EMPOWERMENT OF NURSE MANAGERS TO FACILITATE CHANGE MANAGEMENT DURING NAMIBIAN HEALTH SECTOR REFORMS

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DEDICATION

I DEDICATE THIS THESIS TO:

- The ALMIGHTY FATHER, who gave me the guidance and strength to pursue this study. “I can do all things through Christ which strengtheneth me” (Phil. 4:13)

- My late parents, Gerhardt //Hoëbeb (1913-1985) and Ottilië //Hoëbes (1913-2004). My father’s motto was” Work when you have to work and play when you have to play” – a motto that encouraged me to be focused and persistent in whatever I am doing.

- My late brother, Eliakim (1935-1991), who also played the role of father to me and whom I wish had seen my academic success.

DECLARATION

I declare that “The empowerment of nurse managers to facilitate change management during Namibian health sector reforms” is my own work and that all the sources used have been acknowledged by means of a complete reference list.

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ABSTRACT

During the previous dispensation, health services were fragmented along ethnic lines and were curatively biased. To redress the above situation, the Ministry of Health and Social Services embarked on a health sector reform. Out of the previous four health directorates thirteen health regions were established to bring decision making and development to the people. The eight original directorates at the central level merged into five key functional units.

The reform process in the health services in Namibia caused negative reactions among the nurse managers, who had previously worked in a stable environment. This research argued that, while the conceptual frameworks on change tend to focus on its management, the meaning and magnitude of change seems to be given little attention. Consequently, the nurse managers in Namibia seem not to be able to deal with change in order to facilitate an environment conducive to change in the health sector for fundamental change to take root.

The overall aim of this study was to describe a model that could be used by the nurse managers to facilitate change during the Namibian health sector reforms.

To achieve this aim the explorative, descriptive, qualitative, theory generative and contextual designs were used. Data was collected from thirty-nine top, middle and first-line nurse managers. In-depth individual interviews and focus

group discussions, as well as field notes, were used for data collection. The identification and conceptual meaning in respect of facilitating a conducive environment were achieved through the results of the empirical data that explored the experiences of the nurse managers and their needs for empowerment, and the results of concept analysis.

This research has shown that the facilitator is responsible for empowering the nurse managers to establish an enabling environment to manage change in the health sector. It was argued that to achieve this objective the nurse managers must possess the leadership skills necessary for facilitating the empowerment process. To this end, interactive facilitation was recognised as the dynamic through which an environment conducive to change had to be created. In this connection the procedure to facilitate an enabling environment in clinical practice was said to be built around two components, namely, adequately support and interpersonal relations reducing fear of the unknown, and active participation and involvement enhancing confidence and continuous interaction facilitating knowledge and skills development.

The researcher believes that the guidelines that are suggested in the model will bring valuable insights to dealing with the change process in the country.

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LIST OF ABBREVIATIONS

1.	ICN:	International Council of Nurses
2.	PHC:	Primary Health Care
3.	MoHSS:	Ministry of Health and Social Services
4.	HIV/AIDS	Human Immuno Virus/ Acquired Immuno Deficiency Syndrome
5.	FGD:	Focus group discussion

Chapter 1

AN OVERVIEW OF THE STUDY

1.1 BACKGROUND

The focus of this research is on the empowerment of nurse managers to facilitate the management of change during the Namibian health sector reforms. There is abundant evidence in literature showing that change is a product of dissatisfaction with the status quo (Rao, Carr, Dambolena, Kopp, Martin, Rafii et al 1996:426) and that, due to the ceaseless flow of new technologies, new policies, organisational restructuring, downsizing and redundancies (Flanagan & Finger 1998:348; Bryson 1997:250; Cameron & Green 2004:166) change was an inevitable feature of the last decade (Haberberg & Rieple 2001:536; Flanagan & Finger 1998:348; Mills & Bartunek 2003:121; Drucker 1999:73; Mullins 1999:821). Globally in the health care sectors the speed and magnitude of change have been acknowledged. The health care delivery system reforms emerged during the early 1990s in line with the general global changes (Green 1999:63).

Environmental and demographic reasons have led to the increase in the global demand for health care. In developing countries the increase

> in health care needs are mainly as a result of diseases related to poverty, infection, malnutrition, war and HIV/AIDS (ICN 1996:6). However, in recent times, the public has become more aware of its right to quality health care (ICN 1996:6; Booyens 1998:492). Countries throughout the world are trying to balance their available resources in terms of people, facilities and finances in order to meet the demands for health care (ICN 1996:6).

In the Namibian context various factors have prompted reform in the health sector. During the previous dispensation health services were structured along ethnic lines and were managed accordingly. However, the health services were not only fragmented, but also curatively biased. The Ministry of Health and Social Services was prompted to integrate the previous ethnically fragmented health system into one National Health Service, which would be run in accordance with primary health care principles (MoHSS 1995:3-4).

In this regard, the Ministry of Health and Social Services (MoHSS) has undergone dramatic political, technological and structural changes since 1990. A primary health care (PHC) approach has been adopted in Namibia and is an approach which emphasises community participation and empowerment, intersectoral collaboration and cost-effective care, as well as the integration of preventive, promotive, curative and rehabilitative services, in order to redress the fragmentation of the past.

As part of the wider reform process, the Wages and Salaries Commission report of 1996 proposed measures aimed at improving the effectiveness, efficiency and productivity of the public service. This included downsizing the civil service and outsourcing and commercialising noncore public health and social welfare functions.

The previous structure of the MoHSS allowed for multiple lines of communication between the centre and other levels, but this resulted in the overlapping of responsibilities. The most serious overlap was experienced between PHC and Nursing Services, although an overlap also existed between Specialised Services and Nursing, and between the logistics functions of other directorates and Administrative Support Services. The problem was that these overlapping functions created the impression that the central level was overstaffed and, by accumulating sought after skills, had weakened the regional level of the health system by draining it of posts.

The most significant gap in the old system was in the area of overall policy development, analysis and planning, and this included human resources planning, the management and co-ordination of external assistance, health systems research, and the monitoring of service quality. These functions were partly carried out by means of a committee system, but lacked a Secretariat to facilitate implementation. An effort had been made to seek reliance on the

support staff of the various existing directorates, which had priority interest in their mainstream areas of work. The committees themselves were found to be fragmented, for example human resources were separated from planning, and this had left gaps with respect to addressing certain key issues such as donor-coordination, quality assurance and health systems research.

As part of the reform process at the central level, the eight original directorates were merged into five key functional units, namely planning and human resources development, specialised services, primary health care and nursing services, administration and finance, and social services (MoHSS 1995:3-4).

Prior to the delimitation exercise of 1992, the MoHSS consisted of four regional health offices, namely, Central, North East, North West and South, and 34 districts with health centres and clinics at subdistrict level (primary level). Furthermore, 13 regional councils were established in 1994, and the decentralisation policy was adopted in 1996. The whole aim was to bring decision-making and development closer to the people. Although the decentralisation policy was adopted and the 13 health regions established in accordance with the political regions, the MoHSS has decided that, due to financial and personnel constraints, there should be four regional health offices only during the process of establishing and consolidating the other 13 regional health operational offices. 0The health management teams would be established

within the new structure and consolidated in each of the 13 regions instead of in the 34 districts (MoHSS 1995:13-14; MoHSS 1998:6-7).

The regional level is an intermediary level between district level, where implementation takes place, and central level, where policy formulation and strategic planning take place. Moreover facilitating the linkage between these levels is important. The difficulty lies in how the regional level is able to remain well informed about the problems and constraints regarding effective implementation at the district level, while at the same time being well informed about policies and limitations at the central level, and being able to communicate effectively with both levels (MoHSS 1995:13).

It is useful to note that the regional operational level constitutes the implementation arm of the health care system in Namibia. This may correspond to the district health system model in other countries. The regional health management team is responsible for the planning, organisation, implementation and evaluation of regional health plans, and also for other management activities such as motivation, training, supervision and monitoring. The regional health management team represents an integrated team comprising both regional PHC managers and district hospital managers (MoHSS 1995:21).

In Namibia, the district level assumes the peripheral front-line role only, unlike other countries where this role is on the operational level within the respective health systems (MoHSS 1995:27). In this connection district health management is focused on two main committees, the District Health Coordinating Committee, which is the overall district health management agency, and the District Hospital Management Committee, which is the managerial authority.

The main functions of the district health coordinating committee are to facilitate the coordination of activities at the district level in order to ensure, firstly, the efficient and effective implementation of regionally directed and managed projects and programmes, secondly, to ensure that harmonious working relationships are maintained and, thirdly, to ensure the functional integration of the various components of the district health system, including community-based PHC activities, as well as those activities run by clinics, health centres and district hospitals. The main functions of the district hospital management committee are to perform the day-to-day management of the district hospitals, to liaise with other levels and instances at the district level, and to facilitate a healthy working relationship between the hospital (health facility) and the local community (MoHSS 1995:27).

In the light of all the proposed changes in the Namibian health sector, it was imperative for MoHSS to produce a new and updated policy framework, which

would guide the reform and restructuring process of the Ministry, and position it to meet the future needs of the country. These policy guidelines are as follows:

Equity: Equitable access to basic health care and social services with particular attention to resource distribution in Namibia in order to identify and accelerate the correction of any disparities.

Availability and accessibility: Progressive extension of the services to reach all communities in Namibia, with special attention to the disadvantaged regions and underserved communities, as well as to vulnerable groups in the country. Services will be developed based on the strengthening of community-based health and social welfare services, taking into consideration special socio-cultural circumstances.

Affordability: Preventive and promotive health care and welfare will be provided free of charge. Fee structures for other services will make provision for the wide-ranging abilities of Namibians to pay. Funds will be appropriated particularly for the improvement of community health and social welfare services.

Community involvement: Community involvement will involve communication, consultation and co-operation between all development workers and communities in respect of attitudes, interventions and actions as regards the

causes of poor health. The main objective is to give communities authority to sustain primary health care programmes in their own environments.

Sustainability: In order to achieve a lasting impact on the health and social wellbeing of the communities any new programme will be subjected to a sustainability assessment before implementation.

Intersectoral collaboration: Other government and nongovernment sectors will be consulted and involved in the planning, implementation, monitoring and evaluation of health and social welfare programmes at all levels.

Quality of care: National norms, guidelines and standards of care will be reviewed, formulated and applied to ensure that good quality services are provided (MoHSS 1998:6-7).

The Ministry of Health and Social Services went through different phases of health sector reform. However, after staff establishment was approved in August 2003, thirteen health regions became functional with regional directors at each level, although some of the health regions were not fully staffed.

The two departments in the early stages of health sector reform (Health care services & planning and administrative support services) were again restructured into three departments namely:

- *Department of health and social welfare policy,* consisting of four directorates: primary health care services, social welfare services, special programs and tertiary health care and clinical support services (MoHSS 2003: 8-17).
- *Department of policy development and resource management* with three directorates: finance and logistics, human resource management and general services, and policy, planning and human resource development (MoHSS 2003:2-7).
- *Department of regional health and social welfare services,* consisting of thirteen regional directorates. The Undersecretaries at each level direct these three departments (MoHSS 2003:18-110). However, the first two departments are operational, while department of regional health and social welfare services has still to be implemented. Currently the thirteen health regions are under the direction of department of health and social policy.

However, it should be pointed out that downsizing and restructuring produce benefits within a short period of time because they cut costs and temporarily improve the alignment between structure and strategy (Heckscher 1995:6; Rodriguez & Ferrante 1996:18; Cummings & Worley 1997:288; Doherty 1997:27). It is of significance to note, however, that, in most cases, downsizing produces the opposite of what is intended. In a number of instances actual cost increases (Burke 2000:525). Downsizing does not inherently increase the basic

flexibility of the system, in fact downsizing reduces the benefits by increasing the barriers between people (Heckscher 1995:6). Downsizing may result in the loss of personal relationships between employees and customers, increases in rules and procedures, thus resulting in more bureaucracy, and in the loss of a common organisational culture (Burke 2000:525). This could imply that, while change offers a promise of improvement, it does not necessarily *guarantee* improvement, with the result that many people now approach change with scepticism, uncertainty, fear or frustration (Flanagan & Finger 1998:346; Rodriguez & Ferrante 1996:18; Doherty 1997:28).

This was certainly the case in Namibia. In the process of preparing the field for the current research study, the researcher conducted a pilot study in 2000 on the experience of reforms in the health sector of nurse managers in the three health regions. It would appear that the nurse managers are not adequately empowered to address the current reforms in the MoHSS, and that they experience fear, anxiety, uncertainty and insecurity.

The main aim of reform is to provide a cost-effective health service that will restore the balance between basic and advanced services (Du Toit 1998:113). This is also of concern with regards to rendering quality nursing care. Quality nursing care embodies concepts such as access, cost containment, efficiency, and consumer choice (ICN 1996:6; Koivusala & Oliliva 1997:147; *Western Journal of Nursing Research* 1996:314). Lund (1995:488) argues that, while healthcare reform poses both a challenge and an opportunity for nurses, it also poses a threat to them (Lund 1995:488; Adair 1990:7). It may be a challenge in the sense that the particular change may result in nurse managers being promoted or given more challenging jobs, but it may also be a threat in

the sense that some nurses may lose their jobs and status, with, in some instances, the dissolution of established working groups (Dawson 1998:292).

The researcher argues that change affects people in different ways, and that management must accept the individual nature of change. Thus it cannot be expected that people will react to change in the same way. According to Mullins (1999:826), most people feel threatened and disoriented by the challenge of change. However, some authors indicate that change in general may be exciting, challenging, stimulating, yet also frightening, threatening and unsettling (Williams & Johnson 2004:114; Kouzes & Posner 2003:194; Mills & Bartunek 2003:81; Thomson 2002:204), as well as perhaps involving demotion or punishment (Rao et al 1996:434). Therefore, in view of the above statement, it is obvious that change may evoke either positive or negative emotions, and subsequently elicit unintended responses.

According to Stewart (1995:205), the four reasons why individuals do not embrace change are that the individuals do not have the ability to understand the envisaged change, do not know of the change, do not believe in the change or do not agree with the change. The issue of not knowing about change is the most common reason in organisations because it is often top managers who make decisions and adopt policies or strategies that require individuals to behave differently without communicating these changes effectively or even at all. In order to overcome a lack of understanding of the meaning of change, it is important to develop a shared vision of change (i.e. a strategic vision of change).

People may tend to resist change because of uncertainty, concern over personal loss, and the belief that the change is not in the interests of the organisation (Robbins & DeCenzo 2001:235; Hellriegel, Jackson & Slocum 1999:439-440; Williams & Johnson 2004:117; Kirkpatrick 2001:20; Robbins, Odendaal & Roodt 2003:408). Resistance may also result from the fear of losing what one already possesses (Hellriegel et al 1999:440; Kirkpatrick 2001:20). The more people have invested in the current system to which they are attached, the more they resist change. They fear the loss of position, pride and satisfaction, money, authority, friendships, freedom, responsibility, good working conditions, status, personal convenience, or other benefits that they value. This may explain the assertion that senior employees commonly resist change to a greater degree than relatively new employees, as it is assumed that the senior employees generally have more invested in the current system and, therefore, have more to lose by adapting to the change (Robbins & DeCenzo 2001:236; Kirkpatrick 2001:20; Oldcorn 1996:202).

Studies show that participation in the change process reduces resistance. A study carried out by Coch and French in the late 1940s on resistance to change at the Harwood Manufacturing Company plant, as quoted by Robbins and DeCenzo (2004:209), indicated that, when decisions are imposed on people, they resist, as opposed to cases in which they are involved. Coch and French studied three groups. In the first group management made decisions

autocratically and then announced what had been decided. In the second group there was employee participation in decision-making. Representatives and management worked out details of the proposed change, then tried out the new methods and trained others in the new procedures. In the last group, all the employees participated with management in the design of the new methods. In the first group resistance occurred as before. Seventeen percent of the employees resigned during a 40-day period, and grievances and absenteeism increased. In the representative and full-participation groups, there were no resignations, one grievance only, and no absenteeism. Moreover there was a direct correlation between participation and productivity (Robbins & DeCenzo 2004:209).

Research by Moloi (2002:51), Tassie, Zobar and Murray (1996:149), and Kouzes and Posner (2003:143) suggests that the development of shared vision for change creates a context for constructive discussion about changes and important common points of focus. Shared vision has been known to produce a much higher level of sustained commitment, motivation, job satisfaction, pride in the organisation and enhanced performance than is the case when the vision is imposed from above. Successful transformation depends on a powerful and shared vision. However, a shared vision should be communicated, as change is not possible unless managers are willing and motivated to help in the change efforts. Thus, if the change agents wish to create a shared vision, they need to

engage in sustained dialogue and conversations in which individuals feel free to express their wishes and know they are being heard.

The greatest advantage of such shared vision is the empowerment of those subjected to change with competencies, skills and positive attitudes, which in turn leads to better collaboration and improved performance. Moloi (2002:51) further states that the building of shared vision requires patience, as truly shared visions take time to emerge. Thus, if the organisation is determined to bring about meaningful change, the organisation should make an effort to nurture a sense of shared responsibility for and shared commitment towards the shared vision (Moloi 2002:50-52). In this respect, Senge (1999:205-232) asserts that, when people share a vision, they manifest a higher degree of ownership and greater commitment to achieving the vision. In view of the reform in the health sector in Namibia, skilful discussion would help to create an understanding of the importance of the new reforms.

The third reason why individuals do not believe in change could be that they do not believe in the importance of the change, although effectively informed of change. The individuals need to experience a certain degree of control over the decision to change and need to be convinced of certain benefits before they agree with the change. Change is more likely to be adopted if individuals are involved in the decision-making (Stewart 1995:203-205).

Change and reform efforts prompted a new strategy in the management structures within organisations. In Namibia change in management structures usually involves some degree of decentralisation, with a flattening of organisational structures and changes to previous bureaucratic styles. The restructured organisation with flattened structures requires a multiskilled workforce (ICN 1996:10). In view of these statements, it can be argued that any form of reform leading to exposure to new leadership positions is both a challenge and an opportunity for employers as well as for employees (Lund 1995:488).

Therefore, the managers should visualise a future state and be able to give the present a new perspective, and in this way be assured that the proposed change is worthy of support. Without a vision, change efforts dissolve into a list of time-consuming, incompatible, and confusing projects moving in different directions or going nowhere at all.

Employers should create an environment in which change can take place. The health care organisation must move away from previous beliefs, be open to new inputs and learn new assumptions and behaviours in respect of the proposed change. The driving forces for successful implementation should include making known the advantages of the new system, administrative support for the change, staff concern about quality care, and staff ability to learn the new system. On the other hand, restraining forces could be a lack of staff participation in the selection of the new system, little or no staff knowledge of the new system, potential threats to staff feelings of security when giving up old routines, and potential threats to territoriality in various disciplines because of equal access to information in the new system (Tappen 1995:330-332).

Employees are more likely to embrace change when there is an atmosphere of trust between the employees and their managers (Pharmaceutical Representative 2003:47). In the absence of trust people feel more isolated, lonely and vulnerable. The employees then tend to rely more on formal rules than previously and are quicker to protect themselves. However, none of the above constitutes an intended or conducive outcome during any change process (Heckscher 1995:4).

The participative approach to change seeks ways to increase acceptance of the change and to increase people's motivation to change. Thus the people who will be affected by the change are encouraged to engage in dialogue about the alternatives. Resistance is considered natural, and considerable effort is made to identify the causes of resistance and eliminate them (Pharmaceutical Representative 2003:47).

Many researchers have indicated that the management of change is complex (Cumberland 2003:5; Chattell 1995:205; Carnall 1992:93; Martinez & Martineau 1998:357; Wilson 1993:123; Mullins 1999:826), threatening (Mabey & Salaman 1995:110; Williams & Johnson 2004:114; Kirkpatrick 2001:3) and associated with mixed feelings (Crouch, Sinclair & Hintz 1992:44). Change creates human reactions of anxiety and stress, pain, anger, fear, uncertainty, insecurity, and resistance in those who are most likely to be affected, particularly in the absence

of adequate empowerment such as support and involvement (Beckhard & Harris 1987:52; Hardingham 1992:15; Carnall 1992:93; Hofnie 2000:9-13; Mullins 1999:826). It is well documented that change is inevitable (Hayes & Wood, 1999:1; Dawson 1998:290; Williams 2002:313; Lussier 1996:379) and adjusting to change poses a constant challenge (Tappen 1995:320; Williams 2002:313). Adequate empowerment through support and the involvement of the workforce is important in order to counteract reluctance to change and the human reactions of anxiety, uncertainty and pain. Literature has shown that certain people who are likely to be affected by the health reforms are overlooked and not adequately prepared or involved in change management (Martinez & Martineau 1998:354; Williams 2002:313).

During reform there is often a change of focus away from managing and organising according to occupational groupings such as nursing, towards managing and organising around health programme areas. For nurses this means different reporting structures, and more cross-functional and interdepartmental work. Nurses may report to managers who are not nurses, or they may be the managers themselves of health programme areas with a variety of staff from different occupational groups reporting to them. In this type of management change, there are often also increased opportunities for nurses to become involved in health policy development, as new policy jobs are often created as part of health reform (ICN 1996:10; Dawson 1998:292).

The workplace is important for everyone, as is the value placed on people in the enterprise. Thus human resource development is becoming a priority (Carter 1993:141-163; Andersen 1992:2). In the health care system and organisation it is the nurse manager's role to understand the change process to persuade subordinates to buy into the new concept of change (*Western Journal of Nursing* 1996:314; Gewirtz 1996:123; Douglas, Martin & Krapels 2003:1) to introduce any new information that is needed to implement the change, to encourage new behaviour so that the new behaviour becomes part of the system's regular patterns of behaviour, to continue to provide a supportive climate in order to avoid an increase in defensive behaviour and resistance to change, to provide feedback on progress, to clarify goals, to reinforce the change process and to prevent people from becoming sidetracked, to present herself as a trustworthy person in order to keep the lines of communication open, to act as an energiser, to keep the interest level high, to keep the change process moving forward and to overcome resistance that may still arise (Lewin (1951) and Schein (1987) as quoted by Rashford (1994:63-65; Tappen 1995:330-335).

These challenges bring human resource management to centre stage (Dierkes & Antal 1988:604; Silverman 1996:6; Shapero 1997:39; Rodriguez & Ferrante 1996:17; Copcutt 1997:181; Timmons & Bahamon 2004:1; Kristin 2001:1). Without adequate support, help and understanding, the physical and emotional cost of coping with change can be very high (Kitchin 1993:92). Training and development are important aspects of sustainable performance by human

resources and lead to an improvement in performance in the workplace by adding the necessary values of confidence and competence to both the individual and the team. Reforms have had a major impact on workplace relationships as have new approaches based on shared goals, common understanding and a commitment to solving problems creatively.

The nurse manager forms an important link between the consumers (patients/clients) of the health service delivery and the health care system management. Thus she is an advocate for the needs of the consumers. On the other hand, the nurse manager forms the link between the different departments/units and maintains collaboration between them in order to reach the common goal of quality care. Thus any new development, such as a perceived need for change, should be in the interests of the consumers of the health care delivery system. The nurse manager serves as a facilitator, provides the rationale for the change and the benefits of the change, supplies information, and allows the staff to control the process.

However, in order to fulfil the above roles and responsibilities, the nurse manager needs to be empowered. Such empowerment will enable the nurse manager to be committed and to trust the ability of those people working with her, and give to the nurse manager a sense of belonging, acceptance and a feeling of ownership. This empowerment will also enable the nurse manager to create her own destiny

by becoming an effective, stimulating and meaningful communicator, with the result that work will become exciting (Jooste 2003:233).

As shown below, Hellriegel et al (1999:12-14) classify managers into three categories according to their level of responsibilities:

- *Top nurse managers:* These are managers who are responsible for the overall direction and operations of an organisation. In this study, top managers comprise nurse undersecretaries, directors and their deputies. This group of nurse managers develops goals, policies, and strategies for the entire organisation. They set the goals that are handed down through the hierarchy, eventually reaching the workers.

- *Middle nurse managers*: These are managers who receive broad, overall strategies and policies from top managers and translate them into specific goals and plans for implementation by first-line managers. They carry out top management's directives primarily by delegating authority and responsibility to their subordinates, and by coordinating schedules and resources with other managers. For the purpose of this study middle nurse managers comprise regional nurse managers, some of whom are members of regional management teams; others are in charge of the national and regional hospitals, while some are relevant senior nurse managers and primary health care (PHC) supervisors at the intermediate levels.

- *First-line nurse managers*: These managers are directly responsible for the health care services, whether at the district or regional hospital level. In this study first-line nurse managers are in charge of a ward, or are ward supervisors. This level of management forms the link between the operations of each department and the rest of the organisation. Thus this study will focus on the middle and first-line managers who are responsible either for direct care or for direct supervision of the care. If change is proposed or eminent these are the managers who bear the heavy burden of implementing it. Thus, this group of nurse managers should be empowered to ensure effective functioning. If not, the change process may drag on for a long time, as the people they are supposed to direct may not receive clear guidance, or sometimes their negative attitudes towards change may spill over to their subordinates. This calls for adequate preparation and the empowerment of this group of nurse managers.

However, health sector reform was a fairly new concept in the early 1990s (Green 1999: 63) and little is known about models to empower nurse managers during health sector reform or any change process in the health sector. Human reactions of fear, insecurity, pain and uncertainty could hamper the smooth facilitation of change management by nurse managers in the Namibian health sector during the process of reform.

In addition to the human reactions that could have a negative influence on the rendering of quality care during the process of reform, it was also possible that some experienced nurse managers could decide to leave the health sector. This could happen as a result of job insecurity and dissatisfaction due to the changing environment, which they did not understand clearly, or did not accept, because of inadequate preparation, involvement and support during the earlier or current stages of the change process. Another group of nurse managers might also simply decide to remain idle until sure of their position in the new staff establishment structure. This could also negatively affect the quality of care.

A lack of understanding of the change process in the workplace and an underlying reluctance to accept the change seems to have contributed to the de-motivation and even demoralisation of certain nurse managers in certain hospitals in Namibia (Hofnie 1999:10). Demotivation and demoralisation have a negative effect on performance in the workplace.

The importance and the impact of health sector reform are well known (ICN 1996:9; Healy & McKee 1997:289; Jones 1997:1). Thus the use of a model to empower nurse managers to facilitate change, through an environment conducive to change management during the process of reforms would be useful to reduce the human reactions of pain, fear, uncertainty and insecurity. However, as health sector reform was a fairly new concept in the early 1990s (Green

1999:63), little is known about models to empower the nurse managers during health sector reform in the health sector.

Although several conceptual frameworks on change management have been described in literature, such as the Lewin-Schein change process model in Rashford & Coglan (1994:64-65); Havelock's Theory in Welch (1994:318); Lippitt's Stages of Change in Welch (1994:319); Stages of Change and Responsibilities of the Change Agent in Marquis & Huston (2003:82-83, 191); Lewin's Change Process Model in Williams (2002:314), these models and theories do not include a component for empowering the nurse managers to facilitate the change process smoothly through a favourable environment in the health sector during the reforms within the Namibian context. Therefore such an empowerment model is necessary in order to empower nurse managers in this regard.

Against this background, this study aims to explore and develop a change model to empower the nurse managers to create an environment conducive to facilitating the change process currently being experienced in the Namibian health sector. This will in turn ensure quality care while such a change process is in progress. How this is to be done is explained fully by a description in chapter two of the study of the design and strategy to be used.

1.2 PROBLEM STATEMENT

The nurse managers in Namibia are experiencing the destructive effects of change due to their inadequate participation in the change process. A recent study carried out by Hofnie (2000:13) confirmed that inadequate preparation,

involvement and support were the key contributing factors to the human reactions of fear and uncertainty among the nurse managers during the health reforms in Namibia.

Although there was clear motivation for the reform process in Namibia (see pages 2-4), the health reforms were not comprehensively understood by the nurses. It is to be noted that change is always complex and often accompanied by resistance. Certain nurses felt that the adoption of the PHC approach was a lowering of standards in health care provision, as ”letting go” of the curatively oriented and fragmented health service delivery of the past was very difficult for them.

Considerable dissatisfaction was voiced over national radio phone-in programmes in Namibia over certain issues, including cuts in transport in certain areas in which the government had previously provided transport and increases in the costs of accommodation – costs that had been the same since inception and were very low.

Following the structural policy and organisational cultural changes, a new tendency was observed in that young registered nurses enrolled at the University for nonnursing degrees, while others left the country for greener pastures. The issue of skilled nurses leaving the country for greener pastures was voiced in the print media to such an extent that the Justice Deputy Minister was prompted to

suggest a law prohibiting the exodus of nurses (Amupadhi 2002:3). Similar pattern was observed among doctors during the reforms in Zambia, where some doctors left the country (Blas & Limbambala 2001:29)

The negative attitudes of nurses towards the patients, as well as poor nursing care, was frequently reported in the media, particularly in the national radio phone-in programmes. All these issues as experienced by the nurses and by the general public cannot be completely separated from the effects of change in the health sector.

It was reported elsewhere that where health sector reforms did not include human resource management as an integral part of their procedures, this led to the failure of reforms in certain cases (Adams & Hirschfeld 1998:29). Therefore, creating a shared understanding and commitment among management is essential before a restructuring strategy can be executed effectively.

Commitment is built on a detailed understanding of any strategy. Thus, in support of the above observation, Floyd and Wooldridge (1996:119) report that managers who are not committed to the cause of restructuring will try to undermine it, dragging their feet and even sabotaging attempts at innovation. This brings us to the realisation that, however well designed the process of change might be, it takes time for people to understand and come to terms with the way in which new issues will be implemented (Saloner, Shepard & Podolny 2001:117).

Based on the background information, the rationale and the problem statement described, the following research questions were applicable to this study:

Research questions

- How do nurse managers experience reforms within the health service context?
- How can nurse managers be empowered to facilitate change in the health sector, through an environment that is conducive to the management of change?

1.3 OVERALL AIM AND OBJECTIVES

The overall aim of this study is to develop a model to empower nurse managers to facilitate change smoothly during reforms in the Namibian health sector, through an environment that is conducive to the management of change, with guidelines for operationalisation. To achieve this aim the following objectives are stated:

OBJECTIVES

- To explore and describe the experiences of nurse managers regarding the change process in the health sector
- To explore and describe the needs of nurse managers with regard to the way in which the nurse managers can be empowered to manage a change process
- To develop a model to empower nurse managers to facilitate change in the health sector, through an environment that is conducive to the management of change with, guidelines to operationalise the model

1.4 ASSUMPTIONS

Assumptions are considered important as they influence all other aspects of structuring and contextualising theory. These assumptions are regarded as true, although they have not been empirically tested, and they are useful in directing research decisions. However, due to the interactive nature of this study, the assumptions must be stated explicitly (Tomey 1998:4; Chinn & Kramer 1991:96). The researcher presents the following assumptions for this study.

1.4.1 Metatheoretical assumptions

Assumptions are important from the philosophical viewpoint in that no research findings can be proved conclusively on the sole basis of empirical data (Mouton 1996:174). The researcher has to make specific assumptions about specific theories and methodological strategies that have not been tested in order to direct this research as guidelines on which decisions should be made (Mouton 1996:174). Based on the above reasoning, this research study is based on the nursing theoretical framework within King's Systems Framework and Theory of Goal Attainment. The researcher's views with regard to facilitator and nurse manager (person), nursing practice (environment-context) and interactive process (dynamic) will be described.

Person: facilitator and nurse-manager

In this study the term "person" refers to the facilitator of the change process, that is, the advanced nurse manager, and the middle- and first-line managers, as recipients during a progressive, interactive process. The facilitator and nurse managers are bio-psychosocial and spiritual beings, who are capable of making unique choices in a holistic manner, and are in constant interaction with a changing environment (Sieloff, Ackermann, Brink, Clanton, Jones, Tomey et al 1998:305-306). During the change process, it is important that the facilitator be aware of the uniqueness and intrinsic worth of the nurse manager and guides her

in a sensitive and supportive manner during the process of change by means of adequate involvement and communication. This will not only allay fear and uncertainty of the unknown, but will also enable the nurse manager to gain new insights, that is, the knowledge and skills needed to manage the change process. This will come about as a result of the interactive process between her and the facilitator.

Environment: context – health service delivery system

There is constant interaction between the ever-changing context and the nurse manager. Thus, adjusting to the context is influenced by the individual's interactions with the context (Sieloff et al 1998:306). The context of nursing practice includes the internal and external environment (Phillips, Blue, Brubaker, Fine, Kirsch, Papazian et al 1998:249). The internal environment comprises the morale of employees, leadership effectiveness and possible delays in communication, whereas the external environment consists of political, social and economic, technological, globalisation and legal factors (Booyens 1998:481). However, effective interaction between the internal and external environment in nursing practice will contribute to an environment that is conducive to the effective management of the change process in the health sector.

Interaction: dynamic

Interaction indicates a mutual involvement between the facilitator (advanced nurse manager) and the recipients (middle- and first-line managers) holistically in an integrated manner in nursing practice, with the purpose of facilitating the change process. The nature of their interaction contributes to the empowerment of the nurse manager to gain new insights into facilitating an environment conducive to managing a change process in the health sector.

1.4.2 Theoretical assumptions

Theoretical assumptions are measurable and are based on existing theories and models (Mouton & Marais 1990:20). This study has taken, as a point of departure, the Lewin-Schein Change Process Model in Rashford and Coglan (1994:64-65); Havelock's Theory in Welch (1994:318); Lippitt's Stages of Change in Welch (1994:319); Stages of Change and Responsibilities of the Change Agent in Marquis & Huston (2003:82-83, 191); and Lewin's Change Process Model in Williams (2002:314).

The theoretical frameworks specified above were used after the fieldwork and data analysis had been completed. During the data collection, the researcher "bracketed" her preconceived knowledge and was open to any ideas, thoughts and views as expressed by the nurse managers.

1.4.3 Definitions of concepts

Empowerment

Empowerment refers to a wide range of practices that give increased responsibility to individuals and groups to participate in actions and decision-making within a context that supports an equitable distribution of power (MCGraw 1994:240; Boddy 2002: 413; Hayes 2002:98; Mullins 1999:652). It also provides a win-win situation (Lashley 2001:11) and opportunities for personal growth and self-fulfilment (Boddy 2002:413; Lundin & Lundin 1993:117). Empowerment starts with the self, but does not stop there, and realises and conceptualises the relationship between task, work, achievements, and connectedness (Vogt & Murrell 1990:5). Therefore, for the empowerment process to be effective, the nurse managers must firstly manifest professional traits, including being responsible for continuing education, participation in professional organisations, political activism, and a sense of value about their work (Marquis & Huston 2003:191), as well as a moral involvement in the mission of the organisation (Lashley 2001:5). Secondly, the nurse manager must work in an environment that encourages empowerment, and lastly, the process must include an effective leadership style that nurtures the development of an empowered nurse manager (Marquis & Huston 2003:191). Consequently both the organisation and the

individual nurse manager will benefit from this empowerment process. Hence, the empowerment process can be regarded as a win-win situation.

Nurse manager

A nurse manager may be defined as a person registered as a nurse and midwife in terms of section 20 and 64 of the Namibian Nursing Act, No. 8 of 2004 (Nursing Act No. 8. 2004. Government Gazette of the Republic of Namibia 3249:7), who is appointed and authorised to manage a section or a unit. In this study, a nurse manager is a registered nurse in charge of a ward, section, unit, hospital, health region, section of a directorate or an entire directorate. In order to facilitate an environment conducive to the management of change, the nurse manager must be an active participant in the interaction for knowledge and skills development under the guidance of the facilitator so as to gain the necessary skills and knowledge of the dynamic process of change management and thus be able to function autonomously in practice.

Facilitating

Stewart (1995:108) gives the following definition of facilitating – to enable something to happen easily, meaning not to do the something oneself, but to promote the doing of it by others. In the context of this study, the facilitator, who is the advanced nurse manager, should create an environment conducive to

change to enable the middle- and first-line nurse managers to facilitate the change process easily. This means that change cannot be imposed on the nurse managers, but rather that opportunities must be provided that will bring about change easily. These opportunities in the change process could be a supportive environment, characterised by adequate participation and involvement, communication, motivation, mobilisation of resources and continuous support.

Managing change

Managing change refers to co-coordinating a number of activities and inter-relationships so that the organisation may survive and benefit from the process of change, through the implementation of new, more effective methods and systems in an ongoing organisation (Nickols 2004:1, 5; Rockford Consulting Group 1999:1). However, change is complex and creates human reactions of fear, uncertainty, pain and insecurity. Thus the facilitator should communicate the vision of change to those nurse managers who are the most likely to be affected, as understanding counteracts fear of the unknown and contributes to commitment, responsibility and a sense of ownership.

Health reform/ health sector reform

The health reform involves changing health policies, and reforming institutions and organisations in terms of structure and culture in order to improve quality care to the consumers (ICN 1996:7).

1.4.4 Methodological assumptions

In this study theory generative design, which is qualitative, explorative, descriptive and contextual in nature, is used. The qualitative paradigm aims to understand people as conscious, self-directing, symbolic human beings. The primary aim is in-depth descriptions and understanding of actions and events within context (Babbie & Mouton 2001:28-33).

In the qualitative paradigm, the researcher is an instrument of data collection who gathers words or pictures, analyses them inductively, focuses on the meaning of participants, and describes a process that is expressive and persuasive in language (Creswell 1998:14). Thus data collection is not confined to observable behaviour, and also includes descriptions of people's intentions, meanings and reasons. The emphasis is on interpretive understanding, rather than causal relations (Babbie & Mouton 2001:28-33). Thus the qualitative paradigm is the best fit for this study.

1.5 SUMMARY OF RESEARCH DESIGN AND METHODS

- **Design**

The research design of this study constitutes the research approach, population and sampling, data collection methods and data analysis. The purpose was to develop a model to empower the nurse managers to manage change, by facilitating an environment conducive to the management of change. These aspects are described fully in chapter two.

- **Research methods pertaining to the phases**

This study was conducted in three phases.

Phase 1: Experiences during reforms and needs for empowerment of nurse managers to facilitate management of change during health sector reforms

Individual in-depth interviews and focus group discussions were conducted inductively and field notes taken during the exploration of the experiences of nurse managers and their need for empowerment to manage change during the reform process. A literature control was carried out to ascertain similarities in existing literature. In conducting the study the researcher adhered to the ethical considerations. Overall permission was obtained from the Ministry of Health and

Social Services. Individual informed consent was secured from the individual participants after letters inviting them to participate in the study had been written to them.

Phase 2: Concept analysis

During this phase of the study the meaning of ”facilitating a conducive environment” was determined. Concept analysis was done according to Chinn and Kramer (1991), Walker and Avant (1988) and Walker and Avant (2004).

Phase 3: Model description, evaluation and guidelines for operationalisation

This phase was accomplished using the results of phase 1, i.e. experiences during reforms and needs for empowerment of nurse managers to facilitate the management of change during health reforms and phase 2, i.e. concept analysis. Relevant literature was used.

- **Measures to ensure trustworthiness**

It is important that the results should be accepted as authentic without reasonable doubt by the members of the scientific community. Thus the researcher used the model proposed by Lincoln and Guba (1985) to ensure

trustworthiness. The criteria of truth-value, applicability, consistency and neutrality were used.

1.6 DIVISION OF CHAPTERS

This study is divided into the following chapters

Chapter one: This chapter consists of the background and motivation for the study, the statement of the problem, aims of the research, research design, demarcation of research and clarification of concepts, and the outline of the chapters of study.

Chapter two: This chapter contains the theory generation design and methods.

Chapter three: This chapter describes the results of the experiences and the need for empowerment to manage change.

Chapter four: Chapter four deals with the results of the concept analysis – facilitating an environment conducive to managing change.

Chapter five: This chapter describes a model for empowering nurse managers to facilitate change in the health sector, through an environment that is conducive to the management of change.

Chapter six: This chapter presents an evaluation, and the limitations, conclusions and recommendations of the study.

1.7 SUMMARY

This research has argued that managing change is a complex process in any institution. The reform process in the health sector in Namibia prompted the researcher to describe a model for empowering nurse managers to facilitate the change process effectively to ensure quality of care in a changing environment. It was important to establish a model that would help nurse managers to develop an understanding of how to deal with the new reforms. The researcher argued that to achieve the above aim nurse managers needed to be empowered to create an environment that is conducive to the facilitation of such a change process. This chapter covered the general overview and rationale of the whole study, including research problem, research purpose and objectives, and definitions of main concepts, research method and the division of chapters. The next chapter will deal with the specific methods used during the study.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In the previous chapter the background and rationale for the study were presented. In this chapter the researcher presents the research design and methods. The main purpose of this study was to develop a model to empower nurse managers to facilitate change smoothly during reforms in the Namibian health sector through an environment conducive to the management of change, with guidelines for operationalisation.

The manner in which this will be done will be explained in the design and strategy to be used in this study. The research design selected should enhance the validity and trustworthiness of the study. The research design and methods are fully described

2.2 THE RESEARCH DESIGN

A qualitative, explorative, descriptive and contextual design for theory generation was used in this study (Mouton 1996:103-109; Chinn & Kramer 1991:79-120; Mouton & Marais 1990:43). The research strategies given above were used to

achieve the purpose and objectives of the study. The main purpose was to develop a model to empower nurse managers to manage the change process in the health sector, through facilitating an environment conducive to the management of change. Reasoning strategies such as inductive and deductive reasoning, analysis, synthesis, derivation, inference, bracketing and intuiting were also described.

2.2.1 Theory generation design

According to Walker and Avant (1988:131) and Mouton (1996:180), theory generation is a dynamic process whereby scientific knowledge is generated. At the most basic level scientific knowledge is made up of concepts, which act as the bearers of meaning by defining the characteristic features of a phenomenon.

The purpose of theory development is to specify the context and situations in which the theory applies and thus it requires that the practice of nursing achieve its purpose, that is, practice and goals (Chinn & Kramer 1991:109). Thus the management of change in the health services is one of the goals that need to be achieved through a model to empower nurse managers to manage change during the reform process, through facilitating an environment conducive to the management of the change process. The management of change through creating an environment conducive to change will be achieved and utilised as a frame of reference by means of guidelines for nurse managers at all levels of

health care delivery, that is, preventive, promotive, curative and rehabilitative health care, in facilitating change management.

During theory generation the focus is on the constructs of research. Constructs are mental constructions based on observations, which cannot be observed directly or indirectly (Babbie & Mouton 2001:110; Walker & Avant 2004:26; Keck 1998:19). This indicates that these are highly abstract concepts that are open to many interpretations (Keck 1998:19), for example change management. Some constructs have little or no meaning outside the context of a particular theory or discipline. In this study the concepts relating to the facilitation of change management were identified within the context of nursing management.

Chinn and Kramer (1991:123) and Walker and Avant (1988:4-12) describe four levels of theory generation. According to Walker and Avant (1988:4-13) the four levels of theory generation are complex as they are interlinked. Therefore, the researcher needs to be clear about the level at which the theory is generated in order for the method to be directed. The four levels of theory as described by the above authors are presented below:

2.2.1.1 Metatheory

This is the first level of theory development and focuses on philosophical and methodological questions related to the development of a theory base for the

management of change. Metatheory also focuses on broad issues related to theory in nursing and does not produce any grand, middle-range or practice theories. However certain issues needing clarity at this level are

- how to analyse the purpose and the type of theory needed in nursing
- how to propose and assess sources and methods of theory development in nursing
- proposing the criteria most suitable for evaluating theory in nursing

However, meta-theory clarifies the methodology and roles of each level of theory development in a practice discipline (Walker & Avant 1988:4-5, 12).

2.2.1.2 Grand theory

Grand theory is the second level of theory. It is fairly abstract and gives a broad perspective to the goals and structure of nursing practice (Walker & Avant 2004:10; Tomey 1998:5; Tomey 1989:5). These theories attempt to describe large segments of the human experience (Polit & Beck 2004:135).

However, grand theories have provided a global perspective for nursing practice, education and research. They also serve as guides and heuristics for phenomena of special concern at the middle-range level of theory. (Walker & Avant 1988:8-9, 12). In the current study, grand theory is based on the Nursing Theory of King's Systems Framework and Theory of Goal Attainment.

2.2.1.3 Middle-range theory

Middle-range theory comprises third level theories that are less abstract and more specific to certain phenomena (Polit & Beck 2004:135; Walker & Avant 1988:10-11). These theories direct the prescriptions of practice theory into testable reality. Therefore middle-range theory is useful in the research and practice of nursing (Walker & Avant 1988:10-11, 13).

2.2.1.4 Practice theory

At level four a practice-oriented theory is used, in terms of which the research-based knowledge is transferred into protocols for nursing practice in order to produce the desired change. Thus the prescriptions for action to achieve the desired goal emanating from middle-range theories prompt the emergence of this theory (Walker & Avant 1988:11-12).

Practice theory is relevant to the current study, as the envisaged model to empower nurse managers to manage change through facilitating an environment conducive to change is practice oriented. This model, which is described in chapter five, led to the development of guidelines for operationalising the model in the health services. Classification of concepts was done through a conceptualisation process within the practice theory as described by Dickoff,

James & Wiedenbach (1968:435-448). The guidelines will be tested in the practice situation.

2.2.2 Qualitative design

Qualitative research tends to emphasise the dynamic, holistic and individual aspects of the human experience, beliefs, values and practices, and attempts to capture those who are experiencing them by observing, questioning and listening (Holloway & Wheeler 1996:3, 7; Polit & Hungler, 1991:25; Burns & Grove, 1997:67).

Thus this study explored the depth and richness of the experiences of nurse managers during the reform process and their needs for empowerment to be able to manage the change process smoothly. The insight gained from the process facilitated model description and guidelines for operationalisation of the model.

No manipulation of variables is involved in qualitative studies (Burns & Grove 1997:542; Mouton 1996:102). Therefore, during the process of data collection, the researcher avoided influencing the nurse managers with her own ideas and opinions about change management by bracketing her own pre-knowledge.

The goal of qualitative research is to develop theory using rich description, data synthesis and abstraction. Thus, qualitative enquiry is a process of documentation, description, identification of patterns and concepts, identifying relationships between concepts, and creating theoretical explanations that explain reality. Through allowing the nurse managers to express their viewpoints on their experiences of the change process and suggesting how they would like to be empowered, detailed documentation, interpretation, observation and explanation were possible. Other techniques that facilitated the successful use of qualitative design included the bracketing and intuition processes as described in Streubert and Carpenter (1995:32-36).

2.2.3 Explorative design

The goal of the explorative design is to gain in-depth knowledge of subjects about which relatively little is known (Babbie & Mouton 2001:278; Sarantakos 1993:114; Carter 1996:183). Thus this design was used to acquire knowledge and insight into the experiences and need for empowerment of nurse managers. By exploring the experiences of nurse managers and their need for empowerment in the facilitation of the management of change, new insights were gained into how they could be empowered from their own perspective. However, a better understanding of the supportive environment necessary for change from their perspective gave rise to the identification of the central concept of facilitating

an environment conducive to the smooth management of the change process in the health sector.

During the process, the researcher remained open to any new ideas as they emerged, in order to facilitate a meaningful explorative process. The researcher used open-ended questions during the interviews, so as to be less verbal and to enable participants to be the main contributors. The researcher also operated from a “not knowing” viewpoint during the interviews.

Explorative design differs from purely descriptive designs, as explorative designs are more focused on specific areas (Seaman 1987:181). However, descriptive and explorative designs are closely related and were used in this study because of the following advantages:

- They enabled the researcher to assemble a broad range of data with a richness of detail that has not been available before. Such data enabled the researcher to develop a model to empower the nurse managers to facilitate the management of change.
- By describing, comparing, and classifying data the researcher gained a holistic view – the patterns and processes were comprehended as a whole.
- The researcher was able to move from observation and description to classification and then to conceptualisation.

- In the process of analysing the descriptive data the researcher was able to condense the stages of research – moving from the description of data to an empirical generalisation (Seaman 1987:185).

However, the researcher kept in mind that this study intended to develop a model to empower nurse managers to facilitate the change process, thus it was important to maintain clarity throughout data collection and analysis. It is therefore also important that a descriptive design be used in the process of developing an approach.

2.2.4 Descriptive design

Description in this study was carried out after intensive examination of the phenomenon under study and its deeper meanings (Fouche 2002:109), that is, the experiences of nurse managers during the reform process, the need for empowerment of nurse managers to manage the change process and the meaning of the concept “facilitating a conducive environment”. Description was carried out by observing, describing and documenting the situation as it occurred naturally (Polit & Hungler 1991:175). After literature control and synthesis, a change model was described and evaluated, and finally guidelines for operationalisation were described. The researcher realised that intuiting and bracketing techniques were essential, so that the concepts that were identified

emanated from the nurse managers themselves. In this way distortions were prevented.

It was important that this study be conducted in its own natural context, that is, in the three health regions of the Ministry of Health and Social Services and the National Directorate.

2.2.5 Contextual design

The aim of contextual design is to describe and understand events within the concrete, natural context in which they occur (Babbie & Mouton 2001:272). Contextual strategy is used because of its intrinsic and immediate contextual significance, and contextual studies are used to select cases, such as individuals, organisations or events, that are included in the investigation (Mouton 1996:133).

The special interest of this study is to describe a model to empower nurse managers to facilitate change smoothly. The context of the nurse managers is the physical working environments in which they currently find themselves. Thirty-nine participants were interviewed at the three intermediate hospitals of Rundu, Oshakati, and Katutura, and at the National Hospital, the National Health Directorate, the University of Namibia, the Namibian Nursing Council, the Namibian Nursing Association and the Namibia Nurses Union. Five focus group

discussions were conducted with the first-line nurse managers, while fifteen (15) individual in-depth interviews were conducted with the rest of the nurse managers.

The vast distances between the health regions where data were collected were some of the factors that probably influenced the researcher's interactions with the nurse managers. The researcher travelled per motor vehicle from Windhoek to Rundu (700 km), Rundu to Oshakati (700 km) and back from Oshakati to Windhoek (700 km). However, the researcher managed to visit certain sites after the initial data had been collected for verification of data collected. A method suitable to match the above designs was necessary.

2.3 RESEARCH METHODS

The researcher used the approach described by Chinn and Kramer (1991:80-108) for this study. This method was used to develop the model to empower the nurse managers to manage change during the reform process in the health sector, with guidelines to operationalise the model. However, the research was conducted according to the following four steps in generating a model:

- Analysing concepts
- placing concepts within relationship statements;
- describing the model
- generating guidelines to operationalise the model in practice

The reasoning strategies are important in theory generation and thus they will be described next.

2.3 1 Scientific reasoning strategies

The following reasoning strategies such as inductive and deductive reasoning, analysis, synthesis, inference, derivation, bracketing and intuiting will be described.

2.3.1.1 Inductive reasoning

Inductive reasoning is the basic intellectual process underlying theory development, and refers to the process of reasoning from specific observations to more general rules (Polit & Hungler 1991:127; Delport & De Vos 2002:52; Streubert & Carpenter 1995:316; Sarantakos 1993:434; Tomey 1998:5). The inductive process involves integrating what one has experienced or learned into a concise and general conclusion (Polit & Hungler 1991:127), in other words, moving from a specific set of observations to the discovery of a pattern that represents some degree of order among all given events (Delport & De Vos, 2002:52). Inductive reasoning involves thinking about observations after the observations have been made (Seaman 1987:38).

On the other hand, the model to empower nurse managers to manage change is regarded as open ended with the purpose of generating knowledge. Thus, the researcher used data from interviews, focus group discussions and field notes to derive a model to empower nurse managers to manage change through facilitating an environment that is conducive for managing change by describing, naming and positioning relationships. In this study the researcher was not required to test the associations or to predict future trends. Instead, the researcher identified suitable concepts for describing an environment conducive to the management of change and, subsequently, the guidelines to operationalise the model to empower the nurse managers during the process of

reform in the health sector. Therefore, the researcher identified patterns or commonalities by drawing inferences from data collected from fieldwork as she was analysing the data (Morse & Field 1996:7).

In this research study, inductive reasoning was used to identify concepts suitable for describing the intended model for empowerment of nurse managers to manage change. To facilitate the process of induction, the researcher utilised two key questions only during interviews. She also utilised other communication techniques to gain in-depth information. The inductive reasoning strategy formed part of the several data sources employed when creating and defining the criteria for including indicators for the concepts. Induction was also used during literature control when identifying similarities between data.

2.3.1.2 Deductive reasoning

The logic of deductive reasoning differs from inductive reasoning in several ways in that its logic is consistent and somehow structured and fixed. This is the process of developing specific predictions from general principles (Tesch 1990:95; Sarantakos 1993:300; Porter 1996:333; Morse & Field 1996:104; 1995:208; Polit & Hungler 1991:643; Bishop 1998:35). Deductive theory builds on previous knowledge and research, and is valuable in situations where the researcher has clearly identified constructs and concepts with which to work (Morse & Field 1996:6).

The aim of this study was to describe a model for empowering nurse managers to manage change during the process of reform in the health sector. Thus this research study employed an inductive reasoning approach. However, deductive reasoning was used during the development of guidelines for operationalising the model for empowerment of nurse managers to manage a change process in the health sector. Description and evaluation of the model for the management of change was carried out using the principles described by Chinn and Kramer (1991:107-125). This empowerment model will serve as a framework or guideline, and also as a point of departure for future researchers.

The components of practice theory as described by Dickoff et al (1968:436-438) were utilised deductively for this study:

- Goal content is the purpose of the activity. The main purpose of this study was to describe the model that will empower nurse managers to manage the change process currently being experienced in the Namibian health sector, with guidelines to operationalise the model.
- Prescriptions are the specific activities to be carried out to achieve the specific goal content, while utilising a survey list.
- A survey list includes other aspects of the activity, such as context, agent, recipient, terminus, procedure and dynamics, when identifying main concepts, defining and classifying these concepts, and establishing their relationships to each other, and finally describing a model for facilitating

the management of change through facilitating an environment conducive to the management of change.

2.3.1.3 Analysis

Data analysis refers to the resolution of a complex whole into its parts, and is a process of imposing order (Babbie & Mouton 2001:161; Polit & Hungler 1991:500), and structure and meaning to the mass of collected data (Babbie & Mouton 2001:161). On the other hand, De Vos (2002:339-340) refers to qualitative data analysis as a search for general statements about relationships among categories of data, while Morse (1994:25), and Morse and Field (1996:104), stated that data analysis is more comprehensive as a

> … process that requires astute questioning, a relentless search for answers, active observation, and accurate recall; process of piecing together data, of making the invisible obvious, of recognising the significant from the insignificant, of linking seemingly unrelated facts logically, of fitting categories one with another, and of attributing consequences to antecedents; process of conjecture and verification, of correction and modification, of suggestion and defence; a creative process of organising data so that the analytic scheme will appear obvious.

However, in this study, analysis was used throughout the study to construct ideas, thoughts and feelings for a better understanding. Inductive analysis was used in the first phase during the empirical data collection. In the second phase, inductive and deductive analyses were used to identify attributes and connotations of facilitating an environment conducive for managing change. During the third phase, deductive analysis was used for model analysis and the formulation of the guidelines for operationalising the model.

2.3.1.4 Synthesis

Synthesis is the putting together of elements or parts to construct a new meaning or pattern which was not previously recognised. Such a product is drawn from many sources and is more than that which originally existed (Burns & Grove 1997:138). However, analysis and synthesis are two different techniques, although they both contribute to theory generation by systematising data meaningfully during data analysis. Thus these two techniques were used interchangeably during the process of theory generation. Similarly, concept synthesis, statement synthesis and synthesis of the model and guidelines played an important part in this study.

2.3.1.5 Derivation

Derivation refers to the formation of words from their origin (Walker & Avant 1988:66-67). Reading widely, critiquing and becoming familiar with the existing literature on facilitating an environment conducive to change management in phase two, and searching other fields for new ways of looking at the topic of interest, resulted in the concepts of facilitating an environment conducive to change management being redefined, and attributes and related connotations formulated. Restating the parent statements and placing them in meaningful relationships during model development were carried out.

2.3.1.6 Inference

Inference is a process by which one proposition is arrived at and affirmed on the basis of certain other propositions (Copi & Cohen 1994:704). Inference was used to explore the literature to clarify the meaning of facilitating an environment conducive to the management of change and drawing inferences from the empirical data collected, from conceptualisation and model description with strategies for operationalisation.

2.3.1.7 Bracketing

Bracketing is a technique used in qualitative research where the researcher suspends his or her everyday assumptions in order to view the processes by which the apparent concreteness of lived experience is assembled (Polit & Beck 2004:253; Gubrium & Holstein 1997:40; Polit & Hungler 1995:696). This technique enables the researcher to deal with personal biases by "bracketing out" the self and to examine his own prejudgments in order to become a clear receptor of the phenomenon under examination. Accordingly the researcher suspended her pre-knowledge of what is needed to facilitate the change process, and was thus able to be objective and receptive to what the nurse managers came up with, as stated in the previous chapter. Another related and facilitative process is intuiting.

2.3.1.8 Intuiting

This process leads to a greater understanding of the reality under investigation by thinking through the data so that a true and accurate interpretation of the meaning of a particular description is achieved (Streubert & Carpenter 1995:316). However, this process cannot be separated from bracketing, as intuiting facilitates the description of what is being studied, and has to follow the technique of bracketing. For the purpose of this study intuiting was used by becoming completely immersed in what the nurse managers described regarding

their experiences and needs for empowerment in order to manage a change process.

2.3.1.9 Summary of research methods of theory generation

This summary is carried out in accordance with Mouton (1996:180-202) by using the phases of the study, and is presented in table 2.1.

Table 2.1: Research methods in theory generation

Research method	**Population and sampling**	Data collection	**Data analysis**	**Validity and reliability/ Trustworthiness**	**Reasoning strategies**
Phase 1 Experiences and empowerment needs of nurse managers	Nurse managers in Rundu, Oshakati and Katutura intermediate hospitals, two regional PHC centres, National Hospital, National Health Directorate, Namibian Nursing Council, University of Namibia, Professional Nursing Association & Nurses Union. Purposive sampling	Focus groups & in-depth individual interviews using single research question regarding nurses' experiences & single question regarding needs for empowerment. Probing was done throughout in the interests of clarity and completeness	Tesch (1990)	Theoretical validity Lincoln and Guba's method of trustworthiness (1985:290)	Inductive, Analysis, Synthesis, Inference, Bracketing, Intuition
Phase 2 Concept analysis	Subject-related literature, Internet, dictionaries, thesauruses, conceptual frameworks and models	Wilson (1969) in Walker and Avant (1988), Walker and Avant (2004) Chinn & Kramer (1991)	Wilson (1969) in Walker and Avant (1988:35-49), Chinn & Kramer (1991:80-104)	Theoretical validity (Mouton & Marais, (1996:62-64)	Inductive, Deductive, Analysis, Synthesis, Derivation
Phase 3 Model description, evaluation and guidelines	Results of phases one & two	Chinn & Kramer (1991); Dickoff et al (1968); Rossouw (2000/01); Copi & Cohen (1994)	Chinn & Kramer (1991:107-125; 129-137); Rossouw (2000/01:10-11); Copi & Cohen (1994:192-195)	Both theoretical validity and method of trustworthiness	Deductive, Inductive, Synthesis, Analysis, Inference, Derivation

2.4 PHASE 1: EXPERIENCES AND NEEDS FOR EMPOWERMENT OF NURSE MANAGERS TO FACILITATE MANAGEMENT OF CHANGE DURING HEALTH REFORMS

The research method constituted the population and sampling, ethical considerations, data collection, data analysis and trustworthiness. Fieldwork was needed for the identification and defining of the concepts as indicated above. The way in which this fieldwork was conducted will be discussed next.

2.4.1 Fieldwork

According to Van der Waal (2000:162), fieldwork in qualitative research is context bound, therefore it is a method of enquiry whereby the researcher comes into face-to-face contact with the respondents in order to collect and analyse the data. However, thorough preparations and considerations are needed before entering the field to conduct the research. The researcher, in the preparation of the field, visited three health regions in 2000, and held informal discussions with certain nurse managers on their experiences of the health sector reforms taking place in the Namibian health sector. This resulted in the establishment of rapport with the nurse managers before the actual fieldwork commenced. Certain of the preparations and considerations for the actual research study will be discussed next.

2.4.1.1 Gaining access to the research site

The research site refers to the place where the research data is collected. (Cormack 1996:44). These sites can take on a wide variety of settings within which research may take place and can vary in size from a single ward to a sample of hospitals, a community-based service, a private or voluntary sector institution, an individual's home or, in the case of population-based research, a street corner where individual members of the public may be approached (Benton & Cormark 1996:102; Cormack 1996:44). However, an ideal site for the qualitative researcher is a site to which entry is possible, where a rich mix of people, interactions and situations relating to the research question is present; and the researcher may adopt and maintain an appropriate role in relation to the study participants (Polit & Beck 2004:56). This research was conducted in three intermediate hospitals, two regional PHC centres, a national hospital, the National Health Directorate, the University of Namibia, the Namibian Nursing Council, the Namibian Nursing Association and the Namibian Nurses' Union.

Before gaining entry to the research sites in order to conduct the research, the researcher assessed the suitability of the sites identified in terms of the accessibility of the nurse managers. In this regard the above sites were judged to be appropriate.

According to Strydom (2002:282), it is essential that the research sites be within easy reach in order to enable the researcher and participants to communicate whenever the need may arise, even after the fieldwork has been completed. Despite the fact that there are vast distances between the places of data collection as mentioned previously, the researcher was able to reach them all within the time allocated for each research phase. However, even after the initial data had been collected, the researcher managed to visit certain sites physically for verification of the data collected, for example Katutura Intermediate Hospital, the National Hospital and the National Directorate. Some individuals from Rundu and Oshakati hospitals were contacted telephonically for verification. After the full data analysis, a half-day seminar was held with the nurse managers who had participated, as well with others who had not participated in the initial data collection. The reason for doing this was to provide feedback for further verification of data.

2.4.1.2 Role of the researcher

The appearance of the interviewer is important. The researcher was neither arrogant nor intrusive, as such interviewers are not successful in gathering information during interviews. Clothes and grooming are also important considerations in the interviewer-respondent relationship (Sarantakos 1993:194). The researcher dressed in a neutral fashion, ideally in a way similar to the way of dressing of the respondents, and also unobtrusively, so that the focus of the

interview was the research topic and not the researcher. Questions which motivated the respondents to give answers that conformed with the view of the interviewer were avoided.

The researcher did not show disbelief in response to statements given, nor did she evaluate answers by encouraging or discouraging certain types of answer (May 2001:130; Sarantakos 1993:194). She avoided appearing superior, but rather gave the impression of the interested researcher who wishes to learn from the respondents. Thus she was neutral, receptive and eager to know the views of the respondents, views which were interesting and valuable for the researcher (Sarantakos 1993:194).

After a discussion of the expected behaviour for conducting a field study, it was important to direct the attention to the ethical and moral implications, which are covered by ethical measures

2.4.2 ETHICAL CONSIDERATIONS

Social research is a dynamic process involving researchers and respondents, and is based on mutual trust and cooperation, as well as on expectations. Thus the researcher reflected critically on her own views or on the views of her participants, or considered the justification for her actions in comparison to others

(May 2001:59), and protected the participants' dignity, as is essential in the conduct of research (Streubert & Carpenter 1995:308).

2.4.2.1 Informed consent for conducting the research

The right of self-determination includes informed, voluntary consent (Seaman 1987:23) and the right to full disclosure. Full disclosure means that the researcher has fully described the nature of the study, the participants' right to refuse to participate, the researcher's responsibilities, and the likely risks and benefits that could arise (Polit & Hungler 1991:33; Streubert & Carpenter 1995:309; Benton & Cormack 1996:107; Sarantakos 1993:25; Strydom 2002:65).

According to Strydom (2002:67), the right of self-determination implies that individuals have the right and the competence to evaluate the available information, weigh alternatives, and make their own decisions.

The information above was given to the participants in simple, easy to understand language, as indicated by Benton and Cormack (1996:107), Polit and Hungler (1991:37) and Lipson (1994:343), so as to enable them to have a full knowledge and understanding of the research project. The participants were given the opportunity to ask questions and the questions were answered (Strydom 2002:65). The researcher requested permission to conduct the interviews and made appointments for the contact sessions with the relevant

participants. In order to secure informed consent, the researcher wrote a memorandum to all the prospective participants in which she explained the following, in accordance with what is described by certain authors (Polit & Beck 2004:151; Seaman, 1987:29; Polit & Hungler, 1991:36-37) and Burns and Grove (1997:210-211), the purpose of the study, an invitation to participate, why the particular participants had been selected, the length of time that would be needed, the way in which confidentiality, anonymity, privacy would be maintained, the right of each participant to refuse to participate or to withdraw, the use to which the research information would be put, and the contact information of the researcher.

Although full disclosure is normally given to participants before participation in a study, there is often a need for further disclosure after the participants have participated, either in the form of debriefing sessions or written communications (Polit & Hungler 1991:34). However, in this study there were continuous consultations between the researcher and certain participants during data verification.

Overall permission was sought from the Ministry of Health and Social Services before commencement of the study. The Ministry of Health's research and ethics committees scrutinised the proposal mainly for, among other issues, ethical adherence and relevance.

As implied by informed consent, the promises were kept, the self-respect of participants protected and ethical guidelines carefully followed (Seaman 1987:23). The researcher tried in every way to adhere to the above-mentioned ethical measures regarding informed consent.

2.4.2.2. Voluntary participation

The principle of respect for human dignity includes the right to self-determination. The right to self-determination implies that prospective participants have the right to decide voluntarily whether or not to participate in a study, without the risk of incurring penalties or prejudicial treatment. It also implies that participants have the right to decide at any point to terminate their participation, to refuse to give information or to ask for clarification about the purpose of the study or any specific questions (Polit & Hungler 1991:33; Lipson 1994:337).

In this study the researcher explained that participation was voluntary and that the participants had the right to choose whether to participate or not, or to withdraw at any stage of the research without any fear of penalty (Streubert & Carpenter 1995:309; McHaffie 1996:34; Gail 1999:174; Parahoo 1997:302; Burns & Grove 1997:200).

2.4.2.3 No harm to the participants

Research that involves human subjects should protect their safety. Thus, the researcher was aware of possible emotional, psychological and social harm (McHaffie 1996:33). In this study the researcher avoided insensitive questions, or questions that could have embarrassed the participants. The researcher also did not permit the participants to feel that they were being ignorant during the data collection stages, for example, during data collection when they were asked about their experiences and needs for empowerment to manage change during the reform process.

Intellectual honesty and integrity are required at each level of the enquiry, thus there is an initial obligation to ensure that the work the researchers are proposing is appropriate. According to McHaffie (1996:32), it is not appropriate, for example, to conduct a study which does nothing to contribute to further knowledge, to carry out the study for the wrong reasons; or to carry out tasks for which one is inadequately prepared. Thus the researcher explained to the participants the possible benefits this study was likely to offer them, for example, knowledge that the information participants provided could help others with similar experiences, access to an intervention to which they might otherwise not have access, comfort in being able to discuss their situation or experiences with an objective and non-judgmental researcher, increase knowledge about themselves or their conditions, either through direct interaction with the

researcher and an escape from normal routine, or through the excitement of being part of a scientific study, and the satisfaction of curiosity about what it is like to participate in a study. At the same time, the researcher also explained the possible inconveniences that could affect them, for example, the emotional distress resulting from self-disclosure, introspection, fear of the unknown or interaction with strangers, fear of eventual repercussions, and anger at the type of questions being asked (Polit & Hungler 1991:33).

2.4.2.4 Confidentiality and anonymity

Confidentiality refers to the researcher's ability to protect data sources, while anonymity refers to the researcher's ability to keep the subjects nameless (Babbie & Mouton 2001:523; Polit & Beck 2004: 149-150; Lipson 1997:40; Burns & Grove 1997:204). However, anonymity can present a number of challenges in qualitative research, for instance, complete anonymity could handicap the researcher, because it prevents the researcher from contacting subjects for follow up. Anonymity also prevents any longitudinal or follow-up studies (Seaman 1987:24) – the participant's anonymity and confidentiality may be threatened by the detailed description of the qualitative research process (Holloway & Wheeler 1996:43; Burns & Grove 1997:205), the data and the sample, the conflicting role expectations of the researcher as investigator and as professional, over-involvement and empathy could create assumptions and inaccuracies in the

research, ethics committees do not always fully understand the character of qualitative research (Holloway & Wheeler 1996:43).

In this study anonymity was achieved only through nameless group analysis and reporting of data (Burns & Grove 1997:205), as the researcher was continuously involved with the participants in the field. The researcher also promised and maintained the anonymity of participants' identity in respect of others (Burns & Grove 1997:204). Confidentiality can be the best means of protecting participants without damaging the research. Even if there are now thirteen health regions, certain top managers, such as undersecretaries, directors and deputy directors could be easily recognised, thus the researcher, instead of reporting data separately according to the health regions or health directorate, analysed and reported the data on a group basis. As there are only three intermediate hospitals, they could also be easily recognised, despite the fact that different levels of nurse managers were involved. Thus the researcher conducted group analysis and reporting of data, making confidentiality attainable. The researcher also explained to the participants that, after completion of the study, the information would be shared with the scientific community and relevant stakeholders.

2.4.2.5. Right to privacy

Right to privacy includes freedom from intimidation and embarrassment (Seaman 1987:23). According to Lipson (1997:40), privacy refers to persons and their interest in controlling the access of others to themselves. The participants determine the time, extent and general circumstances under which private information will be shared with or withheld from others. In this study private information pertaining to the participants, such as activities, attitudes, beliefs, opinions, were included (Burns & Grove 1997:203). Thus a proper explanation was given as to why, how and what would be done with the information, as previously explained, and permission sought to avoid an invasion of the participants' privacy, in order to avoid loss of dignity, employment, or create feelings of anxiety, guilt, embarrassment or shame (Burns & Grove 1997:203). According to Strydom (2002: 68) the privacy of participants can also be ensured when proper, scientific sampling is used. The researcher always ascertained the extent to which each participant was willing to share privacy. As previously mentioned the group analysis and data reporting concealed the identities of participants and thus ensured privacy was maintained. After permission had been granted and ethical measures carefully considered, attention was given to population sampling and data collection.

2.4.3 Population and sampling

Sampling means the selection of a part of the population as its representatives to participate in a research project (Uys & Puttergill 2000:117; Burns & Grove 1997:290; Polit & Hungler 1991:254; Strydom & Venter 2002:199).

However, the researcher purposefully chose respondents who, in her opinion, would have a broad and general knowledge of the topic under study (Polit & Beck 2004:311; Morse 1989:119). This type of sampling is based entirely on the judgment of the researcher, in that the sample is composed of elements that contain the most characteristics representative of the population (Sarantakos 1993:138; Holloway & Wheeler 1996:74; Polit & Hungler 1991:260; Burns & Grove 1997:306; Babbie & Mouton 2001:166; Strydom & Venter 2002:207; Polit & Beck 2004:311).

The sample was selected using the following sampling criteria:

- Top nurse managers, for the purpose of this study, were nurse undersecretaries, nurse directors or deputy directors.
- Senior nurse managers at the National Health Directorate, University of Namibia and Namibian Nursing Council
- Middle nurse managers comprised nurses in charge of the three intermediate hospitals and a national hospital, members of regional management teams, regional PHC supervisors, as well as other relevant senior nurse managers at the intermediate level
- Professional Nursing Association and Namibia Nurses' Union

- First-line nurse managers. These are nurse managers who are in charge of the wards of the three intermediate hospitals and the national hospital.

The sampling criteria were based on the research problem, purpose, operational definitions and design. The nurse managers described above were also known to have had some degree of exposure to the ongoing reforms at their respective levels of nursing management and were therefore deemed suitable to participate in and contribute to the intended model for the empowerment of nurse managers. In this study the nurse managers at the previously mentioned levels, who were willing to participate, were included, as they were regarded as relevant and appropriate to the research study.

2.4.3.1 Sample size

Qualitative studies are not intended for generalisation to large populations, but are intended to provide a thick and meaningful description in order to increase existing knowledge of the phenomenon under investigation. These factors will determine the sample size (Burns & Grove 1997:302). The aim of most qualitative studies is to discover meaning and uncover multiple realities, thus generalisability is not a guiding principle (Polit & Beck 2004:305). Therefore, a specific number of individuals is not necessary to gain significance. These studies, however, rather seek repetition and confirmation of previously collected

data, known as *data saturation* (Streubert & Carpenter 1995:24; Sarantakos 1993:143; Polit & Beck 2004:57).

Thirty-nine (39) participants were purposefully included from the described sampling criteria in order to take part in this study. The reasons for the sample size of 39 are as follows. Firstly there are vast cultural differences between the health regions and the researcher assumed that these would reveal certain different experiences and needs. Secondly, there could be certain differences in staff ratio, which might influence the experiences and needs for empowerment during the process of reforms. Lastly, the first-line nurse managers from the three intermediate hospitals (hospitals which form a bridge between relative low cost, yet cost-effective, district health services and the expensive specialised health care offered at the national hospital) and the national hospital were selected mainly for focus group discussions. However, the focus was on the saturation of data, where the information repeats itself, with no more new information emerging.

2.4.4. Data collection

Data collection deals with decisions about how the relevant data needed to address a research problem should be collected (Polit & Hungler 1991:642; Sarantakos 1993:105). During this phase the researcher explored empirical data obtained from nurse managers operating at different levels of the health care

delivery system, as well as from others who were at the national health directorate and those who were stakeholders, on their experiences of health sector reforms and the subsequent needs for empowerment regarding management of the change process. However, the researcher used the ”bracketing” technique to suspend pre-knowledge of what is needed to facilitate the change process, and was objective and receptive to what the nurse managers revealed. This strategy allowed the researcher to move away from asking *what* questions to asking *how* and *why* questions, in order to obtain a more in-depth understanding of those aspects which are vitally necessary to facilitate a smooth change process.

2.4.4.1 Data collection methods

After permission had been obtained from the Ministry of Health and Social Services to conduct the study in their facilities, the researcher wrote letters to the three intermediate hospitals, the national health directorate, as well as to different individual nurse managers, as indicated in the sampling criteria, requesting individual permission and participation in the study. The regions were also informed when the researcher envisaged visiting them. The individual prospective participants were asked to give the researcher dates that would be suitable for them. After obtaining positive responses from the participants, appointments were made and the collection of data commenced. Data was collected from 17 June until 1 August 2003.

Qualitative researchers always attempt to use a variety of methods and techniques to gain access to research subjects, for example, participation observation, semi-structured interviewing, the use of personal documents and qualitative methods of analysis, such as grounded theory approach, analytical induction, narrative analysis, and discourse analysis (Babbie & Mouton 2001:270).

In this study the main data collection methods were in-depth interviews, focus group discussions, and the review of field notes. However, other relevant research methods were employed to provide a better understanding of the phenomenon under investigation. Each of these methods is discussed in detail below.

2.4.4.1.1 In-depth individual interviews

In-depth interviews are carried out in cases where the researcher knows very little about the topic (Morse & Field 1996:73). This type of interview involves allowing participants the opportunity to describe their experiences in their own words (Porter 1996:118). Thus, in-depth interviews were considered relevant to this study where the needs for the empowerment of the nurse managers to manage change were to be explored.

The value of in-depth interviewing relies to a large extent on a number of factors, for instance, the relationship established between the interviewer and the respondent which succeeds in making the respondent feel important; the degree of commitment of the parties and their interest in the relationship and discussion; economic and other advantages; the ability of the interviewer to use listening and empathy as significant tools of interaction (Sarantakos 1993:196).

Open communication between the interviewer and the respondent is important. Thus, the researcher would ask a general question such as, “How do nurse managers experience the health reform process taking place in the health sector?” After the first question had been exhausted and data saturation reached, the second question was posed, “How do you want to be empowered to manage change in your health services?” The same question was posed to the ”top management” cadres as follows: “How can the nurse managers be empowered to manage change in the health sector?” Using the above open-ended questions the interviewer established the general direction of the conversation and pursued specific topics raised by the respondent (May 2001:125).

In order to obtain accurate and complete answers the researcher used probing “how” and “why” questions. The probe was actually a secondary question, which assisted in gaining more information about an issue addressed in a primary question (Sarantakos 1993:194). The purpose of probing was to obtain more clarity on a given response (Holloway & Wheeler 1996:58; May 2001:129; Burns

& Grove 1997:355), to remain neutral, to avoid bias (Burns & Grove 1997:355), but, and at the same time, not to stress the interviewer's position of power (Holloway & Wheeler 1996:58). However, the researcher was alert to possible uneasiness in answering the "why" questions, thus the researcher was always careful. Clarity was important for maintaining a mutual understanding between the participant and the researcher.

The researcher summarised the participant's ideas, thoughts and feelings that had been verbalised during the interviews. This aspect also gave the participant the opportunity to correct any possible incorrect interpretations (Poggenpoel 2000:155; Babbie & Mouton 2001:289-291). The above summary technique is also described by Sarantakos (1993:194) as a type of probing. In such probing, the respondents' last statements are summarised, thus motivating the respondent to expand on the issue in question, without leading the discussion in a certain direction. The researcher was also aware of possible biases and avoided leading questions. Ideally the respondents were allowed to do most of the talking, while the researcher listened (Babbie & Mouton 2001:289-291; Morse & Field 1996:73; Poggenpoel 2000:154).

Non-verbal communication was also observed, that is, gestures, movements and tones of voice (Greeff 2002:293-294). All individual and focus group interviews were audiotaped after permission to do so had been obtained from the participants, as this allows a more complete record than notes taken during the

interviews. The researcher concentrates totally on the interview process rather than occupying her time with note taking (Greeff 2002:304). These interviews lasted for 1-2 hours (Hutchinson & Wilson 1994:306).

After conducting in-depth interviews with the top and middle management of the nurse managers, as well as other relevant senior nurse managers, focus group interviews were conducted with the first-line nurse managers in charge of the hospital wards.

2.4.4.1.2 Focus group interviews

Focus group discussions (FGD) are relevant in a needs assessment, especially in the exploration of a new issue such as a model to empower nurse managers to manage change during the reforms (Carey 1994:227). During a FGD there is an opportunity to observe a significant degree of interaction on a topic in a limited period of time, to a far greater extent than is possible during a one-to-one interview session (Greeff 2002:306; Babbie & Mouton 2001:292). FGDs are also useful when multiple viewpoints on a certain topic are needed (Greeff 2002:306). At the same time, focus group participants provide direct evidence about agreements and disagreements in their opinions and experiences (Babbie & Mouton 2001:292).

As with any interview the focus group participants were selected on the basis of the unique characteristics they had in common, characteristics that related to the topic because they were all involved in a collective activity (Greeff 2002:306). Before recruiting a particular number of participants, the researcher had first to decide how much information was needed, and also the type of information needed, in order to prevent too small a group that would not yield sufficient information (Babbie & Mouton 2001:292; Polit & Beck 2004:342). Authors have different views on the exact sample size. Some state that the FGD size should be between 10-15 (Polit & Hungler 1991:280); 8-12 (May 2001:125); 7-10 (Morse & Field 1996:26); 5-12 (Carey 1994:229); and 6-10 participants per session (Greeff 2002: 311). However, according to Polit and Beck (2004:342), people are more likely to feel comfortable in a smaller group of four or more people. Carey (1994:229), in support of the above views, argues that the main considerations are the complexity and sensitivity of the topic, and the abilities, expectations and needs of the group members. Some authors suggest the ideal duration for focus group discussions should be between one and a half-hours and two and half-hours (May 2001:125).

However, during the initial stages of this study, detailed information was needed to develop a model that would empower nurse managers to manage change during reforms, thus the researcher did not recruit fewer than six participants in the first three groups of the five group interviews conducted. There are also different views on the number of focus groups. However certain authors have

indicated that no rigid rules should be made in this regard. Babbie and Mouton (2001:292) suggest three to five groups, while Greeff (2002:312) indicated four groups as a rule of thumb. The authors are of opinion that too few groups will not yield adequate information, while too many groups will be a waste of money and time, as the information will be most likely be saturated after the second group interview (Greeff 2002:312; Babbie & Mouton 2001:292).

As previously stated, focus group discussions are relevant in a needs assessment and have numerous advantages (Babbie & Mouton 2001:292). However, there are some limitations to FGDs as well, such as the possible inadequacy of the researcher in managing the group interviews, particularly if the group is large (Carey 1994:231). Thus the researcher selected a manageable size of six to eight nurse managers from each health facility. However, the researcher was aware that certain of the group participants' chose not to talk, thus she did not go below six participants in a group (Babbie & Mouton 2001:292).

Focus group discussions are useful in attempting to understand the diversity of others' experiences, but at the same time it is important that the group maintain an atmosphere of mutual respect, friendliness and willingness to listen to each other (Greeff 2002:307). The researcher must always maintain eye contact and pay attention to what the participants are saying (Barker 1996:227). Non-verbal communication is also important for better understanding. Thus the researcher

observed and recorded facial expressions, gestures and body postures (Barker 1996:251).

The focus group discussions were conducted in a favourable environment without disturbances. The participants were arranged in a circle and comfortable chairs were provided. After the purpose of using a tape recorder had been explained and permission sought, a quality tape recorder was used to make sure that the information was clearly recorded. The researcher was always sensitive to ethical issues and encouraged voluntary participation, which meant that participants could refuse permission to be audiotaped (Bottorff 1994:244). As previously stated, all the interviews were audiotaped after permission had been granted. The purpose of the audiovisual methods is to document exactly and analyse human expressions, feelings and symbols over time, in order to obtain accurate and reliable data (Leininger 1985:332). This enabled the researcher to preserve the actual words of the participants as accurately as possible (Holloway & Wheeler 1996:68) for the data analysis. Before commencing interviews, the researcher tested the tape recorder to ascertain whether the cassette was in the correct position and taping. To avoid interruptions the researcher had extra cassettes and batteries with her.

At the same time the researcher remained aware that confidentiality is a significant concern of focus group research because the nature of the group session may provide more personal information than the members sometimes have anticipated (Carey 1994:228). Thus, before the interview question was posted, the participants and the researcher agreed on the following ground rules: not to all talk at once; there were no wrong or right answers; everybody should feel free to share experiences; what was discussed would not be talked about outside of the group discussion; people could share as much as possible, but still retain the rights to limits on disclosure; the participants had the right to agree or disagree according to their experiences, but other peoples' opinions should be respected; participants were encouraged to speak audibly during the group interviews, so that all the information would be clearly audible and not lost; that the duration of the discussion would depend entirely on the saturation of the information shared.

During the initial group discussions with the first-line nurse managers, the researcher explained the purpose of the discussion although it had also been explained in the letters in which the researcher had sought the individual permission of the participants. The questions, as indicated in the in-depth interviews, were then posed. The interviewer used interviewing techniques such as active listening, responding, nodding, smiling, reflecting, consistency, paraphrasing, silence, reassurance, restating, probing, empathetic understanding and bracketing to identify the most important themes and feelings (Nickols

2004:4). Those members of the group who were less active were encouraged to contribute to the discussion in such a way that would not embarrass them. After the discussion had been exhausted and data saturated, reflection was carried out to ensure that the key points had been captured, to ascertain whether the group agreed or disagreed, and to give group members a chance to add information or explain what had not been correctly recorded.

Different field notes were made as part of the data collection process.

2.4.4.1.3 Field notes

Field notes are described as a "written account of the things the researcher hears, sees, experiences and thinks in the course of the collecting or reflecting on the data obtained during the study" (Greeff 2002:318). These notes include both empirical observations as well as interpretations. However, the researcher kept separate interpretations of the observations (Greeff 2002:304; Morse & Field 1996:91).

In this study, the researcher used field notes to supplement other forms of data collection, such as tape-recorded data which does not reveal the impressions the researcher could have picked up, or the non-verbal communication in an observed interaction. These notes were also used to identify ideas on relationships within the data, which could later assist in data analysis. However,

subjective and objective data were recorded separately. The reason for this separate recording was that the objective field notes are public property and can be used by future researchers, while subjective impressions remain in the researcher's own file (Morse & Field 1996:91).

After each interview the researcher sat down immediately and jotted down her impressions of the interview. These notes helped the researcher to remember and explore the process of the interview (Greeff 2002:304; Van der Waal 2000:168). According to Seaman (1987:289) the interviewer's observations increase the depth of the data collected.

The type of field notes included non-verbal behaviour such as eye contact, posture, gestures between the group members, laughter, and themes that were significant. The researcher also highlighted the conversation as much as possible, as well as the group dynamics (Greeff 2002:318). Points were jotted down during the interviews that were reworked in detail later the same day. These were short descriptions of events to enable the researcher to concentrate on the interview to ascertain the prevailing atmosphere of the situation as well (Morse & Field 1996:91).

The researcher wrote field notes using the participants' own words and did not summarise, in order to record an exact account of what had been said. The field notes included descriptions of physical appearance, dress, style of talking, and

non-verbal communication, such as gestures and facial expressions (Morse & Field, 1996:92). The researcher used a separate sheet every time for the field notes, and wrote down the date, time and setting when and where the observations had been made, in order to cross-check the information with the tape-recorded data of the particular interview (Morse & Field 1996:93).

After the official fieldwork had been completed, aggressive data analysis was carried out.

2.4.5 Data analysis

Data analysis is not the last phase in the qualitative research process, but occurs concurrently with data collection, as data analysis begins as soon as the first set of data has been gathered (Tesch 1990:95) There is no fixed formula for manipulating qualitative data during analysis, thus each qualitative data analyst finds his own process, while bearing in mind the creative involvement of the individual researcher, which is the aim of qualitative research.

Data analysis in a qualitative enquiry is said to be twofold. Firstly, it starts on the research site, and secondly, away from the site following a period of data collection (De Vos 2002:341; Tesch 1990:95; Sarantakos 1993:300; Porter 1996:333; Morse & Field 1996:104; Streubert & Carpenter 1995:208). Thus the

researcher paid attention by concentrating while listening, observing and taking notes during the interviews.

In this study, all data was first collected using the transcripts of audiotaped individual interviews, focus group discussions, field notes and observations. Thereafter, in accordance with Tesch (1990), open coding was carried out during this phase, and the experiences and need for empowerment of nurse managers to manage change during reforms were described. Open coding involves the naming and creation of certain categories pertaining to certain segments of text through close examination of data (De Vos 2002:346; Babbie & Mouton 2001:499). The researcher then reads through the data several times, line by line, and carefully jots down in the margins of the transcripts any ideas or thoughts that come to mind.

Instead of defining and categorising, the researcher involved herself in a search for the patterns and meaning – a search in which she became completely immersed (Tesch 1990:35; De Vos 2002:343), in order to gain a sense of the whole. The researcher then listed all topics and grouped them together in columns of major categories. Transcripts were read again and topics coded into segments of that particular text (Tesch 1990:85-88). Coding refers to the breaking down of data, conceptualisation and the putting back together of the data in new ways (De Vos 2002:346). During this method, data was broken down into discrete parts, closely examined, and compared for similarities and

differences (De Vos 2002:346). A coding format was provided for the reduction of the data.

Topics were then categorised by grouping them together according to how they related to abbreviations of categories, and thereafter arranged in alphabetical codes (Tesch 1990:85-88; Polit & Hungler 1991:501).

When data is placed in relation to the research question, the meaning of the research objective emerges (Streubert & Carpenter 1995:207). In this research the related questions were “How do nurse managers experience the health sector reforms?” and ”How can nurse managers be empowered to manage change in the health sector, in order to facilitate a change process”. The objective of the study, on the other hand, was to develop a model to empower nurse managers to manage the change process through facilitating an environment conducive to the management of change, and guidelines to operationalise the model. In the process of analysing data, all the records kept were reviewed to discover any additional themes related to the findings arising from the observations during the interviews.

However, the researcher was alert to possible researcher bias regarding the subject and its influence on the interpretation of the data. Therefore, the researcher developed a specific frame of reference, which could direct the interpretation of the data (Streubert & Carpenter 1995:207). Data was then

assembled for preliminary analysis. The raw set of data was given to an independent coder who had experience in qualitative research methods and data analysis. After analysis of the data by the coder, the researcher met with the independent coder for a consensus discussion on the analysed data (Tesch 1990:85-88; De Vos 2002:347). The four study promoters of this study were also involved in the process of evaluating the data analysed.

2.4.5.1 Literature control

The results were recontextualised within the relevant literature in order to promote deeper understanding. However, during the initial stage of open coding, literature was kept separate for the time being while the researcher was working with the empirical data to prevent contamination of the information or, from the researcher's perspective, because the participants' categories were not necessarily identical to well-established concepts as described in the literature or to those of the researcher's experiences (Morse & Field 1996:104).

Recontextualisation is the development of the emerging theory so that the theory is applicable to other settings and to other populations to which the research may be applied. According to Morse (1994:34) theory is the most important product in qualitative research. However, description and operationalisation are often other outcomes. Thus this study intended to develop a model to empower nurse managers to manage change, through facilitating an environment conducive to

the management of the change process. Description will be used as the final outcome of comprehension, synthesis and recontextualisation.

Carrying out qualitative research is a big challenge, however, as the procedures for organising images are ill-defined and rely on the processes of inference, insight, logic, and luck, and eventually, with creativity and hard work, the results will emerge as a coherent whole. The variables are not controlled, and until qualitative researchers are close to the end of a study, they may not even be able to determine what these variables are (Morse 1994:1; May 1994:15).

Once data analysis had been completed during this phase, the findings were linked with the already existing scientific knowledge within the field of change management (Botes 2000/01:108). This was done by identifying similarities and differences in the findings of this study with those in previous studies. It is important to note that this study will also be contributing to the existing knowledge, along with other studies, as the results are being verified. Hereafter, central themes and categories identified for the model were classified and described. It is the duty of the researcher to ensure validity and reliability throughout the entire research process. Thus the ways in which these measures of validity and reliability were ensured in the current research study will be discussed next.

2.4.6 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness means establishing the validity and reliability of a qualitative research study, using the criteria of credibility, dependability and confirmability (Streubert & Carpenter 1995:318; Polit & Beck 2004:36). According to the above authors, an enquiry is trustworthy if the research has been processed in such a way that others will be convinced of its worth. The model by Lincoln and Guba (1985: 290-331) was used to ensure trustworthiness for this study. This model was chosen because the terms used are clearly conceptualised. The model consists of the following four criteria: truth value, which was ensured by making use of the techniques of credibility; transferability; consistency, which was ensured by utilising the techniques of dependability; and neutrality, utilising the strategies of conformability. Each value will now be described.

2.4.6.1 Criterion of truth value

The above criterion was used to determine the extent to which the findings of this study are representative of the viewpoints of nurse managers (Lincoln & Guba, 1985:290; Botes 2000/01:188). Since truth value is achieved through credibility, the following measures were used to ensure its attainment.

According to Lincoln and Guba (1985:294-295), internal validity in qualitative research is based on the accurate descriptions of a situation which people would

immediately share on recognising the given description. However, prolonged engagement, member checking, persistent observations and triangulation allowed the researcher to identify recurring patterns, themes and values (Lincoln & Guba 1985:301). (See table 2.2 for application.)

2.4.6.2. Applicability

Transferability is parallel to external validity and deals with the issue of generalisation. It concerns the enquirer's responsibility to provide readers with sufficient information on the phenomenon under investigation, so that the readers are able to establish the degree of similarity between the phenomenon studied and the phenomena to which the findings might be transferred (Schwandt 1997:164; Polit & Beck 2004:41). However, qualitative research attempts to understand a phenomenon within a particular context, resulting in concept transferability, rather than generalisation. In qualitative research saturation is used as a criterion in support of the transferability of research findings (Botes 2000/01:193-194).

In this study, generalising was not the aim, but rather exploration and description. Thus this study provided only a detailed description of literature, research

methods including concept analysis, a description of a change approach and guidelines for operationalisation. This could enable someone who is interested in making a transfer to reach a conclusion about whether or not transfer is possible (Lincoln & Guba 1985: 316). (See table 2.2 for applicability.)

2.4.6.3 Consistency

This criterion refers to the degree to which the findings of this study will be transferred to other groups, contexts and settings. This would entail generalising the results of the study (Lincoln & Guba 1985:316; Morse & Field 1996:118; Streubert & Carpenter 1995:318; Holloway & Wheeler 1996:166).

This criterion assesses the extent to which this study, when applied by other studies involving nurse managers with similar characteristics in a similar context, would provide the same results (Lincoln & Guba 1985:298; Botes 2000/01:188; Morse & Field 1996:118). (See table 2.2 for applicability.)

2.4.6.4. Neutrality

The strategy of neutrality is the degree to which the results of an investigation are determined by the respondents and conditions of investigation, and not by the biases, motivations, interests or perspectives of the investigator (Lincoln & Guba 1985:290). (See table 2.2 for applicability.)

GTable 2.2: Application of strategies to ensure trustworthiness

Strategy	Criteria	Application
Credibility	• Prolonged engagement	• Researcher had been involved with the participants since 2000, even before the commencement of the actual study in 2003 • The researcher was involved in the current study for three years under the supervision of four experts in qualitative research. Of them two are experts in theory generation • Field notes were taken • Asking and probing for more in-depth information until saturation is reached enhances the credibility of the findings • The researcher repeatedly listened to the audio-tape cassettes to internalise the content of the interview • The interactive focus group discussions with various nurse managers at different health care levels, and who have vast experiences in nursing practice and nursing management, led the researcher to believe in their experiences and needs for empowerment.
	• Reflexibility	• Consensus discussion was held with the

		independent coder on data analysis (themes) • Field notes were used to reflect on the researcher's interactive patterns during interviews • Consensus discussion was held on the results of concept analysis and model development with two model development experts, one expert in General Nursing Science, one in Nursing Management and another expert in Change Management. All were experts in qualitative research
	• Triangulation	• Purposive sampling was used • In-depth individual and focus group interviews were conducted • Follow-up interviews were conducted • Different designs were used • Four promoters supervised the study • Multi-data sources, such as dictionaries, books, thesauruses, journal articles**,** Internet exploration, existing models and theories were used for defining concepts. • Relevant change theories or models were used as a basis for this model • Field notes were made and observations carried out to complement other data collection methods • Data was analysed using Tesch's steps • A coder was used for data analysis • Multiple methods were used in data collection from different nurse managers at different levels • Different communication skills were used in combination to help participants to express

		their experiences during reforms and their needs for empowerment during the reform process • Member checking was done and this added to credibility
	• Member checking	• Literature control was carried out • Discussions were held with peers and Model Development experts during the seminars • During follow-up on a few participants summaries of the interviews, data analysis, interpretations, and conclusions were given to them for comment, and to provide the respondents with the opportunity to correct errors and challenge wrong interpretations, as well as to provide possible additional information • Feedback was given to a large group of nurse managers for possible input before finalising the research report. Those who attended were those nurse managers who had participated in the data collection for this study, as well as others who had not participated, in order to control the consistency and stability of the analysis. There was a general sense of agreement with regards to the findings • An independent coder, an experienced qualitative researcher, analysed the empirical data • A professor, who is an expert in general nursing science and qualitative research, was used as a coder for concept analysis
	• Structural coherence	• The focus was on the empowerment of nurse managers to manage the change process,

		through facilitating an environment conducive to change • The research findings were reflected consistently in accordance with the change management theories
	• Authority of researchers	• The four promoters are experts in qualitative research. Of them, two are also experts in theory generation, one an expert in change management, while the other is an expert in general nursing management • The researcher attended a specialised, intensive, international programme in 'Leadership for Change' (1998-2001), where the main focus was on health sector reform, and was awarded full international credits by the International Council of Nurses (Geneva) • The researcher also attended a pre-doctoral programme in Research methodology (2001)
Transferability	• Dense description and comparison of the sample	• The readers will be provided with a detailed description of the study and findings to assess the potential transferability for their own settings • Guidelines described will be applicable in other settings, once operationalised and refined • Five theories in change management in relation to nursing process gave direction to the procedure as to how an environment conducive to the management of change has to be facilitated in the health sector • The guidelines will be tested as a post-doctoral study and hypotheses generated for further testing

		• The recommendations suggested the application of the model in nursing practice, education and research • Extensive verbatim quotes from empirical data were used in the analysis
Dependability	• Dense description, triangulation, peer examination, code-recode procedure	• The research design and research questions are congruent with the steps of theory generation, according the phases of the study • Research questions are clear and unambiguous • Validation of the results of the first phase (experiences and needs for empowerment) and those of the concept analysis enhance dependability • The study is consistent across the qualitative methods of research • The researcher's role and the setting are explicitly described • Data were collected from different categories of experienced nurse managers • Complete descriptive methodology, literature control and verbatim quotes from empirical data were used
Confirmability	• Audit • Triangulation • Reflexibility	• Study methods and procedures were described explicitly, thus making it possible to carry out a complete audit trial • Same as on page 94 • Same as on page 93

2.5 PHASE 2: CONCEPT ANALYSIS OF FACILITATING AN ENVIRONMENT CONDUCIVE TO MANAGING CHANGE

The purpose of the study is to describe a model to empower nurse managers in the health sector to manage a change process in that sector. Thus data was collected from the nurse managers for the purpose of theory generation. This enabled the researcher to identify the central concepts from the empirical data that was later defined, classified and placed into relationships. Thereafter, the model for the empowerment of nurse managers was described, with subsequent guidelines on operationalising the model. Concept analysis consists of concept identification and concept definition.

2.5.1 Identification of concepts

According to Walker and Avant (1988:38-39), concepts can be identified using various sources, such as clinical practice and/or life experiences. However, in this study, fieldwork was used to identify the central concepts, through exploring the needs of the nurse managers as to how they could be empowered to manage reforms in the health sector. Thus the results from the fieldwork facilitated the identification of the central concepts relevant to the empowerment of nurse managers to manage a change process.

2.5.2 Definition of concepts

Concept definition is an essential component of theory development. It is at this point that those concepts selected for use in the construction of a model for empowerment, through facilitating an environment conducive to the management of change on which guidelines for operationalisation will be based, will be subjected to a process of further refinement. As these concepts are cognitive representations of what can be perceived directly or indirectly from the reality (Chinn & Kramer 1991:59), the process of defining the concepts is necessary in order to make them less abstract by adding to their theoretical meaning. Thus in this study, the concepts were defined in relation to how the nurse managers could be empowered to manage the change process in the health sector. These concepts were defined to the extent that they became measurable, so that others could verify them. However, there were several ways in which this concept definition was done.

The researcher used dictionaries, books, thesauruses, journal articles and Internet exploration for identification of the uses and interpretations of facilitating an environment conducive to managing change in order to obtain synonyms that could convey the commonly accepted usage of the relevant concepts (Chinn & Kramer 1991:84). Existing theories also provided definitions that went beyond the limits of common usage. With regard to the concept of facilitating an environment conducive to the management of change, a list of characteristics was compiled.

This list was sorted into categories to render the concept comprehensible, and then, in order to clarify the concept, the list of characteristics was organised and reduced

However, according to Walker and Avant (1988:40), constructing a model case which represents a life experience for better practical understanding can also create conceptual meaning. The researcher constructed a model case from the experiences shared by nurse managers during the fieldwork.

It is important that operational definitions should adhere to theoretical validity, thus the researcher used criteria described by (Rossouw 2000/01: 10-11; Copi & Cohen 1994:192-195). Accordingly, the definition should state the essential attributes, such as

- should indicate the key characteristics that are unique
- should not be circular or repetitive
- should not be too broad or too narrow
- should not employ ambiguous or figurative language
- should not be formulated negatively

The next step is to put the concepts into more meaningful relationships.

2.5.3 Placing concepts in relationship to each other

Placing concepts in relationship to each other means to link the concepts together. The concepts are linked with one another and with others, to ensure that none remain isolated (Chinn & Kramer (1991:114). In this process of newly formed relationships meaning emerges. Thus the structure of theory is dependant on the relationships of these major concepts. Clarity is therefore essential (Chinn & Kramer 1991:96). The next step is the description and evaluation of the model.

2.6. PHASE 3: MODEL DESCRIPTION AND EVALUATION

This step follows the successful completion of concept identification, definition, and classification, as well as the placing of concepts into relationships. In this study, the findings of the needs of nurse managers to manage change and the results of concept analysis served as the foundation of the model. The method of theory generation used was in accordance with Walker and Avant (1988:24-25), Chinn and Kramer (1991:107-125), Dickoff et al (1968:423), Rossouw (2000/01:10-11), and Copi and Cohen (1994: 192-195).

Five change management theories were selected for use in relation to the nursing process in order to describe the procedure of facilitating an environment

conducive to the management of change in the health sector. The model is described according to Chinn and Kramer (1991:107-125).

2.6.1 An overview of the model

The empowerment model is an interactive model for the facilitator, who is the advanced nurse manager and the middle- and first-line nurse managers as the recipients in a health delivery context. Thus the procedure of facilitating an environment conducive to the management of change is a progressive interactive procedure, with the purpose of creating new insights in the nurse manager in order to be able to function independently and autonomously. At the same time the facilitator will, through the contributions made by the nurse manager during this interactive process, also gain greater facilitation skills for future change management sessions.

2.6.2 The purpose of the model

The purpose of the model is to empower nurse managers to manage change independently and autonomously, through facilitating an environment conducive to the management of change in the health sector.

2.6.3 The structure of the model

The assumptions on which the model was based are described. Diagrammatic presentation of the model is provided to enable the reader to follow the reasoning of the entire model more easily.

2.6.4 Process of the model

The procedure to facilitate a conducive environment for managing change is based on five selected theories: the Lewin-Schein change process model in Rashford and Coglan (1994:64-65); Havelock's Theory in Welch (1994:318); Lippitt's stages of change in Welch (1994:319); Stages of Change and Responsibilities of the Change Agent in Marquis & Huston (2003:82-83, 191); and Lewin's Change Process Model in Williams (2002:314), which are in turn based on Lewin's three stages of unfreezing, moving and refreezing. These three stages of Lewin's change process model relate to the steps in the nursing process. Thus the procedure for facilitating an environment conducive to change consists of two components – adequate support and interpersonal relations, active participation and involvement which enhances confidence, and continuous interaction that facilitates knowledge and skills development, which were described according to the above five theories selected in relation to the nursing process.

Five basic rules described by Rossouw (2000/01:10-11) and Copi and Cohen (1994:192-195) for describing definitions were used. The characteristics of the definitions are described under 2.5.2.

2.6.5 Evaluation and refinement of the model

The model was evaluated in accordance with the following criteria described by Chinn and Kramer (1991:129-137):

- How clear is the model? – semantic clarity, semantic consistency, structural clarity, structural consistency.
- How simple is this model?
- How general is this model?
- How accessible is this model?
- How important is this model?

Four experts in theory development evaluated the model in terms of clarity, simplicity, generality, accessibility, and significance or importance in relation to the health services. All four experts have doctorates and are professors. The researcher presented the model to the panel and ensured debate to justify the relevance, accuracy and applicability of the model.

Theoretical validity was ensured at all times since the theoretical framework of Chinn and Kramer (1991) and the basic rules of definitions were adhered to. Scientific reasoning, such as deductive analysis, inductive reasoning, inference, synthesis and derivation were employed throughout the process of model development.

2.6.6 Description of guidelines for operationalisation of the model

Guidelines for practical application were needed as a framework of reference in the health sector. Thus in this study guidelines, which were deduced from the model, have been proposed for the empowerment of nurse managers to manage a change process in the health sector through facilitating an environment conducive to the management of change. Different reasoning strategies, such as inductive, deductive, inference and derivation, were used to describe the guidelines. Throughout all the stages, however, the measures of trustworthiness as proposed by Lincoln and Guba (1985) were used to ensure the validity of this research study.

2.7 SUMMARY

This chapter covered the research design for theory generation and the methods to be used during the study. The methods for ensuring trustworthiness were also

discussed. The next chapter deals with the results from in-depth interviews, focus group discussions, and field notes based on observations and literature control.

CHAPTER 3

DESCRIPTION OF RESULTS OF PHASE 1 OF THE STUDY: NURSE MANAGERS' EXPERIENCES DURING REFORMS AND NEEDS FOR EMPOWERMENT TO FACILITATE MANAGEMENT OF CHANGE PROCESS IN THE HEALTH SECTOR

3.1 INTRODUCTION

The previous chapter (chapter two) of this study focused on the description of the theory generating research design and methods. The results of phase 1 of this study focus on the experiences and needs of nurse managers as to how they can be empowered to facilitate management of the change process.

Thirty-nine nurse managers from three intermediate hospitals (Rundu, Oshakati and Katutura), a national referral hospital, primary health care divisions in the above three intermediate and national hospitals, as well as relevant senior nurse managers in the Ministry of Health and Social Services, the University of Namibia, the Namibian Nursing Council and the professional nurses' association and the nurses' union were purposefully selected. The purpose of the study was described in detail, and consent from the Ministry of Health and Social Services and individual participants obtained (annexure 1 a & b).

Data was collected through FGDs and individual in-depth interviews held from 17 June until 1 August 2003. It is worth noting that, although the staff establishment programme had been approved in August 2003, the programme had still not been communicated to the nurse managers at the stage data was being collected (17 June until 1 August 2003).

The researcher herself selected individuals for in-depth interviews, but relied on the middle nurse managers who were in charge of the regional hospitals for the selection of the first-line managers. The researcher provided clear information to the intermediate hospitals on the selection of the first-line managers. These criteria included those nurse managers whom the middle managers knew would be able to make a valuable contribution to the question of how nurse managers could be empowered to facilitate the management of change in the health sector. However, the regional middle nurse managers had different criteria in their selection of the first-line managers, for instance, long service experience, management training, an educational and training background. Some of the first-line managers were differentiated from others as they had more management experience.

Different categories of nurse managers were selected for individual in-depth interviews and focus groups according to the sampling criteria as indicated under 2.4.3: Population and sampling. FGD were conducted only with the first-line managers, because it was easy to get at least four to six people from the

different hospital wards together at once, unlike with others. Therefore, the rest of the nurse managers were included in individual in-depth interviews.

The researcher introduced two questions, firstly, “How do nurse managers experience reforms within the health sector?” After the first question had been exhausted and data saturation reached, a second question regarding the need for empowerment was posed, namely: “How can the nurse managers be empowered to manage the reform process in the health sector smoothly?”

Extensive, interactive discussion took place among participants in focus groups, while those in individual in-depth interviews spoke their minds. All the participants thus participated eagerly, as the issue under discussion was familiar to them. No manipulation of variables was involved during the data collection (Burns & Grove 1997:542; Mouton 1996:102). The researcher avoided influencing the nurse managers with her own pre-knowledge. Detailed information was gathered as different levels of nurse managers participated. Nurse managers at operational levels had unique experiences relevant to their particular level, while the senior nurse managers communicated freely about both negative and positive issues regarding the health reforms, and provided suggestions as to how certain of the negative experiences could be redressed.

After the nurse managers had granted permission for its use, the audiotape recorder was used. The researcher asked probing questions throughout the

interviews, for purposes of clarity and also to provoke more discussion. The main discussion points were jotted down and reflected upon, in order to reach consensus, and for clarification or any addition after data had been saturated at the end of each interview. The researcher took field notes during the interviews. The primary aim was in-depth descriptions and interpretive understanding of actions and events within the context (Babbie & Mouton 2001:28-33).

The tape recorders were transcribed verbatim and data analysed using the method described by Tesch (1990). Data analysis was carried out inductively. The empirical data was then linked to the existing literature during the process of literature control.

The need was expressed as to how the nurse managers could be empowered during reforms to allow for the independent and autonomous management of change in the future by individual nurse managers. This also contributed to the development of a model for the empowerment of nurse managers and subsequent guidelines to be used in the facilitation of change management.

After the intensive analysis and interpretation of the narrative accounts of the expressed experiences and needs for facilitating change management by nurse managers, the independent coder was given the themes and categories which had been identified. After studying the data analysed, the researcher and the coder held discussions in order to reach consensus on the themes and

categories. This led to the development of one main theme in relation to the nurse managers' experiences, and two main themes with several categories in relation to the needs of nurse managers to manage the change process. The following themes were finally agreed upon:

A. Question 1: **"How do nurse managers experience reforms within the health sector?"**

- Main theme: Inadequate preparation and participation lead to fear and uncertainty among the nurse managers

B. Question 2: **"How can nurse managers be empowered to manage change in the health sector during the reform process?"**

(See Figure 3.1 for main themes and categories.)

Figure 3.1: Main themes and categories of needs for empowerment of nurse managers.

THEMES AND CATEGORIES IDENTIFIED

THEME 1: NEED FOR PARTICIPATION AND INVOLVEMENT OF NURSE MANAGERS IN THE CHANGE PROCESS, WITH ADEQUATE INTERPERSONAL RELATIONS AND COMMUNICATIONS

Categories:

- participation and involvement in the change process
- communicate clear image of the future
- provide time and opportunities to disengage
- reward behaviour in support of change

THEME 2: NEED FOR A SUPPORTIVE ENVIRONMENT FOR A CHANGE PROCESS

Categories:

- develop human resource training
- provide technical and financial support
- encourage social interaction

3.2 DESCRIPTION OF RESULTS

3.2.1 Experiences of nurse managers during reforms

3.2.1.1 Main theme: inadequate preparation and participation lead to fear and uncertainty among the nurse managers

The majority of the participants had consistently experienced inadequate preparation and participation. This resulted in a feeling of being lost being experienced by certain of the nurse managers during the initial stages. Others perceived themselves as observers, whilst a contribution was expected of them. Some felt victimised, while others felt demoted or being a failure. The following quotes support this statement:

“My personal experience is that we were not prepared. There was lack of information on how this restructuring exercise will affect you. Thus the process has lots of fear”.

“If you really go now and ask one of the people in my ward, I think nobody will actually tell you what restructuring mean.”

“No emotional preparation was given to me … I moved from my division. I needed re-orientation and upgrading of my knowledge. My fear was how it would affect me psychologically…”

… “If you are not involved fully, how could one expect you to implement decisions you were not part of”.

“It was scary and stressful – many meetings, new things and we were expected to contribute, while we did not have the sound background.”

“New things always bring fear, but communication was not adequate from the management’s side … If change is needed, it should be something that should be justified. Why should management not be open and communicate it to others”.

“I was totally lost during the early stages… I didn’t know what restructuring was all about… That time, I saw myself just as an observer.”

… “I was a victim of reforms…”

“I felt demoted during those stages when our directorate merged with another one, because we could not defend it according to the criteria of the “core group”.

“The meetings were not conducive at all. It was more of a quarrelling and full of disruptions”…“It was hard, especially with higher people such as directors,

undersecretaries, people from the Prime Minister's office, to put your point as a nurse across"… "It seemed that people already came with a predetermined agenda. They did not take your word. They had all the answers… Nursing service division had a touch time to convince those people, but they failed."

It is a known fact that change knocks people off balance and results in feelings of fear and disorientation. The nurse managers in the current study also experienced these. Therefore the feelings of being lost, of victimisation and of demotion are well documented (Rao et al 1996:434; Williams & Johnson 2004:114; Kouzes & Posner 2003:194; Mills & Bartunek 2003:81; Thomson 2002:204).

Marquis and Huston (2003:89-90) and Cameron and Green (2004:169) are also in agreement that communication and participation are crucial from the beginning of a change process. Accurate information allows people to understand the reasons for the proposed change, while communication helps to alleviate fear of the unknown (Fisher 1996:91; Pettinger 1996:472). According to Marquis and Huston (2003:89-90), when the people affected by the change are called upon to help design the change process, their resistance may be reduced. The nurse managers in the current study shared the same view. They wondered how they could implement decisions that they had not been part of in the beginning.

3.2.2 Need for empowerment to manage change

The following are the main themes and categories expressed as the needs required for the empowerment of nurse managers in order to manage the change process.

3.2.2.1 Theme 1: need for participation and involvement of nurse managers in the change process with adequate interpersonal relations and communications

The above theme was expressed by the nurse managers as a result of the desperate position in which they found themselves during the early stages of the health reforms. When change (restructuring process) was imminent and regarded as vital for the survival of the Ministry of Health, nurse managers did not understand the need for this exercise (see problem statement on page 23).

Four categories were indicated in this main theme, namely

- participation and involvement in the change process
- communicate clear image of the future
- provide time and opportunities to disengage
- reward behaviour in support of change

3.2.2.1.1 Category 1: Participation and involvement in change

All the participants indicated this category as being the most important – thus those who are the more likely to be affected by the proposed change need to participate in the change process from the very beginning. According to the participants, early involvement and participation foster ownership of the change. In other words it is those who are the more likely to be affected by the change who must be the architects of all the steps of the change process. The following quotations are evidence of this:

"… Not many people were properly consulted as to what the restructuring exercise was all about …"

"The feelings of the people need to be explored and questions answered right from the beginning … We need to be involved in whatever the decision that is taken. … for the ownership of the process."

"People need to be involved in discussions concerning such a change and. should be convinced of the need for change."

Many authors are in agreement with the importance of participation and involvement (Stewart 1995:173; Paton & McCalman 2000:172; Booyens 1998:488-489; Chattell 1995:161; Hofnie 2000:9-13; Western Journal of Nursing

Research 1996:314; Dawson 1998:304-316; Lussier 1996:386; Hellriegel et al 1999:442; Williams 2002:57; Nadler & Tushman 1997:258; Haberberg & Rieple 2001:572; Eales-White 2003:135; Bowman & Asch 1996:99).

According to some authors, involvement and participation are important for commitment, and improving productivity, quality, employee morale, motivation, skills, as well as adapting to future environmental changes, fostering ownership of the change process, adapting to change and reducing negative effects such as resistance to change (Stewart 1995:173; Paton & McCalman 2000:172; Booyens 1998:488-489; Chattell 1995:161; Lawler III, Mohrman & Ledford 1992:10; Mullins 1999:651; Jones & George 2000:321).

However, some participants did acknowledge the importance of involvement and participation, but found it time consuming on occasions. The following statement provides proof of this:

“I think involving people is the most important issue. However, it is not always easy. … I think this process could be time-consuming as well.”

Certain authors (Stonor, Freeman & Gilbert 1995:418; Hellriegel et al 1999:444) support the above findings and have stated that participation and involvement can be very time consuming if participants design an inadequate change. However, they initially acknowledged the advantage that people who participate will be committed to implementing change. This aspect could outweigh the time

spent on involving people. However, the authors indicated that carefully planned participation and involvement does serve the purpose.

3.2.2.1.2 Category 2: Communicate clear image of the future

The participants expressed the importance of the need to communicate the vision of the envisaged change process – in other words they need to know why the restructuring is important? How will it operate in practice, and how will new posts be filled and people selected? Who will be affected? What are the new structure and the new roles? What will be my benefits? Which steps will be followed, and will training be provided? When will the process take off and where?

The need for communicating the future image of the organisation, as well as the importance of creating an environment conducive to change management, were realised by the nurse managers and echoed as follows:

“Inform them (nurse managers) to understand the reason why the change is necessary, that is; what exactly is changing, who will be affected, what will happen to those who will be affected, who will be the beneficiaries, and where is the organisation going and why.”

"… Information should be available in written form, but it must be initially verbally provided … Written information is needed for reference purposes in case the manager forgets what she/he supposed to do. This written information should be given in the form of checklists, guidelines, protocols, procedures, policies or manuals."

"Change brings uncertainty, fear and anxiety among those who are subjected to change, thus it is the prerogative of the change manager to create a conducive environment through effective communication."

In support of above findings certain authors indicate that knowledge of the future state renders people committed to the change process. They argue that, if the information is not communicated clearly, people may easily resist the change as they become confused and coupled by uncertainty about the future state (Paton & McCalman 2000:12; Williams 2002:317; McGhee 2002:2). According to Cummings and Worley (1997:155), organisational change involves moving from the known to the unknown, because of the uncertain future. Thus the researcher argues that those who are affected need to be persuaded of the real need for change in order to support the envisaged change process.

As regards the different modes of communication, certain authors are also in agreement that communication should be simple and clear, and carried out through verbal and written protocols to guide the change process (Tappen

1995:327; Hyman & Mason 1995:78; Williams 2002:616; Marquis & Huston 2003:341).

3.2.2.1.3 Provide time and opportunities to disengage

Change brings about feelings of loss in those people used to stability and control. Thus the facilitator needs to make provision for sufficient time in advance of the change in order to allow nurse managers to disengage and have enough time to mourn for what is acknowledged by them to be a loss. The participants in this current study also echoed that they needed time and opportunity for disengagement. The following quotations are evidence of this:

“Change should be a gradual process … do not rush change.”

“More time is needed when new things are coming, to give people time to think it through and adopt. People need to be psychologically ready...”

“Change at short intervals is stressful and frustrating”

In support of above findings, certain authors state that radical change is likely to provoke the most resistance, as people lose their ability to keep pace (Marquis & Huston 2003:93; Allen-Meyer & Katz, 2000:94; Morris 1995:59). Thus they

suggest that change should be given time and implemented gradually, not sporadically or suddenly.

According to Nadler (1989:502), change frequently creates feelings of loss, thus people need time to mourn the old system or familiar way of doing things. This is why people need to be given sufficient time and opportunity to disengage from the present state. The author further argues that accepting a loss and going through mourning takes time, thus those managing change need to take this into account and provide information about the problems of the status quo. They also have to plan for enough time in advance of the change to allow people to recognise the loss and prepare for it.

Although it is essential for change not to be rushed, it appears that those who are most likely to be affected by such change experience planned change that is dragging on too long as demoralising and frustrating. Some participants responded as follows:

"… The new staff establishment of the restructuring process took very long …. It is frustrating. We know there are positions to be filled, but we are still waiting for the staff establishment to be approved … We need to be informed of the progress of the restructuring process, where and how far it is."

"Change that idles is costly, demoralising and frustrating."

According to Ellis and Hartley (2000:284) most significant projects involving change have a specific date for implementation. Once established these dates should be adhered to as closely as possible. Changing dates or postponing action results in people becoming suspicious or critical of the change process. Thus those who have looked forward to the change are disappointed.

The researcher argues that the change process should be planned in phases, and the people likely to be affected involved and kept informed of progress. This will enable them to know at what stage the change process is, and even if there is any delay, they will not only know about it, but they will also be aware of the reason for the delay.

3.2.2.1.4 Rewards for behaviour in support of change

Change knocks people off balance. Thus internal and external motivation is very important to counteract possible resistance. In this study, the participants indicated motivation as an important morale booster. However, they all acknowledged that motivation does not necessarily take the form of money, but that other types of reward are also valid. The following statements support the above claims:

“Motivation is not about money. It gives you feeling that your work is appreciated by somebody, that is enough sometimes…”

“Appreciation gives one a feeling of been valued. You feel as you are somebody and only not just a working tool or object in the system. It gives you new strength to carry on daily basis”

“Appreciation is a very important need during a change process. A person needs to be rewarded for good work”.

“Even if monitory rewards are not always needed, appreciation could include a form of floating trophy or something like that.”

“Give praise where it is due. Praise the people when they do well, because everybody wants to know whether you are progressing.”

“Motivation should start from the person him/herself.”

“Constant support and feedback are part of motivation.”

“People need to be motivated, otherwise they will be demoralised. They really need motivation during a change process, but sometimes they do not get it from

the managers the way they should and they become demoralised in the process."

In support of the view that monitory rewards are not always needed, certain theorists on motivation such as Herzberg (1977), in Marquis and Huston (2003:317-318), argue that money itself does not motivate people, but when used in conjunction with other motivators, such as recognition or advancement, it can be a powerful motivator. Similar sentiment is shared by Beer and Walton (1989:68), who support the view that money is not a main motivator. They argue that better management may accomplish the same result without incurring some of the problems that result from rising expectations.

Certain authors are in agreement with the current findings that advance individual appreciation in the form of praise and personal congratulations (Lussier 1996:187; Kouzes & Posner 2003:334; Mullins 1999:226). According to these authors, praise and congratulations in front of peers are the most powerful, simplest and yet the most underused motivational techniques – techniques that develop a positive self-image in employees and lead to better performance.

Some forms of tangible gifts such as floating trophies were proposed by some of the nurse managers in the current study as a form of appreciation, even if money was not favoured as the only motivator. In support of above view, Shapero

(1997), indicates that creative behaviour could be maintained and enhanced through incentives that reward creative output and encourage risk-taking.

Various authors are in agreement with the views of the nurse managers on self-motivation. According to them people who are self-motivated will keep working toward a result, even if there is no reward, unlike those who are externally controlled and who will most likely stop trying once the rewards have been removed (Kouzes & Posner 2003:112; Senge 1999:140; Marquis & Huston 2003:317-318).

In support of the role of feedback in motivation, some literature indicates that people produce best when they are given feedback. Thus, without feedback, production will be less efficient, and coupled with stress and anxiety (Kouzes and Posner 2003:341).

3.2.2.2 Theme 2: need of supportive environment for a change process

As a result of different contemporary challenges, a supportive environment is vital for nurse managers during the reform process.

The following insert, voiced by one of the most senior nurse managers, is self-explanatory:

> … While reforms are underway in the Namibian health sector, except for the policy changes, there are many challenges that stress the people. It might be possible that policy demands sort of forcing people to carry out certain things that they might not be able to. But the stress is actually the threat of HIV/AIDS they have to face. Sometimes the people themselves are HIV-positive; sometimes they are affected due to their family members who are infected. I don't know how much attention we as managers are giving to this. Today's world is difficult to get the workforce positive. I mean, to be really positive agent of change, you need a lot of courage, convincing and motivating people to change".

In order to render the above theme more understandable it will be discussed under the following three categories: develop human resource training; provide technical and financial support; and encourage social interaction.

3.2.2.2.1 Category 1: Develop human resource training

Some managers were of the opinion that before change management was introduced, management development was the correct vehicle for change management. This means that skills should first be developed among the people who are more likely to be affected by the proposed change. The following statements are evident of that:

“You can’t just bring the change. You must develop your managers, because they are powerful if they have the knowledge and skills. People are the ones who allow you to change the whole set-up of the organisation.”

“Knowledge and skills development are most important ingredients. The managers should be in a position to understand the basics of management, what manager is and whether he/she will be able to really manage the resources that are the key ingredients in the health sector.”

“Besides general management development which creates a conducive environment for management and paves the way for change management, on the job in-service education is vital when the change is imminent.”

“Educate people, communicate the change and, I think, that it is for me important to change their set values. I think it is about education and communication,

getting trust from the people, then they can support you in what you think should be changed....”

A great deal of literature is in agreement with the findings of this study on the importance of management development as a primary tool of the changing organisation (Marquis & Huston 2003:617; Loose, Dainty & Lingard 2003:100, 9; Dawson 1998:304; Nel 1998:410; Williams 2002:317; Lussier 1996). According to these authors, the purpose of such management development is to ensure the availability of motivated nurse managers needed to meet the present and future needs of the organisation.

According to Stewart (1995:150), training and development is essential for achieving individual change through learning. However, the author further argues that the focus of learning cannot be confined to knowledge and skills, as individual beliefs, values and attitudes play an important role in facilitating learning and in the successful implementation of planned organisational change.

3.2.2.2.2 Category 2: Provide technical and financial support

The participants acknowledged the importance of technical and financial support during the change process. The examples of technical support given included funds, cars, equipment, training according to need, people with know how,

policies, guidelines, procedures, and manuals. The following statements were made:

"… the environment could be sufficiently conducive, people well motivated or committed, but without the technical support, change process will not be effective."

"Change will be practical and easy to implement if the resources are available."

In support of the above findings, various authors voice the importance of sufficient technical back-up for the change process (Williams 2002:317; Petrini & Hultman 1995: 4; SIPTU 1999:3**;** Cisco Systems 2003: 6). Some of them strongly believe that lack of supportive infrastructure can result in frustration during the change process and eventually cause its implementation to fail (Petrini & Hultman 1995:4).

3.2.2.2.3 Category 3: Encourage social interaction

The participants raised the issue of the non-supportive behaviour of leaders during the change process and suggested a list of ways in which they would like to be supported in a changing organisation. The following quotations are evident of this need:

“Good interpersonal relationships are important during a change process to keep the spirit going and for effective implementation of change process.”

”The nurse manager should be available to those with individual questions and grievances. This group of people need to have the freedom even to write letters to the top management to air their concerns and grievances and should be answered/addressed in a polite manner.”

“The manager should be flexible, open-minded, patient, attentive and give constructive criticism.”

“The manager should be knowledgeable to convince the people under her, otherwise the change will flop.”

“The manager should also re-evaluate her leadership style. If she is an autocratic leader, people will always have what is seen as negative attitudes, just to show their revolt.”

”… Give the people responsibilities so they can grow, but support them throughout. This will enable them to own the change process… However, the manager has to always constantly support them. … Show trust in what is allocated to them for feeling of ownership.”

“Communication is the important aspect of change management … Communication channels need to be open from bottom-up and top-down. If communication channels are blocked, change will idle, and change that idles is expensive.”

“Feedback should be given to people so they know how they are progressing … Feedback will also enable us (nurse managers) to know how far the change process is.”

“The managers should also have small climate meetings at the operational level to solve the problem of negative attitudes.”

“Small social events could be organised so that the staff gets to know the manager and vice versa … but respect should be always maintained.”

“She (manager) needs to know that people are different and that they react differently towards any change. Thus the manager needs not to stereotype people and accept their uniqueness. She has to accept people by understanding them and their actions during the process of change.”

“Teamwork is very important during the period of change. One manager will really struggle and take a very long time to implement change if he or she is not supported by others.”

“The factors that are causing stress should be identified and strategies worked out how the people could be supported. The managers need to update themselves, be aware of the change all the time so that they can support others, and guide others. These are very important roles of us as managers.”

Some participants experience continuous change as stressful and manager support groups were suggested. The following statements were made:

“You barely recovered from one change and new change is coming. You have not even clearly seen whether your previous programme was successful, and now the new one has come. It can be frustrating.”

“Manager support groups are needed to boost the morale of the managers when they are being stressed out. I think in the future we must get support staff for our senior managers, even if it is just somebody where you can clear your heart. So that we can also have a place where we can drink coffee or read the newspaper or relax during our lunch hour, just to ease your mind. So we are thinking actually to have a support system in place. We are really under pressure.”

As regards the above statement on manager support groups certain managers shared a different view. They wondered how they could support each other, as they are all in the same situation:

“How can we support each other? All of us have our own different issues that stress us.”

Some managers felt that a manager should be a strong and assertive person, and should update her/himself on issues of management in order to be able to cope with the change process:

“A manager should be a very strong person, I mean with that to be assertive and convincing… you should read management books to enable you to cope with the change.”

The need to create a supportive environment during a change process is overwhelming. A number of authors are quoted in the following paragraphs in support of this assertion:

According to Hogan (1997:127), the key component in the effective management of change is the creation of a climate for change, characterised by mutual trust and respect, advance awareness creation of the change process, and adequate communications and negotiations (Hogan 1997:127). People are unlikely to look up to or to follow someone who they perceive as dishonest, or who is likely to

take advantage of them. Thus mutual trust and respect is important in any interaction, and in change management in particular (Robbins & DeCenzo 2001:366; Mullins, 1999:651).

Dawson (1998:304) and Jooste and Minnaar (2003:297) stress the role of leadership in creating a climate that is conducive to change management. According to them, a leader should understand the characteristics of a changing environment and identify strategies for dealing with it in the health sector. Visionary leadership is indicated to be crucial for setting the direction and priorities in a changing organisation through influencing others to accomplish a mission, task or objective (Robbins & DeCenzo 2001:359-360).

In support of the current findings, top management support has been found to be vital in creating an environment conducive to the management of change (O'Toole 1995:74; Rockford Consultancy Group 1999:1-2; Dick & Dalmau 1997:6; Campbell 1997:122).

Adequate communication, involvement, reward, modelling of required behaviour, training, feedback, mobilisation of resources, as well as the use of humour, indicated by the nurse managers as being necessary for enhancing a supportive environment are supported by a great deal of literature (Paton & McCalman 2000:172; Booyens 1998:275, 488-489; Williams 2002:57, 317; Lussier

1996:187; Marquis & Huston 2003:341; Stewart 1995:150; Nel 1998: 410; Ellis & Hartley 2000:282-283; McGee 2002:1).

However, it is the prerogative of the change manager to identify the driving and restraining forces during any change process. Such identification can help to counteract the negative forces drawing the system away from the proposed change. Similarly, those positive forces that support the change should be promoted. This brings the researcher to the identification of driving and restraining forces prevalent during the Namibian health sector reforms.

3.2.2.3 Identification of driving and restraining forces regarding analysed empirical data

The driving and restraining forces involved in a change process as initially described by Lewin and later refined by different researchers were identified and will now be described. Driving forces are those forces which promote the change, or rather, push the system toward the change, while restraining forces are those forces drawing the system away from the change (Marquis & Huston 2003:85; Johnson 1998:198; Walton 1997:213). In order for change to occur the balance of driving and restraining forces should be altered to allow the driving forces to increase or the restraining forces to decrease.

Based on the empirical data, the researcher intends drawing conclusions about what made nurse managers comply with the change process, despite

experiences that seemed to be largely undesirable. This observation caused the researcher to examine the concept of forces for and against the change process, as described below. See table 3.1 for driving and restraining forces.

Table 3.1: Driving and restraining forces in facilitating change management during Namibian health reforms

DRIVING FORCES	RESTRAINING FORCES
• Commitment and loyalty to the employer (Ministry of Health and Social Services) • Acknowledgment of need for change • Perseverance	• Fear, uncertainty and insecurity • Inadequate involvement and participation • Lack of appreciation and recognition • Inadequate communication • Inadequate resources • Lack of supportive environment

According to the above summary of data obtained during fieldwork (Table 3.1), the restraining forces in respect of the management of change during reforms far outweighed the driving forces. This obviously means that these forces were not

in balance and did not therefore form a platform from which change could take off.

However, it was probably the participants' feelings of commitment and loyalty to the Ministry as an employer that resulted in their compliance with the change process and their cooperation with the change agents, although at that stage they had not yet acknowledged the real meaning of the change process.

Resistance always hinders change because of the complex nature of change. People who are used to stability resist change, mainly because of the unknown which lies ahead as a result of the change. It is difficult to "let go" of that to which one has become accustomed. Pettinger (1996:473) suggests that when change is planned, an implementation time frame should be drawn up, as any delay in implementation makes it difficult for people to let go of the old and accept the new.

However, it is logical that it is no longer enough for the people involved to cooperate on particular tasks; they need to feel ownership of the whole, and to understand its relevance to their work. It is reported that if managers perform tasks with which they do not whole-heartedly agree, this is partly due to fear of retaliation by their superiors. On a more basic level, however it is surprisingly due to the loyalty that managers continue to feel towards their organisations. Managers tend to cling to their organisations as a form of security, even without

trust in the organisation (Heckscher 1995:5-6; Kirkpatrick 2001:11; Allen-Meyer & Katz 2000:66).

In the current study, despite the magnitude of the restraining forces mentioned above, the managers still complied with the change process. This could be due to the loyalty trap; however, they did harbour deep doubts privately in respect of their leaders, but refused to express these doubts in public. Another possibility could be the inevitability of the change process, which had already commenced leaving the managers with very little choice but to comply with the change or resign. However, to comply with the change process is one issue, while the impact of such compliance with regard to the effectiveness of the change process is another issue entirely.

Observations did, however, reveal that certain nurse managers in the Namibian health sector who probably did not wish to comply with the envisaged change process did resign at some stage. Maybe this group is the group who felt that it was not sufficiently involved in the change process, as is shown by the three groups studied by Coch and French (1940) as quoted by Robbins and DeCenzo (2001:236). (See page 12 of chapter one.)

3.3 DISCUSSION OF FIELD NOTES

Greeff (2002:318) describes field notes as a written account of the things the researcher hears, sees, experiences and thinks in the course of collecting or

reflecting on the data obtained during the study. These notes include both empirical observations and interpretations. The researcher kept separate the interpretations of the observations (Greeff 2002:304; Morse & Field 1996:91) in order to supplement other forms of data collection. According to Seaman (1987:289) an interviewer's observations increase the depth of the data collected.

3.3.1 Observational notes

Observational notes are descriptions of events that were experienced through watching and listening whilst conducting in-depth, individual, face-to-face interviews with the nurse managers. Certain examples follow.

The nurse managers were willing to chat. However, the FGD participants were slightly reluctant in the beginning and slow to start. It was also observed that the participants expected leading questions. Some thought that there were too many structured questions with yes or no answers, and were surprised by the fact that there were two research questions only. Many of them were appreciative of what they felt was a participatory approach to the management of the change process by making them part of this research.

3.3.2 Theoretical notes

Theoretical notes are purposeful attempts to derive from the observational notes, because the researcher interprets, infers and conjectures in order to reach a conclusion. The following examples illustrate the above:

All the nurse managers who participated in this study were exposed to health reforms at their different levels of performance in the health sector, thus they were open to talk about their personal experiences, and express their needs during the change process. For example, most senior managers could speak out about the experiences they had had with those they had been directing, whilst middle and first-line managers talked mostly about the feelings they had experienced personally during the change process. These were the people who could reveal how they would like to be supported as they had lacked that particular support during the current change process. However, it seems that both groups had learnt from their different experiences. Most senior managers had experienced what it means to go through major reforms while the support from the top is inadequate, while those who had been directly subjected to the change process had also learnt from their misery and wanted something better for their subordinates during any future change process. Building rapport, respect and explaining the purpose of the research secured the co-operation of the participants in this study.

3.3.3 Methodological notes

These notes are instructions, critiques and reminders to the researcher.

The researcher assisted the participants to continue talking by giving both verbal and non-verbal cues to encourage discussions on the support needed during reforms. This was done through nodding the head, leaning forward and encouraging by stating there was no right or wrong answer. The researcher maintained good relationships with the participants through providing

feedback, being non-judgmental, being a good listener, and being flexible, open and friendly (Holloway & Wheeler 1996:8).

In order to obtain accurate and comprehensive answers, the researcher probed using how and why questions, which help to gain more information about the issue addressed in a primary question (Sarantakos 1993:194). Clarity is important for maintaining mutual understanding between the participant and the researcher.

Reflection on participants' ideas, thoughts and feelings verbalised during the interviews were directed back to the participants. This aspect gave the participant the opportunity to correct any possible wrong interpretations (Poggenpoel 2000:155).

Certain statements were validated to ensure that assumptions were not made and that observations and interpretations were confirmed.

3.3.4 Personal notes

These are notes taken by the researcher for her own reflections. Some examples of personal notes that were recorded during interviews with the nurse managers are given below.

I was overwhelmed by the fear and uncertainty with which nurse managers were wrestling during the process of reform. I was able to realise the negative impact that inadequate or a lack of involvement and preparation of human resources could have during a change process. Certain managers were still negative about the reforms, even though those reforms had been going on for a considerable number of years (dated 1995). They did not seem able to say anything positive about support from their superiors during the transition state.

3.4 SUMMARY

In this chapter research findings on the needs of nurse managers for empowerment were presented and discussed according to two main themes identified, namely, a need for participation and involvement on the part of nurse managers in the change process, with adequate interpersonal relations and communications, and a need of a supportive environment for the change process. The results were discussed in the light of relevant literature in order to contextualise findings and highlight the trustworthiness of the results. The following conclusions may be drawn:

Concrete evidence and data on the need for change are crucial for the success of the change process. Resistance to change is inevitable if the individuals concerned feel that they are going to be worse off. People may comply, even in the presence of disequilibrium in driving and restraining forces, but what is not clear is the effectiveness of such compliance. The achievement of sustainable change requires strong commitment and visionary leadership from the top and it is important to build a working environment that is conducive to change through adequate support, participation and involvement. Commitment to change is approved if those affected by change are allowed to participate as fully as possible in the planning and implementation of the change. The aim should be that those involved in the change process come to own the change. The reward system should encourage innovation and recognise success in achieving

change. The next chapter describes the conceptualisation of the central concept: ”conducive environment” for theory development.

CHAPTER 4

CONCEPT ANALYSIS OF "FACILITATING A CONDUCIVE ENVIRONMENT" FOR NURSE MANAGERS TO MANAGE CHANGE

4.1 INTRODUCTION

In the previous chapter, the results of nurse managers' experiences during reforms and the need for empowerment to facilitate the management of the change process in the health sector were presented. In this chapter the researcher examines the attributes of a concept. The analysis itself must be rigorous and precise, but the end product will always be tentative. This tentativeness is as a result of the fact that two people will often come up with somewhat different attributes for the same concept in their analyses, and also because scientific and general knowledge changes so quickly that what is true today will not necessarily be true tomorrow (Walker & Avant 1988:35).

In the previous chapter, the need for empowerment to enable nurse managers to facilitate a conducive environment was presented. The literature control was integrated within the discussion on the results of the need for empowerment of the nurse managers in order to reach a better understanding of the description of facilitating the management of change for nurse managers. The aim was to manage the reforms currently being experienced in the Namibian health sector or

any similar change processes in the future. Thus the purpose of this chapter is to conceptualise the central concept of ”facilitating a conducive environment”. The central concept will enable the Namibian nurse managers to manage change smoothly during reforms in Namibia, thus ensuring quality care throughout.

On the other hand the main and related concepts of facilitating a conducive environment were identified, analysed and synthesised. Thereafter, a model case was developed from the characteristics of the main concepts identified. In chapter two the process of theory development, according to Wilson (1969) in Walker and Avant (1988:37-43), was discussed in detail.

4.2 IDENTIFICATION AND DEFINITION OF CONCEPTS

The identification of concepts was done on the basis of the results from the completed fieldwork, followed by thorough examination, clarification and analysis of the concepts individually, in order to achieve a well-defined concept. The identification and clarification of concepts was discussed in depth in chapter two.

4.2.1 Identification of the central concept

According to the empirical data of the first phase, it became clear that nurse managers had experienced inadequate participation and involvement, inadequate interpersonal relations and communications, and inadequate support

during the reform process. These factors resulted in fear, insecurity and uncertainty during the reform process, and not one of these factors is conducive to the management of change. On the contrary, these factors are known to create resistance to change, as the people who are being subjected to the proposed changes do not know why the changes are needed, how they will be affected, how they will benefit from these changes, and what exactly will change. Moreover, adequate communication could have enabled the nurse managers to understand the change process envisaged, as by asking questions and receiving answers to their questions they could have found out what exactly was going to change, how they would be affected, and what the benefits would be for them. This means that the participants would have been able to make joint decisions about issues affecting them in the change process from the earliest stages.

Participation and involvement, as well as adequate support, could have given the nurse managers a sense of commitment and ownership of the change process, both of which would have enabled them to manage change in the health sector smoothly whilst the change process was actually in progress. A feeling of ownership allows people to take responsibility and accountability for the change process, as they are the initiators and have a better understanding of the pros and cons of the envisaged change process. In other words they have a feeling of authorship. Those nurse managers with a positive experience of the change process would try their utmost to adhere to the resolutions taken or plans made in the course of the change project, and this would enhance implementation,

resulting in the success of subsequent plans. However, it is quite a different matter if others take decisions, and those who are likely to be affected by such decisions are excluded or inadequately involved during the initial stages, and only later subjected to those decisions in which they did not initially participate.

The experiences of the nurse managers in this current study indicated that they were subjected to changes they did not understand properly and in which they did not participate adequately. It is therefore important that nurse managers should be empowered to create an environment conducive to the effective management of the new changes in the health sector. The nurse managers in the first phase of the current study identified the following concepts as those factors necessary for the empowerment of nurse managers to manage the change process effectively. These factors are adequate participation and involvement, adequate interpersonal relations and communications, and an environment supportive of change

The purpose of the model is to empower nurse managers to be able and ready to manage a change process in the health sector. Thus, through progressive, interactive facilitation, the facilitator should guide the nurse manager to a position of knowledge and skill in facilitating an environment conducive to managing change in the health sector.

According to Walker and Avant (1988:42-43), concept analysis also includes the identification of antecedents and consequences. These authors define antecedents as the necessary skills and events that must occur prior to the occurrence of an event or phenomenon. Thus in this study the nurse manager (recipient) and the facilitator (agent) are considered to be the preceding factors or antecedents who will receive and respond to cues relating to the process of empowerment in attaining a conducive environment. Without either of these two components empowerment cannot occur.

However, empowerment starts with the self (Vogt & Murrell 1990:5), thus the nurse manager (recipient) must first possess the necessary professional traits (Marquis & Huston 2003:191). According to the empirical data and the results of concept analysis, the following characteristics are required to enable the nurse manager to be both responsive and responsible for constructing the knowledge and skills needed to facilitate an environment conducive for the management of change: flexibility; responsibility and accountability; open-mindedness, mutual trust and respect, openness; understanding, competence; commitment; strength; assertiveness; ownership; motivation; good interpersonal relations and communications; patience; supportiveness; confidence; safety; and security.

At the same time the empirical data indicated that the advanced nurse manager as a facilitator needs to possess the following characteristics: to be able to guide the change process successfully: visionary leadership, open-mindedness, persuasive abilities, responsibility, motivation; supportiveness; role modelling; good sense of humour; adaptability; emotional self-control; knowledge; confidence; patience; good interpersonal relations, mutual trust and respect.

Some or all of the above qualities of empowerment may serve as antecedents to the empowerment of the nurse managers (recipients) to facilitate the management of change, through an environment conducive to management of change.

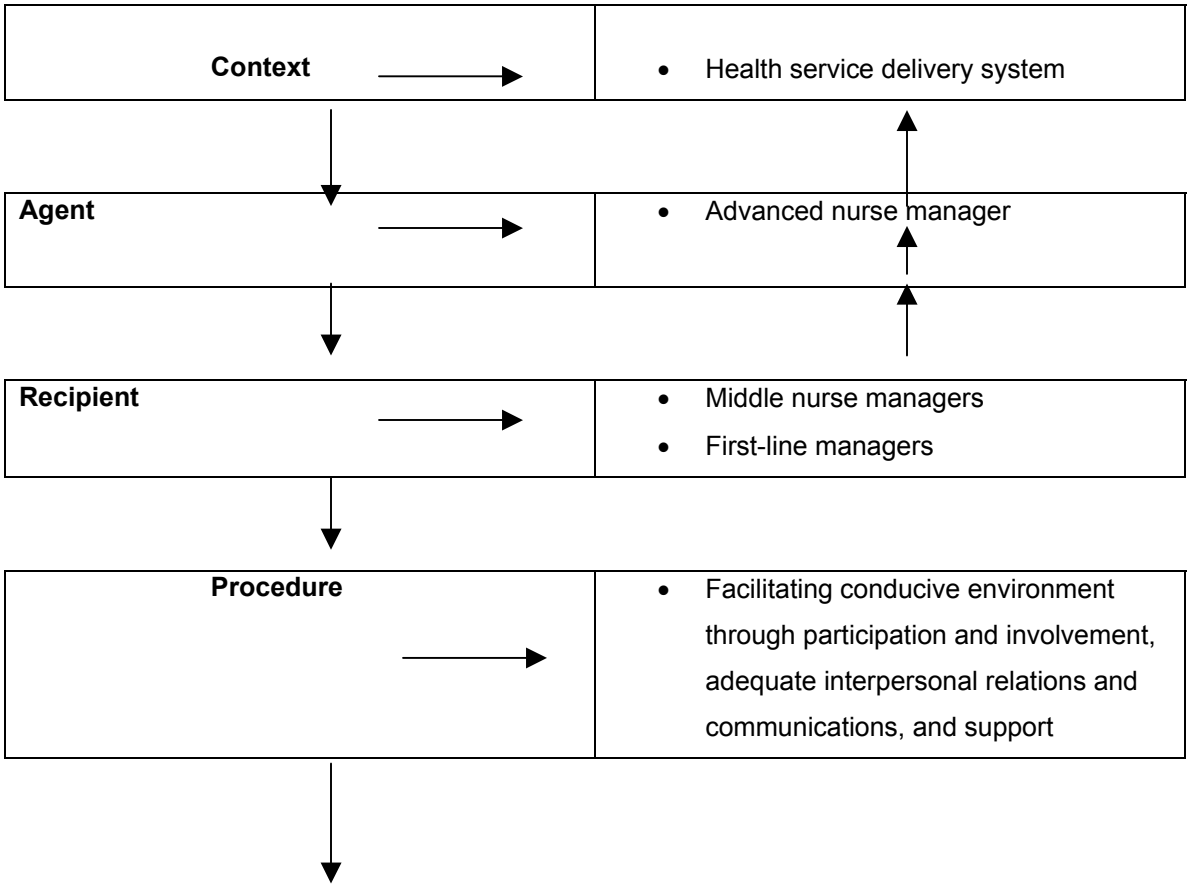
Consequences are those events that result from the occurrence of the concept. In this study the above empowerment traits will enable the nurse manager (recipient) to be responsive to the participatory interactive process between the facilitator (advanced nurse manager) and the nurse manager. Through this interactive process, the nurse manager will gain new insights into knowledge and skills in the management of change. She will become independent and autonomous in managing change in the future. However, the facilitator, who is the primary possessor of the facilitation skills, also gains more experience due to the interactive process during which responses are given by the nurse manager (Yoder 1994:192). These additional skills will also benefit the facilitator during future facilitations, as no two change processes are the same.

The aim of empowerment of nurse managers is to enable them to facilitate the change process, through an environment conducive to the management of change. Therefore, from the concepts identified by nurse managers during the field work (participation and involvement, interpersonal relations and

communication, and supportive environment), "facilitating a conducive environment" becomes the main concept of this model.

4.2.2 The researcher's mental map

The survey list of Dickoff et al (1968:423), which includes the ingredients of context, agent, recipient, dynamics, procedure of the activity and terminus, will be used as a basis for the formulation of the conceptual framework. The aim of this framework is to identify and categorise major and related concepts for further clarification of and reflection on the model for the empowerment of nurse managers to facilitate the change process, through an environment that is conducive to the management of change (See figure 4.1: page 151).



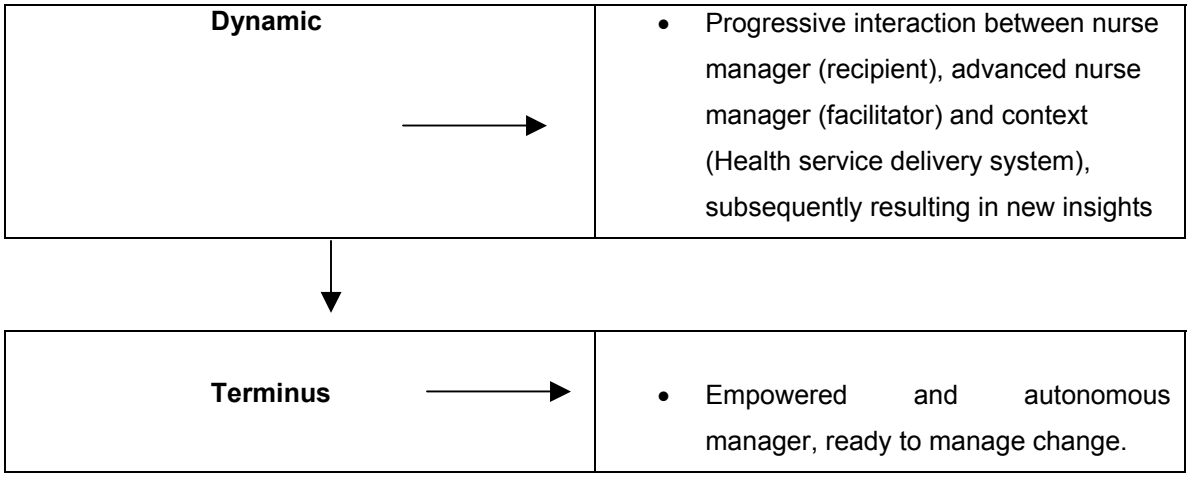


Figure 4.1: The researcher's graphic presentation of the survey list of Dickoff et al (1968:423)

4.3. EXAMINATION OF THE CONCEPT "FACILITATING A CONDUCIVE ENVIRONMENT"

Following the identification of the main concepts of "facilitating a conducive environment", thorough conceptualisation was done. Firstly, the concepts of "facilitating", "conducive" and" environment" were investigated individually, followed by the search for a combined meaning of the full concept "facilitating a conducive environment".

The researcher used dictionaries, books, thesauruses, journal articles, Internet exploration, existing models and theories for the identification of uses and interpretations of "facilitating a conducive environment" to obtain synonyms that would convey the commonly accepted usage of the concepts (Chinn & Kramer 1991:84).

4.3.1 Examination of the concept "facilitating"

Table 4.1: Dictionary and subject definitions of the word "facilitating" and its uses

CONCEPT	SOURCE	MEANING
FACILITATING	**1**. Brown (1993:903)	▪ to make easy or easier ▪ to promote ▪ to help forward ▪ to increase the likelihood of ▪ to strengthen a response
	2. Soukhanov (1992:653)	▪ to make easy or easier
	3. Anderson, Hands & Thompson (1999:195)	▪ to make easier
	4. Trumble & Stevenson (2002:911)	▪ make easy or easier ▪ promote ▪ help forward
	5. Mellish & Wannenburg (1992:187)	▪ make easy ▪ promote or help forward
	6. Hornby (1989:432)	▪ easy or less difficult
	7. Pearsall (1999:508)	▪ make easy or easier
	8. Stewart (1995:108)	▪ enabling something to happen easily, ▪ not to do something oneself, but to promote the doing of it by others
	9. Mellish, Brink & Paton (1998:75)	▪ making things possible

		for others to achieve desired goals
	10. Erickson, Caldwell-Gwin, Carr, Harmon, Hartman, Jarlsberg et al (1998:394)	▪ enable individuals to identify, mobilise, and develop his or her own strengths
	11. Davidson, Seaton, & Schwartz (1999:195).	▪ To make easier
	12. Simpson & Weiner (1989:649)	▪ to render more easily promote ▪ help forward
	13. Robinson (1999:467)	▪ to make something easy or easier to achieve
	14. Schwarz (1994:601)	▪ to make easy or easier
	15. Floyd & Wooldridge (1996:86)	▪ loosening the reins, ▪ encouraging informality ▪ stimulating risk taking in others
	16. Waite (2002:305)	▪ easy ▪ make possible ▪ make smooth ▪ encourage ▪ help ▪ speed up ▪ promote ▪ accelerate ▪ assist

4.3.1.1 Reduction process of identified criteria: "facilitating"

- to make **easy** or **less difficult**
- **promoting** the doing of something by others
- **helping** forward

- **Facilitating means enabling people, by means of adequate support, to identify, develop and achieve their own objectives easily**.

However, in the context of this study, facilitating means that the advanced nurse manager will provide adequate support and guidance to the middle- and first-line nurse managers through the interactive facilitative process to enable them to identify, develop and achieve their own objectives easily and become an autonomous nurse manager ready to manage future change processes.

4.3.2 Examination of the concept "conducive"

Table 4.2: Dictionary and thesaurus definitions of the word "conducive"

CONCEPT	SOURCE	MEANING

CONDUCIVE	**1**. Schwarz (1994:357)	▪ Leading ▪ contributing or ▪ tending ▪ favourable to or ▪ helping towards something ▪ promoting or ▪ encouraging
	2. Davidson et al (1999:109)	▪ tending ▪ helping towards
	3. Neufeldt & Guralnik (1994:290)	▪ something that conduces or ▪ contributes ▪ tending ▪ leading
	4. Pearsall (1999:298)	▪ help to bring about ▪ contributing
	5. Brown (1993:473)	▪ conducing or ▪ tending to (a specific end) ▪ promote or ▪ encourage
	6. Allen (1990:238)	▪ contributing ▪ helping towards something
	7. Soukhanov (1992:393)	▪ tending to bring about ▪ contribute
	8. Cullen, Davidson, Flackett, Grandison, Marshall, Munro, et al	▪ likely to achieve desirable

	Grandison, Marshall, Munro et al (2000:159)	result ▪ encouraging
	9. Hornby (1989:243)	▪ help to bring about something ▪ allowing or helping something to happen
	10. Simpson & Weiner (1989:690)	▪ tending ▪ promote
	11. Robinson (1999:286)	▪ likely to achieve a desirable results ▪ encouraging
	12. Waite (2002:161)	▪ beneficial ▪ advantageous ▪ encourage ▪ promising ▪ convenient ▪ good ▪ helpful ▪ instrumental ▪ productive ▪ useful

4.3.2.1 Reduction process of identified criteria: "conducive"

- **tending, helping** or **contributing**
- **promoting** or **encouraging** condition

- Conducive means a **condition or situation that is supportive to those involved.**

For this study, conducive refers to the health delivery system that is supportive and encouraging to the middle- and first-line nurse managers who are more likely to be affected by the reform process, and an atmosphere conducive to effective change should enable them to adapt easily to the proposed changes.

4.3.3 Examination of the concept "environment"

Table 4.3: Dictionary definitions, and subject definitions and uses of the word "environment"

CONCEPT	SOURCE	MEANING
ENVIRONMENT	**1**. Allen (1990:392)	▪ physical surroundings and conditions, especially as affecting people's lives ▪ external conditions affecting the growth
	2. Brown (1993:832)	▪ the action on environing ▪ the set of

		circumstances or ▪ conditions, especially physical conditions, in which a person or community lives, works, develops… or a thing exists or operates ▪ the region surrounding a place ▪ context, ▪ setting ▪ a structure and condition within which an organism can operate ▪ the combination of things which enables a user to operate a system ▪ the totality of the physical conditions in which a human

		society lives
	3. Schwarz (1994:563)	▪ surrounding ▪ external conditions influencing growth of people ▪ living or ▪ working conditions
	4. Matthews (1997:115)	▪ a context within a word or sentence in which a change or process takes place
	5. Davidson et al (1999:183)	▪ surrounding conditions, especially as influencing a person's development or growth ▪ the natural conditions in which we live
	6. Neufeldt & Guralnik (1994:454)	▪ being surrounded ▪ something that surrounds ▪ all the conditions, circumstances, and influences surrounding, and affecting the

		development of an organism or group of organisms
	7. Soukhanov (1992:616)	▪ the circumstances or ▪ conditions that surround one ▪ surroundings ▪ combination of external physical conditions that affect and influence the growth, development, and survival of organisms
	8. Cullen et al (2000:249)	▪ the surroundings or ▪ conditions that surround and influence a living organism ▪ programme, set of programmes or ▪ an operating system that allows a particular application to be employed ▪ conditions within

		which something or ▪ someone exists
	9. Pearsall (1999:477)	▪ surrounding or ▪ conditions in which a person, animal, or plant lives or operates
	10. Stewart (1 997:129)	▪ the way in which managers behave to other people and the type of business decisions that they take ▪ how they treat their employees, each other, their directors and their customers
	11. WHO/OMS (2001:5)	• environment involves: rules and regulations and laws that govern aspects such as * practitioner behaviour * working conditions

		* facilities • healthcare education among others • environment creates a broad set of incentives and • sanctions for providers and • makes them accountable for their actions • it can be divided into local, regional and national levels, and is created by structures and processes at each of these levels.
	12. Simpson & Weiner (1989:315)	• condition under which any person

	13. Robinson (1999:440)	or thing lives or is developed; • the sum total, total of influences which modify and determine the development of life or character • combination of external conditions that surround and influence a living organism • surroundings or conditions within which something or someone exists
	14. Kahn (1989:171)	• network or • context in which something develops
	15. Lindberg, Hunter & Kruczowski (1994:136)	• physical

	Kruszewski (1994:136)	surroundings of an individual's well-being
	16. Schaefer, Artique, Foli, Johnson, Tomey, Poat et al (1998:199)	• context in which we live our lives.
	17. Phillips et al (1998:248-249)	• all the conditions, circumstances, and influences surrounding and affecting development and behaviour of persons or groups • it is the input into the person as an adaptive system, involving • internal and external factors
	18. Freese, Beckman, Boxley-Harges, Bruick-Sorge, Harris, Hermiz et al (1998:273)	• all the internal and external factors that surround or

		• Interact with man
	19. Tomey (1998:329)	• all physically external factors
	20. Howk, Brophy, Carey, Noll, Rasmussen, Searcy et al (1998:340)	• existing forces outside the organism and in the context of culture
	21. Waite (2002:280)	• territory, • surroundings, • background, • scene, • context, • location, • world, • framework, • nature, • realm, • atmosphere,

4.3.3.1 Reduction of identified criteria of "environment"

- **physical conditions**, circumstances, and **influences** surrounding and **affecting** a person's **life, work, and development.**
- totality of **internal and external** conditions affecting **human beings**

- **internal and external conditions, and circumstances affecting human growth and development positively or negatively**

The environment in this study refers to the physical conditions and circumstances in which the nurse managers find them during the reform process, which were not conducive and resulted in human reactions of fear, insecurity and uncertainty.

4.3.4 Subject definitions and usage of "facilitating conducive environment"

1. Facilitating a conducive environment means:

- establishing an informal, relaxed relationship within the learning group and between the group and the facilitator
    - flexibility in developing relationships (Stewart 1995:109)

2. Facilitating a conducive environment provides:

- praise and recognition
- opportunities for staff to share knowledge, skills and resources
- feelings of being supported (Ellis & Hartley 2000:188-189)

3. New ideas of workers are welcomed

- valued
- encouraged (Williams 2002:301)

4. People are provided with a sense of excitement in their jobs and consequently a sense of belonging to the organisation (Paton & McCalman 2000:151).

5. Environment characterised by empowerment in which effective teamwork is:

- expected
- recognised
- praised
- rewarded
- resources for attaining goals are identified
- facilitator demonstrating patience with team members
- people are listened to and encouraged
- leader relies on two-way communication
- followers are involved in decision making (Hellriegel et al 1999:22, 514)

6. Facilitating a conducive environment:

- provides support
- Is non threatening
- Is backed up by organisational policies that have been clearly communicated to everyone
- people feel safe to express interests and concerns

- bring into public view hidden issues such as
    - creative ideas
    - corporate purpose
    - vision
    - commitment (Vogt & Murrell 1990:52-53)

7. Facilitating a conducive environment:

- involves continuing support
- promotes efficiency in terms of time, cost and impact
- less beaurocracy
- clear policies and clear guidelines
- humanitarian nature is recognised and respected
- human, technical and financial resources are crucial
- sense of ownership is created among employees (Howell 2000:7).

8. A structure with very few job descriptions and where

- rules and procedures are unambiguous and precise
- staff are expected to use their initiative in deciding priorities
- staff work together to solve problems
- communication is largely lateral, rather than through the hierarchy (Boddy 2002:305)

9. Provides an environment that requires a relationship of positive communication characterised by:

- trust, mutual respect, and openness between superiors and subordinates as well as between co-workers

- Work teams support cooperation and help foster a climate characterised by:

- fairness, openness, and trust as the teams place increased emphasis on co-worker communication (Douglas, Martin & Krapels, et al 2003:2).

10. Enabling environment characterised by:

- trust
- authenticity
- openness
- supportive climate (Robbins et al 2003:413).

- **Reduction process of identified criteria within the context of change management**

- Facilitating a conducive environment is about **adequate support** to those affected by the envisaged change process in order to give them a sense of **safety** and **security.**

- Facilitating a conducive environment ensures **adequate interpersonal relations.** Open communication builds **mutual trust** and **respect** between the recipient and the facilitator of the change process**. A clear vision** of the need for and direction of the envisaged change process is crucial for a **reduction in anxiety.**

- Facilitating a conducive environment means the **active participation and involvement** of those involved in the change process to gain **new insights**. An interactive process fosters feelings of **appreciation**, **commitment** and **ownership.**

Conceptualisation of concepts “facilitating conducive environment”:

- situation where win-win approach is applied
- conditions where all ideas are shared, decisions are made collectively and solutions found collectively
- all involved are happy to carry on with the planned change process
- those participating own the change process and are ready to take on the change process
- any possible misunderstandings or any new event that may occur during the change process are dealt with in a participatory manner
- conducive environment is integral to change management
- all involved know what to do, why, when, how, where, what and who during the change process
- everybody is eager to make the change happen
- resistance will not easily occur
- rules and procedures are flattened

A conducive environment involves:

- responsibility to take on new innovations
- top management support which is vital
- transparency of the whole change process
- factors such as participation and involvement, communication, motivation, training, and human and technical resources are crucial for change management
- sensitivity on the part of nurse managers to non-verbal cues

- feelings of safety, security and calmness
- mutual understanding and persuasion
- utilising own initiative
- reduction of stress and anxiety
- acknowledgement of uniqueness of others
- patience and self control on the part of the change agent
- good interpersonal relations
- visionary and knowledgeable leadership
- open-minded and flexible managers
- strong, assertive and trustworthy managers

4.3.5. Reduction process of identified criteria

In this study, the researcher explored the meaning of the concept of "facilitating a conducive environment" in order to provide a theoretical definition of the concept.

This analysis led to the formulation of essential and related criteria relevant to the establishment of a model of empowerment for nurse managers to facilitate an environment conducive to the management of change in the health sector. Criteria with similar meanings contributing to the conceptualisation of the concepts of "facilitating a conducive environment" were clustered together in the drawing up of a list of the essential criteria to be included in the definitions of the term "facilitating conducive environment". A complete list with all the criteria may be found in Annexure 3(c). Related criteria were included as being complementary to the essential criteria (see table 4.4).

Table 4.4: Characteristics of essential and related criteria: facilitating conducive environment

ESSENTIAL CRITERIA	OTHER RELATED CRITERIA
❑ Adequate support and interpersonal relations reduce fear of unknown	• Open communication is encouraged. • Clear vision prevents mistrust and enhances understanding, commitment and motivation to change. • Mutual trust and respect prevail. • Adequate human, financial and technical resources are mobilised and in place. • Feelings of safety, security and calmness prevail.
❑ Active participation and involvement enhances confidence, and continuous	• People are able to work in teams resulting in shared responsibility, accountability and

interaction facilitates knowledge and skills development	ownership • People feel motivated, confident, respected and dignified • The benefit accruing to both the recipient and agent from the continuous interactive process may be utilised in any future change process in the health sector

4.3.6 Conceptual outline

The mental map presented in figure 4.2 represents the progressive, interactive process between the advanced nurse manager (facilitator) and nurse manager (recipient), using the professional traits necessary during the empowerment process for the management of change as **antecedents**, in relation to the components of facilitating a conducive environment which constitute the **process** of facilitating a conducive environment which in turn leads to new **outcome**. However, the concepts of the two components of facilitating a conducive environment are contextualised in the next chapter (Chapter five) in which the definitions of the model will be discussed.

Figure 4.2 Interaction between advanced nurse manager and nurse manager in relation to the components of facilitating a conducive environment that in turn leads to new outcomes.

ANTECEDENTS (Advanced nurse manager)	**ANTECEDENTS** (Nurse manager)	**PROCESS**	**OUTCOME**
• visionary leadership • open-mindedness • persuasion • responsibility • motivation • supportiveness • role modelling • good sense of humour • adaptability • emotional self-control • knowledge • confidence • patience • good interpersonal relations, mutual trust and respect	• flexibility • responsibility and accountability • open-mindedness • mutual trust and respect, openness • understanding, competence • commitment • strength, assertiveness • ownership • motivation • good interpersonal relations and communications • patience • supportiveness • confidence • safety and security	• Adequate support and interpersonal relations reduce fear of unknown. • Active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development.	**Empowered and autonomous nurse manager, ready to manage change process.**

4.4 Model case description

According to Walker and Avant (1988:40), a model case is a real-life example of the use of the concept that includes all the critical attributes of the concept and no attributes of any other concept. Thus a model case was identified and described for the identification of the critical attributes and their related connotations for the meaningful utilisation of a conducive environment in the context of nursing services management.

Ms Nadia (not an original name for the purpose of confidentiality) is a nurse manager who has been in charge of a regional hospital for ten years. The health services were structured along racial and ethnic lines and were curatively biased. The top management of MoHSS deemed it necessary to restructure the health services by introducing the primary health care (PHC) approach. When this idea came to light MoHSS invited certain senior nurse managers, including Ms Nadia, to attend the relevant meetings. Ms Nadia did attend the meetings but was not clear on what restructuring was all about. “I didn’t know what restructuring was all about. That time I saw myself just as an observer.”

During those meetings top management introduced the concept of rationalisation, in terms of which certain directorates would have to merge according to their functions. MoHSS proposed that the previous eight directorates would merge to form five key functional units only, namely: planning

and human resources development; specialised services; PHC and nursing services; administration and finance; and social services.

However, it was expected of Ms Nadia to defend her directorate and convince top management why she was of the opinion that her directorate need not to be merged with other directorates. She did not have sufficient background knowledge of the reforms, and therefore was unable to present an acceptable argument. Eventually Ms Nadia's directorate merged with others. "It was hard, especially with higher people such as directors, undersecretaries, and people from the Prime Minister's office, to put your point as a nurse across, especially if you had no sound background of the restructuring process."

After her (Nadia) directorate had merged with others she felt distressed, demoted, and uncertain of her future career as she had not been able to convince top management. "One's future is in somebody else's hands … It's scaring, we don't know about the implementation. I still have fear for unknown … Restructuring will affect many professionals' lives and result in their downfall."

Ms Nadia felt threatened, uncertain and demoted, and was of no use during the initial stages of the reform process in the health sector. She had needed support in the form of information on the restructuring process and why restructuring was needed in order to reduce her fear of the unknown. ***Adequate support and interpersonal relations reduce fear***, but this had not happened in the case of Ms Nadia. She had been requested to attend meetings in which preprepared agendas had been discussed, but it seems that when the actual change process started, the need for change had either not been clearly communicated, or it had

not been properly understood by Nadia. This level of participation did not allow for the liberty to make joint decisions, as it seemed as if decisions had already been taken and certain participants were merely informed of these decisions, regardless of the fact that participatory decision making enhances commitment.

Two years after the initial stage of reform Ms Nadia was exposed to a particular programme which dealt with health reforms, and she was updated for the first time. By then she had already moved to a new non-nursing department as a manager at the same level on which she had been functioning before. However, when this option of moving to the specific non-nursing department had been proposed, Ms Nadia had been very negative, as she did not know what was awaiting her on the other side.

> I was put into a deep end but I swam ... It was not easy but it was a good thing that happened to me… No emotional preparation was given to me… I moved from my division. I needed re-orientation and upgrading of my knowledge. My fear was how change would affect me psychologically … I will make sure that this will never happen to any other person… It was actually that programme I attended on health reforms that helped me, without that, it could be still very difficult.

“Restructuring is actually a challenge, but without proper preparation it is a nightmare”. Ms Nadia said further that she is now receiving ample support from

her top management in the form of exposure through attending and chairing extremely large and important meetings, and that the amount of support she is enjoying has enabled her to feel comfortable. “I am also exposed to this new field through workshops etc. My director and our permanent secretary are very supportive and have much confidence in me. That is also what makes me more comfortable and confident at this stage.”

Active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development. At her new level, Nadia was more active and not merely in the sense of attending meetings and agreeing on proposed issues. She was supported and trusted by her top managers and was able to chair ”big meetings”. She was empowered firstly through the programme on health reforms, and secondly, in her new area through attending workshops and through the support of the permanent secretary and director. Thus she felt comfortable and confident. Nadia went so far as to say that what happened to her had been a good thing (referring to the move to the new department), and that she would never wish her negative experiences to happen to anybody else in future.

Ms Nadia was confident and comfortable in her new area and did not regret her move.

I have learned lots of new things and I am exposed to very high levels of management … I think I would never learn all these things before which I know

now. I will never think of going back to my previous directorate. Support was not forthcoming in my previous directorate as I would have liked it during the initial stages, but I think this is a learning process for all of us. This is the first time MoHSS is going through such a transformation. So! All of us are learning.

According to Nadia's own observations of her first-hand experiences it is clear that competence is developed through continuous interaction. This implies that both the recipient and the agent learn through the interactive process. The agent learns better methods of facilitating the change process, while the recipient gains new skills and knowledge on the management of change through this interaction.

4.5 DEFINITION OF THE MAIN CONCEPT: "FACILITATING A CONDUCIVE ENVIRONMENT

Facilitating a conducive environment is based on: **adequate support and interpersonal relations that reduce fear of the unknown, while active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development.**

Open communication fosters mutual trust and respect between the recipient and the facilitator during a change process, while a clear vision of the change process reduces fear of the unknown and secures a feeling of ownership in respect of the change process.

Through the continuous, interactive process between the recipient and the facilitator skills and knowledge regarding the dynamics of change management will be developed, and both parties will gain experience and confidence in the facilitation of such change management, resulting in life-long learning, which they will use in any similar change processes in the health sector.

4.6 CONTEXTUALISATION OF FACILITATING A CONDUCIVE ENVIRONMENT

The criteria from the model case also serve to describe the elements, which are associated with facilitating a conducive environment. The essential and related criteria from the model case are pertinent to identify the concept of facilitating an environment conducive for the management of the change process in the health sector, as these criteria have been drawn from the field experiences of the nurse managers during the reform process in the health sector. Thus the researcher will be able to recognise the model elements to be incorporated in the concept definition of the model for empowering nurse managers to manage change, through facilitating an environment conducive for the management of change in the health sector.

4.7 SUMMARY

This chapter dealt with the concept analysis of the central concepts for the later development of the proposed model for empowering the nurse managers to manage the change process, through creating an environment conducive to the

management of change. The results of the concepts analysis revealed two categories and their related connotations, as laid out in table 4.4. Against the background of the identified and defined concepts a model will be formulated to illustrate the relationship between the concepts as well as the situation in which the concepts are operational. The next chapter will focus on the description of a model to empower nurse managers through facilitating a conducive environment.

CHAPTER 5

A MODEL AS A FRAMEWORK OF REFERENCE TO EMPOWER NURSE MANAGERS THROUGH FACILITATING A CONDUCIVE ENVIRONMENT

5.1 INTRODUCTION

The previous chapter dealt with the concept analysis on how an environment conducive to managing change can be facilitated by nurse managers in the health sector. However, the purpose of this chapter is to develop a model to empower nurse managers to facilitate an environment conducive to the management of change in the health sector. The integration of needs identified regarding the empowerment of nurse managers to manage the change process during the first phase, and the results of the concept analysis in the previous phase formed the basis of the conceptual meaning and identification.

This chapter will be divided as follows: firstly, model description using the method described by Chinn and Kramer (1991:107-125), followed by an evaluation of the model also using the method described by Chinn and Kramer (1991:129-137), and then thirdly refinement by experts in model development and qualitative research. Finally, guidelines to operationalise the model will be described.

5.2 MODEL DESCRIPTION

The model will be described under the following subheadings: an overview, the purpose of the model, and then the structure of the model consisting of assumptions on which the model is based, concept definitions, relation statements and the nature of the structure. The above

components will be followed by a model evaluation, and the formulation of guidelines to operationalise the model in the health service delivery sector.

5.2.1 An overview of the model

The diagram in figure 5.1 portrays a model in terms of which nurse managers will be empowered to manage change, through facilitating an environment conducive to the management of change. However, empowerment is an interactive process that develops, builds and increases power through cooperation, sharing and working together. In order for the empowerment process to take place, it is necessary that the nurse manager, who is the recipient, should possess professional traits so as to be able to respond to the cues of the empowerment process. Moreover, the advanced nurse manager must possess empowering skills that will enable the nurse manager be someone who nurtures the development of an empowered staff (Marquis & Huston 2003:191).

This empowerment model is an interactive process, involving the nurse manager as a recipient, the advanced nurse manager as a facilitator of the change process, and the context which is the health services delivery system in which the entire interaction is taking place. Through the above interactive process between facilitator and nurse manager skills, knowledge and confidence are being developed, that will ultimately enable the nurse manager to function independent and autonomously to manage the change process. During the interactive process the advanced nurse manager will also gain greater empowering skills through the contributions made by the nurse managers, as no two-change projects are the same. However, the way in which this knowledge, skills and confidence will be gained will depend on the existing professional traits of the nurse manager and the advanced nurse manager, as has already been indicated.

The procedure of this model is based on the two components of facilitating an environment conducive to change as influenced by the progressive, interactive facilitation within the framework of the nursing process (assessment, planning, implementation, evaluation and feedback) and derived from five theories on the management of the change process. The first component comprises adequate support and interpersonal relations that reduce fear of the unknown, while the second component demonstrates active participation and involvement which enhances confidence, and knowledge and skills development, through interaction.

The results from the data obtained from the participants show that inadequate participation and involvement, inadequate interpersonal relations and communications, as well as inadequate support, are all clear indicators of the negative experiences of nurse managers during the health sector reform. These negative experiences resulted in fear, uncertainty and insecurity among the nurse managers. Instead they needed adequate support and interpersonal relations that reduce the fear of the unknown, as well as active participation and involvement that enhances confidence, and knowledge and skills development, through interaction.

The researcher, as a nurse manager and an educator, well equipped with knowledge and skills relating to “leadership for change”, with special focus on the

health sector reforms, will lead the facilitating strategies in respect of the empowerment of the middle and first-line nurse managers as the recipients of the interactive process. The stakeholders, represented by training institutions of health professionals and co-opted nurse managers from MoHSS dealing with human resource development, will practise as co-facilitators under the direct or indirect guidance of the facilitator.

5.2.2 The purpose of the model

The purpose of this model is to empower nurse managers to facilitate the change process in the health sector, through an environment that is conducive to the management of change. This theoretical framework is provided by means of adequate support and interpersonal relations, and active participation and involvement on the part of all those affected. The dynamic interactive process facilitates skills and knowledge development for future utilisation.

5.2.3 The structure of the model

Based on Chinn and Kramer (1991:107-125), the structure of the model consists of those assumptions on which the model is based – concept definitions, relation statements, and the nature of the structure.

5.2.3.1 The assumptions

Based on the theoretical nursing approach with regard to person, interaction and environment, the following assumptions will be described (Sieloff et al 1998:305). Theoretical frameworks, on which the procedure for facilitating an environment conducive to change in the health sector is based, will be described as well.

- **Assumptions**

According to King's Systems Framework and Theory of Goal Attainment, the nurse managers as the recipients of the skills and knowledge arising from dynamic interaction, have the capacity to think, to know, to make choices and to select alternative courses of action, and are unique and holistic beings in interaction with the changing environment (Sieloff et al 1998:305-306). These aspects emphasise the importance of support, good interpersonal relations and communications, as well as the need for adequate participation and involvement on the part of those who are affected by a change process. Such participation and involvement will enhance confidence, and continuous interaction between the advanced nurse manager (facilitator) and the nurse manager (recipient) will facilitate knowledge and skills development. Based on King's Systems Framework and Theory of Goal Attainment (Sieloff et al 1998:305-306), the following assumptions may be made.

- Nurse managers are unique, holistic, of intrinsic worth and are capable of rational thinking and decision making in most situations. The nurse manager needs to be involved in decision making as early as possible during the process of change. The uniqueness and holism of the nurse managers means that their views, feelings and concerns need to be respected and not be stereotyped.
- Nurse managers are entitled to adequate support and interpersonal relations during the process of change.
- A system has inputs, outputs, and control and feedback processes. Thus the researcher believes in the involvement of nurse managers and adequate feedback throughout the process of change.
- The researcher believes that knowledge and skills will be developed through the dynamic interaction between the nurse manager (recipient) and the advanced nurse manager (facilitator) and the context (health sector). The facilitator will gain facilitation skills, as change is accompanied by several reactions and feelings. This implies that

no two change situations will offer the facilitator a similar experience. On the other hand, the nurse manager, who is a recipient, will gain adequate skills and knowledge on how to facilitate an environment conducive to the management of change.

- The researcher believes that the interactive facilitation that exists between the facilitator, recipient and the context will create an environment conducive for change management.
- The researcher also believes that a lack of balance in the structural or functional interaction in one of the subsystems, that is, the facilitator, recipient or context, could lead to poor adjustment, with the result that the recipient will experience fear, insecurity and uncertainty which will manifest in a lack of cooperation, while the facilitator will be expecting cooperation. A context that is not conducive to change management will, on the order hand, affect the other two components in interaction. Therefore, the facilitator should plan in advance to allow for all these aspects before a change project is implemented. This model is applicable to nursing practice, education and research.

- **Theoretical departure of facilitating a conducive environment**

This theoretical departure of the procedure of empowerment of nurse managers to manage a change process, through facilitating an environment that is conducive to that change, is based on Lewin's Change Process Model – a model that was later refined by different theorists and researchers. Lewin's Change Process Model consists of the three stages of unfreezing, moving and refreezing.

In unfreezing, the change agent loosens the grip of the factors or forces that are maintaining the status quo or keeping the situation as it is. This involves increasing the perceived needs for change and creating discontent with the current situation. During the moving stage, the change agent identifies, plans and implements appropriate strategies to bring about the change. Changes are integrated and stabilised during the refreezing stage. Positive feedback and encouragement are vital during this stage for the new behaviour to persist (Ellis & Hartley 2000:276).

For the purpose of this study the following five theorists were reviewed, based on Lewin's Change Process Model (1951):

- Lewin-Schein Change Process Model in Rashford and Coglan (1994:64-65)
- Havelock's theory in Welch (1994:318)
- Lippitt's Stages of Change in Welch (1994:319)
- Stages of Change and Responsibilities of the Change Agent in Marquis and Huston (2003:82-83, 191)
- Lewin's Change Process Model in Williams (2002:314)

A brief description of the three stages of unfreezing, moving and refreezing as they appear in the works of the above five theorists will be provided for the purpose of highlighting similarities between their work.

- **Lewin-Schein Change Process Model (Rashford & Coglan 1994:64-65)**

- unfreezing stage: motivating change, give direction and support
- moving stage: establishing strategies to restore equilibrium
- refreezing stage: creating stability for new learned behaviour to survive

- **Havelock's Theory (Welch 1994:318)**

- unfreezing: building relationships, diagnosing the problem and acquiring the relevant resources

- moving stage: choosing the solution and gaining acceptance
- refreezing: stabilising and self-renewal

❑ **Lippitt's Stages of Change (Welch 1994:319)**

- unfreezing: diagnosing problem, assessing the motivation and capacity for change, and change agent's motivation and resources
- moving stage: selecting progressive change objectives, choosing the appropriate role of the change agent
- refreezing: maintaining the change once it has been started, and terminating a helping relationship

❑ **Stages of Change and Responsibilities of the Change Agent (Marquis & Huston 2003:82-83)**

- unfreezing: gathering data, accurately diagnosing the problem, deciding if change is needed, making others aware of the need for change.
- moving stage: developing a plan, setting goals and objectives, identifying areas of support and resistance, including everyone who will be affected by the change in its planning, setting target dates, developing appropriate strategies, implementing change, being available to support others and offering encouragement throughout the change, evaluating the change, and modifying the change, if necessary
- refreezing: supporting others so the change remains

❑ **Lewin's Change Process Model in Williams (2002: 314)**

- unfreezing: sharing reasons for change, being empathetic to the difficulties that change will create for managers and employees, communicating the details simply, clearly, extensively, verbally, and in writing
- moving: explaining benefits, identifying respected managers to manage the change effort, allowing the people who will be affected by change to express their needs, not beginning

change at a bad time, such as the busiest part of the year, if possible, maintaining employees' job security to minimise fear of change, offering training to ensure that employees are both confident and competent to handle new requirements, changing at a manageable pace – do not rush change.

- refreezing: Top management to send consistent messages and provide resources, letting others know when and where change is working, offering counselling or other services to help employees deal with the stress of change

5.2.3.2 Concept definitions

Based on the practice theory of Dickoff et al (1968:435), the integral concepts of the model are the following: the health service delivery system (context), the facilitator (agent), the nurse manager (recipient), the interactive facilitation (dynamic), the two components of facilitating an environment conducive to change (procedure) and the purpose, that is, the ability of the nurse manager to manage a change process autonomously.

5.2.3.2.1 Health service delivery system (context)

The health service delivery system is a dynamic, ever-changing context, practised within legal, ethical and professional boundaries at regional and district levels. The Ministry of Health and Social Services, together with its stakeholders, are responsible for providing quality care to their consumers, and are thus equally responsible for creating an environment conducive to change management in order to achieve the above main aim.

5.2.3.2.2 Facilitator (agent)

The facilitator refers to a person registered as a nurse and midwife in terms of section 20 and 64 of the Namibian Nursing Act, No. 8 of 2004 (Nursing Act No.8. 2004. Government Gazette of the

Republic of Namibia 3249:7) and who possesses expert knowledge and skills in leadership for change.

5.2.3.2.3 Nurse manager (recipient)

A person registered as a nurse and midwife in terms of section 20 and 64 of the Namibian Nursing Act, No. 8 of 2004 (Nursing Act No. 8. 2004. GovernmentGazette of the Republic of Namibia 3249:7), who is appointed and authorised to manage a section or a unit. For the purpose of this model, the term "nurse manager" refers to a registered nurse in charge of three intermediate hospitals, a national hospital and its wards, as well as PHC supervisors. In order to facilitate an environment conducive to change, the nurse manager is an active participant in the interaction, under the guidance of the facilitator, in order to gain necessary skills and knowledge in terms of the dynamic process of change management, so as to be able to function autonomously in practice.

5.2.3.2.4. Interactive facilitation (dynamic)

Interactive facilitation involves the dynamic, mutual interaction between the advanced nurse manager (facilitator) and the middle- and first-line nurse managers (recipients), with the aim of facilitating an environment that is conducive to the management of change in the health sector. Facilitating this type of environment refers to adequate support, and interpersonal relations that reduce the fear of the unknown, while active participation and involvement enhance confidence, and continuous interaction facilitates knowledge and skills development.

5.2.3.2.5 Empowered, autonomous nurse manager (purpose)

The progressive, interactive facilitation process results in creating in the nurse manager new insights, which comprise knowledge, skills, attitudes and values in respect of the management of

change, with the ultimate purpose of being able to manage a reform process in the health sector autonomously and independently.

5.2.3.2.6 Components of facilitating an environment conducive to change (procedure)

Facilitating an environment conducive to change involves the following two components:

Component 1: Adequate support and interpersonal relations reduce fear of the unknown.

- Adequate support refers to providing a satisfactory quantity or quality of human, financial and technical resources for the implementation of the change process, and the effective and efficient management of the process.
- Interpersonal relations refer to the mutual understanding, openness, trust and respect on which the interactive process is built.
- Fear refers to an uneasy feeling or the anticipation of something bad.

- Confidence refers to firm trust or a feeling of certainty. Confidence and mutual trust are the pillars on which the relations are built during a process of change. Where there is no confidence or trust the relationships will be corrupt from the outset. Thus it is expected of the facilitator in a changing environment to ensure confidence and trust by being transparent and honest about the change process, and involving those nurse managers who are likely to be affected by such changes.

Component 2: Active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development

- Active participation means either taking part, active involvement, or sharing with others. This implies a mutual involvement in decision making between the facilitator and nurse manager, in order to facilitate the development of the knowledge and skills needed for management of change. Therefore, it is necessary that the facilitator possess the skills to involve nurse managers in the decision-making process, rather than simply telling them what to do after a decision has been made
- Involvement refers to the level of perceived, personal importance and/or interest evoked by a stimulus within a specific situation. In the changing environment the active involvement of the nurse manager will enhance commitment and facilitate knowledge and skills development through a better understanding of the change process. No involvement or

inadequate involvement will eventually lead to a lack of trust, uncertainty, fear and insecurity.

- Enhance means to increase. This implies that the confidence of the nurse manager will be boosted through the interactive facilitation process.
- Knowledge refers to familiarity gained by experience. Successful change management demands knowledge about the emotional conflict of those affected. Thus a knowledgeable facilitator will implement complex transformation processes successfully through involving those nurse managers who are likely to be affected by such organisational changes. The nurse manager will also gain knowledge as a result of the interactive facilitation between her and the facilitator that will increase the possibility of future independent action.
- Skills refers to the ability to do something well. As a result of the guidance during the progressive participation and involvement nurse managers will develop knowledge and skills regarding the process of managing of change through facilitating a conducive environment.

5.2.3.3 Structural format of the model

The nature of the structure of the model will be described to enhance understanding. The diagrammatic presentation of the nature of the structure is depicted by figure 5.1, and includes all the central and related conceptual relationships.

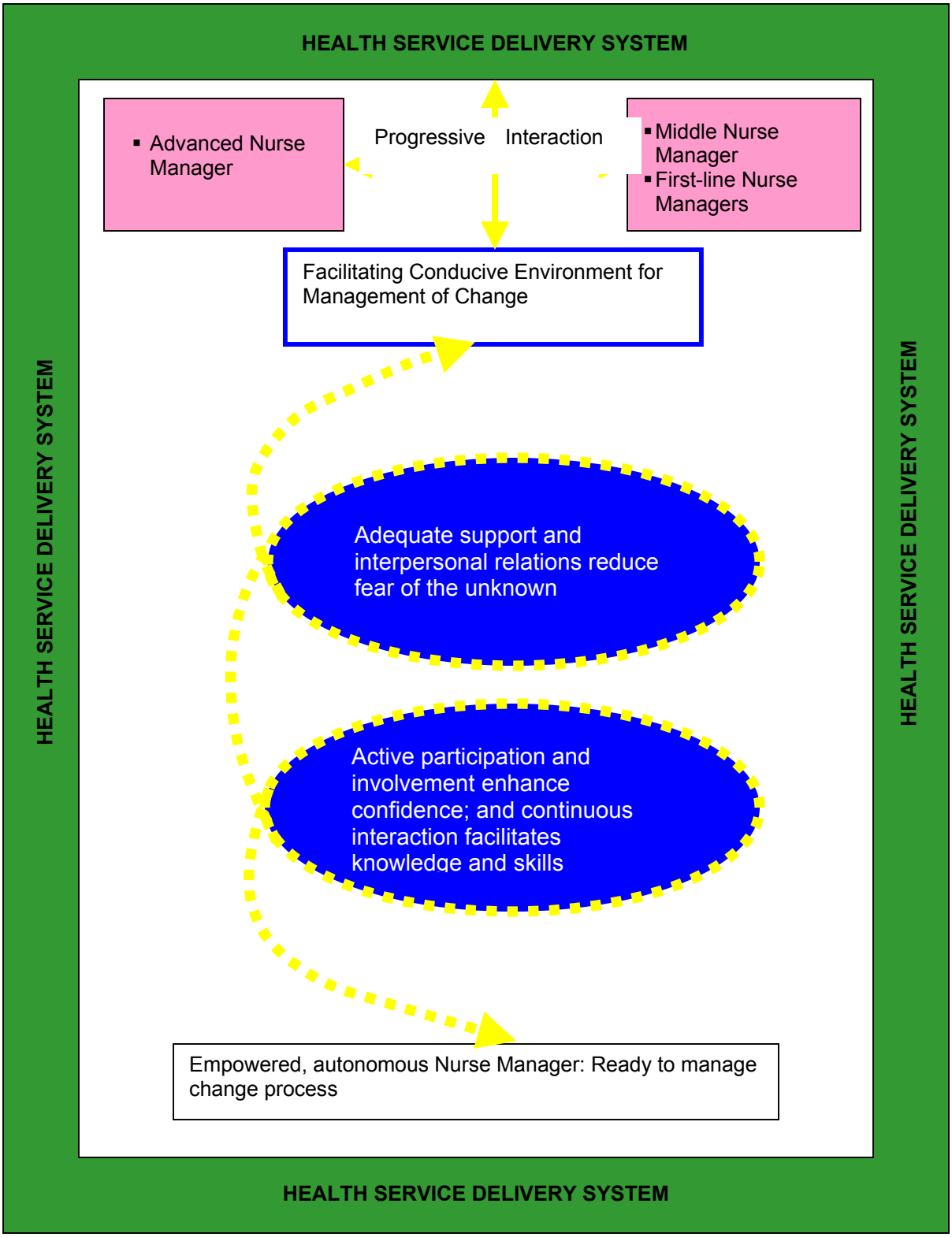

HEALTH SERVICE DELIVERY SYSTEM
Advanced Nurse Manager
Progressive Interaction
Middle Nurse Manager
First-line Nurse Managers
Facilitating Conducive Environment for Management of Change
Adequate support and interpersonal relations reduce fear of the unknown
Active participation and involvement enhance confidence; and continuous interaction facilitates knowledge and skills
Empowered, autonomous Nurse Manager: Ready to manage change process
HEALTH SERVICE DELIVERY SYSTEM
HEALTH SERVICE DELIVERY SYSTEM
HEALTH SERVICE DELIVERY SYSTEM

Figure 5.1: A model to empower nurse managers to manage change, through facilitating conducive environment

The green rectangle or outside border of the model depicts the health service delivery system. The colour green symbolises growth and life, and this depicts a health service delivery system that is a dynamic, constantly changing context for facilitating an environment conducive to managing the change process. The health sector, which is in partnership with other relevant stakeholders, is responsible for the quality of health care through the mobilisation of human, financial and technical resources to create an environment conducive to the management of change. The health service delivery takes place within the legal and professional environment of regional and district levels.

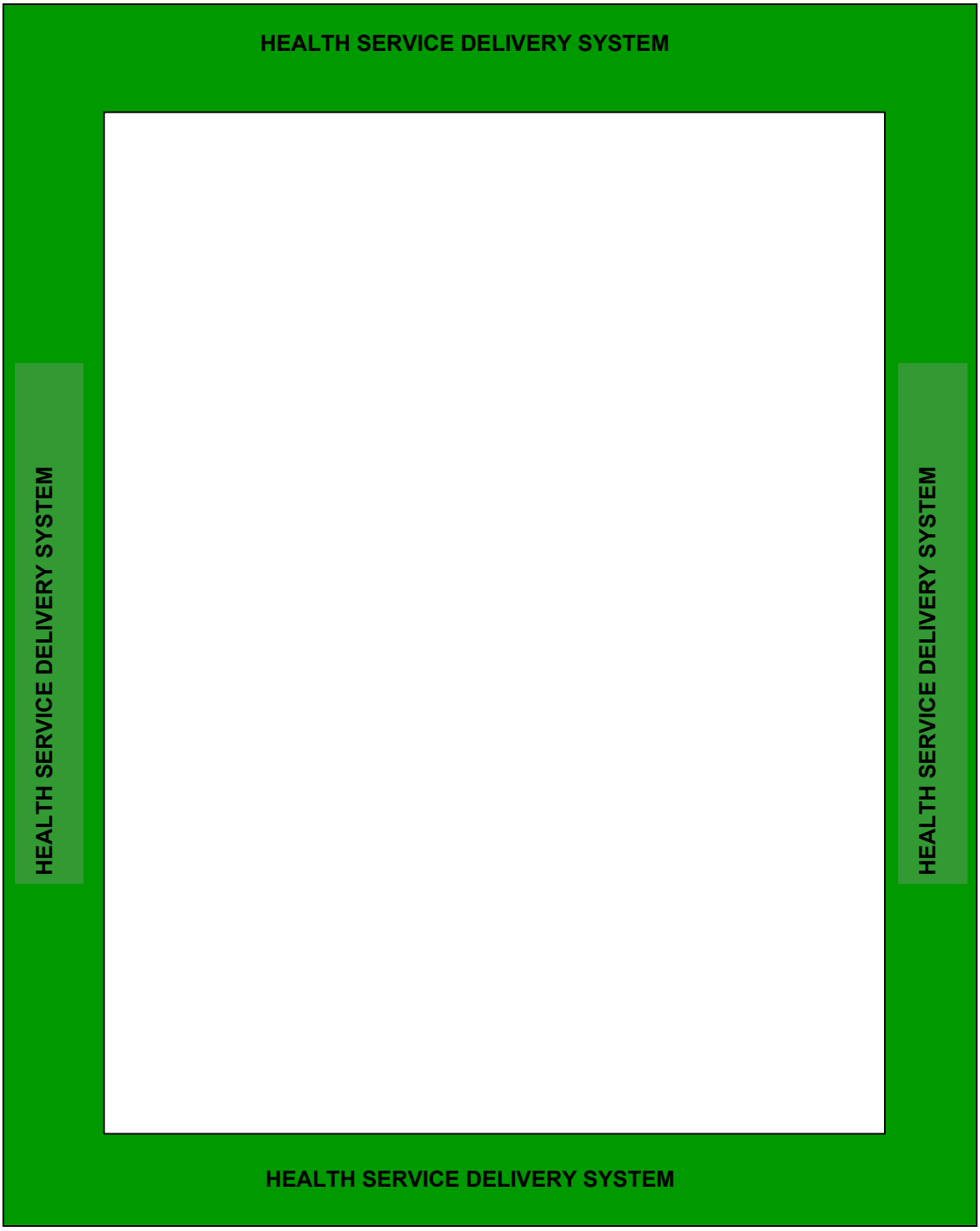


Figure 5.2: Health services delivery system as context

The pink rectangle on the far left-hand side depicts the advanced nurse manager (facilitator), who is in interactive facilitation with the nurse manager, in order to guide her/him to create an environment conducive to the management of change, with the aim of empowering the nurse manager to function autonomously in the health sector.

The pink rectangle on the far right-hand side depicts the nurse manager (recipient), who is under the guidance of the skilled, advanced nurse manager, in order to construct new insights, which comprise the knowledge and skills necessary for the effective management of change. The pink colour depicts the nurturing effect which is an aspect of the progressive interaction taking place between the advanced nurse manager and the middle and first-line nurse managers.

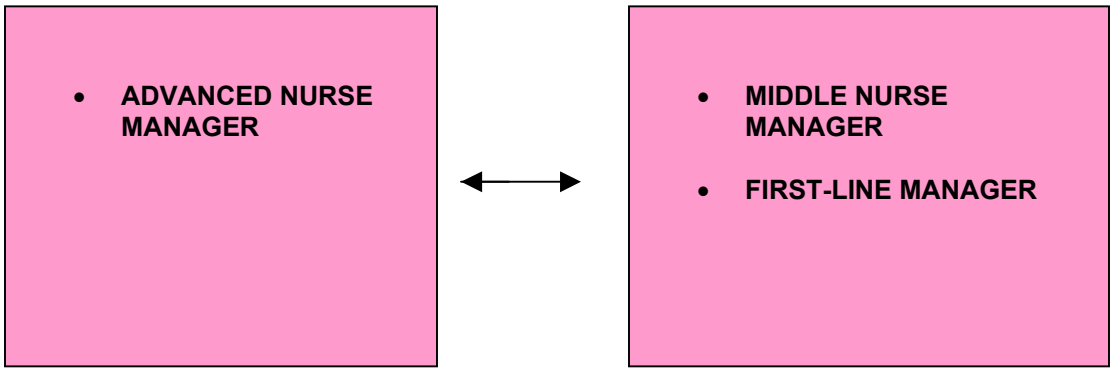


Figure 5.3: Advanced nurse manager as a facilitator and middle and first-line nurse managers as recipients of the interactive, empowerment process

The blue spiral process shown in dotted lines below the advanced nurse manager and the middle and first-line managers depicts the procedure by which the advanced nurse manager and middle and first-line managers facilitate a conducive environment through progressive, interactive facilitation. The strategies used are adequate support and interpersonal relations that reduce fear of the unknown, active participation and involvement that enhance confidence and continuous interaction which facilitates knowledge and skills development.

During the spiral process of interaction, the advanced nurse manager initially takes full responsibility in guiding the middle and first-line managers who are the recipients of the empowerment process. However, as these nurse managers gain new insights by constructing their own knowledge and skills, the advanced nurse manager becomes less instructional. This allows the middle and first-line nurse managers to take charge of creating a conducive environment on their own, and functioning independently and autonomously. However, the

interactive facilitation between the two still continues in respect of support needed, but at a reduced level.

The dotted lines depict the incomplete nature of the change and illustrate the flexibility and openness during the interactive facilitation process between advanced nurse manager as a facilitator and middle- and first-line nurse managers as the recipients.

The blue colour depicts calmness and the feeling of being in control. Middle and first-line managers are actively involved during the procedure in order to be able to construct and internalise knowledge and skills and thus to function independently.

Figure 5.4: Spiral process depicting the procedure of facilitating an environment conducive to the management of change in the health sector

The yellow, cross-like vertical and horizontal arrows between the advanced nurse manager (facilitator) and middle and first-line managers (recipient), health service delivery system (context) and components of facilitating a conducive environment (procedure), as well as the yellow outer layer of the spiral process connecting the above components with the lowest point of the model (purpose), indicate the progressive interaction between the facilitator, recipient, context,

procedure and the purpose. It is by means of the interactive facilitative process indicated that new insights, namely, knowledge and skills, are constructed. This bright yellow colour is stimulating and depicts happiness, and is used to demonstrate decision making by the nurse manager in the envisaged change process. Through involvement in planning, implementation, evaluation and feedback the nurse manager reaches a level of greater calm, security and confidence during the change process, as she constructs new knowledge and skills.

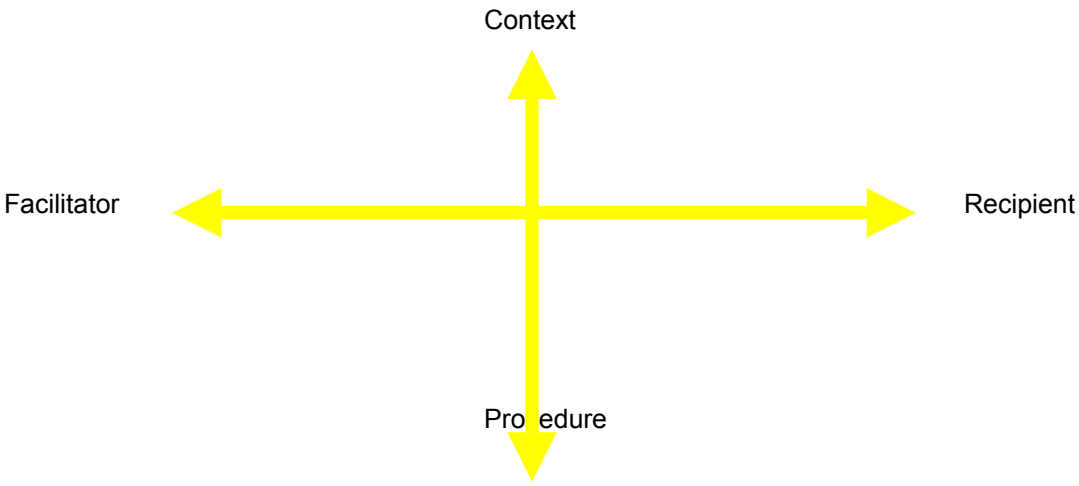


Figure 5.5: Progressive interaction depicted as dynamic during the facilitation process

The rectangle at the very bottom of the model below the spiral process depicts the purpose. As indicated above, the guidance of the advanced nurse manager decreases towards the end of the progressive, interactive facilitation. This paves the way for self-directed, independent decision making by the middle and first-line nurse managers, the recipients. The figure below indicates that the main objective has been achieved, and that the nurse managers are empowered and able to function independently and autonomously. They are thus ready to manage a change process. Accordingly the white colour depicts goal achievement.

EMPOWERED, AUTONOMOUS NURSE MANAGER: READY TO MANAGE CHANGE PROCESS

Figure 5.6: Empowered, autonomous nurse manager: ready to manage the change process which was the purpose of the empowerment process

5.3 PROCESS DESCRIPTION OF THE MODEL

The process of facilitating an environment conducive to nurse managers managing change takes place in relation to two components, which are interdependent and not sequential in nature. This process is an interactive process between the advanced nurse manager (facilitator), who has undergone extensive and specialised training in leadership for change with the main focus on health sector reform, and middle and first-line managers (recipients) in the health service delivery system, who are the recipients.

The facilitation of an environment conducive to change will focus on empowering the nurse managers to ensure the outcome. The desired outcome is an empowered, independent and autonomous practitioner who is capable of managing the change. The nurse managers will be actively involved in the planning and throughout the process. However, the advanced nurse manager will exercise a degree of authority, if only by virtue of her expertise in ensuring participatory process. Although the nurse managers will function under the guidance of the advanced nurse manager they will be personally responsible and accountable for the successful empowerment that will enable them to gain the necessary new insights, which should in turn their confidence.

The middle and first-line nurse managers will be empowered in adequate support and interpersonal relations that reduce fear of the unknown, active participation and involvement that will enhance confidence, and continuous interaction that will facilitate knowledge and skills development.

The theoretical framework on which the procedure of facilitating an environment conducive to change is based, correlates favourably with the nursing process, thus the nursing process will be used in the process of the model. The two components of facilitating a conducive environment are given below:

- **adequate support and interpersonal relations reduce fear of the unknown**
- **active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development**

5.3.1 Assessment and diagnosis

The importance of support and interpersonal relations, as well as active participation and involvement, is as a result of the awareness that any change process may create the negative human reactions of fear, insecurity, and uncertainty. In order for effective change to occur the facilitator has to carry out a thorough and accurate assessment of the extent of the change, the prevailing interest in the change, the nature and depth of motivation, and the environment in which the change will take place. Fostering an environment of open communication and trust, and ensuring the availability of resources and motivation are fundamental during organisational development.

However, it is equally important during these early stages of the envisaged change process that the advanced nurse manager assess the pre-knowledge of the nurse managers with regard to the what, when, why, who, how, and where of the proposed change process, as well as the extent to which the nurse managers possess the professional traits needed for the empowerment process, in order to be aware of how to involve and support the nurse manager throughout the whole change process.

During the phase of assessment and diagnosis, the nurse managers who are affected by change must be made to realise that change is needed. They must become discontented and aware of the need to change. However, this discontent challenges the status quo. It is thus the most difficult stage of the change process, as it is painful and generates a number of psychological responses. It is for reason that the advanced nurse manager (facilitator), with the expert knowledge and skills in leadership for change, will guide and empower the nurse managers sensitively, patiently and with understanding and respect, in order to counteract the psychological responses of fear, insecurity, and uncertainty.

5.3.2 Planning phase

It is at this point that the specific planning will begin to identify exactly how the change is going to occur. The advanced nurse manager (facilitator), together with the nurse managers (recipients), will identify the steps through which change should be channelled, and the measures needed to achieve this. The planning phase includes working out specific timetables and deadlines, and setting goals before the change effort commences. It is important that goals be based on realistic objectives, that they are stated in clear and measurable terms, that they are consistent with the organisation's overall goals and policies, and are attainable. It is also necessary to set a definite trial period in which to try out the innovation, to establish a definite time to re-evaluate the change project, to encourage some of the less involved nurse managers to go along with the change project, to plan change management communication, and to plan

participative empowerment strategies. It is also crucial to plan for the acquisition of resources. Success of a change process does not come from technological leadership, but from having the resources to enable the speedy and successful adoption of innovations. Inadequate resources and a lack of strategic commitment are some of the main causes of resistance to change and why organisations fail in the implementation of new programmes.

The advanced nurse manager should also use humour to reduce tension and to create an atmosphere of partnership. Trusting relationships should be developed with nurse managers through open communication and full participation. Nurse managers need to know how they can benefit from the new order. The suggestions and concerns of nurse managers should be listened to and valued. They should be given positive feedback and the advanced nurse manager should refrain from any value judgment or criticism. The advanced nurse manager should also always be careful not to create the impression that she is manipulating the interactive process, as this could be detrimental to the development of trust. It is worth noting that, due to the knowledge and skills of the advanced nurse manager as compared to that of the nurse managers, the input of the advanced nurse manager is at its maximum during this stage of planning.

5.3.3 Implementation and evaluation phase

Adequate support and interpersonal relations, as well as active participation and involvement, are about building mutual trust and respect, and ensuring feelings of safety and security among those affected by the change process envisaged. The advanced nurse manager (facilitator) shares the components for facilitating an environment conducive to change, such as adequate support and interpersonal relations, and participation and involvement, with the nurse managers (recipients) for a better understanding and subsequent adjustment to the proposed change process. Certain change management empowerment strategies, such as adequate communication and interpersonal relations, mobilisation of resources (human, technical and financial), motivation, and active participation and involvement, were used during the progressive interactive process.

However, the role of the advanced nurse manager should be clarified from the onset, in order to prevent unrealistic expectations arising in this interactive participatory process. The participatory interactive process is a two-way process, which enables the nurse managers to query, argue, agree or disagree, and not merely to be passive followers in the process. Thus frequent communication and feedback will prevent misunderstandings and speed up the process of planned change.

The main purpose of training and development is to overcome the limitations, current or anticipated, which could cause the nurse manager to perform at a lower than desired level. The more the nurse managers are empowered, the more will they be motivated and satisfied with the organisational change as a whole. However, the advanced nurse manager should be aware that training alone will provide little measurable change in the nurse managers' attitudes, unless the training is combined with empowerment that provides significant insights into outcomes, and provides the nurse managers with a certain degree of control over a change process over which they otherwise had no control.

The advanced nurse manager should raise the motivation of the nurse manager during the change process, as organisational success is to a large degree dependent on the motivation and performance of the people involved. Feedback must be provided, regardless of whether the nurse managers are performing well or poorly. The advanced nurse manager should create a working environment which, by providing equitable rewards, provides nurse managers with the opportunity to attain their goals and the experience that they value most. These rewards could take the form of things that the nurse managers value, as well as creating ways to bring enjoyment into different units of the health facilities.

During implementation the advanced nurse manager and nurse managers are in progressive interaction. Empowerment through participation means that the advanced nurse manager should delegate some of the decision making to the

nurse managers. There is a progressive participatory process between the advanced nurse manager and the nurse managers who in the initial stages had no previous experience in organisational change. During these initial stages, the advanced nurse manager's inputs are the greatest, due to the nurse manager's lack of knowledge and skills.

Moreover, as the process progresses, the nurse manager, through this progressive interactive process, creates new insights into the management of the change process. At this stage the inputs of the advanced nurse manager systematically reduce to give the nurse managers sufficient opportunity to function independent and autonomously. Despite the new knowledge and skills being acquired by the nurse managers, the advanced nurse manager will still be providing support to the nurse managers to ensure that pre-change behaviours do not reoccur, and that the new learned behaviours remain permanent.

The process of the model occurs within the context of the health service delivery system, a dynamic and complex system which in its turn functions within the legal and professional environment. When the existing stable condition (behaviours) of the nurse manager is challenged by new developments in the health service context, the nurse manager will again experience disconfirmation, and this will lead to the whole process starting over again. However, during a change process, the driving and restraining forces are being constantly identified at each phase and dealt with accordingly.

5.3.4 Evaluation of implementation

The model has not yet been implemented. However, the following factors will be considered in the proposed model:

- Ensure that nurse managers understand the rationale of the implementation of the change process and explain the benefits to the nurse managers of the envisaged change process.
- Do not stereotype nurse managers, because they are all unique, with an individual body, mind and spirit. The change affects people personally and in unique ways.
- The advanced nurse manager should be aware that people do not necessarily change on the basis of new knowledge alone. Thus attitudes, feelings and status are equally important.
- Encourage active participation and involvement throughout the change process, and respect individual views and opinions.
- Give feedback throughout in order to facilitate learning.

5.4 EVALUATION OF MODEL

The study was conducted under the supervision of four independent experts. Of these four experts, two are experts in model development and qualitative research, one is an expert in

change management, qualitative research and education, while the other is an expert in nursing management, education and qualitative research.

Several consultations were held before the model became clear. The model was presented to two model experts, one expert in change management, two other professors in Nursing Science and Management, and six doctoral students, who attended the doctoral seminar. The model lacked consistency and had certain unnecessary details. The structure of the model for empowering nurse managers to facilitate an environment conducive to managing change effectively needed to be improved in the interests of consistency and simplicity. The model was simplified and made consistent according to the comments given, so as to be acceptable and thus make a contribution to the existing knowledge of change management.

The model was also evaluated in accordance with the criteria for theory generation as described by Chinn and Kramer (1991:129). Accordingly, answers needed to be provided to the following questions:

- How clear is the model?
- How simple is the model?
- How general is the model?
- How accessible is the model?
- How important is the model?

The above five questions will be used to evaluate the model.

5.4.1. Clarity of the model

During the concept analysis, the concept of “facilitating a conducive environment” was explored and described, using the steps described by Wilson (1969) in Walker and Avant (1988:37-43). A

further detailed literature search was carried out to identify the attributes and connotations of facilitating an environment conducive to change. Clarity refers to how the model can be understood and the consistency of the model. Two experts pointed out the inconsistency of the concept “facilitating a conducive environment”. These suggestions were incorporated. A conceptual framework consisting of two components of facilitating a conducive environment was described. The major and related concepts identified were defined and described to enhance the clarity and these concepts were used consistently throughout the study. The model was described using the same concepts to enhance semantic consistency. These concepts were also used to form the structure of the model, using the two components of the conducive environment, and the outer border of the health service delivery system as the context within which the environment conducive to the management of change was to be facilitated. Thus the criteria of structural clarity and consistency have been met.

5.4.2 Simplicity of the model

The model is simple, as core concepts only are used in it. No irrelevant concepts have been introduced in order to avoid unnecessary complexity. The facilitating of a conducive environment is described in terms of two components, using the core and related concepts.

5.4.3 Generality of the model

Reforms are contemporary issues. Currently this model is described in a period during which the health services are undergoing health sector reforms. Therefore there is a need to empower the nurse managers to facilitate an environment conducive to managing the change process in the health sector independently and autonomously. Thus the model can be applied within the context of the health service delivery system to empower the nurse managers to manage the change

process effectively and efficiently. This model could also be applicable to health professional training institutions.

5.4.4 Accessibility of the model

There is evidence of empirical accessibility, due to the fact that the definitions generated for this model are specific, and the related concepts have been also defined, therefore clarifying conceptual meaning.

5.4.5 Importance of the model

The model will be used to steer the nursing practice, education and research according to the guidelines. Thus the model has the potential to influence nursing practice, education and research.

5.5 GUIDELINES FOR OPERATIONALISING THE MODEL

The health sector policy for post-independent Namibia aims at achieving “Health for all Namibians by the year 2000 and beyond”. This aim could be realised if the health services are equitable, available and accessible, affordable, sustainable, and ensure quality, community involvement and intersectoral collaboration. Health sector reform is in line with the above policy, as the primary focus of the policy is on changing health policies, and reforming institutions and organisations to improve quality care to the consumers. Thus the health sector policy is achievable only if an environment conducive to change management could be created in the health sector.

Therefore, these guidelines to operasionalise the model are based on issues arising from the legal and professional aspects. The guidelines are described according to the elements of the practice theory as below – context, agent, recipient, dynamic, procedure and purpose.

5.5.1 Guidelines for the health service delivery system (context)

It is an imperative of the context of the health delivery system to create a positive environment for the management of change. Thus the following strategies could be employed to create an environment conducive to change management.

- The health sector should solicit human, financial and technical resources to ensure a speedy implementation of the planned change process to avoid unnecessary delays.

- Identify a skilled and socio-culturally sensitive change agent who is well versed in organisational change management in order to avoid insensitive handling of the human resources due to a lack of educational and socio-cultural diversity.

- Have a clear vision, which reflects the why, where, who, what, when, and how of the envisaged change process.

- Involve all stakeholders who will make significant contributions in respect of education, quality control, research, advocacy and support to the proposed change process. These stakeholders include institutions of higher learning, Namibian Nursing Council and relevant nursing associations, private sector, United Nations agencies and non-governmental organisations with an interest in health care.

- The health sector needs to establish links with other sister countries which have already undergone health reforms, as well as with other organisations in order to learn from them, and to avoid the unnecessary, negative human reactions of fear, uncertainty and insecurity among the nurse managers affected by the planned changes.

- The Namibian Nursing Council should improve the standards of nursing practice and education within the framework of the national health care policy through a process of consultation, transparency, democracy and inclusivity in a sound professional and administrative manner.

- Stakeholders in the health sector should liaise with non-governmental organisations and the private sector to solicit funding for the career development in management of nurse managers, particularly in change management, in order to ensure the sustainability of the change processes.

- Top management in the health sector should keep the lines of communication open at all levels to allow the nurse managers to air their views. Top management should visit the operational levels during the process of change and familiarise themselves with what is actually going on the ground and not rely only on the given reports. The nurse managers at the operational level are the backbone of service delivery. Thus, if this group is not well informed of the advantages and disadvantages of the envisaged change process, this might delay the implementation of the envisaged change process.

- Central level should support regional and district levels. Special emphasis should be placed on the regional level, which is the level of implementation in Namibia. Thus top management support is vital for the sustainability of the planned change process.

- Involve and educate the communities in respect of the envisaged change process with regards to the who, how, when, what, why and where of the change process, so that the communities know exactly what is going to happen and will cooperate fully when the envisaged change process is implemented.

- Everybody should have the right to inherent dignity, protection, life, freedom of expression and association, and basic education. Thus mutual trust and respect, as well as understanding, are necessary during change communication.

- Health care quality assurance bodies and committees should be established.

- Good interpersonal relationships and communication skills should be maintained between the facilitator and the regional councils, as well as the community health committee members, to promote community participation.

5.5.2. Guidelines for middle and first-line nurse managers (recipients)

In order to participate in a progressive, interactive facilitation process, the nurse manager should possess the following characteristics which will enable her/him to be responsive, and at the same time take responsibility for constructing the knowledge and skills needed to facilitate an environment conducive to the management of change. These characteristics are according to empirical data and the results of concept analysis and are as follows: flexibility, responsibility and accountability, open-mindedness, mutual trust and respect, openness, understanding, competence, commitment, strength, assertiveness, ownership, motivation, good interpersonal relations and communications, patience, supportiveness, confidence, safety, and security,

5.5.3 Guidelines for advanced nurse manager (agent)

The purpose of the model is to empower the nurse managers to be able and ready to manage a change process in the health sector. Thus the advanced nurse manager should guide the nurse manager so as to enable the nurse

manager to gain knowledge and skills on facilitating an environment conducive to managing change in the health sector through progressive, interactive facilitation.

According to empirical data the facilitator needs to possess the following characteristics in order to be able to guide the change process successfully: visionary leadership, open-mindedness, persuasive abilities, responsibility, motivation, supportiveness, role modelling, a good sense of humour, adaptability, emotional self-control, knowledge, confidence, patience, good interpersonal relations, mutual trust and respect

5.5.4 Guidelines for interactive facilitation (dynamic)

- The middle- and first-line nurse managers should be encouraged to identify their own training needs, outcomes, strategies and resources necessary to manage a change process.

- Involve nurse manager in a critical analysis of thoughts and feelings by examining the components of a situation, identifying existing knowledge, challenging assumptions and exploring alternatives.

- Encourage nurse managers to clarify issues from the outset: goals and expectations, and the manner of involvement different from what is known.

- Reasoning and logical argumentation is crucial during the interactive process. Thus the advanced nurse manager and middle and first-line nurse managers should distinguish between relevant and the irrelevant facts, and value judgments. The nurse managers should be encouraged to judge the strength of the argument.

- The advanced nurse manager should empower middle- and first-line nurse managers to collect appropriate data to identify initial patterns or trends, and to compare and contrast given data to identify what remains the same and what changes.

- Provide positive feedback and acknowledgement in respect of the contributions made by the middle- and first-line nurse managers

- In order to be able to construct own knowledge, middle and first-line nurse managers should examine and select the solution or option most likely to be appropriate in solving the problem and drawing inferences.

- The middle and first-line nurse managers should develop an attitude of open-mindedness and critical inquiry in order to gain the maximum out of the dynamic interactive process.

- The middle and first-line nurse managers must engage in logical arguments with the advanced nurse manager so as to learn to justify opinions, facts, thoughts and feelings based on evidence, while at the same time respecting the other person's point of view.

- As the nurse manager gains more insights, the advanced nurse manager should reduce guidance towards the end of the interactive facilitation in order to allow the nurse manager to function autonomously, but still give the necessary support to ensure that pre-change behaviour does not reoccur and that the new learned behaviour remains permanent.

- Mutual trust and respect should be maintained to strengthen the interactive process.

5.5.5 Guidelines for the procedure

The described guidelines for operationalising the model provide an answer to the research question: "How can the nurse mangers be empowered to facilitate an environment conducive to managing the change process in the health sector?"

Guidelines for model procedure to empower nurse managers to facilitate an environment conducive to the management of change (see table 5.1 for the guidelines regarding the procedure)

Table 5.1: Guidelines for model procedure (implementing the nursing process through the components of facilitating a conducive environment)

Please note that in the table below the term facilitator refers to the *advanced nurse manager*, while nurse manager refers to the *middle and first-line nurse managers*.

<table>
<tr><td colspan="2">COMPONENT 1: ADEQUATE SUPPORT AND INTERPERSONAL RELATIONS REDUCE FEAR OF THE UNKNOWN</td></tr>
<tr><td colspan="2">1. 1 SUPPORTIVE INTERPERSONAL RELATIONS</td></tr>
<tr><td colspan="2">❑ COMMUNICATION STRATEGIES</td></tr>
<tr><td>ASSESSMENT</td><td>PLANNING</td></tr>
<tr><td>❑ Assess:
❑ Nature of change
• Is it a structural or cultural change, or a combination of both?
• Motivation for change</td><td>❑ plan
• discussion groups
• meetings</td></tr>
<tr><td>IMPLEMENTATION</td><td></td></tr>
<tr><td>• Facilitator shares the idea of change.</td><td></td></tr>
</table>

• Articulate and communicate a clear vision of how the future will be better. • Facilitator, discusses with the nurse manager the why, when, who, where, how, what of the envisaged change process. • A platform is created for questions and clarification in small, give and take democratic groups to voice nurse managers' needs and concerns. • The nurse manager is provided with opportunities to air guilt and anxiety, as well as other feelings of anger or hostility. • Ample time is given to nurse manager to digest the idea of change. • The facilitator provides a supportive climate to avoid defensive behaviour and resistance to change. • Both the facilitator and nurse manager work according to the objectives, timetables, deadlines, trial periods and evaluation intervals they agreed upon	

jointly. • The facilitator provides the nurse manager with constant support and encouragement to believe in the innovation. • Involve key role-players or influential people to prevent obstacles such as non-compliance. • The facilitator and nurse manager should practice active listening, to avoid premature judgments or interpretations. • As many as possible meetings are held to allow nurse managers to express possible doubts, air differences and ultimately reach consensus and embrace the change. • Honesty, openness, and mutual trust and respect are maintained during the interaction. • The facilitator maintains honesty and does not imply that complete cultural transformation is going to be very pleasant.	

• Avoid talking negatively about others. • Show confidence in the nurse manager. Confidence and trust are pillars upon which the relations are built during a change process. • Communicate the details simply, clearly, extensively, verbally and in writing. • Develop written guidelines, so that nurse managers have sources of reference which may be changed as the need arises. • The facilitator considers the setting in which the communication will take place. • She should be mindful of the nonverbal messages. Tone of voice, facial expression, eye contact, personal appearance and physical surroundings all influence the communication process. • The facilitator and the nurse manager are realistic and respect each other's way of thinking or doing things. • Facilitator should be specific, avoid generalisations and base comments on	

concrete, observable behaviour. The facilitator should also provide a model performance and examples, to assist nurse managers to reach a better understanding of weaknesses and strengths. • Facilitator should time comments appropriately, and respond promptly when feedback is requested in order to give nurse managers needed direction. • Facilitator should be descriptive when pointing out issues and not be evaluative or emotionally manipulative. • The facilitator should be consciously non-judgmental and voice personal reactions and feelings rather than value-laden statements. • Do not compare, but treat each nurse manager as unique, as comparisons may undermine intrinsic motivation. • Use simple words, be direct and say what is meant. Do not use fancy words or abstract language.	

• The facilitator should be positive and point out what she appreciates and genuinely feels. She should not merely focus on what causes a negative reaction in her. • Be aware of own emotional state before giving feedback. Facilitator should be precise and not overload nurse managers because she has a lot to offer. • Be explicit by making it clear what kind of feedback nurse manager is seeking as a recipient, because feedback from the facilitator is entirely to their benefit. • The nurse manager should be attentive, and concentrate fully on what is actually being said and not simply on what she would like to hear. • The nurse manager must refrain from making a response until she has listened carefully to what has been said and has considered the implications. She must not be distracted by the need to explain, and explanations can always be given	

after the feedback session, once all the information has been collected about the feedback.	
ASSESSMENT AND EVALUATION	
• Ensure that the nurse manager understands the rationale by asking for feedback on whether implementation was successful. • Facilitator should be a good listener – rephrase and reflect back. • Use memoranda and group meetings for evaluation and feedback. • Assess driving and restraining forces and act accordingly. • Have a written procedure or policy concerning change to ensure perpetuation.	
1.2. HUMAN RESOURCES DEVELOPMENT	
❑ **EDUCATION**	
ASSESSMENT	**PLANNING**
❑ Assess • pre-knowledge and training needs	❑ Plan • discussion groups • lecture demonstration

IMPLEMENTATION	
• Provide training according to specific areas of required new behaviour. • The facilitator should combined training with empowerment to provide significant insights into the outcomes, and provide nurse mangers with a degree of control. • Involve nurse managers throughout planning, implementation, evaluation and feedback phases. • Using brainstorming sessions in smaller groups to provide an environment of mutual trust and respect. ✓ Listen attentively and reflect on given responses. ✓ Give creative feedback. • Use lecture demonstration: ✓ Give an explanation of the procedure and the reason why it is necessary with special reference to the specific case.	

✓ Activate the use of background knowledge which the nurse manager already possesses. ✓ Give factual, theoretical knowledge on which the procedure is demonstrated. ✓ Avoid jargon and keep language simple and unambiguous. ✓ Give feedback. ✓ Follow-up procedure by means of a review session of questions, discussions, and evaluation. ✓ Listen empathetically and objectively without displaying emotional reactions, prejudice or bias. • Emphasise the importance of active participation, resourcefulness, and cooperation in exchanging knowledge and insight. • Activate existing in-service education programmes to assist nurse managers with ongoing education after initial training.	

❑ **MOTIVATION**	
ASSESSMENT	**PLANNING**
❑ Assess • Aspects that nurse managers valued	❑ Plan • Equitable rewards
IMPLEMENTATION	
• Recognise each nurse manager as a unique individual who is motivated by different factors • Communicate to the nurse manager that she/he is doing well as soon as the facilitator realises it, and inform other people about the accomplishment as well. Public recognition boost the individual's self-esteem and portrays the recipient as a role model. • In order to nurture feelings of self-worth align rewards with what is valued by nurse managers, for example, recognition, training and development opportunities, and salaries.	

• Listen attentively to individual nurse managers • Maintain a positive and enthusiastic image as role model to nurse managers • The facilitator has to demonstrate, through actions and words, her belief that nurse managers wish to achieve the organisational goals. • Provide feedback to nurse managers regardless of either good or poor performance • Clearly communicate expectations to nurse managers • The facilitator has to demonstrate and communicate sincere respect, concern, trust, and a sense of belonging to nurse managers • The facilitator has to identify the achievements, affiliations, or power needs of nurse managers, and develop appropriate motivational strategies to meet those needs • Create ways to bring enjoyment into	

different units of the health facilities in order to build rapport, which is the foundation of successful team building. • Encourage fun to release stress and boost morale, as this motivates nurse managers to be more productive and committed. • Admit mistakes and encourage nurse managers to do likewise. • Reward honesty and integrity	
ASSESSMENT AND EVALUATION	
• Give direct and on-the-spot constructive feedback • Regular group meetings for feedback and evaluation • Assess successes and failures • Use suggestion boxes • Carry out assessments at predetermined intervals to save costs, with the first assessment immediately after the novelty of the change has worn off	
1.3 FINANCIAL AND TECHNICAL SUPPORT	

ASSESSMENT	**PLANNING**
❑ Assess • Available and required financial and technical resources	❑ Plan • Meetings
IMPLEMENTATION	
• Solicit top management support for available and required resources • Explore existing channels to secure funding from stakeholders such as United Nations agencies, non-governmental organisations and the private sector	
COMPONENT 2: **ACTIVE PARTICIPATION AND INVOLVEMENT ENHANCES CONFIDENCE, AND CONTINUOUS INTERACTION FACILITATES KNOWLEDGE AND SKILLS DEVELOPMENT**	
ASSESSMENT	**PLANNING**
❑ Assess • Prior experience in participatory decision-making process	❑ Plan • Work groups

IMPLEMENTATION	
• The facilitator should create a climate that is non-threatening and supportive, and should encourage the nurse manager to share and negotiate knowledge in the group. • The facilitator and the nurse manager together identify and share ideas and experiences in partnership. • The facilitator's attitude toward change should be constructive. • The facilitator should model the behaviour desired from the nurse manager. This is most effective way to change any behaviour. • The facilitator should learn to accept constructive criticism, and should evaluate her own performance and that of others. • Be adaptable, understanding and supportive during the interaction.	

• The facilitator should exercise emotional self-control in order to deal calmly with stress during the change process. • Divide nurse managers in small groups to encourage group interaction in the form of debate and dialogue. • Give opportunities to the nurse managers to debate issues under guidance to gain confidence and skills. • Nurse managers in partnership with the facilitator must have a clear understanding of what is required of them. • The nurse manager is directly empowered through involvement in consultations and problem-solving processes. • During work groups the facilitator coordinates activities, but encourages the active involvement of nurse managers. • Nurse managers gain knowledge and skills through constant guidance by the	

facilitator, are more committed to organisational objectives and develop a sense of ownership through interactive process. • During active participation and involvement the nurse managers develop self-confidence. • Guidance by the facilitator reduces systematically as the knowledge and skills of nurse managers increase so as to allow the nurse managers to function independently.	
ASSESSMENT AND EVALUATION	
• Publicise successes by letting others know when and where change is working. • Assess and record lessons learned. • Assess driving and restraining forces and act accordingly. • Celebrate successful change efforts – large and small – to build confidence in the organisation's capacity for change. • Facilitator should evaluate her own	

effectiveness by viewing the effects of change over time. • Facilitator should assess customer and nurse manager's satisfaction, productivity, and other outcomes which were supposed to result from the change process. • Offer counselling or other services to help nurse managers to deal with the stress of change. • Hold regular meetings to grant opportunities to nurse managers to give feedback and also suggestions for re-planning if necessary. • Direct observations are valid evaluation tools as feedback can also be given on the spot. • Have a policy of genuine participation and involvement of those likely to be affected in order to reduce human reactions such as fear, insecurity and uncertainty.	

5.6 SUMMARY

This chapter dealt with the description of the model to empower nurse managers to facilitate an environment conducive to the management of change. The description was dealt with under the following headings: an overview of the model, purpose and the structure of the model. The structure of the model was described using the assumptions on which the model is based and concept definitions. Relation statements were inherent in the assumptions and definitions, the nature of the structure, and the process description.

The guidelines for operationalising the model were described in accordance with the elements of the practice model as described by Dickoff et al (1968:423). The model was then evaluated in accordance with the set of criteria prescribed by Chinn and Kramer (1991:129). Chapter six will focus on the evaluation, limitations, and justification of the study, as well as on the conclusion and recommendations.

CHAPTER 6

EVALUATION, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS OF THE STUDY

6.1 INTRODUCTION

The previous chapter focused on the model for facilitating an environment conducive to managing change in the health sector and guidelines for the operationalisation of the model. This chapter focuses on the conclusions, limitations and recommendations with reference to the creation of an environment conducive to change in nursing practice, nursing education and nursing research.

6.2 EVALUATION AND CONCLUSIONS

The study will be evaluated on the basis of the rationale, the overall aim and objectives, the justification of the original contribution to existing knowledge in nursing science, the limitations of the study and recommendations with regard to nursing practice, nursing education and nursing research.

6.2.1 The rationale for the study

Change is an inevitable, contemporary issue globally. Locally, health reforms were prompted by the ethnically structured and curatively biased health services of the previous dispensation. The main purpose of the reforms was to render a cost-effective health service that ensures quality nursing care to its customers.

It is of cardinal importance to manage change effectively. For the effective management of change the issue of a shared vision was found to be essential, as those affected designed the change management strategies in collaboration with the change agent. Shared vision boosts the competencies, commitment, responsibility and accountability of those subjected to a change process (Moloi 2002:51).

However, in our young republic, shared vision may have been lacking in the early stages of the reforms, leaving those subjected to change with a fear of the unknown, insecurity and uncertainty about their own futures in general and that of the health sector in particular. These negative human reactions in a changing environment are not conducive to effective change and can lead to resistance to change. Thus, to enable the facilitator to effectively guide the change process, an environment conducive to the management of change is a priority.

Although several conceptual frameworks on change management have been described in literature, namely the Lewin-Schein Change Process Model in Rashford and Coglan (1994:64-

65); Havelock's Theory in Welch (1994:318); Lippitt's Stages of Change in Welch (1994:319); Stages of Change and Responsibilities of the Change Agent in Marquis and Huston (2003:82-83, 191); Lewin's Change Process Model in Williams (2002:314), these models and theories do not address the way in which nurse managers should be empowered to facilitate an environment conducive to change in the health sector during the health sector reforms. Thus the research question of this study is: "How can the nurse managers be empowered to manage change in the health sector, through an environment conducive to the management of change?"

6.2.2 The overall purpose and objectives

The overall purpose of the study is to develop a model to empower nurse managers to manage the change process in the health sector, through facilitating an environment conducive to the management of change, with guidelines to operationalise the model to attain the following objectives:

- to explore and describe the experiences of nurse managers regarding the change process in the health sector
- to explore and describe the needs of nurse managers with regard to the ways in which the nurse managers can be empowered to manage a change process
- to describe a model to empower the nurse managers to facilitate change in the health sector, through an environment that is conducive to the management of change, with guidelines to operationalise the model

- **Objective 1: Experiences of nurse managers regarding change process**

The first objective was met. The results indicated one main theme, namely inadequate preparation and participation led to fear and uncertainty among the nurse managers. The results of this phase were reflected in the next objective, which related to the empowerment needs of nurse managers to be able to manage the change process. The findings were contextualised and a literature control conducted to validate the findings. Guba's model (Lincoln & Guba 1985:290) was used to ensure trustworthiness.

- **Objective 2: Exploration and description of the needs of nurse managers regarding how they can be empowered to manage a change process.**

The needs relating to the empowerment of nurse managers were based on the experiences indicated in Objective 1. This phase dealt with the exploration and description of the needs of nurse managers in respect of how nurse managers could be empowered to manage a change process. The central question was: "How can the nurse managers be empowered to manage change in the health sector?" Two themes emerged, namely the need for the participation and involvement of nurse managers in the change process, with adequate interpersonal relations; and the need for a supportive environment during the change process. The results of this phase guided identification of the central

statement ”facilitation of a conducive environment” in respect of the management of change.

Concept analysis was carried out according to Chinn and Kramer (1991), Walker and Avant (1988) and Walker and Avant (2004). The meaning of ”facilitating conducive environment” was explored using the dictionaries, books, thesauruses, journal articles, Internet exploration, existing models and theories, as well as model-case descriptions that explained the term “facilitating conducive environment”. A list of criteria was generated by underlining those criteria in the existing definitions and in the model case. This list was later reduced to the essential criteria. A theoretical definition was then formulated based on the attributes identified. The following two components emerged from the results of the concept analysis:

Component 1: Adequate support and interpersonal relations reduce fear of the unknown.

Component 2: Active participation and involvement enhances confidence, and continuous interaction facilitates knowledge and skills development.

The results of this phase formed the conceptual framework for guiding nurse managers to manage change by creating an environment conducive to the management of change.

- **Objective 3: Description of the model to empower the nurse managers to facilitate change in the health sector, through an environment that is conducive to the management of change, and guidelines to operationalising the model**

The description of the model of how an environment conducive to change could be facilitated by nurse managers in the health sector was based on the results obtained from Phases 1 and 2. A method of theory generation was used in accordance with the method described by Chinn and Kramer (1991:107-125). Definitions were defined according to Rossouw (2000/01:10-11) and Copi and Cohen (1994:192-195). The nursing process and five selected theories of the change process were used for describing the procedure as to how a conducive environment can be facilitated by using the two components of facilitating a conducive environment (firstly, adequate support and interpersonal relations reduce fear; and secondly, adequate participation, and involvement enhances confidence, and continuous interaction facilitating knowledge and skills development). Guidelines were formulated based on all the phases of the study, using the criteria of the elements of the practice theory as described by Dickoff et al (1968:423). Experts in model development evaluated the model. Corrections were made in respect of clarity and simplicity as recommended by the experts. Criteria described by Chinn and Kramer (1991:129-137) were used and the

model was accepted in terms of clarity, simplicity, generality, accessibility, importance, and contribution to understanding.

All three objectives of the model as described above form the foundation for facilitating an environment conducive for nurse managers to manage change in the health sector. The guidelines formulated will assist the facilitator in creating an environment conducive to facilitating the management of change in the health sector. The nurse managers will be expected to take part in participatory decision making, and function independently and autonomously by involving others affected by an organisational change process in the future, to ensure the smooth management of a change process. Through a progressive interactive facilitation process, the facilitator, as well as the nurse manager, will gain competency in the management of change. The facilitator will acquire more skills in facilitation through the comments given by the nurse manager, while the nurse manager will gain new knowledge and skills about the process of the management of change.

6.2.3 Justification of the research as an original contribution made to the body of knowledge in nursing science and change management

This research is an original contribution to the body of knowledge in nursing practice in general, and to management in particular. The following all support the above statement. The concept analysis of facilitating a conducive environment was carried out systematically, based on scientific principles

(Walker & Avant 1988; Walker & Avant 2004). According to the results of the concept analysis, an environment conducive to the management of change may be facilitated by providing adequate support and interpersonal relations, and by active participation and involvement that enhances confidence and continuous interaction that facilitates knowledge and skills development. However, empirical data from Phase 1 also confirm the findings of the concept analysis. Furthermore, it also became clear that through a progressive, participatory decision-making process, the new insights needed for the future management of the change process are acquired. The results of the concept analysis were presented to experts and peers, and in this way further refined and validated.

This study is unique in that the model for empowering nurse managers to facilitate an environment conducive to the management of change in the health sector did not exist prior to the study. However, in this era of contemporary, inevitable, organisational change, nurse managers and facilitators have to use their own discretion to test and further refine the model and the guidelines for its transferability.

6.2.4 Limitations of the study

Despite the richness of the data the study is limited by a number of factors.

- The vast travelling distances between the regions make the physical follow-up to verify findings difficult. In order to collect the data the researcher travelled by motor vehicle from Windhoek to Rundu (700 kilometres), Rundu to Oshakati (700 kilometres), and Oshakati to Windhoek (700 kilometres). Despite these limitations, the researcher managed to verify the data with certain participants during the period of data collection and analysis. After full data analysis, a half-day seminar was held with those nurse managers who had participated, as well as with others who had not participated in the initial data collection, in order to provide them with feedback for the possible verification of data.
- Only national and intermediate hospitals were targeted. However it is possible that district hospitals could also perhaps have shared their unique experiences and needs.
- The guidelines for implementation of the model have not yet been tested.
- In a qualitative research study such as this, it is not appropriate to generalise the results to all nurse managers in the Namibian health sector. The use of a small purposeful sample indicates that the findings are contextual, and are not representative of all nurse managers. However, it does serve as a point of reference for nurse managers and future research. In other words, despite the above limitations, findings from this study have contributed to an understanding of the experiences and needs of nurse managers during a change process, and enabled the researcher to develop a model to empower nurse managers during similar future change processes.

6.2.5 Recommendations

Recommendations are made in terms of the application of the model and guidelines in clinical practice and management, nursing education and nursing research.

6.2.5.1 Nursing practice

The main purpose of health sector reform is to provide cost-effective, accessible, efficient health services, ensuring quality nursing care to the consumers (Du Toit 1998:113; ICN 1996:6; Koivusala & Oliliva 1997:147). However, in order to achieve this aim the health sector should prepare their organisations for successful organisational change by creating a culture of change so that all employees view the change as a challenge and not as a threat. Thus this model could be implemented to empower the nurse managers and other relevant stakeholders to be responsible and committed to provide adequate support and maintain good interpersonal relations, and allow those who are likely to be affected to participate actively and be involved in the envisaged change process. Therefore, the guidelines to operasionalise the model described to facilitate an environment conducive to the management of change will help the facilitator to create an environment in which effective management of change will occur.

Through using the nursing process, the facilitator was able to assess and identify the need for change, as well as to identify a socio-culturally, sensitive change agent to guide the human

resources sensitively, to plan necessary strategies, implement the planned strategies, evaluate and give feedback to nurse managers and relevant stakeholders at frequent intervals. Throughout the stages of the nursing process, the nurse manager and the facilitator were involved in a progressive, interactive facilitation process that facilitates knowledge and skills development, which should prepare the nurse managers to operate independent and autonomously during the future change processes. Changes should not be rushed, and should be carried out in phases to ensure quality of care to the consumers, while the institution is in the process of reform.

6.2.5.2 Nursing education

Nursing education is the solid foundation of the nursing profession. This implies that the quality of care given to the consumers depends on the quality of the nursing education. In Namibia, the education and training of nurses is based on the primary health care approach that requires teaching strategies based on problem-based learning, and outcome and community-based education.

The following recommendations are made with regards to nursing education:

- There should be a sound collaboration between the health sector and the institutions of higher learning to improve the quality of care, education and research.

- All education and training programmes should be people centred and empower people with management and research skills.

- In the wake of planned change, existing in-service training components should be activated to support the nurse managers in specific areas of change, according to their needs.

- The model should be shared with the institutions of higher learning to empower the nurse educators to utilise it in their basic training programme, as well as in post-basic training studies.

- The nurse managers should be adequately supported and exposed to the management systems during their basic training to gain confidence whilst still in training.

- The nurse educators should be responsible for creating a learning environment that is challenging and motivating and that promotes a culture of learning. This implies that learning opportunities should be characterised by active participation and involvement.

- The nursing educational environment should be supportive, encouraging, safe, caring and stimulating.

6.2.5.3 Nursing research

Research is an integral part of nursing practice in general, and management in particular. However, due to the complexity and dynamism of change management no rigid rules of management can be applied. Nurse managers are influenced in body, mind and spirit by various factors in different ways during any change process and, due to the unique nature of the nursing managers, new ways should be always found to address their needs effectively and timeously. This respect for the uniqueness of the nurse managers is prompted to a large degree by the magnitude and nature of the changes envisaged. This obviously means that more research on this topic should be carried out to refine this empowerment model. Research on the following aspects could be carried out:

- The development, implementation and evaluation of a skills development programme that will enable the nurse managers to facilitate an environment conducive to the management of change in the clinical practice.
- Development of an evaluation instrument to test the model.
- Identification of principles, patterns, ideas and feelings of the ”self” and ”others” in a given situation – an aspect that could lead to self-management of a change process by the nurse managers.

6.3 SUMMARY

This has been the final chapter, in which the overall aim of the study, with its three objectives, was evaluated, conclusions drawn and recommendations made for nursing practice, nursing education and nursing research.

The change model advocated in this study aims at exposing empowerment strategies and practices of potential value to the health sector in Namibia. The change management theories help to give structure to the suggested model. Key themes on the management of change during reform in the health sector in Namibia have been presented. Although these themes are generic, they have contributed in the context of the health sector in Namibia to the meaning of change for each individual involved, and ways in which to cope with the unexpected events concomitant to change. In this sense the study has contributed to the existing knowledge of change within the context of the Namibian health sector.

Evident in this model is the view that, by concentrating on the behaviours, skills and attitudes which are optimal for the nurse managers (recipients) and advanced nurse managers (facilitators), management can facilitate an environment conducive to enhancing the change efforts. The model also demonstrates that by creating a strategic vision for change and communicating the intended change effectively, as well as developing the resident knowledge and skills, some of the ingredients for fundamental change will take root. Finally, the change empowerment model consists of establishing a vision, prioritising actions, developing relationships, expanding networks and providing support (human, technical and financial).

The overall aim of the study, which was to develop a model with guidelines for operationalisation in the health service delivery system to facilitate an environment conducive to the management of change, was achieved. However,

nurse managers, as agents of change, are being challenged to carry out further research to refine the model described.

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ANNEXURE 1(a) Request for permission to conduct research

PERMISSION LETTER FROM MINISTRY OF HEALTH AND SOCIAL SERVICES

ANNEXURE 1(b) Request for consent from participants

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

SUBJECT: DOCTORAL THESIS: EMPOWERMENT OF NURSE MANAGERS TO FACILITATE CHANGE MANAGEMENT DURING NAMIBIAN HEALTH REFORMS

Dear Colleague

I wish to conduct a research project entitled " Empowerment of nurse managers to facilitate change management during Namibian health reforms". This study will be conducted under the supervision of Professors Agnes van Dyk (UNAM) and Kholeka Moloi (University of JohannesburgRAU)).

Health reforms are in the order of the day to for improve improving the quality to the customers.

However, change is complex and creates instability, uncertainty and fear to for those

subjected to it. To reduce the above human reactions, a model to empower nurse managers to manage the change process would be useful. Against this background,

this study aims to explore the experiences and needs of nurse managers to manage the reform process, through by facilitating conducive an environment conducive to change in the health
sector.

This study aims to include the following nurse managers as participants:

- Nurse Secretaries/ Under Secretaries
- Nurse Directors/Deputies
- Nurse managers in- charge of National national and Regional regional hospitals
- Line- managers in- charge of the National national and Regional regional hospital wards
- Professional Nurses Associations/Nurses Unions
- Namibian Nursing Board
- Regional Primary primary health care Supervisorssupervisors
- Nurse managers in Educational educational Institutionsinstitutions
- Any relevant senior nurse manager that who could make a contribution

With your permission, all other categories, except, line- managers, will participate in individual in-depth interviews, while the line- managers will participate only in focus group interviews. To ensure trustworthiness, a tape recorder will be used, but audiotapes will be destroyed after the on completion of the research. No names will be indicated for the sake of

confidentiality. NB!Please note: Your participation is voluntary. (See attached copy of overall

permission from the MoHSS.).

I will be visiting the above sites between 16 June –- 30 July 2003. It will would be appreciated if the you could indicate to me which date suites you best for the above

interviews.

For the line- managers, it would be helpful if you would identify any six nurse managers

from the wards as indicated above, with maximum personnel for ±+- one hour to one an hour and half for focus group discussions, preferably in the morning when thehours where

maximum number of staff is on duty.

Research results will be made available to MoHSS. For any further queries with regard to this research, feel free to contact me or my supervisors or me.

Thanking you

Yours faithfully

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ANNEXURE 2 (a) Excerpts from transcripts of the individual in-depth interviews (Phase one of the study)

Transcripts of the individual in-depth interview on the experiences and needs for empowerment of nurse managers to manage change in the health sector. The rest of the in-depth individual interviews are available on request from the researcher.

Take Note: I: Interviewer

R: Respondent

I: I have only two questions that I want us to explore. The first one is: You have been part of the reform process, which is currently taking place in the health Ministry. Can you please share your experiences with me regarding this reform process?

R: To be honest, I was a victim of this so-called restructuring process. Laughter!

I: Could you please elaborate

R: You know, when this idea of restructuring comes to light, we attended meetings, but we did not have the background of the process. The core group discussed it in the meetings, and it was expected from us to contribute.

I: You said that you did not have the background information, yet expected to contribute. Could you please elaborate on that!

R: We let me say I did not have clear information on the whole process of restructuring. I mean, I did not know what it was and why it was necessary. There was no clear-cut information on that. But we were told to defend why some departments or directorates could not be merged. Because we did not have clear understanding of the whole process, those who had more information on the reform process (the core group) did not accept our reasoning. I think, they should have involved us from the very planning stages so we could know how they come to the idea of merging of existing units and so on. But it was not the case.

I: Mmmh! I hear you are talking of participating in the meetings where restructuring process was discussed. Now! Were these meetings meant to be information meetings?

R: I did not know by then. But maybe the meaning was to inform us and let us air our views. However, the environment was not conducive as such that your ideas were acknowledged. It seems that others from the core committee have already workout something and let us agreed. But I think they could have first sensitizsed us, so we slowly but surely could get on their level.

I: You talk of the environment that was not conducive. Could you please explain?

R: I mean the meetings were more of a quarrelling and full of disruptions. People from the Prime Minister's office (silence). It was very tough to put your point across as a nurse. Thus is why I am saying that if they wanted to inform us, they did not use the right platform.

I: Why was it tough to make your point?

R: It seemed that people already came with a predetermined agenda. They did not take your word. They had all the answers.

I: If you say that the platform was not the right one, which one could you suggest and why?

R: Meetings were not wrong per say, what was wrong was their approach. I think, they could involve us from the very early stages in the process, if they want us to be part of the process. We could have that platform where we could air our concerns and listened to. They could not be that defensive, by answering all our questions. Firstly, they could bring us to the level where we could understand their vision. Because every new thing need time and proper discussion sessions. Proper communication is important if you want to convince people to change.

R: I was totally lost during the early stages. I didn't know what restructuring was all about. That time I saw myself just as an observer. It was scaring and stressful-many meetings, new things and we were expected to contribute, while we did not have the sound background.

R: I felt demoted during those stages when our directorate merged with another one, because we could not defend it according to the criteria of the "core group". I did not understand that merging was a good thing.

I: Aah! Lots have been said! You lacked active involvement and participation during the early stages, where your voice could count. You felt demoted and totally lost due to lack of information. Can you share your experience around that?

R: Do you know what? I have to be a manager in a quite different field. I felt that my future could be totally re-directed. Somehow there was uncertainty. I didn't know how I would perform in the new field, although the management functions might be the same. No emotional preparation was given to me. I moved from my division and I needed orientation and some training. My fear was how it would affect me psychologically. But no orientation was given to me. I felt I was thrown into a deep end. But today when I understand the reforms, it was a good thing that could happened to me.

R: You say that you where not supported well during the initial stages. How come that you understand the reform process now better?

R: I was lucky. Two years after the initial stages, I was exposed to health reform programprogramme outside our country. Fourteen countries participated at that forum since 1998-2001. It was that programprogramme that updated my knowledge on health reforms. If it was not that course, I don't know what could happen to me.

I: If I understand you well, support in the form of training was required.

R: Yes. Now I can see that reforms are actually a good thing. I am actually happy that I was "restructured" (laughter) and working now at this new department. It is a good thing that could happen to me. I could not learn what I know today if I was at my previous department.

I: According to my understanding, reforms can be a challenge and also be an opportunity. Early involvement and participation are necessary, together with support in the form of training on the reform process for better understanding. Lack of early involvement and participation and training contribute to fear, anxiety and uncertainty in those affected by a change process. Is there anything you want to add on your experiences during reform process?

R: No, I think I told you the burning issues.

I: Thank you for your contributions on the first question. Let us explore now the last question.

I: I know you have mentioned already some of the issues of the second and last question. Having experience negative and positive aspects of the current reform process, can you tell me how the nurse managers can be empowered during the reform process to manage change smoothly in the health sector while the reforms or any major change of that nature is in progress?

R: Mrs. HofnieHofnie, I am a victim of change and I think somehow along the line preparation is very important when you are going through any type of change. You cannot just inform the people that the change is there. People must be informed well in time.

R: Being the victim of change at this stage, I don't have really any solution, but change is going together with many, many negative thinking, negative approaches.

I: Let me quickly jump in. What do you mean with many negative thinking and negative approaches?

R: Personally I feel, if there is any change, individuals should be approach, individuals should be seen as individuals on its own and not as part of a mass that is going to be changed now. The needs for change should be properly communicated.

I: Could you please explain what you mean with proper communication?

R: I think you must really include the individuals that are going to be affected. It's not just a thing that you must say should change. Nursing comes from a nursing background. Nursing generally has gone through many, many changes. As you know as humans, we don't really want to be changed, because change is going together with uncertainty, you don't know where you are going to land. You don't know what is going to happen with you next. Maybe you could be part of the people that is going to be without a job on the long run. Thus it develops some type of fear, anxiety, resistance, and so forth. But being through this process, I just feel managers should really look into the aspect of a person, a person that is going to be changed. Sometimes, during the period of preparation, people will agree with certain changes, but for example if a change is especially change of an environment, changing of professional background, maybe change of places, change from a lower rank to a very, very higher rank, it's all this things. Some of them like for instance changing from a lower rank to a higher rank, it's a positive thing, but it does have an affect on the person.

I: What do you think should be done in cases of change that affects a nurse manager as a person?

R: They need to be involved.

I: Involved in which way?

R: Training is very important, capacity building. We must be guided in the new field of work. Capacity building is not a thing of overnight, it's a thing that you learn gradually, like for instance if you are on an operational level and when you are suddenly changed to management level, you must take it step by step into this level. Training is not ending, it's a continuous process, usually when you have being changed from one area to another area, people expect from you to know everything at that level. It's really not good for the person that has been changed. So training is very important, in the process of change.

R: The other issue that should be looked at is, is the issue of families, it's not only the person that is going through anxiety, even the family. What you are thinking at home is what you are carrying to work. So family is also very important to be really involved in this whole issue.

I: How could it be done?

R: I am not saying that Government or the institution should do this, but through this training for capacity building, the person can also convey the process of change correctly to the family. If you are going to a next area, you must also have some confirmation that the life on the other side will not be really difficult.

I: What do you mean with the life that could not be difficult other side?

R: I'm talking now about housing, I'm talking about schooling for children, I'm talking about even the husband to be considered if you are married or even the boyfriend to be considered, because people are staying for years with one boyfriend, and they are just like married people. So these are people that should be considered. To have some positive confirmation of what is going to happen in the future. Looking from the Namibian context, it's very difficult if you look at housing, people are changed from place a to place, but there is no housing on the other side.

R: But looking at change from a general point of view, it's a good thing. However, at first, it was very fearful. I was very unhappy, I was really, really unhappy, but now I can say through experience, I actually like this environment more than the environment in which I was previously operating in. So, change can have also positive things, but it's just only the process of guiding the person from this point of change to the next point of change to where you are changing. The world is

changing. It can happen that you can land in totally different country through change, but change generally is a positive thing, it's just the process in between that has got a very negative connotation. Change brings uncertainty, fear and anxiety. You don't have the capacity. The moment you don't know anything, the fear is coming in.

R: Capacity building from our authorities, looking at Ministry, I think that is what's lacking, support from the executive in all these changes. I know some executives are also restructured, I mean changed from their previous areas. However, it needs really ongoing support and if they are changed, then change should be done sort of in a certain period of time, not leave the person with this uncertain future. I'm talking now about the restructuring, it's also a change process, going on for the past 4-5 years but people have no clear information. Through the process people know that they are going to move or that they will not have places in the new structure. Believe me, for 4-5 years, this person is definitely living in anxiety, uncertainty, they don't know what is the future all about. Change process must not be rush through, but I think especially with the restructuring, it should be done in a certain period of time and changes be made and people go the places where they are supposed to go and start adapting there. If the period of change is very long, than people are demotivated and demoralizeddemoralised. Nobody is taking initiative, because they don't know what will happen with them in the future. You don't even take decisions if you don't know in three months time I will not be anymore in this place. So change

has got it'sits good points and the process of change generally is a negative thing, because any human being do not like to change from routine type of life to a sudden different life. But there are changes that have positive consequences for the individual and the people.

I: You have been talking of a lack or inadequate information on the restructuring process, leading to fear, anxiety and uncertainty of the future. Fear of unknown lead to demotivation and demoralisation in the nurse managers. How would you like to see above negative human reactions caused by lack by inadequate information and communication been address, except those points you have already mentioned.

R: If the change is there, I don't know what example I can take, maybe I must take the restructuring, if the change is there, you will first look at the human side of the person. You are looking as I said at the capacity, knowledge, does the person has the skill, does the person has the know-how to run the area where he has been put now. So these are very important aspects of change, training, guidance, and even the physical situation of somebody.

I: What do you mean with physical situation of someone?

R: You see some of us are not complaining, maybe we are introverts, others are extroverts. There are others who will just carry the burden. It does not matter what happen, because it's not in them to talk about these things, but I think if you

really want to make the change worthwhile than you must talk even with the introvert, you provoke the person to talk about his feelings, to talk about what is happening with him. The field I am in now was not mine, but I think I'm part and parcel of the system and I must make the best of it. So if you have been changed, look at the situation and make the best of it for yourself, otherwise it will influence you negatively in the long run, than you will end up with high blood pressure, things like that. It's only you who can make yourself happy in a situation; we are only looking for guidance from other person and also to be positive about the new changed area. And you even change yourself if you feel; I don't want to be there, than you can look for other. I'm really a "voorstander" (advocate) for physical health for each individual that is only when you can perform well and can take initiatives.

R: If the environment is really supportive during any change process, I think it will not be fearful.

I: What do you mean by supportive environment?

R: It is the environment in which one feels safe; supported physically and emotionally; and knows what is exactly happening. Your contributions are valued and one is encouraged and assisted whenever you need assistance.

R: There must be some support for the person who is going to be changed or is going to be affected by a change process. The moment change is proposed and implemented; there must be some type of support mechanisms in place to support this person. I think capacity building and support will have 80% of positive effect on those affected by change. I feel also there must be support from the higher level, higher from the position in which you are and that's actually what is lacking.

I: I am hearing that you are talking of top management support. Is there any other type of support needed during a change process?

R: I don't know whether support group will be the answer, if you have done not research on this, you will not know, but my experience is the group in which I was before was not supportive, but the new group after restructuring with whom I am now is very supportive. I am favouring top management support during a change process such as this one. I cannot see how we as managers could support each other.

I: Why are you saying so?

R: Mmmh! We are all affected by change at different ways. Everybody is busy with his or her own mind, own fear, same anxiety, not knowing what is going to happen next. So, how are you going to support the next person? So, supporting

each other is lacking. But I don't know whether it will really help to support each other. I'm just thinking about nursing services that's going to be affected by this restructuring, but everybody is fighting on it's own for his or her future. Nobody is really looking at the other one or supporting the other one.

R: I think that maybe the issue of support group could help, although it will not be a 100% solution. I think it is just to put the person at ease. You know, change is a complex thing, therefore you cannot have one solution, but the idea of a support group, I'll go for it.

R: You see the other thing of change is, you have actually fear for the unknown. You don't know what is going to happen, therefore you don't want to change, but change is actually positive if you look at the result. Many of the changes that are taking place globally are positive. In our case, change from curative biased health services to primary health care is a good thing.

R: I should have been prepared for what is waiting for me. I think the preparation is a very, very important part. It's not going to take away all the ups and downs, but will make your thinking easier as far as change is concern. Sometimes if you fear, usually if someone is telling you something, you have make up your own picture already.

R: At this stage I cannot say there is somebody who can really say, they don't believe in change. Life is about change. You are born, you are learning to walk, you mix with other people, and you see other people doing things and than you are changing. Like physical life has got this matter, it is a life of change and things has happened so far in the world, we are talking about globalizationglobalisation, globalization globalisation just means change. The world is changing. We are living for change.

I: What I can deduce is every one is aware of importance of change. But change touches you personally when it comes to you. Thus you have to see it as a challenge.

R: Even as I said positive changes can have its negative things and its only you that can make this change for you positive or negative. It's only you, there is nobody else and the system is not going to stand still, because you don't want to change. The system will change, either you change or go out. The system will go with the planned change process. If survival is the aim, change is the game. You cannot survive without change, my dear.

I: Let me summarise some few points we discussed so far, to make sure that we at the same level or maybe add some issues to it.

- The nurse managers need to be Involved and should participate in the envisaged change process as early as possible
- Information on the why, what, when, where, who, and how should be given to those likely to be affected by a change process for better understanding and ownership.
- Acknowledgement of a person subjected to change process and its unique nature as a holistic being is emphasizedemphasised.
- Training and capacity building is necessary in the early and later stages of a change process.
- Although complex, change is crucial and inevitable. Thus it only needs to be managed skillfullyskilfully.
- Change process must not be rushed. Equally, it must not dragged too long, as those likely to be affected are demotivated and demoralised by long waiting period to know their fade in the new structure.
- Supportive environment is vital. In this environment: people are supported, well informed of the vision of the change process, they are free to air own views and concerns and are listened to.
- Top management support is important. Peer support groups might be a good thing, but there are questions on how effective this could be while each of those likely to be affected have different factors that stress them during a change process.

I: Are these more or less what we have discussed?

R: Yes, but I want to add something.

I: Please go ahead

R: We must not forget resources.

I: Please elaborate

R: With this I mean, you have to budget enough money. Not only money, but also plan to have people with the know-how on the restructuring process, who will drive the process. You may need new equipment and so on, to make the change happen. All these will need funds.

I: Is there anything else you want to add on this topic of us?

R: I think I emptied my mind on the change process.

I: I thank you for your precious time.

ANNEXURE 2 (b) Excerpts from transcripts of the focus group interviews (Phase one 1 of the study)

Transcripts of the focus group discussion on the experiences and needs for empowerment of nurse managers to manage change in the health sector. The rest of focus group discussions are available on request from the researcher.

TakePlease Notenote: I: Interviewer

R: Respondent

I: I want us to discuss two questions related to your experiences during the health reform process.

I: Let us first discuss your experiences of health reform process currently going on in your Ministry?

R: No 5: My personal experience is that we were not prepared. There was lack of information on how this restructuring exercise will affect you. Thus the process has lots of fear.

R: No 6: I just want to agree with my colleague. New things always bring fear, but communication was not adequate from the management's side.

I: Communication was not adequate. Could you please elaborate?

R: No 2: Let me come in. I personally needed proper information on the restructuring process. I needed to know why restructuring was necessary? How will we be affected, meaning what are the benefits and challenges for our future?

R: No 6: Thank you my friend (Laughter). It is actually what I wanted to say when I talked of inadequate communication from the top management.
R: No 4: If new things come, people need to be involved fully, to know what is happening. Sometimes new things are very good, but if not communicated well, it creates fear, insecurity and anxiety.

I: What do you mean with full involvement?

R: Silence.

I: Any person can contribute.

R: Let me come in No 8: I think one should be involved from the very beginning of the process. We need to participate in all planning to be part and parcel of the whole process. If you are not involved fully, how could one expect you to

implement decisions you were not part of. Let me first stop and give my colleagues chance.

R: No 3: I also want to contribute to this discussion. My points are almost the same as those of others. Lack of proper information is a problem. I came across people who are saying that maybe they would be thrown out of the Ministry and will not get jobs due to this restructuring process. That's actually because people were not told how the process would be.

I: You have been quiet No 1and 7. Do you want to comment on this aspect?

R: I am married (Mmeaning covered by other's responses). No 1: (all laughs). I don't know. If change is needed, it should be something that should be justified. Why should management not be open and communicate it to others?

R: No 5: Perhaps they can't simply convince people. You know, some of us are very difficult to be convinced on certain issues. Maybe it is the reason they can't explain certain issues.

R: No 8: But change process is something that needs to be communicated adequately and well in advance. How do the management expect that people have to change or do new things if they are not properly informed. I think, it is totally not acceptable to me.

R: No 7: If it is the case as No 5 is saying that they are not able to communicate this change process, then that change is not a crucial one. I think we need knowledgeable cadres in management of change who know how to manage human resources during such a change process. If they fail in managing people, the change process will fail before it actually takes off the ground.

R: No 2. I really do agree with the previous speaker. I do not want to look around excuses for inadequate preparation. I think it is that causes more fear and insecurity among people. I think not all changes are negative, but it is important to tell us the benefits of the new changes.

R: No 1: I agree with you. What causes fear is the unknown nature of change. But I think the top management should think through any new issue before bringing it to workers. This will also include how to convey it to the workers and try to have all the necessary answers.

R: No 4: I don't think that they need to have all the answers. We as line-managers are at the operational level. They just need to involve us from the start so we plan together. We are dealing with the problems on a daily basis. I really do not think that there is someone who can have all the answers. They have to just involve others.

I: Major experiences are:

Lack of preparation due to:

- Inadequate information
- Inadequate involvement
- Inadequate preparation result in fear, anxiety and insecurity.

I: Is there anybody who wants to add something or correct the main points?

R: Silence

I: Silence means agreement (all laughs)

R: No 6: I think the summary is all inclusive

I: Can we now go over to the last question. How can you as nurse managers be empowered to manage change smoothly during a change process?

R: No 3: We need to be informed before any change can take place.

I: Why? (Laughter)

R: No 3: As we have said previously, anybody can manage change without proper information. Only the person who brings the new way of doing old thing

will know what is that he or she needs to be done differently. Thus I think they have to communicate thoroughly so others can agree or disagree until you reach consensus.

R: No 6: Communication will enable us to know which way to go, why changing, and what are the advantages and disadvantages of the change process. It is always better for me to go into something that I am prepared to do. Thus preparation is always important. You see, we on the operational level have people under us. We need to understand the pros and cons clearly to inform people under us. What now, if we do not have clear information. How will we convince the people? Therefore I agree whole-heartedly with the previous speakers.

R: No 7: Awareness should be created before the change process is implemented. You know change management sometimes brings confusion. People are not aware what is going to happen. Our subordinates need support from us as managers, so that they may know what is going on.

R: No1: Feedback is also needed, because sometimes you find the people are called for a meeting, but sometimes they don't give the feedback what was said in the meeting.

I: Elaborate more on feedback, as an empowerment need

R: Feedback is a two-way thing. How will I as a manager know that people under me understand the task I have delegated to them? It will only be through feedback that she or he will be able to know. Thus we as managers need to give and request for feedback.

R: No 5: I think it is lack of feedback that leaves others in the dark. It is the same with the staff establishment of the Ministry. We are aware that there will be lots of changes, but we don't know anything on when it will be approved. All these issues add up to ones fear and insecurity. Nobody tells us how far it is. There is simply no feedback.

R: No 5: As we said previously, we as nurse managers need to be part and parcel of the change process. This is only how we could convince our subordinates. Otherwise we will be in limbo together with them. I believe involvement and active participation is the answer.

R: No 7: The people need to receive proper orientation during a change process.

I: Could you please elaborate?

R: What I actually mean is guidelines. Guidelines should be available in the wards. We need verbal information, followed by guidelines and clear policies to

follow. These guidelines will always remind you what to do, and when to do certain procedure.

R: No 8: As the previous speaker said, guidelines are really needed. It should direct us to guide our subordinates. It will also make things much easier. People will know that you as a manager are not bringing these changes from your home (laughter), but it is coming from the Ministry because it is a written something.

R: Guidelines are important. Sometimes, if there are guidelines, they can just read from the guidelines or something like that.

I: So, verbal information is not enough during change, you need something that is written that you can rely on. What do other people add to this?

R: A booklet or any kind of a document must be available to everyone, because if I don't know something I must know exactly where to get that information. We must know information like the Patient Charter. If you ask me what is in the Patient Charter, I will not know (laughs). It was just brought to us and we were just told that it's a Patient Charter, we were not involved in the development or was even not explained, so we are not interested to page it through and look what is going on there.

Silence

I: We have been busy with the importance of involvement, participation and information giving or communication as we are discussing. If there is nobody who want to add more on these issues we can maybe proceed to another ways that we as nurse managers wish to be empowered to manage change smoothly during a change process.

R: No 2: Training is also needed. We need to be trained to know what is expected from us. There should be a reason for change. Maybe the old ways of doing things were not adequate enough, therefore we need to know the new ways of doing old things or sometimes new things should be learned.

R: No 6: I agree with you. Capacity needs to be built. If the people are not comfortable with what should be done, they will resist it.

R: No 1: I agree with you. Why people resist new thing is because you don't understand why or how something should be done. Therefore, training is really needed so everybody knows what to do, why and how.

R: No 2: Even after change is implemented, continuous in-service training is necessary. New ideas brought by change need to be maintained throughout. But this is lacking.

I: Training is required for change management. It should be done before the implementation of change process and through the change process. Any further contribution on this point.?

R: No 5: Maybe this is not a new point. People need to be convinced. I mean, one has to understand why certain aspect or aspects of something has to be changed. Therefore training should actually convince others that the new way of doing things is better than the old way. I mean it is how I see training for change.

I: You have been quiet for some time No 4. How do you want to contribute to this point of training or capacity building?

R: I will only join the previous speakers. One cannot change if you have not learned a new behaviour. For me, change is about something new. Whether it is the old thing that should get new elements to look different or so on. You need to learn something knew which is different so you can change.

I: If there are no more contributions on this point, than we can proceed. We have involvement, participation, communication and training so far. Which other ways are there that you would like to be empowered to manage change smoothly during a change process?

R: No 7: I think we need appreciation.

I: Could you please explain.

R: No 7: Change is not an easy thing. You have to let go all you were used to in the past and learn or do new things. For me it is a painful process. Therefore I think the supervisors need only to say well done or say your ward is trying to implement a, b and c.

R: No 2: I want to support you. Appreciation is a very important need during a change process. A person needs to be rewarded for good work (laughs).

I: Could you please elaborate

R: No 2: It does not mean that I must get money. If I do something, someone must learn to appreciate,appreciate; just to appreciate is very important. Not that I get money or a day off, just to appreciate and you create this conducive environment for me, because whether I did what or what, just to say well done, is enough, whether I don't get overtime or extra money, it is very important to me.

R: No 4: Motivation is not only about money. It gives you the feeling that your work is appreciated by somebody, that is enough sometimes.

R: No 8: At least, it is like as my colleague has just said. If you take an example of performance appraisal, most of us were getting one (grading), when you are giving yourself a five, they say you are always coming late for duty and brings you down. Most of the time, you are coming earlier; it was only that day you came late for duty, so most of us end up getting one which is bad. So the managers are just pulling us down and we are so disappointed. Most of us are just getting one notch, instead of at least 2 notches, which they say that you are just normal, what is normal? That's not good.

R: No 5: Appreciation is really needed for managers. Really they have to do that for people. When you do a good thing, they don't see, but immediately you make a mistake, you are in trouble, it demoralizesdemoralises. Most of the time, they look at bad side and not otherwise.

R: No 1: No one will come to you and say, you are doing well, but once you are making a mistake, everyone will start to talk. They have to support you and say, you have to do a,b,c.

I: After listening to you, appreciation is one of the most needed attributes in change management.

R: No 3: Yeah! Appreciation gives one a feeling of been valued. You feel, as you are somebody and only not just a working tool or an object in the system. You feel that you count. It gives you new strength to carry on daily basis.

I: No 6. You have been quiet. What do you want to contribute to this discussion.discussion?

R: No 6: I am listening to my colleagues. Even if monitory rewards are not always needed, appreciation could include a form of floating trophy or something like it to the particular person or a ward that is doing well during the change process. This could also motivate others to follow the example. Sometimes these types of rewards are needed.

R: No 6:I heard one of my colleagues talking about appreciation that creates conducive environment. It is true. When you are valued, as one other colleague said, you can bring out all in you.

I: What do you mean?

R: No 6: I mean, that you will feel free and do all in your ability to make the change happen. I don't know how to express myself. Maybe I want to say that you will be more committed and be responsible. But the fact is that motivated

person will be more productive. Thus motivation is creating conducive environment. That's how I see it.

I: Can you please elaborate on conducive environment in change management.

I: This question goes to all of you, not only No 6.

R: No 8: Be fair to people

I: Can you elaborate on that?

R: At least, you have to treat the people equally, it does not mean that there comes the other one, you treat the other way around and the next person, differently. Treat all the people equally. If some did a mistake, it's so high, but if someone did something good, it's quite. At least managers or those controlling us should treat people equally. It is really demoralizingdemoralising.

R: Be friendly to everybody.

I: What do you mean?

R: No 8: If the manager or supervisor is friendly, he or she is approachable. If not, the person's face or behaviour scars you off. You will not be free to ask anything, as you are already afraid of the unpleasant response that will be coming your way.

R: No 1: I agree with you. Some faces are already telling you that you should not come closer to them (Laughter). How can you discuss something with them?

R: No 3: I just want to add respect. Respect each other to make the environment conducive. If you treat me like a kid, I'm an adult, I'm only here for work, we must respect each other to know how to talk to each other, I mean it's important. Call the person to the office and ask what you want, not just in the corridor and say you did what, what and what. At the end no one is going to give respect to other, because of your manners. Respect starts with yourself, and if you don't have respect, you cannot expect another person to show you respect you.

R: I think continuous training on this of attitudes or psychological approach should be emphasized emphasised in a workshop or on a regular basis. We need this kind of support otherwise we are stagnating.

R: No 2: I think, if everyone can just do something, he/ she is supposed to do than it's going to be a good environment for change. I mean everyone must be responsible.

R: No 7: If there is no respect, even if you delegate work to the subordinates, they would not do it.

I: Are we saying that mutual respect is needed during change management to create environment conducive to change management.

R: Nodding of heads.

R: No 3: Availability of supervisors will also add to the conducive environment.

I: What do you mean by that?

R: No 3:They: They must be available so that people if they need something can be assisted and if there is a problem come back to you.

R: No 7: I think be there for them, you must be available always and answer their questions and assist them, support them in all they need while change is on.

I: Why is this important?

R: No 7: So that you can implement the change very effectively, otherwise they end up being disappointed. I know there is a change, but if you go and ask them, they don't help, so what does it help. If they know there is one who helps, than it motivates them and I think that's good for the change process.

R: No 1: Managers are supposed to know everything so that they can assist others when they come up with queries of that nature.

I: As I am listening to you, I understand if you are a change agent, you need to be knowledgeable about new change so you can assist people as they are asking different questions.

R: No 4: The environment could be how conducive, people could be well motivated or committed, but without the technical support, the change process will not be effective.

I: What do you mean by that?

R: I mean, change will be practical and easy to implement if the resources are available. Look at Windhoek. They have all the resources (all laughs). They have sophisticated machines, educated personnel, while we have nothing. How can we deliver quality care? (Laughter)

I: Am I understanding you correctly.? Are resources playing important role in the change management? Could we dwell more on this.

R: No 3: I agree with my colleague. Quality care needs quality equipment, adequate human resources and so on. Even if you have the know-how, you need sufficient equipment and manpower, as well as tools such as enough baumanometers, medications, linen, and so on. How can you render quality care with two nurses while the ward is overcrowded? It does not work like that.

I: Now, what are you saying.saying? Are we saying that mobilization mobilisation of human and technical resources are crucial in the smooth management of change process. Can you add some on this?

R: Nodding of heads

R: No 5: I think, change process is a dream without adequate resources, which will never materializematerialise. I mean, you can have a very nice plan, but it will not be practical without money. Thus funds and knowledgeable human resources are vital. If there are enough funds, adequate equipment can be assured and so on.

I: Can I summarise what we have discussed so far on the second question so you could come in.

- **Need for participation and involvement**

- **Importance of communication**
- **Training**
- **Appreciation**
- **Creating conducive environment by being:**
  - ✓ **Fair**
  - ✓ **Friendly**
  - ✓ **Respectful**
  - ✓ **Available for support when needs arise and**
- **Importance of human and technical support**

I: Are these all the points we discussed? Please feel free to add or correct.

R: No 1: I think I am done (Laughter).

I: You say you are done, but can others comment. (Laughter).

R: Heads down.

I: If all of you are done like No 1(All laughs), I want to thank you all.

ANNEXURE 3 (a) Guidelines for Co-Coder (Data analysis: Phase 1)

Sir

Could you kindly analyse the enclosed data (transcribed audio taped material of individual in-depth interviews and focuses group interviews) with reference to eight steps of **Tesch's** (1990:142-145) qualitative data analysis.

Step1: Please read through all the transcripts carefully to get a sense of the whole. Jot down thoughts as they come to your mind.

Step 2: Pick any data document from the pile and read through for the meaning, not so much as formore than the content. Jot down the thoughts in the margin of the document.

Step 3: After completing all interview documents, make a list of all concepts and cluster similar ones together. Re-arrange these concepts in three different columns such as major, unique and leftovers. (Keep research topic/purpose in mind.)

Step 4: Revisit the data. Abbreviate the concepts as codes and write the codes next to the appropriate segments of the text. Try out this

preliminary system of data organizing organising to see whether new categories could be observed.

Step 5: Try to find most descriptive wording for your concepts and turn them into categories. Reduce the list of categories by grouping related concepts together. Capture inter-relationships by drawing lines between the categories.

Step 6: Make final decision on the abbreviations for each category and alphabetise these codes.

Step 7: When finishing with coding, assemble the data material belonging to each category in one place and perform preliminary analysis. Please take note of research questions and purpose of research study to maintain the focus during analysis.

Look for commonalities, uniqueness, confusions and contradictions in content, as well as missing information with regard to research questions/purpose. (See attached copy of research questions and purpose of the research.).

Step 8: If necessary, recode the existing data.

Thanking you in advance

Yours truly,

Käthe Hofnie (Doctoral student)

RESEARCH QUESTIONS AND PURPOSE OF THE STUDY

Research Questionsquestions

- **How do the nurse managers experience reforms within the health service context?**
- **How can the nurse managers be empowered to facilitate change in the health sector, through an environment that is conducive to management ofmanage change in the health sector?, through by facilitating environment conducive to the management of change?**
-

Overall aim

The overall aim of this study is to describe a model to empower the nurse managers to facilitate change smoothly during reforms in the Namibian health sector, through bythrough facilitating an conducive environment that is conducive forto the management of change, with guidelines for operationalisation.

ANNEXURE 3 (b) GUIDELINES FOR CO-CODER (CONCEPT ANALYSIS: PHASE 2)

Dear Colleague

Kindly analyse the concepts of “Facilitating conducive environment” with reference to concept analysis by Walker and Avant (1988:35-50) and Walker and Avant (2004:63-84). Please note: A copy of concept analysis is hereby attached.

ANNEXURE 3 (bc) THINKING FRAMEWORK OF CONCEPT ANALYSIS OF FACILITATING CONDUCIVE ENVIRONMENT

CONCEPT "FACILITATING"

COLUMN 1	**COLUMN 2**	**COLUMN 3**
Identified connotations of "facilitating" from literature	Further reduction of connotations from column 1	Final reduction into categories and connotations from column 2
1. ▪ to make easy or easier ▪ ;to promote ▪ ,a help forward ▪ increase the likelihood of ▪ strengthen a response (Brown 1993:903)	1. Facilitating is to make something **easy** or **less difficult** 1, 2, 3,, 4, 5, 65, 76, 8, 97, 108, 911, 120, 131, 142, 153, 164, 175, 186	Facilitating means enabling people through adequate support to ensure that they identify, develop, and achieve own objectives easily, 108, 119, 1219,
2. ▪ to make easy or	2. Facilitating is **promoting** something	

easier (Soukhanov 1992:653)	for others to happen, 1, 4, 56, 8, 108, 142, 175, 168	
3. ▪ to make easier (Anderson et al 1999:195)	3. Facilitating means **helping** forward 1, 4, 56, 1234, 1678	
4. ▪ make easy or easier ▪ promote ▪ help forward (Trumble and & Stevenson 2002:911)		
65. ▪ make easy ▪ promote or ▪ help forward (Mellish and & Wannenburg 1992:187)		
67.		

▪ easy or ▪ less difficult (Cowie 1989:432)		
79. ▪ make easy or easier (Pearsall 1999:508)		
108. ▪ enabling something to happen easily ▪ ,not to do something oneself, but to promote the doing of it by others (Stewart 1995:108)		
911. ▪ making things possible for others to achieve desired goals (Mellish 1998:75)		

120. ▪ enable individuals to identify, mobilise, and develop his or her own strengths (Erickson et al 1998:394)		
113. ▪ to make easier (Davidson et al 1999:195).	.	
12.4 ▪ to render easier ▪ promote ▪ help forward (Simpson and & Weiner 1989:649)		
13.5 ▪ to make something easy or easier to achieve		

(Robinson 1999:467)		
146. ▪ to make easy or easier (Schwarz 1994:601)		
157. ▪ loosening the reins, ▪ encouraging informality and ▪ stimulating risk taking in others (Floyd and & Wooldridge 1996:86)		
168. ▪ easy, ▪ make possible, ▪ make smooth, ▪ encourage,		

▪ help, ▪ speed up, ▪ promote, ▪ accelerate, ▪ assist *Waite (2002:305)*		

CONCEPT "CONDUCIVE"

COLUMN 1	**COLUMN 2**	**COLUMN 3**
Identified connotations of "conducive" from literature	Further reduction of connotations from column 1	Final reduction into categories and connotations from column 2
1. ▪ Lleading ▪ Ccontributing or ▪ Ttending ▪ Ffavourable to or ▪ Hhelping towards something	A. Conducive means **tending**, 1, 2, 3, 5, 7, 10	Conducive condition or situation is supportive to those who are involved

▪ Ppromoting or ▪ Eencouraging (Schwarz, 1994:357)		
2. ▪ Ttending ▪ Hhelping towards (Davidson et al, 1999:109)	B. Conducive means **helping**, 1, 2, 4, 6, 9, 12	
3. ▪ Ssomething that conduces or ▪ Ccontributes ▪ Ttending ▪ Lleading (Neufeldt & Guralnik, 1994:290)	C. Conducive means **contributing,**1,3,4,6,7	
4. ▪ **help to bring about** ▪ **contributing** **(Pearsall 999:298)**	D. Conducive environment is **promoting** others 1, 5, 10	
5. ▪ **conducing or** ▪ **tending to (a specific end)** ▪ **promote or**	E. Conducive conditions are **encouraging,** 1, 5, 11, 12	

▪ encourage (Brown, 1993:473)		
6. ▪ contributing ▪ helping towards something (Allen 1990:238)		
7. ▪ tending to bring about ▪ contribute (Soukhanov, 1992:393)		
8. ▪ likely to achieve desirable result ▪ encouraging (Cullen et al 2000:159)		
9. ▪ help to bring about something ▪ allowing or helping something to happen (Cowie 1989:243)		

10. ▪ **tending** ▪ **promote** **(Simpson and & Weiner 1989:690)**		
11. ▪ **likely to achieve a desirable results** ▪ **encouraging** **(Robinson 1999:286)**		
12. ▪ **advantageous,** ▪ **beneficial,** ▪ **encourage,** ▪ **promising,** ▪ **convenient,** ▪ **good,** ▪ **helpful,** ▪ **instrumental,** ▪ **productive,** ▪ **useful (Waite (2002:161)**		

CONCEPT "ENVIRONMENT"

COLUMN 1	**COLUMN 2**	**COLUMN 3**
Identified connotations of "environment" from literature	Further reduction of connotations from column 1	Final reduction into categories and connotations from column 2
1. ▪ Physical surroundings and conditions, especially as affecting people's lives ▪ External conditions affecting the growth (Allen 1990:392)	A. Physical conditions, circumstances, and influences surrounding and affecting person's lives, work, and development. 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 19, 20	Internal and external conditions and circumstances affecting human growth and development positively or negatively
2. ▪ the action on environing ▪ the set of circumstances or ▪ conditions, especially physical conditions, in	**B. Totality of internal and external conditions and circumstances, affecting human beings 12, 17. 18**	

which a person or community lives, works, develops … or a thing exists or operates ▪ the region surrounding a place ▪ context, ▪ setting ▪ a structure and condition within which an organism can operate ▪ combination of things which enables a user to operate a system ▪ totality of the physical conditions in which a human society lives (Brown 1993:832)		
3. ▪ surrounding ▪ external conditions influencing growth of people		

▪ living or ▪ working conditions (Schwarz 1994:563)		
4. ▪ a context within a word or sentence in which a change or process takes place (Matthews 1997:115)		
5. ▪ surrounding conditions, especially as influencing a person's development or growth the natural conditions in which we live (Davidson et al 1999:183)		
6. ▪ being surrounded ▪ something that surrounds ▪ all the conditions, circumstances, and influences surrounding,		

and affecting the development of, an organism or group of organisms (Neufeldt & Guralnik, 1994:454)		
7. ▪ **the circumstances or** ▪ **conditions that surround one** ▪ surroundings ▪ combination of external physical conditions that affect and influence the growth, development, and survival of organisms (Soukhanov 1992:616)		
8. ▪ **the surroundings or** ▪ **conditions that**		

surrounds and influence a living organism ▪ **programprogramme, set of programprogrammes or** ▪ **an operating system that allows a particular application to be employed** ▪ **conditions within which something or** ▪ **someone exist** (Cullen et al, 2000:249)		
9. ▪ **surrounding or** ▪ **conditions in which a person, animal, or plant lives or operates** (Pearsall 1999:477)		
10. ▪ **the way in which managers behave to**		

other people and of the type of business decisions that they take; ▪ **how they treat their employees, each other, their directors and their customers** (Stewart 1997:129)		
11. ▪ **environment involves: rules and regulations and laws that govern aspects such as** *** practitioner behaviour,** *** working conditions,** *** facilities,** ▪ **health care education among others** ▪ **environment creates a broad set of incentives and** ▪ **sanctions for providers**		

and ▪ **makes them accountable for their actions** ▪ **it can be divided into local, regional and national levels, and is created by structures and processes at each of these levels.** (WHO/OMS 2001:5)		
12. ▪ **condition under which any person or thing lives or is developed;** ▪ **the sum total, total of influences which modify and determine the development of live life or character** (Simpson and & Weiner 1989:315)		
13.		

▪ **combination of external conditions that surround and influence a living organism** ▪ **surroundings or conditions within which something or someone exists** (Robinson 1999:440)		
14. ▪ **network or** ▪ **context in which something develops (Kahn 1989:171)**		
15. ▪ effect of physical surroundings on an individual's well-being (Lindberg et al 1994:136)		
16. ▪ context in which we live our lives. (Schaefer, et al 1998:199)		

17. ▪ **all the conditions, circumstances, and influences surrounding and affecting development and behaviour of persons or groups** ▪ **it is the input into the person as an adaptive system, involving** ▪ **internal and external factors** **Phillips Kennneth, et**		

al 1 9 9 8: 2 4 8- 2 4 9)		
18. ▪ all the internal and external factors that surround or ▪ linteract with man Fr e e s e, et al 1 9 9 8: 2		

7 3)		
19. ▪ all physically external factors (Tomey 1998:329)		
20. ▪ existing forces outside the organism and in the context of culture (Howk, et al 1998:340)		
21. ▪ **territory,** ▪ **surroundings,** ▪ **background,** ▪ **scene,** ▪ **context,** ▪ **location,** ▪ **world,** ▪ **framework,** ▪ **nature,**		

▪ **realm,** ▪ **atmosphere,** Waite (2002:280)		

The meanings of "facilitating"; "conducive"; and "environment" were thoroughly explored and investigated separately as indicated above. Subject definitions and usage of full terms "facilitating conducive environment" were investigated below for similarities of words identified in separate investigation within the context of change management.

COLUMN 1	**COLUMN 2**	**COLUMN 3**
Identified connotations of "facilitating conducive environment" from literature	Further reduction of connotations from column 1	Final reduction into categories and connotations from column 2
1**. Facilitating conducive environment means:** ▪ **establishing, informal, relaxed relationship within the learning group and between**	**A.** Facilitating conducive environment means: adequate **support** to those affected by envisaged	1. Adequate support and interpersonal relations reduce fear of unknown

the group and the facilitator ▪ **flexibility in developing relationships** **(Stewart 1995:109).**	change process to give them sense of **safety** and **security**. Support includes **human, technical and financial** aspects**.** 1, 2, 3, 5, 6, 7, 8, 10, 11	
2**. Facilitating conducive environment provides:** ▪ **praise and recognition** ▪ **opportunities of for willingness of staff to be willing to share knowledge, skills and resources** ▪ **feelings of being supported** **(Ellis and & Hartley 2000:188-189).**	**B.** Facilitating a conducive environment ensures **adequate interpersonal relations**. Open communication builds **mutual trust** and **respect** between the recipient and the facilitator of change process. Clear **vision** of the need and direction of envisaged change process is crucial for **reduction** of **anxiety.** 1, 2, 3, 5, 6,	**2**. Active participation and involvement enhances confidence and continuous interaction facilitates knowledge and skills development

	7, 8, 9, 10, 11	
3. **New ideas of workers are:** ▪ **welcomed,** ▪ **valued, and** ▪ **encouraged** **(Williams 2002:301).**	C. Facilitating conducive environment means **active participation and involvement** of those involved in a change process for **new insights.** Interactive process fosters feeling of **appreciation, commitment** and **ownership**.	
4. People are provided with: ▪ sense of excitement in their jobs and ▪ consequently sense of belonging to the organization organisation (Paton and & McCalman[U1] :151).		
5. ▪ **Environment characterized**		

characterised by empowerment in which effective teamwork is expected, ▪ **recognizedrecognised,** ▪ **praised,** ▪ **rewarded** ▪ **resources for acquiring goals are identified** ▪ **facilitator being patient with team members** ▪ **people are listened to and encouraged** ▪ **leader relies on two-way communication** ▪ **followers are involved in decision making** **(Hellriegel et al, 1999:22, 514)**		
6. **FacilitatiingFacilitating conducive environment provides:** ▪ **Ssupport and is,** ▪ **Is nonthreatening and**		

▪ **backed up by organizational organisational policies that have been clearly communicated to everyone** ▪ **people feel safe to express interests and concerns, and** ▪ **bring hidden issues into public view such as:** • **creative ideas** • **corporate purpose** • **vision** • **commitment** **(Vogt and & Murrell, 1990:52-53)**		
7. **Facilitating conducive environment involves:** ▪ **continuing support** ▪ **allows efficiency in terms of time, cost and impact** ▪ **less beaurocracy** ▪ **clear policies and clear guidelines** ▪ **humanitarian nature is recognized recognised and**		

respected ▪ **human, technical and financial resources are crucial** ▪ **sense of ownership is created among employees,** **(Howell,** ****Page missing **September and & December 2000:7).**		
8. **A structure with very few job descriptions and;** ▪ **rules and procedures are ambiguous and imprecise;** ▪ **staff are expected to use their initiative in deciding priorities;** ▪ **staff work together to solve problems;** ▪ **communication is largely lateral, rather than through the hierarchy** **(Boddy 2002:305)** **(Boddy 2002:305)**		

9. **Allow working climate that nurtures employees (Cherniss and & Goleman 2001:1).**		
910. **Provides environment that requires a positive communication relationship characterized characterised by:** ▪ **trust, mutual respect, and openness between superiors and subordinates as well as between co-workers.** ❑ **Work teams are thought to support cooperation and help foster a climate characterized characterised by:** ▪ **fairness, openness, and trust as the teams place increased emphasis on co-worker communication (Douglas et al, 2003:2).**		

110. **Enabling environment characterizsed by:** ▪ **trust,** ▪ **authenticity,** ▪ **openness, and** ▪ **supportive climate** **(Robbins et al, 2003:413).**		

ANNEXURE 3 (c) GUIDELINES FOR CO-CODER (CONCEPT ANALYSIS: PHASE 2)

Dear Colleague

Kindly analyse the concepts of "Facilitating conducive environment" with reference to concept analysis by Walker and Avant (1988:35-50) and Walker and Avant (2004:63-84). NB!Please note: A copy of concept analysis is hereby attached.