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An Investigation into First-Line Nurse Managers' Lived Experiences in Two District Hospitals in Yaoundé, Cameroon: A Descriptive Phenomenological Inquiry

By

Esther Lydie Wanko Keutchafo

Supervisor

Dr Jane Kerr, PhD.

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DECLARATION

I declare that this thesis titled "An Investigation into First-Line Nurse Managers' Lived Experiences in Two District Hospitals in Yaoundé, Cameroon: A Descriptive Phenomenological Inquiry" is my own unaided work. It has not previously been submitted to UKZN or another tertiary institution for purposes of obtaining a degree or any other academic qualification. All sources used have been acknowledged through the use of referencing.

Student Number: 214584622

STUDENT: Esther Lydie Wanko Keutchafo

Student _____   Date_____

Supervisor   *J kerr*   Date 7 March 2016

DEDICATION

This thesis is dedicated to:

- My parents Mr. and Mrs. Keutchafo; and
- My siblings Josée, Jude, Jeanne and Noël Keutchafo.

ACKNOWLEDGEMENTS

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ABSTRACT

INTRODUCTION: Managing a district hospital ward in the Cameroonian health care system is a challenge for unit managers who are appointed to a managerial position because of their clinical skills, without being trained as managers, and with limited financial, material and human resources.

PURPOSE: The purpose of this study was to describe the first-line nurse managers' lived experiences in two selected district hospitals in Yaoundé, Cameroon in a work environment as described above.

METHODOLOGY: A constructionist, descriptive Husserlian phenomenological approach was used. The researcher interviewed ten unit managers in two district hospitals. Data were collected through semi-structured interviews, then audio-recorded and transcribed verbatim. The seven-steps of Colaizzi's qualitative data analysis method were used to find the essence of what it is like to be a unit manager in the selected district hospitals.

FINDINGS: The data analysis revealed that managing a district hospital unit is like "being a mother of a family". The transition to this role happened by surprise and with no formal training preceding it and includes providing, teaching, controlling, correcting, and planning. This role implies facing difficulties and making some sacrifices. It requires assistance from others and specific characteristics in the role-players.

CONCLUSIONS AND RECOMMENDATIONS: Health care organisations should foster, support and strengthen the roles of unit managers in Cameroon. They should dedicate financial and material resources to education and training in order for unit managers to acquire the necessary leadership and management skills. Finally, unit managers should be transformational leaders in a context where staff are in need of supervisors who not only facilitate an environment that allows them to be productive, but who also demonstrate their concern for the staff's wellbeing as individuals.

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LIST OF ABBREVIATIONS

EDS-MISC   *Enquête Démographique et de Santé et à indicateurs multiples* (Demographic and Health Surveys - Multiple Indicator Cluster Surveys)

FLNM   First-Line Nurse Manager

HSSREC   Human and Social Sciences Research Ethics Committee

ICU   Intensive Care Unit

INS   *Institut National de Statistiques*

IPA   International Phonetic Alphabet

NARP   Nursing Administration Research Project

NM   Nurse Manager

FLNM   Nurse Unit Manager

UK   United Kingdom

UKZN   University of KwaZulu-Natal

USA   United States of America

WISN   Workload Indicators of Staffing Needs

WHO   World Health Organization

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

In nearly all countries, nurses give direct care and supervise the work of others. Their roles have evolved from serving as the handmaidens or the doctors' right hands to maturing into a profession the community cannot do without (Meyer, Naudé, Shangase & van Niekerk, 2009:23). They are responsible for many of the services provided to people in communities and hospitals. They are situated closest to the day-to-day experiences of patients' lives and have a practical understanding of health care systems and work environment. Nursing is the largest sector of the health care workforce, (Cross, 2013) even in Cameroon, where, out of 38207 health care workers in the national system in 2011, 49.6 percent were nurses (Ngah, Kingue, Ndi & Bela, 2013, p.10). However, the nursing shortage, which is acute in most of the countries in the world, (Grohar-Murray & Langan, 2011:10; Janiszewski Goodin, 2003, p.341; Shea-Messler, 2007, p.v; Ugochukwu, Uys, Karani, Okoronkwo & Diop, 2013, p.117) is having an adverse impact on health systems around the world (Outlon, 2006, p34S). This shortage also includes the shortage of nurse managers (Cross, 2013, p.4). Because of these three aspects, (wide responsibilities, the nursing shortage and large **num**bers) it is vital that nurses in management positions such as head managers or front-line nurse managers (FLNMs) have good leadership and effective management skills. What about the day-to-day lived experiences of FLNMs in two district hospitals in Yaoundé, Cameroon?

1.2 Background

Also called "Africa in miniature", Cameroon is a lower middle-income country at the heart of the Gulf of Guinea in Central Africa. It extends from the Atlantic Ocean in the South to Lake Chad in the North. It is bounded in the north by The Chad Republic, in the east by The Central African Republic, in the south by Gabon and Equatorial Guinea, and in the west by Nigeria (Mboti, 2009, p.5) (Figure 1.1). It was discovered by the Portuguese in 1472, placed under German authority in 1884, under the French and British authorities in 1919, and became independent in 1960 (Kelodjoue, Libité & Jazet, 2012, p.2). In 2012 it had about 21.7 million inhabitants within its 474,442 square kilometres, with a life expectancy of 54.8 years in 2005 (Kelodjoue et al., 2012, p.2) and 51.2 years in 2011 (Nzima, 2014, p.2). Although it

has more than 230 ethnic groups[1] spread in ten administrative regions[2], French and English are the two official languages. However, French is the most used language (8 regions over 10 are French speaking).

Figure 1.1: Map of Cameroon in Africa

Concerning the health sector, it is worth noting that Cameroon has experienced many reforms across the decades:

> *Firstly, the Alma Ata Declaration of Primary Health care in 1978, the World Health Organization's (WHO) Interregional conferences in Bamako in 1987, the Declaration of Implementation of the Reorientation of primary health care in 1933, the adoption of 2001-2010 Health Sector Strategy and the revision of the Health Sector Strategy in 2010* (Nzima, 2014, p.2).

However, its health system has some critical challenges to face which include a poor health information system that is highly centralised and not utilised at a peripheral level, structural

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[1] However, there are six major ethnic groups in Cameroon

[2] 58 departments and 360 districts and 339 (Ministère de la Santé Publique, 2011 :11)

and capacity-building problems in health service administration at peripheral and central levels and inadequacy of training of the health workforce (Nzima, 2014, p.ii).

The Cameroonian health care system aims to improve the health of the population by several means. It involves three sub-sectors: (1) the sub-public sector consists of public hospitals and health structures under the guardianship of other department members (Departments of Defence, Employment, Labour and Social Welfare and National Education); (2) the sub-private non-profit sector (religious denominations, associations and various non-governmental organisations) and those for profit; (3) the sub-sector of traditional medicine which is an important component that cannot be ignored. It is financed by the government, public enterprises, foreign-aid donors, private enterprises, households, faith-based missions, and non-governmental organisations (Ngwakongnwi et al., 2014).

The Cameroonian health care system is pyramidal comprising three levels with administrative structures, health facilities and dialogue structures relating to specific functions (Ngah et al., 2013, p.3). The central level (strategic) of the health care system is made up of central services of the Ministry of Public Health. These coordinate, regulate and develop concepts, strategies and policies in the field of health. At this level, general hospitals, central hospitals and university hospitals are included. The intermediate level (technical) comprises regional delegations of the ministry (which provide technical support to the health districts) and regional and related hospitals. The peripheral level (operational) includes district health services, (which implement the national program) district hospitals, sub-divisional medical centres and integrated centres. It is at this level that we find district hospitals. Cameroon has 178 health districts with 162 district hospitals among these, of which only 154 are operational (Amani, 2010, p.3).

Regarding the health workforce, Cameroon is among the African countries currently experiencing a crisis in the area of human resources for health. The major causes of this crisis include, not only the poor production and recruitment planning of health personnel, but also shortcomings related to their management (Ngah et al., 2013, p.2). In fact, there was a decline in the number of public sector employees in the health sector between 1992 and 2001, from 18,247 to 11,016 (Ngah et al., 2013, p.4). Furthermore, about 25 to 30 percent of health workers trained in Cameroon decided to leave the country between 1991 and 2006 (Nzima, 2014, p.33) and 70 to 80 percent of those trained abroad did not come back during the same

period (Amani, 2010). In 2011, 38,207 people were employed in the national system with 13,084 nurses in the public sector and 5,870 in the private sector; 18,954 nurses were employed, with a density of 0.32 nurses per 1000 population (Ngah et al., 2013). It is worth noting that a State Registered Nurse Diploma or a first degree in nursing is the minimum requirement to enter into practice in Cameroon as far as the nursing profession is concerned.

The nursing profession in Cameroon faces many challenges: the chaotic workforce and education, the dysfunctional nursing regulations, the lack of funding and other resources for nursing research and the lack of a directorate of nursing (Suh, 2012). Regarding the work environment, nurses in Cameroon work under poor conditions. Firstly, they have low salaries (Amani, 2010). The monthly wage paid to a nurse officer in 2011 was 347 to 629 US$[3] and for a Registered Nurse, 344 to 528 US$ in the public sector (Ngah et al., 2013:16). Secondly, there is a nursing shortage of 37 percent of nurses in district hospitals at the national level. In fact, based on the Workload Indicators of Staffing Needs (WISN) method, 14,025 nurses were required in 2011 and only 8,069 were available in district hospitals (Ngah et al., 2013, p.18). Therefore, due to this nursing shortage, there is an overload of work and a nurse within a primary health care system (like a district hospital) could function as a medical doctor, a nurse, a pharmacist and a laboratory scientist. Her[4] functions would then include assessment of the patient and/or diagnosis and prescription in some settings (Ugochukwu et al., 2013, p.118). However, most of the time, the nurses are subordinate to the physicians.

One could ask why nothing has been said about unit managers in Cameroon. The first reason is that a descriptive Husserlian phenomenological inquiry requires not to know about the phenomenon before the data collection, and to put in abeyance what we know about the phenomenon before the data collection. Since this first chapter was written before the data collection, the researcher did not mention any literature about the phenomenon under investigation. Furthermore, after having read about nursing unit management, the researcher found that few or nothing has been said about nursing unit management in Cameroon.

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[3] based on an exchange rate of US$1= 500CFA

[4] In a nursing dissertation, she and her also include he and his.

1.3 Problem identification

On the 24th March 2015, an undergraduate friend told me that she had been appointed as a FLNM in one unit in a district hospital in Douala, Cameroon. She is a degreed nurse and has been working as a nurse in that same hospital since June 2012. She was promoted to the position of nurse manager just one month after she had been working in that unit. She received the post description from the senior nurse manager by word of mouth. She is married and has children. When she was a staff nurse, she worked two days from 7.30 a.m. to 5.30 p.m.; two days from 5.30 p.m. to 7.30 a.m. then she rested for the next four days. Now she has to work every day from 7.30 a.m. to 3.30 p.m. when there is no emergency. Normally, she works 24/7 because she can be called to solve a problem at any time. When I asked for her first impressions two weeks after her promotion she told me, "*Well, I am happy but there are many responsibilities in front of me for which I think I am not well prepared…*" (Londo, FLNM at Hospital de District de A, Interviewed by the researcher via Facebook, 24th March 2015).

Like her, nurses in managerial positions sometimes find themselves in a situation of being nurses in the background and promoted from among their peers, (Viitanen, Wiili,-Peltola, Tampsi-Jarvala & Lehto, 2007:115) perhaps, for their clinical skills. Then, they "*must promptly become a strategic planner, an operations manager, a human resource authority, a financial analyst, a quasi-business manager, a clinical expert, and a quality specialist*" (McCallin & Frankson, 2010:320). This role transition has been identified as a source of conflict and stress, (Oroviogoicoechea, 1996) especially when there is no clarity to secure an understanding of the role (Pegram, Grainger, Sigsworth & While, 2014, p.694). Nurses in a managerial role perceive themselves as having many tasks and duties for which they feel ill-prepared (Udod & Care, 2012) for many of the demands of their role (Brown, Fraser, Wong, Muise & Cummings, 2013, p.469) especially in Cameroon, where the work environment is not the best. Currently, it is apparent from the literature that nurse managers struggle with their role in decentralised structures (Loo & Thorpe, 2004) like district hospitals.

Being a nurse manager is not an easy task. It entails being doubly-employed, as a nurse, and as a manager. However, it is a good idea to promote nurses to positions as managers because they can provide nursing care, especially when the staff are busy (Wong, 1998, p.347). Undoubtably, the role of nurse managers is widely recognised as pivotal for health care

organisations (Mickey, Peachey, Baxter & Flaherty, 2014, p.1005) because they link management to employees, facilitate and assure quality of care and meet organisational goals and objectives (Oroviogoicoechea, 1996). Nurses in managerial positions are charged with managing the nursing workforce through rostering; monitoring the budget; performing a myriad of administrative duties and ensuring the provision of quality nursing care (McCallin & Frankson, 2010:320) within a workplace culture that does not appear to support them (Paliadelis, Cruickshank & Sheridan, 2007). Nurses in management positions play a key role in creating healthy work environments to ensure optimal patient outcomes. Moreover, they play a fundamental role in the immediate lives of nurses (Cross, 2013, p.4) and are accountable for coordinating care activities while looking out for the interests of the employees and the employer (Kerr, 2014, p.5).

The FLNMs perform the same tasks as the head managers do, but at the unit level. Today, the FLNM's roles have become multidimensional (Miri, Mansor, Alkali & Chikaji, 2014, p.13) and challenging (Shea-Messler, 2007, p.v). They are responsible for the effectiveness and the efficiency of the unit, but are often required to fulfil functional nursing tasks and perform other roles in relation to the care of patients (Matlakala, Bezuidenhout & Botha, 2014, p.1). Their span of control is larger, because of the increasing number of responsibilities and greater accountability than before (Shea-Messler, 2007, p.1). They have been demonstrated to be key contributors in meeting organisational outcomes, patients' and nurses' satisfaction (Cadmus & Wisniewska, 2013, p.673). They must juggle patient care issues, staff concerns, medical-staff relationships, supply inadequacies and organisational initiatives, while balancing all of this with a personal life (Whiley, 2001, p.356). These are great responsibilities. It makes their role one of the most difficult and most important in any health care setting (De Campli, Kirby & Baldwin, 2010, p.132) where there is a need to attract nurses to managerial positions (Spence, Purdy, Cho & Joan, 2006, p.20).

Some might consider a management role to be prestigious, even powerful (Shea-Messler, 2007). Yet most nurse managers embark on their new roles from a place of clinical expertise and are unprepared for the diverse complexities they will face (Cross, 2013; De Campli, et al., 2010, p.132). The major challenges are the care of diverse patients' cultural backgrounds (Suh, 2012, p.43) and the management of a culturally diverse workforce (Yoder-Wise, 2011, p.158). When they have no formal qualifications in leadership and management, these nurses might largely be expected to develop their leadership skills through experience in their work

(Nilsson & Furaker, 2012, p.107). By doing so, the future of the nursing profession might be compromised, since a managerial position requires some skills, especially in a district hospital where the resources are limited. Do they really have support and the education in order to be successful in their multidimensional roles (Thorpe, 2001)? What about role conflict, especially with female unit managers who have to receive orders from their husbands at home but have to give orders in the workplace?

Based on these facts, the researcher aims to describe how FLNMs 'manage' their role as they are supposed to. It is worth noting that a good front line nursing manager can have the greatest impact on nurse satisfaction, nurse retention and patients' outcomes (Brennan, 2014).

1.4 Purpose

Researchers investigate a phenomenon with the intention of understanding it or to give meaning to it (Botes, 2002, p.23). In this case, the purpose of this study is to describe nurse unit managers' (NUMs) lived experiences in two selected district hospitals in Yaoundé, Cameroon. The reason therefore is to create a better understanding of the role and responsibilities of FLNMs so that organisations can better support and enhance the development of management in nursing.

1.5 Research objectives

Research objectives are defined as clear, concise, declarative statements that are written in the present tense (Brink, 2010, p.79). The main objective of this study is to describe nurse unit managers' lived experiences in selected district hospitals in Yaoundé, Cameroon. In concrete terms, the specific objectives are fourfold:

- To identify how the FLNMs describe their roles and responsibilities;
- To describe the day-to-day practice of FNLMs in these units;
- To describe the challenges that FNLMs face during their day-to-day practices; and
- To identify suggestions for the improvement of FLNMs' efficiency in Cameroon.

1.6 Research questions

Research questions do not come from nowhere (Flick, 1998, p.49). In fact, the research question is similar to the research problem, except that it is stated in a question format (Shelile, 2014, p.4). Moreover, the research question is not just a mundane question. For

Erlingsson and Brysiewicz, (2013, p.94) the research question is the lodestar in any research design. Speziale and Carpenter (2007, p.13) add that the question that needs to be answered will drive the research type and the paradigm selected. Moreover, it is always posed about some past or present human experience (LoBiondo-Wood & Haber, 2010, p.104).

As far as this study is concerned, the researcher answered the question: **What are the lived experiences of FLNMs in a district hospital unit in Yaoundé, Cameroon**? In other words, the researcher answered the following questions:

- How do the unit managers in these two district hospitals describe their role and responsibilities?
- What are the day-to-day practices of a nurse in a managerial position in a district hospital ward in Yaoundé?
- What challenges does a FLNM face every day in a district hospital in Yaoundé?
- What suggestions can be made to improve the efficiency of FLNMs in Cameroon?

1.7 Significance of the study

Undoubtedly, any health care organisation's goal should be to influence the quality of patient care (Brady & Cummings, 2010, p.438). The staff nurse and the nurse manager's goal is to reach the organisation's goal by delivering quality and safe care to patients. Yet the organisation should help them to attain this goal by enabling a positive perceived work environment.

Even though it is important that the FLNMs' roles are clarified to create competency and help them to carry out their roles efficiently, (Miri et al., 2014) this study is about describing their lived experiences and is not about clarifying their roles. It is worth noting that strong nurse management at the unit level can impact on both outcome variables: nurse assessed quality of care and job outcomes (Van Bogaert, Kowalski, Weeks, Van Heusden, Clarke, 2013). This study is expected to create an opportunity for their experiences to be shared (Speziale & Carpenter, 2007, p.93). In so doing, it will influence the day-to-day practices of FLNMs by enriching them because two FLNMs working in the same institution can carry out their functions differently (Johansson, Theorell & Gustafsson, 2007). The nurse managers are

expected to acknowledge aspects of their own practice and to recognise that they are not alone in how they perceive their positions within the health care organisation.

This study could raise debate around FLNMs in district hospitals and reveal the need for further studies in the field of nursing management. By highlighting the existence and extent of nursing unit management in a district hospital, this study is expected to induce interventions and actions that could lead to policy change. Furthermore, the study could stimulate research on how to enhance nurse managers' working environments and to facilitate their effectiveness as leaders.

In addition, when the nurse manager, trained as a nurse, is appointed as a manager, the quality of care may be impaired if she has not been trained as a manager. The training is therefore an important tool by means of which the nurse manager can 'manage' the staff and ensure quality and safety of care within an organisation that wants to have benefits. Even though it is a health care setting, a hospital wants to make some profits as any other organisation. Therefore, this study is expected to help nurse educators to become more adept as they train their student nurses to understand the responsibilities and become better prepared for the challenges nurses face in managerial positions in a health care organisation.

1.8 Definition of key words

FLNM refers to a "*professional nurse who has formal authorisation to manage a nursing unit by virtue of the post description and designated lines of authority*" (Muller, 2002, p.43). She is a nurse in a position with line responsibility for nursing and an acute care patient unit with staff nurses reporting directly to her. In the literature, titles such as unit-level nurse manager, unit director, head nurse, FLNM, charge nurse, to name but a few, can be used to refer to the nursing unit management positions (Baley, 2014, p.8). In Cameroon, "ward charge" is the title used. There is no level of management below this position; however, the incumbents may have charge nurses, supervisors or team leaders who report directly to them (Spence & Wong, 2007).

District hospital is a health care setting situated at the peripheral level of the three-level Cameroonian health care system. It has about 50 to 150 beds with a small number of physicians. It serves as a referral centre. In-patient services include basic emergency and obstetric surgery, maternity for complicated births, general medical and paediatric services.

Laboratory, X-ray and transfusion services are also provided. An outpatient department is open for referred patients only. The above definitions do not form a conceptual framework.

In response to the question regarding why there is no conceptual framework in this study, it is worth noting that a conceptual framework can be defined as a network of interlinked concepts together providing a comprehensive understanding of a phenomenon, (Jabareen, 2009, p.51) the ability to move beyong descriptions of 'what' to explanations of 'why' and 'how', (Vaughan, 2008) the contrary aim of descriptive Husserlian phenomenological research. As explained in Section 1.5, the aim of this study is to describe what it is like to be a unit manager in a district hospital in Cameroon. Therefore there is no need for a conceptual framework in this study, for this would influence the thoughts of the researcher, contrary to the requirement of putting in abeyance one's thoughts and knowledge prior to data collection. Moreover, a conceptual framework could result in giving prominence to some aspects while ignoring others (Vaughan, 2008) while a researcher in a descriptive phenomenological inquiry has to approach the phenomenon with fresh eyes.

1.9 Conclusion

In this first chapter, the background of the study, the Cameroonian context within which the FLNMs work was described. The importance of a nurse manager in a health care organisation was stressed. By describing the FLNMs' day-to-day lived experiences in two district hospitals in Cameroon, this study expects to enable the health care organisation, the nurse manager, the staff and the educators to be aware of what it is to be a FLNM in Cameroon. The next chapter will reveal the methodology used to discover the FLNMs' lived experiences in the health care settings selected.

CHAPTER 2: METHODOLOGY

2.1 Introduction

The researcher decided to discuss the methodology prior to engaging with the literature review. This was effected with intent because a descriptive Husserlian phenomenological inquiry requires that one delays the literature review until after data collection and analysis, so that the researcher does not phrase questions or analyse data according to themes that she knows exist in the literature (Chan, Fung & Chien, 2013, p.2). More details are given in Section 2.2.3.3.

Nursing research is a general term used to "*describe studies designed to find answers to nursing questions, solve a problem or validate nursing knowledge using and objective and systematic search for understanding*" (le May & Holmes, 2012). Its purposes are to (1) promote the development of nursing knowledge; (2) generate information which helps to define the unique role of nursing; (3) help us to demonstrate professional accountability; (4) enable us to make more informed decisions; (5) facilitate evaluation of practice and articulate our role in care delivery; (6) support evidence-based practice; and (7) improve/advance patient care (le May & Holmes, 2012, p.13).

It is worth nothing that researchers have different beliefs and ways of viewing and interacting within their surroundings. As a result, the ways in which research studies are conducted vary. However, a researcher's actions and beliefs are guided by certain standards and rules (Michel, 2009, p.40). In this case, the aim of describing the lived experiences of NUMs in two selected district hospitals in Cameroon is a way to answer questions related to nursing management in this country. Therefore, this chapter will comprise explication of the standards of research, which are the methods that were used, the research design and the research paradigm of the study, the data collection technique and the data analysis process. Finally, the trustworthiness and ethical considerations of this study will also be discussed.

2.2 Philosophy underpinning the study

To gain a better understanding of why and how the researcher chose the methodological approach in this inquiry, an initial display of the philosophy underpinning this inquiry is needed. As a starting point, while developing the research proposal, the researcher tried to

answer the following questions: (1) What methodologies and methods will be employed in this research? (2) How is the choice and use of the methodologies and methods justified? (Crotty, 1998, p.2). These two questions led to four further questions: (1) What methods are intended to be used? (2) What methodology guides the choice and use of methods? (3) What theoretical perspective lies behind the methodology in question? (4) What epistemology informs this theoretical perspective? (Crotty, 1998).

2.2.1 Epistemology: Constructionism

An epistemology is described as a way of understanding and explaining how we know what we know (Crotty, 1998, p.3). It is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible, and how one can ensure that these are both adequate and legitimate. In social sciences, there are three major epistemologies: objectivism, constructionism and subjectivism. Objectivism holds that reality exists independently of consciousness (Crotty, 1998, p.42; Gray, 2013, p.19). The goal of science *"is to develop the most objective methods possible to get the closest approximation of reality"* (Tuli, 2010, p.100). In subjectivism, meaning does not emerge from the interplay between the subject and the outside world, but is imposed on the object by the subject. Subjects do construct meaning but do so from within collective unconsciousness, from dreams, from religious beliefs (Gray, 2013, p.20).

Constructionism claims that human beings construct meanings as they engage with the world they are interpreting (Crotty, 1998, p.43). In constructionism, there is no true or valid interpretation. There are useful interpretations and liberating forms of interpretations too (Crotty, 1998, p.47). Constructionism and phenomenology are very intertwined (Crotty, 1998, p.12; Cohen et al., 2000, p.6). Constructionism brings together objectivity and subjectivity as well as phenomenology. There is a note of objectivity about phenomenology. *"It is in search of objects of experience rather than being content with the description of the experiencing subject"* (Crotty, 1998, p.82). There is also a note of subjectivity about phenomenology. It is characterised by the realisation of the intersubjective interconnectedness between the researcher and the researched (Finlay, 2009, p.12).

In this study, constructionism is used since FLNMs and the researcher are depicted as constructing, together, the essence of the phenomenon of nursing unit management in a

district hospital in Cameroon. They do so by taking a fresh look at the subject and calling into question what is taken for granted when it comes to nursing unit management.

2.2.2 Paradigm: Interpretivism

A paradigm is a philosophical stance that lies behind the chosen methodology or design. Also called theoretical perspectives, the paradigms in research structure not only frame our understanding of research designs and their applicability, but also the meanings and values given to certain types of knowledge (le May & Holmes, 2012, p.63). The paradigms tell us what is important, what is legitimate, what is reasonable and what to do. In nursing research there are three key paradigms: positivism, naturalism and critical theory (le May & Holmes, 2012).

A number of theoretical paradigms are discussed in the literature such as: positivist (and postpositivist), contructivist, interpretivist, transformative, emancipatory, critical and deconstructivist paradigms (Mackenzie & Knipe, 2006, p.194). Though the interpretivist paradigm will be emphasised in this study, positivism and critical theory will also be discussed briefly.

Positivism is based on the assumption that there are universal laws that govern social events, and, uncovering these laws, enables researchers to describe, predict and control social phenomena (Tuli, 2010, p.103). Moreover, empirical facts exist apart from personal ideas or thoughts (Tuli, 2010, p.100). From the positivist viewpoint, objects in the world have meaning prior to, and independently of, any consciousness of them (Crotty, 1998, p.27). For them, the purpose of research is scientific explanation (Tuli, 2010, p.99). Therefore, it is not possible to study someone's lived experiences based on the positivist paradigm. The subjectivity with which the participant tells her story, and the subjectivity with which the researcher analyses what she has heard cannot lead to empirical facts.

Critical theory is often thought of simply as a reaction to the constraints of positivism. Critical inquiry is a metaprocess of investigation which invites both researchers and participants to discard what they term "fake consciouness" in order to develop new ways of understanding as a guide to effective action (Gray, 2013, p.10). It involves ongoing processes driven by ideological, social, cultural, political and economic forces and values (Dieronitou, 2014, p.8). Critical theorists assume that everyone needs to be emancipated (Gray, 2013, p.10) so that by

becoming aware of how oppressed one is, one can act to transform the world (Dieronitou, 2014, p.8). Here again, the researcher did not aim to find out which system of inequity mediated the participants' lives, but aimed to describe what the unit managers experience every day, not in an empirical or scientific way.

Interpretivism involves researchers interpreting elements of the study. This can be also called the "antipositivist" paradigm because it was developed as a reaction to positivism (Mack, 2010). Interpretive researchers assume that access to reality (given or socially constructed) only occurs through social constructions such as language, consciousness, shared meanings and instruments (Dudovskiy, 2015). Their role is to understand, explain and demystify social reality through the eyes of different participants. Therefore, interpretivism is sometimes referred to as constructivism or is linked to constructivism (Gray, 2013, p.16) because it emphasises the ability of the individual to construct meaning (Mack, 2010, p.7). The interpretivist researcher tends to rely upon the "participant's view of the situation being studied" and recognises the impact on the research of her own background and experiences (Mackenzie & Knipe, 2006, p.195). Therefore, interpretivism is the paradigm that suits the most in this study even though it is not about interpreting the participants' experiences but about describing them. After all, to describe is the first step of an interpretation.

The ontological assumptions of interpretivism are that social reality is seen by multiple people and these multiple people interpret events differently, leaving multiple perspectives of an incident (Mack, 2010, p.8). The epistemological assumptions, as well as the ontological assumptions, have been summarised by Mack (2010, p.8) in the table below.

Table 2.1: Interpretivist ontological and epistemological assumptions

Ontological assumptions	Epistemological assumptions
Reality is indirectly constructed based on individual interpretation and is subjective. People interpret and make their own meanings of events. Events are distinctive and cannot be generalised. There are multiple perspectives of one	Knowledge is gained through a strategy that "respects the differences between people and the objects of natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action" (Grix, 2004, p.64). Knowledge is gained inductively to create a

incident.	theory.
Causation in social sciences is determined by interpreted meanings and symbols.	Knowledge arises from particular situations and is not reducible to simplistic interpretation. Knowledge is gained through personal experiences.

Source: Mack, 2010, p.8

It is by listening and analysing unit managers' lived experiences in these two district hospitals that the researcher can gain knowledge about what it is like to be a FLNM in Yaoundé.

2.2.3 Research approach: descriptive Husserlian phenomenological approach

A methodology is a research strategy that translates ontological and epistemological principles into guidelines that show how research is to be conducted (Tuli, 2010, p.102). It refers to a model to conduct research within the context of a particular paradigm, the underlying set of beliefs that guide a researcher to choose one set of research methods over others (Wahyundi, 2012, p.72). The most popular research designs are experiments (true and quasi), surveys, ethnography, phenomenology, case study and action research. According to Gerrish and Lacey, (2006) the three most popular qualitative approaches used in nursing research are grounded theory, ethnography and phenomenology.

The experiment is the empirical investigation under controlled conditions designed to examine the properties of, and relationship between, specific factors (Denscombe, 2007, p.48). The survey is sometimes referred to as a non-experimental design, since it relies on statistical manipulation of data than rather the actual manipulation of interventions important to the experimental design (le May & Holmes, 2012, p.72). Case studies focus on one (or just a few) instances of a particular phenomenon, with a view to providing an in-depth account of events, relationships, experiences or processes occuring in that particular instance (Denscombe, 2007, p.35). One defining characteristic of action research is its commitment to a process of research in which the application of findings and an evaluation of their impact on practice become part of a cycle of research (Denscombe, 2007, p.123). Ethnography is described as the art and science of describing a group or culture regardless of location (le May & Holmes, 2012, p.73).

Phenomenology is derived from the Greek words "*phanoenm*" (appearance) and "*logos*" (reason) (Gearing, 2004, p.1430; Holloway & Wheeler, 2010, p.214). Phenomenology refers to both a philosophical movement and a research method (Fitzpatrick & Kazer, 2011, p.399; Penner & McClement, 2008, p.95; Speziale & Carpenter, 2007, p.81). It is first and foremost a philosophy, (Caelli, 2001, p.275) then an approach to philosophy (Holloway & Wheeler, 2010, p.213). Phenomenology, as a philosophy, is critical to objectivism; it holds that the notion of meaning, independent of mind or being, is inconceivable: meaning cannot inhere in an object independently of any subject (McNamara, 2005, p.696). Phenomenology is not against empiricism, but it is broader than empirical philosophy because its method interrogates phenomena which are not reducible to facts (Giorgi, 2008, p.2).

Unlike certain other qualitative methods, the phenomenological method requires a background in the philosophy which, at certain times, specifies criteria other than empirical ones (Giorgi, 2008, p.2). In this case of descriptive Husserlian phenomenological research, it is good to know that Husserl asserted several ideas. First, to understand a phenomenon fully, one had to comprehend its essence by dwelling with the phenomenon in question or returning 'to the things themselves', (Shea-Messler, 2007, p.20) exactly in the manner in which they are given (Moran, 2002, p.127) or in the way that they present themselves to us (Giorgi, 2005, p.76). He believed that phenomenology, which suspended all suppositions or achieves transcendental subjectivity, was related to consciousness and was based on the meaning of the individual's experience (Reiners, 2012, p.1). Another assumption underlying Husserl's philosophy is that there are features to any lived experience that are common to all persons who have the experience: the universal essences. Husserl has also articulated the idea of radical autonomy. Another concept emerged from Husserl's philosophy: imaginative variation (in order to discover essentials characteristics of the phenomenon being investigated) (Giorgi, 2008, p.3).

Some might ask why the researcher emphasises so strongly the philosophical aspect of phenomenology. Norlyk and Harder (2010, p.431) claimed that nurse researchers are faced with the difficulties inherent in offering adequate philosophical and methodological explanations. Moreover, the choice of an appropriate phenomenological research relies on its philosophical tenets which are vital to the credibility of the proposed research (Reiners, 2012, p.3). Without willing to prove them wrong, the researcher agrees that phenomenological nursing research could be strengthened by greater attention to its philosophical underpinnings

(Norlyk & Harder, 2010, p.427; Thomas, 2005, p.63). Phenomenology has been, and continues to be, an integral field of inquiry that cuts across philosophic, sociologic and psychological disciplines. It is a science whose purpose is to describe a particular phenomenon, or the appearance of things, as lived experience (Speziale & Carpenter, 2007, p.76) from the perspective of those who have experienced it, (Penner & McClement, 2008, p.97) and through the descriptions that are provided by the people involved (Brink, 2010, p.113) to achieve an understanding of its essential structure (Holloway & Wheeler, 2010, p.213).

Phenomenological research is a popular approach (Crotty, 1996, p.9) and an established approach in nursing research (Balls, 2009, p.30; Gerrish & Lacey, 2006, p.226; Parahoo, 2014, p.211; Speziale & Carpenter, 2007, p.75; Thomas, 2005, p.63). It is most useful when the task at hand is to understand an experience as it is understood by those who are having it (Cohen, et al., 2000, p.3). For Wojnar and Swanson, (2007, p.173) and Chan et al. (2013, p.1) there are unique perspectives of phenomenology: descriptive phenomenology; naturalistic phenomenology, existential phenomenology, generative historicist phenomenology, genetic phenomenology, hermeneutic phenomenology and realistic phenomenology. Descriptive phenomenology and interpretive phenomenology guide the majority of phenomenological investigations in nursing (Wojnar & Swanson, 2007, p.173).

Two approaches are common: the descriptive phenomenology of Edmund Husserl (1859-1938) and the hermeneutic of Martin Heidegger (1889-1976) (Gerris & Lacey, 2006, p.228; Penner & McClement, 2008, p.95; Speziale & Carpenter, 2007, p.11). Both of these result in knowledge that reflects insights into the meaning of the phenomena under study and its understanding, using a particular set of guiding principles, (Speziale & Carpenter, 2007, p.11) and its accurate description (Balls, 2009, p.30) with differerence in their aim (Penner & McClement, 2008, p.95). In this study, we are interested in the descriptive phenomenology of Husserl.

2.2.3.1 Descriptive Husserlian phenomenology

Husserl wanted philosophy to be as rigorous as the sciences and thus proposed a method for analysing conscious phenomena (Giorgi, 2008, p.2). Describing/explicating the essence of someone's experience of the world of everyday is the central focus of Husserlian phenomenological inquiry (Brink, 2010, p.113; Parahoo, 2014, p.21; Speziale & Carpenter,

2007, p.81). Its endeavour is to take a fresh look at phenomena uncontaminated by *a priori* common sense or scientific impositions (McNamara, 2005, p.696). The purpose of focusing on an experiential phenomenon is to find insights that apply more generally beyond the cases that were studied, in order to emphasise what we may have in common as human beings: the essence or the essential structures, (Gerrish & Lacey, 2006, p.225) or to capture the richness of a phenomenon as it manifests to the subject who experiences it (Moran, 2002, p.2). In the descriptive phenomenological method, the researcher makes no interpretations. She analyses the descriptions given by the participants and divides them into meaning-laden statements, to bring to written description the structure of the phenomenon of interest (Penner & McClement, 2008, p.95; Reiners, 2012, p.2). However, there is a note of objectivity about phenomenology: "*it is in search of objects of experience rather than being content with the description of the experiencing subject*" (Crotty, 1998, p.83). The novice researcher might have trouble finding the essence of a phenomenon under investigation.

On the other hand, hermeneutic or interpretive phenomenology, is about how people go about understanding the world in which they live, how the phenomena are interpreted, how they make meaning of what they experience (Cohen et al., 2000, p.5). Hermeneutic phenomenologists do not believe that researchers can be very successful in suspending their preconceptions. Rather, they believe that researchers should use their preconceptions, prior knowledge and insights (Penner & McClement, 2008, p.95) positively, making them more explicit, so that the readers of the research can understand the strenghts and limitations of the interpretations that the researcher makes (Gerrish & Lacey:2006, p.228) from the experiences of others (Balls, 2009:30).

In this study, a descriptive phenomenological research was chosen because the researcher wanted to discover what it is like to be a unit manager in a district hospital in Cameroon, without mentioning any social, cultural or political contexts of the participants. It is true that there is a shift of focus of phenomenological inquiry from 'description' to 'interpretation and understanding', (Matua & Van Derwel, 2015) however, to make a start in nursing research, where little has been said about nursing management in Cameroon, the researcher chose to describe the lived experiences of unit mangers in two district hospitals in Yaoundé.

2.2.3.2 Steps of the descriptive phenomenological inquiry

There is quite a controversial description of the different steps of the descriptive phenomenological process in the literature. For Speziale and Carpenter (2007, p.85-86) and Penner and McClement, (2008, p.95) the descriptive phenomenological process encompasses three steps, namely intuiting, analysing and describing. Wojnar and Swanson (2007, p.173) speak of three steps: bracketing, analysing, intuiting. Elsewhere Giorgi (1997) argues that the three phases are: phenomenological reduction, description and search for essences (Finlay, 2009, p.7).

Intuiting in the phenomenological sense, requires that the researchers imaginatively vary the data until a common understanding about the phenomenon emerges (Speziale & Carpenter, 2007, p.79). Phenomenological reduction is a return to original awareness regarding the phenomenon, (Speziale & Carpenter, 2007, p.79) a process of rendering oneself as noninfluential and neutral as possible (Finlay, 2009, p.12). Bracketing requires that researchers remain neutral with respect to belief or disbelief in the existence of the phenomenon (Speziale & Carpenter, 2007, p.80).

In brief, Husserl's philosophical method states that one should adopt a phenomenological attitude, encounter an instance of the phenomenon and then use the process of free imagination variation in order to determine the essence of the phenomenon, and finally, describe carefully the essence that was discovered (Giorgi, 2008, p.2). But, if one applied the above method directly, without modification, one would be doing philosophical analysis or practising philosophy (Giorgi, 2000, p.3). Giorgi (1985) proposed that a disciplinary attitude be adopted, within the context of the phenomenological attitude that also has to be adopted during inquiry. The adoption of the disciplinary attitude brings the proper sensitivity to the analysis and provides a perspective that enables the data to be manageable (Giorgi, 2008, p.2).

Because descriptive phenomenology uses "bracketing" of preconceptions, and attempts to arrive at the "essences" of experienced phenomena (Gerrish & Lacey, 2006, p.224) the next section will emphasise the concept of bracketing, a method of demonstrating the validity of the data collection and analysis process, (Chan et al., 2013, p.1), of justifying or validating individuals' approach (Gearing, 2004, p.1432) and of retaining critical characteristics of the phenomenological method (McNamara, 2005, p.703).

2.2.3.3 Bracketing

The growning disconnection of the practice of bracketing in research, from its origins in phenomenology, has resulted in its frequent reduction to a formless technique, value stance or black-box term (Gearing, 2004, p.1429). Bracketing is a scientific concept that requires investigators to have a methodological awareness of its complexity, theoretical underpinnings and applicability to their respective study (Gearing, 2004, p.1448). Bracketing is about identifying (Brink, 2010, p.113) and setting aside previous knowledge or personal beliefs about the phenomenon under investigation, to prevent this information from interfering with the recovery of a pure description of the phenomenon (Speziale & Carpenter, 2007, p.80).

Overall, bracketing refers to three processes: the process of setting aside, suspending, or holding in abeyance, presuppositions surrounding a specific phenomenon; the process of focusing in on the essences and the structure of the phenomenon, and the process which combines the process of the setting aside of presuppositions and rendering explicit the studied phenomenon (Gearing, 2004, p.1433). Moreover, there are three methods of bracketing: writing memos throughout the data collection and analysis; engaging in interviews with an outside source to uncover and bring to awareness preconceptions and biases; and beginning a reflexive journal prior to defining the research question, in which preconceptions are identified throughout the research process (Penner & McClement, 2008, p.96; Tufford & Newman, 2010, p.86). There is also a temporal structure in bracketing which involves delineating the start point, duration and end point of bracketing (Gearing, 2004, p.1434).

In the literature, there are different opinions about bracketing. Concerning when to bracket, Giorgi (1998) indicates that bracketing should be limited to the analysis phase and should not take place during the interview. Glaser (1978) advocates bracketing at the start of the research endeavour. Other authors encourage bracketing from the start and throughout the research (Tufford & Newman, 2010, p.87). Another issue about bracketing relates to who should do the bracketing: the researcher, or both the researcher and the participants. It is good to remind ourselves that research participants are viewed as genuine co-researchers, inquiring into their own experiences of the phenomenon to elucidate its essential elements (McNamara, 2005, p.198). They should be engaged in the bracketing process as well (Caelli, 2001, p.276).

The researcher did not engage the participants in bracketing during the data collection process. Firstly, the participants might have been aware or not of the requirement to hold in

abeyance what they know about the phenomenon. Secondly, bracketing is an attitude which requires that efforts should be made prior to the data collection phase (Chan et al., 2013, p.4). However, the participants were aware of the research project the day they received the information letter. How then could they jot down their pre-conceptions and try to put them in abeyance before the interview? Even if the researcher constantly probed and challenged, bringing the participants back again and again to a fresh contemplation of the phenomenon, using questions to help them strip away preconceptions, (McNamara, 2005, p.699) it is not guaranteed that she could ensure that the participants bracket their presuppositions (Crotty, 1996, p.171).

The researcher read up on bracketing as it is supported in a descriptive phenomenological inquiry, but, at the end of the research, was not certain that sufficient bracketing had been effected. There is no means to assess someones's ability to bracket. In fact, there is no golden rule explaining how best to bracket. The researcher constantly asked herself how she could forget what she knew for the sake of the research. She had trouble bracketing, and, to be honest, she felt that she had not bracketed enough during the process. She could not stop ideas emerging when she was thinking about the phenomenon. Moreover, she conducted a brief literature review prior to the data collection to shape the topic. She read about nursing management, particularly unit nursing management, and understood what we can see in Appendix 11. Since the researcher is a nurse, she already had some ideas about nursing unit management based on what she had seen during some internships (see Appendix 11).

2.2.4 Research method: semi-structured interviews

Methods are techniques and procedures for gathering and analysing data (Wahyundi, 2012, p.72; Yin, 2011). The way of proceeding or the method must be defensible from the philosophical and epistemological positions that guide the study (Caelli, 2001, p.275). The phenomenological method is the process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience (LoBiondo-Wood & Haber, 2010, p.102).

Qualitative researchers immerse themselves in a culture or group by observing its people and their interactions, often participating in activities, interviewing key people, taking life stories, constructing case studies and analysing existing documents or other artefacts (Tuli, 2010, p.102). Interpretive approaches rely on naturalistic methods such as interviewing, observation

and analysis of existing texts (Cohen & Crabtree, 2006). When the researcher needs to gain insights into things like people's opinions, feelings, emotions and experiences, then interviews will almost certainly provide the most suitable method (Denscombe, 2007). In this case, the in-depth interview was deemed the most suitable, because participant observation is problematic. It sees from the perspective of the researcher, an "outsider" to the experience, while interviews give the ideas of the "insider" (Holloway & Wheeler, 2010, p.225).

Interviews are a valuable method of collecting information about a variety of topics (le May & Holmes, 2012) in most qualitative methods of inquiry (Cohen et al., 2000, p.59) such as phenomenology. They allow entrance into another person's world, and are an excellent source of data (Speziale & Carpenter, 2007, p.95). Although there are many superficial similarities between a conversation and an interview, interviews are more than just conversations (Denscombe, 2007, p.173). Interviewing is more than a verbal interchange and often occurs face to face with someone. The component parts of interviews comprise asking questions, active listening, reflecting on answers and non-verbal cues, the skilled use of nonverbal and verbal communication and the ability to interpret responses in order to appropriately frame the next question (le May & Holmes, 2012, p.83).

It should be also noted that the researcher also had to consider whether to use an unstructured interview, as suggested by Crotty (1998, p.83) and Polit and Beck, (2012, p.536) or a semi-structured interview format. She decided to use semi-structured interviews with open-ended questions to "*ensure a broad coverage of the issues*" (Chan et al., 2013, p.4). Yet she did not guide the interview though she had an interview guide (see Appendix 1). Rather, she asked focusing, but not leading questions "*for clarification or elaboration*" (Chan et al., 2013, p.5) of what the participants were saying. Unstructured interviews are most appropriate for phenomenological studies but semi-structured interviews were chosen for the following reasons: as a novice researcher, the researcher was unsure how to conduct unstructured interviews as they should be. The focusing but not leading questions helped the researcher during the data collection. The guide was not followed as it was, but further questions were asked depending on the answers of the participants. The semi-structured interview questions enabled the researcher to ensure that she cover issues relating to front line nursing management. The researcher made less use of the guide as she became more experienced with interviewing using the research questions as prompts whenever she felt she went astray.

2.3 Research design: qualitative study

Qualitative research is an umbrella term for a number of diverse approaches that seek to understand, by means of exploration, human experience, beliefs, perceptions, motivations, intentions and behaviour. It is based on the premise that interpretation is central to the exploration and understanding of social phenomena (Parahoo, 2014). It is best characterised as a family of approaches whose goal is understanding the lived experience of people who share time, space and culture (Frankel & Devers, 2000, p.113). The ultimate aim of qualitative research is to offer a perspective of a situation and provide well-written research reports that reflect the researcher's ability to illustrate or describe the corresponding phenomena (Myers, 2000).

Qualitative research allows researchers to unearth the inner experience of participants, to determine how meanings are formed (Corbin & Straus, 2008). Its purpose is to primarily describe a situation, a phenomenon, a problem or an event, (Kumar, 2012) rather than to verify truth or predict outcomes (Myers, 2000). Without qualitative research we do not know what the other person is thinking; we do not understand possible alternative interpretations by individuals (Munhall, 2012). We used a qualitative study to understand the phenomenon of nursing unit management in two district hospitals in Yaoundé, Cameroon.

2.4 Research settings

The aim of this study was to describe the FLNMs' day-to-day lived experiences in two district hospitals in Yaoundé, Cameroon. It is worth noting that there is strong evidence of workforce imbalances in the country. The Centre and Littoral regions, with the largest hospitals in Cameroon, account for 42.5 percent of the health workforce (24.3 percent and 18.2 percent, respectively). With 3.2 health workers per 1000 population, Yaoundé is the best-served city in terms of health workers. Yaoundé is the country's administrative capital, and the two largest hospitals of Cameroon are located there (Ngah et al., 2013, p.12). Therefore, it is expected to have some standard for nursing management in those settings. H1 and H2 were chosen because the researcher knew that she would be sure to locate participants with knowledge and experience about the topic. Moreover, Yaoundé was where the researcher would have the easiest access to participants since her family lived there. The researcher chose Yaoundé, due to the above mentioned criteria to describe what it is like to be a FLNM in a district hospital.

The first district hospital, H1, is a public institution established in 1986 as a dispensary. It was transformed into a medical district centre, then into a district hospital in 1995. It serves an area of about 400,000 inhabitants. Its mission is to undertake the rehabilitation of infrastructures to improve reception facilities for the patients and ensure effective patient care. Therefore, it encompasses units such as Laboratory, Emergency, Medicine, Gynaecology, Paediatric, Surgery, Maternity, Physiotherapy, Family planning, Dentistry, and Social assistance. It has about 35 staff nurses among 110 full-time workers.

The second hospital, H2, is a public institution as well, created in 1989, with the main objective of bringing health structures to the populations. It covered an area of about 187,539 inhabitants in 1999. Today, its missions are health promotion, the prevention of diseases with epidemic potential, the restoration and rehabilitation of health, the continuous education of health personnel and students, the academic research of medical and nursing students. It has units such as Laboratory, Emergency, Medicine, Gynaecology, Paediatric, Cardiology, Surgery, Maternity, Physiotherapy, Family Planning, Dentistry, and Social Assistance. It has about 54 staff nurses among 168 full-time workers.

2.5 Research participants

In this study, the research participants are the FLNMs working in two district hospitals units in Yaoundé, Cameroon. They are described in Section 4.2.

2.5.1 Selection of participants

Broadly speaking, the process of selecting subjects to take part in a research investigation on the grounds of providing information considered relevant to the research problem (Oppong, 2013, p.203) is referred to sampling. Sampling implies that the chosen participants might have something to say about an experience they share with others (Cohen et al., 2000, p.45). Sampling is a necessary aspect of all social research. It is almost impossible to carry out a census that collects data from the total population (Gerrish & Lacey, 2006). There are two basic sampling schemes in research: probability and non-probability sampling schemes. The probability sampling schemes mean that each unit in the target population has a known chance of selection. Non-probability sampling schemes are used when it is necessary to derive a sample from an unknown population. These do not involve random selection (Trochim, 2006).

In this study, a non-probability sampling scheme was chosen because, in qualitative studies in nursing research, according to Gerrish and Lacey, (2006, p.176) we will ensure that the resrach samples are rich sources of data that generate in-depth conceptual and theoretical understanding. There are three non-probability sampling schemes which can be used when conducting a qualitative study: convenience sampling, purposive sampling, theoretical sampling (Oppong, 2013, p.203). To understand the lived experiences of FLNMs in Cameroon, the researcher used the convenience scheme.

The researcher was meant to select purposive sampling because she wanted to seek out and sample only FLNMs who had at least two years experience as team leaders. While collecting data, she found FLNMs with less than two years experience, as required by the legislation in Cameroon, who had been appointed as managers because of their clinical skills. She interviewed all the voluntary unit managers and had to ask for an amendment of her proposal by the HSSREC (see Appendix 2).

2.5.2 Number of participants selected

A non-probably sampling scheme implies that the sample size may, or may not, be fixed prior to data collection. For Speziale and Carpenter, (2007, p.95) predetermination of the number of participants for a given study is impossible. Because a number of issues can affect sample size in qualitative research, (Mason, 2010) the sample size is determined in line with theoretical saturation (Oppong, 2013, p.203; Mason, 2010).

Moreover, phenomenologists tend to use a small sample size, often 10 participants or fewer (Loisele, Profetto-McGrath, Polit & Beck, 2007, p.280; Polit & Beck, 2012, p.495). Therefore, to obtain the adequate sample, it was anticipated that less than 10 FLNMs would be included in the sample since qualitatively-oriented studies often work with small samples (Mayring, 2014, p.12). A sample can, however, be viewed as adequate if, and only if, the sampling errors that result from the use of the stated sample size are so small that they do not nullify the conclusions reached by the researcher (Oppong, 2013, p.202).

The researcher interviewed ten unit managers in the two district hospitals. She was supposed to select voluntary FLNMs who were registered, or degree nurses, and those who had a minimum of two years of experience as team leaders prior to attaining the post of manager. Because she found only four participants who met the above criteria, she finally had to

interview all the voluntary unit managers who were registered, or were degree nurses, but who had any amount of experience in a managerial position. After interviewing seven participants, no more themes or essences emerged from the data and the data became repetitive (LoBiondo-Wood & Haber, 2010, p.105; Kumar, 2012, p.213; Speziale & Carpenter, 2007, p.95). The researcher continued to interview four other unit managers to make sure she had obtained sufficient data to have a complete description of the experiences being studied (Cohen et al., 2000, p.12). She reached data saturation even though this notion is hightly subjective (Kumar, 2012, p.213).

2.6 Data collection process

Data collection began after the final ethical clearance was obtained from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (see Appendix 3). The researcher made a copy of the ethics approval as well as the permission for the research and the information letter. The senior head manager of the first hospital welcomed the researcher warmly and explained the requirements regarding conducting the research and provided a description of the hospital. The researcher returned the following day because she could not meet the requirements initially. The medical unit was visited first, followed by the surgical unit, the gynaecologic unit, the paediatric unit and the maternity unit, however all the unit managers asked the researcher to return on another day.

At the second hospital, after meeting with the senior head manager and explaining the purpose for her visit, the researcher was allowed to make arrangements with the unit managers who also requested that she come back the following week.

Since the researcher was new to the phenomenological method, she intended to practice interviewing before entering the field, as suggested by Cohen et al. (2000, p.68) and Balls (2009, p.31). She was supposed to interview a friend or a colleague, record the interview, transcribe it and pay special attention to portions of the interview where the participant changed the subject or abruptly interrupted the narrative flow. Finally, she interviewed one of her siblings and this helped the researcher to test the interview equipment.

Because it is more acceptable to conduct an interview in a location familiar to the respondents, (Balls, 2009, p.31) the researcher interviewed the FLNMs at their workplace. She could not avoid disturbances, since some interviews took place in an open area or in a

patient room (see Section 4.2). The researcher tried to make the recording process as unobtrusive as possible. She hid the audio-recorder as she noticed it distracted participants. She did not ask the participants to speak up when she felt they had lowered their voices because of fear, but no part of any interview was missed.

The researcher started off each interview by briefly explaining the aim of the interview. She placed emphasis on the confidentiality, anonymity and the voluntary nature of the study. Next, she asked for the consent of the interviewee to record the interview. She interacted and engaged in dialogue with each participant in the study (Wahyundi, 2012, p.71) even though she felt stressed at times. She did not record data with her computer as she had planned, even though it made it easier to focus fully on the conversation (Holm, 2015). She used an audio-recording and some written notes to capture what it is like to be a FLNM in a district hospital in Yaoundé, Cameroon. The initial question was mostly: "How long have you been a unit manager?" Next, she asked questions depending on where the participant stopped speaking. The researcher kept her interview guide in front of her, but she did not stick to it; she made sure she kept on track by glancing occasionally at the research questions at the top of the guide.

At the end of the interview, the researcher did not ask for socio-demographic information because she had captured this already during the interview. She thanked each participant and explained the need for possible further interviews.

2.7 Data analysis plan

The process of analysis involves the search for things that lie behind the surface content of the data (Descombe, 2007, p.247). It also involves examining a substance and its components in order to determine their properties and functions, then using the acquired knowledge to make inferences about the whole (Corbin & Straus, 2008, p.45). Because qualitative data are words, either spoken or written, video- or audio-tapes and photographs, (Brink, 2010, p.184) they do not speak for themselves. Although they may appear to do so, they need to be analysed (Abbott & Sapsford, 2002, p.132) via a process different from the analysis of quantitative data. According to Abbott and Sapsford, (2002, p.133) much of the work of qualitative analysis involves sorting data into hierarchical categories in one way or another. Before reaching this stage, the interviews had to be transcribed.

2.7.1 System of transcription: smooth verbatim

According to Mayring, (2014, pp.45-47) a transcription system is a set of exact rules relating to how spoken language is transformed into written text. It is worth noting that the interview transcript almost always implies a loss of information. Therefore, a certain system of transcription has to be defined and argued (Mayring, 2014, p.47). There are several protocols: the selective protocol, comprehensive protocol, clean read or smooth verbatim transcript, pure verbatim protocol, International Phonetic Alphabet (IPA), protocol with special characters, and protocol with comment column.

In this study, the smooth verbatim protocol was used as the system of transcription. Although silence, sighs, laughter, posture and gesture may influence the underlying meaning of the text, (Graneheim & Lundman, 2004, p.112) the parts of the transcripts containing linguistic details such as laughter were deleted (Wahyundi, 2012, p.75) to avoid an extensive amount of data to manage. After deleting the above details, the researcher still felt she had an extensive amount of data to analyse.

2.7.2 Analysis process

There are several approaches to data analysis within the different schools of phenomenology (Holloway & Wheeler, 1996, p.124; Reiners, 2012, p.2). Colaizzi, Giorgi and Van Kaam formulated three methods of data analysis based on Husserl's descriptive phenomenology (Reiners, 2012, p.2) which fit in with the Duquesne school (Holloway & Wheeler, 1996, p.124). Although they are slightly different from each other, there is a general pattern of moving from the participant's description to the researcher's synthesis of all participants' descriptions (LoBiondo-Wood & Haber, 2010, p.105). In this study, the researcher used Colaizzi's method because she was a novice.

Colaizzi (1978) developed his method under the supervison of Giorgi (Edward & Welch, 2011, p.164). He outlined a seven-stage analysis process (Holloway & Wheeler, 1996, p.125; LoBiondo-Wood & Haber, 2010, p.105; Polit & Beck, 2012, pp.566-567; Wojnar & Swanson, 2007, p.177): (1) reading and rereading; (2) extracting significant statements; (3) formulating meaning; (4) categorising into clusters of themes and validating with original texts; (5) integrating results into exhaustive description of the phenomena; (6) reducing the

exhaustive description to the phenomenon essential structure; and (7) returning to participants for validation.

The researcher started becoming immersed in the data by collecting these through face-to-face interviews and translating them from the language of the interview. It has to be borne in mind that Yaoundé is a French area of Cameoon. As was to be expected, the researcher conducted most of the interviews in French and some in English. In the first stage, the researcher transcribed the tape herself, since it was a good opportunity for the the process of "immersion" in the data (Gerrish & Lacey, 2006, p.427). Next, the researcher read and re-read all the participants' transcripts with the aim of continuing to immerse herself in the data. By means of this step of acquiring a sense of each transcript, preliminary understanding of the meaning of the data was developed. The researcher listened repeatedly to the transcripts, especially when she could not match the English translation with the French translation. The researcher interviewed eight participants in French and two in English. She hired a French translator to translate the French interviews into English. Though she checked whether the English translations were accurate, she had to go back to the audio recordings, as well as to the transcripts in French, to make sure she was not altering the participants' descriptions. The researcher made notes of her impressions and thoughts in the margins of each transcript. She highlighted some quotes and changed the colour of the text when she thought some excerpts could be important (see Figure 2.1)
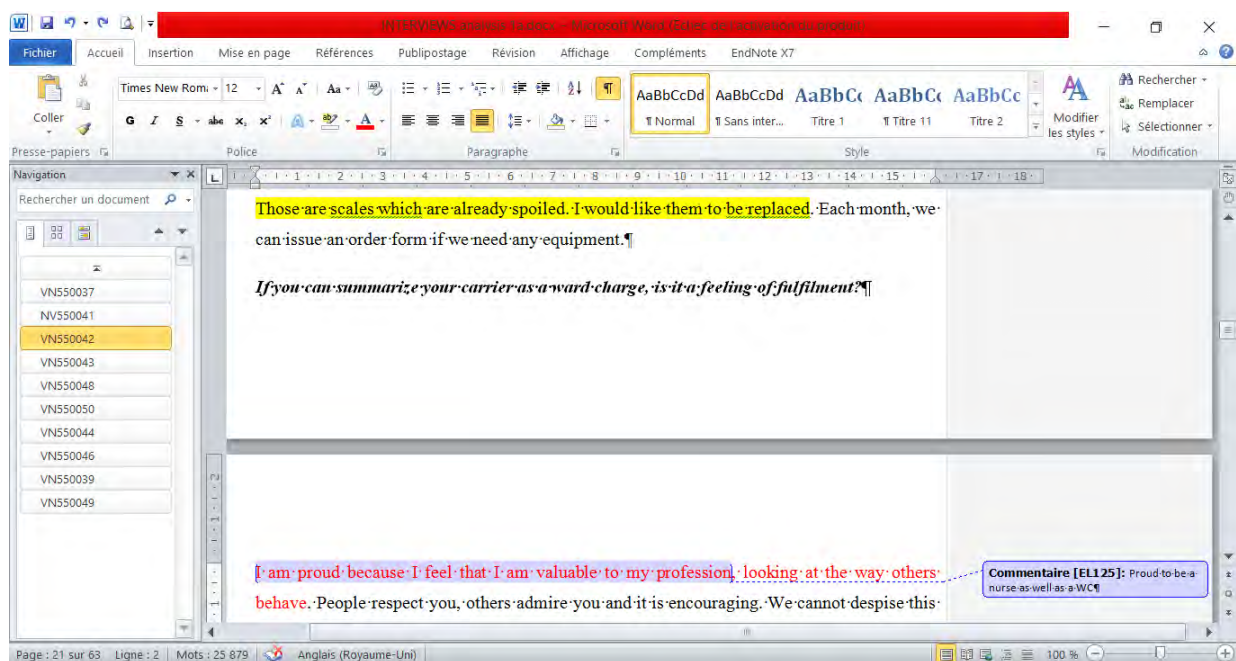
Figure 2.2: Screenshot of data analysis process

The second step is about extracting significant statements. At this stage, the researcher identified and extracted more than 200 significant statements from the early phase. She thought every statement was significant or had the same worth. After some consideration, the researcher combined similar statements, eliminated repetitions and reduced the number.

Next, the researcher formulated meanings from the significant statements. She read and re-read the extracted statements to check whether they were expressing something significant. She struggled for days to obtain the meanings of what the participants said. She ended up grouping the formulated meanings into clusters of themes. She ensured that each theme combined different or similar meanings, but that all were related to the theme. The researcher was aided in this endeavour by her supervisor and Prof. Petra. They were all experienced in qualitative research and asked questions of the researcher which made her question her own assumptions and explore the transcripts more deeply. For example, during a discussion with them, Prof. Petra asked the researcher to express what she meant by a statement and those present realised that this was not what was written down. Next the researcher wrote up the findings as found in Chapter 4. Before getting to this point, the researcher had several meetings with her supervisor in order to agree with the emergent themes. The first draft did not disclose what the data was about. The last one (see Figure 2.2) was better than the previous ones which the researcher had tried to bring out. It is true that no one can attest that the description is exactly what the data is all about, because the descriptions are not empirical facts, but consist of the ideas of the researcher and her supervisor which should be better than the researcher's idea alone.

Figure 2.2: Last draft of data analysis

2.8 Academic rigor

Each research approach employs different evaluation criteria to ensure the rigor of the inquiry because of the philosophical and methodological assumptions guiding each approach (Anney, 2014, p.272). However, irrespective of her research paradigm, any researcher needs to address four trustworthiness concerns, (in terms of questions) related to the truth value, the

applicability, the consistency and the neutrality (Guba, 1981, p.79). These are found in either quantitative or qualitative enquiry, but in different terms (see Table 2.2).

Table 2.2: Quantitative and qualitative inquiry terms appropriate to the four aspects of trustworthiness

Aspects of trustworthiness	Quantitative inquiry	Qualitative inquiry
Truth value	Internal validity	Credibility
Applicability	External validity or generalisability	Transferability
Consistency	Reliability	Dependability
Neutrality	Objectivity	Confirmability

Researcher's adaptation of Gubas's (1981, p.80) table related to scientific and naturalistic terms appropriate to the four aspects of trustworthiness. Retrieved from http://www.jstor.org/stable/30219811 [Accessed: 27 May 2015].

Qualitative research involves collecting data from people, about people. Therefore, qualitative validity is to be determined through the use of strategies to check the accuracy of the findings (Maldonado, 2012). While reliability, validity, generalisability and objectivity are fundamental concerns for quantitative researchers to establish the accuracy of the findings, they are not applicable to qualitative research. Therefore, a qualitative researcher's tools should be geared towards trustworthiness and should encompass issues such as credibility, dependability, transferability and confirmability (Sinkovics, Penz & Ghauri, 2008, p.689).

The search for quality is essential for the research to be accepted and received as suitable for use in various means and ways (Loh, 2013, p.4) summarised in the following table:

Table 2.3: Lincoln and Guba's (1985) trustworthiness criteria and techniques

Criteria	Techniques
Credibility (internal validity)	1) Prolonged engagement
	2) Persistent observation
	3)Triangulation (sources, methods, investigators)
	4) Peer debriefing
	5) Negative case analysis

	6) Referential adequacy (archiving of data)
	7) Members check
Transferability (external validity)	8) Thick description
Dependability (reliability)	9) Overlap methods (triangulation of methods)
	10) Dependability audit (how data was collected; how data was kept; accuracy of data)
Confirmability (objectivity)	11) Confirmability audit (attests that the findings, interpretations and recommendations are supported by data)
All four criteria	12) Reflexive journal (about self and method)

Loh (2013:5). Retrieved from http://www.nova.edu/ssss/QR/QR18/loh65.pdf [Accessed: 27 May 2015].

2.8.1 Credibility

Credibility is ensured when the researcher analyses the data through a process of reflection, sifting, exploring, judging its relevance and meaning, and ultimately developing themes and essences that accurately depict the studied experience (Maldonado, 2012, p.4; Wahyuni, 2012, p.77). It involves establishing that the results of qualitative research are credible or believable from the perspective of the participants in the research (Trochim, 2006). It is about demonstrating that a true picture of the phenomenon under scrutiny is being presented (Shenton, 2004, p.63). In other words, credibility is defined as the confidence that can be placed in the truth of the research findings, (Anney, 2014, p.275) how well the data and process of analysis address the intended focus (Graneheim & Lundman, 2004, p.109).

To ensure credibility in this study, the researcher used peer debriefing and members check according to Table 2.3 above. Firstly, she interviewed different participants with different backgrounds, at different times of the day. Then, she showed the data to her supervisor who said:

I think the major theme here is "being a mother" [Dr. Jane Kerr, 18 October 2015]

This was similar to what the researcher found at an earlier stage of data analysis. Moreover, the researcher discussed this with peers and realised:

It is not perfect but I am not that far from the box [The researcher, 02 November 2015].

The researcher also went back to the participants with the findings, to check whether or not they recognised themselves in the description, (see Section 4.5) described as members checking.

According to Shenton's (2004:64-69) criteria to ensure credibility in this project, the researcher used the examination of previous research findings and was glad to find that some of her findings were similar to other research findings. She wrote a thick description of the phenomenon under scrutiny, as well as her reflexive commentaries (see Section 5.3.5). Moreover, Prof. Petra, an expert in phenomemological research, gave her some precious feedback after reading the work (peer scrutiny). Finally, the researcher used iterative questioning when she went back to the participants to check whether they had changed their views or not. For example, after the researcher asked one participant: "*Why did you say training for unit managers would be important?*" she replied:

As I told you when you were here in September, training for unit managers would help us to do our job better. If I change my view on this point, it means I was not serious during the first interview. [Georges, 18 November 2015].

In the search to ensure credibility, the researcher thought she had used triangulation by collecting data at different points in time, (before and after lunch time) collecting data from multiples sites, (medical, surgical, gynaecologic units) within the two different district hospitals; collecting the data with more than one data collection strategy (interviews). She understood she was wrong after talking with her supervisor and receiving feedback from Prof. Petra. It was true that the research did not need the use of multiple researchers to investigate the same phenomenon or the use of different research methods, however, the researcher wished she could have used different sources of data and had a good background, some qualifications and experiences to ensure triangulation.

2.8.2 Transferability

Transferability refers to the potential for extrapolation, (Polit & Beck, 2012, p.585) the degree to which the results of qualitative research can be generalised (Maldonado, 2012) or

transferred to other contexts or settings (Graneheim & Lundman, 2004, p.110; Wahyundi, 2012, p.77) with other respondents (Anney, 2014, p.277). It is about providing sufficient detail of the context of the fieldwork for a reader to be able to decide whether the prevailing environment is similar to another situation with which she is familiar and whether the findings can be applied to another setting (Shenton, 2004).

Since the findings of a qualitative project are specific to a small number of particular environments and individuals, it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations. A situation can be unique (because each person has his unique story and life world) and typical (because fundamental experiences can be common to many people) at the same time (Delmar, 2010, p.115). But it is not impossible to apply a qualitative study to a different setting (Wahyundi, 2012, p.77). Therefore, it is the responsibility of the investigator to ensure that sufficient contextual information about the fieldwork sites is provided, in order to enable the reader to make such a transfer. Though the authors can give suggestions about transferability, it is the reader's decision whether or not the findings are transferable to another context (Graneheim & Lundman, 2004, p.110).

To ensure transferability in this study, the researcher provided information related to: the number of organisations taking part in the study (two district hospitals) and where they are based (in Yaoundé, Cameroon); any restriction affecting the type of people who contributed data (she deleted one interview of a participant who was temporarily unit manager but voluntary to share her experience); the number of participants involved in the fieldwork (10 unit managers); the data collection methods that were employed (semi-structured interviews); the number and length of the data collection sessions; (about 30 minutes or more for each one except the first that lasted 21 minutes) and the time period over which the data was collected (September 2015). The researcher also gave a clear and distinct description of culture and context; (Cameroonian context with nursing shortage, poor salaries, weak nursing education system; district hospitals with limited human, material and financial resources) selection and characteristics of participants (see Section 3.6) and process of analysis (see Section 3.8.2). The researcher also gave a rich and vigorous presentation of the findings with appropriate quotations (see Chapter 4). Although there is no single correct meaning of the research findings, (Graneheim & Lundman, 2004, p.110) the researcher hopes she has presented the

findings in a way that allows the reader to look for alternative interpretations to increase trustworthiness.

2.8.3 Dependability

According to Maldonado, (2012, p.4) dependability is based on the assumption of replicability or repeatability. Essentially, it is concerned with whether we would obtain the same results if we could observe the same thing twice. On the other hand, the idea of dependability emphasises the need for the researcher to account for the ever-changing context within which research occurs, and how this affects the way research is being conducted (Wahyundi, 2012, p.77). Dependability refers to the stability of the findings over time (Bitsch, 2005, p.86; Graneheim & Lundman, 2004, p.110) and conditions (Polit & Beck, 2012, 585). For Shenton, (2014, p.63) dependability is about enabling a future investigator to respect the study. Therefore, information such as research design and its implementation, operational details of data gathering, reflective appraisal of the project must be provided (Shenton, 2004, p.72).

To ensure dependability, the researcher ensured that the amount of data was not extensive. Furthermore, she made sure that the time of collection did not extend over time. Even though the process of interviewing allows new insights into the phenomenon and subsequently influences follow-up questions, (Graneheim & Lundman, 2004, p.110) the researcher tried to question the same areas for all the participants. During one interview she became bored because the participant was telling her what had happened in his previous job. The interviewee kept on returning to a discussion of his previous job during about 10 minutes. The researcher was tired because it was in the afternoon and she thought:

> *Maybe this unit manager is frustrated by his work environment. Why does he keep going back to what and where he was? This is not the topic now…* [The researcher, 22 September 2015].

In addition, the researcher was glad when she heard her supervisor say to her, after having a look at the transcripts:

> *They are always complaining about the same thing: they are stressed* [Dr. Jane Kerr, 10 October 2015].

2.8.4 Confirmability

Confirmability refers to objectivity; (Polit & Beck, 2012, p.585) the degree to which the results can be confirmed or corroborated by others (Maldonado, 2012, p.4; Anney, 2014, p.279) to ensure that the results reflect the understandings and experiences from observed participants (Wahyuni, 2012, p.77). Shenton (2004, p.63) adds that this is about demonstrating that findings come from the data and not from the researcher's predispositions. Yet bracketing the researcher's preconceptions and recording her reflections in a diary does not ensure sufficiently the success of the process of confirmability (Loisele et al., 2007).

In Table 2.3, other notions are mentioned, related to the establishment of the accuracy of the finding: the triangulation and the reflexivity. Polit & Beck (2012, p.585) state that, as a response to FLNMerous criticisms, authenticity was added as the fifth criterion of trustworthiness in qualitative inquiries. They put it in this way:

> *Authenticity refers to the extent to which researchers fairly and faithfully show a range of realities. It emerges in a report when it conveys the feeling tone of participants' lives as they are lived. A text has authenticity if it invites readers into vicarious experience of the lives being described, and enables readers to develop a heightened sensitivity to the issues being depicted. When a text achieves authenticity, readers are better able to understand the lives being portrayed "in the round" with some sense of mood, feeling, experience, language and context of those lives.*

An external audit by the researcher's supervisor attests that the findings, interpretations and recommendations are supported by data. Before that, since the researcher hired a translator, she revisited the French version of the transcripts whenever she thought the translator might have deleted a part of the transcript. Yet this is not enough to ensure that the interviews have been well transcribed. The researcher would not have double-checked the English version had she not been a novice, but, because she was afraid of missing a part, she had to pay attention to every detail.

2.8.5 Reflexivity

As far as this study is concerned, a research diary has ensured reflexivity. The researcher's interview skills, her opinions of the interviews, her pre-occupation with the tape-recording

process, her nervousness and other impressions were recorded in a journal. Section 5.3 explains this further.

2.9 Ethical considerations

Qualitative research aims to understand how people think about the world and how they act and behave in it. Therefore, it may pose special ethical issues (Government of Canada, 2010). Briefly, there are three core principles originally articulated in The Belmont Report which form a universally accepted basis for research ethics: the respect for persons, the beneficence and the justice. In addition to these established principles, some bioethicists have suggested that a fourth principle, the respect for communities, should be added (Family Health International, 2012, p.9).

These principles, which should be taken into account, are described by Emanuel, Wendler, Killen and Grady (2004, pp.930-937) as follows:

2.9.1 Community participation

This study relates to FLNMs' day-to-day practices and involves voluntary FLNMs of two district hospitals in Yaoundé, Cameroon. At the beginning of the planning of this inquiry, a FLNM in a district hospital in Douala, the economic capital of Cameroon, was approached. She gave the researcher her first impressions after the initial two weeks since she had been appointed as a unit manager. In addition, the Head of Department of Research at École des Sciences de la Santé, a private institution training nurses and other health care workers, was also approached during the shaping of the, topic. The researcher worked with her supervisor, as well as another lecturer at UKZN specialising in phenomenology. Finally, the researcher worked with unit managers from two district hospitals in Yaoundé.

2.9.2 Social value

The data was collected from interviews with the voluntary FLNMs and was analysed to obtain a better understanding of what it is like to be a nursing unit manager in a district hospital in Yaoundé. It is hoped that the study will influence and benefit nurse managers in Cameroon and that thus, the staff under the supervision of these managers will also benefit, as well as the patients who are admitted to these hospitals. Revealing what FLNMs are experiencing in this managerial position may challenge and encourage other nurse managers who experience

difficulties managing their unit. This can also help the nurse managers experiencing the phenomenon to improve their management skills after having examined how they manage the ward with a fresh look, and, indirectly, the staff too. It can also help to attract staff nurses in managerial positions.

2.9.3 Scientific validity

The aim of this qualitative inquiry is to describe the lived experiences of FLNMs related to the management of the nursing unit in two district hospitals. Therefore, voluntary unit managers were interviewed individually in their workplace. The interviews were audio-recorded and transcribed by the researcher. The electronic database was saved on the researcher's computer. The recordings and data hard copies will be saved in a lockable cabinet by the research supervisor for five years following the completion of the study at the School of Nursing and Public Health of the University of KwaZulu-Natal.

2.9.4 Selection of respondents

The FLNMs were supposed to be selected purposively because they should have had at least two years of experience as team leaders before being appointed as nurse managers. In the field, the researcher was unable to find such FLNMs. She had to select all voluntary FLNMs irrespective of their past experiences. Therefore, a convenience sampling was used to explore the FLNMs' day-to-day lived experiences in these district hospitals.

2.9.5 Risk-benefit ratio

There were no potential risks related to the study participants inherent in this study. The benefits to the nursing profession in Cameroon and to the body of knowledge in nursing outweigh the risk to individual informants. Respondents' names and identifying aspects have not been and will not be disclosed. The names used in Section 4.2 are not the real participants' names. These have been attributed to them because the researcher wanted to personalise the participants instead of saying Participant 1 or Participant 2. However, information such as sex, age, years of experience as a manager, degree, etc. were disclosed for the purpose of analysis. In addition, there was no cost to the informants. The researcher contacted the managers and provided refreshments to share after the interviews.

2.9.6 Independent Ethics review

The researcher obtained ethical approval from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal and a permission letter from Hospital 1 (see Appendix 4) and Hospital 2 (see Appendix 5) before the data collection.

2.9.7 Informed consent

In order to obtain the consent of the informants, an information letter in English (see Appendix 6) or in French (see Appendix 7) was given to them by the researcher before asking them to sign the informed consent form in English (Appendix 8) or in French (see Appendix 9). The researcher asked the respondents not to put their names on the consent form when they signed it. The researcher also protected the district hospitals' names by not disclosing them in this report.

2.9.8 Respect for recruited participants and study communities

The informants could withdraw from the study at any time without being penalised, as mentioned on the information letter that they were given. At the end of the inquiry, each district hospital will receive its own copy of the final paper. Furthermore, the research will hopefully be published in an SAPSE approved professional journal once completed. The participating informants and the health care organisations will be informed if such publication occurs. Finally, a copy of the end product of this study will be at the disposal of the University of KwaZulu-Natal.

2.10 Data management, storage and disposal

During the transcriptions, the researcher ensured that no one else helped her to transcribe the interviews. The researcher ensured that no one had access to her computer. She captured the data from the audio-recorder to her laptop and opened a new file in which to save these files. She gave a copy of the audio-recording and the transcripts, as well as the translations, to her supervisor. Contrary to what was planned, the researcher had to email the transcripts to the translator because they were not close by. The latter swore to keep the data confidential. The researcher ensured that the anonymity of the participants was not disclosed. The data will be retained by the University of KwaZulu -Natal for five years after completion of the study before being destroyed.

2.11 Conclusion

This chapter was about the methodology that was used to describe the FLNMs' day-to-day lived experiences in two district hospitals in Yaoundé, Cameroon. The theoretical perspective underpinning this qualitative inquiry is interpretivism. The epistemology is constructionism and the approach is a descriptive Husserlian phenomenological research. The data were collected from ten voluntary FLNMs by individual semi-structured interviews. The interviews have been transcribed before being analysed to generate their essence. The researcher used French as the language, but she made sure to translate every document from French in this report. The researcher has respected the ethical issues. The findings in the literature will be displayed in the next chapter.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

This chapter is all about a review of the literature related to nursing management, roles, responsibilities, functions and challenges of FLNMs all over the world. "*It is necessary to demonstrate how the research is related to previous research, and how it gives rise to particular issues, problems and ideas addressed by the current research addresses*" (Denscombe, 2007, p.325). A literature review has the function of providing a theoretical background to the study; helping establish the links between what is to be examined and what has already been studied; and enabling the findings which contribute to the existing body of knowledge to be described (Kumar, 2012).

Some authors suggest that the researcher should delay the literature review until after data collection and analysis (Chan, Fung & Chien, 2013, p.2) or should withhold an in-depth literature review prior to the investigation (Wojnar & Swanson, 2007, p.173) when it comes to phenomenological research. The researcher felt guilty after having read about the need to delay the literature review until after data collection and the analysis process, because she had thought she was no longer allowed to conduct descriptive phenomenological research. She was comforted, however, by the fact that, in spite of having read about nursing unit management to shape the topic, she did not know that much about FLNMs' lived experiences in Cameroon. Moreover, she maintained her curiosity throughout the process and was ready to understand this phenomenon from a fresh viewpoint. She remained unsure how a researcher could justify the research need and the overall plan of the study without doing some groundwork through the literature review in order to gain a better understanding of the questions in the proposed study (Chan et al., 2013, p.4). Even though bracketing is prescribed in descriptive phenomenological inquiries, some work has to be done in order to see if the phenomenon under investigation is worth studying.

This chapter will start with the display of the strategy used to acquire the findings FLNMs. It will also provide a theoretical background in respect of nursing management and the studies already conducted related to nursing management.

3.2 Literature search strategy

This review of the literature was conducted as follows: scholarly articles were found through search engines like Google scholar, WorldCat, EBSCO, PubMed, ProQuest and Sabinet. The key words used were nursing management, role, responsibilities, functions, nurse managers, FLNMs, lived experiences of FLNMs, nursing unit management. They were combined using the "and" and "or" conjunctions. The researcher consulted articles in English and in French. The review has also included print and eBooks related to nursing management. In addition, websites of the Ministry of Public Health in Cameroon, the World Health Organization were also consulted.

3.3 Management

Management has existed since humankind was first organised into communities (Cherie & Gebrekidan, 2005, p.1). It is a concept and a process of authority that uses human, technical, financial resources as well as time to meet specific goals efficiently and effectively (Grohar-Murray & Langan, 2011, p.4). It is also viewed as a process of coordinating and integrating resources through planning, organising, coordinating and controlling to accomplish specific organisational goals and objectives (Meyer et al., 2009, p.185; Kelly-Heidenthal, 2004, p.2). It is the art of getting things done and reaching organisatonal goals with and through people and other resources (Cherie & Gebrekidan, 2005, p.3).

3.3.1 Difference between leadership and management

Leadership and management are viewed as separate entities. They are closely linked, but are not the same (Kerridge, 2013, p.17). Some view leadership as a function of managers, while others think the skills required for leadership are more complex than those needed for management (Curtis, Jan de Vries & Sherin, 2011, p.307). Nowadays it becomes clear that leadership and management have a symbiotic relationship, and have to be strongly integrated for managers and leaders to be effective (Marquis & Huston, 2003, p.21; Polifko-Harris, 2004, p.71; Yoder-Wise, 2011, p.47).

The term "management" implies planning, taking action and measuring results (Cross, 2013, p.6). It is a "*guiding others engaged process through a set of practices and procedures to satisfy pre-established outcomes based on repeated clinical situations*" (Yoder-Wise, 2011,

p.5). To manage means to bring about, to accomplish, to have responsibility for and to conduct; (Jooste, 2003, p.5) to get the work done through others (Whitebread, Weiss & Tappen, 2010, p.4). It focuses on the daily operations of a setting such as staffing, budgeting, counselling and disciplining (Polifko-Harris, 2004, p.71).

Leadership is broader than management (Whitebread et al., 2010, p.4). It is the ability to move a group toward a common goal (Polifko-Harris, 2004, p.71). It is also "*the engaged decision-making process linked with actions taken in circumstances present in clinical situations for which no standardised solution exists*" (Yoder-Wise, 2011, p.5). Leading entails influencing, guiding in terms of direction, action, course or opinion (Jooste, 2003, p.5). To be a leader, one does not have to occupy a formal managerial position, whereas a manager occupies a formal position in an organisation and is accountable for the effective use of available resources (Manske, 1999). A leader inspires, develops, relies on people and requires trust while a manager administrates, maintains, relies on the system and requires control (Grohar-Murray & Langan, 2011). So managers appeal to the head and leaders appeal to the heart (Cross, 2013).

3.3.2 Nursing Management

Nursing management is literally management in the nursing field. Nursing management is different from professional management in other fields because of the philosophy of the service offered. Nursing's social responsibility toward the health and illness of individuals, families and communities requires a unique approach. Furthermore, nursing management is particularly challenging because of the wide variety of experience and educational backgrounds of the employees in the health care setting (Grohar-Murray & Langan, 2011:152). According to the Nursing Administration Research Project, (NARP) (Lynn, Layman & Richard, 1999) nursing management is unique because of the effects of the managed care environment on patient outcomes; the impact of organisational change(s) on patient outcomes; the development of tools to measure nurse-sensitive patient outcomes; the impact of the administrative practices on patient outcomes; the effect of nursing interventions on patient outcomes; the role of informatics in the measurement of patient outcomes; the effect of changing skill mix on patient outcomes; the identification of nursing's contribution to the bottom line; the development of outcomes that can be used across the care continuum and the quality of care and its key outcomes (Lynn, Layman & Richard, 1999).

3.3.3 Nursing Unit Management

The hospital ward is a sub-system of the health service as is the entire hospital (Muller, 2002:103). Therefore, nursing unit management is:

> *The process of planning, organising, leading and controlling that encompasses human, material, financial and informational resources in an organisation environment in order to achieve predetermined objectives within the context of a specific nursing unit* (Matlaka et al., 2014, p.2).

It is the process through which the manager directs the group toward the attainment of common goals, regardless of the nature of the unit (Meyer et al., 2009, p.186). It is also a process by which managers react to everyday pressures and events by implementing organisational plans through the application of skills, knowlegde, attitudes and values. It is also a process by which opportunities are selected, problems are solved and change is accomplished (Booyens, 2004, p.147). It refers to the execution of the managerial responsibilities by a nurse who is accountable for the outcomes of that unit within the strategic management plan of the organisation (Muller, 2000, p.46).

It is the:

> *Art that entails getting things done through and with people in formally organised groups; creating an environment conducive to quality patient care in which people can perform as individuals yet cooperate to attain group goals; removing obstacles to performance, enhancing quality care and ensuring that the rights of all are respected; optimising efficiency by effectively reaching goals; and monitoring and evaluating how the organisation and its members are performing the activities necessary to achieve organisational goals* (Jones & George, 2007, p.361).

The management process consists of establishing the organisation's objectives, developing plans to meet the stated objectives, assembling the necessary resources, supervising the execution of the plans and evaluating the progress or outcome of the stated plan (Grohar-Murray & Langan, 2011, p.148). Many authors have agreed that the management process consists of four major functions: planning, organising, directing and controlling.

3.3.3.1 Planning

Planning is the primary management function that decides in advance what needs to be done and charts the course for future action (Grohar-Murray & Langan, 2011). It is about determining the long- and short-term objectives and the corresponding actions and resources required to achieve objectives (Meyer et al., 2009). It involves setting goals and identifying ways to meet them (Kelly-Heidenthal, 2004, p.2). It is not only about the FLNM, but it is her intention, as well as the team's, to decide what they want to do, how they are going to do it and how they are going to determine whether they were successful or not (Muller, 2002).

3.3.3.2 Organising

Organising is the process of translating plans into action (Meyer et al., 2009). It is also the management function that provides the relationship between people and activities in such a way that the organisation's objectives are fulfilled (Grohar-Murray & Langan, 2011). It is about ensuring that the necessary human and physical resources are available to attain the planned goals by assigning work to the right person and specifying who can accomplish certain tasks (Kelly-Heidenthal, 2004, p.2).

3.3.3.3 Directing

Directing is the management activity that gets work done through others by giving directions, supervising, leading, motivating and communicating (Grohar-Murray & Langan, 2011). It is also defined as motivating and leading staff to carry out desired actions (Huber, 2006). It is about influencing others to achieve planning goals (Kelly-Heidenthal, 2004, p.2).

3.3.3.4 Controlling

Controlling is the management function that regulates activities with plans according to standards. It is not about adjusting the plans alone, but also the processes and the resources to effectively and efficiently achieve goals (Huber, 2006).

3.3.4 Role of a Nurse Manager

While it is possible to draw inferences about their roles from the literature, it is important not to generalise about them when drawing conclusions about changes in their roles and functions (Duffield & Franks, 2001, p.88). In other words, the roles of FLNMs in other countries could

be different to those in Cameroon. That is the reason why the researcher will describe the FLNMs in Cameroon.

They must respond to and balance multiple and competing demands to meet the goals of the organisation, frequently with inadequate training and support. To be a Nurse Manager nowadays means to subordinate the clinical practice in favour of new managerial practices associated with productivity and efficiency. Therefore, they must possess knowledge in other areas such as information technology, human resources and financial management (Udod & Care, 2012).

3.3.5 Responsibilities of a Nurse Manager

The FLNM is responsible for four groups of entities: herself, the patient, the staff and the organisation.

3.3.5.1 The FLNM and the patient

The main task of a FLNM is to assist patients to overcome physical and emotional barriers to normal living or to achieve the maximum quality of life (Meyer et al., 2009, p.5). For Grohar-Murray & Langan, (2011) the FLNM must maintain the quality of patient care within the financial limitations of the organisation and encourage the motivation of the patient, and even improve their health (Ghalriz, Fakhari, Mehrabi, Moeni, Chazavi & Mehraban, 2008, p.122). For Meyer et al., (2009) the FLNM also acts as a patient advocate. The FLNMs play a key role in coordinating patient care activities and in ensuring safety and quality care in hospital wards (Armstrong, Rispel & Penn-Kekama, 2015, p.2).

3.3.5.2 The FLNM and herself

Because the FLNM is a person, she can become stressed. The literature in the nursing management reflects that nursing has historically been a woman's occupation. Therefore, women experience stress when they combine paid work (especially full-time work) with family responsibilities (especially child-rearing responsibilities) (Loo & Thorpe, 2004, p.89). It is not just the female nurse, but male nurses also, because, according to Lee and Cummings, (2008:769) research has shown that nurses experience more psychological distress than the general population.

3.3.5.3 The FLNM and the staff

The FLNM deals with other nurses who have different backgrounds, training and expectations to hers. She manages health care workers (Meyer et al., 2009). The FLNM should encourage the motivation of employees, increase the ability of subordinates to accept change, develop a team spirit, increase the morale and further the professional development of the personnel (Grohar-Murray & Langan, 2011). Managers are expected to make decision about how others will use their time and be responsible for the supervision of others (Grohar-Murray & Langan, 2011, p.148).

3.3.5.4 The FLNM and the institution

A primary goal of organisation is to retain and recruit effective nurse managers (Shea-Messler, 2007, p.v). For Huber, (2006, p.35) the FLNM attains organisational goals through the use of human physical, financial, and technical resources. For Brady and Cummings, (2010, p.426) nursing leadership styles have an impact on attaining organisational goals.

3.3.6 Skills required for a FLNM

In the 1990s, the characteristics of nurses which contributed to managerial success in the USA were identified as: being experienced and educated in nursing management, having planning, policy and budgeting skills, being decisive, diplomatic and collaborative, and having access to human and material resources (Henry et al., 1992, p.i). In Australia, role descriptions like strategic planner, human resource expert, quasi-business manager, financial analyst, risk manager, operational manager and quality expert as well as having an appreciation for the complexity of the clinical area were identified (Duffield et al., 2001, p.786). FLNMs are not only "managers" as their title implies, but are, by necessity, also leaders (Duffield et al., 2001, p.786) who have the ability to influence nursing staff and promote thoughts and actions leading to the achievement of the organisation's goals (Brady & Cummings, 2010, p.427). Therefore, as leaders, they should "*support staff needs that will reduce burnout by influencing nurses to perceive their work environment as a challenge as opposed to overwhelming*" (Bakker, Killmer, Siegrist & Schaufeli, 2000).

3.3.7 Challenges of FLNMs

In 1988, ten major problems experienced by nurses in management positions in the USA were identified: (1) nursing shortages; (2) shortage of well-educated nurse managers; (3) little participation of nurses in planning and policy activities; (4) lack of recognition and low status of nursing; (5) poor working conditions; (6) subordinate role of nurses; (7) inadequate information system; (8) little inter-professional collaboration and team work; (9) need for supportive legislation; (10) lack of emphasis on primary health care (Henry et al., 1992, p.ii). Nowadays, the challenges are more related to the rising health care costs, the aging population, the rapid advances in technology and medical science, the upsurge of chronic conditions across all ages, and the growing population of mental health disorders (Cross, 2013, p.9).

3.4 The FLNM in Cameroonian context

While in Cameroon, a "ward charge", FLNM, is supposed to be a nurse with at least two years' experience as a team leader, be of good character, preferably a specialist nurse in the field of specialised services such as mental health, reproductive health, etc., this is not always true in all the health care settings there, where one can find unit managers appointed without having been team leaders before.

The ward charge, in a regional hospital is supposed to ensure the good functioning of the unit, distribute stocks and supplies, keep an inventory and ensure fair distribution where possible. She is expected to monitor the nursing activities and organise rounds with nurses to plan nursing care in a concerted manner. Moreover, she must take care of all health care professionals who are under her control in terms of motivation, discipline and evaluation; and propose a unit organogram by taking into consideration the written and oral submissions of the head manager, the physician and any other supervisor. She must also ensure that patients and their families are properly received on admission, and are well-prepared for the exit as well as to supervise the personal hygiene of patients. Finally, she has to prepare and attend all medical rounds, write down any medical prescription that will be used during the scheduled time and carry out frequent visits to the service.

However, in a district hospital, the ward charge is required to watch over the cleanliness and the daily usage of the premises and the supplies, order and manage rationally the stocks and

supplies for the unit. She is expected to watch over the staff's uniform, supervise and give account of the staff's punctuality and assiduity, ensure the continual clinical education of the staff, mark the staff nurse in collaboration with the coordinator, manage short leave which doesn't exceed a half day and become involved with the staff's concerns. She also has to monitor the nursing care, assess the degree of the achievement of the nursing care goals, respect the standards of the quality of care, ensure the respect of visiting hours, prepare and take part in the rounds, ensure the correct completion of any form, ensure the continuity of care, using any appropriate document available, take part in the shift meeting every morning, produce statistics of the unit every five months, contribute to the elaboration of the unit project and ensure payment for any care given in the unit. Moreover, she must receive, guide and give relevant information to the patients and their families, oversee and complete properly the patients' files from their admission to their exit, ensure the classification of patients' files, prepare the patients for medical examinations and special care, psychologically prepare the patients who have to undergo surgery and oversee the effects of the administration of medication. Finally, she is supposed to supervise nursing students, manage conflicts between patients, patients' families and staff, apply the resolutions and instructions given during monthly meetings and daily meetings with staff, and notify the hierarchy of any unusual situation that may occur in the unit.

The above post descriptions show us that there are no formal standards for the nursing unit management in Cameroon. The first description is from a regional hospital in the eastern region and the second description is from a district hospital in the central region. In both cases, the FLNM in a district hospital has many tasks to manage.

3.5 Studies related to FLNMs

Muller (2000) conducted a study whose purpose was to formulate standards for nursing unit management in South African health services, reflected in an evaluation instrument. She posted that the FLNM is responsible and accountable for quality clinical unit management to facilitate quality nursing/midwifery care and education. Nevertheless, without standards on nursing unit management, the quality of nursing unit management cannot be determined (Muller, 2000:45). The following standards were formulated: (1) the clinical unit is managed in accordance with the strategic plan of the health care service; (2) nursing care takes place within the legislative/professional-ethical framework of the nursing profession; (3) the unit

manager facilitates multi-professional and multi-disciplinary teamwork and networking in the interests of patient care; (4) the unit manager practices participative management in the unit; (5) there are written, appropriate, legally valid and updated policies and procedures in the unit; (6) adequate stock, supplies and equipment are available to ensure safe nursing care; (7) the clinical ward is well organised; (8) direction and leadership in the unit is appropriate and adequate; (9) there is evidence of appropriate control in the unit; (10) there is a disaster plan in the unit; (11) there is a formalised clinical unit-based quality improvement program; (12) there is evidence of quality nursing education; (13) there is evidence of research in the nursing unit (Muller, 2000, pp.49-53). Muller recommended that the above standards should be used for the nursing service's quality of nursing unit management in South Africa through a national study.

In 2005, Paliadelis (2005) claimed that little was known about the experiences of nurses as managers, while there was an abundance of studies that explore and describe the various management roles in many professions and industries in Australia. Therefore, he decided to study the experiences of FLNMs in rural New South Wales in Australia. He found that all 20 FLNMs in his study believed that they were promoted because of their clinical expertise, felt unprepared for the managerial and administrative aspects of their role and continued to identify themselves as nurses rather than as managers (Paliadelis, 2005). He suggested that the role of FLNMs needs to be more valued, recognised and supported as a managerial role, rather than being seen as 'just a nursing position' in order to assist FLNMs to perform their role effectively (Paliadelis, 2005, p.7).

Duffield, Roche, O'Brien-Pallas, Catling-Paull and King (2007) asserted that the role of the nursing unit manager is vital for the retention of staff. In their study in some public sector hospitals in New South Wales, Australia, they found that even though a FLNM had little capacity to influence the personal factors which impact on a nurse's decision to remain employed, she could exercise influence over aspects of the work environment. These aspects included increasing staffing to acceptable levels, ensuring that there were sufficent support and allied health staff, decreasing workloads, empowering managers to respond to local staff concerns, supporting improved nurse-physician relationships, improving on-the-job orientation and providing for paid continuous education (Duffield et al., 2007). Therefore, to achieve some of these objectives, FLNMs need support from more senior colleagues, both nursing and non-nursing, to ensure that there are appropriate and sufficient human and

financial resources. The authors have suggested that hospitals need to invest in educating and appointing skilled nurse managers, particularly, but not exclusively, at the ward/unit level (Duffield et al., 2007, p.16).

In 2010, Duffield, Roche, Blay and Stasa conducted a study whose aim was to examine the impact of leadeship characterisics of FLNMs, as perceived by staff nurses, on staff satisfaction and retention in 21 public hospitals across two Autralian states. They found that FLNMs play an important role in staff retention and satisfaction, as well as in savings for the organisation. The leadership characteristics in favour of staff retention and satisfaction were praising and recognising a job well done, developing flexible or modified work schedules, providing positive feedback, creating a positive practice environment and consulting with staff about problems and procedures (Duffield et al., 2010). They concluded by saying that, in order for FLNMs to develop these critical leadership skills, they need training and mentorship. Futhermore, it is vital that they receive adequate organisational support in the form of a visible nurse executive who has a "seat at the table" where decisions about nursing and its future are made (Duffield et al., 2010, p.31).

According to Brady and Cummings, (2010) nurse leaders play a key role in encouraging staff to gain a better understanding of patients' needs and values. In fact, they conducted a review of research articles whose aim was to explore leadership factors that influence nurse performance and particularly the role that nursing leadership behaviours play in nurses' perceptions of performance and motivation. They found that nurse leadership factors such as fostering of autonomy, confidence in employees, stimulation, guidance and encouragement of staff were affecting nurse performance.

Through a systematic review of the literature that examined the determinants of FLNMs' job satisfaction from studies published between 1990 and 2006 in the USA, Canada, Hong Kong and the UK, Lee and Cumming (2008) found 12 predictors of their job satisfaction grouped into five categories: organisational change, organisational support, job characteristics, managerial role and educational development. For these authors, the FLNMs' job satisfaction and ultimately retention is of importance, because they influence organisational culture and outcomes for patients and staff. They concluded that reducing the managerial span of control and workload, as well as developing strategies to increase support and empowerment of front-line managers is pivotal to positively influencing patient and staff outcomes.

In order to explore the charge nurse manager's role, McCallin and Frankson (2010) have investigated the role of 12 nurse managers from an acute care hospital in New Zealand, through their experiences. They have found that, because role guidelines were unclear, role ambiguity increased. This was compounded by a business management deficit and unrealistic expectations that caused overload. They added that, if nurse managers are poorly prepared for clinical and administrative management, the potential for role overload or role confusion increases (McCallin & Frankson, 2010). They concluded that organisations must provide formal structural support to facilitate management development.

In 2010, Matlakala et al. (2014, pp.1-7) conducted a study related to the challenges encountered by large critical care unit managers in five hospitals in Gauteng province, South Africa. They found that unit managers in large ICUs faced multifaceted challenges: challenges related to layout and structure of the unit, the challenge related to the provision of material resources, the challenge related to human resources provision and staffing, challenges related to the stressors in the unit and challenges related to visitors. Finally, they suggested, for future research, the development and implementation of strategies in order to overcome the challenges faced with regard to the management of large ICUs.

To examine whether the activities of nursing unit managers facilitate the provision of quality patient care in South African hospitals, Armstrong et al. (2015) conducted a descriptive study in nine randomly selected hospitals in two South African provinces during 2011. They found that nursing unit managers spent 25.8 percent of their time on direct patient care, 16 percent on hospital administration, 14 percent on patient administration, 3.6 percent on education, 13.4 percent on support and communication, 3.9 percent on managing stock and equipment, 11.5 percent on staff management, and 11.8 percent on miscellaneous activities (Armstrong et al., 2015, p.3). However, there were also FLNMerous interruptions and distractions. They claimed that 25.5 percent of the time which the nursing unit manager spent on patient care might not be appropriate in light of the core management responsibilities of a nursing unit manager. Therefore, the creation of an enabling practice environment, a supportive executive management and continuous professional development are needed to enable nurse managers to lead the provision of consistent and high-quality patient care (Armstrong et al., 2015, p.8).

3.6 Conclusion

Although the role, the challenges, the experiences of FLNMs in some countries have been focused on, a paper related to the lived experiences of FLNMs in Cameroon has not yet been found. Nevertheless, the researcher has found that being a nurse manager is not an easy task. She must reach the organisation's goals, manage the staff, the time and the resources (financial, material…). Therefore, a nurse manager must have skills required for the multiple tasks that include planning, organising, directing and controlling. What about the FLNMs in Cameroon? The next chapter will display the findings related to their day-to-day lived experiences.

CHAPTER 4: FINDINGS AND DISCUSSION

4.1 Introduction

It is worth noting that the purpose of this study was to describe the day-to-day lived experiences of FLNMs in two district hospitals in Yaoundé, Cameroon. The descriptive phenomenology aims to describe the essential structure of a phenomenon. In this chapter, the description of the participants, the theme and sub-themes and a discussion are presented as results of the data collection and analysis described in Section 3.7 and 3.8.2.

4.2 Conduction of the interviews

Eleven interviews were conducted. Each lasted at least 30 minutes, except the first one which lasted 21 minutes. The researcher deleted one interview after transcribing it because the participant was temporarily in the position of unit manager for one month only, as the unit manager was on leave. Before starting each interview, the researcher introduced herself and explained again the topic of her research. She did not emphasise the voluntary aspect greatly, because the interviewees had already agreed to participate. She emphasised the confidential aspect of the study before asking for permission to record the interview. All the participants signed the consent form without entering their names. During the interview, the researcher ensured that she was not obtrusive nor did anything else which might distract the participants.

The participants were initially hesitant to participate but they become more enthusiastic as the interview continued. Most of the time, the interview was conducted in a common space because the unit managers did not have an office. Some staff who were curious, listened to what was being said and this made the researcher feel very uncomfortable. The following table described how she conducted the interviews.

Table 4.4: Description of the interviews

Participant	Venue of the interview	Description of the interview
Elise	In a common space where material is kept, before midday, at Hospital 1	The participant asked me to wait for a while when I arrived on the day she had asked me to come back. She was not that excited at the beginning, but ended up being enthusiastic. I was so stressed because it

		was my first interview and I was standing. However, some nurses were listening to the interview for a while because we were in a place where people were going in and out. The interview was interrupted by curious people.
Louis	In the delivery room before midday, at Hospital 2	The participant was my classmate; we knew each other. When I arrived she laughed at me and asked me to wait until she had finished completing a patient file. No one was listening. The interview was interrupted by a phone call and the middle nurse manager. We joked during the interview, but I tried to stay focused.
Alexandre	In an open space where she has a desk, after midday, at Hospital 2	The participant asked me to wait for a while because she was going to have something to eat. The interview started in a shy way, but the participant became interested as she began describing her experiences. No one was listening but we were interrupted by a phone call, a medical representative and an emergency.
Richard	In an office before midday, at Hospital 1	The participant seemed not to be prepared to welcome me, even though he had asked me to come back. After introducing myself again, he calmed down and started answering my questions. No one was listening and we were not interrupted.
Humbert	In a patient's room before midday, at Hospital 2	The participant was hesitant, but once I presented myself, she asked me about one of my relatives she knew. We started talking about my relative for about 10 minutes. I had to delete this pre-conversation from the audio-recording. The room was not full and some patients were listening. The participant was at ease, but we were interrupted by a phone call.

Georges	In an open space after midday, at Hospital 1	The participant was very kind to me from the beginning to the end. She seemed to be happy to share her experience and provided examples to clarify what she said. No one was listening to us because we were in a corridor, but we were interrupted by a medical doctor.
Pierre	In an office after midday, Hospital 1	The participant seemed to be exhausted, but answered my questions quite directly. She did not give many examples. No one was listening, but we were interrupted by the food delivery and she seemed to be more interested in the food placed in front of her.
Francis	In a patients' room after midday, at Hospital 1	The participant seemed to have found a way to express himself. He was very talkative, but primarily about his previous experiences. Some patients were listening, a child was screaming and it was very disturbing because I was sensitive to his cries. However, we were not interrupted.
Roger	In a common space after midday, at Hospital 1	The patient was very kind to me. She answered questions in detail. She even said, "*I am not done with this point*" when I asked another question while she was still answering the previous one. No one was listening and we were not interrupted.
Charles	In the nurses' office after midday, at Hospital 1	The participant was really busy and she did not want me to come back on another day. She created a space for me and asked me to start by introducing myself. Some staff were listening while others were eating and talking. Since the interview was in English, they did not understand what was being said. Sometimes the participant had to slow down so as not to be heard. We were interrupted by a phone call, the food delivery and some staff.

After describing how the researcher conducted the interviews, the participants who took part in this study will be described.

4.3 Description of the participants

The participants who took part in this study are described in Table 4.2 below, in terms of their age, sex, years in the nursing profession, years in the managerial position, previous experience in a managerial role and whether they received a job description or not. The researcher disclosed the following information because she is certain the participants cannot be identified.

Table 4.5: Description of participants

Participant	Education	Description
Elise, 55-65 years old, female.	35 years of nursing working experience	Three years in the role; has previous experience in a managerial position, was not trained before being appointed unit manager and has never received a job description.
Louis, 55-65 years old; female.	23 years of nursing working experience	Four years in the role; has previous experience in a managerial position but was not trained prior to being appointed unit manager and has never received a job description.
Alexandre, 25-35 years old; female,	13 years of nursing working experience	Three years in the role; has previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Richard, 25-35 years old; male	11 years of nursing working experience	Four months in the role; has no previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Humbert, 25-35 years old; female	Five years of nursing working	Five years in the role; has no previous experience in a managerial position, but was

	experience	not trained before being appointed unit manager and has never received a job description.
Georges, 35-45 years old; female	Nine years of nursing working experience	Five months in the role; has previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Pierre, 35-45 years old; female	19 years of nursing working experience	One year in the role; has previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Francis, 35-45 years old; male,	Nine years of nursing working experience	Four months in the role; has previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Roger, 25-35 years old; female	Six years of nursing working experience	One year in the role; has no previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.
Charles, 25-35 years old; female	Five years of nursing working experience	Five months in the role; has previous experience in a managerial position, but was not trained before being appointed unit manager and has never received a job description.

A total of ten participants were interviewed, eight females and two males. Most of the participants were in the 25 to 35 years age bracket. Two of them were English-speaking and the others were French-speaking. The names on the table are pseudonyms given by the researcher in order to identify the participants but do not correspond to the participants' real

names. The researcher even chose to give male names to female participants to preserve their anonymity.

All the participants were, at least, registered nurses. Two held Master of Nursing Degrees and two had Bachelor of Nursing Degrees. The least experienced had five years' experience as a nurse and the most experienced had 35 years; an average of 13.5 years of work experience.

The person with the least experience as unit manager had four months in the role with no previous experience in a managerial position. The most experienced person in the role had four years in the unit with previous experience as a nurse manager. Among the participants, eight had previous experience in a managerial position, either in a private or in public hospitals. Three participants were not proud to be unit managers; however six found the position of FLNM to be a position to be proud of.

Although none of the participants were trained before being appointed, eight thought there was no need for training as a nurse manager. Furthermore, none of them received a job description. Some are managing using their previous experience, while others learned from their predecessors or learned while managing.

4.3 Summary of the theme and sub-thnemes

The findings revealed one theme describing what is like to be a unit manager in the two district hospitals in Yaoundé, Cameroon. It can be summarised as follows: being a FLNM in Cameroon is like "being a mother of a family". The following table displays the themes and sub-themes.

Table 4.6: List of the theme and sub-themes

Theme	Sub-themes
	Becoming a mother of a family • Surprised • Not been trained • Proud
	Activities by the mother of a family • Solving problems

Being "a mother of a family"	• Facing difficulties
	• Being a role model
	It is not easy being a mother of a family
	• Requiring assistance from others
	• Requiring specific characteristics
	• It is not financially worth it

After analysing the data, one theme emerged: "being a mother of a family". This theme was divided into three sub-themes namely becoming a mother of a family, activities by the mother of a family, and "it is not easy" being a mother of a family.

As a start, most of the participants viewed their role as similar to being part of a family made of staff. They emphasised the notion of a family as similar to how they conceived their work environment because of the fact that the majority of their days and time is spent together with those they work with:

> *A ward charge should … consider that he is dealing with another kind of family; a nuclear family just as in his home… It is just as a family, it can be difficult, you suffer but you must do you part… But I can assure you that the family we meet here is even greater than the one we have at home because we spend a lot of time together* [Elise, 18 September 2015].

> *We are a family because we spend more time here than at home. At 7.30 a.m. we are here and the ward charge can leave this place at 4.30 p.m. You spend less time at home. We are a family here; a nuclear family* [Richard, 22 September 2015].

As was said in the introduction, being a unit manager in a district hospital implies working every day of the week from 7.30 a.m. to at least 3.30 p.m. as opposed to staff who work for four days and then rest for the next four days. Moreover, the unit managers cannot disconnect themselves from their work environment because they also receive calls from the hospital, even at night. Therefore, they spend at least 40 hours per week with the staff. Every gathering contributes towards consolidating this feeling of being part of a family.

4.4 Theme: 'Being a mother of a family'

The theme 'being a mother of a family' has been labelled by the researcher based on the participants' quotes. The feedback of the respondents confirmed the label as can be seen below:

> *And when they do something stupid, you must correct and, at the same time, be flexible, use the carrot and the stick as a parent does. As a parent, there is a day where you will punish and another where you will flatter… We have said being a mother because it makes you handle situations as if you were at home* [Alexandre, 21 September and 18 November 2015].

> *It is just like being the head of a family… Yeah, I recognise myself in being a mother* [Louis, 21 September and 18 November 2015].

What happened before these role-players became mothers of families?

4.4.1 Sub-theme 1: Becoming a mother

As some pregnancies occur without a conscious decision, most of the unit managers claimed that they were surprised when they were appointed as unit managers. In fact, they found themselves being a mother of a family without having decided to be one. Some unit managers expressed their surprise as follows:

> *I was surprised by this post of ward charge; they decided and I was simply informed. I went home for the weekend and, when I came back on Monday, people started calling me ward charge. I thought they were calling someone else* [Georges, 22 September 2015].

> *I came on a Monday morning; I was late for the staff meeting that is held every morning... I heard somebody whisper: "The young ward charge". I did not understand. At the end, others were congratulating me, but I didn't know why. At that moment, the coordinator called me and showed me… I could have fainted... I was so surprised* [Humbert, 23 September].

The participants were not only surprised to be appointed unit managers, they did not receive training prior to being appointed to their managerial positions. All of the participants admitted to not having been trained as we can see below:

No, no; I have not been trained, never! It is in the field that I have been trained, that I formed my character [Elise, 18 September].

I don't think that there should necessarily be training for a ward charge. I have not been trained [Alexandre, 21 September 2015].

Although pregnancies can occur without a conscious decision, the mother is usually proud of her child once she is born. In fact, being a mother in Africa is a matter of pride. Likewise, some unit managers claimed to be proud of being nurse managers, even though they had not been trained and were surprised to be appointed as unit managers. For them, being a nurse manager had a value as we can see from the statements below:

I am proud because I feel that I am valuable to my profession… It is a feeling of joy; you are proud that people can trust you, and give you a certain value [Georges, 22 September 2015].

To be honest, I am proud to be a ward charge because I am valorised. I have the feeling that if after five years, I am still a ward charge; it means that I am doing a good job [Humbert, 23 September 2015].

Being proud was identified as a reason to stay in their managerial role by Cziraki et al.'s participants (Cziraki et al., 2014, p.1009). In their study of the factors that facilitate registered nurses in their FLNM's roles in regional health care settings, the unit managers reported that being proud of their role helped them to stay in that position. Likewise, the participants of this study could cope with their new role because of their pride. Now that they had been appointed, they needed to prove that they deserved it by "acting as a mother".

4.4.2 Sub-theme 2: "Activities by the mother of a family"

The label "activities by the mother of a family" actually reflects "being a mother of a family". It is about what the participants reported they do as the head of a family. In this case, they admitted that they "solve problems" while "facing difficulty" in order to "be a role model".

4.4.2.1 Solving problems

This label came from the mouths of the participants who said that they are there to solve problems as we can see in the following statements:

> *That's the reason why I am here as the ward charge, to solve little problems at the unit level* [Elise, 18 September 2015].

> *When I am in the ward, I pass by and try to solve the problem before the doctor is coming… So, when you are a ward charge, you are overloaded; if there is any emergency you are the one to resolve it, except if it is above your level* [Charles, 22 September 2015].

To prevent is better than to cure, the participants knew. It could be the reason why they plan nursing care and staff nurses to prevent from having problems to solve.

4.4.2.1.1 Planning

Those problems were linked to the nursing care and led the unit managers to plan in order to avoid having problems to solve. For the good functioning of the family, the mother has to plan daily activities at home: who must do what, when and how. Likewise, the unit manager planned the nursing care on a daily basis as follows:

> *I make sure to plan treatments before the head of the unit goes round as he does every morning* [Alexandre, 21 September 2015].

> *Secondly, I take patients' medical files to do the planning of nursing care… When it is the ward charge who does the planning, it enables her to know her patients and her staff also; to know who is lying and who is not* [Humbert, 23 September 2015].

> *I am responsible for coordinating the work, the nurses, giving them their plans of action… So when you come in the morning you know what you have to do: am I in the section of vital signs or in the ward?* [Charles, 22 September 2015].

The unit manager said they also did the scheduling of those who worked during the day and those who worked at night. They formed a team according to how the staff had worked during the month before. The following statements illustrate that point.

You direct and plan things; you take care of medical files, of the planning of nurses during the month; you see those who worked during the month and did not cause any problem and renew their schedule for the following month, but, if there are teams that disturbed things, they should be switched around [Georges, 22 September 2015].

Here there are 18 staff members who have at least 15 years of work experience... I have already done the planning for this month. When I realise that you are disturbing me, I put you on duty, and, if it continues, your shares will be reduced and bonuses cancelled [Francis, 22 September 2015].

If we had newcomers, I wrote the roster for the nurses; those on shifts. I enrolled them, planned how they were going to work from morning to evening, for those who come in the morning. I did the roster for the permanent workers [Charles, 22 September 2015].

These findings concerning planning are similar to those found in a review of 60 texts about the terminology of FLNMs by Miri et al. (2014) where work schedules and task assignments were cited in about 25 percent of the studies (Miri et al., 2014, p.34). After having planned the activities, the unit managers provide resources for the good functioning of the unit.

4.4.2.1.2 Providing resources

Though their primary goal was patients' satisfaction, the unit managers provided resources for the staff to work properly. They made sure that what was needed was available. This could consist of providing the materials or tools required, as is illustrated in the following statements:

After this, I get into the room to make sure that the decontamination solution is available. There are also containers that should be filled and, if they are empty, I ask some interns to fill them [Louis, 21 September 2015].

I make sure that all the necessary documents that we need to do our job effectively are available; temperature forms to follow up patients, discharge forms, stickers to write which drug was administered to the patient so that anyone who comes in will know… For example, all that you see pasted here is to help people to do their jobs easily [Alexandre, 21 September 2015].

After having planned what was supposed to be done and having provided for it to be done well, the unit managers reported that they checked whether the work had been done as it was supposed to have been.

4.4.2.1.3 Controlling

As a mother controls everything to ensure that all goes well at home, the unit managers had to observe and check that everything was running smoothly in the unit. They found time to pass through the ward to check on how the staff were working, to check whether the patients had paid their bills and whether the ward was clean and tidy. The following statements illustrate this point:

> *You should be very demanding; if not, people will do whatever they like in your unit. You should watch almost everything; cleanliness, treatment programming, administration of treatment, a bit of all that* [Alexandre, 21 September 2015].

> *The cleanliness of the premises should be checked in order to limit infections: was the equipment decontaminated, washed and disinfected; was the delivery table cleaned after the delivery… You should verify that the staff work in aseptic conditions: do they change their gloves; do they wash their hands*? [Pierre, 22 September 2015].

> *I have to make sure that the patients coming in pay their fees, undergo lab tests and receive their slips to collect their results* [Charles, 22 September 2015].

All activities mentioned above are not carried out without difficulty. The participants, who are actually mothers of families, said they faced several difficulties.

4.4.2.2 Facing difficulties

The majority of participants faced some difficulties related to the patients, the staff, the organisation and their personal lives. Some participants had trouble dealing with patients who were financially limited or were not grateful as can be seen from the statements below.

> *The first difficulty is having financially limited patients. The patient who comes to the district hospital is limited financially; she prevents you from treating him or her because she is unable to buy drugs or to undergo a lab test* [Humbert, 23 September 2015].

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Another difficulty is that patients are sometimes wicked: somebody who was dying during his admission who you rushed to save, will, as soon as he regains some strength, insult you [Humbert, 23 September 2015].

Sometimes you help patients by making their beds, but later on they say that nurses stole their drugs. I myself have already been accused of stealing; whereas before we used to buy drugs to help patients [Georges, 22 September 2015].

Contrary to the above quotes about the patients who were not grateful for what they received in terms of care during their stay, one participant was surprised by the gifts from patients as a sign of gratitude. The following excerpt depicts this:

I also tell them that I can't count what I receive, sometimes it is a handbag, another time a loincloth; I don't even know what I do that is so special; sometimes it is baby soap or even corn [Alexandre, 21 September 2015].

The participants also admitted having trouble leading the staff because the latter are comprised of people with different personalities as expressed in the following statements:

Each one comes from a family with her own education, accustomed to a way of doing things that she grew up with [Richard, 22 September 2015].

So many people have different backgrounds; where they come from, where they studied, where they did their practical, so the ideal is not always put in place… [Roger, 22 September 2015].

Following the theme of being the mother of a family – the participants who can be viewed as the mothers of legitimate children (their staff) - find that staff often become like adopted children, since they are all so different. The difficulties experienced like giving them instructions, as a result of this are expressed below:

It is not easy to lead people; it is the first difficulty. You say as many times as possible: do not do it like this, do it like that; as soon as you turn your back, they juggle, they turn things around [Alexandre, 21 September 2015].

There is also a problem of consciousness: all the time, we have to shout at those who come late, who leave without any authorisation, abandoning two colleagues in the

unit. There are also misunderstandings because some do not always understand when I give instructions. People do not easily adhere to instructions; I struggle a lot to make people understand how I would like them to do their jobs [Pierre, 22 September 2015].

For example, we have more nursing assistants doing the job of a registered nurse; these assistants don't understand the importance of documentation which is one of the main problems I face with them; when you try to make them understand, they don't know why they have to document occurrences [Roger, 18 September 2015].

The health care organisation was another source of difficulty for the unit managers in these two district hospitals. They complained about the lack of materials and the limited space as we can see below:

We do not even have enough materials to work with, which is why you may notice that sometimes, when we are performing operations, we wash things, we sterilise them afterwards [Roger, 18 September 2015].

As you have seen the premises is too tiny. I do not have an office as a ward charge and, because there are confidential documents here, everyone can read them. There are even cases when patients want to talk with you alone but there is nowhere to sit. That is the problem of a lack of space [Charles, 22 September 2015].

In addition to facing difficulties, the unit managers said they made sacrifices. The transcripts showed that most of the unit managers made sacrifices in order to cope with their professional responsibilities and their family responsibilities. In fact, they have to make sacrifices (Cipriano, 2011:62). For the males, making sacrifices was about dropping other activities which could generate more money in order to focus on their roles as managers. This is illustrated by the following statements:

Honestly speaking, if before, you used to have other activities, as a ward charge, when you are someone that is conscientious, it could be difficult [Richard, 22 September 2015].

It stops me from having any other activity because I am in the hospital every day; sometimes, even on Saturday because of my conscientiousness [Francis, 22 September 2015].

For the females, making sacrifices was essentially about going the extra mile so that their children could be taken care of. The excerpts below illustrate this point.

> *Yes, the role of ward charge influences my life because I have a fiancé and a little girl. Often when I am late home, I am obliged to call so that someone can help her to do her homework* [Humbert, 23 September 2015].

> *We work every day and we do not have much time at home. This means that you have to go the extra mile for someone to take care of your children because you cannot work here and be at home at the same time ... Being a ward charge is time-consuming because you put more effort into the role to see that it works* [Charles, 22 September 2015].

The female nurse managers are in a managerial position at their workplace, but they fall under a male's authority at home. Even though they give orders at the hospital, they still need to be submissive to their husbands and to raise their own children. As a participant said: *"... no head of a nuclear family would wish his family to fail"*, [Elise, 18 September 2015] the women had to go the extra mile to see that their children were raised normally. In fact, it seems that they have to be the perfect woman at home and the perfect woman at work. They have to be role models.

4.4.2.3 Being a role model

This sub-theme comes from the participants' statements. They expressed the notion that they will be a role model for the staff to follow. It is the same in a family where the parents are a role model for their children

> *Now, when you are a ward charge, you should have these virtues in order to be a role model.* [Alexandre, 21 September 2015]

> *Now I am responsible for many things in such a way that I turn to be very careful in my life, I have people who are under me that I need to be a model for them.* [Roger, 18 September 2015]

4.4.2.3.1 Teaching

Being a role model can encompass teaching the staff as we can see from the excerpts below:

Recently, we were in a seminar on hepatitis at the University Hospital Centre. After the first day, I came here before going back home to tell them what we did there... I thought that since I was aware of, things should not continue to be done as they were before [Alexandre, 21 September 2015].

I do continuous education myself, at my own level, during the compulsory end of month unit meeting... Those elders no longer like to learn; if you talk for 10 minutes, they will sleep [Humbert, 23 September 2015].

All the participants also reported teaching nursing and medical students as well:

Academic interns are under my charge and, at the end of their training, I mark them. Generally, we assess them. We should have written assessments but we are too busy, so we do oral assessments. Sometimes, those who come from serious schools have to produce a report. We read their reports and try to help. We follow them up during their internship period. We advise them [Alexandre, 21 September 2015].

The above quote is similar to the findings in a study related to the work dynamics and the impact of nurse managers during health care restructuring in Hong Kong. There, unit managers reported allocating 1.7 percent of their time to supporting a good learning environment and to assessing clinical skills of students, though they were not teaching them every day (Wong, 1998:346). It can happen that, if a child is not able to do something, his mother can be a role model to him by helping him.

4.4.2.3.2 Helping them

To be role models, they had to do what the staff could do, as well as what they could not do. The following excerpts depict this point.

Sometimes when women come and the team on duty said they were not able to assess the cervix and the progression, I let go all I was doing and I helped... [Louis, 21 September 2015].

If, for example, there was a treatment that a colleague is not able to do, they will ask where the ward charge is. You come and help her do what she cannot. It valorises you... You feel great [Georges, 22 September 2015].

By doing what the staff could do, and especially what they could not do, the unit managers felt good or challenged. Likewise, in a family, children follow in the footsteps of their mothers. Furthermore, when the children can rely on their mothers for things they cannot do by themselves, they feel secure. They can even boast about their mothers and wish to be like their mothers one day. If, after teaching the staff and helping them know what to do, the work is still not done correctly, the unit managers had to correct what was done wrong.

4.4.2.3.3 Correcting

Being a mother also means correcting the children when they do something wrong for the sound functioning of the family. Correcting here means disciplining, as well as showing the staff the right thing to do. The researcher could have used the term 'disciplining' instead of 'correcting', but this would not express the whole concept. One has to bear in mind that themes with similar and contrary ideas that flowed in the same direction were labelled. In the district hospitals, the unit managers confirmed that they reprimanded, warned or corrected the staff because the staff are not children, but adults, as stated by the following participants:

> *The difference in the workplace is that you often deal with married people, parents. Of course, you cannot interact with someone in charge of a family as if it was with a child… because he also is a leader* [Elise, 18 September 2015].

> *Here we are dealing with adults; we are not dealing with children, thus when something is wrong, you cannot take a cane to whip them. We have to converse as grown-up people* [Humbert, 23 September 2015].

The staff cannot be spanked by the nurse manager. The only way to approach them is to talk or to negotiate when they do something wrong, as we can see from the statements below:

> *For example, concerning the sale of drugs, before you and I were born, drugs were being sold. It is not for a child like me to come and change the system. What I do is to warn them* [Humbert, 23 September 2015].

> *I always pass by and coordinate the files; I see whether you have done well. If I see a mistake, I correct you* [Charles, 22 September 2015].

And when they do something stupid, you must correct them, and, at the same time be flexible, use the carrot and the stick as a parent does [Alexandre, 21 September 2015].

The activities of a mother of a family are not easy as we can see from the next point.

4.4.3 Sub-theme 3: "It is not easy being a mother of a family"

"It is not easy" was mentioned several times by most of the participants. It is true that nothing in this life is easy, but, when someone has to deal with children who are not theirs, and reach organisational goals, they can say it is not easy. In this study, this means requiring support from others and specific skills. Moreover, the participants believe it is not financially worth it.

4.4.3.1 Requiring support from others

Being a unit manager in a district hospital is not easy, as one can see from the previous points, therefore it requires assistance from others. The FLNMs of this study posited that they needed assistance from the organisation. They expressed this by suggesting assistance as we can see in the following statements:

> *I think that there should be some simple continuous training to guide people in their tasks, to tell them that, as ward charges, this is what is expected of you...* [Louis, 21 September 2015].

> *That is what is lacking. Retraining for the post of ward charge; they do not do it, but in scientific domains, they do* [Pierre, 22 September 2015].

Actually, some participants were grateful to the organisation because they received some assistance from it. This is evident from the fact that they sometimes referred to the senior head manager as illustrated below:

> *Here we hold the ward charge meeting with the general supervisor to talk about problems we face in our units, among staff; we discuss these and anyone can offer a suggestion. This helps, because if you are the ward charge somewhere and things are not well arranged, you will not be able to do your job because of difficulties... There are routine check-ups here every month. They go round different units to see whether there are some difficulties, if the unit is clean; there is a little bonus for that* [Louis, 21 September 2015].

Yes, we are sent to seminars from time to time so that we can remain up to date. I thank the administration for this effort. We acquire knowledge in order to better manage the staff in terms of the technical and administrative aspects [Richard, 22 September 2015].

These findings are similar to those of the study of Johansson et al. (2013) related to role stress, where the unit managers reported to have received and have been satisfied with the support and the appreciation from their supervisors (Johansson et al., 2013, p.455). However, the findings differ from England's (2008) study about the lived experiences of nurse managers in Eastern Tennessee who reported to have been "thrown in" to their current position where "there is nobody there" to talk to (England, 2008, p.46). Brown et al. (2013, p.469) in their systematic review related to the factors influencing nurse managers' intentions to stay or to leave, found that the importance of feeling valued by the organisation, peers and the staff was cited among the frequent personal factors related to nurse managers' intentions to stay. Organisations should place more emphasis on supporting their unit managers. When one feels encouraged, one can give the best of oneself because one knows others care about one.

The participants also admitted to being assisted or encouraged by their family members as well. The following statement illustrates this point:

Actually I have 4-month-old baby; I have somebody at home; my children go to school so my husband helps me a lot; we work together [Roger, 18 September 2015].

The family support finding is similar to the findings of Cziraki et al. (2014, p.1008) where participants identified spousal and family support as important factors in attaching nurse managers to their roles. The rate of employment of working mothers' worldwide is increasing because of changes in society. Mothers are also frequently called to work as the fathers do to financially support the family. Therefore, they are involved in the dual role of being a parent and a paid worker as well. The mothers struggle to balance work and family, even though their experiences from work help some to succeed at home. In this regard, some participants acknowledged the fact that their family members helped them, reporting that, contrary to the study of Cziraki et al., the most experienced unit managers reported having achieved a balance between home and work (Cziraki et al., 2014:1009).

Further assistance required by the unit managers was assistance from God. In fact, religion is strongly established in Cameroon. It is not unlikely to see workers praying for God's assistance for their job. Some unit managers in these two district hospitals in Yaoundé said they prayed either before the handover, or when faced with some issues as we can see from the statements below:

> *It is true we nurses are also stressed, but we should try to hold our stress levels under control. That's the reason we have a prayer here, so that, when you read it, it helps you to rise above it all so that you do not carry problems from your home to work and the patient can achieve 50 percent of his recovery by seeing you before you actually do anything* [Alexandre, 21 September 2015].

> *It may happen that we do not pray together, but I pray when I change, before touching any patient. God has the first place in everything I do because, if He does not allow it, nothing will happen* [Richard, 22 September 2015].

> *It also depends on the grace of God, because it is God who grants wisdom. It is true that there are moments where I ask myself whether I will pull through, but it is the Spirit of God which puts the necessary words in my mouth at the right time to handle any dispute* [Pierre, 22 September 2015].

4.4.3.2 Requiring specific characteristics

Since it is not easy to be a FLNM in a district hospital, the unit managers have admitted that certain characteristics are needed. It is worth noting that a characteristic is a positive or negative trait or quality that distinguishes someone from others, whereas a skill is an ability that could be acquired through training, education and practice (Encinger, 2013, pp.54-57). The unit managers talked about competency, humility and listening. According to most of the participants, a unit manager should be competent and should have mastered nursing. Several reasons were given to explain their views. Some nurse managers said that this was the primary characteristic of a unit manager because a FLNM should not be confused or mocked due to the lack of competence. Others said competence is needed to lead others and teach them. The following statements depict this point.

To a young ward charge, I would say that he simply needs to be vigilant and learn well to master nursing, because if he does not know it, he will become confused [Elise, 18 September 2015].

(Regarding the skills of a unit manager) the first is competence; the second is attendance, availability... In front of so many colleagues or patients, competence is needed. Competence will make others listen to you… For the unit to function well, there should be a competent and dynamic ward charge [Humbert, 23 September 2015].

You need competences because it is not just anyone who can lead 19 people... They look for competent and qualified people to lead others [Georges, 22 September 2015].

The skills of a ward charge: you have to be competent, know what to do before teaching this to others [Charles, 22 September 2015].

Competency or clinical expertise is a quality that a nurse manager must possess to be effective (Yoder-Wise, 2011, p.55; Whitebread et al., 2010, p.16). It is true that it is not necessary or possible for a unit manager to know everything the staff members know, but it is important that she is able to evalute how well the staff members have fared in term of patient outcomes.

Another characteristic required is the ability to listen to others. In most African families, the parent does not always listen to her children. The parent is supposed to be the one who talks and the child the one who listens. Contrary to this view, the participants admitted that a unit manager should listen to others as is illustrated in the statements below:

A ward charge should be calm; should have mastery of nursing; should listen to others … and give all what he has... Learn to share, be prepared to listen to others and also know how to reproach… you should listen and not always spank [Elise, 18 September 2015].

I am not the kind of boss who always gives orders or imposes things. I meet people individually, I listen, and then reprimand. You should listen keenly to others; you should not be the kind of boss who is a dictator. Generally, when this is the case, others run away from you. If you are a democrat, from time to time, information will

come to you.... Listen attentively to others, observe, but do not allow them to threaten you [Alexandre, 21 September 2015].

A ward charge should be someone who is calm, considerate and who listens to others [Georges, 22 September 2015].

"Listening to others" has been identified as important leadership behaviour. It is different from talking with others because it emphasises giving and receiving information (Whitebread et al., 2010, p.10).

The transcripts showed that being humble is another characteristic of a unit manager in a district hospital. Several reasons were given to justify the need for humility. The main reason was that a unit manager should be humble to learn from others as is depicted in the statements below.

(A unit manager*) must be humble, since there is no training for the ward charge position. The advice I would give to a young ward charge is that you should have mastery of your job, be humble...* [Louis, 21 September 2015].

I try to be on the same level with everybody because you do not have a monopoly on knowledge [Alexandre, 21 September 2015].

To be humble and know how to listen to others means that, even if you have very good qualifications, you can still have areas of weakness... You should be humble and listen, from time to time, to what the staff say... It may happen that the shepherd makes a mistake. You should be humble enough to acquire some knowledge from them ... [Richard, 22 September 2015].

Listening to others and being humble are part of the human aspects which the participants in Roche et al.'s study (2015) found to be important elements of nursing leadership, linked to their intention to stay in 11 public acute care hospitals in Australia. For these nurses, unit managers who engaged with them, provided support and motivation, who were sensitive to their needs and facilitate their professional development had more influence than managers who had skills in finance and staffing (Roche, Duffield, Dimitrelis & Frew, 2015, p.61). In order to be that close to the staff, the participants said they had to listen to others and be humble. What if, after doing all this, the financial motivation is not worth the trouble?

4.4.3.3 "It is not financially worth it"

Most of the participants agreed that the financial motivation for unit managers in a district hospital was not enough compared to what was required of them. Some complained about it, others suggested an increase. It is true that there is not enough financial remuneration in a district hospital as there is in a central or general hospital as one participant admitted, describing this in the following terms:

> *We are in a district hospital; we do not have bonuses of CFA 50 000 (Cameroon currency) like the big hospitals do, since we are in a district hospital. The ward charge in a district hospital is poor…* [Humbert, 23 September 2015].

Though they are in a district hospital, the unit managers seemed to work very hard for unequal financial motivation as it is illustrated by the excerpts below:

> *What doesn't make me happy is payment; because, when I consider all I do compared to what I receive as a ward charge bonus, it is not worth the effort* [Humbert, 23 September 2015].

> *It is true that we work a lot but there is no incentive to encourage us. I cannot hide it from you; since I was appointed as a ward charge, my salary has not changed at all. What is the use of all this? You work, they ask you to do things, but what should be given to you is not given to you* [Georges, 22 September 2015].

Some participants therefore suggested that they could be motivated with regard to their many responsibilities as follows:

> *Ward charge goes hand in hand with responsibilities and the workload. I suggest that the State should pay for those responsibilities. It is true that they give us something, but the status of nurses should be improved* [Richard, 22 September 2015].

> *And if, in addition, they could motivate ward charges, it would be interesting* [Pierre, 22 September 2015].

This finding is, in accordance with Cziraki et al.'s (2014) participants who also suggested that financial remuneration needed to be reviewed and merit-based (Cziraki et al., 2014, p.1011). Moreover, monetary gratification was one of the organisational characteristics most strongly

related to the perceived organisational support reported by nurse managers in Spence et al.'s study (Spence, Laschinger et al., 2006, p.20). Some participants said they did not work for the money:

> *Money should not be more important than your work. A ward charge should consider his job as a form of priesthood; a task done for God. A ward charge who puts money first cannot do his job properly* [Georges, 22 September 2015].

Yet these individuals have been trained as nurses to earn a living. All workers expect to have a good salary in order to take care of their families. If not, illicit drug sales could become an option in order to make ends meet.

The participants also reported that they used their own money to buy materials for the unit as we can see below:

> *When we were not yet trained on the new partogram, we had a discussion with some interns. I left the hospital with my own car and my own fuel and went to the University Hospital Centre to meet a lady who I knew who had already been trained on that equipment.. She explained it all to me and the following morning I came back with the new version* [Louis, 21 September 2015].

> *If I stress you in this way, two or three times, you will do your job because you know that if you do not, as soon as I come, I will notice and give you a call. Even though I don't have free airtime, I do it with my own money* [Alexandre, 21 September 2015].

> *… Cleaning materials, gloves, towels; I am the one buying them* [Humbert, 23 September 2015].

The participants who reported having used their own money either to help a patient or to buy some materials or airtime were all women. In Cameroon, it is not impossible to hear a woman complaining about insufficient money, while still using the little she has to satisfy her family. Sometimes, women forget about their own needs in order to provide for their children's. This is the essence of being a mother. A male participant complained about the lack of materials as well, but he did not mention that he had bought any because he wanted to see the work get done. The female participants reported making this additional sacrifice even though the financial motivation was not worth it.

The participants described what it is like to be a unit manager in a district hospital in Yaoundé. It is like being a mother of a family. However, health care organisations are not families. They have to offer a service to the population and they have to have some benefits. Are these participants just mothers, or are they managers?

4.5 Discussion of the findings

This section is about discussing the findings regarding being a manager and the need for training for unit managers.

4.5.1 About being a unit manager

The findings indicated that the unit managers viewed their roles as similar to being a mother of a family. Yet a unit in a health care organisation is not a nuclear family made up of a father, a mother and some children. It is a specific organisation, well-structured, whose aim is the patients' satisfaction. It is affected by political and economic changes, population growth, hunger and poverty, the rate of technological advances, yet most still provide a cost-effective service (Jooste, 2003, p.7). It is characterised by a fast workpace combined with an excessive workload, increased demands for efficiency, and strong requirements for quality and safe patients care (Johansson, Sandahl & Hasson, 2013, p.450). As an organisation, a district hospital is a collection of individuals brought together in a defined setting to achieve predetermined objectives (Yoder-Wise, 2011, p.117). In Cameroon, the national health system, with all its structures, aims to improve the health of the population (Ngwakongnwi et al., 2014). The role of unit managers has also evolved from a head-nurse position with responsibility for nursing staff and practice, to a management position which interfaces with educators, clinical nurse specialists, physicians and non-nursing personnel (Cziraki et al., 2014, p.1006).

"Being a mother" means being a head of a family of a woman's own children, born of her and raised by her in her own way, whereas "being a manager" means being a head of a family of adults born from other mothers and raised by other mothers in different ways. Staff are not children and are not the managers' children. They are adults who have their own families which they are head of. Moreover, they come:

...from a family with his own education, with a way of doing things that he grew up with [Richard, 22 September 2015].

A mother raises her child from the first day according to how she wants her to be. Sometimes her children have similar genetic characteristics to her and it is easy for her to correct them or to bring them back on track. Furthermore, the mother is always older than the children, whereas staff are sometimes older than the managers. The latter, appointed to a position of authority, (Cherie & Gebrekidan, 2005, p.5) have to struggle to impose respect or give direction because:

...people do what they want [Francis, 22 September 2015].

Participants viewed themselves as mothers because they thought they were nurses, but not managers. Moreover, the nursing profession started so long ago when women dressed the wounds of men who came back injured from the hunt. The first person called "nurse" was a woman. Since the nursing profession is comprised of more females than males, the managers are more likely to be females than males. In fact, they all started as nurses and view things from the point of view of their original profession (Ghalriz et al., 2008, p.9).

In fact, a unit manager is a consistent presence, uniquely positioned within the front-row of the intricacies of nurse-patient, nurse-medical doctor and nurse-interdisciplinary team dynamics (Baker, Marshburn, Crickmore & Rose, 2012, p.25). Regardless of the shortage of different resources, FLNMs have to be effective in order to meet organisational goals. They play a pivotal role in the organisation, but view themselves as mothers of families. Are they managing the unit although they are mothers? To answer this question, it is necessary to observe FLNMs' activities which correspond to nurse unit management, like planning, organising, scheduling, budgeting and controlling.

Planning is defining in advance what to do, by whom, how, when and where. It involves a choice among alternatives (Marquis & Huston, 2003, p.55) in order to reach the objective. The participants in this study reported planning nursing care every day according to the state of the patients. They also said they planned how staff should work. This shows that our "mothers" are "managers" as well.

Organising is a process of translating plans into actions. It is about relating people and things to each other in a combined and interrelated unit toward organisational objectives (Functions of administration, 2013). The participants said they organised the unit in such a way that the work was done.

Directing means giving orders, assignments and instructions that can enable the subordinate to contribute effectively and efficiently to the attainment of organisational goals (Functions of administration, 2013). This also includes supervising, leading, motivating and communicating. The participants of this study reported giving instructions even though some expressed having trouble with this. Subordinates' response to orders depended on how the message was conveyed, i.e. what tone or manner was used and the reason for the order. Naturally, a younger unit manager would need to use tact to direct older staff. The participants also reported that they passed through the ward to observe what the staff members were doing or how the work was progressing. They did not mention motivation, but they admitted giving advice instead of shouting at the staff when they did wrong.

Controlling means regulating activities in accordance with the requirements of the plans. It implies establishing standards, measuring performance, comparing the results with the standards and correcting deviations (Functions of administration, 2013). Most of the participants of this study said they had no tools by means of which to assess quality of care. One said:

> *Talking about assessing quality care; when they administer treatments, you are there… You observe him as he works because it is very important. This helps you to know if a staff is competent or not* [Humbert, 23 September 2015].

Other participants used statistics to measure whether there was any progress or not:

> *When I try to check statistics of previous years compared to this year, I notice that there is a gap. There are more admissions than before; this shows that if patients come to us, it means that there is a good follow up... Our statistics help us to see that we are not so bad; we are making an effort and we try to improve* [Alexandre, 21 September 2015].

It's just from the statistics by counting the number of patients that came in, the number of operations, how many became infected, how many got well. We don't have any other tool to evaluate the quality of care [Roger, 18 September 2015].

This shows that the participants exercised control as unit managers are supposed to do. They did not limit themselves to giving orders, but checked whether what they asked to be done had been done properly.

In a health care organisation, staffing means planning to hire and deploy qualified human resources to meet the patient safety demands and deliver quality patient care (Yoder-Wise, 2011:273). It consists of selecting, training, motivating and retaining personnel in the organisation (Functions of administration, 2013). It does not concern unit managers in these two district hospitals because the senior head manager organises the staffing of nurses for every unit. The unit managers do not have a choice but to work with whoever is sent to their unit. They are concerned with scheduling. Scheduling is part of the nurse managers' responsibilities. It is about placing appropriate staff on each shift for safe and effective patient care (Kelly-Heidenthal, 2004, p.124). Because the requirement for night, weekend and holiday work is stressful and frustrating for some nurses, managers should periodically evaluate their staff contentment with the present scheduling system (Marquis & Huston, 2003, p.295). Moreover, the nurse managers must take into consideration the availability and flexibility of qualified staff, as well as the acuity levels of the patients (Polifko-Harris, 2004, p.117). Concerning scheduling, some participants said:

I make sure that good ones work with bad ones so that, when they are doing badly, those who are doing well can correct them [Charles, 22 September 2015].

What we do is to put the staff with the highest degrees as team captains and try to balance each group [Elise, 18 September 2015].

Another participant said he used scheduling as a means of "punishing" staff who had given him a hard time during the previous month. As mothers, the participants were also involved in scheduling.

When it comes to budgeting, all the participants said they were not involved in budgeting. It is worth noting that budgeting is vital in order to meet the organisational goals in a context

where resources are limited and health care costs are escalating, (Yoder-Wise, 2011, p.245) because successful care delivery depends on resources of money, people, supplies and equipment (Polifko-Harris, 2004, p.105). When they are not consulted about the budget, it appears to be similar to our African families where the father decides the amount of money for the food without knowing the food prices. Even for the operational budget that is associated with day-to-day activity within a department, (Kelly-Heidenthal, 2004, p.150) unit managers are not involved, meanwhile they monitor the productivity of their units, decrease the input or increase the output to increase productivity (Kelly-Heidenthal, 2004, p.245). As mothers know the realities of the market, the unit managers are likely to know best what the needs are in order for the unit to function well. The unit managers should be involved in the operational budget of their units; they are able to explain and control some factors that cause variances in the budget better than anyone (Yoder-Wise, 2011). Moreover, if they work in partnership with their staff on the budget activities, innovative and cost-conscious nursing practices that can produce good outcomes for patients, nurses and the organisation could be developed.

4.5.2 About the need for formal training

Contrary to Baley's findings about hospitals' unit nurse leaders in the USA who felt that they had received ample training and were confident in their role, (Baley, 2014, p.83) all the participants reported that they had received no formal training in their role because there is no training for ward charges currently, as one can see below:

> *In our present situation there is no training for ward charges. They observe you; they propose you to the post and ask for others' opinions* [Francis, 22 September 2015].

> *I don't think that there should necessarily be training for ward charge. I have not been trained* [Alexandre, 21 September 2015].

In fact, most of the participants said that there was no need for formal training for the unit managers, especially the older participants. It is worth noting that none of them had been trained before being appointed. And, according to most of the participants, formal training for NUMs is not important. One put it as illustrated below:

There is no training when you want to become the head of a family. No one says that you should go to school [Louis, 21 September 2015].

I don't think that it is important to have training for ward charges because, in school, there are already lessons to train students on their responsibilities in their duty posts [Elise, 18 September 2015].

This can be linked to the fact that they did not view themselves as managers, but as nurses, chosen among others to rule the unit. They said that they could rely on their own basic nursing profession (Viitanen, et al., 2007, p.120) and that they could learn how to manage through trial and mistakes. Likewise, a young lady may think it is not necessary to attend "parenting courses" because of the fact that she is a female, which is enough to enable her to be a mother someday. Mothers frequently refer to the use of common sense and intuition in raising children. This can explain why so many unit managers said it was not important to have formal training for their role. The two most experienced unit managers said that the skills of a unit manager have to be developed by their own life experiences as we can see in the following statements:

You should use your knowledge and discernment to do certain things. The character of a ward charge can be developed from all that [Elise, 18 September 2015].

I don't think there should be training for ward charges. The ward charge position has to do with abilities which you develop on your own [Louis, 21 September 2015].

However, some mothers use childrearing manuals or learn from their own mothers or from their peers' experiences to bring their children up. Likewise, a few unit managers acknowledged the need for formal training for the unit managers as is stated below:

*If it happens, (*that there is a formal training*) it will not be bad; because when they surprise you, what you will do is to try; do what you know. If there was appropriate training, it would be good* [Georges, 22 September 2015].

Of course a ward charge needs to be trained, like any other thing you do in life, you need training, because we are dealing with human beings... I think it is important to train supervisors, especially in leadership training [Roger, 18 September 2015].

It is useful to have formal training. Even seminars on what a ward charge has to do [Charles, 22 September 2015].

A mother does not have to go to school because she is not accountable to an organisation. The nurse managers are accountable for work results (Cherie & Gebrekidan, 2005, p.6). As long as the unit managers viewed themselves as mothers, instead of managers, they would not be managing the unit as it was supposed to be managed. Undoubtedly, unit managers must be trained. They may feel abandoned and inadequate when dealing with issues such as fiscal responsibilities and human resources without adequate orientation and training for the role (Brown et al., 2013, p.469). Moreover, the potential for role confusion or role overload increases if nurse managers are poorly prepared for clinical and administrative management (McCallin & Frankson, 2010, p.320).

Specific education in management helps prepare the unit manager to handle the legal, fiscal, planning, directing and controlling functions, (Cipriano, 2011, p.62) moreover, this was identified in the literature as an initiative to strengthen the role of unit managers (Pegram et al., 2014, p.688). Without previous training in management, nurse managers are likely to learn through trial and error. This could have an effect on the patients' satisfaction. It is good to remind ourselves that nurses with good clinical skills are not necessarily good managers. They immediately become vulnerable if they are expected to take up a managerial role without organisational support (McCallin & Frankson, 2010, p.323).

Management matters, and, without it, nothing can happen; but leadership behaviour is essential in health care settings (Brown et al., 2013, p.465). Nurses in front-line managerial positions are in need of a combination of management and leadership training opportunities (Mintz-Binder, 2013, p.114). People want to be led, not managed, in today's health care organisations (Jooste, 2003, p.5). A nurse manager should not only be in a role of manager to ensure that the work is done correctly on a daily basis. A nurse manager should also adopt the role of leader to raise the level of expectations and help the staff reach their highest level of potential excellence (Yoder-Wise, 2011, p.47).

We hope to see nurses in a managerial position who are not just managers over employees, who command and control and who seek stability in a changing environment, who make decisions and solve problems. We hope to see nurses in a managerial position who are leaders, who have followers, who empower and inspire, who seek flexibility, who set

directions and empower staff to make their own decisions and solve their own problems (Jooste, 2003, p.27). For that to happen, nurse managers must be empowered. However, consideration must be given to such components as self-efficacy, job satisfaction, work motivation, experience of stress, perceived organisational support (Trus, Razbadauskas, Doran & Suominen., 2012, p.419). Therefore, health care organisations have to give room to nurse managers to be transformational leaders who can foster staff job satisfaction and reduce the intention of staff members to leave (Munyewende & Rispel, 2014).

4.5.3 About role ambiguity

There are two forms of role ambiguity linked to the post of unit manager. The first ambiguity occurs in the workplace and the second occurs between the workplace and the home, especially for female unit managers.

Being a FLNM was the source of role ambiguity in the workplace between the desire to remain connected to direct nursing care and the need to perform other daily tasks which remove managers from patient care duties (Baley, 2014, p.41). In this study, some participants reported being more 'bureaucrat' than nurse, as we can see below:

> *I am not happy to be a ward charge, not at all. I became a bureaucrat instead of being a technician* [Richard, 22 September 2015].

> *I am more administrative than technical, I often miss giving care. If, for three weeks, I don't administer a treatment, it is like something is missing. And the more you are in this condition, the more you may forget certain things* [Georges, 22 September, 2015].

By saying they were more administrative than technical, the participants expressed the fact that they were more involved in non-nursing care aspects of their managerial role such as statistics, meetings, form completion, monitoring expenditure, etc., yet they were trained as nurses, and were appointed because of their clinical performance. Now that they are not practising as before, the question of competence can be raised. How will they teach the staff when they are no longer competent, because they remain for long periods without practising? Their span of control seems to be broad, and they have to juggle the need to be a nurse and the need to be a manager. The patient outcomes can sometimes be jeopardised because of this

role conflict. The future of the profession can be also in danger for FLNMs are supposed to train the junior nurses. It is not the only conflict in the role.

The other role ambiguity is related to being a unit manager at work and being a wife at home. In the first setting, the female managers give orders. In the second one, they receive orders. They have to satisfy their employer and their family. Our African context where a wife has to cook and take care of the children even though she is working makes things even harder. These requirements can lead to burn-out and ill health of the unit managers who are a vulnerable group. Without good health, they cannot perform their duties and this can affect the quality of care and health of staff nurses as well (Johansson et al., 2013, p.451).

4.6 Feedback from the participants

To ensure trustworthiness of the data analysis, researchers must return to each participant and ask whether the exhaustive description reflects their experience (Speziale & Carpenter, 2007, p.97). However, this is a venerated, but not always executed practice in qualitative inquiries (Miles & Huberman, 1994, p.275). If the trustworthiness of the study is established when the findings are recognised to be true by the participants, (Speziale & Carpenter, 2007, p.97) there are some possible reasons why participants might reject the interpretations of the researcher: they might not be familiar with the description, they might not understand it, they might think the report is biaised; the description might conflict with their basic values, beliefs or self-images, it might threaten the informant's self-interest. Moreover, it could change participants' perspectives (Miles & Huberman, 1994, p.275). However, if elements are noted to be unclear or misinterpreted, the researcher must revise the desciption (Speziale & Carpenter, 2007, p.97).

In this study, we planned not to count on participants' feedback because, with the intent of validation as required by Colaizzi's method, certain essences found, might not be recognised by the participants since these would be the outcome of a journey from raw data to essential structures "*through a time consuming, painstaking procedure*" (Giorgi, 2008, p.6). The researcher held the opinion that, although the participants described their experiences from a perspective of everyday life, the analysis would be performed from the phenomenological perspective. Moreover, since the purpose of the research is not "only" to clarify the FLNMs' lived experience, but to add to the knowledge of the discipline, (Giorgi, 2008, p.6) some expertise is required from the scholars in order to understand the results. Finally, after sharing

with a phenomenologist from UKZN, the researcher had to go back to the participants to validate the description. Since she was in South Africa, she had to call the participants and ask them if they recognised themselves in the description.

The researcher called back the participants and they all agreed to attempt to recognise themselves in the data compiled after analysis as follows:

Yeah, I recognise myself in all that you said [Louis, 18 November 2015].

It is as you said [Humbert, 18 November 2015].

However, some participants said being a "ward charge" is not just "being a mother".

Being a mother is part of being a ward charge. It is having a maternal heart to handle situations [Georges, 18 November 2015].

We have said being a mother because it makes you handle situations as if you were at home [Alexandre, 18 November 2015].

These answers led the researcher to return to the raw data to check that she had not missed a part during the analysis. The researcher discovered that some particpants also identifed themselves as a boss. The following statements depict this:

I am a peaceable person. I am not the kind of boss who always gives orders, or imposes things [Alexandre, 21 September 2015].

You should not put in your mind that you are the boss, therefore all you say will be true; if not the unit will not work... You were appointed boss simply to lead your flock [Richard, 22 September 2015].

It is not a bad thing to be a boss. It makes others respect you [Georges, 22 September 2015].

Now the question the researcher asked herself was: How can the participants differentiate between being a boss and being a mother? This question highlighted the issue of the role of clarity to ensure and secure an understanding of the role of the unit manager (Pegram et al., 2014, p.694). When you know you have to be strict enough, but you cannot be that strict because you put yourself in the place of your staff; it can be very embarassing. Moreover,

when you are appointed chief but you do not have the authority of a chief, it can be very stressful.

Some participants primarily said that there was no need for unit manager training. They finally changed their perspectives and acknowledged the need for educational support in order to help them manage the unit as we can see below:

> *If there could be a policy that includes training for unit managers in terms of the management of human resources, it would be a good thing* [Louis, 18 November].

> *I think some training in leadership and management would really help us* [Humbert, 18 November 2015].

4.7 Conclusion

This fourth chapter was essentially about reporting the findings of the study related to the unit managers' lived experiences in two district hospitals in Yaoundé, Cameroon. The aim was to describe what is like to be a FLNM in a health care organisation characterised by its limited resources. The findings showed that the participants viewed themselves as "being a mother of a family". Therefore, they had to help, provide for, teach, plan, control and correct both patients and staff on a daily basis. They also acknowledged that it was not easy to be a mother of a family where the children seemed to be adopted and not legitimate. In this regard, they admitted that they needed specific characteristics and assistance from others to help them face difficulties and make sacrifices for the good functioning of the unit. Furthermore, based on the poor financial motivation they received, compared to the amount of responsibilities they embraced, it did not seem worth the trouble to be a unit manager.

The following chapter will summarise these findings and display some recommendations for the nursing profession.

CHAPTER 5: SUMMARY OF THE FINDINGS, REFLEXIVITY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter summarises the main findings of this research related to the lived experiences of unit managers in two district hospitals in Yaoundé, Cameroun. Next, the researcher will disclose how she has been feeling throughout the research process. Based on the findings and her reflexivity, the researcher will make some suggestions for the nursing profession. Finally, she will explain how her work could have been improved on.

5.2 Summary of the findings

This section deals with a summary of the findings of this inquiry related to the unit managers' lived experiences in two district hospitals in Yaoundé, Cameroon. At this point, we are answering the questions of this inquiry, the aim of which was to describe the FLNMs' lived experiences in two district hospitals in Yaoundé, Cameroon.

5.2.1 What is it like to be a unit manager in the district hospitals in Yaoundé?

According to the participants in this study, being a unit manager is like "being a mother of a family". It means taking care of a family comprised of staff nurses. It entails providing for whatever the staff members need to work properly, and what patients need during their stay in the hospital. It also means planning which activities must be carried out, by whom, where and how. It means controlling whether what has been planned has been done well, whether everything is going well in the unit, whether the patients have paid their fees, etc. Furthermore, it means correcting when what has been planned was not done properly. Finally, it means teaching how things must be done. Even if these activities correspond to "mother activities", the findings revealed that these participants perform daily activities related to nursing unit management such as planning, organising, controlling and correcting. Unfortunately they are not involved in the budgeting activities, in a context where there is no medical aid for most of the patients who are financially limited.

It is worth noting that the most experienced and the least experienced in a managerial position both recognised themselves as mothers of families. The female and male unit managers also viewed themselves as mothers. This perception of their role depended on their years of

experience in the role. No matter how many years they had spent in a managerial position, all of the participants faced the same difficulties.

5.2.2 What are the challenges/difficulties that unit managers face in the settings?

The findings indicated that the unit managers faced difficulties related to the patients. Firstly, they are financially limited and this does not allow unit managers to work properly. Some participants reported that the patients do not see the critical difference the nurses make by managing the patients' care and the patients' families. They are not grateful enough and this does not encourage these nurse managers.

The unit managers reported that they faced difficulties when giving instructions to the staff. Since the staff members are not children, nor their own children, the staff did not listen to instructions, or were lazy to do the work they were paid for. Moreover, staff were involved in illegal drug sales, which are forbidden. The low salaries can explain this, but cannot justify it. The unit managers had to call on their consciences and give them advice at any time.

The findings showed that the premises of these two district hospitals were tiny. Unit managers complained about the lack of office space which could alter their confidentiality and their work. They also complained about the fact that materials were not sufficient, they did not receive enough support from the organisation, nor any training related to leadership or management.

Finally, the participants said the financial motivation was not worth the trouble. Compared to all the sacrifices they had to make concerning their families and the workload, what they received as remuneration was not enough. Moreover, they needed assistance from others in order to play their dual role, especially in the cases of those who had a family.

5.2.3 What are the suggestions to improve the work of unit managers in these units?

The unit managers suggested ameliorating their financial motivation, even though one participant acknowledged that, even if they had all the money in the world, they would not be satisfied. They also talked about the need for training, especially in human resources management and in leadership. They also asked for a proper office which could be considered as a home for them.

5.3 Reflexivity

Reflexivity is about the relationship between the researcher and the social world. It suggests that "*there is no prospect of the social researcher achieving an entirely objective position from which to study the social world*" (Denscombe, 2007, p.333). It is about the researcher being aware, developing an "*acute self-awareness*" (Balls, 2009, p.32) and exposing her personal biases and assumptions related to the process of the research (le May & Holmes, 2012).

Reflexivity is especially relevant in nursing research because often, the researcher is also a nurse. In such circumstances, the researcher needs to think carefully - to reflect on the impact that being a member of the same professional group as the study participants may have on all aspects of the research process, especially the interpretation of research findings (Gerrish & Lacey, 2006, p.420). Moreover, in most qualitative research studies, the researchers work alone in the field. Each is a one-person research machine who defines the problem, does the sampling, designs the instruments, collects information, reduces it, analyses it, interprets it and writes it (Miles & Huberman, 1994, p.262).

Futhermore, qualitative research is all about dealing with people while being a person as well. Therefore, the subjectivities of the researcher, and of those being studied, are part of the research process. The qualitative researcher is part of the study and is, in fact, the research instrument (Erlingsson & Brysiewicz, 2013, p.94; Speziale & Carpenter, 2007, p.94). Therefore, researchers' reflexions on their actions and observations in the field, their impressions, irritations, feelings and so on, become data in their own right, forming part of the interpretation and should be documented in research diaries (Flick, 1998, p.6).

Reflexivity is, however, important for three reasons. Firstly, it acts as a form of self-monitoring, so that you can spot something going wrong and correct it. It is a form of data analysis in one way in which you find your way through the material towards the underlying model that simplifies and makes sense of what is going on. Finally, it is a basis of your self-justification in the eventual report, your way of showing that others should believe that your interpretations are reasonable ones (Abbott & Sapsford, 2002, p.150). However, there is a critical danger of engaging researcher reflexivity: the risk of being pulled in directions which privilege the researcher over the participant (Finlay, 2009, p.12). What if, for example, during the interview, one is more focused on how to put aside one's preconceptions than on what the

participant is saying? In the following point, the researcher will focus on herself during the different stages of the research process.

5.3.1 The proposal phase

After having met with my supervisor for the first time, I was quite excited to start the research process. I did not know what I wanted to do but I knew I would conduct a qualitative project. I listened to the ideas my supervisor gave to me and I started shaping a topic. I came across many topics that I dropped after a while. Finally, my supervisor proposed to me that I replicate her PhD study in Cameroon since it was part of her recommendations. I started working on it but I lost interest in it after a while. My supervisor told me not to feel bad because it is sometimes like that when someone starts a research project. She said we would wait until I found an interesting topic before we started. Now I understand why the topic has to interest the researcher: when it is hard, the researcher will still hang onto the topic.

I was so discouraged because I was no longer enthusiastic. One day, I was in the Research Commons and one of my classmates told me she had been appointed unit manager in a district hospital. My heart beat and I knew then that I would deal with unit managers. In Cameroon there is no formal training for nurse managers and I thought of exploring how those who are newly appointed cope with their responsibilities. As a nurse, I have seen unit managers during internships but I had no clue of what it was like to be in a managerial position. I dug a little bit into the literature to learn more about it.

5.3.2 The literature review

As I had a desire to know how NUMs manage their unit in a limited-resources hospital, because I felt for my friend who was newly appointed, I started reading everything I found related to FLNMs. I discovered that these managers are supposed to do a lot of things: planning, organising, directing and controlling.

I was confused and afraid, however, when I read that I should not engage deeply with the literature review due to the concept of bracketing. For me it did not make sense, because, what someone knows, even if she jots it down, will not change the fact that she knows and this can affect the data collection and analysis process.

I kept on reading, but focused more on the methodology.

5.3.3 The methodology

The first book my supervisor asked me to read was Crotty's (1998) book about the foundations of social research. It was quite difficult for me, but even more so when I came across the philosophy underpinning the research. First, I am a French-speaking person and the English words I saw for the first time just scared me. I had to carry the book with me everywhere I went in order to get the point of this philosophy. I asked myself what philosophy has to do with nursing. I was so confused about the link with the epistemology, the paradigm, the methodology and the method that I wrote an email (see Appendix 10) to Prof. Petra when I saw her address on the article I had read. Finally, when I understood the necessity of a philosophy underpinning any research, I said to my supervisor:

> *We have not yet started doing nursing research in Cameroon.* [The researcher, March 2015].

Primarily, I did not intend to use phenomenology, but I found myself taking the flight from nowhere to phenomenology. I read that there are different types of phenomenology and I had to understand the differences before engaging myself in any one way. I finally chose descriptive Husserlian phenomenology because I thought it was a good start for me in the field of nursing research. I learned a lot and my proposal was full of footnotes because I wanted to explain to everyone what I had understood; my supervisor deleted them. It was just a theoretical part of the journey.

Next came the practical part, the data collection. I had trouble getting the HSSREC's full approval for some reasons I did not understand. This stressed me because I was worried about running out of time. I knew that data analysis is a time-consuming task but I did not know it was not that easy to collect data. I arrived in the first hospital and introduced myself: everyone seemed to be interested but asked me to come back another day. I was frustrated. I had thought they would unfold a red carpet and welcome me warmly, but I was wrong. I needed to captivate them without obliging them to take part in the study.

I started the interviews and sometimes these took place in difficult situations. For the first one, I had to stand because there was no place to sit. Under those conditions I wanted the interview to end quickly, but I had to wait until its end for the data analysis' sake. Sometimes, curious people were listening to us and I felt concerned about the lack of privacy. Moreover, I asked

myself if I had the ability to communicate and to allow the participants to communicate easily as well. It is true, the interviews were mostly in French, but being in front of a 35-year-old nurse manager and trying to "steal" her experiences was a daunting task, especially when the answers were so short that they almost seemed to say "*do not ask the next question*". I tried my best because I was aware of needing to acquire the most useful data for the study.

I came back to South Africa to analyse the data. It would have been easier if I had been in the same place as my supervisor, because I could have phoned her at any time and asked her what to do during some hectic times. It is true, I learned from my mistakes and I now know what to do even if my supervisor is not around: wait until I get in touch with her.

5.3.4 The report of findings

After collecting data, the researcher had to analyse these in order to give an exhaustive description of the phenomenon under investigation, the lived experiences of FLNMs in two district hospital in Yaoundé, Cameroon. The data had to be transcribed in order for the researcher to be immersed in them. This long and difficult process took weeks. In the beginning, the researcher thought that she could transcribe the interviews immediately once she had finished interviewing. She even planned to return the transcripts to the participants the following day. My supervisor advised me not to do so, but I did not really believe what she said until I spent nine hours on the first interview of about 30 minutes without finishing it. I was nervous and was tempted to delete a part of some interviews to shorten the process. I wondered how the readers could make sure that the researcher had transcribed the interviews faithfully. Honestly, I transcribed all the interviews because not doing so could play against me during the analysis phase. What if I deleted the most important part of the data? When I had all of the transcripts, I said to my supervisor:

> *Well, I have collected the data but I do not know what to do with them*. [The researcher, 10 October 2015].

She laughed at me and replied:

> *That is exactly the same feeling I had when I was doing my PhD* [Dr. Jane Kerr, 10 October 2015].

It was not nice to hear this from a supervisor, but I realised that I was not the only one going through this "*I don't know what to do*" part of the research process. Even supervisors experienced this. I had to move forward.

As Miles and Huberman (1994, p.91) said, comparing several extended texts carefully was very difficult for me. First, I had to extract the significant statements by asking myself how I could extract those that focused sufficiently to permit a viewing of a full data set in the same location to answer the research questions at hand. Initally, I thought every single phrase was important. I found myself with more than 220 significant statements from which I needed to formulate meanings. I considered repetions and rephrasings. As I was going through the statements, I realised that so many needed to be dropped because they expressed the same participant's point of view just using different words. Again, what if I deleted the most significant statements? I had to go through the original transcripts to double-check.

After many days, I obtained the extracted statements which I considered significant. I needed to formulate meanings. This step was as difficult as the previous one had been because I was supposed to describe the phenomenon and not to interpret. "*What is the difference between describing and interpreting?*" occurred to me. For me, describing is the first level of interpretation and depends on the researcher's background. After sharing with a lecturer at UKZN, I realised how superficial my thoughts were. Naturally I am not a "thinking person" but a "feeling person" who does things when she feels like doing so and thinks about them afterwards. I had to learn how to think, to see what was behind the words. Again, I asked myself: "*Have I captured the reality of the participants' statements or have I formulated them according to my experience?*" In my case, dealing with the mothering part was a little emotional for me, because I had memories of a mother who had beaten me seriously sometimes. In fact, I had been a stubborn child, full of energy that I could not control. My mother had had to use the stick "and the stick" to put me on the right track every time I did something wrong. I easily captured the correcting part of being a mother as described by the participants. It took a discussion with my supervisor and her supervisor to open my eyes to the caring and nurturing part of being a mother. This was transformational with regard to the data, but I could not see it at first.

Next I had to report on the findings: a different story. I needed to display the data in an organised way. They had to flow from top to bottom. I was confronted by the issue of

bracketing; I read that a consistent use of a method prior to knowledge helps to ensure a pure description of the phenomenon at hand (Speziale & Carpenter, 2007, p.97). I asked myself so many questions: *"How can I assume not to know something I know in order to perceive a phenomenon? How will I know I have bracketed sufficiently? How must I deal with all I had read before, since phenomenology was not my primary intention?"* It did not make sense to me and deterred me because I was struggling to stick to the data meanwhile I needed to identify in the data what it is like to be a unit manager. The word "like" is about comparing something to another thing; this other thing was what I already knew. To be honest, I do not know if I have bracketed sufficiently during this data analysis. Moreover, I am not sure other researchers bracket sufficiently as well: it is not possible to bracket fully, according to me. I might be wrong, but bracketing can never be totally achieved, even though researchers strive to bracket in an effort to confront the data in pure form (Polit & Beck, 2012, p.495). After all, it is up to the researcher to commit to the issue of bracketing and to decide how much influence this can exert on the researcher throughout the research process (Chan et al., 2013, p.7). Subjectivity is inevitably implicated in research. To what extent and how should researcher subjectivity be marshalled in phenomenological research? (Finlay, 2009, pp.11-12).

Concerning the feedback from participants, the researcher did not primarily intend to go back to the interviewers for validation. This was because she thought it was unimportant. Moreover, the data analysis is a long process that can lead to something the participants will not recognise. After talking with her supervisor and a senior researcher, she went back to the informants with her findings. She was quite happy to find that the participants recognised themselves in the description of the phenomenon: she had made some reasonable conclusions "*that can be found out there somewhere*" (Miles & Huberman, 1994, p.262). Furthermore, these added up to something she did not see as important. The participants were happy to hear from her, however, one participant thought her report was bad and asked the researcher:

> *Why are you calling me back? Is it because what I said was wrong, or what?* [Alexandre, 18 November].

Now I understand the need to go back to the participants for validation. My findings could have been wrong or blurred and the participants could put me on the right track. I think all researchers should be encouraged to get feedback from their informants.

5.3.5 My own influence on the research process

Bias is an avoidable part of the process of coming to know something (Eliott & Timulak, 2005, p.148). When the researcher is the only instrument used from the shaping of the topic to the reporting of the findings, some bias occurs. The fact that I am a nurse wanting to do research in the nursing field was the first bias.

> *I know about ward charges. I have seen them during my internships so it will not be difficult to come to know what it is like to be a unit manager. The problem is that I have to put all that I know out of my head in order to study this phenomenon with fresh eyes. How? This issue of bracketing does not make sense to me, but I will try my best to put in abeyance my thoughts during the data collection* [The researcher's thoughts, September 2015].

I was thinking like that when I was sitting in a corridor, waiting for a unit manager to make appointments with her. I saw her rushing into one patients' room while talking to a nurse, shouting at a student and jotting something down.

> *What she will say to me will not be that different* [The researcher, 16 September 2015].

I was wrong. It is true that the participant I was referring to above was the last to be interviewed, but what she said to me was different from what I had expected. Firstly, she spoke in English and it seemed that she had some knowledge of leadership and management.

Unlike her, most of the participants were influenced by the fact that I had come from another country. They questioned me about it immediately after I had introduced myself. I was a little ashamed. During some interviews, I lost my French and had to breathe in and out to find my senses. This sentence: "*I come from the University of KwaZulu-Natal*" has influenced the participants during the interview. I saw it from the first interview.

> *Where is the University of Kwa…* (Some participants did not even know how to pronounce it) they asked.

> *It is in South Africa*, I replied.

Why did you go there to do a Master's degree when we have a master's program here in Cameroon? It means your parents have a lot of money to waste… [Humbert, 23 September 2015].

It was not nice to hear such words and sometimes I wanted to go and not come back, but I was there for a purpose and I needed to stay focused. After this first step, I had to take the second one: bracketing. I kept asking myself if I was really bracketing. During the four interviews, I thought as follows:

I am not sure I am bracketing right now because the question I am asking this participant is one of the answers the previous participant gave to me. It is not part of my interview guide. After all, it is just a guide and not a rule [The researcher's thoughts, September 2015].

It was very hard for me to ensure I was bracketing. I was haunted by this idea. Another influence occurred during the data analysis where the researcher was pulled into interpretation instead of sticking to the description of the data. She experienced this dilemma throughout the data analysis process and kept asking herself where the boundary between the two concepts, of description and interpretation lay.

Before I got there, I was concerned about my influence during the transcription process. I asked myself:

How can someone ensure that she has transcribed the interviews faithfully? I am tired of listening to something that is no longer interesting, but I have to capture all that has been said in order to facilitate the data analysis process. [The researcher's thoughts, September 2015].

I know that I transcribed the interviews faithfully. It took me days, but I did it. I also checked the translation in English to make sure it was accurate. I kept saying to myself:

I wish I could write in French [The researcher's thoughts, September 2015].

Later on my supervisor asked me to write in French and translate this into English because she saw how I was struggling to express what I meant. It was helpful. For the last three months, I slept with the data, ate with them, did everything with them. I was so used to the

data that, at certain times, I could recite part of an interview, especially when it was interesting. I do not know how long the participants' words will sound in my head, but they have been part of my life and are still there somewhere.

Overall, I can say that this journey was painful but exciting, especially when I reached a junction and did not know which way to turn to. Thanks to my supervisor, I found my way whenever I was lost and asked for her help. A novice researcher cannot do without a supervisor. The meetings, the fact that she pushed me hard, that she encouraged me to think deeper, the discussions, the "go and read about this", the "Well done, I am proud of you", the "You are doing a master's degree by research and not coursework" were very helpful to me. Having a supervisor who always gave me quick feedback was the most important thing I valued throughout this process because, whenever I was lost, this did not last for long since she always replied immediately to my emails.

5.3.6 *After doing phenomenology*

After doing this descriptive phenomenological research, I feel good about qualitative research. As I have always said, if you want to understand the correlation between phenomenon A and phenomenon B, quantitative research is most suitable, but how will you know phenomenon A and phenomenon B exist if someone has not yet described or explored them through qualitative research?

I heard about phenomenology when I was doing my previous studies in Nursing in Cameroon and I thought it was the easiest qualitative method ever. Now, after struggling with it, I can say doing phenomenology is not an easy task, (Holloway & Wheeler, 2010, p.225) but it is worth the trouble. At the end of the study, someone definitely finds something interesting which can be tested further on.

To be honest, this study could have been better if an interpretive phenomenological approach had been used instead of a descriptive one. For sure, significance would have been attached to the data, sense would have been made of the findings, explanations would have been offered and conclusions would have been drawn (Patton, 2015).

The findings of this study related to the unit managers are about being a mother. It has shown me what a mother can do for her children, apart from correcting them with the stick. My

mother also did so much for me, but I have memories of being beaten more often than being congratulated. It is true that it is now no longer the same. Our relationship is much better than in the past. We can talk about anything; my mother gives me advice and the support I need for my study.

Moreover, as a future mother, this study has taught me what I must do when I have my children. It is true that there is no school where ladies can be trained as mothers, but this research has started training me as a mother. It has also erased the fear I had concerning being a mother. Now I know that it is a matter of pride, it is not easy, but it is all about caring. I will have to face difficulties and to make sacrifices but it will be worth the trouble.

5.4 Recommendations

The findings of this study can enable the formulation of the following recommendations to the following people:

5.4.1 FLNMs

Based on the findings of this research, recommendations are made as follows:

- Because taking on a leadership role by itself is not enough to ensure effectiveness, unit managers should know about leadership and be able to apply the skills in all aspects of work.
- It is imperative for unit managers to have time to communicate face-to-face with nurses. By doing so, they will be aware of nurses' work. This will ensure the development and the sustainability of a healthy workplace environment and good relationships between the unit manager and staff.

5.4.2 Health care organisations

Because ineffective unit managers harm the staff, the patients and the organisation, health care organisations should:

- be committed to dedicating sufficient fiscal and human resources to ensure adequate training and support to nurse managers;

- have funding and flexible scheduling for unit managers to attend education programs that will promote the development of required skills;

- assign a mentor to unit managers who is knowledgeable about available resources and can assist the managers in their role;

- strenghten the role of unit managers by implementing an end-of-shift report schedule. This is a report that can identify management issues that have the potential to cause frustrations at ward level;

- allow the unit managers to have better access to all available resources in the hospital and to provide for the resources on time whenever the managers place an order;

- attract front-line staff nurses into leadership positions by creating and fostering an environment that supports nurse managers;

- increase the financial motivation of unit managers though the financial resources are not enough in such settings;

- allow unit managers to manage the unit-level budget because budgeting is vital to meet the organisation goals in a context where resources are limited and health care costs are escalating;

- clarify the role of unit managers by giving them a written job description when they are appointed because of the possible role confusion and the possible negative impact on patient outcomes; and

- allow nurse managers freedom to be transformational leaders who can foster the job satisfaction of staff and reduce their intention to leave because people want to be led, not managed in today's health care organisations.

5.4.3 Researchers

Because very little or nothing has been said about nursing management in Cameroon, researchers are encouraged to:

- Explore the nurse managers' intentions to stay or leave within the different levels of the Cameroonian health care system;

- Conduct studies related to nurse managers' perceived work environment especially, as well as how nurses perceive their work environment;

- Describe how senior head nurses manage a whole hospital;

- Explore the front line nurse managers' lived experiences using other methods such as hermeneutic phenomenological research or the use of diaries;
- Replicate the same study in different towns, especially in district hospitals where there are not enough resources, such as the Far-north and the Eastern regions; and
- Conduct the same study similar health care settings in South Africa and compare the findings with those of this study.

5.4.4 Cameroonian government

Because the nursing profession is the backbone of the health care system due to its population figures and its span of influence across the clinical spectrum, (Yoder-Wise, 2011, p.4) the Cameroonian government should:

- Revise the salary of all categories of health professionals generally and those of nurses especially;
- Encourage nurses to stay in Cameroon by developing good retention strategies and policies. The problem of nursing shortages might not be due to the small number of nurses who are trained, but could be due to the number of nurses who are not employed or who leave their jobs;
- Fight against illegal drug sales by imposing sanctions against the personnel who practice it; and
- Strengthen nursing education in the country by regulating the training centres for nurses.

5.5 Limitations of the study

As no work by human hands is perfect, this descriptive phenomenological inquiry could have been better without the following limitations:

Firstly, this project could have been better if it had been written in French. I am a French-speaking person who studied for all my previous degrees in French. It is true, Cameroon is bilingual, but I was not fluent in English before I arrived in South Africa. I had to read, listen, understand and write in English. It was worse because I did not attend any lectures to assist me to become accustomed to English quickly. Finally, I wrote the thesis alone and my

supervisor helped me correct the language gap, yet, my thoughts could have been expressed better in French. Thanks to the editing of this paper (see Appendix 12), the worst has been avoided.

Another limitation was the fact that I was a novice researcher. This was my first experience with qualitative research, especially a descriptive Husserlian phenomenological inquiry using Colaizzi's method of qualitative data analysis. I had to read a lot and understand the point of conducting a descriptive phenomenological research study. Practically, it was not that easy. I made mistakes that had to be remedied later. For example, I did not really consider that I was supposed to follow letter by letter what I had set out in my proposal. I ended up requesting an amendment of the proposal when my supervisor discovered I had not respected the eligibility criteria. However, this added something to the data in terms of saturation.

Being a nurse interviewing nurses was another limitation. As a nurse, some participants' answers were obvious and I did not engage deeply with the investigation. For example, one participant said "I do the staff roster". A non-nurse researcher might have asked how, but since I knew what was meant by doing the staff roster, I did not ask further. Moreover, being a nurse enrolled in a Master's program in Nursing in another country might have influenced the participants. Once I introduced myself, what I do and where I came from, their attitudes changed from normal to the extent of awe. They may have been frustrated or amazed, because most of them asked me why I was doing a Master's of Nursing degree in South Africa when there is a Master's program at one university in Cameroon.

The study did not include settings where people are poorer than those living in Yaoundé, the capital. There, patients might be going to a district hospital and quite a number of staff might be employed. Therefore, the unit managers might have different experiences of those expressed by the participants living in the capital of the country where some facilities are present or not than in the other regions.

The last limitation is the fact that this study aimed to describe the day-to-day practice of FLNMs instead of interpreting what is like to be a unit manager. The phenomenon under investigation could have been explained in more detail. Describing, in Bernard's (1988) terms, means "*making complicated things understandable by reducing them to their component parts*". The issue is making a clear accounting of the phenomenon at hand (Miles & Huberman, 1994, p.90). Explaining or interpreting, however, means "*making complicated*

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things understandable by showing how their component parts fit together according to some rules", as suggested by Bernard (1988), cited in Miles & Huberman (1994, p.90). Naturally, there is no clear boundary between describing and explaining; the researcher typically moves through a series of analysis episodes that condense more and more data into a more and more coherent understanding of what, how and why (Miles & Huberman, 1994, p.91). However, to describe is to interpret without penetrating as deeply as when interpreting.

5.6 Conclusion

At the end of this descriptive phenomenological inquiry about the FLNMs' lived experiences in two district hospitals in Yaoundé, Cameroon, one could say that it has not been easy, but one undertook and saw it through, in this case, both the supervisor and the researcher. At the beginning of the inquiry, we did not know what is like to be a unit manager in a district hospital in Yaoundé. Now we can say it is like "being a mother of a family" as well as being a "boss". It does not depend on the years of experience in the role. Since the participants were not trained before being appointed as nurse managers, they learned though trials and mistakes, which could compromise the future of the nursing profession in a challenging setting like a district hospital. Therefore, specific skills in management and leadership are required in order to produce effective and efficient managers. It would have been better if the participants of the study were from different settings in different towns. Furthermore, more could be said if the researcher was not a novice. After all, this study has revealed the need of support from the organisation to strength the role of unit managers.

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Appendix 1: Interview guide

Please could you describe one of your typical working days for me?

What have your experiences as a front-line nurse manager in this unit been like? (Could you tell me about your experiences as an FLNM in this unit?)

Please could you describe an event which needed the support of the health organisation?

What are your priorities and concerns as a nurse unit manager?

What do you think should change in the unit or/and the hospital in order for you to improve your management skills?

What resources are available in the hospital to assist you in the management of the unit?

What specific tools, materials and/or programs could be developed, according to you, to improve the work environment of first-line nurse managers in Cameroon?

How do you ensure quality nursing care with all the responsibilities you embrace?

How do you usually deal with the staff's concerns?

How do you handle the conflict between staff or team?

Please could you tell me what positive or negative impact your work has had on your life?

What difficulties do you usually face while managing the unit?

What about the management of material resources (stocks, supplies, equipment)?

How do you assess staff's quality care?

What about the financial management within the unit?

What else would you like to share?

Appendix 2: Approval for the amendment of the proposal

UNIVERSITY OF KWAZULU-NATAL™

INYUVESI YAKWAZULU-NATALI

19 November 2015

Ms EL Wanko Keutchafo 214584622
School of Nursing and Public Health
Howard College Campus

Dear Ms Keutchafo

Protocol reference number: HSS/1047/015M
Project title: An investigation into first-line nurse managers' experiences in two district hospitals in Yaoundé, Cameroon: A descriptive phenomenological study

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 09 November 2015 has now been approved as follows:

- Change in Research Methodology

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

....
Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Dr Jane Kerr
cc Academic leader Research: Professor M Mars
cc School administrator: Ms Caroline Dhanraj

Appendix 3: UKZN HRSSREC full approval

UNIVERSITY OF ™
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

10 September 2015

Ms EL Wanko Keutchafo 214584622
School of Nursing and Public Health
Howard College Campus

Dear Ms Keutchafo

Protocol reference number: HSS/1047/015M
Project title: An investigation into first-line nurse managers' experiences in two district hospitals in Yaoundé, Cameroon: A descriptive phenomenological study

Full Approval – Expedited Application

In response to your application received on 4 August 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....
Prof Urmilla Bob
University Dean of Research
On behalf of Dr Shenuka Singh (Chair)

/pm

Cc Supervisor: Dr Jane Kerr
Cc Academic Leader Research: Prof M Mars
Cc School Administrator: Mrs Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
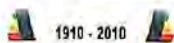Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

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Appendix 4: Permission to conduct research, hospital 1

REPUBLIQUE DU CAMEROUN
****
Paix – Travail – Patrie
****
MINISTERE DE LA SANTE PUBLIQUE
****
DELEGATION REGIONALE DU CENTRE
******
DISTRICT DE SANTE DE ███████
****
HOPITAL DE DISTRICT DE ████
****

B.P. : ████████ssa-Yaoundé
Tél. : ████████████

N° 0 ███ 2 6 ███/Minsanté/DRC/████████

HD
MINSANTE

REPUBLIC OF CAMEROON
****
Peace – Work – Fatherland
****
MINISTRY OF PUBLIC HEALTH
****
REGIONAL CENTER DELEGATION
****
████████ HEALTH DISTRICT
****
████████ DISTRICT HOPISTAL
****

Yaoundé le, 1 5 JUIL 2015

Le Directeur

A

Madame WANKO KEUTCHAFO E. L.

Objet : *Demande d'autorisation de recherche.*

Madame,

J'accuse réception de votre courrier du 11 juillet 2015 dont l'objet est repris en marge. Par cette réponse, je voudrais vous faire connaître que je marque mon avis favorable pour cet accès.

Aussi, seriez-vous obligés de respecter le règlement de notre structure pendant la période de votre recherche.

Veuillez croire, Madame, en l'assurance de ma parfaite considération.

Le Directeur

Dr. ████████████████
Pathologiste
Directeur HD ████████

Appendix 5: Permission to conduct research, hospital 2

REPUBLIQUE DU CAMEROUN

Paix –Travail – Patrie

MINISTERE DE LA SANTE PUBLIQUE

DELEGATION REGIONALE DU CENTRE

DISTRICT DE SANTE DE ▮▮▮▮

HOPITAL DE DISTRICT DE ▮▮▮▮

▮▮▮▮▮▮▮▮▮▮

REPUBLIC OF CAMEROON

Peace-Work-Fatherland

MINISTRY OF PUBLIC HEALTH

CENTER REGIONAL DELEGATION

▮▮▮▮ HEALTH DISTRICT

▮▮▮▮ DISTRICT HOSPITAL

E-mail ▮▮▮▮

N° ▮▮ /L/MINSANTE/DRSPC/▮▮▮▮

Yaoundé, le ▮▮

LE DIRECTEUR DE L'HOPITAL
DE DISTRICT DE ▮▮▮▮

A

MADAME WANKO KEUTCHAFO ESTHER LYDIE
ETUDIANTE A L'UNIVERSITE DE KWA-ZULU

Objet : Votre autorisation de recherche

Madame,

Nous vous informons que votre demande d'autorisation de recherche en vue d'interviewer les majors de service volontaires et qui répondent aux critères d'inclusion et d'exclusion sous le thème : « Expérience des majors de service dans deux hôpitaux de district a Yaoundé, au Cameroun : une recherche phénoménologique descriptive » a obtenu un avis favorable.

Vous prendrez attache avec la Surveillante générale dès votre arrivée pour amples informations dans la mise en œuvre de votre travail de recherche.

Veuillez agréer madame, l'expression de nos salutations distinguées.

Le Directeur

Appendix 6: Information letter in English

Title of the study: An investigation into first-line nurse managers' lived experiences in two district hospitals in Yaoundé, Cameroon: a descriptive phenomenological inquiry.

Supervisor: Dr. Jane Kerr, Bachelor of Nursing Coordinator, University of KwaZulu-Natal.

Dear Research Participant,

I am a student at the University of KwaZulu-Natal, involved in a Master's study required for the fulfilment of the program. The research project that I am conducting is in respect of the title mentioned above. The main purpose of this study is to describe the first-line nurse managers' lived experiences in a district hospital unit. Therefore, the relevant information gathered from the interview with you will provide a broader understanding on how first-line nurse managers manage a unit in a district hospital in Yaoundé. The recording tools that will be used to collect the information will be a computer voice recorder. The interview will last less than one hour. The recording will be transcribed into text and given to you to verify and/or to correct.

Please note that the information you give is strictly confidential and will be used for writing the research dissertation to meet the requirements of degree. All names of persons and organisations will be submitted with pseudonyms to protect both the person's confidentiality and anonymity. Your participation is voluntary and you are free to withdraw from the study at any stage and for any reason. Refusal to answer questions or withdrawal from this research project will in no way result in any form of discrimination or disadvantage. All the data that will be collected will be used for my dissertation and possible publication in an academic journal. You will not be obligated to answer questions that you feel uncomfortable with or which you are unwilling to respond to, due to personal reasons. There will be no risk attached to your participation in this study. Please feel free to ask any questions you may wish to ask. My contact number is 672 311 611.

Thank you for your participation.

Wanko Esther.

Appendix 7: Information letter in French

Titre de l'étude: une étude relative aux expériences des majors de service dans deux hôpitaux de district à Yaoundé, au Cameroun: une recherche phénoménologique descriptive.

Superviseur: Dr Jane Kerr, coordonnatrice de Licence en soins infirmiers de l'UKZN.

Cher participant,

Je suis Wanko Keutchafo Esther Lydie, étudiante en Master en Sciences Infirmières à l'Université de KwaZulu-Natal. Le projet de recherche qui je mène est relatif au titre susmentionné. Le but principal de cette étude est de décrire les expériences des majors de service dans un hôpital de district. Par conséquent, les informations pertinentes recueillies après l'entrevue avec vous donneront une meilleure compréhension sur la façon dont les majors gèrent les services dans un hôpital de district à Yaoundé. L'entretien sera enregistrée dans un ordinateur et durera moins d'une heure. L'enregistrement sera transcrit en texte et vous sera donné pour vérification et/ou correction.

S'il vous plaît noter que les informations que vous donnez sont strictement confidentielles et seront utilisées aux fins de la rédaction du mémoire de recherche pour répondre aux exigences du programme. Tous les noms de personnes et organisations seront remplacés par des pseudonymes pour en protéger la confidentialité et l'anonymat. Votre participation est volontaire et vous êtes libre de vous retirer de l'étude à tout moment et pour n'importe quelle raison. Votre refus de répondre aux questions ou de vous retirer de ce projet de recherche ne sera en aucun cas donner lieu à aucune forme de discrimination ou de désavantage. Toutes les données qui seront recueillies seront utilisées pour mon mémoire et pour publications éventuelles dans des revues spécialisées. Vous ne serez pas obligé de répondre aux questions pour lesquelles vous vous sentez mal à l'aise ou à celles que vous n'êtes pas disposé à répondre, pour des raisons personnelles. Il n'y aura pas de risque attaché à votre participation à cette étude. S'il vous plaît sentez-vous libre de poser toutes les questions que vous souhaiteriez poser. Mon FLNMéro de téléphone est 672 311 611.

Merci pour votre participation.

Appendix 8: Informed consent form in English

I understand that the information gained from me could assist in understanding what it is like to be a front-line nurse manager in a district hospital unit.

I understand that I am free to participate or to refuse participation at any stage during the study without any penalty or prejudice. I have been informed that there will be no risk attached to my participation. I have also been given the right to ask questions related to the study.

I have read the contents of this document with understanding. I …………….…....................... freely and voluntarily consent to participate in this research study.

I hereby provide consent to:

Audio-record my interview   YES / NO

_____   _____

Signature of Participant   Date

_____   _____

Signature of Translator   Date

Appendix 9: Informed consent form in French

Je comprends que les informations obtenues de moi pourraient aider à décrire les expériences des majors de service dans un hôpital de district.

Je comprends que je suis libre de participer ou de refuser de participer à tout stade de l'étude sans aucune pénalité ni préjudice. Je suis informé(e) qu'il n'y aura pas de risque lié à ma participation. J'ai aussi reçu le droit de poser des questions liées à l'étude.

J'ai lu le contenu de ce document. Je .... consens librement et volontairement à participer à cette étude de recherche.

En outre, j'autorise l'enregistrement audio de mon interview   OUI/NON

_____   _____

Signature du Participant   Date

_____   _____

Signature du Translateur   Date

Appendix 10: Email to Prof. Petra

Accueil | Mail | Actualités | Sport | Finance | Style | People | Cinéma | Météo | Questions/Réponses | Screen | Flickr | Mobile | Plus

Rechercher | Recherche dans les mails | Recherche sur le Web | Accueil | Esther Lydie

Écrire | Résultats de la recherche | Supprimer | Déplacer | Pl

Boîte de réce... (284)

Brouillons (282)

Envoyés

Spam (29)

Corbeille (1)

Vues intelligentes
- Important
- Non lu
- Avec étoile
- Personnes
- Social
- Voyages
- Shopping
- Finance

Dossiers
- bourses
- Dr Jane Kerr
- Edith Johannesburg
- KingdomNomics
- Proverbs
- UKZN Communiques

Récents

Publicité

Le guide de
l'art de recevoir
avec Ferrero Rocher

Inquiry about content analysis

Esther Lydie Wanko Keutchafo <wankoesther@yahoo.fr>   jun 12 à 11h35 AM
À Brysiewicz@ukzn.ac.za

Dear Petra,

I am Esther Wanko, nursing student at UKZN enrolled in a master program by research. Student number 214584622. Student address

I have read your article on the introduction to qualitative research and I have found it very interesting to me because I want to use content analysis to understand the experiences of nursing unit manager in my country Cameroon. So I have been advised by my supervisor Dr. Jane Kerr to use content analysis.

I have been reading about this method but I have not yet found the metmethodology which should link the epistemology (constructivism), the paradigm (interpretivism) and the method (content analysis) .

I hereby come to you to ask for your help.

Best regards.

Sent from Yahoo Mail on Android

Répondre | Répondre à tous | Transférer | Plus

Cliquez pour Répondre, Répondre à tous ou Transmettre

Envoyer

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Appendix 11: What I read and what I knew before data collection

What I read about unit management	What I knew about unit management
The NUM plays a pivotal role in a health organisation due to her large span of responsibilities. She must attain the organisational goals as well as ensure the quality of care deliverd by the staff and the patient outcomes. She deals with the human, financial, material resources and with time. She is a nurse but also a manager.	The unit managers are responsible for the unit. The unit management position is a well-paid position. The unit managers are less involved in nursing care. They spend most of the time in their offices. The unit managers do the scheduling for the staff and the nursing students. The unit managers do not deal with the finances of the unit. The unit managers manage the supplies; the materials in the unit. The unit managers work every day of the week but not at night.

Appendix 12: Proof of editing

7 Woodlands Rd
GLENWOOD
DURBAN
4001
083 415 2531

16 December 2015

Reg. No. 2006/156780/23

To whom it may concern

EDITING OF RESEARCH DOCUMENT: ESTHER KEUTCHAFO

I have an MA in English from University of Natal (now UKZN) and have been performing editing services via my company for ten years. My company regularly edits the research dissertations, papers and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal as well as editing for publishing firms and private individuals on contract.

I hereby confirm that I, Catherine Eberle, from WordWeavers cc edited **Esther Keutchafo's** dissertation titled "An Investigation into First-Line Nurse Managers' Experiences in Two District Hospitals in Yaoundé, Cameroon: A Descriptive Phenomenological Inquiry" and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage. Once the queries referred to above have been attended to by Esther, the document should be correct.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

Catherine P. Eberle (MA: University of Natal)