ASPIRATIONS, ECONOMIC AND SOCIAL WELLBEING OF PROFESSIONAL NURSES IN SELECTED PROVINCES OF SOUTH AFRICA.

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A Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing

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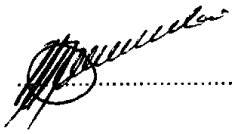
DECLARATION

Student No 605503

I, Tendani Bernard Mabuda, declare that the thesis: **"Aspirations, Economic and Social Wellbeing of Professional Nurses in Selected Provinces of South Africa"** (Human Research Ethics Clearance number **M130806**) is my own original work. It is being submitted for the degree of PhD in Nursing in the University of the Witwatersrand, Johannesburg and that it has not been submitted before for any degree or examination at any other institution. All sources used or quoted have been acknowledged by means of complete reference in the text and bibliography.



Signed at Johannesburg

On the 6th day of November, 2017

DEDICATION

This thesis is dedicated to my late brother Ntshavheni Justice Mabuda, who encouraged me to continue studying. His love for education and belief in lifelong learning has been a great source of inspiration to me.

My gratitude goes to my dear wife Konanani Jublinah Mabuda, my sons (Thendo, Thikho, Thama) and my daughter Tendani (jnr). Thank you very much for the encouragement, motivation and unwavering support throughout the duration of my studies.

ABSTRACT

Background and objectives: The purpose of the study was to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa. The objectives of the study were: to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing, to formulate an aspiration questionnaire based on existing evidence, to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa, to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces and to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

Method: An exploratory, sequential mixed method design was used. The study was conducted in four phases (scoping review, Delphi study, a survey and formulation of recommendations with the assistance of experts through a focus group and follow up verification. The results of qualitative phase were used to build onto the quantitative phase. One thousand, one hundred and thirty-eight (1138) professional nurses participated in the study. The data from all phases of the research was integrated prior to the formulation of recommendations which were organized according to the Walt & Gilson framework (1994) in order to answer the research question.

Results: Important lessons were learned in terms of professional nurses' aspirations for job satisfaction, possessions, financial success, self-acceptance income and status and power. The quantitative data revealed that professional nurses as a group are mainly mature (the majority >40 years old) unmarried females, working irregular hours, highly indebted and who carry the financial and social burden of caring for extended families. They value education, both for themselves and their children, but are part of the 'missing middle' as far as accommodation is concerned as they earn too much to qualify for grants and too little to qualify for housing mortgages. Overall, professional nurses' have aspirations that are not met which impacts on their economic and social wellbeing.

There is no significant difference between the economic and social wellbeing of urban and rural participants.

Conclusion: Recommendations aimed at addressing the aspirations, economic and social wellbeing of professional nurses in South Africa were formulated. However, it is clear that an inter-sectoral and inter-departmental approach is required to address the aspirations, economic and social wellbeing of nurses if a positive impact is to be made.

Keywords: professional nurses, aspirations, economic wellbeing, social wellbeing, wellbeing.

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CHAPTER 1 - OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Since the dawn of democracy in 1994, South Africa has continued to experience a severe shortage of health human resources, including doctors and nurses. The shortage of professional nurses in particular, has been a widespread phenomenon throughout all nine provinces of South Africa. A study done by George and Reardon (2013) amongst South African student nurses and doctors in their final year of study revealed that more than 37% of the respondents intend to work or specialize abroad. The majority of medical (58.9%) and nursing (66.6%) students intended to leave South Africa within five years of completing their medical or nursing studies.

Nurses in South Africa, like in the rest of the world, constitute the largest professional group of the health service providers. In 2014 nurses constituted 76.8% of all health professionals in public sector, of which 38.7% were professional nurses and 17.7% and 20.4% were enrolled nurses and nursing assistants respectively (South African Health Review, 2014/15). According to the figures in the Human Resources Strategy for Health South Africa (HRH Strategy South Africa,2012/2013-2016/2017) compiled by the Department of Health, based on its own assessment of health needs, 56% of doctor posts are vacant (14351) and 46 % (44780) of nursing posts were unfilled (Daily News, 2013). The shortage is exacerbated by the migration of health professionals including nurses to other countries aboard. It is estimated that over 23 000 South African health professionals work abroad in countries such as Australia, Canada, New Zealand, the United States of America and the United Kingdom (DoH: HRH *Strategy South Africa, 2012/2013-2016/2017).*

Apart from the migration of nurses who take up jobs abroad, some nurses leave the public health sector looking for greener pastures elsewhere within South Africa, either working privately or they simply change careers because of poor working environment (Mokoka et al., 2010). This exposes the remaining nurses to stress and burnout and consequently may also decide to leave the public sector (Egerdahl, 2010). Furthermore,

if this brain drain is not arrested it has the potential to cripple the Health Department's ability to provide adequate health care services as stipulated in the Constitution of the Republic of South Africa (1996), the implementation of the envisaged National Health Insurance (NHI) policy(DoH,2017) and ultimately achievement of the Sustainable Development Goals.

In a study done by Hull (2010) in Kwazulu Natal, South Africa it was found that despite the strain caused by migration on family relationships, nurses decide to work abroad to enhance their economic and social wellbeing as they are able to provide for their families, pay mortgage bonds or build new houses for their families within a short period as their foreign earnings are huge compared to the salaries earned in South Africa. These findings are corroborated by Li et al. (2014) who studied international migration and found that the most significant benefit that migration has on nurses is the improved financial situation for the nurse migrant and his /her family and that with the increase in earnings, nurses are able to send money back to their home countries and improve the lives of their families.

According to the World Health Organization (WHO), the root cause of migration of health care workers is a search for a better life and livelihood (WHO, 2006b). The reasons cited for skilled health worker's migration are well documented in literature and are categorised in two broad themes namely the push and pull factors. The push factors include but not limited to the following for South African nurses; low remuneration, poor living and working conditions, lack of career development opportunities, high burden of disease (HIV/AIDS and TB) and high cost of living and job and economic insecurity whereas the pull factors are the availability of positions, higher remuneration, better living and working, career development opportunities and safety and security of the family (Labonte et al.,2006; Egerdahl, 2010; Mokoka et al., 2010; George and Reardon ,2013).

Despite various push or pull factors associated with nurse migration, financial consideration has been found to be more likely the primary reason for nurse migration and job dissatisfaction (Pillay, 2009; Li et al., 2014).In South Africa the Occupational Specific Dispensation (OSD) was introduced in an attempt to improve the salary

packages of professional nurses, address their dissatisfaction, and to reduce the number of nurses leaving the profession specifically in the public sector (DPSA,2007). Yet, as already suggested, despite quite substantial increases in income for many professional nurses, complaints about salaries persist. It is therefore important to develop a greater understanding of economic and social wellbeing as it would appear that salaries alone do not address the reasons for the dissatisfaction of nurses adequately.

In the next section, the remuneration packages of nurses in the public sector will be explored in order to provide background to the income status of nurses. This will be followed by an in-depth exploration of other aspects of economic and social wellbeing in an attempt to understand the factors that impact on nurses' dissatisfaction.

1.2 DETERMINATION OF REMUNERATION FOR PUBLIC HEALTH SECTOR EMPLOYEES

Remuneration is a complex and discretionary concept which differs in both public and private sector. It has multiple determinants which are, but are not limited to, the following: job performance, external equity, organisational tenure, employee skill and job grade (Maloa, 2011). Unpacking each of these determinants and related remuneration theories would require a separate study, therefore the focus of this section will be limited only to the remuneration model used by government in South Africa to determine salaries in public health sector with specific reference to the remuneration of professional nurses.

In the South African context, remuneration of public sector employees is governed by a range of legislative framework which include, but are not limited to, the following, Basic Conditions of Employment Act, 1997; Labour Relations Act, 1995; Skills and Development Act, 1998.The Basic Conditions of Employment Act,1997 in particular makes provision for Sectoral Determination and Collective Bargaining. Following the collective bargaining process, the government and labour organizations signed an agreement to improve salaries and conditions of service for public servants in terms of PSCBC Resolution no1 of 2007. This agreement is referred to as the Occupation Specific Dispensation (DPSA ,2007). The Occupational Specific Dispensation (OSD) is

underpinned by the following principles; a unique salary structure, where salaries of occupational categories will, where necessary, be aligned to the market; adequate career pathing; a salary increase after a pre-determined period based on specific criteria such as performance, qualification, scope of work, experience, pay progression and grade progression. The agreement includes conditions of service and other employment benefits such as leave, allowances and medical assistance (DPSA, 2007). Subsequently the OSD for nurses was also implemented following a sectoral collective bargaining process in terms of PHSDSBC Resolution no 3 of 2007(DoH,2007).

Table 1.1 below shows the status of the salary of professional nurses in South Africa pre-OSD and post-OSD for the period 2007-2009 and the percentage increase over this period, whilst table 1.2 provides more recent OSD salary notches of professional nurses for the period 2014-2016 and table 1.3 shows comparisons of salary scales of professional nurses and other public health professionals (www.dpsa.gov.za).

Table 1.1: Remuneration of professional nurses pre and post OSD 2007-2009

**no information available: Occupation specific dispensation for nurses, 2007.

Service experience	**Revised production grade**	**Annual salary notches as at 1 July 2007**	**Annual salary notches as at 1 July 2008**	**Annual salary notches as at 1 July '09 ***	**% increase in salary 07-08**	**% increase in salary 08-09**
< 4 years	Grade 1	R106 086	R117 225	R130 119	10.5%	11%
5-9 years	Grade 1	R 115 923	R124 365	**		
10-19 years	Grade 2	R130 473	R144 174	R160 032	10.55	11%
20-29 years	Grade 3	R160 470	R177 318	R195 936	10.5%	11%
>30 years	Grade 3	R186 030	R205 563	**		

Table 1.2: More recent salary scales of professional nurses' post OSD: 2014-2016

Revised production grade	**Annual salary notches as at 1April 2014 (Rpa)**	**Annual salary notches as at 1 April 2015 (Rpa)**	**Annual salary notches as at1July 2016 (Rpa)**	**% increase in salary 2014/2015**	**% increase in salary 2015/2016**	**% increase in salary 2016/2017**
Professional Nurses Grade 1(General Nursing)	R183 009	R195 819	R210 702	7.4%	7%	7%
Professional Nurses Grade 2 (General Nursing)	R225 075	R240 831	R259 134	7.4%	7%	7%
Professional Nurse Grade 3 (General Nursing)	R275 571	R294 861	R317 271	7.4%	7%	7%
Professional Nurse Grade 1 (Specialty Nursing)	R275 571	R294 861	R317 171	7.4%	7%	7%
Professional Nurse Grade 2 (Specialty Nursing)	R338 931	R362 655	R390 216	7.4%	7%	7%

Table 1.3: Comparison of salary scales of professional nurses (general) and other public health professionals in South Africa :2017.

Category	Salary notch per annum
Professional Nurse (general)	R226 083
Clinical Technologist	R289 653
Dental Therapist	R293 997
Speech Therapist	R298 413
Occupational Therapist	R316 722

As can be seen from the table above the nurses' salaries have improved significantly, with the implementation of OSD in July 2007 but still far below that of other public health professionals with similar educational qualification level (i.e. degree /diploma). The implementation of the OSD resulted in the Health Personnel budget doubling, from R28 240 million in 2006/2007, to R58 919 million in 2010 (DoH: HRH Strategy South Africa, 2012/2013-2016/2017; DPSA 2017).

When considering the relative improvement of the salaries one needs to consider that the inflation rate in South Africa has varied between 3.37% and 9.35% with an average of 6.132% during the years 2006 to 2016. (Inflation.eu, 2017).

1.3 IMPACT OF SALARY INCREASES ON PROFESSIONAL NURSES

The increase in salaries as described above may have had the effect of slowing migration as recent studies on migration of skilled health workers in South Africa have revealed that the number of nurses migrating to work abroad has reduced and also shows that the reasons for the decision to migrate is predominately no longer salaries (George and Reardon ,2013). Studies also indicate that the salary gap between South Africa and most destination countries abroad has narrowed remarkably owing to the implementation of OSD, and possibly due to the reduction in opportunities to work in other countries however the shortage and the intention to leave the country by these categories of health workers in particular nurses remains high (Labonte et al., 2015). Rispel et al (2014) and Blaauw et al (2013) indicate that nurses in South Africa have high levels of job dissatisfaction. Both these studies were conducted after the introduction of the OSD, so despite a slowing in migration out of the country, South African nurses remain dissatisfied even though salaries have improved. Blaauw et al

(2013) found that South African health workers were the less satisfied than those in both Malawi and Tanzania. While many recent studies (AbuAIRub et al, 2016; Asuquo et al, 2016; Bauer and Fontaine, 2015) have concentrated on exploring the working environment and related human resource issues as a cause for dissatisfaction, they have not attempted to understand the economic and social frame of reference of the professional nurse in South Africa. Without this information, employers will struggle to formulate appropriate measures to retain nurses.

The terms satisfaction, wellbeing and happiness are often used interchangeably in the literature. For the purpose of this study, the term wellbeing is used to include other concepts as indicated in the definitions section of this chapter. The concept wellbeing has further been divided into social wellbeing and economic wellbeing while accepting that these two concepts overlap to a great extent. In order to provide a comprehensive background for this study, a structured review was done of the literature to analyse and explain these key concepts which underpin this research and to provide better understanding of these concepts. Firstly, the overall concept of 'wellbeing' will be discussed according to authors who have published on the subject over a ten-year period. The more specific concepts of social wellbeing and economic wellbeing will then be discussed. The literature search was extended back to 2006 in order to provide an understanding of the development of the concept since the introduction of the Occupational Specific Dispensation to provide the economic and social context in which most of the nurses included in the study have mostly been working.

1.4 THE CONCEPT WELLBEING

1.4.1 Defining wellbeing

It has been widely acknowledged by the authors reviewed, that the concept wellbeing is difficult to define and there is no unanimous agreed definition of this concept nor an agreed approach to its research and evaluation (Thomas, 2009; Dolan et al.,2006; Alatartseva and Barysheva, 2014). However, there is agreement by most researchers that wellbeing is a multidimensional concept (Diener et al.,2009; Abdallar et al., 2012; Stiglitz et al., 2009., Tanasescu et al., 2013).

Dodge (2012) acknowledges the fact that it is a difficult concept to define but stresses the importance of distinguishing between describing and defining a concept – the latter being important if researchers attempt to measure 'wellbeing'.

In the literature reviewed there were three major approaches used in defining the term 'wellbeing' namely subjective approaches, objective approaches, and an approach that emphasises a balance in an individual's life of available resources and required resources.

The subjective approach relates to a person's own and individual assessment of the quality of his life and reaction and satisfaction with his life according to the criteria the person himself chooses (Cummins, 2010; Stratham and Chase 2010; Gasper, 2007; Gough and McGregor, 2007; White, 2010). As the term indicates, the subjective approach to wellbeing is individualised and two people living in and experiencing similar conditions may have differing levels of wellbeing depending on the criteria against which they choose to evaluate their lives.

As the subjective approach to defining wellbeing relates to the term 'quality of life' it is prudent to view what the World Health Organisation (WHO) considers this to be and to understand how they believe it impacts on the understanding of wellbeing. The sin the context of their culture, and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationship to salient features of their environment and could well define the concept wellbeing itself. Another such difficulty relating to defining the term caused by similarities in meaning of terms is the WHO's definition of mental health which too could be taken to be a subjective definition of the term wellbeing. They state, "Mental health is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). This too takes a subjective view as one person's perception of whether they are realizing their own potential and can cope and work fruitfully and productively may differ considerably from another's. Having employment, or being employed may be objective criteria but

Deci and Ryan (2008) also uses a subjective approach to defining wellbeing and actually refers to the term ‘subjective wellbeing’ defining it as experiencing a high level of positive effect, a low level of negative effect and a high degree of satisfaction with one’s life or with certain domains of one’s life. He also believes that the term subjective wellbeing can sometimes be used interchangeably with ‘happiness’. Camfield (2006) however, disputes this, stating that subjective wellbeing is not equated with happiness but is connected with aspects that people value in their lives. These aspects, according to Diener (2009) and White (2010) comprise of people’s life satisfaction, their evaluation of their life domains such as work, health, relationship and how they think and feel about these aspects of their lives. Presumably, though, if one is satisfied, or happy with these aspects of one’s life, a person could be considered to be ‘happy’.

Subjective definitions of wellbeing relate closely to the hedonistic perspective of wellbeing. This approach is used by psychologists who refer to ‘experienced wellbeing’ which is defined by people’s emotional state but may also include sensations such as pain or arousal, and a sense of meaning or purpose. It encompasses moods or emotions termed ‘affect’ and includes happiness, pleasure and joy. Hedonic wellbeing is divided into three dimensions namely positive affect, unpleasant affect and life satisfaction (Dolan et al., 2011; Venkatapuram 2013). Psychological wellbeing may relate to skills in relationships, social insertion, or social wellbeing and/or a set of positive associations within a work/social context (Alves et al., 2012, Salehi et al., 2016).

Another approach to defining wellbeing is the Eudaimonia approach which is derived from the Aristotelian principle of ‘flourishing life’. Eudaimonia is translated as happiness or wellbeing and includes fulfilment at an individual level including achievement of individual goals or aspirations and realisation of the individual’s true potential (Heckman et al.,2006; Dolan et al.,2006, Dolan et al., 2011; Alatartseva and Barysheva, 2014). It conceptualises wellbeing in terms of the cultivation of personal strength and contribution to a greater good, acting in accordance with one’s inner nature and deeply held values (Waterman 1993), the realisation of one’s true potential, and the experience of purpose and meaning in life (Ryff and Keyes 1995). This view is echoed by Coulthard (2012) whose assertion is that the concept of wellbeing (Eudaimonic), entails more than

income, and happiness, but the living of, and flourishing in a life that is valued and deemed worthwhile.

This approach relies on the self-determination theory Ryan and Deci (2000) and Keyes (2002) refer to a self-determination theory of wellbeing which maintains that happiness is related to fulfilment in the area of autonomy and competence. In this approach, subjective wellbeing includes the individuals' global subjective evaluation of life but is frequently limited to the specific domains of life such as satisfaction with work, family life or health (Dolan et al., 2011).

Another subjective definition is put forward by Tan and Tambyah. (2016) who state that a person's wellbeing is a state in which an individual feel and believes life is going well and reflects many values that the person strives for such as relationship, a feeling of belonging and long term goals. Urzua e al (2013) shared similar views, adding that cultural values are mediators in evaluation of quality of life and some of these values are sense of belonging, self-fulfilment, excitement, warm relationship with others, fun and engagements, being well respected, self-respect, security and sense of accomplishments.

The **objective approach to wellbeing** relates more to what other people think of us or what we have achieved, rather than what we, ourselves perceive. Clearly one's own perception is influenced by what others think or how they evaluate us, but in Gasper's (2007) definition, wellbeing relates to "being extremely approved of and thereby being normatively endorsed" and he also refers to these features as "non-feeling features of a person's life' to distinguish them from subjective wellbeing.

Deciding on what drives people's evaluation would depend from one socio-cultural group and another. The WeD research group (Gough and McGregor, 2007) who researched wellbeing in developing countries refer to three interrelated dimensions against which wellbeing can be measured namely; material (objective material resources that a person can use to meet their needs such as food, assets, employment services and the natural environment); relational (which is what a person does through social relationship that enable or disable the pursuit of wellbeing including love, relationships with the family , social institutions, state , cultural rules and norms) and subjective

(which is how an individual thinks and fees about his /her life). There is, therefore, an overlap with subjective definitions of wellbeing but the group's definition of material dimensions, fits well with the objective definition of wellbeing.

The Objective list approach to defining wellbeing does not provide a formal theory of wellbeing but offers a list of attributes and characteristics which, collectively, constitute wellbeing. These attributes include economic resources, political freedom, good health, and the ability to read. This approach is contested by other researchers such as Dodge et al, (2012) and Diner et al (2012) who put forward a subjective definition and believe that a focus on specific factors and indicators, while more easily measurable, is limited as it reduces a persons' wellbeing to only the material realm of market place production and consumption whilst neglecting other aspects of human life such as social relationships, spirituality and meaning from material consumption to a feeling of relaxation and security.

The Preference satisfaction approach is another objective approach, with some underlying subjective notions, as it concentrates on defining wellbeing in terms of a person getting what he wants. In other words, it relates to a person's aspirations and desires and depends on whether those aspirations are met or not. (Dolan et al, 2006).

The **equilibrium approach** to wellbeing use the analogy of a see-saw where wellbeing is maintained when an individual's psychological, social and/or physical challenges are in a state of balance. In case where the individual has more challenges than resources, the see saw dips (disequilibrium) along with their wellbeing and vice versa (Dodge et al., 2012). Wellbeing is a balance between the resources one has and the challenges one faces.

In the South African context, few studies have been done on the wellbeing of South Africans since 1994. None of these studies focused specifically on the wellbeing of professional nurses in South Africa, but study by Bookwalter (2012) on the wellbeing of the people of South Africa nearly twenty years' post-apartheid, found that both black and white South Africans reported high levels of satisfaction. If the equilibrium approach is to be believed, this would mean that both groups have a balance between resources and challenges which seems unlikely. This notion is born out in a study conducted in South

Africa on the structure of the happiness equation in South Africa in comparison with developed countries, it was found that the household income, relative household income and place of residence (i.e. rural, slum, town or city) have effects on an individual's wellbeing (Hinks and Gruen, 2007).

In both the objective view and the equilibrium view of wellbeing, the factors that influence wellbeing are key and, even when looking at the subjective view, although one's own view of what is important differ, these factors are still referred to. The next section therefore examines what the literature sources say about these factors.

1.4.2 Factors associated with wellbeing

While it is clear that many of these factors are inter-related, it is useful to examine the factors that influence wellbeing as external factors, personal factors and socially developed factors.

External factors

These include factors such as income and work or unemployment and place of residence.

Studies have shown that there is a correlation between **income** and wellbeing (Clark et al., 2008). Income or money ensures that the individual has access to resources thereby driving satisfaction, meaning and purpose of life. Unemployment negatively affects wellbeing both in the short and long term. If one looks back to the subjective definitions of wellbeing, the question of "how much' money would make a person feel satisfied, has to come to mind. If one has never earned a great deal but has enough for one's aspirations or needs, (the equilibrium approach) presumably a person would be satisfied. Life circumstances of high income earners are better which, several authors have found, increases their subjective wellbeing (Mizobuchi, 2016; Camfield & Skevington, 2008; Layard et al., 2008). O'Hare (2014) and Tiwari (2009) however, found that while monetary poverty does impact on health, life expectancy, educational attainment and employability, multidimensional poverty, which refers to what one is able to do and be in life, is individualised and is a more relevant measure of poverty. Adding to the difficulties on establishing whether income has an impact on wellbeing, is the

problem of defining poverty. In an e-book published recently and therefore not included in the review, Arndt & Tarp (2017) discuss the problems of definition which seems to present as many problems as defining the term wellbeing.

Dunn et al. (2011) argue that money can be used to build relationships as in the case of donations and/or when providing social welfare services, and, if used to the benefit of others, the person derives gratification and happiness. Perceptions of financial status have a stronger predictive power than actual income which implies that salary increase alone do not improve subjective wellbeing (SWB) for those who have lower income levels as it creates more expectation for increased income (Johnson et al., 2006; Graham, 2011). Similarly, a study by Kahneman and Deaton (2010) found that when an income of beyond $75,000, has been reached in United States, the relationship between income and subjective wellbeing ceases to exist. Additional income may also not increase SWB if the relevant comparison group also gain similar increases in income (Dorn et al., 2007; Brockmann et al.,2009; Knight et al., 2010).

Income is needed not only for basic needs but is an important indicator of one's social position and may therefore be important related to social wellbeing (Kingdon and Knight, 2007; Guillen-Royo, 2011; Fafchamps and Shilpi 2008). Gori-Maia (2013) found that improving one's education and income not only assists in reducing inequality but is one of the most effective ways to improve both the quality of life and the general perceptions of wellbeing in society.

The **geographical area** (urban or rural) where the person lives also has an influence on the subjective wellbeing with the SWB significantly higher in rural than urban communities. This is mainly due to the variation in the cost of living between the urban and rural communities (Curran et al., 2006). In a study on subjective wellbeing conducted in China, it was found that individuals in both rural and urban areas, the results show a positive association between income and subjective wellbeing (Knight et al., 2009; Knight and Gunatilaka, 2010).

Personal factors

There is evidence showing a correlation between the individual **personality** and subjective wellbeing. For instance, people with high self-esteem are less likely to suffer from depression (Helliwell, 2006). However, this assertion is contested by other researchers such as Nes (2010) who maintains that genetic factors have more influence on specific individual variations in subjective wellbeing. Furthermore, age has been found to have influence on subjective wellbeing. It has a U shape relationship with SWB, with SWB lowest around 35-50, with women in particular presenting lower scores on mental health measures than men (Dolan, 2008). In the same vein, Ferrer-i-Carbonelli and Gowdy (2007) found that individuals have high levels of wellbeing at younger and older ages and the lowest level of satisfaction at the middle age. However, Easterlin et al. (2010) argues that the U-shaped relationship suggested by Ferrer-i-Carbonell and Gowdy (2007) is misleading if one takes into consideration the age related differences such as income, health and employment status. In a study of wellbeing and associated factors amongst adults in the occupied Palestinian territory, the study found no effects of age and gender on wellbeing (Harsha et al., 2016). Whether **gender** is a factor relating to wellness is uncertain and is difficult to extricate from gender related issues such as poverty that are known to influence wellbeing. Some studies have shown a higher level of wellbeing amongst men than women but that the difference is minimal (Huppert 2009).

Attitudes and beliefs may also have an influence of wellbeing. The perceptions of our circumstances have already been shown to influence our SWB, and, in addition, the degree of trust in others seems to be positively correlated with SWB but the evidence is very limited. Christianity has also been found to be positively associated with wellbeing. Studies have also found that people attending or participating in religious activities tend to have better levels of wellbeing compared to non-religious individuals (Harsha et al., 2016). Joseph (2014) reported that there is a positive association between wellbeing and spirituality, music, health, and wellbeing and contends that music and spirituality when used in a religious context as a way to connect with God, provides for increased

wellbeing. It is therefore not clear from reviewing these two studies whether it is a person's beliefs or one's religious practices that improve wellbeing.

When considering **ethnicity** as a possible factor relating to wellbeing, one encounters similar problems to those of gender as issues are inter-related. Studies on the subject often deal with minority ethnic groups and wellbeing (Stevenson & Rao, 2014; Western and Tomaszewski, 2016) which are clearly not representative of broader society as minority groups are often subjected to additional difficulties such as poverty, unemployment and prejudice) that may influence their subjective sense of wellbeing. Zdrenka et al. (2015) report an interesting phenomenon in that in majority ethnic groups, national attachment is a significant factor relating to subjective wellbeing, but in minority groups, ethnic attachment has a positive effect on personal wellbeing.

Social factors

The relationship between income, education and subjective wellbeing (SWB) has been well documented by many researchers (Guardiola and Guillen-Royo, 2015; Victoria Reyes-García et al., 2016; Dolan et al., 2006). **Unemployment** is highly detrimental to SWB, although the effect is moderated by living close to others who are unemployed. How the individual spends his or her time, be it in formal activities (e.g. paid work), informal activities (e.g. some forms of volunteering), social (e.g. church attendance) or physical (e.g. taking walks) was generally associated with higher SWB (Dolan et al., 2008). Individuals with **higher education** have more opportunities for better jobs, and high salaries which afford them higher social status than people without higher education who are more likely to be unemployed or, if employed, occupy low paying jobs with a concomitant low social status which therefore impacts negatively on their SWB (Helliwell et al., 2012).

Having a **relationship** with family and friends and particularly an intimate relationship, is associated with higher SWB and the breakdown of that relationship is strongly detrimental to wellbeing (Dolan et al., 2008). People who are married were found to experience high levels of wellbeing compared to those individuals who are divorced, single or widowed (Harsha et al., 2016, Shapiro et al.,2008), however a study done in

Netherlands found no significant difference between married and unmarried persons' social wellbeing (Muller, 2012).

Leisure activities and recreation have also been shown by Newman, Tay & Diener (2013) to have a positive affect on social wellbeing and are believed to be more important than many other indicators of SWB such as education, religion and marital status.

1.5 SOCIAL WELLBEING

The discussion above on the concept of wellbeing makes it clear that the concept is multifactorial and many of the issues are inter-related. Equally, economic and social wellbeing are similarly intertwined, and the term socio-economic wellbeing is also sometimes used. Some distinctions will however be made in the following two sections between economic and social wellbeing in attempt to explain the scope of the study.

According to Social Production Theory (Steverink & Lindenberg, 2006), social wellbeing depends on the fulfilment of three basic needs, the need for affection, for behavioural confirmation and for status. Affection refers to being loved as a person irrespective of what one does or has. This need can be fulfilled by close caring and marital relationship. Behavioural confirmation refers to having ones behaviour confirmed and recognised by others. This need can be fulfilled, for example, by the experience of belonging to a group. Status refers to being appreciated for specific talents or assets that only the specific people possess (Steverink & Lindenberg, 2006). Taking this approach into consideration a nurse may not individually achieve fulfilment, and therefore social wellbeing, without the influence and contributions of other people around him/her who can provide him or her with experiences of affection, behavioural confirmation or status.

The above assertion of social wellbeing is supported by Salehi et al. (2016) who cited Keyes's (1998) definition of social wellbeing as people's valuation of their circumstances and functioning in a society. This is also corroborated by Mozaffari et al., (2015) who maintains that social wellbeing is an explanation of people's perception and experience of being in a good situation, satisfaction with the structure, and social interaction. According to Salehi et al. (2016) there are five dimensions linked to the concept of social wellbeing which are briefly discussed below to offer more clarity.

Social integration- this is sense of belonging to the extent to which an individual feels part of the group and society in which they live.

Social acceptance: one's degree of comfort and acceptance of the positive and negative aspects of our own lives and also the first approach and positive approval and attitudes towards others.

Social contribution: a sense of value to the society, the feeling that you can contribute something valuable to the common good.

Social actualisation: is the confidence in the future of society, belief in progress and social change, sense of continuing growth and development in social institutions and society.

Social coherence: is the ability to perceive quality organisation and functioning of the social world to find a logic meaning of events.

These five elements taken together indicate whether, and to what extent, individuals are overcoming social challenges and are functioning well in their social world and alongside neighbours, co-workers and fellow world citizens (Salehi et al., 2016).

Studies have found that there is a relationship between social wellbeing and marital status. Individuals who are married were found to experience higher level of satisfaction and wellbeing as compared to unmarried, single and widowed (Salehi et al., 2016, Shapiro, 2008). Conversely, as mentioned earlier, a study by Muller (2012) in the Netherlands found that there is no difference between married and unmarried persons' social wellbeing. The researcher concluded that marriage no longer provides an advantage over not being married in social life (Muller, 2012) but these findings may not necessarily be valid in another social or national context.

1.6 ECONOMIC WELLBEING

Economic wellbeing is a multidimensional concept. It has many contributing factors principally current income, which researchers argues that, alone, do not provide a comprehensive picture. Other determinants of an individual's and a family's economic wellbeing such as assets, debts and net worth must be taken into consideration to

provide complete insight into the household financial stability (Williams, 2010). Economic wellbeing is defined as a command over resources (Osberg & Sharpe 2005). It is an important element in determining the individual's quality of life. It affects the capacity of spending on goods and services and thus of ensuring a more stable and pleasant material standard of living. People with high financial resources have access to better health services, education and social relationships (Bakar et al., 2015; Helliwell et al., 2013).

Research conducted by Lewis et al. (2014) on the relationship between personal wellbeing and household income and expenditure using regression analysis, revealed that households with a higher income report higher life satisfaction and happiness and lower anxiety. Conversely a high household income is not significantly related to people's sense that things they do in life are worthwhile. Household expenditure was found to have a stronger relationship with people's life satisfaction (wellbeing) than household income (Lewis et al., 2014). The same study found that a rise in social status due to upward mobility, quality of work circumstances and job rewards causes status anxiety and less life satisfaction and wellbeing (Niedzwiedz et al., 2012).

Multinational studies (Frijters et al., 2004; Lelkes, 2006) have shown that life satisfaction rises with income across the world. In contrast, a study on subjective wellbeing with a sample of Chinese peasants living in a rural village, found that the rural residents' life satisfaction levels were within the normative range of the Chinese population and did not differ from those in an urban Chinese region (Davey et al., 2009). The explanation of this is that the meaning of financial success is influenced by an individual's culture and whether the society is individualistic or collectivistic, which impacts on life satisfaction and wellbeing.

Contrary to the views that absolute or relative income is the source of happiness and wellbeing, studies have found that the effects on happiness of both absolute and relative income are small when compared to the effects of several non-pecuniary factors such as marriage, being healthy and being employed (Ball and Chernova, 2008; Angeles,2011; Easton, 2015). Similarly, in a study by Trung et al. (2013) of ten nations across Asian countries and regions on the relationship between socio-economic variables and

wellbeing, it was found that some regions in Asia have a higher happiness or satisfaction even if their income is low and vice versa. Some are low in happiness or satisfaction even if their income is high, such as in Malaysia, Thailand and Hong Kong. Six out of ten nations were found to have higher satisfaction rates related to with education.

Kasser et al. (2014) found that people's wellbeing improves as they place relatively less importance on materialistic goals. In a similar study in Chile and China, where the income per capita has doubled within a 20-year period, the study found that the life satisfaction has declined (Easterlin et al., 2010; Hilke et al., 2009), which supports the theory that the increase in income does not always translate into increased in happiness and wellbeing.

1.7 THE RELATIONSHIP BETWEEN ASPIRATIONS AND WELLBEING

The relationship between aspirations and wellbeing is well documented by researchers (Rijavec, Brdar and Mijkovic, 2011; Kasser et al., 2014). Individuals have aspirations or goals they set in their lives and how these goals or aspirations are achieved or not achieved have an impact on the individual's wellbeing. Individuals pursue certain goals or aspirations because they are satisfying and contribute to their life satisfaction or wellbeing. These goals are divided into two main categories namely, intrinsic aspirations and extrinsic aspirations (Kasser & Ryan, 1996). Intrinsic goals or aspirations are inherently satisfying and individuals who pursue intrinsic goals experience a high level of satisfaction or wellbeing as opposed to those focusing on extrinsic aspirations (Guillen-Royo ,2015). Aspirations have a significant impact on wellbeing, for instance if a person has a high expectation of a high salary increase, this may negatively affect his /her wellbeing if this aspiration is not met (Dolan et al.,2008).

Studies have been done relating to many aspects of the nursing profession globally and in particular South Africa which include nurse emigration and migration, motivation, job dissatisfaction, dissatisfaction with salaries (Oosthuizen and Ehlers, 2007; Egerdahl, 2010; Abbott et al., 2011; Khunou and Davhana-Maselesele, 2013; Labonte et al.,2015), however no study was found to have been done on the aspirations of the professional nurses and the impact of these on the economic and social wellbeing of the professional

nurses. Understanding the aspirations, economic and social wellbeing of nurses in South Africa is of significant importance primarily because health services in South Africa are nurse driven. Therefore, recruitment and retention of this cadre of health professional is of paramount importance and if these nurses experience a high level of subjective wellbeing they are more likely not leave the public health sector and will provide quality care to the healthcare users. Understanding the aspirations and economic and social wellbeing of nurses could lead to the development of more appropriate remuneration, recruitment and retention policies that are responsive to the aspirations and wellbeing of the nurses. Conversely if nurses experience a low level of wellbeing or satisfaction because their aspirations are not met the quality of care they render to consumers of health care services is more likely to be negatively impacted.

1.8 PROBLEM STATEMENT

Dissatisfaction regarding remuneration has been a long-standing issue amongst professional nurses in South Africa, which led to industrial action in 2007(Department of Labour, 2007). The Occupational Specific Dispensation (OSD) was introduced thereafter in an attempt to improve the salary packages of professional nurses, address their dissatisfaction, and to reduce the number of nurses leaving the profession specifically in the public sector (Department of Health, 2007). In addition, a rural allowance was introduced in an attempt to retain nurses in health facilities in rural areas (George and Reardon ,2013) yet, despite quite substantial increases in income for many professional nurses, complaints about salaries persist. Both the policies relating to rural allowances and the one relating to Occupational Specific Dispensation have proved unsuccessful in their primary objective and have instead provided a further source of discontent amongst nurses (Department of Health, 2004; Ditlopo et at., 2011).

It is recognised that some of the problems related to this attrition continue due to poor working conditions than the actual salary (George and Reardon ,2013). Several studies (Khamisa et al., 2017; Bekker et al., 2015; Munyewende et al., 2014) have examined the impact of the working environment on job satisfaction and the likelihood to leave nursing and Rispel et al, (2014), showed that nurses have continued to moonlight to earn additional income despite their increases in salary. It has also been shown that although improved salaries increase the likelihood of retention, they do not result in job

satisfaction (Terera & Ngirande, 2014). It is therefore clear that increasing salaries and improving the working environment alone are not the answers to improving the professional nurse's satisfaction and a much deeper understanding is required of their economic and social circumstances before this problem can be adequately addressed.

Research shows that many nurses support extended families, placing additional demands on these nurses to provide resources and services for their families. This problem appears to be increasing since nurses remain readily employable and employed, while the unemployment rate for other categories of workers increases, impacting the potential earnings of other family members. Professional nurses from South Africa, and other countries work abroad to improve their economic and social wellbeing despite the considerable strain it puts on families of these nurses and the nurses themselves but it does enable them to improve their status (Hull 2010).

Even if salaries are improved, either by increases, moonlighting, or working abroad feelings of wellbeing do not increase but can be harmful as if income improves, according to the hedonic adaptation prevention model (Bao and Lyubomirsky, 2013) people are still not happy with their current state of affairs and continue to aspire to more. If nurses have demands and aspirations above those which they can support with their salaries and career prospects, they will, inevitably remain dissatisfied. It is known (Stephens et al., 2014) that aspirations change as one moves into a higher social class. With the profound changes in South African since the end of apartheid, changes in social class have occurred and nurses are part of this changing pattern. The social and working circumstances of professional nurses living in rural and urban area differ and yet their remuneration packages are standardised. It is not known whether the continuing dissatisfaction is linked to rising aspirations as those aspirations are poorly understood.

In view of the discussion above it is clear that in this competitive global market economy, offering financial incentives alone to professional nurses is not enough to ensure that the employer attracts and retains them in service. To curb this brain drain employer must understand the aspirations, economic and social wellbeing of these nurses in order to design strategies that commensurate with the both the needs of employees and the employer and to ensure that this healthcare cadre is retained. If the nurse's aspirations

are met they will experience high level of wellbeing and will in turn be able to care for the patients with compassion (Cooper, 2014) and this is more likely to have a positive effect on individual nurse, organisation and health outcomes (Pillay, 2009). It is in this respect that the researcher intends to investigate the aspirations, economic and social wellbeing of professional nurses working in public health sector, in order to suggest policy recommendations that could enhance the wellbeing of professional nurses in the public health sector in South Africa. Given the fact that very little is known on the aspirations of professional nurses and that this area has not been extensively investigated from the nursing perspective, this study will examine both the issue of aspirations of the professional nurses and their economic and social wellbeing. This research will contribute to the body of knowledge in this area and provide a broader understanding of the economic and social context of the professional nurses as well as her aspirations in order to provide the context for future decision making regarding their wellbeing.

1.9 RESEARCH QUESTION

How can the economic and social wellbeing and aspirations of professional nurses in the rural and urban areas of South Africa best be addressed?

1.10 PURPOSE OF THE STUDY

The aim of this study is to explore and describe the aspirations, economic and social wellbeing of professional nurses in selected provinces of South Africa.

1.11 RESEARCH OBJECTIVES

1.11.1. To explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing.

1.11.2. To formulate an aspiration questionnaire based on existing evidence.

1.11.3. To explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa.

1.11.4. To determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces.

1.11.5. To formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

1.12 DEFINITIONS OF TERMS

1.12.1 Aspirations

Aspirations refers to people's life goals/ individuals' wishes and desires for today and for the future (Kasser and Ryan 1993). In this study aspiration refers to the life goals and desires the professional nurses want to achieve to enhance their wellbeing.

1.12.2 Professional Nurse

Professional Nurse - means a person registered as such in terms of section 31(1) of the Nursing Act no 33 of 2005(Nursing Act,2005). In this study, professional nurse refers to a person who is registered with SANC to practice as a Registered Professional Nurse/Midwife, employed by the Provincial Department of Health and was working in the selected study sites at the time of data collection.

1.12.3 Rural area

Rural area - any area that is not classified urban. Rural areas may comprise one or more of the following: tribal areas, commercial farms, and informal settlements (Stats SA 2011). For the purpose of this study, a rural area is represented by the Limpopo Province.

1.12.4 Urban area

Urban area – a continuously build-up area with characteristics such as type of economic activity and land use. An urban area is one which was proclaimed as such (i.e. in an urban municipality under the old demarcation) or classified as such during census demarcation by the geography department of Stats SA, based on their observation of the aerial photographs or settlement type or on other information (Stats SA 2011). For the purpose of this study, an urban area is represented by Gauteng Province.

1.12.5 Wellbeing

Wellbeing is a multidimensional concept which includes the presence of positive emotions and moods (e.g. contentment, happiness), the absence of negative emotions (e.g. depression, anxiety), satisfaction with life, fulfilment and positive functioning (Diener, 2009; Abdallah et al., 2009; Stiglitz et al., 2009) and has many aspects such as physical, emotional, social, economic, developmental, psychological, life satisfaction, domain specific satisfaction, engaging activities and work. It can be described as judging life positively and feeling good (Veenhoven, 2008). In this study focus will be on how professional nurse's life satisfaction and aspirations with specific reference to the economic and social dimensions of their lives.

1.13 STRUCTURE OF THESIS

The remainder of the thesis is presented in seven (7) self-contained chapters as follows: Chapter 2 describes the research methodology. In this chapter the research design, setting, population, sampling, data collection and analyses, reliability and validity including ethical considerations is discussed.

Chapter 3 presents a scoping review on the concept of aspirations.

Chapter 4 describes the formulation of an aspirations questionnaire.

Chapter 5 presents the findings and analysis of the results of the survey of economic and social wellbeing and aspirations of professional nurses

Chapter 6 presents a summary and discussion of the findings and conclusions.

Chapter 7 presents the policy recommendations emanating from the findings of the research.

Chapter 8 presents the conclusions, limitations and recommendations of the study.

CHAPTER 2 - RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter presents an overview of the study methodology, for the four phases of this research. The research setting, population, sampling procedures, data collection methods and instruments, data analyses together with the techniques employed by the researcher to ensure trustworthiness, validity and reliability are discussed. In addition, ethical considerations related to this research are presented. Additional methodological information is provided in chapter three (the scoping review) and chapter 4 (which described the formulation of the aspirations questionnaire). This has been done to ensure congruence of the findings.

2.2 RESEARCH DESIGN

Research design is defined as a strategic framework for action that serves as a bridge between research questions and execution or implementation of the research (Terre Blanche, Durrheim & Painter, 2006). The type of the design directs the selection of the population, procedures for sampling, methods of measurements and plans for data collection (Burns and Grove, 2011; Polit and Beck, 2012). Mixed method research involves mixing or combining quantitative and qualitative research techniques, methods, approaches, concepts or language into single study (Onwuegbuzie and Combs., 2011). This study used an exploratory, sequential mixed method design where the qualitative phase, including the data collection and data analysis, was used to build to the quantitative phase where data was collected and analysed prior to interpreting and combining the results from both phases to answer the research question. The qualitative phase, although smaller, was an important and necessary step to collecting the quantitative data making the study a Qual →QUAN study.

The study was conducted in four phases. Phase one consisted of a scoping review where the concept of aspirations was explored, phase two consisted of a Delphi study with a group of experts using qualitative questions, followed by a pre-test of the tool to develop and test an aspirations questionnaire. Phase three consisted of a survey to determine the economic and social wellbeing and the aspirations of professional nurses.

Phase four consisted of a focus group which was held with a group of experts to assist in interpreting the data followed by an inductive approach aimed at integrating the data and developing recommendations, and organising them according to the Walt and Gilson model (1994) and subjecting them to expert review.

2.3 THE RESEARCH SETTING

This study was conducted in two provinces of the Republic of South Africa, namely Gauteng and Limpopo Provinces in order to represent a rural and an urban province. The details of the research setting for the various phases of the research are described for each phase in turn below together with the population and sample for each. The summary of each of these phases is presented in table 2.1 below. A comprehensive discussion of the methodology used in each of the phases will follow in subsequent paragraphs.

Table 2.1:Road Map of Research Methodology

	DESIGN &	OBJECTIVE/S	SAMPLING	DATA COLLECTION	DATA ANALYSIS
PHASE 1	Qualitative. Scoping review for constructs of aspirations	To explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing.	Five data bases	Search of 5 data bases using a scoping framework developed by Arksey and O'Malley (2005)	Content analysis to determine the constructs used in the articles
PHASE 2	Qualitative. Delphi study and pre-test of questionnaire	To formulate an aspiration questionnaire based on existing evidence.	Purposive sampling. n = 7	Two rounds of the questionnaire circulated to 7 experts	Content analysis including coding & formulation of themes
PHASE 3	Quantitative. Survey	To explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa. To determine if there is any difference between the economic and social	Purposive sampling. n = 1286	Self-administered questionnaire administered to professional nurses. Section 1 consisted of structured questions	**Quantitative data**: Descriptive & inferential statistics Correlation/regression analysis. Use of numeric data for description,

		wellbeing and the aspirations of professional nurses in urban and rural provinces.		and section 2 of open ended questions.	comparing groups, for relating variables, **Qualitative data:** Summative content analysis (Hsieh & Shannon, 2005)
PHASE 4	Qualitative. Focus group, then integration of findings & construction of recommendations	To formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa	Purposive sampling n = 5 (first expert group) n = 8 (second expert group)	One focus group held with 5 nurse leaders Summary & integration of findings from all phases. Expert review of recommendations	Content analysis of focus group discussion using Clarke & Braun (2013) Integration of findings & organisation of recommendations according to Walt and Gilson (1994) model as template.

2.4 PHASE ONE: SCOPING REVIEW RELATING TO ASPIRATIONS CONSTRUCTS

2.4.1 Introduction

In this phase, the researcher conducted a scoping review to identify the aspiration constructs used in other aspiration research with the purpose of developing the aspiration questionnaire for professional nurses during a subsequent Delphi study. The scoping review was done guided by the framework of Arksey and O'Malley (2005).

2.4.2 Objective

To explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing.

2.4.3 Population

Literature was searched in accordance with the literature search strategy presented in chapter 3 and only eligible articles were included in database (Table 3.1 Scanning databases and identification of articles.)

2.4.4 Sampling and sampling criteria

The literature review in this phase was limited to articles published between 1999 and 2016, full text available, scholarly peer reviewed journals.

2.4.5 Data collection

The scoping review for aspirations was conducted. Data was captured using the framework developed by Arksey and O'Malley (2005). A comprehensive account of the scoping review is documented in table 3.2 in Chapter 3.

2.4.6 Data analysis

The data extraction table was analysed by the researcher using a summative content analysis approach as described by Hsieh and Shannon (2005). This approach allows for the identification and quantification of words which is used to explore the contextual use of the words and to explore usage. Ten (10) aspirations constructs which repeatedly appear on the table were extracted. This was further

discussed with the promoter before they were used in the Delphi study which followed.

2.4.7 Results/outcome

Aspirations constructs were extracted from the literature and were entered into the data extraction table. The results of the scoping review are outlined in chapter 3, table 3.2.

2.5 PHASE TWO: FORMULATION OF ASPIRATIONS QUESTIONNAIRE FOR PROFESSIONAL NURSES

2.5.1 Introduction

Although aspirations questionnaires have been used in the other disciplines mainly in the fields of psychology and social sciences - not much is known with respect to the aspirations of professional nurses in the public health sector. The scoping review showed that no aspiration questionnaire has been specifically developed for professional nurses.

This phase consists of two sections namely, a Delphi study which dealt with the confirmation of the constructs related to aspirations followed by the formulation and pre-testing of the questionnaire.

The Delphi technique is a method of measuring the judgements of a group of experts for assessing priorities or making forecast (Burns and Grove, 2005). This technique allows for interaction between the researcher and the experts without the experts having contact with one another. This ensures they do not influence one another. The researcher acted as a facilitator to acquire expert information about the concept and to develop statements regarding each construct of aspirations which had already been derived from the scoping review. A detailed discussion on the Delphi study is presented in chapter 4, but for the sake of completeness of this methodology chapter, a summary appears below.

2.5.2 Section 1 Delphi study

Objective

To formulate an aspiration questionnaire based on existing evidence.

Sampling for the Delphi study

Purposive sampling was used to select experienced individuals in different and relevant fields to participate in the Delphi study. Purposive sampling involves identifying and selecting individuals that are knowledgeable about or experienced with the phenomenon of interest (Creswell and Clark,2011) The Delphi study expert group comprised of seven (7) individuals, with extensive experience in different fields, selected from both private and public organizations and who had agreed to participate in the study. The experts included in the Delphi study were, therefore, an educational psychologist, a senior nursing manager from the public sector, a senior manager from the private sector, a nurse leader representing a nursing education professional organisation, a nurse leader from the higher education sector, a Chief Financial Officer of a statutory health council and a director of finance from a national parastatal company. The selection of the participants ensured that experts with understanding of economics and finances as well as experts in the field of nursing who understand the dynamics and context of professional nurses were included. By including a psychologist, the researcher also made sure that an expert with understanding of individual and group aspirations was included.

Data collection

Data was collected in two rounds which involved establishing a rapport with the Delphi group, obtaining consent for their participation, sending the selected constructs to the Delphi group through email. Round one involved sending a list of constructs, derived from the literature to the experts. The constructs which were included were, educational attainment, better job, possessions, financial status, self-acceptance, affiliation, community feeling, popularity, income and geographical location. They were each asked to define the concepts. Once the responses were received, the researcher collated the responses and eliminated constructs that the

experts did not believe to be part of the construct ‘aspiration’ and added one that they believed should appear. In the second round, participants were provided with the constructs with the defining statements which were derived from round one. Participants were asked to agree or disagree with the defining statements and to the inclusion or otherwise, within the questionnaire, and to make comments as appropriate.

Findings

Details of the analysis of the Delphi and the findings thereof are discussed in chapter 4. The intention of the Delphi was to reach consensus about the constructs which occurred after two rounds.

Eighty-six percent (86%) of the Delphi study participants agreed that the list of constructs in the second round and corresponding statements could be used in developing a tool to measure aspirations for professional nurses whilst 14% indicated no further comment in round 2 without indicating the chosen option. It was assumed that consensus existed among the group.

Section 2 The formulation of the aspirations questionnaire

Once consensus had been reached about inclusion of the constructs, they were collated into an open-ended questionnaire that asked participants, "In terms of you and your family’s aspirations and needs what would you like to have with regards to the following?” after which the constructs were listed with space to comment. Prior to conducting the main study, a pre-test was done of the aspirations questionnaire which was added to the household questionnaire which is discussed later.

Pre-testing involves simulating the formal data collection process on a small scale to identify practical problems with regard to data collection instruments, sessions and methodology (Hurst et al, 2015)**.** Before the aspirations questionnaire was distributed to the target population, a pre-test study was conducted to determine feasibility, word ambiguity and for face validity. Purposive sampling was used to select twelve (12) professional nurses who were working at a Community Health Clinic (CHC) to participate in the pilot study. Professional nurses working at the

CHC were selected because they were not part of the target population but representative of the study population.

The participants were asked to complete the questionnaire and also to comment on whether they experienced any difficulty with understanding terms or in completing the questionnaire. All twelve (12) professional nurses completed the survey questionnaire and returned it to the researcher yielding a response rate of 100%. The participants did not encounter any difficulty in completing or interpreting the questions.

Despite not being referred to in the questionnaire, the respondents commented on the content and the process of implementing the Occupational Specific Dispensation policy, indicating the influence they perceive it to have on their economic and social wellbeing.

There was no problem with the pre-test regarding face validity, and 85% of the participants commented that the survey must include a specific question on the nurses Occupational Specific Dispensation (OSD). The high degree of consensus and affirmation of the questionnaire may be associated with what Calkin (2013) refers to as ‘nurses’ subservient past.’ This is of some concern and is a limitation of the study. However, as the participants in the survey, which included the aspirations questionnaire, were able to add other comments, which were taken into consideration when analysing the final results, this should serve to reduce the effect of this limitation.

2.6 PHASE THREE (SURVEY)

2.6.1 Objectives

2.6.1.1. To explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa.

2.61.2. To determine if there is any difference between the economic and social wellbeing and the aspirations, of professional nurses in urban and rural provinces.

2.6.2 Research Setting

The research was conducted in two provinces of South Africa, namely Limpopo, which is predominately a rural and underdeveloped province, and Gauteng, which is predominately an urban and developed province. Limpopo province has two tertiary hospitals (Polokwane and Mankweng hospitals), five (5) regional hospitals, thirty (30) district hospitals which support 440 community health centres and clinics, which are spread throughout the province. Limpopo province has a population of 5,404,868 which is 10.4 per cent of the total population of South Africa. The province has a total of 17,966 qualified nurses employed in the public service. Of the total number of nurses, 8007 are professional nurses. A large part of the province consists of rural areas, with a large section of the population that is illiterate and unemployed. According to the 2011 census, unemployment in Limpopo was 38.9% compared to 26.3% in the Gauteng province and 29.8% in South Africa as a whole. The majority of those in employment are mainly farm workers and public servants. The average annual household income in Limpopo is R56,844 whilst in Gauteng it is R156,243. (Limpopo DoH, 2011; Stats SA 2014, Gauteng DoH, 2011).

Gauteng province has four (4) tertiary hospitals, nine (9) regional hospitals, eleven (11) district hospitals and 413 community health centres and clinics. Gauteng province has a population of 12,272,263, making it the province with the largest share of the South Africa population (23.7%)-(Stats SA, 2011). Gauteng has a total number of 27307 nurses employed in public service. Of the total number of nurses 14052 are professional nurses. (Gauteng DoH -APP, 2016).

The sites selected for this research are one tertiary hospital, one regional hospital and one district hospital in each of the above two provinces. Each of these hospitals provides a different level of care (i.e. level 1, 2 and 3 hospital services) and, therefore, have different clinical specialty areas which informs skills, competencies, qualifications and categories of nurses and doctors required to work in the specific clinical areas. In tertiary hospitals such as Polokwane, Mankweng and George Mukhari, there are many clinical specialty and sub-specialty areas and, therefore, many medical and nursing specialty posts as compared to regional and district hospitals. George Mukhari tertiary hospital and Tshwane district hospital are

both located in Pretoria, while Far East Rand hospital is ± 87 km from Pretoria and ± 41km from Johannesburg respectively. Similarly, both the Polokwane and the Mankweng hospital are in Capricorn district within the city of Polowane. Tshilidzini Regional Hospital and Siloam District hospital are located in Vhembe district, which is +-200 km away from the city of Polokwane and are surrounded by mostly mining and farming communities and small business enterprises. The level and type of medical and nursing posts (specialty/general) available in each of these hospitals has a profound effect on remuneration of nurses in terms of the Occupational Specific Dispensation for Nurses (OSD).

Table 2.2: Demographic features of Limpopo and Gauteng provinces

	Limpopo **Rural**	**Gauteng** **Urban**
Population	5,404,868	12,272,263
Unemployment rate	38.9	26.3
Annual household income	R56,844	R156,243
No of nurses	17,966	27307
No of professional nurses in public service	8007	14052
No of tertiary hospitals	2	4
No of regional hospitals	5	9
No of district hospitals	30	11
No of community health centres and clinics	440	413

Limpopo DoH-APP, 2011/2012; Stats SA, Census 2011; Gauteng DoH -APP, 2016

2.6.3 Population

The population of this study comprised of professional nurses working in selected public hospitals in two of the nine provinces of South Africa. Two provinces namely Gauteng and Limpopo were purposively selected to represent urban and rural provinces respectively.

2.5.2. Sampling and sampling method

Sampling is the process of selecting a portion of the population that conforms to a designated set of specifications to be studied. A sample is a portion of the target population selected to participate in the study (Polit and Beck, 2012).

2.6.4 Selection of the research sites in Limpopo Province and Gauteng Province

Three hospitals in Limpopo and Gauteng Province were purposively selected by the researcher to represent one tertiary/academic, one regional and one district hospital. Purposive sampling is a sampling method where the researcher purposefully selects participants or sites that will best help the researcher understand the problem and the research question (Creswell, 2009). The three names in Limpopo province which were purposively selected are Polokwane/ Mankeng hospital complex, Tshilidzini hospital and Siloam hospital whilst in Gauteng province selected hospitals are George Mukhari hospital, East Rand hospital and Tshwane District hospital. Although Polokwane hospital and Mankweng hospitals are in different locations in Polokwane they operate as a complex or one unit hence they were also assigned one name for the purpose of this research.

2.6.5 Selection of the participants

For this survey, a purposive sampling method was used. All professional nurses working in selected hospitals in Gauteng and Limpopo provinces, who met the sampling criteria and where on duty at the time of data collection, were requested to participate in the study.

2.6.6 Sampling criteria

Sampling criteria refer to a list of characteristics of the elements that are determined beforehand and are essential for eligibility to form part of the sample (Polit and Beck, 2012). For the purpose of this study, the inclusion criteria were:

a) Professional nurses with more than 1 years' experience practicing as a professional nurse after obtaining a qualification leading to registration as a professional nurse with SANC.
b) Professional nurses employed by the Provincial Department of Health of either Gauteng or Limpopo provinces.
c) Participants stationed at one of the pre-selected health facilities designated as a tertiary/academic, regional or district hospital.
d) Participants were employed at a production level, working in a general or specialty nursing area.

2.6.7 Exclusion criteria:

a) Nurse Managers and Operational Managers.
b) Community Service Nurse Practitioners.

2.6.8 Sample size

The target population for this study was 1962 professional nurses on the staff establishment of the selected public hospitals in Limpopo and Gauteng provinces. Based on the total population (1962) a margin of error of 5% and confidence level of 95% was chosen. Ninety-five percent (95%) is the acceptable confidence level for survey. Using an electronic calculator (www.checkmarket.com), the required sample size is 403 with the estimated response rate of 80%.

However, a total of 1398 (71%) survey questionnaires were distributed to the professional nurses who agreed to participate in this study and were on duty at the time of data collection, which constituted 71% of the target population. Out of 1398 survey questionnaires distributed to participants, 1286 were returned yielding a return rate of 92%. Of 1286 questionnaires that were returned, 148 (11%) were spoiled (either not completed at all or were illegible), and only 1138 completed questionnaires were captured into an excel spreadsheet for analysis, which is 58% of the total sample. Access to the total population was not possible due to some nurses being off duty or on leave (study, vacation, maternity, family responsibility or sick leave etc.) and those who were not willing to participate. The table below indicates the hospitals selected and the number of eligible professional nurses

employed in each of these hospitals. This table also assisted in determining the sample size for this study.

Table 2.3: Total Target Population

Research Setting	Name of Hospital	No of Professional nurses	Province
Academic /tertiary Hospitals	Polokwane/Mankeng Hospital complex	677	Limpopo
	George Mukhari hospital	613	Gauteng
Regional Hospitals	Tshilidzini Hospital	312	Limpopo
	East Rand Hospital	163	Gauteng
District hospitals	Siloam Hospital	92	Limpopo
	Tshwane Hospital	105	Gauteng
TOTAL		1962	

2.6.9 Data collection

Data collection is the process where data is systematically gathered from the participants to address the research question (Polit and Beck, 2012). In this phase, the aspiration questionnaire was administered to all professional nurses in the study sites who were present and willing to complete the survey at the time of data collection. The researcher was assisted by two research's assistants to distribute and collect the aspirations questionnaire from the study sites. These assistants were students following a MSc programme who were trained in data collection methods. The data was collected over a period of 4 weeks to cover different shifts, long distances between the two provinces and between the hospitals within Limpopo and Gauteng province respectively.

2.6.10 Data analysis

Data analysis is the process of systematically applying statistical or logical techniques to describe and analyse data and draw conclusions. The data generated during the data collection process was systematically analysed and interpreted by the researcher with the assistance of a statistician.

A descriptive and inferential statistics was used during data analyses (Polit and Beck, 2012). Descriptive statistical tests were used to summarise the demographic data, including measures of central tendency and dispersion (mean and standard deviation). The use of descriptive statistics assisted in establishing patterns that emerge from the data.

Comparisons were undertaken to analyse differences between demographic characteristics using Kruskal –Wallis statistics for scores that were found not to be normally distributed and include analyses of variance. In addition, correlation and regression analysis was used to assess the level of associations between the types of expenditures and identify expenditures that influence the savings among the Urban and Rural Nurses.

The qualitative data was analysed guided by the qualitative data analyses method suggested in Creswell (2009) which involves some of the following steps, organising and preparing data for analysis, reading through all data, detailed analysis with coding process, developing categories and themes and interpretation or meaning of the data.

The raw data collected from open ended section of the questionnaire was first organised into the excel spread sheet, after reading through the data, repeated statements were colour coded, frequency counted, themes or categories emerged and topics that were related to each other were grouped together in order to reduce the list of categories. This procedure followed a summative content analysis approach (Hsieh & Shannon, 2005). With the assistance of the statistician this was then entered into a computer programme for further statistical analyses. Domain characteristics between Urban and Rural Nurses namely affiliation, image, financial, educational and occupational aspirations were compared using independent t-test statistics. The software used to achieve the objectives was Stata 13.2 (StataCorp. 2015).

2.7 PHASE FOUR: FORMULATION OF THE RECOMMENDATIONS BASED ON RESEARCH FINDINGS

Phase four consisted of integrating the findings from the other phases with the intention of meeting the final research objective which was, “to formulate

recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa" and to address the research question which was, "How can the economic and social wellbeing and aspirations of professional nurses in the rural and urban areas of South Africa best be addressed?"

This phase consisted of the integration of the results from all the phases of the study, a focus group to assist with the formulation of the recommendations, organisation of the recommendations into a policy framework, and finally a round of verification of the recommendations by a group of experts.

2.7.1 Objective

To formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa".

2.7.2 Integration of the findings

Fetters et al. (2013) explain that the integration of the mixed methods can occur at either the design level, the methods level or the interpretation and reporting level. In this study, the latter type of integration was used where, during the interpretation and reporting phase, the data from the qualitative and the quantitative phase were brought together by means of what Fetters et al. (2013) refer to as 'joint displays'. Tables were developed which summarised the findings in order to develop a composite understanding of the data from all phases in order to draw out new insights. Prior to the tables being developed, the quantitative data had to be converted into statements that described the finding. For example, the demographic data relating to the gender of the participants was converted to the statement, "the profession is female dominated". The quantitative data from the survey was categorised into the main headings of the household survey, viz demographic data, place of residence, education, additional employment, transport, accommodation, childcare and income. All the statements were organised into these headings (See table 7.3.).

The qualitative data from the open-ended questions (aspirations questionnaire) at the end of the household survey document were categorised according to the

aspirations and the data relating to these, from the scoping review and the data from the Delphi study, added to these statements in the tables 7.1 to 7.9 in chapter 7.

The summary sheet was designed around the aspirations namely, educational attainment, job satisfaction, possessions, financial success, self-acceptance, community standing, income, status and power as well as quantitative data related to demographics place of residence, education, additional employment, transport, accommodation, child care and income. The table was further divided into one column that indicated what the researcher had discovered from the data and a further column on what had been learned from the data that had been gathered and reported upon.

A directed content analysis approach was used to make these summaries, where, according to Hsieh & Shannon (2005) researchers 'begin by identifying key concepts or variables as initial coding categories'. The authors explain that it is particularly useful when something is already known about the phenomenon, but when it would benefit from further description. In this case the aspirations were used as initial coding and the findings of the scoping review, Delphi study and survey respectively were read and assigned a code depending on which aspiration they related to. The findings of each of the aspirations were then viewed together to develop the 'lessons' learned from the data. The complete summary can be found in tables 7.1 to 7.9 but an extract is given below in table 2.4. to assist in the explanation of the methodology used.

Table 2.4: Key concept: Educational attainment

Source	**Findings**	**Lessons learned**
Scoping Review	Predicts continuity / discontinuity of poverty Used as a means to escape poverty	Educational attainment is a means to an end i.e. to improve economic and social situation. The type of attainment aspired to varies according to their context.
Delphi	Linked to self-actualisation Not only for individual but for family	
Survey	Professional nurses aspire to:	

	Degrees Speciality training Computer training Tertiary qualifications for their children Bursaries for their children	

2.7.3 Focus group discussion

Focus groups involves engaging a small number of people in an informal group discussion or discussions focused around a particular topic or set of issues as defined by Wilkinson, (2004) cited in Onwuegbuzie et al. (2009). Focus group discussion has advantages that it enables in-depth discussions and involves relatively small group of people, it is focused on a specific area of interest that allows participants to pay special attention on (Liamputtong, 2011). A focus group was formed to consider the findings of the study and to make suggestions that could be used in formulating the recommendations based on the findings.

Sampling

Purposive sampling was used to select four (4) persons participate in the focus group discussion to consider the findings of the study and to make recommendations.

The focus group consisted of persons with at least 10 years' experience in the following areas:

i. One person with management experience in the Public Service
ii. One person with experience working in Organized Labour
iii. One person with experience in Nursing Management
iv. One person with experience in Nursing Education

Data collection

Initially the result of the first three phases of the research study were presented to the group, after which one question was posed namely, “After considering the research findings, what preliminary recommendations would you make to address the economic and social wellbeing, and aspirations of professional nurses in South Africa?

The discussions were audio-taped. The researcher moderated the discussion and later transcribed the audio-tapes to facilitate analysis.

Data analysis

- After focus group discussion, the researcher listened to the tape and transcribed the recordings. The transcriptions were analysed using Clarke and Braun’s (2013) process to content analysis, namely:
- Familiarisation with the data during which time the researcher read through the transcripts
- Coding where preliminary codes were assigned to similar ideas or recommendations
- Searching for themes among the coded data
- Reviewing themes to check for consistency
- Defining and naming the themes

Four themes emerged from the analysis of the data viz. financial incentives; living and working environment; education and training and regulatory body issues. Details of these findings can be found in chapter seven.

After consolidation of the statements from the members of the focus group the analysis was emailed to all members for member checking and consensus. This yielded a return rate of 75% meaning one member did not respond. Of those who responded there was consensus on the themes and that they should form the basis of recommendations for the study with some additional comments being made that were used to support the findings.

2.7.4 Formulation of Recommendations

As explained above, the data was integrated and then used to formulate the recommendations which were then organized according to the model of Walt & Gilson 1994). Walt and Gilson's model (1994) was developed to guide policy analysis and has been used in the health policy arena regularly since then (Buse & Walt, 1994; Walt et al., 2008; Ditlopo et al., 2011; Buse et al., 2012; Blaauw et al., 2015). The strength of the framework is that it recognises that people, or actors play a large role in developing policy, implementing policy and that they are also the reason why most health policies are developed. The framework was developed specifically for the health sector and is "grounded in a political economy perspective" (Walt 1994). Making it appropriate to guide the recommendations for this study.

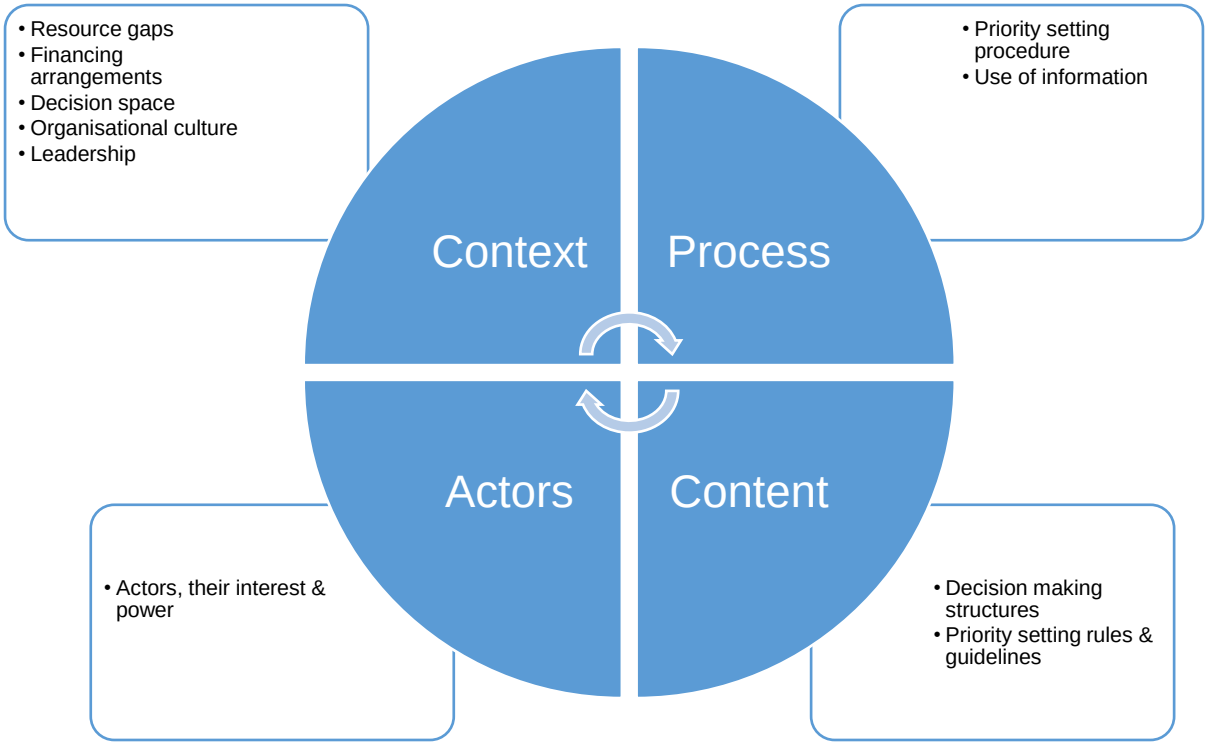


Figure 2.1: Walt and Gilson Framework (1994)

'Actors' in the framework, refer the groups or clusters of people who are connected in some way, either closely or loosely, who are capable of engaging in collective action even if they do not do so. They have the capacity to identify problems, and to create or block proposals for resolving issues. In this study, it is recognised that

professional nurses, who were the focus of this study, are not the only actors, and that the Department of Health, National Treasury and the unions, as well as several other smaller groupings play a role in determining the economic and social status and wellbeing of the professional nurse. The nurses were, however, according to Ditlopo (2013) largely left out of policy development and implementation of the Occupational Specific Dispensation policy and, despite the intention of the policy which was “To provide adequate and clear salary progression and career pathing opportunities based on competencies, experience and performance” (DoH, Resolution 3 of 2007) was seen by the nurses as a salary increment, and that the policy was not based on evidence (Ditlopo et al, 2013). The researcher’s findings related to the professional nurses as actors with regard to their economic and social wellbeing is therefore crucial and forms the basis of this aspect of the framework if problems are, in future, to be resolved.

The ‘context’ in the framework, refers to the setting or situation in which the policy development and implementation occurs. Two provinces viz Gauteng and Limpopo were included in this study and were taken to represent both rural and urban settings. The literature used was from an international context and the Delphi participants and focus group participants spoke from the perspective of South Africa as a whole. All policies related to remuneration of nurses takes place on a national level but clearly, their local context plays an important part in determining economic and social wellbeing.

The ‘content’ of any policy should relate to the aims & objectives, underlying values, and design details of any policy. The data collected did not examine specific policies but the contributions made by the experts in the focus group does go some way to addressing these issues.

The ‘process’ of any policy refers to the way it was developed and implemented. Although this study did not set out to explore this aspect, the consequences of failed policies related to economic and social status became clear and will be addressed in the recommendations.

The recommendations can be found in the chapter 7. Once they had been formulated by the researcher, they were sent to 9 experts to verify that they were

relevant, feasible and clear. At this stage, it was felt necessary to include younger professional nurses who could potentially benefit from any recommendations made to improve the economic and social wellbeing of professional nurses. The eight experts who participated in this review of the recommendations were:

- One person with experience working in Organized Labour
- One Director of Nursing
- Two nurse managers (one from each province)
- Two professional nurses under the age of 40 years living or working in Gauteng
- Two professional nurses under the age of 40 years living or working in Limpopo
- One senior nurse academic with knowledge and experience of the public sector

All were required to have a qualification not less than a Bachelor's degree in Nursing.

The findings of this process are described in chapter 7.

2.8 RIGOUR OF THE STUDY

This study followed a mixed method design Qual→QUAN therefore steps were followed to ensure rigour for both quantitative data and qualitative data which are described respectively below. (Creswell, 2009; Creswell and Clark, 2011).

2.8.1 Validity and reliability

The instrument used in the survey section of the study was the General Household Survey 2013 tool, devised by Stats SA (2014). This is an open domain tool developed and tested by Statistics South Africa, who review and amend the tool each year before use to ensure the relevance of its content. Like all household surveys, there is bound to be some decrease of reliability caused, among other factors by the fact that they have to be developed with cost and potential error in mind and rely to some extent on the fact that they have huge populations and use total samples and therefore the levels of uncertainty are reduced. While the results of each census are widely available and a great deal of information is given by

Stats SA on the reliability of their findings, there is less information available on content validity. General Household Surveys have been conducted annually since 2002 and is, as Stats SA (2014) states, “an omnibus household based instrument aimed at determining the progress of development in the country. It measures, on a regular basis, the performance of programmes as well as the quality of service delivery in a number of key service sectors in the country”. The survey results have been used for secondary analysis by published authors (Wabiri et al, 2013). Most of the aspects of the tool measure economic and social status which made it appropriate for this study. It also made it possible to compare the results relating to the economic and social wellbeing of the professional nurses with the national data.

The reliability of a research instrument concerns the extent on which the instrument yields the same results on repeated measure. The most popular method to measure internal consistency is the coefficient alpha commonly referred to as Cronbach alpha. In this research, the value of reliability was based on Cronbach alpha which showed a good level of reliability coefficient of 0.7748. Cronbach alpha calculates correlation among all the variables in every combination. Reliability coefficients range from 0.00 to 1.00 a high reliability estimate indicate a higher level of reliability (Kimberlin and Winterstein 2008).

Validity refers to the ability of an instrument to measure what it is designed to measure (Sullivan, 2011). To fulfil this criterion, the aspirations questionnaire was pre-tested with a group of 12 professional nurses who were not part of the target population but representative of the study population. This was done to establish the content validity of the instrument, to improve questions and format (Creswell and Clark, 2011). The response rate was 100% with all participants having completed the questionnaire and 85% of the respondents gave additional comment that a question on OSD must be added on the questionnaire as it impacts to their aspirations and wellbeing In response to this the researcher has added additional field on the questionnaire for any other specific comments the participants would like to make Secondly the researcher has also involved the experts (Delphi study) in the process of the formulation of the aspirations questionnaire and lastly the researchers promoter also assessed the questionnaire before it was implemented.

The aspirations questionnaire was pre-tested with a group of 12 professional nurses who were not part of the target population but representative of the study population. This was done to establish the content validity of the instrument, improve questions and format (Creswell and Clark, 2011).

2.8.2 Trustworthiness

Transferability refers to the extent to which the findings can be applied in other contexts or with other participants (Creswell and Clark, 2011). The researcher has used rich thick descriptions of the participants, research methodology and setting understudy to allow the reader to make decisions regarding transferability. A peer review or debriefing provides an external check of the research process (Creswell and Clark, 2011). According to Lincoln and Guba (1985), the peer reviewer is defined as a devil's advocate, an individual who keeps the researcher honest, asks hard questions about methods, meanings and interpretations and provide the researcher with the opportunity for catharsis by sympathetically listening to the researcher. In this research, the researcher had an experienced research lecturer who agreed to serve as a reviewer of the entire research process. The researcher's promoter also had access to the research material and reviewed the process.

The dependability criterion relates to the consistency of findings. Lincoln and Guba (1985) maintains that there can be no validity without reliability and therefore no credibility without dependability. Achievement of the former is sufficient to establish the existence of the latter. To satisfy these criteria, the researcher has provided a dense description of the methodology to conduct the study, description of data, rationale for the study, design for the study and subjects. The different methods used for collecting and analysing data was explicitly explained with specific reference to the mixed method research. Data was also organised in categories and themes. All the data, documents, findings, interpretations and recommendations were kept and were made available and accessible to the supervisor and were preserved for the purpose of conducting an audit trail (Zohrabi, 2013). Member checks were used on two separate occasions during the research study. The triangulation of the data from the various phases of the research further ensured confirmability. This study was done in two provinces in South Africa and

although the participants represent urban and rural communities, generalisability of the findings to the whole country cannot be assured.

2.9 ETHICAL CONSIDERATIONS

To protect human rights, which mainly relates to beneficence (doing good) and to avoid non-malfeasance (doing any harm), the following ethical principles were taken into consideration in this study.

2.9.1 Principle I: Right to self determination

The right to self-determination is based on the ethical principle of respect for a person, therefore prospective participants must be given information about the study to enable them to choose to participate freely without coercion (Burns and Grove, 2005). Participants were given information about the study through an information sheet (appendixes **E, F and G**) and were requested to give informed consent before they participated in the study. No coercion, deception or covert data collection strategies were used. Participants were informed of the purpose of the study and their rights to choose to participate or not to participate. The participants were informed that participation was voluntary and that they had a right to withdraw at any time without fear of any retribution. Permission to conduct the study was also sought and granted from Witwatersrand University ethics committee, the Heads of the Departments of Health in Limpopo and Gauteng provinces respectively. This is contained in appendixes **B, C, and D** respectively.

2.9.2 Principle II: Right to Privacy

Privacy is the right an individual has to determine the time, extent and general circumstances under which personal information will be shared with or withheld from others (Burns and Grove, 2005). This right is also enshrined in the Constitution of the Republic of South Africa under the Chapter 2 of the Bill of Rights. It is further operationalized by the Protection of Personal Information Act (Act No 4 of 2013). In this act, the right to privacy includes “a right to protection against the unlawful collection, retention, dissemination and use of personal information”.

Participants were required to give informed consent to participate in the study. A sample of the consent form is contained in appendix **H, I** and **J**. All participants were informed that the data and information collected would be kept confidential and would only be used for the purpose of this study. All data will remain secured by the researcher, and only the researcher, researcher's assistants and the supervisor have access to the stored data. Participants were informed of their right to withdraw from the study at any time and that participation was voluntary. The researcher complied with the University of the Witwatersrand ethics committee guidelines, Constitution of Republic of South Africa (Act 108 of 1996) and the Protection of Personal Information (Act no 4 of 2013).

2.9.3 Principle III: Right to Autonomy and confidentiality

The participants were informed that the information they provided and the data gathered would only be used for the purpose of the study and that they were not required to disclose their identity (e.g. Persal no or Identity no.) on the survey instrument. The information gathered was only be used by the researcher and will be kept locked away, and only the researcher, researcher's assistants and the supervisor have access to the stored data. The preliminary data was captured on MS-Excel spreadsheets without identification of the institutions where the data had been generated, to minimize the chance of identification of the participants.

2.9.4 Principle IV: Right to fair treatment

The right to fair treatment is based on the ethical principle of justice (Burns and Grove, 2005). All the professional nurses working in the selected study sites, who met the inclusion criteria irrespective of race, age, ethnic background, socio-economic status and religion, were given the opportunity to participate in the study. The researcher further adhered to the agreement regarding the dates and time for distribution and collection of survey instruments without forcing this on the participants or the hospital management.

2.10 CONCLUSION

In this chapter, an overview of the methodology used in this study is outlined. This includes a description of each of the four phases of the thesis, research setting, sampling processes, data collection methods and analysis. The methods employed

by the researcher to ensure reliability, validity and trustworthiness of the research have also been outlined, taking into consideration that the researcher has followed a sequential, mixed method design. Lastly, the researcher has described the ethical considerations pertaining to this research. Details regarding the findings in each of the phases described in the methodology chapter will be discussed further in relevant subsequent chapter.

CHAPTER 3 - THE SCOPING REVIEW FOR ASPIRATION CONSTRUCTS

3.1 INTRODUCTION

Although in most studies the terms “scoping reviews” and “scoping studies” are used interchangeably, the term “scoping study” will be used in this research. Scoping involves the synthesis and analysis of a wide range of research and non-research material to provide greater conceptual clarity about a specific topic or field of evidence (Davis et al., 2009).

The aim of the scoping study is to rapidly identify the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as a stand-alone project in its own right, especially where an area is complex or has not previously been comprehensively reviewed (Arksey and O’Malley, 2005). Scoping studies are commonly policy directed and intended to guide more focussed lines of research and development, while providing the researcher with the opportunity to identify key concepts, gaps in research and sources of evidence to inform practice and research (Davis et al., 2009).

3.2 RESEARCH OBJECTIVE FOR THE SCOPING REVIEW

To explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing.

3.3 SCOPING FRAMEWORK

As little was known about how to measure aspirations of professional nurses, a scoping study was conducted to identify the constructs used by other researchers in the field of aspirations research. While none of the articles specifically set out to define constructs, their work was used to identify those that were used in the course of their study. Once the aspirations had been identified, through the scoping study, further literature was used to define and explain each of the identified constructs.

In this research the scoping process was guided by the scoping framework developed by Arksey and O’Malley (2005) and cited in Levac et al. (2010) which followed the five (5) stages outlined below:

a) Identification of the research topic
b) Identification of relevant studies
c) Study selection
d) Charting the data
e) Discussion of findings.

3.3.1 Stage 1 - Identification of research topic

In this phase of the research the objective is “to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing”.

3.3.2 Stage 2 - Identifying relevant studies

The researcher conducted a search through an electronic database by initially using the search word “Aspirations” which yielded 104 843 search results from Science Direct. The researcher then narrowed the search by using the search key words “Life aspirations and aspirations, socio-economic and aspirations”. The following databases were used: PubMed, Scopus, Science Direct, EBSCO Host and ProQuest. The search was limited to the articles published in the period from 1999 to 2016 and written in English. The wide time line was needed as much of the literature was produced in the previous decade and less more recently. In this phase, a database of 123 articles fitting the selection criteria were generated. This is summarised below:

Table 3.1: Scanning databases and identification of articles

No table of figures entries found.	Key Words	No. of Titles Scanned	No. of Abstracts Read	No. of Articles Included
PUBMED	Life AND aspiration	14	2	1
	Socio-economic AND Aspirations	1	1	1
	Total	15	3	2
SCOPUS	Life AND aspiration	30	5	3
	Socio-economic AND Aspirations	5	5-1R=4	2
	Total	35	9	5
SCIENCE DIRECT	Life AND aspiration	6	5	4
	Socio-economic AND Aspirations	1	1	1
	Total	7	6	5
EBSCO Host	Life AND aspiration	39	17-4R=13	10
	Socio-economic AND Aspirations	6	8-5R=3	2
	Total	45	16	12
ProQuest	Life AND aspiration	19	14-12R=2	0
	Socio-economic AND Aspirations	2	2-2R=0	0
	Total	21	2	0
TOTAL		**123**	**34**	**24**

NB: R signifies repeated articles from previous databases

3.3.3 Stage 3 - Study selection

In this phase, the researcher read the title of all the articles found in the initial search and eliminated the articles which did not fit into the research question of the current research. Out of one hundred and twenty-three (123) articles initially extracted from the different databases, only thirty-two (34) remained on the list after this exercise. The abstracts for the remaining thirty-four (34) articles were printed and sent to the researcher's supervisor and one PhD student for further review. Both these reviewers concurred with the researcher on the inclusion of twenty-four (24) articles in the next round and eliminated ten (10) articles after reading the abstracts of the initial thirty-four (34) articles. The remaining twenty-four (24) full text articles were printed out and the researcher read each of these articles. To manage and assist with referencing, the researcher has used the Mendely reference manager which was downloaded from the website.

3.3.4 Stage 4 - Charting the data

Charting refers to a technique for synthesizing and interpreting qualitative data by sifting, charting and sorting material according to key issues and themes (Richie and Spencer, 1994). In this stage data was synthesized, summarised and charted on a data matrix form created through MS-Word, with columns representing the item number, author, year of publication, population and sample, purpose of the study, definition of aspiration and constructs defining aspiration. Details are presented in the data matrix below:

Table 3.2: Data matrix chart

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
1.	Schmuck et al. (2000)	83 German students (University of Goettingen) and 125 US students (University of Rochester)	The aim of this study was to examine the aspirations and wellbeing in college students from two different cultures, namely the United States and Germany.	Satisfaction of intrinsic goals leads to greater physiological wellbeing and happiness, while the focus on extrinsic goals is associated with unhappiness, stress and lower wellbeing.	Intrinsic aspiration Self-acceptance Affiliation (e.g. intimacy, close relationship) Community feeling Physical fitness (e.g. being healthy) Extrinsic aspirations Financial success (e.g. having material possessions and much wealth

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
					Social recognition (e.g. popular and admired) Attractiveness/Appearance (e.g. being good looking)
2.	Kasser and Ahuvia (2002)	92 business students	The study investigated the association between extrinsic aspirations and lowered wellbeing.	Students who are more strongly orientated to materialist value reported lower levels of subjective wellbeing, lower self-actualisation, vitality and happiness, increased anxiety physical symptoms and unhappiness.	Extrinsic aspirations - materialistic value Money, Image, Popularity Intrinsic aspirations Self-acceptance/personal growth Affiliation Community feeling

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
3.	Martos and Kopp (2012)	Survey of 4841 Hungarian adult participants	The study examined the importance of life aspirations related to socio-economic characteristics, financial status and wellbeing.	Focus on intrinsic goals has positive relationship with Subjective Wellbeing (SWB) and the Meaning of Life, (ML) whereas focus on extrinsic goals had weak and negative relationship to subjective wellbeing (SWB) and Meaning of Life (ML).	Kasser and Ryan (1996) Aspiration index Intrinsic goals Self-acceptance Good relationship Community contribution Extrinsic goals Fame Wealth Good appearance
4	Rijavel et al. (2008)	Questionnaires administered to 835 college students	To explore whether participants can be classified into groups according to their	Both extrinsic and intrinsic goals contribute to wellbeing.	Ryan and Kasser Aspirations index

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
			intrinsic and extrinsic life goals, and how these groups differ in satisfaction of basic psychological needs and wellbeing.		Intrinsic aspirations Self-acceptance Affiliation Community feeling Physical Good health Extrinsic Wealth (money, possessions) Popularity (fame) Image
5	Croll (2008)	British household panel survey, 10,000	The study examined young people's occupational choices at	The researcher argues that young people have high occupational ambitions and	Professional jobs Managerial technical jobs

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
		people interviewed annually since 1991 for a period between 5 and ten years	the age of 15 in relation to their educational attainment, their parent's occupations and actual occupations when they were in their early 20s.	they aspire to well rewarding occupations regardless of the availability of such occupations. Further argues that the parents' socio-economic status, education, and occupation has influence on the child's career aspirations, career choice and educational attainment but does not determine them. "Choice is real but constrained for many people."	Well rewarding occupations
6	Johnson (2008)	Eight experienced financial planners,	The study examined the perceptions about the importance of financial means in contributing to quality of life.	Financial means are not high in order of life domains that contribute to respondent's quality of life. Priorities prior to retirement	Financial security Stable income

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
		12 people working and living in major capital city, aged 45-55 years		are children's education and home mortgage payments.	Interpersonal relationship with family and friends Health of self - free from the constraints of financial resources Education Quality home environment Travel Owning comfortable home Investments on residential property Community service
7	Ferrante (2009)	N/A	To investigate whether the building up of aspirations is in some	The researcher argues that people's life satisfaction depends greatly on how	Socio-economic aspiration Income aspiration

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
			way connected to people's demographic characteristics such as age and gender.	experienced utility compares with the expectation of life satisfaction or decision utility. If aspirations are raised above real life chances, they depress life satisfaction.	
8	Brdar et al. (2009)	N/A	Examines the concepts of intrinsic and extrinsic aspirations in relation to a person's wellbeing.	The researcher argues that pursuance of extrinsic (materialism) aspirations is not necessarily detrimental but may contribute to person’s wellbeing if they help the person to achieve basic financial security or some intrinsic goals. On the other hand, if social comparison or seeking power drives extrinsic	Aspiration index - Kasser Ryan 2001 Intrinsic Personal growth Emotional intimacy Community service Self-understanding (connection with others and community)

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
				orientation, these aspirations may be detrimental for wellbeing, since they do not satisfy our basic psychological needs.	Extrinsic Financial success Physical attractiveness Social fame Popularity Social status
9	Ashby and Schoon (2010)	1851 female and 1825 male cohorts, born in 1971. Longitudinal	Examined the role of gender and teenage ambition value in shaping social status attainment and earning in adulthood.	Parents' educational aspirations and family income played an important role in shaping teenagers' career aspirations, ambition	Career aspiration Professional job Social status Ambition value

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
		study data collected at 5, 10, 16, 26, 30 and 34 years		value and educational performance.	Earn more money (adult earning) Education Perform better in exam
10	Cox et al. (2014)	29 emerging adults who passed high school in rural community 13 had moved out to town pursuing their college /university studies whilst 16 remained in their rural community	The study examines the influence of community context (i.e., social and familial attachments, attachment to place, and economic environment) on rural emerging adults' educational and occupational experiences and aspirations.	The researchers argue that the emerging adult's aspirations (educational, occupational, social and economic) are shaped by the social, familial and economic context of the individual.	Educational aspirations Occupational aspirations Economic security Family/community relationship or attachment

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
11	Henerson-King and Mitchell (2011)	232 (173 females and 56 male) undergraduate students at Grand Valley State University	To examine whether materialism, intrinsic aspirations and research for meanings in life predicted a set of ten meanings that students are known to associate with their education.	The researcher argues that materialism, intrinsic aspirations, and the search for meaning in life are important predictors of the meanings that the student holds for education.	Education Materialism Intrinsic aspirations
12	Romero et al. (2012)	583 Spanish adults (416 women and 161 men)	The objective of the study was to examine the relationship between intrinsic and extrinsic aspirations and subjective wellbeing.	The authors argue that intrinsic aspirations are related to positive indicators of wellbeing, whereas extrinsic aspirations are related to negative indicators of wellbeing.	Intrinsic aspirations Personal growth (growth in meaning and competence in life) Relationship with friends and family Community aspirations (To help others improve in their lives)

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
					Health aspirations (physically well) Extrinsic aspirations Wealth aspirations (money/material) Fame aspirations (famous and admired) Image aspirations (present an attractive look/physical image)
13	Thomas (2011)	11th and 12th grades at Bay City public school district	This study provides specific information regarding the students' post-secondary educational goals, factors that influence post-secondary educational decisions	High school students' aspiration to obtain college education is influenced by many factors including the level of education of parents and the need for better jobs. Educational achievements open opportunity for better	Better jobs Personal growth Career success Obtain master's degree

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
			and measures taken by students related to post-secondary education by the 11th and 12th grades.	jobs and career opportunities.	College degree Living away from home Higher education
14.	Stahl (2012)	23 working class boys from Southern London aged 14-16 years	The aim of this study was to establish how aspirations were conceptualized amongst white working class boys aged 14-16 from South London.	Aspirations are influenced by concepts of social class and social-class identity conceptualized in tension with a neoliberal ideology	Intrinsic and extrinsic aspirations Educational aspirations Qualifications, Participation in future studies Good education Occupational Aspirations Future employment Social status Good job

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
					Material aspirations Own business Material possessions Nice income House Cars Money
15.	Ashby and Schoon (2012)	170 participants from England and Scotland	This study aimed to achieve a detail understanding of the contributions that adolescent career aspirations make in shaping adult career development and adult	'Adolescent aspirations and goals act like a compass to help chart a life span and direct the spending of time and energy.	Job satisfaction Health status Social class

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
			identities and the wellbeing of individuals.		
16.	Tynkkynen et al. (2012)	1034 Finnish adolescents aged 15-16 in last grade of compulsory school and their parents - 720 mothers and 542 fathers	The study explored to what extent the parents' Socio-Economic Status (SES) and psychological control predicts the Grade Point Average (GPA) and educational aspirations for their children.	The lower the parents' SES and the more psychological control they imposed on their children, the lower is their educational aspirations for their children and the lower is their child's GPA. Parent's educational aspirations and family income played an important role in shaping the adolescents' career aspirations, ambition value and educational aspirations. The higher the SES (education and occupation) the higher educational	Educational aspirations Occupational aspirations Socio-economic status Income

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
				aspirations the parents have for their children.	
17	Visser and Pozzebon (2013)	166 Canadian graduates (49 men and 116 women)	The study investigated the relationship between life aspirations and personality and evaluated whether aspirations added to the prediction of psychological wellbeing and sexuality.	The researchers argue that aspirations may account for variance beyond personality in explaining the specific types of wellbeing. Intrinsic aspirations are related to high conscientiousness and agreeableness, while extrinsic aspirations are most related to low openness and agreeableness.	Kasser and Ryan's (1996) Aspiration index Extrinsic scale Financial success Social recognition Appearance Intrinsic Affiliation Self-acceptance Community feeling Health

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
18.	Schoon and Polek (2011)	Two representative sample of British cohorts born in 1958 (n=6474) and 1970 (n=5081) respectively	The study examined the role of adolescents' career aspirations in shaping their adult career development, identities and wellbeing.	The researcher maintains that the parents' socio-economic status and aspirations for their children influences their adolescent's children's career aspirations throughout their life span, and this can be mitigated by encouragement of children and exposure to different career options.	Economic and social status of parents Parents aspirations of their children Lack of exposure to broad career streams
19.	Negru et al. (2010)	N =234 students and employees (Full time students n= 128 Adults employees n=106)	Exploring the dynamics of aspirations in emerging adulthood.	Cultural and economic and social context has significant influence on the development of intrinsic and extrinsic aspirations in students and employed adults	Adopted from Kasser and Ryan (1996) aspiration index Intrinsic aspiration Personal growth Relationship

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
					Extrinsic aspirations Financial success Image
20	Montasen , Brown and Harris (2014)	1199 General dental practitioners selected from 20 of 152 Primary Care Trusts (PCTs) in England	To take a motivational approach testing an idea derived from self-determination theory that pursuit of intrinsic life and professional aspirations in associated with enhanced subjective wellbeing	Both intrinsic and extrinsic aspirations represent long term goals tied to either intrinsic or extrinsic needs. A positive balance of intrinsic to extrinsic aspirations can lead to enhanced wellbeing.	Intrinsic aspirations subscale Personal growth Interpersonal relationship Community contribution Extrinsic aspirations subscale Wealth Fame Personal image

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
21	Niemiec et al. (2009)	Survey conducted to 246 participants, 2 years later following their post university /college life	The study examines the consequences of pursuing and attaining aspirations over a 1-year period in a post college sample (employed young adults)	Attainment of intrinsic aspirations is positively related to psychological health while attainment of extrinsic aspirations does not. Attainment of extrinsic aspirations is positively related to ill-being	Intrinsic aspirations Close relationship Community involvement Personal growth physical health Extrinsic aspirations Money Fame Appealing image
22	Nishimura (2016)	A total of 474 Japanese undergraduates participated in the survey	The study examined the relationship between aspirations (both intrinsic and extrinsic) and life aspirations in Japan	Intrinsic aspirations were positively correlated with life satisfaction (wellbeing) while extrinsic aspirations were negatively related.	Intrinsic aspirations Self-acceptance Affiliation Community feeling

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
					Physical fitness Extrinsic aspirations Financial success Attractiveness Social recognition
23	Bernard and Taffesse (2014)	Purposefully collected data from rural Ethiopia to test for the usability, reliability and validity of the instruments, based on a	To develop a simple measurement instrument for aspirations that could enhance comparability of the results	The researcher maintains that aspirations has three dimensions first, are future oriented, secondly are motivators (they are goals individuals are willing to invest time or money in to achieve this goal), and thirdly they are also related to a specific dimension of wellbeing, such as wealth or	Education aspirations Income aspirations Wealth/Assets Social status aspirations

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
		test–retest approach, along with random variations within the questionnaire and the information set available to respondents, and differential enumerator experience and to ensure comparability of results		social recognition, but are more generally perceived as an ambition to reach a multi-dimensional life outcome	

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
24	Janzen et al. (2017)	Household Survey conducted involving a full sample of 3240 women (including network sample of 944) in rural Nepal	The study empirically test the theories of aspirations failure and formation articulated in using a unique dataset from rural Nepal.	The researchers argue that aspirations correspond with future-oriented economic behavior as predicted by the Inverse-U theory of aspirations failure: investment in the future increases with aspirations up to a certain point, but if the gap between one's current status and aspirations becomes too large, investment subsequently declines. These researchers further argue that an individual's aspirations are influenced and are associated with outcomes of those in her	Education aspirations Income aspirations Social aspirations Health aspirations

No	Author & year	Population and Sample	Purpose	Definition of aspirations	Constructs defining Aspirations
				social network of higher, but not lower, status.	

3.3.5 Stage 5 - Summary and discussion of findings

This stage of scoping involves summarising and reporting of the results (Arksey and Malley, 2005). Key findings regarding aspirations constructs are summarised and discussed. Although there is substantial information on the studies done on aspirations in general, no study was found on the aspirations of professional nurses of their economic and social wellbeing. This gap has therefore made the current study of aspirations of professional nurses very relevant and critical, especially at this time when governments across the globe are facing severe shortages of human resources for health, which amongst others include professional nurses. From this scoping study, it became clear that most studies on aspirations have adapted and used the aspiration index of Kasser and Ryan (1996) cited in Schmuck et al., (2000) who, in their work, have made a distinction between the intrinsic and extrinsic aspirations and how the attainment or non-attainment of these goals affect a person's wellbeing. From this scoping study the researcher extracted the constructs to be used in the next phase which is Delphi study, with a group of experts to develop the aspiration questionnaire for professional nurses. Only constructs that relate to Kasser and Ryan (1996) aspiration index was extracted mainly because it has been used in several studies demonstrating adequate internal reliability and test re-test stability (Schmuck et al., 2000) and were regarded to be of value in developing aspiration questionnaire of the professional nurses. The selected constructs were also checked by the researcher's promoter before they were given to the group of experts (Delphi study). Details regarding a Delphi study will be discussed in Chapter 4. The constructs in table 3.3 below were extracted from the findings of the scoping study and each of this constructs are discussed in the subsequent paragraphs.

Table 3.3: Aspiration constructs extracted from the findings of the scoping study

CONSTRUCTS
Educational attainment
Better job (Job satisfaction)
Materialistic /Possessions (e.g. new car, a new home etc.)
Financial success (e.g. having many material possession and much as wealth
Self-acceptance (e.g. personal growth and choice)
Affiliation (e.g., intimacy, close relationship)
Community feeling (e.g., helping the world be a better place)
Popularity (being popular and admired)
Income
Geographical area

3.4 OVERVIEW OF ASPIRATION CONSTRUCTS EXTRACTED FROM THE LITERATURE

3.4.1 Educational attainment

Many studies have shown a positive association between parents' income and educational attainment for their children, and that education predicts continuity or discontinuity of low socio-economic status across generations. Education creates an avenue to escape poverty and cut down the cycle of poverty across generations (Chen & Kaplan, 2003; Haveman & Smeeding, 2006; Kao and Thompson, 2003; Porter, 2002; Wilson, 2001) cited in Lee et al. (2012). These studies concluded that the child's educational attainment is an important determinant of a person's adult economic status even after controlling the father's occupational status.

The disparity in educational outcomes by socio-economic status is well documented in the literature. Children from low income families face financial hardship during their school years and are more likely to drop out of school compared to children from high income families (Rouse & Barrow, 2006). Studies further found that investing in children's education requires specific values (cultural capital) as well as

the financial means (economic capital) to do so. Expenditure towards children's education includes fees for tuition, accommodation, meals and transport. Value issues concern the symbolic and functional importance the parents hold of achievement of tertiary education. Parents who put higher education for their children in their plans tend to also consider the associated financial costs and subsequently experience related economic stress. In families with low financial resources the results of this consideration is likely to turn out differently from those in a better financial position. For those who have given up, further related financial problems are no longer an issue (Geckova et al., 2010).

3.4.2 Better job (Job satisfaction)

Employee job satisfaction is an important element for sustainability of any organisation and in reducing staff turnover, poor performance and increasing overall productivity. Employee job satisfaction is described as fulfilment, gratification and enjoyment that come with the work. According to Lock (1969), job satisfaction is defined as a pleasurable or positive emotional state resulting from appraisal of one's job or job experience; it also includes one's perception and attitude to work, colleagues and salary. Individuals always look for better jobs that give them job satisfaction.

In a study by Kekana (2007), professional nurses in South Africa were marginally dissatisfied (mean 2.94) mostly with their salaries (2.02), workload (2.24), career development (2.59) and lack of resources (2.73). In contrast, they were satisfied with the relationship with patients (3.74), relationship which they have with their colleagues (3.58), doctors (3.91) and sense of belonging in their communities (3.37). In another study done by Abushaikha et al. (2009), it was revealed that lack of career development opportunities, insufficient hospital policies and practices contribute to job dissatisfaction of employees and subsequent decisions to leave the job**.**

In support of the above assertion, the decision by health professionals, including nurses, to migrate from their home country is mainly influenced by the expectation of better job opportunities and better living conditions elsewhere (Hoppe & Fujishiro, 2015). According to Kingma (2006), many nurses migrate each year for socio-

economic reasons in the destination countries such as better salaries, working conditions, career mobility, professional development and better quality of life. In a study of Spaniards' intentions to migrate to Germany, it was found that those who anticipate benefits for their jobs and career in Germany and those who aspire for a career (value) are more likely to have initial thoughts regarding migration and eventually accept positions in Germany (Hoppe & Fujishiro, 2015).

In the same vein, it was found that occupational aspirations influence other aspects of human life e.g. home ownership, time with the family, friends, life style and living environment. Unmet occupational aspirations negatively affect a person's personal, social and family life. Unmet goals affect a person's wellbeing. These findings are consistent with those in a study of consequences of unmet occupational goals done by Hardie (2014), who found that there is a correlation of unmet occupational goals leading to job dissatisfaction and a low level of wellbeing. On the contrary, other studies have found that unmet occupational goals do not lead to a lower level of wellbeing, particularly if an individual recalibrates their goals (Tomasik et al., 2009).

3.4.3 Materialistic (Possessions)

A high materialism-orientation towards money and possessions, combined with educational level is associated with higher subjective wellbeing (Barbera and Gurhan, 1997). Lee et al. (2012) cites Belk (1988), Richins and Dawson (1992) who developed a materialism scale which has three sub-constructs namely centrality, happiness and success. These authors assert that materialistic people believe that they are the sum of their possessions. Materialists place possessions and acquisition thereof at the centre of their life (centrality), view possessions as essential to their satisfaction and wellbeing. On the contrary, the study by Lipovcan et al. (2015) found that people who believe that owning material goods leads to happiness experienced lower levels of life satisfaction and positive affect, and higher levels of negative affect. The decisions of materialistic people are influenced by the quest to possess something and to outshine others. Given the opportunity, materialistic people spend more money than they earn which lead to low level of happiness and wellbeing.

3.4.4 Financial success

Nickerson et al., (2007) cited studies done by Burroughs, Ring and Joseph (2000); Mick (1996); Sharpe and Ramanaiah (1999) and Solberg et al. (2004) who found that financial aspirations also referred to as materialism were related to neuroticism. Similarly, Cohen and Cohen (1996) and Roberts and Robins (2000) also found that materialism or financial aspirations were related to narcissism. Nickersen et al. (2007) further cite a study by Hoskey (1999) which found that materialism is positively related to Machiavellism, whereas in a study by Saunders and Munro (2000) materialism was positively related to right wing authoritarianism. Thus material worth also gives power.

The study by Nikerson at al. (2007) further affirmed that financial aspiration and household income are reciprocal suppressors' i.e. household income increases with financial aspirations, but financial aspirations pull overall life satisfaction down whereas household income pulls it up. In short, the study found that the relationship between financial aspirations and overall life satisfaction is significantly higher if the household income is high than when the household income is low, which yields no significant relation between financial aspirations and overall life satisfaction. Interestingly Nickersen et al. (2007) also found that the difference in overall life satisfaction between men and women decreases as the household income increases and disappears completely as both men and women earn the highest income. Individuals with strong financial aspirations have high job incomes with financial aspirations influencing both the choice of the job and job income. Women with strong financial aspirations tend to marry for money in order to fulfil their financial aspirations whereas men with strong financial aspirations do not marry for money.

3.4.5 Self-acceptance

In a study of aspirations for intrinsic and extrinsic goals for German and US students, it was found that students whose focus is on intrinsic goals (e.g. self-acceptance, affiliation and community feeling) had a high level of wellbeing compared to those whose focus was on extrinsic goals e.g. financial success, appearance and social recognition (Schmuck, Kasser & Ryan, 2000). These findings affirmed the earlier studies by Kasser and Ryan (1996) which demonstrated that people who are

strongly focussed on extrinsic goals experience relatively low levels of wellbeing and happiness compared to those whose focus is on intrinsic goals, who generally experience high levels of wellbeing and happiness. In contrast, Rijavec, Brdar and Mijkovic (2011) also found that students who place great value in both intrinsic and extrinsic goals had the highest score on measures of wellbeing and satisfaction of basic psychological needs, although there was also an overwhelming support of the findings of the previous studies by Kasser and Ryan (1996).

3.4.6 Affiliation (Intimacy and close relationship)

Although nurses form a significant proportion of the health care workforce, nursing is still perceived as a low status job with a negative public image. A study by Shariff (2014) found that the negative public image of nursing undermines nurse leaders' inclusion in the health policy development process. These findings are corroborated by Phaladze (2003) who studied the role of nurses in HIV/AIDS policy development in Botswana and found that the reasons why nurses are excluded from the policy making process relates to the negative image of the profession amongst the policy makers. Secondly, the nursing profession has been traditionally and predominately seen as a women's profession, and has thus suffered from a poor public image. This is further compounded by the fact that in many countries and cultures women are accorded lower status and rights, which also significantly affects the status of the nursing profession as compared to medicine. This is also the case in South Africa where, despite a democratic dispensation in 1994, women still feel marginalised, exploited, oppressed and discriminated against in various spheres of life. This is also linked to religious beliefs, tradition and cultural practice (Van Der Merwe, 1999).

Kassner and Ryan (1996) have examined seven life goals, namely accumulation of wealth and material possession, social recognition and fame, being physically attractive, having an appealing image, personal growth and development, meaningful affiliation and close relationship and community involvement. These aspirations were later categorised as either intrinsic or extrinsic. The intrinsic aspirations are expressive of humans' inherent growth tendency and are conducive for the attainment of psychological basic needs, whilst the extrinsic goals are not linked directly to basic psychological needs (Kassner and Ryan 1996). This

assertion is supported by Niemic et al. (2009), who studied intrinsic and extrinsic life goals, their relationship, their attainments and psychological health or ill health. The results were that attainment of intrinsic aspirations relates positively to psychological wellbeing and negatively to ill-health, whereas the attainment of extrinsic aspiration relates negatively to wellbeing and positively to ill-health. In this regard it is logical for nurses to aspire to be recognised in the community to enhance their social standing and status in the community and the country in general.

3.4.7 Income

Studies have shown that differences in attitudes towards money influence the perception of one's income (Wilhelm et al., 1993; Tang et al., 2006). Financial satisfaction and sense of wellbeing by definition involve being financially healthy, happy and free from worry. Individuals who are anxious about money would perceive their financial situation as worse. Anxious people complain more frequently in general, are less satisfied with their jobs, their relationships and their lives (Zalewska, 2011). Chaplin et al. (2007) further argue that income and subjective financial wellbeing are independently associated with good health, whereas those with low income and suffering financial hardship experience anxiety and poor health. This is corroborated by Arber et al. (2014) who found that individuals with low income were at a higher risk of reporting 'less than good' health.

Other researchers have also found that the ranked position of an individual's income predicts general life satisfaction or wellbeing, in contrast to the theory that absolute income results in happiness and life satisfaction. The ranked income hypothesis further explains why increasing income of all may not raise the happiness of all even though wealth and happiness are correlated within a society at a given time. Social rank was found to be the key to wellbeing, and individuals compare their own income with significant others and mostly those above their rank in terms of income (Boyce, 2010). This is also corroborated by McBride (2010) who found that past payments, social comparisons and expectations influence aspirations formation, and reported satisfaction and wellbeing. Individuals compare their income with other people in similar circumstances and this influences their income aspirations.

3.4.7 Popularity, status and power

According to Magee and Galinsky (2008), social status is defined as the extent to which an individual or group is respected or admired by others, and social power as holding asymmetric control over valued resources. High status people also possess high power and social prestige, although this may not always be the case. Status is related to the respect one has in the eyes of others and generates expectation for behaviour and opportunities for advancement that favour those with prior status advantage, whereas power is related to one's control over valued resources. Power is defined as an individual's relative capacity to modify others' states by providing or withholding resources or administering punishment (Keltner et al. 2003). Similarly, other researchers have defined power as the ability to control and own resources (Galinsky et al. 2003). Individuals with high power have control and easy access to resources and have been found to have greater popularity and capacity for maintenance of self, are goal directed and are better able to keep these goals at the focus of their attention. On the contrary, individuals with low power lack access to resources and are constrained by their circumstances (Overbeck & Park, 2006; Guinote, 2007).

3.4.8 Community Feeling (Community involvement / standing)

Community feeling aspirations are primarily about trying to improve the state of broader world through activism. Taking part in community activities trying to make the world a better place for all. This goals, are believed to be important in bringing happiness by various philosophical and religious traditions (Kasser & Ryan 1996). Studies have found that pursuit of intrinsic aspirations (personal growth, close relationship, and community involvement) lead too satisfaction of basic psychological needs of autonomy, competence and relatedness and are separated from other goals that are extrinsic (e.g. fame, wealth, appealing image) which are not directly linked to satisfaction of basic needs (Kasser & Ryan 1996; Niemiec et al.,2009).

3.4.9 Geographical location

The influence of geographical location on aspirations has been the subject of research by many researchers in the past. A more recent research study of Ghanaian medical students confirms this idea. The results showed that the students

with rural living experience had different aspirations to those without rural living experience. Amongst the research participants, the students without rural living experience, who had also considered emigration, ranked salary as being more important than those not considering emigration. On the contrary, students with rural living experience ranked salary as being less important, but ranked management style and infrastructure as being more important attributes for rural practice (Johnson, 2011).

These findings are consistent with the concerns raised at the National Nursing Summit, hosted by the South Africa's National Department of Health in 2011, and documented in the *National Strategic Plan for Nurses Education, Training and Practice 2012/2013 - 2016/2017*. This strategic plan confirmed that, amongst other factors, the reasons given by nurses for emigrating are that they are not being valued by managers, communities and the system as a whole; that nurses are confronted daily with shortages of staff, equipment and supplies; and that they are often expected to do non-nursing tasks (NDoH, 2012). Such an environment influences the behaviour of the professional nurses, their aspirations and economic and social wellbeing, hence the importance of understanding their context.

3.5 CONCLUSION

In this chapter background literature on the economic and social status, wellbeing and the scoping study framework has been presented. The scoping study has provided a firm base for studying aspirations further, as it has established what is already known relating to aspirations and how people strive to achieve both the intrinsic and extrinsic goals essential for human survival and their economic and social wellbeing. From this scoping study, it became clear that a gap exists regarding knowledge of aspirations of professional nurses as no studies were found during scoping which have studied the aspirations specifically of this cadre of health care professionals. Based on the results of this scoping study the researcher has extracted the aspiration constructs, which will be used in a Delphi study to develop an aspirations questionnaire. This will be discussed in detail in the subsequent chapters.

CHAPTER 4 - FORMULATION OF THE ASPIRATION QUESTIONAIRE FOR PROFESSIONAL NURSES

4.1 INTRODUCTION

Following the extraction of aspiration constructs during the scoping review, the Delphi expert group was formed to consider the aspirations constructs which could be used in formulating the aspirations questionnaire for the professional nurses. Delphi technique is a method of measuring the judgements of a group of experts for assessing priorities or making forecast (Burns & Grove, 2005). This chapter is divided into two sections namely section 1 which focus on an in-depth description of the Delphi study and section 2 which provide the outline of the pilot study that was done subsequent to the Delphi study to meet the following research objective:

- To formulate an aspiration questionnaire based on existing evidence.

4.2 SECTION 1: SAMPLING FOR THE DELPHI STUDY

Purposive sampling was used to select experienced experts in different and relevant fields to participate in the Delphi study. The Delphi study expert group comprised of the experts, with more than 10 years' experience in different fields, selected from both private and public organizations and who had agreed to participate in the study. It is the researcher's view that a group of individuals with working experience in different fields including nursing could be able to shed more insight on the formulation of the aspirations questionnaire for professional nurses as the subject in question cuts across different fields and the life course. The Delphi study consisted of:

i. One Psychologist (educational) working in a Higher Education Institution.
ii. One Senior Nurse Manager with extensive experience in nursing management in public sector.
iii. One Senior Nurse Manager with extensive nursing management experience in the private sector.

iv. One Nurse Leader, representing a professional Nursing Education Association, with broad understanding of nursing education issues in South Africa.

v. One Nurse Leader, representing the Higher Education Institutions, with extensive experience in the higher education environment.

vi. Two Charted Accountants (one Chief Financial Officer working for the Statutory Health Professions Council, and the other a Director of Finance of national parastatal company). The two accountants were selected in order to give a broader view on financial aspirations.

4.3 DELPHI STUDY: ROUND 1

In this round, the participants of the Delphi study were given the aspiration constructs, and were requested to comment, validate and to provide their opinion on the constructs that should be used in developing the aspiration questionnaire for professional nurses. A detailed information sheet for Delphi participants is contained in appendix **E**. The constructs are listed in table 4.1 below.

Table 4.1: Aspiration constructs derived from the literature

Constructs
Educational attainment
Better job
Possessions (e.g. new car, a new home etc.)
Financial success
Constructs
Self-acceptance
Affiliation
Community feeling
Popularity
Income
Geographical location

4.3.1 Data analysis and findings: Delphi Study: Round 1

In this round, 100% response rate was received and all Delphi participants have responded. The experts commented on all the constructs and gave their suggestions and opinions on each construct. Based on the comments and suggestions of more than 50% of the participants, popularity, affiliation and community feeling were replaced with community standing. Community standing was preferred as the Delphi study participants (60%) found it to be unambiguous. Furthermore, the geographical allocation was also removed from the list of aspiration constructs as the majority of Delphi participants (71%) commented that this element could be part of the demographic, economic and social aspects of the questionnaire (section 1 household survey) which the participants will provide when answering the questionnaire. Based on the comments and suggestions of more than 50% of the Delphi study participants, status and power was added to the list of constructs.

4.4 DELPHI STUDY: ROUND 2

In this round, the researcher sent the refined list of the constructs, with the statements which were consolidated after round 1, back to the Delphi study participants. The participants were asked to agree or disagree with the list of refined constructs and consolidated statements aligned to each construct and to give comments where necessary. The list of constructs and consolidated statements is depicted in table 4.2 below.

Table 4.2: Round 2 Consolidated statements derived from experts (Delphi study)

A	B	C		
Constructs	Consolidated statements derived from experts (Delphi study).	The statements in column "B" describe the construct in column "A" which may be used in formulation of the aspiration questionnaire for the professional nurses		
		Yes	**No**	**Comments if any**
Educational attainment	Educational and developmental opportunities for self, children and dependents Self-actualization			
Better job	Better remuneration/income Growth potential with reference to career path options Better working environment Better job increases the chances of acquiring possessions, which improves self-esteem of the person			

A	B	C		
Constructs	Consolidated statements derived from experts (Delphi study).	The statements in column “B” describe the construct in column “A” which may be used in formulation of the aspiration questionnaire for the professional nurses		
		Yes	**No**	**Comments if any**
Possessions (e.g. new car, a house etc.)	Reflect socio economic status (possession of material things e.g. car, house in specific suburb, children in private school etc.) Priorities may differ depending on individual circumstances and context			
Financial success	Both intrinsic and extrinsic factors that resemble achievement and success in life - relates to how well personal resources are managed			
Self-acceptance	Depends on a realistic understanding of oneself and also acceptance by others, often based on social and financial success			

A	B	C		
Constructs	Consolidated statements derived from experts (Delphi study).	The statements in column “B” describe the construct in column “A” which may be used in formulation of the aspiration questionnaire for the professional nurses		
		Yes	**No**	**Comments if any**
Community standing	This is related to the status of the nurse and the nursing profession in the community and the contribution of a nurse and nursing profession in the community How does the community perceive a nurse and the nursing profession? This is influenced by income, possessions, power etc.			
Income	It is human nature that people always want high income, therefore they will always want to move up the ladder in order to fulfil their financial needs as usually the salary is linked to the position the person occupies in the organization, this in turn assist in meeting the basic needs of self and dependants.			

A	B	C		
Constructs	Consolidated statements derived from experts (Delphi study).	The statements in column “B” describe the construct in column “A” which may be used in formulation of the aspiration questionnaire for the professional nurses		
		Yes	**No**	**Comments if any**
Status and power	These are umbrella terms for aspiration constructs and is influenced by the resources/ possessions one has or owns.			

4.4.1 Data analysis and findings of Delphi Study: Round 2

All the Delphi study participants (100%) provided their responses and comments on the list of consolidated constructs and the corresponding statements that was sent to them in round 2. The researcher did a content analysis of the responses received.

Eighty-six percent (86%) of the Delphi study participants agreed that the list of constructs in table 4.2 and corresponding statements could be used in developing a tool to measure aspirations for professional nurses whilst 14% only indicated no further comment in round 2 without indicating the chosen option. A table of these constructs and corresponding statements is depicted in table 4.3 below.

Table 4.3: Consolidated statements derived from literature and agreed to by the Delphi study participants

A	B
Constructs	**Consolidated statements derived from experts (Delphi study).**
Educational attainment	Educational and developmental opportunities for self, children and dependents Self-actualization
Better job	Better remuneration/income Growth potential with reference to career path options Better working environment Better job increases the chances of acquiring possessions, which improves self-esteem of the person
Possessions (e.g. new car, a house etc.)	Reflect socio economic status (possession of material things e.g. car, house in specific suburb, children in private school etc.) Priorities may differ depending on individual circumstances and context
Financial success	Both intrinsic and extrinsic factors that resemble achievement and success in life - relates to how well personal resources are managed
Self-acceptance	Depends on a realistic understanding of oneself and also acceptance by others, often based on social and financial success
Community standing	This is related to the status of the nurse and the nursing profession in the community and the contribution of a nurse and nursing profession in the community. How does the community perceive a nurse and the nursing profession? This is influenced by income, possessions, power, influence etc.

A	B
Constructs	**Consolidated statements derived from experts (Delphi study).**
Income	It is human nature that people always want high income, therefore they will always want to move up the ladder in order to fulfil their financial needs as usually the salary is linked to the position the person occupies in the organization, this in turn assist in meeting the basic needs of self and dependants.
Status and power	These are umbrella terms for aspiration constructs and is influenced by the resources/ possessions one has or owns.

The constructs depicted in table 4.3 above were used to formulate the aspirations questionnaire which is contained in appendix **A**.

4.5 SECTION 2: THE FORMULATION OF THE ASPIRATIONS QUESTIONNAIRE

4.5.1 Pre-test study

As discussed in Chapter 2 (Research methodology), the researcher has prior to administering the questionnaire to the main study participants(survey) conducted a pre-testing of the aspirations questionnaire with a group of twelve (12) professional nurses, purposefully selected and who were not part of the target population but representative of the study population. A pre-test study was conducted to determine feasibility, word ambiguity and for face validity. Pre-testing involves simulating the formal data collection process on a small scale to identify practical problems with regard to data collection instruments, sessions and methodology (Hurst et al, 2015). The participants were asked to complete the questionnaire and also to comment on whether they experienced any difficulty with understanding terms or in completing the questionnaire.

4.5.2 Data analysis and findings of the pre-test study

All twelve (12) professional nurses completed the pre-testing aspirations questionnaire and returned it to the researcher yielding a response rate of 100%. The participants did not encounter any difficulty in completing or interpreting the questions. Of important to note is that participants have voluntarily commented on the content and the process of implementing the Occupational Specific Dispensation (OSD) policy despite, the fact that this was not asked in the survey questionnaire, which indicate the influence they perceive it to have on their economic and social wellbeing.

There was no problem with the pre-test regarding face validity, and 85% of the participants commented that the survey must include a specific question on the nurses Occupational Specific Dispensation (OSD). A comprehensive discussion on the pre-test study is outlined in chapter 2.

4.6 CONCLUSION

In this chapter, the Delphi study consisted of seven (7) individuals with experience in different fields. The Delphi expert group was formed to consider the aspirations constructs extracted from the literature during the scoping review. The Delphi expert group was asked to make comments and to give inputs on the aspiration constructs which the researcher intend to use in formulation of the aspirations questionnaire for the professional nurses. From the initial list of ten (10) constructs derived from the scoping review which was discussed in chapter 3 and following review by the Delphi expert group only eight (8) aspiration constructs were recommended for inclusion. Eighty-six percent (86%) of Delphi participants agreed on the list of aspiration constructs to be used in the formulation of the aspirations questionnaire for professional nurses. The questionnaire formulated subsequent to the Delphi study will be used in the next phase of this research.

CHAPTER 5 - DATA ANALYSIS AND FINDINGS OF THE SURVEY

5.1 INTRODUCTION

In this chapter, detailed findings relating to objectives three and four of the study are provided. The objectives were:

- To explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa.
- To determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces.

In this chapter, a detailed discussion on data collection, data analysis and research findings are presented.

5.1.1 Data analysis

As discussed in Chapter 2 under research methodology, the researcher used an exploratory, sequential mixed method design that involved a first phase of qualitative data collection and analysis, followed by second phase of qualitative data collection and analysis that built on the results of the first qualitative phase (Creswell, 2009; Creswell and Clark, 2011). The data collected under section one of the questionnaire (closed ended questions) was mainly quantitative, and descriptive and inferential statistics were used during data analyses (Polit and Beck, 2012). The data generated during the data collection process was systematically analysed and various statistical tests were undertaken and interpretation was done by the researcher with the assistance of a statistician. The results of these analyses are presented below in graphs, charts and tables.

The second part of the aspirations questionnaire, which was mainly qualitative (open ended questions) and requested participants to provide unlimited comments in each of the listed aspirations. The last part of the questionnaire, which invited them to give any other comments, yielded volumes of text data that was analysed following a

qualitative data analysis method used in Creswell (2009). The strategies undertaken by the researcher in analysis of this qualitative data is outline below:

a) Reading of the raw data.
b) Capturing of the data into an excel spreadsheet.
c) Cleaning data and removing the outliers.
d) Reading and rereading the text data.
e) Developing code.
f) Enhancing visual representation by colour coding the text and coding.
g) Counting the number of times, a code occurs (frequency of code).
h) Developing themes or categories.
i) Grouping related themes into one category where applicable.
j) Determining the relationship between categories and creating new categories, where necessary.
k) Quantification of qualitative data enabled the researcher to compare the quantitative data with the qualitative data.

With the assistance of the statistician, this data was entered into a computer programme for further statistical analyses. Domain characteristics between Urban and Rural Nurses such as affiliation, image, financial, educational and occupational aspirations were compared, using independent t-test statistics. The software used to achieve the objectives was Stata 13.2 (StataCorp. 2015).

5.2 THE SURVEY

The research objective for the survey was to explore and describe the economic and social wellbeing of professional nurses in selected provinces of South Africa.

Of the 1398 aspirations questionnaires distributed to participants, 1286 were returned yielding a return rate of 92%. Of the 1286 questionnaires that were returned, 148 (11.5%) were spoiled. Ninety percent (90 %) of the questionnaires that were spoiled were from one institution where, on the first day of the data collection, there was misunderstanding between the researcher's assistants, who were distributing the questionnaires and the potential participants. An additional problem which arose was that the research assistants were foreign postgraduate nursing

students who sadly received a hostile reception from the potential participants until the researcher intervened, after which the data collection went smoothly. The remaining portion of spoiled questionnaires consisted of those questionnaires that were returned but not answered (not filled). 1138 completed aspirations questionnaires were first entered in a Microsoft Excel spreadsheet; the data was then cleaned by the researcher before the data was analysed using the statistical method described in Chapter 2.

5.3 DEMOGRAPHIC, ECONOMIC AND SOCIALCIRCUMSTANCES OF PROFESSIONAL NURSES IN LIMPOPO AND GAUTENG PROVINCE

5.3.1 Demographic Profile

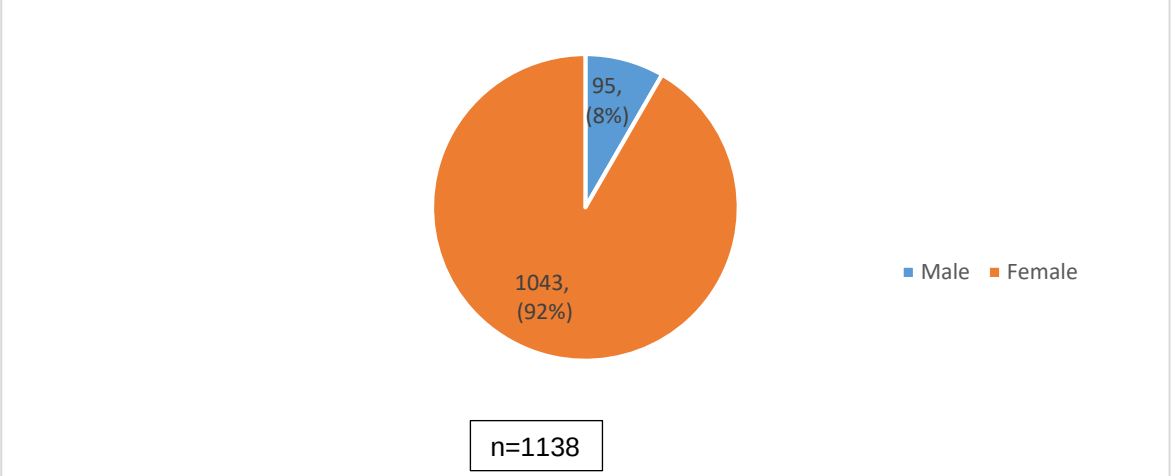


Figure 5.1: Percentage distribution of participants by gender

Out of all survey participants, 92% were females and males constituted only 8%. This finding corroborates South African Nursing Council (SANC) statistics of Professional nurses and Midwives, which shows 91% of all professional nurses and Midwives in the SANC register were females whilst 9% were males. This implies that the nursing profession in South Africa like in the rest of the world is still predominately a female dominated profession (SANC, 2014).

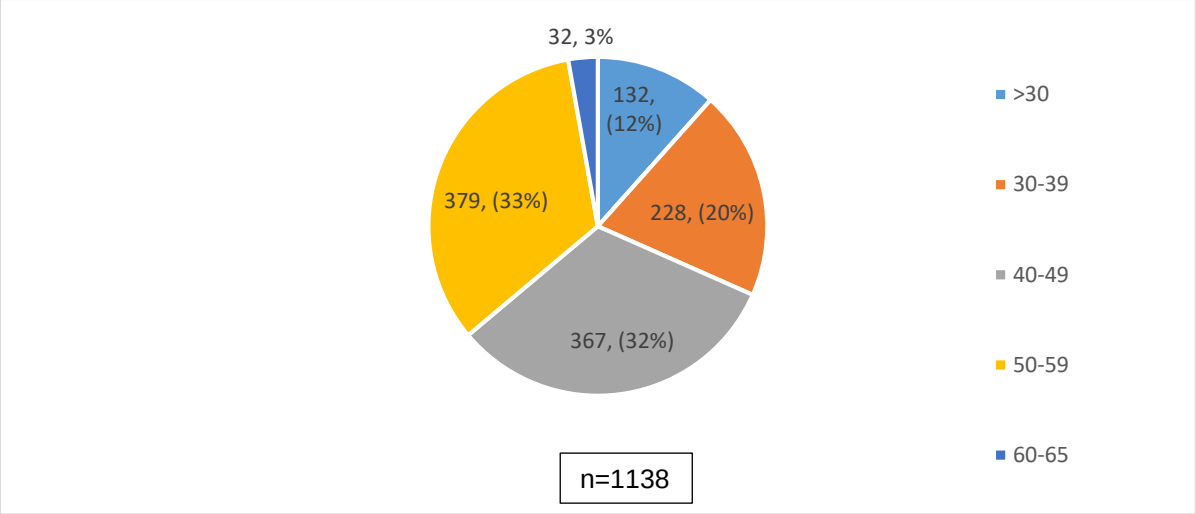
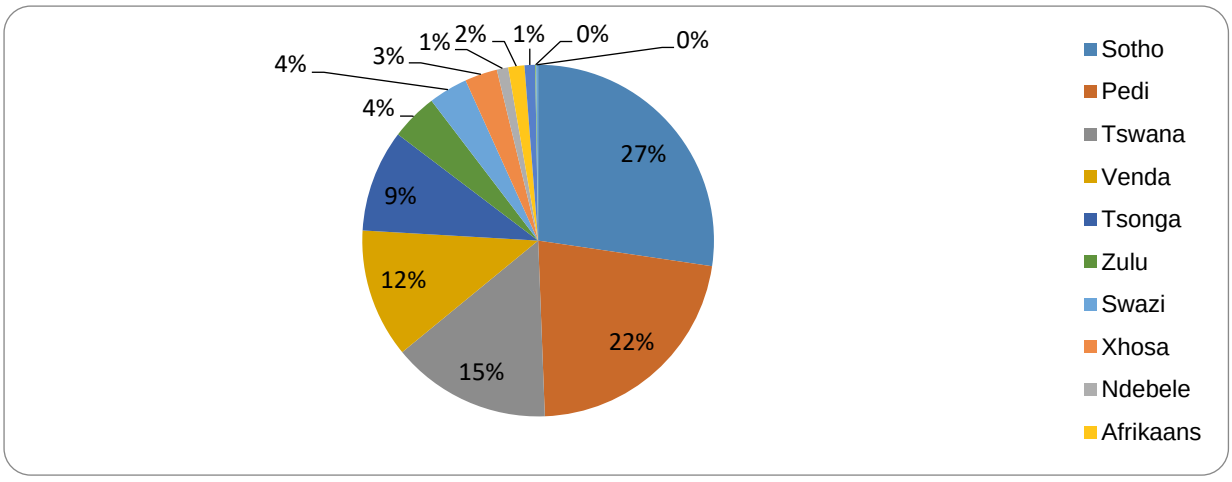


Figure 5.2: Percentage distribution of participants by age

Figure, 5-2 above summarize the age analysis of the participants. Over 60% of participants are more than 40 years old, with 33% between the ages of 50-59, 32% in the age group 40-49, 20% in the age group 30-39, 12% less than 30 years old and lastly 3% older than 60 years. This clearly illustrates an aging nursing population in both Limpopo and Gauteng provinces. These results corroborate SANC statistics (SANC, 2014) which show an aging nursing population in South Africa. By comparison, SANC statistics (SANC, 2014) show that 47% of Professional nurses and Midwives are above 50 years old, whilst a further 29% are above 40 years old.



n=1138

Figure 5.3: Ethnic distribution

In rank order, the participants were Sotho (27.33%), followed by Pedi (22.06%),

Tswana (14.67%) and Venda (11.86%), with the remaining ethnic groups constituting less than 24 % of the total population.

5.3.2 Relationship

Table 5.1: Relationship to the head or acting head of the household

What is your relationship to the head or acting head of the household?	**Province**		**Total**
	LP	**GP**	
Head/acting head	116	152	268
Percentage	22.7%	24.2%	23.5%
Husband/wife/partner	211	256	467
Percentage	22.7%	40.8%	41.0%
Son/daughter	51	59	110
Percentage	9.9%	9.4%	9.6%
Adopted son/daughter	4	10	14
Percentage	0.7%	1.5%	1.2%
Stepchild	0	22	22
Percentage	0%	3.5%	1.9%
Brother/sister	17	8	25
Percentage	3.3%	1.2 %	2.1%
Parent (mother/father)	79	92	171
Percentage	15.4%	14.6%	15.0%
Parent-in-law	1	0	1
Percentage	0.1%	0%	0.08%
Other relative	2	5	7
Percentage	0.3%	0.7%	0.6%
Non-related person	30	23	53
Percentage	5.8%	3.6%	4.6%
	511	627	n=1138

Of the total participants, 41.0 % are living in a relationship as the husband/wife or partner of the head of the household, while 23.5% are head or acting head of the household, 15% are parents of the head of the household, 9.6% are sons/daughters of the head of the household and the remaining percentage (25.9%) is shared among the rest of the categories. According to the 2011 Census, 53% of women who gave birth were single women, and only 30 percent were married which shows that a large percentage of households in South Africa are headed by single mom (Stats SA, 2011).

Table 5.2: Marital Status

What is your relationship to the head or acting head of the household?	Province		Total
	LP	GP	
Married	233	258	491
Percentage	45.5%	41.1%	43.1%
Living together	37	45	82
Percentage	7.2%	7.1%	7.2%
Never married	141	183	324
Percentage	27.5%	29.1%	28.4%
Widower/widow	44	63	107
Percentage	8.6%	10.0%	9.4%
Separated	16	18	34
Percentage	3.1%	2.8%	2.9%
Divorced	27	53	80
Percentage	5.2%	8.4%	7.0%
No response	14	6	20
Percentage	2.7%	0.9%	1.7%
	511	627	n=1138

Of the total participants, 43.1% are married, 7.2% are living together, while a significant percentage (28.4%) has never married, 9.4% are widowers/widows, 7.0% are divorced and 2.9% are separated. This result shows that less than half of the participants were married. According to Stats SA, the lowest number of marriages (150852) were recorded in South Africa in 2014, which shows a decrease of 4.9% from the 158642 marriages recorded in 2013 (Stats SA, 2014).

5.3.3 Main Place of Usual Residence

Table 5.3: Participants usual place of residence

Do you usually live in a	**Province**		**Total**
	LP	**GP**	
City Percentage	68 13.3%	78 12.4%	146 12.8%
Town Percentage	85 16.6%	99 15.7%	184 16.1%
Township Percentage	223 43.6%	380 60.6%	603 52.9%
Tribal area Percentage	111 21.7%	23 3.6%	134 11.7%
Other Percentage	24 4.6%	47 7.4%	71 6.2%
	511	627	n=1138

More than half of the participants live in townships (52%), followed by town (16.1%), cities (12.8%), tribal areas (11.7%), and others (6.2%).

5.3.4 Education

Table 5.4: Participants attending educational institution

Are you presently attending an educational institution?	**Province**		**Total**
	LP	**GP**	
Yes	123	123	246
Percentage	24.0%	19.6%	21.6%
No	379	485	864
Percentage	74.1%	77.3%	75.9%
Did not respond	9	19	28
Percentage	1.7%	3.0%	2.5%
	511	627	n=1138

Fishers exact 0.095

Of the participants, 21.6 % are attending educational institution, while majority of participants 75.9% are not attending any educational institution compared to 4.9% of the general population of South Africa who attend a tertiary institutions(Stats SA,2014).

Table 5.5: Type of educational institution attended

If Yes, which do you attend among those listed below?	**Province**		**Total**
	LP	**GP**	
College	28	53	81
Percentage	6%	8%	7%
University /Technicon	102	124	226
Percentage	20%	20%	20%
Other	5	4	9
Percentage	1%	1%	1%
Did n ’t respond	376	446	822
Percentage	73%	71%	72%
Total	**511**	**627**	**n=1138**

Table 5.5 above shows the percentage of professional nurses attending educational institution by typeof the institution. Of those who are attending 7% attending at the colleges,20% at the universities anfd technichons and 1% attending any other institutions .This shows that thereis limited opportunities for professional nnurses to pursue post basic qualifications as they are to be granted study leave because most of these programmes are done on full time basis. The high percentage of those attending at the universities is mainly in those programmes that are offered through part time and distance learning and are mostly non clinical nursing programmes (e.g. nursing education). Majority of participants (72%) did not respond as they are presumably not attending any educational institution therefore not in any type of such institutions

Table 5.6: Participants highest level of education

What is your highest level of education?	**Province**		**Total**
	LP	**GP**	
Certificate	22	28	50
Percentage	4.3%	4.4%	4.3%
Diploma	267	331	598
Percentage	52%	52.7%	52.5%
Bachelor’s degree	88	110	198
Percentage	17.2%	17.5%	17.3%
Btech	33	36	69
Percentage	6.4%	,5.7%	6.0%
Post Graduate Diploma	51	64	115
Percentage	9.9%	10.2%	10.1%
Honours	35	42	77
Percentage	6.8%	6.6%	6.7%
Masters/PhD	10	7	17
Percentage	1.9%	1.1%	1.4%
Did not respond	5	9	14
Percentage	0.9%	1.4%	1.2%

	511	627	n=1138

Fischer's exact = 0.951

More than half (52.5%) of all participants have a diploma, 17.3% have a bachelor's degree, 6.0% have a BTech, 10.1% a post graduate diploma, 6.7% an honours degree, 4.3% a certificate and only 1.4% have a higher degree (masters/PhD) qualification compared to only 13% of the total population of South Africa with a tertiary qualification (Stats SA, 2014).

5.3.5 Employment Status

Table 5.7: Participation in any work/business outside your employment for salary or wage.

In the last 7 days did you do any work/ business outside your current employment for a wage, salary, commission or payment in kind even for only one hour?	**Province**		**Total**
	LP	**GP**	
Yes Percentage	42 8.2%	43 6.8%	85 7.4%
No Percentage	454 89.3%	566 90.2%	1020 89.6%
Did not respond Percentage	15 2.9%	18 2.8%	33 2.8%
Total	511	627	n=1138

Fisher's exact = 0.690

Of the participants, 89.6% did not participate in any form of business or work outside employment, and only 7.4% participated in business or work outside employment in the last seven days. Majority of professional nurses (89.6%) depend on salaries as source of income. These findings are corroborated by the results from Stats SA General Household Survey (Stats SA, 2014), which found that the majority of South African households depend on salaries. (The largest percentage of households that earn salaries as source of income were found in Gauteng (74.8%) and the Western Cape (78.9%), whilst in Limpopo grants (56.1%) are the highest source of income.

Table 5.8: Participants working overtime or moonlighting

Do you or have you in the last month, worked overtime or moonlighted?	Province		Total
	LP	GP	
Yes Percentage	110 21.5%	154 24.5%	264 23%
No Percentage	392 76.7%	462 73.6%	854 75%
Did not respond Percentage	9 1.7%	11 1.7%	20 2%
	511	627	n 1138

Fischer's exact = 0.126

Of the participants 23% indicated that they had moonlighted or worked overtime in the previous month, while 75% indicated they did not work overtime or moonlight in the previous month. Although the percentage of those who participated in moonlighting appears to be lower in the current study, these findings are corroborated by Rispel et al. (2014), who found that 56.0% of nurses had worked overtime , while 37,8% had participated in agency nursing in the past 12 months preceeding the study in four provinces of South Africa.

Table 5.9: Participants mode of transport to get to work

What is your mode of transport?	Province		Total
	LP	GP	
Bike Percentage	0 0%	1 0.1%	1 0.1%
Bus Percentage	45 8.8%	73 11.6%	118 10.3%
Car Percentage	283 55.3%	343 54.7%	626 55.0%
Taxi Percentage	154 30.1%	180 28.7%	334 29.3%
Walking Percentage	29 6 %	30 4.78%	59 5.1 %
	511	627	n1138

Fishers exact= 0.576

Fifty-five percent (55%) of the participants use a private car to travel to work, making this the most common mode of transport among the participants, while a significant percentage (39.6%) use mainly public transport, e.g. buses (10.3%) and taxis (29.3%). By comparison, 38.2 % of South African households have at least one member who used public transport, while 7.1% of South African households used bus, 32.9% of the South African households use private car (Stats SA, 2014).

Table 5.10: Type of accommodation (subsidised or not subsidised) where participants live

Do you live in subsidised accommodation?	**Province**		**Total**
	LP	**GP**	
Yes Percentage	69 13.5%	73 11.6%	142 12%
No Percentage	439 85.9 %	550 87.7%	989 87%
Did not respond Percentage	3 0.58%	4 0.63%	7 1%
	511	627	n1138

Fisher's exact =.368

Only 12% of the participants live in subsidized accommodation.

Table 5.11: Child care facilities provided by employer

Do your Children attend crèche/children facility?	**Province**		**Total**
	LP	**GP**	
Yes Percentage	29 5.6%	38 6.0%	67 5.8%
No Percentage	479 93.7	581 98.7%	1060 93.1%
Did not respond Percentage	3 0.58%	8 1.2%	11 0.96%
Total	511	627	n1138

The majority of participants (93.1%) work in institutions where the employer does not provide childcare facilities or a crèche. Those working in institutions where the employer provides a crèche or childcare facilities constitute only 5.8% of the total participants.

Table 5.12: Motor vehicle ownership

Do you own a motor vehicle?	**Province**		**Total**
	LP	**GP**	
Yes	313	381	694
Percentage	61.2%	60.7%	60.9%
No	196	242	438
Percentage	38.3%	38.5%	38.4%
Did not response	2	4	6
Percentage	0.39%	0.63%	0.52%
Total	511	627	n1138

Fisher's exact = 0.982

Sixty-one percent (60.9%) of the participants own a car, while a significant percentage of 38.4% of the participants do not have a car, compared to 30.2% of the households in South Africa which own at least one vehicle (Stats SA, 2014).

Table 5.13: Possession of drivers lincence

Do you have a drivers licence?	**Province**		**Total**
	LP	**GP**	
Yes	379	453	832
Percentage	74.1%	72.2%	73.1%
No	129	169	298
Percentage	25.2%	26.9%	26.1%
Did not response	3	5	8
Percentage	0.6%	0.8%	0.7%
Total	511	627	n1138

Fisher's exact = 0.746

The results show that more than half (73.1%) of the participants have driver's licence, while 26.1% have no drivers licence, implying that they depend on public transport, walk to work, or use a lift club to work. It is also important to note that only 60.9% had cars, so the remaining percentage of those with driver's licences but not owning cars (12.2%) might be amongst those with aspirations to buy cars.

5.3.4. Total children surviving and living in the household

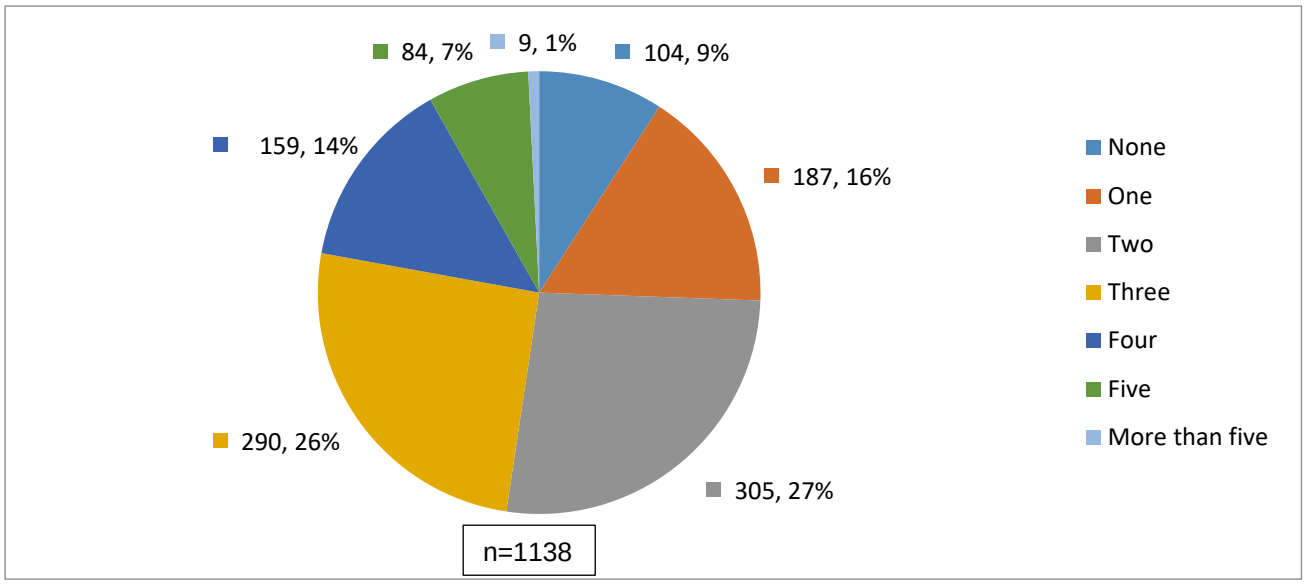


Figure 5.4: Percentage of no of children living in the household

Figure 5-4, above show that 27% of professional nurses have two children living in the household, followed by 26% with three children,16% with one child in the household, 14% with four children living in the household, 7% with five children in the household, whilst 1% have more than 5 children and 9% have no child living in the household. In summary, more than 50% of participants have less than 4 children living in the household, which is consistent with Stats SA 2011 census, which found that the average of four children per household in 2001 census has decreased to 3.5 in 2011 (Stats SA, 2011)

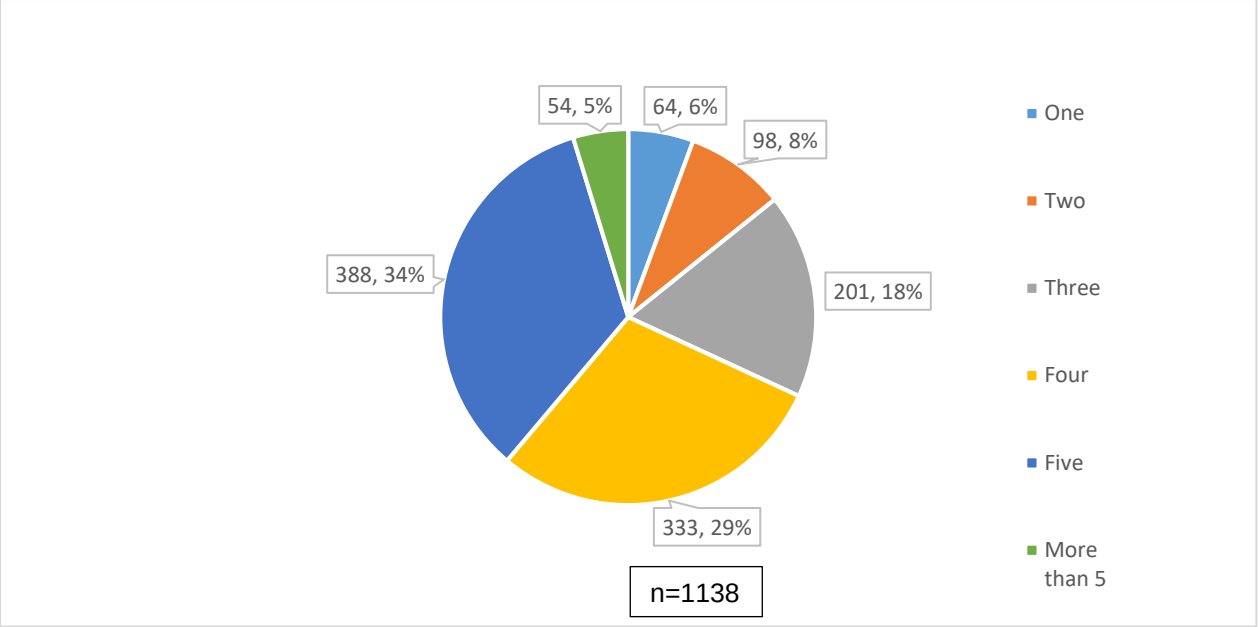


Figure 5.5: Percentage of no of people living in the household including children

According to figure 5-6 above, the largest percentage of professional nurses (34%) are living in a household with a total of five people including their own children. Households with more than five (5) members accounted for 5%, whilst those with four members in a household account for 29%, three (3) members 18% and those with one (1) and two (2) members in the household accounting for 6% and 8% respectively. These results are consistent with the survey conducted by Stats SA (2014/2015), which shows that the average household size was 3.30. However, the results of the current study show that the largest percentage of participants (34%) have five members living in the household.

5.3.6 Income Category

Table 5.14: Participants gross monthly income

What is the income category that best describes your gross monthly income before deductions and including all sources of income?	Provinces		Total
	LP	GP	
7,000-R8,999	12	15	27
Percentage	2.3%	2.3%	2.3%
R9,000-R10,999	52	71	123
Percentage	10.1%	11.3%	10.8%
R11,000.0-R14,999	47	59	106
Percentage	9.1%	9.4%	9.3%
R15,000-16,999	92	99	191
Percentage	18%	15.7%	16.7%
R17,000-R18,999	66	82	148
Percentage	12.9%	13.0%	13.0%
R19,000-R20,000	47	62	109
Percentage	9.1%	9.8%	9.5%
More than 20, 999	167	216	383
Percentage	32.6%	34.4%	33.6%
Less than R7,000	2	5	7
Percentage	0.39%	0.79%	0.6%
None of the above	11	6	17
Percentage	2.1%	0.95%	1.4%
Don't know	15	12	27
Percentage	2.9%	1.9%	2.3%
	511	…….627	n=1138

Pearson chi2 (9) = 7.4933 Pr = 0.783

Only 33.6% of the participants have a gross income of more than R20,999 a month, while 9.5% are within the income range of R19,000 - R20,999; 13.0% are within the income range R17,000 - R18,999, 16.7% are within the income range of R15,000 -

R16,999, and 9.3% in the income range of R11,000 - R14,999. The remaining 10.8% and 2.8% are those who indicated a gross salary below R10,999.00 and R8,999.00 respectively, and who appear to have understated their salaries given the fact that according to salary scales released by DPSA (2014), the gross annual entry level salary notch in 2014, for a professional nurse (general) grade 1, was R183,009 per annum (or R15,250.75 per month).

Table 5.15: Participants net monthly income

What is the income category that best describes monthly income or after deduction?	**Provinces**		**Total**
	LP	**GP**	
R7,000.0 - R8,999 Percentage	53 10.3%	61 9.7%	114 10.0%
R9,000 - R10,999 Percentage	171 33.4%	204 32.5%	375 32.9%
R11,000.0 - R14,999 Percentage	63 12.3%	78 12.4%	141 12.3%
R15,000 -R16,999 Percentage	45 8.8%	56 8.9%	101 8.8%
R17,000.0 – R18,999 Percentage	46 9.0%	55 8.7%	101 8.8%
19,000.0-R20,000 Percentage	44 8.6%	39 6.2%	83 7.2%
More than R20,999 Percentage	55 10.7%	94 14.9%	149 13.0%
Less than R7,000 Percentage	16 3.1%	20 3.1%	36 3.1%
None of the above Percentage	9 1.7%	6 0.9%	15 1.3%
Did not respond Percentage	9 1.7%	14 2.2%	23 2.0%
Total	**511**	**627**	**n=1138**

Pearson chi2 (9) = 7.4933 Pr = 0.586

The largest percentage of participants (32.9%) have net monthly income ranging between R9,000 - R10,999, while only 13.0% have a net monthly income above R20,999 and 3.1% have a net monthly income less than R7,000.

Table 5.16: Assistance with household expenses

Do you have any other persons in the household contributing to the household expenses?	Province		Total
	LP	GP	
Yes Percentage	195 39%	212 35%	407 37%
No Percentage	295 60%	377 63%	672 62%
Don't know Percentage	3 1%	10 2%	13 1%
Total	493	599	n=1092

Pearson chi2(2) = 4.2358; Pr = 0.120; likelihood-ratio chi2(2) = 4.4121; Pr = 0.110

The majority of the participants (62%) indicated that they do not receive support/assistance towards the household expenditures from anyone. Only thirty-six percent (37%) receive contributions towards household expenditures from other person(s), with the remaining one percent (1%) representing those who do not know or did not respond.

5.4 COMPARISON BETWEEN URBAN AND RURAL WITH RESPECT TO THEIR EXPENSES.

Table 5.17: Comparison of contributions received by participants to assist with household expenses

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	99	R7792.939	862.8651	8585.399	R6080.612 -	R9505.267
LP	105	R2923.829	304.3968	3119.139	R2320.198 -	R3527.459
Combined	204	R5286.779	477.53	6820.493	R4345.224 -	R6228.334
Diff		R4869.111	914.9828		R3057.83 -	R6680.392

diff = mean(GP) - mean (LP); t = 5.3215

Satterthwaite's degrees of freedom = 122.128

Those living in Limpopo province (LP) receive significantly less contribution or assistance from other person(s) towards household expenses as compared to those in Gauteng province (GP).

Table 5.18: Expenditure on rent or re-paying a bond/mortgage (housing) per month

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	327	2975.107	114.4123	2068.935	2750.02	3200.187
LP	150	2590.54	159.8226	1957.419	2274.729	2906.351
Combined	477	2854.174	93.41975	2040.318	2670.608	3037.74
Diff		384.567	196.5539		-2.209748	771.3438

diff = mean(GP) - mean (LP) t = 1.9565

Satterthwaite's degrees of freedom = 304.319

Ha: diff != 0

Pr(|T| > |t|) = 0.0513

The results shown in this table indicate that those who live in urban area (Gauteng province) spend significantly more than those in rural area (Limpopo province) on housing.

Table 5.19: Expenses on electricity, gas, water and municipal rates/charges per month

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	416	1321.755	49.06938	1000.823	1225.299	1418.21
LP	332	949.6386	28.63191	521.6982	893.3151	1005.962
Combined	748	1156.591	30.83718	843.3841	1096.053	1217.129
Diff		372.1163	56.8118		260.5596	483.6729

diff = mean(GP) - mean (LP) t = 6.5500

Satterthwaite's degrees of freedom = 651.072

Ha: diff != 0

Pr(|T| > |t|) = 0.0000

The results show that those living in the Gauteng province (urban) spend significantly higher compared to those in the Limpopo province (rural) on electricity, gas, water and rates.

Table 5.20: Expenses on telephones (landlines and cell phones) per month

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	380	594.1316	49.3345	961.7064	497.128	691.1352
LP	303	565.9241	50.50061	879.0588	466.5465	665.3017
Combined	683	581.6179	35.40918	925.393	512.0938	651.142
Diff		28.20749	70.5989		-110.4148	166.8298

diff = mean(GP) - mean (LP) t = 0.3995

Satterthwaite's degrees of freedom = 668.399

Ha: diff!= 0

Pr (|T| > |t|) = 0.6896

The findings show no evidence of a difference in the amount spent on telephone (landlines and cell phones) between the urban and rural participants. The difference of expenditure between Limpopo and Gauteng province is therefore insignificant in this item.

Table 5.21: Expenses on transport (other than repayments on a car) per month

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	382	1219.267	31.76484	620.838	1156.811	1281.723
LP	271	1245.978	40.22591	662.202	1166.782	1325.174
Combined	653	1230.352	24.96551	637.9653	1181.33	1279.375
Diff		-26.71084	51.25552		-127.3882	73.96652

diff = mean(GP) - mean (LP) t = -0.5211

Satterthwaite's degrees of freedom = 557.963

Ha: diff != 0

Pr(|T| > |t|) = 0.6025

There is no significant difference in the amount spent on transport, other than repayments on a car, between those in urban and rural areas.

Table 5.22: Expenses on hire purchase

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	310	3210.194	131.6947	2318.724	2951.062	3469.325
LP	242	3621.467	133.4504	2076.002	3358.589	3884.345
Combined	552	3390.498	94.61865	2223.035	3204.641	3576.356
Diff		-411.2734	187.49		-779.573	-42.97381

diff = mean(GP) - mean (LP) t = -2.1936

Satterthwaite's degrees of freedom = 539.731

Ha: diff != 0

Pr(|T| > |t|) = 0.0287

The results show significant difference between the two provinces. Those living in rural areas spend more on hire purchase compared to those living in urban areas.

Table 5.23: Expenditure on college/university fees

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	303	2137.495	101.8617	1773.096	1937.047	2337.944
LP	275	2292.884	101.8287	1688.683	2092.418	2493.35
Combined	578	2211.426	72.11121	1733.671	2069.793	2353.058
Diff		-155.3886	144.0309	-438.2797	127.5025	

diff = mean(GP) - mean(LP) t = -1.0789

Satterthwaite's degrees of freedom = 574.657

Ha: diff > 0

Pr(T > t) = 0.2811

No evidence of difference on how much is spent on School and college/university fees

Table 5.24: Expenditure on Entertainment

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	287	743.7805	35.73444	605.5798	673.4446	814.1163
LP	187	761.3904	47.38169	647.9348	667.9158	854.865
Combined	474	750.7278	28.56473	621.8981	694.5984	806.8573
Diff		-17.60989	59.34623	-134.2998	99.08001	

diff = mean(GP) - mean(LP) t = -0.2967

Satterthwaite's degrees of freedom = 378.193

Ha: diff > 0

Pr(T > t) = 0.7668

No significant difference between the amount spent on entertainment

Table 5.25: Savings between rural and urban participants

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	335	1545.955	35.73444	605.5798	673.4446	814.1163
LP	209	869.3684	46.22741	668.3019	778.2341	9060.5027
Combined	544	1286.017	76.67792	1788.421	1135.395	1436.638
Diff		676.5868	127.6799	425.6271	927.5465	

diff = mean(GP) - mean(LP) t = 5.2991

Satterthwaite's degrees of freedom = 426.5465

Ha: diff > 0

Pr(T > t) = 0.0000

With respect to Savings, those living in Gauteng have significantly higher savings compared to those in Limpopo (R1546 versus R859)

Table 5.26: Expenditure on clothing between rural and urban participants

Group	Obs	Mean	Std. Err.	Std. Dev.	95% Conf. Interval	
GP	333	1139.459	86.30904	605.5798	673.4446	814.1163
LP	188	1136.415	75.51544	668.3019	778.2341	9060.5027
Combined	521	1138.361	61.48059	1788.421	1135.395	1436.638
Diff		3.044566	114.6814	-222.2646	228.3537	

diff = mean(GP) - mean(LP) t = 0.0265

Satterthwaite's degrees of freedom = 507.181

Ha: diff > 0
Pr(T > t) = 0.9788

The results show no significant difference in respect to amount spent on clothing.

5.5 SERVICES AND HOUSEHOLD INFORMATION

Table 5.27: Main dwelling unit the household (participant) occupies

Which of the following types best describes the main dwelling unit that your household occupies?	**Province**		**Total**
	LP	**GP**	
House or brick structure on a separate stand or yard	369 15	488 78	857 75%
Traditional dwelling/ hut /structure made of traditional material Percentage	17 3%	11 2%	28 3%
Flat in block of flats Percentage	27 5%	32 5%	59 5%
Town/ cluster/ semi-detached house (simplex, duplex, triplex) Percentage	22 4%	30 5%	52 5%
House/flat/room in backyard Percentage	49 10%	35 6%	84 7%
Informal dwelling/ shack in backyard Percentage	7 1%	9 1%	16 1%
Informal dwelling/ shack NOT in backyard e.g. in informal/squatter settlement Percentage	2 0%	2 0%	4 0.2%
Room/ flatlet NOT in backyard but on a shared property Percentage	4 1%	7 1%	11 1%
Workers' hostel (bed/room) Percentage Percentage	7 1%	4 1%	11 1%

Other Percentage	7 1%	9 1%	16 1%
Total	**511**	**627**	**n1138**

A total of seventy percent (75%) of all participants live in a brick house in a separate stand /yard, 7% in a house/flat/room in backyard, 5% in a town cluster semi-detached house, 3% in a traditional dwelling structure, 5% in a flat in a block of flats, 1% in an informal dwelling shack in a yard, 0% in an informal dwelling shack not in back yard / informal squatter settlement, 1% in a workers' hostel and 1% in other unspecified dwellings in both provinces. These findings are consistent with the stats SA General Household Survey conducted in 2014, which found that more than three quarters (79.4%) of South African households lived in formal dwellings, followed by 12.9% who lived in informal dwellings, 6.8% in traditional dwellings. According to Stats SA General Household Survey (Stats SA, 2014), Gauteng was found to be one of the provinces with the highest percentage of informal dwellings (19.2%) compared to 2% found in this study for both provinces and no significant differences were found between Gauteng and Limpopo province.

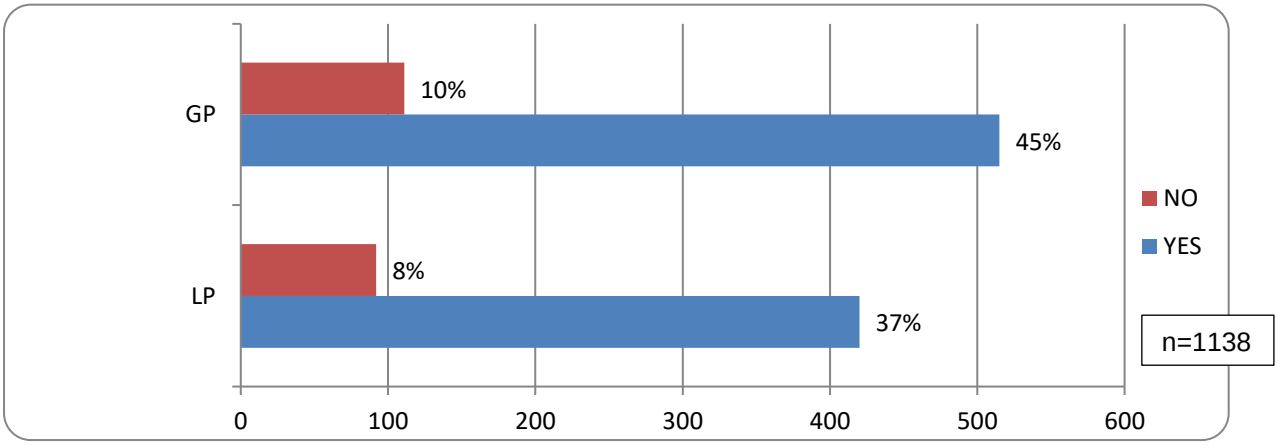


Figure 5.6: Households with radio

A total of eighty-two percent (82 %) of households have a radio, compared to 67.5% of the households in South Africa who were found owning a radio in the 2011 census (Stats SA ,2011).

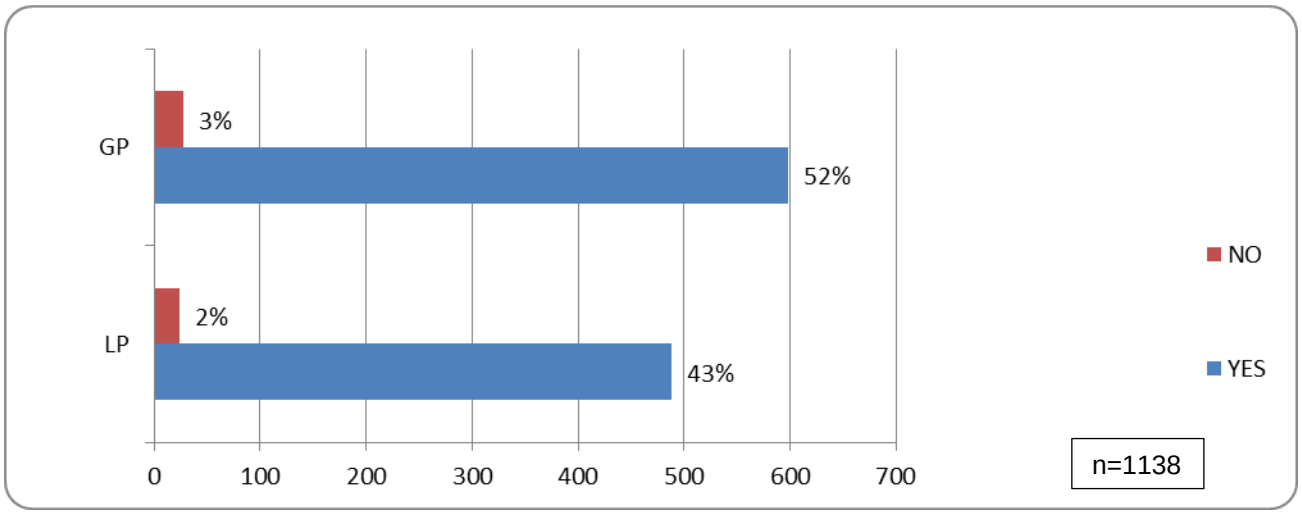


Figure 5.7: households with Refrigerators

Ninety-five percent (95 %) of the participants have refrigerators (43% rural and 52 % urban). By comparison, three quarters or more of metropolitan and urban households in South Africa owned refrigerators, electric stoves and ownership of such goods was more common and 58.8% of rural households owns refrigerators (Stats SA, 2014).

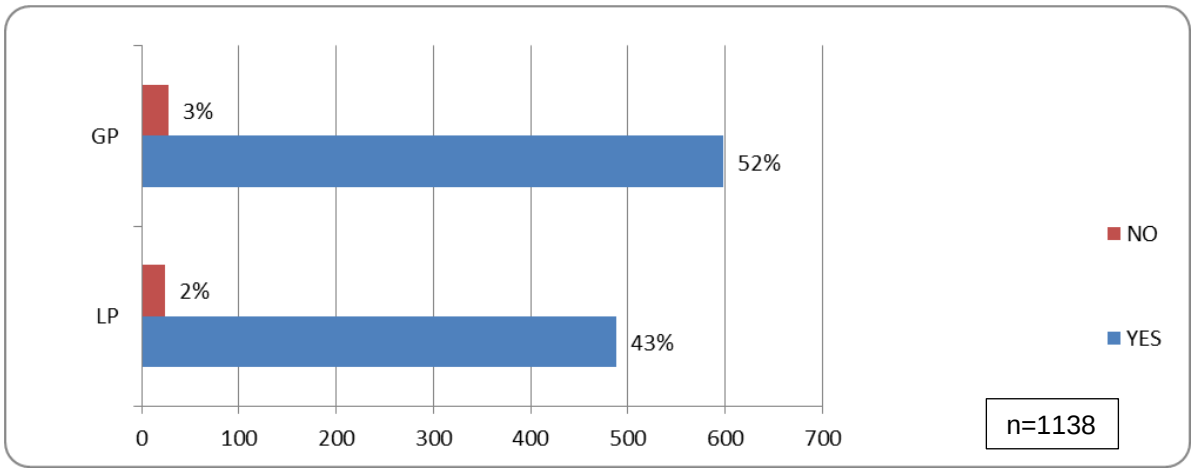


Figure 5.8: households with television unit

Eighty percent (80%) of all participants have a television unit in their household. This is comparable to 81.5% of the households in South Africa who owned television sets (Stats SA, 2014).

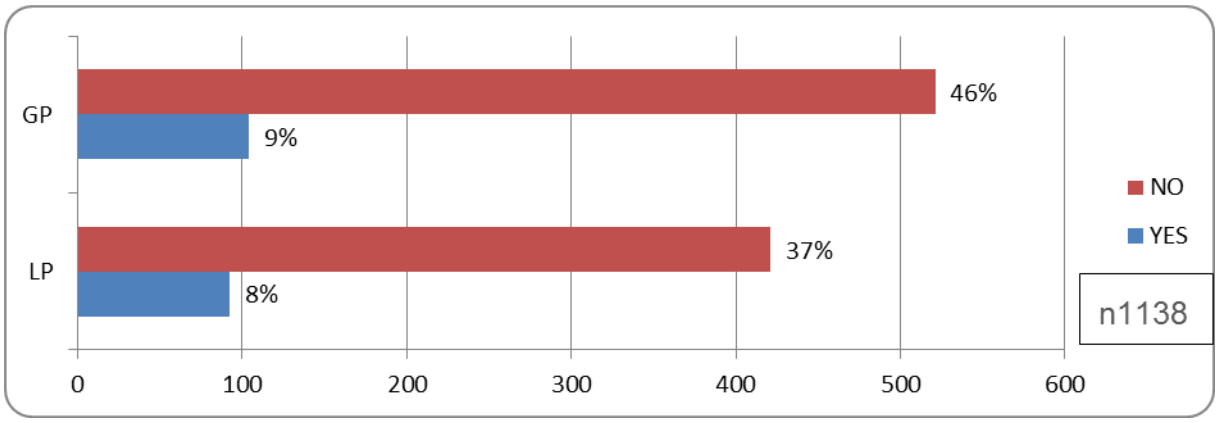


Figure 5.9: Households with telephone landline

Only 17% of households have a telephone landline in both provinces, compared to 0.2% of the total households in South Africa who had a landline according to Stats SA General Household Survey (2014). Due to lack of infrastructure it is difficult to have a landline in most parts of South Africa especially the rural areas.

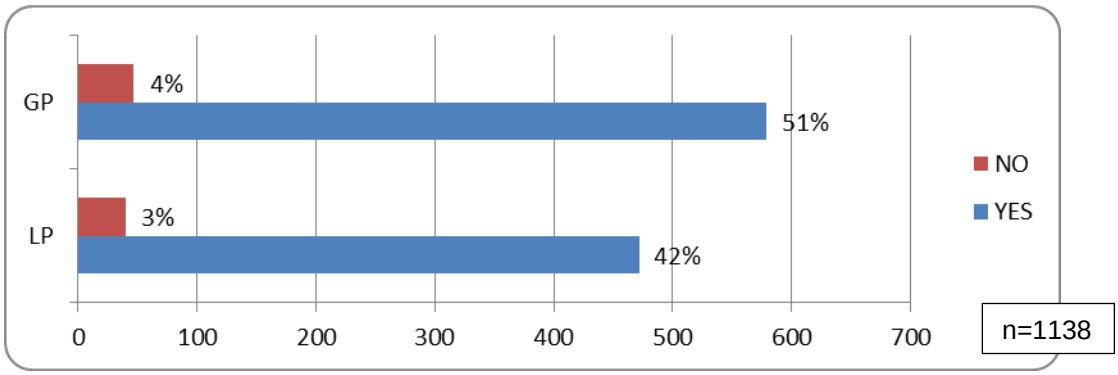


Figure 5.10: Households with Carphone

The results show no significant difference between the provinces. Ninety-two percent (93%) of households have cell phones in both provinces compared to 83.1% of the households in South Africa. Only a small percentage (8%) has no cell phones in both provinces, which is consistent to the findings of Stats SA General Household Survey (2014), which found that only 5% of households do not have access to either landline or cellular phones in 2014 (Stats SA, 2014).

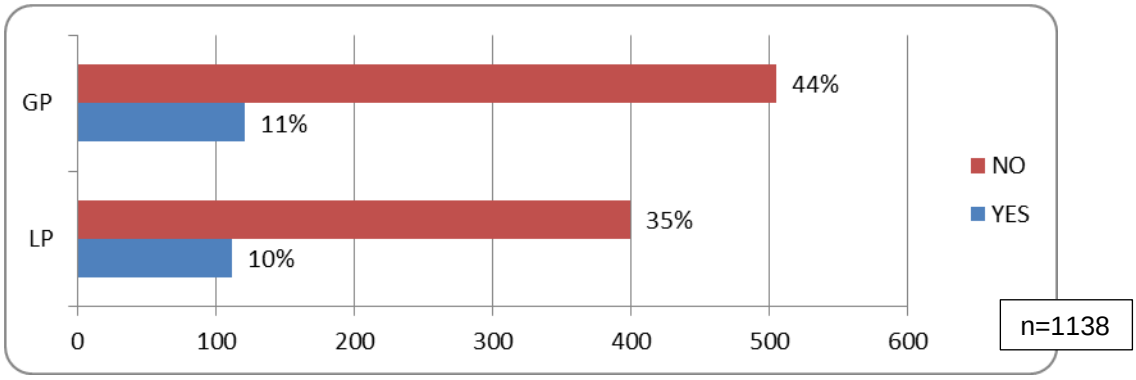


Figure 5.11: Households with internet facility

Twenty percent (21%) of households in the sample of the study have access to internet facilities while, according to the Stats SA General Household Survey (2014), 48.7% of South African households had at least one member who used the internet facilities either at home, work or place of study. The more affluent provinces such as Gauteng have more access (59%) as compared to Limpopo where only 32% of the population had access.

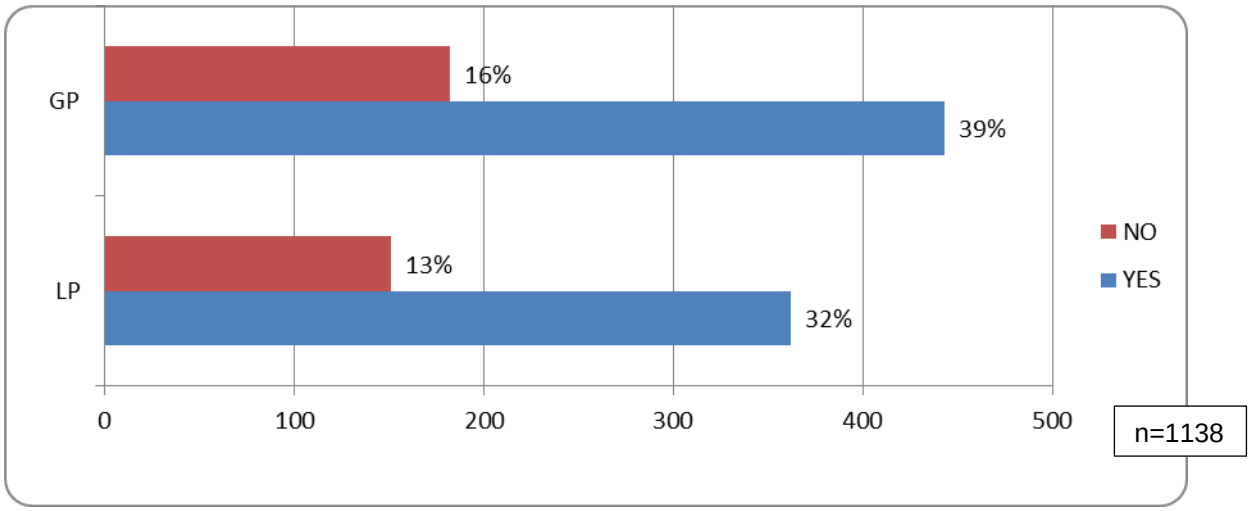


Figure 5.12: households with satellite dish

Seventy-one percent (71%) of households in the sample have a satellite dish. Only 29% do not have satellite dish in both provinces. While these figures relate to access to satellite dishes, it should be noted that 81.5% of the households in South Africa own a television set (Stats SA, 2014).

5.6 DIFFERENCES BETWEEN THE ASPIRATIONS, ECONOMIC AND SOCIAL WELLBEING OF PROFESSIONAL NURSES IN URBAN AND RURAL PROVINCES

The objective of this section was to determine if there is any difference between the aspirations and the economic and social wellbeing of professional nurses in urban and rural provinces.

5.6.1 Aspirations of Rural and Urban Professional Nurses

The participants were asked to indicate their aspirations in relation to the aspirations constructs in the survey instrument. The results were categorized in the following domains: educational, occupational, self-acceptance, financial, possessions, income, status and power and miscellaneous. Comparison between rural and urban nurses was done using t-test statistics, which is depicted in the tables and paragraphs below. In this section, the response rate was 72% with non-response of 28%.

Table 5.28: Educational attainment

Domain		Themes	Urban		Rural		prob	Remark
			n=471	%	n=351	%		
Educational	1	Obtain degree	212	45.1%	128	36.4%	0.014	Sig
	2	Nursing specialty qualification	60	12.7%	67	19.0%	0.013	Sig
	3	Computer training	22	4.7%	15	4.2%	0.730	NS
	4	Tertiary qualifications for children	137	28.8%	89	25.3%	0.250	NS
	5	Bursary for children	40	8.5%	52	14.8%	0.004	Sig

NS = Not significant, Sig = Significant

The largest proportion of participants indicated that they would like to obtain a degree, 45.1% (urban) and 36.7% (rural). This represents a significant difference between urban and rural nurses' aspiration (p-value 0.014). Both rural and urban nurses aspire to have a nursing specialty qualification (rural 18.9% and urban 12.7%) with p-value 0.013. A small minority of participants aspire to have computer training and there is no significant difference between urban and rural province (p-value 0.730). Participants also aspire to have their children receive a tertiary qualification (urban 28.8% and rural 25.3%) with no significant difference between the provinces (p-value 0.250).

From the results above, it is clear that there is significant difference in educational aspirations of urban and rural nurses especially with their wish to obtain a degree (p-value 0.014), their wish to acquire a nursing specialty qualification (p-value 0.013), and their aspirations for bursaries for children (p-value 0.004).

Table 5.29: Better jobs (Occupational domain)

Domain		Themes	Urban		Rural		prob	Remark
			n=471	%	n 351	%		
Occupational (better jobs)	1	High position and paying jobs	107	22.6 %	89	25.0 %	0.641	NS
	2	Management post	151	32.0 %	96	27.0 %	0.137	NS
	3	Nurse educator post	53	11.3 %	33	9.0%	0.372	NS
	4	Nursing specialty post	52	11.0 %	65	18.6 %	0.002	Sig
	5	Family members to be employed	24	5.03 %	31	8.9%	0.027	Sig

NS = Not significant, Sig = Significant

The results show that there is a significant difference between urban and rural nurses in the following elements of this domain: nursing specialty post and family

members to be employed. There were significantly more professional nurses in the rural province with the aspiration for nursing speciality posts (18.6%) than those in the urban province (11.6%), with p- value 0.002. However, the aspirations for family members to be employed is significantly higher for rural professional nurses (8.9%) than urban province counterparts (5.03%) with p-value 0.027.

Table 5.30: Possessions

Domain		Themes	Urban		Rural		prob	Remark
			n=471	%	n=351	%		
Possessions	1	Big car and house	178	37.7	105	29.9	0.02	Sig
	2	Car	131	20.87	154	43.8	0.00	Sig
	3	Furniture	20	4.2	11	3.1	0.037	Sig
	4	House	86	18.3	55	15.6	0.320	NS

NS = Not significant, Sig = Significant

The results show a significant difference between urban and rural professional nurses' aspirations, especially in the following items: big car and house, car only and furniture. For urban professional nurses (37.7%) the aspirations for a big car and house is significantly more than that of rural professional nurses with p-value 0.02. On the aspiration of a car only, rural professional nurses' aspirations (43.8%) were significantly higher than those of urban professional nurses (20.8%), with p-value 0.00. The results also show a significant difference in the aspirations of furniture between the urban (4.2%) and rural (3.1) professional nurses with p-value 0.037.

Table 5.31: Financial success

Domain		Themes	Urban		Rural		prob	Remark
			N471	%	N351	%		
Financial success	1	Financial stability and debt free	151	32.0	92	26.2	0.071	NS
	2	Provide for family needs	205	43.5	159	45.2	0.632	NS

	3	Investments shares and savings	74	15.7	65	18.5	0.255	NS
	4	Business	41	8.7	35	9.9	0.029	Sig

NS = Not significant, Sig = Significant

There are no significant differences between the aspirations of urban and rural nurses in most of the elements in this domain. The largest proportion of urban (43.5%)and rural 45.2%) participants indicated that they would like be able to provide for their family, with p-value -0.48; followed by financial stability (urban 31.9% and rural 26.2%, with p-value 0.071) and investments and shares (urban 15.7% and rural 18.7%, with p-value 0.255). The only significant difference is in the aspirations for business (urban 8.7% and rural 9.9. %) with p-value 0.0029.

Table 5.32:Community standing /feeling

Domain		**Themes**	**Urban**		**Rural**		**prob**	**Remark**
			n=471	**%**	**n=351**	**%**		
Community standing /feeling	1	Work for the betterment of the community	20	4	11	3	0.037	Sig
	2	Help others to improve their lives	86	18	55	16	0.320	NS
	3	To be respected by the community through participation in community activities	178	38	105	30	0.02	Sig

	4	Helping people in need	131	21	154	44	0.00	Sig

NS = Not significant, Sig = Significant

In this domain, there is significant difference between urban and rural participants in respect to the following elements of this domain: working for the betterment of the community (urban 4% and rural 3%, p-value 0.037), to be respected by the community through participation in community activities (urban 38 % and rural 30%, p-value 0.02) and helping people in need (urban 21% and rural 44%, p-value 0.00). This domain is closely related to status and power; as the nurses are helping those in need they assume a dominant position thereby exercising the power and authority that comes with this position, and on the other hand gaining respect from the community members as they volunteer their services, therefore fulfilling their intrinsic aspirations to feel valued.

5.6.2 Self-acceptance (What makes you happy with yourself)

In this domain, the participants indicated that the things that make them happy and to which they aspire for are personal achievements (urban 25.4% and rural 16.38%, with p-value 0.002) and participation in community activities (urban 18.9% and rural 28.0%, with p-value 0.002). Professional nurses in both rural (30.9%) and urban (26.2) provinces also aspire to be able to provide for themselves and their family, and there was significant difference between urban and rural participants in this element with p-value 0.041.

5.6.3 Income

In this domain, there were no significant differences between the aspiration of urban and rural participants. However, the following items were identified: Earning more than R35 000 00 per month, urban (39.1%)and rural (37.0) with p-value 0.551; money for children's education urban (20.1%), rural (23.0); salary increase (40.7%) and rural (39.4%) p-value 0.716 and lastly, investment and shares (urban 15.71) rural (18.5%) with p-value 0.799.

5.6.4 Status and power

The results show significant difference between the urban and rural professional nurses in both items of this domain. The professional nurses in urban (51.2%) and rural (42.4%) areas aspire to be respected by the community and colleagues with p - value0.013. In contrast, the rural professional nurses (46.7%) show a significantly higher percentage than urban professional nurses (39.2%) on the aspirations of management position to influence policy, with p-value 0.030.

5.6.5 Other issues of significance which impact on the aspirations and wellbeing of professional nurses

In the last portion of the questionnaire, participants were asked the following question: If you have any other comments, please write at the back of this questionnaire. Participants comments were recorded into the Microsoft Excel spreadsheet, analysed, and coded into themes and further analysed using the statistical method as described in the methodology chapter 2. The themes that emerged are depicted in the table below.

Table 5.33: Participants comments related to their aspirations

Domain		Items	Urban		Rural		Prob	Remark
			n=627	%	n=511	%		
Other issues	1	Review OSD for Nurses	207	33.08	105	20.5	0.000	Sig
	2	SANC must recognise all post basic speciality qualifications	30	4.88	46	8.97	0.019	Sig
	3	Improve working conditions for nurses	146	23.35	85	16.58	0.016	Sig
	4	Reduce SANC fees	165	26.32	113	22.15	0.192	NS
	5	SANC must provide distinguishing	52	8.27	72	14.02	0.008	Sig

		devices for all post basic qualifications						
	6	Risk allowance	27	4.32	12	2.4	0.138	NS

NS = Not significant, Sig = Significant

The results show significant differences between provinces (urban 33.08%and rural 20.57%, with p- value 0.000) on the reviewing of the OSD, recognition of all post-basic qualifications (urban 4.88% and rural 8.97%), with p-value 0.019; working conditions must be improved (urban 23.37% and rural 16.58%, with p-value 0.016) and lastly, participants in both provinces (urban 8.27% and rural 14.02%, with p-value 0.008) want SANC to provide distinguishing devices for all post-basic qualification. The overall respond rate to this item was 93.1%.

5.7 SUMMARY ANALYSIS OF THE COMPARISON BETWEEN GAUTENG AND LIMPOPO RESPONSES ON QUESTIONS 1–9 (DEMOGRAPHIC, ECONOMIC AND SOCIALCIRCUMSTANCES OF PROFESSIONAL NURSES)

The comparison used both parametric (continuous measure) and non-parametric (categorical measures) methods. For continuous measures, e.g. Age, the t-test was used while Kruskal-Wallis. Kruskal-Wallis test of the hypothesis that several samples are from the same population. This test is a multisampling generalization of the two-sample Wilcoxon (Mann-Whitney) rank-sum test. Summary tables are presented.

Table 5.34: Comparison of responses of Gauteng and Limpopo participants on question 1-9.

Measure/Variable	Group	Mean	Significance	95% CI
Age	GP	44.3	P=0.44	[43.5; 45.2]
	LP	43.8		[42.9; 44.7]
Q6a	GP	2.61	0.26	[2.47; 2.75
	LP	2.49		[2.33; 2.65]
Q6b	GP	3.97	0.58	[3.79; 4.16]
	LP	3.90		[3.69; 4.10]

Q7d	GP	5476.9	0.92	[4565.4; 6389.3]
	LP	5409.6		[4492.7; 6326.9]

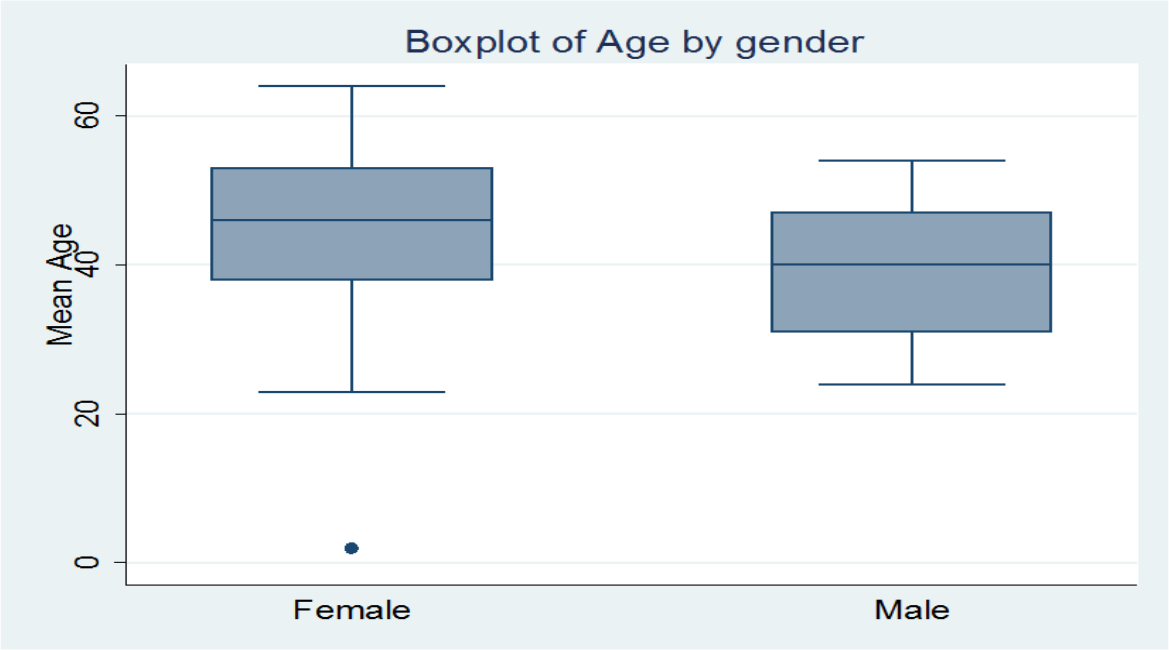


Figure 5.13: Age analysis of participants

The result showed that the age groups are similar no significant differences in both provinces.

Table 5.35:Summary for categorical measures comparing Gauteng and Limpopo groups, using Kruskal-Wallis test.

Measure	Province	Rank Sum	KW statistic Chi-squared	Significance (prob.)
Marital Status	GP	335587.50		
	LP	267763.50	1.434	0.2311
Gender Distribution	GP	342384.00	2.613	0.1060
	LP	289866.00		
Q4a: Are you presently attending an educational institution	GP	344263.0		
	LP	272342.0	2.906	0.09
	GP	25875.0	0.096	0.756

Q4b. If Yes, which do you attend among those listed below	LP	24211.0		
Q4c: What is your highest education level	GP	345321.5	0.215	0.642
	LP	286928.5		

From table 5.35 above, there is no evidence to show differences between the responses of Gauteng and Limpopo participants.

Table 5.36: Summary table related to question 5 (Employment status)

Measure	**Province**	**Rank Sum**	**KW statistic Chi-squared**	**Significance (prob.)**
Q5a. In the last 7days, did you run or do any kind of business, big or small, for yourself or with one or more partners even for only one hour?	GP	354561.0	0.475	0.491
	LP	285585		
Q5b. Did you do any work for a wage, salary	GP	328725.0	0.870	0.351
	LP	277926.0		
Q5c. What did you consider to be your primary job?	GP	343029.0	1.196	0.274
	LP	285852.0		
Q5d. Do you, or have you in the last month, worked overtime or moonlighted?	GP	339878.0	1.843	0.175
	LP	287882.0		
Q5g. What is your mode of transport?	GP	349023.0	1.622	0.203
	LP	296793.0		
Q5i. Do you live in Subsidized accommodation?	GP	355569.5	0.886	0.347
	LP	284576.5		
Q5j. Do your children attend a Crèche/Child facility?	GP	348439.5	0.093	0.761
	LP	287188.5		
	GP	355733.5	0.008	0.927

Q5k. Do you own a motor vehicle?	LP	290082.5		
Q5l.Do you have a driver's license?	GP	357948.5	0.390	0.32
	LP	287867.5		
Measure	Province	Rank Sum	KW statistic Chi-squared	Significance (prob.)
Q7a. What is the income category that best describes your gross monthly income before deductions and including all sources of income?	GP	340788.50	0.038	0.846
	LP	282497.50		
Q7b. What is the income category that best describes your net monthly income or after deductions?	GP	342080.0	0.315	0.574
	LP	275636.0		
Q7c. Do you have any other person/s in the household contributing to the household expenses?	GP	334407.5	2.587	0.108
	LP	262379		

Table 5.37: Summary table related to question 9 (Services and household information)

Measure	Province	Rank Sum	KW statistic Chi-squared	Significance (prob.)
Q9a. Which of the following types best describes the main dwelling Unit that this house	GP		0.475	0.491
	LP			
Q9b. How many room, including kitchen are there in your household?	GP	328148.0	1.190	0.275
	LP	263180.0		
Q9c_1. In which way does your household obtain water for domestic use?	GP	338214.5	0.445	0.54
	LP	272850.5		
Q9c_2. What is the distance from the water access point?	GP	285355.0	0.131	0.72
	LP	236376.0		
Q9c_3. What is the main type of Toilet facility available for use?	GP	345201.0	0.514	0.47
	LP	278085.0		
Q9c_4. What type of energy/fuel does your household Mainly use for cooking?	GP	341780.5	0.710	0.40
	LP	284859.5		
Q9c_5. What type of energy/fuel does your household Mainly use for heating?	GP	341357.5	0.667	0.41
	LP	276358.5		
Q9c_6. How is the rubbish from your household mainly disposed of?	GP	332228.5	0.075	0.78
	LP	272221.5		
Q9c_refrid. Does your household have Refrigerator?	GP	355957.0	0.027	0.86
	LP	290996.0		
Measure	Province	Rank Sum	KW statistic Chi-squared	Significance (prob.)
Q9c_radio. Does your household have Radio	GP	355959.0	0.008	0.93
	LP	290994.0		
Q9c_tel. Does your household have Television?	GP	356294.5	0.030	0.86
	LP	290658.5		
Q9c_comp. Does your household have Computer?	GP	352981.0	0.313	0.58

	LP	293972.0		
Q9c_landln. Does your household have Landline?	GP	353811.5	0.254	0.61
	LP	293141.5		
Q9c_intern. Does your household have Internet facilities?	GP	351601.0	1.092	0.30
	LP	295352.0		
Q9c_cell. Does your household have Cell phones?	GP	356349.0	0.082	0.77
	LP	290604.0		
Q9c_sat. Does your household have Satellite e.g. DSTV?	GP	355908.0	0.004	0.95
	LP	291045.0		

Table 5.37 above summarized the comparison of responses on the questions listed above. The results showed no evidence that there are any significant differences between the two provinces.

Table 5.38: Comparison between average income and average expenditure between Gauteng and Limpopo participants

	Gauteng	Limpopo
Average income	R14 000	R10 767
Average expenditure	R14 593	R13 067
Difference	- R593	- R2 300

Table 5.38 above shows that the average household income for participants in the Limpopo and Gauteng provinces differ significantly. The participants in Limpopo receive much lower contributions from any other person towards houshold expendture (t-test = 5.3215) as compared to the Gauteng participants. Hence, the average monthy income for participants in Gauteng is R14,000 as compared to participants in Limpopo with an average monthly income of R10,767. The average expenditure of participants in Limpopo is R13,067, while the participants in Gauteng have an average monthly expanditure of R14,593 which is more than that of the Limpopo participants.

5.8 CONCLUSION

In this chapter, results were presented that answer the research objectives. Results showing the economic and social circumstances of professional nurses in both urban and rural provinces and the significant differences between the two provinces was presented. The significant differences between the aspirations of urban and rural professional nurses were also presented.

The results show that despite the two provinces differing greatly in terms of their economic and social circumstances i.e. one being rural (Limpopo) and another being urban (Gauteng), professional nurses in these provinces share many similarities in their economic and social circumstances, and also have significant differences in other areas including their aspirations, which impact on their wellbeing. Where applicable the results of this study were also compared with the general population (Stats SA General Household Survey), including statistics of the South African Nursing Council in order to provide a comprehensive presentation of this findings. In the next chapter, these findings and the relevant literature are presented.

CHAPTER 6 - DISCUSSION OF THE FINDINGS OF THE SURVEY

6.1 INTRODUCTION

The purpose of this chapter is to discuss findings of the survey which assisted in meeting the third and fourth objectives of the study viz:

- to explore and describe the aspirations, and the economic and social wellbeing of professional nurses in selected provinces of South Africa.
- to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces.

The economic and social wellbeing and aspirations of professional nurses in rural and urban provinces are presented and discussed and the differences between the responses of rural and urban participants is outlined. Where applicable the comparison between the study population and the general population is also discussed and conclusions are made.

The variables that depict the economic and social circumstances of the professional nurses were assessed; these include demographic data, relationship, place of residence, income, expenditure, education, occupation, housing, mode of transport and household information and the aspirations of professional nurses.

6.2 DEMOGRAPHIC DATA

Despite efforts of transformation in nursing since the democratic dispensation in South Africa in the last 20 years, nursing remains a predominately female profession. Both the national statistics (SANC, 2014) and the current study show that over 90% of nurses are female. Interestingly, there was a decrease in the number of male nursing students enrolled in a 4-year degree/diploma nursing program at the nursing colleges and universities in South Africa in 2015(SANC,2015). The SANC statistics show that the number of male nurses entering the profession has dropped from 1060 in 2014 to 918 in 2015, whilst the number of male student nurses who terminated training has almost doubled from 194 in 2014 to 392 in 2015 (SANC

,2015). The reason for this drop might be associated with the perceived status of nursing in the community and by nurses, role conflict and the poor pay which forces young male nurses to use nursing as a springboard to other opportunities, opt for administrative positions, work as instructors and to explore greener pastures elsewhere. It is indeed a worrying phenomenon, which might lead to the extinction of male nurses, and therefore warrants further research to find out why these nurses terminate training, and whether the few who complete training actually remain in the profession. This is corroborated by Ozdemir, Akansel and Tunk (2008) in their study of student's perceptions of male nursing role in Turkey, who also found that nursing is perceived by both genders as a female- only profession and that male students have role tension and, in turn, desire to occupy administrative positions after graduation.

It is not uncommon for women in South Africa to be the breadwinners in the family. According to census statistics, 15% of households in South Africa have female bread winners, where a married woman is the head of the household (Stats SA , 2011). Furthermore, a recent survey released by Stats SA (Stats SA, 2014/2015) on the living conditions of households in South Africa 2014/2015 indicated that 41,36% of households are headed by women irrespective of their marital status, whilst in the current study 23.5% of the participants are head or acting head of the household. It is also important to note that the majority of the professional nurses who participated in the current study are women (91.6%) and a total of 47.7% represented those participants who are either widow/widower (9.4%), divorced (7.0%), separated (2.9%) and never married (28.4%) and presumably sole breadwinners. The result of this study further shows that 48% of all participants have more than two children living in the household and a total of 63% of all participants have a household size of more than three people, out of which 34% represent households with more than five members. Interestingly the survey conducted by Stats SA (2014/2015) revealed that the average household size was 3.30 with female headed households having a higher average of household size of 3.36 and in rural areas the female headed household have the highest average household size of 4.36. As outlined above, and given the unemployment statistics of South Africa, the majority of the participants, including those who are married, are more likely to be bread winners. This, in itself,

results in economic and social challenges for these women which impact on their wellbeing as they try to meet their economic and social aspirations. These findings are consistent with those of Parry (2014) who found that women heading household are prone to stress caused by trying to balance their roles as providers and home makers, and exhaustion and tension resulting from caring for others at home while in full-time employment (Parry, 2014).

6.3 PLACE OF RESIDENCE, LIVING ARRANGEMENTS AND ACCOMMODATION

The majority of participants live in townships (52.9%), followed by tribal areas (11.7%), with fewer living in towns (16.1%) and cities (12.8%). This is slightly more than the national average, where 38% of people of working age in South Africa live in townships. This could be an indication that nurses either prefer to live in townships or cannot afford to live in towns (suburbs) and cities due to unaffordability. Either way, as Mahajan (2014) points out, living in a township is a disadvanatage from a economic and socialpoint of view as townships are spatially disconnected from urban centres leading to huge trasport cost to commute to towns or working place. Similarly those staying in tribal areas are also disadvantaged , owing to long distances to work and poor infrustructure .Tribal areas are defined by Stats SA (2004) as “Villages that fall within a tribal area. Villages look like pockets of houses/huts clustered throughout the area with large areas of grassland and/or fields in between”. These areas, which are far more prevalent in Limpopo than Gauteng, also tend to be further away from urban centres, adding additional transport costs to nurses living in these areas.

In these rural areas, there is a high unemployment rate, leaving the nurse, who is usually the only bread winner, to support the entire family, including the extended family members. According to the 2011 census, unemployment in Limpopo was 38.9%, compared to 26.3% for Gauteng province, and 29.8% for South Africa as a whole. The majority of those who are employed are mainly farm workers and public servants. The average annual household income in Limpopo is R56,844, whilst in Gauteng it is R156,243 (Limpopo Department of Health and Social Development Annual Performance Plan 2011/12-2013/2014, Stats SA, Census 2011). Salaries of nurses in the public sector are standardized, but the chances of a nurse living in a

rural area having financial support from other family members is less than in urban areas, thus impacting on their economic and social wellbeing and, possibly, their aspirations.

Only 12.4 % of the participants live in subsidised accommodation, whilst 87.0% do not live in any form of subsidised accommodation, whilst 0.6% did not respond. These findings are consistent with the general housing situation in South Africa. In common with many households in South Africa, nurses do not commonly qualify for a Reconstruction and Development (RDP) houses as their salaries are above the qualifying threshold. At the same time, their salaries are too low, to qualify for a bank loan from most of the financial institutions, or they are unable to obtain a bank loan because they have poor credit ratings and are therefore often disqualified by the financial institutions. They are, therefore, unable to gain access to the state housing scheme or a mortgage bond. According to Tissington (2011), who compiled the Resource Guide to Housing in South Africa 1994-2010, published in 2011, the "income group earning between R7, 500 and R15, 000 is currently unable to access bonds and some in this band are currently renting until their financial situation improves or lending criteria are adjusted." The tragedy is that while nurses are paying rent, they are unlikely to be able to save enough for a home of their own.

The challenges of housing in South Africa should be understood in the context of the housing inequalities that still exist in post-apartheid, democratic South Africa between the urban and rural areas, as well as between the nine provinces. This situation is further compounded by the fact that many South Africans are not financially able to provide for their own household needs, as low-income families form a large proportion of South Africa's population. For instance, the average annual household income in Limpopo is R56, 844, whilst in Gauteng it is R156,243 (Limpopo Department of Health and Social Development Annual Performance Plan 2011/12-2013/2014; Gauteng Annual Performance Plan 2011/12-2013/2014, Stats SA, Census 2011). The situation is further worsened by the fact that after the democratic dispensation in 1994, most South African cities were confronted with dire housing needs and service backlogs, inequalities with municipalities' expenditures, lack of expertise to deliver services, the conditions associated with the legacy of

apartheid cities and geographical boundaries, including apartheid local government structures, a high unemployment rate and many poor households (Pillay, Tomlinson & du Toit, 2006). These and many other conditions still prevail now, 20 years after democracy; hence the country continues to experience many service delivery protests related to the provisioning of water, sanitation, refuse disposal and housing. Land and housing were the most cited issues related to service delivery protests, which accounted for 303 protests in the six-year period from 2007-2012 (The Times, 11 October 2012). Professional nurses, as members of the communities, are therefore not immune from this economic and social situation in South Africa, and are caught up in protests and experience the same problems as other members of their communities in respect to housing.

6.4 MARITAL STATUS

The results further showed that of the total participants only 43.1% are married, 7.2% are living together, while a significant percentage of 28.4% has never married, 9.4% are widowers/widows, 7.0% are divorced and 2.9% are separated. Nurses who are single parents carry an additional socio-economic burden, which affects their economic and social wellbeing. An investigation into low-income mothers' patterns of partnership instability and adolescents' socio-emotional WELLBEING showed that married parent families reported less economic hardship, more family routine and father involvement, and less maternal psychological distress and parenting stress than their single and cohabiting counterparts (Becham et al. 2012). However, with the current financial crisis, even those who are married are not immune to financial hardship, especially when the husband is unemployed or retrenched, which is common in South Africa where the unemployment rate is alarmingly high, often leaving the household to depend on the professional nurse's income. This is also the case with the current study a significant percentage of professional nurses' most of whom are female, heads of households, never married widow/widower or even divorced and are therefore sole bread winners. This group represent a total of 47.7% of the study sample.

6.5 EDUCATION

The results of the study showed that only 21.6% of all participants are currently attending educational institutions, while 75.9% are not. While these figures only relate to those currently studying, there is an indication that small number of nurses have the opportunity to further their studies, which limits their chances for appointment to higher positions or even getting speciality posts. Lack of educational opportunities limit the opportunity for these professional nurses to get better jobs and earn a high income, which ultimately will have an impact on their aspirations, economic and social wellbeing.

Furthermore, the majority of participants have a diploma nursing qualification (52.5%), 17.3% have a bachelor's degree, BTech 6.0%, post graduate diploma 10.1%, honours degree 6.7%, certificate 4.3%and only 1.4% have a higher degree (masters or PhD) qualification. In this respect, the majority of professional nurses who are at the operational level have limited chances to move up the career ladder in management, education or clinical specialisation, where the prescribed requirements for such positions are either one year post basic clinical specialisation recognised by SANC, or a degree with specialisation in nursing education or management or an equivalent, in accordance with the Occupational Specific Dispensation for Nurses (PHSDSBC: Resolution no 3 of 2007).

Research has shown that individuals with a higher educational level have a good chance of getting higher positions and better jobs which, in turn, improves the individual's socio-economic status and wellbeing. Education creates an avenue to escape poverty and cut down the cycle of poverty across generations (Haveman & Smeeding, 2006).

6.6 FINANCES

6.6.1 Income

Of all participants, more than half (61.6%) have a gross monthly income of less than R20, 999 per month whilst 24.8% of participants have a monthly net income ranging from R15,000 to R20,999 per month, 45.2% have a net income ranging between R9,000 and R14,999 and thirteen percent (13.1%) have a net income less than R9,000 per month.

Of the total sample, only thirteen percent (13.0%) have a net income more than R20, 999 per month, which represents the few specialist professional nurses who are on a level equivalent with or higher than a grade 1 speciality post and grade 3 of a general professional nursing post. It is for this reason that the majority of nurses, particularly those without speciality qualifications, are disgruntled with the implementation of the OSD, as their salary level and economic position did not significantly improve compared to those professional nurses in speciality posts. For instance, the salary notch of a grade 3 professional nurse (general), who is required to have a minimum of at least 20 years' experience after registration as a professional nurse, is R294,861 per annum (or R24,572 per month), which is a starting salary notch for a professional nurse (speciality) with 1 year post basic speciality qualification recognised by SANC (DPSA,2007; DPSA,2014).

It has to be noted that the gross annual entry level salary for a professional nurse (general) grade 1 is R195,819 (or R16,318 per month), and to progress to grade 2 and grade 3 a minimum of 10 years' and 20 years' experience is required respectively (DPSA,2014). This gap between the entry salary notch for a professional nurse (general) and a professional nurse (speciality) is a major source of unhappiness amongst the professional nurses in South Africa, specifically those in general posts, as they feel the implementation of the OSD has not improved their salary significantly in comparison with the professional nurses in specialist posts hence their low economic and social wellbeing. It is also for this reason that the majority of the participants (53.6%) in this study are dissatisfied with the implementation of the OSD and want this policy to be reviewed. The results also show that an overwhelming majority of professional nurses aspire for management posts (32.0% urban and 27.0 % rural) and to be trained in speciality areas (11.0% urban and 18.5% rural) so that they can earn better salaries and bridge this salary gap.

6.6.2 Income and job satisfaction

These findings are consistent with those of other studies (Motsotsi and Rispel, 2012; Ngwenya and Makhubela Nkondo, 2009; Tshitangano, 2013) who found that there were discrepancies with the implementation of the Nurses' OSD, leading to

dissatisfaction amongst nurses. The discontent amongst nurses with the implementation of the OSD has led to a number of grievances being lodged by nurses and the Labour organisations, with some even reaching the labour court.

Furthermore, in another study by Khunou and Davhana-Maselesele (2016), on the level of job satisfaction amongst nurses in the North West Province, following the introduction of the occupational specific dispensation in South Africa, revealed that the majority of professional nurses (82%) did not have an improved level of satisfaction after the implementation of the OSD. Contrary to the general notion that specialist nurses benefited from the OSD, and that they therefore have a high level of satisfaction, a study by Magana (2013) found that intensive care nurses were still dissatisfied, resulting in a high turnover of these nurses due to problems relating to salaries, organisation and work environment.

6.6.3 Expenditure

Interestingly, the average household income for participants in the Limpopo and Gauteng provinces differs significantly(table 5.42). While these figures represent averages, it is of concern that average expenditure appears to exceed income, giving futher weight to the idea that South Africans, including professional nurses, are indebted. The National Credit Regulator(NCR) report (2016) states that 10 million of the 24 million credit active South Africans are in arrears on their accounts. Although the household expenditure appears to be lower in Limpopo than the Gauteng province, it is worrying that the participants in both Limpopo and Gauteng seem to be living beyond their means as their expenditure is higher than their average income, which might be predisposing them to loan sharks. The inference is that they are living in debt, which may negatively affect their health, financial position and ultimately their economic and social wellbeing. The above challege was affirmed recently by the Department of National Tresurey when briefing the the Parliament Portforlio Committee on Trade and Industry on the report which was widely publicied on the media including SABC news entitled “nurses,teachers in public service are drowing in debts” . The National Treasurey report further states that bulk of the nurses and teachers monthly income goes to repaying debts relating to vehicles,

bonds and personal loans (www.sabc.co.za . SABC news. Wensday 2 August 2017 .Accessed 10 August 2017)

For participants in both Limpopo and Gauteng provinces, the high ticket expenditure items were found to be rent, or repayment of a bond, water, electricity and municipal rates and hire purchase . The expenditure on these items is oftenly influenced by the place of residence. The participants in Gauteng spend more on electricity and municipal rates, and rent or bond repayments compared to those in Limpopo. On the other hand, the study found that participants in Limpopo spent more on hire purchase and loans as compared to their counterparts in Gauteng province. No evidence was, however, found to suggest a difference in the amount spent on transport between the urban and rural participants other than repayments on a car.

These findings are consistent with the Stats SA (2012) income and expenditure survey, conducted in 2010-2011, which found that the average household in South Africa has high expenditure on the following items: housing, water and electricity, gas (32%) and transport 17%, and that residents in Limpopo spent more on furnishings and household equipment and routine maintenance of dwellings (7.0%) as compared to Gauteng (4.5%) on the same expenditure item. Furthermore, the findings in the current study on average household income is not suprising, as it corroborates with the findings by Stats SA (2012), which found that the average household income in South African was R119,542 per annum, which is rounded off at R10,000 per month(Stats SA ,2012).

6.6.4 Additional sources of income

In considering the socio-economic status of a group, it is important to consider that they may have additional income from sources other than their primary employment which, in this study, was nursing. The majority of participants indicated that they do not engage in any other form of business (89.6%) and only 7.4% are egaged in some kind of business.

A common way for nurses to earn additional income is moonlighting or overtime. In this study, 23% indicated that they had participated in moonlighting or had worked overtime in the previous month. Rispel et al. (2014), who studied the factors

influencing agency nursing and moonlighting in South Africa, found that 56.0% of nurses had worked overtime, while 37,8% had participated in agency nursing in the 12 months preceeding the survey. The study further found that the utilization of agency nursing and moonlighting was higher in private hospitals sector nurses (58.4%) compared to provincial public hospitals' nurses (28.4%) in the four provinces surveyed. This is indicative of a similar finding in this study, which only included nurses from the public sector. In public hospitals, nurses are more likely first to work overtime in their own hospitals, as they have to get permission to do Remunerative Work Outside the Public Service (RWOPS) and comply with RWOPS policy before they can engage in agency nursing. The fact that a quarter of professional nurses are working extra hours beyond the normal working week of 40 hours has implications related to the safety of the patients, nurses' well being and that of their families (Stimpfel, Sloane, & Aiken 2012).

In a study conducted by Rispel et al. (2014), it was found that amongst other reasons given by nurses as to why they do moonlighting, it was due to the fact that the nursing agencies pay weekly (81.8%) and that nurses engage in moonlighting to earn additional money (72.5%) to supplement their salaries resulting in a steady flow of income. It is the researcher's observations that although participants in Limpopo may not be receiving huge contributions from any other person towards household expenditures, in rural communities there is strong social cohesion and support such that the communities and family members assist one another, e.g. looking after children after school or babysitting those that are not attending crèche by a family member or neighbour. These forms of contribution, although not monetary, have a huge impact on the household expenditure and are often undermined or unnoticed when people consider matters of financial importance.

6.7 TRANSPORT

Fifty-five percent (55.0%) of the participants use a private car to travel to work, while a 39.6% use public transport. Only a small percentage (5.1%) walk to work. On the other hand, seventy-three percent (73.1%) of the participants have a driver's licence, but only 60.9% own cars, while 38.4% and 26.1% of the participants do not have cars or driver's licences respectively. This finding provides an explanation as to why

the majority of nurses have aspirations, amongst others, to have a car or big car. Reliable transport is important for nurses as the majority of them at the production or operational level work shifts, which start early and often end late in the evening (e.g. 7-16 or 7-7 shifts day or night). By comparison only 30.2% of the households in South Africa own at least one vehicle (Stats SA, 2014).

6.8 CHILD CARE

The majority of participants in this study work in institutions where the employer does not provide a childcare facility or crèche (93.1%). Those working in institutions where the employer provides a crèche or childcare facilities constitute only 5.9% of the total participants, whilst 1% did not respond. The implication of this is that the majority of nurses, who are mainly women, with small children, are paying high fees to private childcare facilities for their children, which adds to their financial burden. Having employer-sponsored child care facilities not only reduces costs for the employee, but also helps in improving the productivity of working mothers in the workplace, including reduction of absenteeism. This is corroborated by Anderson and Geldenhuys (2011) who studied the relationship between absenteeism and employer sponsored childcare and found that there is higher absenteeism in organisations without on-site child care facilities than those with onsite childcare facilities.

The other contributing factor for low income in rural province is the lack of opportunities to earn extra money, either by moonlighting or agency nursing in comparision to the participants in urban province (Gauteng). Participants in Limpopo who are moonlighting have to travel long distances from deep rural areas to Polokwane city(-+200km) in Limpopo and Gauteng province(-+ 500km) respectively, where such opportunities exist. Similarly, the participants in Gauteng are not well-off, while the difference beween their average monthly income and expenditure is statistically insignificant, it should be born in mind that the overall cost of living is higher in Gauteng than in rural Limpopo province, and that there are other indirect costs not mentioned in this study.

6.9 OVERALL FINDINGS

Regrettably, the average household income in South Africa still projects an unequal society, as reflected in the Stats SA survey, when the average income is broken down by racial group. Black Africans were at the lower end of the quintile at R69,632 per annum (or R5,803 per month), Indian and Asian households had an average of R252,724 per annum (or R21,060 per month) and Whites had the highest household average of R387,011. In contrast, these differences were not noticed in the current study as majority of the participants were black Africans, all working in the public health sector and there is no racial disparity in salaries paid in the public sector (Stats SA, 2012). However, when comparing the remuneration amongst health professionals employed by the health department, one sees another form of inequality as the nurse is the lowest paid health professional, even compared to those with a similar or equivalent tertairy qualifications (table 1.3) which negatively impacts on their aspirations, economic and social wellbeing. It can be argued that this explains why they continously express their dissatisfaction with salaries and aspire to earn more money as they often compare themselves with their peers working with them and having similar or equivalent educational qualifications but earning more than them. This phenomena of social comparision relating to income or salaries has been well documented by other researchers (McBride, 2010, Boyce, 2010).

A significant percentage (62%) of all participants indicated that they do not receive support/contribution towards the household expenditure from anyone else in the household. Of those receiving contributions towards household expenditure, rural participants in Limpopo receive lower contributions than the participants in Gauteng. This result shows that the majority of professional nurses carry the financial burden of maintaining the household alone, without support from other family members, hence they aspire for high salaries, better jobs, management and speciality posts so that they can be able to provide for their families and also has potential to improve their economic and social wellbeing.

6.10 A COMPARISON BETWEEN ECONOMIC AND SOCIALASPIRATIONS OF URBAN AND RURAL PROFESSIONAL NURSES

Professional nurses in both rural and urban provinces share much in common in terms of their aspirations and economic and social aspirations and circumstances, however this study has also shown that significant differences between them also exist. These differences are discussed in the subsequent paragraphs below.

6.10.1 Educational aspirations

With regards to educational aspirations there is only a significant difference between the rural and urban nurses relating to obtaining a degree (p-value 0.014); nursing speciality qualifications (p-value 0.013) and bursaries for children (p-value 0.04). Although there are other items in these domains, such as computer training and tertiary qualifications for children, there was no significant difference between the responses of rural and urban professional nurses. Roberge (2008) reviewed literature on the factors influencing rural nurses' retention and found that for both rural and urban nurses job satisfaction and retention is influenced by number of factors that require attention, including providing support to nurses in professional development, speciality training and providing them with the opportunities to take on educator roles. Ingersoll et aI. (2002) also found that nurses who are in education and management roles are more satisfied with their jobs than temporary and per diem nurses. These findings support the results of the current study, which found that the majority of nurses aspire to have degrees and speciality qualifications, as this will provide them with the opportunity for higher posts and more autonomy to practice, which leads to job satisfaction and wellbeing.

Moreover, in the context of South Africa, where the salary of a nurse is based on the OSD and their occupational stream, the only avenue to progress to a higher salary level, if one is in the general stream, is to acquire a degree (with specialisation in education or health service management) or a post basic diploma in one of the accredited nursing speciality areas to secure a position either as an educator, nurse manager or a speciality nurse. The study done by Abushacka and Saca–Hazboun (2009) on Palestinian nurses revealed that a lack of career advancement opportunities and supportive hospital policies and practice contribute to job

dissatisfaction. This is also alluded to by Saari and Judge (2004), who found that supporting education or career opportunities may be another strategy to increase overall job satisfaction. Mokoka et al. (2009) also argues that the best environment for nurses to work in is the one that provides training and opportunity for nurses to develop. The rationale being that when career and educational opportunities are met individuals' prospects for growth within their professional ranks increase. When individuals' career aspirations are fulfilled they become satisfied with their jobs and consequently their socio-economic status and wellbeing may improve. There is also a strong association between educational attainment and better jobs which provides high incomes leading to high economic and social wellbeing (Mizobuchi,2016; Camfield & Skevington,2008; Layard et al. 2008)

The aspiration for computer training by the participants in both rural and urban provinces might be due to the fact that there is increasing use of information technology in hospitals (e.g. Clinicom) and the introduction of electronic patient records. Similarly, in another study by Luhalima (2015) on developing strategies to facilitate the motivation of nurses rendering quality patient care in rural hospitals, it was found that nurses are motivated when they have opportunities for professional growth, access and support for training and education and opportunities to learn new skills. The participants in Luhalima's study further assert that being afforded the opportunity for professional growth enables them to be more knowledgeable, competent and skilled, which assists them in rendering quality patient care, and that professional growth results in higher status in that the nurses become more successful in life and in their career ambitions or aspirations. Participants further stated that doing post-basic courses enabled them to function at a higher level, which improves patient care. Luhalima's (2015) study also lent support to the nurses' aspirations for computer training in that nurses are motivated by being given access to the Internet at the workplace, which enables them to get information they use in planning patient care activities including health education.

Studies have shown that there is a correlation between the socio-economic status (e.g. educational level and income) of parents and the aspirations for their children, hence the participants in this study aspire for their children to have tertiary education

(Spera et al., 2009; Bowden and Doughney, 2009, Vellymalay, 2012; Ching –Ling Wu et al., 2014). As the majority of participants in this study are black Africans from mainly low economic and social status, it makes sense that the majority of participants would aspire for their children to obtain a tertiary qualification (28.8% urban and 25.3%), which will open doors for them to enter the labour market, and thus reduce the financial burden of their parents by contributing towards the household expenses. It must be noted that although South Africa is in a post-colonial and post-apartheid era, the wealth of the country is still concentrated in the hands of the minority, while the majority of South Africans are still not educated and are in deep poverty; therefore, attaining educational goals is their only hope to economic emancipation and improved economic and social wellbeing. With a low household income, most parents are unable to send their children to higher education institutions (e.g. universities or colleges) as these institutions charge high registration, tuition and student residence fees; hence the participants in the study are aspiring for their children to have bursaries. The researcher has done a desktop search on universities' tuition fees and found that for 2015 most public universities charge tuition fees on average ranging from R20,000 to R62,000 per annum, excluding student accommodation (Grant, *2016)*.

6.10.2 Aspirations regarding better jobs

In this study, both urban (22.6%) and rural (25.0%) professional nurses aspire to have high positions and high paying jobs. These aspirations are related to the reasons why professional nurses leave the public health sector either to work abroad or in the private health sector in search for better salaries. A study done by George and Rhodes (2012) found that the salaries of most South African Human Resources for Health (HRH), particularly registered nurses, are dwarfed compared to their international counterparts (notably United States, Canada and Saudi Arabia). Therefore, the OSD increases do not match the salary packages offered to nurses working abroad and that the professional nurses working in general wards without speciality qualifications are still far being underpaid compared to other health care professionals as discussed in the preceding paragraphs.

Similarly, in a study of health worker migration from South Africa, it was found that despite the implementation of the OSD and the perceived reduction or slowing of migration, nurses remain the category that are most likely to report an intention to migrate in the short term, are least supportive of mandatory community service and are least satisfied with the level of pay. In this regard, nurses initiate short term migration to earn money for investment into their families and households (Labonte, Sanders & Mathole et al. 2015).

In this study, it was found that professional nurses aspire for high positions and paying jobs (p-value 0.641), which includes management posts (p-value 0.137) and nurse educators posts (p-value 0.372) and there is no significant difference between rural and urban participants in this elements. In a study on the role of incentives in nurses' aspirations for management roles, conducted by Wong et al. (2014), it was found that 24% of nurses expressed interest in pursuing management roles, and that a 43% variance in career aspiration is influenced by age, education and incentives.

The rationale why professional nurses in the current study aspire to management posts and nursing specialty posts is again related to the OSD for nurses. For a professional nurse in a general post to earn more money she/he has to change the stream by acquiring post basic qualifications and move to the specialty posts, in line with the obtained clinical specialty or nursing education/management qualification recognized by SANC. It is also important to note that the number of specialty posts is limited, and the training opportunities for nurses to acquire such qualifications is also limited, due to the number of education institutions accredited to offer such programs, the tuition cost, number of students per in-take annually and the number of available clinical placement sites, making attaining this qualification a significant milestone in the professional career of a nurse. It carries with it a high potential to increase the likelihood of getting a specialty post with better pay. Studies have found that people with high financial resources have access to better health services, education and social relationships (Bakar, 2015; Helliwell et al.2013) hence participants in this study aspire for high position and paying jobs. There is also significant difference between rural and urban participants in the aspirations for nursing speciality posts (p-value 0.002) and for family members to be employed (p-

value 0.027). The lack of opportunities for training and availability or non-availability of speciality posts as discussed above might be the reason why there is this difference in aspirations of professional nurses in urban and rural provinces.

6.10.3 Aspirations for possessions

Although both the rural and urban nurses aspire to have a car, a house and furniture, there was a significant difference between urban and rural nurses' aspirations in this study. Interestingly despite just having an aspiration of owning a car and a house some aspire for a big car and house and there was a significant difference between urban (43%) and rural (32.3%) nurses in this item with p-v 0.02. Despite the aforesaid differences between the aspirations of professional nurses in both rural and urban provinces in this domain item, it is clear that professional nurses as middle-class workers are still struggling to get decent roof over their heads and transport to commute to work hence they aspire for these basic necessities for survival. Note has to be taken also that public transport and housing is still a major challenge even 20 years post democratic dispensation in South Africa (Thomas, 2016). The need for a car is further exacerbated by the fact that majority of nurses also work shifts and public transport is not reliable hence the aspirations for a car becomes more eminent.

6.10.4 Aspirations for financial success

All the participants in the urban and rural areas aspire to financial success; there is no significant difference between urban and rural professional nurses in this regard. They both aspire to financial stability (p-value 0.071); providing for the family (p-value 0.632); investments and shares (p-value 0.255). However, the results also show significant difference between the rural and urban participants in respect to the aspirations of business (p-value 0.029). It is quite surprising that a lower percentage of professional nurses in the rural area want to own a business, compared to those in the urban area where they have additional income and more opportunities to work for extra money in agencies and by moonlighting. It the researchers view that while the both rural nurses and urban nurses want financial stability, they might have not been exposed to financial education or business opportunities which is something

that might require further research and financial education as it has potential to influence the aspirations, economic and social wellbeing of the nurses.

6.10.5 Self-acceptance

The results showed that there is no significant difference between urban and rural professional nurses in respect to the following elements; being employed p-value 0. 137. However the results also showed a significant difference in the following items of this domain, providing for self and family, p-value 0.041, personal achievements p-value 0.002 and participation in community activities, p-value 0.002. This means that both the participants in rural and urban provinces derive their happiness from, and providing for, their families. This is not surprising given the high rate of unemployment in both these provinces therefore these professional nurses may highly be the only source of household income hence being able to provide for their families is a source of happiness to which they aspire. It is the researcher's view that the difference in the element of participation in the community activities might be related to the fact that the urban communities are people are mostly individualistic as opposed to communitarianism one found in rural communities. Thus, a nurse would aspire to make relationship with the communities easily in rural areas than in urban areas and is more likely to be known and respected by the members of the community she serves. In the current economic climate, it makes a logical sense that despite nurses generally being dissatisfied with their salaries both participants in urban and rural are happy that they are at least employed and the results shows no significant difference in this specific element of this domain with p-value 0.137.

6.10.6 Community standing

The significant difference in respect to the participants' aspirations for participation in the community (urban 18.9% and rural 28.0%), p-value 0.002 and personal achievements (urban 25.4% and rural 16.38%), p-value 0.002 is interesting one and probably lies in the fact that rural communities share collectivistic values as compared to the individualistic values in most urban communities. It therefore flows from this principle that professional nurses in the rural province may gain more happiness and satisfaction by participating in community activities than their counterparts in the urban province, who may value individual achievements.

6.10.7 Income

It is important to note that in this domain there was no significant difference in the four items between the urban and rural professional nurses who participated in the survey. The four items were: earning a monthly salary of R35,000 (urban 39.1% and rural 37.0%, p-value 0.551), having enough money to pay for children's education (urban 20.1% and rural 23.0%, p-value 0.310), getting a salary increase (urban 40.7% and rural 39.4%, p-value 0.716), and having investments and shares (urban 15.7% and rural 18.5%, p-value 0.799).This results shows that geographical location or place of residence have very little influence on the financial aspirations and wellbeing of the professional nurses who participated. These findings corroborate with the findings in other studies (Knight et al.2009; Knight & Gunatilaka, 2010) which found that individuals in both rural and urban areas have shown a positive association between income and subjective wellbeing.

The analysis of income and expenditure in the previous section shows that the majority of nurses are living beyond their means and are possibly indebted; hence they have an aspiration to earn high salaries so that they can improve or even get out of their current financial situation.

According to media reports nurses are over-indebted and struggle to make ends meet hence they resign and leave the country to work abroad. In other instances, like other public servant's nurses resign to simply to cash in their government employee pension fund in order to relieve them from their financial constraints (debts). They give various reasons which include amongst others; poor working conditions, wanting to settle their bonds, children's education fees or being threatened by the pension fund reforms. Interestingly, the majority of these nurses opt for re-employment within the next few months and are appointed to entry level posts, which are at a salary notch lower than the level they were previous occupying before resigning, but this does not seem to matter to them as they had immediate financial relief. Alternatively, they work through the nursing agencies. The down side of this is that when their retirement period eventually comes, they have very little money in the retirement fund to sustain them, and they try all sorts of other things to

get income, such as working in agencies, old age homes, and their overall quality of life is compromised (www.iol.co.za.;www.gepf.gov.za)

6.10.8 Status and power

There is a significance difference between urban and rural professional nurses regarding the aspirations elements in this domain relating to; the respect from colleagues and community, (p- value 0.013) and management position to influence policy, (p-value 0. 030). Despite the significant differences both groups of professional nurses wish to be respected by their communities and colleagues which is important for their wellbeing. A study by Roberge (2008) further found that strategies to retain nurses in rural practice include involvement in community events, recreational activities and educational opportunities for children of nurses working in rural setting. These strategies contribute to the rural nurses' integration and build trust with the community, which enhances their satisfaction and retention. Furthermore, in a rural community the nurse is naturally respected by the community and is regarded as part of the community and neighbourhood. Because of the status the nurse is accorded by the community it also gives him/her power. Status and power are influenced by the hierarchal position of a person within the community or organisation. Whereas in an urban community, nurses are afforded little respect by the community, and due to the number of health professionals in a facility they hardly know each other, nor do they relate to one another, as opposed to the situation in small rural health facilities where there is a sense of community and nurses know one another and their families. The need to be respected by communities and colleagues is further exacerbated by the constant violent attacks on health care workers and health care facilities which is more prevalent in urban than rural communities (https://www.iol.co.za).

For rural participants, getting a management position is important so that they can participate in policy, as most of the time, policies are made in the departmental head offices, which are mostly in cities, without engaging the nurses. In contrast, this study found that there are few professional nurses with masters and doctoral nursing degrees, which poses a challenge in terms of the nature of their involvement and how they are effectively influencing policy in the absence of higher education. Most

of the people who are at the forefront of policy making are doctors and politicians; therefore, there is always a high risk of power play, especially between nurses and doctors, which could be mitigated by the educational attainment which could in turn raise the status of a nurse.

6.10.9 General

The aspirations of professional nurses cannot be viewed in isolation of the context in which they operate and related legislative and policy framework thereof. It is in this respect that despite the specific focus on aspirations, the participants also raised the following issues which has significant impact on their wellbeing:

- the OSD for nurses must be reviewed,
- the employer must improve the working conditions for nurses,
- SANC must recognise all post-basic speciality qualifications,
- SANC must provide the distinguishing devices for all post basic qualifications,
- SANC must reduce annual fees,
- the employer must introduce a risk allowance for nurses.

According to the OSD, only 1-year post basic nursing qualifications are recognised for translation and appointment into the OSD speciality stream. These criteria have only benefited nurses with speciality nursing qualification leaving majority of professional nurses (general) without the aforesaid post basic qualifications not benefiting significantly from the OSD implementation, hence calling for the review of OSD. Similar concerns relating to the challenges experienced by nurses with implementation of the OSD and the working environment were raised by participants in other studies (Motsoi and Rispel, 2012; Ngwenya and Makhubela Nkondo, 2009; Tshitangano, 2013; Magana, 2012). This has led to dissatisfaction amongst nurses who are holders of post-basic qualifications such as infection control, forensic nursing and others, which were offered by certain nursing education institutions but are not accredited by SANC or recognised as additional qualifications in terms of SANC regulations for recognition of additional qualifications; hence the call by the participants for such qualifications to be registered by SANC.

In the same vein, there are other additional (post-basic) qualifications registered by SANC that do not have distinguishing devices (e.g. Medical Surgical Nursing Science. Critical Care Adult and Child Nursing Science). The researcher has also observed that some institutions training post basic nursing courses have created their own distinguishing devices which are sold to nurses after qualification. This varies according to where such a nurse has been trained, even though this is prohibited by SANC as a regulatory body, which prescribed the uniform and distinguishing devices for nurses (SANC, R1201 of 1970).

Secondly, there is a general outcry by nurses and organised labour, which is sometimes also displayed through the social media, such as Facebook, showing discontent amongst nurses with respect to the SANC annual fees. At the second South African Nurses Conference, hosted by DENOSA in 2013, nurses also raised these concerns with the Minister of Public Service and Administration, Ms Sisulu, (DENOSA, 2013). Recently DENOSA lead a marched to SANC offices with list of demands, amongst others, they demanded that SANC must be transparent on how fees are increased and utilised by SANC (DENOSA, 2017). The researcher, as a nurse leader who engages with nurses on daily basis, has also had a personal encounter with nurses who are disgruntled with the SANC and about the OSD respectively. The participants in the current study have raised similar concerns. All these concerns if not resolved have negative impact on the nurses' intrinsic and extrinsic aspirations and ultimately their wellbeing.

6.11 CONCLUSION

From the discussion above, it is clear that the aspirations of professional nurses in both the Gauteng and Limpopo provinces are not being entirely met, and hence they remain unhappy. This is mainly due to their primary aspirations (education, household income and occupation), remaining unfulfilled, which affect their economic and social wellbeing. These aspirations, in particular, have a close relationship to a person's economic and social wellbeing. For instance, the participants in this study aspire to have speciality qualifications and degrees, the rationale being that education is regarded as an avenue to climb the career ladder for these professional nurses. This will not only enable them to earn more money in specialist posts or

management posts, but also accord them social status in their respective communities.

A person with a higher educational qualification is also accorded social status in some communities, particularly in rural communities. This view is corroborated by Gjerustad and von Soests (2010), who cited Bourdieu (1984) and Furlong et al. (2007) who agree that an individual's behaviour and actions are influenced by the environment and by significant others. In this respect, societal beliefs influence the aspirations an individual may have on education and occupation and vice versa. Aspirations are connected to self-identity and a person sees his position through the eyes of others. Failure to achieve this evokes negative emotions such as fear, anger and withdrawal. Therefore, lack of educational opportunities for these nurses is a barrier to achieving their occupational aspirations, which may result in them disengaging, becoming less interested in their work and ultimately withdrawing their services to the employer.

In turn, failure to achieve occupational aspirations has ramifications on these nurses' economic and social wellbeing. In this study, the majority of the participants fall within the middle-class income bracket, which significantly influences their aspirations. The unfortunate part is that participants in this study appear to be living beyond their means, which negatively affects their wellbeing. However, it has to be noted that professional nurses are paid less than other Human Resource for Health (HRH) professionals in the public health sector, and they are only spending their income on the bare necessities; they do not appear to be buying luxury goods or being overly extravagant.

In this chapter, the research results were analysed, discussed and conclusions were made under the relevant research objectives. The results of this study show that, despite the implementation of the OSD for nurses, professional nurses in both rural and urban setting have not realised their aspirations which impacts on their economic and social wellbeing. Despite some commonalities, significant differences exist in the aspirations, economic and social wellbeing of professional nurses in urban and rural provinces. In the next chapter, recommendations emanating from the findings of this study are presented.

CHAPTER 7 - INTEGRATION OF FINDINGS AND RECOMMENDATIONS

7.1 INTRODUCTION

In this chapter, the integration of the qualitative and the quantitative data will be described and discussed. The integrated results were used as a basis for developing the recommendations to meet the last objective of this study, “to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa” and to address the research question which was, “How can the economic and social wellbeing and aspirations of professional nurses in the rural and urban areas of South Africa best be addressed?”

The methods used to do this were described in chapter 2. This chapter will describe the summaries of each phase of the study which were used as a basis for integrating the data, after which the findings of the integration process will be discussed. The recommendations, which were based on the findings of the data will then be discussed.

7.2 SUMMARY OF THE QUALITATIVE DATA

The qualitative data from the open-ended questions (aspirations questionnaire) at the end of the household survey document were categorised according to the aspirations and the data relating to these aspirations from the scoping review and the data from the Delphi study were added to these statements in the tables below.

Table 7.1: Key concept: Educational attainment

Source	Findings	Lessons learned
Scoping Review	• Predicts continuity / discontinuity of poverty • Used as a means to escape poverty	Educational attainment is a means to an end i.e. to improve economic and social situation. The type of attainment aspired to varies according to their context.
Delphi	• Linked to self-actualisation • Not only for individual but for family	
Survey	Professional nurses aspire to: • Degrees • Speciality training • Computer training • Tertiary qualifications for their children • Bursaries for their children	

Table 7.2: Key concept: Job satisfaction

Source	Findings	Lessons learned
Scoping Review	• Important for employer organisations as well as employees • Nurses marginally dissatisfied with salaries • Working environment and relationships play a role • Lack of career development also play a role • Dissatisfaction may lead to migration • Occupational aspiration effects other aspects of people's life (wellbeing)	Job satisfaction impacts not only on the individual but on the organisation and family. Salaries and a positive working environment are important factors in determining job satisfaction. Positional aspirations are linked to remuneration and power to influence policy Salaries remain the most important factor.
Delphi	• Remuneration and acquisition of goods are connected • Working environment has effect	
Survey	Professional nurses aspire to: • High position and well-paying jobs • Management, education and specialty posts • Family members being employed	

Table 7.3: Key concept: Possessions

Source	Findings	Lessons learned
Scoping Review	• Higher education results in materialism and a higher subjective wellbeing • Materialism can lead to overspending which then results in a lowered sense of wellbeing	Theorists believe that possessions and status are related but aspirations for possessions of nurses in study are linked more to a means of survival or ease of retaining employment than status as such.
Delphi	• Possessions are a reflection of socio economic status • Priorities vary depending on individuals and context	
Survey	Professional nurses aspire to: • Cars and houses • Linked more to necessity than status	

Table 7.4: Key concept: Financial Success

Source	Findings	Lessons learned
Scoping Review	• Material worth gives power • Financial means are linked to power • Life satisfaction is higher if one has more money • Financial aspirations rise as a person earns more	Money and power are linked and are indicators of achievement and success, which in turn leads to wellbeing. Nurses' quest for financial success and stability is related to both individual and family needs. Providing for family in turn, improves wellbeing.
Delphi	• Both intrinsic and extrinsic factors influence achievement and success • Related to how well personal resources are managed.	
Survey	Professional nurses aspire to: • Want to be debt free and have financial stability • Provide for family needs • Have investments • Have businesses	

Table 7.5: **Key concept: Self-acceptance**

Source	Findings	Lessons learned
Scoping Review	• Intrinsic goals such as self-acceptance, community feeling and affiliation result in higher levels of wellbeing • A balance of intrinsic and extrinsic goals is important	Realistic understanding of oneself, a balance in social and financial goals and an ability to achieve them leads to wellbeing.
Delphi	• Self-acceptance depends on a realistic understanding of oneself and acceptance by others • A balance of social and financial success is needed	
Survey	Professional nurses aspire to: • Personal achievements • Participation in community activities • Providing for self and family	

Table 7.6: Key concept: Income

Source	Findings	Lessons learned
Scoping Review	• Attitudes and perceptions of income vary and often involve being financially healthy and free from worry	Income and health are directly related but are relative indicators. People

	• If people and anxious and/or ill the tend to view their level of income and their jobs in a negative light • People tend to compare income with those of others and view their own relative to others	compare their income with others and judge their own income according to those of others. People tend never to be satisfied as always want more.
Delphi	• Human nature to want high income so will always want to keep moving up	
Survey	Professional nurses aspire to: • Earn > R35 000 per month • Have enough for their children's education • Have a salary increase	

Table 7.7: Key concept: Status and Power

Source	Findings	Lessons learned
Scoping Review	• The degree to which one is respected or admired by others generates expectations for ones behaviour and opportunities • Power is defined as an individual's capacity to influence others and is related to access to resources	Nurses wish to use their position in the workplace to influence people and policy but that status and power brings with them expectations from others.
Delphi	• Umbrella term for all other aspirations	
Survey	Professional nurses aspire to: • Be respected by the community and by colleagues • A management position so that they can influence policy	

7.3 SUMMARY OF THE QUANTITATIVE DATA

Table 7.8: Summary of the Quantitative Data

CATEGORY OF DATA	SUMMARY / INTERPRETATION
Demographic data	• Profession is female dominated • Nearly half (47.7%) of professional nurses are sole breadwinners in their families compared to 39% of the national norm. • Fewer professional nurses are married, compared to those who are not married. • 28% of all professional nurses have never married

	• Most work shifts and irregular hours causing household strain • Women heading households are prone to stress • Ethnic diversity is the norm in both rural and urban provinces • The majority of nurses are >40 years with obligations to provide for higher education for their children and few years to accumulate assets for retirement.
Place of residence	• 52.9% professional nurses live in townships compared to 38% of general population • In rural areas, farm workers and public service are the largest employers • Less common in rural areas for other members of the family to provide financial support due to high level of unemployment (Gauteng unemployment rate is 26.3%, Limpopo 38.9% Country 29.8%) • Annual household income in Limpopo R56844 pa and in Gauteng R156243 • The average monthly household income of the participants in the study is R14000 for Gauteng and R10767 for Limpopo. • Nurses receive standardized salaries but cost of living higher in urban areas and more people contribute to the household income in Gauteng
Education	• 21.6% of professional nurses are attending an educational institution – clearly motivated by specialist qualification. which will earn OSD but more wishing to enroll than can do • Wish to study nursing management, and nursing specialities • The majority of nurses have diploma qualifications which will reduce their opportunities for future speciality studies after 2020. • More nurses have higher education than the general population (13% of general population vs 52.5% of the study population)
Additional employment	• 23% of professional nurses now moonlighting – no opportunities to do so in Limpopo so it makes a difference where one lives if one has opportunities to earn extra. • Could explain why average income is higher in Gauteng than Limpopo despite standardized salaries.
Transport	• Majority of nurses use private cars to get to work (55.0%) • Some use public transport but as majority of hospitals in cities and nurses live mainly in townships and work shifts, need private cars hence the aspiration for cars. • Only 32.9% of general households use private car to travel to work
Accommodation	• The nurses fall into the ‘missing middle’ income group meaning they do not qualify for grants because they earn too much, and do not qualify for housing loans because they earn too little. • They therefore rent and cannot save for their own houses.
Childcare	• Only 5.8% of nurses have access to childcare provided by the employer.

	• Similar in both provinces • 32% of sample under 40 years and therefore of childbearing age • It may explain absenteeism rates.
Income	• A significant number of nurses are living beyond their means. • Specialty nurses earn considerably more. • It takes a nurse without a speciality qualification 20 year to reach the salary notch of nurses with specialist qualifications. • Nurses (General) earn R195 819 pa compared to R274 323 of an occupational therapist (starting salaries) in 2014/15 • Cost of living for average SA household is R8607.75. Professional nurses earn between R9 000 and R10999. • Note that the above COL is average for ALL South Africans, not just those earning a salary.

7.4 INPUT FROM EXPERT GROUP

As described in chapter 2, a focus group of four persons was convened to consider the findings of the study and to make suggestions that could be used in formulating the recommendations based on the findings. The above information was shared with them and they discussed the findings, the discussions were recorded and transcribed and analysed. This process was useful as it provided for a wider perspective of the findings and fresh ideas regarding possible recommendations to address the issues related to economic and social status of the professional nurse. Once the focus group results had been analysed, draft recommendations were developed which are shown in section 7.5. below.

Four themes were identified namely financial incentives, education and training, living and working conditions and regulatory body issues.

Table 7.9:Themes and categories generated from Expert group

Theme	Category
1. Financial incentives	1.1. Review of the OSD policy 1.2. Implementation of a Clinical Nurse Specialist category 1.3. Closure of entry salary notch gap of professional nurse (general) and specialist nurses

	1.4. Address disparity between nurses' salaries and those of other health professionals
2. Education and training	2.1. Provide financial education to dissuade nurses from cashing in pensions early 2.2. Include financial training in orientation programme at every institution 2.3. Increase post-basic training opportunities and access to study leave 2.4. Provide cash bonuses on completion of courses 2.5. Set up privately funded bursary schemes for children of nurses 2.6. Assist nursing educational institutions to provide blended learning programmes to improve access
3. Living and working environments	3.1. Employers should provide on-site child-care facilities and transport 3.2. The employer must ensure a safe, adequately resourced practice environment 3.3. Employer should consider re-opening nurses' residences to nurses and other shift workers only 3.4. Innovative ways of providing such accommodation should be explored such as providing bed and breakfast accommodation 3.5. A marketing strategy should be developed for nursing to assist in rebuilding the image of the profession.
4. Regulatory body issues	4.1. SANC should do away with current distinguishing devices 4.2. SANC should improve their methods and frequency of communication with nurses 4.3. SANC should speed up the introduction of continuing professional development and implementation of new qualifications

7.4.1 Theme 1: Financial incentive

Financial incentive refers to the monetary benefit offered to employees to encourage behaviour or actions which otherwise would not take place. These incentives include higher salaries, salary supplements, benefits and allowances (Mathauer et al., 2006) An incentive has a motivational power. Beside non-financial incentives money (financial incentives) is the common incentive used to motivate employee. In today's capitalistic society, money plays a critical role in enabling one to meet Maslow's (1943) basic needs (food, shelter, security etc.) for survival. On the other hand, wealth is often associated with status, respect and power. As one expert (E03) puts it….

"…….as a nurse, you compare yourself with other professionals, not only in your working environment but also in the community you belong. You want to have for instance a house and a car like other professionals. Because of your professional status and the assets, you accumulated over years as a nurse you are also accorded status in the community especially in rural traditional communities …. hence how nurses are incentivized has impact on their economic and social wellbeing….."

Another expert E04

……actually, nurses are still poorly paid after OSD implementation as compared to other health professionals even if they all have degrees …., this does not motivate nurses to remain in nursing. If the department want to recruit and retain professional nurses this must be corrected and nurses' salaries must be harmonized with those of other health professionals.

7.4.2 Theme 2: Education and Training

Education and training play a critical role in the aspirations, economic and social wellbeing of professional nurses. Education is a life time investment. It empowers an individual with necessary skills to enable him /her to contribute in today's world economy and to make rational decisions which affect his /her personal life or employment. The level of education and training the nurse has acquired is also related to the nature of job and remuneration package. This is mainly because the remuneration of nurses in South Africa is linked to the nursing education qualification

the nurse has acquired either at basic, post basic and/or at post registration level. It is for this reason that majority of nurses will aspire to acquire nursing speciality qualification (post basic) as a means for career progression, to attain better jobs and higher salaries to meet their financial and basic needs (food shelter and accommodation). Apart from providing a professional formal qualification, education empowers individuals in other spheres of their life such as the economic, social and spiritual domains which in turn influence their goals, behaviour, choices and subsequently their economic and social wellbeing. The following are extracts of verbatim transcripts of the comments of expert group members relating to this issue.
Expert E01

"…to balance service delivery needs and educational aspirations of professional nurse's different methods of offering nursing education program must be explored, this must ensure that significant number of professional nurses are granted opportunities to study and have access to specialty nursing training programmes without disrupting services and compromising quality of patient care, for instance blended learning package…"

Another issue relating to education of nurses is financial education. Although the current nursing education programmes for a qualification leading to registration as a professional nurse covers some aspect health service management and nursing administration which include budgeting at unit /health facility level (Government Notice No. R.425 of 22February 1985 as amended and Government Notice No. R. 683 of 22 February 1985 as amended), however does not cover personal financial management which is critical to this cadre of health professional who after obtaining these qualification and subsequent employment joins a bracket of middle income earners which comes with its own economic and social aspirations which if not properly guided may lend one into deep financial crisis. It is in this respect that the need of financial education becomes evident as some of the experts mention below:

Expert no E03

"… for instance, we recently have high number of professional nurses taking early retirement, or resigning to access their pension pay-out, some even with penalties

and losing out a huge amount of money from the employer contributions. This is mainly because of lack of financial education early in their life, majority are indebted they want to pay out their bonds, buy new car or pay children education. The said thing is that few months after retirement / resignation they come back either through nursing agencies or they are reappointed at the entry salary notch of a professional nurse, they forfeit say 20 or 25 years' previous years of service and when their actual time of retirement come they do not have enough retirement savings…."

Expert no E04 added

…. we need financial orientation package when people come to nursing…… must be orientated about financial issues, create room for expectation…. orientation on financial matters must be done early in the life of a nurse and at different stages of their professional career". Is true we have interventions through EAP but most of this is done late when the nurse is already in financial crisis…."

7.4.3 Theme 3. Living and working conditions

This refers to the availability and access to affordable housing, reliable transport and well-resourced and supportive working environment. Good living conditions (e.g. housing, transport) and reliable childcare facilities are fundamental to WELLBEING of employees who are predominately women at child bearing age. Availability of childcare facilities and children's schools are often a major contributor when the nursing mothers choose a place of employment. Studies (Anderson and Geldenhuys, 2011; Suman Babu & Bhavana, 2013) have also found that there is better retention of staff with employers who offered employer sponsored childcare facilities and the incidents of absenteeism is also low. Similarly, the working conditions (lack of supplies, poor safety, communication, and a lack of support) has negative impact on the employee job satisfaction and wellbeing which then influence their aspirations. The following extract from the expert group illustrates the above view.

Expert E02…

"…the wellbeing of professional nurses is of vital importance as front line service providers. If they have conducive living and working environment their productivity

will certainly be enhanced. (The) majority of these professional nurses are women at (sic) child bearing age or still have young children, therefore it makes a logical sense for an employer to provide child care facilities for these nurses. This will eliminate unnecessary absenteeism as a nurse who is also a mother will find it difficult to come to work if the nanny who takes care of the child is absent, but if there is the employer provide child care facility this challenge is eliminated. It is easy to work and concentrate on patient care knowing that your child is safe ……."

Expert E02 added…

"…yes it may not be possible to provide such facilities in all health care institutions due to operational cost, however such child care facilities can be located within a geographic area and being shared by the employees working in the public service institutions around the child care facility. That's a collaborative inter- departmental/ inter sectoral approach might assist …."

Another comment by Expert E04

"…at times nurses leave public service to go and work through nursing agencies or moonlighting because they can control their own working time. For instance, if you still have small children you need flexi schedule to be able to drop your child at preschool and fetch them in the afternoon. Currently nurses are working long 12 and 8 hour shifts in most public institutions. The employer must consider providing a supportive environment for nurses … by creating flexible scheduling system where a nurse will indicate the time she would like to avail her services (similar to 5/8th contract's). This will attract nurses who would like to take control of their time including those who resigned, now working in private health facilities and young mothers who could still work and care for their children. This can also be in a form of job sharing …. It must really be considered…"

Expert E01

"…in most institutions, the employer no longer provides nurses residence and where such residence still exists they are dilapidated and poorly maintained and often shared by all employees not exclusively for nurses. As a results majority of nurses end up renting accommodation paying high rental fees yet they do not also qualify for the bond to acquire own houses. The employer must revisit policy on nurse's residence and also explore other mechanism to assist nurses to access affordable housing…."

7.4.4 Theme 4. Regulatory body

The 'regulatory body' refers to the South African Nursing Council (SANC) which is the statutory professional body for the nursing profession in South Africa established in terms of section 2 of the Nursing Act no 50 of 1978 repealed by Act no 33 of 2005. The main object of the Council is to protect the public thereby regulating all matters pertaining to education, training and practice of nursing and midwifery in South Africa. The Council also accredits and registers all formal nursing education programs and qualifications including the continuous professional development of nurses and midwives. All nurses and midwives are licensed to practice on an annual basis by the SANC. Therefore, the role played by the SANC as a regulatory body is of paramount importance in the aspirations and wellbeing of nurses in particular with respect to nursing education and the practice of nursing in South Africa. The SANC also prescribes the uniform and distinguishing devices which has impact on the image, social prestige and status of the nurse and the nursing profession (Nursing Act 33 of 2005). Only nursing qualifications that are recognized and registered with SANC are recognized by employer for employment, remuneration and career progression purposes. In view of the role of SANC and the findings of this research, verbatim transcript of the deliberations of the expert group members is outline below.

Expert E01

"…. the issues regarding the desirability or undesirability of the current distinguishing devices by nurses is a long-standing issue which might be resolved by the implementation of the new categories and new nursing qualifications. This will also

require extensive consultation with the profession as historically the distinguishing devices and epaulets are at times seen a status symbol…"

Expert E03

"……furthermore, the implementation of the new nursing qualifications will go a long way in addressing the challenges with the recognition the current post basic nursing qualifications for remuneration purposes. When the new scopes of practice and competencies are approved and implemented the employer must review and consider the remuneration that match the new scope of new nursing categories and nursing cadre. This will certainly also resolve the recognition of new category of nurse specialists and will provide the basis for subsequent creation of relevant remuneration scales by DPSA……."

7.5 RECOMMENDATIONS

It was clear from the integrated findings of the study that many of the issues impacting on the social and the economic wellbeing of the professional nurses in the country are resultant from the society itself rather than the profession or their individual working environments. These generic realities cannot be addressed by any policy or strategy emanating from or created by the health sector, the public sector or the nursing professions. The recommendations that have been drawn from the research acknowledge this fact and concentrate on addressing those issues that the public health sector could potentially change.

The recommendations have been organized into the four themes of the Walt and Gilson framework (1994) namely, content of policy, context, processes and the actors themselves.

7.5.1 Content

Recommendation 1

A flexible, formula driven, remuneration system, separate from the current Occupational Specific Dispensation system used for health professionals, should be implemented.

Rationale: No one system can address the complexities of the nursing profession. Rural and urban nurses have different but equally burdensome problems relating to their economic and social wellbeing. If a rural allowance is given, nurses may be incentivized to remain the rural area, but urban nurses have a higher cost of living and are unlikely to relocate to the rural areas, due to the lack of amenities in rural areas, but instead remain overburdened. The formula used to calculate remuneration should take into consideration the local cost of living, years of experience, scope of practice and local need. The definition for 'rural' should also be re-examined to ensure nurses are incentivized to work in under-resourced and challenging areas rather than the currently geographically bounded definitions of 'rural areas."

Recommendation 2

Professional nurses' starting salaries should be aligned with those of the starting salaries of other health professionals.

Rationale: Currently, despite professional nurses following a four-year programme at either diploma or degree level, their starting salary is lower than those of other health professionals. The Department of Public Service Administration sets the salary scale of the Grade 1 Professional nurse (General) in 2015 at R195 819 as opposed to an Occupational Therapist Grade 1 (and other health professional groups) whose starting salary is R274323. According to the evidence in this study, people compare their salaries with those within their own environment. This discrepancy will clearly effect the nurses' wellbeing.

Recommendation 3

The salaries of nurses working in the general nursing stream (non-specialist nurses) should be significantly improved.

Rationale: Currently nurses are seeking specialist training in order to improve salaries rather than due to interest or passion in a specialty area or even the needs of the employing institution. This is making it difficult to retain experienced nurses in the general stream. Nurses from the rural areas which have fewer specialist units are disadvantaged as they cannot be trained for, or appointed in specialist posts.

Recommendation 4

The current system of housing assistance should be reviewed to provide nurses with flexible options to financing and access to affordable accommodation.

Rationale: The current state housing subsidy is inadequate and does not allow nurses to access bond or mortgages. This means that nurses are obliged to rent which means they do not save enough for deposits on houses. A system of the state acting as guarantor using the employees' pension as security should be investigated which would resolve this issue.

7.5.2 Process

Recommendation 5

An inter-sectoral approach should be adopted to address the challenges of transport, accommodation and child care facilities experienced by public service shift workers.

Rationale: Currently the various public service industries e.g. Health, Police, Traffic provide services on a 24-hour basis which necessitates staff working shifts, but there are few support services available to these staff to enable them to work anti-social hours. A collaborative approach at national, provincial and local level would enable them to be responsive to the needs of the area and simultaneously assist shift workers by sharing facilities and costs of transport, childcare and accommodation.

Recommendation 6

Nurses who have the education and skills to do so, should be involved in policy development and policy formulation in health care at national, provincial and local level.

Rationale: Nurses form a critical mass in health care but are often excluded from policy development. It is only if professional nurses feel empowered to contribute and to feel they have been actively involved in decisions about their own situation, and worked for the betterment of their own communities and the system, that their sense of wellbeing will be improved.

7.5.3 Context

Recommendation 7

The South African Nursing Council (SANC) should fast-track implementation of new categories of nurse and competencies for advanced practice nurses and clinical specialists and improve communication with the profession.

Rationale: Until the scopes of practice are approved, the Department of Public Service Administration cannot formulate new salary scales. The failure to do so impacting on the professional nurses' economic and social recognition, and therefore their wellbeing.

7.5.4 Actors

Recommendation 8

Create training opportunities and support professional nurses plan their career development that will meet departmental needs and priorities.

Rationale: Professional nurses are often motivated to undergo further training by personal reasons rather than the needs of the organization. If a study assignment system were to be adopted, they would be aware of opportunities and could align their requests with the departmental needs and plan more coherently for their career path development. This would also allow for a training for impact approach the department to plan for the provision and allocation of bursaries and study leave based on the needs and priorities of the department.

Recommendation 9

Financial education should be included as part of nurses basic training as well as continuing professional development programmes.

Rationale: The data in the study demonstrated that many nurses are living beyond their means and have engaged in negative practices such as cashing in their pensions thus creating economic and social problems for themselves and their

families as they deal with short term, rather than long-term financial needs. Ongoing financial education could address these problems and assist nurses to manage their finances more appropriately, therefore alleviating stress and improving wellbeing. This will also assist them with their business ambitions as the data showed that many nurses do aspire to run their own business.

Recommendation 10

A programme to market nurses and nursing should be undertaken to address negative perceptions of the community of nurses and nursing.

Rationale: Nurses have a need to be respected by the community and they provide an important service to the community but nurses, as a collective, are often seen in a negative light which impacts on the respect in which they are held. Nurses themselves should seize opportunities in the communities and become involved within communities and contribute to the betterment of the community and encourage integration with the community and feel part of the community.

7.6 VALIDATION OF THE RECOMMENDATIONS

The recommendations drafted by the researcher were sent to nine experts, as described in chapter 2 in order for them to verify that they were relevant, feasible and clear.

A table with recommendations of the research, consent form and information sheet was emailed to each member of the expert group who had agreed to participate. The expert group were asked to review the recommendations and mark with a tick (**Yes/No**) on the appropriate column indicating if the recommendation is **clear** (unambiguous), ***relevant, and feasible***.

7.6.1 Analysis and findings of the verification process

Once the responses from the expert group were received, the researcher collated the responses and entered them on the excel spread sheet. Average responses were calculated and comments made noted. All participants responded (100%

response rate). Summary of the findings of the expert group inputs are outlined below:

Recommendation 1

A flexible, formula driven, remuneration system, separate from the current Occupational Specific Dispensation system used for health professionals, should be implemented.

Eight respondents (88.8%) indicated that the recommendation is clear, 55.5% indicated that it is feasible and100% that it is realistic. Four (44.4%) of all respondents further commented that although they agreed, it may not be feasible to find a remuneration system that will satisfy anyone, such system will also require HR technocrats to design hence uncertainty with feasibility. One cautioned that although a new system is desirable such system must not cause disparity between rural and urban nurses respondents.

Recommendation 2

Professional nurses' starting salaries should be aligned with those of the starting salaries of other health professionals**.**

All respondents (100%) indicated that this recommendation is clear and realistic, whilst eight (88.9%) indicated that it was feasible. No reason was given by the one respondent as to why she did not consider it feasible, but there is no doubt that such a move would have a marked impact on the budget due to the large number of nurses compared to other health professionals.

Recommendation 3

The salaries of nurses working in the general nursing stream (non-specialist nurses) should be significantly improved.

All respondents (100%) indicated that this recommendation is both clear, feasible and realistic. All respondents agreed that nurses' salary must be market related and comparable to those of other health professionals.

Recommendation 4

The current system of housing assistance should be reviewed to provide nurses with flexible options to financing and access to affordable accommodation.

Seven (77.7%) of the respondents indicated that this recommendation is clear. Six (66.6%) said it was feasible and eight (88.8%) that it is realistic. Two of those who did not consider it feasible, were concerned that this recommendation, if implemented, might alienate nurses from other health professionals, and felt it would be preferable to improve nurses' conditions of employment (including salaries) to enable them to buy houses rather than singling them out for specific assistance to finance and access affordable housing.

Recommendation 5

An inter-sectoral approach should be adopted to address the challenges of transport, accommodation and child care facilities experienced by public service shift workers.

All nine respondents (100%) indicated that this recommendation is clear; six (66.6%) that it is feasible whilst eight (88.8 %) indicated that it is realistic. One respondent (11.1%) commented that recommendations numbers 1-5 could, or should, only be addressed once the professional status of the nursing profession had received attention and had been greatly improved before addressing details of salary

Recommendation 6

Nurses who have the education and skills to do so, should be involved in policy development and policy formulation in health care at national, provincial and local level.

Eight respondents (88.8%) agreed that the recommendation it is clear, seven (77.7%) indicated that it is feasible and nine (100%) indicated that it is realistic. One (11.1%) respondent indicated that it is not clear and further stated that it is not clear how these nurses will be involved as they are in many instances invited to comment on policy documents or to participate in policy discussions but often they do not do

so. Unfortunately, the two (22.2%) who indicated that this recommendation is not feasible did not state the reasons thereof.

Recommendation 7

The South African Nursing Council (SANC) should fast-track implementation of new categories of nurses and competencies for advanced practice nurses and clinical specialists and improve communication with the profession.

All nine respondents (100%) indicated that this recommendation is clear, and realistic and eight (88.8%) indicated that it is feasible while only one respondent (11.11%) indicated that this recommendation is not feasible owing to the fact that SANC, by its nature of functioning, has a long process of completing the registration of programmes and has to take the necessary due diligence which also takes some time. It was further recommended that members of the profession must take a stronger position against the slow processes and SANC's inability' to stay on track. In lieu of this challenge fast tracking seems not feasible.

Recommendation 8

Create training opportunities and support professional nurses to plan their career development that will meet departmental needs and priorities.

All respondents (100%) indicated that this recommendation is both clear and realistic, whilst only five (55.5 %) indicated that it is feasible, stating that training is associated with availability of funded posts to absorb these nurses on completion of their training program. Due to current financial constraints, the funded vacant posts are not readily available. There are always competing needs between those of employee personal development and employer service needs which at times may not be compatible. Policies for awarding study bursaries for nurses are based on the need to train for impact mainly to address the service needs.

Recommendation 9

Financial education should be included as part of nurses basic training as well as continuing professional development programmes.

All respondents (100%) indicated that this recommendation is clear, whilst eight (88.8 %) indicated that it is both feasible and realistic. One (11.1%) indicated that this recommendation is not feasible, however no reasons were given.

Recommendation 10

A programme to market nurses and nursing should be undertaken to address negative perceptions of the community of nurses and nursing.

All respondents (100%) indicated that this recommendation is both clear and realistic whilst only eight (88.8%) indicated that is feasible. One (11.1%) respondent indicated that this recommendation is not feasible as marketing programmes should start with the recruitment of student nurses whereas currently educational institutions (public and private) have different criteria they use to recruit the students into their nursing education programmes with some providers only focusing on the affordability of the prospective student than the nursing attributes. Funding related to the implementation of the proposed marketing programme may also be a challenge.

7.7 CONCLUSION

This chapter has presented the integration of the findings emanating from all four phases of this research which were analysed, integrated and organised into the components of Walt and Gilson (1994) framework for policy analysis. Both findings from the qualitative and quantitative data were summarized into main categories and themes. Four themes were emerged namely: financial matters, education and training, living and working environment and lastly regulatory body issues. This was consolidated and presented to a focus group of four (4) experts whose inputs assisted the researcher in generating the recommendations of this research. After obtaining the inputs from the focus group, ten (10) recommendations were generated and this was also subjected to another group of nine (9) experts who were requested

to verify if the recommendations were relevant, feasible and clear validate and to make comments where applicable.

In the next chapter conclusions, limitations and recommendations will be discussed.

CHAPTER 8- SUMMARY OF FINDINGS AND LIMITATIONS OF THE STUDY

8.1. INTRODUCTION

This chapter serves to answer the research question, to summarise the findings relating to each of the research objectives, discuss the limitations of the study and make recommendations emanating from the findings of this study.

The aim of this study was to explore and describe the aspirations, economic and social wellbeing of professional nurses in selected provinces of South Africa. Five research objectives were identified for this study namely : to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing, to formulate an aspiration questionnaire based on existing evidence, to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa, to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces and to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

An exploratory, sequential mixed method design was used wherein, a qualitative phase, including the data collection and data analysis, was used to build to the quantitative phase where data was collected and analysed prior to interpreting and combining the results from both phases. After data integration, recommendations were formulated and organized according to the Walt & Gilson framework (1994) to answer the research question. The findings of this study revealed that the professional nurses' have aspirations that are not met which impacts on their economic and social wellbeing. It also revealed that there is no significant difference in the aspirations of rural and urban professional nurses.

8.2. SUMMARY OF FINDINGS

The following is the summary of the research findings.

8.2.1. Research question

The research question was “How can the economic and social wellbeing and aspirations of professional nurses in the rural and urban areas of South Africa best be addressed?

A summary of the findings of each phase of the study, which was divided into objectives, will be given followed by a discussion relating to the research question.

8.2.2. Research objective 1

To explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing.

The literature reviewed in chapter 1 and the subsequent scoping review for aspirations constructs in chapter 3 has shown that individuals have different aspirations in their lives and attainment and/ or non-attainment of these aspirations have impact on the individual nurse’s economic and social wellbeing. Aspirations can be intrinsic or extrinsic and individuals who focus on intrinsic aspiration (e.g. relationship, community), are happier and more satisfied than those whose main focus is on external aspirations (e.g. wealth, fame, image). Aspirations have a significant impact on wellbeing, for instance, if a person has an expectation of a high salary increase (extrinsic aspiration), this may negatively affect his /her wellbeing if this aspiration is not met.

8.2.3. Research objective 2

To formulate an aspiration questionnaire based on existing evidence.

The aspirations questionnaire was formulated by the researcher during two phases of this research namely the phase 1 in which a scoping review was done to extract aspirations constructs and phase 2 which was the Delphi study wherein the Delphi participants reviewed the aspirations constructs which were then used by the researcher to formulate the aspirations questionnaire. This constituted section 2 of

the questionnaire used for the survey which followed in phase 3 of the study. Section1 consisted of the Stats SA household survey (which was used to focus on the economic and social circumstances of professional nurses). Section 2 focused on the aspirations of professional nurses. The whole tool was pre-tested with a group of professional nurses who were not part of the study sample but were representative of the study population. The formulated aspirations questionnaire is contained in appendix **A**.

8.2.4. Research objective 3

To explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa.

This phase used the tool described above and a survey was conducted in two provinces in South Africa.

The findings of this study revealed that:

- The majority of professional nurses are above 40 years old and have children and other dependants living with them in the households, whom they have to provide for, which impacts on their aspirations, economic and social wellbeing.
- Financial aspirations play a critical role in the wellbeing of professional nurses. This is mainly because of huge financial disparities between the OSD specialist nurse's salaries for those working in speciality nursing stream and professional nurse's salaries working in the general stream. Despite this OSD, nurses remain poorly paid compared to other health care professionals in the public sector which negatively impacts on their economic and social wellbeing
- To meet their financial obligations professional nurses, appear to be spending more than their means in both urban and rural provinces. This also results in some nurses being tempted to resign or take early retirement in order to access money from the pension scheme. Interestingly, they appear to be spending on the basic necessities, and not on luxuries. This explains their perceived urgent need for better jobs, speciality posts, management posts

and their educational aspirations in order to enhance their salaries. They regard attainment of these aspirations as a means to escape their current financial woes.

- The apparent lack of social support which includes a lack of employer-subsidised onsite child care facilities, has an impact on the wellbeing of the professional nurses. It should also be noted that the majority of participants, and in fact professional nurses, are women with children.
- The majority of nurses live far from their place of employment and therefore commute long distances which impacts on their economic and social wellbeing, hence their aspirations for a car. Given the public transport challenges in South Africa and the fact that nurses works shifts whilst most hospitals are no longer providing nurses' homes, having a reliable private car become a necessity for a nurse.
- Due to the monthly income and expenditure of the majority of professional nurses it is difficult for them to access funding from major financial institutions yet they do not qualify for RDP houses (known as the 'missing middle').
- Nurses would like the SANC to address several issues which affect their aspirations and economic and social wellbeing, namely implementation of the new qualifications, distinguishing devices, annual fees and recognition of certain post basic qualifications.

8.2.5. Research Object 4

To determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces.

Despite the participants coming from a rural (Limpopo) and an urban (Gauteng) province the findings of this study have not shown any evidence that a significant difference exists between the economic and social wellbeing of professional nurses in these provinces, except that the nurses in Gauteng (urban) spend more on rent or

re-paying a bond/mortgage (housing) per month and on electricity, gas, water and rates compared to those in the Limpopo province (rural).

8.2.6. Research Objective 5

To formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

Recommendations were developed by the researcher, with the help of an expert group and then verified by a second expert group. It is clear there needs to be an inter-sectoral approach in addressing the economic and social wellbeing and aspirations of the nurses. These include but are not limited to the following; reviewing the current OSD and implementing a flexible remuneration system that addresses the complexity of the nursing profession, parity between nurses' salaries and those of other health professionals, recognising that the burden of disease requires the nurses in general stream to also work in a more complex environment hence their salaries should be improved, assistance with transport, housing and childcare facilities. Furthermore, mechanism should be explored to maximize the educational opportunities for nurses including development of personal financial management skills.

As stated above, the research question read, "How can the economic and social wellbeing and aspirations of professional nurses in the rural and urban areas of South Africa best be addressed?"

The data collected in the process of meeting the research objectives shows that professional nurses in South Africa are carrying a heavy financial burden, as they are one of the groups that are employed, being a scarce resource who do not struggle to get employment, even in a recession. Evidence from this study shows that majority of professional nurses are bread winners with dependants while on the other hand they are a group of health care professionals that are paid less than equivalent grades of employees in other health professions meaning that nurses feel undervalued. While it is understood that there are many more nurses than other health professionals, and that increasing their salaries would therefore have a significant impact on the government coffers, they are left feeling resentful and

carrying a heavy burden. It is clear that many of these problems relate as much, if not more, to social problems in South Africa, and that these social problems will need to be addressed before the wellbeing of nurses can be significantly improved. There is therefore no one single solution to addressing the economic and social wellbeing and aspirations of professional nurses, and efforts need to be made on an inter-sectoral basis.

It was argued by two of the experts that it would be preferable to improve the overall salaries of nurses and bring them in line with other health professionals in preference to providing special support for them such as crèche facilities. It must be remembered however, that nurses are the only professional group who provide 24-hour care to patients and thus have special needs which are currently having a negative impact on their wellbeing. A joint solution including improved pay and special benefits is therefore necessary. One of the lingering concerns at the end of this study is that while making these evidences based recommendations, what if the government cannot afford to implement them? Further research is therefore needed to cost the recommendations and find creative solutions to implement them.

8.3. LIMITATIONS

- The study was conducted in two provinces of South Africa, and only focused on one tertiary/academic hospital, one regional hospital, and one district hospital in each of the provinces in the current study. Professional nurses working in nursing education institutions and Primary Health Care facilities were excluded, which could have provided a different dimension to this study, as they operate in different contexts and may receive differing compensation packages. Although the study population in the current study has given a fair representation of rural and urban provinces of South Africa these results may not be generalised to the entire nursing community in South Africa as each of the nine provinces of South Africa has a unique social, economic and political context which might influence the professional nurses' aspirations, economic and social wellbeing.

- A self-reporting survey tool was used to gather data. Due to the problems which are inherent with the use of “self-reporting surveys” such as response bias (this refers to individual tendencies to respond a certain way regardless of the actual evidence they are assessing), the participants might have understated or overstated the facts when answering the survey questionnaire.

- The other limitation which is related to the data collection methods used in this research is social desirability bias (the tendency of the survey respondents to answer questions in a manner that will be viewed favourably by others by either over-reporting or under-reporting the phenomena under study). However, the use of a mixed method design and data triangulation has, to some extent, mitigated against this bias.

- In calculating the aspirations, no consideration was given to those respondents who did not provide information on a particular aspiration, so it is not known how many did not aspire to any of the domains or elements within those domains which may have resulted in bias.

- Had the respondents been given the opportunity to rank the aspirations, it may have provided richer data as it would have been known how important each aspiration was and this could have been calculated for the whole sample providing some useful insights. Respondents were also not specifically told they could mark an aspiration as not applicable, or that they did not aspire to a particular aspiration. However, some participants left some blank which indicated to the researcher that they did not consider that aspiration important to them. Despite the limitations above relating to the aspirations questionnaire, the study has provided a valuable insight into the aspirations and wellbeing of professional nurses, and created a platform for future research in this area which has not previously been explored.
- The study focused on economic and social aspects of the lives of professional nurses, and did not investigate the quality of their working environments. This latter aspect must inevitably and inextricably impact on feelings of wellbeing.

The failure to look into this aspect may have narrowed the focus of the understanding of their wellbeing.

- It was a well-considered choice on the part of the researcher to use the existing Stats SA household survey in this study as it is accepted by academics as being an important tool to measure economic and social status within South Africa and is context specific. As the tool is designed as a census document, there were some questions such as the question relating to the respondents' primary job, that were redundant in this study which consisted solely of professional nurses.
- The recommendations have not been costed and may therefore not be feasible to apply in the public sector.

8.4. STRENGTHS OF THE STUDY

The survey provided data from a large sample and had a high return rate which added to the strengths of this study. The use of experts at two different stages of the study assisted in ensuring that interpretation of the data was objective. The second expert group included younger members of the profession in order to reduce bias and ensure that the perspective of professional nurses on whose lives the recommendations would impact for many years, was considered.

8.5. RECOMMENDATIONS

The recommendations were organized into the four themes of the Walt and Gilson framework (1994) namely, content of policy, context, processes and the actors themselves. A comprehensive discussion of recommendations was presented in Chapter 7. As such the paragraph below only presents the recommendations for further study:

8.5.1. Recommendations for further study

It is recommended that:

- Further research must be done with a wider population and sample covering all nine provinces of South Africa.

- A qualitative study focusing on aspirations and economic and social wellbeing of professional nurses should be undertaken, which could provide rich data and a deeper understanding of the aspirations of nurses.
- Future research could look into the development of the aspirations questionnaire with both qualitative and quantitative measurement including a rating scale to rate the responses of professional nurses on pre-determined score of 1-5.
- A more in-depth comparative study of the remuneration of different categories of human resources for health, including the post requirements (educational qualifications) should be done, to determine if nurses are underpaid compared to other health professionals with similar NQF level academic qualifications and experience.
- Further study should include impact of work environment as well as economic and social factors as nurses are also social beings.

8.6. CONCLUDING REMARK

The economic and social wellbeing of a professional nurses in the two provinces studied is of concern and their aspirations are not realised. Policy makers in health need to give special attention to this matter if this cadre of health professionals is to be retained in the health care arena in public health sector. It is also important to note that if the wellbeing of these professional nurses is attended to, they will be happy and will deliver quality care to clients and contribute immensely to the health department's quest to achieve better health care outcomes and ultimately meet the Sustainable Development Goals (SDG's).

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APPENDICES

APPENDIX A – QUESTIONNAIRE ON ECONOMIC AND SOCIAL CIRCUMSTANCES

SECTION 1

QUESTIONNAIRE ON ECONOMIC AND SOCIAL CIRCUMSTANCES

(Based on the Household Survey of Stats SA)

<table>
<tr><th colspan="5">1. DEMOGRAPHIC DATA</th></tr>
<tr><td>Age at last birthday (in years)</td><td></td><td>Gender</td><td>Male</td><td>Female</td></tr>
<tr><td>Population group</td><td></td><td>Ethnic group</td><td colspan="2"></td></tr>
<tr><th colspan="5">2. RELATIONSHIP (Circle most appropriate answer)</th></tr>
<tr><td colspan="3">What is your relationship to the head or acting head of the household?

01 Head/acting head

02 Husband/wife/partner

03 Son/daughter

04 Adopted son/daughter

05 Stepchild

06 Brother/sister

07 Parent (mother/father)

08 Parent-in-law

09 Other relative

10 Non-related person</td><td colspan="2">What is your PRESENT marital status?

1 Married

2 Living together as married partners

3 Never married

4 Widower/widow

5 Separated

6 Divorced</td></tr>
</table>

3. MAIN PLACE OF USUAL RESIDENCE (Circle most appropriate answer)	
Do you usually live in a 1. City 2. Town 3. Township 4. Tribal area?	Do you usually live in a 1. Suburb 2. Village 3. Informal settlement 4. Farm? 5. Other or none of these
4. EDUCATION (Circle most appropriate answer)	
Are you presently **attending an educational institution?** Attendance includes all part-time and full-time studies, whether in person or as a distance learner 1 Yes 2 No	**If yes, do you attend a** 1. College 2. University/University of technology/Technikon 3. Other (State which)
What is your current highest level of education? (i.e. mark the level you have completed) 1. Certificate 2. Diploma 3. Bachelor's degree	

4. BTech 5. Post graduate diploma 6. Honours degree 7. Higher degree (Masters/PhD)	
5. EMPLOYMENT STATUS (Circle most appropriate answer/s)	
In the last 7 days, did you run or do any kind of business, big or small, for yourself or with one or more partners even for only one hour? 1. Yes 2. No 3. Don't know	**In the last 7 days, did you do any work for a wage, salary, commission or payment in kind even for only one hour?** 1. Yes 2. No 3. Don't know
What do you consider to be your primary job? 1. Paid employee 2. Self-employed 3. Employer	**Do you, or have you in the last month, worked overtime or moonlighted?** 1. Yes 2. No 3. Don't know
What is your main occupation? (State)	**What is your rank? (State)**
What mode of transport do you usually use to get to work? (State)	**How long does it take you to get to work?** (State)
Do you live in subsidized accommodation even if for some of the time? (e.g. a nurses' residence) 1. Yes 2. No	**Do your children attend a crèche / childcare facility provided by your employer?** 1. Yes 2. No

Do you own a motor vehicle? 1. Yes 2. No	**Do you have a driver's license?** 1. Yes 2. No
6. TOTAL CHILDREN SURVIVING AND LIVING IN THIS HOUSEHOLD	
How many of your children are still living with you in your household, including grown-ups? (State)	
How many people (including your own children) are living with you in your household? (State)	
7. INCOME CATEGORY (Circle most appropriate answer/s)	
What is the income category that best describes your gross monthly income of <u>before</u> deductions and including all sources of income? 01 R7000 – R8 999 02 R9 000 – R10 999 03 R11 000 – R12 999 04 R13 000 – R14 999 05 R15 000 – R16 999 06 R17 000 – R18 999 07 R19 000 – R20 999 08 More than R20 999 09 Less than R7000	**What is the income category that best describes your net monthly income or <u>after</u> deductions?** 01 R7000 – R8 999 02 R9 000 – R10 999 03 R11 000 – R12 999 04 R13 000 – R14 999 05 R15 000 – R16 999 06 R17 000 – R18 999 07 R19 000 – R20 999 08 More than R20 999 09 Less than R7000

10 None of the above 11 Do not know	10 None of the above 11 Do not know
Do you have any other persons in the household contributing to the household expenses? 1. Yes 2. No 3. Don't know	**If you do have anyone else contributing to the household expenses, approximately how much (in Rands) do they contribute? (State)**

8. EXPENDITURE **Approximately how much do you spend on yourself and members of your household on the following items in the average month?**	
Rent or re-paying the bond / mortgage on your house?	
Electricity, gas, water and municipal rates/charges?	
Telephone (landlines and cell phones)?	
Hire purchase or loan repayments?	
Transport (other than repayments on a car)?	
School and college/university fees?	
Entertainment?	
Savings?	
Clothes?	
Other (state which)	
Other (state which)	
Other (state which)	

9. SERVICES AND HOUSEHOLD INFORMATION (Circle most appropriate answer/s)	
Which of the following types best describes the main dwelling unit that this household occupies? 01 House or brick structure on a separate stand or yard 02 Traditional dwelling/ hut /structure made of traditional material 03 Flat in block of flats 04 Town/ cluster/ semi-detached house (simplex, duplex, triplex) 05 House/flat/room in backyard 06 Informal dwelling/ shack in backyard 07 Informal dwelling/ shack NOT in backyard e.g. in informal/ squatter settlement 08 Room/ flatlet NOT in backyard but on a shared property 09 Caravan or tent 10 Private ship/boat 11 Workers' hostel (bed/room)	**How many rooms, including kitchens, are** **there in your household?** Count all rooms in all dwellings. Exclude bathrooms, sheds, garages, stables, etc. unless persons are living in them. 1. 2. 3. 4. 5. 6. 7. 8. 9. **More (specify)** _____

12 Other (specify)_____	
In which way does your household obtain WATER for domestic use? 1 Piped water inside the dwelling 2 Piped water inside the yard 3 Piped water from access point outside the yard 4 Borehole 5 Spring 6 Dam/pool 7 River/stream 8 Water vendor 9 Rain water tank 10 Other	**What is the distance from the water access point?** 1 Less than 200m 2 Between 200m and 500m 3 Between 500m and 1km 4 More than 1km
What is the MAIN type of TOILET facility **available for use by this household?** 1 Flush toilet (connected to sewerage system) 2 Flush toilet (with septic tank) 3 Dry toilet facility	**What type of energy/fuel does** **your household MAINLY use for cooking?** 1 Electricity 2 Gas 3 Paraffin

4 Pit toilet with ventilation (VIP) 5 Pit toilet without ventilation 6 Chemical toilet 7 Bucket toilet system 8 None	4 Wood 5 Coal 7 Animal dung 8 Solar 9 Other (specify)_____
What type of energy/fuel does? **this household MAINLY use for heating?** 1 Electricity 2 Gas 3 Paraffin 4 Wood 5 Coal 7 Animal dung 8 Solar 9 Other (specify)_____	**How is the refuse or rubbish from your household MAINLY disposed of?** 1 Removed by local authority/ private company at least once a week 2 Removed by local authority/ private company less often 3 Communal refuse dump 4 Own refuse dump 5 No rubbish disposal 6 Other (specify)_____
Does your household have any of the following? 1. Refrigerator 2. Radio 3. Television	

4. Computer 5. Landline telephone 6. Internet facilities 7. Cell phone/s 8. Satellite TV e.g. DSTV	

SECTION 2: Aspiration questionnaire

In terms of you and your family aspirations and needs what would you like to have regarding the following?

a) Educational attainment

---

b) Better jobs

---

c) Possessions

---

d) Financial success

---

e) Self-acceptance (What makes you happy with yourself)

---

f) Community standing (your status and professional status in the community

---

---

g) Income

---

h) Status and power

Any comments you would like to make?

…….

……

……

……

……

APPENDIX: B – APPROVAL LETTER - WITS HUMAN RESEARCH ETHICS COMMITTEE

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130806

NAME: (Principal Investigator)	Mr Tendani B Mabuda
DEPARTMENT:	Department of Nursing Education CM Johannesburg Academic Hospital
PROJECT TITLE:	Aspirations, Economic and Social Wellbeing of Professional Nurses in Selected Provinces of South Africa
DATE CONSIDERED:	30/08/2013
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Sue Armstong
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 18/11/2013

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature M130806Date 4/09/2013

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX: C–APPROVAL LETTER -LIMPOPO DEPARTMENT OF HEALTH-ETHICS COMMITTEE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

ETHICS COMMITTEE
CLEARANCE CERTIFICATE
UNIVERSITY OF LIMPOPO
POLOKWANE MANKWENG HOSPITAL COMPLEX

PROJECT NUMBER : PMREC – 85/2014

TITLE : The aspirations and socio-economic well-being of professional nurses in selected provinces of South Africa

RESEARCHER : Mr TB Mabuda

ALL PARTICIPANTS : N/A

Supervisor : Dr Sue Armstrong

DATE CONSIDERED : 11 September 2014

DECISION OF COMMITTEE

- Approved

DATE : 07 October 2014

PROF A J MBOKAZI
Chairperson of Polokwane Mankweng Hospital Complex Ethics Committee

NOTE: *The budget for research has to be considered separately. Ethics committee is not providing any funds for projects.*

APPENDIX: D – APPROVAL LETTER -GAUTENG PROVINCIAL PROTOCOL REVIEW COMMITTEE

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Mr Tendani Mabuda
Organization / Institution	University of Witwatersrand
Research Title	The aspirations and socio-economic well-being of Professional Nurses in selected Provinces of South Africa
Protocol number	P010714
Date submitted	10 June 2014
Date reviewed	30 July 2014
Outcome	APPROVED
Date resubmitted	N/A
Date of second review	N/A
Final outcome	N/A

It is a pleasure to inform that the Gauteng Health Department Provincial Protocol Review Committee (PPRC) has approved your research on "The aspirations and socio-economic well-being of Professional Nurses in selected Provinces of South Africa".

Data should be collected at:
George Mukhari Hospital
East Rand Hospital
Tshwane district hospital

We kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.

Dr P Mazamisa
Acting DDG N Mmazamisa

Date 120814

APPENDIX: E- INFORMATION SHEET FOR DELPHI STUDY

Mr Tendani Mabuda
P.O.Box 2897
The Reeds
Centurion
Pretoria
0158

Dear Sir/Madam

RE: INFORMATION FOR PARTICIPATING IN A DELPHI STUDY

Introduction and Background

My name is Mr. Tendani Mabuda. I am a PhD student at the Department of Nursing Education of the University of Witwatersrand (Wits). The title of my thesis is: ***Aspirations, Economic and Social Wellbeing of Professional Nurses in Selected Provinces of South Africa*.** The aim of this study is to explore and describe the aspirations, economic and social wellbeing of professional nurses in selected provinces of South Africa. May I request you to participate in this study?

The specific objectives of this study are to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing, to formulate an aspiration questionnaire based on existing evidence, to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa, to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces and to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

Before agreeing to participate it is important that you understand the purpose of the study and the study procedures, as well as understanding your right to withdraw from the study at any time. This information sheet is to help you decide if you would like to participate. You need to understand what is involved before you proceed. If you have any questions, do not hesitate to ask me. If you decide to take part in this study you will be asked to sign the attached consent form to confirm that you understand the study and agree to participate.

You are invited to participate in the first phase of this study aimed at the formulation of the aspirations questionnaire of professional nurses for their economic and social wellbeing. As an expert in your specific field your participation in a modified Delphi technique to determine the constructs of “aspirations” is herewith requested. Your expert opinion of aspirations constructs that should be used in formulation of the aspirations questionnaire of professional nurses is important during this phase of the research process. The initial round will be based on literature reviewed to provide the constructs on which your opinion will be sought. After the first round, the researcher will analyse the responses and send out a composite list of statements for you to decide on. This process will continue until consensus is reached. It is expected that there will be at least four rounds in this study. There will be no consequences (negative or positive) resulting from your answers.

Confidentiality

Your participation in this study is voluntary and confidentiality and anonymity will be maintained for all participants. The Delphi survey will be completed by e-mail but only the researcher and his supervisor will know what responses you gave. A separate email has been created to receive the responses and the data will be transferred from the email to an external hard drive which will be kept in locked cupboard. No name is required on the document. To ensure anonymity the code will be used on the research data. Only the researcher and the supervisor will have access to your responses.

Consent

Permission to conduct the study has been obtained from the Research Ethics Committee (HREC, Medical) of the University of Witwatersrand Other relevant permissions were sought from the relevant provincial health authorities. You will also be requested to sign informed consent related to your participation in this study.

Risk and Benefit

Participation in this study is voluntary and there are neither risks nor direct benefits related to your participation. You may discontinue your involvement in the Delphi study at any stage of the project and there will be no negative consequences if you decide to do this.

Should you have any questions about your rights as a study participant, or questions or concerns about any aspect of this study, please call the Ethics Department of the University of the Witwatersrand on +27 11 717 1234 or my study supervisor Dr Sue Armstrong on +27 11 488 3094.

You may contact me at the telephone number or email address indicated at the end of this letter.

Thank you for considering your participation.

Sincerely

Tendani Mabuda

Email- tendani.mabuda@outlook.com

Cell 0796994521

Supervisors: Dr Sue Armstrong (Tel 011488 3094)

APPENDIX: F – PARTICIPANT INFORMATION SHEET FOR PRE-TEST GROUP

Mr Tendani Mabuda
P.O.Box 2897
The Reeds
Centurion
Pretoria
0158

Dear Sir/Madam

RE: INVITATION TO PARTICIPANTE IN THE STUDY

Introduction and Background

Hello, my name is Mr. Tendani Mabuda. I am a PhD student at the Department of Nursing Education of the University of Witwatersrand (Wits). The title of my thesis is: ***Aspirations, Economic and Social Wellbeing of Professional Nurses in Selected Provinces of South Africa*****.** The purpose of this study is to explore and describe the aspirations, economic and social wellbeing of professional nurses in selected provinces of South Africa.

The specific objectives of this study are to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing, to formulate an aspiration questionnaire based on existing evidence, to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa, to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces and to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

Before agreeing to participate it is important that you understand the purpose of the study and the study procedures, as well as understanding your right to withdraw from the study at any time. This information sheet is to help you decide if you would like to participate. You need to understand what is involved before you proceed. If you have any questions, do not hesitate to ask me. If you decide to take part in this study you will be asked to sign the attached consent form to confirm that you understand the study and agree to participate.

You are requested to take part in the pre-testing of the professional nurses' aspirations questionnaire. You are requested to complete the aspirations questionnaire and also to indicate if it is easy to understand the terminology used. There will be no consequences (negative or positive) resulting from your answers.

Confidentiality

Your participation in this study is voluntary and confidentiality and anonymity will be maintained for all participants. The exercise will be completed anonymously so no one will know what answers you have given.

Consent

Permission to conduct the study has been obtained from the ethics committee of the University of Witwatersrand. Other relevant permissions were sought from the relevant provincial health authorities. You will also be requested to sign informed consent related to your participation in this study.

Risk and Benefit

Participation in this study is voluntary and there are neither risks nor direct benefits related to your participation. You may discontinue your involvement in the study at any stage and there will be no negative consequences if you decide to do this.

Should you have any questions about your rights as a study participant, or questions or concerns about any aspect of this study, please call the Ethics Department of the University of the Witwatersrand on +27 11 717 1234 or my study supervisor Dr Sue Armstrong on +27 11 488 3094.

You may contact me at the telephone number or email address indicated at the end of this letter.

Thank you for your participation.

Sincerely

Mr Tendani Mabuda
Email- tendani.mabuda@outlook.com
Cell 0796994521
Supervisor: Dr Sue Armstrong (Tel 011488 3094)

APPENDIX: G - PARTICIPANT INFORMATION SHEET FOR THE SURVEY - ASPIRATIONS QUESTIONNAIRE

Mr Tendani Mabuda
P.O. Box 2897
The Reeds
Centurion
Pretoria
0158

Dear Participant

RE: INVITATION TO PARTICIPATE IN THE STUDY

Introduction and Background

My name is Mr. Tendani Mabuda. I am a PhD student at the Department of Nursing Education of the University of Witwatersrand (Wits). The title of my thesis is: ***Aspirations, Economic and Social Wellbeing of Professional Nurses in Selected Provinces of South Africa*****.** The aim of this study is to explore and describe the aspirations, economic and social wellbeing of professional nurses in selected provinces of South Africa. May I request you to participate in this study?

The specific objectives of this study are to explore the existing evidence on the nature and meaning of aspirations and their impact on wellbeing, to formulate an aspiration questionnaire based on existing evidence, to explore and describe the economic and social wellbeing and aspirations of professional nurses in selected provinces of South Africa, to determine if there is any difference between the economic and social wellbeing and the aspirations of professional nurses in urban and rural provinces and to formulate recommendations for addressing the economic and social wellbeing and aspirations of professional nurses in South Africa.

Before agreeing to participate it is important that you understand the purpose of the study and the study procedures, as well as understanding your right to withdraw from

the study at any time. This information sheet is to help you decide if you would like to participate. You need to understand what is involved before you proceed. If you have any questions, do not hesitate to ask me. If you decide to take part in this study you will be asked to sign the attached consent form to confirm that you understand the study and agree to participate.

You are requested to complete the professional nurses' aspirations questionnaire which has two sections namely household survey section adopted from Stats SA household survey tool, which ask your economic and social circumstances and section 2 which contains the aspirations constructs. In each of this constructs you are requested to provide comments relating to your aspirations including your family aspirations and needs. There will be no consequences (negative or positive) resulting from your answers. It should take approximately 30 minutes to complete the aspirations questionnaire. You will be given the questionnaire in an envelope and asked to complete it after which you are requested to place the completed questionnaire back in the blank envelope, seal it and place it in the box that will be placed in your ward. This will be collected at the end of your shift by the research assistant. No one will know whether or not you completed the form or what you said on the form.

Confidentiality

Your participation in this study is voluntary and confidentiality and anonymity will be maintained for all participants. No name is required on the document. To ensure anonymity the code will be used on the research data. Only the researcher and the supervisor will have access to your responses.

Consent

Permission to conduct the study has been obtained from the Research Ethics Committee (HREC, Medical) of the University of Witwatersrand. Other relevant permissions were sought from the relevant provincial health authorities. You will also be requested to sign informed consent related to your participation in this study.

Risk and Benefit

Participation in this study is voluntary and there are neither risks nor direct benefits related to your participation. You may discontinue your involvement in the Delphi study at any stage of the project and there will be no negative consequences if you decide to do this.

Should you have any questions about your rights as a study participant, or questions or concerns about any aspect of this study, please call the Ethics Department of the University of the Witwatersrand on +27 11 717 1234 or my study supervisor Dr Sue Armstrong on +27 11 488 3094. You may also contact me at the telephone number or email address indicated at the end of this letter.

Thank you for considering your participation.

Sincerely

Tendani Mabuda

Email- tendani.mabuda@outlook.com

Cell 0796994521

APPENDIX: H – CONSENT FORM FOR DELPHI STUDY

ASPIRATIONS, ECONOMIC AND SOCIAL WELLBEING OF PROFESSIONAL NURSES IN SELECTED PROVINCES OF SOUTH AFRICA.

I hereby confirm that I have been informed by the researcher, Tendani Mabuda, about the nature of his study entitled “Aspirations, Economic and Social Wellbeing of professional nurses in selected provinces of South Africa.”

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study, including personal details and the answers I give will be anonymously processed into a study report and all information will remain confidential and there will be no penalty or loss of benefits resulting from my responses or participation.

I may, at any stage, without prejudice, withdraw consent and participation in the study and there will be no penalty or loss of benefits to my withdrawal.

I have had sufficient opportunity to ask questions and, of my own free will, declare myself prepared to participate in the study.

Participant:

…… ……

Signature Date

APPENDIX: I – CONSENT FORM FOR PRE-TEST OF THE ASPIRATION QUESTIONNAIRE

ASPIRATIONS, ECONOMIC AND SOCIAL WELLBEING OF PROFESSIONAL NURSES IN SELECTED PROVINCES OF SOUTH AFRICA.

I hereby confirm that I have been informed by the researcher, Tendani Mabuda, about the nature of his study entitled “Aspirations, Economic and Social wellbeing of professional nurses in selected provinces of South Africa.”

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study, including personal details and the answers I give will be anonymously processed into a study report and all information will remain confidential and there will be no penalty or loss of benefits resulting from my responses or participation.

I may, at any stage, without prejudice, withdraw consent and participation in the study and there will be no penalty or loss of benefits to my withdrawal.

I have had sufficient opportunity to ask questions and, of my own free will, declare myself prepared to participate in the study.

Participant:

…… ……

Signature Date and time

APPENDIX J - CONSENT FORM FOR SURVEY

ASPIRATIONS, ECONOMIC AND SOCIAL WELLBEING OF PROFESSIONAL NURSES IN SELECTED PROVINCES OF SOUTH AFRICA.

I hereby confirm that I have been informed by the researcher, Tendani Mabuda, about the nature of his study entitled "Aspirations and socio-economic well-being of professional nurses in selected provinces of South Africa."

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study, including personal details and the answers I give will be anonymously processed into a study report and all information will remain confidential and there will be no penalty or loss of benefits resulting from my responses or participation.

I may, at any stage, without prejudice, withdraw consent and participation in the study and there will be no penalty or loss of benefits to my withdrawal.

I have had sufficient opportunity to ask questions and, of my own free will, declare myself prepared to participate in the study.

Participant.

…… ……

Signature Date