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Management support, role conflict and role ambiguity among professional nurses at National Health Insurance pilot site in North West.

**Submitted in partial fulfilment of the requirement for the degree of
Masters of Social Sciences**

By

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DECLARATION

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged according to the American Psychological Association 6th Edition. This dissertation is being submitted in partial fulfillment of the requirements for the degree of Master of Social Sciences (Industrial Psychology) in the School of Applied Human Sciences, University of Kwa-Zulu Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination at any other University.



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ABSTRACT

Background

South Africa's victory over apartheid meant that the newly elected government needed to address the challenges of a weakened health care system that was characterised by disempowerment, discrimination and underdevelopment for over centuries (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). This was driven by a need to provide essential health care to disadvantaged people and to redress historical inequalities. Coovadia et al. (2009) argued that the public health care system was transformed into an integrated and comprehensive service. This resulted in improved access to primary health care services. This was not the end as the South African National Department of Health (NDoH) strived for more improvements within health care and is currently undergoing various reforms (Khuzwayo, 2015). These reforms included the introduction of National Health Insurance (NHI) and the re-engineering of Primary Health Care (PHC). Noticeably, these reforms require a re-examination of organisational systems that promote health care workers (HCWs) to execute changes in the most effective manner.

At present, the country's health care system is highly labour intensive and is mainly nurse-based, thus nurses are placed at the forefront of both public hospitals and clinics (Chopra et al., 2009). It is therefore argued that the quality, efficiency and the success of implemented interventions are largely dependent on the availability, performance and morale of health professionals (Naledi et al., 2011). Thus, it is essential that health workers receive adequate training and support from management to deliver the required services. By management playing their role in supporting and helping to facilitate changes to health care, this could potentially decrease the presence of role conflict and role ambiguity that may result due to

challenges brought about by the transformation. Therefore, the need to study the presence of management support, role conflict as well as role ambiguity in primary health care (PHC) facilities is paramount to a good health care system.

Objective:

The objective of the study was to understand perceptions of management support, role conflict and role ambiguity among nurses within the context of the NHI and re-engineered PHC. The study explored professional nurses' perceptions and experiences of the following: management support, reforms in the health care system and its influence on their role. The study also sought to understand nurses' opinions of challenges associated with these reforms and how these challenges can be overcome.

Methods:

The study used is based on secondary data that was collected through semi-structured interviews which were conducted with eighteen professional nurses in PHC facilities that are also part of NHI pilot sites in the North West province. The study used the interpretative phenomenology approach (IPA) as the researcher aimed to explore the lived experiences of professional nurses, their realities and how these realities are shaped by various challenges associated with working within a health system characterised by many reforms.

Findings:

Participants shared their perceptions and experiences of a lack of management support in PHC facilities. They argued that management, including their front-line managers did not provide support to staff. This was largely due to managers not always at the facility due to administrative duties. Thus managers were viewed as mainly responsible for disciplinary action processes when there are problems. With regards to reforms in the health care system, the majority of participants had positive perceptions and argued that some of the reform

initiatives implemented were beneficial not only to patients but to health professionals as well. However, participants further shared their negative experiences on how reform initiatives were implemented, arguing that there was a lack of consultation and inadequate training to prepare HCWs for these changes. In relation to their role, participants indicated that although the job description was clear however because of several challenges in PHC facilities, they perform more tasks than what is simply stipulated in their job description. Further, participants mentioned several challenges such as shortage of staff, increased patient numbers as well as a lack of management support. Participants further made recommendations on how to overcome some of the challenges faced in PHC facilities such as to increase management support and increasing the staff complement per facility amongst others.

Conclusion:

Drawing from the findings, health reforms benefits to clinical outcomes and patient-centred care is undeniable. It is therefore imperative for professional nurses' to receive management support during this transition. It is also vital for nurses' to receive adequate resources to ensure they are able to undertake their role with clarity, training and development as well as sufficient resources support to achieve the desired health outcomes in PHC facilities.

Keywords: *Management Support, National Health Insurance, Role Conflict, Role Ambiguity, Primary Health Care, Professional Nurses*

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CHAPTER 1: INTRODUCTION

1.1 Introduction

This introductory chapter provides the background to the study, followed by an outline of the research problem. Thereafter, the research objectives and questions are presented in the chapter. Subsequently, the chapter is concluded with an outline of the dissertation.

1.2 Background to the study

South Africa spends an estimated 8.6% of its Gross Domestic Product (GDP) on health alone, which is substantially higher compared to its neighbouring African countries, yet these investments are not mirrored back in the countries' health outcomes (Naledi, Barron, & Schnieder, 2011). Although this expenditure on health has increased over the years to 13.5% in 2017, there are still no signs of growth (United Nations International Children's Emergency Fund (UNICEF), 2017). Furthermore, it is budgeted to increase by R3.3 billion between the years of 2018 and 2019, which may be attributed to the implementation of the National Health Insurance (NHI) policy (National Treasury, 2018). Scholars suggest that this stagnate growth within the health care system could be due to many reasons and challenges faced in the transition of re-engineered Primary Health Care (UNICEF, 2017).

The concept of Primary Health Care can be defined as the "philosophy governing principles and strategies for organising health systems, central to which the notion of health as a human right, with health systems seen as a vehicle to deliver the equitable right" (Naledi et al., 2011, p.18). Inherent in this definition is the indication that health should be measured as an essential right and thus, no one should be deprived of it. Therefore, there is a noticeable drive towards

the provision of quality health care, and so authors as early as Chopra et al. (2008) argued that poor health outcomes can be attributed to the following, namely: the rapid growth of HIV and AIDS epidemic as and the escalation of tuberculosis as well as other communicable and non-communicable diseases coupled with a weak primary health care (PHC) system. In addition, Chopra et al. (2008) identified further challenges which exacerbate these problems including inadequate coverage, access and quality of services, limited management capacity, governance and a limited supply of health professionals as well as low staff morale.

Furthermore, a study by Mayosi et al. (2012) argued that social determinants and racial disparities such as poverty and unemployment amongst others are core elements for much of the deprivation and ill health in the country. Secondly, Mayosi et al. (2012) mentioned lack of integration and coordination of the country's public and private sectors especially in health, a lack of surveillance and information in terms of reporting as well as a lack of scaling up innovative interventions as some of the major challenges currently facing the health care system in South Africa.

Consequently, as an attempt to strengthen the health care system, the government has introduced various health reforms, as well as pro-equity policies and regulations throughout the public health system, which are designed to deal with significant challenges (Naledi et al., 2011). These key health reforms include the following: Re-engineering of PHC, the National Health Insurance (NHI), and Integrated Chronic Disease Management (ICDM) which aims to improve clinical outcomes for patients. More emphasis has been placed on Quality Improvement (QI) within facilities and the provision of quality care for patients. Mohamed et al. (2014) further mention that ICDM aims to achieve optimal clinical outcomes for patients

suffering from communicable and non-communicable diseases, improve operational efficiency through shorter waiting periods and reducing the patient load.

Moreover, there is growing attention on creating a health environment that facilitates patient/client centred care within PHC facilities. The patient centric approach puts patients at the centre of the consultation session, allowing them to take the lead in exploring what could be diagnosis (O'Donnell et al., 2016). In other words, it allows them to tell the nurse what seems to be the issue instead of the nurse making a diagnosis based on assumptions. Rather, this is based on the facts the patient would have mentioned as the one experiencing the problem or symptoms. According to O'Donnell et al. (2016), this approach fosters a relationship to be built between the nurse and patient, as getting to the diagnosis becomes a collaborative effort between the two parties. Therefore, this brings an element of training for the nurses to build this collaborative relationship (Mohamed et al., 2014; O'Donnell et al., 2016). Furthermore, O'Donnell et al. (2016) argue that this type of approach has many benefits for the patient such as increase in well-being and a positive effect on patient behaviour and outcomes as patients take more responsibility for their own health.

However, most of these new reforms that have been introduced and implemented as part of changes have not been introduced in a proper, organised and integrated manner. Moreover, scholars argue that Human Resource Management (HRM) within PHC facilities suffer from a lack of planning, poor change management as well as a shortage of skilled health workers (Chopra et al., 2009; Delobelle et al., 2011). The shortage of skilled health professionals may be fuelled by “push” and “pull” factors of migration which include improved working conditions, better pay, training and improved career prospects that contribute to an increase of nurses leaving poorly resourced areas for better opportunities (Delobelle et al., 2011). In

addition, Khamisa, Oldenburg, Peltzer and Ijic (2015) argued that nurses often migrate from the public sector to the private sector due to the reasons mentioned above. It is therefore important to investigate the role of management of human resources and how this may limit effectiveness of various PHC interventions in place. Fundamental to our understanding is to draw a discussion on professional nurses within the South African health care system.

Khuzwayo and Tlhotse (2015) reported that professional nurses form the largest portion of human resources personal throughout the South African health care system. Therefore, professional nurses are often labelled as the backbone of PHC. This consequently means that most of the backlog falls on them. Nurses as PHC workers typically work in challenging environments that are mostly in rural areas, where they are charged with working on the frontline as the first point of patient contact (Vasan et al., 2016). Furthermore, Vasen et al. (2016) argue that they are usually inadequately trained or educated and have limited resources and tools at their disposal. In addition Khamisa et al. (2015) argue the responsibilities placed on nurses are continuously increasing, and it is required that they provide empathic, culturally sensitive, moral care that is also proficient while working in working environments with limited resources. This shows an imbalance between coping with stressful working environments and providing high quality care which may lead to burnout (Khamisa et al., 2015). Consequently, this makes nurses in PHC facilities more susceptible to burnout which is related to job dissatisfaction, and this is especially true for nurses in public sectors. Similarly, Delobelle et al. (2011) argue that nursing shortages have increased at an alarming rate due to production and migration (between sectors). As a result, the efforts to cope with national health reforms are hindered. These authors further reported that the above has detrimental consequences for health care delivery especially in rural and remote areas of South Africa.

Despite these adversities, nurses still play a vital a role in successful implementation of various health reforms in PHC facilities. Therefore, there have been many significant changes that have been made to make their roles manageable. For example, Nalendi et al. (2011) argue that there have been changes made in the training curricula for nurses within learning institutions to make the move towards a PHC orientation system easier. In addition, Dizon et al. (2017) argue that there has been greater emphasis on clinical practice guidelines (CPG's) which is underpinned by a desire to provide high quality health care based on best available scientific evidence. This was also done to reduce inappropriate variations in PHC facilities (Dizon et al., 2017).

However, these changes have been gradual and health care workers (especially nurses and doctors) in the field are still not adequately prepared for the challenges of implementing PHC within an imperfect health system (Dizon et al., 2017; Munjanja et al., 2005; Naledi et al., 2011). Drawing from the above statement, this means that although nurses are key players in the PHC system, they still lack appropriate orientation and preparation, neither do they receive adequate support from their superiors. To illustrate this point, Naledi et al. (2011) draws from a study based on educators in 12 nursing schools in the Eastern Cape province which discovered that only 6% of the educators had been trained in the integrated management of childhood illness, 1% in voluntary counselling and testing, and none in current tuberculosis (TB) management strategies. The study illustrates that even the educators that train professional nurses did not have adequate skills and knowledge required for the effective implementation of PHC. Naledi et al. (2011) further suggest that there seems to be a disjunction between health professionals, educators and managers, training on service delivery needs and health priorities and therefore existing training, to some extent fails to prepare professional nurses for the workplace. This means that nurses may experience role ambiguity and conflict which will ultimately have negative implications on the provision of quality health care.

Furthermore, Pillay (2011) argued that because of the critical role nurses play within the PHC philosophy, it is important that they are managed in a manner that ensures effective and efficient delivery of quality health care. Hence, the need for a study that seeks to understand nurses' perceptions of management support, the role of a professional nurse within the changing health care system, and the challenges they are faced with because of all the changes. The study will be beneficial to researchers working for the betterment of human resources (HR) practices within health systems, and policy makers that develop health policies around HRM. Through understanding nurses' views around management support, role conflict and role ambiguity, the knowledge gained from this study can influence interventions centred on improving managerial support and job clarification for professional nurses in PHC settings.

1.3 Problem statement

South Africa is regarded as a middle-income country in terms of its economy, however, its health outcomes are worse than many lower-income countries (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Naledi et al., 2011). Moreover, the government expenditure on health has increased from 8.6% to 13.5% in the year 2017. Despite much effort, health outcomes do not mirror such investments, instead there are growing challenges to management. Furthermore, Perper (2018) argues that the country's health care system is highly inequitable in terms of the distribution of both human and financial resources mainly favouring the private sector. In addition, Perper (2018) argues that the private sector has 59% medical specialists while it only serves 28-38% of the country that can afford it through medical aid and out-of-pocket costs. This has important implications for South Africa's ability to achieve universal health coverage which was envisioned by the World Health Organisation (WHO). WHO emphasises a need to improve resource equitability, accessibility and productivity amongst

health care workers (Perper, 2018). In doing so, South Africa is committed to implementing a comprehensive NHI system aiming to provide quality affordable health services for all its citizens based on their health needs irrespective of socio-economic status (Perper, 2018). Aligned with this has been the need to develop and equip health care workers to be able to provide quality health care to all South Africans (Ashley, Halcomb, & Brown, 2016).

As the government seeks to achieve universal health coverage through NHI, professional nurses must be developed, monitored and evaluated as the backbone of the health care delivery system (Khuzwayo, 2015). As mentioned by Naledi et al. (2011), the availability, performance and morale of health professions plays a large role in the quality, efficiency and success of newly implemented PHC initiatives. In addition, Cherian, Alkhatib and Aggarwal (2018) argue that employee satisfaction and commitment are major contributing factors towards organisational success. Furthermore, Cherian et al. (2018) argue that behaviour as well as performance in an organisational setting that is undergoing change, can either be supportive or detrimental to organisational success and it is important to keep this in mind especially when aiming to bring about organisational change.

For the health environment to effectively meet ever changing and complex societal needs, it is required that it constantly evolve and introduce new programs or initiatives to meet this need (Ashley et al., 2016). Consequently, this results in the ongoing challenge to ensure that health professionals are adequately equipped with appropriate knowledge, resources and skills to meet these changes (Ashley et al., 2016). This is especially true in PHC facilities in South Africa as initiatives are constantly introduced to meet the country's health needs. The roles played by nurses in health care are bound to change along with the transformations in the health care system. Ashley et al. (2016) further argue that formal mentorship, team support and frequent

conversations with managers and supervisors facilitates the process of closing the gap between old and new roles. Moreover, a study by Jaeger et al. (2018) on nurses in Sub-Saharan Africa found that nurses experienced the following challenges in this region; work overload, a lack of training, adverse working conditions, perceived lack of recognition and appraisal as well as a lack of management support. Both these studies emphasise the importance of management support within PHC settings, how it may be used to buffer role conflict and role ambiguity.

Although, there are numerous studies on management support and role stressors such as role conflict and role ambiguity, there are currently no published studies that the researcher is aware of that collectively examine these constructs, both locally and internationally. Furthermore, Chang and Liu (2009) argue that previous literature published in South African on re-engineered PHC mostly based on managers or supervisors. In addition, these studies mainly aimed to understand managers' attitudes and knowledge on change initiatives, often neglecting to review managerial support from the prospective receiver, i.e. nurses. This is further supported by Chang and Liu (2009) who reported that little attention has been paid to factors such as experience, support knowledge attitude, mental and physical perceptions and psychological feelings among nurses within re-engineering PHC settings. Furthermore, Jaeger et al. (2018) argue that nurses' perspective on health care, the challenges they encounter to provide quality health care services and opportunities to improve these services are rarely investigated especially in Sub-Saharan Africa.

Hence, this study focuses on nurses' perceptions and experiences of management support in primary health care facilities. Only a few studies are based on how nurses have dealt with transformations in health care, such as that by Delobelle et al. (2010) that focuses on job satisfaction and turnover intent amongst South African nurses and a study by Munyewende,

Rispel and Chirwa (2013) which aims to measure job satisfaction amongst clinic nurse managers. It is important to mention that there is no study that has examined the potential impact of health care reforms on management support, role conflict and role ambiguity in South Africa. Thus, the findings of this study are unique from various studies published on management support, role conflict and role ambiguity because they are based on NHI pilot sites in South Africa.

1.4 Research objectives

- i. To understand nurses' perceptions and experiences on management support within an NHI pilot sites in the North West province.
- ii. To understand nurses' perceptions of change in the primary health care system and its influence on their role within NHI pilot sites in the North West province.
- iii. To understand challenges associated with changes happening in primary health care within NHI pilot sites in the North West province.
- iv. To understand nurses' opinions on what could be done to overcome challenges they faced in NHI pilot sites across the North West province.

1.5 Research questions

- i. What are the perceptions and experiences of nurses, on management support within NHI sites in the North West province?
- ii. What are nurses' perceptions of change in primary health care system and its influence on their role within NHI pilot sites in the North West province?
- iii. What challenges are associated with changes happening in primary health care within NHI pilot sites in the North West province?

- iv. What are nurses' opinions on what could be done to overcome challenges they faced in NHI pilot sites across the North West province?

1.6 Outline of the dissertation

The first chapter of this report provides the reader with an introduction to the research by providing an overview of the research problem and the rationale for the study. The research objectives have been highlighted for the reader and what the researcher hoped to achieve out of the research study.

Chapter Two provides the reader with a literature review. This chapter discusses the current and past literature on management support, role conflict and role ambiguity amongst nurses working in re-engineered PHC and NHI pilot sites. Additionally, the researcher explains why research on this topic is necessary. The theoretical framework is also presented. The researcher presents how the theory is applicable to the current research problem.

Chapter Three provides a detailed description of the research methodology. The chapter describes the research design and the paradigm adopted, as well as the study site, sampling method, data collection method and the tools used to collect data. The chapter also covers the type of research design, study site, sampling type and the research participants. The chapter also discusses the data collection method, instruments used for data collection, study procedure, the study's generalisability and trustworthiness.

Chapter Four provides an analysis of the findings, as well as a discussion which is framed by current empirical literature and selected theoretical frameworks.

Finally, the fifth chapter is the presentation of conclusions drawn, recommendations for future research, and limitations of the current study. Contributions to knowledge are also highlighted.

1.7 Chapter summary

This chapter has given a brief introduction to the topic, arguing that a lack of management support, role conflict and role ambiguity may limit or buffer expected positive outcomes associated with changes happening in health care. The chapter further elaborated the aims and rationale for the study as well as the questions the study sought to answer.

CHAPTER 2: LITERTURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter is made up of two components, firstly a review of the relevant literature in the context of management support, role conflict and role ambiguity in the workplace and then an examination of the two core theoretical frameworks used in this study namely: The Social Support Theory and Organisational Role Theory. The review begins with a brief overview of health reforms within the South African re-engineered PHC system. Thereafter, each of the components of the study aims is reviewed. This chapter will then conclude with an understanding of the above mentioned theoretical frameworks adopted for the current study.

2.2 Overview of health reforms within the South African re-engineered PHC system

The main emerging values of the PHC approach is community participation and a delivery of health care which is not only curative, but also preventative and educational in nature and this served as the ideal of the health system in South Africa (Kaurtzky & Tollman, 2008). In addition, Dizon et al. (2017) argue that PHC is a concept to assist and support individuals, families and communities in treating and preventing disease as well as improving their health. It was through the Pholela Health Centre model which provided comprehensive health care, highlighted community enablement and participation, that the first efforts to inform and define the practice of PHC were demonstrated (Kautzky & Tollman, 2008).

Since the end of apartheid, South Africa has experienced some political changes which have placed the country on a new direction of hope in which human rights aim to replace discrimination of any form (Chopra et al., 2009). According to Khuzwayo and Tlhohe (2015), during the pre-1994 democratic regime, the South African health care system was made up of racial lines and therefore highly fragmented. The authors argue that on the one hand, this system provided highly resourced services to the predominantly white population while on the other, the black majority received health services that were very poor and had a highly limited supply of resources. Various state policies and legislation have been formed for the purposes of redressing the inequality and the injustices of the past, they also represent all ethnic and racial groups instead of the white minority (Chopra et al., 2009).

Naledi et al. (2011) argue that the first five years of democracy were characterised by an intense amount of restructuring. The most noticeable changes that have occurred since the victory over apartheid include the combination of health departments into one overall department of health that is not racially segregated, removal of user fees in PHC facilities including hospitals for pregnant mothers and children under the ages of six (6) years in the public sector (Chopra et al., 2009). Key policy documents such as the adopted National Health Plan and the *White Paper for the transformation of Health system in South Africa* of 1997 which sought to uphold a democratic ideology and eliminate the fragmentation of services emphasising the use of the District Health System (DHS) and upholding the principals of the PHC system (Chopra et al., 2009; Naledi et al., 2011). Other significant changes are part of the development and advancement of the PHC Package are the compilation of an Essential Drug List, Publication of Standard treatment guidelines for PHC and hospitals, HIV/AIDS programmes including the campaigns of condom use, Voluntary Counselling and Testing (VCT), Antiretroviral (ARV)

programme and prevention of mother to child treatment (PMTCT) measures and many more (Schneider, Barron, & Fonn, 2007).

The changes in the health care system have brought about many advantages such as collaborative and innovative thinking that aims to improve health care delivery to all South Africans. A study by Blenchor, Kollipara, Dejager and Zulu (2011) discovered that although HIV prevention is improving and the national mortality of 612 462 deaths in 2006 is gradually decreasing, but life expectancy at birth had escalated from 54.3 years in 2003 to 58.8 years in 2010. Furthermore, recent statistics estimate a decrease in infant mortality to 32. 8 per 1000 live births while the number of people living with HIV was estimated to be 7.06 million (Stats SA, 2017). Therefore, despite the highlighted efforts, literature on the development of PHC mainly highlights its challenges and failures, and is silent on some of the positive PHC outcomes. This portrays the paradoxical implications of the changes in the health care system.

Kautzky and Tollman (2008) highlighted the following as part of the obstacles and challenges facing the health care system in South Africa, namely the imbalance of resources across the public and private sectors. As well as the increase in the burden of diseases, which included the escalation of communicable and non-communicable disease epidemics especially in rural areas within the country including an immense problem with poverty as majority of the country lives below the 2015 poverty line of R441 per person per month (Kautzky & Tollman, 2008). Furthermore, Stats SA (2017) argues that the headcount of South Africans living in poverty is increasing, currently more than half (55.5%) of the nation's citizens are poor. In addition, Mayosi et al. (2012) argue that South Africa faces a quadruple disease burden namely the HIV/AIDS epidemic as well as the high burden of TB, high maternal and child mortality as well as high levels of violence and injuries, and the growing number of non-communicable

diseases. Dookie and Singh (2012) identify further challenges facing primary health care which include inadequate political, financial, human and material commitments, misuse of available resources, inadequate changing management techniques including decentralisation and ensuring effective community participation and intersectional collaboration. Another challenge mentioned by Blenchor et al. (2011) is that of health worker shortages and the management being unable to retain health workers.

The above-mentioned obstacles, challenges and failures have brought about disbelief of any fully applied PHC oriented health system in South Africa. In the study by Peterson and Swatz (2002), it was discovered that the PHC approach in South Africa was never comprehensive in nature, but was selective and was driven by demand rather than needs. According to Naledi et al. (2011), previous studies published on the topic recommend a re-engineered PHC system which will tackle the challenges and failures of PHC. Hence, it is argued that the emergence of the PHC re-engineering, aims to reinforce the District Health System (DHS) which will assist in the delivery of community-based services and then bring into perspective the social determinants of health (Schaay, Sanders, & Kruger, 2011). The proposed re-engineered PHC was adopted from Brazil's Unified Health System which emphasised health coverage for all and succeeded in improving access to primary and emergency care (Naledi et al., 2011). According to the authors, the aims and objectives of a re-engineered PHC are not new, they have been the core principles of the PHC initiated in the Alma Ata Declaration.

Furthermore, Hall and Taylor (2003) argued that PHC was adopted by the Alma Ata Declaration as one of the biggest milestones of the twentieth-century public health field which aimed to provide comprehensive universal equitable and affordable health care for all. It may seem that South Africa is repackaging material that has been used previously because, the re-

engineered PHC has not discarded the initial PHC values, but rather developed a new approach. Naledi et al. (2011) interpreted this in a subtler way, by suggesting that PHC has advanced to a more proactive, integrated and population-based approach from a passive, curative and individually orientated system. This highlights the shift in PHC to be more in line with the needs of the wider population of South Africa.

According to Naledi et al. (2011), the re-engineering of PHC aims to shift the current highly individualistic, passive, curative and vertically orientated system to one that is more population-based or patient-centred, proactive and integrated. Naledi et al. (2011) mention the following as some of the core principles of PHC re-engineering: firstly, developing a population-based health care system by making the needs of all South Africans a priority especially in rural areas. Secondly, focusing on health outcomes aimed at decreasing mortality and morbidity rates, as well as focusing on integrating effective and well-supported teams. These teams will be guided by and accountable to communities, establishing a well-operative DHS among others. This would be done using three elements namely, the multi-disciplinary teams comprising a vast variety of health professions with nurses playing a critical role, as well as municipal ward made up of multi-disciplinary teams of health professionals.

Naledi et al. (2011) name the following three main streams where the re-engineering of PHC has envisaged three main streams namely: health teams in clinics, secondly community and municipal ward health teams and lastly the implementation of national school-based PHC system, these teams consist of clinically competent health professionals that form multi-disciplinary teams. PHC re-engineering has been piloted in various sites. South Africa's National Department of Health (2015) argues that various results concerning the meeting of core quality standards has been displayed from these pilot sites. However, as mentioned by the

National Department of Health (South Africa) (2015), these results display poor scores for PHC facilities and hospitals with slightly better scores.

According to the National Department of Health (South Africa) (2015), one of the ways in which this will be addressed is through the Operation Phakisa Ideal Clinic Realisation project which aims to strengthen the implementation and monitoring of progress achieved by target facilities to achieve the National Core Standards for quality. Along with PHC re-engineering came about the National Health Insurance (NHI) which came about in 2011 and is described by Naidoo (2012) as a bold new direction that aims to change the face of the South African health care system over the next fourteen years. Khuzwayo and Tlhotse (2015) argue that introduction of the NHI will bring hope to many South Africans and it intends to ensure that everybody has access to appropriate, efficient and quality health care services which is one of the core principles of PHC re-engineering.

South Africa's health care system is currently mainly two-tiered, divided along socio-economic lines, the private health care system which is well resourced, mainly catering for the richer portion of the population (National Department of Health of South Africa, 2015). The authors argue that the public health care which is inadequately resourced mainly catering for the average South African unable to afford the stark rated of medical aid. According to Greyling and Stanz (2010), the private sector serves 16% of the population whilst the public sector serves the rest of the 84% of the population who are largely black and poor. Furthermore, Naidoo (2011) draws from the NHI policy green paper by positing that not only is the current two-tiered health care system unsustainable and costly, it is also highly curative. The introduction of the National Health Insurance Scheme was aimed to bridge the gap between the rich and poor, by providing universal access to health care regardless of one's socio-economic status

(Weimann, London, & Stuttford, 2013). Khuzwayo and Tlhotse (2015) argue that like the re-engineering of PHC, NHI is also based and adapted from Brazil and this new direction aims to provide better access to quality health care services for all South Africans and will focus mainly on community outreach services using a defined comprehensive primary care package of services.

According to the Status of NHI Pilot districts report of May 2015, NHI pilot programs were distributed among the following 11 districts: Tshwane in Gauteng, O.R Tambo in the Eastern Cape, Pixley in the Northern Cape, Eden in the Western Cape, Dr. Kenneth Kaunda in the North West, Gert Sibande in Mpumalanga and uMzinyathi, uMgungundlovu and Amajubula, all three in KwaZulu-Natal. This study only focuses on one of these 11 districts, Dr Kenneth Kaunda, which is regarded as one of the biggest NHI pilot sites. The above-mentioned report mentions the following as part of some of the achievements of NHI over the years; in the years 2014-2015 all piloted districts reported integration, coordination and alignment between health planning and implementation. Secondly, districts reported that they were spending less or close to 90% of their grant funds which begs the question whether if these grants were spent in a strategic way benefiting health care and thirdly most districts had plans for infrastructure improvements (Status of NHI Pilot districts report, 2015).

Moreover, the Status of NHI Pilot districts report of May 2015 argued that there has also been an increase in the number of General Practitioners (GP- doctors) in primary health care as they now operate as independent service providers among many more achievements. The above-mentioned report then raised several concerns in NHI pilot sites. For example, the existence of a significant disconnection between district teams and the National Department of Health. Another concern mentioned in the report was use of the medical grant mainly towards the

procurement of equipment and in most instances, managers did not know what this grant was being spent on. Batemen (2012) draws from a statement made by the National Health Minister at the time Dr Aaron Motsoaledi to parliament, claiming that the reasons for the failure of government to spend allocated the budget was due to poor performance of contractors and delays in awarding letters, and the poor performance of contractors. From the above challenges, one can see that there is still a lot to be done not only in facilities but also in terms of government as well in to ensure the success of the NHI policy.

According to Peterson et al. (2015), the introduction of NHI necessitated the implementation of a range of services as well as systems all aimed to support service delivery. Du Plessis (2015) argues that along with these newly introduced systems and changes came the implementation of the Performance Management and Development System (PMDS) regarded as being vital to the provision of quality care, resource management and inter-professional work of health care workers. Lutwama, Ross and Dolamo (2013) argue that performance management involves more than measuring, evaluating the performance of individual or teams and aligning those evaluations with the strategic goals of the organisation but also involves a major developmental component. The authors argue that this development component of performance management involves providing feedback and information on the strengths as well as weaknesses of health care workers, along with training, career development and progression. However, there is evidence that at present, professional nurses lack the knowledge to implement such a system although they are regarded as the important key in the effectiveness of this system along with the re-engineering of PHC and NHI (Du Plessis, 2015). According to the author, nurses in the Tswana District of Gauteng Province verbalised that they found the PMDS to be time-consuming, confusing, non- beneficial and that it does not drive performance.

Du Plessis (2015) argues that nurses play a very important role in the implementation and effectiveness of various new initiatives and interventions such as the re-engineering of PHC, NHI and PMDS. However, according to a study by Khuzwayo and Tlhotse (2015) on nurses' attitudes and perceptions of NHI, it was discovered that nurses believed that they were hardly consulted on various changes taking place within the health care system. The authors also discovered that nurses felt as though changes were enforced on them without prior consultation. Khuzwayo and Tlhotse (2015) argue that this then can cause various issues such as role ambiguity and role conflict because nurses are expected to perform additional tasks, as required by the new changes. This means that management and supervisors need to be present assisting and supporting nurses during this transformative stage.

In addition, Walker and Gilson (2004) draw from the policy analysis theory which offers mainly two approaches in which policies may be introduced namely the top-down approach (when planned change or policies are introduced from top management and filters down to employees). Secondly, Walker and Gibson (2004) mention the bottom-up approach which is a more dynamic process as employees are included in the decision-making process as well as the introduction of change initiatives. However, as stated by Khuzwayo and Tlhotse (2015), the current health care system mainly uses the top-down approach as nurses argue that they are not consulted before changes are implemented in facilities. Having an inadequate understanding of the implemented changes and experiencing role ambiguity can also bring about poor performance and stress amongst nurses. Thus, limiting the success of the various initiatives in place aimed at improving the health care system of South Africa.

2.3 Review of relevant literature

The failure of health service delivery in South Africa can be attributed to many factors, some of which have been mentioned above such as the complex quadruple disease burden as well as a dysfunctional health system (Gray & Vawda, 2015). Furthermore, Coovadia et al. (2009) argue that South Africa has one of the world's well written policies, some of which aim to transform the public health system into an integrated and comprehensive national service. However, due to the failures in leadership, stewardship and weak management, these policies have not been adequately implemented to achieve their intended purpose (Coovadia et al., 2009). In terms of organisational development when any organisation goes through change it is important that management provides employees with clear responsibility and priorities as well as adequate communication as well as information regarding the change (Waddell, Cummings & Worely, 2011). This is done to gain buy-in from employees as well as avoid negative experiences such as role conflict and role ambiguity.

According to Tunc and Kutains (2009), role conflict happens when an individual has two or more task requirements at work against each other while role ambiguity happens when an individual is uncertain about what should be accomplished as part of his or her job. The statement by Waddell et al. (2011) highlights the importance of management in the change management process. Literature around the changes in the health care system in South Africa has also continuously recognised the need to improve management capability (Coovadia et al., 2009; Gray & Vawada, 2015). There has also been a call for a more person-centred, emotionally and socially intelligent type of leadership capability especially within PHC facilities (Gray & Vawada, 2015). Therefore, this provides the rationale to study the role and importance of management support within re-engineered PHC facilities that are pilot sites for

NHI. The following section addresses literature on management support and its link with positive organizational outcomes such as well-being and job satisfaction.

2.3. 1 Management support

As early as 1996, management, also known as supervisor support was defined as the extent to which an employee perceives that his supervisor or manager offers him support, encouragement and concern is referred to as supervisor or management support (Babin & Boles, 1996). In addition, Kurtessis et al. (2015) argue that the extent to which an employee perceived that their manager values their contribution and well-being is known as management support. According to Nahum-Shani, Lim, Hendersom and Vinokur (2014), organisational effectiveness as well as performance are highly dependent on interpersonal relationships formed at work. Therefore, of special importance is the interpersonal relationship formed between the employee and his or her manager. Nahum-Shani et al. (2014) further posits that because supervisors are believed to be agents of the organisation, employees tend to view their behaviour towards them as indicative of the organisation's perception of them. This means supervisors or managers are perceived to act as organisational representatives in the employees' eyes. These authors argue that literature suggests that employee performance is highly affected by supervisor support and mediated by role stressors such as role conflict and role ambiguity.

Furthermore, Babin and Boles (1996) argue that providing key resources for employee such as equipment, training, as well as supervisor and management support can facilitate employee performance. Further, Nahum-Shani et al. (2014) argues that supervisors can help employees deal with occupational stress and challenges, they provide guidance, support and feedback to employees that can help them complete their tasks. Therefore, employees that lack these key

resources will reveal symptoms of role stress especially role conflict. This means that although employees may know their role, they may experience role conflict due to a lack of resources, which may lead to decreased levels of job performance and productivity. Babin and Bole (1996) posit that when a supervisor or management is unsupportive, they may fail to communicate with subordinates about the new expectations and the strategies of fulfilling these new expectations. In turn, a subordinate may feel overwhelmed and confused about these new expectations and may experience role ambiguity because of the lack of communication from management.

Collins (2007) adopts the same definition of support as Babin and Bole (1996) who argue that support is defined as the extent to which the environment makes resources available to the person in need of support. One must keep in mind that the reason for talking about the above-mentioned authors and their studies which may be a bit old is because they provide appropriate context and add more value to this study's approach, which is to understand management support. This author argues that the demands mentioned above are made upon the system. This means that through having supportive relationships with others, one can be able to cope with situations such as job or role stress. She further argues that support systems can be separated into two groups, namely formal and informal support. Formal support refers to support one gets from their line manager, supervisor and any form of appraisal system. Collins (2007) defines informal support refers to support one received from friends and family. This means that formal support is within one's working environment while informal support is from outside the working environment and in various social settings. Both these forms of support are important for employees to have but this study focuses on the formal support that nurses within NHI pilot sites experience from their facility managers.

The Organisational Support theory proposes that perceived organisational support or in other words perceived management support is formed from employees' general perceptions concerning the extent to which the organisation cares for their well-being as well as values their contributions (Eisenberger, 2002). The author argues that perceived supervisor support is related to employees' general perceptions of the extent to which their supervisors care for their well-being as well as value their contributions. A more recent study by Kurtessis et al. (2017) indicated that a favourable perception of management support results in employee commitment as well as identification with the organisation, an increased aspiration to want to help the organisation achieve its goals as well as greater psychological well-being. Drawing from these benefits associated with perceived management support, it would be advantageous for health professionals especially nurses to hold such perceptions and opinions on management support.

However, as part of the findings in a study by Atefi, Abdullah, Wong and Mazlom (2014) on registered nurses, it was discovered that there was a lack of organisational support leadership by supervisors and management which increased occupational stress and nurses' dissatisfaction. Drawing from this study, the dissatisfaction of nurses regarding management support is highlighted and that a lack thereof can have adverse impacts on one's job satisfaction. A study by Thomas and Kelly (2008) highlights the importance of understanding the relationship between perceptions of support and work attitudes. This study also emphasises the need for formal support as it focuses on perceptions of employees on both supervisor support and co-worker support within the organisation. Perceived supervisor support and perceived co-worker support are respectively defined by Thomas and Kelly (2008) as beliefs which are held by employees with regards to either their supervisor or co-workers, which give emotional and work-related assistance.

Thomas and Kelly (2008) argue that since previous studies have sometimes combined supervisor and co-worker support, this could limit our understanding of their prevalence among employees especially if employees react differently to the different forms of formal social support. Furthermore, by separating the two, Thomas and Kelly (2008) argue that one can be able to see practical implications for organisational interventions. For example, providing supervisors with training for them to be more supportive if perceived supervisor support is discovered to be more influential in forming positive work attitudes (Thomas & Kelly, 2008). A meta-analysis study by the above- mentioned authors indicated that perceived supervisor support was strongly related to job satisfaction, affective commitment and turnover compared to perceived co-worker support. These findings indicate that it is likely that perceived supervisor support will have a larger impact on work attitudes resulting in more commitment and less turnover as compared to perceived co-worker support.

Furthermore, a more recent study by Martin et al. (2016) highlights the importance of the interpersonal relationship formed between a manager and an employee. The authors examine the quality of the relationship between a leader and a follower within a work context, this is formally classified as Leader-member Exchange theory (LMX). Martin et al. (2016) discovered a positive relationship between LMX and task performance, citizenship performance and a negative relationship with counterproductive performance. Another study by Schuh, Zhang, Morgeson and Tian (2018) on LMX discovered that employees scored more favourably on performance in high-quality relationships, moreover this was also influenced by the leader's perceptions of an employee's performance. Both these studies highlight the importance of a relationship between the manager and an employee and how this may affect performance. Hence, the importance of this study is to be more focused on understanding perceived supervisor support and the relationship formed between management and employees. This will

be done through interviewing participants to understand their views on the support they receive from management and their immediate supervisor.

To get a full understanding of formal support, be it from co-workers or supervisors, it is important that we also note the various contradictions that have been published in the literature about its presence in the workplace (Nahum- Shani, Henderson, Lim, & Vinokur, 2014). The authors conducted a study on the interplay between supervisor support and supervisor undermining behaviours in a military setting. Although supervisors play an important role in guiding, supporting and coaching employees to improve performance, Nahum- Shani et al. (2014) argue that in other instances this may not be the case. This is because of the power inequality between the supervisor and subordinate as well as poor performance by the subordinate, hence a supervisor may sometimes behave in an undermining manner. This undermining behaviour may range from the supervisor's consistent criticism to other actions that may hinder a subordinate to accomplish instrumental goals (Nahum- Shani et al., 2014). This study highlights the important role that supervisors play in the organisation that if this role is not carried out properly, it may have adverse effects on employee health and well-being, leading to consequences such as emotional exhaustion and depression. The study also highlights how the presence of supervisor support may lead to positive consequences such as decreased uncertainty and exacerbating performance as well as productivity, while a lack thereof may lead to negative consequences such as increased occupational stress.

Aligned with this statement is a study by Nichols, Swanberg and Lyn-Bright (2016) which aimed to understand how supervisor support influenced turnover intentions among frontline hospital workers in the United States. The authors discovered that both supervisor support and

affective commitment were significant predictors of turnover intent. This meant, participants that reported greater levels of supervisor support and affective commitment displayed lower turnover intentions (Nicholas et al., 2016). Both these studies display the importance of management support as well as its benefits. Contradictory to these findings is a study by Kaufmann and Beeher (1986, cited in Nelson & Quick, 1991) which found that the level of stress or strain that participants displayed was related to a presence of high social support. This means that in some instances, social support whether be it from one's supervisor or co-worker can increase the presence of stress that one experiences. In line with this statement, a study by Zeffane, Melhem and Baguant (2018) based on a sample of 311 employees from the service sector of the United Arab Emirates (UAE) discovered that supervisor support played an insignificant role in shaping perceptions of organisational performance. This goes against expectations of a positive relationship of supervisor support and performance that has been mentioned, which emphasises the contradictory findings within management or supervisor support in the literature.

When studying management support, it is also important to review literature that has studied this concept from a South African context. The study by Milner et al. (2013) focuses on the relationship between leader support, workplace health promotion and employee well-being in South Africa. This study was based on 71 different South African organisations and they discovered that a leader's support played an important role for workplace health promotion (WHP). They study also found no direct relationship between leadership support and well-being among employees (Milner et al., 2013). The authors argue that if managers do not show an interest in the WHP program then employees will also not show any interest or support in being involved in the program.

Another study that highlights the influence of management support on work interventions is a study by Berry, Mirabito and Baun (2010), that focuses on Employee Wellness Programs. Berry et al. (2010) argue that passionate, persistent and persuasive leadership plays an important role in creating a new culture within any organisation. Berry et al. (2010) further posit that in many organisations, it is the middle management (such as supervisors or team managers) that have a bigger stake in ushering in the change as they play a bigger role in shaping the organisational subculture which influences the employees on the ground. This means that management attitude towards a certain program or change also affects an employee's actions and attitudes towards a certain program such as a WHP or EAP programme.

In the South African health care system, there is in need for great managerial and leadership based interventions to provide support to nursing staff considering the current changes in health care. According to Gilson, Elloker, Olckers and Lehmann (2014), there need to be fundamental changes to the health care system's culture which supports new forms of leadership. Gilson et al. (2014) argue that these fundamental changes need to be in a form of leadership that will support and strengthen PHC. In PHC facilities, nurses have facility managers' also known as operational managers who mainly oversee the functions of the facility. The operations managers, are also the first line of management and act as supervisors for nurses. Therefore, for the purposes of this study, management support also refers to supervisor support and shall be used interchangeably.

A study by Van der Cloff and Rothmann (2014) based on South African professional nurses indicated that nurses believed that there was inadequate management support in facilities that supervisors, as well as management, did not support staff. According to Cloff and Rothmann (2014), this was part of nurses' significant stress as well as dissatisfaction factors. This is

aligned with the results discovered by Atefi et al. (2014) on registered nurses in Malaysia, indicating that a lack of management support seems to be experienced not only within the South African health care system. A lack of management support buffers employee performance, motivation, satisfaction and may hinder the outcome of changes that have been implemented in the health care system (Atefi et al., 2014; Van der Cloff & Rothmann, 2014). This means a lack of management support may also bring about negative attributes associated with change such as role conflict and role ambiguity. With the above said, no further published studies regarding management support and positive organisational outcomes in the South African context were discovered. The section that follows discusses role conflict and its influence on job performance and other productivity factors.

2.3.2 Role conflict

Role conflict occurs when individuals experience demands of a job that are mutually different or opposite and they cannot meet one of the expectations without rejecting the other (Beena & Poduval, 1999). There are four types of conflicts which the authors argue conceptualises within the context of role enactment, these are namely: personal role conflict which refers to expected behaviour that is incompatible with an individual's basic values, attitudes and morals (Beena & Poduval, 1999). Secondly, inter-role conflict which occurs because of individuals occupying multiple roles. Thirdly, Intra-sender role conflict happens when the individual is unable to behave in a manner that is consistent with their role assignment and this usually occurs when one is expected to perform a task within specified limits (Beena & Poduval, 1999). Finally, the authors mention inter-sender conflict that occurs when pressures from different role senders are different or conflict with each other. These types of conflicts show how role conflict refers to incongruence of expectations associated with certain roles.

More recently, Belias, Koustelios, Sdrolias and Asoridis (2014) argue that to effectively perform their roles, employees usually have several and often different expectations from themselves, managers and other stakeholders. Belias et al. (2014) further define role conflict as employees having incompatible or conflicting expectations from various stakeholders. This is in line with Beena and Poduval's (1999) conceptualisation of role conflict which they believe derives from incompatible demands from role senders (such as supervisors, managers, co-workers, including clients or customers).

In addition, Dhurup and Mahomed (2011) argue that the presence of role conflict is raised by individuals experiencing conflicting demands within a single role or among different roles. For example, this can happen when an employee (a nurse) is expected to play a role of a caregiver to her patients while at the same time also tending to the needs and requirements of management. In relation to this example, there may be an instance where a new filing system is introduced in all health care facilities by management therefore now the nurse must firstly transfer old information which was on the old file into the new one, to meet the expectations and demands by management. At the same time, the nurse has an ethical responsibility to provide efficient and effective health care services to her patients. Therefore, the nurse ends up conflicted between meeting the expectations of management which may be time-consuming while at the same time patients should not have to wait for extremely prolonged periods especially as part of quality improvement strategies.

This may be related to Dhurup and Mohamed's (2011) study on public schools educators that mainly face similar issues as public health care nurses such as a shortage of staff and inadequate resources amongst other challenges. Dhurup and Mohamed's (2011) study sought to understand the relationship between job satisfaction, role conflict, role ambiguity and work

overload. The authors discovered a negative relationship between job satisfaction, role conflict, role ambiguity and work overload. This means job satisfaction is buffered by role conflict, role ambiguity and work overload. Dhurup and Mohamed (2011) further argue that literature suggests employing different people (clerks managing administrative tasks and letting public school educators or professional nurses concentrate on their role) will inevitably decrease role conflict, role ambiguity as well as work overload. Providing training or an opportunity acquire skills to meet both expectations can be a solution to this issue (Dhurup & Mohamed, 2011).

Similarly, a study by Floyd and Lane (2000) that aimed to understand role conflict in the context of a strategic renewal taking place within an organisation had earlier discovered that role conflict cannot be utterly eliminated, however its presence can be minimised. According to Floyd and Lane (2000), experiencing role conflict is inevitable and a by-product of changes happening in any workplace or work environment. This means that organisations need to be able to come up with innovative ideas to minimise its influence on the individual and his or her performance and productivity. Furthermore, Belias, Kousteilos, Sdrolias and Aspridis (2015) argue that employees experience several and different expectations and demands from role senders including themselves in carrying out their roles effectively in many contemporary organisations today. In many instances, these expectations and demands may be incompatible or conflicting, leading to role conflict while at times the authors argue that they can also be vague leading to role ambiguity experienced by individuals within the organisation.

Moreover, Belias et al. (2015) posit that the negative influences of role conflict in organisations among employees such as increased dissatisfaction, an increase of unfavourable events leading to negative emotions experienced at work such as feelings of anger, frustration, fear and anxiety (Belias et al., 2015; Dhurup & Mohamed, 2011). In the study based on a Greek banking

organisation by Belais et al. (2015), it was discovered that role conflict was negatively correlated to job satisfaction and in addition, autonomy played a moderating role in the relationship between role conflict and job satisfaction. This study indicates that role conflict can buffer employee satisfaction and motivation. An employee's job satisfaction is as important for him as it is for the organisation. Acker (2004) argues that the reason for this is that employees who derive satisfaction from their occupation are more likely to remain within the organisation and provide high-quality services to clients.

Piko's (2006) study based on the psychological work environment of health care staff found among other discovers that role conflict was a factor contributing positively to emotional exhaustion and depersonalisation sources. The studies by Piko (2006) and Belias et al. (2015) both illustrate negative influences which role conflict has on employees' job satisfaction as well as emotional well-being regardless of the sector they may be working under. Like health care facilities, the banking environment involves interaction with clients. Bank employees and health professionals are therefore are required to meet the expectations of both management and clients. This shows the importance of organisations coming up with innovative ways through which to minimise role conflict as it does not only have a negative influence on the organisation itself (in terms of customer care) but also on the employees' emotional state as well. Another antecedent that has featured in literature to have a negative influence on the emotional state and well-being of employees is role overload (Iroegbu, 2014).

As early as 1970, Rizzo, House and Lirtzman conceptualised role overload as an antecedent of role conflict and argued that it occurred in a situation where expectations, demands, instructions regarding one's role, exceed the amount of time, resources and energy available to that

individual (role occupant) for their effective execution. More recently, Dhurup and Mohamed (2011) also believed that work overload occurred when an employee has to fulfil multiple roles but without having adequate time and resources to complete these tasks. Iroegbu (2014) argues that when such situations arise, the individual may experience dissatisfaction, stress and perform his or her job less effectively. Iroegbu (2014) further posits that organisations should reduce workload according to the capacity of every individual that jobs should be redesigned to meet the capabilities of employees and more workers should be employed to reduce role overload.

Bowling, Alarcon, Braff and Hartman (2015) conducted a meta-analysis on work overload. The authors argue that the results indicated a positive relationship between occupational stressors and role overload, as a presence of occupational stress indicates an organisations disregard for the well-being of its employees. They also believed that there is a particularly strong relationship between role conflict and role overload. Dhurup and Mohamed (2011) posit that work overload within one particular role makes it difficult to satisfy the demands of other roles as this requires additional time and energy that one employee may not possess. Bownline et al. (2015) further discovered a general negative relationship between management support and role overload as a presence of support especially from supervisors, co-workers, as well as top management, decreases role overload.

In relation to role conflict in a South African nursing context, the study by Abrahams (2008) based professional nurses within three public academic hospitals in the Western Cape Province aimed to analyse the relationship between role stress and turnover intention. The author explained the construct of role stress using the following dimensions: role conflict, role ambiguity, resources inadequacy, skills inadequacy and constant change. Abrahams (2008)

argued that the results of the study indicated that overall turnover intention was relatively low among turnover intention dimensions being the organisation, profession and emigration. There was a significant correlation between role stress and turnover intention and it was further discovered that role conflict proved to be the strongest predictor of organisational turnover intention (Abrahams, 2008).

It was further argued by Abrahams (2008) that the shortage of nursing staff, dissatisfaction among nurses with their employers, bad working conditions, resource inadequacy due to the budgets having been cut in health care facilities and constant change were associated with the high levels of stress experienced by nurses which then increases turnover rates. This means that all the mentioned factors such role overload due to a shortage of staff, can lead to role conflict. The above can lead to nurses having intentions to leave their current facility rather than the profession. With that said, it is important that management in health care settings come up with innovative ways in which to deal with role stress experienced by nurses to further decrease turnover intentions. However, fairly linked to role conflict is role ambiguity, this is discussed in detail in the next section.

2.3.3 Role ambiguity

Khan et al. (1964) posited that role ambiguity can be attributed to the degree of uncertainty associated with the expectations of one's role, including a lack of information in terms of the method for fulfilling those expectations. This may cause employees to experience negative emotions, fatigue, stress and tension if the positions they occupy are ambiguous and conflicting (Beena & Poduval, 1999). According to Papastylianou, Kaila and Polychronopoulos (2009), role ambiguity and uncertainty may arise when an individual does not understand nor know the following; what is expected of him or her, how these expectations will be met and how he or

she is expected to behave at work. For example, this may happen when an employee is relatively new to the organisation and is still trying to get accustomed to their role. For instance, a newly qualified nurse attains employment at a local primary health care facility (a local clinic) may experience a degree of role ambiguity. This can happen if her supervisor does not try to brief her on what is expected from her and how these expectations are to be met.

Furthermore, Peterson (2017) posits that role ambiguity may occur when an employee receives unclear information from multiply sources which may hinder them to fully understand their duties. A study by Kim and Byon (2017) on the relationship between role ambiguity and customer participative behaviour and employee citizenship behaviour in fitness illustrates this point. The authors mainly discovered a positive relationship between high levels of customer participative behaviour and role ambiguity. This means that a high interaction with customer demands tends to increase role ambiguity. Moreover, an individual experiences ambiguity because of various aspects of the role and the situations surrounding it, including the potential degree of clarity or ambiguity which is assessed by investigating the availability of relevant information within the role set (Beena & Poduval, 1999). The authors argue that confusion may be aroused because of unclear organisational rules which regulate the role played and the individual may also be uncertain about who has the legitimate right to influence him or her and him being uncertain of his own authority over others. Because of this confusion, the individual is likely to experience two types of role ambiguity, the first one concerning the task at hand including its related activities and the other concerning the feedback regarding the performance of the task (Beena & Poduval, 1999).

Role ambiguity can be conceptualised using the following three distinct parameters; being working methods, organisational planning and finally performance criteria (Papastylianou et

al., 2009). Furthermore, Rogalsky, Doherty and Paradis (2016) argue that role ambiguity has also been conceptualised in the following dimensions, firstly expectations an employee should met, how the employee is to perform those expectations, thirdly prioritising expectations in a matter of importance, how performance is evaluated and finally the consequences of completing or not completing one's responsibilities. The mentioned parameters and dimensions of role ambiguity are highly related and are important to conceptualise as they help us understand the concept of role ambiguity as experienced by various organisational members and individuals in society outside the organisation.

According to Fazli Aghghaleh, Mohamed and Ahmad (2014), role ambiguity can be further divided into two factors namely; individual factors which include competency and autonomy, secondly organisational factors which could be formalised, organic and mechanistic. The authors conducted a study based on 202 internal auditors (including both in-house and outsourced auditors) in Malaysian companies, investigating the effects of personal and organisational factors on role ambiguity. According to Fazli Aghghaleh et al. (2014), the results of the study indicated that individual and organisational factors do have impacts on the sample and that individuals with higher competency and autonomy (individual factors) experienced lower levels of ambiguity. The study results also showed that there was a negative relationship between role ambiguity and role conflict and commitment to independence. It was further discovered that companies which were highly structured where auditors were in-house experienced lower levels of role ambiguity (Fazli Aghghaleh et al., 2014). This means that if employees have some degree of autonomy within a structured organisation such as health care facilities (hospitals and clinics), there would be a lesser degree of role ambiguity.

Another study by Judea (2011) focused on role ambiguity and role conflict as a mediated relationship between employee satisfaction and organisational commitment. The author argues that the results indicated that both proposed mediators, role ambiguity and role conflict, had a significant relationship between employee socialisation and organisational commitment. This means that the presence of either or both role conflict and role ambiguity is likely to have an impact on an individual's organisational commitment and socialisation. Rai's (2016) study based on 1732 staff members from a set of 10 health and rehabilitation centres aimed to examine how organisational justice, formalisation and organisational commitment can minimise role conflict and role ambiguity. The results indicated that although role conflict and role ambiguity are likely to be minimised by procedural justice, formalisation and organisational commitment. Rai (2016) also discovered that distributive justice was found to have a negative significant relationship with role conflict but not with role ambiguity (Rai, 2016). This study highlights that not in all instances will role conflict and role ambiguity, have the same impact on certain constructs although in most studies they have been widely conceptualised as antecedents of role stress. It is therefore important that they are each studied as separate constructs.

Schmidt, Roesler, Kusserow and Rau (2014) argue that role stress can occur in every job setting with or without organisational change and define role ambiguity as lack of information in specific job position which leads individuals to be uncertain about their role. The authors conducted a meta-analysis of health-related research on role stress in the workplace which focused on depression and anxiety. The findings indicated that a moderate significant positive relationship between both variables being role ambiguity and role conflict (Schmidt et al., 2014). According to Schmidt et al. (2014), although role ambiguity and role conflict overlap, they should be examined as distinct concepts for workplace research. The authors argue that

clearly defined roles and objectives can be seen as one of the contributing factors to employee health and can help the organisation prevent costs arising as a result of absenteeism. This study emphasises the need for one to not limit their understanding of role conflict and role ambiguity to them just being factors of role stress but to also understand them as separate independent concepts that can be studied on their own. This study is also similar to some of the studies highlighted previously, which argued that role conflict and role ambiguity have an impact on depression and other negative emotions that have an impact on an employee's performance and productivity. It is important that management comes up with innovative ways to help reduce the presence of role conflict and role ambiguity while at the same time watching out for the health of their employees.

The mentioned study by Dhurup and Mahomed (2011) based on educators who also play the role of being a sports facilitator in public school in the Vaal Triangle in South Africa also obtained significant findings regarding role ambiguity. This study aimed to study role conflict, role ambiguity and work overload and its influence on job satisfaction amongst the chosen population. According to the authors, the results of the study indicated a significant negative relationship between the measures of role ambiguity role conflict, role overload and job satisfaction. Dhurup and Mahomed (2011) argue that results further indicated that low levels of job satisfaction seemed to be predicted by the high levels of role ambiguity, role conflict and role overload present in the sample. According to Rogalsky et al. (2016), literature argues that role ambiguity has been associated with various constructs such as decreased effort, performance, job satisfaction, as well as one's understanding of their expectations amongst others.

Another study by Dhurup and Dubihlela (2013) based on 201 sports facilitators employed at various sports organisations in South Africa focused on the prevalence of the relationship between role ambiguity and job satisfaction. The results indicated a prevalence of role ambiguity and fairly low levels of job satisfaction among the sample. There were no significant differences between the different sexes (male and female sports facilitators) regarding role ambiguity and job satisfaction (Dhurup & Dubihela, 2013). According to these authors, role ambiguity is a poor predictor of job satisfaction. The findings of this study are contradictory to the ones discovered by Dhurup and Mahomed (2011) and the point made by Rogalsky et al. (2016) which displayed role ambiguity as a strong predictor of job satisfaction along with role conflict although they were both based on sports facilitators in South Africa. This could be due to the different demands each of the compared occupations entails. Like this study's focus on public health care, the above research studies are also based on participants from public schools. When discussing role ambiguity within the health setting in South Africa, it is important to keep in mind the reforms that have been happening and the fact that both role conflict and role ambiguity do not always have a negative influence on aspects such as performance and job satisfaction. Below section discusses previous studies that have found a positive influence of role conflict and role ambiguity.

2.3.4 Toward a positive side of role conflict and role ambiguity

As early as 1975, scholars realised the positive sphere of role stressors such as role conflict and role ambiguity, by discovering a greater likelihood for role stress to be having a more positive impact on constructs such as job satisfaction and performance (Johnson & Stinson, 1975). More recently, Belias et al. (2015) argued that role conflict and role ambiguity encouraged employees to be more flexible and broaden their sources of information and made them more open to new ways of doing things. This means that not all employees respond negatively to role conflict and

ambiguity and that in fact, some may be able to rise above all the adversity. Johnson and Stinson (1975) draw from a study conducted by Khan et al. (1964) using 53 managerial-level workers from various organisations and industries as participants and discovered that a significant positive relationship existed between role conflict and job-related tensions for individuals classified as introverts. However, there was no relationship between role conflict and job-related tensions for individuals classified as extroverts (Johnson & Stinson, 1975). This means that role conflict can also depend on an individual's personality and how they deal with pressure and conflicting expectations or instructions.

In addition, Belias et al. (2015) argue that in some cases employees develop practical and effective ways to as adjustment to the conflict or ambiguity of their roles. This means that in some situations, it is possible for employees to come up with creative ways to deal with role conflict and role ambiguity, however this is not to say that all employees can do this, some factors to consider may be personality as mentioned. Furthermore, Tang and Chang (2010) argue that for some people and in certain daily instances, confrontation with conflicting roles is likely to make them more 'open' to different ways of doing things. More specifically, the authors argue that the process of conflict resolution reinforces teamwork, building alliances and cooperation with several groups of people to come up with different and new ways to solve issues and gain clarification.

A study on 202 employees from Taiwanese companies by Tang and Chang (2010) mainly made the following discoveries, firstly there was a direct negative link between role ambiguity and creativity, and on the other hand, there was a positive link between role conflict and creativity. Chang (2010) argues that in some instances when individuals engage in multiple roles, it may create a positive impact on creativity which may lead to cognitive variation which stimulates

creativity. This means that higher levels of job demand (including role ambiguity and conflict) and trigger innovative responses. Chang (2010) argues that previously published literature suggested that role conflict can expose individuals to different perspectives, making them more flexible and expand their source of information. Therefore, role conflict may also have a positive impact instead of the widely published and popularised negative impact.

In modern-day organisations, employees experience several and different expectations from both themselves and others, in an attempt to carry out their roles effectively. According to Belias et al. (2015) these expectations can be vague, conflicting and incompatible with each other which brings about a presence of both role conflict and role ambiguity amongst employees. This can then create problems leading to lower levels of job satisfaction and performance. Belias et al. (2015) conducted a study aimed at measuring the levels of job satisfaction, role conflict and autonomy of employees in the Greek banking sector, which supports Tang and Chang's (2010) argument that some people are able to adopt different ways of dealing with role conflict or role ambiguity. However, the results of Belias et al.'s (2015) study found that role conflict is negatively correlated with job satisfaction. In addition, the authors found that autonomy has a moderating role in the relation between role conflict and job satisfaction. Belias et al. (2015) explain their findings by arguing that in some instances, people develop practical and effective skills as an adjustment to conflicting roles. This means that as people experience the presence of role conflict, they come up with innovative ways through which they can combat and make the best out of it. What makes this study relevant to this study research is that it is also based on a modern and highly complex organisation which runs a hierarchical system of management like health care facilities.

The negative effect both role conflict and role ambiguity have on factors such as job performance and production cannot be overlooked as employees perceive that the greater role stressors the more the cognitive resources required. According to Onyemah (2008), the reason for this is that cognitive resources within every individual are limited, making it difficult for the available cognitive resources to be used reconciling and making sense of expected demands. Fried et al. (1998) argue that the use of limited cognitive resources on role clarification is not advisable because prolonged exposure to a particular contextual stressor such as role conflict or role ambiguity increases the demand on employee cognitive resources. Drawing from these arguments, one can, therefore, assume that although some people rely upon their cognitive resources to come up with innovative ways of dealing with different role stressors (Fried et al., 1998; Onyemah, 2008).

However, dedicating too many resources to dealing with stress causes other important areas such as job performance to decline. The same could be argued among nurses in re-engineered PHC that although some might be able to rise above the presence of role conflict and role ambiguity, prolonged exposure to either both or one of the role stressors will eventually have a negative influence on performance in the long run. According to Rogalsky et al. (2018), one is likely to experience role conflict and role ambiguity where there is a lack of communication and support from one's manager. This highlights the need of an interpersonal relationship between the manager and employee(s).

2.4 Management support, role conflict and role ambiguity within current PHC and NHI

Literature has long studied role stress and its relationship between organisational and individual outcomes and suggested that exposure to role stressors tends to reduce an individual's capacity to control their work environment which in turn, is expected to adversely affect the individual's

ability to function effectively (Fried et al., 1998; Seers, McGee, Serey, & Graen, 1983). The general adverse health and organisation consequences of role conflict and role ambiguity has increased attention in exploring variables that might moderate role stress or strain, thus minimising these negative health and role consequences (Seers et al., 1983). More recently, Schmidt et al. (2014) argued that having an unclear job description, including a lack of information in a specific job position leads to individuals being uncertain about a role and experience role ambiguity. Schmidt et al. (2014) argue that clearly defined roles which are not conflicting can be seen as one of the contributing factors to employee health and can help the organisation prevent costs arising due to absenteeism.

One of the variables that has been previously studied as one of the ways to minimise the negative impacts of role conflict and role ambiguity in organisations is social support, specifically management or supervisor support (Babin & Boles., 1996; Seers et al., 1983). The study by Seers et al. (1983) sought to examine three alternative hypotheses (buffer, coping, no interaction) predicting job outcomes by job stress and social support. Seers et al. (1983) argue that the results indicated that for role ambiguity, very little interaction effects were found while for role conflict, supportive evidence was found to help employees cope. This means that having a supportive work environment will help employees be able to cope with the impacts of role conflict, however, the same was not true for role ambiguity. Contradictory to these findings was the study by Rogalsky et al. (2016) on understanding sport volunteers' experience of role ambiguity, difficulty, satisfaction and performance. Amongst the study's significant findings was a negative association between role ambiguity and effective supervision and support (Rogalsky et al., 2016). This means that although participants believed that they had adequate supervision and support, they still experienced role ambiguity.

African countries are attempting to improve the functioning of the health care system to ensure that its people receive timely quality health care always (Awases et al., 2006). According to Awases et al. (2006), there are many challenges faced by African health care systems such as a shortage of health professionals, increased caseloads for health workers due to the migration of skilled health professionals and the quadruple burden of disease and the HIV/AIDS epidemic that affect both the general and health professionals. Moreover, Ravangard, Yasami, Shokrpour, Sajjadnia and Farhadi (2015) argue that in any organisation in any field or industry, human resources are one of the most important assets, especially within health care. Furthermore Ravangard et al. (2015) argued that nurses are the largest and most important part of health care providers in the health care system and play a key role in the effective implementation of change initiatives within health care facilities. Therefore, paying attention to factors affecting their performance such as role ambiguity and role conflict is very important.

South Africa has a largely nurse-based health care system and therefore it is important to study factors which may hinder their performance and ultimately the success of implemented interventions. This is because overlooking what influences nurse performance or what issues they seem to be facing in facilities, limits our understanding on what goals should be set to achieve desired goals such as a quality health care for all South Africans or what still needs to be done to be where we desire to be in health care. According to Harrison (2009), the most consistent finding in previous literature in all parts of the country is that the morale among health workers is low, especially among nurses. Harrison (2009) stated that, the morale of health workers is largely dependent on the ability of national and provincial managers to articulate a clear vision and plan of action this is also bound to make them feel like they have a real sense of mission and personal fulfilment. This suggests that health professionals

experience a slight presence of role ambiguity and role conflict which may hinder them from having a real sense of mission as indicated.

According to Dookie and Singh (2012), a poor understanding of primary care and primary health care raises unrealistic expectations in the delivery of services and health outcomes, and blame is assigned (mostly towards nurses) when expectations are not met. This means that nurses need the support and guidance from their supervisors which will help them get a better understanding of primary health care and the role they now play in the transitioning South Africa's health care system. It is also important for all health practitioners to consider the contextual influences on health and ill-health and to recognise the role of the underlying factors of ill-health, namely, social, economic, and environmental influences. The authors argue that the primary health care approach provides a strong framework for this delivery but it is not widely applied properly. According to Delobelle et al. (2011), for this relatively new PHC system to work, strong leadership is required, along with efforts directed towards the strengthening of the current district health system and a greater emphasis on health promotion, prevention and community participation and empowerment.

As most of the backlog of all the changes in PHC mostly falls on nurses, Khuzwayo and Tlhotse (2015) argue that basic professional nurse training excludes diagnosis and treatment from clinical skills, however, these are crucial if the vision of PHC is to be properly implemented. This indicates that there is still a lot of work to be done towards the effective implementation of PHC especially among nurses.

2.5 Theoretical framework

Two theoretical frameworks have been adopted in this study, firstly House's (1981) Social Support Theory and secondly, the Organisational Role Theory proposed by Khan, Wolfe, Quinn, Snoek and Rosenthal (1964). Therefore, this study uses triangulation, which allows the researcher to apply more than one approach to answering the research question (Heale & Forbs, 2013). There are five types of triangulation namely methodological, investigator, data, analysis and theoretical triangulation (Hussein, 2015). The current study uses theoretical triangulation, which means that two theories are used to reflect on the findings (Hussein, 2015). This was done because both theories help the researcher to see the problem at hand from multiple lenses. According to Heale and Forbs (2013), the use of theoretical triangulation may be useful in confirming suggested findings as well as to determine the completeness of data. Hence, the adoption of both Social Support Theory and Role Theory in the current study.

2.5.1 Social Support Theory

House (1981) argues that social support can be seen as something that lessens or buffers the impact of occupational stress on health and production. Furthermore, the interrelated social relations and connections kept by individuals is known as social support, this helps us cope and deal with stressful situations be it personal or work related (Amarneh, 2017). According to Nelson and Quick (1991), there are four types of social support namely, emotional, appraisal, informational and instrumental support. These forms of support can then be expressed in various ways, for example, emotional support involves giving and showing concern for another person (Nelson & Quick, 1991). According to House (1981), emotional appraisal involves providing empathy, caring, love and trust and sees those aspects as important while appraisal support involves giving constructive feedback and monitoring. Informational support according to House (1981), involves giving recommendations or suggestions, and finally,

instrumental support includes modifying an environment to suit the person or people concerned. In relation to the study, a supervisor or manager in a PHC facility should be able to provide mentioned social support types especially, within the current turbulent health care system, most importantly appraisal support.

Furthermore, Fletcher (2001) argues that the concept of performance appraisal has widened as a concept, it has become part of a more strategic approach to combining business policies and human resource activities. This is achieved through various practices of performance management. This means that from something that was only done annually by a line manager on a subordinate's performance, it has become something that is done more regularly as it indicates the organisation's appreciation for hard work and value what employees bring to the table. A study by Alameddine et al. (2015) on nurses in Lebanon discovered that although performance appraisal is a managerial exercise, to carry it out appropriately and in a timely manner, it requires good planning as well as dedication in terms of human and financial resources. As a form of social support done on a managerial level, it is important that it done in a timely manner.

It is important to note that social support can also be divided into two categories namely formal support and informal support (Babin & Bole, 1996). Formal support refers to the type of support one receives from within the organisation (namely supervisors and co-workers), while informal support refers to the support one receives outside the organisation (this includes friends and family). This study focuses on formal support, specifically supervisor or management support. The study by Amarneh (2017) mainly focused on informal social support, as it sought to understand social support behaviours and work stressors amongst

nurses. The findings indicated the presence of work stress amongst nurses and suggested that social support behaviours should be present to buffer work related stress.

Another study by Fiorilli, Albanese, Gabola and Pepe (2016) on social support and teacher emotional competence discovered that teacher burnout was mediated social support and a sense of satisfaction about one's own job. All the studies identified the important role played by social support be it formal or informal in an organisational context. This theory shows the importance of social support, this could also be applied to a work setting as Nelson and Quick (1991) argue that the four mentioned types of social support reduces stressors which an employee may face, decreased the effects of those stressors and may be able to moderate the relationship between stressors and health-related outcomes. This means management or supervisor support can help moderate the presence of role conflict and role ambiguity which both fall under the boundaries of organisational role theory. This theory is discussed in length below.

2.5.2 Organisational Role Theory

The Organisational Role Theory provides insight into the processes that affect the physical and emotional state of an individual in a work setting (Parker & Wickham, 2006). This makes the theory by House (1981), similar to most of the ideas proposed by role theory such as recognising that employees are not robots but are emotional human beings. According to Parker and Wickham (2006), the Organisational Role Theory focuses on the way individuals accept and perform their roles in the workplace. As early as 1970, this could be illustrated by previous literature which argues that employees that are perceived to lack a manner of facilitation and support, will reveal symptoms of role stress (Rizzo et al., 1970). Drawing from this statement, one can assert that employees will display high levels of role conflict and ambiguity if they are

inadequately facilitated and supported by supervisors or management. Therefore, the Organisational Role Theory distinguishes role conflict and role ambiguity as two distinct constructs (Schmidt et al., 2012). Therefore, the Organisational Role Theory defines role ambiguity as a lack of necessary information available to complete a given task, and role conflict is defined as expected behaviours which are inconsistent (Rizzo et al., 1970; Schmidt et al., 2012).

Although House's theory of Social Support and Organisational Role Theory were both proposed in the 90s and are relatively old and organisations have remarkably changed from that time until now. Both these theories are still widely proposed as ideal frameworks in which to examine the behaviour of individuals in the workplace (Nelson & Quick 1991; Parker & Wickham, 2007). This point illustrates the relevance of this theoretical framework as a lack of management support that has a negative influence on role conflict and role ambiguity.

There have been many changes in South Africa's Primary Health Care, however, Chopra et al. (2009) argued that these reforms, especially within different health care facilities, were not introduced in a proper, organised integrated way. Chopra et al. (2009) further mention that the human resources departments with PHC facilities suffer from a lack of planning and not having enough professionals to fill vacant posts. As a result, the authors argue that neither primary-care nurses nor their supervisors understand how to deliver comprehensive services hence this limits the effectiveness of the various PHC interventions in place. This warrants the need to explore lack of management support, the presence of both role ambiguity and role conflict not only among nurses but also managers who are the ones who are supposed to be leading the whole process of reform. The theoretical frameworks adopted in this study are best suited because they both incorporate management support, role conflict and role ambiguity and

further argue that the presence of either one of these constructs will have a negative effect not only on performance but on the well-being of employees as well.

2.6. Chapter summary

This chapter aimed to define the prominent constructs of the current study, these are namely: management support, role conflict and role ambiguity. A comprehensive review of literature on these constructs was provided, importantly, international and local studies were examined to identify current gaps in the literature. In terms of the theoretical frameworks adopted in the study, Social Support Theory guides our understanding on the type of support that should be fostered in health care settings to improve nurse performance and decrease role conflict and role ambiguity. On the other hand, the Organisational Role Theory guides our understanding of role conflict and role ambiguity as distinct concepts that may have detrimental influences on nurses in the current PHC system.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the methods and research tools used in collecting data for the current study. While the study uses secondary data, the chapter discusses the type of research design, the study site, sampling type and the research participants. The secondary data from a PhD study titled: The public service Performance Management and Developmental System (PMDS) and its influence on job performance and quality improvement in re-engineering Primary Health care (PHC) Health facilities. BREC reference number: BE084/16. The chapter also discusses the data collection method, instruments used for data collection, study procedure, reliability (generalisability) and validity (trustworthiness) as well as data analysis. In addition ethical considerations are discussed and lastly the chapter summary.

3.2 Research design

The study adopted a qualitative research design. According to Golafshani (2003), qualitative research uses a naturalistic approach that seeks to understand phenomena without any form of manipulation which makes this type of research approach suitable for the current study. More recently, Marshall and Rossman (2014) argued that qualitative research aims to understand subjective meanings of everyday experiences. This grants the researcher the ability to compare narratives of experiences, views and beliefs of participants (Marshall& Rossman, 2014). Furthermore, using a qualitative approach allows the researcher to interact with participants to reveal rich, valuable, quality, in-depth material as opposed to simply quantifying the problem and reducing it to numbers (Golafshani, 2003; Marshall& Rossman, 2014). Moreover, Neuman (2011) argues that this approach allows the researcher and the readers to understand

the broader social, cultural, psychological, economic and political contexts which are in line with the research questions.

By using the qualitative research design, people and events are studied in their natural settings and the meaning that people bring to the setting is also studied (Golafshani, 2003). This method is very useful when a researcher is looking for more than just one-word answers but rather the feelings, perceptions and experiences of participants, it also allows the researcher to make comparisons across participants. The disadvantage of this approach is that it is based on a relatively small sample, therefore generalisability of the findings is limited. However, the qualitative research design was useful for the current study as it aimed to understand nurses' perceptions and experiences of the managerial support they received from facility managers as well as their experiences of role conflict and role ambiguity.

Furthermore, the interpretivist paradigm was used to inform the qualitative research design adopted in the study as one is a methodology and another a means of collecting data. Thanh and Thanh (2015) argue that the interpretivist paradigm claims that reality is shaped or is understood through human experience. Therefore, reality can be discovered through participants' views or perceptions and experiences. This is suitable for this study as the researcher aims to capture participants' perceptions and experiences. According to interpretivist researchers, one of the most critical elements to the interpretation of data gathered is a good understanding of the context within which the study is conducted (Thanh & Thanh, 2015). This has also been done in this study as the researcher outlines the context of the study in Chapter One and the beginning of Chapter Two.

Tuli (2010) argues that interpretivist researchers tend to be non-manipulative and non-controlling, this is because of their naturalistic approach to conducting research which allows real-world situations to unfold naturally and relies on human experience and perception. Moreover, literature suggests a strong connection between the interpretivist paradigm and qualitative methodology (Thanh & Thanh, 2015; Tuli, 2010). This is because both the interpretivist paradigm and qualitative methodology believe that the world is “socially constructed, interpreted and experienced by people in their interactions with each other and with wider social systems” (Tuli, 2010, p.100). This makes both the interpretivist paradigm and qualitative method appropriate for the current study as it allows the researcher to collect and analyse the data around management support, role conflict and role ambiguity as experienced by nurses in NHI sites.

3.3 Study site

Dr Kenneth Kaunda district in the North West province of South Africa was chosen as the study site. The district has an estimated total population of 742 821 million (Stats SA, 2017). This district consists of four local municipality districts namely: City of Matlosana, Maquassie Hills, Ventersdrop and Tlokwe (previously known as Potchefstroom Municipality). In terms of the current structure of health services, Dr Kenneth Kaunda district comprises one regional hospital, three district hospitals, nine community health centres, twenty-seven clinics, six satellite clinics and two mobile health service units (Peters, 2017). This district is ideal because there are ten NHI pilot sites in South Africa. The interest in the North West pilot is also due to various interventions the health district is experiencing, which include change management and mental health interventions.

3.4 Type of sampling

In this study, the researcher used purposive sampling which is a non-probability sampling technique. Terre and Kelly (1999) argue that unlike probability sampling, non-probability sampling does not involve selecting elements using statistical randomness. Etikan, Musa and Alkassim (2016) posit that data gathering as well as the sampling technique is very critical in research, especially since no amount of analysis can make up for data that was not collected properly. Furthermore, Etikan et al. (2016) argue that purposive sampling which also known as judgemental sampling allows the researcher to deliberately choose a participant according to the qualities the participant possesses. This may involve selecting individuals according to their knowledge, experience, as well as their availability and willingness to participate. According to Guarte and Barrios (2006), the use of purposive sampling allows the researcher to select participants that are deemed to have the valuable information on the characteristic of interest.

This sampling method was selected because the researcher was looking for specific personnel with a specific purpose in mind, that is, professional nurses in Primary Health Care facilities that are part of the NHI pilot.

3.5 Research participants

This study consisted of eighteen participants. All the participants were professional nurses employed within the Dr Kenneth Kaunda District across four sub-districts in the North West province, South Africa. A professional nurse in South Africa is defined is defined by the South African Nursing Council as a person registered as such in terms of section 31. This section stipulates nurse registration as prerequisite to practice. According to this section, “Subject to the provisions of section 37, no person may practise as a practitioner unless he or she is

registered to practise in at least one of the following categories: (a) Professional nurse; (b) midwife; (c) staff nurse; (d) auxiliary nurse; or (e) auxiliary midwife.” - (South African Nursing Act, 2005, p. 25).

3.6 Data collection method

The study used semi-structured interviews as a method to collect the relevant data to answer the study’s key research questions. Choice of this data collection method was influenced by the nature of questions the study sought to answer. Participants were thus asked to share their perceptions and experiences in relation to the core questions. According to Whiting (2008), semi-structured interviews provide in-depth information, and they also use open-ended and verbal questions. The author claims that interviews are widely used with health professionals. Whiting (2008) argues that researchers attempt to control the interview process through asking questions that help the researcher keep in mind the aims and objectives of the study. According to Huysamen (2001), by using semi-structured interviews, the researcher can gain in-depth knowledge from the point of view of the participants. Huysamen (2001) argues that because questions are asked in a systematic manner, the use of semi-structured interviews allows the researcher to probe for further information which helps to extract both rich and tick data from the participants. This feature ensures that the researcher captures data that is reflective of the participants’ experiences, perceptions as well as opinions on a certain topic. In the current study, the worthwhile data relates to the changes currently happening within Primary Health Care settings in the NHI sites in North West province.

However, like every other data collecting technique semi-structured interviews are not without disadvantages. Adams (2015) mentions the following as some of the drawbacks associated with semi-structured interviews: they are time-consuming, labour intensive and require interviewer

sophistication. Furthermore, the process of preparing for the interviews, setting up, conducting and analysing interviews requires considerable time and effort. Depending on the size of the population, Doody and Noonan (2013) argue that without enough time and personnel, semi-structured interviews are unlikely to encompass a large enough sample representative of a whole population. Despite these disadvantages, using semi-structured interview was ideal for this study as it helped capture the narratives presented by participants.

It is important to note that this study used secondary data collected for a PhD study titled: The public service Performance Management and Development System (PMDS) and its influence on job performance and quality improvement in re-engineering Primary Health care (PHC) Health facilities -BREC reference number: BE084/16.

3.7 Data collection instruments

Data was collected using two instruments namely a biographical questionnaire and a semi-structured interview schedule. The biographical questionnaire was mainly used to collect demographic information along with participants' basic professional experience. The biographical questionnaire captured the following information related to all the participants namely: gender, age group, marital status, race, number of dependents, highest qualification, and the number of years working for current PHC facility, previous positions held within a PHC facility, job title and years working in the current position. This information was collected to help the researcher contextualise and interpret findings more meaningfully in case management support was experienced differently based on participants' age group or the number of years working for the current PHC facility among the other characters mentioned.

The study also used a semi- structured interview schedule. The interview schedule was generated after a thorough literature search was conducted. Study participants were asked to share their perceptions and experiences in relation to the core questions. According to Whiting (2008), semi structured interviews provide in-depth information because they use open-ended and verbal questions. Whiting (2008) argues that researchers attempt to control the interview process through asking questions that help the researcher keep in mind the aims and objectives of the study.

Additionally, the study also made use of the Interpretative Phenomenology Approach (IPA) as a means of guiding the data collection processes. Palmer, Larkin, De Visser and Fadden (2010) define IPA as an approach used to “understand and make sense of another person’s sense-making activities, with regard to a given phenomenon, in a given context. IPA is best suited for forms of data collection which invite participants to articulate stories, thoughts, and feelings about their experiences of a target phenomenon” (p.121).According to Fadden (2010), IPA is frequently used for one-on-one interviews hence its suitability for this study as it allows participants to provide rich experiential data. Using IPA, the researcher aimed to explore the lived experiences of professional nurses, their realities and how these realities are shaped by various challenges associated with working within a health system characterised by many changes.

3.8 Study procedure

Since this study is based on secondary data, the principal investigator (PI) of the research project began by obtaining ethical clearance from relevant authorities within the University of KwaZulu-Natal (UKZN), namely the Biomedical Research Ethics Committee (BREC). The

BREC deals with all health related biomedical and social research at the University and is recognised by the South African Department of Health's National Health Research Council.

Upon obtaining provisional ethical clearance, the PI was requested to obtain a gatekeeper's permission letter. The research team contacted the relevant authority in the North West Province's Department of Health for the permission letter. When the permission letter was obtained, the PI submitted all the relevant documents to the BREC and full ethical clearance was obtained. Once full ethical clearance was obtained, the research team began contacting various Primary Health Care facilities to arrange the date and time to conduct research in each of the facilities.

At the beginning of each interview session, the researcher would begin by explaining the purpose of the study, the interviewee's rights as a participant in the study (such as the right to confidentiality and being duly informed about the study), explanation on how the interview process would unfold and requesting the interviewee for permission to audio record the interview. In each facility, participants received an information sheet further explaining the study and providing contact details of the PI in case the participant would decide to withdraw from the study or require further information. Participants were also asked to sign an informed consent form as well as complete a biographical questionnaire before commencing with the interview. The average time an interview typically lasted for was 45-60 minutes. After the interview, each participant was given an opportunity to ask questions. Participants were each given a UKZN branded mug as a token of appreciation for participating. The researcher explained to the participants that the mug was not in any way a form of payment for having participated.

For the purposes of this study, the secondary researcher also had to apply for ethical clearance from relevant authorities within UKZN to complete this study based on secondary data. The secondary researcher was only able to gain access to the data when ethical clearance was attained (BREC ref no: BE519/17).

3.9 Reliability and Validity

Concepts such as reliability and validity must be redefined for their usefulness in qualitative research (Golafshani, 2003; Smith, 2015). According to Smith (2015), reliability can be understood as consistency and confirmability which is related to trustworthiness and emphasises the need for the researcher to account for the ever-changing context in which research occurs (Smith, 2015). Furthermore, confirmability questions how research findings are supported by the data collected (Golafshani, 2003). Moreover, Shenton (2004) draws from Guba's assessment of trustworthiness, and argues that the following criterion requirements must be met by qualitative researchers: credibility, transferability, dependability and confirmability. According to Shenton (2004), credibility refers to how congruent are the findings with reality. This was done through ensuring that the specific data collection procedures were in line with previous comparable studies. Roets, Poggenpoal and Myburgh (2018) argue that transferability refers to whether the findings can be justifiably applied to a similar environment or setting. This was done through describing the context of study in detail, thereby allowing the reader to decide whether the current environment is similar to another situation. The dependability criterion questions if the research enables a future investigator to repeat the study (Roets et al., 2018). This was done by through specifying the procedure followed in completing the study. Lastly, confirmability aims to demonstrate that the research findings are informed by the data collected and not the researcher's own predispositions

(Shenton, 2004). This was done by the researcher transcribing the interview recordings verbatim. It is from these verbatim transcriptions that themes were formed. Furthermore, confirmability questions how research findings are supported by the data collected (Golafshani, 2003). This process aims to detect any form of bias brought forward by the researcher and this is due to the assumption that qualitative research allows the researcher to bring a unique perspective to the study. Therefore, the researcher is responsible for documenting such changes in the setting and describing how these changes affected the way the researcher approached the study.

According to Smith (2015), validity in qualitative research is referred to as credibility or in other words the truth value, meaning that this type of research design recognises that multiple realities exist and it is the researcher's responsibility to capture an outline these different personal experiences and viewpoints as clearly and as accurately as possible. This also refers to establishing if the findings of the research are believable or credible from the standpoint of the participants. According to Golafshani (2003), the truthfulness of the study is achieved by asking the participants to give an honest account of their experiences and feelings. Member checks were used to validate the information received by providing each participant with a copy of their transcribed interview as member checks involve taking the analyses and conclusions back to the participants and allowing them to check whether the researcher's account was accurate and true. Unfortunately, due to time constraints, follow up interviews were not conducted. By using an interview schedule where participants are asked the same questions in the same order, can help increase the reliability of the study and bring about consistency when making observations (Golafshani, 2003; Smith, 2015).

3.10 Data analysis

For this study, thematic analysis was used to analyse the data. Thematic analysis is a widely used analysis method in qualitative data, it involves more than simply reporting what is in the data, rather it allows the researcher to tell an interpretive story about the data in relation to the research questions (Braun & Clark, 2014). The purpose of this was to identify patterns or rather themes of meaning across a rich dataset that provide an answer to the research question being addressed (Braun & Clarke, 2014).

Furthermore, Braun and Clark (2014) argue that thematic analysis is done through a six-phase process: firstly familiarising yourself with data, secondly generating initial codes, and thirdly searching for themes, reviewing potential themes, defining and naming themes and finally producing the report. These themes were identified using a rigorous process of data familiarisation, data coding, searching for themes with the dataset, reviewing themes, defining and naming them and finally writing up the report. In terms of the process followed in the study, data was transcribed verbatim. This also involved reading and re-reading the data to be immersed and intimately familiar with its content. The second phase of generalising initial codes involved creating interesting codes that identify important features of the data that might be relevant to answering the research questions. According to Braun and Clarke (2014), this should be done in a systematic way across the entire dataset, collecting relevant data to each code.

Thirdly, searching for themes was done through examining the codes and collecting data to identify significant potential themes. The review of themes was done by checking potential themes against the dataset, to determine that they represent the true story of the data and one that answers the research question. According to Braun and Clarke (2014), this phase also

involves generating what is termed a thematic ‘map’. In the fifth phases, themes are defined and named, which involves developing a detailed analysis of each these, working out the scope and focus of each theme and determining the ‘story’ for each. Lastly, producing the report is the final opportunity for analysis and it involved putting together a narrative and data extracts, and contextualising the analysis in relation to existing literature. According to Braun and Clarke (2006) although the phases are sequential, it also allows the researcher to move back and forth between phases which makes this data analysis method flexible and hence its suitability for the current study.

3.11 Ethical considerations

This study is based on secondary data (BREC reference number: BE084/16). Ethical clearance was sought from the Research Committee Ethics Board at the University of Kwa-Zulu-Natal. Provincial ethical approval was granted to the researcher by BREC on the 15th of November 2017. Once provincial clearance was granted, the researcher attained permission from the gatekeeper, being the North West Department of Health (NWDOH) to conduct the study amongst professional nurses and facility management in the North West Province. However, for the purposes of this study, data focused on professional nurses was used and ethical protocols were adhered to always. After receiving approval from both UKZN and NWDOH, the researcher gained access to the data. The following ethical principles were adopted as a guide by the researchers to guide the data collection and analysis processes.

3.11.1 Guideline 1: Research participants must be volunteers

Participants volunteered to be part of the study and were informed that they could withdraw from the study at any time without any negative consequences. Furthermore, participants were informed that the interview would be recorded and consent for doing this was sought. In

addition, participants were asked to sign an informed consent form granting the researchers' permission to use the data collected from the interview in the research.

3.11.2 Guideline 2: Sufficient information about the study should be given to potential research participants about any possible risks or discomforts as well as benefits

Participants were informed at the beginning of each interview. They were informed of the purpose of the study and ethical principles were presented on the informed consent form. An information was also given to all participants informing them more about the study and providing researcher's contact details, should need arise for participants to contact the research team. Participants were informed of all their rights during the research process and were given the opportunity to ask questions if they required clarity on a certain aspect regarding the study.

3.11.3 Guideline 3: No harm

The study did not have any potential to cause any harm to participants. Where any emotional harm occurred because of the study, the researcher provided emotional support to the participant.

3.11.4 Confidentiality

Participants remain anonymous as the researcher assigned pseudonyms to each of the participants to ensure that their privacy was protected. At this stage, participants were reassured that they would remain completely anonymous and the researcher explained clearly in terms of who would have access to the data as well as how it would be stored. Participants were reminded once again that they could withdraw from the study should they wish to do so.

3.11.5 Storing research data

Recorded interviews were transferred onto a computer that is password protected. As per UKZN procedures and protocols, these recordings will be safely kept in a locked cupboard in the School of Applied Human Sciences. After a period of five years all research material will be destroyed.

3.12 Chapter summary

In this chapter, the research method and methodology that was used during the study were discussed in detail. Although the study used secondary data, the study site at which the data was collected was described adequately. The study used semi-structured interviews and the Interpretative Phenomenology Approach as a method to collect data. The study procedure was discussed in detail from how data was collected by the research team to how the secondary researcher gained access to the data. Lastly, ethical guidelines that were adhered to during the study were briefly discussed.

CHAPTER 4: FINDINGS AND DISCUSSION

4.1. Introduction

This chapter presents the findings of the study and a discussion on the relevance of the findings in relation to literature on the discussed phenomena. The chapter begins with an outline of the characteristics of the participants followed by a table of demographic data and another on highlighting the number of participants from four districts of Dr. Kenneth Kaunda in the North West province of South Africa. The findings are reported according to four main themes that are outlined in Table 3.

For purposes of confidentiality and anonymity, pseudonyms are used. The chapter then ended with a summary of findings.

4.1.1 Findings

The demographic characteristics of professional nurses that participated in the study are provided in table 1 below.

Table 4.1 Demographic characteristics of the Professional Nurses

Demographics	Professional Nurses (n=18)	Percentage
Race:		
African	16	89%
White	2	11%
Indian	0	0
Coloured	0	0
Gender:		
Male	3	17%
Female	15	83%
Age:		
20-30	3	17%
31-40	3	17%
41-50	10	55%
51-60	2	11%
Marital status:		
Single	10	55%
Married	5	28%
Divorced	1	6%
Widowed	2	11%
Highest qualification:		
Certificate	0	0
Diploma	13	72%
Degree	5	28%
Postgraduate studies	0	0
Years of experience:		
0-5	9	50%
6-10	8	44%
11-15	1	6%
16-20	0	0
20+	0	0

The above table summarised the demographics of participants interviewed in the study. Majority of the participants were African (89%), female (83%) and between the ages of 41 and 50 years (55%) while the minority were White (11%), male (17%) and between the ages of 51-60 (11%). This is in line with the findings of Stats SA (2017) which reveal that 65.4%- 80.33% of the population is African, female and below the age of 65 years. Most of the participants were single (55%), and had a diploma in nursing (72%) as their highest qualification with 0-5

(50%) and 6-10 (44%) years of experience. Below is a table displaying participation distribution per sub-district of Dr. Kenneth Kaunda District.

Table 4.2 Participant distribution per sub district

Name of Sub-district	Number of Professional Nurses (PN) Interviewed	Percentage
Matlosana	8	44%
Potchefstroom (Tlokwe)	4	22%
Ventersdrop	3	17%
Maquassi Hills	3	17%
Total Numbers	18	100

Majority of the participants were from Matlosana (44%) followed by Tlokwe (22%) sub-district. These two sub-districts also have the highest population compared to other sub-districts in Dr Kenneth Kaunda District (Stats SA, 2017). Both these tables display the demographics of the study’s participants which are also in line with the statics discovered by Stats SA (2017) of the district, making the study easily generalisable.

As mentioned in Chapter 3 and illustrated in table 2, the study is made up of eighteen participants. Participants are referred to as PN, which refers to professional nurse and the number allocation refer to each participant number, these range from 1 to 18. For example, PN1 refers to Professional Nurse 1. Four major themes emerged from the interview data collected from participants. Table 3 presents the four major themes as well as sub-themes discovered from the interview data set.

Table 4.3: A representation of the research objectives, questions and associated themes

Objectives	Research Question	Main Themes	Sub-themes
To understand nurses' perceptions and experiences on management support within an NHI pilot sites in the North West province	What are the perceptions and experiences of nurses, on management support within NHI pilot sites in North West?	Nurses opinions on management support	<ul style="list-style-type: none"> Experiences of Management Support
To understand nurses perceptions of change in the primary health care system and its influence on their role within NHI pilot sites in North West	What are nurses' perceptions of change in the primary health care system and its influence on their role within NHI pilot sites in North West?	Nurses perceptions and experiences of reforms happening in the Primary Health Care system and its influence on the role of a professional nurse	<ul style="list-style-type: none"> Nurses perceptions and experiences of change happening in primary health care and its influence on their role The new role of a nurse
To understand challenges associated with changes happening in primary health care within NHI pilot sites in North West	What challenges are associated with changes happening in primary health care within NHI pilot sites in North West?	Nurses perceptions of challenges associated with changes happening in health care	<ul style="list-style-type: none"> Lack of training and development Too many changes at once Other challenges hindering positive outcomes of changes in health care
To understand nurses opinions on what could be done to overcome challenges faced in NHI pilot sites in North West	What are nurses opinions on what could be done to overcome challenges faced in NHI pilot sites within North West?	Nurses suggestions on what could be done to overcome challenges that hinder expected positive outcomes associated with changes in the health care system	<ul style="list-style-type: none"> Improved Management Less role conflict and ambiguity Organisational factors

4.2 Theme 1: Nurses' opinions on management support

As mentioned in Chapter 2, management support is defined as the extent to which an employee perceives that their manager offers them support, encouragement and shows genuine care for

their well-being (Babin & Boles, 1996; Kurtessis et al., 2015). The authors suggest that a lack of management or supervisor support involves a failure to communicate with subordinates' new expectations and strategies of fulfilling those expectations, a lack of feedback, care and empathy towards employees amongst others. The following is an analysis of participants' perceptions and experiences of management support in PHC facilities that are also NHI pilot sites.

4.2.1 Experiences with management support

It is important to note that when asked about management and supervisor support, a few participants spoke about it being present at primary health care (PHC) facilities. They argued that there was not enough of management support. Only six out of eighteen nurses spoke about management and supervisor support being present at PHC facilities.

***PN1:** The support we receive from the manager... hmmm honestly ok, it's not that good but I can say that it is fair.*

***PN8:** Our supervisors support us, I don't want to lie... 100%... Hmm, that's why we are so motivated... if there is a new programme they put you there and work there until you are satisfied and understand what you are doing...when there is a problem you don't hesitate to ask and they are always there to assist.*

***PN11:** My one supervisor, really does tries... uhm she does come and say that, this is a really good job... but that's like the only form of support we get and like I said she always helps me when I go with a question.*

The excerpts above are an illustration of perceived facility manager support although this is not enough. Esienberger et al. (2002) define perceived supervisory support as perceptions held by employees regarding the degree that their supervisors care about their well-being as well as the value their supervisors place on their contributions. A more recent study, previously

mentioned in the literature review, by Nahum-Shani (2014) argues that since managers are mostly perceived as being agents of the organisation, they usually act as evaluators of employee performance and play a huge coaching role. This explains the reason why the favourable or unfavourable orientation of the supervisor towards the employee is indicative of organisational support (Esienbereger et al., 2002; Nahum- Shani et al., 2014). In other words, because supervisors are closest to top management and usually rely on their evaluations towards management, employees see them as top management representatives or as the liaison between them and top management. This is especially true in Primary Health Care facilities in South Africa as facility managers are the first line of management. In their role as management, facility managers play a great role of influence which means that employees see them as the organisation's representatives, hence they affect nurses' experiences in the work environment.

The excerpts above supported the postulation by Nahum-Shani et al. (2014), that supervisor support can act as a buffer against occupational stress and adversity as it suggests that employees are valued, cared for, belong to a network of communication and there is a mutual obligation between them and management. The excerpt from PN8 shows the participant's positive experience of management support that had led to her feeling motivated. This supports the statement made by Munc, Eschleman and Donnelley (2015) that argued that employees usually evaluate supervisor support based on the resources provided by the supervisor. According to Munc et al. (2015), these resources can either be tangible or intangible, for example emotional resources which are intangible can include empathy and sympathetic listening. Instrumental resources which are tangible can include time, money, investing in training or modifying the work environment so that it suits the needs of employees (Munc et al., 2015). Excerpts from PN8 and PN11 mainly focus on positive experiences of management support and are more related to the emotional resources that managers provide to their

subordinates. Participants argued that although these emotional resources provided by facility managers were present; however, it was not enough.

Participants (PN8 and PN11) support one of the theoretical frameworks adopted in this study being House's (1981) Social Support Theory which argues that social support can act as a buffer to occupational stress while at the same time increasing employee satisfaction, motivation and performance. The author argues that there are four types of social support, namely; emotional, appraisal, informational and instrumental support. Amongst the four types of support, the current findings reveal that there was appraisal support given to professional nurses by supervisors as mentioned by PN11 as well as informational support as mentioned by PN8. As mentioned by most of the participants, although there was a positive presence of management or supervisor support, this was not enough. Considering the Social Support Theory, professional nurses seem to be missing instrumental and emotional support as none of the participants referred to it in the context of PHC facilities. Even the other forms of social support that were mentioned by participants as being present, they too are not enough as most of the participants felt there was a lack of management and supervisor support.

Although a few participants had positive experiences of management support; however, it is important to note that majority of the participants expressed negative experiences and perceptions of management support. Participants mainly argued that facility managers did not have enough time or they were mostly out of the facilities for long periods which did not allow them the opportunity to play an active role as facility management. Out of eighteen participants, twelve expressed negative perceptions and experiences of management support.

PN2: Eish management, hmm the managers. They don't have time. Even when you have a problem or you are sitting down with her, she will just tell you this and this and then you must go...

PN3: My supervisor is always gone (not available at the facility)... she just comes in and tells us do this and this...

PN3 expressed that her manager is mostly absent from the facility. She only interacts with her facility manager only when she is providing instructions of what is expected to be done.

PN9: I would say yes or and no... sometimes we just feel she abandoned us because most of the time she's not around here.

The above suggests that most nurses do not receive adequate support from their facility managers. Most nurses expressed the concern that facility managers were often absent from the work sites and this may be attributed to the administrative demands of the job of a facility manager. These perceptions held by participants indicate that supervisors mainly play the role of giving instructions and making sure targets are met by professional nurses to satisfy the provincial health department management demands of them. These excerpts are aligned with the discoveries made by Atefi, Abdullah, Wong and Mazlom's (2014) South African study on nurses' perceptions of job satisfaction who found that nurses believed that their leaders had poor leadership skills. The authors argue that nurses reported that they felt facility managers were non-supportive and non-cooperative, did not acknowledge their staff's work problems or listen to their issues.

PN1: Sometimes she will be looking at what the management (district management) says then what we say...sometimes they largely consider what the management says or needs at the expense of what we say and then tell us not to worry about our comfort.

PN5: I can say that there is no support because even if we report what doesn't feel alright with us, even if we can report to them, they will simply e make excuses or tell us that they will come. However, we sometimes wait forever.

Both PN1 and PN5 commented on a lack of management support and that the reports or complaints they raise are not addressed. Participants claimed that that they are given endless justifications by facility managers regarding their concerns, hence, nothing is resolved. Participants highlighted that it was difficult to voice their concerns to facility managers. Similar sentiments were shared by the study participants below:

PN17: Ah, I don't feel like there is that support.

PN10: ... really, they are not supportive... they offer no support because they are concerned about numbers (productivity)... more concerned about the numbers, for us to reach the targets... than quality, they just want the numbers...the top sub- district is not doing well so they come down and they will put pressure on us.

These excerpts are aligned with the statement made by Nichols, Swaneberg and Bright (2016) about supervisors acting as the frontline management especially in health care facilities such as hospitals and clinics. These authors argue that as frontline management such as supervisors play an important role of ensuring top management goals are being accomplished and achieved by employees through the management of employee performance goals and rewards, they also play a role in maintaining work quality and providing support to employees. The participants mentioned most parts of the previous statements by Nichols et al. (2016) indicating that facility managers were more concerned with the demands of their own superiors compared to those of their subordinates. There was a lack of management support among participants. Mayosi et al. (2012) argue that facility managers should go beyond the implementation of mundane and

routine rules and instructions given to them by the provincial health department and instead use local information to guide and lead change in their facilities.

As previously mentioned, Naledi et al., (2011) argue that South Africa spends close to 9% of its GDP on health care, yet those investments are not mirrors in the country's outcomes of health amongst the county's population. The authors argue that this is because of the many challenges facing the current health care system in South Africa along with the changes happening in the health system and finances being utilised inappropriately (by it being directed to non-priority areas) by those in positions of power. This offers an explanation to posts being frozen and some being non-existent in some facilities, and facility managers being placed on short term contracts (six month) and in acting positions. As mentioned by PN17 below:

PN17: If you can check up in the management in (mentions district name), most of these posts is just acting, what, what... in our facility, they said they should just act for 6 months...

This puts the acting facility managers in awkward and difficult positions having to change facilities every six months and then having to develop a relationship with professional nurses along with other health professionals at the facilities as well as providing the support the nurses need. This offers a good explanation for the lack of management or supervisor support in PHC facilities.

According to Guchait, Cho and Meurus (2015), perceived management support is an antecedent of organisational support and this is because supervisors are seen by employees as a personification of the organisation. Thus, Guchait et al. (2015) suggested that increased perceived organisational support is influenced by employees' belief that their supervisor cares

about their well-being and value their contributions. This means that the more support an employee receives from her employee, the greater her perception of the organisation being supportive. The above excerpts present a general lack of supervisor support perceived by professional nurses, suggesting a general lack of management or organisational support in PHC facilities. This is a serious concern because lack of either management support or supervisor support leads to a lack of job satisfaction, a decrease in production, poor performance and an increase in organisational stress, role conflict and role ambiguity. Some participants indicate the challenges experienced due to lack of management support below:

***PN12:** It is only when something happens afterwards that they will come in and say, why did this happen or how best we should handle this issue.*

***PN15:** Even with the management from the (mentions sub-district name), the only time we see them is when they must discipline someone.*

The above excerpts mention that top management only comes down to facilities once something is wrong, that they only intervene in times of trouble. According to the participants, top management is more like a disciplinary figure, than one that provides support and appreciates or praises good work. Eisenberger et al. (2003) argue that organisational or management support is generally the employees' beliefs about management's concern for their well-being as well as the value placed on their contributions. Drawing from these excerpts, one can recognise the negative and punitive management support system in place at these facilities. Further challenges are highlighted by the participants below:

***PN6:** If you look at our clinic, it is the biggest and its' busy so the people that are working here are working under that stress but if the environment or situation makes you happy, you can overwork yourself.*

PN15: Yesterday I was telling her (facility manager) that “the way you are doing things, you are going to end up with a depressed staff because you are not giving us any support that we need from our manager”.

Both these participants further discussed the hardships they have endured because of a lack of management or supervisor support. The PN6 argues that nurses’ work is very stressful and that if the environment was positive, nurses would work over the required effort. These findings are in line with a study by Khamisa et al. (2015) who posited that nurses are exceptionally susceptible to burnout because of their stressful and emotionally demanding profession. PN15 argues that a lack of management or supervisor support is bound to have adverse effects such as depression and demotivation amongst staff.

The findings show that a lack of management support is bound to have adverse bearings such as occupational stress which results in role conflict and ambiguity, impaired performance, effectiveness, and productivity, increased absenteeism, high work accidents and high turnover rates. Furthermore, lack of management support can also lead to health problems such as depression and anxiety (Rizzo et al., 1970; Schmit et al., 2014; Van der Colff & Rothmann, 2009). Therefore, it is important that management, as well as supervisors, provide a supportive environment to all nurses in PHC facilities, because a lack of management support may limit the positive outcomes expected from the change in the PHC level.

4.3 Theme 2: Nurses’ perceptions and experiences of change happening in the Primary Health Care system and its influence on the role of the professional nurse

Health outcomes in South Africa do not mirror the investments spent in improving basic health services. Naledi et al. (2011) argue that as an attempt to strengthen the public health system,

the government has introduced various health reforms and interventions, pro-equity policies and regulations throughout the public health system, which are designed to deal with significant challenges. Khuzwayo and Tlhotse (2015) argue that health care delivery is highly labour intensive and that South Africa's health care system is mainly nurse based. Ross (2006) claimed that the quality, efficiency and the success of implemented initiatives are largely dependent on the availability, and morale of health professionals. It is therefore essential that health workers receive adequate training and support from management to deliver the required services at a high standard. Below is an analysis of participants' perceptions and experiences of reforms happening in the health care system and its effects on the role played by professional nurses at PHC facilities in NHI pilot sites.

4.3.1 Nurses' perceptions and experiences of change happening in the primary health care system and its influence on their role

It is important to note that when nurses were asked about their perceptions and experiences of change occurring in the PHC system, a few mentioned the positive outcomes that the change had brought about and even fewer mentioned their positive experiences of it in their facilities. Few participants mentioned both negative and positive perceptions and experiences of the changes happening in health care. Out of the eighteen participants, nine (half of the participants in the study) had positive perceptions and experiences of changes happening in PHC.

PN1: *They are good initiatives the way I see them, they help us do our job.*

PN6: *You know some changes have advantages...changes are good because we going to start to take it easy... changes are very good, really, they not a burden at all.*

PN8: *You get information and your knowledge becomes empowered and it makes it easier so you can manage each case that comes ... so I think those changes, it assists in knowledge empowerment.*

PN8 expressed a sense of empowerment associated with the changes happening in PHC and indicated that this makes their work as professional nurses easier. Similarly, the participant below expressed:

***PN18:** It has improved the way I have been doing my job. At least I can say that we are now having guidelines instead of wasting time calling the doctor or someone to give me advice.*

From the above excerpt, one can see that change has helped improve the way that participants do their work, that it has made their work much easier and has made them feel empowered. According to Kautzkey and Tollman (2008), the changes happening in the South African primary health care system are not only meant to benefit patients but they are also meant to make the health professionals work more efficiently. The changes empower them, lessens the workload and make the whole health care system more effective, which benefits the whole country's population.

***PN5:** At least the approach is OK because at least we are offered some workshops... Fortunately for me, I am a mentor, I mentor the clinic and I can say there is no problem with that.*

***PN9:** ICDM (Integrated Chronic Disease Management)... that one really works for us because they are trying to reduce the workload for us.*

***PN15:** For ICDM... since it has been introduced, patients now know... when they are supposed to come. They know on which date they are supposed to come to the clinic. But sometimes; like I said, the clerk is not there so we struggle to get patients' files.*

In the above statements discuss the benefits associated with the changes introduced in PHC facilities such as the introduction of ICDM. South Africa, like many other countries around the

globe is experiencing a shortage in nursing (Littlejohn, Campbell, Collins-McNeil, & Khayile, 2012), yet nurses are the backbone of most health care systems around the world. To overcome this challenge, nurses interviewed in the study proposed that facilities choose mentors, basically, someone within the facility that goes for training and comes back to teach the others what he or she was taught during the training.

The above is aligned to the cascade model training that is directed to train all professional nurses using appointed facility and regional trainers (master trainers), that will be sent for training and then directed to train their fellow nurses on how to implement various programs and initiatives (Mahomed, Asmall, & Freeman, 2014). The authors argue that this cascade training model has been brought about through ICDM that is part of the changes happening in health care because of NHI. In the above excerpt, the participant mentions the positive experience she had regarding the change as she has benefited from various training sessions as a mentor in the facility.

PN15: I think they (change interventions introduced) help a lot... for instance... you get a patient... you can just go to your PC 101 and then you will be checking the different symptoms your patient has...

PN17: PC101 is helping us do our job... because at least we can manage according to the guideline, it is easier that way... according to PC 101, it is there, everything is there, you just go to the symptom page and then you diagnose the patient.

The above excerpts mentioned the positive experiences that nurses had with specific change initiatives and programs implemented in PHC facilities. They argued that these programs have helped them in terms of providing guidelines in terms of how they can effectively do their work and has hence resulted in reduced workloads. Participants argued that these change initiatives

have not only been beneficial for them but have also been benefitted patients. For example, waiting periods have been reduced and patients are better managed.

Mahmmed et al. (2014) mentioned the following changes as part of the new services and systems that were introduced such as patient-centred health care, Primary Care 101 (PC 101), nurse-initiated management and antiviral treatment (NIMART) along with various other programs that have been introduced. The authors argued that these programs mainly aim to strengthen the health care service delivery system through the introduction of standardised medical records, infrastructure, and equipment. From the above excerpts, the programs introduced have had a positive outcome on nurses, who are the ones that implement and carry out the programs.

Although many nurses spoke about the positive benefits that changes initiatives had on their role, another half (nine out of the eighteen) of those participants spoke of their negative perceptions and experiences. Majority of the participants spoke about their negative perceptions and experiences of changes in primary health care. The participants stated the positive experiences they had with changes and then went on to mention the negative parts of their experiences with changes in PHC. Many felt as though the change programs or initiatives substantially increased their workload, that some of the programs introduced entailed tedious and sometimes confusing work. These sentiments are shared below:

PN9: The only thing that affected us in (mentions the name of the facility) is the new filing system ... that is really a lot of work... because we have to transfer old information into the new file and that takes considerable time and increases workload... we're going to miss most of the patients in terms of monitoring them.

PN11: All that stuff takes a long time and we really do not have enough of staff. So, we definitely are overworked.

Both PN9 and PN11 commented about some change interventions being time consuming and contributing to heavy workloads. PN11 further argued that the increased workload is due to facilities being short staffed:

PN14: It adds yoh! It increases the workload, these changes of policy and these guidelines. You will be knowing this policy and mastering it and then two months later they introduce another one wabona (you see?)...it is affecting the queuing, the waiting and the quality care of the patients...

PN17: I feel like those changes are piling up the workload on us and they don't bring any extra stuff so they just bring more work on the personnel... they put more pressure on us.

The above excerpts expressed the different negative perceptions and experiences of changes happening in PHC by professional nurses. From the above excerpts, one can decipher that majority of the participants felt as though the changes happening in PHC only added to their workload. The changes culminate into PHC nurses doing tedious tasks such as the one mentioned by PN9, that these changes resulted in nurses feeling overwhelmed and pressurised and therefore patients suffering from prolong waiting periods.

A study by Pillay (2009) that aimed to quantify professional nurses work satisfaction in public and private sectors discovered that professional nurses, especially those from the public sector, were generally dissatisfied. The author argues that these nurses were most dissatisfied with their pay, workload, available resources and career development opportunities. The current study highlights nurses' dissatisfaction with their workloads over the years because of the change interventions introduced in the health care system (Pillay, 2009). Van der Colff and

Rothmann (2014) argued that due to the high work demand, nurses are often overworked, work through their break times, work after hours or take work home.

***PN16:** But for me as far as all these changes have been introduced... they didn't bear uhm the results as expected...there is no change, it is exactly what we have been doing.... It is more work but there are challenges within it. They were looking at the fast way to do things but they didn't look at the challenges within that department... like now they introduced another thing they call Opti-Pharm which is in conjunction with (name of supplier)... the medication is not coming!... the program is failing right from the start!... you see and then you get the file back, see what the patient is getting, now you are going back... it is no longer a fast line... the logistic around it needs to be adjusted.*

Unlike the above negative experiences and perceptions of change expressed by participants, PN16 believed that there was no change in PHC, that the introduced programs were basically repackaging already invented programs. In addition, the participant believed that the programs that were introduced were not planned properly nor did they account for the possible challenges and limitations for their success. This is an interesting view which is contradictory to the above-mentioned views by participants that all spoke about the presence of changes happening in health care either having a positive or negative influence on their roles as professional nurses.

***PN2:** We're doing a lot of things, every time there is change introduced, there is an increase in the workload.*

***PN9:** Too many changes at the same time... only when we are adjusting to it and correcting our mistakes again it is this new filing system.*

As part of their negative experiences, participants argued that the change programs or initiatives were being implemented at a fast pace which makes it difficult for them to cope and keep up. As part of planned change activities, Waddell, Cummings and Worely (2011) suggested that the change management agent should motivate employees for the change, which involves creating a readiness for change and overcoming resistance to change. Peters (2017)

also highlights this critical role by facility managers as change agents and posits that it is vital that this is done in a manner encourages employee buy-in.

The above excerpts suggest that when change programs were introduced, management or the change agents did not do an adequate job planning and motivating for change nor did they create a readiness for change amongst professional nurses. This is also aligned with the results discovered by a study by Bowling, Alarcon, Bragg and Hartman (2015) based on health professional's perceptions on hypertension and diabetes guidelines. Bowling et al. (2015) discovered that health professionals felt that the many change interventions implemented within the South African health facilities compromised the standards of quality care provided to patients.

***PN1:** I just think that sometimes they need to come back to us as the implementers to get the proper way to do it... the books they sent are not properly done. I think if they had involved the implementers in the development of such books they would have been properly done.*

PN1 expressed concern over the lack of involvement of professional nurses in the development or planning of change interventions implemented in PHC facilities. The participants made an example of the inadequacy of the new filing system and that she believed that the filing system could have been done better with the involvement of nurses in its development. The narratives below supported the above analysis:

***PN10:** But if they have an idea and they want to implement it, they should first come to the people that are on the ground to check if they can implement it... it ends up not working for us because they just come in and drop it. Just like it has been decided in the office and then they come and impose it on us.*

***PN14:** I think they should consult with us or just make a pilot study to check if this is working or will it work, will they manage.*

The above excerpts argue that professional nurses are not included in the decision-making process before changes are introduced in health care facilities. Six of the eighteen participants argued that change programs were introduced without nurses being involved nor consulted during the decision-making or development process, that they were only involved in the implementation stage where managers instructed them to start working on a certain program. Some of the participants believed that this had led to some of the programs or interventions not working as intended. This is in line with the information flow process that was mentioned by Peters (2017), that within the South African PHC system this process starts from the National Department of Health to provinces which then communicate to districts and various sub-districts. From a sub-district level it trickles down to facility managers who are then the one's responsible for informing staff (Peters, 2017). This is also typically how policies will be introduced.

According to Walker and Gilson (2004), the way in which policies and changes are introduced or implemented has an impact on their success. This can either be a top-down approach or a bottom-up approach. The above excerpts represent a more top-down approach, as participants argued that nurses are not included in decision making or developing process, rather management instructs them to implement various changes without them being consulted. This also applies to the process reported by Peters (2017) in terms of how important information and policies are introduced and communicated from the top management level to employees. Walker and Gilson (2004) argue that in the case of health care, bottom-up approaches work best when introducing new programs, however, this is not done in the current South African primary health care system. Many studies have also indicated the lack of consultation of nursing staff in the planning and implementation of new health guidelines and policies

(Bowling et al., 2015; Walker & Gilson, 2004). The findings of this study confirm and add to these discourses.

There are contradictory perceptions and experiences of how changes happen in PHC settings and its influence on the role of the professional nurse can be attributed to the fact that participants came from different facilities and fell under different sub-districts. Although all the participants were from one district, how information is communicated and how policies are implemented from a sub-district, facility manager to employee level might be different. Hence, the interest and urge to understand the new role of a nurse keeping in mind these contradictory findings.

4.3.2 The new role of the nurse

As part of understanding nurses' perceptions and experiences of changes happening in the primary health care system, we also asked nurses for their understandings of their job and if their job description reflects their daily duties at work. We first asked participants if they believed they had a clear job description and thirteen out of the eighteen participants of the participants believed that this was true. They further elaborated, the job description described what they did in the health facilities although it did not cover everything they were doing in the facilities. The participant's narratives are shared below:

PN7: *Yes, I have a clear job description... it clearly states what I do.*

PN10: *As for the stipulation of the job description, yes, I agree... job description and stipulation I think they are correct and relevant.*

PN14: *My job description is clear and it is what I do as a professional nurse.*

All of the narratives above stated positive reviews of nurses job descriptions as provided by the district. According to Tunc and Kutanis (2009), having a clear job description helps employees understand their responsibilities, what is expected from them, know the different stakeholders they are answerable to, and understand their goals and limitations. The above excerpts represent participants affirming that they had clear job descriptions, indicating a clear link between what is stipulated in their job description and what happens in practice.

However, it is important to note that although many of the participants felt as though they had a clear job description, twelve out of eighteen participants also mentioned that they were doing more than what was stated in the document. These participants mainly attributed these differences were due to the shortage of health professionals in facilities, as well as an increase in their workloads.

***PN4:** We do more because the workload increases every now and then. Therefore, they need to go back and review our job description*

***PN9:** We go the extra mile especially here in (mentions the name of the facility), essentially we are short staffed ... sometimes you will be running the maternity ward alone... then baby clinic, if there is an emergency you also need to attending those things. So to me huh ah... we are working too much...*

***PN11:** Yes, I think that it is clear in terms of what we are supposed to do. Sometimes the things they do change, like maybe now we must enrol more patients, maybe there is less time to do more Pep smears but they so let us know if maybe we are underperforming. So yeah, I do think it's clear what we should do.*

***PN13:** Because of staff shortages, we must go an extra mile. For example, we currently don't have an assistant pharmacist so now I must go there and assist. We don't have a cleaner so we must wipe and our councillors should stand in front and help with the files.*

PN17: For me, there are many things I do but not within my scope of practice... basically actually our job description is so limited, it doesn't explain or expand on other things... sometimes I help at the male circumcision section of which they don't even apply in my scope of practice.

The above excerpts argue that because of the shortages of health professionals as well as an increase in work demands, professional nurses do more than what is required for them as per job description. Nurses play various extra roles for example as stated by PN 9, sometimes professional nurses are expected to manage various programs and services offered in facilities and sometimes should handle programs which are outside their scope of practice as mentioned by PN13. In addition, when there is no one to handle various tasks such as administration and cleaning, they also make up for those gaps even though this is not part of their job description. According to Littlejohn et al. (2012), there has been a global shortage in the nursing profession and in the case of South Africa, it is bound to have a negative impact on the quality of care delivered to patients as well as the well-being of nurses that ultimately bear the increased workloads due to staff shortages. This is what is currently being experienced by professional nurses in PHC facilities.

The way in which an individual accepts and performs their role in the workplace is outlined by the Organisational Role Theory (Rizzo et al., 1970). Rizzo et al. (1970) argue that Organisational Role Theory defines role conflict as expected behaviours which are inconsistent, has and have a negative outcome on performance and employee well-being. Floyed and Lane (2000) reported that role conflict is inevitable and a by-product of changes happening in any workplace or work environment. Therefore, Floyed and Lane (2000) argue that it is important that organisations come up with innovative ways to decrease these effects such as hiring more staff to do the different roles that one employee may occupy.

Rizzo et al. (1970) conceptualised role overload as a type of role conflict and argued that it occurs in a situation where expectations, demands, instructions regarding the role, exceed the amount of time, resources and energy available to that individual (role occupant) for their effective execution. The above excerpts represent the role conflict experienced by professional nurses in PHC facilities because of the changes that have brought about through the introduction of NHI and various other programs. This has resulted in an increase in workload as well as a shortage of health professionals in health facilities forcing nurses to play active roles that are not stipulated in their job descriptions. This is also aligned to the findings by Atefi et al. (2014) in their study on South African registered nurses. The authors argue that nurses perceived their responsibilities as unclear and that they carried out extra responsibilities which was not stipulated on their job descriptions such as those carried out by auxiliary nurses and security responsibilities.

The above excerpts also highlight the new role played by nurses which is broader than what is mainly stipulated by their job description, as PN4 suggested that this needs to be expanded upon. According to Atefi et al. (2014) the role of a nurse has transformed from mainly being an assistant to a doctor to a more proactive role, as nurses are now in the frontline and one of the first health professionals in PHC facilities that a patient comes into contact with. Nurses are also the ones that manage and help implement new health intervention programs and manage or run departments in facilities such as the maternity ward, male circumcision section, baby clinic amongst many others. As mentioned by the participants these roles are usually not stipulated in the job description, nor does it take into consideration the shortage of staff amongst other challenges that force nurses to take more responsibility in facilities.

4.4 Theme 3: To understand challenges associated with changes happening in primary health care within NHI pilot sites in North West

According to Naledi et al. (2011), changes in the health care system has been gradual and health care workers (especially nurses and doctors) in the field are still not adequately prepared for implementing and carrying out a re-engineered PHC system within the current health care system. Dookie and Singh (2012) argue that some of the major challenges facing primary health care include inadequate political, financial, human and material commitments, misuse of available resources, inadequate changing management techniques including decentralisation and ensuring effective community participation and intersectional collaboration. Another challenge mentioned by Blenchor et al. (2011) is the issue of health worker shortages and management being unable to retain health workers. There are many challenges that have been captured by scholars associated with the changes happening in health care which has been mentioned in Chapter 2, these buffers the outcomes expected from the implemented change interventions and initiatives. The following is an analysis of the challenges participants perceived to be associated with changes in health care.

4.4.1 A lack of training and development

Twelve out eighteen of the participants felt that professional nurses lacked adequate training to function effectively within the changing health care system. These views are expressed below:

PN3: I think we still need more training.... because we want to know more about what they want us to do and what they want from us.

PN7: I don't think we have adequate training... at times things are being introduced... we are not stubborn to change ne. We will be starting to do the change and then we will be doing mistakes in between you see so... ey, you learn as you go.

PN7 commented on having inadequate training and that changes were implemented too frequently making it hard for nurses to keep up. Therefore, mistakes are easily made which compromises on the quality of services provided to patients.

***PN14:** Trainings are not enough... trainings for maybe three days and then they expect us to do this thing thoroughly and perfectly... training should be lengthy... it should be step by step, not just three days with a whole bunch of forms to complete... the time at which they give the training is not enough for the workload on that thing, it is a lot, not enough training for that thing.*

Participants argued that professional nurses did not have adequate training to function effectively with all the changes happening in the PHC system. They argued that because of the constant changes, sometimes trainings were not done properly, that trainings were not long enough nor did they cover everything part of the change initiative or program. Participants argued that this made professional nurses susceptible to making mistakes in their work and them having limited knowledge and capability to deliver quality care to patients. That having adequate training would motivate and empower them to function effectively in PHC facilities. As part of the findings in a study by Atefi et al. (2014) on nurses, it was discovered that nurses felt the need for more training, as well updating their clinical knowledge through attending workshops and seminars. The authors argued that nurses were of the view that they were not given any support nor any training opportunities due to their heavy work schedules (Atefi et al., 2014). These findings are aligned with the above excerpts which indicate professional nurses' needs for more training. The participants below stated their views on training needs:

***PN1:** When there is a training, most of the time they tell you about shortage, then they will expect you to do the job how?*

***PN9:** Yes like (mentions professional nurse's name) for PC 101 he is trained but he does not give feedback.*

PN17: Because maybe they will take only one person from the facility to go to the training and she comes back she is supposed to train and mentor us but then those things don't really count... because now she is pregnant so she will be going on maternity leave... So you see we have a gap... they told themselves let us make each facility to have a trainer, but is the trainer doing the job, is the trainer doing justice to the other personnel... this is not being monitored.

These participants argued that because of a shortage in staff, professional nurses are not sent for training such that one professional nurse is sent for training (an appointed facility mentor) and is to come back and teach the others. The above excerpts mention the challenges with this way of doing things (allocating certain individuals for training sessions). They argued that factors such as people leaving the clinics, pregnancy, maternity and other types of leave are not considered. Furthermore, they mentioned that the cascade based training system is not monitored which results in some of the facility mentors not passing on their knowledge to others after being sent for training to represent the facility.

Mohamed et al. (2015) argue that as part of the change initiatives and programs brought about by the NHI policy was the cascade training model. This mentor type of training approach has been frowned upon by the participants of this study. As mentioned previously, lack of training also brings about feelings of uncertainty in performing one's role. The same could be said in the case of these participants as they mentioned that because of a lack of training, their ability to perform their role effectively is limited. This displays the presence of role ambiguity experienced by professional nurses mainly due to inadequate training and development for health professionals.

4.4.2 Too many changes at once.

Six out of eighteen participants argued that changes were implemented at a continuous fast pace and this made it difficult for them to cope and function effectively within the changing health care system. These views are shared below:

***PN6:** The nurses yes; they have training but unfortunately some of the things that are being built up for nurses don't add value... last week there were people from the state (NDoH) and they came with new files... next day the very same filing system and forms start. As professional nurses, we are not provided with any form of orientation regarding the forms, in fact we don't know anything about these forms! ... So now we must learn to complete those forms ... we are just fumbling. This puts a lot of pressure on us, it's really hectic. .*

PN6 argues that professional nurses do not receive adequate training for some of the programs introduced at PHC level. Instead, their workload and the pressure on them increases. The participant then makes an example of the new filing system which was introduced during the time when data for this study was collected, which nurses were expected to use without being adequately trained on it. The below participants further elaborate on this issue.

***PN11:** Every month there is something new. Things are changing in the system... things are changing every now and then.*

***PN14:** While you are still struggling to cope with that thing, there is another one... you jump, you leave this one and then go to the next one.*

These excerpts indicate the fast pace of change initiatives or programs that are introduced in facilities which professional nurses find difficult to manage. Participants argued that because of this fast pace, not enough training is done, that nurses are expected to find their own way to implement the change which results in mistakes and increased work pressure. Awases, Bezuidenhout and Ross (2006) claimed that the quality, efficiency and the success of implemented initiatives are largely dependent on the availability, performance and morale of

health professionals. The negative perceptions of pressure and being unable to cope with the changes due to a lack of training is greatly problematic and require strategies to improve how training is implemented to nurses. Key to the above success will be the involvement of nurses in identifying factors that would be conducive for nurse training. As previously stated by Waddell et al. (2011), it is important that change agents include employees during the planning and implementation of change thereby creating a vision for change amongst employees so that they feel they feel at ease and can manage the change. The above excerpts indicate professional nurses having negative perceptions about being able to effectively function within the changing health care system. The fast pace in which change initiatives are introduced in facilities add to the previously mentioned new role of the professional nurse, as they are now expected to manage new tasks without being adequately being trained on them. This increases role ambiguity and brings about role conflict amongst professional nurses.

As part of the findings by Daniels et al. (2000), it was discovered that health professionals had negative feels regarding the lack of consultation, that guidelines and policies were introduced without formal educational sessions. These findings are aligned to the above-mentioned excerpts as professional nurses felt that because of a lack of consultation, some of the programs did not work effectively. This is because different facilities have different challenges that should be taken into consideration when planning and implementing change programs.

4.4.3 Other challenges hindering positive outcomes of changes happening in health care

Seven out of eighteen participants mentioned a shortage of staff as part of the challenges that may further hinder positive outcomes of changes happening in the health care system. These narratives are supported by the participants as seen below.

PN3: We want them to increase the number of professional nurses in the facilities. Because now we are few, patients are more and sometimes we feel we are neglecting patients but there is nothing we can do.

PN4: Patients are frustrated, they even swear at us because we are short staffed but the government is introducing these many programs that must be implemented as from the first day of this month. And who should do that? The nurses but with which staff... there is no money, posts are being freezed (frozen) but you need to implement whatever that needs to be implemented.

PN3 and PN4 both mentioned the impact of the shortage of staff on patient care. PN4 further expressed frustration not only from her side as the professional on site however as well as from a client perspective. That clients even “swear” at them out of anger or dissatisfaction with the service. The participant further argued that government and various stakeholders that introduce change interventions were not considering the fact that facilities were short staffed, which limited the success of the newly implemented change intervention or program. Thus, both participants reported that although some of the changes that were introduced were advantageous, not only for them but as well for patients, the shortage of staff hindered the positive outcomes expected from those changes. There were not enough professional nurses to meet the requirements of those change initiatives. Participants argued that nurses were not hired due to financial constraints and that the shortage of staff resulted in dissatisfied and frustrated patients as well as nurses. Munyewende, Rispel and Chirwa (2014) argue that South Africa like many other countries face a challenge of a shortage of health care professionals that is characterised inadequate production, along with adequate recruitment, retention as well as staff management. This is aligned with the findings of this study as participants suggested that there were not enough professional nurses in facilities which may hinder outcomes of health care change programs.

PN6: I don't know how they are going to implement the changes within the structure itself... like Ideal clinic it is very good but the place here that is trying to introduce Ideal clinic is not “ideal” ... we experience shortage, the working environment is not

good and spaces for patients are limited... There is shortage of staff, space and resources.... We hardly have a doctor in the maternity section, and during the weekend, he is not here, nor do we have ambulances... changes are good but the resources are not 100%... most of us working here feel burnout, we are just hanging on.

The above excerpt argues that PHC facilities were not adequately resourced to yield the expected positive outcomes of changes happening in health care provision. The participant highlighted that, facilities lacked both human (inadequate supply of health professionals) and physical resources (lack of equipment and physical resources). PN6 talks about IDEAL clinic which falls under one of the strategies to lay the foundation for the implementation of the NHI. According to Fryatt, and Hunter (2014), this initiative seeks to address the current deficiencies in the quality of PHC services. As part of the findings in the study by Khuzwayo and Tlhotse (2015), it was discovered that nurses believed that there was an inadequate supply of health professionals, supplies and medical equipment in health care facilities. These results are aligned with the above-mentioned excerpt as PN6 mentioned that the lack of staff and resources was bound to buffer expected change outcomes.

4.5 Theme 4: Nurses' suggestions on what could be done to overcome challenges that hinder the expected positive outcomes associated with change in the health care system

The above findings were mainly focused on participants' perceptions of challenges facing the changes happening in health care, researchers then went on to ask them about the ways in which these challenges may be overcome. Dookie and Singh (2012) make the following recommendations: for this relatively new PHC system to work, strong leadership is required, along with management support, as well as efforts directed towards strengthening of the current district health system and a greater emphasis on health promotion, and disease prevention.

4.5.1 Improved management

Participants were asked about their opinions on what could be done to overcome the challenges that hinder nurses' performance as well as other positive outcomes associated with a change in PHC. Twelve out of eighteen participants suggested a need for more management support especially in facilities from their facility managers. Narratives pertaining to this are indicated below:

PN2: *They must have more time with us, us and be available to us and be able to explain everything and be more supportive.*

PN3: *They must give us feedback and help us come up with inputs (ideas) on how to fix our problems and our incompetence.*

PN7: *They should also give us the support always. I think it will be better that way.*

PN16: *Because of the many problems in nursing... we need a very strong support structure*

The above excerpts indicate a need for more management support especially from facility managers, that as supervisors, they should give nurses more feedback especially regarding performance. This is aligned with the statement by Nahum- Shani et al. (2014) who argues that supervisors are usually perceived by employees as the agents of the broader organisation. Meaning if an employee perceives his supervisor as supportive and caring for his well-being, he would also perceive the organisation to also be supportive and caring for his well-being. As previously mentioned, scholars have indicated that supportive supervision positively affects health workers in PHC facilities as well as increase their motivation. (Delobelle et al., 2011). The authors argue that although management support has been indicated to have positive

effects on health care workers in PHC facilities, it still seems to be one of the weakest aspects of human resources management. The above excerpts confirm this finding as most of the participants argued for a need for more supervisor and management support in PHC facilities.

The below participants further highlight the need for health managers to actively engage with health professionals at PHC level for the purpose of interesting support to facility managers and maintain continuous communication between district managers, facility managers and professional nurses. These views are expressed below

***PN14:** The management, not the supervisor because the supervisor will be feeling the same way we are because they demand too much from him or her... mara (but) top management should come down to us at least and check... the Human Resources must come... to the clinic and find out what they can help us with.*

***PN15:** Our district manager in the facility...may occasionally come down for support.*

***PN17:** I think support and communication would be the best, I mean if management can come down and maybe look at the work that we do to understand how many patients that we do.*

Participants argued for more involvement from top management, that they should also provide support and communicate more with professional nurses in facilities. According to Guchait et al. (2015), there is a balance in the exchange between employees and organisation which is based on employees' attitudes and behaviours towards the support given to them by employers. Kurtessis et al. (2015) argue that if this support is perceived as favourable, employees feel more obliged to help the organisation achieve goals and objectives, there are greater identification and commitment to the organisation as well as greater psychological well-being.

The above excerpts present an unfavourable balance in the exchange between employees and the organisation, as participants believed that management did not come down to facilities unless to discipline workers and that there was a lack of communication and support on their part. The perceptions held by PN14 regarding supervisors in health facilities are aligned with the statement by Nichols et al. (2016). According to Nichols et al. (2016), although frontline supervisors in health facilities have a major impact on workplace performance and outcomes, they are rarely included in the decision-making process, nor do they receive enough training to provide support to health professionals.

4.5.2 Less role conflict and role ambiguity

Many participants argued that with the challenges as well as changes happening in health care, the role of a professional nurse had also changed. They argued that professional nurses were doing more than what was stipulated in their job description and therefore argued that their job description should take into consideration the various factors in the PHC environment.

PN14: They need to change our job description so that it covers everything, they need to go back to review our job description.

PN17: Basically, our job description is so limited because it doesn't explain or expand on other things.

The above excerpts posit that the job description of professionals needs to be expanded upon to include the new front-line, proactive role they currently play in PHC facilities, thereby decreasing role conflict and role ambiguity. According to Schmidt et al. (2014), an unclear job description, including a lack of information in a specific job position leads to individuals being uncertain about a role and experiencing role ambiguity. Schmidt et al. (2014) argue that clearly defined roles and objectives are one of the contributing factors to employee health and can help

the organisation prevent costs arising because of absenteeism. The above excerpts argue the need of a clearer job description, stipulating the roles played by professional nurses in the current health care system.

4.5.3 Organisational Factors

Participants mentioned many organisational factors that should be taken into consideration in terms of improving their experience and overcoming challenges in PHC. These organisational factors include an increase in the number of staff, more training and an increased spirit of teamwork within PHC facilities. As previously mentioned, a lack of staff was mentioned as one of the major challenges in PHC facilities. Participants suggested that more health professionals are hired in facilities. This is captured by the participants below:

***PN9:** First, especially for our clinic, they must first hire more professional nurses.*

***PN15:** If we can get more staff because sometimes they that say we didn't perform because we didn't do some of the things due to a lack of staff. Sometimes you find yourself, another one or two professional nurse and one ENA. So, you cannot do everything you are supposed to do.*

***PN16:** Hiring more staff, hire enough staff. I won't perform because I am running (managing) two or many departments.*

The above excerpts indicate a lack of adequate staffing to attain the desired change outcomes in primary health care facilities. Participants argued that due to a shortage of staff, professional nurses play various roles in facilities and manage many programs at once. According to Coovadia et al. (2009), there are many challenges faced by African health care such as a

shortage of health professionals, increased caseloads, the quadruple burden of disease and the HIV/AIDS epidemic that affect both the general and professional health workers.

Daviaud and Chopra (2008) discovered that a shortage of staff leads to problems in both quality and efficiency, especially when higher categories of staff are expected to perform duties of a lower category of staff. This is aligned with the above-mentioned excerpts as professional nurses are then expected to perform the work of lower category staff as well as play multiple roles. According to Beena and Poduval (1999), occupying multiple roles which are also contradictory results in role conflict, which may lead to role overload. The above excerpts represent the presence of role conflict experienced by participants as they occupy multiple roles which may at times be contradictory to what is expected from them as professional nurses. As part of the suggestions made by participants, more training would be beneficial as a lack thereof at times hinders their performance. These aspects was also mentioned by the participants below:

PN4: If there are new services being introduced, they should conduct in-service so that everyone can be on board... now we are using these books but no one came into in-service (train) us about this... you must figure it out yourself... ..it's like we have been saying why don't they come down or get those people who can write the PMDS perfect, conduct an in- service to all the personal.

PN7: I think if they give us the in- service trainings in all spheres it will benefit us.

Participants argued for more training in terms of all the change initiatives and programs that were being introduced, that nurses were expected to manage as part of the new role of a professional nurse. Munjanja, Kibuka and Dovlo (2005) suggested the following as part of scaling up health interventions: restructuring and enhancing investments on human resources as well as enhancing and expanding the skills of health professionals in health care facilities.

This is aligned with the above-mentioned excerpts as participants also argued for a need for more training opportunities to enhance and expand the skills of professional nurses.

Another organisational factor that participants recommended to overcome challenges in facilities was teamwork. In that regard, a culture of teamwork needs to be fostered in facilities to achieve desired health outcomes.

PN3: I think if we can work as a team... work hand in hand, helping each other. If someone doesn't understand something we show the person without judging him/her.

PN11: Working together... there should be a system where you get punished if you don't do the work because it would be so much easier if everyone that comes to work does the work... if all of us have the same goal we will be performing because you won't be performing as an individual. Even the clinic will also be doing well.

The above excerpts argue for more teamwork, support amongst health professionals as colleagues, with everyone doing their part to achieve the desired goals in health care. According to Delobelle et al. (2011), PHC nurses often work in isolated team units especially in rural areas, whereas a team structure and group cohesion plays an important role in improving the motivation and retention of health workers. Teamwork was found to be an antecedent of job satisfaction in a study by Atefi et al. (2014) that reported nurses being satisfied with their relationships with co-workers. However, the above excerpts argue for more teamwork in facilities suggesting a lack thereof.

4.6 Chapter summary

The participants were appreciatively reflective regarding their experiences and perceptions of management support in PHC facilities that are also part of NHI pilot sites. It is important to note that unlike other PHC facilities, the participants interviewed as part of this study have been through additional changes that have been brought along with piloting NHI. This chapter revealed the findings discovered as part of this study. It is important to note that the demographical characteristics of participants in the study did not influence participants' experiences and perceptions of management support, role conflict and role ambiguity in PHC facilities. In relation to participants' perceptions and experiences of changes happening in health care, the findings were widely mixed. Participants felt that changes were necessary and beneficial to professional nurses as well patients, however, the same changes brought a substantial increase in their workloads, pressure as well as uncertainty in the role played by professional nurses.

Participants also spoke about the new role of a professional nurse that were brought about by the changes in the approach to primary health care. This was widely explored when participants were asked about their perception of their job description being clear and related to what they do in practice and the challenges faced in facilities. In relation to challenges associated with changes happening in health care facilities, participants mentioned the biggest challenges to be the lack of management support and the fast pace of changes introduced in health care facilities. Participants then went on to make suggestions on what could be done to overcome challenges associated with the changes happening in the health care system. The following was mentioned as part of participant suggestions: more management support, a more precise and inclusive job description covering all the roles professional nurses play, more training and that more health professionals should be hired among others.

The next chapter presents recommendations and limitations of the study which should be taken into consideration by the NDoH in preparation of implementing NHI nationwide and subsequent research based on Primary Health Care.

CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 Introduction

This chapter provides an overview of the main findings in the study. It explores nurses' opinions and perceptions of management support as well as their perception of change in the PHC system and its influence on their roles within NHI pilot sites. Furthermore nurses' opinions on what are the challenges in PHC within NHI pilot sites and how these challenges can be defeated is explored in the chapter. In addition the contribution of the study, limitations and possible recommendations are explored in the chapter. Finally the chapter and the chapter summary is outlined at the end.

5.2. Summary of the main findings

The main aim of the study was to understand the management support, role conflict and role ambiguity perceived and experienced by professional nurses within the context of NHI and re-engineered PHC. Drawing from the Social Support Theory and Organisational Role Theory, this study had four broad research questions:

What are the perceptions and experiences are of nurses on management support within the context of NHI pilot sites in the North West province? What are nurses' perceptions of change in primary health care and its influence on their role? What are the challenges associated with changes happening in PHC, and finally; nurses' opinions regarding what could be done to overcome challenges faced by them in NHI pilot sites in the North West province? For the purposes of this study, the interpretive phenomenological approach was selected as the most suitable method for analysing the collected data. As it aims to capture the lived experiences of

participants while understanding the interpretive role of the researcher in making sense of how the individual “makes sense of lived experiences” (Millward, 2006, p.574).

5.2.1 To understand nurses’ opinions and perceptions of management support within a NHI pilot site in the North West province

In unpacking this objective, Social Support Theory was kept in mind as the theoretical framework which argues that social support can be divided into two categories: namely formal support (relating to the support one receives from within the organisation) and informal support (relating to the support one receives from outside the organisation including family and friends) (Amarneh, 2017). This study focused on formal support and participants mainly perceived and experienced a lack of management support in PHC, which was part of one of the major findings of this study. As part of the findings, participants indicated that facility managers did not spend enough time in facilities for them to provide adequate support, nor do they listen to staff concerns as they were preoccupied with the concerns of top management.

According to Nichols et al. (2015), frontline supervisors play an important role in health care facilities, being the liaison between employees and top management. In terms of these findings, facility managers as frontline supervisors seem to be mainly preoccupied with top management concerns and disregarding or rather belittling health professionals’ concerns. The findings suggest that the only support professional nurses receive from top management is one of a disciplinary nature. Considering the changes happening in the health care system, this lack of management support may also bring about role conflict and role ambiguity amongst professional nurses.

5.2.2 To understand nurses' perceptions of change in the PHC system and its influence on their roles within NHI pilot sites in North West

In terms of participants' perceptions and experiences of changes happening in the current health care system, findings represent positive perceptions on the benefits of changes happening in health care not only for patients but also for health personnel. Participants went on to share their negative experiences on changes that have been implemented in facilities, that these changes, in fact, increased their workloads. Participants also argued that changes were implemented too frequently and at times with inadequate training and that there was a lack of consultation before changes were introduced. These contradictory findings could be attributed to the fact that participants came from different sub-districts and changes might have been implemented differently amongst those sub-districts.

In understanding the new role of a professional nurse, the findings further revealed a presence of role ambiguity and role conflict when participants were asked about the role they played in facilities in relation to the job description of a professional nurse. According to Rizzo et al. (1970), the Organisational Role Theory defines role ambiguity as a lack of necessary information available to complete a given task, and role conflict is defined as expected behaviours which are inconsistent and can have a negative outcome on performance. As another major finding of this study was that although majority of the participants believed that they had a clear job description, in practice, they were doing a lot more than what was stipulated on their job description.

Participants argued that they played various roles mainly due the lack of adequate staffing in facilities and managed multiple programs at the same time which may be contradictory and out of their scope of practice. Findings also revealed that the job description of professional nurses

had limitations as it did not cover all the roles that they played. Drawing from these findings, the study calls for a newly defined role of a professional nurse that takes into consideration the proactive and front-line role nurses currently play in facilities. In addition, the patient-centred role that professional nurses currently play also needs to consider the challenges such as a lack of training and staffing.

5.2.3 To understand challenges associated with changes happening in PHC within NHI pilot sites in the North West province

In relation to challenges associated with changes happening in health care, findings reveal that majority of participants argued that professional nurses did not have adequate training to function effectively within the changing health care system. Participants also expressed difficulties having to cope with the fast pace of change programs being implemented in PHC facilities along with a lack of consultation before these changes are introduced. As part of other challenges associated with changes, findings reveal a shortage of staff along with facilities being inadequately equipped to carry out changes. These challenges should also be taken into consideration in defining the new role of professional nurses in PHC facilities.

5.2.4 To understand nurses' opinions on what could be done to overcome challenges faced in NHI pilot sites in North West

In terms of participants' perceptions on the ways in which challenges associated with changes can be overcome, the findings revealed that there needs to be more management support, that their job description needs to be expanded and be aligned with what professional nurses actually do in facilities as well as the challenges they face which force them to go over and beyond their stipulated job description. Findings also revealed a need for more training opportunities as well as a work atmosphere that fosters teamwork among health professionals.

5.3 Contribution of the study

This study contributed to the body of knowledge on research in management support, role conflict and role ambiguity within the PHC context in South Africa. The findings of the study also contribute towards research done on the NHI in the PHC facilities. Furthermore the study also contributed to the knowledge under the banner of positive psychology and nursing. The findings indicate a need for management support to help nurses cope better with the demands or challenges currently faced in NHI pilot sites. It is important that facility managers receive adequate leadership, coaching and mentoring training as a means to improve nurses' perceptions and experiences of management support.

5.4. Limitations and recommendations for future research

The limitations to the present study are expressed below:

5.4.1 Use of secondary data

This study was based on secondary data, where the primary researcher mainly focused on the perception of PMDS amongst professional nurses and its influence on job performance and quality improvement. Although it was apparent that there was a strong need for management support amongst professional nurses, it would be beneficial to conduct another study to understand nurses' perception of management support once NHI has been officially launched throughout South Africa.

5.4.2 Sample

Another limitation was the sample. All participants were professional nurses in NHI pilot sites in the North West province in a PHC setting. This was due to the purposive sampling approach adopted by the researcher and that unlike other types of nurses, majority of the change

interventions are designed to be carried out and implemented by professional nurses. However, it is recommended that future research includes other health professionals that are key to PHC based teams such as doctors and community health workers. Thus, it would be interesting to apply this similar study on different categories.

In addition, this study is limited to a NHI pilot based in the North West province, and may only be generalised to similar settings from other provinces. It is recommended that future researchers consider exploring this study from a different province so to enquire if the same may be true in another NHI pilots

5.5 Recommendation for future research

In light of the fact that this study was based on secondary data it is recommended that future research use primary data focused on understanding nurses perceptions of management support in facilities and their role in light of the changes happening in health care. It is further recommended that future research incorporate the different types of nurses such as auxiliary nurses and staff nurses etc. in order to understand the different perspectives of those of the various nursing categories. It would also be interesting to understand. Furthermore, in agreement with Petrus (2017) it is also recommended that future studies examine a team- based approach to health care and understand all PHC staff members' experiences of team work within facilities.

5.6 Chapter Summary

This chapter summarised the main findings of this study in relation to the objectives. The contribution which this study makes to the different bodies of knowledge was outlines in this chapter. Furthermore the chapter outlines the limitations that were experienced in the study.

This chapter ends with recommendations for future research within the area of positive psychology and nursing.

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APPENDICES

Appendix 1: Informed Consent

CONSENT FORM

I..... (Full name of the participant) have been informed about the study entitled: The Public Service Performance Management and Development System and its influence on Job Performance and Quality Improvement in re-engineered Primary Health Care (PHC) health facilities by Cynthia Zandile Madlabana. I consent to participating in the research project.

Please tick
or initial

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had my answers to my satisfaction.

I understand that if I decide at any time during the study that I no longer want to take part, I can notify the researchers, withdraw without having to give a reason and without any consequences to me.

I agree that the research team may use my data (information) for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. In such cases as with this project, my identity would not be identifiable in any report.

I consent to the research team contacting me via agreed method such

as telephone, home visit or any other agreed method for follow-up interviews.

If I have any questions or concerns about my rights as a study participant or if I am concerned about any aspect of the study or the researchers then I may contact:

For questions related to the study	For your rights as a research participant
Primary Researcher Cynthia Zandile Madlabana Tel: 27 31 260 8389 Email: madlabana@ukzn.ac.za	Biomedical Research Ethics Administration Research Office Westville Campus Govan Mbeki Building Private Bag X 54001 Durban 4000 KwaZulu-Natal, SOUTH AFRICA Tel: 27 31 2604769 -Fax: 27 31 2604609 Email: BREC@ukzn.ac.za

Signature of Participant

Date

Signature of Witness

Date

Appendix 2: Ethical Clearance



Ms NN MPili (212538242)
Discipline of Psychology
School of Applied Human Sciences
missnoxypili@gmail.com

Dear Ms Mpili

Protocol: Management support, role conflict and role ambiguity among professional nurses at a NHI pilot site in North West. Degree: Master of Social Science in Industrial Psychology
BREC Ref No: BE519/17

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 14 August 2017.

The study was provisionally approved pending appropriate responses to queries raised. Your response received on 08 November 2017 to BREC correspondence dated 06 October 2017 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given **full ethics approval** and may begin as from 15 November 2017.

This approval is valid for one year from **15 November 2017**. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **12 December 2017**.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely



Prof YR Rambiritch