, as their supervisors could not teach them about the process, and they too were as ignorant about the changes as local authority nurses and provincial authority nurses, hence they could not influence local authority nurses and provincial authority nurses to accept integration:

"I personally do not blame the poor nurses for resisting change, because they were never involved, nor consulted, as well we do not know a thing about this integration, I actually feel pity for the poor nurses."

"You know, worse, we are supposed to drive this integration process, how the hell can we drive something we do not know, maybe they think we are traditional healer, ag! Shame we are not, nor nurses are, the poor nurses are expected to perform miracles, like local authority nurses are expected to render primary health care curative service, like seeing sick patients and prescribing drugs for them without training, this is really not fair for the nurses, you know mn.... I don't know, it is really sad."

Elkins (1984:22-23) confirms that knowledge and understanding produce behaviour change, meaning that if people are taught, and changes explained to them, it is easy for them to accept change.

Mallick, Hall and Howard (1998:607-611) are of the opinion that nurse managers need to create an environment conducive to change, understand how to encourage acceptance of the need to change and generate ideas for successful change, so that subordinates gain confidence and trust in a knowledgeable manager.

Mallick et al (1998:607-611) are of the opinion that employees who are not involved in the change process tend to suffer from fear of the unknown, uncertainty, lack of knowledge and a feeling of powerlessness, and at the end may resist change.

Hinchliff, Norman and Schober (1989:131) emphasise that management needs to be honest and open with their subordinates about the change process, so that it does not raise suspicions.

Rorden and McLennan (1992 :28-29) recommend that for change to be successful, people go through stages of unfreezing old habits, moving and refreezing of new habits.

Haffer (1986:18-22) asserts that change should be communicated effectively so that individuals affected by change are both willing and able to change.

Lancaster and Lancaster (1982:776) recommend that the identification of goals, plans and priorities about change should be communicated to the participants so that trust is developed between the nurse and participants.

Kelly and Connor (1979:103) propose an emotional cycle of change to deal with resistance to change and enhance a successful change:

Uniform optimism, where certainty is cultivated through education, motivation and boosting the morale of those affected.

People affected by change need to be encouraged, involved, supported during change, so that the change process becomes their own and as such they will accept and support change.

Keyser (1986:103) is of the opinion that since change alters or replaces existing knowledge, so the nurse as a change agent must ensure that ideas are generated, people are trained and educated to deal with change, and the environment is conducive to change, to prevent resistance to change.

3.9.7 Description of concepts/definitions

In this study, numerous concepts were identified in the discussion, but two concepts, namely uncertainty and consultation were selected and explored in greater depth as a process of model development. The data analysis has revealed that both provincial and local authority nurses are not happy about the integration process, they have a feeling of insecurity and uncertainty about their posts and this has led to a negative perception of the whole process as a result of lack of consultation.

The provincial authority nurses perceive integration negatively and feel more aggrieved about their status as they believe they were just slotted in to local authority clinics without consultation and because of the fact that they get inferior benefits compared with those received by local authority nurses. On the other hand, the local authority nurses also feel threatened about their positions because they have a perception that provincial nurses are continuously on courses and upgrading themselves, while they (local authority nurses) are busy rendering the services, and therefore they resent the provincial nurses and feel that they can work alone.

The negative perceptions among nurses emanate from lack of consultation and information about integration and have led to resistance to change and this has inhibited integration of local authority nurses and provincial authority nurses rendering primary health care services in the district.

Most importantly, negative perception is seen as a mechanism for resisting change or the Integration of the provincial and local authority nurses.

Uncertainty about their future (provincial and local authority nurses) emanates from lack of information, and therefore creates lack of tolerance among them and this has led to unhappiness, frustrations, and burnout and, in turn, has hindered integration.

It became apparent from the discussion that local authority nurses and provincial authority nurses resisted change because they were uncertain about the process, as they were not fully informed or consulted about the integration.

It is also clear that uncertainty would never even have surfaced or created negativity among local authority nurses and provincial authority nurses, if only these people had been consulted.

The results of the three focus groups suggested that consultation, management of resistance to change and uniform conditions of service for provincial authority nurses and local authority nurses may promote integration and in turn lead to promotion of adaptation among local authority nurses and provincial authority nurses in the district.

It seems that consultation and information about integration may contribute towards acceptance of change by local authority nurses, provincial authority nurses and the district management team.

With this in mind, therefore, uncertainty and consultation will be the central or main concepts. The two concepts have been chosen as main concepts because they both represent the negativity and positivity associated with the process of integration.

Uncertainty is seen as a major reason for nurses to have negative perceptions towards integration, and it is hoped that it will provide a broader picture in explaining the negative perceptions of local authority nurses, provincial authority nurses and the district management team, as part of model development.

Consultation represents the positive perceptions of local authority nurses, provincial authority nurses and the district management team, and it is also hoped that it will provide a broader picture in this regard, as part of model development.

The researcher did not imply that other concepts were not as important as consultation and uncertainty, but found that these two are not trivial, but are rather relevant and contribute significantly to knowledge and development of a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

◆ **Concept definition**

As indicated in chapter 2, in this study concepts were explicitly defined using Wandelt and Stewart's (1975:34) and Wilson's (1987:114) combined methods of analysis by identifying the characteristics of concepts from:

- (1) general dictionary definitions
- (2) subject literature definitions
- (3) model cases

The two identified concepts of uncertainty and consultation are defined below, using general dictionary definitions as well as subject definitions. The concepts are then given a conceptual meaning by developing a model case.

◆ **Dictionary definition of uncertainty**

Little, Fowler and Coulson (1999:1890) define uncertainty as a state of not being definite, doubtful, vagueness and hesitant.

According to Brown (1993:3472), uncertainty is defined as something doubtful, unknown not assured unknown and not clearly defined.

Steinmet (1997:1166) refers to uncertainty as something that is unreliable, unstable, unpredictable, insecure, problematic and questionable.

Pearsall (1999:1558) defined uncertainty as a state of not being definite, as something unreliable and not known.

Barnhart and Barnhart (1988:2269) refers to uncertainty as something doubtful, not reliable, suspicious, distrust and not to depend upon.

Fowler and Fowler (1980:1263) defined uncertainty as a state of being unsure of something, dubiety, sceptical, suspicious and mistrustful.

◆ **Subject definition of uncertainty**

In this study, the researcher defines uncertainty as a process where the local authority nurses and provincial nurses rendering primary health care services in a district within the community are in a state of not being certain of the outcomes of the integration process and therefore being insecure about their posts. This feeling of uncertainty is aggravated by the fact that they have not been fully informed of the process, as expressed in the focus group interview: "We are frustrated, confused, we do not know what is happening." As a result they developed negative attitudes towards integration as a process and these negative attitudes resulted in resistance to change.

Their situation of being not sure of what is happening and being unsettled makes them feel that they are being undermined by the authorities. As a result they develop their own coping mechanisms.

If the nurses of both the local and the provincial authorities had been informed about the integration process, it could have resulted in

- better understanding of the process
- an understanding of both positive and negative factors that could influence the process
- an awareness of possible outcomes of the processes

They were in a state of flux, with no assurance of what was happening around them. They perceived the integration process to be unpredictable, undetermined, unstable and unreliable, as it was not clearly defined to them, the people affected. In short, they developed negative perceptions about the integration process, to such an extent that they resisted any move or change that came with integration.

As these nurses were vague about the integration process, they became hesitant to accept any change brought by the process.

Although the integration process was meant to improve the health services and their conditions of service, they rejected it, because they lacked the full background or knowledge about the intended integration.

◆ **Dictionary definition of consultation**

Webster (1975:244) defined consultation as a process of asking for advice or opinion, act of conferring and deliberating together.

Fowler and Fowler (1980:218) refer to consultation as an act of deliberation, an act of conferring and taking into consideration of someone's opinion.

While Little et al (1999:1088) concur with Fowler and Fowler that consultation means deliberation, he further defines it as a process of taking counsel together.

Pearsall (1999:306) refers to consultation as an act of asking for advice, considering jointly taking measures for the advantage and looking up for information.

According to Marriner-Tomey (1993:292), consultation refers to a situation where

management have complete confidence in their staff, staff-associated ideas are always sought and members of staff feel completely free to discuss their jobs with managers where there is a great deal of communication upwards, downwards and sideways that is accurate and received with an open mind, managers are very well informed about the problems faced by their staff and vice versa and decision-making is well integrated throughout the organisation with full involvement of staff.

Marriner-Tomey (1993:28) defines consultation as "a helping relationship". It is a process of interaction between the consultee - a person who has a problem - and a consultant who has specialised knowledge and skills to be able to solve the consultee's problem.

The difference between consultation and negotiation depends on the proposition that consultation is noncompetitive and integrative in nature, whereas negotiation is competitive and concerned with temporary and unsatisfying compromise, consultation therefore being equipped to resolve conflict and negotiation merely to conceive it.

A confederation of British Industry working party has taken the view that consultation cannot be separated from communication and negotiation, but that it is necessary to plan for each, and has selected a merging of consultation and negotiation on the grounds that it might lead to excessively easy negotiation, that it might make all management plans and decisions negotiable and that negotiations may not be fully representative of all groups (Marriner-Tomey 1993:296).

Steimetz (1997:423) describes consultation as a process involving a set of activities on the part of the helper that assists the client to perceive, understand, and act on events occurring in the client's environment.

Brown (1993:321) refers to consultation as a process in which a specialist identifies ways to handle work problems involving the management of clients or the planning and implementation of programmes.

Barnhart and Barnhart (1988:209) refer to consultation as an interpersonal interaction between the person with expert knowledge and a client, helping the client make constructive behavioural changes.

The goal of consultation is to stimulate the clients to take more responsibility, feel more secure, deal constructively with their feelings and with others in interactions and internalise flexible and creative skills (Stanhope & Lancaster 1992:663).

◆ **Subject definition of consultation**

For the purposes of this study, the researcher defined consultation as follows:

Consultation refers to a process where local authority nurses and provincial authority nurses and authorities exchange opinions, and discuss integration in order to ascertain each other's opinions or reach an agreement about the process, so that local authority nurses and provincial authority nurses can understand the process and make inputs, so that in the end they are able to accept and own the process and adapt to changes brought in by the integration process.

Local authority nurses and provincial authority nurses are actively involved in the negotiations for integration, they make a meaningful input into the process, they are assisted by authorities to understand the importance of the integration process so that all the changes that accompany integration are well understood, accepted and implemented without any drop in morale and commitment and service delivery to the community is not compromised.

The uncertainty of local authority nurses, provincial authority nurses and the district management team identified during the collection of data on local authority nurses and provincial authority nurses rendering primary health care services in a district will be corrected through consultation.

The two concepts (uncertainty and consultation) were defined and both satisfy the rules set by Copi (1986:57-161) as discussed in chapter 2 and both state essential attributes and are neither too broad, circular nor too narrow. Furthermore, the definitions are stated

in the affirmative as well as in concrete terms.

◆ **A model case**

As part of concept definition and classification, a model case was developed to create more conceptual meaning in respect of uncertainty and consultation as concepts used in the model. The model case in this study represents the concepts "uncertainty" and "consultation" to the best of the researcher's present understanding of the two concepts.

A model case for the concepts "uncertainty" and "consultation"

Located in central Ohio, the two long-standing, regionally known acute care hospitals formally merged in 1995 to become one hospital at two geographic sites. These were the Royal and Millan hospitals. As part of an integrated delivery system, the two shared the same governing body and fiscal ownership. The larger of the two, suburban hospital with over a thousand beds, specialised in heart and maternity care. Located in a central, downtown setting, the urban site is a 640-bed hospital known for trauma, orthopaedic, and ophthalmic care. At the time of the merger, each hospital had separate nursing administrations, centralised nursing departments, and duplicative functional responsibility for its respective campus.

Beginning in 1996 and expanding in 1997, service lines for the care of patients with cardiac, trauma, women's health, cancer, surgical, behavioural health, neuroscience, and emergency care began to emerge. Vice-presidents, mostly physicians or nurses, led the service lines. In addition to responsibility for fiscal management, marketing, physician relationships, clinical quality, and growth, the service lines assumed line accountability for the nursing units or other departments associated with the particular service line. Thus, the centralised department of nursing as such was eliminated. Remaining responsibilities were assigned to a chief nursing officer (CNO) who remained accountable for the centralised cost centres for staff education, patient education, float and per diem pools, and in-house nursing supervisors. The CNO also maintained authority for final approval on all centralised nursing policies and procedures as they were developed or revised, as well as final signature authority of distribution of foundation funds for nursing. In addition

the CNO acted as the liaison with the state board of nursing and had responsibility for ensuring that the organisation complied with state law with regard to the practice of nursing and mandatory reporting requirements. The CNO or designee also represented the discipline of nursing at medical staff meetings and hospital board meetings.

Since the CNO maintained additional responsibilities for service line management and campus-specific operations, a centralised director of nursing position was created to coordinate the elements of the discipline of nursing that support nursing practice. This position had cross-campus reporting relationships for centralised staffing, house supervisors, employee education services, patient education services, and both campuses' nursing administration offices. A recent modification to the organisational structure was introduced in the autumn of 1999, when the designated campus-specific operational leaders and one of the vice-presidents, who is also an registered nurse, assumed the role of the campus-specific CNO. The original CNO role was then changed to a chief nursing executive position, with cross-campus responsibility for the discipline of nursing.

Given the changes introduced in the two hospitals through the integration of the two, the lower staff members alleged that they were excluded in the merger/integration process.

The staff indicated that they had just been instructed to merge. The nurses from the Royal hospital were told that their hospital was closing down, and that they would be allocated to work in the Millan suburb hospital. On the other hand the Millan suburb hospital also claimed that they were not consulted about the move, they were only told that they would be working with nurses from the Royal hospital. According to them, they were happy to have additional staff members, but they were worried and uncertain about their senior positions and their benefits.

The nurses from the Royal urban hospital were unhappy about the situation at the Millan suburb hospital; they felt that they had been slotted in, they were now reporting to the Millan nurses, as if they had been demoted. They were *uncertain* about their future at that hospital. Their signs of frustrations were evident from the high absenteeism rate, resignations and burn out. These nurses felt rejected, unimportant and frustrated as a result of not knowing what was happening around them. On the other hand, the Millan

nurses rejected these nurses from the Royal hospital because they thought that they were going to occupy their positions.

All these behaviours were due to *uncertainty* and lack of information about their future. The nurses from both hospitals started to liaise with one another about their unhappiness with the merger. The long and short of it is that they went on a go-slow strike, after which management started to react to find out why. During their meeting with management, they indicated their dissatisfaction with *nonconsultation* by management about the merger, *uncertainty* about their positions and benefits, and lack of assurance on part of management.

Management responded positively to the complaints from the nurses from both hospitals, by requesting the nurses to coordinate the second meeting, at which nurses should bring a written proposal on how management could solve their problems. A second meeting was held with management and the following proposals were outlined:

- Proper consultation, involvement of nurses in the proposed merger before the merger could be implemented.
- Choice to be given to nurses to be part of the merger or not, before a decision was taken on merger.
- Better conditions of service for all the nurses.
- Assurance of all the nurses that their benefits won't be affected negatively during the merger.

At this meeting, task teams were formed to look into those recommendations for implementation. Members of the task teams were top management and representatives from lower level staff.

Several meetings took place, but at last employees had been thoroughly *consulted*, and were well informed, after which *uncertainty* and misconception about the merger were done away with, and ultimately the nurses of the two hospitals nurses were merged successfully.

The above definitions state the essential attributes of consultation and uncertainty and the definitions are neither circular, too broad nor too narrow.

◆ **Theoretical definition of concepts in the model**

Mouton (1996:188) states that theoretical definition should bring into focus the relationships between a given concept and related concepts within a specific framework. In this study, the theoretical definition of the central concept, uncertainty and consultation, has been covered. In order to enhance conceptualisation of consultation and uncertainty, it is only prudent to provide a definition of other related concepts.

Uncertainty identified as one of the main concepts gives a broader picture of the negative perceptions of local authority nurses and provincial authority nurses and the district management team about the integration of services. It reflects the effects of lack of consultation and information on the nurses rendering primary health care services in a district.

Lack of consultation created uncertainty among local authority nurses and provincial authority nurses and in turn developed negative perceptions towards integration. Negative perceptions among the local authority nurses and provincial authority nurses is demonstrated by their resistance to change.

The focus group discussions also revealed disparities in conditions of service between local authority nurses and provincial authority nurses, which made the nurses more negative towards change. The three focus groups recommended that if they were reassured and consulted about the process, they would accept change as introduced, tolerate one another and work well together in the district.

The concept consultation represents the positive perceptions, and it is suggested by the three groups and supported by the literature that through it (consultation), integration of local authority nurses and provincial authority nurses rendering primary health care services in a district may be achieved.

Though uncertainty and consultation were identified as main concepts and further explored in-depth, there are other concepts that were identified in the discussion. For the purpose of clarity, definitions of these concepts will also be provided.

Acceptance

Acceptance can be defined as:

- adequate
- belief in something, agreement
- favourable reception, approval
- the action of accepting, receiving what is offered, with approbation, satisfaction or acquiescence (Pearsall 1999:7)

Assurance

Fowler and Fowler (1980:52) define assurance as an act of assuring, freedom from doubt, instilling self-confidence, and as a statement or indication that inspires confidence, a guarantee or pledge.

Change

Pearsall (1999:235) refers to change as a process of:

Make or become difference, move from one to another. A conscious, deliberate and collaborative effort to improve the operation of human system, whether it be a self system, social system, or a cultural system, through the utilisation of knowledge.

Resistance to change

Resistance to change can be defined as to:

- strive to fend or offset the actions, effects or force of

- remain firm against the action, effects or force
- strive against, to endeavour to counteract, defeat, or frustrate to act in opposition to (Pearsall 1999:1218)

Tolerance

Fowler and Fowler (1980:379) describe tolerance as a process of:

- allowing to exist without intolerance
- enduring with forbearance
- allowing differences of opinion without discrimination

◆ Researcher's mental map

The researcher's mental map as described in chapter 2, serves the purpose of identifying and categorising the main and related concepts of the model for further clarity in relation to Roy's Adaptation Model, using the survey list supplied by Dickoff et.al (1968:434-452) as a point of departure:

- Agent
- Recipient
- Dynamics
- Procedure
- Context
- Terminus

Agent

In this study a community nurse who is expected to implement the model for the integration of local authority nurses and provincial authority nurses in the district.

Recipient

Local authority nurses and provincial authority nurses as adaptive systems are the recipients of the integration process in this study.

Dynamics

In this study dynamics is illustrated by negative perceptions: lack of consultation, resistance to change, and disparities in conditions of service and uncertainty.

Procedure

In this study procedure is referred to as:

- proper consultation
- management of resistance to change
- uniform conditions of service

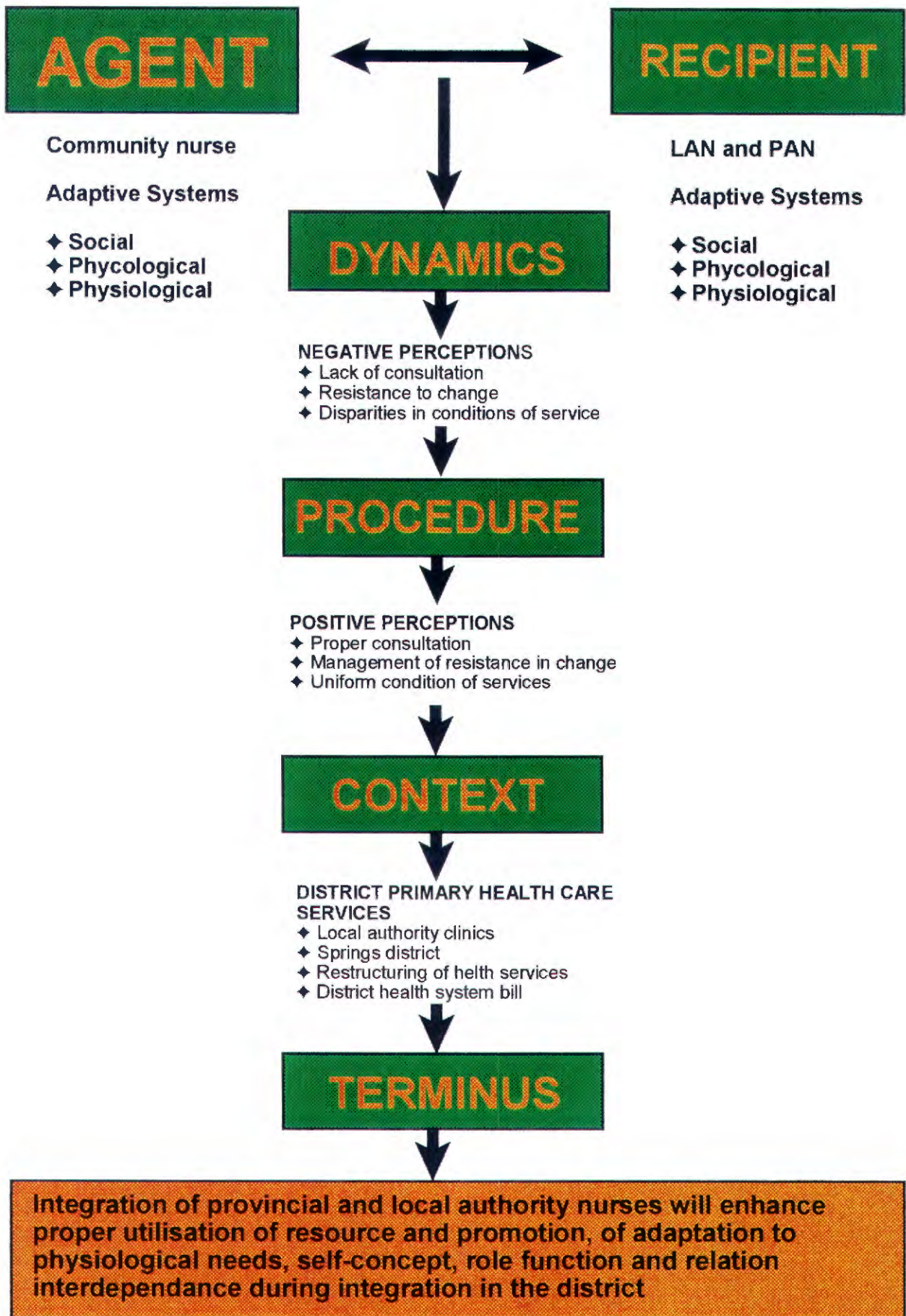
Context

The context in this study refers to:

- district health system
- community nursing service
- primary health care services

Terminus

In this study terminus, as the last in the list, is illustrated by the successful integration of local authority nurses and provincial authority nurses, and the promotion of adaptation to physiological needs, self-concept role function and interdependence of local authority nurses and provincial authority nurses during integration in the district. See diagram illustrating the process of the researcher's mental map (figure 3.1).



*Figure 3.1
Researcher's mental map*

◆ **Reduction process of identified concepts: uncertainty and consultation**

The major attributes of the concepts of consultation and uncertainty were underlined in both dictionary and subject definitions and these were clustered together to form a list of essential and related criteria to include in the definition of consultation and uncertainty.

Table 3.3: Characteristics of essential and related criteria

ESSENTIAL CRITERIA	UNCERTAINTY	CONSULTATION
OTHER RELATED CRITERIA	UNSTABLE UNPREDICTABLE UNSTEADY UNSETTLED	CONFER DISCUSSION ADVICE MEETING

◆ **Concept maps**

Concept maps are schematic designs for the representation of concepts in which the understanding of the concept is inherent in the framework of the concept (Wandersee, 1990:923). Concept mapping assists readers to view the concepts and relationships between concepts in a holistic fashion, and their better understanding of concepts in the model is achieved.

Conceptual mapping

The essential criteria of consultation and uncertainty in the tables below are respectively presented in separate concept maps in order to provide an understanding of the dynamics involved from the concept map of consultation. The following items of importance were identified: provincial authority nurses, local authority nurses and district management team, and integration. Definitions of these identified concepts were given in chapter 1, and are also applicable here, and as such, will not be repeated.

Similarly, the important associated concepts from the concept map of uncertainty, figure 4.2 (b), namely district management team, provincial authority nurses, and local authority nurses were also defined in chapter 1.

Conceptual mapping of the two concepts will provide more clarity and meaning about consultation and uncertainty.

For the purposes of the study these definitions will be contextualised in chapter 5 (see tables 3.4a and 3.4b).

Table 3.4a: Concept map of consultation

COMMUNITY NURSE PROMOTES INTEGRATION		
<p>LOCAL AUTHORITY NURSE</p> <p>SUPPORTIVE UNDERSTANDING COOPERATIVE COMMITTED ATTITUDE ACCEPTS CHANGES POSITIVE PERCEPTION</p>	<p>CONTEXT</p> <p>COMMUNITY NURSING</p> <p>PROCESS</p> <p>COMMUNICATION TRANSPARENCY REASSURANCE INVOLVING SHARING IDEAS</p> <p>NEGOTIATING DISCUSSION</p> <p>INTEGRATION</p>	<p>PROVINCIAL AUTHORITY NURSE</p> <p>SUPPORTIVE UNDERSTANDING COOPERATIVE COMMITTED ATTITUDE ACCEPTS CHANGES POSITIVE PERCEPTION</p>

Table 3.4b: Concept map of uncertainty

COMMUNITY NURSE		
<p>LOCAL AUTHORITY NURSES</p> <ul style="list-style-type: none"> • Negative towards integration • Unsure • Resent provincial authority nurses • Irritable, overworked intolerant towards provincial authority nurses • Insecure • Finger pointing of provincial authority nurses • Unsettled 	<p>DMT</p> <ul style="list-style-type: none"> • Lack of consultation • No full information about integration • Unsure • Uncertain • Lack of information about the integration process 	<p>PROVINCIAL AUTHORITY NURSES</p> <ul style="list-style-type: none"> • Negative towards integration • Negative perception • Indifferent • Uncooperative • Insecure • Unsure • Irritable, frustrated, pointing fingers at local authority nurses • Unsettled • Worried • Feel unwanted and worthless

◆ **Relating and structuring concepts**

According to Chinn and Kramer (1995:112-115), concepts should be given structural form so as to clarify their relationships by means of a symbolic representation.

The overlapping circles depict discrete components that have common areas between and among them. Local authority and provincial authority nurses have been placed in certain circles and the environment in another, reflecting the interaction between local authority

nurses and provincial authority nurses as individuals with their environments.

The rectangular blocks depict the community nurse, who promotes the integration of local authority nurses and provincial authority nurses through consultation, management of resistance to change, and uniform conditions of service, which in turn promote the adaptation of local authority nurses and provincial authority nurses to the changing environment.

The lines and arrows between the rectangular blocks illustrate the way the community nurse promotes integration.

The community nurse promotes the integration of local authority nurses and provincial authority nurses through consultation, management of resistance to change, and uniform conditions of service, which in turn promotes the adaptation of local authority nurses and provincial authority nurses to the changing environment (see figure 4.2).

3.10 SUMMARY

This chapter presented the results of the focus groups' revealed perceptions about the integration as well as strategies to improve integration, contextualised against the background of literature control.

The results have shown that negative perceptions about integration emanated from lack of consultation and information about the process, and then brought about resistance to change among local authority nurses and provincial authority nurses. Both local authority nurses and provincial authority nurses widely reported lack of consultation as a major cause of concern and impediment to integration.

They remarked that they are not opposed to integration, but to the way it was introduced. They made wild remarks about various attributes of negative perceptions that resulted from lack of consultation, disparities in conditions of services and resistance to change that made them think negative thoughts about the integration or about working together and they were supported by the district management team who felt that it was difficult for them

to prepare these nurses about integration as they themselves did not have guidelines to direct integration.

Both local authority nurses and provincial authority nurses were uncertain and as a result were suspicious of authority's move for integration, because they did not share information with them, and thought that they had something negative they (authorities) were trying to hide.

There was a general feeling that integration was not a bad idea, as it would bring equity in services delivery and in conditions of services for all the employees. There was consensus on strategies to improve integration, which emanated from a major category "positive perceptions"

The following themes were discussed under positive perceptions: proper consultation, management of resistance to change and uniform conditions of service for all nurses as attributes that will enhance integration.

The data analysis has revealed that the integration of local authority nurses and provincial authority nurses is being hindered by negative perceptions that emanated from lack of consultation, resistance to change and disparities in conditions of service.

This process has also revealed that the integration of local authority nurses and provincial authority nurses can only be realised through positive perceptions, that is proper consultation of local authority nurses and provincial authority nurses, who will in turn be fully informed about the process, internalise the process, and be part of the process.

Consultation of local authority nurses and provincial authority nurses on their integration will empower both, enabling them to understand and accept integration as their own process. The goal the consultation aims to achieve is to integrate local authority nurses and provincial authority nurses, which may, in turn, lead to the adaptation of local authority nurses and provincial authority nurses to the changing environment.

Chapter 4

Designing of the model for the integration process

4.1 INTRODUCTION

In phase 1 the exploration of the integration process through focus group interviews was done, and in this second phase of the research, the model for the integration process will be designed based on the findings. The following issues will be addressed in this chapter:

- A brief overview of the model
- The implementation of strategies
- Description of the model
- Process of implementation of the model

4.2 BRIEF OVERVIEW OF THE MODEL

A brief overview of the model will be given to reflect the relationships between concepts used in the model. The concepts used in the model were selected from the results of the focus group interviews held between local authority nurses, provincial authority nurses and the district management team.

The positive perceptions; proper consultation, management of resistance to change and uniform conditions of service were suggested by the three focus groups as strategies to improve the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district. Based these strategies the researcher then identified consultation as the main concept that could drive the process of integration between local authority nurses and provincial authority nurses.

Uncertainty was selected as a main concept, representing the negative perceptions and subsequently consultation was selected as a main concept for positive perceptions, with the assumption that it would promote successful integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

Roy's Adaptation Model which was used as theoretical framework stimulated the design of the model to illustrate how a changing working environment can be managed and adapted to, without compromising quality of care.

4.2.1 Visual presentation of the model

The arrow pointing into the central circle (coping mechanism) represents the stimuli that affect the coping mechanism of local authority nurses and provincial authority nurses rendering primary health care services in the district. The stimuli in this study are the changing working environment, changing in policies and integration of services.

The big circle in the centre of the diagram illustrates the coping mechanisms of the nurses in a changing environment. Coping mechanisms are determined and influenced by physiological characteristics, the concepts of self within the working environment, the role and functions which nurses have to perform as well as other inter-related issues.

The top left circle (physiological mode) represents the physiological integrity of local authority nurses and provincial authority nurses rendering primary health services in the district and this includes: burnout, overworked. There was a perception that local authority nurses is overworked due to the integration process.

The circle adjacent the physiological mode on the top right of the bigger circle is called the self-concept mode. This mode focuses on the psychic integrity of local authority nurses and provincial authority nurses rendering primary health care services in the district. This includes the following perceptions emanated from local authority nurses and provincial authority nurses:

- mistrust
- demotivation
- frustration
- lack of consultation
- lack of information
- insecurity
- the feeling of despair
- irritation
- confusion
- the feeling of being unwanted
- isolation
- rejection

The left lower circle, called interdependence, emphasises the social integrity of local authority nurses and provincial authority nurses rendering primary health care services in the district. The interdependence mode illustrates how local authority nurses and provincial authority nurses perceived the following as a mechanism of improving their integration, that is consultation, information, negotiations, security, team building workshops and mental preparedness towards the integration process.

The bottom right small circle represents the role function mode of local authority nurses and provincial authority nurses rendering primary health care services in the district. The role function mode also emphasise the need for social integrity of local authority nurses and provincial authority nurses. The mode addresses issues covered in the interdependence mode.

The outer ring or layer of the big circle illustrates the potential for adaptation of local authority nurses and provincial authority nurses through the implementation of proper consultation, management of resistance to change and uniform conditions of service (see figure 4.1)

STIMULI

- Changing working environment
- Changing policies
- Integration of services

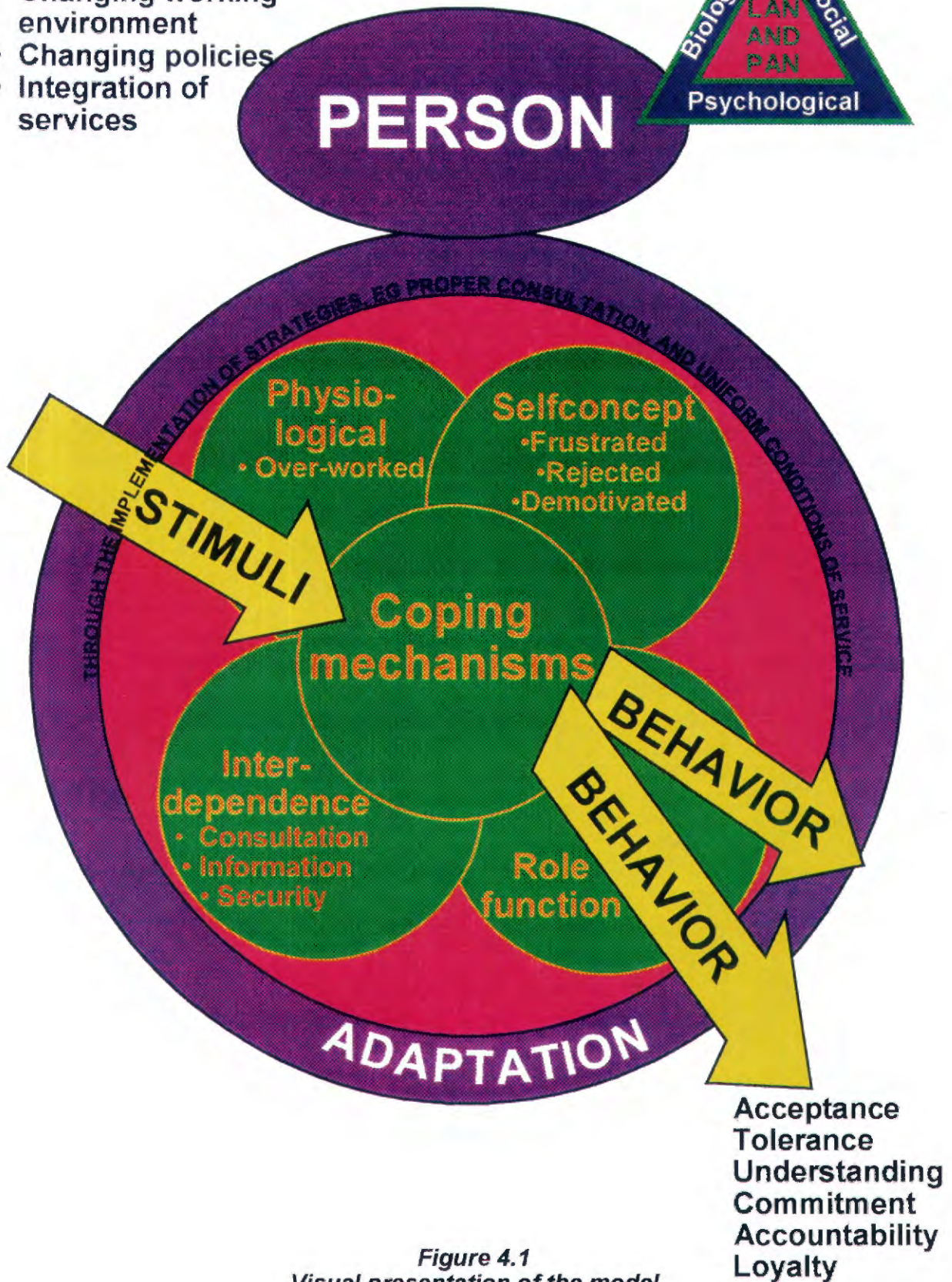


Figure 4.1
Visual presentation of the model

The consultation between provincial authority nurses and local authority nurses and the authorities may enhance their understanding, acceptance and ownership of the process and automatically they may be agents for change and may be successfully integrated.

In the context of applying the Roy's Adaptation Model as a paradigmatic point of departure, for this study, integration in turn facilitates self-actualisation and adaptation to the changing environment and active participation in future prosperity of both local and provincial nurses.

The integration of local authority nurses and provincial authority nurses is taking place within the context of community nursing, hence the researcher refers to the community nurse (chief nurse) as a facilitator of the integration process, and as a person responsible for implementing recommendations for the successful integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

The community nurse as the person responsible for implementing integration should create a climate for the nurses from the two authorities which is conducive to participation and involvement in the process, which affects them all.

Both local authority nurses and provincial authority nurses are biosocial beings, who are in constant interaction with the changing environment to achieve their quest for adaptation. They have great potential for self-actualisation and creative participation in their own destiny; they will therefore be able to adapt to their integration.

Figure 4.1 illustrates the application of Roy's Adaptation Model of nursing in the proposed model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

The left top one triangular block next to the big circle of a person show local authority nurses and provincial authority nurses as biological, social and psychological beings during their initial encounter and just after integration was implemented.

4.2.2 Purpose of the model

The purpose of this model is to provide a theoretical framework that can be utilised to effectively facilitate an integration process of local authority nurses and provincial authority nurses rendering primary health care services in a district and to encourage local authority nurses and provincial authority nurses to actively participate in their integration process, which in turn will promote adaptation of both local authority nurses and provincial authority nurses.

4.2.3 Assumptions on which the model is based

Consultation of local authority nurses and provincial authority nurses by the authorities promotes assurance, acceptance and ownership of the integration process and in turn improves the morale and well-being of these nurses.

Other assumptions of this model are derived from Roy's Adaptation Model.

- The local authority nurses are biopsychosocial beings who are in constant interaction with the changing environment in the district primary health care services.
- The provincial nurses, likewise, as an adaptive system, are in constant interaction with changes in the context of the district primary health care services.
- The two participants are engaged in a process of integration but are uncertain about their future and positions.
- A community nurse facilitates integration of the two participants through proper consultation, management of resistance to change, and uniform conditions of services.

4.2.4 Context of the model

The context of the model is the local authority primary health care clinics in the specific district of Gauteng, where local authority nurses and provincial authority nurses function as a group within the community.

4.2.5 Structural form of the model

The model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district depicts local authority nurses and provincial authority nurses integrating in an environment characterised by uncertainty, lack of consultation, resistance to change and disparities in conditions of service. Their integration is negative. the local authority nurse and provincial authority nurse interact in an internal and external environment.

To counteract negative integration the model suggests three strategies which may promote integration, namely consultation, management of resistance to change and uniform conditions of service.

After implementing the suggested strategies of the integration model at the district, the expected outcome is the adaptation of local authority nurses and provincial authority nurses to the changing environment. Since health services are being restructured, health workers will always find themselves in disharmonious situations of change and therefore, the integration model, which is proposed, will be reimplemented to achieve integration.

4.2.6 Relationship statement of the model

Interaction takes place between local authority nurses and provincial authority nurses, who are spiritual beings functioning as biopsychosocial beings in the district, thus affecting each other's internal and external environment through their patterns of interaction. The relationship between local authority nurses and provincial authority nurses, and their relationship with management, remains the primary relationship.

For integration to be realised at the district level, both local authority nurses and provincial authority nurses and management have to promote integration through consultation, management of resistance to change and uniform conditions of services.

Interaction promotes adaptation of local authority nurses and provincial authority nurses to the changing environment and therefore promotes integration of local authority nurses

and provincial authority nurses.

The more consultation there is between local authority nurses, provincial authority nurses and management the greater will be the understanding, acceptance and ownership of the integration process by all parties involved.

4.3 IMPLEMENTATION OF STRATEGIES

The implementation of strategies to enhance the integration of local authority nurses and provincial authority nurses will result in the smooth, acceptable integration process of local authority nurses and provincial authority nurses rendering primary health care services in the district.

4.3.1 Proper consultation

A proper consultation process implies the following:

- Ensure extensive consultation with employees of both the provincial and the local authority by developing a communication strategy for the implementation of the integration process.
- Spell out guidelines and develop criteria for the integration of personnel
- Recognise that the nurses as employees have the right and duty to participate in changes affecting them.
- Participation as empowerment of local authority nurses and provincial authority nurses to manage the integration process, enabling them to understand, accept and own the process as theirs.
- Tell people what is happening, that is, the district management team informs the local authority nurses and provincial authority nurses about integration.
- Clarify misunderstanding with local authority nurses and provincial authority nurses about the integration process.
- Involve local authority nurses and provincial authority nurses in the integration process, allow them time to comprehend the process.
- Allow nurses to choose whether to be part of integration or not.

- Show local authority nurses and provincial authority nurses that their opinions are being taken note of, and do not implement any change before they consent to that.
- Create a forum for discussion.
- Encourage participation of all affected by change.
- Allow employees to make suggestions for solving their problems.
- Allow upward, downward and sideways communication with employees.

4.3.2 Management of resistance to change

Leaders/managers must articulate difficult concepts concerning change clearly, and if the concepts are not well understood management must be willing to try new approaches, and explanations until the change process and its concepts are well understood by employees.

Sharing information through story telling can also assist people to relate the change to things they already know, and these make the change more palatable.

Managers should support employees during change, as a way of demonstrating caring and compassion to employees and in turn they (employees) will accept change as a joint venture between themselves and management.

- Keep the finger on the pulse of employees' morale, acceptance of change and attitudes.
- Communicating perceptions about change should be addressed as a matter of urgency.

The need for and the logic behind change should be explained early in meetings or through elaborate audio-visual education campaigns to employees so as to pave the way for successful change.

Facilitation and support through retraining programmes, allowing time off after a difficult period and offering emotional support and understanding, may help overcome resistance to change.

- Practical strategies should be in place to guide managers to deal with both planned and unplanned change, that is:
 - How to encourage and sustain team work
 - Common hours of duty, tea and lunches
- Working towards a common work culture and ethic is important.
- Support should be provided to staff to deal with the many changes and still maintain existing services.

Recognition that planned change such as the integration of local authority nurses and provincial authority nurses can be achieved by focusing on them (local authority nurses and provincial authority nurses) as the major locus of attention.

- Stimulate the need for change
- Establishment of a change relationship
- Diagnosis of the client system and problem
- The examination of alternative route and goals
- The transformation of intentions into actual effort
- The generalisation and sterilisation of change
- Achieving a terminal relationship
- Unfreezing of old behaviours, changing to a new level of behaviour and refreezing of looking the new level of behaviour.

4.3.3 Uniform conditions of service

It would be appropriate for the district management team to make provision for uniform conditions, so as to enhance harmony among these nurses. This could be achieved through the following:

- Transfer of provincial nurses to local authority clinics with the functions they perform.
- Transfer of assets, rights, liabilities and obligations regarding provincial authority nurses and local authority nurses.
- Parity in salaries and conditions of service for nurses throughout the district.

- Representivity of both provincial and local authority nurses in management and front-line staff.
- Uniform performance appraisal system for all nurses in the district.
- Skills of staff reflecting the needs of the district with optimal utilisation of skills of all the nurses.
- Appropriate training of nurses to meet the service needs of the people in the district.
- Improved training and skills development of middle and senior managers of both the province and the local authority in finance and budgeting skills.
- Uniform adequate and fair remuneration: this includes adequate payment, and fringe benefits enabling the employees to maintain an acceptable standard of living while working within the instruction.
- Equal opportunities to develop and utilise human capacities: includes autonomy, work requiring multiple skills, information.
- Equal opportunities for continued growth and security: this involves expanding one's capabilities, the opportunity to use new knowledge and skills, promotion opportunities, as well as job and financial security.

Though the above-mentioned three themes were identified as strategies to enhance the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district, the following themes were found to be valuable in terms of improving the integration process:

4.3.4 Provision of information

Management should take responsibility for the following:

- Be transparent to local authority nurses and provincial authority nurses about the integration process.
- Make documents available for local authority nurses and provincial authority nurses to read more about the integration process.
- Develop an effective communication strategy that will ensure understanding and acceptance of the integration process by local authority nurses and provincial

authority nurses rendering primary health care services in the district.

4.3.5 Emotional support

Management should give emotional support to local authority nurses and provincial authority nurses rendering primary health care services in the district, because the integration process created uncertainty to them so that they are reassured and their confidence is built in a manner that will enhance acceptance of the integration process.

4.3.6 Budgetary issue

Management should make budget available to bridge the gap between the different salary scales and benefits given to local authority nurses and provincial authority nurses rendering primary health care services in a district.

4.3.7 New structure

Management should create a new structure to accommodate both local authority nurses and provincial authority nurses in the structure so that nurses with same qualifications and experience are placed accordingly in the structure and are paid similar.

4.3.8 Team building workshops

Management should arrange team building workshops for local authority nurses and provincial authority nurses, so that there is no disharmony among them, and are able to work together as colleagues.

4.3.9 Empowerment strategies

Management should ensure that both local authority nurses and provincial authority nurses are empowered with new skills so that they are able to work competently in the new environment.

4.4 DESCRIPTION OF APPLYING THE MODEL

The model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district takes place in three phases.

- Phase 1: The initiation phase
- Phase 2: The Implementation phase
- Phase 3: The Incorporation phase

The three phases are independent and are discussed below.

4.4.1 Initiation phase

The initiation phase reflects the self-concept mode of the model and refers to the period during which provincial authority nurses are transferred into local authority clinics without proper consultation to work with local authority nurses who were also not prepared mentally to be able to work with provincial authority nurses. There were no proper guidelines to work from; it was just an informal and uninformed exercise. Local authority nurses and provincial authority nurses found themselves in the same boat, both uncertain about the process of integration, and uncertain about their posts. Their uncertainty resulted from lack of knowledge and assurance from management about what is happening now and in the future. As human beings they developed their own coping mechanisms. Local authority nurses rejected provincial authority nurses, they did not want to share equipment and rooms with them. On the other hand provincial authority nurses felt rejected, undermined, unwanted, isolated and belittled by local authority nurses.

The phase in general is characterised by anxiety, doubts, negativism and mistrust, pessimism, animosity, rejection, frustration, irritability, burnout and poor productivity in service delivery.

The phase is characterised by negative perceptions about integration, which are manifested by resistance to change, complaints about disparities in conditions of services, because of lack of consultation. Local authority nurses and provincial authority nurses

blame authorities for not consulting with them. The district management team on the other hand did not consult with local authority nurses and provincial authority nurses, as indicated in the study, because they, too, did not have tangible information about integration to share with provincial authority nurses and local authority nurses.

◆ **Lack of consultation**

Lack of consultation by the district management team about the integration of local authority nurses and provincial authority nurses during this phase has led to complaints by the nurses that the district management team never consulted them, and as a result they were not mentally prepared to integrate or work together. They also indicated that they were made to integrate without any information on what would happen to their designations, positions, benefits and salaries and the reporting structure. They indicated that they did not know whether they were coming or going. Uncertainty comes about because of a lack of information and consultation, and to them; in fact, uncertainty led to negative perceptions and the rejection of the whole process of change, which is integration.

◆ **Resistance to change**

As a result of lack of consultation and uncertainty about the integration, local authority nurses and provincial authority nurses developed coping mechanisms, by resisting change and rejecting integration. Resistance to change was manifested through finger pointing between local authority nurses and provincial authority nurses. Provincial authority nurses perceived local authority nurses as resisting change by being negative, rejecting them and wanting the status quo to remain, and enjoy their benefits alone.

On the other hand local authority nurses pointed fingers at provincial authority nurses as being uncooperative towards change, not committed, clinging to the old fragmented system by being disruptive and negative.

Provincial authority nurses did not want to report to the facility head, they were uncooperative and not accountable, they would be off work without leave forms or

reporting to the facility head, and as a result local authority nurses were left to do the work alone and were in fact overworked.

Local authority nurses did not want to share their offices with provincial authority nurses; they rejected provincial authority nurses, alleging that provincial authority nurses are lazy, and unaccountable.

Their behaviour of resisting change was supported by the district management team who claim that they understand the behaviour, as the poor nurses were not prepared mentally for the integration.

◆ **Disparities in conditions of service**

Local authority nurses, provincial authority nurses and the district management team indicated that there are disparities in conditions of service between local authority nurses and provincial authority nurses, and as a result these nurses are unable to work together on integration before this problem has been addressed.

Local authority nurses are paid better salaries, they receive car loans and allowances, uniform allowances, and therefore they all drive beautiful cars and wear colourful beautiful uniforms while provincial authority nurses with the same qualifications, experience and doing the same work get lower salaries, do not get car loans and travelling allowances, and hardly get a uniform allowance.

4.4.2 The implementation phase

The implementation phase reflect the interdependent and role function modes and is characterised by management and subordinates becoming more involved in the change process, and thereby accepting integration.

During this phase the community nurse encourages the district management team, local authority nurses and provincial authority nurses to go back to the negotiating table and start discussing ways of improving integration so as to restore harmony in the district. Now

local authority nurses and provincial authority nurses start to recognise personal values, talents and abilities. They contribute to the decisions affecting them, feel more empowered assured and in control of the integration process as they have now been fully informed and consulted by district management team.

Local authority nurses and provincial authority nurses are focused on achieving successful integration, they work together and are able to adapt as they identify and solve problems. There is a team perspective among them, and they look out for each other and for the good of the district. The district management team keep the team effort coordinated and responsive to changing needs and conditions.

To achieve the objective of this phase the following processes are followed:

◆ **Proper consultation**

To consult is to confer or get advice with the aim of reaching consensus on an issue. The district management team should get full information about the integration of local authority nurses and provincial authority nurses, and in turn consult with them, get their understanding so that they accept their integration and then harmony will be restored.

The district management team should arrange workshops where local authority nurses and provincial authority nurses can communicate and participate in the discussion around their integration so that they will not later feel that the integration has been imposed on them, rather than that they own it and are driving it.

◆ **Management of resistance to change**

The district management team must create mechanisms to deal with resistance to change by local authority nurses and provincial authority nurses. After consulting with local authority nurses and provincial authority nurses the district management team must assess the attitudes, and then work on the negative attitudes, after which new positive attitudes to change must be refrozen, and therefor local authority nurses and provincial authority nurses will accept change and as a result their integration will be harmonious.

◆ **Uniform conditions of services**

Though there is no legislation laid down to indicate how conditions of service can be equalised among professionals with the same qualifications and experience and doing the same job, it is the duty of the district management team to ensure that such a strategy is implemented before provincial authority nurses and local authority nurses can be integrated so that there is harmony within the district where they render primary health care services.

It is high time that the National Health Department came out with mechanisms and a budget to level the playing fields, so that nurses doing the same job are remunerated equally, and this will in turn promote adaptation of local authority nurses and provincial authority nurses to the changing environment among local authority nurses and provincial authority nurses and as a result their integration will be positive.

During this phase, the community nurse encourages local authority nurses, provincial authority nurses and the district management team to restart the whole process, by first consulting one another, giving more information about integration, and clarifying misperceptions about integration, so that local authority nurses and provincial authority nurses can be fully informed about the process, understand, accept and later own the process, and this will in turn enhance the integration of these nurses (local authority nurses and provincial authority nurses), thus setting the stage for the next phase of incorporation.

4.4.3 The incorporation phase

The incorporation phase reflects the adaptation phase which represents the extent to which different practices become part of change. During this phase, positive, professional communication fosters synergistic relationships between local authority nurses, provincial authority nurses and the district management team. There is attainment of targeted goals that will enhance the integration of local authority nurses and provincial authority nurses rendering primary health care in the district.

Local authority nurses and provincial authority nurses are seeing integration as something over which they have control. Strategies suggested for integration are embraced as a means of empowering local authority nurses and provincial authority nurses to create their future. What were formally considered negative perceptions are now considered challenges and positive perceptions.

The incorporation phase advocates a smooth and a more informed integration where local authority nurses and provincial authority nurses are partners with management in the integration process and there is full support for integration from their side, and acceptance of integration.

The process of local authority nurses and provincial authority nurses and the district management team, working together towards the integration of local authority nurses and provincial authority nurses, will produce a successful integration and in turn promotion of adaptation of local authority nurses and provincial authority nurses to the changing environment.

For the purposes of greater clarity, guidelines will be presented in tabular form (see table 4.1).

Table 4.1: Summary of strategies

THEME	AIM	STRATEGY
<p>Proper consultation</p>	<p>To ensure that local authority nurses and provincial authority nurses are well-informed, and involved so as to avoid misconceptions and poor information about the integration process</p>	<p>Development of a communication strategy.</p>
		<ul style="list-style-type: none"> • Have a clear communication strategy for selling success and communicating the vision of change to local authority nurses and provincial authority nurses so that they are fully informed
		<ul style="list-style-type: none"> • Build appropriate networks to facilitate communication
		<ul style="list-style-type: none"> • Focus on spreading successful practices
		<ul style="list-style-type: none"> • Understand local authority nurses' and provincial authority nurses' priorities in order to offer them clear benefits
		<ul style="list-style-type: none"> • Offer support and encouragement to local authority nurses and provincial authority nurses and do not add another problem
		<ul style="list-style-type: none"> • Listen to local authority nurses and provincial authority nurses in order to identify their agendas and then sell them the benefits of integration as a change process
		<ul style="list-style-type: none"> • Stakeholders or people affected by change need to be kept informed on all issues related to the integration process, in order to minimise stress and frustration all around
		<ul style="list-style-type: none"> • Management needs to establish a task team to device why, what when and how to communicate
		<ul style="list-style-type: none"> • Management need to ensure that a positive buy-in and vision is communicated to all affected. (Local Authority nurses, Provincial Authority Nurses and District Management Team).
<ul style="list-style-type: none"> • Mobilise commitment through communication of vision and strategies towards the integration process 		

THEME	AIM	STRATEGY
		<ul style="list-style-type: none"> • Management should communicate visionary strategies and core values down to everyone (the Local Authority nurses and Provincial Authority nurses) in the district, using every possible communication vehicle like memos, meetings, workshops and forums • Management must ensure that Local Authority Nurses and Provincial Authority nurses understand and react to the proposed changes. It should be a two way communication. • Frequent and repetitive communication of simple message are necessary for management to ensure continuous contact with the Local Authority nurses
<p>Management of resistance to change</p>	<p>To ensure that local authority nurses and provincial authority nurses are able to understand and accept integration as their own change process</p>	<p>Instill sense of purpose about change</p> <ul style="list-style-type: none"> • Local authority nurses and provincial authority nurses should be fully aware of the need to change. They should have a vision of what can be achieved, and understand the change process itself • The need for and the logic behind the change should be explained to subordinates <p>Participation and involvement</p> <ul style="list-style-type: none"> • Allow those affected by the change process to participate in the design of the change <p>Facilitation and support</p> <ul style="list-style-type: none"> • Management should provide support for those caught up in the change process of integration • Management should arrange retraining programmes, allow time off and offer emotional support and show understanding to local authority nurses and provincial authority nurses as people affected by the change • Ensure that mechanisms are in place to continue the change, and to spread it

THEME	AIM	STRATEGY
		<ul style="list-style-type: none"> • Embed the change by making it an important part of a hinder strategy • Develop processes to respond to the needs of Primary Health Care Services in a district and of all stakeholders (Local Authority Nurses, Provincial Authority Nurses and District Management Team) <p>Negotiation and agreement</p> <ul style="list-style-type: none"> • Management should negotiate with Local Authority Nurses and Provincial Authority Nurses and also obtain written letters of understanding • Management need to help the Local Authority nurses and Provincial Authority Nurses to develop a shared diagnosis of what is happening in the district and what can and must be done to improve their integration process • Management should foster consensus for the new vision, and revitalize the morale and spirit of Local Authority nurses and provincial Authority nurses without pushing it from the top <p>Change should be strategically connected</p> <ul style="list-style-type: none"> • Change should be well connected with sources of power and influence
<p>Uniform conditions of service</p>	<p>To enhance harmony among local authority nurses and provincial authority nurses rendering primary health care services in a district</p>	<p>Develop detailed audit of provincial authority nurses and local authority nurses' establishment and associated salary and benefits expenditure. Use actual annual salary and benefits data per post designation</p> <ul style="list-style-type: none"> • Compare the annual salary and remuneration expenditure of each employer authority (local authority and provincial authority). Establish and get agreement on the posts to be compared. Estimate the difference for each post according to what the equivalent post would have been under the other authorities

THEME	AIM	STRATEGY
		<ul style="list-style-type: none"> <li data-bbox="920 190 1398 561">• Develop detailed audit of conditions of service and all service benefits, focus on the range of benefits on offer to employees, make a list of eligibility criteria, and total expenditure for the Primary Health Care Services' staff (local authority nurses and provincial authority nurses). Specific attention to be drawn towards the estimation of pension per staff member, accumulated holiday leave, overtime allowance if any is paid to staff <hr/> <ul style="list-style-type: none"> <li data-bbox="920 621 1398 993">▪ Develop proposals on the way forward, noting the numbers of staff, their salary and benefits expenditure. Address the practicalities of what further issues need attention, role of the Provincial and Local Authority, Department of Finance, time frame for the process to result in enabling the process of integration of Local Authority nurses and Provincial Authority nurses rendering Primary Health Care Services in a district <hr/> <ul style="list-style-type: none"> <li data-bbox="920 1013 1398 1256">• Inform staff (Provincial Authority nurses and Local Authority nurses) of the evidence to show that the salary disparity issue is dealt with and is in fact serving as a precluding factor to the proper integration of Local Authority nurses and Provincial Authority nurses <hr/> <ul style="list-style-type: none"> <li data-bbox="920 1285 1398 1344">▪ Transfer of Provincial nurses to Local Authority <hr/> <ul style="list-style-type: none"> <li data-bbox="920 1373 1398 1490">▪ Management should transfer Provincial Authority nurses to Local Authority Clinics with the function they perform <hr/> <ul style="list-style-type: none"> <li data-bbox="920 1519 1398 1610">▪ All assets, rights and obligations regarding Provincial Authority nurses should be transferred as is <hr/> <p data-bbox="920 1639 1310 1667">Parity in salaries and benefits</p> <hr/> <ul style="list-style-type: none"> <li data-bbox="920 1696 1398 1778">• Management should ensure equal salary for same qualifications and job descriptions

4.5 SUMMARY

In this chapter, the designing of the model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district were described. The model is based on the concepts uncertainty and consultation, which were identified from the fieldwork and defined after exploration. In the accompanying proposed guidelines for the implementation of the model by the community nurse the specific objectives, strategies and activities are proposed for further clarity. The process is dynamic and calls for each situation to be applied within its own unique context. Any exclusion in this regard will be justified within the context of the model.

Chapter 5 will examine whether the objectives of the study have been met as well as present limitations and recommendations for operationalisation in practice, education and research.

Chapter 5

Conclusions, limitations and recommendations

5.1 INTRODUCTION

The main purpose of this research was to develop a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

The background to the research problem emanates from the poor integration process of local authority nurses and provincial authority nurses. The history of health care services was given to create more understanding of how nurses in both tiers of government had been operating prior to the integration of health services.

Because of the nature of fragmentation of health services, and inadequate health care services to other areas, the Government engaged itself in the total transformation of the health care delivery in South Africa.

The researcher in the study indicated in chapter I that there are two types of integration processes, namely structural and functional, but this study is confined to the functional integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

Given the background of the study, the following objectives were formulated:

- To explore and describe the perceptions of local authority nurses and provincial authority nurses rendering primary health care services in a district, and the suggestion of local authority nurses and provincial authority nurses on strategies to improve their integration in the district.
- To explore and describe the perceptions of the district management team about the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district, and strategies that can be implemented to improve the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.
- The development of guidelines to operationalise the model.

Though the general purpose of the study was to develop a model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district, the researcher had to formulate the above-mentioned objectives as the process of achieving the main purpose of the research.

The results of the three focus group revealed that the integration of local authority nurses and provincial authority nurses was introduced without proper consultation and guidelines, and as such impacted negatively on nurses and on service delivery.

It is recommended that the proposed model for the integration of provincial and local authority nurses rendering primary health care services be implemented to improve the integration process.

It is hoped that proper consultation, uniform condition of service, management of resistance to change will enhance involvement and participation of nurses rendering integrated services, and in turn, these nurses may integrate successfully leading to improve service delivery to the community.

It was very fulfilling and rewarding for the researcher to develop a model that addresses a chronic problem for government when integrating health services. The researcher feels

personally and professionally enriched.

5.2 LIMITATIONS OF THE STUDY

The researcher had problems in getting provincial nurses to take part in the study; these nurses did not want to participate, initially they kept on making excuses leading to rescheduling of meetings, until one of them explained to the researcher that they had a problem about participating because the researcher was a local authority director who would be biased and possibly their information would be disclosed.

Although they were persuaded to join the group, they had to be prompted to talk about their perceptions about integration, they were hesitant to participate and in fact they preferred to suggest strategies to improve integration. However, they later decided to participate in the study (see annexure B).

5.3 RECOMMENDATIONS

It is recommended that the model should be applied in nursing education, nursing practice and nursing research.

5.3.1 Operationalisation of the model in nursing education

Nursing colleges and universities can no longer be left out when all around them there is transformation. The Minister of Education is in the process of transforming the education systems, and nursing education as part of the whole system is also subject to transformation. The Minister's aim is to integrate universities and colleges with the hope of promoting equity, reducing costs in terms of human and material resources and eradicating duplication. Obviously personnel employed by those universities that are transforming will have to be integrated and this model will serve as a theoretical framework for these institutions. It is recommended that nurse educators in these institution study the model for the purpose of utilising the model in their teaching process.

Change management programmes need to be introduced at the fourth level of training of student nurses to prepare them to understand change as a process, if introduced in their institutions. Inter personal skills courses need to be introduced so that nurses are able to work with new comers to their system, and are able to adapt to changes and integrate with other nurses or categories if need be.

Managers must be trained to be change agents, so that they are able to accept changes and introduce changes to their subordinates without difficulty.

5.3.2 Operationalisation in nursing practice

In order to be instrumental in operationalising the model successfully in nursing practice, the community nurses are required to increase their knowledge on the integration process, and be change agents to effect changes brought in by the integration process. Their ability to become change agents, will enable them to view change as a positive process and inturn be able to inteprete and introduce change to their subordinates. They will be able to deal with any resistance towards integration, any negativity towards change.

The community nurses need to be well acquainted with change management programmes, so that they are bale to deal with queries arising from their subordinates about the challenges facing their integration process.

The community nurses should posses good communication and negotiation skills, that they are able to communicate change, and negotiate with local authority nurses and provincial authority nurses about their integration.

If integration of local authority nurses and provincial authority nurses, rendering primary health care services in a district, has to be successful, the community nurses, and management, need to be empowered and or capacitated to implement integration as a change process without difficulty.

Application of this model in the nursing practice, requires monitoring and evaluation - this implies that the community nurses need to continuously communicate with local authority

nurses and provincial authority nurses, clarify issues, answer queries, listen and encourage feedback to ensure that resistance to change or negativity towards integration is dealt with.

5.3.3 Operationalisation in nursing research

The researcher indicated in chapter two that this research is theory-generative and the process of developing this model was based on the steps of theory generation, which have been fully described and incorporated into the model. However, the last step, which is evaluation of the model, is left to serve as a recommendation for other researchers to evaluate this model.

The criteria for evaluating the model were outlined in this research process as a means of promoting clarity of the model for the potential researchers.

Another study can be conducted to check if both semantic and structural clarity are evident in the model. This can only be realised if the main concepts of uncertainty and consultation have been adequately defined and there is a connection between all concepts used in the model.

Since transformation of health services is a national mandate, it is recommended that this model be subjected to pilot studies in other regions in the province, and ongoing empirical studies conducted on the identified negative perceptions, that is:

- lack of consultation
- resistance to change
- disparities in conditions of service

5.4 CONCLUSION

The model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district was designed and recommendations were made on the improvement of the integration process through:

- proper consultation
- management of resistance to change
- uniform conditions of service
- provision of information
- emotional support
- budgetary issues
- new structure
- team building workshops
- empowerment strategies

It is believed that the implementation of the model will lead to integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

BIBLIOGRAPHY

- African National Congress. 1994a. *The national health plan for South Africa*. Maseru: Bahr Mapping and Printing.
- African National Congress. 1994b. *The reconstruction and development programme*. Johannesburg. Umnyano.
- ANC see African National Congress.
- Akasia, B. 2000. Integration of health services in the Western Cape. *Health System Trust* 51:6-8.
- Armentrout, B. 2000. Have your plans for change had a change of plan? *Journal of Organizational Change Management* 2(1):38-47.
- Andrews, HA. 1991. Overview of the self-concept model, in *The Roy adaptation model: the definite statement*. Norwalk, CT: Appleton.
- Asia, B. 2000. Growing pains in the district health system. *Health Systems Trust Update* 51:6-8.
- Azadevo, V. 1999. A look at the South Peninsula integration experience. *Health Systems Trust Update* 45:5-8.
- Balogun, J, & Hailey, VH. 1999. Exploring strategic change: exploring strategic management. *Financial Times*.
- Bamform, L. 1999. The integration of health services in East Vaal Region: a case study. *HST* 45(5).
- Bandman, EL & Bandman, B. 1988. *Critical thinking in nursing*. Norwalk: Appleton & Lange
- Barnhart, CL & Barnhart, RK. 1988. *The World Book Dictionary*. Chicago: Worldbook.
- Barker, AM. 1990. *Transformational nursing leadership*. Baltimore: Williams & Wilkens.
- Barker, C, Beglinger, J, King Salyards, M, & Thompson, A. 2000. Transforming negative work cultures: a practical strategy. *JONA* 30(7/8):357-363
- Barry-Walker, J. 2000. The impact of systems redesign on staff, patient and financial outcomes. *Journal of Nursing Administration* 30(2):77-89.
- Beer, M, Eesenfet, R & Spector, B. 1990. Why change programs don't produce change. *Harvard Business Review* November/December:158-167.
- Bendix, S. 1997. *Industrial relations in South Africa*. 3rd edition. Cape Town: Juta.

- Bernard, AL & Walsch, M. 1990. *Leadership: the key to the professionalization of nursing*. 2nd edition. Toronto: Mosby.
- Bernstein, L, & Bernstein, RS. 1980. *Interviewing : a guide for health professionals*. 3rd edition. New York: Appleton Century Crofts.
- Bezuidenhout, MC, Garbers, CJ & Potgieter, S. 1998. *Managing for healthy labour relations: a practical guide for health services in South Africa*. Pretoria: Van Schaik.
- Blackie, C. 1998. *Community health care nursing*. New York: Harcourt Brase.
- Blancett, T & Flarey DL. 1995. *Redesigning and nursing delivery, transforming our future*. Philadelphia: Lippincott.
- Bloom, BS. 1956. *Taxomy of educational objectives. (Handbook I: Cognitive Domain)*. New York: Makay.
- Booyens, SW. 1995. *Dimensions of nursing management*. Cape Town: Juta.
- Botes, AC. 1991. A functional approach in nursing. *Curationis* 14(1):19-23.
- Bromfield, S. 1999. Decentralization and health systems. *Heath Systems Trust Update* 45(5):5-7.
- Brook, A. 1990. *Managing change*. London: MacMillan.
- Brammer, LM. 1985. *The helping relationship: process and skills*. Englewood Cliffs: Prentice-Hall.
- Brooten, DA., Hayman, LL & Naylor, MD. 1988. *Leadership for change: an action guide for nurses*. 2nd edition. Philadelphia: Lippincott.
- Brown, L. 1993. *The New, Shorter English Dictionary Oxford*. Oxford: University Press.
- Burack, E & Tord, F. 1979. *The manager's guide to change*. London: Wadsworth.
- Burke, JB. 2001. Surviving hospital restructuring: next step. *Journal of Nursing Administration* 31(4):169-172.
- Burley, S, Mitschell, LE, Melling, K, Smith, M, Chilton, SC & Rumplin, C. 1997. *Contemporary community nursing*. London: Arnold.
- Burns, N & Grove, SK. 1993. *The practice of nursing research: conduct, critique and utilization*. Philadelphia: Saunders.
- Carnall, S. 1995. Images of change. *Journal of Management Development* 19(5):355-411.

- Carrel, MR, Elbert, NF, Hattfield, RD, Grobler, PA, Marx, M & Van der Schyf, S. 1998. *Human resource management in South Africa*. Cape Town: Prentice-Hall.
- Carrel, MR, Jennings, DF & Hearin, C. 1997. *Fundamentals of organisational behaviour*. Cape Town: Prentice-Hall.
- Castledine, G. 1986. A stress adaptation mode, in *Models of nursing*, edited by B Kerkshaw & J Salvage. New York: Wiley.
- Chenits, WC & Swanson, JM. 1986. *From practice to grounded theory: qualitative research in nursing*. Menlo Park: Addison Wesley.
- Chinn, PL & Jacobs, MK. 1987. *A model for theory development in nursing*. New York: MacMillan.
- Chinn, PL & Kramer, MK. 1995. *Theory and nursing: a systematic approach*. St Louis: Mosby.
- Clarke, E. 1999. Introduction to integration of services. *Health Systems Trust Update* 45:5-6.
- Coch, L & French, JR. 1984. *Community health care nursing: principles for practice*. London: Butterworth.
- Coch, L & French, JR. 1948. Overcoming resistance to change. *Human Relations* August: 512-532.
- Cook, CAL & Buck, EA. 1999. Caring for yourself during times of organizational change. *Nursing Administration* 29(6):9-11.
- Copi, IM. 1986. *Informal logic*. New York: MacMillan.
- Copi, IM & Chomem, C. 1990. *Introduction to logic*. London: MacMillan.
- Creasia, JL & Parker, B. 1996. *Conceptual foundation of professional nursing practice*. Philadelphia: Mosby.
- Cresswell, JW. 1994. *Research design: qualitative and quantitative approaches*. California: Sage.
- De Beer, C. 1988. *Primary health care management: ways of looking at health and health care*. Johannesburg: University of the Witwatersrand.
- Democratic Nurses Association of South Africa. 1998. *Ethical measures in research*. Pretoria: Denosa.
- De Vos, AS. 1998. *Research at grass roots: premier for the caring professions*. Pretoria: Van Schaik.

- Dickoff J, James, P & Wiedenbach, E. 1968. A theory of theories. A position paper.
- Dickoff, JP & Wiedenbach, E. 1968. Theory in a practice discipline. Part 1. Practice orientated theory. *Nursing Research* 17(5):434-452.
- Difonzo, N & Bordia P, 1998. A tale of co-operations: managing uncertainty during organizational change. *Human Resource Management* 37(3/4): 295-303.
- District Management Team. 2001. February Report of Monthly Meetings.
- District Management Team for Springs. 2001. District Management Team Report.
- Dixon, D & Mark, M. 1999. Marketing mergers, acquisitions and alliances work. *Health Forum Journal* 42(6):30-33
- Drake, JM. 1993. *Veranderingsbestuur in 'n verpleegdiens*. Johannesburg: Rand Afrikaans University.
- Eden, C & Spender, JC. 1998. *Managerial and organizational cognition: theory, method and research*. London: Sage.
- Elkins, CP. 1984. *Community health nursing skills and strategies*. Virginia: Donnelley.
- Engelbrecht, B. 1999. Case Study of the Free State experience. *Health Systems Trust Update* 45:10-12.
- Fawcett, J. 1984. *Analysis and evaluation of conceptual models of nursing*. Philadelphia: Davis.
- Field, PA & Morse, J. 1985. *Nursing research: the application of qualitative approaches*. London: Croom & Helm.
- Finnemore, M & Van der Merwe, R. 1996. *Introduction to labour relations in South Africa*. 4th edition. London: Butterworths.
- Flarey, DL. 1995. *Redesigning and nursing delivery, transforming our future*. Philadelphia: Lippincott.
- Fowler, HW & Fowler, FG. 1980. *The Concise Oxford Dictionary of Current English based on the Oxford English Dictionary and its Supplements*. 6th edition. Oxford: Clarendon.
- Frey, JH & Fontana, A. 1993. *The group interview in social research successful focus groups: advancing the state of the art*. Newbury Park: Sage.
- Gannon, MJ, 1982. *Management: an integrated framework*. 2nd edition. Toronto: Little Brown.
- Geddes, N, Salyer, J & Mark, BA. 1999. Nursing in the nineties: managing the uncertainty. *Journal of Nursing Administration* 29(5):40-48.

- George, VM, Burke, LJ & Rodgers, BL. 1997. Research-base after hospital requisition: planning for change. Assessing Nurses Attitudes towards governance and professional practice autonomy. *Journal of Nursing Administration* 27(5):53-61.
- George, JB. 1990. *Nursing theories: the base for professional nursing practice*. 3rd edition. Cape Town: Prentice-Hall.
- Gerber, PD, Nel, PS & Van Dyk, PS. 1994. *Human resource management*. Halfway House: Southern Book.
- Gerber, PD, Nel, PS & Van Dyk, PS. 1998. *Human resources management*. 4th edition. Halfway House: Thomson.
- Gillies, DA. 1989. *Nursing management: a systems approach*. Philadelphia: WB Saunders.
- Gillies, DA. 1994. *Nursing management: a systems approach*. 3rd edition. Philadelphia: WB Saunders.
- Gillett, S. 2000. Turn of the screw merger project management. *Health Services Journal* 110(5699):22-24.
- Glaser, B & Strass, A. 1967. *The discovery of grounded theory*. Chicago: Aldine.
- Glesne, CG & Peshkin, A. 1992. *Becoming qualitative researcher: an introduction*. New York: Longman.
- Goodstein, L. 1991. Creating successful organization change. *Organizational Dynamics* 5-17.
- Greater Johannesburg Metropolitan Council. 2000. *Igoli Transitional HR and LR Employee Brochure*.
- Greenberg, J & Baron, RA. 1997. *Behaviour in organisations, beditron*. New Jersey: Prentice-Hall.
- Guba, EG. 1981. *Criteria for assessing the trustworthiness of naturalistic inquiries*. Newbury Park: Sage.
- Guntred, P. 1997. Cultural chaos in the trenches: staff perspective. *Seminars for Nurse Managers* 7(1):21-24.
- Haffer, A. 1986. Facilitating change. *Journal of Nursing Administration* 16(4):18-22.
- Harrison, R. 1993. *Human resource management issues and strategies*. New York: Addison-Wesley.

- Harrison, S. 2000. A legislative framework for a district health system. *Health Systems Trust Update* 51:8-9.
- Hart, E & McMillan, J. 1996. Leadership and organisational transformation. *Human Resource Management*, February:4-12.
- Hawkins, P & Winter, J. 1997. *Mastering change: learning the lessons of the enterprise in higher education initiative*. Shaftesbury Centre: White Research.
- Hayes, R. 1985. Strategic planning ? forward in reverse? *Havard Business Review* 111-119.
- Haydel, J & Moss, M. 1999. How to merge caregivers corporate cultures. *Nursing Management* 30(5):34-36.
- Hellriegel, D, Slocum, JW & Woodman, S. 1983. *Organization behavior*. 3rd edition. New York: West.
- Helvie, CO. 1991. *Community health nursing: theory and practice*. New York: Springler.
- Hinchliff, SM, Norman, SE, & Schrober, JE. 1989. *Nursing practice and health care*. London: Edward Arnold.
- Holland, C. 1998. Paving the road to maximum productivity. *Clinical Laboratory Management Review* 12(6):410-417.
- Ingersol, GL, Kirsch, JC, Merk, F & Lightfoot, BS. 2000. Relationship of organizational culture and readiness for change to employee commitment to the organisation. *Journal of Nursing Administration* 30:11-20.
- Iyer, PW & Camp, HN. 1991. *Nursing documentation: a nursing process approach*. Mosby Year Book
- Jick, TD (ed). 1993. *Managing change cases and concepts*. Boston:. Richard Irwin.
- Johnson, DE. 1998. Emergency medical services integration into hospital disaster planning. *Topics in Emergency Medicine* 20(2):1-7.
- Jost, SG. 2000. An assessment and intervention strategy for managing staff needs during change. *Journal of Nursing Administration* 30(1):34-40.
- Johnson, G & Scholes, K. 1999. *Exploring strategic management: exploring strategic change*. England: Prentice-Hall.
- Kanter, RM. 2001. Men and Women in the co-orporation. *Journal of Nursing Administration* 31(5):413-425.

- Kamrad-Marron, SL, Stabbile, MA & Smelts, CH. 1999. Understanding and championing the merger process: key leadership roles for successful outcomes. *Nursing Administration Quarterly* 23(4):47-57.
- Kelley, D & Connor, DR. 1979. The emotional cycle of change, in *Annual handbook for group facilitators* edited by JE Jones and JW Pheiffer. California University Associate.
- Kelly, KJ. 1992. *Nursing staff development: current competence, future focus*. Philadelphia: JB Lippincott.
- Kershaw, B & Salvage, J (eds). 1986. *Models for nursing*. New York: John Ley & Sons.
- Keyser, D. 1986. Using nursing contracts to support change in nursing organizations. *Nurse Education Today* 6(3):103-108.
- Kirkman, JB. 1996. Unfairness and resistance to change. *Journal of Organizational Change and Management* 12(1):380-384.
- Kooi, R, White, P. & Smith, H. 1998. Managing organizational mergers. *Journal of Nursing Administration* 8(3):10-20.
- Kotter, JP & Schlesinger, S 1969. Choosing strategies for change. *Harvard Business Review* January/February (5):7-11.
- Kotter, JP. 1996. Leading change. *Boston Harvard Business School Press Review* March- April:59-67.
- Kozier, B & Erb, G. 1988. *Concepts and issues in nursing practice*. California: Wesley.
- Krass, P. 2000. *The book of management wisdom*. New York: John Wiley.
- Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy* 45(3):214-222.
- Lancaster, J & Lancaster, W. 1982. *Concepts for advanced nursing: the nurse as a change agent*. Mosby: St. Louis.
- Leavitt, HJ. 1964. *Applied organisational change in industry: structural, technical and human approaches*. Boston: Irwin.
- Lemone, P, Lillis, J & Taylor, C. 1993. *Fundamentals of nursing*. 2nd edition. Philadelphia: Lippincott.
- Lincoln, YS & Guba, EA. 1985. *Naturalistic enquiry*. London: Sage.
- Lippitt, R, Watson, J & Westley, B. 1958. *The dynamics of planned change*. New York: Harcourt, Brace.

- Little, W, Fowler, HW, & Coulson, J. 1999. *The Shorter Oxford English Dictionary on historical principles*. 3rd edition. Oxford: Clarendon Press.
- Locke, EA. 2000. *The Blackwell handbook of principles of organizational behaviours*. New York: Blackwell.
- Louis, M, & Koertvelyessy, A. 1989. The Neuman model in nursing research, in *The Neuman Systems Model* edited by B Neuman. 2nd edition. Norwalk: Appleton & Lange.
- Luijpen, WA, 1969. *Existential phenomenology*. Pittsburg: Duquesne University Press.
- Lundy, O & Cowling, A. 2000. *Strategic human resource management*. Halfway House: Thomson.
- Lynn, AL. 1993. Managing the challenges of trigger events: the mindsets of governing adaptation to change, in *Managing change, cases and concepts*, edited by TD Jick. Boston: Richard D Irwin
- Magwaza, S. 1999. *Progress of integrating reproductive health services at district level in South Africa*. Women's Health Research Unit Rep 1-7, University of Cape Town.
- Makan, B & Asia, B. 1996. *Parity and transfer of staff to municipalities*. First Draft Report. Department of Health.
- Mallick, M, Hall, C & Howard, D. 1998. *Nursing knowledge and practice: a decision-making approach*. London: Baillière Tindall
- Machine, A. 1998. The workplace challenge report back: the plastics sector. *South African Labour Bulletin* 22(5):47-48.
- Manion, JO, Lorimer, N & Leander, WJ. 1996. *Team based health care organizations: blue print for success*. Maryland: Aspen.
- Marchand, DA. 1995. Brushing up on re-engineering: will your efforts succeed? *People Dynamics* 13(9):12-17.
- Marriner, A. 1979. Planned change as a leadership strategy. *Nursing Leadership* 2(2):9-14.
- Marriner-Tomey, A. 1993. *Transformational leadership*. St Louis: Mosby.
- Marshall, C & Ross, GB, 1989. *Designing qualitative research*. London: Sage.
- McGoldrick, 1996. *Case in human resource management*. London: Pitman.
- McMahon, R, Barton, E & Piot, M. 1992. *On being in charge: a guide to management in primary health care*. Geneva: World Health Organization.

- McRae, H. 1996. Seismic forces of global change. *Strategy and Leadership* November-December:6-11.
- Miles, MB & Huberman, AM. 1994. *An expanded source book: qualitative data analysis*. New Delhi: Sage.
- Morse, JM. 1989. *Strategies for sampling qualitative nursing research: a contemporary dialogue*. Rockville: Aspen.
- Morse, JM. 1994. *Critical issues in qualitative research methods*. London: Sage.
- Mouton, J & Marais, HC, 1991. *Basic concept in methodology for human sciences*. Pretoria: Human Sciences Research Council.
- Mouton, J. 1996. *Understanding social research*. Pretoria: Van Schaik.
- Munro, T & Maken, B. 1999. Building district health systems in the Western Cape. *Health Systems Trust Update* 45:6:7.
- Nadler, D. 1983. *Concepts for the management of organisation change. Section V: organisation adaptation and change*. New York: Delta.
- Neuman, B. 1982. *The Neuman Systems Model: application to nursing education and practice*. Norwalk, C.T: Century Croft.
- Newhouse, R & Bang, D. 2001. Measuring role changes for nurses. *Journal of Nursing Administration* 31(4):15-21.
- Nicholson, N. 1995. *The Blackwell Encyclopedic Dictionary of organizational behavior*. London: Blackwell.
- Parse, R, Coyne, AB, & Smith, MJ. 1985 . Nursing research: qualitative and practical application. *American Journal Orthopsychiaty* 85(2):281-287.
- Paterson, BL. 1994. A framework to identify reactivity in qualitative research. *Western Journal of Nursing Research* 16(3):301-316.
- Patton, MQ 1990. *Qualitative evaluation and research on methods*. London: Sage.
- Pearsall, J. 1999. *The Concise Oxford Dictionary*. 10th edition. Oxford: University Press.
- Pelletrer, KR, Marie, A, Krasner, M & Haskell, WL. 1997. Current trends in the integration and reimbursement of complementary and alternative medicine by managed care, insurance carriers and hospital providers. *American Journal of Health Promotion* 12(2):112-123.

- Pendlebury, J, Grouand, B & Meston, F. 1998. *The ten keys to successful change management*. New York: John Wiley.
- Perko, JE & Kreigh, HZ. 1988. *Psychiatric and mental health nursing: a commitment to care and concern*. East Norwalk: Appleton & Lange.
- Pietrone, C & Pietrone, C. 1996. *Innovation in community care and primary health: the Mary Lebone experiment*. Edibury: Churchill Livingstone.
- Polit, DF & Hungler, BP. 1987. *Nursing research: principles and methods*. 3rd edition. Philadelphia: Lippincott.
- Reason, P. 1996. The transfer of provincial staff to local government health department. *Health Systems Trust Update* 6:237-271.
- Rathwell, TO, Godinho, J & Gott, M. 1995. *Tipping the balance towards primary health care*. Al Dershot: Avenbury.
- Riehl-Sisca, J. 1989. *Conceptual models for nursing practice*. 3rd edition. New York: Appleton & Lange.
- Riehl, JP & Roy, C. 1980. *Conceptual models for nursing practice*. 2nd edition. New York: Appleton Century Crofts.
- Robbins, PR. 1997. *Managing today!* New Jersey: Prentice-Hall.
- Robbinson, SP. 1990. *Organizational theory: structure design and application*. 3rd edition. St Louis: Mosby.
- Rorden, JW & McLennan, J. 1992. *Community health nursing theory and practice*. Australia: Harcourt Brace.
- Rosengren, K, Engstrom, AK & Axelsson, L. 1999. Health: facility merger. Survival: organizational change. *Nursing Administration Journal* 8(6):289-298.
- Rosenthal, T & Nolingo, W. 1998. Defend, empower, advance: CWIU? Approach to company restructuring. *South African Labour Bulletin* 22(1):63-69.
- Roy, C. 1984. *Introduction to nursing and adaptation model*. 2nd edition. New Jersey: Prentice-Hall.
- Scholtes, PR. 1991. *Management of change, joiner associates and the team handbook*. Philadelphia: WB Saunders.
- Schultz, R & Johnson, AC. 1990. *Management of hospitals and health services: strategic issues and performance*. 3rd edition. St. Louis: Mosby.

- Seaman, CHC. 1987. *Research methods: principles, practice and theory for nursing*. Norwalk: Appleton & Lange.
- Sibaya, W. 2000. Transform action management of primary health care services in two selected local authorities *Curationis* 23(4):6-10.
- Smith, HN. 1982. *Strategies of social research*. Englewood Cliffs: Prentice Hall.
- Smit, PJ & Cronje, GJ, 1999. *Management principles: a contemporary edition for Africa*. 2nd edition. Cape Town: Juta.
- South Africa (Republic). 1995. *A policy for the development of a district health system for South Africa*. Pretoria: Department of Health.
- South Africa (Republic). 1996a. *Constitution of the Republic of South Africa (Act No 105 of 1996)*. Pretoria: Government Printer.
- South Africa (Republic). 1996b. *Local Government Transition Act (Act No. 9 of 1996)*. Pretoria: Government Printer.
- South Africa (Republic). 1997. *White Paper for the transformation of health systems in South Africa (Notice No. 667 of 1997)*. Pretoria: Government Printer.
- South Africa (Republic). 1999. *White Paper on district health system*. Pretoria: Department of health.
- South Africa (Republic). 2001a. *A comprehensive primary health care service package document*. Pretoria: Department of Health.
- South Africa (Republic) 2001b. *National Health Bill*. Pretoria: Department of Health.
- South Africa (Republic) 2001c *The primary health care package for South Africa: a set of norms and standards*. Pretoria: Department of Health.
- Spradley, BW. 1985. *Community health nursing: concepts and practice*. 2nd edition. Canada: Little Brown.
- Springs Town Council. 1992. *Finance committee report: 2-10*.
- Springs Town Council. 1999. *Community service. Committee report*.
- Stanhope, M & Lancaster, J. 1992. *Community health nursing*. St Louis: Mosby
- Statt, DA. 1993. *Concise Dictionary of business management*. New York: Routledge.
- Statt, DA. 1999. *The Concise Dictionary of management*. 2nd edition. New York: Routledge.

- Steinmet, S. 1997. *English language desk reference: a comprehensive language resource*. New York : Random.
- Stickland, F. 1998. *The dynamics of change: insight into organizational transition from the natural world*. New York: Routledge.
- Stoner J & Wankel, C. 1986. *Managing transformation and change*. 3rd edition. New Jersey: Prentice-Hall.
- Strachan, K. 1999a. A case study of the East Vaal region. *Health Systems Trust Update* 45:14-15.
- Strachan, K. 1999b. A look at the South Peninsula experiment. *Health Systems Trust Update* 45:7-8.
- Strachan, K. 1999c. Building district health systems in the Western Cape health system. *Health Systems Trust Update* 45:6-7.
- Strachan, K. 1999d. What do the nurses think. *Health Systems Trust Update* 45:9-10.
- Strauss, A & Corbin, J. 1990. *Basic of qualitative research, grounded theory procedures and techniques*. London: Sage.
- Strebel, P. 1996. Why do employees resist change? *Harvard Business Review*, May-June:86-92.
- Streubert, HJ & Carpenter, DR. 1995. *Qualitative research in nursing: advancing the humanistic imperative*. Philadelphia: Lippincott.
- Stuart, GW & Sundeen, SJ. 1991. *Principles and practice of nursing*. St. Louis: Mosby.
- Swanepoel, B, Erasmus, B & Van Wyk, M. 1998. *South African human resource management: theory and practice*. 2nd edition. Cape Town: Juta.
- Swanepoel, B, Erasmus, B, Van Wyk, M & Schenk, H. 2000. *South African human resource management: theory and practice*. 2nd edition. Cape Town: Juta.
- Swanson Kauffmann, K & Schonwald, E. 1988. *Phenomenology in Patus to knowledge: innovative research methods for nursing*. New York: Sarter.
- Swanson, JM & Nies, AM. 1997. *Community health nursing*. 2nd edition. Philadelphia: WB Saunders.
- Tesch, R. 1990. *Qualitative research analysis types and software*. New York: Falmer.
- Tinkhan, CW, Voorhies, EF & McCarthy, NG. 1984. *Community health nursing: evolution and process in the family and community* 3rd edition. New York: Appleton Century Croft.

- Torrington, D. 1974. *Encyclopaedia of personnel management*. London: Gowers.
- Twinn, S, Roberts, B & Andrews, S. 1996. *Community health care nursing: principals for practice*. St Louis: Mosby.
- Untied, P. 1999. Cultural chaos in the trenches: staff perspective. *Seminars for Nurse Managers* 7(1):21-4.
- Urden, LD & Rogers, S. 2000. Tips for successful merger. *Journal of Nursing Administration* 30(4): 161-162.
- Verstal, KW. 1995. *Nursing management: concepts and issues*. 2nd edition. Philadelphia: Lippincott
- Villakazi, SS, Chabeli, M & Roos, SP. *Integration of the primary health care approach into a community nursing science curriculum*. Johannesburg: Rand Afrikaans University.
- Von Eckartsberg, R. 1986. *Life word experience: existent tral-phenomenological research approaches in psychology*. Washington, DC: University Press.
- Walker, L & Avant, K. 1995. *Strategies for theory construction in nursing*. Norwalk: Appleton & Lange.
- Wallace, JD & Mintzes, JJ. 1990. The concept map as a research tool: exploring conceptual change in Biology. *Journal of Research in Science Teaching* 27(10):1033-1052.
- Wallace, L, Grane, A & Boyle, G. 2001. Question of attitude health services. *Journal* 2000 110(5699):26-28.
- Walston, SL, Kimberley, JR & Burns, LR. 1996. Owned vertical integration and health care promise and performance. *Health Care Management Review* 21(1):83-92.
- Wandelt, MA & Stewart, DS. 1975. *Slater nursing competence's ranting scale*. New York: Appleton Century Crofts.
- Wandersee, JH. 1990. Concept mapping and the cartography of cognition. *Journal of Research in Science Teaching* 27(10):923-936.
- Ward, MJ & Moran, SG. 1984. Resistance to change: recognise, respond, overcome. *Nursing Management* 15(1):30-33.
- Warren, W. 1992. Changing corporate culture or corporate behaviour? How to change your company. *Academy of Management Executive* 13(3):14-20.
- Webster, N. 1975. *The Living Webster Encyclopaedia Dictionary of the English language*. Belair.

Weick, KE. 2001. *Making sense of the organization*. New York: Blackwell.

While, I. 1986. *Research in preventive community nursing care: fifteen studies in health visiting*. Toronto: John Wiley.

Wilson, HS. 1989. *Research in nursing*. 2nd edition. Redwood City: Addison.

Woods, NF & Catanzaro, M. 1988. *Nursing research: theory and practice*. St Louis: Mosby.

World Health Organization. 1985. *Health manpower requirements for the achievement of health for all by the year 2000 through primary health care*. Technical Report Series, 717. Geneva: WHO.

Wright, SG. 1992. *Changing nursing practice*. 2nd edition. London: Arnold.

Annexure A

Request for consent from participants

Student No. 616-5923
Department of Health and Welfare
Springs Town Council

360-2456
082-8521613

1 November 2000

.....
.....
.....
.....

Dear Sir/Madam

REQUEST FOR CONSENT FROM PARTICIPANTS

I intend conducting a research project entitled "A model for integration of Local Authority Nurses and Provincial Authority Nurses rendering Primary Health Care Services in a district" in order to comply with the requirements for a Diitt et Phil degree in Community Nursing Science which I am pursuing at UNISA. This study will be done under the supervision and guidance of Professor L. King and Dr. S. Human of the Department of Advance Nursing Science (UNISA).

The overall purpose of this research project is to develop a model for the integration of Local Authority Nurses and Provincial Authority Nurses rendering Primary Health Care Services in a district:

- To explore and describe the perceptions of Local Authority Nurses about their integration with Provincial Authority Nurses rendering Primary Health Care Services in a district.
- To explore and describe the perceptions of Provincial Authority Nurses about their integration with Local Authority Nurses rendering Primary Health Care Services in a district.
- To explore and describe the perceptions of District Management Team about the integration of Local Authority Nurses and Provincial Authority Nurses rendering Primary Health Care Services in a district.
- To explore and describe the strategies of Local Authority Nurses, Provincial Authority Nurses and the District Management Team for the integration of

Provincial and Local Authority Nurses rendering Primary Health Care Services in a district.

For these objectives to be achieved, a qualitative research study which is contextual, exploratory and descriptive in nature is envisaged. It is estimated that about eight Local Authority Nurses, eight Provincial Authority Nurses and eight District Management Team will be required to participate in the study, depending on saturation of the data. Selection of the participants will be done by utilizing a purposive sample.

It will be highly appreciated if you can agree to be one of the participants (interviewees). Should you agree, focus group interviews will be conducted with you at a time and place in the offices suitable for you. Your identity will be protected by requesting you not to indicate your name nor that of your college in the interview(s).

Needless to say, you and your clinics, as well as the nursing fraternity of this country at large, stand to benefit directly or indirectly from the outcome of this research study.

Research results will be made available to you, on request.

Should you agree as requested, you will be required to give informed consent by attaching your signature and date at the end of this letter as indicated. You reserve the right to withdraw your consent at any stage during the process of this research study. It should be clearly understood that you are under no obligation to participate in this project.

I will be pleased to answer any further questions about this project, if any.

Thank you

Yours faithfully

IMOGEN MASHAZI, R.N. MCUR
Dlitt et Phil (Department of Advanced Nursing Science) student

I

agree to participate in the research project proposed above.

SIGNED ON THIS

DAY OF 2000.

.....
PARTICIPANT

DATE:

Annexure B

Transcripts of provincial authority nurses

TRANSCRIPTS

R = "Good afternoon ladies, and how are you today?"

Group of P = "Good afternoon Ma'am we are together thanks, and we are glad to see you."

R = "I am also excited to see these beautiful faces, well for those who don't know me, my name is Mrs. Mashazi and I hope we will all explore your perceptions about the integration process, but before we start, please allow me to call you by P1.. P2.. etc, for the purpose of protecting your identity, is that okay with you?"

Group = "That's fine with us".

R = "How do you perceive your integration with local authority nurses?"

R = "Yes ... P2"

P = "I, Ee ... I am covered".

R = "P2 can you explain, you are covered by who? And what is it that you are covered for?"

P = "E ... maybe she is afraid of you, because you are the local authority nurses' boss".

Group ... Mmm noisy.

R = "Can we listen to one person please?"

P = "Ma'am, to be honest, we don't trust you, are you not going to tell LAN what we were discussing?"

R = "Thanks, it is a good question that you are raising but be assured, what we are discussing now is between us, nobody will know our discussion. Hence I said we should use numbers not your actual name, but please feel free to talk, because I as a researcher would be in trouble if I disclosed your information to anyone. Is that okay?"

P = ... (Clearing her throat before speaking)

P = "Ma'am, well, if that happens, I will deny everything, ... anyway I am joking, I am now free to talk".

R = "Yes ... go ahead".

P = "Er ... people, whether we keep quiet, we are not solving our problem, let's talk, may be this research will solve our problems alright ..."

R = "Yes, P1"

P = "Okay ... well I don't care, we are telling the truth ... but we need some conditions of service, or schemes, smart uniform and so on"

R = "Yes, I hear your concern, that is a good recommendation, but can we first hear your perception about the integration, or can you first explain how do you perceive the integration before we can recommend?"

R = "Is it clear?"

P = "Mam, we understand, but you must also note our recommendations, they are important to us".

R = "Thanks, P2, I get your point, as I said, can we talk about your integration, how do you perceive it".

R = "Okay, lets continue..."

P = "Well, we are confused, we don't know whether we are coming or going, as a result, we perceive this integration as being negative, frustrating and useless."

R = Mnh...

P = "Er... I would like to support, the previous speaker, yes this integration brought a lot of frustration to us as provincial people. First, we were not properly informed about it, nobody knows anything about it, managers and us, you know it is confusing."

R = "Can you elaborate more please, on what you've just said".

P = "Ok, I am saying that, it is confusing because it looks as if this integration imposed itself on all of us, and that nobody introduced it, because when we want more information, nobody knows what is happening".

R = "Can you explain to me, how did you know about the integration?"

P = "Let me explain, we were called to a meeting by our managers and told us that, in two weeks our Clinic will be closed down, and that we will integrate with local authority nurses and work with them in their clinics".

R = "Mnh... just like that ...?"

P = "Mnh... yes of course, it was an instruction, we were all ~~stunt~~ tense, anxious and everything, and at the end we did not get answers to our questions, to put it bluntly we were slotted in, like you would slot in your goats into a kraal".

There is giggling... by the group

R = "People, can we be quiet and listen to one person please, yes P3 go on"

P = "Er... You see our managers were not fair to us. They treated us like small children or robots. They were supposed to have called us, informed us about the changes, and then listened to our opinion as to whether we understand and accept changes, or as to whether we reject the changes, because we have rights as employees to oppose to any unplanned and uncommunicated change".

R = Mm...

P = "Let me conclude by saying, employers cannot just wake up in the morning and implement changes without getting the approval of employees".

R = "So, according to what I hear, the changes introduced through integration were not

communicated to you and they were unplanned. Can you elaborate more?"

P = "Can I come in there: Ma'am you know what happened. We were just told, in fact instructed, no communication and consultation, by the way communication is a two-way process, you listen and respond, and consultation is a process that involves inputs from both parties, and I want to assure you that, never happened in our case."

R = "Ok, I hear what you are saying, that you were not properly consulted and that this integration or changes were not communicated to you, ok ... then".

P = "Ma'am, I must say, if I was a manager, firstly I would get proper information before I called subordinates to a meeting, then I would call them to a meeting and inform them about the changes that will be introduced, and allow them to air their views, and listen to their suggestion towards implementing the changes that integration brings with and that is all!"

R = "Mnh... Yes P6"

P = "I think she is correct. By allowing all of us to be part of planning, developing mechanisms to deal with integration and this, I am telling you, that can actually work better, compared to the confusion we are in now." Mnh

R = "Yes"

P = "Let me add that I will also give my subordinates a choice, to be part of the integration or not to be part of the integration".

R = "Can you explain how will that work in your situation where your clinic has closed down as indicated by the other speaker. Where will those nurses go who choose not to be part of the integration process?"

P = "Well there are other choices, if a nurse does not want to be part of the integration, she could be allocated at the hospital or retrenched."

R = "Retrench! Is this integration so scary that it can make people lose their jobs?"

P = "Err... Ma'am, as I explained. We take this integration as an enemy, because we do not know it, where it comes from, what it stands for, and what benefits it brings. We are uncertain and fearful of it, only, and only because it is an unknown monster and I must indicate to you that some of us we are old, rather than frustrating yourself with crazy changes, rather take your money and go."

R = "Please tell me, is retrenchment allowed in this case?"

P = "Err ... I don't know if it is allowed, because it means that everybody will request retrenchment instead of being part of integration. I think people are frustrated because they were not consulted, and are uncertain about their future. That is why they say all these things. I personally feel that integration is a good thing, in terms of services delivery and shortage of staff. But the way it was introduced left many of us wondering, anxious, unhappy, frustrated and unwilling to accept it because we do not understand a thing about it".

R = "Ok, can you explain what you mean when you say you do not understand a thing about

it?"

P = "You see, everybody just gives an instruction, and this give us a problem and confuses us more".

P = "We are confused, we don't know who to report to, we are shunted around, we are always referred to, as those people, we are labelled as lazy and irresponsible and not accountable, we feel lost, unwanted and deserted."

R = "All right - what makes you confused?"

P = "We are expected to do immunisation and we were never trained on it, when we attend such courses, they complained that we are always on courses. It is our right to be empowered, so that we are competent to perform a particular task, is it not so?"

"Yes, P3"

P = "Ma'am, I think it will be fair if we are all multi-skilled so that we are able to do the work, klaar? Er ... besides we cannot be doing extra work, without extra pay, LAN can do all the jobs, because they get better money and benefits, so I don't see any problem".

O ... they giggle

R = "Can we give her a chance to finish please, yes P3 go ahead".

P = "Ma'am, I have covered everything and I want to stress that we want money and not

peanuts, I think we all know that, if you pay peanuts, you'll get monkeys”.

R = “People are you saying you are not working or committed to work with LAN because you are paid peanuts?”

P = “No, No ... Let me correct the previous speaker. She doesn't represents all of us. We are committed, we are working hard, we want to be integrated with LAN because it is a national directive and we will benefit from this integration, like getting a better salary, car schemes and a nice uniform, it is a question of time that we achieve all that. I hope with your help we will get there soon”.

R = “I get your point, but please people understand one thing, I am conducting this research with you, to get solutions to your problem through recommending actions to the higher authority”.

P = “Can I ask a question when do you think you will be ready to make these recommendations to the higher authority?”

R = “Er ... I cannot say now - I still have more work to do on this, but I will let you know when I have completed the work.”

P = “All right ... It will be nice if that happens. I personally feel positive, that we will be better integrated with same benefits very soon, and I think we should all be positive, people you know that Rome was not built in one day, change is a process and we need to acknowledge that.”

R = "Mnh ... yes P8".

P = "Ma'am, I hate people who pretends to be holier than thou, the previous speaker pretends to be positive but she is very negative towards integration, she spent two weeks at home, pretending to be sick but today she is trying to impress you.. God..."

There is a noise at the back.

R = "People lets be quiet and let P1 speak. Yes P1".

P = "Oh ... Quiet please. I urge that people should behave like adults and not speak badly about others. We are in a difficult situation of change and transformation, we should be united against this monster called integration and not fight among ourselves at province, not fight with LAN because people there is noting that beats united people".

R = "Yes ... P1 ... it is important that you do not point fingers at your colleagues."

P = "and I think we are wasting times, fighting among ourselves instead of fighting the authorities for undermining and not consulting with us about matters affecting us, and our families".

R = "Mmh ... Yes P2, your hand is up".

P = "I personally don't mind working with LAN, but I hate being shunted around by them, as if they are our seniors".

R = "Can you explain about being shunted around, Yes P1".

P = "The local authority nurses shunt us around because they do not want to work with us."

R = "Why wouldn't they want to work with you?"

P = "We really don't know why, maybe they think we have come to take their posts, Eh... but it is funny if they believe that we want to take their posts because they said we are lazy and irresponsible Mnh..."

R = "Can someone explain to me, why do they say you are lazy, what is it that you are doing that makes them say you are lazy and irresponsible?"

P = "Well... it is obvious if you don't like a person, you will always say anything negative about her."

P = "Err... Can I come in there, I think they undermine us too much because we are beggars, we do not have a clinic of our own, so they call the shots you see! ..."

R = "Please tell me, what exactly do you mean, when you say they call the shots?"

P = "Err.... I mean that they are in control of everything, they allocate work to us, you know, they treat us like small children"

R = "Err... who does the allocation of work to you, is it an ordinary nurse or the nurse in charge of the facility?"

P = "...let me explain this, the nurse in charge of the facility allocates work to everyone,

including her local authority subordinates, and there is no problem in that, but we feel that we are allocated more work than local authority nurses."

R = "All right can you explain why would you think that you as provincial nurses are allocated more work than local authority nurses?"

P = "Er... you know what..., the situation is, we have our tasks of doing school health services, oxygen services, forms and factories, Mnh..., and over and above that, we are allocated extra duties of assisting with family planning, child health care and other things in the clinic you see, while they do not assist us in our areas, but we are expected to assist them?"

R = "Ok... why wouldn't they assist you in your areas, did you enquire?"

Group One...

R = "Please can we give one person a chance to speak... yes go on P2"

P = "Shame, they won't assist us with our services, they will tell you they have job descriptions, and they must stick to them as they are not paid to do extra services."

R = "Can we make a follow-up here, you mentioned earlier that you are labelled as lazy, irresponsible and not accountable, can you give us more clarity?"

P = "Err... yes I've said that, you know what makes them say that we are lazy and unaccountable is that, we do not want to take instructions from them any more, we report

to our supervisors not to their facility heads, because we are sick and tired?"

R = "Tell me, does that not cause confusion and lack of control if you do not report to one person who is in charge of the facility?"

P = "Well, we don't think so, I think we feel much better that way, because as we explained earlier, these people don't want us... period?"

Silence!

P = "Can I come in there..., while I support my colleague that we feel better, but it causes too much confusion and lack of control and coordination, and it makes it difficult for the nurse in charge to plan the services properly....., I am being honest...." (Nodding her head)

R = Okay...

P = "Yes... I think that's why they say we are lazy and accountable because we are doing what we think we must do, that's all..., and the other thing when we go on leave we hardly tell their facility head, we report only to our supervisor you see..."

R = "So, what you are saying is the local authority nurses hardly know your movements, as to whether you will be on duty or not, or they cannot plan with you for the day-to-day running of the clinic?"

P = "Yes, why would they want to know where we are, because we hardly know their whereabouts, so it takes two to tango?"

R = Mnh...

P = Let me try to explain Ma'am..., there is a duty roster that we sign every morning, I think it makes it clear, for them to see whether we are on duty or not, that's all, have I answered you correctly... Mnh" (She clears her throat) ... but though it makes it difficult for them to plan services, but the fact of the matter is, they also don't inform us when they are off sick or on leave."

P = 'Err... can I come in there; firstly, we were not properly consulted, we were just told that in a week's time our clinic will be closed down and we will be transferred to local authority clinics; mm.. We were shocked and we raised a lot of concerns to our supervisors who also did not have full information on the whole process; and promised that she would call the regional director to explain to us.

R = Oh.... Is that so! And then ...?

P = "Unfortunately we were transferred before we could meet the Director. Nonetheless the Director met with us, three weeks later. In that meeting we were very furious and emotional about the process and the way we were being treated by the local authority nurses. He actually informed us that the integration process is a national instruction, and it is beyond his scope, but he will arrange a meeting with local authority managers to discuss our interpersonal issues with local authority nurses"

R = "Are you saying you were not consulted at all?"

P = "Yes, ... you know what, we read about the integration process in the District Health

System Bill, but the actual consultation with us was not done'. I want to assure you that we are not opposed to the integration process, but what we are saying is, we want clarity on lot of issues, like the benefits, salaries and organigrams."

R = "Ok, I get your point that you are not opposed to the integration process but your problem is proper consultation, what would you regard as proper consultation?"

P = "Er... by proper consultation, we mean that the employer must workshop the whole idea with us around the table, get our views and our way forward."

R = "Er... explain this, what if your way forward is not in line with national policy, as the previous speaker said, integration is the national instruction, what then?"

P = "Let me explain by saying that our way forward will be based on the Labour Relations Act, and I don't think it will impact negatively on the National Health Policy."

P = "Er... Can I come in there, according to the Labour Relations Act, the employer is supposed to engage employees and get their consensus as well as their permission to be transferred, and the employee must be given a choice whether to remain in the current employment or be transferred."

R = Yes.... "I understand that, but now in your case, your clinic was closed down and there was nowhere you could be allocated, then what would be the best option?"

P = "Well... as we said before we are not opposed to integration or transfer to local authority clinics, but we wanted to correct the process."

R = "Ok! ... Point taken, so you are comfortable with the integration and working in local authority clinics?"

P = "Er... we are allocated one office space, for the three of us, while local authority nurses have individual offices, they have privacy and comfort."

P = "Well... we are happy and not happy at the same time, because sometimes you need your privacy."

R = "How... is it possible for three nurses to work in one office, what type of services are you rendering?"

P = "Yes... we are three in one room, and we are rendering school health services, section 30 services."

R = "Oh... "You do not consult clients in those offices."

P = "Er... yes, we do not consult any clients, but sometimes you need privacy to do your admin work."

R = "Tel me, what is happening to your colleagues who render other services like family planning, child health, TB, etc."

P = "Fortunately they complained and they have now been given individual rooms, and others are sharing rooms with local authority nurses."

R = "All right, so, those rendering services that need confidentiality they are given separate

rooms...is that so?"

P = "Yes... That's correct, I think we should not be petty and complain about office space, because the local authority nurses are also inconvenienced and are congested in their clinics. What we should complain about are major things that affect our lives as individuals."

R = "Can you explain what you mean Ma'am?"

P = "Er.... I am actually referring to the type of benefits we get compared to those of local authority nurses, our benefits are inferior."

R = "Ok' ... inferior, explain further P2?"

P = "Our conditions of employment are so inferior to those of local authority nurses. It hurts that they all drive beautiful cars and wear colourful uniforms."

"They get all the benefits in the world, as if they were better qualified than us and most of them boast about those benefits."

R = Mnh

P = "Er.... It is actually sickening for someone who is less qualified than you, and she gets paid higher than you, and also qualifies for a car scheme."

R = "Er... sorry can you qualify your statement?"

P = "I am talking from experience, I have seen one of their pay-slips".

R = "Tell me how did you see their pay-slips, did they show you their salary slips, what happened?"

P = "No... big no... they did not show us their pay-slips, but the way they are boasting it shows."

R = "Er.... Sorry, I don't understand now..."

P = "Er... can I come in there, maybe she wants to say that they have lot of things that we don't have, maybe they always have money."

R = "Mnh... always have money..."

P = "Let me explain they don't show us their pay-slips, but some of us saw their salary levels and packages of different categories of nurses at their pay-office".

R = "Okay! ... Is salary packaging of individuals not a confidential issue?"

R = "Mm... Err... It is confidential but I am referring to remuneration packages that are made available during advertisement of posts at the local authority clinics."

R = Ok! ... "Point taken, but er ... are you sure that the local authority nurses' salary package and benefits are better than yours in general or are you just speculating?"

P = "We are not speculating Ma'am, it is true, that they get better benefits than us, you can see, it is obvious?"

R = "Ok..., Mm ... tell me, what if they claim the opposite, that you get better benefits than them?"

P = Oh.... "They will be lying if they say that, it is known everywhere that local authority nurses get better paid than provincial nurses and it affect us mentally."

R = "Mnh..."

"Er.... You know, if you think of going to work, it is a nightmare, because your experience and qualifications are not recognised, we are not involved in programs, only local authority nurses are."

R = "What do you mean by not being involved in programs?"

P = "Err.... I mean that local authority nurses are coordinating programs like AIDS, EPI, TB, etc, and none of our provincial nurses are involved."

R = "Tell me, did you try to find out why?"

P = "At some stage in our monthly meetings we enquired and we were told we do not qualify under the criteria."

R = "Are there criteria?"

P = "Mam, we don't know if there are any criteria, my thinking is, even if there are any I think some of us will qualify to coordinate programmes if we are given a chance."

R = "Alright... Mnh... didn't you find them already coordinating programmes or these programmes were allocated to local authority nurses in your presence?"

P = "... To be honest, most of them have been co-ordinating programmes before we joined them, but there were two other programmes, like HIV/AIDS and EP1, available to be coordinated by maybe one of us."

R = "Did you perhaps register your dissatisfaction with local authority nurses about the allocation of programmes or with their managers?"

P = "Err... we have tried to object to the whole thing, but we are often not taken seriously by local authority nurses you know."

R = "Mnh... did you maybe discuss the matter with your supervisors?"

P = "Yes.... We had several meetings with our supervisors, I believe they also don't have any authority in initiating anything in local authority clinics."

R = "You have mentioned that you mentioned the key issue in your monthly meeting, do you hold joint meetings, and how often?"

P = "Can I explain this, we normally hold our individual meetings fortnightly on Monday afternoons, and then hold a joint meeting fortnightly on Friday afternoons, but the situation remains the same."

R = "Do you perhaps discuss under the item "General", or do you get a formal agenda, before

meetings?”

P = “Er.... To be honest, we do not receive agendas, we only discuss problems encountered at the workplace and that is all.”

R = “Do you perhaps minute the minutes, or do you actually check or evaluate your strategies for solving problems. If it is really working, or do you see some difference?”

P = “Er.... Yes we see some differences, though things are happening slowly for example, we used to drink tea in separate tea rooms, but now we drink tea together in one tea room and our working hours have been synchronised.”

R = “Mnh... Ok... Good progress at least...”

P = “Ohr... At least we have positive things coming out of your meetings, though there are some of them especially some of their junior nurses who have attitude problems in the meetings you know?”

R = “Mnh... attitude problems in the meetings?”

P = “Err.... I would say yes we do, but to a lesser extent as our supervisors are also present at those meetings. What I can say to you is, we feel the pinch when the meetings are held, maybe at a different clinic, where we need transport to take us there, as you won't get a lift from some of them (local authority nurses). They will tell you, they can't give you a lift because they are not indemnified to carry you in their cars, you know such things.”

R = "So, then how do you get to the meetings?"

P = "Err.... To be honest some of the local authority nurses are not bad, they are friendly, they actually travel with us in their cars."

R = "Ok, people do you think there is a way to solve these problems?"

Group Yes' Yes' ...

R = "Fine, lets hear now?"

P = "Yes ..."

P = "I think if the Government can actually give us same benefits like car schemes, uniforms and salaries, we can be the happiest employees in the whole world."

P = She added ..., "I think if we could be promoted according to our experience and qualifications, it could be better."

R = "What do you mean, do you all want to be in charge of clinics, and then what should happen to nurses who are in charge of clinics?"

P = "Er... can I explain this, I am saying we should have two in charges for each clinic, one from province and one from local authority."

R = "People.. Is it really possible to have two in charges in one clinic, won't it be confusing?"

P = No! No!... Er we don't think so, at least we will be appeased, or maybe our supervisors should deputise local authority facility heads."

R = Mnh

P = "...I think it is also important that we should wear the same uniform, because they wear pretty, quality, colourful uniforms and we wear the old blue and white uniform which we bought for ourselves years ago. We cannot afford to buy new uniforms yearly as we do not get a uniform allowance."

R = "Oh... it that so, you don't get anything?"

P = "No, no, ... we do get an allowance of R100 per month. What can one buy with this amount, compared to ± R2 500 given to local authority nurses, it is actually a sham."

R = "Ye..ss.."

P = "Er.... It is actually frustrating because patients sometimes prefer to be attended to by local authority nurses who are in colourful, smart uniforms."

R = "Tell me is it the uniform that makes a nurse approachable and efficient or is it the way she examines or liaises with patients?"

P = "O, I think, if you wear a smart uniform, you will feel good and confident, and the patients normally wants to be attended to by a confident smart nurse".

"Er... I did not know this, is there anything else you want to share with me?"

P = "Yes, Ma'am, the workload is not fairly distributed, we as provincial nurses, we are still rendering school, health services, mental health, factories alone."

R = "Ok! ... Tell me are some of the functions new, or are these your old functions before integration with local authority nurses?"

P = "Er... let me put it this way, these are our traditional functions as provincial nurses, but we thought that we were going to get help from them since we were understaffed and since we also assist them with their clinic work."

R = "Mnh... was there a sort of agreement between yourselves and local authority nurses about the functions?"

P = "No... a big no, what happened is we were just slotted into the clinics, and no formal layout of functions was done".

R = Mnh... Strange..."

P = "Er... In fact, what is happening is we are helping them with some of their functions, but we still do our own functions."

P = "... I was about to say the same, that we are slotted into their clinics, there is no integration."

R = "Are you saying that we were transferred to local authority clinics without any proper agreement that goes with integration?"

P = "Yes... Yes... In fact the correct word is slotted into their clinics."

R = "Ok... point taken."

P = "We are overworked, we do all the farms alone without any help from the local authority nurses."

R = "Did you discuss work allocation with them or the managers?"

P = "As we have said, we do hold meetings and the person in charge will always tell you that, the local authority nurses have job descriptions and contracts so we cannot add more duties to them, but they expect us to assist in EPI, FP and other services they render."

R = "Tell me, don't you people have job descriptions?"

P = "Er... to be honest, we believe as professional nurses we are trained to render health services not to cherry pick the type of service you want to render."

R = "Can I get this one clear, do you have job descriptions or not?"

P = "Can I come in here, we do not have individual job descriptions, but we have a general scope of functions for professional nurses."

R = "(Is that so ... ok, let's hear from you P4)"

P = "You know what, our recruitment or human resource procedures are not the same, you know with us, if you are appointed as a professional nurse in the district you know what is expected of you that you are supposed to do child health, family planning, school health, TB, curative services, etc you know!..."

R = "Ok.... I get your point"

R = Yes, P2

P = "Er... I want to add that local authority nurses are enjoying all the benefits, like posh big offices, while we are given small shabby offices."

R = "People, thanks for your concerns and problems can we now come with a way forward to your problems?"

P = "I will like to suggest that the managers should inform, consult and negotiate the changes with us, give us a chance to choose. Secondly, we should develop a new organogram for all of us local authority nurses and provincial authority nurses and new senior post should be created and equally distributed among us. And lastly we should have uniform conditions of service, equal work for equal pay".

R = "Yes... lets hear P3"

P = "I think it is also important that our authorities should empower us, they must sit around the table with us, hear our views about the changes they want to introduce, so that we know such changes, and I assure you that they won't get any resistance towards changes."

R = "Yes P2"

P = "Er.... I want to add that, it is common knowledge that people who are fully involved in their change process will support and own that process, and I think it was stupid for management not to involve and consult us in the initial stage. They thought we are stupid, and shame, some of us are university graduates, we know all these things."

R = "Ok, you are saying if you were involved in the initial phase, you were going to support the changes."

P = "Yes of course, even local authority nurses were not going to resist change or reject us, if they knew about all these changes."

R = "Mnh... Yes P3"

P = "Mam, I suspect that local authority nurses were also not consulted like us. I think we are in the same boat of being uncertain about the changes, so I think as way forward, we both need consultation and uniform conditions of service, and most importantly management of attitudes towards change by local authority nurses."

R = "Er... can you elaborate on the last sentence about if management works on the attitudes of local authority nurses towards change."

P = "Er... all I am saying is that, if people resist change, something must be done. I mean from our experience working with local authority nurses, they portrayed a picture of resisting change, by rejecting us, so I think it will be important for managers to work on their

attitudes of resisting change, ok..."

R = "All right, I get your point. Can we come up with more suggestions to improve your integration with local authority nurses?"

P = Let me add ... Er..., I think it will be important for authorities firstly to respect our views as casualties of that integration process, they should consult, involve and empower us so that we best understand change. Secondly they must work on local authority nurses' attitudes so that their resistance towards change is managed, and we won't have any problem about integration in our district, we will work nicely together.

"Lastly, and importantly, same conditions of service, equal pay for equal work."

R = "Mnh.... You reckon that if management can consult with you, manage the resistance to change of local authority nurses and ensure same conditions of service, you can integrate successfully with local authority nurses?"

P = 6 "Err... I think it is true, that if suggestions like proper consultation, managing resistance and uniform conditions of service are addressed, then our integration would be smooth. I want to add that, if we are all informed, then changes will no longer create any uncertainty, but will introduce positive thinking to us as people affected."

R = "So, you are saying, change will bring positivity instead of uncertainty if you are informed and empowered."

Group ...Yes... Yes...

R = "Ok... Can one person speak?"

"Yes P3"

P = "I think, it is also important that work and responsibilities be distributed properly."

R = "You mean daily tasks should be distributed equally?"

P = "Can I come in there, I don't think tasks and responsibilities are major and important, these things will unfold only after consultations and negotiation with us, uniform conditions of services and mental preparedness of all us".

R = "I hear what you saying, but I don't understand the last sentence: mental preparedness of all of you, can you elaborate?"

P = "Er... by being mentally prepared, I mean that we are all informed, happy and accept integration, meaning we are mentally prepared by the employer to understand and accept the changes integration is bringing."

R = "Thank you very much for your input, but before we close can we summarise what you've said"

Your are saying that you were not consulted, informed and involved in the integration process, you were not part of the planning team that introduced these changes, you are not opposed to integration and lastly you are rejected and not treated properly by local authority nurses. Lastly you propose that, the employee should consult and negotiate with you, ensure uniform conditions of service for all, and a new organogram be developed to fit

everyone into the system properly”.

Group? “Yes... that’s all”.

R = “Thanks once more for your input, results will be communicated to you later.”

Annexure C

**Permission to conduct a research
in the clinics of Springs Town Council**

Departement van
Gemeenskapsdienste

Suid-Hoofrifweg / South Main Reef Rd ☒ 416, Springs 1560

Department of
Community Services

☎ 812-1244 ☎ 750923 Fax: 812-1427

U Verw.: / Your Ref.:

Ons Verw.: / Our Ref.:

Navrae: / Enquiries:



Sprems Town Council
Office of the Chief Executive Officer
360-2002

15 October 2000

Mrs Mashazi

**RE: PERMISSION TO CONDUCT A RESEARCH IN THE CLINICS OF SPRINGS
TOWN COUNCIL**

Permission is hereby granted to Mrs. Imogen Mashazi to conduct a research project on the topic given as : A model for the integration of local authority nurses and provincial authority nurses rendering primary health care services in a district.

It will be appreciated if you could communicate your results after your completion as promised.

**S.K. KHANYILE
CHIEF EXECUTIVE OFFICER**



Annexure D

Protocol for the independent coder

Protocol for the independent coder

2 March 2001

Dear Colleague

You are requested to do open coding of the enclosed data.

Please follow the steps below to analyse the data of the transcribed interviews:

- 1 Read through all of the transcriptions carefully, while "bracketing" and "intuiting" to get a sense of the whole. Bracketing means placing preconceived ideas within brackets, and intuiting means focusing the perceptions of local authority nurses, provincial authority nurses and the district management team about the integrations process of local authority nurses and provincial authority nurses rendering primary health care services in a district and what strategies can be implemented to improve the integration process.
- 2 Do the same with field notes.
- 3 Identify the major categories represented in each universum as you read through the transcripts and field notes.
- 4 Underline units of meaning that are related to the identified major categories.
- 5 Identify subcategories within the major categories.
- 6 make a comparison of all transcriptions and indicate in each category how many subjects used the same words and themes.
- 7 Identify interrelationships between major categories and subcategories.

Thank you

MI Mashazi

(DLitt et Phil student)