THE PERCEPTIONS OF NURSES ON TASK SHIFTING AND DECENTRALIZATION OF HEALTH SERVICES TO THE PRIMARY LEVEL OF CARE IN THE MANZINI REGION, SWAZILAND

BY

SIBONGILE NONHLANHLA MABUZA

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SUPERVISOR: DR. SAMUEL MNDZEBELE

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DECLARATION

I, Sibongile Nonhlanhla Mabuza hereby declare that the work outlined in this dissertation is original (except where indicated by acknowledgements). It is being submitted in partial fulfilment of the Masters in Public Health degree at the University of Limpopo. Neither the whole work nor any part of it has been, is being or shall be submitted for another degree at this or any other university or institution for tertiary education or examining body.

Sibongile N. Mabuza

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Date

The dissertation was undertaken in the National School of Public Health, University of Limpopo, Medunsa Campus
DEDICATION

To the Almighty God for giving me the strength, wisdom and perseverance whilst I carried out this work and to my husband and children, thank you guys for your love and support as I pursued this masters program.
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ABSTRACT

Background: Overall government health policy is one of the significant factors that have been found to affect the health of people (Cheshire, 2010). Decentralization of health services and task shifting are two phenomena that have been formulated into policy in many countries and have been adopted in order to address challenges within the health sector which include the shortage of human resource and the ever increasing burden of disease.

Decentralization is the devolution of the responsibility of providing certain services and/or functions from central government to either subunits of government, regional authorities, semi-autonomous corporations or even private organizations; this transfer of responsibility ideally should be accompanied by corresponding authority (Rondinelli, 1981). Task shifting on the other hand is the rational and structured redistribution of tasks among health workforce teams; specific tasks are reassigned from highly qualified health workers to those who possess less extensive training and fewer qualifications as appropriate (WHO/UNAIDS/PEPFAR, 2008).

The impact decentralization of health services and task shifting amongst patients has been widely studied; however these two phenomena amongst the health workers have been studied less. This study therefore sought to contribute further to what is known about the impact that the two phenomena have had from the perspective of health care workers; more specifically the primary health nurses.

Goal and objectives of the Study: The goal of this study was to explore the perceptions of nurses on task shifting and decentralization of health services to the primary level of care in the Manzini region, Swaziland. In addition to exploring the perceptions of nurses working in primary health facilities on task shifting and the decentralization of health services to the primary level of care in the Manzini region as one of its objectives, the second objective of this descriptive study was to explore the advantages and disadvantages of these two phenomena as perceived by these nurses.

Methodology: The design of this study was qualitative; five focus group discussions were therefore conducted with a total of twenty-nine nurses. Each study participant gave a written informed consent to participate in the study. The focus group discussions were conducted using an interview guide where part I had open ended questions that assisted to guide each discussion and part II had a set of biographical questions. Each focus group discussion was
recorded and written notes were also taken. The recorded discussions were then transcribed and the data was analysed with the assistance of the NVIVO software for qualitative data analysis.

**Results:** The analysis of the data from this study revealed that nurses working in the primary level of care in the Manzini region in Swaziland were able to describe what the phenomena of decentralization and task shifting relatively well; this was inspite of the fact that they said they were not consulted as these phenomena were being put into operation and there were no guidelines they could refer to that guided the roll-out processes. They also said that the roll out of these two phenomena was not well supported in terms of resources which they saw as a disadvantage; another disadvantage that was cited as the increased workload for them which made them concerned about the quality of work they were producing and the loss of love for the profession. The nurses were however fully supportive of these two phenomena as they felt they brought a number of advantages especially to the patients.

**Conclusions:** The study findings show that there are a number of issues that make up the experiences of nurses working at the primary level of care that relate to decentralization and task shifting. These experiences give rise to what the nurses cited as the advantages of decentralization and task shifting. The advantages of the two phenomena were identified by the nurses as being mainly for the patients. The nurses also identified disadvantages with decentralization and task shifting and these disadvantages were said to affect themselves as nurses and service delivery.
CHAPTER 1: BACKGROUND TO THE STUDY:

1.1 Introduction:

This chapter provides a background for this research by giving the definitions of decentralization and task shifting in the context of this study. It also outlines the importance of these two phenomena within different health systems especially those of developing countries which have to be strengthened in the light of many challenges that include a shortage of personnel against a background of an ever increasing burden of disease. This background information leads into the study goal, questions and the objectives of the study; finally the justification of the study, its focus and scope are described.

1.2 Policies and Health:

Generally, it has been found that overall government health policies are one of the most significant factors affecting the health of citizens whether the policy comes from national, regional or rural village level (Cheshire, 2010). This was one of the reasons why it was important to look into how policies like task shifting and decentralization have been implemented by governments in various countries as well as in Swaziland; and also the impact these two phenomena have had in the various populations where they have been instituted.

1.3 Decentralization:

According to Pokharel (2000), decentralisation primarily relates to the devolution of authority. Experts in administration and management and the liberalization of the economy have expanded the definition such that in present context the meaning of decentralization is not limited just to the political arena but also includes administration, management and economy (Pokharel, 2000). One of the definitions of decentralization can therefore be said to be “the transfer or delegation of planning, decision making or managerial authority from the central government and its agencies to field organizations, subordinate units of government, semi-autonomous public corporations, regional authorities or nongovernmental organizations (Pokharel, 2000).

“Health ministries in developing countries have a reputation of being the most bureaucratic and the least effectively managed institutions” (Pokharel, 2000). Pokharel (2000) also
observes how these centrally managed health care systems have to a large extent been poorly structured, led and organised. This has meant therefore, the performance of these health systems has been largely under par and this failure to perform has resulted in the need for “people centred” health care systems that build on bottom up approaches in planning (Pokharel, 2000). This need has been one of the instrumental factors that have led to the governments in these developing countries realising that the management and services within the health sector need to be decentralised. Notably, in recent years, this concept of decentralization has been used in the health sector in such a way that public reforms in developing and least developed nations have followed a global trend towards the decentralization of services from central government, large hospital and district health clinics (Foley, 2008).

The idea behind decentralization in relation to health was to increase efficiency and citizen participation in health services and therefore improve access to health care and drugs in rural populations (Akin, Hutchinson and Strumpf, 2005); it was also in order to expand the reach of health services beyond the large cities to the diverse populations that exist outside urban areas (Loubiere et al, 2009). These non urban populations were found to have needs that were unique from urban populations and also unique from each other; however, it was thought, if the health decision making was provided directly to the officials of these populations and smaller facilities were built nearby, the personalised health issues of these groups could be specifically addressed and interventions could be directed to the affected individuals (Cheshire, 2010). Decentralization within the health sector has therefore in part involved taking health services to the people at the primary level of care as instituted in the Alma ata Declaration of 1978. In addition to this, Pokharel (2000) states that “as a part of reforms in the health care delivery system, decentralization is currently being promoted in many countries as a means to improve the performance and outcomes of national health care systems”.

This decentralization within the health sector has been adopted in a number of developing countries using a number of diverse methods; in some countries a link with another phenomenon known as task shifting has been made. The World Health Organization (WHO) makes a number of recommendations for the decentralization of health care; these recommendations have specific application to anti-retroviral therapy (ART) but what is also important to note is that within these recommendations the use of the phenomenon of task
shifting as part of the mechanism for decentralization comes out strongly. In addition, it is important to be aware that there are many key features that are required for a decentralised health care system to function effectively and thus ensure accessibility and efficacy. So, even though the diverse forms of decentralization that have been instituted in many developing countries are generally correlated with improved health system performance, particularly in regions with strong local management practices (Atkinson and Haran, 2004); however these various forms of decentralization have not always resulted in the improved health of the national population for various reasons. It is therefore a phenomenon that has proven to have an extensive list of pros and cons which have resulted in success in some countries and it being unsuccessful in others (Cheshire, 2010).

The government of Swaziland has a common goal of decentralizing services (Government of Swaziland, 2003 cited in Ministry of Health and Social Welfare, 2006); this includes health services (Ministry of Health and Social Welfare, 2006).

1.4 Task Shifting

Task shifting involves the rational redistribution of tasks among health workforce teams; this is not done haphazardly however, specific tasks are reassigned from highly qualified health workers to those who possess less extensive training and fewer qualifications as appropriate (WHO/UNAIDS/PEPFAR, 2008). The main objective for adopting task shifting within the health sector was to increase the efficiency of the available human resource for health. The global recommendations and guidelines on task shifting by WHO proposed for the adoption or expansion of a task shifting approach as one method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health care services (USAID, 2008). According to the WHO/UNAIDS/PEPFAR (2008) consultation, a situational analysis, national endorsement and a regulatory framework are key elements in ensuring that when any country adopts a task shifting policy it is safe, efficient, effective, equitable and sustainable. Quality assurance mechanisms are also a very important component in the implementation of any task shifting policy within any health system; these involve standardized training, supportive supervision, certification and assessment (WHO/UNAIDS/PEPFAR, 2008). The quality assurance mechanisms are necessary in order to ensure quality care is maintained at all times (WHO/UNAIDS/PEPFAR, 2008). In addition to the key elements and the quality assurance mechanisms there also needs to be support structures that will ensure that there are
adequate resources for implementation and a system that will enable access to advice and information on how to organise clinical care services within a task shifting approach is also necessary (WHO/UNAIDS/PEPFAR, 2008).

The key driving factor for the use of the task shifting approach within the health sector is the shortage of human resource against a background of increased disease burden within many countries; however this phenomenon is not a new one; it has been informally applied throughout history in response to human resource needs. The recommendations and guidelines that were developed by WHO were therefore a way of setting up a formal framework that will support task shifting as a national strategy for organising the health workforce; and they were developed in the context of trying to scale up access to HIV services especially in countries that have a high incidence and prevalence (USAID, 2008). This however does not imply that this approach based on the WHO recommendations and guidelines should be restricted to the delivery of HIV service; the implications for other essential health services and the potential for wider health system strengthening are recognised (USAID, 2008). A number of countries have adapted these recommendations and guidelines in order to apply the task shifting approach within their own health systems.

In Swaziland, the task shifting recommendations and guidelines have also been adopted especially in relation to the delivery of HIV and TB services; however this adoption has not been formalised through written guidelines (East, Central and Southern African Health Community (ECSA-HC)/USAID/Health Policy Initiative, 2010).

1.5 Decentralization and Task Shifting in the Provision of Health Care:

Even though WHO had been trying to push the agenda of primary healthcare for a number of decades, The Alma-Ata declaration on “Health for All by 2000” provided the defining moment in the process of decentralization in health services (Maciocco, 2008). However as in other sectors, the decentralization of health services cannot be looked into in isolation; task shifting is said to be essential as one of the many broader requirements for decentralised health care as recommended by the WHO (Cheshire, 2010). Task shifting is said to be essential in settings where physicians are limited and therefore nurses or clinical officers may provide treatment to increased patient loads (Gills et al, 2003). In a number of countries, especially those with a high burden of disease (mainly due to HIV/AIDS) that is accompanied by limited resources, a number of tasks that were done by doctors are now being done by other cadres especially the nurses (Mukora et al, 2010). This has also allowed the
decentralization of such tasks/services to be possible resulting in them becoming accessible where doctors are often not available e.g. at the peripheral level of care.

So according to Cheshire (2010), in order for governments to reap the benefits of decentralization, this decentralization must be accompanied by reforms that include among others taking advantage of task shifting policies. So in the recent past the phenomenon of decentralisation has been linked with the concept of task shifting. This move has drastically changed the face of services available at the primary level of care and it therefore has changed the scope of work of nurses at this level of care.

In order to make services more accessible to the people, Swaziland has made decentralization a common goal of the government; this holds true even for healthcare services (Ministry of Health and Social Welfare, 2006). Task shifting is also a concept that has been cited as being well understood by the Ministry of Health (East, Central and Southern African Health Community (ECSA-HC)/USAID/Health Policy Initiative, 2010). Both phenomena have therefore been used to mitigate the problem of human resource shortage in the presence of a high HIV/AIDS prevalence and also to move HIV/AIDS and related services closer to patients. Decentralisation together with task shifting has therefore been used within the health sector in Swaziland to move a number of health services to the primary level. Initially HIV Testing and Counselling services were decentralised, then it was the Prevention of Mother to Child Transmission services, then HIV care and treatment services to the point that nurses are now initiating patients on HAART; along with this has come the management of opportunistic infections including tuberculosis (TB).

A number of studies have been done in Swaziland and other countries that focus on how these phenomena have affected the patients and patient care however few studies have reported on the how the healthcare workers have experienced the phenomena. It was for this reason that this study was carried out; the intention was to investigate how this phenomenon of decentralization coupled with task shifting has affected the nurses who work at the primary level of care by exploring their perceptions on these phenomena.
1.6 Research Goal

The goal of this study was to explore the perceptions of nurses on task shifting and decentralization of health services to the primary level of care in the Manzini region, Swaziland.

1.7 Research Questions

1. How do nurses perceive/view task shifting and decentralization of health services to the primary level of care?

2. What are the advantages and disadvantages of task shifting and decentralization of health services to the primary level of care as described by the nurses?

1.8 Research Objectives

(i) To explore how nurses perceive task shifting and decentralization of health services to the primary level of care in the Manzini region, Swaziland?

(ii) To explore the advantages and disadvantages of task shifting and decentralization of health services to the primary level of care as described by the nurses in the Manzini region, Swaziland?

1.9 Problem Statement

Decentralization and task shifting as experienced by patients has been widely studied and their successes well recorded. Studies done on task shifting and decentralisation mainly focus on the impact of these phenomena on service quality, patient outcomes, patient satisfaction, patient attitudes etc. Part of a study carried out in Swaziland by ECSA-HC in consultation with staff from USAID and Health Policy Initiative in 2010 looked into whether different cadre of health care workers working at the secondary and tertiary levels of care would be willing to shift tasks to other cadre. There was however still a gap in information that gave insight into the perceptions of health care workers at the primary level of care as they have experienced decentralisation and task shifting. Also it seems like sending more health services to the periphery is here to stay; this study therefore sought to augment the information known about decentralization and task shifting from the perspective of nurses in
particular as they are pivotal in the provision of primary health care. This was done by exploring in depth what the common perceptions on decentralization and task shifting are among nurses working at the primary level of care in Manzini, Swaziland. The findings of such a study could assist the policy makers within the Ministry of Health in Swaziland to make more informed decisions as these policies continue to be implemented; with it they will have some idea how the people working on the ground are affected.

1.10 Focus and Scope of the Study

The study focused on the nurses that work at the primary level of care in the Manzini region in Swaziland; it explored their perceptions on task shifting and decentralization.

1.11 Limitation of the Study

The sample of participants within this study may not have been representative of the larger population of nurses working in the primary level of care; that is nurses who work in other regions within the country or even those beyond the borders of Swaziland. This study also cannot be said to be representative of the perceptions of the three (3) nurses who declined to participate in the study; the perceptions of these nurses might have been different from the perceptions of those who agreed to participate. The findings therefore are representative of those nurses who work in the Manzini region and consented to participating in the study. It is however hoped that the findings will provide useful insight to policy makers on the phenomena of task shifting and decentralization from the perspective of the implementers i.e. nurses in this case. It is also hoped that the findings from this study will encourage further studies that will be centre around decentralization and task shifting from the perspective of health care providers rather than focusing too much on the perspective of the patients.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to examine how the literature connects the phenomena of decentralization and task shifting with the primary health care approach to health service delivery. It also demonstrates how the scarcity of human resource for health plays a vital role in the need for innovative mechanisms, like decentralization and task shifting, for health service delivery if the great demand for health care is to be met. Finally the chapter then explores what the literature has to say about the phenomena of decentralization of health services and task shifting globally, within the African continent and then in Swaziland.

2.2 Primary Health Care:

Primary health care is an approach to health care which when described in its simplest terms advocates for taking healthcare services as close as possible to the people. This approach is seen as a way of expanding the accessibility of healthcare services within countries; meaning the primary health approach, decentralization of health services and task shifting can be linked within health systems in an attempt to make health services more available to all populations within the country. Decentralization and task shifting can be seen a way of implementation of one of the Alma ata Declaration of 1978 which states there must be a “reorientation and skills broadening of health personnel to allow them to respond to the challenges of implementing primary health care and work in teams as well as with other sector professionals and communities” (Lehmann, 2008). The Alma ata Declaration of 1978 was key for the agenda of primary health care that had been in existence for more than 30 years; and most countries in sub-Saharan Africa adopted the primary health care model as a model for health service delivery (Levers et al, 2009). According to Gorgen and Schmidt 2004 as cited by Levers el al 2009 there are six guiding principles for primary health care; these include maximum accessibility, utilisation of local resources, involvement of the target population in planning and implementation, integration of preventative and curative services, rationalization of health services and inter-sectorial co-operation.

The primary health care approach has had its fair share of successes which include improving the health of the people, decreasing child mortality (Kruk et al, 2010), addressing pervasive health inequalities, improving access and community involvement in healthcare (Haines and
Horton, 2007), acting as a base for health system strengthening in some countries (Kruk et al, 2010) etc. Swaziland adopted the primary health care approach in 1978, this resulted in the country making a number of positive strides in a number of health care indicators; these include the infant mortality rate which fell from 156/1000 live births in 1986 to 79/1000 live births in 2010, there was also a significant reduction in vaccine preventable diseases like whooping cough and measles, in 2005 the country was able to attain the polio free status, routine immunization coverage went from 8% in 1980 to 90% for diphtheria and 80% for measles in 2011, an increased contraceptive prevalence from 4% in 1986 to 44% in 2010 and 97% of women attend at least one antenatal care visit during pregnancy (MOH, 2010). However the primary health care approach has also experienced some challenges for example, because it has been unable to show how it is unique as a phenomenon therefore it has failed to justify its value; it has also taken on too much due to the burden of new diseases. These shortcomings have stifled the ability of primary healthcare to evolve (Gordon and Showstacks, 2011).

Primary health care and the district or regional health systems have remained relevant for the delivery of health care in Africa and decentralization policies have placed a greater emphasis on the role and authority of the districts or regions (Gorgen and Schmidt 2004 as cited by Levers et al, 2009). In addition, with the advent of the Millennium Development Goals (MDGs) where the target is that they should be achieved by 2015, renewed interest in primary health care has emerged as it has been noted that this is one strategy that could be refined and used to assist different countries in attaining the health MDGs (Kruk et al, 2010).

2.3 Human Resource for Health (HRH):
The “brain drain” especially amongst doctors and nurses in some Sub- Saharan African countries including Swaziland has adversely affected health services delivery; this is an issue of great concern in these countries because it results in the shortage of health personnel which leads to a number of challenges within the health systems of these countries (Physicians for Human Rights, 2004 cited in Mills et al, 2006). In a report called Working Together for Health produced by the World Health Organization in 2006, it was estimated that countries that had less than 2.28 doctors, nurses and midwives per 1000 population were on average unable to achieve an 80% coverage rate for deliveries by skilled birth attendants (WHO, 2006 as cited by Fulton et al, 2011). WHO found that 57 countries fall short of that threshold and this resulted in a needs-based shortage of 4.3 million health workers, including 2.4 million
doctors, nurses and midwives (Fulton et al, 2011). It was also found that 36 of these 57 countries are in Africa (WHO/UNAIDS/PEPFAR, 2008 cited by Callagan et al, 2010). In Swaziland HRH accounts for more than 60% of government expenditure and nurses constitute 41% of the total workforce; in 2010 34% of the nurses in the country were expatriates and in the same year the nurse to population ratio in the Manzini region was 189/100000 population whereas the WHO benchmark is 173/ 100000 population, this latter statistic shows that the Manzini region was above the WHO benchmark in terms of the nurse to population ratio (MOH, 2010). From just looking at the health worker to population ratio in many countries it is obvious that the problem of the shortage human resources within the health sector is a serious one worldwide but more especially in Africa. This problem is further compounded by issues of HIV/AIDS and poverty which results in more disease in the population (Ministry of Health- Swaziland, 2006). This shortage of the health workforce in the face of increasing disease has made it necessary for governments to become innovative when it comes to health policy especially that which will impact on the delivery of health care services. A number of interventions have therefore been tried in a number of countries, including Swaziland, to try to deal with the challenges that result from a shortage in human resource within the health system. These include decentralization and task shifting. Malawi is an example of a country that has been able to significantly scale-up ARV treatment using a public health approach to the epidemic that has been used in the midst of human resource challenges that also exist in that health system; this approach has included simplified treatment protocols, decentralizing HIV care to primary health care levels and task shifting amongst health care workers (Medecins Sans Frontieres-MSF, 2012).

A critical point that is related to the issue of human resources within health systems was raised by Mills and colleagues in 2006; this was that “in planning for human resource needs, countries must relate the numbers and levels of each category of staff members to health policy goals and the priorities that are set given the overall availability of resources and local labour constraints.” With this in mind it would therefore be important to take into consideration the healthcare providers as such noble initiatives like decentralization and task shifting are rolled out.

2.4 Decentralisation:

There are a number of organizational options when one speaks of decentralisation within public institutions including the health sector (Smith, 1997); in addition the term
decentralisation can be used to define a number of concepts for service delivery including health service delivery. In the context of this study the focus will be looking at decentralisation of services as the principle revolving around taking services closer to the people that use them. This phenomenon is not a new one either, in-fact, in relation to health services it was also instituted as the Alma ata Declaration (Maciocco, 2008). Therefore decentralisation can be said to work hand in hand with the concept of primary health care which also advocates for taking healthcare services as close as possible to the people.

Various forms of decentralization have instituted in a number of developing countries. A number of pitfalls that have seemed to accompany decentralization in some of these countries; these include lack of local financial control, decreased funding overall and exacerbation of discrepancy between wealthy and poorer regions (Khan and Willis, 2009). However, what has been found to be important is that as decentralization is rolled out, in order to make it effective other policies may need to be modified to support this system of health delivery (Cheshire, 2010). If an enabling environment that has been created by modified policies that support decentralization is in place; this phenomenon of decentralization has been found to bring a number of positive effects into the health system e.g. regions with strong local management practices improve their performance (Atkinson and Haran, 2004), there is an increased equity of resources allocation between municipalities of different incomes (Bossert et al, 2003) and it has enabled increased access to ART and health in general for patients in countries like Cameroon and Brazil respectively. In many countries the decentralization of the health system has been linked to a decrease in the total government expenditure on health; an example of a country where this is true is China where the government saw the national government expenditure on health dropping from 32% to 15% during a period of health reform where decentralization of the health system was one of the key policy measures instituted (Blumenthal and Hsiao, 2005). It can therefore be said that different countries have had varied experiences with the decentralised approach towards health care service delivery; this can be credited to a variety of reasons which also differ from country to country.

2.5 Task Shifting:

Another phenomenon which is quickly re-emerging within the context of healthcare delivery is task shifting; it has been occurring for decades but due to the health care needs for
HIV/AIDS patients and the overall health worker needs based on shortages it has become more urgent (Fulton et al, 2011). The overall objective of task shifting is to increase the productive efficiency; this means task shifting aims to increase the number of health care services provided at a given quality and cost, or, alternatively, to provide the same level of care services at a given quality at a lower cost.

Task shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialised health workers (WHO/PEPFAR/UNAIDS, 2008 cited in ECSA-HC/USAID/Health Policy Initiative, 2010). Dolvo 2004 as cited by Fulton et al 2011 describes various methods used to implement task shifting such as shifting tasks from higher-to lower-skilled workers, also it may include the creation of new professional or non-professional cadres, and then tasks are shifted from workers with more general training to workers with specific training for a particular task.

A number of studies done in Africa and around the world have shown that task shifting is an important policy option that helps in alleviating health workforce shortages and skills mix imbalances without necessarily compromising the quality of care that is received by the patients (Fulton et al, 2011). This evidence has been produced within various treatment programs for example HIV/AIDS care and treatment programs, obstetric surgery, the treatment of young children, hypertension, diabetes, mental health and the list goes on (Fulton et al, 2011). There is also substantial evidence that task shifting has the potential to increase productive efficiency and reduce the time needed to scale up (Fulton et al, 2011).

It is important to however to emphasize that the success of task shifting depends on local contextual factors. So even though task shifting is a policy that enjoys a considerable amount of evidence to support its implementation, it does come with a number of challenges and the results have not always been favourable (Fulton et al, 2011). Various studies in different parts of the world have shown that the quality of care can be compromised when care and treatment is delegated to lower level or new professional or non-professional cadres. Specific examples come with the findings of a study done by Buchan and Calman in 2005 where it was concluded that many questions remain on the efficacy of nurses replacing doctors prior to a patient receiving a diagnosis (Fulton et al, 2011) and in Mozambique the Ministry of Health had to suspend training for non physician clinicians providing antiretroviral therapy until the training program could be revised because of quality of care results (Brentlinger et al
2010 cited by Fulton et al, 2011). In addition it has also been argued that task shifting should not be seen as a substitute for investments into getting more health professionals into the health system as the health system can crumble even with a task shifting policy in place if shortages of human resource exist at all professional levels (Gaede, 2006, Schneider et al, 2008 and Philips et al, 2008 & 2009 cited by Callaghan et al, 2010). It has also been of concern to some people that shifting additional tasks to lower level cadres could risk competing with other service priorities (Ojikutu, 2007 and Van Rensburg et al 2008 cited by Callaghan et al, 2010)

The challenges and unfavourable results of task shifting that have come out of some places underscore the need for careful, critical analysis, particularly where task shifting policies rewrite the job description of some cadre; where task shifting is already widespread in practice or maybe in policy the process should be formalised and rationalised for the long term (Callaghan et al, 2010). This includes ensuring the health workers have the necessary competencies and appropriate working conditions for carrying out the tasks that have been newly assigned to them (Callaghan et al, 2010).

2.6 Decentralisation and Task Shifting Together:

Most countries have instituted various versions of decentralisation within their health systems; however it is apparent that the common goal has been that outlined by the Alma ata Declaration which is the need for all governments and the international community as a whole to prioritise the protection and promotion of health among all the people of the world through primary healthcare (WHO, 1978). For Africa it emphasized that “post independence Sub-Saharan African countries should stress on building networks of the peripheral facilities” (Mills et al, 2006).

Globally task shifting is seen as far back as the 19th century where in France Offices de Sante were a commonly used group of non physician health care workers (Heller, 1978) and in the mid-20th century in China what was known as the “bare-foot doctors” were used widely in the country (Sidel, 1972 cited in Mukora et al, 2010).

Brazil and Cameroon have been successful in reforming their health care programs to be decentralised (Cheshire, 2010). The decentralised health care program found in Brazil has resulted in a largely successful public health system in most regions in the country. In the
poor rural areas of Brazil however, the health services that are available to the people in these areas are less extensive when compared to those offered in other parts of the country (Collins, Araujo and Barbosa, 2000).

In Africa, the concept of task shifting has also been widely used; for example non physician clinicians have long been trained across the continent to fill various roles (Mullan, 2007 cited in Callaghan et al, 2010). In recent years due to the high prevalence rates of HIV/AIDS in many Sub-Saharan countries especially, task shifting coupled with decentralization has become an intimate part of HIV service delivery in order to mitigate the problem of shortage in health human resource which has been seen to be one of the factors that severely hamper the roll out antiretroviral therapy (ART)(Callghan et al 2010). So, decentralisation and task shifting have in some cases become intertwined especially in countries where there is high burden of disease especially HIV/AIDS. This is because these two phenomena have been proposed as solutions to the staffing shortages that exist in the health sector which have been presented as one of the major barriers in the delivery of HIV services in high prevalence countries (Mukora et al, 2010).

2.7 What Information is available on Decentralisation and Task Shifting?

A majority of the studies done on task shifting and decentralisation mainly look into the impact of these phenomena on the quality of service, patient outcomes, nurse-led care versus physician lead care (especially in the context of HIV), patient satisfaction and attitude towards services provided by the lower level cadres instead of physician care etc; there is however little published information that looks into how health care workers have experienced these phenomena. Part of the results of one study carried out in Iran that “explored health stakeholders’ perceptions on moving towards comprehensive primary health care to address childhood malnutrition in Iran” showed that health care providers perceived “staff motivation, advocacy and involvement to be the main challenges that needed to be addressed before the move towards the provision of comprehensive primary health care to address childhood malnutrition could be made; whereas policy makers and the health service recipients cited other factors (Javanparast et al, 2009). This study showed that different stakeholders could have different perceptions about the same aspect of the health system (Javanparast et al, 2009). A qualitative study done in rural Uganda found that almost all clinic staff interviewed on the impact of the introduction of community workers into the care of
HIV patients strongly agreed or agreed that peer health workers improved the care of patients and also made their own jobs easier (Arem, 2009 cited by Callaghan, 2010). Another structured survey conducted among national and provincial managers and HIV clinic staff in Mozambique indicated that non-physician clinicians should initiate ART for adults, pregnant women and patients with TB (Sherr, 2009 cited by Callaghan, 2010).

Studies have also identified Cameroon as having the best model for the decentralization of health care and such a system has resulted in the highest rate of access to ARVs for patients who are HIV positive in Western and Central Africa (Cheshire, 2010). The Cameroonian government adopted and adapted the recommendations made by the World Health Organization for scaling up ART treatment in low-resource settings (Gilks et al, 2003). In the 1990s the government of the time in Cameroon reorganised the framework of the health facilities into one that had 174 district hospitals that were under the supervision of 18 provincial and national hospitals; there were 24 accredited treatment centres for ART treatment in the major hospitals which supervised 108 HIV management units at the district level (Loubiere et al, 2009). This new decentralised framework for the delivery of ART treatment allowed for this treatment to be efficiently distributed across Cameroon; it therefore allowed for 58% of all HIV positive patients eligible for treatment to access treatment. This is one of the highest treatment rates in Africa (Cheshire, 2010).

In Malawi Universal Access to ARV treatment was achieved by the Ministry of Health in this country with the support of MSF in 2007. This was made possible by using strategies that combined the decentralization of services, task shifting from clinicians to nurses and the simplification of testing and treatment protocols. In recent years access to treatment has increased dramatically and there are now ARV treatment services available in 650 of the country’s 772 public sector health facilities.

In Swaziland task shifting and decentralisation have almost worked synonymously where as a result of the limited number of doctors (10 per 100 000 population) (National Health Sector Strategic Plan, 2008-2013 cited in ECSA-HC/USAID/Health Policy Initiative, 2010) within the health system especially in the context of the public sector, often the nurses (56 per 100 000 population) (National Health Sector Strategic Plan, 2008-2013 cited in ECSA-HC/USAID/Health Policy Initiative, 2010) have to carry out tasks that would otherwise have been done by medical doctors. Such tasks therefore one would find being also done by a
nurse that works at the primary level of care. Some of the findings from one study carried out in Swaziland by ECSA-HC in consultation with staff from USAID and Health Policy Initiative in 2010 were as follows:

Swaziland has not formalised task shifting through an official framework, however it is occurring at both institutional and community levels. The Ministry of Health in the country understood the concept of task shifting well and there was a well demonstrated move within the health system of Swaziland for a spontaneous shift of some tasks from one category to another. This was found to have been mainly due to the increased workload that has been created by HIV epidemic and the high co-infection rates of HIV and tuberculosis (TB). A number of tasks have been shifted from doctors to nurses mainly due to the lack of physicians with the health institutions however as this has happened nurses have been unable to shift to lower levels of staff because the guidelines to do so were not available, the nurses have found themselves overloaded as they performed tasks in their original job descriptions as well as those shifted to them by doctors.

Part of the methodology of the study carried out by ECSA-HC involved focus-group-discussions (FGDs) including doctors, nurses, lab technologists, pharmacist etc within secondary and tertiary health institutions where the discussion was around whether these would be willing to shift tasks and whether they saw any benefit in terms of quality of care in the task shifting that has already occurred in the country. Even though this study by ECSA-HC contained a qualitative piece where one of the study objectives was to increase the understanding of the attitudes and perceived needs of health workers on task shifting, the FGDs however were done as mixed groups of health workers, no FGDs were done with specific cadres alone and this study was carried out in secondary and tertiary institutions. So aspect of this study done in Swaziland, there is still need for information about the attitudes health workers at the primary level of care on task shifting and decentralisation which for them work synonymously.
CHAPTER 3: METHODOLOGY

3.1: Introduction:

This methodology chapter describes the steps that were followed when carrying out this research; this description will include the method, study design, sample, and the inclusion and exclusion criteria that were used to decide the participants of the study. The materials and data collection tools will also be highlighted in this chapter. The procedure that was followed in analysing the data will then be explained, followed by the specifications that were used to enhance the validity and reliability of the research. Lastly the bias and ethical considerations within the study will also be expressed.

3.2: Method:

Five (5) focus group discussions were conducted with nurses that work in the primary level of care in the Manzini region. The focus group discussions had between five (5) to seven (7) participants and they were conducted at the clinics where the participants work, as it proved not to be possible to convene the nurses at a central place as it would have meant taking them out of their work stations during working hours. To organize a focus group discussion, the facility was visited and an appointment was made with the senior nurse to visit the facility on a day in the week when the clinic was least busy; on the day of this visit the nature of the study was described to the nurses and then a process of recruiting participants was undertaken by asking each nurse whether they were willing to be part of the study. If there were at least five (5) nurses within the facility who were willing to participate then an appointment for carrying out the focus group was made. On the day of the focus group discussion, the research topic was once again explained and an informed consent form was also explained and given to each participant to sign. The method of using focus groups discussions was also described to the participants and the ground rules of the focus group discussion were also expressed. The focus group discussions were used to carry out the research as these increase sample size, help conserve resources and they are an effective method to collect rich data due to the interaction between the researcher and the participants. In terms of duration, the focus group discussions were between one (1) hour and one hour twenty minutes (1 hour 20 minutes); In the discussions, the nurses were systematically asked to explain decentralization and task shifting of health services as they have experienced it. The participants were encouraged to express as much of their views as possible, however guide questions which
had a semi-structured format were used to assist in moderating the discussion. The nurses were allowed to respond to the questions in English or Siswati, Siswati being the language commonly used in Swaziland. The focus group discussions were carried out by the researcher who was the moderator of the discussion with the assistance of a research assistant who also listened and took notes during the discussion. The research assistant also assisted with the peer debriefing session after each focus group discussion. The discussions were audio recorded using a digital recording device in order to capture as much of the discussion as possible, however some notes were also written down.

3.3: Study Design:

The study design that was used in this research was descriptive; it was an explorative qualitative study using focus groups and it followed a phenomenological design that explored the lived experiences of nurses working in the primary level of care in the Manzini region in relation the phenomena of decentralization and task shifting. This approach was chosen because the study sought to understand how the group of nurses in the Manzini region have experienced the “phenomena” of decentralization and task shifting to the primary level of care.

3.4: Sample:

The participants of the study were nurses working at the primary level of care in the Manzini region in Swaziland. The non probability sampling method was used in this study because the nurses working in the primary level of care in the Manzini region were chosen as part of the target population in a non random manner; no predetermined chance of being selected as a subject in this study existed. Specifically the purposive method of non probability sampling was used because the units were selected from the spectrum of nurses that were of interest as this was determined to be the population that would provide the information that this study was seeking to find. The chosen population was the one that had the nurses that had experienced the phenomena of decentralization and task shifting of health services to them and so they provided first hand information on what the study sought to find.

Further, under the purposive method of sampling judgment sampling was used as the units were only from primary healthcare facilities in the Manzini region. As the study wanted to elicit the opinions and experiences of nurses working in the primary level of care about the
phenomena of decentralization and task shifting of health services this is why nurses working in clinics in the Manzini region were chosen to participate in this study.

3.5: Inclusion and Exclusion Criteria:
All nurses working in the clinics (i.e. the primary level of care) in the Manzini region were eligible to be part of this study. Nurses that work in the secondary or even the tertiary level of care were not eligible to be part of this study and therefore were excluded as participants, also all other health care workers who do not belong to the nursing cadre were excluded from this study. Some nurses were working in the Manzini region but if they are not working in a primary healthcare facility then they were not eligible to be in this study.

3.6: Materials:
The materials were used for this study are an interview guide, pen, paper and a digital recording device. The interview guide consisted of a set of guide questions that were used to guide the discussions within the focus groups discussions; the questions assisted in keeping the discussion relevant to the topic of interest. As the discussion was taking place, it was recorded with the digital recording device to ensure that all that was said during the discussion was captured; in addition the research assistant was writing notes using the pen and paper.

3.7: Data Collection and Tools:
Data was collected using focus group discussions. The data collection tool was a semi-structured question guide in which the first part of the guide had the questions that were used to assist in guiding the unstructured part of the data collection process i.e. the focus group discussions in which participants were mostly allowed to expound on their experiences on the decentralization and task shifting of health services to the primary level of care. The second part of the semi-structured question guide involved asking biographical questions which included for example gender, qualification, years of experience etc. The participants were requested to complete this part of the question guide at the end once the focus group discussion had been completed.
In this research primary data was collected and the data collected was qualitative in nature which means it was particularly in the form of words. In addition the information given by
the participants in this study was subjective as they were giving their own interpretation of how they had experienced the phenomena of decentralization and task shifting of health services to the primary level of care. The data was therefore peculiar to this research.

The proceedings of the focus group discussions were audio recorded using a digital recording device and then some notes were also taken. During each focus group discussion the researcher was the moderator of the discussion and the role of the moderator was to facilitate the discussion. The researcher had been trained on how to conduct focus group discussions. There was also a research assistant during each focus discussion and the role of the assistant during the discussion was to listen and also take notes of the discussion. The research assistant was trained prior to the focus group being conducted by the researcher. This training comprised of explaining the research topic to the assistant, explaining why the study was being conducted and the kind of information that the researcher was hoping to elicit from the study. The research assistant was also introduced to the method of using focus group discussions as a method of collecting qualitative data, their role within the discussion was also explained and the type of information they were expected to look out for and document during the discussion. The research assistant was also trained on the question guide and how it was to be used to guide the discussion but also it was explained that the participants would be encouraged to expound on the topic if they so desired. It was also explained that it was possible that some questions within the question guide could evolve if necessary as the focus groups were being done.

3.8: Data Analysis:

To analyze the data there are a number of steps that were undertaken, these included:

(i) Transcribing the data from the audio recordings:
The recordings were transcribed in order to have a written form of the focus group discussions.

(ii) Organizing the data collected in preparation for analysis:
Once the first focus group was transcribed, an attempt was made to organize the data question-by-question. Organizing the data by questions was not easy to achieve and so the major themes were identified and extracted from this first focus group and the nodes that were formulated in qualitative data analysis software were formulated according to these themes. Other themes however were as a result of the theoretical orientation of the researcher. The themes that were identified became the names of the nodes in the software. Any
information from the transcript that was relevant to a particular theme was attached to that theme. This meant the transcript was therefore then organized according to these themes and so the themes were used to label sections of the data. Once the researcher was satisfied that all possible themes had been identified from the first focus group then the second focus group was done; it was carried out, transcribed and then any information from the transcript that fitted into the themes that had already been formulated from the first focus group was extracted and fitted under the relevant theme and any new themes that emerged from this focus group were extracted and added as new themes and the information for these new themes were attached accordingly. Once the second focus group had been analysed the process was repeated with the third focus group and so the process continued until all five focus group discussions had been analysed.

Initially a number of broad themes were identified; however as the analysis continued some themes were seen as being linked and lower level concepts for thinking about the data were also identified. Therefore some themes were eventually seen as being subthemes of another theme and so these themes and subthemes were highlighted and grouped together accordingly.

(iii) Looking at the different themes and subthemes more closely:
Once the different themes and subthemes had been identified then these can be looked at more closely by asking basic questions about each like what can one tell about the nurses and decentralization/task shifting from the data, what can one read between the lines of the data and what is the basis of this, what tentative conclusions can be drawn, etc?

(iv) Presenting of the analysis of data in the form of findings:
As each theme and subthemes were looked at more closely, this initiated the presenting of the analysis of the data in the form of findings i.e. doing the write-up. So the analysis process was taken further and concluded by doing a write-up of the findings.

The NVivo software was used to carry out this analysis.

(v) Analysis of biographical data:
The biographical data that was collected using the second part of the question guide was also analysed. This analysis was carried out using excel to find the mean age of the participants, the ratio of males to female, the mean number of years of experience of the participants, the ratios of the different qualifications and ranks
Validity and Reliability:

As this was a qualitative study the validity and credibility of the research could also be referred to as the trustworthiness of the research (Guba, 1981). In this research the validity of the conclusions and inferences drawn from the data was guaranteed using extensive quotation. So to enhance internal validity (i.e. credibility) and the reliability (i.e. dependability) of the study extensive quotation from the transcripts of the audio recordings of the discussions were used; these assisted with getting the exact quotations. The information from the audio recordings was used in conjunction with the notes taken by the research assistant during the discussions. In addition, in order to ensure the validity of the data peer debriefing sessions were done. These sessions were done between the researcher and research assistant so as to ensure that the data that is captured in the transcripts is indeed a true reflection of focus group discussions.

The audio recordings also assisted with the reliability of the research; reliability (dependability) in qualitative research can be achieved through “multiple listening of audio tapes”. The validity of the raw data was verified by the researcher going through the information from the FGDs and identifying common themes. These themes were then checked for validity by the research assistant also going through the information from the FGDs. The researcher and research assistant then had discussions to see if a consensus could be reached on the themes.

One of the intentions of this study was to accurately explore how the nurses in the Manzini region describe the process of decentralization and task shifting of health services to the primary level of care; writing and audio recording assisted in attaining this accurate documentation. A research could display low reliability and high validity due to the nature of the study (Ratcliff, 1995) i.e. it was desired that the nurses express their own opinions of the decentralization and task shifting processes, in the way they saw it and have experienced it. It was not expected that all the nurses saw and had experienced decentralization and task shifting in the same way so the opinions were expected to differ. When these different perspectives were put together one was able to gain a better understanding of the phenomena of decentralization and task shifting from the perspective of the nurses working at the primary level of care in the Manzini region. So the consistency and therefore reliability might have been low in this study due to the different accounts of the nurses but in the same vein the different accounts were able to produce a high validity. To make sure that there was internal validity within the study, by the researcher checked the ongoing dialogue between the
participants’ reality and the concept which they put forward. The researcher’s role within the FGDs was to moderate the discussions and the role of the research assistant was to take some notes during the discussion. As the researcher moderated the discussions close attention was paid not to influence the opinions of the participants in any way.

3.10: Bias

Non response bias was possible in this study as the nurses who chose to participate in the study could be different from those who do not to participate. This bias could not be controlled as the nurses who chose not participate in the study could not be forced into participating. As the researcher was the primary data collection instrument, to reduce bias the researcher clearly identified their personal values, assumptions and involvement in the phenomena of decentralization of health services to and task shifting within the primary level of care. In this study the researcher believed that the intentions of decentralization and task shifting are very noble especially when looked at from the perspective of the patient. However it is important that as the services are rolled out to the periphery the government should have the personnel that works at the primary level in mind so that they are not overwhelmed and they can continue to provide quality healthcare services.

3.11: Ethical Considerations:

During this study the ethical issues that were considered were that first of all the researcher treated the participants with respect in order not to jeopardize the chances of doing further research in the future among the same participants. The researcher also ensured that the rights, interests and wishes of the nurses were respected; in addition the final decision with regards as to what will be done with the information that was obtained from this study lay with the participants and their right to remain anonymous was respected and the researcher made all efforts to ensure that the identity of the participants was protected.

As ethically required the study was carried out once careful reflection of the predictable risks in comparison to the foreseeable benefits to the subjects and others had been made. It was determined that a perspective of the implementers of the policies of decentralization of health services and the shifting of tasks within the health sector was not only appropriate but also necessary especially because the implementation of these phenomena was expanding. It also of importance that nurses who participated in the study would not be jeopardized in any way in when it came to their wellbeing, reputation or job; this is why confidentially was
maintained in this study and this was done by protecting the identity of the nurses who participated in the study. The integrity of the participants was always respected; it was also made certain that the right of the participants as research subjects would safeguard them and that there would be minimal impact on them physically, mentally, emotionally or personally. This was in order to ensure that the nurses who participated in the study were not harmed in any way as a result of the opinions they had put forth in the study. All potential subjects were adequately informed of the aims and methods of the study; they were also informed that they were free to abstain participating in the study and even if they did agree to participate, they were free to withdraw from participation at anytime. This was done in order to obtain informed consent from the study participants. The research protocol which contained a detailed description of the procedures to be followed to ensure the protection of the nurses that were involved in the study was submitted to the Research Ethics and Publications Committee, Faculty of Medicine, University of Limpopo (MEDUNSA Campus) (SREC) and once approval from SREC had been obtained, this proposal was then submitted to the MEDUNSA Research and Ethics Committee (MREC). Once the clearance certificate had been received from MREC, permission was sort to carry out the study with nurses working within primary health facilities in the Manzini region by submitting the proposal to the Manzini Regional Health Management Team (RHMT) through the office of the Manzini Regional Health Administrator. This approval was also received before the research was carried out. The chance of misleading results was also minimized by carefully considering issues of bias, generalizing of results, reliability and validity as the study was being developed. This was done in order to ensure that no conclusions made from this study were misleading.
CHAPTER 4: RESULTS

4.1: Introduction:

This chapter focuses on the findings of the study, which were drawn from five focus groups. Overall there were 29 nurses working in the primary level of care that participated in the study. The average number of participants per focus group discussion was 5.8 nurses (6 nurses). The results from the biographical data collected using the second part of the question guide is presented first; this shows some of the demographic attributes of the participants of this study. The findings of the focus group discussions are then presented and these show the different themes and subthemes that were identified as a result of the analysis of the data; this is be supported by verbatim quotations from the participants.

4.2: Biographical Results:

![PROPORTION OF PARTICIPANTS BY SEX](image)

**Figure 4.1: Focus Group Discussion Participants Segregated by Sex**

From figure 4.1 it can be seen that in this study 79% of the participants were female nurses and 21% were males.
Figure 4.2: Focus Group Participants Segregated by Marital Status

Figure 4.2 shows that in terms of their marital status, 34% of the participants were single and 66% were married. None of the participants were either separated, divorced or cohabiting.

Figure 4.3: Frequency Distribution of Participants by Qualification

Figure 4.3 shows that the majority of the nurses who participated in the study were double qualified nurses; there were eighteen (18) of such nurses in all. These nurses hold either a diploma or degree in general nursing and in addition they also have a certificate in midwifery or psychiatric nursing. There were eight (8) nursing assistants who participated in the study.
and these nursing hold a nursing assistant certificate. There were then three (3) general nurses who participated in this study; these nurse are single qualified and hold just a diploma in general nursing.

![Frequency Distribution of Participants by Current Title at Work](image)

**Figure 4.4: Frequency Distribution of Participants by Current Title at Work**

Figure 4.4 shows that the majority of participants i.e. nineteen (19) had the title nurse at work, there were two (2) senior nurses who participated in the study and then there were eight (8) nursing assistants who participated.

**Table 4.1: Frequency Distribution Table of Participants’ Years of Experience:**

<table>
<thead>
<tr>
<th>WORKING EXPERIENCE (In Years)</th>
<th>FREQUENCY</th>
<th>FREQUENCY PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>1 - 4</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td>5 - 9</td>
<td>8</td>
<td>28%</td>
</tr>
<tr>
<td>10 - 14</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td>15 - 19</td>
<td>6</td>
<td>21%</td>
</tr>
<tr>
<td>&gt; 19</td>
<td>4</td>
<td>14%</td>
</tr>
<tr>
<td>SUM TOTAL</td>
<td>29</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 4.1 shows that the majority of nurses who participated in the study i.e. twenty eight percent (28%) had worked for between 5 to 9 years as nurses and only 3% of the nurses had worked as nurses for less than a year. Nurses who had worked for more than 19 years in the field formed 14% of the participants in this study.

### Table 4.2: Frequency Distribution Table of the Number of Years Stationed at the Current Clinic:

<table>
<thead>
<tr>
<th>YEARS STATIONED AT PRESENT CLINIC (In Years)</th>
<th>FREQUENCY</th>
<th>FREQUENCY PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>6</td>
<td>21%</td>
</tr>
<tr>
<td>1 to 4</td>
<td>12</td>
<td>41%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>10</td>
<td>35%</td>
</tr>
<tr>
<td>≥10</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>SUM TOTAL</td>
<td>29</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.2 shows 41% of the participants had been stationed at their present clinic for between 1 to 4 years and only 3% of the participants had been stationed at their present clinic for 10 years or more.

### 4.3: Findings of Focus Group Discussions:

As the participants discussed their opinions and lived experiences of the decentralization of health services to the primary level of care and task shifting a number of themes and subthemes came out from within the various discussions. These themes and subthemes are summarized below:
**Table 4.3: Summary Table of Themes and Subthemes from Focus Group Discussions:**

<table>
<thead>
<tr>
<th>THEME NO.</th>
<th>THEME</th>
<th>SUB-THEME NO.</th>
<th>SUBTHEME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nurses mainly understand decentralization as a phenomenon that is carried out by government to bring services to where the people are in the communities in order for the services to be accessible to the people. They recognise this decentralization should come with the necessary resources</td>
<td>1.1</td>
<td>The nurses felt that the decentralization of services and task shifting was being imposed on them; they had no input. They therefore could only observe what is happening and according to what they saw they thought the process was to a large extent not going well even though they were not sure of the true processes as these were not shared with them</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses see task shifting as the moving of work from a higher level to a lower level:</td>
<td>2.1</td>
<td>Nurses do not know the criteria and the limits that guide how the task shifting is done</td>
</tr>
<tr>
<td>3.</td>
<td>Nurses see decentralization and task shifting as having had an impact on service provision within their facilities</td>
<td>3.1</td>
<td>Nurses see decentralization and task shifting as having advantages/benefits however they are mainly for the patient and not them</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2</td>
<td>Nurses see decentralization and task shifting as having many disadvantages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3</td>
<td>Nurses see that decentralization and taskshifting is bringing the services but without the necessary resources which compromises the quality of care.</td>
</tr>
<tr>
<td></td>
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<td>Nurses are concerned about the compromised quality</td>
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<td>Nurses are losing the love for, commitment and motivation towards the nursing profession</td>
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<td>4.</td>
<td>Nurses see decentralization and task shifting as having increased their workload within the clinic</td>
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From the focus group discussions the views, opinions and experiences of nurses working at the primary level of care on the decentralization and task shifting of health services were as follows:

4.3.1. THEME 1:

Nurses mainly understand decentralization as a phenomenon that is carried out by government to bring services to where the people are in the communities in order for the services to be accessible to the people. They recognise this decentralization should come with the necessary resources:

SM: “What I understand about that, well, I understand that this is a program that the government is taking because we know that services were in towns, yes, but in
decentralization the government is taking services to the community. To the people; to where the people are staying”.

**MM:** “In summary ngingatsi-nje (I can say) it is taking the services to the people more than people going for the services etindzaweni letikhashane” *(in faraway places)*

**LM:** “I think when you talk about decentralizing you are talking about taking every service to every person even in the rural area”

**AT:** “I think mine its just improving accessibility of health care services to the community of Swaziland so that everyone accesses health care services easily......”

**NM:** “My name is NM. Basically what has been said is what it means to decentralise. To get all services near to the people wherever they are for example people won’t have to maybe struggle to get to like to Mbabane for such services; they can get them near making them to cut costs to get the services”

**NM:** “...... As we have said decentralization is whereby the services are easily accessible to the people.....”

**GD:** “I think it is moving the services from a localised central area to the lowest level where the people are meaning from way up down to the roots of that service so that the people or the community are nearer to that service and also to me it has to go with the responsibility and authority over the resources”

4.3.1.1 **SUBTHEME 1.1:**

The nurses felt that the decentralization of services and task shifting was being imposed on them; they had no input. They therefore could only observe what is happening and according to what they saw they thought the process was to a large extent not going well even though they were not sure of the true processes as these were not shared with them:

**BN:** “Ok I think our government in most cases they impose”

**CD:** “No frankly speaking it has been imposed. It has been imposed, most of the things actually, 100% of the things they are just being imposed and most of the time you are not even involved in the planning part of it. You are only called come and attend such and such a workshop because you are expected next week to be doing such and such a thing so without you trying to be on board or whatever”

**VM:** “Ngifuna kusho njengoba asho kutsi cishe vele lokunengi kuyaimpozwakutsi intfo emalanga nakusaplanwanakudiskaswakutsikutohambakanjani kutsiwa gidli ngelilanga kutsiwe kuchubekani” *(I want to say just what has been said, almost a lot of the things are imposed, things are planned and discussed, and then in one day they are thrown on you and you are told to just get on with it)*
BL: “Ngicabanga lokutsi unfortunately asiyati lokutsi leprocess hulumende wayibekahabanjani nakatawenta loku decentraliza ngikolokwenta ngatsi asikhoni lokuphendvula kahle
lokutsi vele kwenteka kahle yini ngoba asati kutsi wayiplana yabanjani tsine sibukalokwentsakako kufuneka loku, asati sitokutsi wo nayi ke yona mbamba sokulandzeleka yona”

(I think unfortunately we do not know what the process that government planned for decentralization is, this is why we cannot respond to this question properly. We do not know whether what is going on now is what is right, we just see what is going on and we do not know whether this is the real thing, whether they are following the right path)

ZD: “Mine what I can say is that ngekubuka kwami (the way I see it) I don’t know what is the process .......... so ngibona ngatsi le process ayihambi kahle ngingati kutsi injani but ayihambi kahle. Ngoba ngitsi lelesideli this health care to the people and kuleprocess yabo bona they feel like ngabe kwenteka kanje kanje kanje, batafike bablame wena although bangakakutjeli kutsi leprocess kufuneka ihambe kanje”

(I can see that the process is not going well, I don’t know what it should be but it is not going well; we are delivering the service to the people but the process is theirs, they feel this is the way it should be done, they come and blame you but they haven’t told you what the process should be).

BL: “Kutsi kahle kahle we are lacking in two area one kushoda tintfo letibhalwe phansi letisho kutsi kutodecentralizwa naku number two naku lokutawu shiftwa nang’kha emaguirelines akhona. Nako kusuka umuntfu I was expecting you to do 1, 2, 3, this is for the doctor hhayi you are suppose to do this then ngatsi kuyangcundwana kute name lokungivikelako naye kute lokushoko kutsi la yenta 1, 2, 3. Ngaicabanga kutsi nakungabuyelwa emuva nabangakhona sekubhaleke phansi”

(Really we are lacking in two areas; one we lack documents that are written down that explain that this is what is to be decentralised and number two this is what to be shifted and here are the guidelines for that. For now a person just says I was expecting you to do 1,2,3 this for the doctor, no you are suppose to do this then its as if there is conflict, there is nothing that protects me and there is nothing that guides him to do 1,2,3. I think if we can back track and if they can let it be documented).

CD: “And maybe another thing mhlambe ngalokutsi we are not clear about the decentralizing maybe they’ve got another definition bona yale decentralization natsi sinalenye idefinition.”

(And maybe another thing about why we are not clear about the decentralization is because maybe they’ve got another definition for this decentralization and we also have another)

GD: “Yes there is no defined process, if there is we were not involved and we are still not involved”

MM: “.....Even if they (the services) are palatable for them they are none palatable for you, you have no excuse to say I am not taking them because they are decentralized to you, you have to take them as are.......”
4.3.2. THEME 2:

Nurses see task shifting as the moving of work from a higher level to a lower level:

NS: “Ngingatsi kushershira umsebenti to the lower level relevant personnel......... but kubukwa these services langawaprovida dokotela kubukwa kutsi even the nurse can provide it is not all of them but kubukwa nje those lekuatjangwa kutsi even the nurse can provide them even though bekaprovidwa ngu dokotela”

(I can say it is to share tasks with relevant personnel at a lower level...they look at the services that are being provided by a doctor they see that even the nurse can provide; it is not all of them but they look at those they think even the nurse can provide them even though they were being provided by the doctor)

LM: “Its something like umsebenti lobekentiwa some people like labebasuperior then is shifted to labanga phansi like lobekentiwa bodokotela soweniwa bo nesi”

(Its something like the tasks that were being done by some people like superiors are shifted to subordinates like tasks that were being done by doctors are now being done by nurses)

CD: “Hhawu sekudzinwe bodokotela and then sebatsatsa babisa lakitsi”

(Ah! The doctors are tired and they are now giving to us)

VM: “Ngulokushiftha emaresponsibitlities some responsibilities and duties to those people lower”

(It is the shifting of responsibilities, some responsibilities and duties to those people lower)

SS: “I think this also affects the cadres of the lower level because if the tasks are shifted the cadres are affected because those of the lower cadre are suppose to do the work or duties of the higher level ....”

MG: “I think its when some responsibilities, duties are moved from the higher level to the lower level for instance when they initiated NARTIS, they made the staff nurses to initiate ARVs and so nursing assistants to refill when before only doctors were suppose to initiate and staff nurses refill now refilling has been shifted down to nursing assistants and so some other duties for nursing assistants may be shifted to orderlies.”

4.3.2.1 SUBTHEME 2.1:

Nurses do not know the criteria and the limits that guide how the task shifting is done:

NS: “Wo mine letask shifting eish...angati kutsi ngamtsatsa njani ngingatsi angati noma unawoyini lama limits njena but ngatsi sekwehlele kakhulu lakunesi nalokungakafaneli ok kuyekutsiwe nesi unayo lecapacity yekuprescriber but nje u...eish..solo kakhona lokutsi task shifting is it ok? Coz nasibuka nje nakubukeka still nakuchubeka sesingasabukeli linesi nadokotela kakhona emaservices lengivasekutsiwa atongena kata task shifting asatongena
ngakumgcugcuteli so lotask shifting ngibe ngibuke kamatima kutsi akunogcina kuchamuka lokulitje coz ngikenengeva sekutsiwa umgcugcuteli asekhaya ok uyabakala bantfwna afike lelikhadi liplothwe ngu task shifting loyo bese utsi ngubani lobbale lapha?! Ngulangcugcuteli enkhundleni!! So nomina sisambuka kufanele sibuke kutsi kulungana yini, usalungayini, kusalunga yini kutsi sente letask shifting lotask shifting yes kulesinye sikhatshi ngeva kutsi kunalabanye lababuya e...yini batagcina sebajoviwa, kwake kwatsi hem-nje so sengibuka kutsi nadokotela uvanjani nasekutsiwa emaARVs ayodispatchwa le. Nasisacala nje kwakutsiwa RFM akafuni labodokotela abafuni bodokotela batsi nani so nami sengiva buhlungu nase kutsiwa komjovo wami sewutawu.. so nami nginalokutsiwa dokotela uva kunjani nasekutsiwa sekuya phasi kuinishiyetha emaARVs so lo task shifting angabota kamatima as kuchubeka coz as kuchubeka mhlambe humulende abuke kutsi ngani loku bayakukhona kungacishe kuchubeke kwehle konkhe nje”

(For me this task shifting I don’t know how I took it, does it have limits? But I think too much has been shifted down to the nurses, even what is not supposed to be. Ok they usually say the nurse has the capacity to prescribe but there is still this thing that makes me ask is this task shifting ok? When we look at things it is still continuing, not looking at the doctor and nurse there are services which I’ve heard are going to be done by the rural health motivators(RHM) (community health workers). So I usually take a hard look at task shifting and think isn’t a mammoth thing going to come in the future; I have heard that the RHM in the community ok they do weigh the children but they then plot the road to health cards funny. So as we look at this task shifting we must assess whether it is still ok, is it still ok, whether it is still ok for us to do this task shifting. At one time I heard they will end up giving injections, I just heard a rumour, so I think how does the doctor feel when ARVs are being dispatched here; when we started, I heard the doctors at RFM were not happy they were refusing so I myself it pains me to hear that my injection is going to...so I also think how does the doctor feel when they say initiating ARVs is now being shifted down so this task shifting must not come down hard because as time goes on government might think because we were able to do this they can continue to shift almost all tasks down)

CD: “No seemingly nawutsi uyakuassesa njengoba angikase ngive even neguideline yale task shifting nawutsi uyakuassesa nabodokotela batsi nabahle li phasi batsi hhayi mani nanesi angakwenta loku akuhame kuye kunesi. Atsi nanesi nakahleli phasi atsi hhayi isupport staff can do this akuhambe kuye kusupport staff. Mhlabe nguwo lamaareas lokhandzeke kutsi sekubonakala a gray area dokotela utsate watask shiftena nesi and then nesi watsi nakwenta wakwenta wrong kwase kuback fire kutsiwa a nurse is not suppose to do this. Nesi wa task shiftena isupport staff yatsi naseikwenta ikwenta wrong kwafika supervisor watsi no no no and orderly cannot do such and such a thing because mhlambe kunaley yekutsi kute lokusiguidako in terms of task shifting kubonakala ngazutsi its like its my discretion kutsi eish no iART nyalo bo nesi sebangayicala eclinic ayihambe iye eclinic”

(no seemingly when one assesses as I have not heard of a task shifting guideline when doctors are sitting they just feel no a nurse can do this let it go to the nurses and the nurse sits and thinks this can be done by the support staff lets shift it to the support staff. Maybe
that is where the gray areas are; the doctor shifted to the nurse, and when the nurse did it they did it wrong and it backfired and they said a nurse is not suppose to do this. The nurse task shifted to the support staff and the support staff did it wrong the supervisor came and said no, the orderly cannot do such and such and this maybe because there is nothing that is guiding us in terms of the task shifting, its like its at my discretion that ART can now be initiated by nurses let it go to the clinics)

BL: “Mawungaya ku facility lenye nakhona kwentakala something different uyabona lokutsi umuntfu utokhulumela yena endzaweni lakuyo uyabona kusho kutsi kute kahle kahle lokutsi nomu uyakaDvokolwako you are expected to follow this noma uye eSipiki naku, uye Mkhuzweni naku”

(If you can go to another facility something different is happening so you find that a person can speak for the place where they are so one can see that really there is nothing to say when you go to Dvokolwako you are expected to follow this or whether you go to Piggs Peak this is it, you go to Mkhuzweni this is it)

MM: “I think we don’t have the criteria explained to us in the sense that as we are the bearers of those tasks shifted but we don’t have an explanation as to “we have decided to shift this to your level just because we are faced with this and this and this challenges”. So we just have it you know, I would say its just coming in you just see it coming in and you are told that this is the way uyabo (you see); its not really clear as to which tasks will be shifted when and how and why?”

MM: “You cannot even foresee which other tasks are coming because we know exactly they are coming but which are now coming we don’t know their pipeline; their pipeline is too wide for us. Its just like a closed envelope which comes without your knowledge what is inside.”

4.3.3. THEME 3:

Nurses see decentralization and task shifting as having had an impact on service provision within their facilities

NS: “Mine ngicabanga kutsi its good idecentralization ibekahle because nasibuka lamaclients its people labala ku community lesihlala nabo for which in the past bekutsatsa sikhatshi kutsi aye for other services esibhedelela lesikhulu so nyalo siyakhona lokutsi as kubantu lesihlala nabo in the community uyakhona lokutsi ulandzelele”

(I think decentralization is good, it has been fine because when we look at the patients its the people in the community and we live with them for which in the past it use to take time for them to go for other services at the large hospital but now as its people we live with in the community one is able to do the follow up)
NS: “Lokunye lokutsi kulesinye sikhatsi besiyaye sibuke bodokotela kulamanye emafacilities vele bekungatsi bakhuluma sigreek-nje uyabona lokunye vele singakhoni kuku understanda so nyalo siyakhona lokutsi siuunderstanda even though singatokhona kumsita but urefeya ngati kutsi u yokwentani because bacale basi orientha kutsi loku bakwentela naku loku ukwentela naku so you tend to understand nananawe ukhandze kutsi iclient uyikhansela isengala before”

(Another thing is that at times we would look at doctors within other facilities as if they are speaking Greek and you see we were really not able to understand but now something we are able to understand even though sometimes we are unable to help the client but when we refer we know what is going to be done for them because we were first oriented on when a doctor does such and such why are they doing it and so you also tend to understand and you are able to counsel the client before you refer them)

MM: “iadvantage yakhona kutsi cishe umsebenti sewuyakhona kutsi iclient yakho uycial from ekucaleni uze ufike nayo ekugcineni wenetiseke kutsi onkhe emaservices ngiprovidile”

(The advantage is in the work, you are now almost able to start the service provision to your client from the beginning until the end and you are satisfied that you have provided all the services)

LM: “But kuphindze kwasita, kuyasitasita nalakule amount yebantfu labetako emaclients sekayehlayehla as kube nanangu ART wabuya lakumaclinics coz bantfu sebayakhona kutsi bainishiathe kuART ayekale lokuphokubuya, namuhla uuyagula kusasa unani kusasa unani sebaba stable nje sekuyayehlisa”

(It also assists in the number of clients coming to the facility, the number of clients are decreasing, as there are now ART services at the clinics as the people can be initiated and they stop coming everyday with different complaints/illnesses, they have become stable so the numbers patients are coming down)

ID: “Lengikubonako kulodecentralization lokunye lokwentekile among staff cishe sonkhe kutsi ematrainings were provided to us kusiequipha nje with the skill and the knowledge so that we can be able kuprovida wona lamaservices that are going down to the clinics”

(What I can see is that among the staff almost all of us have had trainings that equipped us with the skill and the knowledge so that we are able to provide the services that are going down to the clinics)

LN: “Yes! Yes! Natsi we feel good babonge “hhawu ngasengifile nesi” so you feel good so ngite neservice lapha impela”

(Yes! Yes! We also feel good as they come back to say thank you, “I would be dead nurse” so you feel good that you have provided a real service here)
CD: “Yah ichange ibe khona but ichange ite at the expense of the service provider because the service provider yena ubese ugucura vele yena ubasigulumba so that atokhona kutotsatsa onkhе lamaitems lasadecentraliziwe onkhе lamataks lasashiftwe to him or her”

(Yes the change has come but the change has come at the expense of the service provider because the service provider has been turned into this tireless machine so that they can take up all these items that have been decentralized, all these tasks that have been task shifted to him or her)

CD: “........ what has happened sibone labonesi sebab ma”Jack of all Trades” expected kutsi konkhe bakwente and bakwente njengoba bebenta emaservices itolo......”.

(.....what has happened we have seen is that the nurses become “Jack of all Trades” expected to do everything and to do all services as they were doing them in the past)

4.3.3.1 SUBTHEME 3.1:

Nurses see decentralization and task shifting as having advantages/benefits however they are mainly for the patient and not them:

TM: “Yinye kuphela (only one) to speak the truth there is just one on the patient side but on the working side there is nil. Iadvantage ye (the advantage is for) patient only but bonesi (the nurses). Nalestructure semsebenti (and the structures for doing the work) its not good at all”

BN: “.... the community public at large I think kubasitile bona because sewuyati kutsi ngitoya eclinic ngiyabekisa, ngitopopola sisu ngiphindze ngitfole nema ARVs ami ngiphindze ngihlole nashukela ngiphindze ngihlole ne BP mhlambhe ngihlolene TB mhlawumbhe kube siyayiniketa. So kupublic yona kukahle its an advantage.....”

(...I think the community at large has been helped because you now know I will go to the clinic for example I will get ANC services, get my ARVs, check my glucose levels and also check my blood pressure and also maybe be screened for TB if that service is available. So for the public it is good, its an advantage....).

BN: “Like we said before ihambe kahle to some extent kubhenefithethe community, the patients; tsine kute lasibhenefithethe khona. Ema patients abhenefithethe ngani? Akasandzingi kuma sikhati lesidze bamele dokotela because bonurses labanye bangakhona kwenta lokungentiwa ngu dokotela. Tsine asikabhenefithethe ngoba sekunemalayini lamdze lakagadze tsine. Uma nifika bekute munfu la bhentjini aseniphume nibuke bantu sebanganani lapha ngaphandle. Abasafuni kuya etibhedlela ngoba etibhedlela eNazareen batobonwa ngu dokotela”

(Like we said before, it has gone well to some extent, it has benefitted the community, the patients; we haven’t benefitted anywhere. The patients have benefitted because they do not need to wait in queues for a long time waiting for a doctor as some nurses can do what the doctor is doing. We haven’t benefitted because we have long queues waiting for us. When you
came there was no one on the bench outside but if you would step out now and see how many people there are; they do not want to go to the big facilities as there they have to be seen by the doctor)

CD: “Cha tigulane tibhenefithile kakhulu, yinhle iyabonakala even though nakhona ngicabanga kutsi isengaba improved in terms of kutsi tibhenefithe tona. But kiwo wona lamahealth care providers ibenefit cha babe nayo basesibhedlela thats an honest fact because even if you can go to RFM namuhla you are struggling to get a client bakutjela kahle kutsi eish emaclients sekaba le kini we are struggling”

(The patients have really benefitted a lot, it is good we can see the benefits even though there is room for improvement even for the patients. But for the health providers, those working in the bigger facilities have benefitted thats an honest fact as even if you go to RFM today you are struggling to get a client, they tell you that the clients are with you we are struggling)

GD: “We are seeing the fruits of the task shifting in the sense of reduced disease burden like the people who were coming now and again for curative services; when they have accessed ART they come less on the other ailments than they were coming before. Yes we realise that they have come to the benefit to the people but what we are crying about it is how this change it is carried about on the shifting. We realise the benefit to the community and we are for that idea also”

MD: “We are now able to initiate more patients than before, like before patients were initiated in the hospital and so the patients had it tough to go up there but now we are doing it here so we have benefitted”

GD: “Another thing that is good now is that you are able to see your patient from the time of encounter to the, to the I cannot not say to the end the time when the patient is on care. There is no time where you have to wait with your patient and say a doctor is coming on a certain day or just go to a hospital for this and that. We are happy to see our patients from the time we see them until they are enrolled into care and also the patients do have the confidence to us as nurses because when they see you you’ll give the whole package you are not going to wait for anybody”

MS: “I think its an advantage to our clients because they had difficulty to go up there because of financial constraint but now the health services are near to them to make sure they access them easily”

4.3.3.2. SUBTHEME 3.2:

Nurses see decentralization and task shifting as having many disadvantages:

BN: “..... Disadvantage number 1-ke lomkhulu bodokotela bese abasawenti umsebenti wabo sebaphelekusiftela lapha kitsi bonesi kutsi asale senta lomsebenti lebekufanele bawente nomal osekute lama ques labamele bawente. Bese idisadvantage 2 ukhandze kwukutsi tsine noma mine ngicashelwe kubangunesi angisakwenti lobengifanele ngikwente sengenta
nakulobekumele kwentiwe ngudokotela ngoba sengiva shengatsi sengimbhetse lijazi lelimihlope sengingudokotelanyana lomncane uyabona so ugcina so wu....eh! inemaadvantages nemadisadvantage”

(....The first biggest disadvantage is that doctors do not do their job and keep on shifting to us nurses that we do what they were suppose to do even when there are no queues. The second disadvantage is that even though I am employed to be a nurse I then do not do my job as I feel like I am wearing a white coat and I am a mini doctor you see, you end up....eh! it has many disadvantages)

FD: “....irresult yalentfo leyo ungcine ikwenta wena ungasesi productive emsebentini bese lomsebenti sowuyadrageka sowubuyela emuva sowutagcina wente umsebenti longa siwo wakho sowuyekele lowakho lomele uwenta....”

(....The result of that thing is that you are no longer productive in your job and the work is dragged back and you end up doing what is not your job and neglect what is not your job)

TD: “Nalenye idisadvantage kutsi encenye sewuyabona lokokutsi lomsenti sowuncono sowungabuyela kulomninakati wawo besekubalukhuni lokuwushintja umuntfu sowenta ngatsi bekufaneli kutsi ucale ledrip, utsatse ingati, bekufanele kutsi ngimkale shukela yini nyalo awusakhoni awusakhoni leni? Noma sewuyeva kutsi ngatsi sengiyahlukubeteka lana kani ngisebeta imsebenti walabanye bantfu ngedvwa ngivangatsi ngabe sengiyayekele bese kuba nemaproblems yidisadvantage yetask shiftingleyo”

(Another disadvantage is that maybe you can see that the workload has improved and should be going back to the owner but it becomes hard to change, the person then behaves as is you are suppose to put up the IV, draw the blood, I’m suppose to check the glucose levels and if you are not able to then why? Even when you feel as if you are being abused here and I am doing other people’s jobs on my own I feel like stopping, then there are problems, that is the disadvantage of task shifting)

BN: “Shortage of drugs, shortage of equipment, shortage of staff. So how do you decentralise if you don’t have a simple Panado. You see a client and then you write a prescription go to the pharmacy what is that is that decentralization? That is not decentralization its abuse”

MS: “.....is that the work it has been shifted to us but human resources is very few, we cannot do all the work, the tasks all the time so I think nurses up there have to come down here. They have to be decentralized to our clinic level so that the work will be easier”

MG: “Maybe just to add on what she has just said we don’t have enough equipment for doing the job; we have many departments and you find we have more than 2 consultations but we have only 2 BP cuffs so the equipment is not enough whilst compromising the care.”
4.3.3.3 SUBTHEME 3.3:

Nurses see that decentralization and taskshifting is bringing the services but without the necessary resources which compromises the quality of care. Resources to the nurses include:

SM: “Kepha lokukahle ngako kutsi siyabona kona kutsi konkhule hulumende uuyazama kutsi lamaservices awaletse khona lapha kumacommunities but lapha utfola kutsi akukhonakali kutsi kwenteke kahle nguletindzaba temareasources. Njengayalo sewutfola kutsi ipatients vele sekutfolakala kutsi vele la alayine sikhatse lesidze solo ayo ngena ngoba nami ngingunesityingedwvana sekunyenti lelefumanele ngikwente ngingedwva kunyenti so loko sewutfola kutsi sekune delay kule flow yala ma patients”

(What is good we see that the government is trying to bring the services to the communities but what makes things not run smoothly is the issue of resources? Right now you see the patients queue for a long time because as a nurse I am alone and there is a lot I have to do and this causes a delay in the flow of the patients)

MM: “ekuhambeni kxesikhatsi nangabe leser bowumniketa yona icontinous ubese ubaworried esustainability kutsi ingabe kuleservice lesengicale kumniketa yona itasichuba isibekephi uhlala uworried kutsi eish! Kungabophela phela endleleni”

(As time goes on if the service you were giving is continuous you then become worried that eish you must not run out of the ability to be able to provide in the long run)

LN: “When they decentralise they expecting the client to get everything there at the clinic and the patient don’t get all the care here sometimes at times you have to send the patient to ibig facility because I do not have the thing there”

LN: “idecentralization ikahle kuphelanje ayetiwe ngalokugcwele ngalokuphelele tiphelele tonkhe tintfo tayo”

(Decentralization is fine the only thing is it must be done in full and all the things that go along with it)

NM: “According to me in Swaziland decentralization hasn’t gone well why because its like most of the issues or most of the areas that have been decentralised there wasn’t proper preparation technically, because you find that there is a program that has been decentralised an yet there are no, they don’t have enough drugs, they don’t have enough human resources”

1. Personnel:

MM: “..... in our mother facility they see almost a quarter of the clients we see in the rural because those clients who have been flocking to them were the very same clients who are coming from the grassroots so now who are not going there anymore. So its like they have abandoned the work not shifting, now its like an abandonment .... From looking at the numbers, comparing the numbers now its almost double or triple the number of our mother facility the number that we see but the nurses who are working there they are still that
number which was initial; then number of nurses who are the rural are still that same number
again they just added the tasks on he already existing nurses”

2. Space:

SM: “Yes nespacing naso ngitobekisa-nje lapha kitsi njenyalo kufakwe iTB bafuna
kute iTB iservice yaka TB but nawucabanga iservice yaka TB kufuneka kunespecial indlu
letsite leyakhwe ngenlela yakhona bo-air conditioning everything kodywa utfola kutsi
hulumende ufuna kukufaka-nje akuholhlobetle konkhe angakakubuki konke kutsi actually
lespacing vele at the same time uyabona kutsi tsine lesitakwenta nasitsi-nje tsine siyayifaka
iTB langekhatsi”

(Yes even the spacing for example in our clinic TB services are suppose to be added, there is
no TB service but when you think of the TB service there is a special room build in a certain
way, with air-conditioning everything; that government wants to force all this without having
considered everything actually the spacing you see what we are going to do if we add TB
services inside)

NS: “Ngicabanga kutsi nale decentralization itanemaservices cishe lasadiverse kakhulu so
nalamaclients etfu sengulahlukene and letanemadrugs laseluhukene of which kungete
kwabukwelwa naleinfrastructure kutsi nase kuta ART, kutaTB treatment ngabe sibabekaphi-
nje”

(I think even the decentralization comes with diverse services especially with our clients they
are diverse too and the drugs are diverse of which it wouldn’t look good with the
infrastructure that ART is coming and TB treatment where can we put them)

FD: “Another thing is that kungenteka, it is possible, kutsi kungenteka but it is not possible
like for us when we talk about the clinic the kute lendzawo ye clinic leclinic kutsi utositi
loku utotsi akwentiwe kwentiwele la kutelamarooms aloko nje so I feel like
naloko bayaku over lokha bangakubuki kani kuyamela lokutsi bakubuke kutsi sitsi abakwente
labantfu but sikhona lesitructure sekutsi bangakwenta vele”

(Another thing is that it is possible, that it is not possible for us as a clinic
there is no space for you to say this must be done here there are no rooms so I feel they also
overlook this, they do not look at this whereas they aught to look at it that we are saying these
people should do this but is the structure there for them to do it)

NqM: “I think in Swaziland it was a good idea, it is a good idea but the implementation part
wasn’t really critically looked into there are gaps in the human resources that are suppose to
perform or are qualified to perform the task. I think it was a good idea, it has benefitted the
community but its not a good idea not for the implementers.”

NM: “..... its a very good thing decentralization and also there should be enough preparation
so that enough human resources is also put in place so that people can cope they don’t end up
with burn out syndrome and maybe opt out”
4. Drugs:

**ID:** “Ngalesinye sikhatsi kuba difficult because ukhandza kutsi uyayibona leclient as emacolleagues ashiyo uyibona wholistically but ukhandza kwekutsi the drug you know kutsi utositwa ngunalidrug nali but unfortunately ukhandze kutsi at primary level asinalo lelo drug” (Sometimes its difficult because you see the client as my colleagues have said and you see them wholistically but you find that the drug you know will help the client is not available at the primary level)

**LS:** “so ngalamanye emagama yona lemitsi lamaphilisi lenatsi siwatfola kute, kuhle kubate” (So in other words the medication we are supposed to have we don’t have)

**SM:** “Uyabona lendzaba lechazwa yicolleague lendzaba yekutsi nyalo sesiinishiaitha nemaARVs, asengibekise njena lapha bekuta dokotela waseNazareen abeta ete nemadrugs akhe ale-esibhshedlela langekho la labetofika bese lepatient seuyaitretha naseyibaka leproblem lekhona but tsine lamadrugs site still itoyibeka leproblem lanayo ngati kutsi I have to give my patient this drug but there is no drug here”

(You know this issue being described by my colleagues that we are now initiating ARVs let me make an example we use to have a doctor coming here from RFM and they would bring their own drugs from the hospital which we do not have here which he would use to treat patients. The problem that exists is that we do not have the the drugs, we do not hav but still the client will tell us their complaint and I know that I have to give my patient this drug but the drug is not there)

**SM:** “but lengicabanga kutsi akakwenti kutsi lamadrugs akakhoni lokuwadecentralize asengibekise angitsi ngifundzisekile nge ARV ngiyati kutsi ipatient yami nangiyinkite leARV nakwenteka kuvela loku iside effect ngiyati kutsi I have to give this drug ngifundzisiswe ngalo but ayikho this drug ngitamnikaniibe ngifundzisiswe ngalo I know about it? So ngulapho-ke langibona kutsi hulumende akenti kahle”

(But what she hasn’t been able to do is to decentralise the drugs for example I have been well trained on ARVs I know that if I give my patient this ARV if it so happens that this side effect is experienced i knowto give this drug I have been trained on it don’t have the drug and yet I have been trained on it so this is where I feel government has not done well)

**BN:** “....There is nothing nyalo nje site itreatment lana nyalo nje sihle sicela kulamanye emaclinic uyabo. Batofike bantfu bafike babhale sibhala emaprescriptions vele bayaemakhemisi vele batsenga khona kuncono ...”

(There is nothing now, we do not have the treatment here, we ask other clinics sometime, when the patients come we write prescriptions and they go to retail pharmacies to buy, thats where they buy)
4. Other:

LS: “Nalokunye noma sekukuhona sesikutfolile asesitsi-nje ngale etingatini sesiyakhona kutsatsa leCD4 kodwva-ke kuhamba kuhambe kuphele lelesikusebentisako kutsi kungaphela kuphindze kutsatse sikhotsi kutsi sikufole”

(And another thing even when we have it and we have got it for example in the lab we are now able to draw blood for CD4 but the supplies we use sometimes run out and when this happens it takes time for these supplies to come back)

MM: “ayitsi ita ledecentralization kubukeke konkhe kutsi iequipment letodzingekako ikhona yonkhe yini kusho kutsi emaresources alungiswe nawa kucala kungahambi nje leidea emoyeni yodvwana kutsi sifisile kutsi kuphinda loku but singabuki kutsi siyophiba kuphi njani do we have lamaresource lawaenough”

(As this decentralization comes let it be looked into that the equipment that is going to be needed ia available, that the resources have been prepared before hand prior to the idea just flying on its own. We have the desire to provide this but before we look into we are providing where, how and are the resources enough)

BN: “....angati kutsi ngingakubeka kanjani but nje I will make an example kutsi like kune clinic letovulwa somewhere kashane emakhaya ukhandze kutsi lonesi akakhelwa indlu lapo and yet bebati kutsi bafuna kuyovula sibhedlela kutoba nemuntfu losebentako lesistaff sakhona sitohlalaphi akukacatjangwa loko phela nakwentsiwa kumele bacabange kutsi ok sifuna kuvula sibhedlela.....coz utovula leclinical but kute iBP cuff isita kuphi-ke leyo clinic ngoba lomuntfu kusetomele agilebe aye eNhlangano health centre because bekute iBP cuff eMatsanjeni”

(I don’t know how to put is but I will make an example that there is a clinic that will be open far away somewhere in the rural areas you find that the nurse has not been provided with accommodation and yet tey knew that a clinic was going to be opened and someone who will work, where is the staff going to stay that is not thought of when that is done they must think of that and they must say ok we want to open a clinic....because a clinic will be open but there is no BP cuff where does that clinic help as that person then has to travel to another health facility because their nearest facility had no BP cuff)

CD: “Kuphindze mhlambe itsi letask shifting inayo le disadvantage in terms of yekwekutsi something longakabi trained ngayo eskolweni you will never ever administer it like someone lobetrained because a workshop is different from itraining. So tsine ukhandza kwekutsi you are given just a week in a workshop and in the following week you are expected the following Monday you are an expert in t

(Again maybe the task shifting has the the disadvantage of if you have not been trained in something at school you will never do it like someone who has been trained because a workshop is different from training. So you find that you are given just a week in a workshop
and the following week you are expected the following Monday you are an expert in terms of delivering that service)

4.3.3.4 SUBTHEME 3.4:

Nurses are concerned about the compromised quality

MM: “ukhandza-ke kutsi nalequality seiyacompromizeka njengoba nje lomunye colleague abekisile kutsi nawubone 5 wemaclients uvangatsi yeye ngisebentile kantsi lelilayini langephandle uyyadlala wena batsi batawungena so lentfo imagine kutsi-ke as uchubeka ubona labantfu babanengi ngabe kutsi kuyoshaya 4 lequality of the service?”

( You find that the quality is compromisedlike my other colleague said that if you have seen 5 clients you feel as if hey I have worked hard whereas the queue outside you are joking they are still going to come in. So you can imagine as you continue to see the many patients by the time it is 4pm the quality of the service?

MM: “Lokunye ngingete-ke futsi ukhulumile colleague ngendzaba yale spacing kusti yes decentralization itsi emaclients asitowasita but njengoba ashito-nje kutsi angcina angasasitakali kahle ngoba angcina sainfectheka in terms of ngoba lesspacing setfu-nje nasingasiso lesikahle nasingasi up to standard emaclient etfu atogcina atfola kugula labengaketi nako la eclinic”

(Another thing as an addition my colleague talked about about the issue of space that yes decentralization says we must help the clients but as they said they end up not being helped properly because they end up being infected in terms of because the space we haveis not right, if it is not up to standard our clients will end up getting illnesses they did not come with when they came to the clinic)

BN: “....Kuaffectedha umsebenti wami. I become less productive and be aggressive besengiyatsetsa nje ngiyakwata because kute longirecogniz.....”

(.....It affects my work. I become less productive and am aggressive and I start to shout and I become angry because no one recognizes me....)

BN: “.........abuke kutsi leflow yalamapatients itobanganani. Khona nyalo kune congestion, kuba over crowded. Uplace sa emapatients kurisk kutsi angaba ne TB but bantfu baka TB bayeta la mine ngiyabati ngoba vele ngibatreathile so ngiyababona ngitsi wena awukayileni eTB hospital? Atsi kubanelilayini noma bekukuvutane bayatsandza vele kuta lana vele kudvutane uyabo. Kube bebahleti phansi babuka bapilotha kucala kutsi vele kutobonwa bantfu labangakanani la nga base bayaimprova esitsructure sabo sabasikhulu bakhona nekfaka emafasitetelo lamakhulu kube well ventilated manje akusiko well ventilated uyabona”

(....and look at how large the flow of patientsis going to be. Right now there is a congestion and it becomes over crowded.It places the patients at risk of getting TB because people with TB come here I know them as I have treated them so I see them and I ask them why they didn’t go to the TB hospital and they say there is a queue there or they say it is near here,
they like it here because it is near, its true coming here is near. If they had sat down and looked and piloted first that exactly how many people do we see here they would have then improved the structure and made it bigger and they would have been able to put in big windows so that the place is well ventilated right now it is not well ventilated you see......)

CD: “........Ngeke ukone futsi utsi asesikwentsi njengase sesiko lwenci because the moment you say asikwentsi njengasesiko lwenci ngulesi khatsi lomsebenti ugenteke and bekungake kwenteke a situation whereby ugcine batisi bonesi sebayayekela kwalamuKhla sebotho chubeka kusasa Ungatikhandza urebukwa ngelho ngulabanye bonesi balamanye emaclini kutsi hhayi khona nyadlala nine ngeke tigulane tijike nawutsi wena uzama kwenta lecare njengoba ingiyo, ngulesi katsi wena ungashayi ematargets, So it is better kutsi ushaye lama targets akho icare ingabi nangu so inayo leproblem letask shifting sikhulma ngale emaservices adokotela ngeke ngiwente njengoba dokotela bekawenta ngitowenta abe subnormal. Lokubuhlungu you will that lamamistake leswentako lamuKha leukhandza kutsi they will manifest 10years sesikhohlwe kutsi sawenta 2012 bese sekubangazutsi its something nje lechamukako noma kutsi ikuyo creectheka seku creectheka sesente a lot of damage”

(...you can not say lets do it the way we use to do it at school because the moment you say lets do it the way we did it at school thats when the work is not doable and if i so happened that the nurses say they are stopping work for today and will continue tomorrow you would find that even the other nurses from other clinics rebuke you and say you guys are playing you cannot send patients back. When you try to give the proper care thats when you don’t meet the targets; so it is better to hit the targetsand the care is not up to standard so that is the problem of task shifting. As I talk the services that belong to the doctor I cannot do them as the doctor use to do them they will be subnormal. What is painful is that the mistakes that we do today you will find they only manifest in 10 years time when we have forgotten that we did them in 2012 and then its as if its something thats just appearing or if it is correctable we will correct it after having done a lot of damage)

SS: “And in the process the quality of nursing care is compromised, and yet you are expected to give quality, how can you give quality when you are already burnt out”

MS: “Adding to that point that ok sometimes ok the tasks have been shifted so tsine its always difficult to shift the task to other supporting staff like bo mother 2 mother you find that you’re asking them to do this and that, they end up saying that this is not what they are suppose to do so you find yourself considering that this person is not employed to do that. Loko it caused a lot of burn out so ukhandza kutsi the care vele is not up to standard”

MG: “......so the equipment is not enough whilst compromising the care.”

4.3.3.5. SUBTHEME 3.5:

Nurses are losing the love for, commitment and motivation towards the nursing profession:
LM: “Sekukhokhe emavila kimi lesengikubonile nje umsebenti nasumnengi ubese ubabete lenkhaphunkhaphu yekutsi uwente lomsebenti up to the standard sowuyenta nje kutsi yeyi akundlule embikwaki loku”

(It has made us lazy, when there is too much work you then lose the zeal to do it to the required standard, you just do it so as to get over and done with it)

ZD: “And if you have noticed people are running away from even the nursing or angitsi nje nawe uye eMedunsa I think ufuna ubuye give the orders and the nurses will take the orders and those nurses are running away nami nje ngifisa kutsi bengingaya eMedunsa because sengibalekela lomsebenti. Si endapha singasawutsandzi lomsebenti sowenyanya because everthing seyishiftelwe nurses nurses, sonkhe sitogcina sifike ebudokoteleni because kushokutsi bodokotela sebaphila kahle”

(And if you have noticed people are running away from even the nursing...nurses are running away I also wish I would go to MEDUNSA because I am running away from the work. We end up not loving the work, hating it because everything is being shifted to the nurses, we will end up being doctors as it means doctors now have it good)

CD: “.....the very unfortunate part of it and lalakushoko its critical awuanalaze kutsi bangakhi bonesi labalwela kuyakuNGO sonkhe we are fighting kuyakhona impela.......... every nurse unemotivation yekutsi angitfole idegree ngitobaconsidered by emaNGOs, angitfole idegree ngitota nami sengitomentorisha......”

(the very unfortunate part of it and what she is saying is critical, just follow how many nurses have that have moved to NGOs, we are all fighting to go there.....every nurse has the motivation to get a degree so they can be considered by the NGOs, let me get a degree so I can also come and mentor...)

NM: “For me personally decentralization has impacted negatively on my nursing duties er why I say so because so much of my nursing duties which I’d known have been taken away from me and are being done by other people and I am doing somebody else’s duties which I wasn’t trained for so it has impacted negatively on me its just that even motivation, theres no more motivation as it is.”

SD: “Ok personally I think decentralization and task shifting ok both are good for the consumer but for us there is a very heavy workload and sometimes the conditions are not very favourable, you find yourself at the end of the day you’re very tired and it just drains you of the love of the profession.”

4.3.4. THEME 4:

Nurses see decentralization and task shifting as having increased their workload within the clinic
SM: “kusete ledecentralization kantsi ledecentralization ita with more work uyabo so there should be so there should be comparable human resources in that way”

*(Before decentralization, this decentralization is coming with more so there should be comparable human resources in that way)*

NS: “Its more because it is expected kutsi iclient nayingena nje kuwe uba nesupermarket approach kutsi nakaphuma la ngimetele konkhe if ete for curative ngitamelapha phindze FP khona la phindze naART kona uyagula so thats one nurse so many conditions so ukhandza umuntfu amunye so nomna ngetababangu 5 but I am tiired!! So umuntfu angachamuka nje atsi ubukeka ngatsi udziniwe but ubone 5 webantu? So e-its too much”

*(Its more because its expected that when the client enters in your consultation room you mst have a supermarket approach, that when they leave I must have done everything; if they had come for curative I will also give them family planning here, and ART, yes they are sick so thats one nurse many conditions no one person. So even if I see 5 patients I am so tired. So someone may come and say you look so tired but you have only seen 5 patients. So its too much)*

MM: “Eh ngingatsini? Kute kuspecializa kutsi ungatsi mine I am specializing in this. Utikhandza wenta all the services uwendwana. Yebo nangikubuka esigabeni sahulumende kucost saving because utokha ndza kutsi umsebenti webantu labangu 10 wentiwa nguwe wena ungunesi because utobu ngucounselor, ubengunurse utikhandze ungudokotela, utikhandze ungupharmacist Ungu data clerk so ungunesi so lakuwe as a nurse lework load itoo much”

*(Eh, what can I say? You cannot specialize, you cannot say I am specializing in this, you find yourself providing all the services. Yes at the level of government it is cost saving as you find that the work of 10 people is being done by you as a nurse because you will be a counsellor, nurse, you find yourself being a doctor, pharmacist, data-clerk so for you as a nurse the work load is too much)*

MM: “kutsi phela lomsebenti nasewumnengi ugcinaukwekhama and umsebenti nase ukwekhama-ke”

*(When the work load is too much you end up struggling and when you struggle)*

LM: “Ok ngucona loku kwe primary prevention then sekungetekile coz nakacurative nje akusesiwo those minor ailments sesigoer deeper as dokotela.Singeteke nayindzaba yakaHIV seyichamuke ok sicle sarefilla ainitiathe dokotela ngale esibhedlela besesifike tsine ngala sesifike siyarefilla nyalo natsi sesiyachubeka siti initathela sodywana la nomna dokotela angekho”

*(Ok its the primary prevention and then there is more because even the curative its no longer of minor ailments, we now go deeper like a doctor. This issue of HIV has been added, it has*
come with, we started by refilling and the doctor would initiate at the hospital and we just refill on this side but now we initiate on our own even when the doctor is not around)

SM: “Konkhe letintfo titufihlelwa lakimi sekukabi loko sengi overloaded bese sengisebenta more than lendlela lokufanele ngibhadaleke ngayo”

(all these things have been dumped on me this is bad, I am overloaded and I work more than what I am getting paid for)

SM: “uyabona lededcentralization sayita nalomsebenti incumbi losokhona kitsi lakumaclinic. Ngiko nangingunesi beseutfola kutsi phambi kwami sekuhleti kumbe separate/7 wemabhuku, ngisuka la ngite la ngisuke la ngite la sowutfola loko sekubangumtfwalo lomkhudlwana.”

(You see decentralization has come with a lot of work at clinic level. That is why you find as a nurse in front of you there are 7/separate registers, I move from one to the next and this is largish burden)

TD: “Eh lepaper work” (Eh! The paper work)

FD: “Paper work just too much. Hambe e child welfare uyoattendu umntfwanana lona6 months loexposed utobona kahle”

(The paper work is just too much. Go to child welfare and attend to a 6 month old baby who is exposed you will suffer)

FD: “....... Like nyalo nje we are suppose to initiate ARVS, refill emaARVS so many things attached lapho kubuya to one person a nurse”

(Like now we are supposed to initiate ARVs, refill ARVs, so many things attached there and it all comes back to the one person the nurse)

VM: “We are now lab technicians, we provide PMTCT, HTC the list is endless (laugh) really the list is endless.”

VM: “Eish! Kusinikete i workload leningi, sesabaneburn sesikhandza sitsetsa nje nalamapients its due to the burn out”

(Eish! It has given us a greater workload, we are burnt out and we find ourselves shouting at the patients, its due to the burn out)

SD: “Ok personally I think decentralization and task shifting ok both are good for the consumer but for us there is a very heavy workload and sometimes the conditions are not very favourable, you find yourself at the end of the day you’re very tired and it just drains you of the love of the profession,”

GD: “It is an added task that we are now initiating, following up patients; we are diagnosing, treating, initiating, refilling, following patients, monitoring the program now at large; the ART program, we just monitor in total. Yet before the doctor would do that, so that yes we
see the patient, we screen them and set them apart for the doctor to assess for initiation and initiate......”

**MM:** “I think that has been stretched out by my colleague who mentioned that basically for now, I say for now in quotes because there are still other items that are still going to come. I say for now we are faced with the ART initiation and the TB initiation which was not done earlier on especially on the TB aspect we were not following up patients especially MDR, XDR those were taken care of at the TB centre but now they are taken care of by us here. So that is the heavy burden and looking at that program its a very broad one really its a very broad on.”

**4.3.4.1 SUBTHEME 4.1:**

Nurses see a lot of the work they are doing as a result of decentralization and task shifting as work that is not theirs:

**LN:** “We are mini doctors”

**NS:** “Mini doctors, mini phlebotomists”

**LN:** “Sesingene naselab ngitsi lesitsatsa letingati sekute utongena elaboratory utfole lab technician natsi bonesi sesingene khona lapho”

*(we are also in the laboratory, we are the ones who draw blood, you will not go in the lab and find a lab technician we are right in there)*

**NS:** “Sesenta umsebenti wabodokotela” *(we are doing the work of the doctor)*

**LN:** “Ha! We are a hospital without a doctor”

**AT:** “The doctors, most of the work is done by the nurses yet the nurses’”

**ZD:** “......, these reports I don’t think ngicedzi icurative ya80 people alone kufuna ngiphindze ngigatherishe leinformation alone ngiyihambise. There should be kufune kubenebantfu bakhona labatsatsa idata. ....... Kunebantfu labahambwe bayofundzela kugatherisha idata bente emareports, kunebantfu lahambwe bayofundzela kwelapha sigulane, kunebantfu labafundzele kungena elab so if sibambisene kuto phuma intfo sibili. But nasekutsiwa nesi donsa lelab uyibeke laeceleni kwakho utsi ungacendza udonse lamabhuku ugatherishe leinformation, uhamb enabamikisele le ngoba baphindze bafune bumbangisele lahambleti khona. ......”

*(these reports, I don’t think having seen 80 patients at curative alone I must then gather the information alone and send it. There should be people collecting data....there are people who studied how to collect data and produce reports, and people who went to school to study how to treat a patient, and there are people who studied to work in the lab and so is we work together we will succeed . But when they say the nurse bring the lab close to you, and when you are done with that bring the registers close and gather the information, and then take it to them as they then want you to take it to them)
CD: “.......sesaba mJack of all trades loku lesakufundza esikolweni lamatfuba ekukwenta sekakhashane kakhulu lelesakufundza lesesifuna sale sikwenta kakhulu; she has touched a very critical area even if ungadoja tonkhe letigulane wakhona nje kwakha lereport, wapheka nje lereport kahle and then ligama lakho lihle. ...... So sekuvele kwaba, its a very painful scenario sesima M&E officers, sibodokotela, sibolab tech sekulukhuni-ke lokwetfu, sekulukhuni lokwetfu kakhulu sekusafarishile lokwetfu kubuyela laboburn out labayishoko.........”

(We have become Jack of all trades, what we learn at school, the chances of practising it are very far away, she has touched a very critical area even if you can cheat all the patients as long as you can put together the report, cooking the report well and then your name is good, its a painful scenario we are now M & E officers, we are doctors, lab technicians, ours is hard, ours is suffering then we go back to the burn out that have been said....)

KC: “....... Now we don’t have a proper direction of who a nurse is because we have been jack of all trades even on the computer we can sit there and do everything, the data clerk, my job?”

4.3.5. THEME 5:

Nurses see decentralisation and task shifting as being a result of vertical programs and related partners:

FD: “........ngikunothise mine utokhandza kwekutsi kuneprogram lefuna icale etibhedlela yentiwe bonesi abafiki le banibute kutsi wer were planning to do this sesihambie sefika kuphi, bachamuka sebatsi sebaniniketa emabhuku lamakhulu liphile leli nail lelidze nail lifuana nilivule nibe 2 lomunye abhale ngale lomunye abhale ngale. Bafika sebachamuka naletintfo setivele ti in place abakanibuti nine kutsi nitokhona nobe cha sebavele babheke kutsi nihambone niyokwenta. Nalunye abale naye walenye iprogram achamuke nelakhe lelisuka laliyoshayisa laphehungayo nibhekeke kutsi nalo niligwalise. At the end wena uwedvwana nakuphela inyanga kkekutsi kwami nikwentile yini, kkekutsi kwami nikwentile anana ngimunye yebonine”

(...what I have noticed you find that there is a program that must be started in health facilities by nurses, they come and ask you and say we are planning to to this, we have gone this far, they just come to give you these big register, where is this long one that needs 2 people to fill it one this side and the other the other side. They come with the things in place, they don’t ask you whether you will be able or not, they just expect you to go and do. And another one from another program will come with their own register that stretches from here to the door and you are expected to also complete it. In the end you are left alone at the end of the month everyone is asking whether you ave completed theirs and you are alone).

TD: “Emadonors akahealth aye efika” (Donors for the health ministry come)
FD: “Because I feel like angati lokutsi basebentisa yiphi icriteria nabakwenta letfo but its like nje ngitsi letintfo leti takaHealth ukhandza kutsi lamadepartments maningi kunTB, kunazibanibani kunazibanibani nguloyo zibanibani ufuna kutsi naye iprogram yami sengifuna ihambe iye eclinic and the other person nami ngifuna iprogram yami iye eclinic its like bona akwentsuki kutsi bahlangane babe joined together babuke kutsi really are we supposed to take all the services aye le kumaclinics ngoba nangabe HIV iyashifta neTB uyashifta konkhe lentfo leyo iyakumuntfu munyethat is a nurse”

(Because I feel like I don’t know which criteria they use when they do this thing but you find these things from the ministry of health ther are many departments, there is TB and others and each one wants their program in the clinics, its like it doesn’t happen that they sit together and consider whether are all services suppose to be taken to the clinic because if HIV is shifting, TB is shifting all this is going to one persong the nurse)

BN: “Mhlambe ianswer yami itobuyela to the last speaker I think lamaprograms should just meet besebayabuka kutsi le clinic banabonesi labangakhi, babona bantfu labangakhi on a monthly basis or on a daily basis basis itsengitsi mine bonesi eclinic abascreene for TB, baphindze bente preART, baphindze bainitiathe iART baphindze batsatse esamotja, baphindze batsatse nakokonkhe lentfo nabomalaria nato tonkhe lelintfo leto coz sesiyakwenta konkhe la eclinic batokhona yini labonesi asiba overworkhi yini so kumele ahlangane lamaprograms abuke kutsi kumcoka yini kutsi yonkhe intfo kutsi yonkhe kutfolakale endzaweni under one roof but kutowenteka yini”

(maybe the answer will go ack to the last speaker, I think te programs should just meet and look at the clinic how many nurses are there, how many people do they see on a monthly basis or on a daily basis, when I say these nurses should screen for TB, and do preART, also initiate ART and also draw blood for CD4 and also test for malaria and all those things, we do all those things at the clinic. Are the nurses going to cope? Aren’t we overworking them? So the programs must come together and see whther its important that all things must be comprehensive, all things are found under one one roof but is it possible)

4.3.5.1. SUBTHEME 5.1:

Nurses see decentralization and task shifting as focusing on specific programs i.e. they have lead to the improvement of ART and TB services meanwhile the other services have been left behind:

NS: “Manzini region nakarefeya eRFM kaART cishe the referral system is good so ngicabanga kutsi lededcentralization bazame kutsi ibabheke natsi singatikhandzi sifrustrated”

(Manzini region when referring to RFM ART the referral system is good. With the decentralization they have tried to make it good so that we don’t find ourselves frustrated)

ID: “Mine idecentralization ngibuka ngatsi isite ngalaka ART, and those conditions related ne HIV cishe lapho isitile TB lalamanye nje vele ngibona i at zero still because lana solo
siyababona nabo gogo but emad Drugs abo still akatifolakali kani sitse abe lapha entfolaphilo batayitfola the services”

(I see decentralization has helped the ART side and those conditions related to HIV, there it has helped. It has helped TB; the others I see them being at zero because here we still see the old people but their drugs are not available and yet we have said they should come to the health facility and they’ll get the services)

LN: “Nayo ikaART kuphela itask shifting” (Task shifting is also with ART)

ID: “Its one sided, ikaART kuphela kute kulokunye” (It is one sided, its with ART alone)

NS: “Sowungu nesi coz site these visits adokotela besides akaART lalamanye emadepartments aketi nje dokotela asatongibonisa kutsi uyati insindza betjadzi-ke nayi siyatichubekela so lotask shifting akangibukele kutsi ngi covered until kuphi kungatsi nje sekuchamuka hulumende asatsi naloku akuye eclinical”

(As a nurse because there are no doctor visits besides ART the other departments do not come to help me out with difficult cases we just continue on our own. So task shifting doesn’t consider how far I am covered, It just looks as if government comes and says hero to the clinics)

CD: “And then we come, sometimes kubuhlungu (its painful) if I can make an example because i HIV leyasiletsela yonkhe lentfo yabo task shifting...”(because its HIV that brought all this task shifting thing)

BL: “99.9% vele wale task shifting iletfwe iHIV” (Of course 99.9% of task shifting is as a result of HIV)

ZD: “And all lamaprogram noma the services labese ayangeteka at clinic level are due to HIV”

(All the programs or services that have been added at the clinic are due to HIV)

BL: “Nalamapartners onkhe ukhuluma ngani wena? Sikhluma ngeHIV. Nine-ke I HIV ilamkhatsini”

(And all the partners what are you about, we are about HIV, and you HIV is in the midst)

CD: “Kute leletimele yodvwa asengibekise nje kube yeta ngenhlitiyo yekukholwa le task shifting ngabe sibone kwakhiwa emaXray le emaclinic iservice lengatsintsani naHIV but sibone TB ehliswa because kutsiwa TB ngumzala waHIV kute lesikubone kutitela kutimela nje kutsiwa no nyalu sesidecida kwekutsi vele at clinic level aithole imini delivery sekutawubekeliswa nje bomake ngoba sibona ngatsi bomake bayahlupheka bahambe bayowaitha eNazareen, lolokumile nje lokungayamani naHIV kute kakhulu konkhe kufanele kutsi kube ngumzala, ngumalume waHIV”
(There is none that is on its own, for example if task shifting was innocent there would be X-ray machines in the clinics, a service that is not HIV related but we saw TB being taken to lower level facilities and this is a cousin to HIV we saw nothing coming on its own for example they have not come to say we have decided that clinics should have a mini delivery service, women are now going to give birth at clinics as we have seen that women struggle and have to go to the waiting huts at RFM, something thats on its own that doesn’t have to do with HIV but there is nothing it all has to be a cousin, uncle of HIV)

4.3.6. THEME 6:

Nurses support decentralization and task shifting:

LN: “Mine ngiyayisekela kakhulu because kusitakala bantfu kumacommunities kakhulu bantfu labebangake bakhone kuya esibhedlela”

(I support them very much as the people in the communities are benefitting especially those who cannot go to the hospital)

SM: “Cha nami idecentralization ngiyayisekela kakhulu futsi yenta kutsi nalabo nkosi yami labete lemali yekugibela bayofika le esibhedlela letinkhulu emadolobheni sibabonile bakhona basitakala so loko vele siyayisekela kakhulu lokutsi ya ayichubeke iyeephambili. I task shifting sibonile nayo isitile kakhulu ngoba nyalo siyabekisa kutsi lokwa kucaala emapatient beka nangabekufanele ipatient ingene kumaARVs kufuneka size simele lilanga ladokotela kutsi dokotela uтоочamuka nini afike nini omunye uтооle kutsi sowuchamuka sowusishiyi nasemhlabeni sowufile so uvabuhlu naye kutsi lomuntfu lona kube nkosi yami usheshe wachamuka koďvwa-ke itask shifting siyahona kutsi er tigulane nkosi yami tisitakale tisitakale ngesikhatsi so ngeke sitsi ikabi cha iyasita kakhulu le task shifting”

(I also support decentralization very much, it also makes those who do not have money for transport to go to the big hospitals in towns they have seen they can be helped so due to that we support it a lot for it to continue. We have also seen task shifting also being of assistance because we have seen in the past when a patient was suppose to initiate ARVs we had to wait for the doctor and sometimes the doctor would come and find that the patient has passed away and that was painful and you wish if only the doctor had come sooner. But with task shifting we are able to help the patients in time so we cannot say it is bad not his task shifting is really of benefit)

ID: “Mine itask shifting ngiyisaphota lalokutsi naledecentralization yona lehealth information ngema conditions nangema health practices bantfu ibasitile coz bantfu basheshe bayitfola kamelula kuta kwababili noma munye lapha laecclinic for leyo service utoyitfola leyo health information aphindze asati ngalama services lamanye lasakhona so incase ekhaya asanemuntfu uyasho kutsi lapha eclinic kutsiwa sewuyakufola kwekutsi sekumalula sewuyeta so leinformation giving nayo yente kwekutsi lamaservice abe up to standard”
(For me task shifting I support it and decentralization too, that health information on conditions and health practices the people have been helped, they quickly and easily. One or two people come to the clinic for that service, they will get that health information and they will also find out about the other services that are now in the clinic so incase a person at home they are able to say you know at the clinic they say you can now get such and such a service and so one finds it becomes easy and the person comes. So the information giving has made the services up to standard

**BN:** “Yes I support decentralization but 1st ayiphindze ibuketwe kahle kubekungahlalwa phasi” (but it must reassessed properly, they have to sit down again)

**CD:** “100% I support it for the sake of our people yah. Kufanele kutsi bantu betfu balutfole lusito (our people must get the help) at anywhere, at any time”

**GD:** “Myself I do its only that we are seeing the holes in it which need to be attended to. We really are, I myself I support fully decentralizing services to the people, it is what the people need yes.”

**SS:** “I think the decentralization is ok but the task shifting has loopholes, I think if they have to decentralise the doctor has to be there kube nadokotela la so that if kuba nemacomplications bese urefeya kuye because these people don’t get to hospital, batsi bête imali”

**MS:** “Decentralization is ok I think the only problem is with the task shifting”

### 4.3.7. THEME 7:

Nurses believe the decentralization and task shifting experience can be improved through the following:

1. Provision of resources

**NS:** “Yes nalestructure si expandwe nasifuna kakhulunywa ngestore room lesitotfwala emadrugs alabantfu lekutsiwa akudecentralizwe emaservices akuexpandwe sibone natsi kutsi cha sikhone nekubeka konkhe kube up to the standard”

(Yes and the structure must be expanded when we want talk of the store room for the drugs for the people for whom we are decentralizing the services for and we can see that we are able to keep everything and it is up to standard)

**NS:** “so then this data clerk siyafuna siyamcela” (the data clerk we need them)

**LM:** “Nalamaquipment nasingawatfola abekhona especially nalamadrug kubebete lokutzi lenidrug ise hospital abuye nabo abela kumaclinics ngoba labantu sebayeta lakumaclinics”
(If we can also get the equipment especially the drugs, there must be no drugs that are just for hospitals, the drugs must also be at the clinics because the people are coming to the clinics)

LN: “Nale personnel ayibuye njegapharmacist nje this is big clinic indzinga kubanapharmacist. This is sort of a health centre makhulu this clinic shem pharmacist nje siyamcela”

(The personnel must also come for example the pharmacist, this clinic is big we need a pharmacist, this is sort of a health centre we need a pharmacist please)

LN: “Pharmacist, data clerk kakhona space sabo” (we have a need for a pharmacist and data clerk)

2. Partner coordination

SM: “Lengingakungeta lokungentakutsi kubekahle kutsi tinini tenkhosi natingabuya tibe banye ngoba utokhandza esikhatsini lesiningi sekudzinana kutsi ngitobekisa kuchamuka namuhla lesinini senkhosi lesi sifuna sente loku kusasa ngisabuko loku kuchamuka lesi sinini senkhosi sitse asente loku kantsi ngisabuko loku kantsi labantu nokungatsiwa abete bonke bahlale kanye kuhlalwe kanye kubonakala khona kutsi ngatsi loku sekucishe kuyaphana ngatsi bonesi sesibabengetela umsebeni lomkhulu nasenta kanje. Kani ngalesikhatsi beta ngamunye ngamunye utfola kutsi abeva nasikhuluma kantsi nakutsatfwa konkhe kuhlalelwe phansi kuyevakala kube one loko ngifola kutsi kungasisita naledentralization ingentiwa kanjalo”

(What I can add which can make things better is if the partners can come together as you find that in the majority of cases its tiring for example today this partner wants us to do this, tomorrow while I am still focusing on this another partner says we should do something else. If these people can come together similar things can identified, and they can identify areas areas where they are overloading the nurses. However if they come one by one they don’t understand when we tell them, when everything can be taken and they sit down together we can understand one another it can help usif decentralization can be carried out that way)

3. Incentives to be attached to the added duties that result from decentralization and task shifting:

ZD: “......why don’t we share nama-ke leliholo lingetwe kutotsi ngibe ngiwenta lomsebeni ube wati kutsi leliholo cha ngisebenta ngadvolo cina tintfo time kahle......”

(...why don’t we share or at least let the salary be added so that as I do the job you know that you have the confidence to do the work...)

BL: “Lalakushoko kutsi letask shifting kube ita nemaincentives”

(What has just been said that if the task shifting was coming with incentives)
FD: “Like there is this thing angitsi (that) everyone sewuyati kwekutsi nasema clinic sekuyarefilwa emaARVs niyayibona lentfo leyo (knows that ARVs are being refilled at clinics you see) something that has been done by doctors before uyabo (you see). So because there is this added job nyalo leseyikhona (that is there) maybe 2% from your salary this is just an example uyabona (you see) so kuyakwenta nawe kutsi utsi at least kuyabonakala kutsi ngiyandzingeka” (it makes one to say at least it is can be seen that I am important)

BN: “A token of appreciation”

SM: “Thank you. I concur with NqM. I think task shifting is good for the people who come for the services, to access the services; its not good for the people who are giving out the services because you are always piled to give more services yet there is no motivation behind this, you are just piled piled piled the services for you to give to the people but the motivation is zero so its not good that way.”

MM: “..... And the welfare of those people to where the tasks are shifted to is not well catered for, its just the same stuff, the same mannerism they have been living in no improvement no what; because I understand if doctors were shifting some of their tasks, I think a way of strengthening it would be er putting some incentives to those junior staff to see that they are being thought of because really when you add something some more work on someone you expect that person to add some more energy or strength over that but there is no strength giving that person from you who are decentralizing which means somehow its only the benefit of the consumers that is being looked for not to the ones who are performing......”

MM: “Well with me I think my colleagues have just said my heart on task shifting and decentralization. But mine is just that if they want this to work they must look into the implications of the whole process because if they ignore those things it will mean they are not careful on what they are doing and to me I think its good to be skilled in many ways even in the grassroots but I think government should open her mind on the aspect of task shifting because there is more involved there, there should be more training even to the nurses, some of the nurses should be upgraded to the doctorate level because they are more experienced now, they will be even more effective and efficient and you know in many to the client, they deal with the clients all the time, they have initiated them, they know exactly what is in place exactly on the people, they have the people, they live with the people. But somehow it seems as if government ignores those implications because there are no just free scholarships flown in the air just to these nurses to whom we have shifted these tasks to they need to have a certain level of skill, they need to go out and come back. I think that will be even cost effective even to government”

MG: “My suggestion is that maybe if they can add the staff and the way we were doing before like we are working straight shift; they must give us er some time, they must give us off days to rest because now from Monday to Friday we are suppose to be here until 4:45pm we are suppose to be here; weekends we work so imagine, its from Monday, its my weekend up to another Friday and I’m still here, at the end I think burn out will arise, care can be
compromised. So I think if they added some maybe we can have shifts that this week we’ve got a number of nurses to be off and the other week they work, others rest and including also the annual leave because for now the annual leave it is not beneficial I think to us because it comes once in 12 months”

MM: “what about the services of a doctor, when are they going to be decentralized to the community level meaning the clinic level so there must be a way that the doctors are also decentralized with their services to the clinics so that the decentralization we are talking about it is not complete, they shifted the tasks and pretended it was a decentralizing in that aspect. So if the doctors are in the hospital and with the decentralized one with the system now we still say go to a doctor at a higher level, no the services of doctors are not decentralized.”

GD: “...... I haven’t heard a change on the establishment meaning the number of nurses in a clinic that are supposed to be there. Is that looked after in this era when things have turned that a number of people are no longer seen in the bigger institutions they are seen in the clinics and I think that also should be taken care of, the establishment in the clinics......”

MG: “My suggestion is that maybe if they can add the staff....”.

4.3.8. THEME 8:

Nurses feel government should consult and involve them as decentralization of health services and task shifting was taking place:

LM: “Ok. Mine ngiva ngatsi nakwenteka ledecentralization maye asibe involved tsine lesitawu even if lesiaffected. Yebo-ke asibe at par kutse kwentekani kanjani. Ngitobekisa ngiyatifikela ngiyacashwa kahulumende hulumende uyangitsatsa uyongifaka kuMangcongco of which mine bengingekho ngalesiyasikhatsi bekwentiwa lendzaba yaMangcongco azame akazame kusichazela angati nomangiyevakala yini”

(Ok, I feel like when this decentralization happens please let us be involved as we are the ones that will be affected. Let are be at par with whats happenin, let me give an example, I am new in government, just been employed and theypost me at a particular clinic and I wasn’t there when the plans about this clinic were made and so let government try to explain to us, I don’t know whether I’m being understood)

BN: “Tintfo letipartaina health like labafuna kukwenta noma kufike tinini tenkhosi noma inini abainvolvi labantfu labatowenta lomsebenti baya le eMinistry, leMinistry ngeke iwente lomsebenti; bainforme bona babekelane nemadates kutsi kutowenteka nini mhlb kabana”

(Things that pertain to health like what they want to do or when the partners come or whatever the don’t involve the people who are going to do the workthey go to the ministry,
the very ministry that won’t do the wor, the inform them, they see each others and plan dates that what will happen when)

MM: “Yah justa follow up observation on what my sister has said, when I look at the programs I think from grassroot. I think they were suppose to involve us first, they were suppose to engage us on issues they have on the desk so that we can have a say, we can have input on it because as to now its just a heavy thing that you cannot avoid that is coming over your head, they are just bombarding you with this without having any place to shift to running away from that thing coming to you.”

MM: “....We need to involved in the system itself not just finding yourself has jumped into it not knowing how high to jump, what to jump over......”

4.3.9. THEME 9:

Nurses suggest decentralization and task shifting should be evaluated:

AT: “The people responsible for the decentralization have to revisit their plan and see to it if its effective ayinyatseli lomunye umuntu ibenje fair”

GD: “I’m also wondering who is going to evaluate this program because task shifting is a new thing who is going to look if it is working the way it was planned? So now we are seeing it going and going but no one is coming to check if it is working or it is the benefitting people as it is suppose to. Like there here highlighted the issues of quality also the burden of not being able to down shift from the nurses because there is no definite duties that a nurse know that this one I can shift down, to whom? Were they involved those who are down there to say “now you have to take this task”. So there are a lot of things. I am just wondering on the issues of evaluation, my colleague here has compared the clinics with the mother facilities, is there anyone who is looking to a nurse how many number of patients are you suppose to see in a day in the ART program oh! For this one you can manage or its just see them as it is the case with us. You cannot turn away a patient and say no you are tired you need to see a patient and continue.”

NS: “....So noma sisambuka kufanele sibuke kutsi kusalunga yini usalungayini kusaluga yini kutsi sente letask shifting lotask shifting ........”

(...So even if we can have a look at it, look at whether are things still going well, is it still alright, is it still ok for us to do the task shifting, this task shifting....)

NqM: “.... That they should consult even us yes we won’t say no or yes but maybe there is somewhere where we can help them to say ok you want to come here to offer the service, yes the people they need it and it would be good to grow the facility; but then again there are these things that need to be in place for the project to be successful. Maybe and then some of the things as maybe we are continuing with the service we won’t be able to foresee, then
before in the planning stage, that this and this and this can come up but they should also follow up that after decentralizing the services what are the problems that are there and modify whatever is being offered because really we end up suffering”

KC: “When they are planning they should include the people of the law and law itself as well as psychologists. Why I say so is because when they shift a task on you and there is no proper documents or no proper guidelines to protect you”
CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1: Discussion

5.1.1: Introduction

In this chapter the results of this study are discussed. Within the discussion generalizations on the results are made, the researcher also attempts to deduce possible explanations for some of the findings and then also relate some of the key findings within the study to literature and other studies that have been carried out within the phenomena of decentralization and task shifting. In addition to the discussion of the findings of the study, the conclusions that can be drawn from the results of the study in relation to its objectives are highlighted. Finally recommendations that can be made as a consequence of this study are also made.

5.1.2: Definition of Decentralization

According to various versions of the dictionary, by definition decentralization should include “a distribution of administrative functions or powers of (a central authority) among several local authorities”; also decentralization is sometimes described as the redistribution (of urban populations and industry) to suburban areas (Farlex, n.d.). Essentially therefore, within literature there are therefore various meanings of decentralization which have been given by both authors and the governments that implement it (FAO, 1997). One of the best general definitions of decentralization has been given by Rondinelli (1981) which states that decentralization is “the transfer of responsibility for planning, management and resource-raising and allocation from the central government to (a) units of central government ministries or agencies, (b) subordinate units or levels of government (c) semi-autonomous public authorities or corporations (d) area-wide regional or functional authorities or (e) nongovernmental organizations and private organizations”.

Within the health sector decentralization is primarily linked with the improving access to health care which includes the expansion of services beyond the urban areas into the rural areas (Akin, Hutchinson and Strumpf, 2005). Ideally this increased reach of services is achieved through citizen participation where health decision making is provided directly to the officials of that population and therefore health issues are addressed directly and this is in order to increase efficiency within the health system (Akin, Hutchinson and Strumpf, 2005). Based on what these various pieces of literature are saying, this means therefore,
decentralization not only means the expansion of services to smaller or maybe even rural health facilities but it also involves the devolution of authority and responsibility to officials that have a closer contact with the population who are to benefit from the services.

Within the context of this study, the main focus when it comes to decentralization was on the devolution of health services from a higher level of care to a lower level of care. The nurses working in the primary level of care in this study essentially described decentralization as the deployment of health services from central health facilities that are mainly in the urban areas (or at the higher level i.e. hospitals) to the health facilities that are in the periphery i.e. the clinic; only one nurse out of the 29 nurses who participated in the study went further to describe and associate decentralization with the devolution of responsibility and authority. The reason for this (i.e. almost all the nurses associating decentralization with the devolution of services alone) possibly could be that, it would seem this is mainly what the nurses have experienced when it comes to decentralization, they have experienced the deployment of the services to them but the responsibility and authority that is also suppose to be associated with decentralization is not something that they could relate to because in the context of the health system in Swaziland the bulk of the responsibility and authority does still lie with the national office of the Ministry of Health and not with the Regional Health Office in Manzini (the region where the study was carried out). Examples of important functions and authority that have not been decentralized include the hiring of personnel, financial control, the allocation of other resources (equipment and medicines) to health facilities and the maintenance of relations with and coordination of implementing partners.

In addition even when asked to describe the true process that is associated with decentralization in Swaziland, they described a process that did not involve the devolution of authority and responsibility. What they thought should be part of the process was mainly an initial assessment of whether the decentralizing would be feasible, ensuring that the resources for the implementation of the decentralization were in place and then consultation with not only the community where the services were being taken to but also them as the implementers (which they saw as being themselves) of the decentralization policy. They saw all these processes as being the responsibility of government but they did not specify at which level of government this responsibility should lie, national or regional. Community participation is a part of the decentralization process which the nurses described as being very important, this is consistent with what is mentioned in literature; citizen participation is also
said to be an important part of decentralization by literature (Akin, Hutchinson and Strumpf, 2005). In addition the recommendations that resulted from the consultation by WHO, UNAIDS and PEPFAR in 2008 for the processes to be followed in decentralization which is coupled with task shifting are that a situational analysis, national endorsement and a regulatory framework are key elements in ensuring that when any country adopts a task shifting policy it is safe, efficient, effective, equitable and sustainable. This supports what the nurses in this study were saying that they felt government had missed carrying out certain critical steps, like wide consultation (situational analysis) and the alignment of the regulatory framework, before adopting these policies

5.1.3: Why Decentralize

Loubiere et al (2007) state that decentralization was meant to expand the reach of health services beyond the large cities to the diverse populations that exist outside urban areas; but beyond this, according to Akin, Hutchinson and Strumpf (2005) the idea behind decentralization in relation to health was to increase efficiency and citizen participation in health services and therefore improve access to health care and drugs in rural populations. The nurses working in primary health care facilities identified with and acknowledged that the process of decentralizing health services has definitely made certain health services accessible to people in the rural areas or to the places where the people are and this has brought with it a number of very important advantages to the patient. It can however be noted that nurses also said that it is only certain services that have become accessible to the rural populations and other services which the people in these areas still need have not become available. The services that were said to have become more accessible are those related to HIV, services related to other chronic illnesses like diabetes and hypertension have not become more accessible.

The possible reason for the imbalance in accessibility between HIV related services and services related to other conditions could be that a large part of the financial support of health services in Swaziland has been channelled to HIV and services that are related to it e.g. HIV testing and counselling, laboratory tests related to HIV (CD4, Full Blood Count-FBC, Chemistry, Dried Blood Spot-DBS etc), TB screening and treatment, PMTCT etc. Almost all the funds that come from donors is for HIV and even with the drugs government makes all efforts to make sure that money for purchasing antiretrovirals is available. The nurses stated
that decentralization that is outside HIV was limited e.g. hypertensive and diabetic service delivery was said to be inadequate at the primary level of care even though there were still a large number of people in the communities that were in need of these services, but as they were not fully available these patients have to be referred. This was a concern to the nurses because according to them, amongst the general population there seems to be the notion that the decentralization covers all services that should be in a hospital, i.e. people believe all hospital services are also at the clinic level but when the patients who are not in need of HIV related services come to the clinic and do not find the service they need, they then believe and even say that the nurses working within the clinic is doing them a dis-service.

The disparity in the decentralization of health services related to HIV and the decentralization of health services related to other condition as mentioned could to be related to the fact that for over 20 years HIV has been seen as a health emergency not only in Swaziland but in other parts of the world as well. Due to the devastating effect that HIV has had in Swaziland, this has resulted in the government of Swaziland having it as a priority when it comes to health; in addition to this even the health related donor funding has largely been directed towards HIV and HIV related issues. This could be the reason why much attention has been given to HIV and related services especially when it comes to ensuring that these services are available at the lowest level of care. Whilst HIV has been getting all the attention, the services that are related to other health conditions like diabetes and hypertension have lagged behind. An analytical summary of the health financing system of Swaziland published by WHO in 2009 observed that despite an increase on health spending by the government between the year 1998 and 2009, there has however been a focus on channelling funds towards vertical programs like HIV/AIDS and in addition to this the increased donor funds that have been received by the country have mainly accrued towards HIV and HIV related services and conditions. This WHO report noted that the health system however has not enjoyed such privileges which in itself could explain why health facilities have experienced an imbalance when it comes to the attention given to HIV and that given to other conditions.

5.1.4: Resources as linked to Decentralization and Task shifting

The nurses also stated that in spite of some services being decentralized and task shifted some services that are now meant to be available at lower level facilities are not available. Decentralization and task shifting are then limited by the fact that even though the services
are coming to the primary level of care and task are being shifted to nurses working in the primary level of care, they (the services) are however not adequately supported by the necessary resources. So according to the nurses the improved access is often hindered by for example the shortage of drug, laboratory supplies, human resource etc. Aiming for an improved access to drugs has been highlighted as being one aspect that is behind decentralization i.e. decentralization is seen as a mechanism for ensuring that rural populations have access to drugs (Akin, Hutchinson and Strumpf, 2005); however the results of this study show that the decentralization of health services to lower level facilities in the Manzini region in Swaziland according to the nurses has not necessarily resulted in the improved access to drugs for the patients. The nurses state that certain drugs have become more accessible like antiretrovirals, however other drugs like the antihypertensive drugs, medicines for diabetes and some drugs for treating some opportunistic infections for patients that are HIV positive are not available at the clinic level. The nurses stated that the shortage of drugs in the lower level health facilities is twofold i.e. stock outs (i.e. the drugs they are suppose to have at the clinic are not available) and the fact that some drugs in Swaziland are not distributed to the clinic level.

The likely cause for the stock out of medicines that should be available at the clinic could be due to two things, the possible poor inventory management of medicines within the facility or due to drugs not being available at the central warehouse. There are a number of reasons that could result in this unavailability of drugs at the central level, including the fiscal crisis that is currently being experienced by the country due to the sharp decline in the Southern African Customs Union (SACU) revenues (in 2011) which are the major source of income that supports the country’s budget (African Economic Outlook, 2012). The fact that some drugs are not distributed to clinics is as a result of the present policy that controls distribution of drugs to health facilities in Swaziland. The drugs that do not go to clinics are what are known as B, C and S level drugs; these are only distributed to health centres, hospitals and are for specialist use respectively. It is only A level drugs that go to the clinics and so due to this system the nurses see certain conditions, know how they should treat them but because they do not have the drugs they have to refer the patients to a higher level facility. This system is however currently under review after the launching of the Standard Treatment Guidelines and Essential Medicines List in September 2012.
Nurses also stated that due to drug stock outs sometimes they have to write a prescription for the patient to go and purchase the medication at a pharmacy which proves to be a challenge for those patients who cannot afford to do this but in addition those patients who live in places that are rural where there are no pharmacies near to those facilities and so those patients end up going without their medication.

The nurses also said that there were challenges in terms of the human resource which they felt should accompany decentralization and task shifting. In relation to this, first of all the nurses thought a distinction should be made between decentralization and task shifting, they stated that according to their understanding there is a difference between these two phenomena. They saw decentralization as the deploying of services so that they are not concentrated at a central level or in the urban setting but they are spread out to the periphery or the rural areas and they felt the services of a doctor, pharmacist, laboratory, data personnel etc should accompany this decentralization process. They therefore believed decentralization has not happened in earnest in their setting because deployment of the services of the different personnel in the health care setting has not happened. They said what has happened is that a number of tasks have been shifted to be done by nurses and they felt as long as the services of other health care providers are still being done by a nurse then this was not true decentralization. So somehow they considered this as a blurring between the decentralization and task shifting and somehow these according to the nurses these should be separated. The explanation for this blur could be because essentially decentralization has happened almost simultaneously especially when one looks at the provision of HIV and TB care and treatment services at the primary level of care.

Infrastructure was also highlighted as a major problem within the primary health facilities; the nurses stated that the infrastructural development within primary health facilities was lagging behind the services that were being deployed to the facilities; the nurses felt that the infrastructural problem really had to be addressed within their health facilities so as to for example infection of patients with TB and also in order to have adequate storage facilities for all the medicines that accompany the decentralised services. The likely reason for this is that decentralization and task shifting in Swaziland has mainly been supported by development partners, especially when it comes to the resources including infrastructural resource. One finds that as partners assist in bringing the services to the clinics the funds which they have to do this work do not allow them to build permanent structures or if they do the processes and
procedures involved are long (that is just the policy within these funds) and this means therefore the best thing they can do is to provide prefab structures which are not permanent and are therefore not seen as a sustainable solution to the infrastructural challenges within these health facilities.

Generally the nurses who participated in this study said that in their experience decentralization and task shifting in Swaziland was not being adequately supported by the necessary resources which included infrastructure, human resource, drugs and other supplies. Literature however emphasises that for either phenomena (task shifting or decentralization) to be successful the support of adequate resources is necessary; the WHO guidelines on task shifting (2008) actually state that there are certain elements that have to considered in order to ensure that adequate resources are available for implementing task shifting; whereas decentralization on the other hand is suppose to come with the authority of allocating and the responsibility of raising especially financial resources as services are being deployed from a central authority to the local authority.

5.1.5: Efficiency and Citizens Participation in Decentralization and Task Shifting

The decentralization of health service also aims to increase efficiency in the system and citizen participation (Akin, Hutchinson and Strumpf, 2005) and task shifting mainly targets increasing productive efficiency which basically involves either “increasing the number of health care services provided at a given quality and cost or providing the same level of health care services at a given quality at a lower cost” (Fulton et al, 2011). If one wants to find whether a service is efficient or not in the health system an economic evaluation must be carried out; this could involve weighing the costs of for example providing the health service versus the benefits that will result from that particular service. When the economic evaluation is carried out in this manner this is also known as a Cost-Benefit Analysis (CBA). In order for the provision of the service to be said to be efficient the benefits must outweigh the costs. In the case of both decentralization and task shifting as these policies aim to increase efficiency in the system, the CBA should show that the benefits outweigh the costs if this policy will be said to have increased the efficiency of health service delivery within the system. The results of this study show that the nurses working in the primary level of care say an evaluation of decentralization and task shifting has not been carried out and they state that according to them an evaluation is necessary.
A number of studies within care and treatment programs of HIV have demonstrated that economic evaluations can be carried out and some have shown that task shifting increases program efficiency. The studies quantified the time and money saved when task shifting was implemented. In relation to time there are studies that showed that there is a reduction in waiting times and lost-to follow-up when task shifting is implemented within the ART programs (Kosgei et al, 2008, McGuire et al, 2008, Torpey et al, 2008 and Udegboka et al, 2009) and when it comes to cost there are studies that showed that when ART programs reduce their dependence on doctors the clinic operating costs are reduced or the patient load could be vastly increased at the same cost (Harling et al, 2007 and Stearns et al, 2008). In addition as there are a number of combinations that are possible in terms of skills with human resources for health, other studies have have been carried out to compare the productive efficiency of different skill mixes. These studies can be carried out in order to establish which skills mix of human resources combined with which non human resources provide the most efficient delivery of health service. A number of these skills mix studies show that a number of countries are not operating at levels that are productively efficient (Fulton et al, 2011). What must be noted with productive efficiency studies however is that when comparing the skill mixes between different countries or even within the same country, there are other factors that must be considered that also affect the productive efficiency; it is not just the skills mix alone. These other contextual factors include the health services being provided, health system in which the study is being carried out, payment scheme, workforce training and management culture; these factors could also cause the productively efficient skill mix to vary across and within countries (Fulto et al, 2011). The different studies that can be carried out in order to evaluate the decentralization and task shifting policies that are being implemented in Swaziland further emphasize that there is a need to evaluate these policies as the nurses that participated in this study were suggesting; and a lot of information that could be important in informing further roll out of these policies can be derived from these evaluation studies.

In addition literature states that citizen participation is a very important part of decentralization; the nurses who participated in this study agree that in the decentralization process the community needs to be involved; the nurses state that the involvement of the community is important in order for there to be more community ownership of the process and the services that are decentralization. Cheshire (2010) says either than ownership,
because these communities have needs that are unique, if decision making is provided directly to the officials of these populations, the personalised health issues of these groups could be addressed directly.

5.1.6: The Process of Task Shifting

Task shifting according to WHO/UNAIDS/PEPFAR (2008) involves the rational redistribution of tasks among health workforce teams, the tasks are reassigned from highly qualified health workers to those who possess less extensive training and fewer qualifications as appropriate; this means therefore according to the definition given by WHO, UNAIDS and PEPFAR task shifting is not a haphazard process, it has definite guidelines and procedures which are used to carry it out.

According to the nurses that participated in this study, they acknowledge that task shifting involves the shifting of tasks from higher more qualified personnel to lower level personnel who are less trained and have who are less qualified. They therefore speak of the task shifting that they have experienced as being tasks being shifted from doctors to nurses and from nurses to support staff. The nurses are however unclear about what the process or criteria that is used or should be followed when shifting the tasks in Swaziland. Some actually stated that they have not seen any document that gives guidance to the manner in which task shifting should be taking place. They therefore describe the process as being haphazard and feel that there is a variation in what is happening in different health facilities when it comes to task shifting this is especially so with the shifting of tasks from nurses to support staff, the nurses feel the shifting of tasks from themselves to support staff is somewhat more difficult as the support staff is generally not employed for and therefore not trained in some of the tasks they feel they should be shifting and also because there is no formal guideline it is difficult for them to know which tasks they can shift.

The nurses also feel that the tasks that are being shifted to them from the doctors is being done with no guideline; according to them, just as the nurses are deciding for themselves which tasks to shift, the doctors are also deciding for themselves the tasks they are shifting to the nurses and they see this as something that has resulted to some extent in what they termed as “task dumping” where tasks from a higher level cadre are being given to a lower level cadre because the lower level does not feel like doing the task. The tasks that are “dumped” are not supported or evaluated when they are shifted onto the lower level.
A health policy report by USAID (2010) states that Swaziland does not have a national policy on task shifting and yet task shifting occurs informally throughout the country; it also states that doctors have managed to shift some of their tasks to nurses to reduce their workload whereas nurses on the other hand have only shifted a few of their tasks to others and so nurses end up performing their own tasks and the tasks that have been shifted to them from the doctors and this results in the nurses being overloaded. The nurses in this study also attested to the fact that they were overloaded, they stated they were doing the work of others (doctors, pharmacist, laboratory technicians, data clerks etc) plus their own which they said was too much;

LN: “We are mini doctors”

KC: “...... Now we don’t have a proper direction of who a nurse is because we have been jack of all trades even on the computer we can sit there and do everything, the data clerk, my job?”

So the nurses saw the workload as being so much for them they even called themselves “mini doctors” and “jack of all trades”

5.1.7: Revision of Establishments Registers of Health Facilities in the Era of Task Shifting and Decentralization

The results in this study show that the nurses working in the primary level of care in the Manzini region in Swaziland acknowledge that they see task shifting as a phenomenon that has mostly been the result of the shortages in the health workforce in the country. According to literature task shifting is one method that can be used by countries to increase the efficiency of the available human resource for health. The literature also states that by using task shifting governments can strengthen and expand the health workforce in order to increase access to HIV and other services (WHO, 2008). The nurses working at the primary level of care feel there is a need to look into and address the distribution of the health work force in Swaziland. They feel that due to the decentralization policy of the country the majority of patients are now being directed to primary health facilities to receive their care there; then some of the health care workers within the larger health facilities need to be redeployed from these large health facilities to the clinics as there is more work there now. They therefore believe that the establishments register of the health facilities should be revised and more nurses for instance should be allocated for the clinics and in addition to more nurses, the
other types of personnel should also make up the staff compliment of the personnel at the clinic e.g. pharmacy personnel, laboratory personnel, data personnel etc. It is possible that this issue of the distribution of health personnel has not been looked at because the task shifting policy in Swaziland has not been formalised.

Statistics in 2010 showed that in the Manzini region the nurse to population ratio was 189/100000 population whereas the WHO benchmark is 173/ 100000 population, this statistic shows that the Manzini region was above the WHO benchmark in terms of the nurse to population ratio (MOH, 2010). Even though the statistics in 2010 showed that nurses in the Manzini region were adequate, the nurses in this study however said the primary health facilities were short staffed for the services they now have to offer. They recommended that the establishment registers be reviewed to ensure that the staff compliment within the different levels of health care was still according to the amount of work that was within these levels. This is review of staff compliment within facilities is an exercise that the Ministry of Health has to take up to ensure that the staff, especially the nurses have been deployed in such a manner that the busiest facilities do get the most staff.

5.1.8: Quality Assurance within Decentralization and Task Shifting

The nurses were also concerned about quality assurance issues of the services they are providing as a result of decentralization and task shifting. Their concerns were first of all linked to the fact that the decentralization and task shifting were happening in facilities with inadequate infrastructure; and this made them particularly concerned about the provision of TB services within such facilities. The nurses felt the provision of TB services within clinics that had improper infrastructure would result patients that do not have TB becoming infected with TB.

In addition there were those nurses that felt that even though the training was being provided to support the task shifting however they felt this training was not adequate to make them provide the service that a doctor was suppose provide like a doctor or to enable the support staff to provide the service the nurse was suppose to provide in the manner that the nurse provides it; one nurse went on to say that in order to task shift the week or sometimes even less that is taken in order to train people on tasks that other people took years in tertiary school studying was giving the false implication that the many years of training was not really necessary.
According to the WHO guidelines on task shifting there are quality assurance mechanisms which include standardized training, supportive supervision and certification and assessment that are important for ensuring quality of care (WHO, 2008); if however these formal quality assurance frameworks are not in place then the quality of care being provided through task shifting cannot be clearly assessed and there may also be conflict and tasks being neglected in instances where there is an overlap in job descriptions and a lack of communication. The nurses that participated in this study did say they had not come across any document that guides task shifting in Swaziland as literature states and without this formal policy this could result in what was stated in USAID (2010) which is that the assessment of the quality of the services provided through task shifting would not be possible and conflict and task neglect could also be possible. The lack of a formalised task shifting policy in Swaziland could probably be cited as a basis that makes the concern of these nurses about quality of care genuine.

The lack of a formal policy also has legal implications; there is no legal protection for those undertaking the additional tasks and therefore the ability to protect the patients is also absent. Some of the nurses who participated in this study did highlight the legal implications that go along with the way they practice nursing within primary health facilities in the area in which the study was carried out. These nurses said some of the duties they carry out now go beyond their scope of practice as nurses and so they were concerned about what would happen if anything were to go wrong.

KC: “When they are planning they should include the people of the law and law itself as well as psychologists. Why I say so is because when they shift a task on you and there is no proper documents or no proper guidelines to protect you......”

5.1.9: Additional Tasks and Incentives

A number of the nurses who participated in this study were concerned about the fact that even though they find more tasks accruing to them, they did not get any increase in renumeration neither was there any other type of incentive to encourage them to keep on doing the work with vigour and love. The nurses felt since they were taking on more tasks then they should be paid more since their workload had increased. They felt that it was only logical for more work to result in more pay; however, they said no one seemed to be looking out for their welfare; below is what some of them said on this matter:
MM: “..... And the welfare of those people to where the tasks are shifted to is not well catered for, its just the same stuff, the same mannerism they have been living in no improvement no what; because I understand if doctors were shifting some of their tasks, I think a way of strengthening it would be er putting some incentives to those junior staff to see that they are being thought of because really when you add something some more work on someone you expect that person to add some more energy or strength over that but there is no strength giving that person from you who are decentralizing which means somehow its only the benefit of the consumers that is being looked for not to the ones who are performing......”

BN: “A token of appreciation”

SM: “Thank you. I concur with NqM. I think task shifting is good for the people who come for the services, to access the services; its not good for the people who are giving out the services because you are always piled to give more services yet there is no motivation behind this, you are just piled piled piled the services for you to give to the people but the motivation is zero so its not good that way”.

In this study the majority of nurses indicated that there should be monetary incentives as compensation for them doing more work; there were however a few non monetary suggestions that were given like scholarships for the nurses to upgrade their qualifications or adopting a system where by by they also worked in shifts even at clinic level or they were able to accrue more leave days than what they currently have:

MM: “Well with me I think my colleagues have just said my heart on task shifting and decentralization. But mine is just that if they want this to work they must look into the implications of the whole process because if they ignore those things it will mean they are not careful on what they are doing and to me I think its good to be skilled in many ways even in the grassroots but I think government should open her mind on the aspect of task shifting because there is more involved there, there should be more training even to the nurses, some of the nurses should be upgraded to the doctorate level because they are more experienced now, they will be even more effective and efficient and you know in many to the client, they deal with the clients all the time, they have initiated them, they know exactly what is in place exactly on the people, they have the people, they live with the people. But somehow it seems as if government ignores those implications because there are no just free scholarships flown in the air just to these nurses to whom we have shifted these tasks to they need to have a certain level of skill, they need to go out and come back, I think that will be even cost effective even to government”.

MG: “My suggestion is that maybe if they can add the staff and the way we were doing before like we are working straight shift; they must give us er some time, they must give us off days to rest because now from Monday to Friday we are suppose to be here until 4:45pm we are suppose to be here; weekends we work so imagine, its from Monday, its my weekend up to another Friday and I’m still here, at the end I think burn out will arise, care can be
compromised. So I think if they added some maybe we can have shifts that this week we’ve got a number of nurses to be off and the other week they work, others rest and including also the annual leave because for now the annual leave it is not beneficial I think to us because it comes once in 12 months.”

Recommendation thirteen (13) of the Treat, Train Retain (TTR) guidelines formulated by WHO in (2008) says “Countries should consider measures such as financial and/or non-financial incentives or other methods as means by which to retain and enhance the performance of health workers with new or increased responsibilities, commensurate with available resources in a sustainable manner”. This shows that according to the WHO guidelines, for the adoption of task shifting within countries the recommendation was that the they should consider accompanying this with some sort of compensation or incentives as tasks are being shifted; this compensation would be either be for new cadres of personnel to whom tasks were being shifted to or to the already existing cadres to whom additional tasks were being given. In some countries like Zambia and Malawi where task shifting has been adopted as one of the mechanisms for compensating for the scare human resource for health strategies for providing incentives to the workers have been introduced by the governments in these countries for both existing and new cadres (WHO, 2008). So for the nurses working at the primary level of care in the Manzini region in Swaziland to request for incentives for the additional tasks that they have taken on with decentralization and task shifting is not something that is out of the ordinary, it has been done in other countries and it is in line with the recommendations given by WHO to countries that choose to adopt and adapt the TTR guidelines.

5.1.10: Advantages and Disadvantages of Decentralization and Task Shifting

According to the results of this study the nurses working at the primary level of care support the decentralization of health services fully and to a large extent task shifting as well. The possible reasons for this are they have experienced some of the advantages that come with these phenomena; these advantages include them being able to take care of their patients holistically, which to some extent brings with it a peace of mind in terms not worrying about losing the patient to care which is something one would assume use to happen a lot when there were more referrals to the secondary and tertiary levels of care. Also due to the services being accessible within the community and the people who access the services are from within the community the nurses are able to see the results of the work they have put into the
patients when they see them improving and this is not only a major ego boost for the nurses but also gives them confidence to continue providing the services as they experience the results of their efforts first hand. Also it is fulfilling for the nurses when they know that a good number of the patients within the community receive the care they require and the financial constraints which is the major barrier for most patients when it comes to receiving the health care they need is over. According to the TTR guidelines produced by WHO in 2008 some of the benefits of task shifting that were cited for the patient was that the patient would save time and money. The nurses within this study also cited the fact that due to task sifting and decentralization the patients were able to save money as they did not have to travel far to access health care.

However the disadvantages which the nurses say have been as a result of the implementation of these two phenomena within primary health facilities seems to come about mainly due to what can be summarised as limited communication between the people that come up with the plans of how these two phenomena are to be rolled out and the implementers of the phenomena; one would like to predict that if the people planning would communicate with the implementers and involve them in their planning just a bit more there would be a better understanding of the processes that are involved within decentralization and task shifting and possibly what the nurses currently cite as disadvantages of the two phenomena would become less.

The fact that nurses were able to cite both advantages and disadvantages os decentralization and task shifting is in line with literature; literature shows that in some countries these phenomena have been successful and have brought a number of positives to the health system whereas in some countries these phenomena have brought more disadvantages than advantages to the health system (Cheshire, 2010; Collins, Araujo and Barbosa, 2000; MSF, 2007)

One limitation to this study was that it did not include interviews with expert opinions that could have included the regional health administrator, the regional health matron or clinic supervisors or maybe even the chief nursing officer. These would have been interviewed so that they can also describe what decentralization and task shifting are within the context of the Ministry of Health in Swaziland and in particular the Manzini region; these people would might also have been able to shed some light on what the processes of decentralization and
task shifting are supposed to entail in the context of the health sector in Swaziland and in addition also describe from their perspective the extent to which the community and the nurses have been involved in planning the roll out of these two phenomena.

Another limitation to this study is that it cannot be said to be representative of the perceptions of the three (3) nurses who declined to participate in the study; the perceptions of these nurses might have been different from the perceptions of those who agreed to participate. The findings therefore are representative of those nurses who work in the Manzini region and consented to participating in the study.

5.2: Conclusions

From the findings of this study therefore it can be concluded that there are a number of issues that make up the experiences of nurses working at the primary level of care in the Manzini in Swaziland with decentralization and task shifting. The experiences of the nurses with these phenomena also give rise to what the nurses cite as the advantages and the disadvantages of decentralization and task shifting.

Generally it can be concluded that nurses see the two phenomena having advantages for the patient; these advantages include: the services are now in the communities and therefore closer to the patients and therefore patients with financial constraints can access services, also due to task shifting patients do not have to wait in long queues in order to see a doctors, they can receive their care from the nurse in their local clinic, there are less chances of patients being lost to care as they receive their care in the community in which they live and therefore can be easily followed up and as patients receive care from nearby, diagnosis and treatment for more patients can happen sooner and therefore its possible for patients to receive care before they become too sick and even if they do become very sick it is possible for these patients to pick up as a result of care they have received at the clinic level. In addition even the advantages one would have classified as being for the nurses see these as ultimately being to the advantage of the patient for example as a result of decentralization and task shifting the nurses receive more training which is an advantage for them as they gain more knowledge however some of the nurses say even the knowledge they gain is ultimately for the benefit of the patient.
The experiences that the clinic nurses have had in relation to task shifting and decentralization that have resulted in them citing that these phenomena have numerous disadvantages are mainly linked with the shortage of resources to adequately support these two phenomena in the primary health facilities. Resources that are lacking include infrastructure, personnel, drugs, laboratory supplies etc. The shortage in human resource ultimately result in nurses feeling like the outcome of these two phenomena has been an increased workload which has caused burn out and loss of love for the profession for some of the nurses. In addition the gap in human resource and infrastructure result in there being a concern amongst the nurses about the quality of the services that are being provided to the patients.

It can also be concluded that nurses see it as a disadvantage that the community and the implementers of the decentralization and task shifting are not involved during the planning stages of the roll out of these phenomena; this was cited as being one of the reasons why there are gaps in the supporting resources.

So finally it can be said that the nurses describe a number of issues that relate to their experiences with decentralization and task shifting at the primary level of care and they are also able to cite a number of advantages and disadvantages that are related to these phenomena.

5.3: Recommendations

1. It is necessary for the government of Swaziland to formalise the task shifting policy so that not only are all health workers including the nurses clear about the processes and guidelines for task shifting in Swaziland but also so that assessment of the quality of care being provided through task shifting is assured and conflict and tasks being neglected in instances where there is an overlap in job descriptions and a lack of communication.

The legislators in the parliament Swaziland need to pass the general decentralization bill into an act. This bill speaks into how the local governments within the Tinkhundla system are going to function. One would earnestly recommend this to happen because this bill should also have an influence on how the health care system of the country is going to be run; how it is going to be decentralized and this should speak into resource raising and allocation within health in the decentralized system. So maybe with the decentralization bill functioning as an
act, it may be easier to address the problems of resources that are not following the services to the periphery.

2. With a formal policy for task shifting in place, this would ensure that the quality assurance framework also exists and is functional so that the assessment and therefore an evaluation of the quality of health care services provided through task shifting takes place and this is what some of the nurses wanted to see happening.

3. It is important that the leaders within the ministry of health, policy makers or government as a whole engage the implementers of the decentralization and task shifting phenomena because they have a large influence on the success to failure of these two policies within the health system; it is therefore critical that as the roll out of these continues the implementers are involved so that they not only own the process (i.e. so that they do not feel it is imposed as they are saying presently) but so that they are also able to inform the process so that it is more fitting and more acceptable to them as well.

4. Other studies that could be undertaken following on from this study are:

   - A similar qualitative study done with primary health nurses within other regions
   - A study that would explore the experiences of doctors, support staff or community health workers with decentralization and task shifting
REFERENCES:


USAID, (2010), “Creating an enabling environment for task shifting in HIV and AIDS services: Recommendations based on two African countries case studies” last viewed 9th December 2012 available from the internet at www.healthpolicyinitiative.com/.../1109_1_Task_Shifting_Summary

Annexure 1: Approval Letter from Medunsa Research and Ethics Committee

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 05/2012
PROJECT NUMBER: MRECH/93/2012: PG
PROJECT:
Title: Perceptions of nurses on task shifting and decentralization of health services to the primary level of care in Manzini, Swaziland
Researcher: Ms SN Mabuza
Supervisor: Dr S Mdzebele
Department: Public Health
School: Health Care Sciences
Degree: MPH

DECISION OF THE COMMITTEE:
MREC approved the project.

DATE: 06 June 2012

PROF N Ebrahim
DEPUTY CHAIRPERSON MREC

The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (ICORG00043199), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00004195).

Note:

i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.
Annexure 2: Letter Seeking Permission from Manzini Regional Health Management Team

University of Limpopo (Medunsa Campus)
School of Health Care Sciences
Department of Public Health
P.O. Box 215
Medunsa
0204

The Regional Health Management Team
c/o Regional Health Administrator
Ministry of Health
P.O. Box 110
Manzini
Swaziland
Dear Sir

Re: The Perceptions of Nurses on Task Shifting and Decentralization of Health Services to the Primary Level of Care in the Manzini Region, Swaziland

This letter serves to request for permission from the Regional Health Management Team to carry out the above mentioned study. I would like to carry out the research on the perception of nurses on task shifting and decentralization of health services to the primary level of care in the Manzini region, Swaziland as a prerequisite for my masters’ degree. The study is done under the supervision and guidance of my supervisor from the Department of Public Health at the University of Limpopo, Medunsa Campus.

The aim of the study is to explore the perceptions of nurses on task shifting and decentralization of health services to the primary level of care in the Manzini region, Swaziland. The areas that will be looked at include the nurses’ lived experiences of the processes of task shifting and decentralization of health services and what they describe as the advantages and disadvantages of task shifting and decentralization of health services.

The voluntary respondents will be nurses working at primary health care facilities within the Manzini region. These respondents will only participate after having signed informed consent to participate in the study. Their names will not appear in any of the documents and confidentiality will be maintained. Your approval of this research will be appreciated.

Yours sincerely

Sibongile Mabuza
Master of Public Health Student
University of Limpopo (Medunsa)
Contact: (00268) 76558505
sibongile.mabuza@yahoo.com
Annexure 3: Approval Letter from Manzini Regional Health Management Team

THE KINGDOM OF SWAZILAND

MINISTRY OF HEALTH
Regional Health Administration
P.O. BOX 6364
MANZINI

Our Ref: RHA/MZ/01

28/05/2012

Sibongile Mabuza
University of Limpopo (MEDUNSA Campus)
School of Health Care Sciences
Department Of Public Health
P. O. Box 215
MEDUNSA
0204

Dear Madam

Re: Granting of permission to carry a Research Study on the Perception of Nursing Personnel on Task Shifting and Decentralization of Health Care Services to the Primary level of Care in the Manzini Region Swaziland

The Manzini RHMT, through the Personnel Sub - Committee has carefully looked at your request to undertake the above clearly elaborated research study. I have been directed by the Personnel Sub - Committee on behalf of the RHMT to inform you that your request has been successful and therefore approved.

We wish you all the best as you carry on with the Research Study.

Yours Faithfully

Mlondolozi Dlamini
Regional Health Administrator
Annexure 4: Guide and Biographical Questions for Focus Group Discussion – English and Siswati:

Perceptions of Nurses on Task Shifting and Decentralization of Health Services to the Primary Level of Care in the Manzini Region, Swaziland

<table>
<thead>
<tr>
<th>PART I- ENGLISH</th>
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</table>
| 1. | What is your understanding of “taking health services to the people” or “decentralisation of health services” and “task shifting” mean to you? (Probe each separately)  
✓ Explain what you think happens with each of these phenomena |
| 2. | Do you think decentralisation and task shifting has resulted in the change in service provision within your facility?  
✓ What services were provided at your facility before these phenomena came about?  
✓ What services are provided at your facility now?  
✓ What are your opinions on this change? |
| 3. | As service provision has changed within your facility what has been your experience with this?  
✓ How has this impacted on you and your work?  
✓ How has this impacted on your care for your patients?  
✓ How has this made working at the primary level of care easy?  
✓ How has this made working at the primary level of care more difficult? |
| 4. | What do you think are the advantages of decentralisation and task shifting? |
| 5. | What do you think are the disadvantages of decentralisation and task shifting? |
| 6. | In your opinion what has gone well with decentralisation and task shifting? |
| 7. | In your opinion where do you feel could be improved? |
| 8. | Do you support decentralisation and task shifting? Explain |
### PART I- SISWATI

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1. Nakutsiwa “simikisa imisebenti kubantu” kuchazani loko kuwe noma kufikani engcondweni yakho?</td>
<td>✓ Ucabanga kutsi kwentiwani nakwentiwa loku?</td>
</tr>
<tr>
<td>4. Lokutsi kuya-decentralizwa neku task shiftwa ema-services, yini lokuhle ngako?</td>
<td></td>
</tr>
<tr>
<td>5. Lokutsi kuya-decentralizwa neku task shiftw ema-services, yini lokubi ngako?</td>
<td></td>
</tr>
<tr>
<td>6. Kulosekwentekile ngalokusondzetwa kwema-services kubantu, ngekubuka kwakho yini lokuhambe kahle ngako (kule-process)?</td>
<td></td>
</tr>
<tr>
<td>7. Ngekubuka kwenu nicabanga kutsi indzinga kulungiswa kuphi futsi le-process kute ibencono- nangabe iyandzinga kulungiswa?</td>
<td></td>
</tr>
<tr>
<td>8. Lokusondzeta ema-services kubantu kuyinto leniyisekelako yini? Chaza?</td>
<td></td>
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</table>
**PART II**

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1.</td>
<td>Sex of Participant?</td>
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<tr>
<td>2.</td>
<td>Marital status?</td>
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<tr>
<td>3.</td>
<td>What is your qualification?</td>
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<tr>
<td>4.</td>
<td>When did you qualify?</td>
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<td>5.</td>
<td>What is your title?</td>
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<tr>
<td>6.</td>
<td>Which clinic are you stationed at?</td>
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<td>7.</td>
<td>How many years have you been stationed at this clinic?</td>
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<tr>
<td>8.</td>
<td>Have you been stationed at any other place either than this clinic? If so describe.</td>
</tr>
<tr>
<td>9.</td>
<td>What position do you currently hold? How long have you held this position?</td>
</tr>
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</table>
UNIVERSITY OF LIMPOPO (Medunsas Campus)

ENGLISH INFORMED CONSENT FORM

TITLE OF STUDY:

THE PERCEPTIONS OF NURSES ON TASK SHIFTING AND DECENTRALIZATION OF HEALTH SERVICES TO THE PRIMARY LEVEL OF CARE IN THE MANZINI REGION, SWAZILAND

I …………………………………………(name) consent to participating in this study conducted by Sibongile N. Mabuza. The purpose of the study was explained. I have also read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue.

The aim and objectives of the study are sufficiently clear to me I have also been made aware that if I experience some discomfort due to any questions that might be asked during the discussion of the topic then I am free not to respond to these questions. I have also been made aware that this study is voluntary and that I am free to withdraw from participating in the study at any time without giving reason and with no penalty.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed. Reassurance was given that all data will be kept safe by the researcher and that no information will be released or published which bears my identity.

I know that this study has been approved by the Medunsa Research Ethics Committee.
(MREC), University of Limpopo (Medunsa Campus), the Ministry of Health in Swaziland and the Regional Health Management Team (Manzini). I am fully aware that the results of these results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby willingly give consent to participate in the research study.

........................................................................................................................................
Signature Date

........................................................................................................................................
Witness Date

____________________________________________________________________

Statement by the Researcher

I provided verbal and/or written Study

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

Sibongile N. Mabuza .............................. 10/10/2012  Manzini
Name of Researcher Signature Date Place
Sitatimende lesimaqondzana nekuba yincenye yelucwaningo

Ligama lolucwaningo

IMUVO YABONESI LABASEBENTA E-CLINIC NGEKUMIKISWA KWEMISEBENTI KUBANTFU.


Ngiyaqondza kutsi ngiyincenye lwalolucwaningo ngekutsandza kwami lokuphelele ngako ngingahocisa kulo nomalolukwanele kwakumayelana sizafo. Ngatisiwe kutsi kuyincwanele kwakumayelana ngakungahle kutyelunyane kwakukhuza.


Ngiyati kutsi lolucwaningo lugunyatwe yi-Medunsa Research Ethics Committee (MREC),

Lapha nginiketa imvume yekubayincenyelulucwaningo

........................................................................................................................................

Libito lalotibhandzakanisako i-signature walotibhandzakanisako.

........................................................................................................................................

Indawo. Lusuku. Fakazi

............................................................

Sitatimente salocwanikako

Ngichazile ngalolucwaningo ngemlomo kanye/noma ngalokubhaliwe. Ngiyavuma kuphendvula noma nguyphi imibuto esikhatsini lesitako maqondzana nalolucwaningo ngalolonkhe lwati lenginalo. Ngitogcina lesivumelwano sekuchuba lolucwaningo lesigunyatiwe

Sibongile N. Mabuza 10/10/2012 Manzini
Libito leMcwaningi i-signature Lusuku Indawo